Leapfrog Hospital Survey
Hard Copy

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Welcome to the 2020 Leapfrog Hospital Survey

https://leapfroggroup.org/hospital

Leapfrog's Response to COVID-19 and its Impact on the 2020 Leapfrog Hospital Survey

Leapfrog is deeply grateful to the hospitals that voluntarily report to the Leapfrog Hospital Survey. These hospitals demonstrate their commitment to putting patients first every day, year in and year out. That commitment has never been more important to Americans than it is now amid the COVID-19 crisis. To uphold our shared vision for quality, safety, and transparency, while allowing hospitals to devote their time to the urgent needs of the moment, Leapfrog is implementing several one-time-only changes to the 2020 Leapfrog Hospital Survey:

- **Hospitals may maintain their 2019 Survey Results in lieu of reporting to the 2020 Leapfrog Hospital Survey.** Hospitals that submitted a 2019 Leapfrog Hospital Survey may choose to maintain last year's Leapfrog Hospital Survey Results on our public reporting website. To select this option, no action is required. Hospitals that submitted a 2019 Leapfrog Hospital Survey will automatically have their 2019 Survey Results maintained on our public reporting website. These 2019 Survey Results will also automatically be used in the Fall 2020 Leapfrog Hospital Safety Grade.

For hospitals choosing to submit a 2020 Leapfrog Hospital Survey:

- **Many Survey deadlines have been extended.** All deadlines for the 2020 Leapfrog Hospital Survey can be viewed on the Deadlines page of the website.
- **Significant reductions to the submission requirements for the 2020 Leapfrog Hospital Survey.** Hospitals choosing to submit the 2020 Leapfrog Hospital Survey must complete the five sections of the Survey that constitute Leapfrog's minimum requirements for submission. Hospitals submitting the minimum required sections will **not** be scored or publicly reported as "Declined to Respond" for any additional Survey sections that are not submitted. Leapfrog will score and publicly report the remaining sections of the Survey as "Not Available," which will be described on our public reporting website as unavailable data due to the COVID-19 crisis. Hospitals are still encouraged to submit all applicable sections of the Survey.
- **Additional changes to measures on the 2020 Leapfrog Hospital Survey:**
  - The CPOE Evaluation Tool has been removed.
  - The reporting period for administering a culture of safety survey has been updated from 24 months to 36 months.
  - Only hospitals that scored as "Achieved the Standard" (or four out of four bars) or "Considerable Achievement" (or three out of four bars) on Hand Hygiene will have their results publicly reported.
- **Suspension of On-Site Data Verification**. As part of Leapfrog's standard protocols to ensure data accuracy, we will suspend On-Site Data Verification of 2020 Leapfrog Hospital Survey Results. All other verification protocols will continue.
- **One-on-One technical assistance calls with the Help Desk**. Help Desk Coordinators will be available to review 2019 Survey Results and discuss reporting options for 2020, in addition to answering any questions about these changes or addressing any other issues related to submitting the 2020 Leapfrog Hospital Survey. **To request a technical assistance call,** visit https://leapfroghelpdesk.zendesk and select "Technical Assistance Call" from the Leapfrog Hospital Survey related issues drop-down menu. Calls will be scheduled within 24 hours.

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Important Notes about the 2020 Survey

1. Leapfrog has made several one-time only changes to the Survey process as part of our COVID-19 response, including updating the Submission Deadline to **August 31** (previously June 30) and the Late Submission Deadline to **December 31** (previously November 30), delaying the public reporting of Survey Results until **September** (previously July), as well as removing the CPOE Evaluation Tool requirement for the 2020 Survey Cycle (see Note 5). Please review all changes on our website.

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

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

4. Leapfrog has updated the requirements for submitting a Leapfrog Hospital Survey. In order to submit a Survey via the Online Hospital Survey Tool, hospitals will be required to complete and affirm the following five sections: Section 1 Basic Hospital Information, Section 2 Medication Safety – CPOE, Section 4 Maternity Care, Section 5 ICU Physician Staffing, and Section 6 Patient Safety Practices.

5. Leapfrog has removed the CPOE Evaluation Tool requirement for adult and general hospitals for the 2020 Leapfrog Hospital Survey as part of our COVID-19 response. All hospitals will be scored based on their implementation status only and the CPOE Evaluation Tool will not be available. The CPOE Evaluation Tool will be required again for adult and general hospitals on the 2021 Leapfrog Hospital Survey.

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

7. Leapfrog Hospital Survey Results will be available on the Hospital Details Page and publicly reported on our new public reporting website beginning in **September**. After September, the Hospital Details Page and public reporting website will be refreshed monthly within the first five (5) business days of each month to reflect Surveys submitted or resubmitted between September 1 and December 31 and previously submitted Surveys that were corrected before January 31. Survey Results are frozen from February to July 25.

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

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

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

11. The Submission Deadline for the 2020 Leapfrog Hospital Survey is **August 31, 2020** and the Late Submission Deadline is **December 31, 2020**. Hospitals that do not submit a Survey before midnight Eastern Time on **December 31, 2020** will have to wait until the launch of the 2021 Leapfrog Hospital Survey on April 1, 2021.

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Overview of the 2020 Leapfrog Hospital Survey

The Leapfrog Hospital Survey is divided into ten sections. A description of each section is listed below. For a more detailed overview of the 2020 Leapfrog Hospital Survey, including a crosswalk of nationally endorsed measures and a description of how measures are publicly reported, visit the Survey Overview webpage.

Section #	Section Title	Brief Description
	Hospital Profile	The profile section includes questions about demographic and contact information. The profile section can be accessed and updated anytime throughout the year by logging into the Hospital Survey Dashboard with your hospital's security code.
1	**Basic Hospital Information**	Section 1 includes questions about your hospital's bed size, admissions, teaching status, and ICUs operated.
2	**Medication Safety - Computerized Physician Order Entry (CPOE)**	Section 2 includes questions about your hospital's use of CPOE to prevent medication ordering errors and adverse drug events.
3	**Adult and Pediatric Inpatient Surgery**	Section 3 includes questions about your hospital and surgeon volume for eight high-risk procedures and surgical appropriateness criteria to prevent unnecessary procedures. Three additional high-risk procedures have been added, but they will not be scored or publicly reported in 2020: total hip replacement, total knee replacement, and Norwood procedure.
4	**Maternity Care**	Section 4 includes questions about elective delivery, cesarean birth, episiotomy, newborn bilirubin screening, and DVT prophylaxis for women undergoing cesarean delivery. The section also includes questions about high-risk deliveries including volume, outcomes, and the administration of antenatal steroids.
5	**ICU Physician Staffing (IPS)**	Section 5 includes questions about the staffing structure of your hospital's pediatric and adult general medical and/or surgical ICUs and neuro ICUs.
6	**Patient Safety Practices**	Section 6 includes questions about your hospital's adherence to three National Quality Forum-endorsed Safe Practices and new practices for Hand Hygiene, which were first added to the Survey in 2019 and will be scored and publicly reported in 2020.
7	**Managing Serious Errors**	Section 7 includes questions about your hospital's response to Never Events. In addition, Leapfrog collects information via its NHSN Group about five healthcare-associated infections (CLABSI, CAUTI, MRSA, *C. Diff.*, and SSI: Colon) and antibiotic stewardship practices. Hospitals reporting on Section 7B Healthcare-Associated Infections and Section 7C Antibiotic Stewardship Practices are required to join Leapfrog's NHSN Group. Important information and deadlines are available on the Join NHSN Group webpage.
8	**Medication Safety**	Section 8 includes questions about additional processes your hospital has in place to prevent medication errors, including bar code

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Section #	Section Title	Brief Description
		medication administration and medication reconciliation. In 2020, a new subsection on opioid prescribing is also included. This subsection (8C) is optional and will not be scored or publicly reported in 2020.
9	**Pediatric Care**	Section 9 includes questions about patient experience (CAHPS Child Hospital Survey) and Computed Tomography (CT) radiation dose for pediatric patients.
10	**Outpatient Procedures**	Section 10 was new in 2019 and includes questions about same day procedures performed in hospital outpatient departments. This section will be scored and publicly reported by hospital in 2020.

Section 1 Basic Hospital Information, as well as Section 2 CPOE, Section 4 Maternity Care, Section 5 ICU Physician Staffing, and Section 6 Patient Safety Practices are required in order to submit a Survey via the Online Hospital Survey Tool. Hospitals are strongly urged to submit all sections of the Leapfrog Hospital Survey that are applicable to their facility.

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

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

In addition to the Survey questions, adult hospitals that indicate they have a CPOE system in at least one inpatient unit are asked to demonstrate, via a test, that the inpatient CPOE system can alert physicians to at least 60% of frequent serious medication errors known to cause harm to patients. However, Leapfrog has removed the CPOE Evaluation Tool requirement for adult and general hospitals for the 2020 Leapfrog Hospital Survey as part of our COVID-19 response. All hospitals will be scored based on their implementation status only and the CPOE Evaluation Tool will not be available. The CPOE Evaluation Tool will be required again for adult and general hospitals on the 2021 Leapfrog Hospital Survey.

Any changes made to the measure specifications after April 1 will be reflected in the hard copy of the Survey in the Reference Information sections under the "Change Summary" header (see Table of Contents). In addition, the updates to the specifications will be highlighted in yellow. If the changes are substantial, we will email the Primary Survey Contact your hospital indicated in the Hospital Profile section of the Survey. If the notification is sent before your hospital submits a 2020 Leapfrog Hospital Survey, the email will go to the Primary Survey Contact provided in the previous year's Survey.

The Leapfrog Group and its participating members are committed to presenting information that is as current as possible and therefore we allow hospitals to update and resubmit their Survey until the **December 31** Late Submission Deadline (updated from November 30, as part of Leapfrog's COVID-19 response). Please carefully review the reporting periods in each section before updating your Survey. Leapfrog Hospital Survey Results are updated monthly beginning in September (updated from July 25, as part of Leapfrog's COVID-19 response) on Leapfrog's public website. Hospitals are required to update the information in their Survey within 30 days of any change in status. We reserve the right to decertify information that is not current.

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Pre-Submission Checklist

Before you complete and submit the Survey via the Online Hospital Survey Tool, there are a number of steps every hospital should complete:

- ☐ **Visit the Survey website pages at** https://leapfroggroup.org/hospital**.**
- ☐ **Make sure you have a 16-digit security code**. If you don't, download a Security Code Request form. If your hospital is part of a multi-hospital healthcare system, you will need a separate security code for each individual hospital within the system. Please refer to Leapfrog's Multi-Campus Hospital Reporting Policy.
- ☐ **Download a hard copy of the Survey** on the Survey and CPOE Materials webpage. Read through the entire Survey document to ensure that you understand what information is required.
- ☐ **Review the reference information** in each section of the Survey document and **download other supporting materials**. These documents and tools contain information that you will need to accurately respond to the Survey questions.
- ☐ **Join Leapfrog's NHSN Group**. Adult and pediatric hospitals reporting on Section 7B Healthcare-Associated Infections and Section 7C Antibiotic Stewardship Practices are required to join Leapfrog's NHSN Group. More information, including important deadlines, is available on the Join NHSN Group webpage.
- ☐ **Identify individuals from your hospital to help you** gather the data you will need to complete the various sections of the Survey.
- ☐ **Complete a hard copy of the Survey before you log in to the Online Hospital Survey Tool**. This will expedite the online completion and help to avoid the Online Hospital Survey Tool from "timing out" after 20 minutes of idle time (a security precaution). Once all of the information has been collected and recorded in the hard copy of the Survey, the CEO or his/her designee can typically complete the Survey online in less than 60 minutes from the hard copy record. Please note, responses can only be submitted using the Online Hospital Survey Tool.
- ☐ **Download and review a copy of the Quick Start Guide** on the Get Started webpage. This document includes important instructions on how to navigate the Online Hospital Survey Tool.
- ☐ **Check Survey deadlines.** Carefully review Survey deadlines before you begin (Leapfrog has made updates for the 2020 Survey Cycle as part of our COVID-19 response). Ensure that you have enough time to collect the data, complete a hard copy of the Survey, and complete and submit via the Online Hospital Survey Tool. For hospitals reporting on Section 7B Healthcare-Associated Infections and Section 7C Antibiotic Stewardship Practices, make sure you have joined Leapfrog's NHSN Group by the appropriate deadline.
- ☐ **Download and review the 2020 Leapfrog Hospital Survey Scoring Algorithms.**
- ☐ **Review Leapfrog's policies and procedures regarding data accuracy**. Detailed information can be found on the Data Accuracy webpage.

Leapfrog Hospital Survey Binder
The Leapfrog Hospital Survey Binder was developed to assist hospitals that have been selected for On-Site Data Verification.

However, all hospitals can utilize the binder to assist in organizing the documentation used to complete the survey. Download a copy of the binder on the Survey and CPOE Materials webpage.

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Instructions for Submitting a Leapfrog Hospital Survey

Important Notes:

Note 1: Please carefully review these instructions and the Quick Start Guide before you begin.

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

1. Log into the Hospital Survey Dashboard using your 16-digit security code.
2. The first time you log into the 2020 Leapfrog Hospital Survey, you will need to complete and save your hospital's Profile. The Hospital Profile includes demographic and contact information. The Hospital Profile should be updated throughout the year if any information changes. **Failure to maintain current contact information could result in important, time-sensitive information being sent to the wrong person.**
3. Once the Hospital Profile has been completed and saved, you will be taken to the Hospital Survey Dashboard.
4. You can navigate to sections of the Online Hospital Survey Tool using the links on the Hospital Survey Dashboard. More information about navigating within the Online Hospital Survey Tool is available in the Quick Start Guide.
5. Answer questions in the applicable sections or update responses to previously submitted sections. The Online Hospital Survey Tool will automatically save your responses as you enter them. There is no 'save' button.
6. Once you have completed each section of the Online Hospital Survey Tool, you will need to return to the Hospital Survey Dashboard to affirm each section of the Survey. Please remember that if you are making updates, all updated sections must be re-affirmed.
7. Before you are able to select the "*submit affirmed sections*" button on the Hospital Survey Dashboard, you will need to "*check for data review warnings*." When you select the "*check for data review warnings*" button, the sections of your Survey that have been affirmed will be scanned for potential reporting errors. If any errors are identified, a data review warning message will be generated and will appear on the Hospital Survey Dashboard.
8. If any data review warnings are generated, you will still be able to submit your Survey. However, you will need to address the potential reporting errors identified during the scan or risk having related sections of your Survey decertified.
9. Once you have checked for data review warnings, you can select the "*submit affirmed sections*" button.
10. Use the "*Print Last Submitted Survey"* button on the Hospital Survey Dashboard to print a copy of your submitted Survey and review it for accuracy and completeness. Remember, sections that are not affirmed will not be submitted.
11. Review the 2020 Leapfrog Hospital Survey Scoring Algorithms to see how your Survey responses will be scored and publicly reported by Leapfrog.
12. Review your Survey Results on the Hospital Details Page or public reporting website. Generally, hospitals that submit by June 30 are able to preview their Survey Results on the Hospital Details Page beginning on July 12, before Leapfrog publicly reports Survey Results beginning on July 25. As part of Leapfrog's COVID-19 response, however, the Submission Deadline for the 2020 Leapfrog Hospital Survey is **August 31**, and Survey Results will be publicly reported **beginning in September**. After September, the Hospital Details Page and public reporting website will be refreshed monthly within the first five (5) business days of each month following your (re)submission.

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13. Leapfrog is committed to verifying the accuracy of Leapfrog Hospital Survey Results. Please review our data accuracy protocols on the Data Accuracy webpage.

14. Responses can be updated or corrected, and the Survey can be resubmitted at any point during the Survey Cycle (April 1 – December 31). Please remember that if you are making updates, all updated sections must be re-affirmed.

Verifying Submission

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

- **Check the Hospital Survey Dashboard:** Refer to the "Section Status" column on the Hospital Survey Dashboard. All submitted sections will be marked as "Submitted."
- **Check your email:** You will receive a survey submission confirmation email within five minutes of submitting a Survey. Please Note: This email will not specify what sections were submitted – you will need to use the other tips to determine which of the sections were submitted.
- **Print Last Submitted Survey:** The Survey submission date will be listed at the top of the page under the heading "Submitted Survey." Be sure to check the submission date, review each section for accuracy and completeness, and check that each affirmation is complete (Sections 1-10).
- **Review the Hospital Details Page:** Your Survey Results will be available in September (updated from July 12 as part of Leapfrog's COVID-19 response) via the Hospital Details Page link on the Hospital Survey Dashboard. Carefully review your results, including your NHSN information for applicable healthcare-associated infections and antibiotic stewardship practices.
- **Check your publicly reported results:** Always check your Leapfrog Hospital Survey Results on the public website. Results are posted within the first 5 business days of the month following your submission starting in September (updated from July 25 as part of Leapfrog's COVID-19 response.

Updating or Correcting a Previously Submitted Leapfrog Hospital Survey

Hospitals have the opportunity to update or correct previously submitted Survey responses at any point during the Survey Cycle (April 1 to December 31). Please review the Survey Deadlines webpage. Most updates or corrections are made:

- At the request of Leapfrog:
  - Following Leapfrog's Extensive Monthly Data Verification, the Primary Survey Contact, Secondary Survey Contact, and System Survey Contact will receive an email from the Help Desk detailing potential reporting errors
- Following On-Site Data Verification:
  - Hospitals selected for On-Site Data Verification will receive a findings report at the end of the scheduled visit which will indicate any responses that need to be updated or corrected. Please note that Leapfrog has suspended On-Site Data Verification of 2020 Leapfrog Hospital Survey Results as part of our COVID-19 response. All other verification protocols will continue.
- At the discretion of the hospital:
  - To correct a data entry or reporting error
  - To reflect a change in status or performance on a measure (e.g., closed a unit or stopped performing a procedure or implemented a new policy)
  - To provide more current responses based on reporting periods outlined in the hard copy of the Survey

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Updating a Survey after Receiving a Help Desk Email or Following On-Site Data Verification

Leapfrog conducts an Extensive Monthly Data Verification of responses submitted to the Leapfrog Hospital Survey starting with Surveys submitted by the August 31 Submission Deadline (updated from June 30, 2020 as part of Leapfrog's COVID-19 response) and monthly thereafter until the Online Survey Tool is taken offline on January 31. Following the Extensive Monthly Data Verification, the **Primary Survey Contact, Secondary Survey Contact, and the System Contact** are notified by email of any Survey responses that need to be reviewed and/or updated by the hospital.

If you receive a Data Verification email, you are required to document that your original responses were correct or update/correct your previously submitted Leapfrog Hospital Survey by the end of the month using the **original** reporting period that was used for that section of the Survey in the original submission. For example, if a hospital submitted a Survey for the first time on August 20, 2020 and then received a Data Verification email at the beginning of September, they would update their responses based on the reporting period used in the August 20, 2020 submission.

Hospitals that receive a Category A Data Verification message at the beginning of the month for any measure will have until the end of that same month to contact the Help Desk to either (1) document that the original response was correct or (2) correct the data entry or reporting error, or they will be publicly reported as "Pending Leapfrog Verification" for that measure. This term is used to indicate that the hospital has self-reported survey responses that are under further review by Leapfrog.

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

Hospitals that are selected for On-Site Data Verification will receive a findings report following the scheduled visit. If the findings report details any responses that need to be updated or corrected, please contact the Help Desk. Please note that Leapfrog has suspended On-Site Data Verification of 2020 Leapfrog Hospital Survey Results as part of our COVID-19 response. All other verification protocols will continue.

Making General Updates (for hospitals that have not received a Help Desk Email)

Leapfrog offers hospitals multiple reporting periods so that they have the opportunity to report the most current data. Updating a Survey is optional. However, we do recommend that if your performance or if a structure has changed significantly, you update your Survey within 30 days. In addition, hospitals should update their Surveys if they become aware of any reporting errors or data inaccuracies in their previous submission.

Hospitals may update one or more sections of the Survey, without updating the entire Survey.

General updates and corrections can be made at any point during the Survey Cycle (April 1 – December 31). The month of January is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the December 31 Late Submission Deadline. **Updates made to reflect a change in performance after December 31 will not be scored or publicly reported.**

Hospitals that are submitting general updates should:

- Use the stated reporting period at the top of each section selected based on the date of your resubmission.
- Update responses to ALL questions within the section they wish to update using the same reporting period. For example, if a hospital submitted a Survey for the first time in June and then wanted to update the responses for the Early Elective Deliveries questions in subsection 4B in

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November, they would update the entire Section 4 Maternity Care based on the updated reporting period for November.

For information on Leapfrog's automatic updates to Section 7B Healthcare-Associated Infections and Section 7C Antibiotic Stewardship Practices, please review the Join NHSN Group webpage.

Quick Tip: Remember to re-affirm any section of the Survey that has been updated, and then resubmit the Survey. Print a copy of your Last Submitted Survey and review it for accuracy and completeness. Check your updated Survey Results within the first 5 business days of the month following your resubmission on the public website.

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Deadlines

Deadlines for the 2020 Leapfrog Hospital Survey

Please note that Leapfrog has made updates to the deadlines for the 2020 Survey Cycle as part of our COVID-19 response. The 2020 Leapfrog Hospital Survey opens on April 1 and has a Submission Deadline of **August 31, 2020**. The Late Submission Deadline is **December 31, 2020**. Surveys must be submitted before midnight Eastern Time on **December 31**. The CPOE Evaluation Tool will not be available for the 2020 Leapfrog Hospital Survey.

Corrections to Surveys submitted by **December 31** must be submitted by the **January 31, 2020** Correction Deadline. The Online Hospital Survey Tool will not be available after **January 31**. Find detailed information about the 2020 Leapfrog Hospital Survey Deadlines, including deadlines for receiving free Competitive Benchmarking Summary Reports and consideration for Top Hospital Awards on the Deadlines webpage.

Deadlines to Join Leapfrog's NHSN Group

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

Deadlines Related to the Hospital Safety Grade

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

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Technical Assistance

Help Desk

Leapfrog operates an online Help Desk to provide hospitals with technical assistance and answers to content-related Survey questions. The Help Desk is staffed Monday-Friday from 9:00 am to 5:00 pm ET. Help Desk support staff typically respond to inquiries within 1-2 business days (See Help Desk Holiday Schedule), but we do ask that hospitals plan ahead and allow ample time to fulfill security code requests and other urgent tickets before Survey deadlines.

Hospitals can also submit feedback regarding the questions, measure specifications, and FAQs to the Help Desk.

To review the Help Desk holiday schedule, visit the Get Help webpage.

Tickets can be submitted electronically at https://leapfroghelpdesk.zendesk.com. You will receive a confirmation email and response from support@leapfroghelpdesk.zendesk.com. **To ensure that you receive our emails, please work with your IT Team to:**

1) Add the @leapfrog-group.org and @leapfroghelpdesk.zendesk.com domains to your email's safe sender list
2) Whitelist the following IP addresses (these are the IP addresses for our database that other emails are sent from):
    i. 67.212.170.242
    ii. 67.212.170.243
    iii. 67.212.170.244

Leapfrog Hospital Survey Users Group

Leapfrog hosts a monthly Hospital Survey Users Group. For an annual fee of $250 per user, hospitals will have access to all User Group benefits for one Survey Cycle (March – December). Hospitals that join the Users Group will have access to:

- Topical monthly technical assistance calls
    - Topics will include changes to Leapfrog's Online Hospital Survey Tool, changes to scoring algorithms, overview of new measures, utilizing Leapfrog results in your market, etc.
    - Every call will include 20 minutes for Q&A
- Special webinars and presentations regarding Leapfrog standards
- Presentations by Leapfrog's Expert Panel Members

For more information and to register, please visit the Users Group webpage.

Hospitals that choose not to join the Users Group will still have access to the Help Desk for free. The Hospital Survey Users Group is designed for hospitals that would like additional support in understanding the Survey and the scored results.

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Reporting Periods

Important Note: Reporting periods should be updated based on the date of Survey or section submission.

	Survey Submitted Prior to September 1	Survey (Re)Submitted On or After September 1
Survey Section/ Measure	**Reporting Period**	**Reporting Period**
1 Basic Hospital Information	12 months ending 12/31/2019	Optional - 12 months ending 06/30/2020
2 Medication Safety - Computerized Physician Order Entry (CPOE)	Latest 3 months prior to Survey submission	Latest 3 months prior to Survey submission
3A Hospital and Surgeon Volume	Volume: 12 months or 24 months ending 12/31/2019	Volume: Optional - 12 months or 24 months ending 06/30/2020
	STS MVRR Composite: Latest 36-month report	STS MVRR Composite: Latest 36-month report
3B Surgical Appropriateness	Latest 12 months prior to Survey submission	Latest 12 months prior to Survey submission
4A Maternity Care Volume	12 months ending 12/31/2019	Optional - 12 months ending 06/30/2020
4B Elective Deliveries	12 months ending 12/31/2019	Optional - 12 months ending 06/30/2020
4C Cesarean Birth	12 months ending 12/31/2019	Optional - 12 months ending 06/30/2020
4D Episiotomy	12 months ending 12/31/2019	Optional - 12 months ending 06/30/2020
4E Process Measures of Quality	12 months ending 12/31/2019	Optional - 12 months ending 06/30/2020
4F High-Risk Deliveries	Volume: 12 months ending 12/31/2019	Volume: Optional - 12 months ending 06/30/2020
	VON: 2018 report	VON: 2019 report
	Antenatal Steroids: 12 months ending 12/31/2019	Antenatal Steroids: Optional - 12 months ending 06/30/2020
5 ICU Physician Staffing	Latest 3 months prior to Survey submission	Latest 3 months prior to Survey submission
6A Practice #1 – Culture of Safety Leadership Structures and Systems	Latest 12 months prior to Survey submission	Latest 12 months prior to Survey submission
6B Practice #2 – Culture Measurement, Feedback, and Intervention	Latest 24 or 36 months prior to Survey submission (see individual safe practice for specific reporting period)	Latest 24 or 36 months prior to Survey submission (see individual safe practice for specific reporting period)
6C Practice #9 – Nursing Workforce	Latest 12 months prior to Survey submission	Latest 12 months prior to Survey submission
6D Hand Hygiene	N/A	N/A
7A Never Events Policy	N/A	N/A

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	Survey Submitted Prior to September 1	Survey (Re)Submitted On or After September 1
Survey Section/ Measure	**Reporting Period**	**Reporting Period**
7B Healthcare-Associated Infections	12 months ending 12/31/2019*	12 months ending 12/31/2019*
7C Antibiotic Stewardship Practices	2019 NHSN Annual Survey	2019 NHSN Annual Survey
8A Bar Code Medication Administration (BCMA)	Latest 3 months prior to Survey submission	Latest 3 months prior to Survey submission
8B Medication Reconciliation	Latest 3 months or 6 months prior to survey submission	Latest 3 months or 6 months prior to survey submission
8C Opioid Prescribing	N/A	N/A
9A CAHPS Child Hospital Survey	Latest 12 months prior to Survey submission	Latest 12 months prior to Survey submission
9B Pediatric Computed Tomography (CT) Radiation Dose	12 months ending 12/31/2019	Optional - 12 months ending 06/30/2020
10A Basic Outpatient Department Information	12 months ending 12/31/2019	Optional - 12 months ending 06/30/2020
10B Medical, Surgical, and Clinical Staff	Latest 3 months prior to Survey submission	Latest 3 months prior to Survey submission
10C Volume of Procedures	12 months ending 12/31/2019	Optional -12 months ending 06/30/2020
10D Safety of Procedures	Patient Follow-up: Latest 3 months prior to Survey submission	Patient Follow-up: Latest 3 months prior to Survey submission
	Patient Selection and Consent to Treat: N/A	Patient Selection and Consent to Treat: N/A
	Safe Surgery Checklist: Latest 3 months prior to Survey submission	Safe Surgery Checklist: Latest 3 months prior to Survey submission
10E Medication Safety for Outpatient Procedures	12 months ending 12/31/2019	Optional - 12 months ending 06/30/2020
10F Patient Experience (OAS CAHPS)	Latest 12 months prior to Survey submission	Latest 12 months prior to Survey submission

*Adult and pediatric hospitals reporting on Section 7B Healthcare-Associated Infections and Section 7C Antibiotic Stewardship Practices are required to join Leapfrog's NHSN Group. More information, including important deadlines, is available on the Join NHSN Group webpage.

Leapfrog will update data 4 times per Survey Cycle for all members of our NHSN group that have provided an accurate NHSN ID in the Profile and submitted Section 7: Managing Serious Errors.

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HOSPITAL PROFILE

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

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Hospital Profile

The Hospital Profile asks you to provide certain demographic and contact information. The Hospital Profile can be accessed and updated anytime throughout the year by logging into the Hospital Survey Dashboard with your hospital's security code.

The Hospital Profile must be completed and submitted before you can access Sections 1-10 in the Online Hospital Survey Tool.

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Hospital Profile

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

Important Notes:

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

Note 2: The Primary Survey Contact, Secondary Survey Contact, and System Contact will be notified at the beginning of each month if Leapfrog finds any error in your Survey that needs to be corrected.

Facility Information

Organization Name	**CMS Certification Number (CCN)**[1] If the CCN displayed in the Online Hospital Survey Tool is not correct, contact the Leapfrog Help Desk immediately.
	Does your hospital share this CCN with another facility?
	☐ Yes ☐ No
	NHSN ID[2]
	Federal Tax Identification Number (TIN)[3]
	National Provider Identifier (NPI)[4] If the NPI displayed in the Online Hospital Survey Tool is not correct, contact the Leapfrog Help Desk immediately.
	Does your hospital share this NPI with another facility?
	☐ Yes ☐ No

Demographic Information

Physical Address (used for public reporting)	**Mailing Address** (used to send important communications)
Street Address	**Street Address or P.O. Box**
City	**City**
State[5]	**State**
Zip Code	**Zip Code**
Zip Code Suffix	**Zip Code Suffix**
Main Phone Number	
Hospital Website Address[6] (So consumers can learn more about your hospital's efforts in the area of patient safety and quality improvement)	

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Contact Information

Chief Executive Officer (CEO)	**Chairperson of the Board**
First Name	**First Name**
Last Name	**Last Name**
Email Address (required for emailing of security codes and Top Hospital notification)	

Primary Survey Contact	**Secondary Survey Contact**
First Name	**First Name**
Last Name	**Last Name**
Title	**Title**
Phone Number	**Phone Number**
Phone Number Extension	**Phone Number Extension**
Email Address	**Email Address**

Hospital Public Relations Contact (required so that Leapfrog may provide information on Leapfrog accolades, such as Top Hospital notification, and announcements)
First Name
Last Name
Phone Number
Phone Number Extension
Email Address

Opt-Out Opt-out of having information in the "Contact Information" subsection shared with third parties.	☐ Opt-out

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Health System Information	
Is this hospital part of a healthcare system or Integrated Delivery Network[7]?	**System Public Relations Contact First Name**
☐ Yes ☐ No If yes, provide contact information.	
Name of the healthcare system or Integrated Delivery Network	**System Public Relations Contact Last Name**
System Contact First Name	**System Public Relations Contact Phone Number**
System Contact Last Name	**System Public Relations Contact Phone Number Extension**
System Contact Email Address	**System Public Relations Contact Email Address**
Additional Contact Information Please provide the email address for your hospital's general inbox (e.g., info@hospital.com). This will be used on the Leapfrog Hospital Survey Results website for patients and consumers to provide feedback directly to your hospital.	

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SECTION 1: BASIC HOSPITAL INFORMATION

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

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Section 1: 2020 Basic Hospital Information

Section 1 includes questions about your hospital's bed size, admissions, teaching status, and ICUs operated.

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1: Basic Hospital Information

Specifications: See ***Basic Hospital Information Specifications*** in the Reference Information on page 33.

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

Reporting Time Period: 12 months

- 01/01/2019 – 12/31/2019
- Optional - Surveys (re)submitted on or after September 1: 07/01/2019 – 06/30/2020

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

1)	Reporting time period used:	☐ 01/01/2019 – 12/31/2019 ☐ 07/01/2019 – 06/30/2020
2)	Total number of licensed acute-care[8] beds.	_____
3)	Total number of staffed acute-care[9] beds.	_____
4)	Total number of adult acute-care admissions[10] to your hospital during the reporting period.	_____
5)	Total number of pediatric acute-care admissions[11] to your hospital during the reporting period.	_____
6)	Does your hospital operate any adult or pediatric general medical and/or surgical or neuro ICUs? *If "no" to question #6, skip questions #7-9 and continue on to question #10.*	*Yes* *No*
7)	Total number of licensed ICU[12] beds in adult and pediatric general medical/surgical ICU(s) and neuro ICU(s).	_____
8)	Total number of staffed ICU[13] beds in adult and pediatric general medical/surgical ICU(s) and neuro ICU(s).	_____
9)	Total number of admissions to adult and pediatric general medical/surgical ICUs and neuro ICUs[14] during the reporting period.	_____
10)	Does your hospital operate any of the following specialty ICUs: medical cardiac, respiratory, surgical cardiothoracic, burn, trauma, pediatric cardiothoracic, oncology, or any level neonatal ICU? *If "no" to question #10, skip question #11 and continue on to question #12.*	*Yes* *No*
11)	Total number of admissions to any level neonatal ICU[15] during the reporting period.	_____
12)	Is your hospital a Major or Graduate teaching hospital for physicians and/or physicians-in-training?	*No response required here. Determined automatically based on NHSN 2019 Patient Safety Component – Annual Hospital Survey.*

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Affirmation of Accuracy

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

The hospital and I understand that The Leapfrog Group, its members, the public and entities and persons who contract or have other business dealings with The Leapfrog Group are relying on the truth and accuracy of this information. The hospital and I also understand that The Leapfrog Group will make this information and/or analyses of this information public through the Survey Results public reporting website, The Leapfrog Group's Hospital Safety Grade, and/or other Leapfrog Group products and services. This information and/or analyses and all intellectual property rights therein shall be and remain the sole and exclusive property of The Leapfrog Group in which The Leapfrog Group retains exclusive ownership. This information does not infringe upon any third-party intellectual property rights or any other third-party rights whatsoever and is free and clear of all encumbrances and liens of any kind. The hospital and I acknowledge that The Leapfrog Group may use this information in a commercial manner for profit. The hospital shall be liable for and shall hold harmless and indemnify The Leapfrog Group from any and all damages, demands, costs, or causes of action resulting from any inaccuracies in the information or any misrepresentations in this Affirmation of Accuracy. The Leapfrog Group and its members and entities and persons who contract or have other business dealings with The Leapfrog Group reserve the right to omit or disclaim information that is not current, accurate or truthful.

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

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Section 1: 2020 Basic Hospital Reference Information

What's New in the 2020 Survey

There are no substantive changes to this section. Leapfrog will continue to obtain information on teaching status directly from the CDC's National Healthcare Safety Network (NHSN) Patient Safety Component – Annual Hospital Survey. Find instructions on how to join Leapfrog's NHSN Group and deadlines for the 2020 Survey at http://www.leapfroggroup.org/survey-materials/join-nhsn. Please note that NHSN deadlines have been updated to reflect the December 31 Late Submission Deadline (updated from November 30 as part of Leapfrog's COVID-19 response).

Change Summary since Release

None. If substantive changes are made to this section of the Survey after release on April 1, 2020, they will be documented in this Change Summary section.

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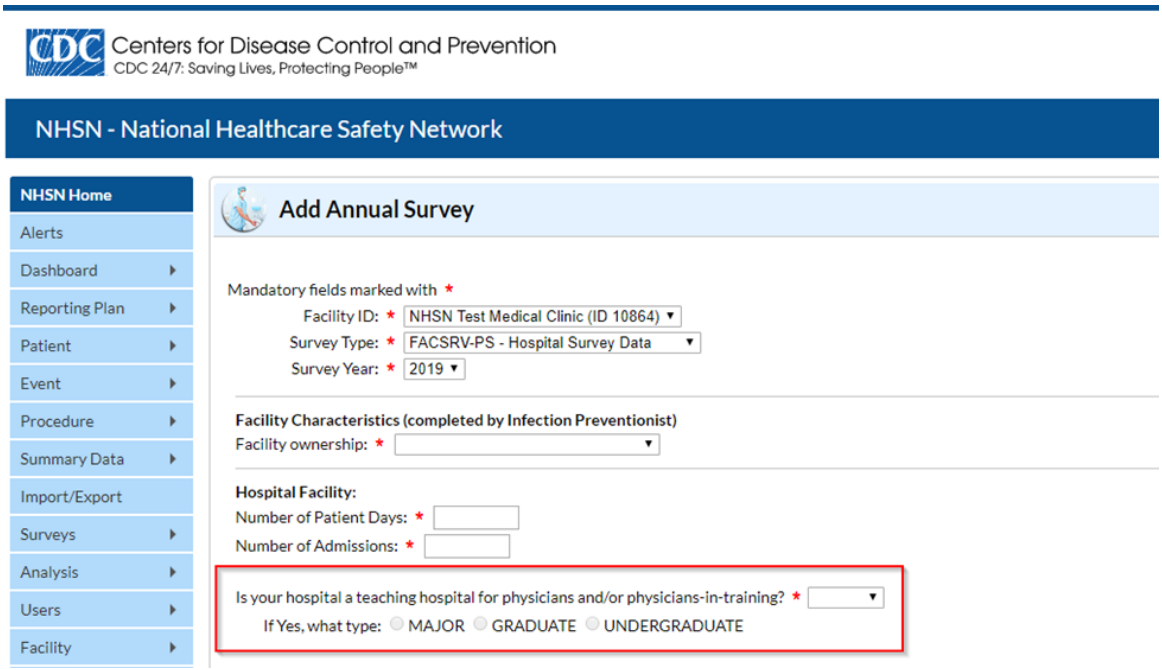
Section 1: Basic Hospital Information Specifications

Important Notes:

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

Teaching Status is obtained directly from CDC's National Healthcare Safety Network (NHSN) using a hospital's response to the following questions within the "Hospital Facility" section of the 2019 Patient Safety Component – Annual Hospital Survey:

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



For the purposes of the 2020 Leapfrog Hospital Survey and Leapfrog's Top Hospital program, Leapfrog will consider the following types a "teaching hospital": Major and Graduate. NHSN's definitions for types of teaching hospitals may be reviewed here.

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

1. Join* Leapfrog's NHSN Group by the published deadlines,
2. Provide an accurate NHSN ID in the Profile section of the Online Hospital Survey Tool, and
3. Submit Section 7: Managing Serious Errors.

*Hospitals are not required to "re-join" Leapfrog's NHSN Group if they joined and conferred rights for the 2017, 2018, or 2019 Leapfrog Hospital Survey. However, all hospitals in Leapfrog's NHSN Group must review their Rights Acceptance Report at least annually by **August 20, 2020**.

Instructions for joining or verifying that you are in Leapfrog's NHSN Group are available here (See "Join NHSN Group and Data Rights Template").

Hospitals can view their teaching status response to the 2019 Patient Safety Component – Annual Hospital Survey by following the instructions provided here (See "Downloading Reports from NHSN to Verify Data").

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

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

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Section 2: 2020 Medication Safety - Computerized Physician Order Entry (CPOE)

CPOE Fact Sheet: http://www.leapfroggroup.org/ratings-reports/computerized-physician-order-entry

Leapfrog has removed the CPOE Evaluation Tool requirement for adult and general hospitals for the 2020 Leapfrog Hospital Survey as part of our response to COVID-19. The Pediatric Inpatient CPOE Evaluation Tool will continue to be unavailable. All hospitals should complete questions #1-4 only.

In 2020, all hospitals will be scored based on their implementation status only and the CPOE Evaluation Tool will not be available. The CPOE Evaluation Tool will be required again for adult and general hospitals on the 2021 Leapfrog Hospital Survey.

Section 2 includes questions about your hospital's use of CPOE to prevent medication ordering errors and adverse drug events.

Each hospital achieving the standard for Computerized Physician Order Entry:
Assures that prescribers* enter at least 85% of inpatient medication orders via a computer system that includes decision support software to reduce prescribing errors.

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

Download the 2020 Leapfrog Hospital Survey Scoring Algorithm on the Scoring and Results webpage.

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2: Medication Safety - Computerized Physician Order Entry (CPOE)

Specifications: See ***CPOE Measure Specifications*** in the Reference Information on pages 40-41.

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

Reporting Time Period: 3 months
Answer questions #1-4 for the latest 3-month period prior to the submission of this section of the Survey.

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

1) What is the latest 3-month reporting period for which your hospital is submitting responses to this section? 3-month reporting time period ending:	*Format: MM/YYYY*
2) Does your hospital have a functioning CPOE system in one or more inpatient units of the hospital that: • includes decision support software to reduce prescribing errors; and, • is linked[16] to pharmacy, laboratory, and admitting-discharge-transfer (ADT) information in your hospital? *If "no" to question #2, skip the remaining questions in Section 2, and go to the Affirmation of Accuracy.*	*Yes* *No*
3) Total number of **inpatient medication orders**, including orders made in units that do NOT have a functioning CPOE system. (*See CPOE Measure Specifications*)	*Format: Whole numbers only*
4) Total number of **inpatient medication orders** in question #3 that licensed prescribers entered via a CPOE system that meets the criteria outlined in question #2. (*See CPOE Measure Specifications*)	*Format: Whole numbers only*
5) What was your hospital's score when it tested its CPOE system using the Leapfrog CPOE Evaluation Tool? *Please note: Leapfrog has removed the CPOE Evaluation Tool requirement for adult and general hospitals for the 2020 Leapfrog Hospital Survey. All hospitals will be scored based on their implementation status only and the CPOE Evaluation Tool will not be available. The CPOE Evaluation Tool will be required again on the 2021 Leapfrog Hospital Survey.*	*No response required here.*

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Affirmation of Accuracy

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

The hospital and I understand that The Leapfrog Group, its members, the public and entities and persons who contract or have other business dealings with The Leapfrog Group are relying on the truth and accuracy of this information. The hospital and I also understand that The Leapfrog Group will make this information and/or analyses of this information public through the Survey Results public reporting website, The Leapfrog Group's Hospital Safety Grade, and/or other Leapfrog Group products and services. This information and/or analyses and all intellectual property rights therein shall be and remain the sole and exclusive property of The Leapfrog Group in which The Leapfrog Group retains exclusive ownership. This information does not infringe upon any third-party intellectual property rights or any other third-party rights whatsoever and is free and clear of all encumbrances and liens of any kind. The hospital and I acknowledge that The Leapfrog Group may use this information in a commercial manner for profit. The hospital shall be liable for and shall hold harmless and indemnify The Leapfrog Group from any and all damages, demands, costs, or causes of action resulting from any inaccuracies in the information or any misrepresentations in this Affirmation of Accuracy. The Leapfrog Group and its members and entities and persons who contract or have other business dealings with The Leapfrog Group reserve the right to omit or disclaim information that is not current, accurate or truthful.

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

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Section 2: 2020 Medication Safety - Computerized Physician Order Entry Reference Information

Leapfrog has removed the CPOE Evaluation Tool requirement for adult and general hospitals for the 2020 Leapfrog Hospital Survey as part of our response to COVID-19. The Pediatric Inpatient CPOE Evaluation Tool will continue to be unavailable. All hospitals should complete questions #1-4 only.

What's New in the 2020 Survey

Leapfrog has further refined the measure specifications for question #4 (total number of inpatient medication orders included in question #3 that were entered via a qualified CPOE system) to clarify the types of orders which should be included.

As noted above, Leapfrog has removed the CPOE Evaluation Tool requirement for adult and general hospitals as part of our response to COVID-19. In 2020, all hospitals will be scored based on their implementation status only and the CPOE Evaluation Tool will not available. The CPOE Evaluation Tool will be required again for adult and general hospitals on the 2021 Leapfrog Hospital Survey.

Change Summary since Release

None. If substantive changes are made to this section of the Survey after release on April 1, 2020, they will be documented in this Change Summary section.

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Medication Safety - Computerized Physician Order Entry (CPOE) Measure Specifications

Important Notes:

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

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

Reporting Time Period: 3 months
Report on the latest 3-month period prior to the submission of this section of the Survey.

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

Include:

- Medications ordered for any patient with an inpatient status, including those with an inpatient status who may be in an outpatient unit during an overflow situation.
- Medications ordered for any neonatal ICU patient.
- Medications ordered by **any individual**, including nurses and pharmacists.
- Medications ordered electronically, verbally, or via paper.

Exclude:

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

Question 4 (numerator): The number of medication orders in question # 3 (above) that **licensed prescribers** entered via a CPOE system that includes decision support software to reduce prescribing errors and is linked[16] to pharmacy, laboratory, and admitting-discharge-transfer (ADT) information in your hospital.

Include:

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

Exclude:

**continued on next page*

- Medications ordered verbally or via paper.

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

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

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CPOE Frequently Asked Questions (FAQs)

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

2. **My hospital transitioned to a new CPOE system and we have not been on the new system for a full 3 months. How should we respond to Section 2?**
   When responding to questions #3 and #4 in Section 2, hospitals can combine data from their old CPOE system with their new CPOE system in order to have three full months of data.

3. **Can we report the numerator and denominator from our Stage 2 Meaningful Use Reports?**
   No. Hospitals should refer to the measure specifications on pages 40-41.

4. **Should we include medications ordered verbally during a rapid response by a rapid response team in the denominator (question #3)?**
   Yes. Verbal medication orders entered during a rapid response should be counted in the denominator (question #3). A rapid response is used for the prevention of serious injury, cardiac arrest, and respiratory arrest, while a 'code blue' is called for a person who has stopped breathing or who does not have a heart rate. Medications ordered verbally during a 'code blue' should be excluded from question #3.

5. **Should we include medications ordered verbally or via paper during system downtime in the denominator (question #3)?**
   Yes. Medication orders entered during system downtime should be counted in the denominator (question #3) but excluded from the numerator (question #4).

6. **What is an example of a per protocol order?**
   Some examples are vancomycin, dosing per protocol, heparin drip per protocol, etc. In these situations, the medical staff was asked to approve the (usually) evidence-based guidance in the protocol in advance of its use, usually through a review and recommendation of the P&T committee to the MEC, and then once approved, whenever indicated for a particular patient a licensed prescriber is required to order the protocol prior to the protocol being acted on (by pharmacy, nursing, radiology, respiratory therapy, etc.). These orders should be included in the numerator (question #4).

7. **What are some examples of standing orders?**
   Classic examples might include influenza vaccine, pneumonia vaccine, hepatitis B vaccine, or erythromycin eye ointment. Standing orders are usually rare, limited use situations. These orders should be included in the numerator (question #4).

8. **When should we take the CPOE Evaluation Tool?**
   The CPOE Evaluation Tool is a core element of Leapfrog's CPOE Standard. However, Leapfrog has removed the CPOE Evaluation Tool requirement for adult and general hospitals for the 2020 Leapfrog Hospital Survey as part of our COVID-19 response. All hospitals will be scored based on their implementation status only and the CPOE Evaluation Tool will not be available. The CPOE Evaluation Tool will be required again for adult and general hospitals on the 2021 Leapfrog Hospital Survey.

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SECTION 3: ADULT AND PEDIATRIC INPATIENT SURGERY

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

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Section 3: 2020 Adult and Pediatric Inpatient Surgery

Inpatient Surgery Fact Sheet: http://www.leapfroggroup.org/ratings-reports/inpatient-surgery

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

Section 3 includes questions about your hospital and surgeon volume for eleven high-risk procedures and surgical outcomes for select high-risk procedures, as well as surgical appropriateness criteria to prevent unnecessary procedures.

New questions regarding surgical outcomes will not be used in scoring or public reporting in 2020.

Questions regarding the three new procedures (total knee replacement, total hip replacement, and Norwood procedures) will also not be scored or publicly reported in 2020.

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

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

Download the 2020 Leapfrog Hospital Survey Scoring Algorithm on the Scoring and Results webpage.

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3A: Hospital and Surgeon Volume

Important Notes:

Note 1: Section 3 is applicable to both Adult and Pediatric Hospitals. Adult and Pediatric Hospitals that do not electively perform the high-risk procedures included in Section 3A should select "None of the above" in question #2 and move on to the Affirmation of Accuracy. Your hospital's results will be displayed as "Does Not Apply" on Leapfrog's public reporting website.

Note 2: Information on total knee replacement, total hip replacement, and Norwood procedure will not be scored or publicly reported in 2020.

Specifications: See ***Hospital and Surgeon Volume*** in the Adult and Pediatric Inpatient Surgery Reference Information on pages 55-90.

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

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

- 01/01/2019 - 12/31/2019 (12-month count) or 01/01/2018 – 12/31/2019 (24-month annual average)
- Optional - Surveys (re)submitted on or after September 1: 07/01/2019 - 06/30/2020 (12-month count) or 07/01/2018 – 06/30/2020 (24-month annual average)

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

1) 12-month or 24-month reporting time period used:	☐ 01/01/2019 – 12/31/2019 (12-month count) ☐ 01/01/2018 – 12/31/2019 (24-month annual average) ☐ 07/01/2019 – 06/30/2020 (12-month count) ☐ 07/01/2018 – 06/30/2020 (24-month annual average)
2) Check all procedures that your hospital performs electively as defined in the Adult and Pediatric Inpatient Surgery Reference Information. *Do not check the box for a procedure if your hospital does not electively perform the procedure, or ONLY does so when a patient is too unstable for safe transfer, or ONLY does so when a procedure is urgent.* *If "none of the above," skip the remaining questions in Section 3A and 3B and go to the Affirmation of Accuracy. The hospital will be scored as "Does Not Apply."*	☐ Carotid endarterectomy ☐ Mitral valve repair and replacement ☐ Open aortic procedures ☐ Lung resection for cancer ☐ Esophageal resection for cancer ☐ Pancreatic resection for cancer ☐ Rectal cancer surgery ☐ Bariatric surgery for weight loss ☐ Total knee replacement ☐ Total hip replacement ☐ Norwood procedure ☐ None of the above

3) To help ensure that patients are cared for by adequately trained physicians, are **those physicians** who are authorized to perform the high-risk procedures selected in question #2 at your hospital board certified or board eligible:	*All are board certified or board eligible (100%)* *Most are board certified or board eligible (>=75%)* *Some are board certified or board eligible (>=50%)* *Few are board certified or board eligible (< 50%)* *None are board certified or board eligible*
4) To help ensure that patients are cared for by adequately trained anesthesiologists and/or certified registered nurse anesthetists, are **those providing anesthesia** for the high-risk procedures selected in question #2 at your hospital board certified or board eligible:	*All are board certified or board eligible (100%)* *Most are board certified or board eligible (>=75%)* *Some are board certified or board eligible (>=50%)* *Few are board certified or board eligible (<50%)* *None are board certified or board eligible*

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

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

Procedure	*Total hospital volume (12-month count or 24-month annual average)* *Format: Up to one decimal place (e.g., 10.5)*
Carotid endarterectomy	
Mitral valve repair and replacement	
Open aortic procedures	
Lung resection for cancer	
Esophageal resection for cancer	
Pancreatic resection for cancer	
Rectal cancer surgery	
Bariatric surgery for weight loss	
Total knee replacement	
Total hip replacement	
Norwood procedure	

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6) Does your hospital's privileging process include the surgeon meeting or exceeding the minimum surgeon volume standard listed below?		
Procedure	*Surgeon Volume Standard*	
Carotid endarterectomy	*10*	*Yes* *No* *Plan to implement within 12 months*
Mitral valve repair and replacement	*20*	*Yes* *No* *Plan to implement within 12 months*
Open aortic procedures	*7*	*Yes* *No* *Plan to implement within 12 months*
Lung resection for cancer	*15*	*Yes* *No* *Plan to implement within 12 months*
Esophageal resection for cancer	*7*	*Yes* *No* *Plan to implement within 12 months*
Pancreatic resection for cancer	*10*	*Yes* *No* *Plan to implement within 12 months*
Rectal cancer surgery	*6*	*Yes* *No* *Plan to implement within 12 months*
Bariatric surgery for weight loss	*20*	*Yes* *No* *Plan to implement within 12 months*
Total knee replacement	*25*	*Yes* *No* *Plan to implement within 12 months*
Total hip replacement	*25*	*Yes* *No* *Plan to implement within 12 months*
Norwood procedure	*5*	*Yes* *No* *Plan to implement within 12 months*

If your hospital electively performs mitral valve repair and replacement (selected the checkbox in question #2), continue on to question #7. Otherwise, skip questions #7-10 and continue on to the next subsection.

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

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

7) Does your hospital participate in the Society of Thoracic Surgeons (STS) Adult Cardiac Surgery Database (ACSD) and did your hospital submit data for all applicable procedures during the most recent 36-month period for which performance reports are available? *If "no" to question #7, skip questions #8-10 and continue on to the next subsection.*	*Yes* *No*
8) What is the most recent 36-month reporting time period for which STS performance reports are available?	_____ *Format: MM/YYYY*
9) Does your hospital choose to report data from the most recent performance report to this Survey? *If "no" or "yes, but did not meet the Data Completeness Requirement during the reporting period," skip question #10 and continue on to the next subsection.*	*Yes* *No* *Yes, but did not meet the Data Completeness Requirement during the reporting period*
10) What are your hospital's Mitral Valve Repair/Replacement results?	
a) Mitral Valve Repair/Replacement Composite Score	*1 star – lower-than-expected performance* *2 stars – as-expected performance* *3 stars – higher-than-expected performance*
b) Absence of Operative Mortality	*1 star – lower-than-expected performance* *2 stars – as-expected performance* *3 stars – higher-than-expected performance*
c) Absence of Major Morbidity	*1 star – lower-than-expected performance* *2 stars – as-expected performance* *3 stars – higher-than-expected performance*

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3B: Surgical Appropriateness

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

Reporting Time Period: Answer questions #1-6 for the latest 12-month period prior to the submission of this section of the Survey.

