Leapfrog Hospital Survey
Hard Copy

QUESTIONS & REPORTING PERIODS
ENDNOTES
MEASURE SPECIFICATIONS
FAQS

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Welcome to the 2019 Leapfrog Hospital Survey

http://leapfroggroup.org/hospital

Important Notes about the 2019 Survey

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

2. Note the word "hospital" used throughout this Survey refers to an individual hospital. If your hospital is part of a multi-hospital 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.

3. 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. Hospitals cannot access the CPOE Evaluation Tool until they have submitted Sections 1 Basic Hospital Information and 2 Medication Safety - CPOE of the online Survey. More information about the CPOE Evaluation Tool, including instructions, scoring, and FAQs are available on the Survey website. All hospitals are urged to take a Sample Test prior to beginning an Adult Inpatient Test.

4. 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.

5. Leapfrog Hospital Survey Results will be available for hospitals to view on July 12 via the Hospital Details Page link on the Hospital Survey Dashboard. Survey Results will be posted to the public website on July 25 and then updated within the first 5 business days of each month to reflect Surveys submitted or resubmitted between June 30 and November 30 and previously submitted Surveys that were corrected before January 31. Survey Results are frozen from February to July 25.

6. 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 24-48 hours.

7. 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 in order for Survey data to be used in the Hospital Safety Grade.

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

9. The Submission Deadline for the 2019 Leapfrog Hospital Survey is **June 30, 2019** and the Late Submission Deadline is **November 30, 2019**. Hospitals that do not submit a Survey or CPOE Evaluation Tool (adult hospitals only) before midnight Eastern Time on **November 30, 2019** will have to wait until the launch of the 2020 Leapfrog Hospital Survey on April 1, 2020.

Overview of the 2019 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 2019 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. This section also includes the CPOE Evaluation Tool.
3	**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.
4	**Maternity Care**	Section 4 includes questions about elective delivery, cesarean birth, episiotomy, newborn bilirubin screening, and DVT prophylaxis for women undergoing cesarean section. 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	**NQF Safe Practices**	Section 6 includes questions about your hospital's adherence to five National Quality Forum-endorsed Safe Practices. In 2019, a new standard on Hand Hygiene Practices is included. This subsection (6F) is optional and will not be publicly reported in 2019.
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 medication administration and medication reconciliation.

Section #	Section Title	Brief Description
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 is new in 2019 and includes questions about same day procedures performed in hospital outpatient departments. This section is optional and will not be scored or publicly reported by facility in 2019. Leapfrog plans to aggregate responses submitted to this section of the Survey along with responses submitted to Leapfrog's first ASC Survey and publish a national report.

Section 1 Basic Hospital Information, as well as Section 2 CPOE, Section 4 Maternity Care, Section 5 ICU Physician Staffing, or Section 6 NQF Safe 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. Adult hospitals cannot access the CPOE Evaluation Tool until they have submitted Section 1 Basic Hospital Information and Section 2 Medication Safety - CPOE of the Online Hospital Survey Tool. Carefully review the information on the Prepare for a CPOE Tool webpage.

Any changes made to the measure specifications after April 1 will be reflected in the hard copy of the Survey in the Reference Information sections under the "Change Summary" header (see Table of Contents). In addition, the updates to the specifications will be highlighted in yellow. If the changes are substantial, we will email the Primary Survey Contact your hospital indicated in the Hospital Profile section of the Survey. If the notification is sent before your hospital submits a 2019 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 **November 30**. Please carefully review the reporting periods in each section before updating your Survey. Leapfrog Hospital Survey Results are updated monthly beginning on July 25 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.

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** http://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 35 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. 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. In addition, for hospitals that have CPOE in at least one inpatient unit, make sure you have enough time to take a CPOE Evaluation 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.
- ☐ **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.

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 2019 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 your results on the Hospital Details Page via the link on the Hospital Survey Dashboard beginning on July 12 and review your publicly reported results after the first 5 business days of the month following your (re)submission starting on July 25.
12. Hospitals submitting a CPOE Evaluation Tool should carefully review the instructions, scoring information, and FAQs available on the Survey and CPOE Materials webpage.
13. Leapfrog is committed to verifying the accuracy of Leapfrog Hospital Survey Results. Please review our data accuracy protocols on the Data Accuracy webpage.

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 on July 12 via the Hospital Details Page link on the Hospital Survey Dashboard. Carefully review your results, in particular 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 on July 25.

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. Please review the Survey Deadlines webpage. Most updates or corrections are made:

- At the request of Leapfrog:
  - Following Leapfrog's Monthly Data Review, the Primary 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.
- At the discretion of the hospital:
  - To correct a data entry error identified by the hospital
  - To reflect a change in status or performance on a measure (e.g., closed a unit or stopped performing a procedure)
  - To provide more current responses for those measures with multiple reporting periods

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

Leapfrog conducts a Monthly Data Review of responses submitted to the Leapfrog Hospital Survey starting with Surveys submitted by the June 30 Submission Deadline and monthly thereafter until the Online Survey Tool is taken offline on January 31. Following the Monthly Data Review, the **Primary 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 review notification by 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, 2019 and then

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received a data review notification email at the beginning of September, they would update their responses based on the reporting period used in the August 20, 2019 submission.

Hospitals that receive a Category A data review message at the beginning of the month for any measure will have until the end of that same month to 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 Review messages are not resolved by January 31 (when the Online Hospital Survey Tool is taken offline), the entire section in which the flagged responses were included will be decertified and all measures within the section will be publicly reported as "Declined to Respond."

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.

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. With the exception of Section 7B Healthcare-Associated Infections and Section 7C Antibiotic Stewardship Practices, updating a Survey is optional. However, we do recommend that if your performance or if a structure has changed significantly, you update your Survey within 30 days. In addition, hospitals should update their Surveys if they become aware of any reporting errors or data inaccuracies in their previous submission. Hospitals may update one or more sections of the Survey, without updating the entire Survey. In addition, hospitals are not required to retake the CPOE Evaluation Tool if making updates to Section 2 CPOE questions #3 and #4.

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 sub-section 4B in December, they would update the entire Section 4 Maternity Care based on the updated reporting period for December.

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.

Deadlines

Deadlines for the 2019 Leapfrog Hospital Survey

The 2019 Leapfrog Hospital Survey, including the CPOE Evaluation Tool, opens on April 1 and has a Submission Deadline of **June 30, 2019**. The Late Submission Deadline is **November 30, 2019**. Surveys and Adult Inpatient CPOE Tests must be submitted before midnight Eastern Time on **November 30**. The CPOE Evaluation Tool will not be available after **November 30**.

Corrections to Surveys submitted by **November 30** must be submitted by the **January 31, 2019** Correction Deadline. The Online Hospital Survey Tool will not be available after **January 31**. Find detailed information about the 2019 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.

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 24-48 hours, but we do ask that hospitals plan ahead and allow ample time to fulfill security code requests and other urgent tickets before Survey deadlines.

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 @leapfroggroup.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.

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 12/31/2018	12-months ending 06/30/2019
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	12-months or 24-months ending 12/31/2018	12-months or 24 months ending 06/30/2019
3B Surgical Appropriateness	Latest 12-months prior to Survey submission	Latest 12-months prior to Survey submission
4A Maternity Care	12-months ending 12/31/2018	12-months ending 06/30/2019
4B Elective Delivery	12-months ending 12/31/2018	12-months ending 06/30/2019
4C Cesarean Birth	12-months ending 12/31/2018	12-months ending 06/30/2019
4D Episiotomy	12-months ending 12/31/2018	12-months ending 06/30/2019
4E Bilirubin Screening & DVT Prophylaxis	12-months ending 12/31/2018	12-months ending 06/30/2019
4F High-Risk Deliveries	Volume: 12-months ending 12/31/2018	Volume: 12-months ending 06/30/2019
	VON: 2017 report	VON: 2018 report
	Antenatal Steroids: 12-months ending 12/31/2018	Antenatal Steroids: 12-months ending 06/30/2019
5 ICU Physician Staffing	Latest 3-months prior to Survey submission	Latest 3-months prior to Survey submission
6 National Quality Forum (NQF) Safe Practices	Latest 12- or 24-months prior to Survey submission (see individual safe practice for specific reporting period)	Latest 12- or 24-months prior to Survey submission (see individual safe practice for specific reporting period)
7A Never Events Policy	N/A	N/A
7B Healthcare-Associated Infections	12-months ending 12/31/2018*	12-months ending 06/30/2019*
7C Antibiotic Stewardship Practices	2018 NHSN Annual Survey	2018 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

Survey Section/ Measure	Survey Submitted Prior to September 1 Reporting Period	Survey (Re)Submitted On or After September 1 Reporting Period
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 12/31/2018	12-months ending 06/30/2019
10A Basic Outpatient Department Information	12-months ending 12/31/2018	12-months ending 06/30/2019
10B Medical, Surgical, and Clinical Staff	N/A	N/A
10C Volume and Safety of Procedures	Volume: 12-months ending 12/31/2018	Volume: 12-months ending 06/30/2019
	Patient Selection: N/A	Patient Selection: N/A
	Safe Surgery Checklist: Latest 3-months prior to Survey submission	Safe Surgery Checklist: Latest 3-months prior to Survey submission
10D Medication Safety in Outpatient Departments	12-months ending 12/31/2018	12-months ending 06/30/2019
10E 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 current members of our NHSN group that have provided an accurate NHSN ID in the Profile and submitted Section 7: Managing Serious Errors. Before September 1, Leapfrog will use calendar year 2018 data for the healthcare-associated infections. On or after September 1, Leapfrog will use 2018 Quarter 3 data through 2019 Quarter 2 data for these infections. Antibiotic Stewardship data will only be based on the 2018 NHSN Patient Safety Component – Annual Hospital Survey.

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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.

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.

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 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. Secondary Survey Contacts are not included on these notifications.

Facility Information

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

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)	

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

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.

Section 1: 2019 Basic Hospital Information

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

1: Basic Hospital Information

Specifications: See ***Basic Hospital Information Specifications*** in the Reference Information on page 30.

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
- Surveys submitted prior to September 1: 01/01/2018 – 12/31/2018
- Surveys (re)submitted on or after September 1: 07/01/2018 – 06/30/2019

1)	Reporting time period used:	☐ 01/01/2018 – 12/31/2018 ☐ 07/01/2018 – 06/30/2019
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 2018 Patient Safety Component – Annual Hospital Survey.*

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 with Leapfrog 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. This information does not infringe any third party's intellectual property rights. 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 with Leapfrog reserve the right to omit or disclaim information that is not current, accurate or truthful.

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

Section 1: 2019 Basic Hospital Reference Information

What's New in the 2019 Survey

To more accurately identify hospitals that are eligible to report on Section 9A Patient Experience (CAHPS Child Hospital Survey), Leapfrog added a new question regarding the total number of admissions to any level neonatal ICU[15] to Section 1. Hospitals with fewer than 100 non-NICU pediatric admissions are not required to administer the CAHPS Child Hospital Survey and this question, as well as question #11 which asks for the total number of pediatric acute-care admissions[11], will be used in Leapfrog's Monthly Data Review to help ensure that hospitals are responding accurately to Section 9A.

Leapfrog has also updated several endnotes within Section 1 to clarify what types of beds and admissions should be included when reporting on this section of the Survey. All endnotes should be carefully reviewed prior to responding to the questions in Section 1.

Change Summary since Release

April 2, 2019 – Endnote #10 Total Adult Acute-Care General Admissions and endnote #14 ICU Admissions to Adult and Pediatric General Medical and/or Surgical or Neuro ICUs have been updated. The following exclusion has been removed from both endnotes: "Exclude admissions for patients that were transferred to another facility." This exclusion only applies to endnote #11 Total Pediatric Acute-Care General Admissions and endnote #15 Neonatal ICU Admissions as these questions are used to qualify hospitals for reporting on the CAHPS Child Hospital Survey.

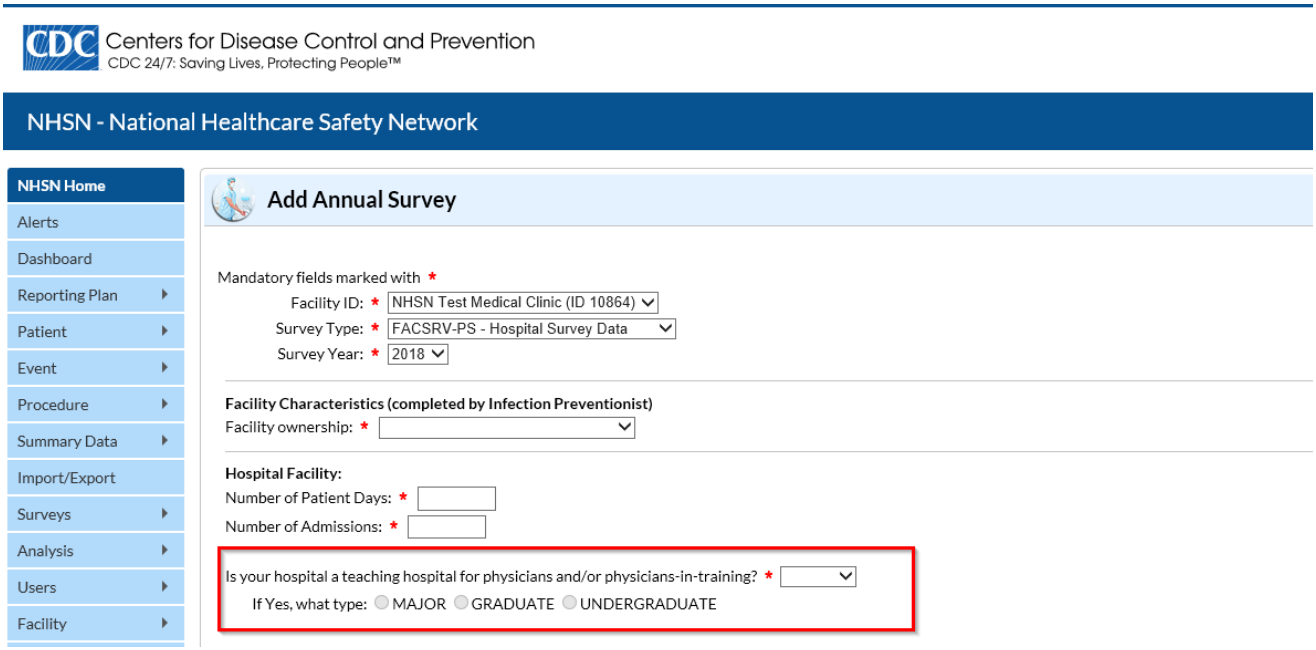
Basic Hospital Information Specifications

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 2018 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 2019 Leapfrog Hospital Survey and Leapfrog's Top Hospital program, Leapfrog will consider the following types a "teaching hospital": Major and Graduate.

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 or 2018 Leapfrog Hospital Survey. However, all hospitals in Leapfrog's NHSN Group must review their Rights Acceptance Report annually by the **first** NHSN join-by date of each Survey Cycle.

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 2018 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.

Section 2: 2019 Medication Safety - Computerized Physician Order Entry (CPOE)

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

The Pediatric Inpatient CPOE Evaluation Tool is not available. Pediatric Hospitals should complete questions #1-4 only.

Section 2 includes questions about your hospital's use of CPOE to prevent medication ordering errors and adverse drug events. This section also includes the CPOE Evaluation Tool.

Each hospital fully meeting this standard:

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

* "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.

** For the 2019 Survey, scored results on the Adult Inpatient Test of the CPOE Evaluation Tool will be used to assess if an adult or general hospital's CPOE system is alerting prescribers to at least 60% of frequent serious medication errors known to cause harm to patients. A hospital may access the CPOE Evaluation Tool (Sample and Adult Inpatient Test) only after:

a) Responding "yes" to question #2, indicating that your hospital has a functioning CPOE system in at least one inpatient unit
b) Responding to questions #3-4
c) Submitting Section 1: Basic Hospital Information and Section 2: Medication Safety - CPOE from the Hospital Survey Dashboard

Important Notes:

Note 1: Hospitals must complete an Adult Inpatient Test at least once per Survey Cycle (April to November). Hospitals are encouraged to ensure that the Adult Inpatient CPOE Test is submitted along with the Survey in order to meet the deadlines for Leapfrog's Programs such as Top Hospital, Leapfrog Hospital Safety Grade, etc. Hospitals are only able to retake a CPOE Evaluation Tool after 120 days have passed since they last completed the CPOE Evaluation Tool. All hospitals are urged to complete a Sample Test prior to starting an Adult Inpatient Test and to review the updated instructions and scoring criteria.

Download the 2019 Leapfrog Hospital Survey Scoring Algorithm on the Scoring and Results webpage.

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

Specifications: See ***CPOE Measure Specifications*** in the Reference Information on page 37.

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.

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 which do NOT have a functioning CPOE system. (*See CPOE Measure Specifications*)	_____ *Format: Whole numbers only*
4) The number of **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*

*If "yes" to question #2 and you are an **adult or general hospital**, you will be able to access the **CPOE Evaluation Tool** from the Hospital Survey Dashboard after submitting Section 1: Basic Hospital Information and Section 2: Medication Safety – CPOE. Question #5 does not apply to pediatric hospitals.*

5) What was your hospital's score when it tested its CPOE system using the Leapfrog CPOE Evaluation Tool? ***Adult Inpatient Test must be completed between April 1 – November 30, 2019.***	*No response required here. Determined automatically based on **separately completing** a test using the Leapfrog CPOE Evaluation Tool.*

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 with Leapfrog 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. This information does not infringe any third party's intellectual property rights. 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 with Leapfrog reserve the right to omit or disclaim information that is not current, accurate or truthful.

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

Section 2: 2019 Medication Safety - Computerized Physician Order Entry Reference Information

The Pediatric Inpatient CPOE Evaluation Tool is not available. Pediatric Hospitals should complete questions #1-4 only.

What's New in the 2019 Survey

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

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

Additional refinements have been made to the measure specifications to further clarify which orders to include when responding to questions #3 and #4. Hospitals should review the 2019 CPOE Measure Specifications carefully.

The CPOE Evaluation Tool has also been updated to incorporate feedback received from hospitals in 2018. Please refer to the CPOE Evaluation Tool Instructions for more information.

No updates have been made to the CPOE Scoring Algorithm.

Change Summary since Release

None. If substantive changes are made to this section of the Survey after release on April 1, 2019 they will be documented in this Change Summary section.

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 which 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.
- 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 and standard medication order sets 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:

- Medications ordered verbally or via paper.
- Medication orders entered into the CPOE system by a non-licensed prescriber, such as a nurse or pharmacist, that were NOT part of a per protocol or standard order set.
- 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.

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-month reporting period for which data is available. For example, hospitals submitting Section 2 in April, should use data from December 2018, January 2019, and February 2019 or January, February, and March 2019. 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. Hospitals should take the CPOE Evaluation Tool using the new CPOE system, but are advised to ensure that licensed prescribers are fully trained on the new system. All hospitals are urged to take a Sample Test before attempting the Adult Inpatient Test.