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

1) Does your hospital have appropriateness criteria[17] for any of the following procedures: *If your hospital does not electively perform any of the procedures listed in this question (did not select them in Section 3A question #2), select "none of the above."* *If "none of the above," skip questions #1b-5 and continue on to question #6.*	☐ Carotid endarterectomy ☐ Mitral valve repair and replacement ☐ Open aortic procedures ☐ Bariatric surgery for weight loss ☐ Total knee replacement ☐ Total hip replacement ☐ None of the above
1b) Did your hospital do any of the following in developing the appropriateness criteria:	☐ Use the latest evidence and clinical guidelines ☐ Solicit input from employed surgeons, and if applicable, non-employed surgeons ☐ Incorporate relevant Choosing Wisely lists ☐ Review, and if appropriate, update the criteria on an annual basis ☐ None of the above
2) Does your hospital have processes or structures in place to promote ongoing adherence to the appropriateness criteria for any of the following procedures:	☐ Carotid endarterectomy ☐ Mitral valve repair and replacement ☐ Open aortic procedures ☐ Bariatric surgery for weight loss ☐ Total knee replacement ☐ Total hip replacement ☐ None of the above
3) Does your hospital conduct regular retrospective reviews of surgical cases to evaluate the extent to which your appropriateness criteria are met or not met by each surgeon for any of the following procedures:	☐ Carotid endarterectomy ☐ Mitral valve repair and replacement ☐ Open aortic procedures ☐ Bariatric surgery for weight loss ☐ Total knee replacement ☐ Total hip replacement ☐ None of the above

4) Does your hospital have a process in place for communicating with surgeons, surgical leadership, and administrative leadership when a surgeon's trend or pattern suggests challenges to adhering to your appropriateness criteria and work to understand potential barriers to meeting the criteria for <u>any</u> of the following procedures:	☐ Carotid endarterectomy ☐ Mitral valve repair and replacement ☐ Open aortic procedures ☐ Bariatric surgery for weight loss ☐ Total knee replacement ☐ Total hip replacement ☐ None of the above
5) Does your hospital report annually to its Board the findings from the retrospective reviews and plans to improve adherence to the appropriateness criteria for <u>any</u> of the following procedures:	☐ Carotid endarterectomy ☐ Mitral valve repair and replacement ☐ Open aortic procedures ☐ Bariatric surgery for weight loss ☐ Total knee replacement ☐ Total hip replacement ☐ None of the above
6) Does your hospital have national accreditation from the American College of Surgeons (applies to rectal cancer surgery only) OR Does your hospital have a multidisciplinary tumor board that prospectively reviews cancer cases to ensure surgical appropriateness for <u>any</u> of the following procedures: *If your hospital does not electively perform any of the procedures listed in this question (did not select them in Section 3A question #2), select "none of the above."*	☐ Lung resection for cancer ☐ Esophageal resection for cancer ☐ Pancreatic resection for cancer ☐ Rectal cancer surgery ☐ None of the above

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Affirmation of Accuracy

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

The hospital and I understand that The Leapfrog Group, its members, the public and entities and persons who contract or have other business dealings with The Leapfrog Group are relying on the truth and accuracy of this information. The hospital and I also understand that The Leapfrog Group will make this information and/or analyses of this information public through the Survey Results public reporting website, The Leapfrog Group's Hospital Safety Grade, and/or other Leapfrog Group products and services. This information and/or analyses and all intellectual property rights therein shall be and remain the sole and exclusive property of The Leapfrog Group in which The Leapfrog Group retains exclusive ownership. This information does not infringe upon any third-party intellectual property rights or any other third-party rights whatsoever and is free and clear of all encumbrances and liens of any kind. The hospital and I acknowledge that The Leapfrog Group may use this information in a commercial manner for profit. The hospital shall be liable for and shall hold harmless and indemnify The Leapfrog Group from any and all damages, demands, costs, or causes of action resulting from any inaccuracies in the information or any misrepresentations in this Affirmation of Accuracy. The Leapfrog Group and its members and entities and persons who contract or have other business dealings with The Leapfrog Group reserve the right to omit or disclaim information that is not current, accurate or truthful.

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

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Section 3: 2020 Adult and Pediatric Inpatient Surgery Reference Information

What's New in the 2020 Survey

Significant changes have been made to Section 3A Hospital and Surgeon Volume for 2020.

First, Leapfrog has added three new procedures to this section, including one pediatric procedure. The new procedures are: Norwood procedure (for pediatric patients), total knee replacement (for adult patients), and total hip replacement (for adult patients). Pediatric facilities will now need to report on Section 3, as appropriate.

The Norwood procedure was selected for inclusion on the Survey for two reasons: (1) it is a high-risk surgery, categorized by The Society of Thoracic Surgeons (STS) in their highest risk category for congenital heart surgery (STAT Mortality Category 5) and; (2) the peer-reviewed literature has identified a strong volume-outcome relationship for the procedure. Leapfrog's minimum volume standard is 8 cases for hospitals and 5 cases for surgeons. Leapfrog will not score or publicly report any information on the Norwood procedure in 2020.

Leapfrog's national expert panel has finalized their recommendations for minimum hospital and surgeon volume standards for total knee replacement and total hip replacement procedures. The minimum volume standards for total knee replacement are 50 cases for hospitals and 25 cases for surgeons. The minimum volume standards for total hip replacement are 50 cases for hospitals and 25 cases for surgeons. Leapfrog will not score or publicly report any information on total knee replacement or total hip replacement procedures in 2020.

Next, in 2020, Leapfrog added two new questions to Section 3A to assess the proportion of physicians authorized to perform the high-risk procedures at the hospital who are board certified or board eligible, as well as the proportion of anesthesiologists and/or certified registered nurse anesthetists providing anesthesia for the high-risk procedures at the hospital who are board certified or board eligible. These questions are aligned with those already included in Section 10 Outpatient Procedures and in the Leapfrog ASC Survey. This information will not be scored or publicly reported in 2020.

Also, beginning in 2020, hospitals that electively perform mitral valve repair and replacement (MVRR) procedures are asked to report additional information about their quality, including:

- Participation in The Society of Thoracic Surgeons' (STS) Adult Cardiac Surgery Database (ACSD)
- One/Two/Three star ratings for their STS Mitral Valve Repair/Replacement (MVRR) domain scores (Absence of Operative Mortality and Absence of Major Morbidity) and their Overall Composite Score

This additional information for mitral valve repair and replacement will not be scored or publicly reported in 2020. Hospitals will continue to be scored on hospital volume and surgeon privileging processes only.

In addition, based on recommendations from our national expert panel and our technical coding expert, Leapfrog has updated the list of mitral valve repair and replacement procedures codes to reflect only procedures that use an "open" approach, removing those procedures that use a "percutaneous endoscopic" approach.

Lastly in Section 3A, based on recommendations from hospitals, Leapfrog added additional diagnosis codes for identifying hospital volume for lung resection for cancer and pancreatic resection for cancer.

In Section 3B Surgical Appropriateness, total knee replacement and total hip replacement have been added to the list of procedures for questions regarding surgical appropriateness but will not be publicly reported in 2020. Given the evidence around appropriateness regarding Norwood procedure cases, this procedure will not be included in Section 3B Surgical Appropriateness in 2020.

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Change Summary since Release

None. If substantive changes are made to this section of the Survey after release on April 1, 2020, they will be documented in this Change Summary section.

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Adult and Pediatric Inpatient Surgery Measure Specifications – Hospital and Surgeon Volume

Important Notes:

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

Note 2: For each of the eleven high-risk procedures included in Section 3A Hospital and Surgeon Volume, Leapfrog has provided a set of ICD-10 procedure codes, and in some cases an additional set of ICD-10 diagnosis codes, for counting **patient discharges**. The ICD-10 procedure and diagnosis codes are provided below and also in an Excel Document under "Other Supporting Materials" for Section 3 on the Survey and CPOE Materials webpage.

Note 3: Information on total knee replacement, total hip replacement, and Norwood procedure will not be scored or publicly reported in 2020.

Source: The Leapfrog Group

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

- 01/01/2019 - 12/31/2019 (12-month count) or 01/01/2018 – 12/31/2019 (24-month annual average)
- Optional - Surveys (re)submitted on or after September 1: 07/01/2019 - 06/30/2020 (12-month count) or 07/01/2018 – 06/30/2020 (24-month annual average)

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

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

Do not check the box for the procedure if:

- Your hospital does not electively perform the procedure, or ONLY does so when a patient is too unstable for safe transfer, or ONLY does so when a procedure is urgent.
- Your hospital has started to perform the procedure in the last 18 months. Leapfrog gives hospitals an 18-month grace period before having to report on your hospital volume and your process for privileging surgeons for new service lines.

Do check the box for the procedure if:

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

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Question 3: To help ensure that patients are cared for by adequately trained physicians, are those physicians who are authorized to perform the high-risk procedures selected in question #2 at your hospital board certified or board eligible:

Select the percentage of physicians who are authorized to perform the high-risk procedures selected in question #2 at your hospital that are board certified or board eligible.

Refer to FAQ #4 for a definition of board certified or board eligible.

Question 4: To help ensure that patients are cared for by adequately trained anesthesiologists and/or certified registered nurse anesthetists, are those providing anesthesia for the high-risk procedures selected in question #2 at your hospital board certified or board eligible:

Select the percentage of anesthesiologists and/or certified registered nurse anesthetists who are providing anesthesia for the high-risk procedures selected in question #2 at your hospital that are board certified or board eligible.

Refer to FAQ #4 for a definition of board certified or board eligible.

Question 5: Total **hospital volume** for each selected procedure (from question #2) during the reporting period:

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

When calculating total **hospital volume**:

- Count the number of **patients** discharged from your facility within the reporting period with any one or more of the ICD-10 codes specified for each procedure, subject to the inclusion criteria below:
  - Only the ICD-10 procedure and diagnosis codes provided by Leapfrog should be used to report on the questions in Section 3A Hospital and Surgeon Volume.
  - For procedures that include TWO sets of codes, both sets of codes must be used for counting patient discharges (e.g., at least one procedure code AND one diagnosis code must be present or at least one procedure code from both sets of procedure codes must be present).
  - With the exception of bariatric surgery for weight loss, where the ICD-10 diagnosis code must be the primary diagnosis, the ICD-10 codes for the other procedures can appear in ANY procedure field and ANY diagnosis field.
  - Age restrictions apply – For Norwood procedure only include discharges for pediatric patients (ages 17 years and younger). For the remaining ten procedures, only include discharges for adult patients (ages 18 years and older).

Question 6: Does your hospital's privileging process include the surgeon meeting or exceeding the minimum surgeon volume standard listed below?

Carotid endarterectomy: 10
Mitral valve repair and replacement: 20
Open aortic procedures: 7
Lung resection for cancer: 15

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Esophageal resection for cancer: 7
Pancreatic resection for cancer: 10
Rectal cancer surgery: 6
Bariatric surgery for weight loss: 20
Total knee replacement: 25
Total hip replacement: 25
Norwood procedure: 5

When reporting on your hospital's privileging process:

- ICD-10 diagnosis codes used for determining total hospital volume for each selected procedure can be ignored. When determining whether surgeons have met or exceeded Leapfrog's minimum surgeon volume standards for the purposes of privileging, only refer to the ICD-10 procedure codes.

Source: The Society of Thoracic Surgeons (STS)

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

Question 7: Does your hospital participate in the Society of Thoracic Surgeons (STS) Adult Cardiac Surgery Database (ACSD) and did your hospital submit data for all applicable procedures during the most recent 36-month period for which performance reports are available?

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

Question 8: What is the most recent 36-month reporting time period for which STS performance reports are available?

Select the most recent 36-month reporting time period for which STS performance reports are available. The reporting period is displayed when reviewing your "MVRR Results" at https://publicreporting.sts.org/search/mvrr_report_card/hospital. See screenshot provided for question #10 below.

Question 9: Does your hospital choose to report data from the most recent performance report to this Survey?

Select "yes" if your hospital elects to share the MVRR data from your most recent performance report with Leapfrog. This data will not be scored or publicly reported in 2020.

Question 10: What are your hospital's Mitral Valve Repair/Replacement results?

Report your Mitral Valve Repair/Replacement results from the STS Public Reporting website: https://publicreporting.sts.org/search/mvrr_report_card/hospital.

Find your hospital in the list and click your hospital name. On the next page find your "MVRR Results" – these are the results you will report to the Leapfrog Hospital Survey:

a) Mitral Valve Repair/Replacement Composite Score: Report the number of stars displayed for "Overall Composite Score" represented in the screenshot below.

b) Absence of Operative Mortality: Report the number of stars displayed for "Absence of Operative Mortality" represented in the screenshot below.

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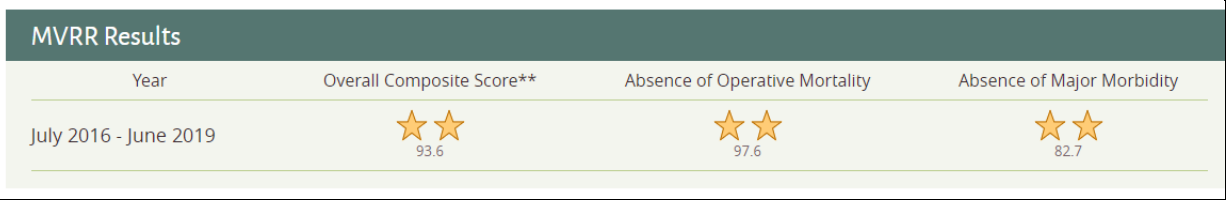
c) Absence of Major Morbidity: Report the number of stars displayed for "Absence of Major Morbidity" represented in the screenshot below.



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

Carotid Endarterectomy Measure References

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

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

ICD-10 Carotid Endarterectomy Procedure Codes

ICD-10 Procedure Code	Code Description
03CH0Z6	Extirpation of Matter from Right Common Carotid Artery, Bifurcation, Open Approach
03CH0ZZ	Extirpation of Matter from Right Common Carotid Artery, Open Approach
03CJ0Z6	Extirpation of Matter from Left Common Carotid Artery, Bifurcation, Open Approach
03CJ0ZZ	Extirpation of Matter from Left Common Carotid Artery, Open Approach
03CK0Z6	Extirpation of Matter from Right Internal Carotid Artery, Bifurcation, Open Approach
03CK0ZZ	Extirpation of Matter from Right Internal Carotid Artery, Open Approach
03CL0Z6	Extirpation of Matter from Left Internal Carotid Artery, Bifurcation, Open Approach
03CL0ZZ	Extirpation of Matter from Left Internal Carotid Artery, Open Approach
03CM0Z6	Extirpation of Matter from Right External Carotid Artery, Bifurcation, Open Approach
03CM0ZZ	Extirpation of Matter from Right External Carotid Artery, Open Approach
03CN0Z6	Extirpation of Matter from Left External Carotid Artery, Bifurcation, Open Approach
03CN0ZZ	Extirpation of Matter from Left External Carotid Artery, Open Approach

ICD-10 Occlusion and Stenosis and Cerebral Infarction Diagnosis Codes

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

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ICD-10 Diagnosis Code	Code Description
I65.23	Occlusion and stenosis of bilateral carotid arteries
I65.29	Occlusion and stenosis of unspecified carotid artery
I65.8	Occlusion and stenosis of other precerebral arteries
I65.9	Occlusion and stenosis of unspecified precerebral artery

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Mitral Valve Repair and Replacement Measure References

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

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

ICD-10 Mitral Valve Repair and Replacement Procedure Codes

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

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Open Aortic Procedures Measure References

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

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

ICD-10 Open Aortic Procedure Codes

ICD-10 Procedure Code	Code Description
0410090	Bypass Abdominal Aorta to Abdominal Aorta with Autologous Venous Tissue, Open Approach
0410091	Bypass Abdominal Aorta to Celiac Artery with Autologous Venous Tissue, Open Approach
0410092	Bypass Abdominal Aorta to Mesenteric Artery with Autologous Venous Tissue, Open Approach
0410093	Bypass Abdominal Aorta to Right Renal Artery with Autologous Venous Tissue, Open Approach
0410094	Bypass Abdominal Aorta to Left Renal Artery with Autologous Venous Tissue, Open Approach
0410095	Bypass Abdominal Aorta to Bilateral Renal Artery with Autologous Venous Tissue, Open Approach
0410096	Bypass Abdominal Aorta to Right Common Iliac Artery with Autologous Venous Tissue, Open Approach
0410097	Bypass Abdominal Aorta to Left Common Iliac Artery with Autologous Venous Tissue, Open Approach
0410098	Bypass Abdominal Aorta to Bilateral Common Iliac Arteries with Autologous Venous Tissue, Open Approach
0410099	Bypass Abdominal Aorta to Right Internal Iliac Artery with Autologous Venous Tissue, Open Approach
021W08B	Bypass Thoracic Aorta, Descending to Subclavian with Zooplastic Tissue, Open Approach
021W08D	Bypass Thoracic Aorta, Descending to Carotid with Zooplastic Tissue, Open Approach
021W08F	Bypass Thoracic Aorta, Descending to Abdominal Artery with Zooplastic Tissue, Open Approach
021W08G	Bypass Thoracic Aorta, Descending to Axillary Artery with Zooplastic Tissue, Open Approach
021W08H	Bypass Thoracic Aorta, Descending to Brachial Artery with Zooplastic Tissue, Open Approach
021W08P	Bypass Thoracic Aorta, Descending to Pulmonary Trunk with Zooplastic Tissue, Open Approach
021W08Q	Bypass Thoracic Aorta, Descending to Right Pulmonary Artery with Zooplastic Tissue, Open Approach
021W08R	Bypass Thoracic Aorta, Descending to Left Pulmonary Artery with Zooplastic Tissue, Open Approach
021W08V	Bypass Thoracic Aorta, Descending to Lower Extremity Artery with Zooplastic Tissue, Open Approach
021W09B	Bypass Thoracic Aorta, Descending to Subclavian with Autologous Venous Tissue, Open Approach
021W09D	Bypass Thoracic Aorta, Descending to Carotid with Autologous Venous Tissue, Open Approach
021W09F	Bypass Thoracic Aorta, Descending to Abdominal Artery with Autologous Venous Tissue, Open Approach

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ICD-10 Procedure Code	Code Description
021W09G	Bypass Thoracic Aorta, Descending to Axillary Artery with Autologous Venous Tissue, Open Approach
021W09H	Bypass Thoracic Aorta, Descending to Brachial Artery with Autologous Venous Tissue, Open Approach
021W09P	Bypass Thoracic Aorta, Descending to Pulmonary Trunk with Autologous Venous Tissue, Open Approach
021W09Q	Bypass Thoracic Aorta, Descending to Right Pulmonary Artery with Autologous Venous Tissue, Open Approach
021W09R	Bypass Thoracic Aorta, Descending to Left Pulmonary Artery with Autologous Venous Tissue, Open Approach
021W09V	Bypass Thoracic Aorta, Descending to Lower Extremity Artery with Autologous Venous Tissue, Open Approach
021W0AB	Bypass Thoracic Aorta, Descending to Subclavian with Autologous Arterial Tissue, Open Approach
021W0AD	Bypass Thoracic Aorta, Descending to Carotid with Autologous Arterial Tissue, Open Approach
021W0AF	Bypass Thoracic Aorta, Descending to Abdominal Artery with Autologous Arterial Tissue, Open Approach
021W0AG	Bypass Thoracic Aorta, Descending to Axillary Artery with Autologous Arterial Tissue, Open Approach
021W0AH	Bypass Thoracic Aorta, Descending to Brachial Artery with Autologous Arterial Tissue, Open Approach
021W0AP	Bypass Thoracic Aorta, Descending to Pulmonary Trunk with Autologous Arterial Tissue, Open Approach
021W0AQ	Bypass Thoracic Aorta, Descending to Right Pulmonary Artery with Autologous Arterial Tissue, Open Approach
021W0AR	Bypass Thoracic Aorta, Descending to Left Pulmonary Artery with Autologous Arterial Tissue, Open Approach
021W0AV	Bypass Thoracic Aorta, Descending to Lower Extremity Artery with Autologous Arterial Tissue, Open Approach
021W0JB	Bypass Thoracic Aorta, Descending to Subclavian with Synthetic Substitute, Open Approach
021W0JD	Bypass Thoracic Aorta, Descending to Carotid with Synthetic Substitute, Open Approach
021W0JF	Bypass Thoracic Aorta, Descending to Abdominal Artery with Synthetic Substitute, Open Approach
021W0JG	Bypass Thoracic Aorta, Descending to Axillary Artery with Synthetic Substitute, Open Approach
021W0JH	Bypass Thoracic Aorta, Descending to Brachial Artery with Synthetic Substitute, Open Approach
021W0JP	Bypass Thoracic Aorta, Descending to Pulmonary Trunk with Synthetic Substitute, Open Approach
021W0JQ	Bypass Thoracic Aorta, Descending to Right Pulmonary Artery with Synthetic Substitute, Open Approach
021W0JR	Bypass Thoracic Aorta, Descending to Left Pulmonary Artery with Synthetic Substitute, Open Approach
021W0JV	Bypass Thoracic Aorta, Descending to Lower Extremity Artery with Synthetic Substitute, Open Approach
021W0KB	Bypass Thoracic Aorta, Descending to Subclavian with Nonautologous Tissue Substitute, Open Approach
021W0KD	Bypass Thoracic Aorta, Descending to Carotid with Nonautologous Tissue Substitute, Open Approach
021W0KF	Bypass Thoracic Aorta, Descending to Abdominal Artery with Nonautologous Tissue Substitute, Open Approach

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ICD-10 Procedure Code	Code Description
021W0KG	Bypass Thoracic Aorta, Descending to Axillary Artery with Nonautologous Tissue Substitute, Open Approach
021W0KH	Bypass Thoracic Aorta, Descending to Brachial Artery with Nonautologous Tissue Substitute, Open Approach
021W0KP	Bypass Thoracic Aorta, Descending to Pulmonary Trunk with Nonautologous Tissue Substitute, Open Approach
021W0KQ	Bypass Thoracic Aorta, Descending to Right Pulmonary Artery with Nonautologous Tissue Substitute, Open Approach
021W0KR	Bypass Thoracic Aorta, Descending to Left Pulmonary Artery with Nonautologous Tissue Substitute, Open Approach
021W0KV	Bypass Thoracic Aorta, Descending to Lower Extremity Artery with Nonautologous Tissue Substitute, Open Approach
021W0ZB	Bypass Thoracic Aorta, Descending to Subclavian, Open Approach
021W0ZD	Bypass Thoracic Aorta, Descending to Carotid, Open Approach
021W0ZP	Bypass Thoracic Aorta, Descending to Pulmonary Trunk, Open Approach
021W0ZQ	Bypass Thoracic Aorta, Descending to Right Pulmonary Artery, Open Approach
021W0ZR	Bypass Thoracic Aorta, Descending to Left Pulmonary Artery, Open Approach
02BW0ZX	Excision of Thoracic Aorta, Descending, Open Approach, Diagnostic
02BW0ZZ	Excision of Thoracic Aorta, Descending, Open Approach
02CW0ZZ	Extirpation of Matter from Thoracic Aorta, Descending, Open Approach
02QW0ZZ	Repair Thoracic Aorta, Descending, Open Approach
02RW07Z	Replacement of Thoracic Aorta, Descending with Autologous Tissue Substitute, Open Approach
02RW08Z	Replacement of Thoracic Aorta, Descending with Zooplastic Tissue, Open Approach
02RW0JZ	Replacement of Thoracic Aorta, Descending with Synthetic Substitute, Open Approach
02RW0KZ	Replacement of Thoracic Aorta, Descending with Nonautologous Tissue Substitute, Open Approach
02SW0ZZ	Reposition Thoracic Aorta, Descending, Open Approach
02UW07Z	Supplement Thoracic Aorta, Descending with Autologous Tissue Substitute, Open Approach
02UW08Z	Supplement Thoracic Aorta, Descending with Zooplastic Tissue, Open Approach
02UW0JZ	Supplement Thoracic Aorta, Descending with Synthetic Substitute, Open Approach
02UW0KZ	Supplement Thoracic Aorta, Descending with Nonautologous Tissue Substitute, Open Approach
02VW0ZZ	Restriction of Thoracic Aorta, Descending, Open Approach
041009B	Bypass Abdominal Aorta to Left Internal Iliac Artery with Autologous Venous Tissue, Open Approach
041009C	Bypass Abdominal Aorta to Bilateral Internal Iliac Arteries with Autologous Venous Tissue, Open Approach
041009D	Bypass Abdominal Aorta to Right External Iliac Artery with Autologous Venous Tissue, Open Approach
041009F	Bypass Abdominal Aorta to Left External Iliac Artery with Autologous Venous Tissue, Open Approach
041009G	Bypass Abdominal Aorta to Bilateral External Iliac Arteries with Autologous Venous Tissue, Open Approach
041009H	Bypass Abdominal Aorta to Right Femoral Artery with Autologous Venous Tissue, Open Approach

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ICD-10 Procedure Code	Code Description
041009J	Bypass Abdominal Aorta to Left Femoral Artery with Autologous Venous Tissue, Open Approach
041009K	Bypass Abdominal Aorta to Bilateral Femoral Arteries with Autologous Venous Tissue, Open Approach
041009Q	Bypass Abdominal Aorta to Lower Extremity Artery with Autologous Venous Tissue, Open Approach
041009R	Bypass Abdominal Aorta to Lower Artery with Autologous Venous Tissue, Open Approach
04100A0	Bypass Abdominal Aorta to Abdominal Aorta with Autologous Arterial Tissue, Open Approach
04100A1	Bypass Abdominal Aorta to Celiac Artery with Autologous Arterial Tissue, Open Approach
04100A2	Bypass Abdominal Aorta to Mesenteric Artery with Autologous Arterial Tissue, Open Approach
04100A3	Bypass Abdominal Aorta to Right Renal Artery with Autologous Arterial Tissue, Open Approach
04100A4	Bypass Abdominal Aorta to Left Renal Artery with Autologous Arterial Tissue, Open Approach
04100A5	Bypass Abdominal Aorta to Bilateral Renal Artery with Autologous Arterial Tissue, Open Approach
04100A6	Bypass Abdominal Aorta to Right Common Iliac Artery with Autologous Arterial Tissue, Open Approach
04100A7	Bypass Abdominal Aorta to Left Common Iliac Artery with Autologous Arterial Tissue, Open Approach
04100A8	Bypass Abdominal Aorta to Bilateral Common Iliac Arteries with Autologous Arterial Tissue, Open Approach
04100A9	Bypass Abdominal Aorta to Right Internal Iliac Artery with Autologous Arterial Tissue, Open Approach
04100AB	Bypass Abdominal Aorta to Left Internal Iliac Artery with Autologous Arterial Tissue, Open Approach
04100AC	Bypass Abdominal Aorta to Bilateral Internal Iliac Arteries with Autologous Arterial Tissue, Open Approach
04100AD	Bypass Abdominal Aorta to Right External Iliac Artery with Autologous Arterial Tissue, Open Approach
04100AF	Bypass Abdominal Aorta to Left External Iliac Artery with Autologous Arterial Tissue, Open Approach
04100AG	Bypass Abdominal Aorta to Bilateral External Iliac Arteries with Autologous Arterial Tissue, Open Approach
04100AH	Bypass Abdominal Aorta to Right Femoral Artery with Autologous Arterial Tissue, Open Approach
04100AJ	Bypass Abdominal Aorta to Left Femoral Artery with Autologous Arterial Tissue, Open Approach
04100AK	Bypass Abdominal Aorta to Bilateral Femoral Arteries with Autologous Arterial Tissue, Open Approach
04100AQ	Bypass Abdominal Aorta to Lower Extremity Artery with Autologous Arterial Tissue, Open Approach
04100AR	Bypass Abdominal Aorta to Lower Artery with Autologous Arterial Tissue, Open Approach
04100J0	Bypass Abdominal Aorta to Abdominal Aorta with Synthetic Substitute, Open Approach
04100J1	Bypass Abdominal Aorta to Celiac Artery with Synthetic Substitute, Open Approach
04100J2	Bypass Abdominal Aorta to Mesenteric Artery with Synthetic Substitute, Open Approach

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ICD-10 Procedure Code	Code Description
04100J3	Bypass Abdominal Aorta to Right Renal Artery with Synthetic Substitute, Open Approach
04100J4	Bypass Abdominal Aorta to Left Renal Artery with Synthetic Substitute, Open Approach
04100J5	Bypass Abdominal Aorta to Bilateral Renal Artery with Synthetic Substitute, Open Approach
04100J6	Bypass Abdominal Aorta to Right Common Iliac Artery with Synthetic Substitute, Open Approach
04100J7	Bypass Abdominal Aorta to Left Common Iliac Artery with Synthetic Substitute, Open Approach
04100J8	Bypass Abdominal Aorta to Bilateral Common Iliac Arteries with Synthetic Substitute, Open Approach
04100J9	Bypass Abdominal Aorta to Right Internal Iliac Artery with Synthetic Substitute, Open Approach
04100JB	Bypass Abdominal Aorta to Left Internal Iliac Artery with Synthetic Substitute, Open Approach
04100JC	Bypass Abdominal Aorta to Bilateral Internal Iliac Arteries with Synthetic Substitute, Open Approach
04100JD	Bypass Abdominal Aorta to Right External Iliac Artery with Synthetic Substitute, Open Approach
04100JF	Bypass Abdominal Aorta to Left External Iliac Artery with Synthetic Substitute, Open Approach
04100JG	Bypass Abdominal Aorta to Bilateral External Iliac Arteries with Synthetic Substitute, Open Approach
04100JH	Bypass Abdominal Aorta to Right Femoral Artery with Synthetic Substitute, Open Approach
04100JJ	Bypass Abdominal Aorta to Left Femoral Artery with Synthetic Substitute, Open Approach
04100JK	Bypass Abdominal Aorta to Bilateral Femoral Arteries with Synthetic Substitute, Open Approach
04100JQ	Bypass Abdominal Aorta to Lower Extremity Artery with Synthetic Substitute, Open Approach
04100JR	Bypass Abdominal Aorta to Lower Artery with Synthetic Substitute, Open Approach
04100K0	Bypass Abdominal Aorta to Abdominal Aorta with Nonautologous Tissue Substitute, Open Approach
04100K1	Bypass Abdominal Aorta to Celiac Artery with Nonautologous Tissue Substitute, Open Approach
04100K2	Bypass Abdominal Aorta to Mesenteric Artery with Nonautologous Tissue Substitute, Open Approach
04100K3	Bypass Abdominal Aorta to Right Renal Artery with Nonautologous Tissue Substitute, Open Approach
04100K4	Bypass Abdominal Aorta to Left Renal Artery with Nonautologous Tissue Substitute, Open Approach
04100K5	Bypass Abdominal Aorta to Bilateral Renal Artery with Nonautologous Tissue Substitute, Open Approach
04100K6	Bypass Abdominal Aorta to Right Common Iliac Artery with Nonautologous Tissue Substitute, Open Approach
04100K7	Bypass Abdominal Aorta to Left Common Iliac Artery with Nonautologous Tissue Substitute, Open Approach
04100K8	Bypass Abdominal Aorta to Bilateral Common Iliac Arteries with Nonautologous Tissue Substitute, Open Approach
04100K9	Bypass Abdominal Aorta to Right Internal Iliac Artery with Nonautologous Tissue Substitute, Open Approach

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

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ICD-10 Procedure Code	Code Description
041C0Z0	Bypass Right Common Iliac Artery to Abdominal Aorta, Open Approach
041D090	Bypass Left Common Iliac Artery to Abdominal Aorta with Autologous Venous Tissue, Open Approach
041D0A0	Bypass Left Common Iliac Artery to Abdominal Aorta with Autologous Arterial Tissue, Open Approach
041D0J0	Bypass Left Common Iliac Artery to Abdominal Aorta with Synthetic Substitute, Open Approach
041D0K0	Bypass Left Common Iliac Artery to Abdominal Aorta with Nonautologous Tissue Substitute, Open Approach
041D0Z0	Bypass Left Common Iliac Artery to Abdominal Aorta, Open Approach
04B00ZX	Excision of Abdominal Aorta, Open Approach, Diagnostic
04B00ZZ	Excision of Abdominal Aorta, Open Approach
04C00Z6	Extirpation of Matter from Abdominal Aorta, Bifurcation, Open Approach
04C00ZZ	Extirpation of Matter from Abdominal Aorta, Open Approach
04L00ZZ	Occlusion of Abdominal Aorta, Open Approach
04Q00ZZ	Repair Abdominal Aorta, Open Approach
04R007Z	Replacement of Abdominal Aorta with Autologous Tissue Substitute, Open Approach
04R00JZ	Replacement of Abdominal Aorta with Synthetic Substitute, Open Approach
04R00KZ	Replacement of Abdominal Aorta with Nonautologous Tissue Substitute, Open Approach
04U007Z	Supplement Abdominal Aorta with Autologous Tissue Substitute, Open Approach
04U00JZ	Supplement Abdominal Aorta with Synthetic Substitute, Open Approach
04U00KZ	Supplement Abdominal Aorta with Nonautologous Tissue Substitute, Open Approach

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Lung Resection for Cancer Measure References

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

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

ICD-10 Lung Resection for Cancer Procedure Codes

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

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

ICD-10 Malignant Tumor and Cancer in Situ Diagnosis Codes

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

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Esophageal Resection for Cancer Measure References

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

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

ICD-10 Esophageal Resection for Cancer Procedure Codes

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

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

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

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

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

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

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

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

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ICD-10 Procedure Code	Code Description
0D158J6	Bypass Esophagus to Stomach with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic
0D158J9	Bypass Esophagus to Duodenum with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic
0D158JA	Bypass Esophagus to Jejunum with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic
0D158JB	Bypass Esophagus to Ileum with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic
0D158K4	Bypass Esophagus to Cutaneous with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D158K6	Bypass Esophagus to Stomach with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D158K9	Bypass Esophagus to Duodenum with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D158KA	Bypass Esophagus to Jejunum with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D158KB	Bypass Esophagus to Ileum with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D158Z4	Bypass Esophagus to Cutaneous, Via Natural or Artificial Opening Endoscopic
0D158Z6	Bypass Esophagus to Stomach, Via Natural or Artificial Opening Endoscopic
0D158Z9	Bypass Esophagus to Duodenum, Via Natural or Artificial Opening Endoscopic
0D158ZA	Bypass Esophagus to Jejunum, Via Natural or Artificial Opening Endoscopic
0D158ZB	Bypass Esophagus to Ileum, Via Natural or Artificial Opening Endoscopic
0DB10ZZ	Excision of Upper Esophagus, Open Approach
0DB13ZZ	Excision of Upper Esophagus, Percutaneous Approach
0DB17ZZ	Excision of Upper Esophagus, Via Natural or Artificial Opening
0DB20ZZ	Excision of Middle Esophagus, Open Approach
0DB23ZZ	Excision of Middle Esophagus, Percutaneous Approach
0DB27ZZ	Excision of Middle Esophagus, Via Natural or Artificial Opening
0DB30ZZ	Excision of Lower Esophagus, Open Approach
0DB33ZZ	Excision of Lower Esophagus, Percutaneous Approach
0DB37ZZ	Excision of Lower Esophagus, Via Natural or Artificial Opening
0DB50ZZ	Excision of Esophagus, Open Approach
0DB53ZZ	Excision of Esophagus, Percutaneous Approach
0DB57ZZ	Excision of Esophagus, Via Natural or Artificial Opening
0DT10ZZ	Resection of Upper Esophagus, Open Approach
0DT14ZZ	Resection of Upper Esophagus, Percutaneous Endoscopic Approach
0DT17ZZ	Resection of Upper Esophagus, Via Natural or Artificial Opening
0DT18ZZ	Resection of Upper Esophagus, Via Natural or Artificial Opening Endoscopic
0DT20ZZ	Resection of Middle Esophagus, Open Approach
0DT24ZZ	Resection of Middle Esophagus, Percutaneous Endoscopic Approach
0DT27ZZ	Resection of Middle Esophagus, Via Natural or Artificial Opening
0DT28ZZ	Resection of Middle Esophagus, Via Natural or Artificial Opening Endoscopic
0DT30ZZ	Resection of Lower Esophagus, Open Approach
0DT34ZZ	Resection of Lower Esophagus, Percutaneous Endoscopic Approach

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ICD-10 Procedure Code	Code Description
0DT37ZZ	Resection of Lower Esophagus, Via Natural or Artificial Opening
0DT38ZZ	Resection of Lower Esophagus, Via Natural or Artificial Opening Endoscopic
0DT50ZZ	Resection of Esophagus, Open Approach
0DT54ZZ	Resection of Esophagus, Percutaneous Endoscopic Approach
0DT57ZZ	Resection of Esophagus, Via Natural or Artificial Opening
0DT58ZZ	Resection of Esophagus, Via Natural or Artificial Opening Endoscopic
0DT60ZZ	Resection of Stomach, Open Approach
0DT64ZZ	Resection of Stomach, Percutaneous Endoscopic Approach
0DT67ZZ	Resection of Stomach, Via Natural or Artificial Opening
0DT68ZZ	Resection of Stomach, Via Natural or Artificial Opening Endoscopic
0DX60Z5	Transfer Stomach to Esophagus, Open Approach
0DX64Z5	Transfer Stomach to Esophagus, Percutaneous Endoscopic Approach
0DX80Z5	Transfer Small Intestine to Esophagus, Open Approach
0DX84Z5	Transfer Small Intestine to Esophagus, Percutaneous Endoscopic Approach
0DXE0Z5	Transfer Large Intestine to Esophagus, Open Approach
0DXE4Z5	Transfer Large Intestine to Esophagus, Percutaneous End

ICD-10 Malignant Tumor and Carcinoma in Situ Diagnosis Codes

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

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Pancreatic Resection for Cancer Measure References

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

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

ICD-10 Pancreatic Resection for Cancer Procedure Codes

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

ICD-10 Malignant Tumor Diagnosis Codes

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

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Rectal Cancer Surgery Measure References

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

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

ICD-10 Rectal Cancer Surgery Procedure Codes

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

ICD-10 Malignant Tumor and Carcinoma in Situ Diagnosis Codes

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

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Bariatric Surgery for Weight Loss Measure References

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

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

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

ICD-10 Bariatric Surgery Procedure Codes

ICD-10 Procedure Code	Code Description
0D16079	Bypass Stomach to Duodenum with Autologous Tissue Substitute, Open Approach
0D1607A	Bypass Stomach to Jejunum with Autologous Tissue Substitute, Open Approach
0D1607B	Bypass Stomach to Ileum with Autologous Tissue Substitute, Open Approach
0D160Z9	Bypass Stomach to Duodenum, Open Approach
0D160ZA	Bypass Stomach to Jejunum, Open Approach
0D160ZB	Bypass Stomach to Ileum, Open Approach
0D16479	Bypass Stomach to Duodenum with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0D1647A	Bypass Stomach to Jejunum with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0D1647B	Bypass Stomach to Ileum with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0D164Z9	Bypass Stomach to Duodenum, Percutaneous Endoscopic Approach
0D164ZA	Bypass Stomach to Jejunum, Percutaneous Endoscopic Approach
0D164ZB	Bypass Stomach to Ileum, Percutaneous Endoscopic Approach
0DB60Z3	Excision of Stomach, Open Approach, Vertical
0DB60ZZ	Excision of Stomach, Open Approach
0DB63Z3	Excision of Stomach, Percutaneous Approach, Vertical
0DB63ZZ	Excision of Stomach, Percutaneous Approach
0DB64Z3	Excision of Stomach, Percutaneous Endoscopic Approach, Vertical

ICD-10 Morbid Obesity Diagnosis Codes

ICD-10 Diagnosis Code	Code Description
E66.01	Morbid (severe) obesity due to excess calories
E66.09	Other obesity due to excess calories
E66.8	Other obesity
Z68.35	Body mass index (BMI) 35.0-35.9, adult

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ICD-10 Diagnosis Code	Code Description
Z68.36	Body mass index (BMI) 36.0-36.9, adult
Z68.37	Body mass index (BMI) 37.0-37.9, adult
Z68.38	Body mass index (BMI) 38.0-38.9, adult
Z68.39	Body mass index (BMI) 39.0-39.9, adult
Z68.41	Body mass index (BMI) 40.0-44.9, adult
Z68.42	Body mass index (BMI) 45.0-49.9, adult
Z68.43	Body mass index (BMI) 50-59.9, adult
Z68.44	Body mass index (BMI) 60.0-69.9, adult
Z68.45	Body mass index (BMI) 70 or greater, adult

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Total Knee Replacement Measure References

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

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

ICD-10 Total Knee Replacement Procedure Codes

ICD10 Procedure Code	Code Description
0SRC0J9	Replacement of Right Knee Joint with Synthetic Substitute, Cemented, Open Approach
0SRC0JA	Replacement of Right Knee Joint with Synthetic Substitute, Uncemented, Open Approach
0SRC0JZ	Replacement of Right Knee Joint with Synthetic Substitute, Open Approach
0SRD0J9	Replacement of Left Knee Joint with Synthetic Substitute, Cemented, Open Approach
0SRD0JA	Replacement of Left Knee Joint with Synthetic Substitute, Uncemented, Open Approach
0SRD0JZ	Replacement of Left Knee Joint with Synthetic Substitute, Open Approach
0SRT0J9	Replacement of Right Knee Joint, Femoral Surface with Synthetic Substitute, Cemented, Open Approach
0SRT0JA	Replacement of Right Knee Joint, Femoral Surface with Synthetic Substitute, Uncemented, Open Approach
0SRT0JZ	Replacement of Right Knee Joint, Femoral Surface with Synthetic Substitute, Open Approach
0SRU0J9	Replacement of Left Knee Joint, Femoral Surface with Synthetic Substitute, Cemented, Open Approach
0SRU0JA	Replacement of Left Knee Joint, Femoral Surface with Synthetic Substitute, Uncemented, Open Approach
0SRU0JZ	Replacement of Left Knee Joint, Femoral Surface with Synthetic Substitute, Open Approach
0SRV0J9	Replacement of Right Knee Joint, Tibial Surface with Synthetic Substitute, Cemented, Open Approach
0SRV0JA	Replacement of Right Knee Joint, Tibial Surface with Synthetic Substitute, Uncemented, Open Approach
0SRV0JZ	Replacement of Right Knee Joint, Tibial Surface with Synthetic Substitute, Open Approach
0SRW0J9	Replacement of Left Knee Joint, Tibial Surface with Synthetic Substitute, Cemented, Open Approach
0SRW0JA	Replacement of Left Knee Joint, Tibial Surface with Synthetic Substitute, Uncemented, Open Approach
0SRW0JZ	Replacement of Left Knee Joint, Tibial Surface with Synthetic Substitute, Open Approach

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Total Hip Replacement Measure References

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

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

ICD-10 Total Hip Replacement Procedure Codes

ICD10 Procedure Code	Code Description
0SR9019	Replacement of Right Hip Joint with Metal Synthetic Substitute, Cemented, Open Approach
0SR901A	Replacement of Right Hip Joint with Metal Synthetic Substitute, Uncemented, Open Approach
0SR901Z	Replacement of Right Hip Joint with Metal Synthetic Substitute, Open Approach
0SR9029	Replacement of Right Hip Joint with Metal on Polyethylene Synthetic Substitute, Cemented, Open Approach
0SR902A	Replacement of Right Hip Joint with Metal on Polyethylene Synthetic Substitute, Uncemented, Open Approach
0SR902Z	Replacement of Right Hip Joint with Metal on Polyethylene Synthetic Substitute, Open Approach
0SR9039	Replacement of Right Hip Joint with Ceramic Synthetic Substitute, Cemented, Open Approach
0SR903A	Replacement of Right Hip Joint with Ceramic Synthetic Substitute, Uncemented, Open Approach
0SR903Z	Replacement of Right Hip Joint with Ceramic Synthetic Substitute, Open Approach
0SR9049	Replacement of Right Hip Joint with Ceramic on Polyethylene Synthetic Substitute, Cemented, Open Approach
0SR904A	Replacement of Right Hip Joint with Ceramic on Polyethylene Synthetic Substitute, Uncemented, Open Approach
0SR904Z	Replacement of Right Hip Joint with Ceramic on Polyethylene Synthetic Substitute, Open Approach
0SR90J9	Replacement of Right Hip Joint with Synthetic Substitute, Cemented, Open Approach
0SR90JA	Replacement of Right Hip Joint with Synthetic Substitute, Uncemented, Open Approach
0SR90JZ	Replacement of Right Hip Joint with Synthetic Substitute, Open Approach
0SRA009	Replacement of Right Hip Joint, Acetabular Surface with Polyethylene Synthetic Substitute, Cemented, Open Approach
0SRA00A	Replacement of Right Hip Joint, Acetabular Surface with Polyethylene Synthetic Substitute, Uncemented, Open Approach
0SRA00Z	Replacement of Right Hip Joint, Acetabular Surface with Polyethylene Synthetic Substitute, Open Approach
0SRA019	Replacement of Right Hip Joint, Acetabular Surface with Metal Synthetic Substitute, Cemented, Open Approach
0SRA01A	Replacement of Right Hip Joint, Acetabular Surface with Metal Synthetic Substitute, Uncemented, Open Approach
0SRA01Z	Replacement of Right Hip Joint, Acetabular Surface with Metal Synthetic Substitute, Open Approach
0SRA039	Replacement of Right Hip Joint, Acetabular Surface with Ceramic Synthetic Substitute, Cemented, Open Approach
0SRA03A	Replacement of Right Hip Joint, Acetabular Surface with Ceramic Synthetic Substitute, Uncemented, Open Approach

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0SRA03Z	Replacement of Right Hip Joint, Acetabular Surface with Ceramic Synthetic Substitute, Open Approach
0SRA0J9	Replacement of Right Hip Joint, Acetabular Surface with Synthetic Substitute, Cemented, Open Approach
0SRA0JA	Replacement of Right Hip Joint, Acetabular Surface with Synthetic Substitute, Uncemented, Open Approach
0SRA0JZ	Replacement of Right Hip Joint, Acetabular Surface with Synthetic Substitute, Open Approach
0SRB019	Replacement of Left Hip Joint with Metal Synthetic Substitute, Cemented, Open Approach
0SRB01A	Replacement of Left Hip Joint with Metal Synthetic Substitute, Uncemented, Open Approach
0SRB01Z	Replacement of Left Hip Joint with Metal Synthetic Substitute, Open Approach
0SRB029	Replacement of Left Hip Joint with Metal on Polyethylene Synthetic Substitute, Cemented, Open Approach
0SRB02A	Replacement of Left Hip Joint with Metal on Polyethylene Synthetic Substitute, Uncemented, Open Approach
0SRB02Z	Replacement of Left Hip Joint with Metal on Polyethylene Synthetic Substitute, Open Approach
0SRB039	Replacement of Left Hip Joint with Ceramic Synthetic Substitute, Cemented, Open Approach
0SRB03A	Replacement of Left Hip Joint with Ceramic Synthetic Substitute, Uncemented, Open Approach
0SRB03Z	Replacement of Left Hip Joint with Ceramic Synthetic Substitute, Open Approach
0SRB049	Replacement of Left Hip Joint with Ceramic on Polyethylene Synthetic Substitute, Cemented, Open Approach
0SRB04A	Replacement of Left Hip Joint with Ceramic on Polyethylene Synthetic Substitute, Uncemented, Open Approach
0SRB04Z	Replacement of Left Hip Joint with Ceramic on Polyethylene Synthetic Substitute, Open Approach
0SRB0J9	Replacement of Left Hip Joint with Synthetic Substitute, Cemented, Open Approach
0SRB0JA	Replacement of Left Hip Joint with Synthetic Substitute, Uncemented, Open Approach
0SRB0JZ	Replacement of Left Hip Joint with Synthetic Substitute, Open Approach
0SRE009	Replacement of Left Hip Joint, Acetabular Surface with Polyethylene Synthetic Substitute, Cemented, Open Approach
0SRE00A	Replacement of Left Hip Joint, Acetabular Surface with Polyethylene Synthetic Substitute, Uncemented, Open Approach
0SRE00Z	Replacement of Left Hip Joint, Acetabular Surface with Polyethylene Synthetic Substitute, Open Approach
0SRE019	Replacement of Left Hip Joint, Acetabular Surface with Metal Synthetic Substitute, Cemented, Open Approach
0SRE01A	Replacement of Left Hip Joint, Acetabular Surface with Metal Synthetic Substitute, Uncemented, Open Approach
0SRE01Z	Replacement of Left Hip Joint, Acetabular Surface with Metal Synthetic Substitute, Open Approach
0SRE039	Replacement of Left Hip Joint, Acetabular Surface with Ceramic Synthetic Substitute, Cemented, Open Approach
0SRE03A	Replacement of Left Hip Joint, Acetabular Surface with Ceramic Synthetic Substitute, Uncemented, Open Approach
0SRE03Z	Replacement of Left Hip Joint, Acetabular Surface with Ceramic Synthetic Substitute, Open Approach
0SRE0J9	Replacement of Left Hip Joint, Acetabular Surface with Synthetic Substitute, Cemented, Open Approach

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0SRE0JA	Replacement of Left Hip Joint, Acetabular Surface with Synthetic Substitute, Uncemented, Open Approach
0SRE0JZ	Replacement of Left Hip Joint, Acetabular Surface with Synthetic Substitute, Open Approach
0SRR019	Replacement of Right Hip Joint, Femoral Surface with Metal Synthetic Substitute, Cemented, Open Approach
0SRR01A	Replacement of Right Hip Joint, Femoral Surface with Metal Synthetic Substitute, Uncemented, Open Approach
0SRR01Z	Replacement of Right Hip Joint, Femoral Surface with Metal Synthetic Substitute, Open Approach
0SRR039	Replacement of Right Hip Joint, Femoral Surface with Ceramic Synthetic Substitute, Cemented, Open Approach
0SRR03A	Replacement of Right Hip Joint, Femoral Surface with Ceramic Synthetic Substitute, Uncemented, Open Approach
0SRR03Z	Replacement of Right Hip Joint, Femoral Surface with Ceramic Synthetic Substitute, Open Approach
0SRR0J9	Replacement of Right Hip Joint, Femoral Surface with Synthetic Substitute, Cemented, Open Approach
0SRR0JA	Replacement of Right Hip Joint, Femoral Surface with Synthetic Substitute, Uncemented, Open Approach
0SRR0JZ	Replacement of Right Hip Joint, Femoral Surface with Synthetic Substitute, Open Approach
0SRS019	Replacement of Left Hip Joint, Femoral Surface with Metal Synthetic Substitute, Cemented, Open Approach
0SRS01A	Replacement of Left Hip Joint, Femoral Surface with Metal Synthetic Substitute, Uncemented, Open Approach
0SRS01Z	Replacement of Left Hip Joint, Femoral Surface with Metal Synthetic Substitute, Open Approach
0SRS039	Replacement of Left Hip Joint, Femoral Surface with Ceramic Synthetic Substitute, Cemented, Open Approach
0SRS03A	Replacement of Left Hip Joint, Femoral Surface with Ceramic Synthetic Substitute, Uncemented, Open Approach
0SRS03Z	Replacement of Left Hip Joint, Femoral Surface with Ceramic Synthetic Substitute, Open Approach
0SRS0J9	Replacement of Left Hip Joint, Femoral Surface with Synthetic Substitute, Cemented, Open Approach
0SRS0JA	Replacement of Left Hip Joint, Femoral Surface with Synthetic Substitute, Uncemented, Open Approach
0SRS0JZ	Replacement of Left Hip Joint, Femoral Surface with Synthetic Substitute, Open Approach

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Norwood Procedure Measure References

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

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

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

ICD-10 Arch Repair Procedure Codes

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

ICD-10 Shunt Procedure Codes

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

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ICD-10 Procedure Code	Code Description
021K0KQ	Bypass Right Ventricle to Right Pulmonary Artery with Nonautologous Tissue Substitute, Open Approach
021K0KR	Bypass Right Ventricle to Right Pulmonary Artery with Nonautologous Tissue Substitute, Open Approach
021Q08A	Bypass Right Pulmonary Artery from Innominate Artery with Zooplastic Tissue, Open Approach
021Q08B	Bypass Right Pulmonary Artery from Subclavian with Zooplastic Tissue, Open Approach
021Q08D	Bypass Right Pulmonary Artery from Carotid with Zooplastic Tissue, Open Approach
021Q09A	Bypass Right Pulmonary Artery from Innominate Artery with Autologous Venous Tissue, Open Approach
021Q09B	Bypass Right Pulmonary Artery from Subclavian with Autologous Venous Tissue, Open Approach
021Q09D	Bypass Right Pulmonary Artery from Carotid with Autologous Venous Tissue, Open Approach
021Q0AA	Bypass Right Pulmonary Artery from Innominate Artery with Autologous Arterial Tissue, Open Approach
021Q0AB	Bypass Right Pulmonary Artery from Subclavian with Autologous Arterial Tissue, Open Approach
021Q0AD	Bypass Right Pulmonary Artery from Carotid with Autologous Arterial Tissue, Open Approach
021Q0JA	Bypass right pulmonary artery from innominate w/synthetic substitute, open approach
021Q0JB	Bypass right pulmonary artery from subclavian w/synthetic substitute, open approach
021Q0JD	Bypass right pulmonary artery from carotid w/synthetic substitute, open approach
021Q0KA	Bypass Right Pulmonary Artery from Innominate Artery with Nonautologous Tissue Substitute, Open Approach
021Q0KB	Bypass Right Pulmonary Artery from Subclavian with Nonautologous Tissue Substitute, Open Approach
021Q0KD	Bypass Right Pulmonary Artery from Carotid with Nonautologous Tissue Substitute, Open Approach
021V0ZP	Bypass Superior Vena Cava to Pulmonary Trunk, Open Approach
021V0ZQ	Bypass Superior Vena Cava to Right Pulmonary Artery, Open Approach
021V0ZR	Bypass Superior Vena Cava to Left Pulmonary Artery, Open Approach

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Adult and Pediatric Inpatient Surgery Frequently Asked Questions (FAQs)

General Questions

1. **Does this section apply to critical access hospitals?**
   Leapfrog recognizes the important role that critical access hospitals play in serving their communities. In general, critical access hospitals do not perform the types of procedures that are included in this section, but if the critical access hospital does perform the procedure, the standards still apply.

2. **Do hospitals get credit for procedures performed in combination with other procedures?**
   Yes, hospitals should count all patients that meet the criteria specified on pages 55-90. For example, if a patient has a CABG and a mitral valve repair done at the same time, the hospital should count the mitral valve repair.

3. **Should we select a procedure in Section 3A question #2 if we only schedule these as outpatient procedures?**
   No. If all the procedures of a particular type are scheduled with the intention of the patient being released on the same day, the hospital should not report performing that procedure in question #2. If some of the procedures are scheduled with the intention of the patient being admitted and staying in the hospital overnight, the hospital should report on performing the procedure in question #2 and then ONLY report on the volume of patients discharged following an inpatient stay.

4. **How does Leapfrog defined board certified and board eligible?**
   For physicians:
   - Board certified means that the physician has been awarded certification from the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA).
   - Board eligible indicates that the physician has completed their initial training/fellowship but has not yet passed an existing board-certifying exam in a specialty. Leapfrog adheres to the ABMS and AOA Board Eligibility Policy for all specialties, which may be reviewed here: https://www.abms.org/media/176507/abms-board-eligibility-overview-and-faqs-abmsorg-20180511.pdf and https://certification.osteopathic.org/about/, respectively. These eligibility periods provide the physician with an adequate window to take her/his boards and re-take if necessary.