3. **Can we report the numerator and denominator from our Stage 2 Meaningful Use Reports?**
   No. Hospitals should refer to the measure specifications on page 37.

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

   Hospitals that submit Section 2 via the Online Hospital Survey Tool, but do not submit an Adult Inpatient Test via the CPOE Evaluation Tool, are scored and publicly reported as "Willing to Report" on the CPOE measure.

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

6. **If we update our responses to questions #3 and #4, do we need to re-take the CPOE Test?**
   No. Hospitals are not required to retake the CPOE Evaluation Tool if making updates to Section 2 Medication Safety - CPOE. Retaking a test is only recommended if a hospital has made changes to their CPOE system and would like to try to improve their score.

7. **How do hospitals access the CPOE Evaluation Tool?**
   Log into the Online Hospital Survey Tool with your 16-digit security code. Submit Section 1 Basic Hospital Information and Section 2 Medication Safety - CPOE. The CPOE Tool button will appear on the Hospital Survey Dashboard. Once the Adult Inpatient Test is complete, hospitals will need to log back in to the Survey and submit any uncompleted sections of the Survey or they will be scored and publicly reported as "Declined to Respond" for those sections. Download a link to the Quick Start Guide.

Additional information including instructions and FAQs specific to the CPOE Evaluation Tool is available on the Survey and CPOE Materials webpage.

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SECTION 3: INPATIENT SURGERY

This section includes questions and reference information for Section 3: 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.

Section 3: 2019 Inpatient Surgery

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

This section is not applicable to Pediatric hospitals.

Section 3 includes questions about your hospital and surgeon volume for eight high-risk procedures and surgical appropriateness criteria to prevent unnecessary procedures.

Each hospital fully meeting this 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 2019 Leapfrog Hospital Survey Scoring Algorithm on the Scoring and Results webpage.

3A: Hospital and Surgeon Volume

Specifications: See ***Hospital and Surgeon Volume*** in the Inpatient Surgery Reference Information on pages 48-75.

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)

- Surveys submitted prior to September 1: 01/01/2018 - 12/31/2018 (12-month count) or 01/01/2017 – 12/31/2018 (24-month annual average)
- Surveys (re)submitted on or after September 1: 07/01/2018 - 06/30/2019 (12-month count) or 07/01/2017 – 06/30/2019 (24-month annual average)

1) 12-month or 24-month reporting time period used:	☐ 01/01/2018 – 12/31/2018 (12-month count) ☐ 01/01/2017 – 12/31/2018 (24-month annual average) ☐ 07/01/2018 – 06/30/2019 (12-month count) ☐ 07/01/2017 – 06/30/2019 (24-month annual average)
2) Check all procedures that your hospital performs electively as defined in the 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 ☐ None of the above

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

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

Procedure	*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	

4) 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*

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.

1) Does your hospital have appropriateness criteria[17] for any of the following procedures: *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 ☐ 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 ☐ 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 ☐ 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 any of the following procedures:	☐ Carotid endarterectomy ☐ Mitral valve repair and replacement ☐ Open aortic procedures ☐ Bariatric surgery for weight loss ☐ 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 any of the following procedures:	☐ Carotid endarterectomy ☐ Mitral valve repair and replacement ☐ Open aortic procedures ☐ Bariatric surgery for weight loss ☐ 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 any of the following procedures:	☐ Lung resection for cancer ☐ Esophageal resection for cancer ☐ Pancreatic resection for cancer ☐ Rectal cancer surgery ☐ None of the above

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 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 with Leapfrog 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. This information does not infringe any third party's intellectual property rights. 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 with Leapfrog reserve the right to omit or disclaim information that is not current, accurate or truthful.

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

Section 3: 2019 Inpatient Surgery Reference Information

This section is not applicable to Pediatric hospitals.

What's New in the 2019 Survey

The instructions, measure specifications, and FAQs for Section 3 Inpatient Surgery have been significantly updated in 2019. Hospitals should review the updated information before responding to the questions in this section of the Survey.

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

The measure specifications for Section 3A Hospital and Surgeon Volume have been updated to include 'carcinoma in situ' diagnosis codes that should be used in identifying hospital volume for the following procedures: lung resection for cancer, esophageal resection for cancer, and rectal cancer surgery. Please use the updated codes provided in the *Hospital and Surgeon Volume Measure Specifications*. These codes are also available in an Excel Document under "Other Supporting Materials" for Section 3 on the Survey and CPOE Materials webpage.

As is the case for all procedures, the diagnosis codes should be ignored when determining surgeon volume for the purposes of surgeon privileging. Hospitals should carefully review the updated measure specifications and FAQs before responding to the questions in Section 3 Inpatient Surgery.

In Section 3B Surgical Appropriateness, Leapfrog will continue to ask hospitals to report on the steps they have taken to ensure surgical appropriateness for the following four high-risk procedures: carotid endarterectomy, mitral valve repair and replacement, open aortic procedures, and bariatric surgery for weight loss. However, for the four cancer surgeries, lung resection for cancer, pancreatic resection for cancer, esophageal resection for cancer, and rectal cancer surgery, Leapfrog is asking a single question regarding national accreditation status from the American College of Surgeons (applies to rectal cancer surgery only) OR regarding whether or not the hospital has a multidisciplinary tumor board that prospectively reviews cancer cases to ensure surgical appropriateness.

Change Summary since Release

None. If substantive changes are made to this section of the Survey after release on April 1, 2019 they will be documented in this Change Summary section.

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 eight 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**. These 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.

Source: The Leapfrog Group

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

- Surveys submitted prior to September 1: 01/01/2018 - 12/31/2018 (12-month count) or 01/01/2017 – 12/31/2018 (24-month annual average)
- Surveys (re)submitted on or after September 1: 07/01/2018 - 06/30/2019 (12-month count) or 07/01/2017 – 06/30/2019 (24-month annual average)

Question 2: Check all procedures that your hospital performs as defined in the 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

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.

Question 3: 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

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 BOTH procedure and diagnosis codes, both sets of codes must be used for counting patient discharges (e.g., at least one procedure code AND one diagnosis code must be present).
  - 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 to all eight procedures. Only include discharges for adult patients (ages 18 years and older).

Question 4: 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
Esophageal resection for cancer: 7
Pancreatic resection for cancer: 10
Rectal cancer surgery: 6
Bariatric surgery for weight loss: 20

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 or not surgeons have met or exceeded Leapfrog's minimum surgeon volume standards for the purposes of privileging, only refer to the ICD-10 procedure codes.

See FAQs for additional information about responding to 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

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

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
02RG47Z	Replacement of Mitral Valve with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
02RG48Z	Replacement of Mitral Valve with Zooplastic Tissue, Percutaneous Endoscopic Approach
02RG4JZ	Replacement of Mitral Valve with Synthetic Substitute, Percutaneous Endoscopic Approach
02RG4KZ	Replacement of Mitral Valve with Nonautologous Tissue Substitute, Percutaneous Endoscopic 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

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

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

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

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

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

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

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

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

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
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

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

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

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

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

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

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

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

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

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

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
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

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

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. 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. 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

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

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 48-75. 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 of 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.

Hospital Volume

4. **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.

5. **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. volume of year one plus volume of year 2 divided by two equals the 24-month annual average).

6. **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.

7. **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.

Surgeon Volume

8. **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.

9. **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.

10. **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.

11. **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.

12. **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

13. **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.

14. **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.

15. **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.

16. **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 2019, 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.

Section 4: 2018 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 section. The section also includes questions about high-risk deliveries including volume, outcomes, and the administration of antenatal steroids.

Each hospital fully meeting 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 fully meeting the High-Risk Deliveries standard:

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 2019 Leapfrog Hospital Survey Scoring Algorithm on the Scoring and Results webpage.

4A Maternity Care Volume

Specifications: See ***Maternity Care Volume*** in the Maternity Care Reference Information on page 94.

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
- Surveys submitted prior to September 1: 01/01/2018 - 12/31/2018
- Surveys (re)submitted on or after September 1: 07/01/2018 - 06/30/2019

1) 12-month reporting time period used:	☐ 01/01/2018 - 12/31/2018 ☐ 07/01/2018 - 06/30/2019
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 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."*	_____

4B: Elective Deliveries

Specifications: See ***Elective Deliveries*** in the Maternity Care Reference Information on pages 95-98.

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)

- Surveys submitted prior to September 1: 01/01/2018 - 12/31/2018
- Surveys (re)submitted on or after September 1: 07/01/2018 - 06/30/2019

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:	☐ 01/01/2018 - 12/31/2018 ☐ 07/01/2018 - 06/30/2019
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 99-102.

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)
- Surveys submitted prior to September 1: 01/01/2018 - 12/31/2018
- Surveys (re)submitted on or after September 1: 07/01/2018 - 06/30/2019

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:	☐ 01/01/2018 - 12/31/2018 ☐ 07/01/2018 - 06/30/2019
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*

4D: Episiotomy

Specifications: See ***Episiotomy*** in the Maternity Care Reference Information on page 103.

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
- Surveys submitted prior to September 1: 01/01/2018 - 12/31/2018
- Surveys (re)submitted on or after September 1: 07/01/2018 - 06/30/2019

1) 12-month reporting time period used:	☐ 01/01/2018 - 12/31/2018 ☐ 07/01/2018 - 06/30/2019
2) Total number of vaginal deliveries, with **Excluded Populations** removed.	_____
3) Total number of mothers indicated in question #2 that had an episiotomy procedure performed.	_____

4E: Process Measures of Quality

Specifications: See ***Maternity Care Process Measure Specifications*** in the Maternity Care Reference Information on pages 104-105.

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)
- Surveys submitted prior to September 1: 01/01/2018 - 12/31/2018
- Surveys (re)submitted on or after September 1: 07/01/2018 - 06/30/2019

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:	☐ 01/01/2018 - 12/31/2018 ☐ 07/01/2018 - 06/30/2019

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. The hospital will be scored as "Declined to Respond."* *If "Yes, but fewer than 10 cases met the inclusion criteria for the denominator," skip questions #3-5 and continue on to question #6. 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*
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 Section	
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 section clinical guideline? *If "no" to question #6, skip questions #7-9 and continue on to the next subsection. The hospital will be scored as "Declined to Respond."* *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. 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*

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*

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 106.

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
- Surveys submitted prior to September 1: 01/01/2018 - 12/31/2018
- Surveys (re)submitted on or after September 1: 07/01/2018 - 06/30/2019

4) 12-month reporting time period used:	☐ 01/01/2018 - 12/31/2018 ☐ 07/01/2018 - 06/30/2019
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 107.

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: 2017 VON data
- Surveys (re)submitted on or after September 1: 2018 VON data

6) Does your hospital participate in the Vermont Oxford Network performance reporting system for high-risk deliveries and did your hospital submit data for <u>all</u> such deliveries during the most recent 12-month period for which performance reports have been released?	*Yes* *No*
7) What is the most recent 12-month reporting time period for which VON performance results are available?	_____ *YYYY* *Format: 2017*
8) From the report, what is your hospital's volume?	_____
9) From the same report, what was your hospital's **SMR 95% lower bound**?	_____ *Format: 0.8*
10) From the same report, what was your hospital's observed to expected ratio of morbidity or mortality (**SMR shrunken**)?	_____ *Format: 1.0*

11) From the same report, what was 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 108-109.

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: 2017 VON data
- Surveys (re)submitted on or after September 1: 2018 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:

- Surveys submitted prior to September 1: 01/01/2018 - 12/31/2018
- Surveys (re)submitted on or after September 1: 07/01/2018 - 06/30/2019

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: 2017*
14) If The Joint Commission, 12-month reporting time period used:	☐ 01/01/2018 - 12/31/2018 ☐ 07/01/2018 - 06/30/2019
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*

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 with Leapfrog 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. This information does not infringe any third party's intellectual property rights. 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 with Leapfrog reserve the right to omit or disclaim information that is not current, accurate or truthful.

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

Section 4: 2019 Maternity Care Reference Information

What's New in the 2019 Survey

In 2019, hospitals participating in the California Maternal Quality Care Collaborative (CMQCC) Maternal Data Center may use the data provided in 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.

Leapfrog has added a response option to Question #2 in Section 4A Maternity Care Volume so that hospitals can indicate if they delivered newborn babies during the reporting period, but now have a closed labor and delivery unit or had/have a labor and delivery unit that was not open for the entire reporting period. Hospitals meeting this criteria will be scored as "Does Not Apply" for all maternity care measures.

Due to CMS' October 2018 update to the national MS-DRG codes, Leapfrog has included additional MS-DRG codes that should be used in identifying vaginal deliveries for the purposes of reporting on the episiotomy denominator (question #2). The measure steward has included these MS-DRG codes in their updated specifications for this NQF-endorsed measure as well. Leapfrog has also provided APR-DRG codes that can be used in addition to the MS-DRG codes for identifying vaginal deliveries for those facilities that use APR-DRG coding instead of or in addition to MS-DRG coding. Please review the *Episiotomy 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 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).

Change Summary since Release

April 2, 2019 – Added 6 additional MS-DRG codes to the *Appropriate DVT Prophylaxis in Women Undergoing Cesarean Delivery Measure Specifications* for the purposes of identifying cesarean deliveries for inclusion in the denominator. These codes have been added to align with CMS' October 2018 update to the national MS-DRG codes. See page 105 in the hard copy of the Survey for the additional codes.

April 17, 2019 – Updated the measure specifications for the *High-Risk Deliveries Volume Standard* to exclude newborns admitted to the neonatal ICU (NICU) weighing 1500 grams or more. This exclusion criterion was added to ensure alignment between Leapfrog's definition for very-low birth-weight babies and the cases that hospitals are identifying using the ICD-10-CM codes in the instructions for volume reporting. Currently, two of the ICD-10-CM codes do not include birth weight in their definitions: P05.2 newborn affected by fetal malnutrition and P05.9 newborn affected by slow intrauterine growth. See page 106 in the hard copy of the Survey for details.

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 • Surveys submitted prior to September 1: 01/01/2018 - 12/31/2018 • Surveys (re)submitted on or after September 1: 07/01/2018 - 06/30/2019
Question 3: The number of live births 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
- v2017B2: Discharges between 01/01/2018 – 06/30/2018
- v2018A1: Discharges between 07/01/2018 – 12/31/2018
- v2018B1: Discharges between 01/01/2019 – 06/30/2019

Reporting Time Period: 12 months
- Surveys submitted prior to September 1: 01/01/2018 - 12/31/2018
- Surveys (re)submitted on or after September 1: 07/01/2018 - 06/30/2019

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 to retrospectively collect and report data for this measure. The PC-01 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:
- v2017B2: Discharges between 01/01/2018 – 06/30/2018
- v2018A1: Discharges between 07/01/2018 – 12/31/2018
- v2018B1: Discharges between 01/01/2019 – 06/30/2019

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 TJC Measure Algorithm flow chart at the bottom of each set of specifications linked above, for an example of how to identify cases.

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 60 cases.
Step #1:
- Review your hospital's first delivery as of **April 15, 2018** (or **October 15, 2018** if (re)submitting a Survey on or after September 1, 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.

<table>
<tr><td colspan="2">

- Continue through cases in sequential order until **a sample of at least 30 cases** is reached, or all cases in the first 6-month reporting period of **01/01/2018 – 06/30/2018** (or **07/01/2018 – 12/31/2018** if (re)submitting a Survey on or after September 1, 2019) are reviewed, whichever comes first.

Step #2:

- After sampling the first 30 cases, review your hospital's first delivery as of **October 15, 2018** (or **April 15, 2019** if (re)submitting a Survey on or after September 1, 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 in the second 6-month reporting period of **07/01/2018 – 12/31/2018** (or **01/01/2019 – 06/30/2019** if (re)submitting a Survey on or after September 1, 2019) are reviewed, whichever comes first.

When sampling, use the measure specifications based on the correct discharge date, which are outlined below:

- v2017B2: Discharges between 01/01/2018 – 06/30/2018 (sample cases as of April 15, 2018)
- v2018A1: Discharges between 07/01/2018 – 12/31/2018 (sample cases as of October 15, 2018)
- v2018B1: Discharges between 01/01/2019 – 06/30/2019 (sample cases as of April 15, 2019)

</td></tr>
<tr><td rowspan="2">Discharges between 01/01/2018 – 06/30/2018
(v2017B2)
Review deliveries starting on April 15, 2018</td><td>

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/TJC2017B2/MIF0166.html.

If fewer than 10 cases during the reporting period, skip the next question.

</td></tr>
<tr><td>

Question 3 (numerator): Patients with elective deliveries included in the denominator.

</td></tr>
</table>

	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/TJC2017B2/MIF0166.html**.**

Discharges between 07/01/2018 – 12/31/2018 (v2018A1) *Review deliveries starting on* ***October 15, 2018***	**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/TJC2018A1/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/TJC2018A1/MIF0166.html.
Discharges between 01/01/2019 – 06/30/2019 (v2018B1) *Review deliveries starting on* ***April 15, 2019***	**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/TJC2018B1/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/TJC2018B1/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
- v2017B2: Discharges between 01/01/2018 – 06/30/2018
- v2018A1: Discharges between 07/01/2018 – 12/31/2018
- v2018B1: Discharges between 01/01/2019 – 06/30/2019

Reporting Time Period: 12 months
- Surveys submitted prior to September 1: 01/01/2018 – 12/31/2018
- Surveys (re)submitted on or after September 1: 07/01/2018 – 06/30/2019

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:
- v2017B2: Discharges between 01/01/2018 – 06/30/2018
- v2018A1: Discharges between 07/01/2018 – 12/31/2018
- v2018B1: Discharges between 01/01/2019 – 06/30/2019

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 TJC Measure Algorithm flow chart at the bottom of each set of specifications linked above, for an example of how to identify cases.

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 60 cases.

Step #1:
- Review your hospital's first delivery as of **April 15, 2018** (or **October 15, 2018** if (re)submitting a Survey on or after September 1, 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 in the first 6-month reporting period of **01/01/2018 – 06/30/2018** (or **07/01/2018 – 12/31/2018** if (re)submitting a Survey on or after September 1, 2019) are reviewed, whichever comes first.

Step #2:

- After sampling the first 30 cases, review your hospital's first delivery as of **October 15, 2018** (or **April 15, 2019** if (re)submitting a Survey on or after September 1, 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 in the second 6-month reporting period of **07/01/2018 – 12/31/2018** (or **01/01/2019 – 06/30/2019** if (re)submitting a Survey on or after September 1, 2019) are reviewed, whichever comes first.

When sampling, use the measure specifications based on the correct discharge date, which are outlined below:

- v2017B2: Discharges between 01/01/2018 – 06/30/2018 (sample cases as of April 15, 2018)
- v2018A1: Discharges between 07/01/2018 – 12/31/2018 (sample cases as of October 15, 2018)
- v2018B1: Discharges between 01/01/2019 – 06/30/2019 (sample cases as of April 15, 2019)

Discharges between 01/01/2018 – 06/30/2018 (v2017B2) *Review deliveries starting on **April 15, 2018***	**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/TJC2017B2/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/TJC2017B2/MIF0167.html
Discharges between 07/01/2018 – 12/31/2018 (v2018A1) *Review deliveries starting on* ***October 15, 2018***	**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/TJC2018A1/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/TJC2018A1/MIF0167.html

<table>
<tr>
<td rowspan="2">Discharges between 01/01/2019– 06/30/2019
(v2018B1)
Review deliveries starting on April 15, 2019</td>
<td>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/TJC2018B1/MIF0167.html.

If fewer than 10 cases during the reporting period, skip the next question.</td>
</tr>
<tr>
<td>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/TJC2018B1/MIF0167.html</td>
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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

- Surveys submitted prior to September 1: 01/01/2018 - 12/31/2018
- Surveys (re)submitted on or after September 1: 07/01/2018 - 06/30/2019

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:

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

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

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

- Surveys submitted prior to September 1: 01/01/2018 - 12/31/2018
- Surveys (re)submitted on or after September 1: 07/01/2018 - 06/30/2019

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 60 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 60; just measure and report on ALL eligible cases that you have in that reporting time period.

If you have more than 60 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 60 of them for the denominator of each 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 guideline.

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.

Appropriate DVT Prophylaxis in Women Undergoing Cesarean Delivery

Source: National Quality Forum #0473

Reporting Time Period: 12 months

- Surveys submitted prior to September 1: 01/01/2018 - 12/31/2018
- Surveys (re)submitted on or after September 1: 07/01/2018 - 06/30/2019

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 60 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 60; just measure and report on ALL eligible cases that you have in that reporting time period.

If you have more than 60 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 60 of them for the denominator of each 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 guideline.

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:

- 765: Cesarean section with CC/MCC
- 766: Cesarean section without CC/MCC
- 783: Cesarean section with sterilization with MCC
- 784: Cesarean section with sterilization with CC
- 785: Cesarean section with sterilization without CC/MCC
- 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.

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.

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.

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 2018A1)

Reporting Time Period: 12 months

- Surveys submitted prior to September 1: 01/01/2018 - 12/31/2018
- Surveys (re)submitted on or after September 1: 07/01/2018 - 06/30/2019

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 2018A1) 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/TJC2018A1/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 60 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 60; just measure and report on ALL eligible cases that you have in that reporting time period.

If you have more than 60 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 60 of them for the denominator of each 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 guideline.

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/TJC2018A1/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/TJC2018A1/MIF0168.html.

Maternity Care Frequently Asked Questions (FAQs)

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

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

3. **Should hospitals use delivery date or discharge date when including births/cases for the measures reported in Section 4 Maternity Care?**
   The discharge date should be used to determine whether or not a case falls within the reporting period specified.

4. **Why are hospitals being asked to use multiple TJC measure specifications when collecting data retrospectively for PC-01 and PC-02? Why is the sample size for PC-01 and PC-02 now 60 cases instead of 100 cases?**
   For hospitals that do not submit data to The Joint Commission (TJC) and need to retrospectively collect data using the TJC specifications provided, two of the three TJC measures included in Section 4 (Elective Delivery (PC-01) and 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 sample size to 60 cases starting in 2018 to reduce some of the reporting burden. The sampling for these measures includes two steps as hospitals will need to sample 30 cases from two separate sets of measure specifications to obtain a total sample size of 60 cases.

5. **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?**
   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 as long as the serum or transcutaneous screen is conducted prior to discharge and risk is managed appropriately.

6. **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 60 cases for those facilities that opt to report on a sample instead of full case reporting. You can find those instructions on page 104 of the hard copy of the Survey.

7. **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.

8. **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.

Section 5: 2019 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.

A hospital fully meeting this standard 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 a 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 2019 Leapfrog Hospital Survey Scoring Algorithm on the Scoring and Results webpage.

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 teleintensivists per Leapfrog's specifications (More Information[27]). However, at this time hospitals cannot fully meet the standard through the sole use of teleintensivists.

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.

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*
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 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 "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 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 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*
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 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 rounds on all critical care patients 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 with Leapfrog 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. This information does not infringe any third party's intellectual property rights. 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 with Leapfrog reserve the right to omit or disclaim information that is not current, accurate or truthful.

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

Section 5: 2019 ICU Physician Staffing (IPS) Reference Information

What's New in the 2019 Survey

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

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

1. Be a graduate with a training license from an ACGME accredited training program or have an active state license to practice as a physician, nurse practitioner, or physician assistant in the state in which the patient is located.
2. Have privileges to provide medical services in the unit (i.e. ICU) and for patients of the age range approved in advance by the hospital's governing body (e.g., medical staff committee, chief medical officer, chief nursing officer, etc.), as specified by the institution's internal policies (bylaws).
3. Carry out the intensivist's orders and instructions, under the intensivist's guidance, when they are serving in a responder role.

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

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

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

Change Summary since Release

None. If substantive changes are made to this section of the Survey after release on April 1, 2019, they will be documented in this Change Summary section.

IPS 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.

Telemedicine Questions

5. **Can you clarify what you mean by combined presence of tele-intensivists and on-site intensivist, 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.

6. **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?**
   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) on-site during that time period to carry out the teleintensivist's orders and can reach the ICU patient within 5 minutes, 95% of the time.

Certification Questions

7. **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.

8. **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.

9. **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.

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

Response Time Questions

11. **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.

12. **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.

13. **If my hospital has little to no 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.

14. **Regarding the use of "effectors," our hospital has a nurse practitioner (NP) or physician assistant (PA) 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 NP/PA 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, as long as the NP/PA meets all requirements outlined in endnote #31.

15. **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.

16. **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: NQF SAFE PRACTICES

This section includes questions and reference information for Section 6: NQF Safe 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.

Section 6: 2019 NQF Safe Practices

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

Section 6 includes questions about your hospital's adherence to five National Quality Forum-endorsed Safe Practices.

It also contains questions on Leapfrog's new Hand Hygiene Practices, which will not be scored or publicly reported in 2019.

Download the 2019 Leapfrog Hospital Survey Scoring Algorithm on the Scoring and Results webpage.

Instructions for Reporting on Section 6: NQF Safe Practices

- ☐ **Prepare**
  - ☐ Download and review a copy of the National Quality Forum's *Safe Practices for Better Healthcare – 2010 Update* report (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 November 30). In addition, the documentation can be helpful if your hospital is planning to update and resubmit this section of the Survey prior to November 30.

- ☐ **Assess:** When all of the supporting documents are assembled, it is recommended that hospitals review their final responses to Section 6 with the CEO and/or responsible leadership. Hospitals should update their answers online as they adopt additional practices throughout the Survey Cycle (April 1 to November 30).

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

Section	*NQF Safe Practice*	*Results Shown On Leapfrog's Consumer Site As:*	*Weighting (pts)*
6A	Culture of Safety Leadership Structures and Systems	*Effective leadership to prevent errors*	120
6B	Culture Measurement, Feedback, and Intervention	*Staff work together to prevent errors*	120
6C	Risks and Hazards	*Track and reduce risks to patients*	100
6D	Nursing Workforce	*Enough qualified nurses*	100
6E	Hand Hygiene	*Handwashing*	60
	GRAND TOTAL		500

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** even if no items are checked, to mark the Safe Practice as complete. This checkbox must be checked for all five Safe Practices in order to affirm Section 6 in the Online Hospital Survey Tool.

Please note that the new Section 6F Hand Hygiene Practices will not be scored or publicly reported in 2019. Hospitals should continue to report on the existing NQF Hand Hygiene Safe Practice 19 in Subsection 6E, which will continue to be scored, publicly reported, and included in the Fall 2019 and Spring 2020 Leapfrog Hospital Safety Grades.

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 144-154, not to endnotes. These hyperlinks are not included in the online version of the Survey.

Check all boxes that apply.

1.1 AWARENESS	**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 for the past 12 months 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 family 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 to the community in the last 12 months of ongoing efforts to improve safety and quality in the organization and the results of these efforts. (p.75) d ☐ all staff and independent practitioners were made aware in the past 12 months of ongoing efforts to reduce risks and hazards and to improve patient safety and quality in the organization. (p.75)
1.2 ACCOUNTABILITY	**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 at least the past 12 months 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 **all** three of the following: • root cause analyses (as defined by *Safe Practice #4, Risks and Hazards*); • 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)

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1.3 ABILITY	**In regard to implementation of the patient safety program, the board (governance) and senior administrative leadership have provided resources to cover the implementation during the last 12 months, and:** a ☐ dedicated patient safety program budgets support the program, staffing, and technology investment. (p.77)
1.4 ACTION	**Structures and systems for assuring that senior administrative leadership is taking direct and specific actions have been in place for the past 12 months, 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 check box 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.*

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 144-154, not to endnotes. These hyperlinks are not included in the online version of the Survey.

Check all boxes that apply.

2.1 AWARENESS	**In regard to Culture Measurement, our organization has done the following within the last 24 months:** 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 includes 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	**In regard to accountability for improvements in the measurement of the culture of safety, our organization has done the following within the last 24 months:** a ☐ involved senior administrative leadership in the identification and selection of sampled units; and, in the selection of an appropriate tool for measuring the culture of safety. (p.88) b ☐ shared the results of the culture measurement survey with the board (governance) and senior administrative leadership in a formal report and discussion. (p.88) c ☐ 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	**In regard to the culture of safety measurement, the organization has done the following (or has had the following in place) within the last 12 months:** 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.
2.4 ACTION	**In regard to culture measurement, feedback, and interventions, our organization has done the following or has had the following in place within the last 12 months:** 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 check box is in the Online 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.*

6C: Practice #4 - Risks and Hazards

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 144-154, not to endnotes. These hyperlinks are not included in the online version of the Survey.

Check all boxes that apply.

4.1 AWARENESS	**Within the last 12 months our organization has done the following:** a ☐ assessed risks and hazards to patients by reviewing multiple retrospective sources, such as: • serious reportable events; • sentinel event reporting; • adverse event reporting; • root cause analyses; • independent comparative mortality and morbidity information with the hospital's performance; • patient safety indicators; • trigger tools; • hospital accreditation surveys; • risk management and filed litigation; • anonymous internal complaints, including complaints of abusive and disruptive caregiver behavior; and, • complaints filed with state/federal authorities; and based on those findings, documented recommendations for improvement. (p.105) b ☐ assessed risks and hazards to patients using prospective identification methods: Failure Modes and Effects Analysis (FMEA) and/or Probabilistic Risk Assessment, and has documented recommendations for improvement. (p.106) c ☐ combined results of (a) and (b) above to develop their risk profile, and used that profile to identify priorities and develop risk mitigation plans. (p.107) d ☐ shared results from the two assessments, noted in (a), (b), and the risk mitigation plan noted in (c) above widely across the organization, from the board (governance) to frontline caregivers. (p.107) ***This item may not be checked unless all items 4.1a, b, c are checked.***

4.2 ACCOUNTABILITY	**Leadership is accountable for identification of risks and hazards to patients, and mitigation efforts in the past year, as evidenced by:** a ☐ approval of an action plan by the CEO and the board (governance) for undertaking the assessments of risk, hazards and for the mitigation of risk for patients. (p.106) b ☐ incorporation of the identification and mitigation of risks to patients into performance reviews for senior administrative leadership and the Patient Safety Officer as identified in the approved action plan **OR** outlined financial incentives for senior administrative leadership and the Patient Safety Officer for identifying and mitigating risks to patients as identified in the approved action plan. ***This item may not be checked unless 4.2a is checked.***
4.3 ABILITY	**In regard to developing the ability to appropriately assess risk and hazards to patients, the organization has done the following or had in place during the last 12 months:** a ☐ resourced patient safety program budgets sufficiently to support ongoing risk and hazard assessments and programs for reduction of risk. b ☐ provided managers at all levels with training on the prospective identification tools for monitoring risk in their areas. Training was documented. (pp.107-108)
4.4 ACTION	**Structures and systems for assuring that direct and specific actions have taken place to mitigate risks to patients for the past 12 months, include:** a ☐ provided risk identification training to midlevel management, service line management, and frontline caregivers in high risk patient safety units such as: emergency department, labor and delivery, ICUs, and operating rooms. b ☐ established or already had in place a structure, developed by the CEO and senior administrative leadership, for gathering all information related to risks, hazards and mitigation efforts within the organization with input from all levels of staff within the organization and from patients and their families. (p.110) c ☐ evidence of high-performance or actions taken for the following four patient safety risk areas: falls, malnutrition, aspiration, and workforce fatigue. (p.108)
4.5	☐ Review of this Safe Practice is complete. *This check box 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: 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 144-154, 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	**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 within the last 12 months:** 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)

9.2 ACCOUNTABILITY	**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 within the last 12 months:** 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	**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 within the last 12 months:** 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	**In regard to ensuring adequate and competent nursing staff service and nursing leadership at all levels, our organization has done the following within the last 12 months or has had the following in place during the last 12 months and updates are made regularly:** 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 check box 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.*

6E: Practice #19 - Hand Hygiene

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 144-154, not to endnotes. These hyperlinks are not included in the online version of the Survey.

Check all boxes that apply.

19.1 AWARENESS	**In regard to preventing hospital-acquired infections related to inadequate hand hygiene, our organization has done the following or has had the following in place within the last 12 months:** a ☐ conducted a hospital-wide evaluation of the potential impact of improvements in hand hygiene on the frequency of hospital-acquired infections in our patient population. b ☐ submitted a report to the board (governance) with recommendations for measurable improvement targets.
19.2 ACCOUNTABILITY	**In regard to preventing hospital-acquired infections related to inadequate hand hygiene, our organization has done the following or has had the following in place within the last 12 months:** a ☐ held nursing leadership and physician leadership directly accountable for this patient safety area through performance reviews or compensation. b ☐ held senior administrative leadership directly accountable for performance in this patient safety area through performance reviews or compensation. c ☐ held the Patient Safety Officer directly accountable for improvements in performance through performance reviews or compensation. d ☐ reported to the board (governance) the results of the measurable improvement targets.

19.3 ABILITY	**In regard to preventing hospital-acquired infections related to inadequate hand hygiene, our organization has done the following or has had the following in place within the last 12 months:** a ☐ conducted staff education/knowledge transfer and skill development programs, with attendance documented. (p.251) b ☐ documented expenditures on staff education related to this Safe Practice in the previous year.
19.4 ACTION	**In regard to preventing hospital-acquired infections related to inadequate hand hygiene, our organization has done the following within the last 12 months or has had the following in place during the last 12 months and updates are made regularly:** a ☐ developed and implemented explicit policies and procedures across the entire organization to prevent hospital-acquired infections due to inadequate hand hygiene including CDC Guidelines with category IA, IB, or IC evidence. (p.250) b ☐ implemented a formal performance improvement program addressing hospital-acquired infections focused on hand hygiene compliance, with regular performance measurement and tracking improvement (pp.250-251) **OR** monitored a previously implemented hospital-wide performance improvement program that measures, and demonstrates full achievement of, the impact of this specific Safe Practice. (pp.250-251)
19.5	☐ Review of this Safe Practice is complete. *This check box 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.*

6F: Hand Hygiene Practices

Important Notes:

Note 1: This section is **optional** in 2019. Responses will not be scored or publicly reported.

Note 2: Hyperlinks, not followed by a superscript, throughout this subsection refer to the Safe Practices FAQs on pages 144-154. These hyperlinks are not included in the online version of the Survey.

Note 3: The framework and questions in Section 6F are modeled after the World Health Organization's Hand Hygiene Self-Assessment Framework.

Note 4: Hospital responses should reflect patient care units only, including all inpatient units, outpatient units (pre-operative, operative, procedural, and post-operative), and emergency department units.

Reporting Time Period: Answer questions #1-26 based on the current status of the facility at the time you submit this section of the Survey, unless otherwise noted.

Training and Education

1) Does your hospital use a professional with appropriate training and skills[33] to serve as its trainer for hand hygiene educational programs?	*Yes* *No*
2) How frequently do individuals who touch patients or who touch items that will be used by patients receive training regarding hand hygiene in your hospital? *Select all that apply.* *If "never," skip questions #3-5 and continue on to question #6.*	☐ *Never* ☐ *At the time of hire* ☐ *Regular training, at least annually* ☐ *Regular training, but less frequently than annually* ☐ *None of the above*
3) Is your hospital able to provide documentation that confirms that **all** individuals who touch patients or who touch items that will be used by patients complete the hand hygiene training indicated in question #2 above? .	*Yes* *No*
4) Does each individual who touches patients or who touches items that will be used by patients need to **physically demonstrate** proper hand hygiene with soap and water and alcohol-based hand sanitizer in order to pass their initial hand hygiene training?	*Yes* *No*

5)	Which of the following topics are included in your hospital's hand hygiene training? *Do not leave any questions blank.*	
a)	Evidence linking hand hygiene and infection prevention	*Yes* *No*
b)	When individuals who touch patients or who touch items that will be used by patients should perform hand hygiene (e.g., WHO's 5 Moments for Hand Hygiene, CDC's Guideline for Hand Hygiene)	*Yes* *No*
c)	How individuals who touch patients or who touch items that will be used by patients should clean their hands with both alcohol-based hand sanitizer and soap and water as to	*Yes* *No*

	ensure they cover all surfaces of hands and fingers, including thumbs and fingernails	
d)	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*
e)	The minimum time that should be spent performing hand hygiene with soap and water and alcohol-based hand sanitizer	*Yes* *No*
f)	How hand hygiene compliance is monitored	*Yes* *No*

Infrastructure for Supporting Hand Hygiene

6) Does your hospital have a process in place to ensure that **all** of the following are done, as necessary, and quarterly audits are conducted 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 hospital)	*Yes* *No*
7) What percentage of the rooms or bed spaces in your patient care units have **both**: • one alcohol-based hand sanitizer dispenser per patient; **and** • an alcohol-based hand sanitizer dispenser accessible at their entrance?	*None (0%)* *Some (1-50%)* *Most (51-99%)* *All (100%)*
8) Does your hospital conduct audits of the volume of alcohol-based hand sanitizer[34] that is delivered with each activation of a wall-mounted dispenser (manual and automated) at **all** of the following times: • upon installation; • whenever the brand of product changes; and • annually throughout the facility? *If "no" or "does not apply, wall-mounted dispensers are not used," skip question #9 and continue on to question #10.*	*Yes* *No* *Does not apply, wall-mounted dispensers are not used*
9) Do all of the dispensers deliver a volume of alcohol-based hand sanitizer that covers the hands completely and requires 15 or more seconds for hands to dry (ideally 1.0-1.1 mls per dose)?	*Yes* *No*

Monitoring and Feedback

Indirect Monitoring

10) Does your hospital use indirect monitoring methods for assessing hand hygiene compliance? *Indirect monitoring methods would include monitoring the hospital-wide consumption of alcohol-based hand sanitizer and soap on a regular basis (at least every 3 months).*	*Yes* *No*