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

   Section 3A question #4 is only referring to CRNAs that are board certified, as board eligible CRNAs are not licensed and are not yet able to provide clinical care in hospital outpatient departments.

5. **What is the Data Completeness Requirement for the STS Mitral Valve Repair/Replacement (MVRR) Composite Score?**
   Participants are excluded from the analysis if they have fewer than 36 isolated MVRR procedures in the patient population. Please find more information in the NQF-endorsed measure specifications, available here.

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Hospital Volume

6. **When counting patients, should we only include those who had the procedure performed electively? Can we also include those patients who had the procedure performed urgently?**
   Hospitals should count all patients discharged with the relevant procedure or diagnosis for those procedures indicated in question #2 in Section 3A.

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

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

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

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

Surgeon Volume

11. **When counting surgeon volume for the purposes of privileging, should we consider procedures performed by the surgeon at other hospitals?**
    When determining whether a surgeon has met or has exceeded Leapfrog's minimum surgeon volume standard, we expect that hospitals will consider total experience in the privileging process - this would include procedures performed within the reporting period at different facilities. It is our understanding that through the OPPE process (https://www.advisory.com/topics/physician-issues/oppe), hospitals have access to total surgeon volume, including the number of procedures performed at other hospitals.

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

13. **When counting surgeon volume for the purposes of privileging, if a procedure is completed by two surgeons (i.e. an assistant or co-surgeon) would they both be able to count the case?**

If a surgeon assists another surgeon or is a co-surgeon during a procedure, the procedure should NOT count for both surgeons' procedure totals. The case should be applied to a single surgeon.

14. **If a surgeon was not 'active' during the entire reporting period (e.g., just hired, sabbatical, illness, etc.), how should this surgeon's procedures be reported?**
If a surgeon was absent for an extended time during the reporting period, the procedures performed by this surgeon during the reporting period should still be counted towards the hospital's procedure total (question #5). However, the surgeon would not need to be considered when responding to question #6 regarding whether or not your hospital's process for privileging includes the surgeon having to meet Leapfrog's minimum surgeon volume standards until they have been active again for an entire reporting period (likely the next year).

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

Surgical Appropriateness

16. **What documents can be used as supporting evidence of a hospital's implementation of surgical appropriateness?**
Hospitals may use department meeting minutes, centers of excellence criteria, retrospective reviews of surgical cases, or any other materials that show that there are surgical appropriateness standards of care for each of the 4 non-cancer surgeries/procedures. For the 4 cancer surgeries/procedures hospitals may use documentation of accreditation from the American College of Surgeons (rectal cancer surgery only) or use meeting minutes from the multidisciplinary tumor board referenced in question #6.

17. **How often do we need to perform "regular retrospective reviews" as described in question #5 in Section 3B?**
More than once per year. Some hospitals may decide to do review quarterly or even monthly, depending on the size of the service.

18. **What is a multidisciplinary tumor board?**
A multidisciplinary tumor board is a board that may include radiologists, pathologists, surgeons, medical oncologists, radiation oncologists, nurses, social workers, psychiatrists or psychologists, palliative care staff, nutritional services, and physical/occupational therapy, that prospectively reviews cancer cases to ensure surgical appropriateness.

19. **Our hospital's multidisciplinary tumor board reviews some, but not all cancer cases. Can we check the box for each cancer procedure in Section 3B, question #6?**
In 2020, hospitals can receive credit for any cancer procedure where at least some cases are presented to their multidisciplinary tumor board for prospective review to ensure surgical appropriateness.

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SECTION 4: MATERNITY CARE

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

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Section 4: 2020 Maternity Care

Maternity Care Fact Sheet: http://www.leapfroggroup.org/ratings-reports/maternity-care

Adult and Pediatric Hospitals that did not deliver newborns during the reporting period or did not have an open labor and delivery unit during the entire reporting period should respond "no" to question #2 and move on to the Affirmation of Accuracy. Your hospital's results will be displayed as "Does Not Apply" on Leapfrog's public reporting website.

Section 4 includes questions about elective delivery, cesarean birth, episiotomy, newborn bilirubin screening, and DVT prophylaxis for women undergoing cesarean delivery. The section also includes questions about high-risk deliveries including volume, outcomes, and the administration of antenatal steroids.

Each hospital achieving the standards for Maternity Care:

1. Meets or is better than the 5.0% target for performance on the nationally-endorsed "Elective Deliveries Before 39 Weeks Gestation" outcome measure
2. Meets or is better than the 23.9% target for performance on the nationally-endorsed "NTSV Cesarean Section" outcome measure
3. Meets or is better than the 5.0% target for performance on the nationally-endorsed "Incidence of Episiotomy" outcome measure
4. Meets or exceeds a 90% target for both process measures of care: "Newborn Bilirubin Screening Prior to Discharge" and "Appropriate DVT Prophylaxis in Women Undergoing Cesarean Delivery"

Each hospital achieving the standard for High-Risk Deliveries:

1. Achieves favorable hospital volume characteristics for high-risk deliveries by admitting 50 or more very low birth weight newborns/year to its neonatal ICU or achieves favorable outcomes for high-risk deliveries as measured by the Vermont Oxford Network
   and
2. Meets or exceeds a 90% target for the antenatal steroids process measure

Download the 2020 Leapfrog Hospital Survey Scoring Algorithm on the Scoring and Results webpage.

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4A: Maternity Care Volume

Specifications: See ***Maternity Care Volume*** in the Maternity Care Reference Information on page 111.

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

Reporting Time Period: 12 months

- 01/01/2019 - 12/31/2019
- Optional - Surveys (re)submitted on or after September 1: 07/01/2019 - 06/30/2020

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

1) 12-month reporting time period used:	☐ 01/01/2019 - 12/31/2019 ☐ 07/01/2019 - 06/30/2020
2) Did the hospital deliver newborn babies during the reporting time period? *If "no" or "yes, but unit is now closed or wasn't open for the entire reporting period," skip the remaining questions in Section 4, including all subsections, and go to the Affirmation of Accuracy. The hospital will be scored as "Does Not Apply."*	*Yes* *No* *Yes, but unit is now closed or wasn't open for the entire reporting period*
3) Total number of live births (i.e., liveborn infants) at this hospital location for the reporting time period. *If fewer than 10 cases, skip the remaining questions in Section 4, including all subsections, and go to the Affirmation of Accuracy. The hospital will be scored as "Unable to Calculate Score."*	_____
4) To help ensure that patients are cared for by adequately trained physicians, are **those physicians and other individuals, such as midwives,** who are authorized to deliver newborn babies at your hospital board certified or board eligible:	*All are board certified or board eligible (100%)* *Most are board certified or board eligible (>=75%)* *Some are board certified or board eligible (>=50%)* *Few are board certified or board eligible (<50%)* *None are board certified or board eligible*
5) To help ensure that patients are cared for by adequately trained anesthesiologists and/or certified registered nurse anesthetists, are **those providing anesthesia** to mothers delivering newborn babies at your hospital board certified or board eligible:	*All are board certified or board eligible (100%)* *Most are board certified or board eligible (>=75%)*

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	Some are board certified or board eligible (>=50%) *Few are board certified or board eligible (<50%)* *None are board certified or board eligible*

4B: Elective Deliveries

Specifications: See ***Elective Deliveries*** in the Maternity Care Reference Information on pages 112-113.

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

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

- 01/01/2019 - 12/31/2019
- Optional - Surveys (re)submitted on or after September 1: 07/01/2019 - 06/30/2020

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

Sufficient Sample: See ***Elective Deliveries*** for instructions for identifying a sufficient sample to answer questions #2 and #3.

1) 12-month reporting time period used:	☐ 01/01/2019 - 12/31/2019 ☐ 07/01/2019 - 06/30/2020
2) Total number of mothers (or sufficient sample of them) that delivered newborns with >=37 weeks of gestation completed and <39 weeks of gestation completed, with **Excluded Populations** removed. *If fewer than 10 cases met the criteria for the denominator, skip questions #3-5 and continue on to the next subsection. The hospital will be scored as "Unable to Calculate Score."*	_____
3) Total number of mothers indicated in question #2 that had their newborn delivered electively (not spontaneously).	_____
4) Do the responses in questions #2 and #3 above represent a sample of cases?	*Yes* *No*
5) If "yes" to question #4, did your hospital sample using The Joint Commission's sampling algorithm or Leapfrog's sampling instructions, as provided in the Maternity Care Reference Information?	*The Joint Commission* *The Leapfrog Group*

4C: Cesarean Birth

Specifications: See ***Cesarean Birth*** in the Maternity Care Reference Information on pages 114-117.

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

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

- 01/01/2019 - 12/31/2019
- Optional - Surveys (re)submitted on or after September 1: 07/01/2019 - 06/30/2020

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

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

1) 12-month reporting time period used:	☐ 01/01/2019 - 12/31/2019 ☐ 07/01/2019 - 06/30/2020
2) Total number of nulliparous mothers (or sufficient sample of them) that delivered a live term singleton newborn in the vertex presentation with >=37 weeks of gestation completed, with **Excluded Populations** removed. *If fewer than 10 cases met the criteria for the denominator, skip questions #3-5 and continue on to the next subsection. The hospital will be scored as "Unable to Calculate Score."*	_____
3) Total number of mothers indicated in question #2 that had their newborn delivered via cesarean section.	_____
4) Do the responses in questions #2 and #3 above represent a sample of cases?	*Yes* *No*
5) If "yes" to question #4, did your hospital sample using The Joint Commission's sampling algorithm or Leapfrog's sampling instructions, as provided in the Maternity Care Reference Information?	*The Joint Commission* *The Leapfrog Group*

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4D: Episiotomy

Specifications: See ***Episiotomy*** in the Maternity Care Reference Information on page 118.

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

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

- 01/01/2019 - 12/31/2019
- Optional - Surveys (re)submitted on or after September 1: 07/01/2019 - 06/30/2020

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

1) 12-month reporting time period used:	☐ 01/01/2019 - 12/31/2019 ☐ 07/01/2019 - 06/30/2020
2) Total number of vaginal deliveries, with **Excluded Populations** removed. *If fewer than 10 cases met the criteria for the denominator, skip question #3 and continue on to the next subsection. The hospital will be scored as "Unable to Calculate Score."*	_____
3) Total number of mothers indicated in question #2 that had an episiotomy procedure performed.	_____

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4E: Process Measures of Quality

Specifications: See ***Maternity Care Process Measure Specifications*** in the Maternity Care Reference Information on pages 119-120.

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

Reporting Time Period: 12 months
Answer questions #1-10 based on all cases (or a sufficient sample of them)

- 01/01/2019 - 12/31/2019
- Optional - Surveys (re)submitted on or after September 1: 07/01/2019 - 06/30/2020

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

Sufficient Sample: See ***Maternity Care Process Measure Specifications*** for instructions for identifying a sufficient sample to answer questions #3-4 and #7-8.

1) 12-month reporting time period used:	☐ 01/01/2019 - 12/31/2019 ☐ 07/01/2019 - 06/30/2020

Newborn Bilirubin Screening Prior to Discharge	
2) Did your hospital perform a medical record audit on all cases (or a sufficient sample of them) **and** measure adherence to the newborn bilirubin screening prior to discharge clinical guideline? *If "no" to question #2, skip questions #3-5 and continue on to question #6.* *If "Yes, but fewer than 10 cases met the inclusion criteria for the denominator," skip questions #3-5 and continue on to question #6.*	*Yes* *No* *Yes, but fewer than 10 cases met the inclusion criteria for the denominator*
3) Number of cases measured against the guideline, either all cases or a sufficient sample of them (**denominator**).	_____
4) Number of cases in question #3 that adhere to the clinical process guideline (**numerator**).	_____
5) Do the responses in questions #3 and #4 represent a sample of cases?	*Yes* *No*

Appropriate DVT Prophylaxis in Women Undergoing Cesarean Delivery	
6) Did your hospital perform a medical record audit on all cases (or a sufficient sample of them) **and** measure adherence to the appropriate DVT prophylaxis in women undergoing cesarean delivery clinical guideline? *If "no" to question #6, skip questions #7-9 and continue on to the next subsection.* *If "Yes, but fewer than 10 cases met the inclusion criteria for the denominator," skip questions #7-9 and continue on to the next subsection.*	*Yes* *No* *Yes, but fewer than 10 cases met the inclusion criteria for the denominator*

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7) Number of cases measured against the guideline, either all cases or a sufficient sample of them (**denominator**).	_____
8) Number of cases in question #7 that adhere to the clinical process guideline (**numerator**).	_____
9) Do the responses in questions #7 and #8 represent a sample of cases?	*Yes* *No*

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4F: High-Risk Deliveries

High-Risk Deliveries

1) Does your hospital electively admit high-risk deliveries[18]? *If "no" to question #1, skip the remaining questions in Section 4F, and go to the Affirmation of Accuracy.*	*Yes* *No*
2) Does your hospital operate a neonatal ICU (NICU), or is it co-located[19] with a hospital that operates a NICU, that admits or accepts transfers of very low birth weight babies[20]? *If "no" to question #2, skip questions #3-11 and continue on to question #12. If the NICU is co-located in another hospital and your hospital immediately transfers all complicated newborns there, answer question #3 and either questions #4-5 or #6-11 based on information pertaining to the co-located hospital's NICU.*	*Yes* *No*
3) Hospitals that participate in the Vermont Oxford Network (VON) and have a recent 12-month report available may elect to report their facility's Volume (questions #4-5) **OR** the VON's Death or Morbidity Measure[21] (questions #6-11). Hospitals that do not participate in the Vermont Oxford Network should report their facility's Volume (questions #4-5). Please indicate which measure the hospital will report on*:* *If you elect to report on Volume, answer questions #4-5 and skip questions #6-11. If you elect to report on the VON National Performance Measure, skip questions #4-5 and report on questions #6-11.*	*Volume* *VON National Performance Measure*

Neonatal Intensive Care Unit(s) – Volume

Specifications: See ***High-Risk Deliveries Volume Standard*** in the Maternity Care Reference Information on page 121.

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

Reporting Time Period: 12 months
- 01/01/2019 - 12/31/2019
- Optional - Surveys (re)submitted on or after September 1: 07/01/2019 - 06/30/2020

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

4) 12-month reporting time period used:	☐ 01/01/2019 - 12/31/2019 ☐ 07/01/2019 - 06/30/2020
5) For the reporting time period, how many very low birth weight babies were admitted to your hospital's neonatal intensive care unit(s)?	_____

Neonatal Intensive Care Unit(s) – National Performance Measurement

Specifications: See ***VON National Performance Measure Specifications*** in the Maternity Care Reference Information on page 122.

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

Reporting Time Period:
Base your responses on the latest **12-month** report received from the Vermont Oxford Network (VON) for the **Death or Morbidity Measure.**
- Surveys submitted prior to September 1: 2018 VON data
- Surveys (re)submitted on or after September 1: 2019 VON data

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

6) Does your hospital participate in the Vermont Oxford Network performance reporting system for high-risk deliveries and did your hospital submit data for all such deliveries during the most recent 12-month period for which performance reports are available?	*Yes* *No*
7) What is the most recent 12-month reporting time period for which VON performance results are available?	_____ *YYYY* *Format: 2018*

8) From the report, what is your hospital's volume?	_____
9) From the same report, what is your hospital's **SMR 95% lower bound**?	_____ *Format: 0.8*
10) From the same report, what is your hospital's observed to expected ratio of morbidity or mortality (**SMR shrunken**)?	_____ *Format: 1.0*
11) From the same report, what is your hospital's **SMR 95% upper bound**?	_____ *Format: 1.2*

Process Measure of Quality – Antenatal Steroids

Specifications: See ***Antenatal Steroids Process Measure Specifications*** in the Maternity Care Reference Information on pages 123-124.

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

Reporting Time Period:
For hospitals reporting on the **VON** measure, answer questions #12-18 based on a **12-month** reporting time period:

- Surveys submitted prior to September 1: 2018 VON data
- Surveys (re)submitted on or after September 1: 2019 VON data

For hospitals reporting on **The Joint Commission's PC-03** measure, answer questions #12-18 based on a **12-month** reporting time period:

- 01/01/2019 - 12/31/2019
- Optional - Surveys (re)submitted on or after September 1: 07/01/2019 - 06/30/2020

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

12) Do the responses for questions #15-18 below represent data collected using VON or The Joint Commission measure specifications? *If "VON," skip question #14. If "The Joint Commission," skip question #13.*	*VON* *The Joint Commission*
13) If VON, what is the most recent 12-month reporting time period for which VON performance results are available?	_____ *YYYY* *Format: 2018*
14) If The Joint Commission, 12-month reporting time period used:	☐ 01/01/2019 - 12/31/2019 ☐ 07/01/2019 - 06/30/2020

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15) Did your hospital perform a medical record audit on all cases (or a sufficient sample of them) for certain high-risk deliveries **and** measure adherence to the antenatal steroids clinical process guideline for these high-risk deliveries? *If "no" or "yes, but fewer than 10 cases met the inclusion criteria for the denominator," skip the remaining questions in Section 4F, and go to the Affirmation of Accuracy. The hospital will be scored as "Unable to Calculate Score."*	*Yes* *No* *Yes, but fewer than 10 cases met the inclusion criteria for the denominator*
16) Number of cases measured against the guideline, either all cases or a sufficient sample of them (**denominator**).	_____
17) Number of cases in question #16 that adhere to the clinical process guideline for this condition (**numerator**).	_____
18) Do the responses in questions #16 and #17 represent a sample of cases?	*Yes* *No*

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Affirmation of Accuracy

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

The hospital and I understand that The Leapfrog Group, its members, the public and entities and persons who contract or have other business dealings with The Leapfrog Group are relying on the truth and accuracy of this information. The hospital and I also understand that The Leapfrog Group will make this information and/or analyses of this information public through the Survey Results public reporting website, The Leapfrog Group's Hospital Safety Grade, and/or other Leapfrog Group products and services. This information and/or analyses and all intellectual property rights therein shall be and remain the sole and exclusive property of The Leapfrog Group in which The Leapfrog Group retains exclusive ownership. This information does not infringe upon any third-party intellectual property rights or any other third-party rights whatsoever and is free and clear of all encumbrances and liens of any kind. The hospital and I acknowledge that The Leapfrog Group may use this information in a commercial manner for profit. The hospital shall be liable for and shall hold harmless and indemnify The Leapfrog Group from any and all damages, demands, costs, or causes of action resulting from any inaccuracies in the information or any misrepresentations in this Affirmation of Accuracy. The Leapfrog Group and its members and entities and persons who contract or have other business dealings with The Leapfrog Group reserve the right to omit or disclaim information that is not current, accurate or truthful.

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

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Section 4: 2020 Maternity Care Reference Information

What's New in the 2020 Survey

Leapfrog has added two new questions to Section 4A to assess the proportion of board certification or board eligibility among physicians and other individuals, such as midwives, who are authorized to deliver newborn babies at the hospital, as well as anesthesiologists and/or certified registered nurse anesthetists who provide anesthesia to mothers delivering newborn babies at the hospital. These questions are aligned with those already included in Section 10 Outpatient Procedures and in the Leapfrog ASC Survey. This information will not be scored or publicly reported in 2020.

To align with the other measures in Section 4 Maternity Care, Leapfrog added minimum reporting criteria for reporting on episiotomies in Section 4D. Hospitals will only report a numerator in Section 4D question #3 if they have at least 10 qualifying cases in the denominator (question #2). Hospitals with less than 10 cases will be publicly reported as "Unable to Calculate Score."

Due to CMS' FY 2019 update to the national MS-DRG codes, Leapfrog has removed the following MS-DRG codes that were previously used in identifying vaginal deliveries for the purposes of reporting on the episiotomy denominator (Section 4D, question #2):

- 767: Vaginal delivery with sterilization and/or D&C
- 774: Vaginal delivery with complicating diagnoses
- 775: Vaginal delivery without complicating diagnoses

In addition, Leapfrog has removed the following MS-DRG codes that were previously used in identifying women undergoing cesarean delivery for the purposes of reporting on the denominator for appropriate DVT prophylaxis (Section 4E, question #7):

- 765: Cesarean section with CC/MCC
- 766: Cesarean section without CC/MCC

These MS-DRG codes were retired as of October 2018 discharges and should no longer be used for reporting on Section 4D Episiotomy and Appropriate DVT Prophylaxis in Women Undergoing Cesarean Delivery in Section 4E Process Measures of Quality in the 2020 Leapfrog Hospital Survey. Please review the *Episiotomy Measure Specifications* and the *Appropriate DVT Prophylaxis in Women Undergoing Cesarean Delivery Measure Specifications* for a list of updated codes.

In addition, measure specifications have been updated for hospitals that do not submit data to The Joint Commission (TJC) or do not participate in the California Maternal Quality Care Collaborative (CMQCC) Maternal Data Center and need to retrospectively collect data for the TJC measures included in Section 4: Elective Deliveries (PC-01), Cesarean Births (PC-02), and Antenatal Steroids (PC-03). 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, 4E Process Measures of Quality, and Antenatal Steroids within Section 4F High-Risk Deliveries.

Change Summary since Release

April 13, 2020 - Updated the definition of a 'sufficient sample size' from 60 to 30 cases for the following measures:

- Section 4B Elective Deliveries
- Section 4C Cesarean Birth

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- Section 4E Process Measures of Quality (both Newborn Bilirubin Screening Prior to Discharge and Appropriate DVT Prophylaxis in Women Undergoing Cesarean Delivery)
- Section 4F High-Risk Deliveries (Antenatal Steroids Process Measure only)

This update is intended to ease the burden of data abstraction while facilities are responding to COVID-19. See updated specifications on pages 112-117, 119-120, and 123-124 in the hard copy of the Survey for details.

May 18, 2020 – Updated the scoring for Section 4E Process Measures of Quality. Leapfrog originally announced scoring and publicly reporting Newborn Bilirubin Screening Prior to Discharge and Appropriate DVT Prophylaxis in Women Undergoing Cesarean Delivery separately in 2020. However, this change has been delayed to allow for easier comparison between 2019 and 2020 Leapfrog Hospital Survey Results, which will both be publicly reported as part of Leapfrog's response to COVID-19. Please review the updated scoring in the 2020 Leapfrog Hospital Survey Scoring Algorithms on the Scoring and Results webpage for more information.

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Section 4: Maternity Care Measure Specifications

Maternity Care Volume

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

Source: The Leapfrog Group
Reporting Time Period: 12 months • 01/01/2019 - 12/31/2019 • Optional - Surveys (re)submitted on or after September 1: 07/01/2019 - 06/30/2020
Question 3: The number of live births (i.e., infants) at this hospital location (inborn cases only), reported to your state during the reporting time period. Alternatively, the below list of Z codes can be used to identify live births, with the caution that these codes are coded for the newborn, not the mother; likely to be found in your hospital's birth CIS/medical record system; but often not in claims data since normal newborn care may be included in the mother's claim without baby's diagnosis coding. Z38.00 – Z38.01: Single liveborn infant, born in hospital Z38.30 – Z38.31: Twin liveborn infant, born in hospital Z38.61 – Z38.69: Other multiple liveborn infant, born in hospital Note: This data point is simply used to qualify a hospital for further reporting of the normal delivery measures.

Elective Deliveries

Important Notes:

Note 1: Elective Deliveries can be reported based on all eligible cases OR a sufficient sample of cases as outlined in the denominator specifications.

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

Note 3: Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review Leapfrog's Multi-Campus Reporting Policy.

Source: Joint Commission PC-01 (version 2019A1)

Reporting Time Period: 12 months

- 01/01/2019 - 12/31/2019
- Optional - Surveys (re)submitted on or after September 1: 07/01/2019 - 06/30/2020

If you measured this quality indicator, reported the results to The Joint Commission (TJC), and continue to submit these data to The Joint Commission, **use those data when responding to this subsection of the Survey.**

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

Otherwise, use TJC's PC-01 Elective Deliveries measure specifications (version 2019A1) to retrospectively collect and report data for this measure. The PC-01 measure specifications are outlined below. To access the measure specifications directly on The Joint Commission's website, visit https://manual.jointcommission.org/releases/TJC2019A1/MIF0166.html.

Sampling Cases: Hospitals that report the Perinatal Care Measure Set to TJC may use the sampling methodology used by the TJC to report on these questions.

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

- Review your hospital's first delivery as of **April 15, 2019** (or *optionally*, **July 15, 2019** if (re)submitting a Survey on or after September 1, 2020 and sampling from 07/01/2019 – 06/30/2020 discharges).
- Evaluate this case against the inclusion criteria; retain the case for the sample if it meets the inclusion criteria.
- Evaluate this case against the exclusion criteria; retain the case for the sample if it does not meet any of the listed exclusions.
- Move to the next delivery and evaluate for inclusion/exclusion applicability.
- Continue through cases in sequential order until **a sample of at least 30 cases** is reached, or all cases discharged during the reporting period are reviewed, whichever comes first.

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Discharges between 01/01/2019 – 12/31/2019 & 07/01/2019 – 06/30/2020 (v2019A1) *If sampling, review deliveries starting on **April 15, 2019** (or **July 15, 2019** if (re)submitting a Survey on or after September 1, 2020)*	**Question 2 (denominator):** Patients delivering newborns with >= 37 and < 39 weeks of gestation completed with ***Excluded Populations*** removed. *Note: The denominator should include both mothers that had their newborn delivered electively and mothers that delivered spontaneously at the specified weeks of gestation.* **Included Populations**: • *ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes* for delivery as defined in Appendix A, Table 11.01.1. • *ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes* for planned cesarean birth in labor as defined in Appendix A, Table 11.06.1. **Excluded Populations:** • *ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes* for conditions possibly justifying elective delivery prior to 39 weeks gestation as defined in Appendix A, Table 11.07 • History of prior stillbirth • Less than 8 years of age • Greater than or equal to 65 years of age • Length of stay > 120 days • *Gestational Age* < 37 or >= 39 weeks or UTD **Data Elements:** Visit https://manual.jointcommission.org/releases/TJC2019A1/MIF0166.html. ***If fewer than 10 cases during the reporting period, skip the next question.***

	Question 3 (numerator): Patients with elective deliveries included in the denominator.
	
	Included Populations:
	ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes for one or more of the following:
	• Medical induction of labor as defined in Appendix A, Table 11.05 while not in *Labor* prior to the procedure
	• Cesarean birth as defined in Appendix A, Table 11.06 and all of the following:
	  ○ not in *Labor*
	  ○ no history of a *Prior Uterine Surgery*
	
	Excluded Populations: None
	
	Data Elements: Visit https://manual.jointcommission.org/releases/TJC2019A1/MIF0166.html.

Cesarean Birth

Important Notes:

Note 1: Cesarean Births can be reported based on all eligible cases OR a sufficient sample of cases as outlined in the denominator specifications.

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

Note 3: Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review Leapfrog's Multi-Campus Reporting Policy.

Source: Joint Commission PC-02
- v2019A1: Discharges between 01/01/2019 – 06/30/2019
- v2019A1: Discharges between 07/01/2019 – 12/31/2019 (same as above)
- v2020A1: Discharges between 01/01/2020 – 06/30/2020

Reporting Time Period: 12 months
- 01/01/2019 – 12/31/2019
- Optional - Surveys (re)submitted on or after September 1: 07/01/2019 – 06/30/2020

If you measured this quality indicator, reported the results to The Joint Commission (TJC), and continue to submit these data to The Joint Commission, **use those data when responding to this subsection of the Survey.**

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

Otherwise, use TJC's PC-02 Cesarean Birth measure specifications to retrospectively collect and report data for this measure. The PC-02 measure specifications are outlined below based on discharge date. To access the measure specifications directly on The Joint Commission's website, see the specification manuals linked below:
- v2019A1: Discharges between 01/01/2019 – 06/30/2019
- v2019A1: Discharges between 07/01/2019 – 12/31/2019 (same as above)
- v2020A1: Discharges between 01/01/2020 – 06/30/2020

Sampling Cases: Hospitals that report the Perinatal Care Measure Set to TJC may use the sampling methodology used by the TJC to report on these questions.

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

Sampling instructions for 01/01/2019 – 12/31/2019 discharges:
- Review your hospital's first delivery as of **April 15, 2019**.
- Evaluate this case against the inclusion criteria; retain the case for the sample if it meets the inclusion criteria.
- Evaluate this case against the exclusion criteria; retain the case for the sample if it does not meet any of the listed exclusions.
- Move to the next delivery and evaluate for inclusion/exclusion applicability.
- Continue through cases in sequential order until **a sample of at least 30 cases** is reached, or all cases discharged during the reporting period are reviewed, whichever comes first.

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When sampling for the 01/01/2019 – 12/31/2019 reporting period, use one set of measure specifications:

- v2019A1: Discharges between 01/01/2019 – 12/31/2019 (sample cases as of April 15, 2019)

Sampling instructions for 07/01/2019 – 6/30/2020 discharges (Optional - Surveys (re)submitted on or after September 1):
Sampling requires hospitals to use two different sets of measure specifications and therefore sampling has two steps, both of which need to be completed to obtain a sample of at least 30 cases.

Step #1:

- Review your hospital's first delivery as of **July 15, 2019**.
- Evaluate this case against the inclusion criteria; retain the case for the sample if it meets the inclusion criteria.
- Evaluate this case against the exclusion criteria; retain the case for the sample if it does not meet any of the listed exclusions.
- Move to the next delivery and evaluate for inclusion/exclusion applicability.
- Continue through cases in sequential order until **a sample of at least 15 cases** is reached, or all cases discharged during the first 6-month reporting period of **07/01/2019 – 12/31/2019** are reviewed, whichever comes first.

Step #2:

- After sampling the first 15 cases, review your hospital's first delivery as of **April 15, 2020**.
- Evaluate this case against the inclusion criteria; retain the case for the sample if it meets the inclusion criteria.
- Evaluate this case against the exclusion criteria; retain the case for the sample if it does not meet any of the listed exclusions.
- Move to the next delivery and evaluate for inclusion/exclusion applicability.
- Continue through cases in sequential order until **a sample of at least 15 cases** is reached, or all cases discharged during the second 6-month reporting period of **01/01/2020 – 06/30/2020** are reviewed, whichever comes first.

When sampling for the 07/01/2019 – 06/30/2020 reporting period, use the measure specifications based on the correct discharge date, which are outlined below:

- v2019A1: Discharges between 07/01/2019 – 12/31/2019 (sample cases as of July 15, 2019)
- v2020A1: Discharges between 01/01/2020 – 06/30/2020 (sample cases as of April 15, 2020)

Discharges between 01/01/2019 – 06/30/2019 & 07/01/2019 – 12/31/2019 (v2019A1) *If sampling, review deliveries starting on **April 15, 2019** (or **July 15, 2019** if (re)submitting a Survey on or after September 1, 2020)*	**Question 2 (denominator):** Nulliparous patients delivered of a live term singleton newborn in vertex presentation with ***Excluded populations*** removed. *Note: The denominator should include both nulliparous mothers with a live term singleton newborn in vertex presentation that had their newborn delivered via cesarean section and nulliparous mothers that delivered vaginally.* **Included Populations:** • *ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes* for delivery as defined in Appendix A, Table 11.01.1. • Nulliparous patients with *ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes* for outcome of delivery as defined in Appendix A, Table 11.08, and with a delivery of a newborn with 37 weeks or more of gestation completed. **Excluded Populations:** • *ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes* for multiple gestations and other presentations as defined in Appendix A, Table 11.09 • Less than 8 years of age

	• Greater than or equal to 65 years of age • Length of stay >120 days • *Gestational Age* < 37 weeks or UTD **Data Elements:** Visit https://manual.jointcommission.org/releases/TJC2019A1/MIF0167.html. ***If fewer than 10 cases during the reporting period, skip the next question.***
	Question 3 (numerator): Patients in the denominator with cesarean births. **Included Populations:** *ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes* for cesarean birth as defined in Appendix A, Table 11.06 **Excluded Populations:** None **Data Elements:** Visit https://manual.jointcommission.org/releases/TJC2019A1/MIF0167.html
Discharges between 01/01/2019– 06/30/2019 (v2020A1) *If sampling, review deliveries starting on* ***April 15, 2020***	**Question 2 (denominator):** Nulliparous patients delivered of a live term singleton newborn in vertex presentation with ***Excluded populations*** removed. *Note: The denominator should include both nulliparous mothers with a live term singleton newborn in vertex presentation that had their newborn delivered via cesarean section and nulliparous mothers that delivered vaginally.* **Included Populations:** • *ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes* for delivery as defined in Appendix A, Table 11.01.1. • Nulliparous patients with *ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes* for outcome of delivery as defined in Appendix A, Table 11.08, and with a delivery of a newborn with 37 weeks or more of gestation completed. **Excluded Populations:** • *ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes* for multiple gestations and other presentations as defined in Appendix A, Table 11.09 • Less than 8 years of age • Greater than or equal to 65 years of age • Length of stay >120 days • *Gestational Age* < 37 weeks or UTD **Data Elements:** Visit https://manual.jointcommission.org/releases/TJC2020A1/MIF0167.html. ***If fewer than 10 cases during the reporting period, skip the next question.***

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	Question 3 (numerator): Patients in the denominator with cesarean births. **Included Populations:** *ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes* for cesarean birth as defined in Appendix A, Table 11.06 **Excluded Populations:** None **Data Elements:** Visit https://manual.jointcommission.org/releases/TJC2020A1/MIF0167.html

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Episiotomy

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

Source: National Quality Forum #0470

Reporting Time Period: 12 months

- 01/01/2019 - 12/31/2019
- Optional - Surveys (re)submitted on or after September 1: 07/01/2019 - 06/30/2020

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

Question 2 (denominator): Total number of vaginal deliveries during the reporting time period, with Excluded Populations removed.

For the purposes of this measure, use the following MS-DRGs to identify a vaginal delivery:

- 768: Vaginal delivery with O.R. procedure except sterilization and/or D&C
- 796: Vaginal delivery with sterilization/D&C with MCC
- 797: Vaginal delivery with sterilization/D&C with CC
- 798: Vaginal delivery with sterilization/D&C without CC/MCC
- 805: Vaginal delivery without sterilization/D&C with MCC
- 806: Vaginal delivery without sterilization/D&C with CC
- 807: Vaginal delivery without sterilization/D&C without CC/MCC

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

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

Excluded Populations:
Exclude any cases with the following ICD-10-CM diagnostic code in a primary or secondary field:

- O66.0: Obstructed labor due to shoulder dystocia

Question 3 (numerator): Total number of mothers included in question #2 (the denominator) that had an episiotomy procedure performed.

For the purposes of this measure, the following ICD-10-PCS procedure codes should be used for identifying an episiotomy:

- 0W8NXZZ: Division of female perineum, external approach

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Maternity Care Process Measure Specifications

Important Notes:

Note 1: For Maternity Care Process Measures, hospitals with a sufficient sample size (as defined below), can randomly sample for the denominator of each indicator, and measure and report adherence based on that sample. Most likely, the numerator criteria for these two measures will require medical chart review if these specific data are not already extracted or coded consistently for other purposes.

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

Newborn Bilirubin Screening Prior to Discharge

Source: Providence Health

Reporting Time Period: 12 months

- 01/01/2019 - 12/31/2019
- Optional - Surveys (re)submitted on or after September 1: 07/01/2019 - 06/30/2020

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

Sampling: If you have fewer than 30 cases that meet the criteria for inclusion in the denominator of the process measure during the time period of the medical record audit, include ALL of these cases in measuring adherence to the process guidelines. You need NOT use more than 12 months of historical data to increase the eligible cases beyond 30; just measure and report on ALL eligible cases that you have in that reporting time period.

If you have more than 30 cases that meet the criteria for inclusion in the denominator of the process measure during the time period of the medical record audit, you may randomly sample at least 30 of them for the denominator of each guideline, and measure and report adherence based on that sample.

Question 3 (denominator): Eligible cases include all normal newborns born at or beyond 35 completed weeks gestation that were delivered in the facility during the reporting period (all inborns) with **Excluded Populations** removed.

Excluded Populations:

- admitted to a neonatal ICU, either at your hospital or another hospital; or
- with parental refusal to test; or
- prenatal documentation of severe congenital anomalies in the newborn and documentation that the newborn will receive comfort care measures only; or
- newborn died prior to discharge

Question 4 (numerator): Number of eligible cases included in the denominator who have a serum or transcutaneous bilirubin screen prior to discharge to identify risk of hyperbilirubinemia.

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Appropriate DVT Prophylaxis in Women Undergoing Cesarean Delivery

Source: National Quality Forum #0473

Reporting Time Period: 12 months

- 01/01/2019 - 12/31/2019
- Optional - Surveys (re)submitted on or after September 1: 07/01/2019 - 06/30/2020

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

Sampling: If you have fewer than 30 cases that meet the criteria for inclusion in the denominator of the process measure during the time period of the medical record audit, include ALL of these cases in measuring adherence to the process guidelines. You need NOT use more than 12 months of historical data to increase the eligible cases beyond 30; just measure and report on ALL eligible cases that you have in that reporting time period.

If you have more than 30 cases that meet the criteria for inclusion in the denominator of the process measure during the time period of the medical record audit, you may randomly sample at least 30 of them for the denominator of each guideline, and measure and report adherence based on that sample.

Question 7 (denominator): Eligible cases include all women undergoing cesarean delivery during the reporting period.

Include cases with one of the following MS-DRG codes:

- 783: Cesarean section with sterilization with MCC
- 784: Cesarean section with sterilization with CC
- 785: Cesarean section with sterilization without CC/MCC
- 786: Cesarean section without sterilization with MCC
- 787: Cesarean section without sterilization with CC
- 788: Cesarean section without sterilization without CC/MCC

Excluded Populations: None.

Question 8 (numerator) Number of eligible cases included in the denominator who received either fractionated or unfractionated heparin or heparinoid, or pneumatic compression devices prior to surgery.

Note: Use of a pneumatic compression device may be documented in the OR log, but must be placed pre-operatively to qualify for inclusion in the numerator.

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High-Risk Deliveries Measure Specifications

High-Risk Deliveries Volume Standard

Important Notes:

Note 1: Hospitals should respond on **either** Volume OR the VON National Performance Measure.

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

Hospitals opting to report on Volume should only use ICD-10-CM codes as indicated in the specifications. When calculating hospital volume, count the number of patients with any one or more of the specified diagnosis codes for high-risk deliveries, subject to the other inclusion/exclusion criteria below. The diagnosis codes may be in any primary or secondary field. The count can include inborn as well as transfer cases.

Question #5: Instructions for Volume Reporting

Source: The Leapfrog Group

Included Populations:
Number of newborns admitted to the neonatal ICU with the following ICD-10-CM codes:

ICD-10-CM Code	Description
P05.02	Newborn light for gestational age, 500-749 grams
P05.03	Newborn light for gestational age, 750-999 grams
P05.04	Newborn light for gestational age, 1000-1249 grams
P05.05	Newborn light for gestational age, 1250-1499 grams
P05.12	Newborn small for gestational age, 500-749 grams
P05.13	Newborn small for gestational age, 750-999 grams
P05.14	Newborn small for gestational age, 1000-1249 grams
P05.15	Newborn small for gestational age, 1250-1499 grams
P05.2	Newborn affected by fetal malnutrition not light or small for gestational age
P05.9	Newborn affected by slow intrauterine growth, unspecified
P07.02	Extremely low birth weight newborn, 500-749 grams
P07.03	Extremely low birth weight newborn, 750-999 grams
P07.14	Other low birth weight newborn, 1000-1249 grams
P07.15	Other low birth weight newborn, 1250-1499 grams

Excluded Populations: Newborns admitted to the neonatal ICU weighing 1500 grams or more.

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VON National Performance Measure Specifications

Important Notes:

Note 1: Hospitals should respond to **either** Volume OR the VON National Performance Measure.

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

Hospitals opting to report on the VON National Performance Measure should use these instructions. There is only one set of instructions for the VON National Performance Measure.

Questions #6-11: Instructions for reporting on Death or Morbidity

Download instructions for using the VON Nightingale online tool on the Survey and CPOE Materials webpage.

Entity:	**Vermont Oxford Network (SMR Report from Nightingale online tool)**
Volume	For the latest 12-month standardized mortality or morbidity ratio (SMR) report for Death or Morbidity, enter your hospital's "N" for the volume of cases for the reporting period.
SMR 95% (lower bound)	From the same report, enter your hospital's "SMR 95% (lower)" for Death or Morbidity. This represents the lower value of your hospital's 95% confidence interval.
SMR (shrunken)	From the same report, enter your hospital's "SMR (shrunken)" for Death or Morbidity. This is the weighted average of the hospital value and the population (Vermont Oxford Network) mean value.
SMR 95% (upper bound)	From the same report, enter your hospital's "SMR 95% (upper)" for Death or Morbidity. This represents the upper value of your hospital's 95% confidence interval.

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Antenatal Steroids Process Measure

Important Notes:

Note 1: The specifications provided below include instructions for hospitals participating in VON, as well as those hospitals participating with The Joint Commission (TJC) or the California Maternal Quality Care Collaborative (CMQCC) Maternal Data Center. Other facilities should use The Joint Commission's PC-03 Antenatal Steroids measure specifications provided below to retrospectively collect and report data for this measure. Please be sure that you review the appropriate specifications below based on your participation status in VON, TJC, or CMQCC.

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

For hospitals that participate in the Vermont Oxford Network (VON)

If your hospital participates in the Vermont Oxford Network and has:

- measured adherence to the antenatal steroids process-of-care quality indicator,
- reported the results to VON, and
- continues to submit these data to VON, then

your hospital may use those data (numerator and denominator) when responding to this subsection of Survey and ignore The Joint Commission (TJC) specifications listed below for the measure.

Download instructions for using the VON Nightingale online tool on the Survey and CPOE Materials webpage.

For all other hospitals

Source: Joint Commission PC-03 (version 2019A1)

Reporting Time Period: 12 months

- 01/01/2019 - 12/31/2019
- Optional - Surveys (re)submitted on or after September 1: 07/01/2019 - 06/30/2020

If you measured adherence to this process-of-care quality indicator, reported the results to The Joint Commission (TJC), and continue to submit these data to The Joint Commission, **use those data when responding to this subsection of the Survey**.

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

Otherwise, use The Joint Commission's PC-03 Antenatal Steroids measure specifications (version 2019A1) detailed below to retrospectively collect and report data for this measure. To access the measure specifications directly on The Joint Commission's website, visit https://manual.jointcommission.org/releases/TJC2019A1/MIF0168.html.

Sampling Cases: Hospitals that report the Perinatal Care Measure Set to TJC may use the sampling methodology used by the TJC to report on these questions.

Otherwise, if you have fewer than 30 cases that meet the criteria for inclusion in the denominator of the process measure during the time period of the medical record audit, include ALL of these cases in measuring adherence to the process guidelines. You need NOT use more than 12 months of historical data to increase the eligible cases beyond 30; just measure and report on ALL eligible cases that you have in that reporting time period.

If you have more than 30 cases that meet the criteria for inclusion in the denominator of the process measure during the time period of the medical record audit, you may randomly sample at least 30 of them for the denominator of each guideline, and measure and report adherence based on that sample.

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Question 16 (denominator) Patients delivering live preterm newborns with >=24 and <34 weeks gestation completed with ***Excluded populations*** removed.

Included Populations:

- *ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes* for delivery as defined in Appendix A, Table 11.01.1.

Excluded Populations:

- Less than 8 years of age
- Greater than or equal to 65 years of age
- Length of Stay >120 days
- Documented *Reason for Not Initiating Antenatal Steroids*
- *ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes* for fetal demise as defined in Appendix A, Table 11.09.1
- *Gestational Age* < 24 or >= 34 weeks or UTD

Data Elements: Visit https://manual.jointcommission.org/releases/TJC2019A1/MIF0168.html.

Question 17 (numerator): The number of patients included in the denominator with antenatal steroids initiated prior to delivering preterm newborns.

Included Populations:
Antenatal steroids initiated (refer to Appendix C, Table 11.0, antenatal steroid medications)

Excluded Populations: None.

Data Elements: Visit https://manual.jointcommission.org/releases/TJC2019A1/MIF0168.html.

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

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Maternity Care Frequently Asked Questions (FAQs)

1. **Under normal circumstances our hospital does not perform newborn deliveries. However, during the reporting period we had a few emergency situations and/or transfers. Should we indicate delivering newborns during the reporting period?**
   If your hospital does not electively perform newborn deliveries (i.e. no labor/delivery unit, only admit in an emergency situation), you would respond "no" to question #2 in Section 4A, as hospitals are instructed to report inborns only.

2. **Should newborns that are delivered outside of the hospital that are brought to labor and delivery be included in the total number of live births in Section 4A?**
   When calculating the total number of live births in Section 4A question #3, refer to the measure specifications for Maternity Care Volume. Only inborns should be included in the total volume.

3. **How does Leapfrog define board certified and board eligible?**
   For physicians:
   - Board certified means that the physician has been awarded certification from the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA).
   - Board eligible indicates that the physician has completed their initial training/fellowship but has not yet passed an existing board-certifying exam in a specialty. Leapfrog adheres to the ABMS and AOA Board Eligibility Policy for all specialties, which may be reviewed here: https://www.abms.org/media/176507/abms-board-eligibility-overview-and-faqs-abmsorg-20180511.pdf and https://certification.osteopathic.org/about/, respectively. These eligibility periods provide the physician with an adequate window to take her/his boards and re-take if necessary.

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

   Section 4A question #5 is only referring to CRNAs that are board certified, as board eligible CRNAs are not licensed and are not yet able to provide clinical care in hospital outpatient departments.

4. **Should hospitals use delivery date or discharge date when including births/cases for the measures reported in Section 4 Maternity Care?**
   The discharge date should be used to determine whether a case falls within the reporting period specified.

5. **Why are hospitals being asked to use multiple TJC measure specifications when collecting data retrospectively for PC-02? Why is the sample size for PC-01 and PC-02 now 30 cases instead of 60?**
   For hospitals that do not submit data to The Joint Commission (TJC) and need to retrospectively collect data using the TJC specifications provided, Cesarean Birth (PC-02), will use multiple TJC measure specifications based on the discharge dates of included cases. This is due to updates between each version. These include updates to the ICD-10 tables. Leapfrog elected to decrease the minimum sample size to 30 cases for the 2020 Leapfrog Hospital Survey to ease the burden of data abstraction while facilities are responding to COVID-19. The sampling for this measure includes two steps as hospitals will need to sample at least 15 cases from two separate sets of measure specifications to obtain a total sample size of at least 30 cases if using the optional second reporting period (07/01/2019 – 06/30/2020).

6. **In Section 4E, what tools should hospitals use for managing patients that receive a serum or transcutaneous bilirubin screen to assess the risk of hyperbilirubinemia prior to discharge?**

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One example hospitals can use is the Bhutani Nomogram. For an example, please see:
American Academy of Pediatrics Clinical Practice Guidelines: Management of Hyperbilirubinemia in the Newborn Infant 35 or More Weeks of Gestation.
http://pediatrics.aappublications.org/content/114/1/297.full
Tip: To view any Figure in the reference, click on it to open, then again to enlarge.

Other tools may also be used if the serum or transcutaneous screen is conducted prior to discharge and risk is managed appropriately.

7. **In Section 4E, what codes or diagnoses should be used to identify severe congenital anomalies for exclusions for newborn bilirubin screening prior to discharge?**
Leapfrog's Maternity Care Expert Panel has opted to not overcomplicate the measure by providing ICD-codes for identifying congenital anomalies in the newborn. Instead, we would suggest that you focus on identifying the following exclusions: documentation that the newborn will receive comfort care measures only, which would accompany the prenatal documentation of severe congenital anomalies in the newborn.

   If you have concerns about the level of effort required to identify these exclusions, please note that Leapfrog allows hospitals to report on a sample of 30 cases for those facilities that opt to report on a sample instead of full case reporting. You can find those instructions on page 119 of the hard copy of the Survey.

8. **In Section 4E, would anti-embolic stockings qualify for inclusion in the numerator for DVT prophylaxis in women undergoing cesarean delivery?**
No. Anti-embolic stockings are an example of Graduated Compression Stockings (GCS) but are not pneumatic compression devices as they do not fill with air and squeeze the leg. The measure, as currently specified and recommended by our Maternity Care Expert Panel, only allows hospitals to report on the number of cases where a pneumatic compression device was placed on the patient prior to surgery.

9. **In Section 4F, if we don't have a neonatal ICU (NICU) located in our hospital, why does the NICU have to be co-located in order to earn credit?**
A co-located NICU is one that is physically connected, either by a tunnel, an enclosed bridge, or the NICU abuts the hospital so that the hallways readily connect. Based on available research evidence, the pivotal factor is that the neonatal team be able to attend the high-risk deliveries whenever a neonatal resuscitation might be necessary. If the hospital and NICU are not immediately adjacent to each other, this isn't possible.

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SECTION 5: ICU PHYSICIAN STAFFING (IPS)

This section includes questions and reference information for Section 5: ICU Physician Staffing. Please carefully review the questions, endnotes, and reference information (e.g., measure specifications, notes, and frequently asked questions) before you begin. Failure to review the reference information could result in inaccurate responses.

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Section 5: 2020 ICU Physician Staffing (IPS) Standard

IPS Fact Sheet: http://www.leapfroggroup.org/ratings-reports/icu-physician-staffing

Adult and pediatric hospitals that do not have licensed or staffed adult or pediatric general medical and/or surgical ICU beds or neuro ICU beds should respond "No" to question #2 and move on to the Affirmation of Accuracy. Your hospital's results will be displayed as "Does Not Apply" on Leapfrog's public reporting website.

Section 5 includes questions about the staffing structure of your hospital's pediatric and adult general medical and/or surgical ICUs and neuro ICUs.

Each hospital achieving the standard for ICU Physician Staffing assures that:
All critical care patients[22] in its adult or pediatric general medical and/or surgical ICUs and neuro ICUs[23] are managed or co-managed[24] by physicians certified in critical care medicine[25] who:

- Are ordinarily present in the ICU[26] (on-site, or via telemedicine[27]) during daytime hours for at least 8 hours per day, 7 days per week, and during this time provide clinical care exclusively[26] in the ICU; and
- At other times*
  - Return more than 95% of ICU calls within 5 minutes, based on a quantified analysis[28] of notification device response time; and
  - Can rely on a physician, physician assistant, nurse practitioner[31], or an FCCS-certified nurse "effector"[29] who is in the hospital and able to reach ICU patients within 5 minutes in more than 95% of cases, based on a quantified hospital analysis of notification device response time.

*Not applicable for hospitals with 24/7 intensivist coverage.

Download the 2020 Leapfrog Hospital Survey Scoring Algorithm on the Scoring and Results webpage.

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5: ICU Physician Staffing (IPS)

Review each of the endnotes referenced in the questions below before responding to each question.

Important Notes:

Note 1: Some intensivist "presence" may be accomplished via tele-intensivists per Leapfrog's specifications (More Information[27]). However, at this time hospitals cannot fully meet the standard through the sole use of tele-intensivists.

Note 2: On an interim basis, other categories of physicians may be considered by Leapfrog to be "certified in Critical Care Medicine" (More Information[25]).

Reporting Time Period: Answer questions #1-14 based on the staffing structure currently in place at the time that you submit this section of the Survey. The staffing structure should have been in place for at least the past 3 months and reflect the ordinary staffing structure for each applicable ICU.

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

1) What is the latest 3-month reporting period for which your hospital is submitting responses to this section? 3 months ending:	*Format: MM/YYYY*
2) Does your hospital operate any adult or pediatric general medical and/or surgical ICUs or neuro ICUs[23]? *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) Do physicians certified in critical care medicine[25], when present on-site or via telemedicine, manage or co-manage[24] all critical care patients[22] in these ICUs? *If "no" to question #3, skip questions #4-10 and continue on to question #11.*	*Yes, all are certified in critical care* *Yes, based on expanded definition of certified* *No*

4) Are all critical care patients[22] in each of these ICUs managed or co-managed[24] by one or more physicians certified in critical care medicine[25] who meet **all** of 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 (More Information[27]) • supported by an on-site intensivist who establishes and revises the daily care plan for each ICU patient *If "yes" to question #4, skip question #5 and continue on to question #6. If "no," continue on to question #5.*	*Yes* *No*

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If your hospital does not have any tele-intensivist coverage, or meet all three bullets in question #4, select "no" to question #4 and continue on to question #5 to report on on-site intensivist coverage.	
5) Are all critical care patients[22] in each of these ICUs managed or co-managed[24] by one or more physicians certified in critical care medicine[25] who meet **all** of the following criteria: • ordinarily present[26] on-site in each of these ICUs during daytime hours • for at least **8 hours per day, 7 days per week** • providing clinical care exclusively[26] in one ICU during these hours	*Yes* *No*

If "no" to question #4 and question #5, skip questions #6-7 and continue on to question #8.

6) When the physicians (from question #3) are not present in these ICUs 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[28] of notification device response time? (More information on the use of telemedicine to cover calls[30])	*Yes* *No* *Not applicable, intensivists are present on-site 24/7*
7) 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[31], or FCCS-certified nurse or intern "effector"[29] 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[28] of notification device response time?	*Yes* *No* *Not applicable, intensivists are present on-site 24/7*

If "no" to either question #6 or #7 in this section, please answer questions #8-14. If "yes" or "not applicable, intensivists are present on-site 24/7" to questions #6 and #7, skip the remaining questions in Section 5, and go to the Affirmation of Accuracy.

8) Are all critical care patients[22] in each of these ICUs managed or co-managed[24] by one or more physicians certified in critical care medicine[25] who meet **all** of the following criteria: • ordinarily present[26] 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[26] in one ICU during these hours?	*Yes* *No*
9) Are all critical care patients[22] in each of these ICUs managed or co-managed[24] by one or more physicians certified in critical care medicine[25] 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 (More Information[32]) • 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*

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10) Are all critical care patients[22] in each of these ICUs managed or co-managed[24] by one or more physicians certified in critical care medicine[25] 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 #8, #9, or #10, skip question #11 and continue on to question #12.