Direct Monitoring – Electronic Compliance Monitoring System

11) Does your hospital use an electronic compliance monitoring system for assessing hand hygiene compliance?	*Yes* *No* *Plan to implement within 3 years*

Electronic compliance monitoring systems would include door minder or activity monitoring systems, systems that include the wearing of electronic badges, and camera-based systems. *If "no" or "plan to implement within 3 years," skip questions #12-13 and continue on to question #14.*	

12) What patient care units in your hospital use an electronic compliance monitoring system? *Select all that apply.*	☐ *Inpatient* ☐ *Outpatient* ☐ *Emergency Department*

13) Which of the following describe your hospital's electronic compliance monitoring system and how it is used? *Do not leave any questions blank.*		
a)	The hospital itself has validated the accuracy of the data collected by the electronic compliance monitoring system	*Yes* *No*
b)	The system can identify both opportunities for hand hygiene and that hand hygiene was performed	*Yes* *No*
c)	The system can determine who practiced hand hygiene and verify when they practiced it, which is dependent upon the hospital measuring compliance with wearing badges/tags; the hospital provides feedback to individuals about their compliance based on this tracking	*Yes* *No*
d)	Unit-level data collected from the system are fed back to staff at least monthly for improvement work	*Yes* *No*
e)	The unit-level data are used for creating unit-level action plans	*Yes* *No*

Direct Monitoring – Direct Observation

14) Does your hospital use direct observation methods for assessing hand hygiene compliance? *This may be in addition to or instead of using an electronic compliance monitoring system.* *If "no" to question #14, skip questions #15-17 and continue on to question #18.*	*Yes* *No*

15) What patient care units in your hospital use direct observation methods?	☐ *Inpatient* ☐ *Outpatient* ☐ *Emergency Department*

16) Which of the following describe your hospital's direct observation methods? *Do not leave any questions blank.*		
a)	Observers immediately intervene prior to any harm occurring to provide non-compliant individuals with immediate feedback	*Yes* *No*
b)	Observations within a unit are conducted weekly or monthly across all shifts and on all days of the week proportional to staff on duty for that shift	*Yes* *No*

c)	The monthly sample size of observations in a unit reflects at least 200 observations or 1.7% of all possible hand hygiene opportunities in that unit, whichever number is less	*Yes* *No*
d)	The observations identify both opportunities for hand hygiene and compliance with those opportunities	*Yes* *No*
e)	The observations determine who practiced hand hygiene, verify when they practiced it, and whether their technique was correct	*Yes* *No*
f)	The observations identify individuals who touch patients or who touch items that will be used by patients that are wearing artificial nails, nail extenders, and jewelry and monitor that they are practicing proper hand hygiene	*Yes* *No*
g)	Unit-level data are fed back to staff at least monthly for improvement work	*Yes* *No*
h)	The unit-level data are used for creating unit-level action plans	*Yes* *No*

17) Is a system in place for both the initial and recurrent training and validation of hand hygiene compliance observers?	*Yes* *No*

Feedback

18) Do "just-in-time" coaches approach non-compliant individuals prior to any harm occurring to provide them with real-time feedback on the missed opportunity and to seek to understand the causes of the failure?	*Yes* *No*
19) Does your hospital have a written protocol in place for communicating with individuals who touch patients or who touch items that will be used by patients when their trend or pattern suggests they have challenges to adhering to the hospital's established hand hygiene practices and working to understand the potential barriers to adhering to these practices?	*Yes* *No*

20) Is regular (at least every 3 months) feedback of hand hygiene compliance data with demonstration of trends over time given to: *Do not leave any questions blank.*		
a)	Hospital leadership, including senior administrative leadership (e.g., CEO, COO, etc.), physician leadership (e.g., CMO), and nursing leadership (e.g., CNO)	*Yes* *No*
b)	Hospital's board (governance)	*Yes* *No*
c)	Medical executive committee	*Yes* *No*
21) If "yes" to question #20a, is hospital leadership held directly accountable for hand hygiene performance through performance reviews or compensation?		*Yes* *No*

Additional Questions (Fact Finding Only)

22) What percentage of the rooms or bed spaces in your patient care units have a sink for hand washing?	*None (0%)* *Some (1-50%)*

	Most (51-99%) *All (100%)*
23) What methods are used by your hospital to educate patients and visitors about how to properly perform hand hygiene? *Select all that apply.*	☐ *Verbal instruction at admission* ☐ *Video review at admission* ☐ *Posters in patient care units* ☐ *Pamphlet provided at admission* ☐ *Other* ☐ *No standard patient education*
24) How are patients and visitors invited to remind individuals who touch patients or who touch items that will be used by patients to perform hand hygiene? *Select all that apply.*	☐ *Posters in patient care units* ☐ *Bedside placards* ☐ *Staff wearing buttons* ☐ *Other* ☐ *Patients are not invited*
25) Which of the following individuals (or their equivalents) have 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)? *Select all that apply.*	☐ *Chief Executive Officer* ☐ *Chief Medical Officer* ☐ *Chief Nursing Officer* ☐ *None of the above*

26) Which initiatives does your hospital use to support continuous improvement? *Do not leave any questions blank.*		
a)	Hand hygiene E-learning tools[35] for individuals who touch patients or who touch items that will be used by patients	*Yes* *No*
b)	A hospital-wide target for hand hygiene compliance is established each year	*Yes* *No*
c)	A regular dedicated group meets at least quarterly to plan and conduct active hand hygiene promotion, e.g., teaching, monitoring hand hygiene performance, organizing new activities, etc., and **not** just infection control	*Yes* *No*
d)	Explicit action plans have been developed to address identified gaps or deficiencies	*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 NQF Safe 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 with Leapfrog 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. This information does not infringe any third party's intellectual property rights. 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 with Leapfrog reserve the right to omit or disclaim information that is not current, accurate or truthful.

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

Section 6: 2019 NQF Safe Practices Reference Information

What's New in the 2019 Survey

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

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

In 2019, Leapfrog has also added a new subsection which focuses on adherence to Hand Hygiene "best practices" identified by a National Hand Hygiene Expert Panel and adopted in part from the World Health Organization's Hand Hygiene Self-Assessment Framework. This new subsection 6F Hand Hygiene Practices will not be scored or publicly reported in 2019.

Hospitals should continue to report on the existing NQF Hand Hygiene Safe Practice 19 in Subsection 6E, which will continue to be scored, publicly reported, and included in the Fall 2019 and Spring 2020 Leapfrog Hospital Safety Grades. Beginning in 2020, Leapfrog anticipates this new Hand Hygiene Practice measure will be scored and publicly reported, and will replace Safe Practice 19 in the Leapfrog Hospital Survey and the Hospital Safety Grade. Leapfrog is seeking feedback on this new subsection and is asking hospitals to submit comments to the Help Desk.

Change Summary since Release

None. If substantive changes are made to this section of the Survey after release on April 1, 2019, they will be documented in this Change Summary section.

Safe 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.

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 to 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 which 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. With the exception of 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.
- **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

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 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 these elements.

8) 1.1b: What is meant by "patients and family of patients are active participants in safety and quality committees?"
To meet the intent of this element, hospitals must have patients and/or family 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 family 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 patient and/or family of patient is invited, but does not regularly attend. It is the responsibility of the hospital to ensure that patients and/or family 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.

Hospitals can document adherence to this element by maintaining committee rosters and meeting minutes with attendance and participation noted. Patients and/or family 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.

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.

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 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.

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 on 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.

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 24-month reporting period is used because these elements are related to conducting the culture of safety survey, which is typically conducted every other year. Within the *Ability and Action* elements a 12-month reporting period is used because these practices are related to follow-up activities that would be completed after the results from the culture of safety survey are available.

20) 2.1a: What are the minimum requirements to qualify as a "culture of safety survey?"
A number of surveys are readily available that specifically address culture, safety climate, and teamwork. These surveys incorporate all of 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.

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) 2.2a: Senior administrative leadership requires that all departments participate in the culture of safety survey. Does this requirement meet the intent of Safe Practice?
If senior administrative leadership requires that ALL departments participate in the survey, then the intent of this element is met.

26) 2.2c: Does performance evaluation criteria for senior administrative leadership need to include the actual targeted response rate to the culture of safety survey?
Yes. The organization's targeted response rate to the culture of safety survey should be included in performance evaluation criteria for senior administrative leadership. Criteria for using the survey results in improvement efforts should also be included to meet the intent of this element.

27) 2.3a: Which employees should be included in the staff education program? Employees in all units or just those in low-performing units?
Staff education needs to include education for all levels of staff, from senior administrative and clinical leadership to frontline caregivers. In addition, because all units have opportunities for improvement, the staff education should include all units, but can focus on deficiencies of a specific unit or department.

28) 2.1e and 2.4b: What is the difference between 2.1e and 2.4b? Both seem to focus on sharing and discussing the Culture of Safety Survey results.
While both elements focus on sharing and discussing Culture of Safety Survey results, these elements focus on different audiences and activities, and the result is that different kinds of feedback are collected. Safe Practice 2.1e requires local leaders (e.g., unit/department manager) to engage their unit/departments in a discussion about the survey results, while Safe Practice 2.4b requires senior administrative leadership to engage each sampled unit in a discussion about the survey results and their concerns.

6C: Safe Practice 4 Identification & Mitigation of Risks and Hazards

29) 4.1a: What are "trigger tools?"
As described in the NQF Safe Practices for Better Healthcare 2010 Update, organizations should employ various tools that assist them in identification of risks and hazards as close to or at the time that they may occur. Some of these may include Trigger Tools that send "flags" or messaging electronically that something could or already has transpired that needs immediate attention, direct observations of potential or real safety-related instances during the walk-rounds process, as well as immediate identification through "stop the line" actions that are further evaluated. To document your hospital's use of trigger tools, you might include the number of charts reviewed using a Trigger Tool performed manually or on an automated basis in a report.

30) 4.1a: Do hospitals need to have a list of recommendations for improvement based on the analysis of multiple retrospective sources?
Yes, after assessing risks and hazards to patient safety by reviewing multiple retrospective sources, hospitals should develop a list of recommendations for improvement. Hospitals may find it helpful to use a severity/frequency/risk assessment grid to identify which risks and hazards the hospital needs to focus on.

31) 4.1b: What is meant by "prospective identification methods?"
Proactive identification of risks and hazards to patient safety involves the use of Failure Modes and Effects Analysis (FMEA) and/or Probabilistic Risk Assessment (PRA). Organizations are most likely most familiar and have some experience with the FMEA process in conjunction with current Joint Commission standards requirements. The NQF Safe Practices for Better Healthcare 2010 Update

includes several references that further illustrate how to employ use of these tools as a means to systematically identify possible failure areas before these events occur.

32) 4.1c: What is an example of how a hospital can create a risk profile based on both retrospective and prospective sources?
An example of how to create a risk profile based on both retrospective and prospective sources is described in the International Journal for Quality in Healthcare: Integration of prospective and retrospective methods for risk analysis in hospitals.

33) 4.1d: What are the minimum requirements for a "risk mitigation plan?"
For each patient safety risk identified from retrospective sources (4.1a) and prospective sources (4.1b), the hospital should:

- Determine the action(s) needed to decrease the effect of and potential occurrence of the event, and
- Determine the response(s) to the event. An example of a risk mitigation plan is described in the article Healthcare Risk Mitigation Plan: Overview, Components & Sample.

34) 4.2b: To meet the intent of this element, do financial incentives need to be outlined for ALL members of the senior administrative leadership team?
Yes, financial incentives for identifying and mitigating risks to patients, as identified in the approved action plan, would need to be for ALL senior administrative leadership and the Patient Safety Officer.

35) 4.3b: What type of training can hospitals provide to managers on "tools for monitoring risk" to meet the intent of this element?
Examples of prospective identification tools for monitoring risk are a FMEA and the Tinetti Balance Assessment. Training on the use of prospective identification tools for monitoring risk may be performed by in-house or external educators.

36) 4.4a: Is it acceptable for a hospital to provide risk identification training on one specific risk?
No. Training would need to be on a broader set of risks. Ideally, hospitals would emphasize training on a generalizable set of skills that could help with the mitigation of all risks.

37) 4.4c: Does the evidence of high-performance or actions taken need to be for all patients, or just specific types of patients?
The focus should be on all patients, not just specific patients.

For example, if all patients are not being screened for the risk of aspiration, then the intent of this safe practice is not being met.

As described on page 108 of the NQF Report Safe Practices for Better Healthcare, "upon admission and regularly thereafter, each patient should be screened for the risk of aspiration. An aspiration risk and prevention plan should be documented in the patient's record."

6D: Safe Practice # 9 Nursing Workforce

38) 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.

39) 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 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.

40) 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 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.

41) 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 they make-up of your hospital's patient population may require more intensive staffing than are prescribed by the state's minimum.

42) 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 their targets. For more information on what data sources might be used to develop a staffing plan, see FAQ #44 below.

43) 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 accuracy of targets established and determine adjustments as needed.

6E: Safe Practice # 19 Hand Hygiene

44) 19.1a: How can our hospital conduct a hospital-wide evaluation for this Safe Practice?
The goal of this element is to understand how hospital hand hygiene compliance tracks with rates of hospital-acquired infections. One way of evaluating this relationship is to create a scatter plot with hand hygiene performance on one axis and HAI rates on the other axis. Best practice would be to create a separate plot for each type of infection and it is likely most meaningful to look at compliance rates and infection rates by unit or unit type (e.g., ICUs, medical wards, etc.).

45) 19.4a: Where can hospitals find the CDC guidelines referenced in this element?
Visit https://www.cdc.gov/handhygiene/providers/guideline.html. As a reminder, hospitals must include guidelines with category IA, IB, IC evidence.

6F: Hygiene Practices (New in 2019)

46) Do the questions in Section 6F Hand Hygiene Practices apply to ancillary units, such as radiology, laboratory, etc.?
Please see Note 4. Hospital responses should reflect patient care units only, including all inpatient units, outpatient units (pre-operative, operative, procedural, and post-operative), and emergency department units. Ancillary units should not be included.

47) How would hospitals demonstrate adherence to the questions in Section 6F Hand Hygiene Practices?
In the first year of reporting, Leapfrog does not want to be overly prescriptive by specifying the documentation required to demonstrate adherence to each question. We instead ask hospitals to submit feedback to our Help Desk so we can develop FAQs and guidelines for the 2020 Leapfrog Hospital Survey. In 2019, hospitals are still expected to be able to demonstrate adherence to the practices they select through documentation and eventually (starting in 2020) via on-site data verification as well.

48) Who would be included in "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 and specifically those working in patient care units, including all inpatient units, outpatient units (pre-operative, operative, and post-operative), and emergency department units. This would include: doctors, mid-levels, nurses, pharmacists, environmental services staff, laboratory techs, etc. **This would also include students and volunteers.** Patients and their visitors would not be included in this definition. While patients and their visitors are important parts of the patient care process, they are not formally engaged by the hospital for this work. Individuals working in ancillary areas, such as kitchen staff, etc. would also not be included in this definition.

49) 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: through Occupational Health, as part of the TB test; at new-hire orientation; or at a department orientation. A group "teach-back" would be acceptable, but with no more than 10 students per one trainer/monitor.

50) 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?
The audit should include checking the paper towels, soap, and alcohol-based sanitizer in a sample of dispensers throughout the hospital. 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 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).

51) Why does question #10 ask about hospital-wide indirect monitoring, whereas the other questions in this section only pertain to patient care units?
Indirect monitoring methods include monitoring the consumption of alcohol-based hand sanitizer and soap. This type of monitoring is usually not feasible at the unit level.

52) Is Leapfrog encouraging hospitals to implement electronic compliance monitoring? These systems can be expensive and the technology still needs to advance.
In an expert review of the literature, a common theme that was identified is the use of multimodal strategies to improve hand hygiene, including observations, training/education, and electronic compliance monitoring. The questions in Section 6F Hand Hygiene ask about a variety of strategies that can be used to monitor and improve hand hygiene, and while responses will not be scored or publicly reported in 2019, Leapfrog is encouraging hospitals to take a multimodal approach. As with Computerized Physician Order Entry (CPOE) systems and Bar Code Medication Administration Systems (BCMA), we anticipate that electronic compliance monitoring technology will improve over time and become an important component of a comprehensive hand hygiene program.

Evidence for this measure can be found in the Hand Hygiene bibliography available at http://www.leapfroggroup.org/ratings-reports/hand-hygiene.

53) How do we estimate the number of hand hygiene opportunities in a 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 formula:

= Number of open/staffed beds in unit * monthly occupancy rate in unit * no. of days in month * 30 hand hygiene opportunities

The monthly sample size of hand hygiene observations should be at least 1.7% of the unit's monthly HHO value or 200 observations, whichever is less.

Citation: 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.

54) 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.

55) For the purposes of responding to question #21, 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.

56) What are some examples of demonstrating a commitment to hand hygiene improvement as referenced in question #25?

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.

Section 7: 2019 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 fully meeting the standards for this section of the Survey:

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 2019 Leapfrog Hospital Survey Scoring Algorithm on the Scoring and Results webpage.

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.

Below are the nine elements which make up The Leapfrog Group's Policy Statement regarding never events.[36] Indicate which of the following principles are included in your hospital's never events policy.	
1) We apologize to the patient[37] and/or family affected by the never event[36].	*Yes* *No*
2) We report the event to at least one of the following external agencies[38] within 15 business days of becoming aware that the never event[36] has occurred: √ Joint Commission, as part of its Sentinel Events policy √ 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,[39] 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[36].	*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[36] 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 that occurred.	*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 165-166.

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

- Surveys submitted prior to September 1: 01/01/2018 - 12/31/2018
- Surveys (re)submitted on or after September 1: 07/01/2018 - 06/30/2019

Leapfrog will update data 4 times per Survey Cycle for all current members of our NHSN group that have provided an accurate NHSN ID in the Profile and submitted Section 7: Managing Serious Errors. Before September 1, Leapfrog will use calendar year 2018 *data. On or after September 1, Leapfrog will use* 2018 *Quarter 3 data through* 2019 *Quarter 2 data.*

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 or 2018 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 the **first** NHSN join-by date of each Survey Cycle.

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 "Declined to Respond" for each of the five infection measures.

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.

7C: Antibiotic Stewardship Practices

Specifications: See ***Healthcare-Associated Infections and Antibiotic Stewardship Practices Measure Specifications*** in the Managing Serious Errors Reference Information on pages 165-166.

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 2018 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 or 2018 Leapfrog Hospital Survey. However, all hospitals in Leapfrog's NHSN Group must review their Rights Acceptance Report annually by the **first** NHSN join-by date of each Survey Cycle.

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 "Declined to Respond" for each of the five infection measures.

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.

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 with Leapfrog 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. This information does not infringe any third party's intellectual property rights. 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 with Leapfrog reserve the right to omit or disclaim information that is not current, accurate or truthful.