11) If not all critical care patients[22] are managed or co-managed[24] by physicians certified in critical care medicine[25], either on-site or via telemedicine[27], are **some patients** managed or co-managed by these physicians?	*Yes* *No*
12) Does an on-site clinical pharmacist do **all** of the following: • At least 5 days per week, makes daily on-site rounds on all critical care patients[22] 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[28] of notification device response time **OR** • Makes daily on-site rounds on all critical care patients[22] in each of these ICUs 7 days per week	*Yes* *No* *Clinical pharmacist rounds 7 days per week*
13) Does a physician certified in critical care medicine[25] lead daily interprofessional rounds on-site on all critical care patients[22] in each of these ICUs 7 days per week?	*Yes* *No*
14) When physicians certified in critical care medicine[25] are on-site in each of these ICUs, do they have responsibility for all ICU admission and discharge decisions?	*Yes* *No*

Affirmation of Accuracy:

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

The hospital and I understand that The Leapfrog Group, its members, the public and entities and persons who contract or have other business dealings with The Leapfrog Group are relying on the truth and accuracy of this information. The hospital and I also understand that The Leapfrog Group will make this information and/or analyses of this information public through the Survey Results public reporting website, The Leapfrog Group's Hospital Safety Grade, and/or other Leapfrog Group products and services. This information and/or analyses and all intellectual property rights therein shall be and remain the sole and exclusive property of The Leapfrog Group in which The Leapfrog Group retains exclusive ownership. This information does not infringe upon any third-party intellectual property rights or any other third-party rights whatsoever and is free and clear of all encumbrances and liens of any kind. The hospital and I acknowledge that The Leapfrog Group may use this information in a commercial manner for profit. The hospital shall be liable for and shall hold harmless and indemnify The Leapfrog Group from any and all damages, demands, costs, or causes of action resulting from any inaccuracies in the information or any misrepresentations in this Affirmation of Accuracy. The Leapfrog Group and its members and entities and persons who contract or have other business dealings with The Leapfrog Group reserve the right to omit or disclaim information that is not current, accurate or truthful.

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

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Section 5: 2020 ICU Physician Staffing (IPS) Reference Information

What's New in the 2020 Survey

There are no substantive changes to this section.

Change Summary since Release

None. If substantive changes are made to this section of the Survey after release on April 1, 2020, they will be documented in this Change Summary section.

ICU Physician Staffing Frequently Asked Questions (FAQs)

General Questions

1. **What is the reporting period for this measure?**
   Hospitals should report on Section 5 based on their staffing structure at the time they submit this section of the Survey. The staffing structure must have been in place for at least the past 3 months and should reflect the ordinary staffing structure for the ICU.

2. **How should hospitals report if they have more than one type of qualifying ICU?**
   Hospitals with more than one ICU type are instructed to respond to each question in Section 5 based on the unit with the least intensive staffing structure, not the most intensive staffing structure as described in endnote #23.

3. **Does Leapfrog's IPS standard apply to mixed acuity units? A multi-organizational service unit (MOSU) unit?**
   Coverage is dictated by the patient's status, not the physical bed. The standard applies to those patients considered to be critical care patients.

4. **What roles should be included in interprofessional rounds?**
   For rounds to be considered interprofessional, the team should include 3 or more persons. Typical personnel that would be part of the rounding team include physician, nurse, pharmacist, physical and/or occupational therapist, and nutritionist.

5. **How does Leapfrog define "makes on-site daily rounds" for clinical pharmacists in question #12?**
   A clinical pharmacist would need to make on-site daily rounds (5 or 7 days a week) on **all** ICU patients (not some or most ICU patients) in **all** applicable ICUs (adult or pediatric general medical and/or surgical ICUs and neuro ICUs).

   Please note that if your clinical pharmacist is rounding 5 days per week, then, during the other 2 days per week, a clinical pharmacist still needs to respond to calls/texts/pages within 5 minutes, as determined by a response time audit.

Telemedicine Questions

6. **Can you clarify what you mean by combined presence of tele-intensivists and on-site intensivists, as needed, for 24 hours per day/7 days per week in question #4?**
   Hospitals can Fully Meet Leapfrog's IPS Standard by having a telemedicine service that meets all ten of the requirements outlined in endnote #27 and a tele-intensivist continually monitoring all critical care patients when an on-site intensivist is not present. For example, if an on-site intensivist rounds on patients for two hours in the morning, but a tele-intensivist is continually monitoring critical care patients for the remaining 22 hours, for a combined total of 24 hours per day/7 days per week, then the hospital can respond 'yes' to question #4.

   However, hospitals should minimize the number of hand-offs between the on-site intensivist and the tele-intensivist during a 24-hour period and maximize the continuous time that one type of intensivist is caring for critical care patients. An example of this is given in the previous paragraph where a tele-intensivist is covering patients for the majority of the day when on-site intensivists are not rounding. **Leapfrog does not recommend more than 4 hand-offs per 24 hours.** More information about hand-off procedures is available in endnote #27.

7. **Our hospital uses a telemedicine service to provide coverage in our ICU for 16 hours/7 days a week coverage when the on-site intensivist is not present at the hospital. Can our hospital still fully meet Leapfrog's standard?**

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Hospitals that use telemedicine to cover "call" for the on-site intensivist are able to fully meet Leapfrog's standard if: (1) the telemedicine service meets all ten of the requirements outlined in endnote #27; and (2) the hospital has an "effector" (physician/PA/NP/FCCS-certified nurse or intern) on-site during that time period to carry out the tele-intensivist's orders and can reach the ICU patient within 5 minutes, 95% of the time.

Certification Questions

8. **Is there any empirical basis for specifying a minimum annual number of days of ICU experience for each board-eligible physician providing ICU care?**
   No. Accordingly, if it is added to the Leapfrog standard in the future, it will be based on newly published research and expert advice.

9. **Do all intensivists serving as tele-intensivists need to meet Leapfrog's definition of "certified in critical care medicine"?**
   Yes. All intensivists who serve as tele-intensivists do need to meet Leapfrog's definition of "certified in critical care medicine" as specified in endnote #25.

10. **Is a physician who is awaiting the results of the certification test considered "certified in critical care medicine"?**
    A physician is considered to be certified in critical care medicine as long as the board that originally certified the physician in critical care medicine deems that physician certified. Intensivists that are close to having their certification lapse should check with the board that certified them to see how exactly that board defines a lapsed certification.

11. **How should intensivists trained in critical medicine in a foreign country be treated for purposes of meeting the ICU Physician Staffing (IPS) Standard?**
    Foreign trained physicians who were certified in critical care medicine in the country in which they trained, would be considered certified for the purposes of the ICU Physician Staffing (IPS) standard.

Response Time Questions

12. **Does Leapfrog specify standards for second tier calls (e.g., the initial call to a physician is not answered within 5 minutes)?**
    No. We do not intend to reach this level of detail in our specifications, absent a compelling case that the gain would offset its added complexity.

13. **Are there definitions for what constitutes high and low urgency calls/pages/texts?**
    No, and hospitals don't have to focus only on high urgency calls/pages/texts, but some notification device systems can make this differentiation and, in these instances, low urgency calls/pages/texts can be carved out of the analysis of response times.

14. **If my hospital has few instances where there is no intensivist coverage, how should we conduct the response time audit? Can we perform mock pages to satisfy the intent?**
    Unannounced, mock pages would meet the intent. In order for the audit to be reliable, 20 unannounced mock pages over 90 days should be evaluated.

15. **Regarding the use of "effectors," our hospital has a nurse practitioner (NP)/physician assistant (PA)/FCCS-certified nurse or intern that is always on-site in the ICU, so it is difficult to measure their response time to pages. What should we do?**
    If the effector is dedicated to the ICU (as defined as being within a 5 min walk to the ICU), then hospitals can indicate 'yes' to meeting the response time requirement (5 min response; 95% of the time), in lieu of conducting a response time audit. Please note that an NP/PA effector must meet all requirements outlined in endnote #31.

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16. **When an intensivist is not on-site in the ICU, can hospitals use a non-FCCS-certified CRNA as the "effector?"**
    No. To serve as the "effector," CRNAs require FCCS-certification.

17. **When an intensivist is not on-site in the ICU, can hospitals use FCCS-certified interns as the "effector?"**
    Yes. An FCCS-certified intern can serve as the "effector."

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SECTION 6: PATIENT SAFETY PRACTICES

This section includes questions and reference information for Section 6: Patient Safety Practices. Please carefully review the questions, endnotes, and reference information (e.g., measure specifications, notes, and frequently asked questions) before you begin. Failure to review the reference information could result in inaccurate responses.

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Section 6: 2020 Patient Safety Practices

NQF Safe Practices Fact Sheet: http://www.leapfroggroup.org/ratings-reports/safe-practices
Hand Hygiene Fact Sheet: http://www.leapfroggroup.org/ratings-reports/hand-hygiene

Section 6 includes questions about your hospital's adherence to three National Quality Forum-endorsed Safe Practices and best practices for hand hygiene which are modeled after the World Health Organization's Hand Hygiene Self-Assessment Framework.

Each hospital achieving the standard for NQF Safe Practice #1 – Culture of Safety Leadership Structures and Systems, NQF Safe Practice #2 – Culture Measurement, Feedback, and Intervention, and NQF Safe Practice #9 – Nursing Workforce:
Has earned 100% of points (adopted all elements) for the NQF Safe Practice.

Each hospital achieving the standard for Hand Hygiene:
Has met both the Monitoring and Feedback domains, as well as **2 of the 3** remaining domains for hand hygiene:

- Training and Education Domain
- Infrastructure Domain
- Culture Domain

Download the 2020 Leapfrog Hospital Survey Scoring Algorithm on the Scoring and Results webpage.

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Instructions for Reporting on Section 6: Patient Safety Practices

- ☐ **Prepare**
  - ☐ Download and review a copy of the National Quality Forum's *Safe Practices for Better Healthcare – 2010 Update* report for reporting on subsections 6A-6C (see link on http://leapfroggroup.org/survey-materials/survey-and-cpoe-materials)
  - ☐ Print and review a hard copy of (1) the Survey questions, (2) practice-specific FAQs, and (3) the scoring algorithm

- ☐ **Identify Individuals to Assist:** Decide who should participate on your team to assist in collection of the documentation for assessment.

- ☐ **Plan:** The team should be briefed and assigned duties to help capture the key information necessary for submission of this section.

- ☐ **Collect and Maintain**: Key documentation must be collected to support answering the questions in this section of the Survey. Documentation should be maintained to ensure that your hospital can respond to Leapfrog's request for documentation should you be selected for our random monthly review. Reviews are performed every month during the Survey Cycle (April 1 to December 31) and throughout the Corrections Period). In addition, the documentation can be helpful if your hospital is planning to update and resubmit this section of the Survey prior to December 31.

- ☐ **Assess:** When all the supporting documents are assembled, it is recommended that hospitals review their final responses to Section 6 with the CEO and/or responsible leadership. Hospitals should update their answers online as they adopt additional practices throughout the Survey Cycle (April 1 to December 31). As a reminder, the Corrections Period (January 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the December 31 Late Submission Deadline. Updates made to reflect a change in performance after December 31 will not be scored or publicly reported.

- ☐ **Submit:** Section 6 must be completed and affirmed before it can be submitted with the Survey.

Important Note: In the Online Hospital Survey Tool, make sure to click the **"Review of this Practice Complete" checkbox at the bottom of each safe practice** (subsections 6A-6C only) even if no items are checked, to mark the Safe Practice as complete. This checkbox must be checked for all three NQF-endorsed Safe Practices in order to affirm Section 6 in the Online Hospital Survey Tool.

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6A: Practice #1 - Culture of Safety Leadership Structures and Systems

Important Notes:

Note 1: Page numbers reference NQF Safe Practices for Better Healthcare – 2010 Update report.

Note 2: Hyperlinks throughout this subsection refer to the Safe Practices FAQs on pages 154-165, not to endnotes. These hyperlinks are not included in the online version of the Survey.

Check all boxes that apply.

1.1 AWARENESS	**Within the last 12 months, in regard to raising the awareness of key stakeholders to our organization's efforts to improve patient safety, the following actions related to identification and mitigation of risk and hazards have been taken:** a ☐ board (governance) minutes reflect regular communication regarding **all** three of the following: • risks and hazards (as defined by *Safe Practice #4, Identification and Mitigation of Risks and Hazards*); • culture measurement (as defined by *Safe Practice #2, Culture Measurement, Feedback, and Intervention*); and, • progress towards resolution of safety and quality problems. (p.75) b ☐ patients and/or families of patients are active participants in safety and quality committees that meet on a regularly scheduled basis (e.g. biannually or quarterly). (p.75) c ☐ steps have been taken to report ongoing efforts to improve safety and quality in the organization and the results of these efforts to the community. (p.75) d ☐ all staff and independent practitioners were made aware of ongoing efforts to reduce risks and hazards and to improve patient safety and quality in the organization. (p.75)
1.2 ACCOUNTABILITY	**Within the last 12 months, in regard to holding the board, senior administrative leadership, midlevel management, nursing leadership, physician leadership, and frontline caregivers directly accountable for results related to identifying and reducing unsafe practices, the organization has done the following:** a ☐ an integrated patient safety program has been in place for the entire reporting period, providing oversight and alignment of safe practice activities. (p.76) b ☐ a Patient Safety Officer (PSO) has been appointed and communicates regularly with the board (governance) and senior administrative leadership; the PSO is the primary point of contact of the integrated patient safety program. (p.76) c ☐ performance has been documented in performance reviews and/or compensation incentives for all levels of hospital management and hospital-employed caregivers noted above. (p.76) d ☐ the interdisciplinary patient safety team communicated regularly with senior administrative leadership regarding **both** of the following: • progress in meeting safety goals; • provide team training to caregivers; and, documented these communications in meeting minutes. (pp.76-77) e ☐ the facility reported adverse events to external mandatory or voluntary programs. (p.77)

1.3 ABILITY	**Within the last 12 months, in regard to implementation of the patient safety program, the board (governance) and senior administrative leadership have provided resources to cover the implementation as evidenced by:** a ☐ dedicated patient safety program budgets that support the program, staffing, and technology investment. (p.77)
1.4 ACTION	**Within the last 12 months, structures and systems have been in place to ensure that senior administrative leadership is taking direct action, as evidenced by:** a ☐ CEO and senior administrative leadership are personally engaged in reinforcing patient safety improvements, e.g., "walk-arounds," holding patient safety meetings, and reporting to the board (governance). Calendars reflect allocated time. (p.78) b ☐ CEO has actively engaged leaders from service lines, midlevel management, nursing leadership, and physician leadership in patient safety improvement actions. (p.79) c ☐ hospital has established a structure for input into the patient safety program by licensed independent practitioners and the organized medical staff and physician leadership. Input documented in meeting minutes or materials. (p.79)
1.5	☐ Review of this Safe Practice is complete. *This checkbox is in the Online Hospital Survey Tool to ensure that your hospital has reviewed data entry for the above questions. This question must be marked, even if no items are checked.*

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6B: Practice #2 - Culture Measurement, Feedback, and Intervention

Important Notes:

Note 1: Page numbers reference NQF Safe Practices for Better Healthcare – 2010 Update report.

Note 2: Hyperlinks throughout this subsection refer to the Safe Practices FAQs on pages 154-165, not to endnotes. These hyperlinks are not included in the online version of the Survey.

Note 3: As part of Leapfrog's COVID-19 response, the reporting period for administering a culture of safety survey has been updated to the last 36 months, rather than the last 24 months, and the reporting period for all follow-up activities has been updated to the last 24 months, rather than 12 months.

Check all boxes that apply.

2.1 AWARENESS	**Within the last 36 months, in regard to culture measurement, our organization has done the following:** a ☐ conducted a culture of safety survey of our employees using a nationally recognized tool that has demonstrated validity, consistency, and reliability. The units surveyed account for at least 50% of the aggregated care delivered to patients within the facility and include the high patient safety risk units or departments. (p.88) ***If item 'a' is not checked, no other items in this Practice #2 may be checked.*** b ☐ portrayed the results of the culture survey in a report, which reflects both hospital-wide and individual unit level results, as applicable. (p.88) c ☐ benchmarked results of the culture survey against external organizations, such as "like" hospitals or other hospitals within the same health system. d ☐ compared results of the culture surveys across roles and staff levels. e ☐ service line, midlevel managers, or senior administrative leaders used the results of the culture survey to debrief at the relevant unit level, using semi-structured approaches for the debriefings and presenting results in aggregate form to ensure the anonymity of survey respondents.
2.2 ACCOUNTABILITY	**Within the last 36 months, in regard to accountability for improvements in culture measurement, our organization has done the following:** a ☐ shared the results of the culture measurement survey with the board (governance) and senior administrative leadership in a formal report and discussion. (p.88) b ☐ included in performance evaluation criteria for senior administrative leadership both the response rates to the survey and the use of the survey results in the improvement efforts.
2.3 ABILITY	**Within the last 24 months, in regard to culture measurement, the organization has done the following (or has had the following in place):** a ☐ conducted staff education program(s) on methods to improve the culture of safety, tailored to the organization's survey results. b ☐ included the costs of annual culture measurement/follow-up activities in the patient safety program budget.

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2.4 ACTION	**Within the last 24 months, in regard to culture measurement, feedback, and interventions, our organization has done the following (or has had the following in place):** a ☐ developed or implemented explicit, hospital-wide organizational policies and procedures for regular culture measurement. (p.88) b ☐ disseminated the results of the survey widely across the institution, and senior administrative leadership held follow-up meetings with the sampled units to discuss the unit's results and concerns. (p.88) c ☐ identified performance improvement interventions based on the survey results, which were shared with senior administrative leadership and subsequently measured and monitored. (p.88)
2.5	☐ Review of this Safe Practice is complete. *This checkbox is in the Online Hospital Survey Tool to ensure that your hospital has reviewed data entry for the above questions. This question must be marked, even if no items are checked.*

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6C: Practice #9 - Nursing Workforce

Important Notes:

Note 1: Page numbers reference NQF Safe Practices for Better Healthcare – 2010 Update report.

Note 2: Hyperlinks throughout this subsection refer to the Safe Practices FAQs on pages 154-165, not to endnotes. These hyperlinks are not included in the online version of the Survey.

Check all boxes that apply.

9	Is your hospital currently recognized as an American Nurses Credentialing Center (ANCC) Magnet® organization? ☐ Yes ☐ No *If "yes," your hospital will receive full credit for this Safe Practice and no additional boxes need to be checked. If "no," please check all of the boxes that apply.*
9.1 AWARENESS	**Within the last 12 months, in regard to ensuring adequate and competent nursing staff service and nursing leadership at all levels, our organization has done the following (or has had the following in place):** a ☐ held at least one educational meeting for senior administrative leadership, nursing leadership, midlevel management and service line management specifically related to the impact of nursing on patient safety. (p.155) b ☐ performed a risk assessment that includes a hospital-wide evaluation of the frequency and severity of adverse events that can be related to nurse staffing. (p.155) c ☐ submitted a report to the board (governance) with recommendations for measurable improvement targets. (p.155) d ☐ collected and analyzed data of actual unit-specific nurse staffing levels on a quarterly basis to identify and address potential patient safety-related staffing issues. (p.155) e ☐ provided unit-specific reports of potential patient safety-related staffing issues to senior nursing leadership, senior administrative leadership and the board (governance) at least quarterly. (p.155)

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9.2 ACCOUNTABILITY	**Within the last 12 months, in regard to ensuring adequate and competent nursing staff service and nursing leadership at all levels, our organization has done the following (or has had the following in place):** a ☐ held nursing leadership directly accountable for improvements in performance through performance reviews or compensation. (p. 155) b ☐ included nursing leadership as part of the hospital senior administrative leadership team. (p.155) c ☐ reported performance metrics related to this Safe Practice to the board (governance). (p.155) d ☐ held the board (governance) and senior administrative leadership accountable for the provision of financial resources to ensure adequate nurse staffing levels. (p.155)
9.3 ABILITY	**Within the last 12 months, in regard to ensuring adequate and competent nursing staff service and nursing leadership at all levels, our organization has done the following (or has had the following in place):** a ☐ conducted staff education on maintaining and improving competencies specific to assigned job duties related to the safety of the patient, with attendance documented. (p.155) b ☐ allocated protected time for direct care staff and managers to reduce adverse events related to staffing levels or competency issues. c ☐ documented expenses incurred during the past year tied to quality improvement efforts around this Safe Practice. d ☐ budgeted financial resources for balancing staffing levels and skill levels to improve performance. (p.155) e ☐ board (governance) has approved a budget for reaching optimal nurse staffing.
9.4 ACTION	**Within the last 12 months, in regard to ensuring adequate and competent nursing staff service and nursing leadership at all levels, our organization has done the following (or has had the following in place with regular updates):** a ☐ implemented a staffing plan, with input from nurses, to ensure that adequate nursing staff-to-patient ratios are achieved. (p.154) b ☐ developed policies and procedures for effective staffing targets that specify number, competency and skill mix of nursing staff. (p.155) c ☐ implemented a performance improvement program that minimizes the risk to patients from less than optimal staffing levels. (p.155) **OR** monitored a previously implemented hospital-wide performance improvement program that measures, and demonstrates full achievement of, the impact of this specific Safe Practice. (p.155)
9.5	☐ Review of this Safe Practice is complete. *This checkbox is in the Online Hospital Survey Tool to ensure that your hospital has reviewed data entry for the above questions. This question must be marked, even if no items are checked.*

6D: Hand Hygiene

Important Notes:

Note 1: Hyperlinks, not followed by a superscript, throughout this subsection refer to the Safe Practices FAQs on pages 154-165. These hyperlinks are not included in the online version of the Survey.

Note 2: The framework and questions in Section 6D are modeled after the World Health Organization's Hand Hygiene Self-Assessment Framework.

Note 3: Hospital responses should reflect patient care units only, including all inpatient units, outpatient units (pre-operative and post-operative), observation units, and emergency department units.

Reporting Time Period: Answer questions #1-21 based on the practices currently in place at the time you submit this section of the Survey.

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

Training and Education

1) Do individuals who touch patients or who touch items that will be used by patients[33] in your patient care units receive hand hygiene training from a professional with appropriate training and skills[34] at **both:** • the time of onboarding; and • annually thereafter? *If "no" to question #1, skip questions #2-3 and continue on to question #4.*	*Yes* *No*
2) In order to pass the **initial** hand hygiene training, do individuals who touch patients or who touch items that will be used by patients[33] in your patient care units need to physically demonstrate proper hand hygiene with soap and water and alcohol-based hand sanitizer?	*Yes* *No*
3) Are **all** six of the following topics included in your hospital'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[33] 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[33] 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 • When gloves should be used in addition to hand washing (e.g., caring for *C. difficile* patients) and how hand hygiene should be performed when gloves are used	*Yes* *No*

• The minimum time that should be spent performing hand hygiene with soap and water and alcohol-based hand sanitizer • How hand hygiene compliance is monitored	

Infrastructure

4) Does your hospital have a process in place to ensure that **all** of the following are done, as necessary, and quarterly audits are conducted on a sample of dispensers in your patient care units to ensure that the process is followed? • Refill paper towels, soap dispensers, and alcohol-based hand sanitizer dispensers when they are empty or near empty • Replace batteries in automated paper towel dispensers, soap dispensers, and alcohol-based hand sanitizer dispensers (if automated dispensers are used in the patient care units)	*Yes* *No*
5) Do all rooms or bed spaces in your patient care units have an alcohol-based hand sanitizer within 5 steps of the patient's bed that is easily accessible to individuals who touch patients or who touch items that will be used by patients[33]?	*Yes* *No*
6) Does your hospital conduct audits of the volume of alcohol-based hand sanitizer that is delivered with each activation of a wall-mounted dispenser (manual and automated) on a sample of dispensers in your patient care units at **all** of the following times: • upon installation; • whenever the brand of product or system changes; and • whenever adjustments are made to the dispensers? *If "no" or "does not apply, wall-mounted dispensers are not used," skip question #7 and continue on to question #8.*	*Yes* *No* *Does not apply, wall-mounted dispensers are not used*
7) Do all of the audited dispensers deliver, with one activation, a volume of alcohol-based hand sanitizer that covers the hands completely and requires 15 or more seconds for hands to dry (on average)?	*Yes* *No*

Monitoring

8) Does your hospital collect hand hygiene compliance data on at least 200 hand hygiene opportunities, or 1.7% of all possible hand hygiene opportunities, **each <u>month</u> in each patient care unit**? *If "yes" to question #8, skip question #9 and continue on to question #10.*	*Yes, using only an electronic compliance monitoring system* *Yes, using only direct observation* *Yes, using both an electronic compliance monitoring system and direct observation* *No*
9) Does your hospital collect hand hygiene compliance data on at least 100 hand hygiene opportunities **each <u>quarter</u> in each patient care unit**? *If "no" to question #9, skip questions #10-18 and continue on to question #19.*	*Yes, using only an electronic compliance monitoring system* *Yes, using only direct observation* *Yes, using both an electronic compliance monitoring system and direct observation* *No*
10) Does your hospital use hand hygiene coaches or compliance observers to provide individuals who touch patients or who	*Yes* *No*

touch items that will be used by patients[33] in your patient care units with feedback on both when they are and are not compliant with performing hand hygiene?	

Direct Monitoring – Electronic Compliance Monitoring System
If "yes, using only an electronic compliance monitoring system" or "yes, using both an electronic compliance monitoring system and direct observation" to question #8 or question #9, answer questions #11-12.

11) In those patient care units where an electronic compliance monitoring system is used, does the monitoring system used meet **both** of the following criteria? • The system can identify both opportunities for hand hygiene and that hand hygiene was performed • The hospital itself has validated the accuracy of the data collected by the electronic compliance monitoring system	*Yes* *No*
12) In those patient care units where an electronic compliance monitoring system is used, are direct observations also conducted for coaching and intervention purposes that meet **all** of the following criteria? • Observers immediately intervene prior to any harm occurring to provide non-compliant individuals with immediate feedback • Observations identify both opportunities for hand hygiene and compliance with those opportunities • Observations determine who practiced hand hygiene, verify when they practiced it, and whether their technique was correct • Observations within a unit are conducted weekly or monthly across all shifts and on all days of the week proportional to the number of individuals who touch patients or who touch items that will be used by patients[33] on duty for that shift • Observations capture a representative sample of the different roles of individuals who touch patients or who touch items that will be used by patients[33] (e.g., nurses, physicians, techs, environmental services workers)	*Yes* *No*

Direct Monitoring – Direct Observation
If "yes, using only direct observation" or "yes, using both an electronic compliance monitoring system and direct observation" to question #8 or question #9, answer questions #13-14.

13) In those patient care units where an electronic compliance monitoring system is NOT used, do the direct observations meet **all** of the following criteria? • Observations identify both opportunities for hand hygiene and compliance with those opportunities • Observations determine who practiced hand hygiene, verify when they practiced it, and whether their technique was correct • Observations within a unit are conducted weekly or monthly across all shifts and on all days of the week proportional to the number of individuals who touch	*Yes* *No*

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patients or who touch items that will be used by patients[33] on duty for that shift • 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[33] (e.g., nurses, physicians, techs, environmental services workers)	
14) Does your hospital have a system in place for both the initial and recurrent training and validation of hand hygiene compliance observers?	*Yes* *No*

Feedback

15) Are unit-level hand hygiene compliance data fed back to individuals who touch patients or who touch items that will be used by patients[33] at least monthly for improvement work?	*Yes* *No*
16) Are unit-level hand hygiene compliance data used for creating unit-level action plans?	*Yes* *No*
17) Is regular (at least every 6 months) feedback of hand hygiene compliance data, with demonstration of trends over time, given to: • senior administrative leadership, physician leadership, and nursing leadership; • the board (governance); and • the medical executive committee? *If "no" to question #17, skip question #18 and continue on to question #19.*	*Yes* *No*
18) If "yes" to question #17, is senior administrative leadership, physician leadership, and nursing leadership held directly accountable for hand hygiene performance through performance reviews or compensation?	*Yes* *No*

Culture

19) Are patients and visitors invited to remind individuals who touch patients or who touch items that will be used by patients[33] to perform hand hygiene?	*Yes* *No*
20) Have **all** of the following individuals (or their equivalents) demonstrated a commitment to support hand hygiene improvement in the last year (e.g., a written or verbal commitment delivered to those individuals who touch patients or who touch items that will be used by patients[33])? • Chief Executive Officer • Chief Medical Officer • Chief Nursing Officer	*Yes* *No*

Additional Questions (Fact Finding Only)

21) Do **all** rooms or bed spaces in your patient care units have a sink for hand washing within 20 feet of the patient's bed that is easily accessible to individuals who touch patients or who touch items that will be used by patients[33] ?	*Yes* *No*

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Affirmation of Accuracy

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

The hospital and I understand that The Leapfrog Group, its members, the public and entities and persons who contract or have other business dealings with The Leapfrog Group are relying on the truth and accuracy of this information. The hospital and I also understand that The Leapfrog Group will make this information and/or analyses of this information public through the Survey Results public reporting website, The Leapfrog Group's Hospital Safety Grade, and/or other Leapfrog Group products and services. This information and/or analyses and all intellectual property rights therein shall be and remain the sole and exclusive property of The Leapfrog Group in which The Leapfrog Group retains exclusive ownership. This information does not infringe upon any third-party intellectual property rights or any other third-party rights whatsoever and is free and clear of all encumbrances and liens of any kind. The hospital and I acknowledge that The Leapfrog Group may use this information in a commercial manner for profit. The hospital shall be liable for and shall hold harmless and indemnify The Leapfrog Group from any and all damages, demands, costs, or causes of action resulting from any inaccuracies in the information or any misrepresentations in this Affirmation of Accuracy. The Leapfrog Group and its members and entities and persons who contract or have other business dealings with The Leapfrog Group reserve the right to omit or disclaim information that is not current, accurate or truthful.

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

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Section 6: 2020 Patient Safety Practices Reference Information

What's New in the 2020 Survey

Section 6 NQF Safe Practices has been renamed Section 6 Patient Safety Practices.

NQF Safe Practice #4 – Risks and Hazards (Section 6C of the 2019 Leapfrog Hospital Survey) has been removed due to the changing evidence supporting the impact of this practice on reducing adverse events. NQF Safe Practice #19 – Hand Hygiene (Section 6E of the 2019 Leapfrog Hospital Survey) has also been removed and replaced with the new subsection on Hand Hygiene that was added in 2019.

In 2020, Section 6 Patient Safety Practices includes three NQF-endorsed Safe Practices and the new Hand Hygiene standard:

- Section 6A: NQF Safe Practice #1 – Culture of Safety Leadership Structures and Systems
- Section 6B: NQF Safe Practice #2 – Culture Measurement, Feedback, and Intervention
- Section 6C: NQF Safe Practice #9 – Nursing Workforce
- Section 6D: Hand Hygiene

The practices being removed from the 2020 Survey will no longer appear in the Safety Grade starting in Fall 2020.

NQF Safe Practices
As part of Leapfrog's COVID-19 response, the reporting period for administering a culture of safety survey for NQF Safe Practice #2 (Section 6B) has been updated to the last 36 months, rather than the last 24 months, and the reporting period for all follow-up activities has been updated to the last 24 months, rather than 12 months.

In addition, the NQF Safe Practices will be scored and publicly reported in 2020 using updated scoring algorithms. Please refer to the 2020 Leapfrog Hospital Survey Scoring Algorithm on the Scoring and Results webpage for more information.

Hand Hygiene
The questions for Section 6D Hand Hygiene have been significantly updated based on feedback from participating hospitals and guidance from Leapfrog's national Hand Hygiene Expert Panel and the new standard will be publicly reported beginning in September 2020. The questions and scoring algorithm encourage a multimodal approach and emphasize the importance of monitoring and feedback, which are both required in order to meet Leapfrog's standard.

As part of Leapfrog's COVID-19 response, Leapfrog will only publicly report results for hospitals scored as "Achieved the Standard" and "Considerable Achievement." Hospitals scored as "Some Achievement" or "Limited Achievement" will be publicly reported as "Not Available" for the Hand Hygiene standard. Please refer to the 2020 Leapfrog Hospital Survey Scoring Algorithm on the Scoring and Results webpage for more information.

Results from this subsection will be included in the Hospital Safety Grade starting with the Fall 2020 release and will replace NQF Safe Practice #19 – Hand Hygiene.

Change Summary since Release

None. If substantive changes are made to this section of the Survey after release on April 1, 2020, they will be documented in this Change Summary section.

Patient Safety Practices Frequently Asked Questions (FAQs)

General FAQs for the Safe Practices:

1) For the purposes of reporting on Section 6 of the Leapfrog Hospital Survey:

- **Frontline caregivers** include, but are not necessarily limited to employed physicians, mid-levels (NPs, PAs), nurses, environmental services staff, allied health professionals, and occupational and physical therapists.
- **Service line management** refers to those who manage all functions within a specific service line (e.g., oncology, cardiac, women's, orthopedics). These individuals may be managing a departmental sub-function within a broader department (e.g., cardiac care within the Department of Medicine).
- **Midlevel management** includes the intermediate management of an organization that is subordinate to the executive management and responsible for at least two lower levels of staff below them. An example would include a Director of Nursing, who might oversee Nursing Managers, who oversee the nurses who care directly for patients.
- **Physician leadership** refers to physicians who serve in a leadership role in the organization. Titles may include positions such as Chief Medical Officer, Vice President for Medical Affairs, Medical Director, and/or Department Chair.
- **Nursing leadership** refers to nurses who serve in a leadership role (e.g., Chief Nursing Officer, Vice President/Assistant Vice President of Nursing, Vice President/Assistant Vice President for Clinical Operations, etc.)
- **Senior administrative leadership** refers to administrators who are responsible for hospital-wide departments or services (e.g., Chief Executive Officer, Chief Administrative Officer, Chief Nursing Officer, Chief Medical Officer, etc.).
- **Patient Safety Officer** refers to the patient safety leader (who may or may not have the title “Patient Safety Officer”) who has responsibility for multiple and integrated areas of patient safety. The organization may appoint an officer who may have other assigned duties or may specifically employ a Patient Safety Officer designated with this responsibility. Multiple executives who are responsible for individual areas (i.e. risk, quality, infection prevention, etc.), but do not assess the integrated safety issues, would not qualify.
- **Board (governance)** refers to the individual hospital’s board of directors, or the board that governs the hospital and has the ability to pass policies that impact the hospital, or a committee of the board (such as a board-appointed, hospital-wide Patient Safety and Quality Committee, which includes board members).
- **Medical executive committee** refers to a primary governance committee for medical staff. The medical executive committee makes leadership decisions related to medical staff policies, procedures, and rules, with an emphasis on quality control and quality improvement. They also adopt and implement these policies and procedures and are responsible for medical staff appointment and reappointment.

2) Why is it necessary to continue to review a safe practice once it has been implemented?
All too often in the hectic pace of providing patient care in a hospital, with frequent staff turnover and lots of part-time employees, it is difficult to get a change in practice well-established. Annual review with monitoring and tracking of the safe practices will ensure that they are embedded in the operations of the hospital and not lost in the transition of new staff coming in or part-time employees coming and going.

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3) The phrase "performance reviews or compensation" is used throughout Section 6 within many *Accountable* elements. Do performance reviews and compensation plans need to have specific language about the Safe Practice or can a set of patient safety goals related to the specific Safe Practice be attached?

A performance review or compensation plan should include specific language about a Safe Practice. A list of Safe Practices and related goals may be incorporated into the performance review and/or compensation plan or formalized programs whereby a measure of success of those activities or programs is tied to individual performance reviews or compensation incentive plans of executives.

Every employee should have a patient safety component included in their annual review. Another option is to include in the employee's competency review (OPPE, FPPE).

4) There are several references to hospital budgets throughout Section 6 within many *Ability* elements. How can hospitals meet the intent of these elements?

The intent of these elements is to verify that actions specific to the Safe Practices have been included in hospital budgets. To meet the intent of these elements, hospitals should ensure that these actions can be identified within a department budget or hospital budget. If the budget includes categories that address the Safe Practice but do not specifically name the Safe Practice, then the intent of the element is met.

Further, if a hospital has not allocated budget dollars for activities tied to a Safe Practice but can document expenses specific to the Safe Practice during the reporting period, the intent of the element is met. Plans to allocate specific budget dollars for a Safe Practice should be incorporated into the next upcoming budget year as an ongoing process.

Hospitals may also document training or education expenditures specific to the Safe Practice or expenditures on educational materials that are specific to the Safe Practice.

Hospitals that have invested in in-house staff educators and who include in their job descriptions the coordination and delivery of training and education to appropriate hospital staff on specific Safe Practices meet the intent of this element. For example, if the position description for the Clinical Nurse Educator includes the coordination and delivery of in-service training and educational sessions related to preventing hospital-acquired infections by improving hand hygiene, the intent of this practice is met. Except for Safe Practice 9.3b, specific time allocations are not required as long as there is documentation of staff participation through dated meeting minutes or attendance records.

5) How should staff education be measured?

Educational meetings should clearly address the subject matter pertinent to adverse events and performance improvement targeted by the specific Safe Practice. Hospitals should track meeting dates, frequency of training sessions provided, attendance records or completion records, and the percentage of the total staff who received the information.

6) There are several references to developing or implementing Performance Improvement Programs throughout Section 6 within many *Action* elements. How can hospitals meet the intent of these elements?

At a minimum, performance improvement programs should include **all** of the following five criteria:

- **Education** regarding the pertinent adverse event frequency, severity, and/or impact of best practices. These expenses should be budgeted and tracked to meet the budget elements of the Safe Practices.
- **Skill building** in use of performance improvement tools. These expenses should be budgeted and tracked to meet the budget elements of the Safe Practices.
- **Measurement** of process measures or outcomes measures. The "Outcome, Process, Structure, and Patient-Centered Measures" section at the end of each Safe Practice in the NQF Safe Practices for Better Healthcare 2010 Update suggests performance measures that can be used to support measuring and monitoring quality improvement efforts.

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- **Process improvement** and interventions.
- **Reporting** of performance outcomes.

A "campaign" such as an awareness campaign would not meet the intent of these elements.

FAQs Specific to Safe Practices

Section 6A: Safe Practice 1 Leadership Structures and Systems

7) 1.1a, 1.2b, and 1.2d: Several elements within Safe Practice 1 mention that "regular communication" is required. How does Leapfrog define "regular communication?"
Regular communication means more than once a year. Some hospitals may discuss these items quarterly or even monthly. Hospitals can document that these communications took place through dated meeting minutes. We would urge hospitals to improve the detail of their board and other meeting minutes to ensure they are able to clearly document that the issues were discussed.

The discussion of these items can be a general note in the minutes, without specific details. However, hospitals should maintain copies of dated presentations and reports related to these agenda items in order to document adherence to these elements.

8) 1.1b: What is meant by "patients and/or families of patients are active participants in safety and quality committees?"
To meet the intent of this element, hospitals must have patients and/or families of patients participate on the hospital-wide safety and quality committee. Safety and quality committees should have influence over hospital-wide quality and safety issues, not just a particular department or service line. Meetings should be formal, and minutes should be taken. In most hospitals, due to the scope of issues discussed at Patient and Family Advisory Council (PFAC) meetings, having a PFAC would not meet the criteria for a safety and quality committee.

Patients and/or families of patients can participate in these meetings in person, via conference call, or via video conference. Hospitals do not meet the intent of this element if the patients and/or families of patients are invited but do not regularly attend. It is the responsibility of the hospital to ensure that patients and/or families of patients can provide their perspectives to other committee members during meetings. We prefer that hospitals identify non-Board members, non-employees to serve on the committee so the participant can represent the views of patients and without conflict. Board members have a fiduciary responsibility to the organization, and therefore may have a potential conflict representing the views of patients and/or families of patients.

Hospitals can document adherence to this element by maintaining committee rosters and meeting minutes with attendance and participation noted. Patients and/or families of patients should have the opportunity to present or co-present a topic, lead or co-lead a discussion, or co-chair the committee, and this should be noted in the meeting minutes.

9) 1.1c: How can a hospital document the steps that it has taken to report to the community ongoing efforts and results of these efforts to improve safety and quality?
Hospitals can utilize several communication vehicles, including webpages that are prominent from the organization's homepage, electronic newsletters, mailings or annual reports, or an ad in the local paper. The communication must include **both** efforts the hospital is taking to improve safety and quality and the results of those efforts. As the sole focus of the NQF Safe Practices for Better Health Care report is reducing or preventing adverse events (refer to NQF list of adverse events at http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=69573), patient safety and quality efforts **reported to the community** must have this focus as well. In other words, efforts the hospital is taking to improve safety and quality should be related to reducing or preventing these adverse events and the results of those efforts would be the measurable outcomes.

Meetings where a few community members are present would not meet the intent of this practice as the intent is to reach a larger audience.

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10) 1.1d: How can a hospital document that all staff and independent practitioners were "made aware" of ongoing efforts to reduce risks and hazards and to improve patient safety and quality?
Hospitals can share information via email or intranet, reports or presentations at meetings with meeting attendance recorded. If utilizing an intranet, hospitals must ensure that non-employed practitioners have access to the information.

11) 1.2a, 1.3a, 1.4c: What are the minimum requirements to qualify as a "patient safety program?"
As part of accreditation through The Joint Commission, hospitals are required to meet standard LD.04.04.05, which identifies the elements that must be included in an integrated patient safety program (see pages PS-33 to PS-35 in Patient Safety Systems chapter of the CAMH). Hospitals that are not accredited by The Joint Commission can use these elements as a guide as well.

12) 1.2d: What is the role of an interdisciplinary patient safety committee?
An interdisciplinary patient safety committee is an internal hospital committee that oversees the activities defined in the NQF Safe Practice 1 Practice Element Specifications and develops action plans to create solutions and changes in performance.

13) 1.2d: What is an example of team training that is appropriate for caregivers?
Hospitals can utilize TeamSTEPPS, a comprehensive, evidence-based training program for healthcare professionals. At a minimum, the elements of basic teamwork training should be met as described on page 96 of the Safe Practices for Better Healthcare– 2010 Update, which is available for download here: http://www.leapfroggroup.org/survey-materials/survey-and-cpoe-materials.

14) 1.2e: How can hospitals that have not had any adverse events during the reporting period earn credit for this element?
First, we urge your hospital to reassess its conclusion that no adverse events occurred; that would be highly unusual. Following the reassessment, if no adverse events were identified **and** the hospital can document that it has policies in place to report such events when they do occur (to a mandatory or voluntary program), the hospital would meet the intent of this element. Please see Section 7A Never Events for a list of adverse events and components of a Never Events Policy.

15) 1.4a: How can hospitals document that the CEO and senior administrative leadership are personally engaged in reinforcing patient safety improvements?
Executive walk-arounds are an example of how the CEO and senior administrative leadership can be personally engaged in reinforcing patient safety improvements. The executive walk-arounds provide staff with visibility and access to senior management. They also provide the CEO and senior administrative leadership with the opportunity to address issues and concerns in various departments in real-time. Monthly meetings with staff in a centralized location do not meet the intent of this Safe Practice.

Progress on the implementation of walk-arounds can be measured by tracking the number of walk-rounds performed per unit or clinical area for designated time periods as shown in the calendars of the CEO and senior administrative leadership. Some progressive hospitals have tied incentives to regular executive walk-rounds and to reliable exchange of information on clinical unit performance. Some hospitals have established a feedback loop between the CEO and senior administrative leadership and staff to measure the implementation of performance improvement ideas that were generated during executive walk-arounds.

16) 1.4b: What are some examples of how the CEO can actively engage leaders from service lines, midlevel management, clinical leadership, and physician leadership in patient safety improvement actions?
Hospitals can refer to the American College of Healthcare Executives professional policy statement, which includes examples of how leaders should be engaged in patient safety and quality.

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17) 1.4c: What are some examples of how hospitals can engage the medical staff as direct contributors to the patient safety program?

Examples may include:

- Senior leadership requests time on Medical Staff Department standing agendas to provide patient safety updates and elicit direct feedback on specific areas as well as "what keeps the medical staff up at night."
- Medical staff are invited and encouraged to be active participants in clinical unit meetings where patient safety is addressed.
- The board appoints a community-based active medical staff member to represent the organization on a regional patient safety initiative.

18) 1.4c: In a hospital where all medical staff is employed, how do we answer this question?

The intent of this element is to ensure that physicians and medical staff have the opportunity to provide input on the hospital's patient safety plan because often they do not have a significant position in the hierarchal structure of an organization, but carry a great deal of influence over how the organization is run. Thus, they are informal leaders who can be change agents and "accelerators or barriers for improvement." If the organization's board and senior administrative leadership seek and document input from physicians and medical staff regarding patient safety programs, the intent of this element has been met.

Section 6B: Safe Practice 2 Culture Measurement, Feedback, and Intervention

19) Why are two different reporting periods used in Safe Practice 2?

Within the *Awareness and Accountability* elements, a 36-month reporting period (updated from 24 months as part of Leapfrog's COVID-19 response) is used because these elements are related to conducting the culture of safety survey, which is typically conducted every other year. Within the *Ability and Action* elements, a 24-month reporting period (updated from 12 months as part of Leapfrog's COVID-19 response) is used because these practices are related to follow-up activities that would be completed after the results from the culture of safety survey are available.

20) 2.1a: What are the minimum requirements to qualify as a "culture of safety survey?"

Several surveys are readily available that specifically address culture, safety climate, and teamwork. These surveys incorporate all the additional specifications as outlined in NQF Safe Practice 2 (see 2010 NQF Safe Practice Report). A general employee satisfaction survey that has a small component of the survey addressing organizational culture does not qualify.

Hospitals that do not use a nationally recognized culture of safety tool must ensure that their culture survey meets Leapfrog's guidelines for what constitutes a valid, consistent, and reliable survey tool. These guidelines were developed in consultation with Leapfrog's Culture of Safety Expert Panel. The guidelines can be found on the Survey and CPOE Materials webpage under supporting materials for Section 6.

21) 2.1a: What does "50% of the aggregated care delivered to patients within the facility" mean?

As described on page 88 of the NQF Safe Practices for Better Healthcare Report, "a census of units or service areas that in aggregate deliver care to more than 50 percent of the patients receiving care should be surveyed, service lines or units where there is a high patient safety risk should be measured, and there should be a valid sample to allow for unit-level analysis and facilitate improvement."

22) 2.1b: For reporting individual unit level results, what is the minimum number of responses a hospital should have?

Most major vendors use a threshold of 5 or more responses and a 40% response rate. For larger units, a lower response rate may be acceptable. If a unit does not meet these thresholds, your hospital could aggregate the results of "like" units together (e.g., medical/surgical units, ICUs, ORs). Hospitals should not combine results across "unlike" units.

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23) 2.1c: What is meant by "like" hospitals? Can hospitals benchmark against those within the same network or system? How would a pediatric hospital benchmark against other pediatric hospitals?
Hospitals should benchmark their results against hospitals with similar demographics, such as hospital type, number of beds, number of admissions, urban/rural designation, etc. Hospitals in systems or healthcare networks should benchmark throughout the health system, but not within the same region.

Pediatric hospitals utilizing the AHRQ Hospital Survey on Patient Safety Culture can benchmark their results using the AHRQ's User Comparative Database Report (refer to instructions starting on page 29).

24) 2.1d: What is meant by roles and staff levels?
Roles are job types (e.g., surgeons, nurses, hospitalists, physician assistants, or clinical and non-clinical, etc.). Staff levels are defined within the organization's hierarchy (e.g., senior administrators, directors, managers, etc.).

25) 2.2b: Does performance evaluation criteria for senior administrative leadership need to include the actual targeted response rate to the culture of safety survey?
Yes. The organization's targeted response rate to the culture of safety survey should be included in performance evaluation criteria for senior administrative leadership. Criteria for using the survey results in improvement efforts should also be included to meet the intent of this element.

26) 2.3a: Which employees should be included in the staff education program? Employees in all units or just those in low-performing units?
Staff education needs to include education for all levels of staff, from senior administrative and clinical leadership to frontline caregivers. In addition, because all units have opportunities for improvement, the staff education should include all units but can focus on deficiencies of a specific unit or department.

27) 2.1e and 2.4b: What is the difference between 2.1e and 2.4b? Both seem to focus on sharing and discussing the Culture of Safety Survey results.
While both elements focus on sharing and discussing Culture of Safety Survey results, these elements focus on different audiences and activities, and the result is that different kinds of feedback are collected. Safe Practice 2.1e requires local leaders (e.g., unit/department manager) to engage their unit/departments in a discussion about the survey results, while Safe Practice 2.4b requires senior administrative leadership to engage each sampled unit in a discussion about the survey results and their concerns.

Section 6C: Safe Practice # 9 Nursing Workforce

28) 9.1a: How can our hospital document that it has held at least one educational meeting for senior administrative leadership, nursing leadership, midlevel management, and service line management specifically related to the impact of nursing on patient safety?
The goal of this element is to educate these specific audiences on topics such as current nurse staffing levels, rates of nursing-sensitive harms (i.e. falls, pressure ulcers), and any links found between nurse staffing (levels or competencies) and patient harms. Hospitals holding these educational meetings would have a list of meeting attendees and a meeting agenda.

29) 9.1b: How can our hospital document that it performed a risk assessment that includes a hospital-wide evaluation of the frequency and severity of adverse events that can be related to nurse staffing?
The goal of this element is to understand how nurse staffing, nurse work hours, nursing skill mix, and temporary nurse coverage track with the frequency and severity of adverse events in all units within the hospital. In order for a hospital to be fully aware of the extent that any patient safety issue exists within the organization, a hospital needs to review **all** adverse events to determine how often they occur and to establish an impact severity scale on the patient (e.g., the NCC MERP

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Index or other severity indexing tool). Hospitals may find it helpful to use a severity/frequency/risk assessment grid to identify where they need to place a focus on nurse staffing. This element reflects a retrospective review of patient safety events associated with nurse staffing.

This assessment must then be reviewed by senior administrative management and the governance board at least annually to ensure that resources are allocated, and performance improvement programs are implemented.

30) 9.1d: How can our hospital document that it collected and analyzed data of actual unit-specific nurse staffing levels on a quarterly basis to identify and address potential patient safety-related staffing issues?

The goal of this element is to collect and analyze nurse staffing levels on each unit and to use those data for identifying the potential for an adverse event. In each unit, data should include nursing hours per patient day, as defined in Table 1 on page 14 and page A-7 of the National Quality Forum report, National Voluntary Consensus Standards for Nursing-Sensitive Care: An Initial Performance Measure Set. [NQF, 2004]. This element reflects a prospective review of patient safety events associated with nurse staffing.

31) 9.2d: If the state has set minimum nurse to patient staffing ratios, do hospitals in that state automatically meet the intent of this element?

No. Minimum ratios do not necessarily address the "adequacy" issue, as the make-up of your hospital's patient population may require more intensive staffing than are prescribed by the state's minimum.

32) 9.4a: What are the minimum requirements to qualify as a "staffing plan?"

"A staffing plan" refers to nursing policies and procedures or a specific process used by the organization to pre-determine appropriate staffing patterns based on usual patient mix and nursing qualifications. A hospital must demonstrate full achievement of its targets. For more information on what data sources might be used to develop a staffing plan, see FAQ #33 below.

33) 9.4: What staffing processes address the expectations of the *Action* elements of this Safe Practice?

Recognizing that there is no national standard that represents "the correct" nurse staffing pattern, organizations must integrate a number of data sets into a staffing system that predefines and quantifies appropriate staffing targets. These data sets include:

- Historical Data (e.g., patient volumes, acuity levels, and staff volumes of direct caregivers)
- Comparative Data (e.g., comparisons between similar units internally and comparative external data from hospitals of like size and geographic location)
- Clinical Outcomes
- Skill Mix of Staff (e.g., licensing levels and educational training, years of experience, and volume of new graduates on a unit)
- Physical environment (e.g., distance staff have to travel to access support equipment, visibility of patients, locations of nursing stations to patient rooms, etc.)
- Type of patient care needs
- Support services available

Daily monitoring should take place to determine variances between predetermined staffing patterns and actual staffing patterns. If necessary, corrective action should be taken. Regular monitoring should take place to determine the accuracy of targets established and determine adjustments as needed.

6D: Hand Hygiene

General

34) What units are included in Leapfrog's hand hygiene standard?

Please refer to Note 3. Hospital responses should reflect patient care units only. Leapfrog defines a patient care unit as a unit of the hospital where patients are receiving direct bedside nursing care, which would include the following settings:

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- inpatient units (e.g., medical/surgical, pediatric, mother/baby, intensive care units (ICUs), post-anesthesia care units (PACUs), step-down, dialysis, rehabilitation, psychiatric, hospice)
- outpatient units (e.g., pre-operative and post-operative),
- observation units, and
- emergency department units

Areas of the hospital where the patient would not be expected to receive direct bedside nursing care (e.g., operating rooms, procedural areas, radiology, laboratory, pathology, physical therapy, etc.) are not included in this standard.

Training and Education

35) Are online training modules acceptable for the purposes of question #1 and question #3?
Online training modules are acceptable for the purposes of answering question #1 and question #3 if they meet all requirements outlined in the question.

For question #1, the online training must be done at the frequency specified and would need to be delivered and/or developed by a professional with appropriate training and skills[34]. For question #3, the online training must meet all six topics outlined in the question.

Physical demonstration (question #2) **cannot** be done using an online training module.

36) What are examples of what can count as "physically demonstrating" proper hand hygiene during the initial hand hygiene training?
Before new individuals to your hospital have contact with patients and the patient care space, they will need to demonstrate proper hand hygiene with soap and water and alcohol-based hand sanitizer. This demonstration could be done as part of other onboarding activities, during occupational health activities as part of the TB test, during department orientations, in small groups, etc. A group "teach-back" would be acceptable, but with no more than 10 students per one trainer/monitor. An online or in-person "simulation" would not be sufficient for this purpose. Hospitals that are starting to implement this component should add physical demonstration to their **initial** training for any **new hires.** Leapfrog is not asking hospitals to retroactively train individuals.

Infrastructure

37) What would need to be the extent of a quarterly audit that checks that paper towels, soap, and alcohol-based hand sanitizer dispensers are refilled and that batteries in automated dispensers are replaced?
The audit should include checking the paper towels, soap, and alcohol-based sanitizer, as well as batteries (if automated dispensers are used) in a **sample** of dispensers throughout your patient care units. The sample should be based on a random or systematic sampling procedure, where the sampling plan assures wide sampling (i.e., the same places would not always be monitored). A reasonable goal would be to audit 5% of the dispensers in 20% of the patient care units. The quarterly audit should ideally be a supplement to a system that checks these supplies on a routine basis (e.g., environmental services checks with their regular cleaning). Results from these audits can be used to improve processes.

38) Due to fire code, some of our patient rooms and bed spaces cannot have an alcohol-based hand sanitizer dispenser within 5 steps of every patient bed. In addition, hospital protocols do not allow us to have alcohol-based hand sanitizer dispensers in some patient care units, such as psychiatric units. How should we answer question #5?
For the purposes of question #5, individuals who touch patients or who touch items that will be used by patients could carry alcohol-based hand sanitizer on their person in order to meet the "5 steps" requirement.

39) How should a hospital audit the volume of alcohol-based hand sanitizer for the purposes of reporting on questions #6-7?
To audit the amount of alcohol-based hand sanitizer that is delivered with each activation of a wall-mounted dispenser (manual and automated), Leapfrog recommends the following process:

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1. Identify multiple individuals (at least 10) with varying hand sizes (by quick observation).
2. Select a sample of dispensers based on a random or systematic sampling procedure, where the sampling plan assures wide sampling (i.e., the same places would not always be monitored). The sample should include at least 5% of the dispensers in 20% of the patient care units.
3. For each sampled dispenser, have each of the individuals identified in step #1 dispense a volume of alcohol-based hand sanitizer dispenser.
4. For each individual, have a separate person time the amount of hand rubbing time required for hands to dry completely.
5. Repeat this process for each individual and calculate an **average** time based on the ten observations conducted.
6. Repeat this process for each sampled dispenser.

In order to answer "yes" to question #7, the **average** hand rubbing time for **each** sampled dispenser in your patient care units needs to be at least 15 seconds.

40) How should we respond to questions #6 and #7 if our hospital uses wall-mounted dispensers, but has not recently made any of the updates or changes noted in question #6 (i.e., has not installed any new dispensers, has not made any changes to the brand of product or system, and has not made any adjustments to the dispensers)?
If your hospital is just starting to adopt this practice, but has not yet had any of the updates or changes noted in question #6, an audit should be conducted on a sample of existing dispensers and a process should be in place to conduct additional audits when any new dispensers are installed, changes are made to the brand/product, or adjustments are made to the dispensers in order to answer "yes" to question #6. In order to answer "yes" to question #7, the audit would need to show that the volume of alcohol-based hand sanitizer dispensed covers the hands completely and requires 15 or more seconds for hands to dry (on average).

Monitoring

41) For the purposes of hand hygiene compliance monitoring, how does Leapfrog define a hand hygiene opportunity?
Hand hygiene opportunities are the number of times that an individual who touches patients or who touches items used by patients should have cleaned his or her hands given the hand hygiene framework your hospital has adopted (e.g., WHO's "5 moments", Ontario's 4 moments, CDC's guidelines, etc.). In terms of determining opportunities to monitor, this would depend on the guidelines the hospital chooses to follow. For example, many facilities choose to audit before and after patient contact or room entry and exit because this is operationally the simplest method. Auditing opportunities before clean and after dirty tasks is operationally difficult. There is some evidence that measuring adherence on room entry and exit may be an acceptable stand-in for other opportunities within the patient encounter.

42) How do we estimate the number of hand hygiene opportunities in a patient care unit in a month?
Steed et al. found in their study that a patient in a general medical-surgical ward in a small community hospital has an average of 30 hand hygiene opportunities (HHO) per 24-hour period. This estimate is even higher for academic medical centers and patients in the ICU.

To estimate the number of HHOs in a unit in a **month**, hospitals should use the following formulas. Sample sizes should be calculated per unit using historical data on monthly occupancy rates or procedure/patient volume:

In units where the monthly occupancy rate can be calculated –
= *number of open or staffed beds in unit* ***x*** *monthly occupancy rate in unit* ***x*** *number of days in month* ***x*** *30 hand hygiene opportunities* ***x*** *1.7%*

The monthly sample size of hand hygiene opportunities monitored should be at least 1.7% of the unit's monthly HHO value (based on formula above) or 200 hand hygiene opportunities, whichever is less.

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In units where the monthly occupancy rate cannot be calculated –
Outpatient Units:
***=** number of patients with a procedure in a month **x** number of staff per patient (can assume 2) **x** 4 HHOs per patient (one of the 5 moments is "after body fluid exposure/risk" which may not apply to every patient) **x** 6%*

The monthly sample size of hand hygiene opportunities monitored should be at least 6% of the outpatient unit's monthly HHO value (based on formula above) or 200 hand hygiene opportunities, whichever is less.

Emergency Department Units:
*= number of emergency department unit visits per month **x** average of 2.5 hours per visit **x** 4 HHOs per hour **x** 1%*

The monthly sample size of hand hygiene opportunities monitored should be at least 1% of the emergency department unit's monthly HHO value (based on formula above) or 200 hand hygiene opportunities, whichever is less.

200 hand hygiene opportunities was chosen as the sample size based on a study by Yin et. al which showed that 180-195 opportunities would need to be monitored to accurately observe a 10% change in hand hygiene compliance (Yin et al.). The calculations above are for smaller patient care units where monitoring 200 opportunities may not be feasible.

References:
Steed C, Kelly JW, Blackhurst D, Boeker S, Diller T, Alper P, Larson E. Hospital hand hygiene opportunities: where and when (HOW2)? The HOW2 Benchmark Study. American journal of infection control. 2011 Feb 1;39(1):19-26.

Jun Yin MS, Heather Schacht Reisinger PhD, Mark Vander Weg PhD, Marin L. Schweizer PhD, Andrew Jesson, Daniel J. Morgan MD MS, Graeme Forrest MD, Margaret Graham, Lisa Pineles MA and Eli N. Perencevich MD MS Infection Control and Hospital Epidemiology Vol. 35, No. 9 (September 2014), pp. 1163-1168

43) My hospital uses an electronic compliance monitoring system, but it does not meet all the criteria outlined in question #11-12. Can I report on the hand hygiene compliance data we collect via direct observation instead?
Yes. If your hospital also uses direct observation to collect hand hygiene compliance data (not just for coaching/intervention) in **all** patient care units (including those with the electronic compliance monitoring system), you can select "yes, using only direct observation" in either question #8 or question #9 and report on your adherence to the direct observation criteria only. Otherwise, you will need to respond "no" to question #11.

44) What types of electronic compliance monitoring systems would meet the first criteria outlined in question #11 (i.e., identifying both opportunities and that hand hygiene was performed)?
Group monitoring systems and badge-based systems would qualify if they are able to identify both opportunities for hand hygiene and that hand hygiene was performed. For example, an electronic monitoring system that records when an individual (not identified) enters and exits a room and also records if a dispenser was used within the same time frame, would qualify as the entry and exit is used as a proxy for a hand hygiene opportunity (before and after touching a patient) and the dispenser use is used as a proxy for a hand hygiene event. This data can be adjusted to take visitors into account and used to estimate hand hygiene compliance. Another example would be a badge-based system where individuals or their roles can be identified.

45) How can hospitals validate the accuracy of the data collected by the electronic compliance monitoring system for the purposes of question #11?
Validation should ideally be performed by hospital personnel or independent third-party personnel, in addition to any validation conducted by the manufacturer. It should include both a "planned path"

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phase where the researcher(s) make timed observations of room entries and exits and use of dispensers and compare their results to data recorded by the electronic compliance monitoring system. Followed by a "behavioral path" phase where observers record the same variables when individuals who touch patients or who touch items that will be used by patients are performing their usual duties, as this tends to be more chaotic and variable. A general validation protocol that can be used for both group monitoring systems and badge-based systems has been described in a fair amount of detail in the 2016 article by Limper H et al. Similar methods for conducting validation studies of badge-based system have been described by Pineles LL, Morgan Dan, et al in 2014, and by Doll ME et al. in 2019.

References:

Limper HM, Garcia-Houchins S, Slawsky L, Hershow RC, Landon E. A validation protocol: assessing the accuracy of hand hygiene monitoring technology. infection control & hospital epidemiology. 2016 Aug;37(8):1002-4.

Limper HM, Slawsky L, Garcia-Houchins S, Mehta S, Hershow RC, Landon E. Assessment of an aggregate-level hand hygiene monitoring technology for measuring hand hygiene performance among healthcare personnel. infection control & hospital epidemiology. 2017 Mar;38(3):348-52.

Pineles LL, Morgan DJ, Limper HM, Weber SG, Thom KA, Perencevich EN, Harris AD, Landon E. Accuracy of a radiofrequency identification (RFID) badge system to monitor hand hygiene behavior during routine clinical activities. American journal of infection control. 2014 Feb 1;42(2):144-7.

Doll ME, Masroor N, Cooper K, Trimmer T, Pryor R, Auricchio J, Armstrong-Novak JD, Stevens MP, Bearman G. A comparison of the accuracy of two electronic hand hygiene monitoring systems. Infection Control & Hospital Epidemiology. 2019 Oct;40(10):1194-7.

46) Is Leapfrog encouraging hospitals to implement electronic compliance monitoring? These systems can be costly, and the technology still needs to advance.

The questions in the new hand hygiene standard ask about a variety of strategies that can be used to monitor and improve hand hygiene. Leapfrog is encouraging hospitals to take a multimodal approach. With regard to monitoring, while hospitals can achieve the Leapfrog standard with direct observation alone, Leapfrog is communicating a strong preference for use of electronic monitoring (implemented according to evidence-based principles). In addition to literature suggesting electronic monitoring works better to pinpoint compliance issues, sheer numbers of hand hygiene opportunities covered by the two monitoring strategies represent powerful evidence in favor of electronic monitoring. Electronic monitoring allows facilities to monitor virtually every patient encounter, while direct observation monitors a selection. Based on the evidence, our standard calls for monitoring 200 hand hygiene opportunities per unit per month, which is a small subset of overall hand hygiene opportunities. Even beyond capturing more encounters aligned with the evidence, electronic monitoring alleviates the ethical quandary of an observer watching patient harm without intervening.

As with Computerized Physician Order Entry (CPOE) systems and Bar Code Medication Administration (BCMA) systems, we anticipate that electronic compliance monitoring technology will improve over time and become an important component of a comprehensive hand hygiene program. Electronic monitoring is a routine component of public safety in other industries where compliance is critical, so health care can and should achieve those standards for its patients.

All items included in Section 6D are based on the evidence review and recommendations from Leapfrog's national Hand Hygiene Expert Panel and others. We have included in the Hand Hygiene bibliography a number of peer-reviewed studies that have examined the benefits of using electronic monitoring systems over direct observation. The bibliography is available at http://www.leapfroggroup.org/ratings-reports/hand-hygiene.

47) When conducting direct observations, what should our hand hygiene compliance observers be documenting?

Hand hygiene compliance observers should be able to determine who practiced hand hygiene, verify when they practiced it, and whether their technique was correct. We recommend that they use an observation form, such as the WHO Observation Tool and record at least the following:

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- The role of the individual being observed (e.g., nurse, physician, etc.) and the unit where the observation session is being conducted
- The date as well as the start and end time for the observation session
- The unit and shift being observed
- The indication (or moment) for performing hand hygiene (e.g., before/after touching a patient, before/after a procedure, before/after touching patient surroundings, etc.)
- Whether hand hygiene was performed or not performed based on the indication noted and if the technique was correct

48) Are online training modules acceptable for the purposes of training hand hygiene compliance observers in question #14?
Online training can be used for the initial and recurrent training of hand hygiene compliance observers. Please refer to FAQ #49 for more information on the requirements for the validation of hand hygiene compliance observers.

49) For question #14, what would the validation of hand hygiene compliance observers include?
Hospitals should be conducting regular quality monitoring of the accuracy of observations that are collected by each observer. This would include having an individual from Infection Control simultaneously collecting data with the hand hygiene compliance observers and comparing results. In response to hospital policies on minimizing the number of extra staff in units during the COVID-19 pandemic, videos which include an interactive assessment and completion of an observation form, such as the WHO Hand Hygiene Training Films and Slides Accompanying the Training Films, would also be sufficient for validating hand hygiene compliance observers. Once resources and infection control practices allow, hospitals are encouraged to expand the testing scenarios that are included in the WHO videos (i.e., the videos should be expanded to include: various types of individuals who touch patients or who touch items that will be used by patients, a larger number of scenarios where individuals are adherent and non-adherent, the inclusion of all moments observed, etc.) and/or resume regular quality monitoring where an individual from Infection Control is simultaneously collecting data with the hand hygiene compliance observers and comparing results.

Feedback

50) For the purposes of responding to question #18, what are some examples of how hospital leadership can be held accountable through performance reviews or compensation?
A performance review or compensation plan should include specific language about hand hygiene performance. A list of hand hygiene practices and related goals may be incorporated into the performance review and/or compensation plan or formalized programs whereby a measure of success of those activities or programs is tied to individual performance reviews or compensation incentive plans of executives. Examples include meeting targets for hand hygiene compliance rates, having bonuses tied to structural changes like the implementation of electronic compliance monitoring systems, etc. Language pertaining solely to infection control practices and performance would NOT be sufficient.

Culture

51) What are some examples of how patients and visitors can be invited to remind individuals who touch patients or who touch items that will be used by patients to perform hand hygiene?
Patients and visitors can be invited to remind individuals who touch patients or who touch items that will be used by patients to perform hand hygiene with posters placed in patient care units, bedside placards, buttons worn by the staff, etc.

52) What are some examples of demonstrating a commitment to hand hygiene improvement as referenced in question #20?
Some examples of how individuals can demonstrate a commitment to support hand hygiene improvement are written or verbal commitments given during town hall meetings, videos, e-mails from the CEO, public comments to staff, etc. This needs to be a verbal or written commitment that is delivered to those individuals who touch patients or who touch items that will be used by patients.

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SECTION 7: MANAGING SERIOUS ERRORS

This section includes questions and reference information for Section 7: Managing Serious Errors. Please carefully review the questions, endnotes, and reference information (e.g., measure specifications, notes, and frequently asked questions) before you begin. Failure to review the reference information could result in inaccurate responses.

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Section 7: 2020 Managing Serious Errors

Never Events Fact Sheet: http://www.leapfroggroup.org/ratings-reports/never-events-management

Section 7 includes questions about your hospital's response to Never Events. In addition, Leapfrog collects information via its NHSN Group about five healthcare-associated infections (CLABSI, CAUTI, MRSA, *C. Diff*, and SSI Colon) and antibiotic stewardship practices.

Each hospital achieving the standards for Managing Serious Errors:

1. Has a policy that includes the nine principles of Leapfrog's Never Events policy and will implement this policy if a "never event" occurs within their facility.

2. Has a CLABSI standardized infection ratio of less than or equal to 0.413 for ICU and select ward inpatients.

3. Has a CAUTI standardized infection ratio of less than or equal to 0.427 for ICU and select ward inpatients.

4. Has a MRSA standardized infection ratio of less than or equal to 0.496 for facility-wide inpatients.

5. Has a *C. Diff.* standardized infection ratio of less than or equal to 0.621 for facility-wide inpatients.

6. Has a SSI: Colon standardized infection ratio of less than or equal to 0.349 for inpatients following eligible colon procedures.

7. Has implemented all 7 of the CDC's Core Elements of Antibiotic Stewardship Programs.

Download the 2020 Leapfrog Hospital Survey Scoring Algorithm on the Scoring and Results webpage.

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7A: The Leapfrog Group "Never Events" Policy Statement

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

Important Note: To earn credit for these questions, hospitals must have a policy in place that addresses the National Quality Forum's list of Serious Reportable Events. All references to "never event" or "serious reportable event" are specific to the National Quality Forum list available at http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=69573.

Reporting Time Period: Answer questions #1-9 based on the principles currently included in your hospital's never events policy at the time you submit this section of the Survey.

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

Below are the nine elements which make up The Leapfrog Group's Policy Statement regarding never events.[35] Indicate which of the following principles are included in your hospital's current never events policy.	
1) We apologize to the patient[36] and/or family affected by the never event[35].	*Yes* *No*
2) We report the event to at least one of the following external agencies[37] within 15 business days of becoming aware that the never event[35] has occurred: √ Joint Commission, as part of its Sentinel Events policy √ DNV GL Healthcare √ State reporting program for medical errors √ Patient Safety Organization (as defined in The Patient Safety and Quality Improvement Act of 2005)	*Yes* *No*
3) We perform a root cause analysis[38], which at a minimum, includes the elements required by the chosen external reporting agency.	*Yes* *No*
4) We waive all costs directly related to the never event[35].	*Yes* *No*
5) We make a copy of this policy available to patients, patients' family members, and payers upon request.	*Yes* *No*
6) We interview patients and/or families, who are willing and able, to gather evidence for the root cause analysis.	*Yes* *No*
7) We inform the patient and/or his/her family of the action(s) that our hospital will take to prevent future recurrences of similar events based on the findings from the root cause analysis.	*Yes* *No*
8) We have a protocol in place to provide support for caregivers involved in never events[35] and make that protocol known to all caregivers and affiliated clinicians.	*Yes* *No*
9) We perform an annual review to ensure compliance with each element of Leapfrog's Never Events Policy for each never event[35] that occurred. *Cannot respond "yes" to this question, unless "yes" to questions #1-8.*	*Yes* *No*

7B: Healthcare-Associated Infections

Specifications: See ***Healthcare-Associated Infections and Antibiotic Stewardship Practices Measure Specifications*** in the Managing Serious Errors Reference Information on pages 176-177.

Hospitals that share a CMS Certification Number, must have a unique NHSN ID as required by NHSN. Please carefully review Leapfrog's NHSN Instructions webpage.

Reporting Time Period: 12 months

- 01/01/2019 - 12/31/2019

Leapfrog will update data 4 times per Survey Cycle for all members of our NHSN group that have provided an accurate NHSN ID in the Profile and submitted Section 7: Managing Serious Errors for 01/01/2019-12/31/2019.

Visit the Join NHSN Group webpage for important information on deadlines for joining Leapfrog's NHSN Group.

Leapfrog obtains standardized infection ratios (SIRs) for each of the following applicable infection measures directly from the CDC's National Healthcare Safety Network (NHSN):

- CLABSI in ICUs and select wards
- CAUTI in ICUs and select wards
- Facility-wide inpatient MRSA Blood Laboratory-identified Events
- Facility-wide inpatient *C. Diff.* Laboratory-identified Events
- SSI: Colon

In order for Leapfrog to obtain the SIRs for each applicable infection from NHSN, hospitals must complete the following steps:

1. Join* Leapfrog's NHSN Group by the published deadlines using the checklist in the Healthcare-Associated Infections and Antibiotic Stewardship Measure Specifications,
2. Provide an accurate NHSN ID in the Profile section of the Online Hospital Survey Tool, and
3. Submit Section 7: Managing Serious Errors.

*Hospitals are not required to "re-join" Leapfrog's NHSN Group if they joined and conferred rights for the 2017, 2018, or 2019 Leapfrog Hospital Survey. However, all hospitals in Leapfrog's NHSN Group must review their Rights Acceptance Report annually to ensure that Leapfrog has access to the data from all of the locations that were active during the reporting period, even if those locations are no longer active, to ensure that Leapfrog obtains the appropriate SIR. Hospitals must review their Rights Acceptance Report by **August 20, 2020**.

Hospitals that join Leapfrog's NHSN group, but do not provide an accurate NHSN ID in their Profile or do not submit Section 7: Managing Serious Errors, will be scored and publicly reported as "Not Available" for each of the five infection measures and for the antibiotic stewardship practices.

For all other deadlines, please refer to the "Deadlines and Reporting Periods" table provided in the Healthcare-Associated Infections and Antibiotic Stewardship Practices Measure Specifications, as well as online.

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7C: Antibiotic Stewardship Practices

Specifications: See ***Healthcare-Associated Infections and Antibiotic Stewardship Practices Measure Specifications*** in the Managing Serious Errors Reference Information on pages 176-177.

Hospitals that share a CMS Certification Number, must have a unique NHSN ID as required by NHSN. Please carefully review Leapfrog's NHSN Instructions webpage.

Reporting Time Period: Results are based on your hospital's responses to the 2019 NHSN Patient Safety Component – Annual Hospital Survey.

Leapfrog obtains antibiotic stewardship practices data directly from the CDC's National Healthcare Safety Network (NHSN).

In order for Leapfrog to obtain antibiotic stewardship practices data from NHSN, hospitals must complete the following steps:

1. Join* Leapfrog's NHSN Group by the published deadlines using the checklist in the Healthcare-Associated Infections and Antibiotic Stewardship Measure Specifications,
2. Provide an accurate NHSN ID in the Profile section of the Online Hospital Survey Tool, and
3. Submit Section 7: Managing Serious Errors.

*Hospitals are not required to "re-join" Leapfrog's NHSN Group if they joined and conferred rights for the 2017, 2018, or 2019 Leapfrog Hospital Survey. However, all hospitals in Leapfrog's NHSN Group must review their Rights Acceptance Report annually by **August 20, 2020**.

Hospitals that join Leapfrog's NHSN group, but do not provide an accurate NHSN ID in their Profile or do not submit Section 7: Managing Serious Errors, will be scored and publicly reported as "Not Available" for each of the five infection measures and for the antibiotic stewardship practices.

For all other deadlines, please refer to the "Deadlines and Reporting Periods" table provided in the Healthcare-Associated Infections and Antibiotic Stewardship Practices Measure Specifications, as well as online.

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Affirmation of Accuracy

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

The hospital and I understand that The Leapfrog Group, its members, the public and entities and persons who contract or have other business dealing with The Leapfrog Group are relying on the truth and accuracy of this information. The hospital and I also understand that The Leapfrog Group will make this information and/or analyses of this information public through the Survey Results public reporting website, The Leapfrog Group's Hospital Safety Grade, and/or other Leapfrog Group products and services. This information and/or analyses and all intellectual property rights therein shall be and remain the sole and exclusive property of The Leapfrog Group in which The Leapfrog Group retains exclusive ownership. This information does not infringe upon any third-party intellectual property rights or any other third-party rights whatsoever and is free and clear of all encumbrances and liens of any kind. The hospital and I acknowledge that The Leapfrog Group may use this information in a commercial manner for profit. The hospital shall be liable for and shall hold harmless and indemnify The Leapfrog Group from any and all damages, demands, costs, or causes of action resulting from any inaccuracies in the information or any misrepresentations in this Affirmation of Accuracy. The Leapfrog Group and its members and entities and persons who contract or have other business dealing with The Leapfrog Group reserve the right to omit or disclaim information that is not current, accurate or truthful.

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

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Section 7: 2020 Managing Serious Errors Reference Information

What's New in the 2020 Survey

Leapfrog will continue to obtain healthcare-associated infection and antibiotic stewardship practices data directly from the CDC's National Healthcare Safety Network (NHSN). Find instructions on how to join Leapfrog's NHSN Group and deadlines for the 2020 Survey at http://www.leapfroggroup.org/survey-materials/join-nhsn. Please note that NHSN deadlines have been updated to reflect the December 31 Late Submission Deadline (updated from November 30 as part of Leapfrog's COVID-19 response).

The antibiotic stewardship practices data is based on responses to the "Antibiotic Stewardship Practices" section of the 2019 Patient Safety Component – Annual Hospital Survey within NHSN. The CDC calculates the number of Core Elements of an Antibiotic Stewardship Program that a hospital has met based on a hospital's responses to questions #31-40 and Leapfrog uses this information to place a hospital in a performance category.

Hospitals can find the Crosswalk of the Core Elements of Antibiotic Stewardship Mapping from the Patient Safety Annual Survey on the NHSN website (https://www.cdc.gov/nhsn/ps-analysis-resources/reference-guides.html), under "Detailed Guides for Specific Analysis Options." This document shows which questions from the 2019 Patient Safety Component – Annual Hospital Survey correspond to the seven Core Elements.

Change Summary since Release

April 13, 2020 - Updated the reporting period for Leapfrog's October and December NHSN data downloads for Section 7B Healthcare-Associated Infections from 07/01/2019 – 06/30/2020 to 01/01/2019 – 12/31/2019. This update is based on CMS' announcement that hospital reporting of healthcare-associated infection data to NHSN is optional from January 1 to June 30, 2020. A lack of six months of data may result in missing standardized infection ratios for many hospitals. Leapfrog will continue to download data from NHSN four times during the 2020 Survey Cycle to account for new hospitals that join our NHSN group and submit Section 7. Hospitals should continue to download their reports on each of the published dates to verify their data.

The last NHSN download date will be on December 18, 2020. That data will be included in Survey Results for hospitals that submit a Leapfrog Hospital Survey by the Late Submission Deadline of December 31, 2020 (updated from November 30).

See the updated reporting period on page 170 and updated specifications on pages 176-177 in the hard copy of the Survey for details.

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Never Events Frequently Asked Questions (FAQs)

1. **When reporting Never Events, what "state reporting program for medical errors" applies in my state?**
   Congress has passed legislation requiring all states to develop a reporting program for medical errors. At this time, many states have already enacted or adopted some requirement that hospitals report serious medical errors or similar adverse events to a state agency. Others are still implementing legislation or regulations that define that requirement. States that have developed programs may also define reportable events differently.

2. **What if there is no "state reporting program for medical errors" in my state? Do we still have to report Never Events to meet Leapfrog principles for this policy? To whom?**
   Hospitals in states that do not have a state reporting program or requirement in effect can meet the reporting requirement of Leapfrog's principles for implementation of a Never Events policy by reporting all Never Events voluntarily to The Joint Commission, DNV GL Healthcare, or a Patient Safety Organization.

   If there is no state-required reporting program in effect, no available Patient Safety Organization to which your hospital can report, and your hospital is not Joint Commission or DNV GL Healthcare accredited, the Leapfrog requirement for reporting to an external agency is amended. Hospitals must report the Never-Event to their governance board. And, hospitals must still perform a root-cause analysis internally of each Never Event to meet Leapfrog's principle for full implementation of its Never Events policy.

3. **The reportable adverse events defined by our state's reporting program don't include all twenty-nine (29) Never Events endorsed by the National Quality Forum (NQF) and adopted in the Leapfrog policy. Will reporting only the state-required reportable events to the state agency suffice for meeting Leapfrog's requirement for reporting Never Events to an external agency? Does our hospital have to report other Never Events, as defined by NQF/Leapfrog, to that state agency even though not required by our state's reporting program?**
   Hospitals should report all of their state-required reportable events to the state agency. All other Never Events, as defined by NQF's list of Serious Reportable Events, that cannot be reported to the state agency, should be reported to another external agency (e.g., accreditor, Patient Safety Organization), if possible. If reporting those events to another external agency is not possible, the final option is to report those events to the hospital's governance board.

4. **Won't Leapfrog's request to have hospitals apologize to the patient put the hospital at risk for liability?**
   Not necessarily. Research indicates that malpractice suits are often the result of a failure on the hospital's part to communicate openly with the patient and apologize for its error. Patients feel the most anger when they perceive that no one is willing to take responsibility for the adverse event that has occurred. A sincere apology from the responsible hospital staff can help to heal the breach of trust between doctor/hospital and patient. (When Things Go Wrong: Responding to Adverse Events. Boston, 2006. Mass Coalition for the Prevention of Medical Errors)

5. **How does Leapfrog define "waive cost?"**
   At its core, Leapfrog's approach to never events is about improving patient care. While the policy asks hospitals to refrain from billing either the patient or a third-party payer, such as a health plan or employer company, for any costs directly related to a serious reportable adverse event, Leapfrog understands that, due to the wide array of circumstances surrounding never events, specific details of what constitutes "waiving cost" should be handled on a case-by-case basis by the parties involved. For an example, please see "Lessons learned from implementing a principled approach to resolution following patient harm" by Smith et. al.

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6. **Does Leapfrog recommend any resources for hospitals looking to adhere to Leapfrog's Never Events principles?**
   Yes, the Agency for Healthcare Research and Quality (AHRQ) has developed and tested the Communication and Optimal Resolution (CANDOR) Toolkit, which outlines a process for hospitals and practitioners to respond to unexpected events in a timely, thorough, and just way. The National Patient Safety Foundation (NPSF) has issued a report titled RCA^2: Improving Root Cause Analyses and Actions to Prevent Harm, which examines best practices and provides guidelines to help standardize and improve Root Cause Analysis. In addition, hospitals can download tips and tools for interviewing patients and families for the Root Cause Analysis on the Survey and CPOE Materials webpage.

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Healthcare-Associated Infections and Antibiotic Stewardship Practices Measure Specifications

Checklist for Joining Leapfrog's NHSN Group and Ensuring the Data are Accurate

- ☐ **Join or verify that you are in Leapfrog's NHSN Group by the** join-by dates
  - Instructions for joining or verifying that you are in Leapfrog's NHSN Group are available here. (See "Join NHSN Group and Data Rights Template")
  - Join-by dates are listed in the "Deadlines and Reporting Periods" table below.

- ☐ **Review and accept Leapfrog's Data Rights Template within NHSN**
  - **All hospitals** are required to review and accept the Data Rights Template at least annually before the **August 20, 2020** NHSN join-by date and whenever updates are made to their location mapping in NHSN
    - Include any locations that were active during the reporting period even if they are currently inactive to ensure that Leapfrog obtains the appropriate SIR.
    - Confirm that you have given Leapfrog access to data from your 2019 NHSN Patient Safety Component - Annual Hospital Survey. Surveillance data from the 2019 NHSN Annual Hospital Survey is used by NHSN to risk adjust SIRs; SIRs cannot be calculated by NHSN or downloaded by Leapfrog if you restrict access to this data.
    - Failure to review and update (as needed) your Data Rights Template may result in Leapfrog pulling incorrect data for your facility.
  - Instructions for reviewing and accepting the Data Rights Template are available here. (See "Join NHSN Group and Data Rights Template")

- ☐ **Generate datasets and download reports within NHSN on the same day as Leapfrog**
  - All hospitals are required to (a) generate datasets within NHSN, (b) download CMS IQR reports, and (c) and download a copy of your 2019 Patient Safety Component - Annual Hospital Survey from NHSN on the **same day** that Leapfrog will be downloading the data from NHSN for all current group members.
  - Instructions for generating datasets and downloading these reports from NHSN are available here. (See "Downloading Reports from NHSN to Verify Data")
  - NHSN data download dates are listed in the "Deadlines and Reporting Periods" table below (please note that there are 4 NHSN pull dates per Survey Cycle)
  - By generating datasets and downloading reports within NHSN on the same day as Leapfrog, hospitals will be ensured that the data matches what Leapfrog has obtained.
  - If hospitals do not generate datasets and download reports on the same day as Leapfrog, the Help Desk will not review any discrepancies.

- ☐ **Review SIRs and Antibiotic Stewardship Practice data**
  - For verification purposes, hospitals are required to pull reports from NHSN on the **same day**, as described above.
  - Once Leapfrog has published the healthcare-associated infection and antibiotic stewardship practices Survey Results on the Hospital Details Page, hospitals are urged to compare the Survey Results to their NHSN reports that were pulled on the same day as Leapfrog.
  - Dates on which the Survey Results will be available on the Hospital Details page are listed in the "Deadlines and Reporting Periods" table below.

- ☐ **Report discrepancies**
  - If, while comparing your NHSN reports to your Leapfrog Hospital Survey Results, you find a discrepancy, you must contact Leapfrog's Help Desk immediately. If you do not contact Leapfrog by the **end of the month** in which scored results are available on your Hospital Details Page (i.e., September, November, and January, respectively), the issue will not be investigated by the Help Desk.

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Deadlines and Reporting Periods

Join 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	Antibiotic Stewardship Reporting Period (Patient Safety Component – Annual Hospital Survey)	Available on Hospital Details Page and Public Reporting Website
June 22, 2020	June 23, 2020	N/A*	01/01/2019 – 12/31/2019	2019	N/A*
August 20, 2020	August 21, 2020	August 31, 2020	01/01/2019 – 12/31/2019	2019	September 2020
October 22, 2020	October 23, 2020	October 31, 2020	01/01/2019 – 12/31/2019	2019	November 6, 2020
December 17, 2020	December 18, 2020	December 31, 2020	01/01/2019 – 12/31/2019	2019	January 8, 2021

*2020 Leapfrog Hospital Survey Results will be scored and publicly reported beginning in September as part of Leapfrog's COVID-19 response.

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SECTION 8: MEDICATION SAFETY

This section includes questions and reference information for Section 8: Medication Safety. Please carefully review the questions, endnotes, and reference information (e.g., measure specifications, notes, and frequently asked questions) before you begin. Failure to review the reference information could result in inaccurate responses.

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Section 8: 2020 Medication Safety

Bar Code Medication Administration Fact Sheet: https://www.leapfroggroup.org/ratings-reports/bar-code-medication-administration
Medication Reconciliation Fact Sheet: https://www.leapfroggroup.org/ratings-reports/medication-reconciliation
Opioid Prescribing Bibliography: https://www.leapfroggroup.org/ratings-reports/opioid-prescribing

Section 8 includes questions about additional processes your hospital has in place to prevent medication errors, including bar code medication administration and medication reconciliation. It also contains questions on opioid prescribing, which will not be scored or publicly reported in 2020.

Each hospital achieving the standard for Bar Code Medication Administration:

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

Each hospital achieving the standard for Medication Reconciliation:

1. Uses a nationally endorsed protocol to collect data on the accuracy of its medication reconciliation process and reported the data collected to Leapfrog.
2. Has no potential data entry errors.

Download the 2020 Leapfrog Hospital Survey Scoring Algorithm on the Scoring and Results webpage.

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8A: Bar Code Medication Administration

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

Reporting Time Period: 3 months
Answer questions #1-15 for the latest 3-month period prior to the submission of this section of the Survey.

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

1) What is the latest 3-month reporting period for which your hospital is submitting responses to this section? 3-month reporting time period ending:	_____ *Format: MM/YYYY*
2) Does your hospital use a Bar Code Medication Administration (BCMA) system that is linked to the electronic medication administration record (eMAR) when administering medications at the bedside in at least one inpatient unit? *If "no" to question #2, skip questions #3-15 and continue on to the next subsection.*	*Yes* *No*
3) Does your hospital operate Intensive Care Units[39] (adult, pediatric, and/or neonatal)? *If "no" to question #3, skip questions #4-5 and continue on to question #6.*	*Yes* *No*
4) If "yes," how many of this type of unit are open and staffed in the hospital?	_____
5) How many of the units in question #4 utilized the BCMA/eMAR system when administering medications at the bedside?	_____
6) Does your hospital operate Medical and/or Surgical Units (including telemetry units)[40] (adult and/or pediatric)? *If "no" to question #6, skip questions #7-8 and continue on to question #9.*	*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) Does your hospital operate a Labor and Delivery Unit[41]? *If "no" to question #9, skip questions #10-11 and continue on to question #12.*	*Yes* *No*
10) If "yes," how many of this type of unit were open and staffed in the hospital?	_____

11) How many of the units in question #10 utilized the BCMA/eMAR system when administering medications at the bedside?	_____

If "no" to questions #3, #6, and #9 above, skip questions #12-15 and continue on to the next subsection. Your hospital will be scored as "Does Not Apply."

12) The number of scannable inpatient medication administrations during the reporting period in those units that utilize BCMA as indicated in questions #5, #8, and #11 above?	_____
13) The number of medication administrations from question #12 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)?	_____

14) What types of decision support does your hospital's BCMA system provide to users of the system?

Do not leave any questions blank.

a)	Wrong patient	*Yes* *No*
b)	Wrong medication	*Yes* *No*
c)	Wrong dose	*Yes* *No*
d)	Wrong time (e.g., early/late warning; warning that medication cannot be administered twice within a given window of time)	*Yes* *No*
e)	Second nurse check needed	*Yes* *No*

15) Which of the following mechanisms does your hospital use to reduce and understand potential BCMA system "workarounds"?

Do not leave any questions blank.

a)	Has a formal committee that meets routinely to review data reports on BCMA system use	*Yes* *No*
b)	Has back-up systems for BCMA hardware failures	*Yes* *No*
c)	Has a Help Desk that provides timely responses to urgent BCMA issues in real-time	*Yes* *No*
d)	Conducts real-time observations of users at the unit level using the BCMA system	*Yes* *No*
e)	Engages nursing leadership at the unit level on BCMA use	*Yes* *No*
f)	In the past 12 months used the data and information obtained through items a-e to implement quality improvement projects that have focused on improving the hospital's BCMA performance **OR**	*Yes* *No*

	In the past 12 months used the data and information obtained through items a-e to monitor a previously implemented quality improvement project focused on improving the hospital's BCMA performance *Cannot respond "yes" to this question, unless "yes" to either 15a, b, c, d, or e.*	
g)	In the past 12 months evaluated the results of the quality improvement projects (from f) and demonstrated that these projects have resulted in higher adherence to your hospital's standard medication administration process **OR** In the past 12 months evaluated the results of the quality improvement projects (from f) and demonstrated continued adherence to your hospital's standard medication administration process *Cannot respond "yes" to this question, unless "yes" to 15f.*	*Yes* *No*
h)	Communicated back to end users the resolution of any system deficiencies and/or problems that may have contributed to workarounds *Cannot respond "yes" to this question, unless "yes" to either 15a, b, c, d, or e.*	*Yes* *No*

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8B: Medication Reconciliation

This section is not applicable to Pediatric hospitals.

Specifications: See ***Medication Reconciliation Measure Specifications*** in the Medication Safety Reference Information on pages 194-199.

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

Reporting Time Period: 3 months or 6 months
Answer questions #1-9 for the latest 3-month period or 6-month period prior to the submission of this section of the Survey.

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

1) What is the latest 3-month reporting period or 6-month reporting period for which your hospital is submitting responses to this section? 3-month or 6-month reporting period ending:	_____ *Format: MM/YYYY*
2) During the reporting period, did your hospital conduct any protocol to measure the accuracy of its existing medication reconciliation process? *If "no" to question #2, skip questions #3-9 and continue on to the next subsection. The hospital will be scored as "Limited Achievement."*	*Yes* *No*
3) During the 3-month or 6-month reporting period, did your hospital conduct a random sample of adult patients and have a pharmacist complete the following steps for each patient included in the sample: • Interview Patient and Obtain the Gold Standard Medication History • Complete a Medication Reconciliation Worksheet for each sampled patient • Compare Gold Standard Medication History to Admission Orders • Compare Gold Standard Medication History to Discharge Orders *If "no" to question #3, skip questions #4-9 and continue on to the next subsection.*	*Yes, over a 3-month period* *Yes, over a 6-month period* *No*
4) Does your hospital choose to report the data collected in question #3 to the Survey? *If "no" to question #4, skip questions #5-9 and continue on to the next subsection.*	*Yes* *No*

For questions #5-9, report on a sample of at least 15 patients if from a 3-month period, or 30 patients if from a 6-month period.	
5) Number of adult patients that your hospital sampled[42].	_____

6) Total number of medications obtained by the pharmacist from the Gold Standard Medication History[43] for the adult patients included in the sample.	_____
7) Total number of unintentional discrepancies in admission and discharge among the gold standard medications[44] in question #6.	_____
8) Total number of unintentionally ordered additional medications[45] for the adult patients included in the sample on admission and/or discharge.	_____
9) Total number of discrepancies due to unintentionally ordered additional medications[46] in question #8.	_____

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8C: Opioid Prescribing

Important Notes:

Note 1: This section is **optional** in 2020. Responses will not be scored or publicly reported.

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

Reporting Time Period: Answer questions #1-10 based on the protocols and practices currently in place at the time you submit this section of the Survey.

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

1) Does your hospital require all licensed prescribers who are authorized to prescribe scheduled drugs to register for access to your state or regional Prescription Drug Monitoring Program (PDMP)? *If "no" to question #1, skip questions #2-3 and continue on to question #4.*	*Yes* *No*
2) Does your hospital require all licensed prescribers who are authorized to prescribe scheduled drugs to query and assess the PDMP prior to prescribing an opioid pain medication to a patient?	*Yes* *No*
3) Which of the following processes or structures does your hospital have in place to promote the ongoing use of the PDMP by licensed prescribers? *Select all that apply.*	☐ Uses a proven method to match and link the same patient's records ☐ Provides continuous online access and automated reports to authorized users ☐ Integrates PDMP data with electronic health record ☐ None of the above
4) Does your hospital require that all licensed prescribers who are authorized to prescribe scheduled drugs adhere to national, evidence-based Surgical Opioid Guidelines? *If "no" or "not applicable; do not perform any of the procedures included in the guidelines," skip the remaining questions in Section 8C, and go to the Affirmation of Accuracy. The procedures are applicable to adult patients only.*	*Yes* *No* *Not applicable; do not perform any of the procedures included in the guidelines*
5) Does your hospital conduct regular retrospective reviews of licensed prescribers to identify the extent to which they adhere to the Surgical Opioid Guidelines?	*Yes* *No*

6) Does your hospital have a process in place for communicating with licensed prescribers, as well as leadership, when a licensed prescriber's trend or prescribing pattern suggests challenges to adhering to the Surgical Opioid Guidelines to understand barriers and improve adherence?	*Yes* *No*

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Affirmation of Accuracy:

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

The hospital and I understand that The Leapfrog Group, its members, the public and entities and persons who contract or have other business dealings with The Leapfrog Group are relying on the truth and accuracy of this information. The hospital and I also understand that The Leapfrog Group will make this information and/or analyses of this information public through the Survey Results public reporting website, The Leapfrog Group's Hospital Safety Grade, and/or other Leapfrog Group products and services. This information and/or analyses and all intellectual property rights therein shall be and remain the sole and exclusive property of The Leapfrog Group in which The Leapfrog Group retains exclusive ownership. This information does not infringe upon any third-party intellectual property rights or any other third-party rights whatsoever and is free and clear of all encumbrances and liens of any kind. The hospital and I acknowledge that The Leapfrog Group may use this information in a commercial manner for profit. The hospital shall be liable for and shall hold harmless and indemnify The Leapfrog Group from any and all damages, demands, costs, or causes of action resulting from any inaccuracies in the information or any misrepresentations in this Affirmation of Accuracy. The Leapfrog Group and its members and entities and persons who contract or have other business dealings with The Leapfrog Group reserve the right to omit or disclaim information that is not current, accurate or truthful.

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

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Section 8: 2020 Medication Safety Reference Information

What's New in the 2020 Survey

In 2020, based on feedback from hospitals and Leapfrog's national BCMA Expert Panel, Leapfrog updated the definition of Labor and Delivery units in Section 8A BCMA question #9 to exclude operating rooms and procedural areas. Please refer to endnote #41 for a full definition.

There are no substantive changes to Section 8B Medication Reconciliation.

Leapfrog has also added a new subsection (Section 8C Opioid Prescribing) focused on safe opioid prescribing. This new subsection will be optional in 2020, and responses will not be scored or publicly reported.

The subsection focuses on two areas of opioid prescribing: prescription monitoring via state or regional prescription drug monitoring programs (PDMPs) and adherence to national evidence-based prescribing guidelines for surgical patients.

First, to assess participation in what the Centers for Disease Control and Prevention have identified as a promising practice to improve opioid prescribing and to protect patients, Leapfrog is asking hospitals about their participation in their state or regional prescription drug monitoring program (PDMP) and whether prescribers are required to check the database before writing a new prescription. These questions are applicable to adult and pediatric hospitals and have also been added to the 2020 Leapfrog ASC Survey.

Second, Leapfrog is asking hospitals to report on their adherence to national evidence-based prescribing guidelines for surgical patients and how they monitor adherence to these guidelines. These measures are not applicable to pediatric hospitals but have been added to the 2020 Leapfrog ASC Survey.

Change Summary since Release

None. If substantive changes are made to this section of the Survey after release on April 1, 2020, they will be documented in this Change Summary section.

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BCMA Frequently Asked Questions (FAQs)

General Questions

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

Units

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

3. **How should a hospital report if they had BCMA implemented in some units but not all during the reporting period?**
   In order to answer "yes" to question #2, your hospital must have a Bar Code Medication Administration (BCMA) system that is linked to the electronic medication administration record (eMAR) when administering medications at the bedside in *at least one* inpatient unit. You should only report on inpatient units that have been in operation for the entire 3-month reporting period selected in question #1. If you have 3 surgical units and are only using BCMA in 1 of the 3 units, you would respond 3 in question #7 and 1 in question #8. You should only include inpatient medication administrations that were ordered and scannable in the open and staffed units in which a BCMA system was implemented (as indicated in questions #5, #8, and #11) when reporting on compliance in questions #12-13.

Compliance

4. **Should we exclude medications that were administered in units that are not currently implementing BCMA?**
   Yes. Question #12 is asking about inpatient medication administrations ordered and scannable in those units that are open and staffed and that have implemented a BCMA system. You should include all scannable medications ordered and administered to inpatients in the open and staffed units (from questions #5, #8, and #11) in which a BCMA system was implemented. Question #12 is used as the denominator to calculate the rate of compliance and should include administrations whether or not the medication and/or patient was scanned during the administration. Question #13 is used as the numerator and is where you would report the number of inpatient medication administrations from these units where the patient and medication were scanned during the administration. We would not expect these two responses to be the same.

5. **What is considered a "scannable" medication?**
   Any medication that has a bar code and could be scanned if BCMA were in use would be considered "scannable." In question #12, hospitals should only include ordered and "scannable" medications from the units they indicated in questions #5 #8, and #11 where a BCMA system was implemented.

6. **Our hospital uses BCMA to scan nutrition products and we are unable to exclude these products from our BCMA reports. Should we include them when reporting on Section 8A BCMA, questions #12-13?**
   Yes, hospitals should include in their reporting any products that are considered "scannable" (see FAQ #4 above). Leapfrog's BCMA Expert Panel has not agreed upon a strict definition of what

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should be considered a “medication,” but medications could include: pills, compounded products, topicals, IV medications/solutions, breast milk, eye drops, nebulized/inhaled medications, nasal sprays, injectables (subcutaneous and intramuscular), patches, etc.

7. **Should we be excluding medications that are given during emergencies when responding to questions #12-13?**
   No. If the medications are considered "scannable" e.g., any medication that has a bar code and could be scanned if BCMA were in use, they should be included in question #12 (the denominator), but would not be counted in question #13 (the numerator) if the patient and medication were not scanned during administration, even if due to an emergency.

   Leapfrog's target rate for compliance is 95% to allow for emergency cases such as these.

8. **Should we exclude medications that are given during a system downtime when responding to questions #12-13?**
   No. Medications administered during a system downtime should be included in question #12 (the denominator) but would not be counted in question #13 (the numerator) if the patient and medication were not scanned during administration because your BCMA system was down.

9. **Our vendor report provides medication and patient scanning rates separately. How can we report on our compliance if our reports do not provide the number of administrations that had both the medication and patient scanned?**
   For responding to questions #12-13, if your vendor’s report only provides the percentage of patients scanned and the percentage of medications scanned separately, but does not provide the rate of administrations where both the patient and medication were scanned, please report the lower of the two rates (supply the denominator in question #12 and numerator in question #13), as that would be the maximum possible rate of having both scanned.

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

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

11. **Our process is to scan the patient once and then scan each medication. Question #13 seems to want each medication and patient scanned with each medication. Can you clarify?**
    In question #13, hospitals should report on the number of administrations where both the patient and the medication were scanned during the administration. During administrations where multiple medications are administered sequentially, the patient should be scanned first, but does not need to be rescanned before each medication is administered.

12. **In our hospital some medications are ordered and scheduled, but not administered. Should medications that are ordered and scheduled, but not administered be included when responding to questions #12-13?**
    No, medications that are not administered should not be included in questions #12 and #13.

Decision Support

13. **If an alert is part of the eMAR, but not the Bar Code Medication Administration system, should we respond “yes” to the decision support elements in question #14a - e?**
    If the provider and pharmacist are notified or alerted (e.g., second nurse check), but the nurse or provider administering the medication does not receive an alert at the point of administration, then your hospital should answer “no” to these questions about decision support.

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

Workarounds

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

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

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

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

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

19. **What are some appropriate mechanisms for communicating back to end users for question #15h?**

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Appropriate mechanisms for communicating back to end users would include: staff meetings, safety briefings or unit huddles, or sharing in a Nursing Informatics eNewsletter, through a Medication Safety Team, or Quality Committee newsletter/flyer.

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Medication Reconciliation Measure Specifications

Important Notes:

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

Note 2: A hospital pharmacist plays two important roles in data collection for this measure. First, the pharmacist is responsible for obtaining the Gold Standard Medication History from each sampled patient. Second, the pharmacist is responsible for identifying the unintentional discrepancies by comparing the Gold Standard Medication History to admission orders and discharge orders.

Source: Brigham and Women's Hospital (NQF #2456)

Reporting Period: The latest 3-month period or 6-month period prior to submission of this section of the Survey.

Medication Reconciliation Workbook (Excel) and Medication Reconciliation Worksheet (Word)

To complete the data collection for this subsection and respond to questions #5-9, hospitals should download four important tools:

- The **Medication Reconciliation Workbook** (Excel) includes 3 tabs: Instructions, Sampling, and Data Entry. This can be used to identify patients to sample and collect data from, as well as calculate the responses to enter into the Online Hospital Survey Tool from the completed Worksheets.
- The **Medication Reconciliation Worksheet** can be used by the pharmacists to identify the number of unintentional discrepancies at admission and/or discharge for each sampled patient (question #7). The Medication Reconciliation Worksheet can also be used to track additional medications that were ordered unintentionally at admission and/or discharge (questions #8-9).
- The **MARQUIS 2 Best Possible Medication History: Quick Tips** tri-fold (PDF) includes important information on how the pharmacist should obtain the Gold Standard Medication History
- **Identifying Discrepancies Flow Charts** (PDF) includes important information on how the pharmacist should identify discrepancies between the Gold Standard Medication History and admission and discharge orders.

All of these tools are available on the Survey and CPOE Materials webpage and should be used when reporting on this measure.

The intent of this measure is to calculate your hospital's rate of unintentional medication discrepancies per medication. Data collection requirements for this measure can be met in two ways:

1. Hospitals that started and continued to sample 15 patients on a quarterly basis using the 2019 Leapfrog Hospital Survey measure specifications, can use those data when reporting on this section of the Survey (i.e. 30 patients over a 6-month reporting time period).
2. Hospitals that did not start sampling patients in 2019, can sample in real-time (i.e. sampling occurs after April 1) and start data collection anytime during the Survey Cycle from 15 patients if using a 3-month reporting time period (i.e. April, May, and June). Sampling can be performed over the entire reporting time period, or within a single week or number of days.

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

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

a. Hospitals are required to sample at least 15 patients in medical/surgical units if reporting on a 3-month period, or at least 30 patients if reporting on a 6-month reporting period. Exclude patients under 18 years old, patients who were discharged or expired before the Gold Standard Medication History could be obtained, and patients that do not have discharge orders written during the reporting period. Hospitals may expand their sampling to patients in

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additional units of the hospitals; inclusion of patients from medical/surgical units is the minimum requirement.

b. We recommend sampling patients from different days of the week, including patients admitted on the weekend.
c. On the day of data collection, obtain a list of patients that were admitted the day before to medical/surgical units, in the order that they were admitted.
d. Open the Sampling Tab of the Medication Reconciliation Workbook, and filter for today's date. This will give you a list of random numbers, which represent the patients to include in your sample based on the order of admittance.
e. Send the list of patients to be sampled to the pharmacist so he/she can schedule to interview each patient to obtain their Gold Standard Medication History.

Step 2: Interview Patients and Obtain the Gold Standard Medication History (Pharmacist)

a. A trained pharmacist or pharmacy resident must interview the patients from Step 1 and obtain the Gold Standard Medication History within 24 hours after admission. Note that this is in addition to, and separate from, any pre-admission medication list that was created as part of normal care.
b. The pharmacist can customize the following script to explain to the patient the reason for the interview: "Hi, I'm *(pharmacist's name)*, a pharmacist at *(name of hospital)*. I know *(care team member who may have collected a pre-admission medication list or PAML)* already asked you about the medications you were taking before you were admitted to the hospital. I'm here to ask you about these medications again. Our hospital has asked me to collect this information again so I can use it to measure how well we are doing in gathering these medication histories. What we learn will help us improve our processes of care in the future and make sure we manage patients' medications safely when they come into and after they leave the hospital."
c. The Gold Standard Medication History is the list of medications that the patient was taking prior to admission. Best practices for collecting the Gold Standard Medication History can be found in the "Other Supporting Materials" for Section 8 on our website.
    i. Pharmacists should try to use two sources of information (see MARQUIS BPMH Tri-Fold Pocket Guide and Medication Reconciliation Implementation Toolkit for examples) and explore any discrepancies (e.g., errors related to dose, route, timing, etc.) before finalizing the Gold Standard Medication History. Once the pharmacist has completed the patient interview, the pharmacist can utilize support from pharmacy technicians, medical assistants, and nurses to investigate second or third information sources (e.g., EHR list, pharmacy list, primary or specialty provider information, etc.). However, the pharmacist must be the one to finalize the Gold Standard Medication History.
    ii. Medications that a patient is completely non-adherent to (i.e. has not been taking at all in the previous month) should be excluded from the Gold Standard Medication History.
    iii. If a patient has been taking a medication differently to how it was prescribed, then the Gold Standard Medication History should list the medication as the patient was taking it.
    iv. Exclude the following medications **unless** they are clinically relevant:
        1. as needed (PRN) medications, except for the following, which should be included: inhalers, nitroglycerin, analgesics (opioid and non-opioid), muscle relaxants, and sedatives;
        2. topical lotions/creams;
        3. saline nasal spray and artificial tear eye drops;
        4. herbals and supplements; and
        5. vitamins
    v. Two examples of clinically relevant medications that should not be excluded from the gold standard pre-admission medication list would be iron for a patient with iron-deficiency anemia or calcium/vitamin D for a patient with osteoporosis.