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

Section 7: 2019 Managing Serious Errors Reference Information

What's New in the 2019 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 2019 Survey at http://www.leapfroggroup.org/survey-materials/join-nhsn.

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

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

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 2018 Patient Safety Component – Annual Hospital Survey correspond to the seven Core Elements.

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

Change Summary since Release

None. If substantive changes are made to this section of the Survey after release on April 1, 2019, they will be documented in this Change Summary section.

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 either The Joint Commission 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 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.

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.

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 annually before the first NHSN join-by date: **June 20, 2019**
    - 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 2018 NHSN Patient Safety Component - Annual Hospital Survey. Surveillance data from the 2018 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 (a) generate datasets within NHSN, (b) download CMS IQR reports, and (c) and download a copy of your 2018 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., end of July, September, November, and January, respectively), the issue will not be investigated by the Help Desk.

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
June 20, 2019	June 21, 2019	June 30, 2019	01/01/2018 – 12/31/2018	2018	July 12, 2019
August 22, 2019	August 23, 2019	August 31, 2019	01/01/2018 – 12/31/2018	2018	September 9, 2019*
October 23, 2019	October 24, 2019	October 31, 2019	07/01/2018 – 06/30/2019	2018	November 7, 2019*
November 30, 2019	December 20, 2019**	November 30, 2019	07/01/2018 – 06/30/2019	2018	January 8, 2020*

* Same date as public release of Survey Results

** The Leapfrog Hospital Survey closes on November 30, 2019. The last NHSN data pull is on December 20, 2019 to incorporate any corrections facilities that joined by the last join date of November 30, 2019 may have made to their NHSN data since the last NHSN data pull and to take into account changes made due to the CMS Reporting Deadline in November for the 2019Q2 data.

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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.

Section 8: 2019 Medication Safety

Bar Code Medication Administration and Medication Reconciliation Fact Sheets:
http://www.leapfroggroup.org/ratings-reports/medication-safety

Section 8 includes questions about additional processes your hospital has in place to prevent medication errors, including bar code medication administration and medication reconciliation.

Each hospital fully meeting the BCMA standard:

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 fully meeting the Medication Reconciliation standard:

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 2019 Leapfrog Hospital Survey Scoring Algorithm on the Scoring and Results webpage.

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.

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[40] (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)[41] (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[42]? *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 inpatient medication administrations ordered and scannable 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** 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	*Yes* *No*

	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*

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 181-186.

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.

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 the remaining questions in Section 8B, and go to the Affirmation of Accuracy.*	*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 the remaining questions in Section 8B and go to the Affirmation of Accuracy.*	*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 the remaining questions in Section 8B, and go to the Affirmation of Accuracy.*	*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[43].	_____
6) Total number of medications obtained by the pharmacist from the Gold Standard Medication History[44] for the adult patients included in the sample.	_____

7) Total number of unintentional discrepancies in admission and discharge among the gold standard medications[45] in question #6.	_____
8) Total number of unintentionally ordered additional medications[46] for the adult patients included in the sample on admission and/or discharge.	_____
9) Total number of discrepancies due to unintentionally ordered additional medications[47] in question #8.	_____

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 Bar Code Medication Administration 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 with Leapfrog 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. This information does not infringe any third party's intellectual property rights. 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 with Leapfrog 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 _____.

Section 8: 2019 Medication Safety Reference Information

What's New in the 2019 Survey

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

In addition, based on feedback from hospitals, health systems, and Leapfrog's National Expert Panel, as well as a review of the current literature, Leapfrog removed the patient-specific allergy check and vital sign check from the list of required types of decision-support. The 2019 BCMA standard requires five types of decision-support: Wrong patient, wrong medication, wrong dose, wrong time, and second nurse check needed. Hospitals should review a copy of the updated Section 8A: BCMA Scoring Algorithm.

In 2019, Leapfrog has made updates to the questions and scoring algorithm for Section 8B Medication Reconciliation to better understand what hospitals are doing to ensure the accuracy of their existing medication reconciliation process:

- Hospitals will be asked if they have implemented ANY process or protocol to measure the accuracy of their existing medication reconciliation process.
- Hospitals will then be asked if they have implemented the NQF-endorsed protocol of measuring the accuracy of their existing medication reconciliation process (same questions as in previous years).
- The scoring algorithm will be updated to allow hospitals to earn partial credit ("Willing to Report") if they are at least implementing some process or protocol to measure the accuracy of their existing medication reconciliation process.
- To "Fully Meet the Standard," hospitals must continue to implement the NQF-endorsed protocol and report the data collected to Leapfrog.

Hospitals should review a copy of the updated Section 8B: Medication Reconciliation Scoring Algorithm.

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

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

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

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

Change Summary since Release

None. If substantive changes are made to this section of the Survey after release on April 1, 2019, they will be documented in this Change Summary section.

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

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. **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.

9. **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.

10. **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 was 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.

11. **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

12. **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.

13. **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 that a 'wrong patient' is not encountered.

Workarounds

14. **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.).

15. **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.

16. **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

17. **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.

18. **What are some appropriate mechanisms for communicating back to end users for question #15h?**
    Appropriate mechanisms for communicating back to end users would include: staff meetings, safety briefings or unit huddles, or sharing in a Nursing Informatics eNewsletter, through a Medication Safety Team, or Quality Committee newsletter/flyer.

Medication Reconciliation 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 2018 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 2018, 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

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 medication 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 inhalers, nitroglycerin, opioids, muscle relaxants, sedatives, and non-opioid analgesics;
        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)

a. Once the Gold Standard Medication History is complete, print out the Medication Reconciliation Worksheet for each sample 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 *if completely non-adherent, do not include	☐ Systematically non-adherent ☐ Adherent
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 until 8-12 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".

Admission Comparison	
Note Differences: (select all that apply) ☐ Dose ☐ Frequency ☐ Additional med ☐ 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 Admission Comparison column 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

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.

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 discrepancy rate 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)

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 #41. 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 from 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. **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.

8. **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.

9. **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.

10. **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

11. **What orders are considered admission orders?**
    All orders written from the time of admission until 8:00 a.m. the following morning or until 8-12 hours after the time of admission, whichever comes first.

12. **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).

13. **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

14. **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.

15. **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

16. **What is an example of a data entry or reporting error that would lead to being scored as "Some Progress?"**
    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 monthly data review and scored as "Some Progress" until the data is corrected.

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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.

Section 9: 2019 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 fully meeting the Pediatric Care Standard:

1. Performed in the top quartile based on responses submitted by June 30, 2018 regarding the number of points received for 5 of the 18 Pediatric CAHPS 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 to benchmarks calculated from responses submitted by June 30, 2018.

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[48] 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 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: 12 months
Answer questions #1-24 for the latest 12-month period prior to the submission of this section of the Survey.

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 "Declined to Respond."*	*Yes* *No*

4) How many surveys were returned during the reporting period? *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."*	_____ *Format: Whole numbers only*

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[48]" 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*
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*

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.

Specifications: See ***Pediatric Computed Tomography (CT) Radiation Dose Measure Specifications*** in the Pediatric Care Reference Information on pages 201-203.

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)

- Surveys submitted prior to September 1: 01/01/2018 - 12/31/2018
- Surveys (re)submitted on or after September 1: 07/01/2018 - 06/30/2019

1) 12-month reporting time period used:	☐ 01/01/2018 - 12/31/2018 ☐ 07/01/2018 - 06/30/2019
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 "Declined to Respond."*	*Yes* *No*
4) Which of 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*

6) Enter your facility's 25th, 50th, and 75th percentiles for CT radiation dose length product (DLP) in **head** scans for pediatric patients for each age stratum. If available, please calculate the data using a 16 cm phantom.

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 **abdomen/pelvis** scans for pediatric patients for each age stratum. If available, please calculate the data using a 32 cm phantom.

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				

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 with Leapfrog 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. This information does not infringe any third party's intellectual property rights. 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 with Leapfrog reserve the right to omit or disclaim information that is not current, accurate or truthful.

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

Section 9: 2019 Pediatric Care Reference Information

What's New in the 2019 Survey

In Section 9A: Patient Experience (CAHPS Child Hospital Survey), Leapfrog has updated question #2 and its response options to ensure that the Top Box Scores from the CAHPS Child Hospital Survey represent an appropriate sample of patients. Hospitals completing the Child CAHPS Hospital Survey should have at least 100 pediatric acute-care admissions to inpatient units other than a neonatal ICU (NICU) to ensure that the hospital's sample is not overly represented by NICU discharges. Hospitals with fewer than 100 non-NICU admissions out of the total number of acute care pediatric admissions do not have to administer the CAHPS Child Hospital Survey and will be scored as "Does Not Apply."

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

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

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

No updates have been made to the Section 9 Pediatric Care Scoring Algorithms.

Change Summary since Release

None. If substantive changes are made to this section of the Survey after release on April 1, 2019, they will be documented in this Change Summary section.

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"[48] score for each of the 18 measures of patient experience, which include 10 composite measures and 8 single-item measures.

Hospitals using Press Ganey or NRC 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.

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 2019, hospitals that have been administering the CAHPS survey without including NICU discharges in their sample can report those results to Leapfrog, provided they meet the minimum sample size and timing requirements in the Leapfrog Hospital Survey. However, 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 2019 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 2019 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 or NRC be used to answer questions #7 – 24?**
   Hospitals that use Press Ganey or NRC 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.

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, chest, abdomen/pelvis, or chest/abdomen/pelvis). For example, a CT scan is conducted on a patient's head. Thirty minutes later, another CT scan is conducted on the same patient's head. Together, these two scans are considered one "encounter." Scans of two different anatomic areas would not be considered to be 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.

Source: University of California, San Francisco (NQF #2820)

Reporting Time Period: 12 months

- Surveys submitted prior to September 1: 01/01/2018 - 12/31/2018
- Surveys (re)submitted on or after September 1: 07/01/2018 - 06/30/2019

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 in the "Per Exam" 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 **head scans** for each age stratum (<1, 1-4, 5-9, 10-14, 15-17). Enter these values into the Survey.

Exclusions:
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 should not report on a sample of cases. They should 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 **head scans**. 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.

For hospitals using dose monitoring software, if possible, generate the DLP using the following Phantom Dose Specifications.

Phantom Dose Specifications:
For head scans, use a 16 cm phantom dose value. For patients older than 1 year, use a 32 cm phantom dose value for abdomen/pelvis scans. For patients less than a year old, you may use either a 16 cm or 32 cm phantom dose value, as dictated by your CT scanner's manufacturer. The orange box in the screenshot below the table is an example of a Dose Report which shows the phantom dose value used. The phantom dose value is used to estimate the radiation dose to the patient.

Q.7
Repeat the instructions from question #6 to respond to question #7 (abdomen/pelvis scans).

Hospitals <u>not</u> 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. The workbook includes three tabs: Instructions, Head, and Abdomen/Pelvis. 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, and those values should be entered in the Survey.

The tool 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 for each anatomical area and age stratum, you will need to obtain dose reports. See sampling instructions below.

Exclusions:
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.

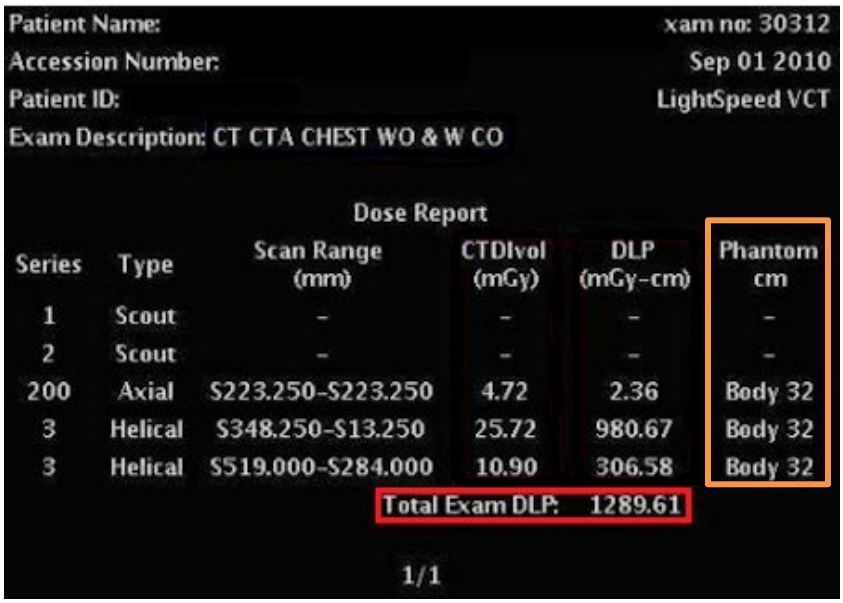
Sampling Cases:
Hospitals that are using information stored in the CT Machine have the option of reporting on all encounters or a sample of encounters. Hospitals opting to identify a sample of encounters for this measure should follow these instructions:

- Review your hospital's scans starting on January 15, 2018 (or July 15, 2018 if (re)submitting a Survey on or after September 1, 2019).
- Work sequentially until **<u>a sample of at least 30 encounters per anatomic area and age strata combination</u>** (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 **Total DLP (mGY-cm)** for each encounter into the appropriate tab of the CT Dose Workbook. Be sure to review the instructions tab carefully before you begin entering data. Each tab is dedicated to an anatomical area, and each marked column within each tab is dedicated to an age stratum. The worksheet will automatically calculate the total number of encounters, as well as the 25th, 50th, and 75th percentiles for each anatomical area and age stratum. See the example CT Dose Report from a CT scanner below this table. The red box highlighted the Total DLP. Note that your CT scanner may have a differently formatted Dose Report.

Q.7
Repeat the instructions from question #6 to respond to question #7 (abdomen/pelvis scans).

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

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) **Are any procedures excluded from this measure?**
   No, all scans of the anatomic area must be included. This includes all procedures and contrasts. However, examinations that cross multiple anatomic areas should be excluded. For example, encounters involving both the head and neck are excluded from the "head" anatomic region.

4) **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.

5) **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. Currently other patient information such as height and weight are not captured at the time of scanning nor held in the CT machine. Therefore, much of that data is unavailable to some hospitals at this time.

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.

Section 10: Outpatient Procedures

Outpatient Procedures Bibliography: http://www.leapfroggroup.org/outpatient-procedures

This section is optional in 2019 and will not be scored or publicly reported.

Section 10 Outpatient Procedures includes questions about your hospital's outpatient departments. It is not applicable to surgical centers that are certified separately by Medicare as an Ambulatory Surgery Center (ASC). ASCs should report separately on the inaugural 2019 Leapfrog Ambulatory Surgery Center Survey.

Leapfrog will not score Survey responses or publicly report individual Section 10 Outpatient Procedure Results in 2019. However, participating hospitals will receive a free individual benchmarking report. For hospitals that submit a Survey by June 30, this benchmarking report will be available to view in September and February via the Hospital Details Page link on the Hospital Survey Dashboard. Leapfrog plans to score Survey responses and publicly report individual Hospital Outpatient Department and ASC Survey Results in 2020.

10A Basic Outpatient Department Information

Important Notes:

Note 1: This section will not be scored or publicly reported in 2019.

Note 2: The term "facility" is used to refer to your hospital or the separate hospital location where outpatient procedures are performed, which you have chosen to report on as indicated in Section 10A question #6. You should be reporting on the location selected in question #6 for all questions in Section 10.

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
- Surveys submitted prior to September 1: 01/01/2018 - 12/31/2018
- Surveys (re)submitted on or after September 1: 07/01/2018 - 06/30/2019

General Information

1) 12-month reporting time period used:	☐ 01/01/2018 – 12/31/2018 ☐ 07/01/2018 – 06/30/2019
2) Does your hospital perform any of the procedures listed in Section 10C (questions #2-11) on an outpatient basis **in the hospital** or at a facility co-located[19] with the hospital?	*Yes* *No*
3) Does your hospital perform any of the procedures listed in Section 10C (questions #2-11) on an outpatient basis **outside of the hospital** at a separate hospital outpatient location that shares your hospital's license and CMS Certification Number? *If "no" to question #3, skip questions #4-5 and continue on to question #6.*	*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) How many separate hospital locations that perform the procedures listed in Section 10C (questions #2-11) on an outpatient basis share the hospital's license and CMS Certification Number?	_____

5) Please provide the name and physical address of **one** of the separate hospital outpatient locations from question #3 where the hospital is performing the procedures listed in Section 10C (questions #2-11) on an outpatient basis: a) Name b) Street Address c) City d) Zip Code	_____ _____ _____ _____
6) For the purposes of responding to the questions in Section 10 Outpatient Procedures, please select a location to report on: *Hospitals should either choose to report on their hospital (including all outpatient departments/procedures in the hospital and/or at outpatient locations co-located with the hospital) OR one separate hospital outpatient location listed in question #5.*	*Hospital* *Separate hospital location listed in question #5*

Answer the remaining questions in Section 10 based on the location selected in question #6 above for the 12-month reporting period.

7) Total number of outpatient operating rooms[49].	_____
8) Total number of outpatient endoscopic procedure rooms[50].	_____

Transfer Policies and Agreements

If selecting "hospital" in question #6, skip questions #9-14 and continue on to the next subsection. Only facilities reporting on their "separate hospital outpatient location" are asked to answer questions #9-14.

9) Does your hospital's separate hospital outpatient location have a written transfer agreement[51] with a pediatric or general acute care hospital for patients who require a higher level of care? *If "no" to question #9, skip question #10 and continue on to question #11.*	*Yes* *No*
10) Which hospital does your hospital's separate outpatient location have a written transfer agreement[51] with? *Select all that apply.*	☐ *Our own hospital* ☐ *Another hospital within our system* ☐ *A hospital that is not within our system*

11) Whether or not your facility has a written transfer agreement in place for patients who require a higher level of care, please provide information on your facility's written transfer policies[52] related to the transfer of: *Select all that apply or "no written transfer policies."* *If "no written transfer policies," skip questions #12-14 and continue on to the next subsection.*	☐ *Emergent transfers* ☐ *Urgent transfers* ☐ *Non-urgent transfers* ☐ *No written transfer policies*
12) In emergent transfers, when there is an immediate threat to life or limb, our facility has a written transfer policy[52] that includes the following components: *Select all that apply or "none of the above."*	☐ *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*
13) In urgent transfers, when care is required within 24 hours, but there is no immediate threat to life or limb, our facility has a written transfer policy[52] that includes the following components: *Select all that apply or "none of the above."*	☐ *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*
14) In non-urgent transfers, when treatment is required, but time is not a factor, our facility has a written transfer policy[52] that includes the following components: *Select all that apply or "none of the above."*	☐ *Patient is transferred to the nearest hospital* ☐ *Receiving facility must have an ED and/or ICU* ☐ *Patient must be transferred within an established amount of time* ☐ *Patient's medication information must be transferred within an established period of time* ☐ *None of the above*

10B Medical, Surgical, and Clinical Staff

Important Notes:

Note 1: This section will not be scored or publicly reported in 2019.