Step 3: Complete a Medication Reconciliation Worksheet for each sampled patient (Pharmacist)

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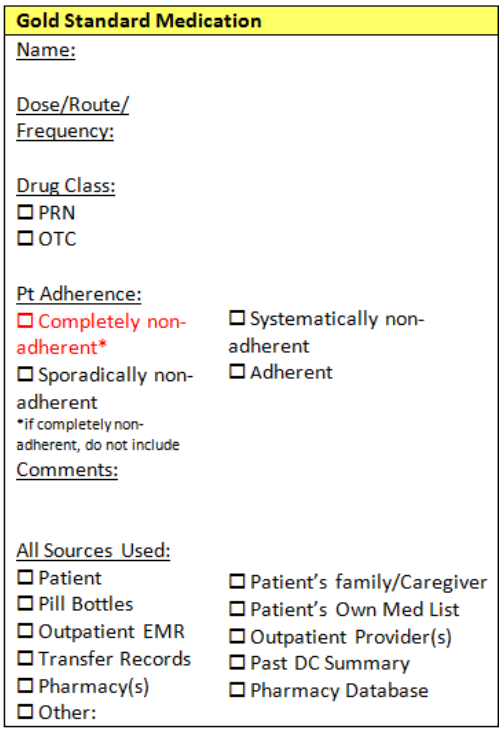
a. Once the Gold Standard Medication History is complete, print out the Medication Reconciliation Worksheet for each sampled patient.
b. Page 1 needs to be printed out for each sampled patient. Page 2 needs to be printed for each Gold Standard Medication the patient was taking.
c. Complete the "Gold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



Gold Standard Medication

Name:

Dose/Route/ Frequency:

Drug Class:
☐ PRN
☐ OTC

Pt Adherence:
☐ Completely non-adherent*
☐ Sporadically non-adherent
☐ Systematically non-adherent
☐ Adherent
*if completely non-adherent, do not include

Comments:

All Sources Used:
☐ Patient
☐ Pill Bottles
☐ Outpatient EMR
☐ Transfer Records
☐ Pharmacy(s)
☐ Other:
☐ Patient's family/Caregiver
☐ Patient's Own Med List
☐ Outpatient Provider(s)
☐ Past DC Summary
☐ Pharmacy Database

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

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

a. After the patient has been discharged, obtain the admission and discharge orders for the patient. (Instructions for comparing the discharge orders are in Step 5 below). Admission orders include all orders written from the time of admission until 8:00 a.m. the following morning or up until 12 hours after the time of admission, whichever comes first.
b. Compare the admission orders to each Gold Standard Medication on the Medication Reconciliation Worksheet. Note any differences.
    vi. Review the records for the patient to determine if the differences were intentional or unintentional. Use the Identifying Discrepancies Flow Charts to help with this step.
    vii. If the discrepancy was unintentional, then check the box next to "Yes" highlighted in orange. Otherwise, check "No".

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

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

Additional Medications that were Ordered Unintentionally:

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

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

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

a. Obtain the discharge orders for the patient.
b. Perform the comparison between the Gold Standard Medications and the discharge orders using the same steps as the admission comparison. Remember to use the Identifying Discrepancies Flow Charts to help with this step.
c. Review the discharge orders for any medications that were not listed in the Gold Standard Medication History. If any of the additional medications were ordered **unintentionally**, list

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them on the first page of the Medication Reconciliation Worksheet in the blue-highlighted column.

i. If an unintentionally ordered additional medication was only ordered on admission, then check the "Admission" box in the pink-highlighted column.
ii. If an unintentionally ordered additional medication was only ordered on discharge, then check the "Discharge" box in the pink -highlighted column.
iii. If the unintentionally ordered additional medication was ordered on both admission and discharge, then check the "Both" box in the pink-highlighted column

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

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

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

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

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

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

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

Step 7: Contact providers if necessary (Pharmacists)

a. If you found any serious discrepancies that could cause the patient harm, you will need to contact the providers. The provider may need to reach out to the patient, PCP, or pharmacies to have the issue corrected.

Step 8: Enter data into Excel Workbook and Online Hospital Survey Tool (Survey Coordinator)

a. Collect all of the Medication Reconciliation Worksheets from the pharmacists. Open the Data Entry Tab of the Medication Reconciliation Excel Workbook.

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

Step 9: Use your hospital's results in quality improvement (Survey Coordinator and Pharmacist)
The developer of this measure has two toolkits available for hospitals that wish to implement a medication reconciliation program:

Medication Reconciliation Implementation Toolkit (free)
The MARQUIS Collaborative (fee to participate)

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

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Medication Reconciliation Frequently Asked Questions (FAQs)

Sampling

1. **Are we required to use the Leapfrog's random sampling methodology?**
   You may use a different sampling methodology from the methodology provided in the Medication Reconciliation Workbook. However, you should be sure to sample from different days of the week, including weekends.

2. **Which patients should be included in sampling?**
   The sample should only include inpatients 18 years or older admitted to a medical and/or surgical unit. A definition of medical/surgical units can be found in endnote #40. Patients who were discharged or expired before the gold standard history could be obtained should be excluded from the sample.

3. **Do we have to limit our sample to medical/surgical units?**
   At a minimum, hospitals should sample from medical/surgical units, but are not required to limit their sampling to those units.

Gold Standard Medication History

4. **A pharmacist creates the pre-admission Medical List as part of normal care. Can this be used as the Gold Standard Medication List?**
   No, a different trained pharmacist should collect the Gold Standard Medication List when collecting data for this measure.

5. **Does the same pharmacist need to obtain the Gold Standard Medication List and perform the review to identify unintentional medication discrepancies?**
   No, different pharmacists can play different roles in the data collection process.

6. **Can a pharmacy tech or student obtain the Gold Standard Medication List?**
   No. In accordance with the research and testing by measure developers as well as compliance with the NQF measure endorsement, only licensed pharmacists will be allowed to obtain the Gold Standard Medication List and identify unintentional discrepancies. Pharmacy residents who have been trained and have experience (at least several months) obtaining medication histories from patients could fill this role.

7. **It has been the standard for the pharmacists to meet with the patients face to face upon discharge however with the COVID-19 outbreak, can the pharmacist obtain the Gold Standard Medication List via a phone interview with the patient?**
   Yes, a phone interview is acceptable for the medication reconciliation measure. Through this method, the intent of getting first-hand information from the patient is being met and we appreciate your innovative solution to continue to ensure medication safety for patients.

8. **When should the Gold Standard Medication History be obtained by the pharmacist?**
   The pharmacist should obtain the gold standard medication history within 24 hours of admission, typically the morning after admission.

9. **The patient was taking a medication prior to admission differently from how it was originally prescribed. What should be listed as the gold standard medication?**
   The Gold Standard Medication History should reflect the medications that the patient was taking prior to admission, as the patient was taking it. For example, if a patient was prescribed 100 mg daily for a medication, but had only been taking 50 mg daily, then the Gold Standard Medication History would list 50 mg of this medication.

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10. **Pharmacy records indicate the patient was prescribed a medication, but the patient had not actually been taking it prior to admission. Should it be included in the Gold Standard Medication History?**
    If a patient is completely non-adherent and has not taken the medication at all in the 30 days prior to admission, then the medication should not be included in the Gold Standard Medication History.

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

Admission and Discharge Orders

12. **What orders are considered admission orders?**
    All orders written from the time of admission until 8:00 a.m. the following morning or up until 12 hours after the time of admission, whichever comes first.

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

14. **Should admission orders that are discontinued prior to discharge be included?**
    Yes. Some of these orders may end up being counted in question #8 (additional medications that were unintentionally ordered).

Identifying Discrepancies

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

16. **Do all of the additional medications that were ordered unintentionally in question #8 count as unintentional discrepancies in #9**?
    Yes. If a medication is unintentionally ordered at admission, then this counts as one discrepancy. If the same medication is unintentionally ordered at discharge, then this counts as a second discrepancy. If an unintentionally ordered medication in question #8 was ordered on both admission and discharge, then this would count as **two** discrepancies in question #9 (but counts as one medication in question #8).

Scoring

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17. What is an example of a data entry or reporting error that would lead to being scored as "Some Achievement?"

Data reported in Section 8B will be reviewed for potential data reporting errors that suggest the data was collected incorrectly or a data entry error was made. For example, hospitals that reported an extremely large sample or reported zero medications from the Gold Standard Medication History for each patient in the sample, are scenarios that will be flagged in the Extensive Monthly Data Verification and scored as "Some Achievement" until the data is corrected.

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Opioid Prescribing Frequently Asked Questions (FAQs)

1. **What are examples of proven methods that can be used to match and link the same patient's record?**
   Patient matching and linking can be accomplished with three methods of matching:
   - Probabilistic matching is the process of using statistical analysis to determine the overall likelihood or probability that two records are the same patient.
   - Referential matching is a form of probabilistic matching where records are matched against a comprehensive and continuously updated reference database of identities such as a statewide Health Information Exchange.
   - Deterministic matching is the process of determining whether records refer to the same patient if they have an exact match based on a subset of data such as name and date of birth. When using deterministic matching, care needs to be taken that it also allows for alternate uses of the same name (e.g., Robert and Bob, Will and William, Margaret and Peggy).

   The use of any one or a combination of any of these methods would be considered a proven method to match and link the same patient's record.

   The prescriber should be able to connect directly with the PDMP through a button or link that takes them directly to the patient record within the PDMP (it should match the patient they are viewing).

2. **What does continuous online access and automated reports to authorized users refer to?**
   Continuous online access refers to the availability of the PDMP and how frequently it is updated (i.e., the database is always available and updated in real-time). If the database is refreshed on a periodic basis rather than in real-time as prescriptions are being processed by the pharmacies or prescribers, it is not continuous online access.

   Automated reports refer to the alerting capability of the PDMP (i.e., does it alert a prescriber of a possible concern such as active opioid prescription in place when a prescriber is writing a new prescription).

3. **What is required for the integration of PDMP data with the electronic health record?**
   For integration, the electronic health record should automatically document that the prescriber checked the PDMP when they view the patient's record within the PDMP.

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SECTION 9: PEDIATRIC CARE

This section includes questions and reference information for Section 9: Pediatric Care. Please carefully review the questions, endnotes, and reference information (e.g., measure specifications, notes, and frequently asked questions) before you begin. Failure to review the reference information could result in inaccurate responses.

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Section 9: 2020 Pediatric Care

This section is only applicable to general, acute-care hospitals and free-standing pediatric hospitals that care for patients 17 years of age or younger.

Pediatric Care Fact Sheets: http://www.leapfroggroup.org/ratings-reports/pediatric-care-0

Section 9 includes questions about patient experience (CAHPS Child Hospital Survey) and Computed Tomography (CT) radiation dose.

Each hospital achieving the standards for Pediatric Care:

1. Performed in the top quartile based on responses submitted by August 31, 2020 for at least 4 of the 5 Pediatric CAHPS domains (a subset of the 18 domains), listed below:
    a. Communication with Parent – Communication about your child's medicines
    b. Communication with Parent – Keeping you informed about your child's care
    c. Communication with Child – How well nurses communicate with your child
    d. Communication with Child – How well doctors communicate with your child
    e. Attention to Safety and Comfort – Preventing mistakes and helping you report concerns
2. Received 75% or more of the possible points based on comparing CT radiation doses across two anatomic areas and 5 age strata and by phantom dose to benchmarks calculated from responses submitted by August 31, 2020.

Download the 2020 Leapfrog Hospital Survey Scoring Algorithm on the Scoring and Results webpage.

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9A: Patient Experience (CAHPS Child Hospital Survey)

Important Notes:

Note 1: This section is only applicable to general, acute-care hospitals and free-standing pediatric hospitals that care for patients 17 years of age or younger.

Note 2: To help ensure that the Top Box Scores[47] represent an appropriate sample of patients, hospitals must have at least 100 pediatric acute-care admissions to inpatient units other than a neonatal ICU (NICU). Otherwise, they should respond "Yes, but fewer than 100 pediatric admissions were for non-NICU patients" to question #2 and skip the remaining questions in Section 9A. The hospital will be scored as "Does Not Apply." For example, if your hospital had 600 pediatric acute-care admissions, and 550 of those admissions were to a neonatal ICU, you should respond "Yes, but fewer than 100 pediatric admissions were for non-NICU patients" to question #2 as your hospital only has 50 admissions to inpatient units other than a neonatal ICU.

Specifications: See ***Patient Experience (CAHPS Child Hospital Survey) Measure Specifications*** in the Pediatric Care Reference Information on page 214.

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

Reporting Time Period: 12 months
Answer questions #1-24 for the latest 12-month period prior to the submission of this section of the Survey.

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

1) What is the latest 12-month reporting period for which your hospital is submitting responses to this section? 12-month reporting time period ending:	_____ *Format: MM/YYYY*
2) Did your hospital have at least 500 pediatric acute-care admissions during the 12-month period referenced in Section 1, question #5? *Refer to your responses to questions #5 and #11 in Section 1 Basic Hospital Information.* *If "no" or "yes, but fewer than 100 pediatric admissions were for non-NICU patients," skip questions #3-24 and continue on to the next subsection. The hospital will be scored as "Does Not Apply."*	*Yes* *Yes, but fewer than 100 pediatric admissions were for non-NICU patients* *No*
3) Has your hospital administered, or started to administer, the entire CAHPS Child Hospital Survey during the reporting period? *If "no" to question #3, skip questions #4-24 and continue on to the next subsection. The hospital will be scored as "Limited Achievement."*	*Yes* *No*

4) How many surveys were returned during the reporting period?	_____ *Format: Whole numbers only*

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If less than 100, skip questions #5-24 and continue on to the next subsection. Hospitals with less than 100 returned surveys will be scored as "Unable to Calculate Score."	
5) Which of the following modes were used to administer the survey? *Select all that apply.*	☐ Mail ☐ Phone ☐ Email ☐ Tablet
6) Which of the following times were surveys administered during the reporting period? *Select all that apply.*	☐ Day of discharge ☐ After discharge

In questions #7 – 24, report your hospital's "Top Box Score[47]" from each patient experience measure from your 12-month vendor report that matches the reporting period that you selected in question #1.

7) Communication with Parent – Communication between you and your child's nurses	_____ *Format: Whole numbers only*
8) Communication with Parent – Communication between you and your child's doctors	_____ *Format: Whole numbers only*
9) Communication with Parent – Communication about your child's medicines	_____ *Format: Whole numbers only*
10) Communication with Parent – Keeping you informed about your child's care	_____ *Format: Whole numbers only*
11) Communication with Parent – Privacy when talking with doctors, nurses, and other providers	_____ *Format: Whole numbers only*
12) Communication with Parent – Preparing you and your child to leave the hospital	_____ *Format: Whole numbers only*
13) Communication with Parent – Keeping you informed about your child's care in the Emergency Room	_____ *Format: Whole numbers only*
14) Communication with Child – How well nurses communicate with your child	_____ *Format: Whole numbers only*

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15) Communication with Child – How well doctors communicate with your child	*Format: Whole numbers only*
16) Communication with Child – Involving teens in their care	*Format: Whole numbers only*
17) Attention to Safety and Comfort – Preventing mistakes and helping you report concerns	*Format: Whole numbers only*
18) Attention to Safety and Comfort – Responsiveness to the call button	*Format: Whole numbers only*
19) Attention to Safety and Comfort – Helping your child feel comfortable	*Format: Whole numbers only*
20) Attention to Safety and Comfort – Paying attention to your child's pain	*Format: Whole numbers only*
21) Hospital Environment – Cleanliness of hospital room	*Format: Whole numbers only*
22) Hospital Environment – Quietness of hospital room	*Format: Whole numbers only*
23) Global Rating – Overall rating	*Format: Whole numbers only*
24) Global Rating – Recommend hospital	*Format: Whole numbers only*

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9B: Pediatric Computed Tomography (CT) Radiation Dose

This section is only applicable to general, acute-care hospitals and free-standing pediatric hospitals that care for patients 17 years of age or younger.

Important Notes:

Note 1: All pediatric patient (ages 17 years and younger) scans performed at your hospital should be included when reporting on this measure, including cases that were never admitted to an inpatient ward.

Specifications: See ***Pediatric Computed Tomography (CT) Radiation Dose Measure Specifications*** in the Pediatric Care Reference Information on pages 216-220.

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

Reporting Time Period: 12 months
Answer questions #1-7 based on all cases (or a sufficient sample of them)
- 01/01/2019 - 12/31/2019
- Optional - Surveys (re)submitted on or after September 1: 07/01/2019 - 06/30/2020

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

1) 12-month reporting time period used:	☐ 01/01/2019 - 12/31/2019 ☐ 07/01/2019 - 06/30/2020
2) Does your hospital perform CT scans on pediatric patients? *If "no" to question #2, skip the remaining questions in Section 9B, and go to the Affirmation of Accuracy. The hospital will be scored as "Does Not Apply."*	*Yes* *No*
3) Did your hospital calculate its distribution of CT radiation doses for pediatric patients over the reporting period, and do you choose to report those data to this Survey? *If "no" to question #3, skip the remaining questions in Section 9B, and go to the Affirmation of Accuracy. The hospital will be scored as "Limited Achievement."*	*Yes* *No*
4) Which of the following is your hospital using to report the CT radiation dose length product (DLP)? *Check all that apply.* *If selecting "manual data collection," complete question #5. Otherwise, skip question #5 and continue on to question #6.*	☐ Manual data collection ☐ Dose Monitoring Software ☐ ACR National Radiology Data Registry Report
5) If using manual data collection, do the responses in questions #6 and #7 represent a sample of cases?	*Yes* *No*

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6) Enter your facility's 25th, 50th, and 75th percentiles for CT radiation dose length product (DLP) in routine **head** scans for pediatric patients for each age stratum standardized to 16cm phantoms.

If the number of encounters for an age stratum is less than 10 (in column a), skip columns b, c, and d and then move to the next age stratum. If zero, enter "0" in column a.

Age Group	HEAD			
	(a) Number of encounters	**(b) 25th Percentile**	**(c) 50th Percentile**	**(d) 75th Percentile**
< 1 year				
1 - 4				
5 - 9				
10 - 14				
15 - 17				

7) Enter your facility's 25th, 50th, and 75th percentiles for CT radiation dose length product (DLP) in routine **abdomen/pelvis** scans for pediatric patients for each age stratum standardized to 32cm phantoms.

If the number of encounters for an age stratum is less than 10 (in column a), skip columns b, c, and d and then move to the next age stratum. If zero, enter "0" in column a.

Age Group	ABDOMEN/PELVIS			
	(a) Number of encounters	**(b) 25th Percentile**	**(c) 50th Percentile**	**(d) 75th Percentile**
< 1 year				
1 - 4				
5 - 9				
10 - 14				
15 - 17				

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Affirmation of Accuracy

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

The hospital and I understand that The Leapfrog Group, its members, the public and entities and persons who contract or have other business dealings with The Leapfrog Group are relying on the truth and accuracy of this information. The hospital and I also understand that The Leapfrog Group will make this information and/or analyses of this information public through the Survey Results public reporting website, The Leapfrog Group's Hospital Safety Grade, and/or other Leapfrog Group products and services. This information and/or analyses and all intellectual property rights therein shall be and remain the sole and exclusive property of The Leapfrog Group in which The Leapfrog Group retains exclusive ownership. This information does not infringe upon any third-party intellectual property rights or any other third-party rights whatsoever and is free and clear of all encumbrances and liens of any kind. The hospital and I acknowledge that The Leapfrog Group may use this information in a commercial manner for profit. The hospital shall be liable for and shall hold harmless and indemnify The Leapfrog Group from any and all damages, demands, costs, or causes of action resulting from any inaccuracies in the information or any misrepresentations in this Affirmation of Accuracy. The Leapfrog Group and its members and entities and persons who contract or have other business dealings with The Leapfrog Group reserve the right to omit or disclaim information that is not current, accurate or truthful.

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

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Section 9: 2020 Pediatric Care Reference Information

What's New in the 2020 Survey

There are no substantive changes to the questions in Section 9A Patient Experience (CAHPS Child Hospital Survey, but Leapfrog revised the scoring algorithm to align with the scoring algorithm for Section 10F Patient Experience (OAS CAHPS Survey). The revised scoring algorithm assesses the number of domains where the hospital is performing in the top quartile. The quartiles for each domain will be updated based on 2020 Leapfrog Hospital Surveys submitted by August 31, 2020. In addition, hospitals that were eligible, but did not administer the CAHPS Child Hospital Survey, will be scored and publicly reported as "Limited Achievement" (the category previously used for "Willing to Report"), instead of "Declined to Respond." Please refer to the 2020 Leapfrog Hospital Survey Scoring Algorithm on the Scoring and Results webpage for more information.

For Section 9B Pediatric Computed Tomography (CT) Radiation Dose, hospitals will continue to be scored on their performance for head scans and abdomen/pelvis scans separately by comparing the median radiation dose length product (DLP) for each anatomic region and age stratum. However, hospitals are asked to report on all applicable scans, with head scans standardized to 16cm phantoms and abdomen/pelvis scans standardized to 32cm phantoms. This change aligns with how the American College of Radiology (ACR) reports on scans. Hospitals can obtain scans standardized to specific phantoms in one of three ways: (1) specialized Leapfrog reports from ACR will already have scans standardized to these phantoms; (2) the CT Dose Workbook developed by Leapfrog has been updated to automatically standardize scans for hospitals obtaining scan data through manual data collection; and (3) the use of dose monitoring software.

Leapfrog will update the benchmarks for each age stratum and anatomic area based on Leapfrog Hospital Surveys submitted by August 31, 2020.

In addition, hospitals that perform pediatric CT scans, but did not calculate their distribution of CT radiation doses for the Survey, will be scored and publicly reported as "Limited Achievement" (the category previously used for "Willing to Report"), instead of "Declined to Respond." Please refer to the 2020 Leapfrog Hospital Survey Scoring Algorithm on the Scoring and Results webpage for more information.

Lastly, in order to ensure standardized reporting, Leapfrog has revised the measure specifications to include a list of routine head and abdomen/pelvis scans that hospitals should use for reporting on these measures. The list of routine scans noted in the measure specifications account for over 85% of all head CT scans and over 95% of all abdomen/pelvis CT scans for pediatric patients.

Change Summary since Release

None. If substantive changes are made to this section of the Survey after release on April 1, 2020, they will be documented in this Change Summary section.

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Patient Experience (CAHPS Child Hospital Survey) Measure Specifications

Source: Agency for Healthcare Quality and Research (AHRQ) (NQF #2548)
Reporting Time Period: 12 months Report on the latest 12-month period prior to the submission of this section of the Survey.
This section of the Survey asks hospitals who care for pediatric patients about their results from the CAHPS Child Hospital Survey. The first several questions are designed to learn more about the current administration of the survey. The last 18 questions capture the "Top Box"[47] score for each of the 18 measures of patient experience, which include 10 composite measures and 8 single-item measures. Hospitals using Press Ganey, NRC, or PRC to administer the CAHPS Child Hospital Survey can use the AHRQ CAHPS Crosswalk posted on the Survey and CPOE Materials webpage. The Crosswalk is designed to help translate the standard vendor report to the AHRQ Domains used in questions #7 – 24.

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

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Patient Experience (CAHPS Child Hospital Survey) Frequently Asked Questions (FAQs)

1. **Why does Leapfrog refer to two different reporting periods in Section 9A, question #2: one reporting period which refers to the number of pediatric admissions during the 12 months from Section 1 and one reporting period which refers to the results of our CAHPS Child Hospital Survey?**
   These two reporting periods are different because hospitals that have not historically had 500 pediatric admissions annually may not have begun to administer the CAHPS Survey to their patients and therefore it would not be appropriate to ask these facilities to report on their current results in Section 9A.

2. **Do I need to include neonatal ICU (NICU) discharges when administering the CAHPS Child Hospital Survey and reporting those results to Leapfrog?**
   The Child CAHPS Hospital Survey was designed to be administered to pediatric discharges including NICU discharges. Additional details on fielding the CAHPS Child Hospital Survey can be found here.

   In 2020, hospitals that have been administering the CAHPS survey without including NICU discharges in their sample can report those results to Leapfrog, provided they meet the minimum sample size and timing requirements in the Leapfrog Hospital Survey. However, we are urging those hospitals to begin including NICU discharges-- per the manual guidelines-- immediately, as CAHPS is designed to include those patients. Hospitals that are just starting to administer the survey in 2020 should include NICU discharges in their sample per the sampling framework detailed in the manual.

3. **Can we use other lower cost modes for administering the CAHPS Child Hospital Survey? Survey administration is costly, and our hospital has low response rates.**
   Some hospitals have asked about the use of alternative, lower cost modes of survey administration, such as administering paper surveys at discharge that can then be batched and mailed to a vendor to calculate results. This approach is potentially an opportunity both to lower the cost of administration and to increase response rates.

   Leapfrog's Pediatric Expert Panel has noted that while administering the CAHPS Child Hospital Survey using paper forms at discharge is not on the list of AHRQ-approved modes, hospitals that are trying to find ways to administer the survey and increase response rate should be able to submit results to the 2020 Leapfrog Hospital Survey. That said, the Pediatric Expert Panel has expressed a desire for these different modes to be tested, and so we cannot guarantee that you will be able to submit these results for future Leapfrog Hospital Surveys.

4. **Is Interactive Voice Response (IVR) or texting a link to an online survey an acceptable mode for administering the CAHPS Child Hospital Survey?**
   Hospitals that administer the CAHPS Child Hospital Survey via IVR should select "phone" in question #5. Hospitals that administer the CAHPS Child Hospital Survey by texting a link to an online survey to the patient should select "email."

5. **How can a vendor report from Press Ganey, NRC, or PRC be used to answer questions #7 – 24?**
   Hospitals that use Press Ganey, NRC, or PRC to administer the CAHPS Child Hospital Survey should receive regular vendor reports with your top box scores for each domain. To translate the domains listed on your vendor report to the AHRQ Domains in questions #7 – 24 of the Leapfrog Hospital Survey, use the CAHPS AHRQ Crosswalk posted on the Survey and CPOE Materials webpage. This document also lists the specific questions from the CAHPS Child Hospital Survey that are used to calculate the top box score for each domain.

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Pediatric Computed Tomography (CT) Radiation Dose Measure Specifications

Important Notes:

Note 1: For purposes of this measure, an "encounter" consists of a full examination and any CT scans performed within one hour of each other involving the designated anatomic area (i.e. head or abdomen/pelvis). For example, two CT scans conducted 30-minutes apart on the same patient's head are considered one "encounter." CT scans of the same anatomic area performed with and without contrast are considered one "encounter." Scans of two different anatomic areas performed within one hour would not be considered the same "encounter." Scans of the same anatomic area performed greater than 60 minutes apart would also not be considered the same "encounter".

Note 2: This measure includes two sets of instructions in the table below: one for hospitals using dose monitoring software and one for hospitals that are not using dose monitoring software. Please be sure to use the correct set of instructions.

Note 3: Hospitals performing manual data collection must use the updated CT Dose Workbook to standardize their CT radiation dose length product (DLP) for head scans to 16cm phantoms and abdomen/pelvis scans to 32cm phantoms.

Source: University of California, San Francisco (NQF #2820)

Reporting Time Period: 12 months

- 01/01/2019 - 12/31/2019
- Optional - Surveys (re)submitted on or after September 1: 07/01/2019 - 06/30/2020

Hospitals participating in the ACR National Radiology Data Registry:
Data for this measure can be obtained directly from a special Leapfrog report. See details below.

Hospitals that report to the American College of Radiology (ACR) and receive reports through the National Radiology Data Registry (NRDR) will be able to respond to questions #6-7 in Section 9B using a specialized report that will be made available with the quarterly Dose Index Registry Executive Summary reports. This separate "Leapfrog" report will be available for download through the NRDR portal and will contain data according to the age ranges and measure specifications of the Leapfrog Hospital Survey. **Enter values from the "Leapfrog" tab using the "Table: Pediatric Exams for Leapfrog Survey" and the appropriate percentiles in the Head and Abdomen Pelvis columns rounded to the nearest whole number directly into the Online Hospital Survey Tool.**

Hospitals using dose monitoring software:
Data for this measure can be obtained using dose monitoring software. See instructions below.

Q.6, column a: Total Number of Encounters
Using your dose monitoring software, obtain the total number of encounters in routine **head scans** for each age stratum (<1, 1-4, 5-9, 10-14, 15-17). Enter these values into the Survey.

Inclusions:
CT HEAD BRN WO IVCON
CT HEAD WO IVCON
CT PEDS HEAD WO IVCON
CT HEAD
CT PEDS HEAD BRN WO IVCON
CT BRN WO IVCON
CT HEAD BRN
CT HEAD BRN W IVCON
CT HEAD W IVCON
CT HEAD WO & W IVCON

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CT HEAD BRN WO & W IVCON
CT BRN WO & W IVCON
CT BRN W IVCON

Exclusions:
- Encounters involving facial bones or sinuses
- Encounters where the indication is for a biopsy, including prop studies and stereotactic studies and procedures
- Encounters that cross multiple anatomic areas should be excluded. For example, encounters involving both the head and neck are excluded from the "head" anatomic region.

Sampling Cases:
Hospitals using dose monitoring software must report on all encounters in the 12-month reporting period.

Q.6, columns b, c, and d: 25th, 50th, and 75th Percentiles
Based on the encounters identified for each age stratum (column a), use your dose monitoring software to calculate the 25th percentile (column b), the 50th percentile (column c), and the 75th percentile (column d) for CT radiation dose length product (DLP) in routine **head scans standardized to 16cm phantoms**. Enter these values into the Survey rounded to the nearest whole number.

If the number of encounters for an age stratum (i.e. <1 or 1-4, etc.) is less than 10 (column a), skip columns b, c, and d. If the number of encounters for an age stratum is zero, enter "0" in column a, and skip columns b, c, and d. You cannot leave any rows in column a blank.

Phantom Dose Specifications:
For head scans, use a 16 cm phantom dose value. The green box in the screenshot below the table is an example of a Dose Report which shows the phantom dose value used. The phantom dose value is used to estimate the radiation dose to the patient.

Q.7 column a: Total Number of Encounters
Using your dose monitoring software, obtain the total number of encounters in routine **abdomen/pelvis** for each age stratum (<1, 1-4, 5-9, 10-14, 15-17). Enter these values into the Survey.

Inclusions:
CT ABD PELVIS W IVCON
CT ABD/PEL W IVCON
CT PEDS ABD PELVIS
CT ABD PELVIS WO IVCON
CT ABD/PEL WO IVCON
CT ABD/PEL
CT PEDS ABD/PEL WO IVCON
CT ABD PELVIS WO & W IVCON
CT ABD/PEL WO & W IVCON
CT ABD PELVIS
CT ABD PELVIS WO IVCON

Exclusions:
- Encounters where the indication is for a biopsy, including prop studies and stereotactic studies and procedures
- Encounters that cross multiple anatomic areas should be excluded. For example, encounters involving both the chest and abdomen/pelvis are excluded from the "abdomen/pelvis" anatomic region.

Sampling Cases:
Hospitals using dose monitoring software must report on all encounters in the 12-month reporting period.

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Q.7, columns b, c, and d: 25th, 50th, and 75th Percentiles
Based on the encounters identified for each age stratum (column a), use your dose monitoring software to calculate the 25th percentile (column b), the 50th percentile (column c), and the 75th percentile (column d) for CT radiation dose length product (DLP) in routine **abdomen/pelvis scans standardized to 32cm phantoms**. Enter these values into the Survey rounded to the nearest whole number.

If the number of encounters for an age stratum (i.e. <1 or 1-4, etc.) is less than 10 (column a), skip columns b, c, and d. If the number of encounters for an age stratum is zero, enter "0" in column a, and skip columns b, c, and d. You cannot leave any rows in column a blank.

Phantom Dose Specifications:
For abdomen/pelvis scans, use a 32cm phantom dose value. The green box in the screenshot below the table is an example of a Dose Report which shows the phantom dose value used. The phantom dose value is used to estimate the radiation dose to the patient.

Hospitals not using dose monitoring software:
Data for this measure can be obtained from Dose Reports that come directly from the CT Machine and are sent along with the images to the Picture Archiving and Communications (PACS) used to review the images. See instructions below.

CT Dose Excel Workbook
To assist hospitals who do not use dose monitoring software in calculating the responses to questions #6 and #7, Leapfrog has developed a CT Dose Workbook to assist hospitals in standardizing their CT dose data based on these specifications. The workbook includes 12 tabs: Instructions, Summary, and 10 Data Entry tabs for each anatomic area/age stratum combination. The tabs for head scans are red and the tabs for abdomen/pelvis scans are blue. Once you enter your hospital's CT radiation dose length product (DLP) data into the appropriate tab, the workbook will automatically calculate your responses to questions #6 and #7 in the Summary tab, and those values should be entered in the Survey.

The CT Dose Workbook is available on the Survey and CPOE Materials webpage and should be used when reporting on this measure.

Q.6, column a: Total Number of Encounters
To determine the total number of encounters in routine **head scans** for each age stratum (<1, 1-4, 5-9, 10-14, 15-17), you will need to obtain dose reports. See sampling instructions below.

Inclusions:
CT HEAD BRN WO IVCON
CT HEAD WO IVCON
CT PEDS HEAD WO IVCON
CT HEAD
CT PEDS HEAD BRN WO IVCON
CT BRN WO IVCON
CT HEAD BRN
CT HEAD BRN W IVCON
CT HEAD W IVCON
CT HEAD WO & W IVCON
CT HEAD BRN WO & W IVCON
CT BRN WO & W IVCON
CT BRN W IVCON

Exclusions:
- Encounters involving facial bones or sinuses
- Encounters where the indication is for a biopsy, including prop studies and stereotactic studies and procedures

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- Encounters that cross multiple anatomic areas should be excluded. For example, encounters involving both the head and neck are excluded from the "head" anatomic region.

Sampling Cases:
Hospitals that are using information stored in the CT Machine have the option of reporting on all encounters or a sample of encounters. Hospitals opting to identify a sample of encounters for this measure should follow these instructions:

- Review your hospital's scans starting on January 15, 2019 (or July 15, 2019 if (re)submitting a Survey on or after September 1, 2020).
- Work sequentially until **a sample of at least 30 encounters per anatomic area and age strata combination** (i.e. head <1; head 1-4, etc.) is reached, or all cases in the reporting period are reviewed, whichever comes first.

Q.6, columns b, c, and d: 25th, 50th, and 75th Percentiles
Using your dose reports, enter the phantom dose and **Total DLP (mGY-cm)** for each encounter into each of the 5 "Head" tabs of the CT Dose Workbook. Be sure to review the instructions tab carefully before you begin entering data. The worksheet will automatically standardize your dose data to a 16cm phantom, if necessary. The worksheet will then automatically calculate the total number of encounters, as well as the 25th, 50th, and 75th percentiles for each anatomic area and age stratum. See the example CT Dose Report from a CT scanner below this table. The green box in the screenshot below the table is an example of a Dose Report which shows the phantom dose value used. The phantom dose value is used to estimate the radiation dose to the patient. The red box highlights the Total DLP. Note that your CT scanner may have a differently formatted Dose Report.

Q.7 column a: Total Number of Encounters
To determine the total number of encounters in routine **abdomen/pelvis scans** for each age stratum (<1, 1-4, 5-9, 10-14, 15-17), you will need to obtain dose reports. See sampling instructions below.

Inclusions:
CT ABD PELVIS W IVCON
CT ABD/PEL W IVCON
CT PEDS ABD PELVIS
CT ABD PELVIS WO IVCON
CT ABD/PEL WO IVCON
CT ABD/PEL
CT PEDS ABD/PEL WO IVCON
CT ABD PELVIS WO & W IVCON
CT ABD/PEL WO & W IVCON
CT ABD PELVIS
CT ABD PELVIS WO IVCON

Exclusions:

- Encounters where the indication is for a biopsy, including prop studies and stereotactic studies and procedures
- Encounters that cross multiple anatomic areas should be excluded. For example, encounters involving both the chest and abdomen/pelvis are excluded from the "abdomen/pelvis" anatomic region.

Q.7 columns b, c, and d: 25th, 50th, and 75th Percentiles
Using your dose reports, enter the phantom dose and **Total DLP (mGY-cm)** for each encounter into each of the 5 "Abdomen Pelvis" tabs of the CT Dose Workbook. Be sure to review the instructions tab carefully before you begin entering data. The worksheet will automatically standardize your dose data to a 32cm phantom, if necessary. The worksheet will then automatically calculate the total number of encounters, as well as the 25th, 50th, and 75th percentiles for each anatomic area and age stratum. See the example CT Dose Report from a CT scanner below this table. The green box in the screenshot below the table is an example of a Dose Report which shows the phantom dose value used. The

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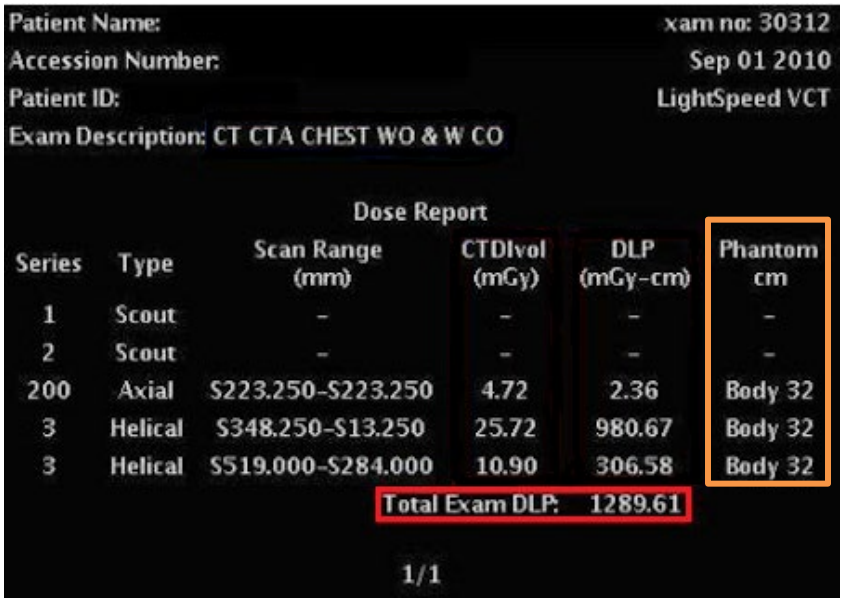
phantom dose value is used to estimate the radiation dose to the patient. The red box highlights the Total DLP. Note that your CT scanner may have a differently formatted Dose Report.

Example of Dose Report



Patient Name: xam no: 30312
Accession Number: Sep 01 2010
Patient ID: LightSpeed VCT
Exam Description: CT CTA CHEST WO & W CO

Dose Report

Series	Type	Scan Range (mm)	CTDIvol (mGy)	DLP (mGy-cm)	Phantom cm
1	Scout	-	-	-	-
2	Scout	-	-	-	-
200	Axial	S223.250-S223.250	4.72	2.36	Body 32
3	Helical	S348.250-S13.250	25.72	980.67	Body 32
3	Helical	S519.000-S284.000	10.90	306.58	Body 32

Total Exam DLP: 1289.61

1/1

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

Pediatric CT Radiation Dose Frequently Asked Questions (FAQs)

1) **Is this measure only applicable to pediatric inpatients, or should all pediatric scans be included?**
   All pediatric patient (ages 17 years and younger) scans should be included when reporting on this measure, including cases that were never admitted to an inpatient ward.

2) **Should multiple phase scans be included in the reporting?**
   Yes, the intent of this measure is to capture the entire dose a patient receives, even if this radiation is received over multiple phase scans.

3) **Should any CT encounters involving anatomic areas not listed in the Survey questions (i.e. head or abdomen/pelvis) be included in the reporting?**
   No. When reporting CT encounters in the Survey, only encounters involving the head or abdomen/pelvis should be included. Encounters involving any other anatomic area should not be reported. For example, encounters involving both the head and neck are excluded from the "head" anatomic region.

4) **Are the CT doses adjusted for any factors other than age, such as height and weight?**
   No, CT doses are only stratified by age and anatomic region. The pediatric CT radiation dose measure is an NQF-endorsed measure, developed so that all hospitals in the country who do pediatric CT scans can report. Its known limitation is that it does not consider patient size (e.g., height and weight) but instead uses age as a proxy for size. Part of the reason is that unless hospitals use dose monitoring software, which not all hospitals currently do due to cost, they would not have this information readily available to them. However, to align with the American College of Radiology (ACR), head scans are standardized to 16cm phantoms and abdomen/pelvis scans are standardized to 32cm phantoms.

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SECTION 10: OUTPATIENT PROCEDURES

This section includes questions and reference information for Section 10: Outpatient Procedures. Please carefully review the questions, endnotes, and reference information (e.g., measure specifications, notes, and frequently asked questions) before you begin. Failure to review the reference information could result in inaccurate responses.

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Section 10: Outpatient Procedures

Outpatient Procedures Fact Sheet: http://www.leapfroggroup.org/outpatient-procedures

Section 10 Outpatient Procedures includes questions about outpatient procedures performed at your hospital outpatient departments, including surgery centers and free-standing hospital outpatient departments that share your hospital's license and CMS Certification Number. Questions in this section of the Survey are closely aligned with those in the Leapfrog ASC Survey.

Surgery Centers that are assigned a 10-digit CMS certification number should complete the Leapfrog ASC Survey, even if owned and operated by a hospital.

Select measures from Section 10 Outpatient Procedures and the 2020 Leapfrog ASC Survey will be scored and/or publicly reported in 2020. An overview of Section 10 Outpatient Procedures is below:

Section #	Measure	Scored and/or publicly reported
10A	**Basic Outpatient Department Information**	
	General Information	*Not scored but publicly reported*
	Transfer Policies and Agreements	
10B	**Medical, Surgical, and Clinical Staff**	
	Certified staff present when patients are recovering	*Scored and Results are publicly reported*
	Board certification	*Not scored but publicly reported*
10C	**Volume of Procedures**	
	Volume of Procedures	*Not scored but publicly reported*
10D	**Safety of Procedures**	
	Patient Follow-up	*Not scored or publicly reported*
	Patient Selection	*Not scored but publicly reported*
	Consent to Treat	*Not scored but publicly reported*
	Safe Surgery Checklist	*Scored and Results are publicly reported*
10E	**Medication Safety for Outpatient Procedures**	
	Medication and Allergy Documentation	*Scored and Results are publicly reported*
10F	**Patient Experience (OAS CAHPS)**	
	OAS CAHPS	*Scored and Results are publicly reported*

Each hospital achieving the standards for Outpatient Procedures:

1. Has an ACLS certified clinician, plus a second clinician, present at all times and immediately available in the building while adult patients are present in the hospital outpatient department and has a physician or CRNA is present at all times and immediately available in the building until all adult patients are physically discharged from the hospital outpatient department.
2. Uses a safe surgery checklist on **all** patients undergoing an applicable procedure (reported on in Section 10D) and has documented that **all** safe surgery checklist elements listed were completed for each patient.
3. Has met the 90% target for documenting all three components: home medications, visit medications, and allergies/adverse reaction(s) in the clinical record.

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4. Performed in the top quartile based on responses to the 2020 Leapfrog ASC Survey and Section 10 of the 2020 Leapfrog Hospital Survey submitted by August 31, 2020 for the 4 OAS CAHPS domains, listed below:
   a) Facilities and Staff
   b) Communication About Your Procedure
   c) Patients' Rating of the Facility
   d) Patients Recommending the Facility

Download the 2020 Leapfrog Hospital Survey Scoring Algorithm on the Scoring and Results webpage.

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10A: Basic Outpatient Department Information

Important Notes:

Note 1: Information from Section 10A will not be scored, but will be used in public reporting (e.g., Leapfrog may display the number of operating and/or procedure rooms on individual hospital Summary Pages).

Note 2: The term "hospital outpatient department" is used to refer to all hospital outpatient departments that perform the procedures listed in Section 10C and that share your hospital's license and CMS Certification Number (CCN). This would include, but is not limited to surgery centers, free-standing hospital outpatient departments, as well as outpatient departments that are located in your hospital or are co-located[19] with your hospital. Hospitals should only include those hospital outpatient departments that perform the procedures listed in Section 10C.

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

Reporting Time Period: 12 months

- 01/01/2019 - 12/31/2019
- Optional - Surveys (re)submitted on or after September 1: 07/01/2019 - 06/30/2020

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

General Information

1) 12-month reporting time period used:	☐ 01/01/2019 - 12/31/2019 ☐ 07/01/2019 - 06/30/2020
2) Does your hospital perform any of the procedures listed in Section 10C on an outpatient basis **in the hospital** or at a **hospital outpatient department co-located[19] with the hospital**?	*Yes* *No*
3) Does your hospital perform any of the procedures listed in Section 10C on an outpatient basis at a **surgery center** or **free-standing hospital outpatient department** that **shares your hospital's license and CMS Certification Number**?	*Yes* *No*

If "no" to question #2 and question #3, skip the remaining questions in Section 10, including all subsections, and go to the Affirmation of Accuracy.

4) Total number of operating rooms[48] used to perform the outpatient procedures listed in Section 10C.	_____

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5) Total number of endoscopic procedure rooms[49] used to perform the outpatient procedures listed in Section 10C.	_____

Transfer Policies and Agreements

If "no" to question #3, skip questions #6-7 and continue on to the next subsection. Only hospitals with surgery centers and free-standing hospital outpatient departments are asked to answer questions #6-7.

6) Does your surgery center or free-standing hospital outpatient department have a written transfer agreement[50] with a pediatric or general acute care hospital for patients who require a higher level of care? *Hospitals with more than one surgery center or free-standing hospital outpatient department should respond based on the location with the fewest written transfer policies.*	*Yes* *No*
7) Whether or not your surgery center or free-standing hospital outpatient department has a written transfer agreement in place for patients who require a higher level of care, does your surgery center or free-standing hospital outpatient department have a written transfer policy[51] for emergent transfers, when there is an immediate threat to life or limb, that includes the following components: *Select all that apply or "none of the above or no written transfer policy."*	☐ *Patient is transferred to the nearest hospital* ☐ *Receiving facility must have an ED and/or ICU* ☐ *Patient must be transferred within an established period of time* ☐ *Patient's medication information must be transferred within an established period of time* ☐ *None of the above or no written transfer policy*

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10B: Medical, Surgical, and Clinical Staff

Important Notes:

Note 1: Information regarding certified staff present when patients are recovering from Section 10B (questions #1-6) will be scored, and results will be used in public reporting.

Note 2: Information regarding board certification for clinicians (questions #7-8) will not be scored, but will be used in public reporting (e.g., Leapfrog will display the percentage of board certified/board eligible physicians and certified registered nurse anesthetists on individual hospital Summary Pages).

Note 3: The term "hospital outpatient department" is used to refer to all hospital outpatient departments that perform the procedures listed in Section 10C and that share your hospital's license and CMS Certification Number (CCN). This would include, but is not limited to, surgery centers, free-standing hospital outpatient departments, as well as outpatient departments that are located in your hospital or are co-located[19] with your hospital. Hospitals should only include those hospital outpatient departments that perform the procedures listed in Section 10C.

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

Reporting Time Period: Answer questions #1-8 based on the staffing structure currently in place at the time that you submit this section of the Survey. The staffing structure should have been in place for at least the past 3 months and reflect the ordinary staffing structure for each applicable hospital outpatient department.

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

1) Is there an Advanced Cardiovascular Life Support (ACLS) trained clinician[52], as well as a second clinician[52] (regardless of ACLS training), present at all times and immediately available in the building while an adult patient is present in the hospital outpatient department? *Hospitals with more than one hospital outpatient department, including a surgery center or free-standing hospital outpatient department, should respond based on the least intensively staffed location.* *If "no" to question #1, skip question #2 and continue on to question #3. If "not applicable; pediatric patients only," skip questions #2-3 and continue on to question #4.*	*Yes* *No* *Not applicable; pediatric patients only*
2) Which of the following medical, surgical, and clinical staff are required by the hospital to maintain ACLS certification? *Select all that apply.*	☐ Anesthesiologists ☐ Certified Registered Nurse Anesthetists (CRNAs) ☐ Physicians ☐ Nurses (RN or MSN)

	☐ Physician Assistants (PAs) ☐ Nurse Practitioners (NPs) ☐ Surgical Technicians ☐ First Assists
3) Is there a physician or CRNA present at all times and immediately available in the building until **all** adult patients are physically discharged from the hospital outpatient department? *Hospital outpatient departments who have a physician or CRNA serving as their ACLS trained clinician in question #2 may respond "yes" to question #3 if the physician/CRNA is present until all adult patients are physically discharged from the hospital outpatient department.*	*Yes* *No*
4) Is there a Pediatric Advanced Life Support (PALS) trained clinician[52], as well as a second clinician[53] (regardless of PALS training), present at all times and immediately available in the building while a pediatric patient (infant through 12 years) is present in the hospital outpatient department? *Hospitals with more than one hospital outpatient department, including a surgery center or free-standing hospital outpatient department, should respond based on the least intensively staffed location.* *If "no" to question #4, skip question #5 and continue on to question #6. If "not applicable; adult patients only," skip questions #5-6 and continue on to question #7.*	*Yes* *No* *Not applicable; adult patients only*
5) Which of the following medical, surgical, and clinical staff are required by the hospital to maintain PALS certification? *Select all that apply.*	☐ Anesthesiologists ☐ Certified Registered Nurse Anesthetists (CRNAs) ☐ Physicians ☐ Nurses (RN or MSN) ☐ Physician Assistants (PAs) ☐ Nurse Practitioners (NPs) ☐ Surgical Technicians ☐ First Assists
6) Is there a physician or CRNA present at all times and immediately available in the building until **all** pediatric patients (infant through 12 years) are physically discharged from the hospital outpatient department? *Hospital outpatient departments who have a physician or CRNA serving as their PALS trained clinician in question #5 may respond "yes" to question #6 if they physician/CRNA is present until all*	*Yes* *No*

pediatric patients are physically discharged from the hospital outpatient department.	
7) To help ensure that patients are cared for by adequately trained physicians, are **those physicians** who are authorized to perform procedures at your hospital outpatient department(s) board certified or board eligible? *Hospitals with more than one hospital outpatient department, including a surgery center or free-standing hospital outpatient department, should respond based on all physicians who are authorized to perform the procedures listed in Section 10C at your hospital outpatient departments.*	*All are board certified or board eligible (100%)* *Most are board certified or board eligible (>=75%)* *Some are board certified or board eligible (>=50%)* *Few are board certified or board eligible (<50%)* *None are board certified or board eligible*
8) To help ensure that patients are cared for by adequately trained anesthesiologists and/or certified registered nurse anesthetists, are **those providing anesthesia** at your hospital outpatient department(s) board certified or board eligible? *Hospitals with more than one hospital outpatient department, including a surgery center or free-standing hospital outpatient department, should respond based on all anesthesiologists and/or certified registered nurse anesthetists who provide anesthesia for the procedures listed in Section 10C at your hospital outpatient departments.*	*All are board certified or board eligible (100%)* *Most are board certified or board eligible (>=75%)* *Some are board certified or board eligible (>=50%)* *Few are board certified or board eligible (<50%)* *None are board certified or board eligible*

10C: Volume of Procedures

Important Notes:

Note 1: Information from Section 10C regarding the volumes of procedures will not be scored but will be used in public reporting to inform purchasers and consumers about the hospital's experience with the procedure. Additionally, this information will be used to facilitate the search functionality on Leapfrog's public reporting website (e.g., allowing users to search for hospitals that perform the procedure they need on an outpatient basis).

Note 2: Information from Section 10C regarding registry participation will not be scored or publicly reported.

Note 3: The term "hospital outpatient department" is used to refer to all hospital outpatient departments that perform the procedures listed in Section 10C and that share your hospital's license and CMS Certification Number (CCN). This would include, but is not limited to, surgery centers, free-standing hospital outpatient departments, as well as outpatient departments that are located in your hospital or are co-located[19] with your hospital. Hospitals should only include those hospital outpatient departments that perform the procedures listed in Section 10C.

Note 4: Hospitals should only report on procedures they electively perform. If your hospital does not perform the procedure on an outpatient basis or ONLY does so when a procedure is urgent, you should answer "no" and not report on those procedures.

Specifications: See ***Volume of Procedures Measure Specifications*** in the Reference Information on pages 261-267.

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

Reporting Time Period: 12 months

- 01/01/2019 - 12/31/2019
- Optional - Surveys (re)submitted on or after September 1: 07/01/2019 - 06/30/2020

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

Volume of Procedures

1) 12-month reporting time period used:	□ 01/01/2019 – 12/31/2019 □ 07/01/2019 – 06/30/2020
2) During the reporting period, were one or more of the following **gastroenterology** procedures performed at your hospital outpatient department(s) on adult or pediatric patients: • Upper GI endoscopy • Other upper GI procedures • Small intestine and stomal endoscopy • Lower GI endoscopy *If "no" or "yes, but no longer performs these procedures," skip questions #12-16 below.*	*Yes* *Yes, but no longer performs these procedures* *No*

3) During the reporting period, were one or more of the following **general surgery** procedures performed at your hospital outpatient department(s) on adult or pediatric patients: • Cholecystectomy and common duct exploration • Excision of skin lesion • Hemorrhoid procedures • Inguinal and femoral hernia repair • Other hernia repair • Laparoscopy • Lumpectomy or quadrantectomy of breast • Mastectomy • Skin graft *If "no" or "yes, but no longer performs these procedures," skip questions #17-21 below.*	*Yes* *Yes, but no longer performs these procedures* *No*
4) During the reporting period, were one or more of the following **ophthalmology** procedures performed at your hospital outpatient department(s) on adult or pediatric patients: • Anterior segment eye procedures • Posterior segment eye procedures *If "no" or "yes, but no longer performs these procedures," skip questions #22-26 below.*	*Yes* *Yes, but no longer performs these procedures* *No*
5) During the reporting period, were one or more of the following **orthopedic** procedures performed at your hospital outpatient department(s) on adult or pediatric patients: • Finger, hand, wrist, forearm, and elbow procedures • Shoulder procedures • Spine procedures • Hip procedures • Knee procedures • Toe, foot, ankle, and leg procedures • General orthopedic procedures *If "no" or "yes, but no longer performs these procedures," skip questions #27-31 below.*	*Yes* *Yes, but no longer performs these procedures* *No*
6) During the reporting period, were one or more of the following **otolaryngology** procedures performed at your hospital outpatient department(s) on adult or pediatric patients: • Ear procedures • Mouth procedures • Nasal/sinus procedures • Pharynx/adenoid/tonsil procedures *If "no" or "yes, but no longer performs these procedures," skip questions #32-36 below.*	*Yes* *Yes, but no longer performs these procedures* *No*
7) During the reporting period, were one or more of the following **urology** procedures performed at your hospital outpatient department(s) on adult or pediatric patients:	*Yes* *Yes, but no longer performs these procedures*

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• Circumcision • Cystourethroscopy • Male genital procedures • Male sterilization procedures • Urethra procedures • Vaginal repair procedures *If "no" or "yes, but no longer performs these procedures," skip questions #37-41 below.*	*No*
8) During the reporting period, was the following **dermatology** procedure performed at your hospital outpatient department(s) on <u>adult</u> patients: • Complex skin repairs *If "no" or "yes, but no longer performs this procedure," skip questions #42-46 below.*	*Yes* *Yes, but no longer performs this procedure* *No*
9) During the reporting period, was the following **neurological surgery** procedure performed at your hospital outpatient department(s) on <u>adult</u> patients: • Spinal fusion procedures *If "no" or "yes, but no longer performs this procedure," skip questions #47-51 below.*	*Yes* *Yes, but no longer performs this procedure* *No*
10) During the reporting period, were one or more of the following **obstetrics and gynecology** procedures performed at your hospital outpatient department(s) on <u>adult</u> patients: • Cervix procedures • Hysteroscopy • Uterus and adnexa laparoscopies *If "no" or "yes, but no longer performs these procedures," skip questions #52-56 below.*	*Yes* *Yes, but no longer performs these procedures* *No*
11) During the reporting period, were one or more of the following **plastic and reconstructive surgery** procedures performed at your hospital outpatient department(s) on <u>adult</u> patients: • Breast repair or reconstruction • Musculoskeletal grafts or implants *If "no" or "yes, but no longer performs these procedures," skip questions #57-61 below.*	*Yes* *Yes, but no longer performs these procedures* *No*

Gastroenterology

12) Does your hospital and/or the physicians performing the gastroenterology procedures in question #14, currently participate in a national clinical quality registry that provides physician, physician group, and/or hospital-level benchmarking on quality measures?	*Yes, the hospital participates* *Yes, physicians participate* *Both the hospital and physicians participate*

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If "neither the hospital nor physicians participate," skip question #13 and continue on to question #14.	*Neither the hospital nor physicians participate*
13) What is the name of the national clinical quality registry?	_____

14) Total adult and/or pediatric volume for each of the following applicable procedures performed at your hospital outpatient department(s) during the reporting period.