Note 2: The term "facility" is used to refer to your hospital or the separate outpatient department which you have chosen to report on as indicated in Section 10A, question #6. You should be reporting on the facility selected for all questions in Section 10.

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

1) Is there an Advanced Cardiovascular Life Support (ACLS) trained clinician[53], as well as a second clinician[53] (regardless of ACLS training), present at all times in the facility while a patient is recovering? *If "no" or "not applicable; pediatric patients only," skip question #2 and continue on to question #3.*	*Yes* *No* *Not applicable; pediatric patients only*
2) Which of the following medical, surgical, and clinical staff are required to maintain ACLS certification? *Select all that apply.*	☐ Anesthesiologists ☐ Nurse Anesthetists (CRNAs) ☐ Physicians ☐ Nurses (RN or MSN) ☐ Physician Assistants (PAs) ☐ Nurse Practitioners (NPs) ☐ Surgical Technicians ☐ First Assists
3) Is there a Pediatric Advanced Life Support (PALS) trained clinician[53], as well as a second clinician[53] (regardless of PALS training), present at all times in the facility while a pediatric patient is recovering? *If "no" or "not applicable; adult patients only," skip question #4 and continue on to question #5.*	*Yes* *No* *Not applicable; adult patients only*
4) Which of the following medical, surgical, and clinical staff are required to maintain PALS certification? *Select all that apply.*	☐ Anesthesiologists ☐ Nurse Anesthetists (CRNAs) ☐ Physicians ☐ Nurses (RN or MSN) ☐ Physician Assistants (PAs) ☐ Nurse Practitioners (NPs) ☐ Surgical Technicians ☐ First Assists

5) To help ensure that patients are cared for by adequately trained physicians, are **those physicians** who are authorized to perform procedures at your facility board certified or board eligible:	*All are board certified or board eligible (100%)* *Most are board certified or board eligible (>=50%)* *Some are board certified or board eligible (<50%)* *None are board certified or board eligible*
6) To help ensure that patients are cared for by adequately trained anesthesiologists and/or certified nurse anesthetists, are **those providing anesthesia** at your facility board certified or board eligible:	*All are board certified or board eligible (100%)* *Most are board certified or board eligible (>=50%)* *Some are board certified or board eligible (<50%)* *None are board certified or board eligible*

10C Volume and Safety of Procedures

Important Notes:

Note 1: This section will not be scored or publicly reported in 2019.

Note 2: The term "facility" is used to refer to your hospital or the separate outpatient department which you have chosen to report on as indicated in Section 10A, question #6. You should be reporting on the facility selected for all questions in Section 10.

Note 3: Hospitals should only report on procedures they electively perform in the location selected in Section 10A question #6. If your facility 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 230-248.

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
- Surveys submitted prior to September 1: 01/01/2018 - 12/31/2018
- Surveys (re)submitted on or after September 1: 07/01/2018 - 06/30/2019

Volume of Procedures

1) 12-month reporting time period used:	□ 01/01/2018 – 12/31/2018 □ 07/01/2018 – 06/30/2019
2) During the reporting period, were one or more of the following **gastroenterology** procedures performed at your facility on adult or pediatric patients: • Upper GI Endoscopy • Other upper GI procedures • Small intestine and stromal endoscopy • Lower GI Endoscopy *If "no" or "yes, but no longer perform these procedures," skip question #12 below.*	*Yes* *Yes, but no longer perform these procedures* *No*
3) During the reporting period, were one or more of the following **general surgery** procedures performed at your facility 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	*Yes* *Yes, but no longer perform these procedures* *No*

If "no" or "yes, but no longer perform these procedures," skip question #13 below.	
4) During the reporting period, were one or more of the following **ophthalmology** procedures performed at your facility on adult or pediatric patients: • Anterior segment eye procedures • Posterior segment eye procedures *If "no" or "yes, but no longer perform these procedures," skip question #14 below.*	*Yes* *Yes, but no longer perform these procedures* *No*
5) During the reporting period, were one or more of the following **orthopedic** procedures performed at your facility 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 perform these procedures," skip question #15 below.*	*Yes* *Yes, but no longer perform these procedures* *No*
6) During the reporting period, were one or more of the following **otolaryngology** procedures performed at your facility on adult or pediatric patients: • Ear procedures • Mouth procedures • Nasal/sinus procedures • Pharynx/ adenoid/ tonsil procedures *If "no" or "yes, but no longer perform these procedures," skip question #16 below.*	*Yes* *Yes, but no longer perform these procedures* *No*
7) During the reporting period, were one or more of the following **urology** procedures performed at your facility on adult or pediatric patients: • Circumcision • Cystourethroscopy • Male genital procedures • Male sterilization procedures • Urethra procedures • Vaginal repair procedures *If "no" or "yes, but no longer perform these procedures," skip question #17 below.*	*Yes* *Yes, but no longer perform these procedures* *No*

8) During the reporting period, was the following **dermatology** procedure performed at your facility on <u>adult</u> patients: • Complex skin repairs *If "no" or "yes, but no longer perform this procedure," skip question #18 below.*	*Yes* *Yes, but no longer perform this procedure* *No*
9) During the reporting period, was the following **neurological surgery** procedure performed at your facility on <u>adult</u> patients: • Spinal fusion procedures *If "no" or "yes, but no longer perform this procedure," skip question #19 below.*	*Yes* *Yes, but no longer perform this procedure* *No*
10) During the reporting period, were one or more of the following **obstetrics and gynecology** procedures performed at your facility on <u>adult</u> patients: • Cervix procedures • Hysteroscopy • Uterus and adnexa laparoscopies *If "no" or "yes, but no longer perform these procedures," skip question #20 below.*	*Yes* *Yes, but no longer perform these procedures* *No*
11) During the reporting period, were one or more of the following **plastic and reconstructive surgery** procedures performed at your facility on <u>adult</u> patients: • Breast repair or reconstruction • Musculoskeletal grafts or implants *If "no" or "yes, but no longer perform these procedures," skip question #21 below.*	*Yes* *Yes, but no longer perform these procedures* *No*

Gastroenterology

12) Total adult and/or pediatric volume for each of the following applicable procedures performed at your facility 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 **<u>all</u>** 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	_____	_____

General Surgery

13) Total adult and/or pediatric volume for each of the following applicable procedures performed at your facility 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	_____	

Ophthalmology

14) Total adult and/or pediatric volume for each of the following applicable procedures performed at your facility 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	_____	

Orthopedics

15) Total adult and/or pediatric volume for each of the following applicable procedures performed at your facility 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	_____	_____
Knee procedures	_____	_____
Toe, foot, ankle, and leg procedures	_____	_____
General orthopedic procedures	_____	_____

Otolaryngology

16) Total adult and/or pediatric volume for each of the following applicable procedures performed at your facility during the reporting period.

*You cannot leave any blank. If you did not perform one or more of the procedures listed below enter 0 (zero). If you had zero volume for **all** procedures, go back to question #6 and update your response from "yes" to "no."*

	(a) Adult Volume	*(b) Pediatric Volume*
Ear procedures	_____	_____
Mouth procedures	_____	_____
Nasal/ sinus procedures	_____	_____
Pharynx/ adenoid/ tonsil procedures	_____	_____

Urology

17) Total adult and/or pediatric volume for each of the following applicable procedures performed at your facility 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	_____	_____

Dermatology

18) Total adult volume for the following procedure performed at your facility 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	_____	

Neurological Surgery

19) Total adult volume for the following procedure performed at your facility 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	_____	

Obstetrics and Gynecology

20) Total adult volume for each of the following applicable procedures performed at your facility 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	_____	

Plastic and Reconstructive Surgery

21) Total adult volume for each of the following applicable procedures performed at your facility 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	_____	

Patient Follow-up and After-Hours Communication

Note 1: The term "facility" is used to refer to your hospital or the separate outpatient department which you have chosen to report on as indicated in Section 10A, question #6. You should be reporting on the facility selected for all questions in Section 10.

22) Does your facility have a process in place for facility staff to follow up by phone with **patients** who have undergone any one of the procedures in Section 10C questions #2-11 within 24-hours of discharge?	*Yes* *No*
23) Does your facility have a process in place for facility staff to follow up with **physicians** who perform any one of the procedures in Section 10C questions #2-11 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?	*Yes* *No*

24) Does your facility have a process in place to ensure that patients who have undergone any one of the procedures in Section 10C questions #2-11 know whom to contact after hours (e.g., written after-hours instructions shared at discharge, email sent to patient with instructions after discharge, etc.)?	*Yes* *No*

Patient Selection and Consent to Treat

Note 1: The term "facility" is used to refer to your hospital or the separate outpatient department which you have chosen to report on as indicated in Section 10A, question #6. You should be reporting on the facility selected for all questions in Section 10.

Patient Selection

25) Does your facility have a standard, written screening protocol to determine whether a patient's procedure can safely be performed on an outpatient basis? *If "no" to question #25, skip questions #26-28 and continue on to question #29.*	*Yes* *No*
26) Which of the following components are included in your facility's standard, written screening protocol: *Select all that apply.*	☐ *Body Mass Index (BMI)* ☐ *American Society of Anesthesiologists (ASA) Physical Status Classification* ☐ *Recent Medical History (within 30 days of scheduled procedure)* ☐ *Frailty Assessment* ☐ *Cognitive Assessment* ☐ *Sleep Apnea Assessment* ☐ *Availability of transportation following discharge* ☐ *Availability of a caregiver following discharge*
27) 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* ☐ *Nurse Anesthetist (CRNA)* ☐ *Physician* ☐ *Nurse (RN, MSN)* ☐ *Physician Assistant (PA)* ☐ *Nurse Practitioner (NP)* ☐ *Other*

28) When patients are identified through your facility's screening protocol as high-risk, does an anesthesiologist, CRNA, 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

29) To help ensure that patients and their families have adequate time to review and ask questions about written surgical consent materials, it's our facility's policy to provide these materials to patients:	*At least 3 days prior* *1-3 days prior* *Same day* *Not sure* *Not at all*
30) To help ensure that patients and their families have adequate time to review and ask questions about written anesthesia consent materials, it's our facility's policy to provide these materials to patients:	*At least 3 days prior* *1-3 days prior* *Same day* *Not sure* *Not at all*

Safe Surgery Checklist

Note 1: The term "facility" is used to refer to your hospital or the separate outpatient department which you have chosen to report on as indicated in Section 10A, question #6. You should be reporting on the facility selected for all questions in Section 10.

Reporting Time Period: 3 months
Answer questions #31-37 for the latest 3-month period prior to submission of this section of the Survey.

31) What is the latest 3-month reporting period for which your facility is submitting responses to questions #32-37? 3-month reporting time period ending:	_____ *Format: MM/YYYY*
32) Does your facility utilize a safe surgery checklist when performing each of the applicable procedures reported on in Section 10C? *If "no" to question #32, skip questions #33-37 and continue on to the next subsection.*	*Yes* *No*
33) Who leads the safe surgery checklist? *Select one.*	*Anesthesiologist* *Nurse Anesthetist (CRNA)* *Physician* *Nurse (RN, MSN)* *Physician Assistant (PA)* *Nurse Practitioner (NP)* *Surgical Technician* *First Assist*

34) Who leads the pre-operative briefing or the sign-in (if using the WHO checklist)? *Select one.*	*Anesthesiologist* *Nurse Anesthetist (CRNA)* *Physician* *Nurse (RN, MSN)* *Physician Assistant (PA)* *Nurse Practitioner (NP)* *Surgical Technician* *First Assist*
35) Who calls the 'time-out'[54] before the procedure begins? *Select one.*	*Anesthesiologist* *Nurse Anesthetist (CRNA)* *Physician* *Nurse (RN, MSN)* *Physician Assistant (PA)* *Nurse Practitioner (NP)* *Surgical Technician* *First Assist*
36) Who leads the post-operative debriefing or the sign-out (if using the WHO checklist)? *Select one.*	*Anesthesiologist* *Nurse Anesthetist (CRNA)* *Physician* *Nurse (RN, MSN)* *Physician Assistant (PA)* *Nurse Practitioner (NP)* *Surgical Technician* *First Assist*
37) Who has spoken up about potential patient safety issues during the safe surgery checklist process in the past? *Select all that apply.*	☐ *Anesthesiologist* ☐ *Nurse Anesthetist (CRNA)* ☐ *Physician* ☐ *Nurse (RN, MSN)* ☐ *Physician Assistant (PA)* ☐ *Nurse Practitioner (NP)* ☐ *Surgical Technician* ☐ *First Assist* ☐ *Do not document*

10D Medication Safety for Outpatient Procedures

Important Notes:

Note 1: This section will not be scored or publicly reported in 2019.

Note 2: The term "facility" is used to refer to your hospital or the separate outpatient department which you have chosen to report on as indicated in Section 10A, question #6. You should be reporting on the facility selected for all questions in Section 10.

Specifications: See ***Medication Safety for Outpatient Procedures Measure Specifications*** in the Reference Information on pages 252-253.

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),

- Surveys submitted prior to September 1: 01/01/2018 - 12/31/2018
- Surveys (re)submitted on or after September 1: 07/01/2018 - 06/30/2019

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:	☐ 01/01/2018 – 12/31/2018 ☐ 07/01/2018 – 06/30/2019
2) Did your facility perform an audit of clinical records for adult and/or pediatric patients undergoing those procedures included in Section 10C (or a ***sufficient sample*** of them) who were discharged 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 60 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 60 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 **home medication(s),** including dose, route, and frequency, documented in their clinical record.	_____
5) Number of cases in question #3 with a list of **any medication(s) ordered, prescribed, or administered during the visit**, including the strength, dose, route, date, and time of administration, documented in their clinical record.	_____
6) Number of cases in question #3 with a list of **allergies and adverse reaction status** documented in their clinical record.	_____

7) Do the responses in questions #3-6 represent a sample of cases?	*Yes* *No*

10E Patient Experience (OAS CAHPS)

This section is not applicable to Pediatric hospitals.

Important Notes:

Note 1: This section will not be scored or publicly reported in 2019.

Note 2: The term "facility" is used to refer to your hospital or the separate outpatient department which you have chosen to report on as indicated in Section 10A, question #6. You should be reporting on the location selected for all questions in Section 10.

Specifications: See ***Patient Experience (OAS CAHPS) Measure Specifications*** in the Reference Information on pages 255-257.

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.

1) What is the latest 12-month reporting period for which your facility is submitting responses to this section? 12-month reporting time period ending:	_____ *Format: MM/YYYY*
2) Did your facility have at least 300 eligible discharges[55] during the 12-month period referenced above? *If "no" to question #2, skip the remaining questions in Section 10E, 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 10E, and go to the Affirmation of Accuracy.*	*Yes* *No*
4) Total number of months in which your facility 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 10E, and go to the Affirmation of Accuracy.*	_____ *Format: Whole numbers only*
6) Do the responses to the questions in this subsection include discharges from more than one hospital outpatient department location (e.g., hospital and separate hospital outpatient departments, multiple separate hospital outpatient departments, etc.)?	*Yes* *No*

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In questions #7-10, report your facility's Top Box Score[48] 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*

In questions #11-13, report your facility's Top Box Score[48] 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*

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 with Leapfrog 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. This information does not infringe any third party's intellectual property rights. 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 with Leapfrog reserve the right to omit or disclaim information that is not current, accurate or truthful.

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

Section 10: 2019 Outpatient Procedures Reference Information

What's New in the 2019 Survey

Leapfrog has added questions on hospital outpatient departments in Section 10 Outpatient Procedures. This section will not be scored or publicly reported by facility in 2019. Results will be published in an aggregate report and made available to participating facilities in private benchmarking reports. Leapfrog plans to publicly report results by facility starting in 2020. Leapfrog is seeking feedback on this new section and is asking hospitals to submit comments to the Help Desk.

Change Summary since Release

May 29, 2019 - Updated the Measure Specifications for identifying the following orthopedic procedures for both adult and pediatric patients: *Finger, Hand, Wrist, Forearm, and Elbow Procedures* and *Toe, Foot, Ankle, and Leg Procedures*. CPT Code Range 28192-28250 (CCS 160) was removed from *Finger, Hand, Wrist, Forearm, and Elbow Procedure CPT Codes* and added to *Toe, Foot, Ankle, and Leg Procedure CPT Codes*. See pages 237-238 of the hard copy of the Survey for the updated Measure Specifications for *Finger, Hand, Wrist, Forearm, and Elbow Procedures*, for both adult and pediatric patients. See page 240 of the hard copy of the Survey for the updated Measure Specifications for *Toe, Foot, Ankle, and Leg Procedures*, for both adult and pediatric patients.

Basic Outpatient Department Information Frequently Asked Questions (FAQs)

1) **Our hospital shares a CMS Certification Number (CCN) with other hospitals and we have many separate hospital outpatient locations (i.e. endoscopy centers, day surgery centers, etc. all under the same CCN). Which separate hospital outpatient location should we select? Can all our hospitals report on the same hospital outpatient location (i.e. the same endoscopy center)?**
   Hospitals can choose to report on their hospital, which includes all outpatient departments in the hospital and co-located with the hospital, OR they can choose to report on one separate hospital outpatient location. If electing to report on a separate hospital outpatient location, Leapfrog recommends choosing the separate hospital outpatient location that is closest in proximity to your hospital. This will help limit the number of hospitals that may report on the same separate hospital outpatient location. Please contact the Help Desk with any additional questions or scenarios not covered in this example.

2) **How should our facility report on the number of operating rooms and endoscopic procedure rooms in questions #7-8 if our operating/procedure rooms are used for both inpatient and outpatients?**
   Facilities 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, facilities should only report on the number of operating/procedure rooms that are used for outpatients.

Medical, Surgical, and Clinical Staff Frequently Asked Questions (FAQs)

1) **In Section 10B questions #1-4, what staff should be included when reviewing ACLS/PALS certification? Would this include inpatient staff as well?**
   Questions #1-4 refer to the staff that are present when patients are recovering from the outpatient procedures specified in Section 10C Volume and Safety of Procedures. In questions #2 and #4, you should select the types of staff that are required to maintain ACLS/PALS certification and that are present when patients are recovering, even if all staff of that type (i.e. staff that do not care for recovering patients) are not required to be ACLS/PALS certified. The intent of this question is to ensure that there is an ACLS/PALS certified clinician present on-site (and one additional clinician to assist) in the event a patient in recovery needs a lifesaving intervention.

2) **If a free-standing pediatric hospital has clinicians trained in PALS, but a small percentage of the patient population is over 18, should these clinicians also have ACLS training or would the PALS training be sufficient?**
   If your facility is performing procedures on both adult and pediatric patients, there should be at least one clinician with ACLS training when adult patients are recovering and one clinician with PALS training when pediatric patients are recovering. This could mean that some clinicians maintain both certifications or some maintain ACLS and others maintain PALS.