*You cannot leave any blank. If you did not perform one or more of the procedures listed below enter 0 (zero). If you had zero volume for **all** procedures, go back to question #2 and update your response from "yes" to "no."*

	a) Adult Volume	*b) Pediatric Volume*
Upper GI endoscopies	_____	_____
Other upper GI procedures	_____	_____
Small intestine and stomal endoscopies	_____	_____
Lower GI endoscopies	_____	_____

15) Where were these **gastroenterology** procedures performed? *Select all that apply.* *If only "hospital" is selected, skip question #16 and continue on to question #17.*	☐ *Hospital* ☐ *Surgery center or free-standing hospital outpatient department*

16) Please provide the name and city location of each surgery center or free-standing hospital outpatient department performing **gastroenterology** procedures:

	Name	*City*
Surgery Center/ Free-Standing Hospital Outpatient Department 1		
Surgery Center/ Free-Standing Hospital Outpatient Department 2		
Surgery Center/ Free-Standing Hospital Outpatient Department 3		
Surgery Center/ Free-Standing Hospital Outpatient Department 4		
Surgery Center/ Free-Standing Hospital Outpatient Department 5		

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General Surgery

17) Does your hospital and/or the physicians performing the general surgery procedures in question #19, currently participate in a national clinical quality registry that provides physician, physician group, and/or hospital-level benchmarking on quality measures? *If "neither the hospital nor physicians participate," skip question #18 and continue on to question #19.*	*Yes, the hospital participates* *Yes, physicians participate* *Both the hospital and physicians participate* *Neither the hospital nor physicians participate*
18) What is the name of the national clinical quality registry?	_____

19) Total adult and/or pediatric volume for each of the following applicable procedures performed at your hospital outpatient department(s) during the reporting period.

*You cannot leave any blank. If you did not perform one or more of the procedures listed below enter 0 (zero). If you had zero volume for **all** procedures, go back to question #3 and update your response from "yes" to "no."*

	(a) Adult Volume	*(b) Pediatric Volume*
Cholecystectomies and common duct explorations	_____	
Excisions of skin lesions	_____	
Hemorrhoid procedures	_____	
Inguinal and femoral hernia repairs	_____	_____
Other hernia repairs	_____	_____
Laparoscopies	_____	
Lumpectomies or quadrantectomy of breast procedures	_____	
Mastectomies	_____	
Skin grafts	_____	

20) Where were these **general surgery** procedures performed? *Select all that apply.* *If only "hospital" is selected, skip question #21 and continue on to question #22.*	☐ *Hospital* ☐ *Surgery center or free-standing hospital outpatient department*

21) Please provide the name and city location of each surgery center or free-standing hospital outpatient department performing **general surgery** procedures:

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	Name	*City*
Surgery Center/ Free-Standing Hospital Outpatient Department 1		
Surgery Center/ Free-Standing Hospital Outpatient Department 2		
Surgery Center/ Free-Standing Hospital Outpatient Department 3		
Surgery Center/ Free-Standing Hospital Outpatient Department 4		
Surgery Center/ Free-Standing Hospital Outpatient Department 5		

Ophthalmology

22) Does your hospital and/or the physicians performing the ophthalmology procedures in question #24, currently participate in a national clinical quality registry that provides physician, physician group, and/or hospital-level benchmarking on quality measures? *If "neither the hospital nor physicians participate," skip question #23 and continue on to question #24.*	*Yes, the hospital participates* *Yes, physicians participate* *Both the hospital and physicians participate* *Neither the hospital nor physicians participate*
23) What is the name of the national clinical quality registry?	_____

24) Total adult and/or pediatric volume for each of the following applicable procedures performed at your hospital outpatient department(s) during the reporting period.

*You cannot leave any blank. If you did not perform one or more of the procedures listed below enter 0 (zero). If you had zero volume for **all** procedures, go back to question #4 and update your response from "yes" to "no."*

	(a) *Adult Volume*	(b) *Pediatric Volume*
Anterior segment eye procedures	_____	_____
Posterior segment eye procedures	_____	

25) Where were these **ophthalmology** procedures performed? *Select all that apply.* *If only "hospital" is selected, skip question #26 and continue on to question #27.*	☐ *Hospital* ☐ *Surgery center or free-standing hospital outpatient department*

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26) Please provide the name and city location of each surgery center or free-standing hospital outpatient department performing **ophthalmology** procedures:

	Name	*City*
Surgery Center/ Free-Standing Hospital Outpatient Department 1		
Surgery Center/ Free-Standing Hospital Outpatient Department 2		
Surgery Center/ Free-Standing Hospital Outpatient Department 3		
Surgery Center/ Free-Standing Hospital Outpatient Department 4		
Surgery Center/ Free-Standing Hospital Outpatient Department 5		

Orthopedics

27) Does your hospital and/or the physicians performing the orthopedic procedures in question #29, currently participate in a national clinical quality registry that provides physician, physician group, and/or hospital-level benchmarking on quality measures?

If "neither the hospital nor physicians participate," skip question #28 and continue on to question #29.

Yes, the hospital participates
Yes, physicians participate
Both the hospital and physicians participate
Neither the hospital nor physicians participate

28) What is the name of the national clinical quality registry? _____

29) Total adult and/or pediatric volume for each of the following applicable procedures performed at your hospital outpatient department(s) during the reporting period.

*You cannot leave any blank. If you did not perform one or more of the procedures listed below enter 0 (zero). If you had zero volume for **all** procedures, go back to question #5 and update your response from "yes" to "no."*

	(a) Adult Volume	*(b) Pediatric Volume*
Finger, hand, wrist, forearm, and elbow procedures	_____	_____
Shoulder procedures	_____	_____
Spine procedures	_____	_____
Hip procedures	_____	_____

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Knee procedures	_____	_____
Toe, foot, ankle, and leg procedures	_____	_____
General orthopedic procedures	_____	_____

30) Where were these **orthopedic** procedures performed? *Select all that apply.* *If only "hospital" is selected, skip question #31 and continue on to question #32.*	☐ *Hospital* ☐ *Surgery center or free-standing hospital outpatient department*

31) Please provide the name and city location of each surgery center or free-standing hospital outpatient department performing **orthopedic** procedures:

	Name	*City*
Surgery Center/ Free-Standing Hospital Outpatient Department 1		
Surgery Center/ Free-Standing Hospital Outpatient Department 2		
Surgery Center/ Free-Standing Hospital Outpatient Department 3		
Surgery Center/ Free-Standing Hospital Outpatient Department 4		
Surgery Center/ Free-Standing Hospital Outpatient Department 5		

Otolaryngology

32) Does your hospital and/or the physicians performing the otolaryngology procedures in question #34, currently participate in a national clinical quality registry that provides physician, physician group, and/or hospital-level benchmarking on quality measures? *If "neither the hospital nor physicians participate," skip question #33 and continue on to question #34.*	*Yes, the hospital participates* *Yes, physicians participate* *Both the hospital and physicians participate* *Neither the hospital nor physicians participate*
33) What is the name of the national clinical quality registry?	_____

34) Total adult and/or pediatric volume for each of the following applicable procedures performed at your hospital outpatient department(s) during the reporting period.

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*You cannot leave any blank. If you did not perform one or more of the procedures listed below enter 0 (zero). If you had zero volume for **all** procedures, go back to question #6 and update your response from "yes" to "no."*

	(a) Adult Volume	*(b) Pediatric Volume*
Ear procedures	_____	_____
Mouth procedures	_____	_____
Nasal/sinus procedures	_____	_____
Pharynx/adenoid/tonsil procedures	_____	_____

35) Where were these **otolaryngology** procedures performed? *Select all that apply.* *If only "hospital" is selected, skip question #36 and continue on to question #37.*	☐ *Hospital* ☐ *Surgery center or free-standing hospital outpatient department*

36) Please provide the name and city location of each surgery center or free-standing hospital outpatient department performing **otolaryngology** procedures:

	Name	*City*
Surgery Center/ Free-Standing Hospital Outpatient Department 1		
Surgery Center/ Free-Standing Hospital Outpatient Department 2		
Surgery Center/ Free-Standing Hospital Outpatient Department 3		
Surgery Center/ Free-Standing Hospital Outpatient Department 4		
Surgery Center/ Free-Standing Hospital Outpatient Department 5		

Urology

37) Does your hospital and/or the physicians performing the urology procedures in question #39, currently participate in a national clinical quality registry that provides physician, physician group, and/or hospital-level benchmarking on quality measures?	*Yes, the hospital participates* *Yes, physicians participate* *Both the hospital and physicians participate*

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If "neither the hospital nor physicians participate," skip question #38 and continue on to question #39.	*Neither the hospital nor physicians participate*
38) What is the name of the national clinical quality registry?	_____

39) Total adult and/or pediatric volume for each of the following applicable procedures performed at your hospital outpatient department(s) during the reporting period.

*You cannot leave any blank. If you did not perform one or more of the procedures listed below enter 0 (zero). If you had zero volume for **all** procedures, go back to question #7 and update your response from "yes" to "no."*

	(a) Adult Volume	*(b) Pediatric Volume*
Circumcisions	_____	_____
Cystourethroscopies	_____	_____
Male genital procedures	_____	_____
Male sterilization procedures	_____	
Urethra procedures	_____	_____
Vaginal repair procedures	_____	_____

40) Where were these **urology** procedures performed? *Select all that apply.* *If only "hospital" is selected, skip question #41 and continue on to question #42.*	☐ *Hospital* ☐ *Surgery center or free-standing hospital outpatient department*

41) Please provide the name and city location of each surgery center or free-standing hospital outpatient department performing **urology** procedures:

	Name	*City*
Surgery Center/ Free-Standing Hospital Outpatient Department 1		
Surgery Center/ Free-Standing Hospital Outpatient Department 2		
Surgery Center/ Free-Standing Hospital Outpatient Department 3		
Surgery Center/ Free-Standing Hospital Outpatient Department 4		

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Surgery Center/ Free-Standing Hospital Outpatient Department 5		

Dermatology

42) Does your hospital and/or the physicians performing the dermatology procedures in question #44, currently participate in a national clinical quality registry that provides physician, physician group, and/or hospital-level benchmarking on quality measures? *If "neither the hospital nor physicians participate," skip question #43 and continue on to question #44.*	*Yes, the hospital participates* *Yes, physicians participate* *Both the hospital and physicians participate* *Neither the hospital nor physicians participate*
43) What is the name of the national clinical quality registry?	_____

44) Total adult volume for the following procedure performed at your hospital outpatient department(s) during the reporting period.

You cannot leave any blank. If you did not perform the procedure listed below, go back to question #8 and update your response from "yes" to "no."

	(a) Adult Volume	*(b) Pediatric Volume*
Complex skin repairs	_____	

45) Where were these **dermatology** procedures performed? *Select all that apply.* *If only "hospital" is selected, skip question #46 and continue on to question #47.*	☐ *Hospital* ☐ *Surgery center or free-standing hospital outpatient department*

46) Please provide the name and city location of each surgery center or free-standing hospital outpatient department performing **dermatology** procedures:

	Name	*City*
Surgery Center/ Free-Standing Hospital Outpatient Department 1		
Surgery Center/ Free-Standing Hospital Outpatient Department 2		
Surgery Center/ Free-Standing Hospital Outpatient Department 3		
Surgery Center/		

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Free-Standing Hospital Outpatient Department 4		
Surgery Center/ Free-Standing Hospital Outpatient Department 5		

Neurological Surgery

47) Does your hospital and/or the physicians performing the neurological surgery procedures in question #49, currently participate in a national clinical quality registry that provides physician, physician group, and/or hospital-level benchmarking on quality measures? *If "neither the hospital nor physicians participate," skip question #48 and continue on to question #49.*	*Yes, the hospital participates* *Yes, physicians participate* *Both the hospital and physicians participate* *Neither the hospital nor physicians participate*
48) What is the name of the national clinical quality registry?	_____

49) Total adult volume for the following procedure performed at your hospital outpatient department(s) during the reporting period.

You cannot leave any blank. If you did not perform the procedure listed below, go back to question #9 and update your response from "yes" to "no."

	(a) Adult Volume	*(b) Pediatric Volume*
Spinal fusion procedures	_____	

50) Where were these **neurological surgery** procedures performed? *Select all that apply.* *If only "hospital" is selected, skip question #51 and continue on to question #52.*	☐ *Hospital* ☐ *Surgery center or free-standing hospital outpatient department*

51) Please provide the name and city location of each surgery center or free-standing hospital outpatient department performing **neurological surgery** procedures:

	Name	*City*
Surgery Center/ Free-Standing Hospital Outpatient Department 1		
Surgery Center/ Free-Standing Hospital Outpatient Department 2		
Surgery Center/		

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Free-Standing Hospital Outpatient Department 3		
Surgery Center/ Free-Standing Hospital Outpatient Department 4		
Surgery Center/ Free-Standing Hospital Outpatient Department 5		

Obstetrics and Gynecology

52) Does your hospital and/or the physicians performing the obstetrics and gynecology procedures in question #54, currently participate in a national clinical quality registry that provides physician, physician group, and/or hospital-level benchmarking on quality measures? *If "neither the hospital nor physicians participate," skip question #53 and continue on to question #54.*	*Yes, the hospital participates* *Yes, physicians participate* *Both the hospital and physicians participate* *Neither the hospital nor physicians participate*
53) What is the name of the national clinical quality registry?	_____

54) Total adult volume for each of the following applicable procedures performed at your hospital outpatient department(s) during the reporting period.

*You cannot leave any blank. If you did not perform one or more of the procedures listed below enter 0 (zero). If you had zero volume for **all** procedures, go back to question #10 and update your response from "yes" to "no."*

	(a) Adult Volume	*(b) Pediatric Volume*
Cervix procedures	_____	
Hysteroscopies	_____	
Uterus and adnexa laparoscopies	_____	

55) Where were these **obstetrics and gynecology** procedures performed? *Select all that apply.* *If only "hospital" is selected, skip question #56 and continue on to question #57.*	☐ *Hospital* ☐ *Surgery center or free-standing hospital outpatient department*

56) Please provide the name and city location of each surgery center or free-standing hospital outpatient department performing **obstetrics and gynecology** procedures:

	Name	*City*
Surgery Center/		

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Free-Standing Hospital Outpatient Department 1		
Surgery Center/ Free-Standing Hospital Outpatient Department 2		
Surgery Center/ Free-Standing Hospital Outpatient Department 3		
Surgery Center/ Free-Standing Hospital Outpatient Department 4		
Surgery Center/ Free-Standing Hospital Outpatient Department 5		

Plastic and Reconstructive Surgery

57) Does your hospital and/or the physicians performing the plastic and reconstructive surgery procedures in question #59, currently participate in a national clinical quality registry that provides physician, physician group, and/or hospital-level benchmarking on quality measures? *If "neither the hospital nor physicians participate," skip question #58 and continue on to question #59.*	*Yes, the hospital participates* *Yes, physicians participate* *Both the hospital and physicians participate* *Neither the hospital nor physicians participate*
58) What is the name of the national clinical quality registry?	_____

59) Total adult volume for each of the following applicable procedures performed at your hospital outpatient department(s) during the reporting period.

*You cannot leave any blank. If you did not perform one or more of the procedures listed below enter 0 (zero). If you had zero volume for **all** procedures, go back to question #11 and update your response from "yes" to "no."*

	(a) Adult Volume	*(b) Pediatric Volume*
Breast repair or reconstructive procedures	_____	
Musculoskeletal graft or implant procedures	_____	

60) Where were these **plastic and reconstructive surgery** procedures performed? *Select all that apply.* *If only "hospital" is selected, skip question #61 and continue on to the next subsection.*	☐ *Hospital* ☐ *Surgery center or free-standing hospital outpatient department*

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61) Please provide the name and city location of each surgery center or free-standing hospital outpatient department performing **plastic and reconstructive surgery** procedures:

	Name	*City*
Surgery Center/ Free-Standing Hospital Outpatient Department 1		
Surgery Center/ Free-Standing Hospital Outpatient Department 2		
Surgery Center/ Free-Standing Hospital Outpatient Department 3		
Surgery Center/ Free-Standing Hospital Outpatient Department 4		
Surgery Center/ Free-Standing Hospital Outpatient Department 5		

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10D: Safety of Procedures

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

Patient Follow-up

Important Notes:

Note 1: Information from Section 10D Patient Follow-up (questions #1-6) will not be scored or publicly reported.

Note 2: The term "hospital outpatient department" is used to refer to all hospital outpatient departments that perform the procedures listed in Section 10C and that share your hospital's license and CMS Certification Number (CCN). This would include, but is not limited to, surgery centers, free-standing hospital outpatient departments, as well as outpatient departments that are located in your hospital or are co-located[19] with your hospital. Hospitals should only include those hospital outpatient departments that perform the procedures listed in Section 10C.

Reporting Time Period: 3 months

Answer questions #1-6 for the latest 3-month period prior to the submission of this section of the Survey.

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

1) Do your hospital outpatient department(s) have a process in place for staff to follow up with **physicians** who perform any one of the procedures in Section 10C to document complications (i.e., surgical site infections, excessive bleeding, ER admissions, return to OR, etc.) among those patients undergoing procedures within 30 days of discharge? *Hospitals with more than one hospital outpatient department, including a surgery center or free-standing hospital outpatient department, should respond based on the location with the fewest processes in place.* *If "no" or "does not document," skip questions #2-6 and continue on to question #7.*	*Yes* *No* *Does not document*
2) Where do your hospital outpatient department(s) document complications?	*Paper Medical Record* *Electronic Health Record* *Both*
3) When documenting complications among those patients undergoing the procedures listed in Section 10C within 30 days of discharge, what types of complications are included:	☐ *Surgical site infections*

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Select all that apply or "none of the above." *If "none of the above," skip question #4 and continue on to question #5.*	☐ *Excessive bleeding* ☐ *Wound dehiscence* ☐ *Wound hematoma* ☐ *Excessive pain* ☐ *Other* ☐ *None of the above*
4) What percentage of patients undergoing any one of the procedures in Section 10C have a documented complication (listed in question #3) within 30 days of discharge?	*< 5%* *> 5%, but < 10%* *> 10%, but < 25%* *> 25%*
5) In addition to documenting complications among those patients undergoing the procedures listed in Section 10C, which of the following do your hospital outpatient department(s) document within 30 days of discharge: *Select all that apply or "none of the above."* *If "none of the above," skip question #6 and continue on to question #7.*	☐ *ER admission* ☐ *OR admission* ☐ *Other hospital admission* ☐ *Urgent care visit* ☐ *Other* ☐ *None of the above*
6) What percentage of patients undergoing any one of the procedures in Section 10C have a documented admission or clinical visit (listed in question #5) within 30 days of discharge?	*< 5%* *> 5%, but < 10%* *> 10%, but < 25%* *> 25%*

Patient Selection and Consent to Treat

Important Notes:

Note 1: Information from Section 10D Patient Selection (questions #7-10) will not be scored, but will be used in public reporting (e.g., Leapfrog will display the components of a hospital's patient screening tool on individual hospital Summary Pages). Information from Section10D Consent to Treat (questions #11-12) will not be scored, but will be used in public reporting alongside information about procedure volume.

Note 2: The term "hospital outpatient department" is used to refer to all hospital outpatient departments that perform the procedures listed in Section 10C and that share your hospital's license and CMS Certification Number (CCN). This would include, but is not limited to, surgery centers, free-standing hospital outpatient departments, as well as outpatient departments that are located in your hospital or are co-located[19] with your hospital. Hospitals should only include those hospital outpatient departments that perform the procedures listed in Section 10C.

Reporting Time Period: Answer questions #7-12 based on the practices currently in place at the time you submit this section of the Survey.

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

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Patient Selection

7) Do your hospital outpatient department(s) have a standard, written screening protocol to determine whether a patient's procedure can safely be performed on an outpatient basis? *Hospitals with more than one hospital outpatient department, including a surgery center or free-standing hospital outpatient department, should respond based on the location with the fewest processes in place* *If "no" to question #7, skip questions #8-10 and continue on to question #11.*	*Yes* *No*
8) Which of the following components are included in your hospital outpatient department(s)' standard, written screening protocol: *Select all that apply.*	☐ *History of difficult intubation* ☐ *Difficult airway/aspiration risk* ☐ *Body Mass Index (BMI)* ☐ *American Society of Anesthesiologists (ASA) Physical Status Classification* ☐ *Recent Medical History (within 30 days of scheduled procedure)* ☐ *Cognitive Assessment* ☐ *Sleep Apnea Assessment* ☐ *Availability of transportation following discharge* ☐ *Availability of a caregiver following discharge*
9) Who completes the standard, written screening protocol to determine whether a patient's procedure can safely be performed on an outpatient basis? *Select all that apply.*	☐ *Anesthesiologist* ☐ *Certified Registered Nurse Anesthetist (CRNA)* ☐ *Physician* ☐ *Nurse (RN or MSN)* ☐ *Physician Assistant (PA)* ☐ *Nurse Practitioner (NP)* ☐ *Other*
10) When patients are identified through your hospital outpatient department(s)' screening protocol as high-risk, does an anesthesiologist, certified registered nurse anesthetist, or Medical Director complete an additional medical review to determine whether a patient's procedure can safely be performed on an outpatient basis?	*Yes* *No*

Patient Consent to Treat

11) To help ensure that patients and their families have adequate time to review and ask questions about written surgical consent materials, it's our hospital outpatient department(s)' policy to provide these materials to patients: *Hospitals with more than one hospital outpatient department, including a surgery center or free-standing hospital outpatient department, should respond based on the location with the fewest processes in place.*	*At least 3 days prior* *1-3 days prior* *Same day* *Not at all*
12) To help ensure that patients and their families have adequate time to review and ask questions about written anesthesia consent materials, it's our hospital outpatient department(s)' policy to provide these materials to patients:	*At least 3 days prior* *1-3 days prior* *Same day* *Not at all*

Safe Surgery Checklist

Important Notes:

Note 1: The elements required for each stage of the safe surgery checklist in questions #13-20 are adapted from the WHO Surgical Safety Checklist.

Note 2: Information from Section 10D Safe Surgery Checklist (questions #13-20) will be scored and results will be publicly reported.

Note 3: The term "hospital outpatient department" is used to refer to all hospital outpatient departments that perform the procedures listed in Section 10C and that share your hospital's license and CMS Certification Number (CCN). This would include, but is not limited to, surgery centers, free-standing hospital outpatient departments, as well as outpatient departments that are located in your hospital or are co-located[19] with your hospital. Hospitals should only include those hospital outpatient departments that perform the procedures listed in Section 10C.

Reporting Time Period: 3 months
Answer questions #13-20 for the latest 3-month period prior to submission of this section of the Survey.

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

13) What is the latest 3-month reporting period for which your hospital is submitting responses to questions #13-20? 3-month reporting time period ending:	_____ *Format: MM/YYYY*
14) Do your hospital outpatient department(s) utilize a safe surgery checklist on every patient, every time one of the applicable procedures reported on in Section 10C is performed? *Hospitals with more than one hospital outpatient department, including a surgery center or free-standing hospital outpatient department, should respond based on the location with the fewest processes in place.*	*Yes* *No*

If "no" to question #14, skip questions #15-20 and continue on to the next subsection.	
15) Does your safe surgery checklist include all of the following elements **before the induction of anesthesia**: • Patient ID • Confirmation of procedure • Patient consent • Site marked • Anesthesia/medication check • Pulse ox functioning • Allergies assessed • Difficult airway/aspiration risk • Risk of blood loss, if applicable • Availability of devices on-site, if applicable?	*Yes* *No*
16) Who leads the checklist **before the induction of anesthesia**? *Select all that apply.*	☐ *Anesthesiologist* ☐ *Certified Registered Nurse Anesthetist (CRNA)* ☐ *Physician* ☐ *Nurse (RN or MSN)* ☐ *Physician Assistant (PA)* ☐ *Nurse Practitioner (NP)* ☐ *Surgical Technician* ☐ *First Assist*
17) Does your safe surgery checklist include <u>all</u> of the following elements **before the skin incision and/or before the procedure begins:** • Clinical team introduction • Confirmation of patient name, procedure, and, if applicable, surgical/incision site • Antibiotic prophylaxis, if applicable • Anticipated Critical Events (non-routine steps, length of procedure, blood loss, patient-specific concerns, sterility) • Equipment check/concerns • Essential imaging available • Device representative in the OR, if applicable?	*Yes* *No*
18) Who leads the checklist **before the skin incision and/or before the procedure begins**? *Select all that apply.*	☐ *Anesthesiologist* ☐ *Certified Registered Nurse Anesthetist (CRNA)* ☐ *Physician* ☐ *Nurse (RN or MSN)* ☐ *Physician Assistant (PA)* ☐ *Nurse Practitioner (NP)* ☐ *Surgical Technician* ☐ *First Assist*

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19) Does your safe surgery checklist include an assessment, for each patient, of <u>all</u> of the following elements **before the patient leaves the operating room and/or procedure room**: • Confirmation of procedure performed • Instrument/supply counts • Specimen labeling, if applicable • Equipment concerns • Patient recovery/management concerns?	*Yes* *No*
20) Who leads the checklist **before the patient leaves the operating room and/or procedure room**? *Select all that apply.*	☐ *Anesthesiologist* ☐ *Certified Registered Nurse Anesthetist (CRNA)* ☐ *Physician* ☐ *Nurse (RN or MSN)* ☐ *Physician Assistant (PA)* ☐ *Nurse Practitioner (NP)* ☐ *Surgical Technician* ☐ *First Assist*

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10E: Medication Safety for Outpatient Procedures

Important Notes:

Note 1: Information from Section 10E Medication Safety for Outpatient Procedures will be scored and results will be publicly reported

Note 2: The term "hospital outpatient department" is used to refer to all hospital outpatient departments that perform the procedures listed in Section 10C and that share your hospital's license and CMS Certification Number (CCN). This would include, but is not limited to, surgery centers, free-standing hospital outpatient departments, as well as outpatient departments that are located in your hospital or are co-located[19] with your hospital. Hospitals should only include those hospital outpatient departments that perform the procedures listed in Section 10C.

Specifications: See ***Medication Safety for Outpatient Procedures Measure Specifications*** in the Reference Information on pages 270-271.

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

Reporting Time Period: 12 months

Answer questions #2-7 based on all cases (or a sufficient sample of them),

- 01/01/2019 - 12/31/2019
- Optional - Surveys (re)submitted on or after September 1: 07/01/2019 - 06/30/2020

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

Sufficient Sample: See ***Medication Safety for Outpatient Procedures Measure Specifications*** for instructions on identifying a sufficient sample for questions #2-7.

1) 12-month reporting time period used:	☐ 01/01/2019 – 12/31/2019 ☐ 07/01/2019 – 06/30/2020
2) Did your hospital perform an audit of clinical records for all patients undergoing those procedures included in Section 10C (or a *sufficient sample* of them) who were discharged from a hospital outpatient department for the reporting period selected **and** measure adherence to medication documentation guidelines regarding home medications, medications ordered during the visit, and medication allergies? *If "no" or "yes, but there were fewer than 30 outpatients discharged for the reporting period," skip questions #3-7 and continue on to the next subsection.*	*Yes* *No* *Yes, but there were fewer than 30 outpatients discharged for the reporting period*
3) Number of cases measured (either all cases or a sufficient sample of them).	_____
4) Number of cases in question #3 with a list of **all home medication(s),** including dose, route, and frequency, documented in the clinical record.	_____

5) Number of cases in question #3 with a list of **all medication(s) ordered, prescribed, or administered during the visit**, including the strength, dose, route, date, and time of administration, documented in the clinical record.	_____
6) Number of cases in question #3 with a list of **all allergies and adverse reaction(s)** documented in the clinical record.	_____
7) Do the responses in questions #3-6 represent a sample of cases?	*Yes* *No*

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10F: Patient Experience (OAS CAHPS)

This section is not applicable to Pediatric hospitals.

Important Notes:

Note 1: Information from Section 10F Patient Experience (OAS CAHPS) will be scored, and results will be publicly reported.

Note 2: The term "hospital outpatient department" is used to refer to all hospital outpatient departments that perform the procedures listed in Section 10C and that share your hospital's license and CMS Certification Number (CCN). This would include, but is not limited to, surgery centers, free-standing hospital outpatient departments, as well as outpatient departments that are located in your hospital or are co-located[19] with your hospital. Hospitals should only include those hospital outpatient departments that perform the procedures listed in Section 10C.

Specifications: See ***Patient Experience (OAS CAHPS) Measure Specifications*** in the Reference Information on pages 273-275.

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

Reporting Time Period: 12 months
Please answer the following questions for the latest 12-month period prior to the submission of this section of the Survey.

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

1) What is the latest 12-month reporting period for which your hospital is submitting responses to this section? 12-month reporting time period ending:	_____ *Format: MM/YYYY*
2) Did your hospital have at least 300 eligible discharges[53] during the 12-month period referenced above? *If "no" to question #2, skip the remaining questions in Section 10F, and go to the Affirmation of Accuracy.*	*Yes* *No*
3) Has your hospital administered, or started to administer, the entire OAS CAHPS Survey during the reporting period? *If "no" to question #3, skip the remaining questions in Section 10F, and go to the Affirmation of Accuracy.*	*Yes* *No*
4) Total number of months in which your hospital administered the OAS CAHPS Survey during the reporting period?	_____ *Format: Whole numbers only*
5) Total number of returned surveys during the reporting period. *If less than 100, skip the remaining questions in Section 10F, and go to the Affirmation of Accuracy.*	_____ *Format: Whole numbers only*

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6) Do the responses to the questions in this subsection include discharges from more than one location (e.g., hospital and surgery center or free-standing hospital outpatient department, hospital and multiple free-standing hospital outpatient departments, etc.)?	*Yes* *No*

In questions #7-10, report your hospital's Top Box Score[47] from each of the following patient experience **domains** from your 12-month vendor report that matches the reporting period that you selected in question #1.

7) Facilities and Staff	_____ *Format: Whole numbers only*
8) Communication About Your Procedure	_____ *Format: Whole numbers only*
9) Patients' Rating of the Facility	_____ *Format: Whole numbers only*
10) Patients Recommending the Facility	_____ *Format: Whole numbers only*

Additional Questions (Fact Finding Only)

In questions #11-13, report your hospital's Top Box Score[47] from each of the following patient experience **questions** from your 12-month vendor report that matches the reporting period that you selected in question #1.

11) Q14: Did your doctor or anyone from the facility prepare you for what to expect during your recovery?	_____ *Format: Whole numbers only*
12) Q19: Before you left the facility, did your doctor or anyone from the facility give you information about what to do if you had bleeding as a result of your procedure?	_____ *Format: Whole numbers only*
13) Q21: Possible signs of infection include fever, swelling, heat, drainage or redness. Before you left the facility, did your doctor or anyone from the facility give you information about what to do if you had possible signs of infection?	_____ *Format: Whole numbers only*

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Affirmation of Accuracy

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

The hospital and I understand that The Leapfrog Group, its members, the public and entities and persons who contract or have other business dealings with The Leapfrog Group are relying on the truth and accuracy of this information. The hospital and I also understand that The Leapfrog Group will make this information and/or analyses of this information public through the Survey Results public reporting website, The Leapfrog Group's Hospital Safety Grade, and/or other Leapfrog Group products and services. This information and/or analyses and all intellectual property rights therein shall be and remain the sole and exclusive property of The Leapfrog Group in which The Leapfrog Group retains exclusive ownership. This information does not infringe upon any third-party intellectual property rights or any other third-party rights whatsoever and is free and clear of all encumbrances and liens of any kind. The hospital and I acknowledge that The Leapfrog Group may use this information in a commercial manner for profit. The hospital shall be liable for and shall hold harmless and indemnify The Leapfrog Group from any and all damages, demands, costs, or causes of action resulting from any inaccuracies in the information or any misrepresentations in this Affirmation of Accuracy. The Leapfrog Group and its members and entities and persons who contract or have other business dealings with The Leapfrog Group reserve the right to omit or disclaim information that is not current, accurate or truthful.

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

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Section 10: 2020 Outpatient Procedures Reference Information

What's New in the 2020 Survey

Section 10A
In Section 10A Basic Outpatient Department Information, Leapfrog is no longer asking hospitals to report on a single location (their hospital and co-located hospital outpatient departments or a surgery center/free-standing hospital outpatient department). Instead, hospitals will report on all hospital outpatient departments that perform the procedures listed in Section 10C Volume of Procedures and that share their hospital's license and CMS Certification Number (CCN). If processes/structures differ between locations, hospitals are asked to report on the hospital outpatient department with the least adherence to the standard.

Leapfrog has updated the questions regarding written transfer policies to only assess written transfer policies for emergent transfers.

Information from Section 10A will not be scored, but will be used in public reporting (e.g., Leapfrog will display the number of operating and/or procedure rooms on individual hospital Summary Pages).

Section 10B
In addition to refining the questions regarding the presence of Advanced Cardiovascular Life Support (ACLS) and Pediatric Advanced Life Support (PALS) trained clinicians while patients are present in the hospital outpatient department, Leapfrog added questions to Section 10B to assess whether a physician or certified registered nurse anesthetist (CRNA) is present at all times and immediately available in the building until all adult and pediatric patients are physically discharged from the hospital outpatient department. Hospital outpatient departments that have a physician or CRNA serving as their ACLS or PALS trained clinician are not required to have a third clinician present while patients are present in the hospital outpatient department.

The questions regarding the presence of an ACLS/PALS trained clinician, as well as a physician or CRNA, in the building will be scored and publicly reported in 2020 in accordance with the 2020 Leapfrog Hospital Survey Scoring Algorithm, which is available on the Scoring and Results webpage.

In addition, Leapfrog will continue to ask questions to assess the proportion of physicians and CRNAs who are board certified or board eligible. This information will not be scored but will be used in public reporting (e.g., Leapfrog will display the percentage of board certified/board eligible physicians and nurse anesthetists on individual hospital Summary Pages).

Section 10C
In 2020, Leapfrog will continue to ask hospitals to report on their annual volume for selected outpatient procedures. While the volume of procedures will not be scored in 2020, the information will be used to facilitate the search functionality on Leapfrog's public reporting website (e.g., allowing users to search for facilities that perform the procedure they need) and the information will be publicly reported to inform purchasers and consumers about the facility's experience with the procedure (e.g., Leapfrog will display the number of procedures performed on individual hospital summary pages).

The procedure definitions have been updated to include additional CPT codes from several hospitals and ASCs that provided recommendations in 2019. Additionally, Leapfrog has obtained a license with the American Medical Association (AMA) that enables us to list individual CPT codes and descriptions rather than CPT code ranges. The CPT codes used to define each of the 39 procedures are available in a downloadable Excel file in the Library on the Survey Dashboard. Hospitals are required to accept the AMA's Terms of Use Agreement before downloading the Excel file and using the individual CPT codes to query their EHR or billing system.

Leapfrog has added fact-finding questions to Section 10C to determine whether hospitals and/or the physicians performing procedures at the hospital outpatient departments are currently participating in a national clinical quality registry that provides opportunities for individual and/or hospital-level

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benchmarking on quality measures. Examples of national clinical quality registries include the American Academy of Orthopaedic Surgeons (AAOS) Registry, the Reg-ent[SM] ENT Clinical Data Registry, and the American Academy of Ophthalmology IRIS® Registry (Intelligent Research in Sight). Procedure volume information will not be scored but will be used in public reporting in 2020. Clinical registry questions will not be scored or publicly reported.

Section 10D
Leapfrog has moved the questions pertaining to Patient Selection and Consent to Treat, as well as the questions regarding the use of a Safe Surgery Checklist to a new subsection 10D Safety of Procedures.

Patient Follow-Up
Leapfrog has added fact-finding questions asking hospitals whether they collect documentation of patient complications and admissions/office visits. This data will not be scored or publicly reported.

Patient Selection and Consent to Treat
Leapfrog has updated the list of patient screening tool components to include history of difficult intubation and difficult airway/aspiration risk and has removed frailty assessment. This information will not be scored but will be used in public reporting (e.g., Leapfrog will display the components of a hospital outpatient department's patient screening tool on individual hospital Summary Pages).

There are no changes to the Patient Consent to Treat questions in Section 10D. Responses to these questions will not be scored in 2020 but will be publicly reported alongside information about procedure volume.

Safe Surgery Checklist
Questions regarding the use of a Safe Surgery Checklist were updated in 2020 so that Leapfrog can better assess whether hospital outpatient departments are ensuring that that every element of the checklist is being used on every patient undergoing an applicable procedure. The elements required for each stage of the safe surgery checklist are adapted from the WHO Surgical Safety Checklist and the AHRQ Endoscopy Checklist. In addition, Leapfrog has identified elements that may not be applicable to all endoscopy procedures. Responses will be scored and publicly reported in 2020.

Section 10E
In Section 10E Medication Safety for Outpatient Procedures, Leapfrog has made minor updates to the wording of the questions to specify that **all** home medications, medications ordered, prescribed, or administered during the visit, and allergies and adverse reaction types should be documented in the clinical record for each patient in order for that patient to be counted in the numerator during your medication documentation audit. The measure specifications have also been refined for further clarification. This measure will be scored and publicly reported in 2020.

Section 10F
There are no changes to the questions in Section 10F Patient Experience (OAS CAHPS). Responses to these questions will be scored and publicly reported.

Change Summary since Release

April 13, 2020 - Updated the definition of a 'sufficient sample size' from 60 to 30 cases for Section 10E Medication Safety for Outpatient Procedures. This update is intended to ease the burden of data abstraction while facilities are responding to COVID-19. See updated questions on pages 251-252 and updated specifications on pages 270-271 in the hard copy of the Survey for details.

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Basic Outpatient Department Information Frequently Asked Questions (FAQs)

1) **Our hospital shares a CMS Certification Number (CCN) with other hospitals and we have many hospital outpatient department locations (e.g., surgery centers, endoscopy centers, free-standing hospital outpatient departments, etc.) all under the same CCN. How should we report on Section 10 Outpatient Procedures?**
   As per Leapfrog's Multi-Campus Reporting Policy, all hospital campuses will need to complete their own Leapfrog Hospital Survey unless they are co-located.

   For Section 10 Outpatient Procedures, each hospital campus will need to indicate in Section 10A if they are performing the outpatient procedures listed in Section 10C at their hospital and/or at a surgery center or free-standing hospital outpatient department that shares their hospital's CMS Certification Number (CCN). You should only include those hospital outpatient departments that your hospital refers patients to. The remainder of the questions in Section 10 will need to be answered based on:
   - all hospital outpatient departments in your hospital (as reported in Section 10A question #2); and,
   - all surgery centers and free-standing hospital outpatient departments that share your hospital's CCN (as reported in Section 10A question #3)

   In Section 10C, you will be able to provide total volume across all hospital outpatient department locations (as reported in Section 10A questions #2 and #3) and information for the different outpatient locations where the specific outpatient procedures are performed. All other questions should be answered based on all outpatient locations. If you have different adherence across locations, you should answer based on the least adherent location.

   If all hospital campuses are referring patients to the same surgery centers and free-standing hospital outpatient departments, you would include the information and volume for these locations when responding to Section 10 on all their Leapfrog Hospital Surveys.

2) **How should our hospital report on the number of operating rooms and endoscopic procedure rooms in questions #4-5 if our operating/procedure rooms are used for both inpatient and outpatients? How should we report if we have multiple hospital outpatient departments?**
   Hospitals should report on the total number of adult and pediatric operating rooms or procedure rooms if these rooms are used for both inpatient and outpatients. Otherwise, hospitals should only report on the number of operating/procedure rooms that are used for outpatients. If your hospital has multiple hospital outpatient departments, report the total number of adult and pediatric outpatient operating rooms or procedure rooms across all locations. You should only be reporting on operating rooms and procedure rooms that are used to perform the outpatient procedures listed in Section 10C Volume of Procedures.

4) **How should hospitals report on their transfer policies and agreements if they have more than one hospital outpatient department performing the procedures listed in Section 10C Volume of Procedures?**
   Hospitals with more than one hospital outpatient department are instructed to respond to questions #6-7 based on the location with the fewest of the listed policies in place. For example, if one of your free-standing hospital outpatient departments has a written transfer agreement with a hospital, but another free-standing hospital outpatient department does not, you should answer “no” to question #6.

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Medical, Surgical, and Clinical Staff Frequently Asked Questions (FAQs)

1) **How does Leapfrog define "immediately available" and "in the building" as it pertains to ACLS and/or PALS trained clinicians?**
"Immediately available" is defined as being physically present in the building and not engaged in an activity or procedure that cannot be interrupted if hand-on intervention is needed for a patient.

   Leapfrog defines "in the building" as within the hospital outpatient department or surgery center or in an area co-located with the hospital outpatient department or surgery center. Leapfrog defines co-located as a location within "immediate physical proximity," meaning the two locations are physically connected, either by a tunnel, an enclosed bridge, or the locations abut each other so that hallways readily connect.

2) **In Section 10B questions #1-2 and questions #4-5, what staff should be included when reviewing ACLS/PALS certification? Would this include inpatient staff as well?**
Questions #1-2 and questions #4-5 refer to the staff that are present and immediately available when patients who had one of the outpatient procedures specified in Section 10C Volume of Procedures are in the hospital outpatient department. In questions #2 and #5, you should select the types of staff that are required to maintain ACLS/PALS certification and that are present and immediately available in the building when patients are in the hospital outpatient department, even if all staff of that type (i.e., staff that do not care for these patients) are not required to be ACLS/PALS certified. The intent of these questions is to ensure that there is an ACLS/PALS certified clinician present and immediately available on-site (and one additional clinician to assist) in the event a patient in the hospital outpatient department needs a lifesaving intervention.

3) **How should hospitals report on ACLS/PALS certification if they have more than one hospital outpatient department performing the procedures listed in Section 10C Volume of Procedures?**
Hospitals with more than one hospital outpatient department are instructed to respond to questions #1-6 based on the location with the least intensive staffing. For example, if one hospital outpatient department has an ACLS trained clinician, as well as a second clinician present at all times and immediately available in the building when adult patients are in the hospital outpatient department, but another hospital outpatient department does not, you should answer "no" to question #1.

4) **If a free-standing pediatric hospital has clinicians trained in PALS, but a small percentage of the patient population is over 12, should these clinicians also have ACLS training or would the PALS training be sufficient?**
If your hospital outpatient departments are performing procedures on both adult and pediatric patients, there should be at least one clinician with ACLS training when adult patients (13 years and older) are recovering and one clinician with PALS training when pediatric patients (infant to 12 years) are recovering. This could mean that some clinicians maintain both certifications or some maintain ACLS and others maintain PALS.

5) **How does Leapfrog define board certified and board eligible?**
For physicians:
   - Board certified means that the physician has been awarded certification from the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA).
   - Board eligible indicates that the physician has completed their initial training/fellowship but has not yet passed an existing board-certifying exam in a specialty. Leapfrog adheres to the ABMS and AOA Board Eligibility Policy for all specialties, which may be reviewed here: https://www.abms.org/media/176507/abms-board-eligibility-overview-and-faqs-abmsorg-

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20180511.pdf and https://certification.osteopathic.org/about/, respectively. These eligibility periods provide the physician with an adequate window to take her/his boards and re-take if necessary.

For CRNAs:

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

Section 10B question #8 is only referring to CRNAs that are board certified, as board eligible CRNAs are not licensed and are not yet able to provide clinical care in hospital outpatient departments.

6) **In Section 10B questions #7-8, should we include all physicians and anesthesiologists/certified registered nurse anesthetists that work in our hospital outpatient departments when determining how many are board certified or board eligible?**
No. Questions #7-8 are only asking about board certification/board eligibility for those physicians and anesthesiologists/certified registered nurse anesthetists that are authorized to perform the outpatient procedures specified in Section 10C Volume of Procedures.

Volume of Procedures Measure Specifications

Important Note: For each of the procedures included in Section 10C: Volume of Procedures, Leapfrog has provided a set of CPT codes for counting **patients,** which are available in a downloadable Excel file in the Library on the Survey Dashboard. Hospitals are required to accept the American Medical Association's (AMA) Terms of Use Agreement before downloading the Excel file and using the individual CPT codes to query their EHR or billing system.

Source: The Leapfrog Group, American Medical Association, The Health Care Cost Institute

Reporting Time Period: 12 months

- 01/01/2019 - 12/31/2019
- Optional - Surveys (re)submitted on or after September 1: 07/01/2019 - 06/30/2020

Questions #2-11: Respond "yes" or "no" based on whether or not your hospital outpatient departments performed any of the procedures during the reporting period on adult and/or pediatric patients. The procedures fall within 10 specialty areas:

Adult Procedures

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

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

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

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

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

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

Dermatology procedures: complex skin repairs

Neurological surgery procedures: spinal fusions

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

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

Pediatric Procedures

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

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

Ophthalmology procedures: anterior segment eye procedures

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

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

Urology procedures: circumcisions; cystourethroscopies; male genital procedures; urethra procedures; and vaginal repair procedures

Respond "yes" if:

- One or more of your hospital outpatient departments performed the procedure on an outpatient basis for the entire reporting period (12 months) and continues to do so
- One or more of your hospital outpatient departments performed the procedure on an outpatient basis during part of the reporting period (less than 12 months) and continues to perform the procedure

Respond "yes, but no longer perform these procedures" if:

- Your hospital outpatient departments performed the procedure for all or some of the reporting period, but NO longer perform the procedure

Respond "no" if:

- Your hospital outpatient departments do not perform the procedure

Questions #12-61: Based on your responses to questions #2-11, report on the total (a) adult and/or (b) pediatric volume for each procedure (from questions #2-11) during the reporting period:

Adult Procedures

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

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

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

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

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

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

Dermatology procedures: complex skin repair

Neurological surgery procedures: spinal fusion

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

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

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

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

Ophthalmology procedures: anterior segment eye procedures

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

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

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

When calculating total **hospital outpatient department volume for (a) adult and/or (b) pediatric patients**:

- Count the number of **patients** discharged from your hospital outpatient departments within the reporting period with any one or more of the codes specified for each procedure, subject to the criteria below:
    - Only the procedure codes provided by Leapfrog should be used to report on questions in Section 10C.
    - If a patient had more than one of the listed procedures performed on the same visit (i.e., repair of dislocating knee cap (CPT: 27422) and repair of superior labrum anterior/posterior (SLAP) lesion (CPT: 29807)), include the patient in the total volume for both procedures.

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

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Gastroenterology Measure Specifications

For gastroenterology procedures, use the CPT codes available in the Library on the Survey Dashboard to count **patients** discharged from your hospital outpatient departments who have undergone any of the 4 procedures during the reporting period.

All four procedures apply to **both adult and pediatric patients**:

- Upper GI Endoscopy
- Other Upper GI Procedure
- Small Intestine and Stomal Endoscopy
- Lower GI Endoscopy

Using the "Gastroenterology_adult" sheet, count the total number of adult (18 years of age or older) patients discharged for each procedure with any of the CPT codes listed. The CPT code can be in any procedure field (primary or secondary).

Using the "Gastroenterology_peds" sheet, count the total number of pediatric (17 years of age and younger) patients discharged for each procedure with any of the CPT codes listed. The CPT code can be in any procedure field (primary or secondary).

General Surgery Measure Specifications

For general surgery procedures, use the CPT codes available in the Library on the Survey Dashboard to count **patients** discharged from your hospital outpatient departments who have undergone any of the 9 procedures during the reporting period.

Seven procedures apply to **adult patients only**:

- Cholecystectomy and Common Duct Exploration
- Excision of Skin Lesion
- Hemorrhoid Procedure
- Laparoscopy
- Lumpectomy or Quadrantectomy of Breast
- Mastectomy
- Skin Graft

Two procedures apply to **both adult and pediatric patients**:

- Inguinal and Femoral Hernia Repair
- Other Hernia Repair

Using the "General surgery_adult" sheet, count the total number of adult (18 years of age or older) patients discharged for each procedure with any of the CPT codes listed. The CPT code can be in any procedure field (primary or secondary).

Using the "General surgery_ped" sheet, count the total number of pediatric (17 years of age and younger) patients discharged for each procedure with any of the CPT codes listed. The CPT code can be in any procedure field (primary or secondary).

Ophthalmology Measure Specifications

For ophthalmology procedures, use the CPT codes available in the Library on the Survey Dashboard to count **patients** discharged from your hospital outpatient departments who have undergone either of the 2 procedures during the reporting period.

One procedure applies to **adult patients only**:

- Posterior Segment Eye Procedures

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One procedure applies to **both adult and pediatric patients**:

- Anterior Segment Eye Procedures

Using the "Ophthalmology_adult" sheet, count the total number of adult (18 years of age or older) patients discharged for each procedure with any of the CPT codes listed. The CPT code can be in any procedure field (primary or secondary).

Using the "Ophthalmology_ped" sheet, count the total number of pediatric (17 years of age and younger) patients discharged for each procedure with any of the CPT codes listed. The CPT code can be in any procedure field (primary or secondary).

Orthopedic Measure Specifications

For orthopedic procedures, use the CPT codes available in the Library on the Survey Dashboard to count **patients** discharged from your hospital outpatient departments who have undergone any of the 7 procedures during the reporting period.

All 7 procedures apply to **both adult and pediatric patients**:

- Finger, Hand, Wrist, Forearm, and Elbow Procedures
- Shoulder Procedures
- Spine Procedures
- Hip Procedures
- Knee Procedures
- Toe, Foot, Ankle, and Leg Procedures
- General Orthopedic Procedures

Using the "Orthopedic_adult" sheet, count the total number of adult (18 years of age or older) patients discharged for each procedure with any of the CPT codes listed. The CPT code can be in any procedure field (primary or secondary).

Using the "Orthopedic_ped" sheet, count the total number of pediatric (17 years of age and younger) patients discharged for each procedure with any of the CPT codes listed. The CPT code can be in any procedure field (primary or secondary).

Otolaryngology Measure Specifications

For otolaryngology procedures, use the CPT codes available in the Library on the Survey Dashboard to count **patients** discharged from your hospital outpatient departments who have undergone any of the 4 procedures during the reporting period.

All four procedures apply to **both adult and pediatric patients**:

- Ear Procedure
- Mouth Procedure
- Nasal/Sinus Procedure
- Pharynx/Adenoid/Tonsil Procedure

Using the "Otolaryngology_adult" sheet, count the total number of adult (18 years of age or older) patients discharged for each procedure with any of the CPT codes listed. The CPT code can be in any procedure field (primary or secondary).

Using the "Otolaryngology_ped" sheet, count the total number of pediatric (17 years of age and younger) patients discharged for each procedure with any of the CPT codes listed. The CPT code can be in any procedure field (primary or secondary).

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Urology Measure Specifications

For urology procedures, use the CPT codes available in the Library on the Survey Dashboard to count **patients** discharged from your hospital outpatient departments who have undergone any of the 6 procedures during the reporting period.

One procedure applies to **adult patients only**:

- Male Sterilization Procedures

Five procedures apply to **both adult and pediatric patients**:

- Circumcision
- Cystourethroscopy
- Male Genital Procedures
- Urethra Procedures
- Vaginal Repair Procedures

Using the "Urology_adult" sheet, count the total number of adult (18 years of age or older) patients discharged for each procedure with any of the CPT codes listed. The CPT code can be in any procedure field (primary or secondary).

Using the "Urology_ped" sheet, count the total number of pediatric (17 years of age and younger) patients discharged for each procedure with any of the CPT codes listed. The CPT code can be in any procedure field (primary or secondary).

Dermatology Measure Specifications

For dermatology procedures, use the CPT codes available in the Library on the Survey Dashboard to count **patients** discharged from your hospital outpatient departments who have undergone the procedure during the reporting period.

One procedure applies to **adult patients only**:

- Complex Skin Repair

Using the "Dermatology_adult" sheet, count the total number of adult (18 years of age or older) patients discharged with any of the CPT codes listed. The CPT code can be in any procedure field (primary or secondary).

Neurological Surgery Measure Specifications

For neurological surgery procedures, use the CPT codes available in the Library on the Survey Dashboard to count **patients** discharged from your hospital outpatient departments who have undergone the procedure during the reporting period.

One procedure applies to **adult patients only**:

- Spinal Fusion

Using the "Neurological surgery_adult" sheet, count the total number of adult (18 years of age or older) patients discharged with any of the CPT codes listed. The CPT code can be in any procedure field (primary or secondary).

Obstetrics and Gynecology Measure Specifications

For obstetrics and gynecology procedures, use the CPT codes available in the Library on the Survey Dashboard to count **patients** discharged from your hospital outpatient departments who have undergone any of the 3 procedures during the reporting period.

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Three procedures apply to **adult patients only**:

- Cervix Procedure
- Hysteroscopy
- Uterus and Adnexa Laparoscopy

Using the "Obstetrics and gynecology_adult" sheet, count the total number of adult (18 years of age or older) patients discharged for each procedure with any of the CPT codes listed. The CPT code can be in any procedure field (primary or secondary).

Plastic and Reconstructive Surgery Measure Specifications

For plastic and reconstructive surgery procedures, use the CPT codes available in the Library on the Survey Dashboard to count **patients** discharged from your hospital outpatient departments who have undergone either of the 2 procedures during the reporting period.

Two procedure applies to **adult patients only**:

- Breast Repair or Reconstruction
- Musculoskeletal Grafts or Implants

Using the "Plastic_reconstruct surg_adult" sheet, count the total number of adult (18 years of age or older) patients discharged for each procedure with any of the CPT codes listed. The CPT code can be in any procedure field (primary or secondary).

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Volume of Procedures Frequently Asked Questions (FAQs)

1) **How did Leapfrog select these 10 specialties and the procedures in this section of the Survey?**
   Leapfrog worked with the Healthcare Cost Institute (HCCI) to identify the most commonly billed surgical procedures in ambulatory surgery centers and hospital outpatient departments for commercially insured adult and pediatric patients. Leapfrog's technical experts then assessed the list of procedures based on their frequency and type of anesthesia used during the procedure. Those selected for the Survey represent the highest volume procedures nationally requiring moderate to general anesthesia (including nerve blocks).

   Please reach out to the Leapfrog Help Desk if you believe additional CPT Codes should be added to the Survey; Leapfrog will take these suggestions to our technical experts.

2) **When counting patients for the purposes of identifying total volume in Section 10C, should we only include patients with scheduled outpatient procedures? Should we include patients with urgent/emergent procedures?**
   When counting patients for the purposes of identifying total volume in Section 10C, you should include all patients with procedures performed at your hospital outpatient departments if their procedure was scheduled as an outpatient procedure and can be identified using the Measure Specifications provided on pages 261-267 and the CPT codes available in the Library on the Survey Dashboard. You should exclude scheduled outpatient procedures where the patient had to be admitted as an inpatient or for observation since these procedures are likely coded used ICD-10 codes.

   All emergent/urgent cases should be excluded, such as procedures for patients that come through the emergency department.

3) **Why is Leapfrog asking about national clinical quality registry participation?**
   Leapfrog added new fact-finding questions to Section 10C to determine whether hospitals and/or the physicians performing procedures at the hospital outpatient department are currently participating in a national clinical quality registry that provides opportunities for **individual and/or hospital-level** benchmarking on quality measures. These questions were added to help Leapfrog identify fully developed and tested quality measures that could be added in 2021 to provide purchasers and consumers with a more complete assessment of the quality of these procedures in ASCs and HOPDs. Examples of measures of interest include facility and/or surgeon volume standards, as well as patient reported outcomes measures, quality and efficiency measures, and appropriateness measures.

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Safety of Procedures Frequently Asked Questions (FAQs)

General

1) How should hospitals report on the processes in Section 10D Safety of Procedures if they have more than one hospital outpatient department performing the procedures listed in Section 10C Volume of Procedures?
Hospitals with more than one hospital outpatient department are instructed to respond to Section 10D based on the location with the fewest processes in place. For example, if one hospital outpatient department uses a safe surgery checklist on all patients, but another hospital outpatient department does not, you should answer "no" to question #14.

Patient Selection and Consent to Treat

2) What are examples of appropriate tools for assessing cognition as part of patient screening and selection?
Examples of tools that may be used to assess cognition include the Montreal Cognitive Assessment (MOCA), Mini-Mental State Exam (MMSE), and Mini-Cog.
More information on these cognitive assessments, as well as other commonly used tools, may be found here: https://www.americangeriatrics.org/sites/default/files/inline-files/kkaycee_sink.pdf, as well as here: https://www.aafp.org/patient-care/public-health/cognitive-care/cognitive-evaluation.html

3) Why does a Medical Director need to perform a second screening of high-risk patients?
If an anesthesiologist and/or CRNA performs the initial screening for high-risk patients, then the second screening should be conducted by a Medical Director, as the Medical Director should take ownership of how the hospital outpatient department screens patients. The Medical Director should also have the clinical expertise to determine whether it is safe and appropriate for a patient to have an invasive procedure or surgery performed on an outpatient basis.

Safe Surgery Checklist

4) Does the safe surgery checklist referenced in Section 10D questions #13-20 apply to all procedures, including colonoscopies, endoscopies, etc.?
Yes, it applies to all procedures in Section 10C questions #2-11. If your hospital outpatient departments do not utilize a safe surgery checklist for colonoscopy and/or endoscopy, respond "no" to question #14.

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Medication Safety for Outpatient Procedures Measure Specifications

Source: The Leapfrog Group

Reporting Time Period: 12 months

- 01/01/2019 - 12/31/2019
- Optional - Surveys (re)submitted on or after September 1: 07/01/2019 - 06/30/2020

Medication Safety for Outpatient Procedures Audits Workbook (Excel)
To complete the data collection for this subsection and respond to questions #3-7, hospitals should download the Medication Safety for Outpatient Procedures Audits Workbook (Excel). This workbook includes six tabs: Instructions, Sampling, Home Meds, Visit Meds, Allergies, and Data Entry and can be used to identify patients to sample in order to complete the three clinical record audits, as well as calculate the responses to enter into the Online Hospital Survey Tool for each of the audits.

This workbook is available on the Survey Materials webpage and should be used when completing this subsection.

Sampling:
For hospitals with one hospital outpatient department that performs the procedures listed in Section 10C:
If you have more than 30 cases that meet the criteria for inclusion in the denominator of the process measures during the time period of the clinical record audit, you may randomly sample 30 of them for the denominator of each documentation guideline, and measure and report adherence based on that sample. When sampling from a larger population of cases, this is the minimum number of cases needed to make a statistically reliable statement of percentage adherence to the process guidelines.

For hospitals with multiple hospital outpatient departments that perform the procedures listed in Section 10C:
If you have more than 30 cases total (across all hospital outpatient departments) that meet the criteria for inclusion in the denominator of the process measure during the time period of the clinical record audit, you may randomly sample a minimum of 10 cases from each hospital outpatient department and report on a total minimum sample size of at least 30 for the denominator of each documentation guideline, and measure and report adherence based on that sample. When sampling from a larger population of cases, this is the minimum number of cases needed to make a statistically reliable statement of percentage adherence to the process guidelines.

For example, if you are reporting on 3 hospital outpatient departments you could sample 10 cases from each for a total sample size of 30. If you are reporting on 7 hospital outpatient departments, you could sample 10 cases from each for a total sample size of 70.

Note: Hospitals that share a CMS Certification Number (CCN) with other hospitals may use the same sample for reporting on a shared hospital outpatient department location (e.g., surgery center, endoscopy center, free-standing hospital outpatient department, etc.). For example, Hospital A and Hospital B share a CCN and both refer patients to the same gastroenterology center. Hospital A samples 15 cases from their hospital outpatient department and 15 cases from the gastroenterology center. Hospital B can use the sample of 15 cases from the gastroenterology center in addition to sampling from their additional hospital outpatient departments when reporting on their own Leapfrog Hospital Survey.

Question #3 (denominator): Number of cases measured (either all cases or a sufficient sample of them).

Your hospital should perform a clinical record audit of either all adult and/or pediatric patients undergoing those procedures included in Section 10C questions #2-11 discharged during the reporting period or a sufficient sample of those patients discharged during the reporting period as described above.

This audit of clinical records can be done retrospectively (anytime during the Survey Cycle of April 1 – December 31).

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The total number of clinical records included in your audit is reported for question #3.

Excluded cases:

- Patients discharged from the hospital outpatient departments without having one of the procedures included in Section 10C questions #2-11 performed during the reporting period.

Question #4 (numerator): Number of cases in question #3 with a list of **all home medication(s),** including dose, route, and frequency, documented in the clinical record.

Determine the total number of clinical records included in the audit (in question #3), where a list of all home medication(s), including dose, route, and frequency, was documented in the clinical record on the day of the procedure.

"Home medications" are defined as medications that the patient was taking prior to admission. The following home medications may be excluded from the clinical record unless they are clinically relevant (e.g., herbal supplement that is known to interact with anesthesia):

- as needed (PRN) medications, except for the following, which should be included: inhalers, nitroglycerin, analgesics (opioid and non-opioid), muscle relaxants, and sedatives
- topical lotions/creams
- saline nasal spray and artificial tear eye drops
- herbals and supplements and vitamins

Question #5 (numerator): Number of cases in question #3 with a list of **all medication(s) ordered, prescribed, or administered during the visit**, including the strength, dose, route, date, and time of administration, documented in the clinical record.

Determine the total number of clinical records included in the audit (question #3), where a list of all medication(s) ordered, prescribed, or administered during the visit, including the strength, dose, route, date, and time of administration, was documented in the clinical record on the day of the procedure.

Local and global anesthesia medications must only have **total dose, date, and time of administration** documented in the clinical record to be considered complete.

Question #6 (numerator): Number of cases in question #3 with a list of **all allergies and adverse reaction(s)** documented in the clinical record.

Determine the total number of clinical records included in the audit (question #3), where a list of all allergies and adverse reaction(s) was documented in the clinical record.

Included cases:

- The clinical record includes documentation that the patient reported no known allergies.

Excluded cases:

- The clinical record does **not** include either a list of allergies and adverse reaction(s) **nor** documentation of no known allergies.
- The clinical record does include a list of allergies but does not include documentation of the adverse reaction(s) for each allergy.

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

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Medication Safety for Outpatient Procedures Frequently Asked Questions (FAQs)

1) **Do all medications documented in the clinical records need to have all of the elements listed in Section 10E questions #4, #5 and #6?**
   Yes, when responding to Section 10E questions #4, 5 and 6, with the count of qualifying cases (the numerators), all elements listed must be documented in the clinical record in order to count a case.

   For **question #4**, home medications must have dose, route, and frequency documented, with the exception of 'route' in cases where a home medication only has one possible route of administration. If no home medications were taken, the clinical record should have 'no home medications,' or similar, documented.

   For **question #5**, all ordered, prescribed, and administered medications should have the strength, dose, route, date, and time of administration documented in the clinical record ('time of administration' may be omitted if the medication was not administered at the hospital outpatient department). Local and global anesthesia medications must only have **total dose, date, and time of administration** documented in the clinical record to be considered complete.

   For **question #6**, all allergies and adverse reaction(s) should be documented in the clinical record, unless there is documentation that the case has 'no known allergies.'

   More information on included/excluded medications may be reviewed in the Section 10E Medication Safety for Outpatient Procedures Measure Specifications on pages 270-271.

2) **How up to date/how often do home medications need to be updated in the clinical record for Section 10E question #4?**
   Home medications should be recorded or updated on the day of the clinical procedure (for all procedures included in Section 10C of the 2020 Leapfrog Hospital Survey).

   Patients who are returning for a second or follow-up procedure within 12 months of the initial procedure are not required to have an updated home medication list in their clinical record in order for the record to be counted in the numerator of the home medication audit (i.e. included in the count in question #4). However, in cases of frequent repeated clinical visits, the home medications list should be updated at least once every 12 months.

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Patient Experience (OAS CAHPS) Measure Specifications

Source: Developed by Centers for Medicare and Medicaid Services (CMS) using Agency for Healthcare Quality and Research (AHRQ) guidelines. More information available at https://oascahps.org/General-Information/About-OAS-CAHPS-Survey.

Reporting Time Period: 12 months
Report on the latest 12-month period prior to the submission of this section of the Survey.

Question #2: Did your hospital have at least 300 eligible discharges[53] during the 12-month reporting period?

This section of the Survey is designed for hospitals that discharged at least 300 eligible patients during the reporting period. Hospitals that discharged fewer than 300 eligible patients should respond "no," skip the rest of the questions, and move on to the Affirmation of Accuracy.

Eligible discharges include discharges for adult patients (ages 18 years and older) who had both medically and non-medically necessary outpatient surgeries and/or procedures. A detailed description of patient sampling criteria, including a list of OAS CAHPS-eligible surgeries and procedures, is available in the Protocols and Guidelines Manual, version 4.0 at https://oascahps.org/Survey-Materials.

Question #3: Has your hospital administered the OAS CAHPS Survey, or started to administer, the entire OAS CAHPS Survey, during the reporting period?

The OAS CAHPS survey includes questions about patients' experiences with their preparation for the surgery or procedure, check-in processes, cleanliness of the facility, communications with the facility staff, discharge from the facility, and preparation for recovering at home. The survey also includes questions about whether patients received information about what to do if they had possible side-effects during their recovery. OAS CAHPS is designed to be national in scope and requires standardized administration protocols.

There are three approved modes of administration: mail only, telephone only, and mail with a telephone follow-up. In addition, in 2020, Leapfrog will be accepting OAS CAHPS results from hospitals who have administered the survey using unapproved modes of administration, such as electronic administration, as long as they have not altered the questions, response options, or domains.

If your hospital is not currently administering the OAS CAHPS Survey, a list of approved vendors is available at https://oascahps.org/General-Information/Approved-Survey-Vendors.

Question #4: Total number of months in which your hospital administered the OAS CAHPS Survey during the reporting period.

It is recommended that hospitals (or their survey vendor) sample over a 12-month period and ensure an even distribution of patients is sampled over the 12-month period. However, in 2020, Leapfrog will be accepting OAS CAHPS results from hospitals that have administered the survey over a period of time less than 12 months if they have at least 100 returned surveys.

Question #5: Total number of returned surveys during the reporting period.

It is recommended that hospitals (or their survey vendor) administer the survey to a large enough sample in order to achieve 300 returned surveys in a 12-month reporting period. However, in 2020, Leapfrog will be accepting OAS CAHPS results from hospitals that have at least 100 returned surveys.

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Question #6: Do the responses to the questions in this subsection include discharges from more than one location (e.g., hospital and surgery center or free-standing hospital outpatient department, hospital and multiple free-standing hospital outpatient departments, etc.)?

Indicate "yes" if your OAS CAHPS results include eligible patient discharges from multiple locations (e.g., hospital and surgery center or free-standing hospital outpatient department, hospital and multiple free-standing hospital outpatient departments, etc.). Otherwise indicate "no."

Questions #7-10: In questions #7-10, report your hospital's Top Box Score[47] from each of the following patient experience domains from your 12-month vendor report that matches the reporting period selected in question #1. Hospitals should not use domain scores that are publicly reported on the CMS Hospital Compare website as these scores have been risk adjusted. Hospitals should report results from all hospital outpatient departments.

These 4 questions capture the Top Box Score for each of the 4 domains of patient experience: facilities and staff, communication about your procedure, patients' rating of the facility, and patients recommending the facility.

The following questions from the OAS CAHPS Survey are included in each domain:

Facilities and Staff
Q3: Did the check-in process run smoothly?
Q4: Was the facility clean?
Q5: Were the clerks and receptionists at the facility as helpful as you thought they should be?
Q6: Did the clerks and receptionists at the facility treat you with courtesy and respect?
Q7: Did the doctors and nurses treat you with courtesy and respect?
Q8: Did the doctors and nurses make sure you were as comfortable as possible?

Communication About Your Procedure
Q1: Before your procedure, did your doctor or anyone from the facility give you all the information you needed about your procedure?
Q2: Before your procedure, did your doctor or anyone from the facility give you easy to understand instructions about getting ready for your procedure?
Q9: Did the doctors and nurses explain your procedure in a way that was easy to understand?
Q10: Anesthesia is something that would make you feel sleepy or go to sleep during your procedure. Were you given anesthesia?
Q11: (If 'Yes' to Q10) Did your doctor or anyone from the facility explain the process of giving anesthesia in a way that was easy to understand?
Q12: (If 'Yes' to Q10) Did your doctor or anyone from the facility explain the possible side effects of the anesthesia in a way that was easy to understand?

Patients' Rating of the Facility
Q23: Using any number from 0 to 10, where 0 is the worst facility possible and 10 is the best facility possible, what number would you use to rate this facility?

Patients Recommending the Facility
Q24: Would you recommend this facility to your friends and family?

Additional Questions (Fact Finding Only)
Questions #11-13: In questions #11-13, report your hospital's Top Box Score[47] from each of the following patient experience questions from your 12-month vendor report that matches the reporting period selected in question #1. Hospitals should report results from all hospital outpatient departments.

These 3 questions capture the Top Box Score for each of these 3 questions regarding patient experience following a surgery or procedure that are not included in the 4 domains above:

Q14: Did your doctor or anyone from the facility prepare you for what to expect during your recovery?

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Q19: Before you left the facility, did your doctor or anyone from the facility give you information about what to do if you had bleeding as a result of your procedure?

Q21: Possible signs of infection include fever, swelling, heat, drainage or redness. Before you left the facility, did your doctor or anyone from the facility give you information about what to do if you had possible signs of infection?

Please note that question numbers are taken from the OAS CAHPS Survey, which you can download at https://oascahps.org/Survey-Materials.

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

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Patient Experience (OAS CAHPS) Frequently Asked Questions (FAQs)

1) **Why is Leapfrog asking for results of the OAS CAHPS Survey, given that it is not required by CMS and many hospitals are not currently administering it?**
While we understand that the OAS CAHPS Survey is still a voluntary component of the CMS Hospital Outpatient Quality Reporting Program, this survey is the only nationally standardized instrument designed to compare patient experience in both HOPDs and ASCs. No other survey has been tested and validated for this purpose. All measures included in Leapfrog's programs are predicated on the latest evidence and recommended by Leapfrog's panels of experts. They are also selected because of their importance to consumers, employers, and other purchasers.

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

2) **If my hospital administers a version of OAS CAHPS Survey that has not been approved by CMS, can we still use the results for reporting on the Leapfrog Hospital Survey?**
If hospitals are administering an 'unofficial' OAS CAHPS Survey, on adult discharges, that is identical to the official OAS CAHPS Survey in terms of domains/questions, but is administered in a non-CMS approved mode (e.g., electronically administered), these OAS CAHPS results can be used for the purposes of responding to Section 10F of the Leapfrog Hospital Survey. Additionally, facilities can report OAS CAHPS results to Leapfrog even if they are not reporting OAS CAHPS results to CMS.

3) **Isn't 300 returned surveys the minimum sample size recommended by CMS?**
Yes, however, Leapfrog has received feedback that many hospitals and ambulatory surgery centers have only recently started to administer the survey. In order to ensure as many hospitals and ambulatory surgery centers as possible are able to report on this subsection, we have reduced the minimum sample size for reporting results to the Leapfrog Hospital and ASC Surveys to 100 returned surveys. This will help ensure that hospitals and ASCs that have made the investment to administer the Survey are able to earn credit for doing so. Additionally, this minimum sample size aligns with Section 9A of the Leapfrog Hospital Survey, which asks about the CAHPS Child Hospital Survey, and with the CMS requirement for the CAHPS Child Hospital Survey.

   If possible, however, it is recommended that hospitals (or their survey vendor) administer the survey to a large enough sample in order to achieve 300 returned surveys in a 12-month reporting period.

4) **We administer our own patient experience survey to collect specific information about our patient's experience. Can we report the results from our hospital's patient experience survey?**
No; hospitals can only report the results of the official OAS CAHPS Survey on Section 10F of the Leapfrog Hospital Survey.

   However, according to the OAS CAHPS Protocols and Guidelines Manual, survey vendors and ASCs/HOPDs may choose to add up to 15 supplemental questions after the 'core' OAS CAHPS Survey questions that are personalized to the hospital/vendor. More information on these supplemental questions, including restrictions and required approval, may be reviewed on pages 18-20 of the CMS OAS CAHPS Survey Protocols and Guidelines Manual, which is available for download here: https://oascahps.org/Survey-Materials. Please note, the responses to these supplemental questions will not be reported on the Leapfrog Hospital Survey.

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Endnotes and More Information

[1] ***CMS Certification Number (CCN)***
A CMS Certification Number (CCN) is issued by the Centers for Medicare and Medicaid Services (CMS) to financial reporting entities, which may be individual hospitals or a group of hospitals, for purposes of reimbursement. While Leapfrog does ask each campus of a multi-hospital system to submit an individual Survey, hospitals within the system may be assigned the same CMS Certification Number and therefore should have the same CCN reported in this field. CCNs are six digits; with the first two digits representing the state in which the hospital is located. Hospitals that do not receive Medicare reimbursement may not have a CMS Certification Number and should not have a CCN reported in this field. Leapfrog pre-populates this field in the Online Hospital Survey Tool. If the hospital's CCN is different from the one shown online, please contact the Help Desk.

[2] ***National Health Safety Network (NHSN) ID***
A NHSN ID is issued by the Centers for Disease Control and Prevention and is used as a unique identifier for facilities participating in NHSN surveillance activities. Each hospital within a system, even if they share a CCN, should report separately to NHSN and should have their own NHSN ID if they are located separately. Please see the NHSN instructions available at http://www.leapfroggroup.org/survey-materials/join-nhsn. NHSN IDs are five digits. Leapfrog pre-populates this field in the Online Hospital Survey Tool for hospitals that provided a valid NHSN ID, joined our NHSN Group, and submitted Section 7 in 2019. If the hospital NHSN ID is different from the one shown online, please update accordingly.

In order to be scored and publicly reported for any of the five applicable infection measures, the antibiotic stewardship standard, and to have the hospital's teaching status represented, hospitals must: (1) provide an accurate NHSN ID in the Profile, (2) join Leapfrog's NHSN Group by the appropriate deadline, and (3) submit Section 7 of the Survey by the appropriate deadline.

[3] ***Federal Tax Identification Number (TIN)***
Enter the TIN that your hospital uses for billing purposes. *The number is a nine-digit number (e.g., 098765432) and must conform precisely to this format – be sure to enter any leading 0.* If your hospital has more than one TIN, use the one that would most typically be used for UB-04 claims filed with commercial health insurance plans for inpatient hospital stays.

[4] ***National Provider Identifier (NPI)***
The NPI is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number of covered health care providers. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or medical specialty. Leapfrog pre-populates this field in the Online Hospital Survey Tool. If the hospital's NPI is different from the one shown online, please contact the Help Desk.

[5] ***State***
Your hospital is assigned to a state based on the CMS Certification Number assigned (or identifier specially issued by the Leapfrog Help Desk) to your hospital. If your hospital is incorrectly assigned to a state, contact the Help Desk to resolve the discrepancy.

[6] ***Tips for entering Web addresses***
- This address becomes the link attached to your hospital's name in the public release of Survey Results. Enter it exactly as you wish it to be and test it.

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- Do not exit out of the Online Hospital Survey Tool to go to the Web page of interest while you are entering data into the Survey or some of your Survey entries may be lost.
- Instead, minimize (but don't close) the Survey window and any other windows that are open, then open your internet browser in a separate window. Find the Web page whose address you wish to enter and Copy/Paste the entire address into the Survey entry. **The http:// prefix needs to be included.**
- If entering the Web page address manually, be careful to type it correctly, without embedded spaces. Forward (/) or backward (\) slashes may be used. Don't forget the "www." if that is part of the address. **The http:// prefix needs to be included.**
- Make sure to use .org, rather than .com, if that's the domain for your hospital's website.
- Although many hospitals elect to enter the address for the home page of their hospital website, consider pointing it to a page specific to patient safety, the Leapfrog safety practices, or other quality improvement activities that you want to communicate to your community.

[7] ***Healthcare System***
A hospital is considered part of a system if it is owned, leased, or sponsored by a central organization that owns, leases, or sponsors two or more hospitals. If your hospital is submitting a Survey for only one facility in the health care system, you would mark "yes" to this question and indicate the name of the health care system.

[8] ***Licensed Acute-Care Beds***
If your state does not designate and license bed types, enter the number of staffed beds from question #3. Include short-term, acute-care medical, surgical, obstetrical, and ICU beds, as licensed by your state. Exclude beds licensed or used for psychiatric care, rehabilitation, or sub-acute care (e.g., skilled nursing facility, hospice extended care, sub-acute eating disorder treatment, extended care facility, or residential substance abuse treatment). If the number of licensed beds has changed in the last year, indicate the most recent number for which it is licensed.

[9] ***Staffed Acute-Care Beds***
Include licensed beds regularly in operation, whether currently occupied by a patient or not. If the number has changed over the last year, indicate the average or other number most representative of your operating bed capacity over the last year.

[10] ***Total Adult Acute-Care General Admissions***
Include adult (aged 18 years and older) acute-care medical, surgical, obstetrical, and ICU admissions to any inpatient unit. Include transfers from other hospitals as admissions to your hospital. Include any admissions directly to an ICU in your hospital, even if counted in question #9. Include admissions to progressive units and telemetry units.

Exclude rehabilitation, observation, short and long-term psychiatric, or sub-acute care (e.g., skilled nursing facility, hospice extended care, sub-acute eating disorder treatment, extended care facility, or residential substance abuse treatment) admissions.

[11] ***Total Pediatric Acute-Care General Admissions***
Include pediatric (ages 17 years and younger) acute-care medical, surgical, and ICU admissions to any inpatient unit. Include transfers from other hospitals as admissions to your hospital. Include any admissions directly to an ICU or neonatal ICU (NICU) in your hospital, even if counted in question #9 or #11. Include admissions to progressive units and telemetry units.

Exclude newborn admissions to the nursery and pediatric patients admitted for maternity care, rehabilitation, observation, short and long-term psychiatric, or sub-acute care (e.g., skilled nursing facility, hospice extended care, sub-acute eating disorder treatment, extended care facility, or residential substance abuse treatment). Exclude admissions for patients that were transferred to another facility.

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[12] ***Licensed ICU Beds***
If your state separately designates ICU beds, indicate the number of licensed beds in adult and pediatric general medical and/or surgical ICUs and neuro ICUs (medical and surgical). If your state does not designate and license ICU beds, enter the number of staffed beds from question #8. See endnote #23 for more information.

Exclude beds "dedicated exclusively" to patients with specialized conditions (e.g. cardiac, burn, trauma, neonatal) that are distinct and separate from other adult or pediatric general medical and/or surgical ICUs or neuro ICUs unless the same ICU is used for both specialized intensive care patients as well as general medical and/or surgical or neuro intensive care patients. "Dedicated exclusively" means that general medical and/or surgical or neuro patients are not also cared for in these specialized units (except in rare overflow situations).

[13] ***Staffed ICU Beds***
Indicate the number of ICU beds from question #7 that are regularly in operation, whether currently occupied by a patient or not. If the number has changed over the last year, indicate the average or other number most representative of your operating ICU capacity over the last year. See endnote #23 for more information.

[14] ***ICU Admissions to Adult and Pediatric General Medical and/or Surgical or Neuro ICUs***
Include admissions to adult and pediatric general medical and/or surgical ICUs and neuro ICUs (medical and surgical) from question #8, whether directly admitted to the unit or transferred to the unit from another area of your hospital (e.g., post-operatively). Include transfers from other hospitals as admissions to your hospital. Count the number of hospitalizations that include an ICU stay, not the number of patient trips to the ICU.

Exclude admissions to units "dedicated exclusively" to patients with specialized conditions (e.g., cardiac, burn, trauma, neonatal, etc.) that are distinct and separate from other adult or pediatric general medical and/or surgical ICUs or neuro ICUs unless the same ICU is used for both specialized intensive care patients as well as general medical and/or surgical or neuro intensive care patients. "Dedicated exclusively" means that general medical and/or surgical or neuro patients are not also cared for in these specialized units (except in rare overflow situations). Ignore admissions or transfers to intermediate care or step-down units for this question.

[15] ***Neonatal ICU Admissions***
Include admissions to any level neonatal ICU (NICU), even if counted in question #5. Include transfers from other hospitals as admissions to your hospital. Exclude admissions for patients that were transferred to another facility.

[16] ***CPOE Linked to Pharmacy, Laboratory, ADT Information***
The ability of a CPOE system to catch the majority of common, serious prescribing errors depends on proper identification of patients (ADT information), current and recent pharmacy orders and drug dispensing history, and access and integration of key laboratory results for the patient. CPOE systems that are not linked to those other systems or do not reflect that current information accurately about the patient are not likely to catch serious prescribing errors.

[17] ***Appropriateness Criteria***
A procedure-specific set of criteria developed and implemented at the hospital that surgeons use to evaluate whether the patient is appropriate for surgery. These criteria should not be surgeon-specific, but procedure-specific. These criteria should be developed by those performing the procedure at the hospital and are not solely the product of a payment or reimbursement program.

[18] ***High-Risk Deliveries Electively Admitted***
Includes deliveries with:

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- *expected* birth weight <1500 grams; or
- gestational age at least 22 weeks but <32 weeks.

Not all women at risk for delivery of babies with these conditions are known beforehand to be at risk. Therefore, deliveries in which these high-risk conditions were unknown prior to admission are not considered electively admitted high-risk deliveries.

If your hospital admits deliveries where these conditions are known prior to admission, then your hospital electively admits high-risk deliveries and you should answer "yes" to question #1; otherwise, answer "no."

[19] ***Co-located***
A location within "immediate physical proximity" of the hospital would be considered a co-located location or unit, e.g., a co-located neonatal ICU (NICU) or co-located hospital outpatient location. "Immediate physical proximity" means the two locations must be physically connected, either by a tunnel, an enclosed bridge, or the locations abut each other so that the hallways readily connect.

[20] ***Very low birth weight babies***
Complicated newborns are those infants with a birth weight <1500 grams. If your hospital has a neonatal ICU (or is co-located with a hospital that has a neonatal ICU) that admits or accepts transfers of neonates with these conditions, you should answer "yes" to question #2.

[21] ***VON's Death or Morbidity Measure***
This measure is collected and calculated by the Vermont Oxford Network and includes patients who have died or are known to have one or more of the following: severe intraventricular hemorrhage (SIVH); chronic lung disease (CLD); necrotizing enterocolitis (NEC); pneumothorax; any late infection (bacterial, fungal, or coagulase negative staph); or cystic periventricular leukomalacia (PVL).

[22] ***All Critical Care Patients***
"All critical care patients" means all general medical and/or surgical ICU patients and neuro ICU patients in the ICU.

[23] ***Adult or Pediatric General Medical and/or Surgical ICUs or Neuro ICUs***
Section 5 IPS standard applies only to adult and pediatric general medical and/or surgical ICUs and neuro ICUs (medical and surgical). When responding to Section 5, only include adult and pediatric general medical and/or surgical ICUs and neuro ICUs (medical and surgical). Ignore units "dedicated exclusively" to patients with specialized conditions (e.g., cardiac, burn, trauma, neonatal, etc.) that are distinct and separate from other adult or pediatric general medical and/or surgical ICUs or neuro ICUs unless the same ICU is used for both specialized intensive care patients as well as general medical and/or surgical or neuro intensive care patients. "Dedicated exclusively" means that general medical and/or surgical or neuro patients are not also cared for in these specialized units (except in rare overflow situations). Ignore admissions or transfers to intermediate care or step-down units for this question.

For hospitals that have more than one type of ICU included in this standard, where the ICU physician staffing structure may differ among ICU types, hospitals are instructed to report on the least restrictive ICU when responding to questions #1-14 in Section 5 ICU Physician Staffing. 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, the hospital would respond to questions #1-14 based on the adult medical ICU.

[24] ***Managed or Co-Managed***
The intensivist, when present (whether on-site or via telemedicine), is authorized to diagnose, treat, and write orders for a patient in the ICU on his/her own authority. Mandatory consults or daily rounds by an intensivist are not sufficient to meet the managed/co-managed requirement. However, an ICU need not be closed to meet this requirement.

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[25] ***Certified in Critical Care Medicine***
A physician who is "certified in Critical Care Medicine" is a board-certified physician who is additionally certified in the subspecialty of Critical Care Medicine. Certification in Critical Care Medicine is awarded by the American Boards of Internal Medicine, Surgery, Anesthesiology, Pediatrics, and Emergency Medicine.

"Neurointensivists" are classified as physicians who are board-certified in their primary specialty and who are additionally certified in the subspecialty of Neurocritical Care Medicine. Certification in Neurocritical Care Medicine is awarded by the United Council for Neurologic Subspecialties (UCNS) or, beginning in 2021, by the American Board of Psychiatry and Neurology, Inc. (ABPN). Physicians who have not yet passed a certifying exam, either through UCNS or ABPN, are considered to be equivalent to a physician "certified in Neurocritical Care Medicine" for up to 3 years after they are eligible to take either: (1) the UCNS exam (UCNS currently offers a "grandfathering" option for their "Practice Track" for exam eligibility) or (2) the ABPN exam (ABPN currently offers a "grandfathering" or practice pathway track for exam eligibility, which will last until 2026). These options provide a 3-year grace period for clinicians to take and pass the necessary exams. To qualify for the grace period, hospitals and/or clinicians will need to provide clear documentation of what their eligibility dates were to sit for one or both of these exams.

Expanded Definition of Certified in Critical Care Medicine
On an interim basis, three other categories of physicians are considered by Leapfrog to be equivalent to a physician "certified in Critical Care Medicine" for the purpose of meeting the standard:

- Physicians who completed training prior to availability of subspecialty certification in critical care in their specialty (1987 for Internal Medicine, Surgery, Anesthesiology, Pediatrics and 2013 for Emergency Medicine), who are board-certified in their specialty, and who have provided at least six weeks of full-time ICU care annually. (The weeks need not be consecutive weeks.)
- Physicians who have finished their fellowship in Critical Care Medicine, but have not yet passed an existing board-certifying exam, are considered to be equivalent to a physician "Certified in Critical Care Medicine" for up to three years after completion of the fellowship. This provides the physician an adequate window to take her/his boards and re-take if necessary.
- Physicians who are board-certified in their primary specialty and have completed a critical care fellowship at an ACGME-accredited program, but are ineligible to sit for a board-certifying exam in Critical Care in either their primary specialty or subspecialty because their training occurred under two separate certifying boards, are considered to be equivalent to a physician "Certified in Critical Care Medicine" if they are board-certified in their primary specialty and have provided at least six weeks of full-time ICU care annually. (The weeks need not be consecutive weeks.)

Physicians who have let their board certification lapse are not considered to be "Certified in Critical Care Medicine."

[26] ***Ordinarily and Exclusively Present in the ICU***
"Ordinarily present in the ICU" refers to direct on-site presence in the ICU (or presence via telemedicine – see endnote #27) of an intensivist during the 4-hour or 8-hour period. While it need not be the same intensivist for the entire 4-hour or 8-hour period, it is expected that the ICU(s) are primarily staffed by dedicated ICU intensivists who are ordinarily and exclusively present in the ICU(s). "Presence" does *not* mean staffed part-time by multiple physicians who are not ordinarily and exclusively dedicated to the ICU, *nor* does it mean the cumulative time that one or more intensivists spend in the unit visiting, rounding, consulting, or responding to pages.

Note: To meet the Leapfrog ICU requirement for intensivist presence in the ICU via telemonitoring, a hospital must affirm that its telemonitoring intensivist presence fulfills all 10 key features found in endnote #27, including daily care planning by an on-site intensivist.

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The standard allows for normally expected intensivist activities outside of the ICU related to their responsibilities in the ICU (e.g., evaluating patients proposed for ICU admission), as long as intensivists are ordinarily present in the ICU and return immediately when paged. An intensivist present in one ICU immediately adjacent to another can be considered present in both units as long as s/he can respond to demands in both units as if s/he would if both units were one larger unit. For the purposes of this Survey, "adjacent" units are those units that can be reached within 5 minutes. While tele-intensivists can be used to meet the presence requirement, some on-site intensivist presence is still necessary to meet the Leapfrog specifications.

"Exclusively" means that when the physician is in the ICU, s/he has no concurrent clinical responsibilities to non-ICU patients.

[27] ***Intensivist Presence via Telemedicine***
To meet the Leapfrog ICU requirement for intensivist presence in the ICU via telemonitoring, a hospital must affirm that its telemonitoring intensivist presence fulfills all of the following 10 key features based on a modification of the approach reported in Critical Care Medicine (Rosenfeld, B. et al. "Intensive care unit telemedicine: Alternate paradigm for providing continuous intensivist care," *Critical Care Medicine*, Vol. 28, No. 1, pp. 3925-3931). Note that, as with other Leapfrog specifications, these features must be met under ordinary circumstances.

1. A physician certified in critical care medicine (see endnote #25) who is physically present in the ICU ("on-site intensivist") performs a comprehensive review of each ICU patient each day and establishes and/or revises the care plan. The on-site intensivist must be available by phone to answer any questions from the tele-intensivist related to the established or revised care plan.

   The tele-intensivist, who must also be a physician certified in critical care medicine (see endnote #25), has immediate access to information regarding the on-site intensivist's care plan at the time monitoring responsibility is transferred to him or her by the on-site intensivist.

   When care is transferred back to the on-site intensivist, the tele-intensivist will communicate any changes to the care plan to the on-site intensivist. Hospitals relying on electronic hand-offs should ensure that physician sign-in and sign-out of reports is being recorded. In addition, these reports should be monitored as one way to audit compliance with the hand-off process described above.

2. When an intensivist is not on-site in the ICU managing or co-managing all ICU patients, a tele-intensivist is continuously monitoring and able to manage all ICU patients for the remaining 24 hours per day, 7 days per week. The tele-intensivist must be available to respond to alerts of physiological instability or perform periodic video rounding. "Continuously monitoring" means the tele-intensivist has no other concurrent responsibilities, is immediately available to communicate with ICU staff, and is continuously in the physical presence of the tele-ICU's patient monitoring and communications equipment. "Manage" means authorized to diagnose, treat, and write orders for a patient in the ICU on his/her own authority.

3. A tele-intensivist has immediate access to key patient data, including:
   a) physiologic bedside monitor data (in real-time);
   b) laboratory orders and results;
   c) medications ordered and administered; and,
   d) notes, radiographs, ECGs, etc. on demand.

4. Data links between the ICU and the tele-intensivist are reliable (>98% up-time) and secure (HIPAA compliant).

5. Via AV support, tele-intensivists are able to visualize patients with sufficient clarity to assess breathing pattern and communicate with on-site personnel at the bedside in real time.

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6. Written standards for remote care are established and include, at a minimum:
   a) tele-intensivists are certified by a national medical specialty board in critical care medicine;
   b) tele-intensivists are licensed to practice in the legal jurisdiction in which the ICU is located;
   c) tele-intensivists are credentialed in each hospital to which he/she provides remote care (can be special telemedicine credentialing);
   d) activities of the tele-intensivist are reviewed within the hospital's quality assurance committee structure;
   e) there are explicit policies regarding roles and responsibilities of both the on-site intensivist and the tele-intensivist; and,
   f) there is a process for educating staff regarding the function, roles, and responsibilities of the tele-intensivist.

7. Tele-ICU care is proactive, with routine review of all patients at a frequency appropriate to their severity of illness.

8. Within five minutes of the request for assistance being initiated by hospital staff, a tele-intensivist's patient workload ordinarily permits him or her to complete a comprehensive assessment of any patient.

9. There is an established written process to ensure effective communication between the on-site care team and the tele-intensivist.

10. The tele-intensivist documents patient care activities and this documentation is incorporated into the patient record.

[28] ***Quantified Analysis of Response Times***
Providers can monitor call/pager/text response times from notification devices in multiple ways, as long as the data collection process is non-biased and scientific.

As an example . . .
Providers could maintain an exception log in the ICU(s) on six randomly sampled days per year. On those days, ICU nurses could record:

- For question #6, the number of urgent calls/pages/texts made to intensivists when they are not present in the unit (whether on-site or via telemedicine);
- For question #7, the number of urgent calls/pages/texts made to other physicians or FCCS-certified effectors when no physician or FCCS-certified effector is physically present in the unit; and
- For question #12, the number of urgent calls/pages/texts made to a clinical pharmacist on days when they are not rounding on-site in the unit.

For each of the above, the ICU nurse would record the number of times that responses exceed 5 minutes for those respective calls/pages/texts. Hospitals can then cost-effectively estimate whether they meet the 95% timely response standards by dividing the average number of log exceptions per day by the average number of calls/pages/texts per day.

This may exclude low-urgency calls/pages/texts, if the notification device system can designate low-urgency calls/pages/texts, or if the hospital has an alternative scientific method for documenting high-urgency calls/pages/texts that are not returned within 5 minutes.

If a unit has 24/7 on-site intensivist coverage, then an analysis of response times is not required for questions #6 and #7. If an on-site clinical pharmacist makes daily on-site rounds on all critical care patients in each of the ICUs 7 days per week, then an analysis of response times is not required for question #12.

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[29] ***FCCS-Certified Nurse or Intern "Effector"***
FCCS certificates are awarded to nurses and doctors upon their successful completion of a brief course developed by the Society for Critical Care Medicine to improve/confirm critical care knowledge and skills. For more information visit http://www.sccm.org/Fundamentals/FCCS/FCCS-Sixth-Edition. At present, this is the only such course recommended by The Leapfrog Group's expert advisory panel. Intensivists and any other physicians who are certified in critical care medicine (or eligible based on residency training or fellowship) need not also be FCCS certified. Physicians, physician assistants, and nurse practitioners also are not required to be FCCS certified, but they must meet the criteria specified in endnote #31 to serve as the responder/"effector."

[30] ***Use of Tele-intensivists to Cover Calls***
Hospitals that use telemedicine to cover 'call' for the on-site intensivist are able to answer "yes" to question #6 if: (1) the telemedicine service meets all ten of the requirements outlined in endnote #27; and (2) the hospital has an 'effector' (physician/PA/NP/FCCS certified nurse or intern) on-site during that time period to carry out the tele-intensivist's orders and can reach the ICU patient within 5 minutes, 95% of the time.

[31] ***Physician/PA/NP serving as the Responder/"Effector"***
Physicians/PAs/NPs serving as the responder in the ICU should meet the following criteria:

1. Be a graduate with a training license from an ACGME accredited training program or have an active state license to practice as a physician, nurse practitioner, or physician assistant in the state in which the patient is located.
2. Have privileges to provide medical services in the unit (i.e. ICU) and for patients of the age range approved in advance by the hospital's governing body (e.g., medical staff committee, chief medical officer, chief nursing officer, etc.), as specified by the institutions internal policies (bylaws).
3. Carry out the intensivist's orders and instructions, under the intensivist's guidance, when they are serving in a responder role.

[32] ***Modified Intensivist Presence via Telemedicine***
To earn reduced credit on the Leapfrog ICU standard for intensivist presence in the ICU via telemonitoring, a hospital must affirm that its telemonitoring intensivist presence fulfills the following nine key features based on a modification of the approach reported in Critical Care Medicine (Rosenfeld, B. et al. "Intensive care unit telemedicine: Alternate paradigm for providing continuous intensivist care," *Critical Care Medicine*, Vol. 28, No. 1, pp. 3925-3931). Note that, as with other Leapfrog specifications, these features must be met under ordinary circumstances.

1. When an intensivist is not on-site in the ICU managing or co-managing all ICU patients, a tele-intensivist is continuously monitoring and able to manage all ICU patients for the remaining 24 hours per day, 7 days per week. The tele-intensivist must be available to respond to alerts of physiological instability or perform periodic video rounding. "Continuously monitoring" means the tele-intensivist has no other concurrent responsibilities, is immediately available to communicate with ICU staff, and is in the continuous, physical presence of the tele-ICU's patient monitoring and communications equipment. "Manage" means authorized to diagnose, treat, and write orders for a patient in the ICU on his/her own authority.

2. A tele-intensivist has immediate access to key patient data, including:
   a) physiologic bedside monitor data (in real-time);
   b) laboratory orders and results;
   c) medications ordered and administered; and,
   d) notes, radiographs, ECGs, etc. on demand.

3. Data links between the ICU and the tele-intensivist are reliable (>98% up-time) and secure (HIPAA compliant).

4. Via AV support, tele-intensivists are able to visualize patients with sufficient clarity to assess breathing pattern, and communicate with on-site personnel at the bedside in real time.

5. Written standards for remote care are established and include, at a minimum:
   a) tele-intensivists are certified by a national medical specialty board in critical care medicine;
   b) tele-intensivists are licensed to practice in the legal jurisdiction in which the ICU is located;
   c) tele-intensivists are credentialed in each hospital to which he/she provides remote care (can be special telemedicine credentialing);
   d) activities of the tele-intensivist are reviewed within the hospital's quality assurance committee structure;
   e) there are explicit policies regarding roles and responsibilities of both the on-site intensivist and the tele-intensivist; and,
   f) there is a process for educating staff regarding the function, roles, and responsibilities of the tele-intensivist.

6. Tele-ICU care is proactive, with routine review of all patients at a frequency appropriate to their severity of illness.

7. Within five minutes of the request for assistance being initiated by hospital staff, a tele-intensivist's patient workload ordinarily permits him or her to complete a comprehensive assessment of any patient.

8. There is an established written process to ensure effective communication between the on-site care team and the tele-intensivist.

9. The tele-intensivist documents patient care activities and this documentation is incorporated into the patient record.

[33] ***Individuals who touch patients or who touch items that will be used by patients***
This would include individuals who are formally engaged by the hospital to help support the patient care process. This would include both direct and indirect care providers that are likely to have contact with patients in a patient care unit, enter a patient care unit, touch items that will be used by patients in a patient care unit, or interact with patient fluids (e.g., blood, specimens) in a patient care unit, such as doctors, mid-levels, nurses, pharmacists, environmental services staff, phlebotomists, laboratory techs, etc. This would also include students and volunteers. These individuals should be trained to identify and perform proper hand hygiene for the specific indications/moments (see WHO's 5 Moments for Hand Hygiene, CDC's Guideline for Hand Hygiene) that are relevant to their work.

Administrative workers that only perform office duties and do not touch patients or touch items that will be used by patients in a patient care unit would not be included in this definition. Patients and their visitors would also not be included in this definition. While patients and their loved ones are important parts of the patient care process, they are not formally engaged by the hospital for this work.

[34] ***Professional with Appropriate Training and Skills***
This would include staff formally trained in Infection Control or Infectious Diseases, whose tasks include dedicated time for staff training. In some settings, this could also be medical or nursing staff involved in clinical work, with dedicated time to acquire thorough knowledge of the evidence for and correct practice of hand hygiene.

The minimum required knowledge of the trainer can be found in the WHO Guidelines on Hand Hygiene in Health Care and the Hand Hygiene Technical Reference Manual.

[35] ***Never Event***
In 2011, the National Quality Forum released a list of 29 events that they termed "serious reportable events," extremely rare medical errors that should never happen to a patient. Often termed "never

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events," these include errors such as surgery performed on the wrong body part or on the wrong patient, leaving a foreign object inside a patient after surgery, or discharging an infant to the wrong person. This is an update of NQF's original 2002 and 2006 reports. Please see NQF's "Never Events" list at http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=69573. Hospitals may not earn credit for this question if they have only implemented a policy that includes the Center for Medicare and Medicaid (CMS) Never Events.

[36] ***Apology to the Patient***
While Leapfrog recognizes that on very rare occasions "never events" can occur that are not the fault of care systems or clinical care staff, given the high level of trust patients place in health care providers, Leapfrog feels it is appropriate for caregivers to apologize when a patient within their care setting suffers a serious event.

As the National Quality Forum identified in their 2002, 2006, and 2011 Serious Reportable Events Report, given the serious nature of these events, it is reasonable for hospitals to initially assume that the adverse event was due to the referenced course of care. And while further investigation and/or root cause analysis of the unplanned event may be needed to confirm or refute the presumed relationship, delaying an apology to the patient is not treating the patient with compassion and sympathy.

[37] ***Reporting Never Events to External Agencies***
If your hospital is not accredited by The Joint Commission, is located in a state without a state-wide reporting program for medical errors, AND there is no available Patient Safety Organization to which your hospital can report medical errors, the hospital should report the event to the Board of Trustees. Full implementation of the Never Events policy still requires the hospital to conduct a root cause analysis of the event.

[38] ***Root Cause Analysis***
The National Patient Safety Foundation published a set of best practices and guidelines in its report "RCA^2 Improving Root Cause Analysis and Action to Prevent Harm." The report can be found at http://www.ihi.org/resources/Pages/Tools/RCA2-Improving-Root-Cause-Analyses-and-Actions-to-Prevent-Harm.aspx.

[39] **Intensive Care Units**
For the purposes of reporting on Section 8A BCMA, all adult, pediatric, and/or neonatal ICUs should be included, such as general medical/surgical ICUs, all specialty ICUs, and mixed-acuity units that include ICU patients.

[40] **Medical and/or Surgical Units**
An exact definition on which units would be included in general medical, surgical, or medical/surgical cannot be provided because each hospital is laid out differently. For information about what is considered a general medical, surgical, or medical/surgical unit, please refer to the CDC's definitions of Medical Ward, Medical/Surgical Ward, and Surgical Ward on p. 15-18 to 15-20 of the following link: http://www.cdc.gov/nhsn/PDFs/pscManual/15LocationsDescriptions_current.pdf.

The flowchart on p. 15-3 can also be used to help define units in your hospital.

Telemetry units are considered medical/surgical units and must be included in this question. Units for patients from a specific service type (e.g., burn, cardiac) should not be included. Step-down and observation units should be excluded.

[41] **Labor and Delivery Units**
Labor and delivery units should include all antepartum and postpartum units. Nursery units, OR units, and procedural areas should be excluded.

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[42] ***Sampling for Medication Reconciliation***
The sample should contain at least 15 patients if reporting on a 3-month period, or 30 patients if reporting on a 6-month period. Sampling is limited to medical/surgical units. Patients that were discharged or expired before the Gold Standard Medication History could be obtained should be excluded from the sample. Patients that do not have discharge orders written during the reporting period should also be excluded from the sample. A sampling worksheet is available in the Medication Reconciliation Workbook for those who would like assistance in obtaining a random sample of patients.

[43] ***Gold Standard Medication History***
The Gold Standard Medication History is the list of medications that the patient was taking prior to admission. Within 24 hours after admission, a trained pharmacist or pharmacy resident must interview each patient selected for the 3-month or 6-month sample and obtain the Gold Standard Medication History. Note that this is in addition to, and separate from, any pre-admission medication list that was created as part of normal care. Best practices for collecting the Gold Standard Medication History can be found in the "Other Supporting Materials" for Section 8 on our website.

[44] ***Discrepancies in Gold Standard Medications***
For each Gold Standard Medication, there may be up to two unintentional discrepancies: a discrepancy in admission orders and a discrepancy in discharge orders. For example, if a medication on the Gold Standard Medication History is ordered for a patient on admission with the incorrect dose, this counts as one discrepancy. If this medication is ordered on discharge for the same incorrect dose, this counts as a second discrepancy. The number of unintentional discrepancies is a count of medication orders where an unintentional discrepancy occurred. You should not count the number of errors associated with the same medication order (e.g., a discrepancy in the dose and frequency in the same medication in admission orders counts as one discrepancy).

[45] ***Unintentionally Ordered Additional Medications***
Include cases where a patient was not taking (and was not supposed to be taking) a certain medication, but the medical team incorrectly thought the patient was taking the medication and therefore ordered it on admission and/or discharge. Count one per medication, regardless of whether it was ordered on admission, discharge, or both.

[46] ***Discrepancies due to Unintentionally Ordered Additional Medications***
For each unintentionally ordered additional medication, there may be up to two discrepancies: unintentionally ordered at admission, unintentionally ordered at discharge, or both. For example, if a medication is unintentionally ordered at admission, then this counts as one discrepancy. If the same medication is also ordered at discharge, then this counts as a second discrepancy.

[47] ***Top Box Score***
The percent of survey respondents who chose the most positive score for a given item. Looking at the **top box** is an approach to understand the number of responses with a strong sentiment.

For the CAHPS Child Hospital Survey "Global Rating – Recommend hospital" domain, responses of 9 and 10 are included in the top box score. For the "Global Rating – Recommend hospital" domain, responses of "Definitely yes" are included in the top box score. For all other domains included in Section 9A, the top box score is the percent of survey respondents choosing "Always."

For the OAS CAHPS Survey "Patients' Rating of the Facility" domain, responses of 9 or 10 are included in the top box score. For the "Patients Recommending the Facility" domain, responses of "Definitely yes" are included in the top box score. For all other domains included in Section 10E, the top box score is the percent of survey respondents choosing "Yes, definitely."

[48] ***Operating Rooms***
If your state designates and licenses operating rooms, enter the number of operating rooms licensed by your state that are used to perform the outpatient procedures listed in Section 10C. If your state does not

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designate and license operating rooms, enter the number of operating rooms used to perform the outpatient procedures listed in Section 10C that meet the following definition from the 2018 FGI Guidelines: a room that meets the requirements of a restricted area, is designated and equipped for performing surgical or other invasive procedures, and has the environmental controls for an OR as indicated in ASHRAE 170. An aseptic field is required for all procedures performed in an OR.

More information about the 2018 FGI Guidelines can be found at https://www.fgiguidelines.org/wp-content/uploads/2017/08/SLS17_FGI_ExamProcedureOperatingImaging_170721.pdf.

Hospitals should include the total number of operating rooms that are used to perform the outpatient procedures listed in Section 10C, including operating rooms that are used for both inpatient and outpatient procedures.

[49] ***Endoscopic Procedure Rooms***
If your state designates and licenses procedure rooms, enter the number of procedure rooms licensed by your state that are used for endoscopies listed in Section 10C. If your state does not designate and license procedure rooms, enter the number of procedure rooms that are used for endoscopies listed in Section 10C that meet the following definition from the 2018 FGI Guidelines: a room designated for the performance of patient care that requires high-level disinfection or sterile instruments and some environmental controls but is not required to be performed with the environmental controls of an operating room.

More information about the 2018 FGI Guidelines can be found at https://www.fgiguidelines.org/wp-content/uploads/2017/08/SLS17_FGI_ExamProcedureOperatingImaging_170721.pdf.

Hospitals should include the total number of procedure rooms that are used to perform the endoscopies listed in Section 10C, including procedure rooms that are used for both inpatient and outpatient procedures.

[50] ***Written Transfer Agreement***
A written agreement between a hospital outpatient department and a receiving hospital/inpatient unit that describes the transfer of patients, patient care, and clinical information in circumstances of varying acuity where a higher level of care is needed by patients. The transfer agreement should be formalized in advance of any patient care being initiated at a hospital outpatient department and should be applicable to and immediately enacted in any case when a higher level of patient care is necessary.

[51] ***Written Transfer Policies***
Written internal policies and procedures, including, but not limited to, the provisions in the written transfer agreement, for the transfer of patients to a higher level of care. These procedures should be specific to an individual hospital outpatient department and may differ based on patient acuity. Transfer policies may specify qualifications of the receiving facility and timing for transfer of patients and information, among other components. Transfer policies should be internally formalized and circulated to appropriate members of the care team prior to any patient care being initiated at a hospital outpatient department.

[52] ***Clinician***
A clinician here refers to a physician, physician assistant (PA), nurse practitioner (NP), certified registered nurse anesthetist (CRNA), or nurse (RN or MSN).

[53] ***Eligible Discharges***
Discharged adult patients (ages 18 years and older) who had both medically and non-medically necessary outpatient surgeries and/or procedures are eligible to complete the OAS CAHPS Survey. A detailed description of patient sampling criteria, including a list of OAS CAHPS-eligible surgeries and procedures is available in the Protocols and Guidelines Manual, version 4.0 at https://oascahps.org/Survey-Materials.

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