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).
   - Board eligible indicates that the registered nurse (RN) has completed their nurse anesthesia education program accredited by the Council on Accreditation of Nurse Anesthesia Education Programs (COA), but has not yet passed their board-certifying exam. Leapfrog adheres to the NBCRNA Board Eligibility Policy, which states that RNs are eligible to take the National Certification Exam (NCE) within 2-years of completing their accredited nurse anesthesia education program. This policy may be reviewed here (p.8): https://www.nbcrna.com/docs/default-source/initial-certification/program-administration/nce_hb.pdf. These eligibility periods provide RNs with an adequate window to take her/his boards and re-take if necessary.

4) **In Section 10B questions #5-6, should we include all physicians and anesthesiologists/nurse anesthetists that work in our outpatient areas when determining how many are board certified or board eligible?**
   No. Questions #5-6 are only asking about board certification/board eligibility for those physicians and anesthesiologists/nurse anesthetists that are authorized to perform the outpatient procedures specified in Section 10C Volume and Safety 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 code ranges for counting **patients**. These CPT code ranges are provided below and also in an Excel Document under "Other Supporting Materials" for Section 10 on the Survey Materials webpage.

Source: The Leapfrog Group, The Health Care Cost Institute

Reporting Time Period: 12-months

- Surveys submitted prior to September 1: 01/01/2018 - 12/31/2018
- Surveys (re)submitted on or after September 1: 07/01/2018 - 06/30/2019

Questions #2-11: Respond "yes" or "no" based on whether or not your facility 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

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:

- Your facility performed the procedure on an outpatient basis for the entire reporting period (12 months) and continues to do so
- Your facility 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 facility performed the procedure for all or some of the reporting period, but NO longer performs the procedure

Respond "no" if:

- Your facility does not perform the procedure.

Questions #12-21: 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

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 **facility volume for (a) adult and/or (b) pediatric patients**:

- Count the number of **patients** discharged from your facility 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.

Gastroenterology Measure Specifications

For gastroenterology procedures, use the following sets of CPT code ranges to count **patients** discharged from your facility 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
-

For gastroenterology procedures there is one set of codes for each procedure that should be used to count:

a. The total number of adult (18 years of age or older) patients discharged with any of the following CPT codes listed in the range below. The CPT code can be in any procedure field (primary or secondary).
b. The total number of pediatric (17 years of age and younger) patients discharged with any of the following CPT codes listed in the range below. The CPT code can be in any procedure field (primary or secondary).

Upper GI Endoscopy CPT Codes for ADULT AND PEDIATRIC PATIENTS

CPT Code Range	CCS	CCS Description
43248-43249	69	Esophageal dilatation
43234-43242	70	Upper gastrointestinal endoscopy, biopsy
43250-43259	70	Upper gastrointestinal endoscopy, biopsy

Other Upper GI Procedure CPT Codes for ADULT AND PEDIATRIC PATIENTS

CPT Code Range	CCS	CCS Description
43450-43460	69	Esophageal dilatation

Small Intestine and Stomal Endoscopy CPT Codes for ADULT AND PEDIATRIC PATIENTS

CPT Code Range	CCS	CCS Description
44360-44361	70	Upper gastrointestinal endoscopy, biopsy

Lower GI Endoscopy CPT Codes for ADULT AND PEDIATRIC PATIENTS

CPT Code Range	CCS	CCS Description
45355-45378	76	Colonoscopy and biopsy
45380-45393	76	Colonoscopy and biopsy
45308-45331	77	Proctoscopy and anorectal biopsy

General Surgery Measure Specifications

For general surgery procedures, use the following sets of CPT code ranges to count **patients** discharged from your facility 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

For general surgery procedures there is one set of codes for each procedure that should be used to count:

a. The total number of adult (18 years of age or older) patients discharged with any of the following CPT codes listed in the range below. The CPT code can be in any procedure field (primary or secondary).
b. The total number of pediatric (17 years of age and younger) patients discharged with any of the following CPT codes listed in the range below. The CPT code can be in any procedure field (primary or secondary).

Cholecystectomy and Common Duct Exploration CPT Codes for ADULT PATIENTS

CPT Code Range	CCS	CCS Description
47562-47564	84	Cholecystectomy and common duct exploration

Excision of Skin Lesion CPT Codes for ADULT PATIENTS

CPT Code Range	CCS	CCS Description
11200-11646	170	Excision of skin lesion
17000-17380	170	Excision of skin lesion
24071-24071	170	Excision of skin lesion
26111-26111	170	Excision of skin lesion
26115-26115	170	Excision of skin lesion
28039-28039	170	Excision of skin lesion
28043-28043	170	Excision of skin lesion
29893-29893	170	Excision of skin lesion

Hemorrhoid Procedure CPT Codes for ADULT PATIENTS

CPT Code Range	CCS	CCS Description
46221-46262	81	Hemorrhoid procedures

Inguinal and Femoral Hernia Repair CPT Codes for ADULT AND PEDIATRIC PATIENTS

CPT Code Range	CCS	CCS Description
49491-49535	85	Inguinal and femoral hernia repair
49650-49651	85	Inguinal and femoral hernia repair

Other Hernia Repair CPT Codes for ADULT AND PEDIATRIC PATIENTS

CPT Code Range	CCS	CCS Description
43281-43282	86	Other hernia repair
49560-49611	86	Other hernia repair

Laparoscopy CPT Codes for ADULT PATIENTS

CPT Code Range	CCS	CCS Description
49320-49322	87	Laparoscopy

Lumpectomy or Quadrantectomy of Breast CPT Codes for ADULT PATIENTS

CPT Code Range	CCS	CCS Description
19120-19126	166	Lumpectomy, quadrantectomy of breast
19301-19302	166	Lumpectomy, quadrantectomy of breast

Mastectomy CPT Codes for ADULT PATIENTS

CPT Code Range	CCS	CCS Description
19303-19307	167	Mastectomy

Skin Graft CPT Codes for ADULT PATIENTS

CPT Code Range	CCS	CCS Description
14000-15738	172	Skin graft

Ophthalmology Measure Specifications

For ophthalmology procedures, use the following sets of CPT code ranges to count **patients** discharged from your facility who have undergone either of the 2 procedures during the reporting period.

One procedure applies to **adult patients only**:

- Posterior Segment Eye Procedures

One procedure applies to **both adult and pediatric patients**:

- Anterior Segment Eye Procedures

For ophthalmology procedures there is one set of codes for each procedure that should be used to count:

a. The total number of adult (18 years of age or older) patients discharged with any of the following CPT codes listed in the range below. The CPT code can be in any procedure field (primary or secondary).
b. The total number of pediatric (17 years of age and younger) patients discharged with any of the following CPT codes listed in the range below. The CPT code can be in any procedure field (primary or secondary).

Anterior Segment Eye Procedures CPT Codes for ADULT AND PEDIATRIC PATIENTS

CPT Code Range	CCS	CCS Description
65710-65757	13	Corneal transplant
65820-65855	14	Glaucoma procedures
66150-66185	14	Glaucoma procedures
66700-66761	14	Glaucoma procedures
66820-66986	15	Lens and cataract procedures
15820-15823	19	Other therapeutic procedures on eyelids, conjunctiva, cornea
65270-65286	19	Other therapeutic procedures on eyelids, conjunctiva, cornea
65400-65400	19	Other therapeutic procedures on eyelids, conjunctiva, cornea
65420-65426	19	Other therapeutic procedures on eyelids, conjunctiva, cornea
66250-66250	19	Other therapeutic procedures on eyelids, conjunctiva, cornea
67700-67808	19	Other therapeutic procedures on eyelids, conjunctiva, cornea
67820-68040	19	Other therapeutic procedures on eyelids, conjunctiva, cornea
68110-68505	19	Other therapeutic procedures on eyelids, conjunctiva, cornea
68530-68840	19	Other therapeutic procedures on eyelids, conjunctiva, cornea
67311-67345	21	Other extraocular muscle and orbit therapeutic procedures
67405-67414	21	Other extraocular muscle and orbit therapeutic procedures
67420-67445	21	Other extraocular muscle and orbit therapeutic procedures
67500-67560	21	Other extraocular muscle and orbit therapeutic procedures

Posterior Segment Eye Procedures CPT Codes for ADULT PATIENTS

CPT Code Range	CCS	CCS Description
67039-67040	16	Repair of retinal tear, detachment
67101-67113	16	Repair of retinal tear, detachment
66990-67038	20	Other intraocular therapeutic procedures
67041-67043	20	Other intraocular therapeutic procedures
67115-67121	20	Other intraocular therapeutic procedures

Orthopedic Measure Specifications

For orthopedic procedures, use the following sets of CPT code ranges to count **patients** discharged from your facility 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

For 3 of the orthopedic procedures (i.e. finger, hand, wrist, forearm, and elbow procedures; shoulder procedures; and general orthopedic procedures), there are **two** different sets of codes (one for adult patients only and one for pediatric patients only) that should be used to count:

a. The total number **of** adult (18 years of age or older) patients discharged with any of the following CPT codes listed in the range below. The CPT code can be in any procedure field (primary or secondary).
b. The total number of pediatric (17 years of age and younger) patients discharged with any of the following CPT codes listed in the range below. The CPT code can be in any procedure field (primary or secondary).

For 4 of the orthopedic procedures (spine procedures; hip procedures; knee procedures; and toe, foot, ankle, and leg procedures) there is **one** set of codes for each procedure that should be used to count:

a. The total number of adult (18 years of age or older) patients discharged with any of the following CPT codes listed in the range below. The CPT code can be in any procedure field (primary or secondary).
b. The total number of pediatric (17 years of age and younger) patients discharged with any of the following CPT codes listed in the range below. The CPT code can be in any procedure field (primary or secondary).

Finger, Hand, Wrist, Forearm, and Elbow Procedure CPT Codes for ADULT PATIENTS ONLY

CPT Code Range	CCS	CCS Description
29848-29848	6	Decompression peripheral nerve
64702-64727	6	Decompression peripheral nerve
24583-24685	145	Treatment, fracture or dislocation of radius and ulna
25500-25620	145	Treatment, fracture or dislocation of radius and ulna
25622-25645	148	Other fracture and dislocation procedure
25670-25670	148	Other fracture and dislocation procedure
26600-26785	148	Other fracture and dislocation procedure
25441-25449	154	Arthroplasty other than hip or knee
24105-24105	160	Other therapeutic procedures on muscles and tendons
24301-24342	160	Other therapeutic procedures on muscles and tendons
25000-25031	160	Other therapeutic procedures on muscles and tendons
25109-25116	160	Other therapeutic procedures on muscles and tendons
25260-25318	160	Other therapeutic procedures on muscles and tendons
26035-26060	160	Other therapeutic procedures on muscles and tendons
26113-26113	160	Other therapeutic procedures on muscles and tendons
26116-26125	160	Other therapeutic procedures on muscles and tendons
26160-26180	160	Other therapeutic procedures on muscles and tendons
26350-26510	160	Other therapeutic procedures on muscles and tendons
24343-24352	162	Other OR therapeutic procedures on joints

CPT Code Range	CCS	CCS Description
24357-24359	162	Other OR therapeutic procedures on joints
25320-25320	162	Other OR therapeutic procedures on joints
25800-25830	162	Other OR therapeutic procedures on joints
26540-26545	162	Other OR therapeutic procedures on joints
26820-26863	162	Other OR therapeutic procedures on joints
29835-29838	162	Other OR therapeutic procedures on joints
29844-29846	162	Other OR therapeutic procedures on joints

NOTE: CPT Code Range 28192-28250 (CCS 160) was removed and added to *Toe, Foot, Ankle, and Leg Procedure CPT Codes for ADULT AND PEDIATRIC PATIENTS*.

Finger, Hand, Wrist, Forearm, and Elbow Procedure CPT Codes for PEDIATRIC PATIENTS ONLY

CPT Code Range	CCS	CCS Description
28035-28035	6	Decompression peripheral nerve
29848-29848	6	Decompression peripheral nerve
64702-64727	6	Decompression peripheral nerve
24583-24685	145	Treatment, fracture or dislocation of radius and ulna
25500-25620	145	Treatment, fracture or dislocation of radius and ulna
25622-25645	148	Other fracture and dislocation procedure
25670-25670	148	Other fracture and dislocation procedure
26600-26785	148	Other fracture and dislocation procedure
25441-25449	154	Arthroplasty other than hip or knee
24105-24105	160	Other therapeutic procedures on muscles and tendons
24301-24342	160	Other therapeutic procedures on muscles and tendons
25000-25031	160	Other therapeutic procedures on muscles and tendons
25109-25116	160	Other therapeutic procedures on muscles and tendons
25260-25318	160	Other therapeutic procedures on muscles and tendons
26035-26060	160	Other therapeutic procedures on muscles and tendons
26113-26113	160	Other therapeutic procedures on muscles and tendons
26116-26125	160	Other therapeutic procedures on muscles and tendons
26160-26180	160	Other therapeutic procedures on muscles and tendons
26350-26510	160	Other therapeutic procedures on muscles and tendons
24343-24352	162	Other OR therapeutic procedures on joints
24357-24359	162	Other OR therapeutic procedures on joints
25320-25320	162	Other OR therapeutic procedures on joints
25800-25830	162	Other OR therapeutic procedures on joints
26540-26545	162	Other OR therapeutic procedures on joints
26820-26863	162	Other OR therapeutic procedures on joints
29835-29838	162	Other OR therapeutic procedures on joints
29844-29846	162	Other OR therapeutic procedures on joints

NOTE: CPT Code Range 28192-28250 (CCS 160) was removed and added to *Toe, Foot, Ankle, and Leg Procedure CPT Codes for ADULT AND PEDIATRIC PATIENTS*.

Shoulder Procedure CPT Codes for ADULT PATIENTS

CPT Code Range	CCS	CCS Description
23500-23680	148	Other fracture and dislocation procedure
24498-24582	148	Other fracture and dislocation procedure
25431-25440	148	Other fracture and dislocation procedure
29825-29825	150	Division of joint capsule, ligament or cartilage
23470-23474	154	Arthroplasty other than hip or knee
29826-29826	154	Arthroplasty other than hip or knee

CPT Code Range	CCS	CCS Description
23073-23073	160	Other therapeutic procedures on muscles and tendons
23405-23412	160	Other therapeutic procedures on muscles and tendons
23430-23440	160	Other therapeutic procedures on muscles and tendons
29827-29828	160	Other therapeutic procedures on muscles and tendons
29806-29807	162	Other OR therapeutic procedures on joints

Shoulder Procedure CPT Codes for PEDIATRIC PATIENTS

CPT Code Range	CCS	CCS Description
23120-23156	142	Partial excision bone
29824-29824	142	Partial excision bone
23500-23680	148	Other fracture and dislocation procedure
24498-24582	148	Other fracture and dislocation procedure
25431-25440	148	Other fracture and dislocation procedure
29825-29825	150	Division of joint capsule, ligament or cartilage
23470-23474	154	Arthroplasty other than hip or knee
29826-29826	154	Arthroplasty other than hip or knee
23073-23073	160	Other therapeutic procedures on muscles and tendons
23405-23412	160	Other therapeutic procedures on muscles and tendons
23430-23440	160	Other therapeutic procedures on muscles and tendons
29827-29828	160	Other therapeutic procedures on muscles and tendons
29806-29807	162	Other OR therapeutic procedures on joints
29820-29823	162	Other OR therapeutic procedures on joints

Spine Procedure CPT Codes for ADULT AND PEDIATRIC PATIENTS

CPT Code Range	CCS	CCS Description
63265-63308	9	Other OR therapeutic nervous system procedures

Hip Procedure CPT Codes for ADULT AND PEDIATRIC PATIENTS

CPT Code Range	CCS	CCS Description
27125-27138	153	Hip replacement, total and partial
29914-29916	153	Hip replacement, total and partial
29861-29868	162	Other OR therapeutic procedures on joints

Knee Procedure CPT Codes for ADULT AND PEDIATRIC PATIENTS

CPT Code Range	CCS	CCS Description
29870-29871	149	Arthroscopy
29888-29889	149	Arthroscopy
29873-29873	150	Division of joint capsule, ligament or cartilage
29884-29884	150	Division of joint capsule, ligament or cartilage
27403-27409	151	Excision of semilunar cartilage of knee
29880-29883	151	Excision of semilunar cartilage of knee
27420-27424	152	Arthroplasty knee
27427-27429	152	Arthroplasty knee
27437-27447	152	Arthroplasty knee
27570-27580	162	Other OR therapeutic procedures on joints
29874-29879	162	Other OR therapeutic procedures on joints

29885-29887	162	Other OR therapeutic procedures on joints

Toe, Foot, Ankle, and Leg Procedure CPT Codes for ADULT AND PEDIATRIC PATIENTS

CPT Code Range	CCS	CCS Description
27750-27848	147	Treatment, fracture or dislocation of lower extremity (other than hip or femur)
28320-28322	147	Treatment, fracture or dislocation of lower extremity (other than hip or femur)
28400-28675	147	Treatment, fracture or dislocation of lower extremity (other than hip or femur)
29850-29856	147	Treatment, fracture or dislocation of lower extremity (other than hip or femur)
27600-27606	160	Other therapeutic procedures on muscles and tendons
27650-27692	160	Other therapeutic procedures on muscles and tendons
28008-28011	160	Other therapeutic procedures on muscles and tendons
28086-28092	160	Other therapeutic procedures on muscles and tendons
28192-28250	160	Other therapeutic procedures on muscles and tendons
27695-27698	162	Other OR therapeutic procedures on joints
28740-28750	162	Other OR therapeutic procedures on joints
29891-29892	162	Other OR therapeutic procedures on joints
29894-29899	162	Other OR therapeutic procedures on joints

General Orthopedic Procedure CPT Codes for ADULT PATIENTS

CPT Code Range	CCS	CCS Description
29815-29819	149	Arthroscopy
29830-29834	149	Arthroscopy
29999-29999	149	Arthroscopy

General Orthopedic Procedure CPT Codes for PEDIATRIC PATIENTS

CPT Code Range	CCS	CCS Description
29815-29819	149	Arthroscopy
29830-29834	149	Arthroscopy
29999-29999	149	Arthroscopy
20665-20697	161	Other OR therapeutic procedures on bone
23480-23491	161	Other OR therapeutic procedures on bone

Otolaryngology Measure Specifications

For otolaryngology procedures, use the following sets of CPT code ranges to count **patients** discharged from your facility 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

For otolaryngology procedures there is one set of codes for each procedure that should be used to count:

a. The total number of adult (18 years of age or older) patients discharged with any of the following CPT codes listed in the range below. The CPT code can be in any procedure field (primary or secondary).
b. The total number of pediatric (17 years of age and younger) patients discharged with any of the following CPT codes listed in the range below. The CPT code can be in any procedure field (primary or secondary).

Ear Procedure CPT Codes for ADULT AND PEDIATRIC PATIENTS

CPT Code Range	CCS	CCS Description
69610-69637	22	Tympanoplasty
69420-69421	23	Myringotomy
69433-69440	23	Myringotomy
69110-69155	26	Other therapeutic ear procedures
69205-69210	26	Other therapeutic ear procedures
69424-69424	26	Other therapeutic ear procedures
21230-21235	164	Other OR therapeutic procedures on musculoskeletal system

Mouth Procedure CPT Codes for ADULT AND PEDIATRIC PATIENTS

CPT Code Range	CCS	CCS Description
40810-40816	33	Other OR therapeutic procedures on nose, mouth and pharynx
41500-41599	33	Other OR therapeutic procedures on nose, mouth and pharynx
42104-42340	33	Other OR therapeutic procedures on nose, mouth and pharynx
42408-42510	33	Other OR therapeutic procedures on nose, mouth and pharynx
42810-42815	33	Other OR therapeutic procedures on nose, mouth and pharynx

Nasal/ Sinus Procedure CPT Codes for ADULT AND PEDIATRIC PATIENTS

CPT Code Range	CCS	CCS Description
30400-30545	28	Plastic procedures on nose
30110-30117	33	Other OR therapeutic procedures on nose, mouth and pharynx
30130-30160	33	Other OR therapeutic procedures on nose, mouth and pharynx
30310-30310	33	Other OR therapeutic procedures on nose, mouth and pharynx
30801-30802	33	Other OR therapeutic procedures on nose, mouth and pharynx
31239-31240	33	Other OR therapeutic procedures on nose, mouth and pharynx
31251-31259	33	Other OR therapeutic procedures on nose, mouth and pharynx
31261-31269	33	Other OR therapeutic procedures on nose, mouth and pharynx
31271-31299	33	Other OR therapeutic procedures on nose, mouth and pharynx
21300-21495	144	Treatment, facial fracture or dislocation
30930-30930	144	Treatment, facial fracture or dislocation

Pharynx/Adenoid/Tonsil Procedure CPT Codes for ADULT AND PEDIATRIC PATIENTS

CPT Code Range	CCS	CCS Description
42820-42836	30	Tonsillectomy and/or adenoidectomy

Urology Measure Specifications

For urology procedures, use the following sets of CPT code ranges to count **patients** discharged from your facility 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

For urology procedures there is one set of codes for each procedure that should be used to count:

a. The total number of adult (18 years of age or older) patients discharged with any of the following CPT codes listed in the range below. The CPT code can be in any procedure field (primary or secondary).
b. The total number of pediatric (17 years of age and younger) patients discharged with any of the following CPT codes listed in the range below. The CPT code can be in any procedure field (primary or secondary).

Circumcision CPT Codes for ADULT AND PEDIATRIC PATIENTS

CPT Code Range	CCS	CCS Description
54150-54161	115	Circumcision
54162-54162	115	Circumcision
54163-54163	115	Circumcision

Cystourethroscopy CPT Codes for ADULT AND PEDIATRIC PATIENTS

CPT Code Range	CCS	CCS Description
52000-52000	100	Endoscopy and endoscopic biopsy of the urinary tract
52007-52204	100	Endoscopy and endoscopic biopsy of the urinary tract
52351-52351	100	Endoscopy and endoscopic biopsy of the urinary tract
52214-52240	101	Transurethral excision, drainage, or removal urinary obstruction
52300-52315	101	Transurethral excision, drainage, or removal urinary obstruction
52352-52352	101	Transurethral excision, drainage, or removal urinary obstruction
52353-52353	107	Extracorporeal lithotripsy, urinary
52356-52356	107	Extracorporeal lithotripsy, urinary
52277-52285	109	Procedures on the urethra
52287-52287	112	Other OR therapeutic procedures of urinary tract
52355-52355	112	Other OR therapeutic procedures of urinary tract

Male Genital Procedures CPT Codes for ADULT AND PEDIATRIC PATIENTS

CPT Code Range	CCS	CCS Description
54300-54304	118	Other OR therapeutic procedures, male genital
54322-54440	118	Other OR therapeutic procedures, male genital
54510-54692	118	Other OR therapeutic procedures, male genital
55040-55060	118	Other OR therapeutic procedures, male genital
55150-55180	118	Other OR therapeutic procedures, male genital

Male Sterilization Procedures CPT Codes for ADULT PATIENTS

CPT Code Range	CCS	CCS Description
55200-55250	117	Other non-OR therapeutic procedures, male genital

Urethra Procedures CPT Codes for ADULT AND PEDIATRIC PATIENTS

CPT Code Range	CCS	CCS Description
53000-53060	109	Procedures on the urethra
53450-53665	109	Procedures on the urethra

Vaginal Repair Procedures CPT Codes for ADULT AND PEDIATRIC PATIENTS

CPT Code Range	CCS	CCS Description
57287-57288	106	Genitourinary incontinence procedures

Dermatology Measure Specifications

For dermatology procedures, use the following set of CPT code ranges to count **patients** discharged from your facility who have undergone the procedure during the reporting period.

One procedure applies to **adult patients only**:

- Complex Skin Repair

For dermatology procedures there is one set of codes for each procedure that should be used to count:

a. The total number of adult (18 years of age or older) patients discharged with any of the following CPT codes listed in the range below. The CPT code can be in any procedure field (primary or secondary).

Complex Skin Repair CPT Codes for ADULT PATIENTS

CPT Code Range	CCS	CCS Description
12001-13133	171	Suture of skin and subcutaneous tissue

Neurological Surgery Measure Specifications

For neurological surgery procedures, use the following sets of CPT code ranges to count **patients** discharged from your facility who have undergone the procedure during the reporting period.

One procedure applies to **adult patients only**:

- Spinal Fusion

For neurological surgery procedures there is one set of codes for each procedure that should be used to count:

a. The total number of adult (18 years of age or older) patients discharged with any of the following CPT codes listed in the range below. The CPT code can be in any procedure field (primary or secondary).

Spinal Fusion Procedure CPT Codes for ADULT PATIENTS

CPT Code Range	CCS	CCS Description
22532-22812	158	Spinal fusion
22840-22855	158	Spinal fusion

Obstetrics and Gynecology Measure Specifications

For obstetrics and gynecology procedures, use the following sets of CPT code ranges to count **patients** discharged from your facility who have undergone any of the 3 procedures during the reporting period.

Three procedures apply to **adult patients only**:

- Cervix Procedure
- Hysteroscopy
- Uterus and Adnexa Laparoscopy

For obstetrics and gynecology procedures there is one set of codes for each procedure that should be used to count:

a. The total number of adult (18 years of age or older) patients discharged with any of the following CPT codes listed in the range below. The CPT code can be in any procedure field (primary or secondary).

Cervix Procedure CPT Codes for ADULT PATIENTS

CPT Code Range	CCS	CCS Description
57510-57550	125	Other excision of cervix and uterus

Hysteroscopy CPT Codes for ADULT PATIENTS

CPT Code Range	CCS	CCS Description
58559-58561	125	Other excision of cervix and uterus
58563-58563	125	Other excision of cervix and uterus
58555-58558	130	Other diagnostic procedures, female organs

Uterus and Adnexa Laparoscopies CPT Codes for ADULT PATIENTS

CPT Code Range	CCS	CCS Description
58661-58661	119	Oophorectomy, unilateral and bilateral
58670-58671	121	Ligation of fallopian tubes
58662-58662	132	Other OR therapeutic procedures, female organs

Plastic and Reconstructive Surgery Measure Specifications

For plastic and reconstructive surgery procedures, use the following sets of CPT code ranges to count **patients** discharged from your facility 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

For plastic and reconstructive surgery procedures there is one set of codes for each procedure that should be used to count:

a. The total number of adult (18 years of age or older) patients discharged with any of the following CPT codes listed in the range below. The CPT code can be in any procedure field (primary or secondary).

Breast Repair or Reconstruction CPT Codes for ADULT PATIENTS

CPT Code Range	CCS	CCS Description
19316-19380	175	Other OR therapeutic procedures on skin and breast

Musculoskeletal Grafts or Implants CPT Codes for ADULT PATIENTS

CPT Code Range	CCS	CCS Description
20926-20926	175	Other OR therapeutic procedures on skin and breast

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). The procedure codes are grouped into CPT Code Ranges based on the Agency for Healthcare Research and Quality's (AHRQs) Clinical Classification Software (CCS), which groups procedures together based on their similarities.

   Please reach out to the Leapfrog Help Desk if you believe additional CPT Codes Ranges from the AHRQs CCS 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 scheduled outpatient procedures that had to be admitted or transferred? 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 the facility selected in Section 10A question #6 (your hospital or a separate hospital outpatient location) if their procedure was scheduled as an outpatient procedure and can be identified using the CPT codes provided in the Measure Specifications on pages 230-248 of the hard copy of the Survey. You should include scheduled outpatient procedures where the patient had to be admitted as an inpatient or for observation, as well as scheduled outpatient procedures where the patient had to be transferred to another location.

   All emergent/urgent cases should be excluded, such as procedures for patients that come through the emergency department.

Patient Selection and Consent to Treat Frequently Asked Questions (FAQs)

1) **What are examples of appropriate tools for assessing frailty and cognition as part of patient screening and selection?**
   Examples of tools that may be used to assess frailty include the Physical Frailty Phenotype (PFP), Deficit Accumulation Index (DAI), FRAIL Scale.
   More information on these assessments of frailty may be reviewed here:
   https://www.americangeriatrics.org/sites/default/files/inline-files/ravi_varadhan.pdf

   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

2) **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 for how the facility 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 at the facility.

Safe Surgery Checklist Frequently Asked Questions (FAQs)

1) **What are examples of Safe Surgery Checklists that are appropriate to use?**
    a. World Health Organization (WHO) Surgical Safety Checklist: https://www.who.int/patientsafety/safesurgery/checklist/en/
    b. The Joint Commission (TJC) Universal Protocol: https://www.jointcommission.org/standards_information/up.aspx
    c. Association of periOperative Registered Nurses (AORN) Comprehensive Surgical Checklist: https://www.aorn.org/guidelines/clinical-resources/tool-kits/correct-site-surgery-tool-kit/aorn-comprehensive-surgical-checklist

3) **If we are not currently using one of the nationally recognized Safe Surgery Checklists (see examples in FAQ #1), how should we respond to Section 10C questions #31-37?**
In 2019, please answer the questions in Section 10C regarding the Safe Surgery Checklist according to the checklist you are currently using. If you are unable to answer the questions because your checklist does not include the steps we are asking about, please go back to question #32 and answer "no." Leapfrog is currently accepting examples of modified Safe Surgery Checklists via our Leapfrog Help Desk and will be reviewing them for the 2020 Surveys with the national Expert Panel.

2) **Does the safe surgery checklist referenced in Section 10C questions #31-37 apply to all procedures, including colonoscopies, endoscopies, etc.?**
Yes, it applies to all procedures in Section 10C questions #2-11. If your facility does not utilize a safe surgery checklist for colonoscopy and/or endoscopy, respond “no” to question #33.

3) **What if the terms ‘sign-in’ and ‘sign-out’ in Section 10C questions #34 and #36 don’t apply to my facility because we are not using the WHO Surgical Safety Checklist?**
In Section 10C: Volume and Safety of Procedures, the terms ‘sign-in’ and ‘sign-out’ apply specifically to facilities utilizing the WHO Surgical Safety Checklist. The terms ‘pre-operative briefing’ and ‘post-operative briefing’ apply to facilities using a different safe surgery checklist. Please see FAQ #1 for a list of suggested safe surgery checklists that can be used in ASCs and HOPDs.

4) **In Section 10C question #35, how does Leapfrog define, “before the procedure begins?”**
“Before the procedure” is defined as prior to skin incision for the purpose of responding to question #35 in Section 10C.

Medication Safety for Outpatient Procedures Measure Specifications

Source: The Leapfrog Group

Reporting Time Period: 12 months

- Surveys submitted prior to September 1: 01/01/2018 - 12/31/2018
- Surveys (re)submitted on or after September 1: 07/01/2018 - 06/30/2019

Sampling: If you have fewer than 60 cases that meet the criteria for inclusion in the denominator of the process measure during the time period of the clinical record audit, include ALL of these cases in measuring adherence to the documentation guidelines. You need NOT use more than 12 months of historical data to increase the eligible cases beyond 60; just measure and report on ALL eligible cases that you have in that reporting time period.

If you have more than 60 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 60 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.

Question #3 (denominator): Number of cases measured (either all cases or a sufficient sample of them).

Your facility 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 – November 30).
The total number of clinical records included in your audit is reported for question #3.

Excluded cases:

- Patients discharged from the facility 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 **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 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:

- as needed (PRN) medications, except inhalers, nitroglycerin, opioids, muscle relaxants, sedatives, and non-opioid analgesics (opiod analgesics must be included)
- 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 a**ny 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 any 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.

Question #6 (numerator): Number of cases in question #3 with a list of **allergies and adverse reaction status** documented in the clinical record.

Determine the total number of clinical records included in the audit (question #3), where a list of allergies and adverse reaction status 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 status **nor** documentation of no known allergies.
- The clinical record does includes a list of allergies, but does not include documentation of the adverse reaction status for each allergy.

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 10D questions #4, #5 and #6?

Yes, when responding to Section 10D 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 facility).

For **question #6**, all allergies and adverse reactions 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 10D Medication Safety for Outpatient Procedures Measure Specifications on pages 252-253.

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 facility have at least 300 eligible discharges[55] during the 12-month reporting period?

This section of the Survey is designed for facilities that discharged at least 300 eligible patients during the reporting period. Facilities 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 3.0 at https://oascahps.org/Survey-Materials.

Question #3: Has your facility 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 2019, Leapfrog will be accepting OAS CAHPS results from ASCs 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 facility 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 facility administered the OAS CAHPS Survey during the reporting period.

It is recommended that facilities (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 2019, Leapfrog will be accepting OAS CAHPS results from facilities 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 facilities (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 2019, Leapfrog will be accepting OAS CAHPS results from facilities that have at least 100 returned surveys.

Question #6: Do the responses to the questions in this subsection include discharges from more than one hospital outpatient department location (e.g., hospital and separate hospital outpatient departments, multiple separate hospital outpatient departments, etc.)?

Indicate "yes" if your OAS CAHPS results include eligible patient discharges from multiple locations (e.g., hospital and separate hospital outpatient department, multiple hospital outpatient departments, etc.). Otherwise indicate "no."

Questions #7-10: In questions #7-10, report your facility's Top Box Score[48] from each of the following patient experience domains from your 12-month vendor report that matches the reporting period selected in question #1.

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?

Questions #11-13: In questions #11-13, report your facility's Top Box Score[48] from each of the following patient experience questions from your 12-month vendor report that matches the reporting period selected in question #1.

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?

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.

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 facilities are not currently administering it?**
While we understand that the OAS CAHPS Survey is still a voluntary component of the CMS ASC Quality Reporting Program, this survey is the only nationally standardized instrument designed to compare patient experience in both HOPDs and ASCs. No other survey has been tested and validated for this purpose. All measures included in Leapfrog's programs are predicated on the latest evidence and recommended by Leapfrog's panels of experts. 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 facilities.

2) **If my facility 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 facilities 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 10E 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 CAHPS Child Hospital Survey, and with the CMS requirement for the CAHPS Hospital Survey.

   If possible, however, it is recommended that facilities (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 facility's patient experience survey?**
No; facilities can only report the results of the official OAS CAHPS Survey on Section 10E 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 facility/vendor. More information on these supplemental questions, including restrictions and required approval, may be reviewed on pages 21-22 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.

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 2018. 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-92 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 (HIPPA) 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.

[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 public release of Survey Results. Enter it exactly as you wish it to be and test it.
- Do not exit out of the Online Hospital Survey Tool to go to the Web page of interest while you are entering data into the Survey or some of your Survey entries may be lost.
- Instead, minimize (but don't close) the Survey window and any other windows that are open, then open your internet browser in a separate window. Find the Web page whose address you wish to enter and Copy/Paste the entire address into the Survey entry. **The http:// prefix needs to be included.**
- If entering the Web page address manually, be careful to type it correctly, without embedded spaces. Forward (/) or backward (\) slashes may be used. Don't forget the "www." if that is part of the address. **The http:// prefix needs to be included.**
- Make sure to use .org, rather than .com, if that's the domain for your hospital's website.

- Although many hospitals elect to enter the address for the home page of their hospital website, consider pointing it to a page specific to patient safety, the Leapfrog safety practices, or other quality improvement activities that you want to communicate to your community.

[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 normal 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.

[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:

- *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 about 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.

[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 through completion of the Society of Neurological Surgeon's CAST fellowship, with subsequent passage of the associated ABNS exam. On an interim basis, physicians are considered by Leapfrog to be equivalent to a physician "certified in Neurocritical Care Medicine" if they completed the CAST fellowship prior to the availability of the associated ABNS exam, are board- certified in their specialty, and have provided at least six weeks of full-time ICU care annually. (The weeks need not be consecutive weeks.)

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.

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. "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.

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:

- the number of urgent calls/pages/texts made to intensivists when they are not present in the unit (whether on-site or via telemedicine);
- 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
- 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 intensivist coverage, then an analysis of response times is not required.

[29] ***FCCS-Certified Nurse "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 Teleintensivists 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) on-site during that time period to carry out the teleintensivist'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. “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] ***Professional with Appropriate Training and Skills***
This would include staff trained in Infection Control or Infectious Diseases, whose tasks formally 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.

[34] ***Audits of the Volume of Alcohol-based Hand Sanitizer***
To audit the amount of alcohol-based hand sanitizer that is delivered with each activation of a wall-mounted dispenser (manual and automated), hospitals should use the following process:

1. Take a small graduated plastic medicine cup and have the dispenser deliver 10 doses of alcohol-based hand sanitizer.

2. Divide the total volume dispensed by 10 to get an average of the amount dispensed.

The audit should be a random sample across different patient care units, comprising at least 5% of dispensers on at least 50% of units.

[35] ***E-learning Tools***
Examples of E-learning tools for hand hygiene include:

- https://ipac-canada.org/hand-hygiene-e-learning-tool.php
- https://www.cdc.gov/handhygiene/providers/training/index.html

[36] ***Never Event***
In 2011, the National Quality Forum released a list of 29 events that they termed "serious reportable events," extremely rare medical errors that should never happen to a patient. Often termed "never events," these include errors such as surgery performed on the wrong body part or on the wrong patient, leaving a foreign object inside a patient after surgery, or discharging an infant to the wrong person. This is an update of NQF's original 2002 and 2006 reports. Please see NQF's "Never Events" list at 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.

[37] ***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.

[38] ***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.

[39] ***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.npsf.org/?page=RCA2.

[40] **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.

[41] **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.

[42] **Labor and Delivery Units**
Labor and delivery units should include all antepartum and postpartum units. Additionally, OR units for cesarean sections and other procedural areas should be included as labor/delivery units. Nursery units should be excluded.

[43] ***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.

[44] ***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.

[45] ***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).

[46] ***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.

[47] ***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.

[48] ***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."

[49] ***Operating Rooms***
If your state designates and licenses operating rooms, enter the number of operating rooms licensed by your state. If your state does not designate and license operating rooms, enter the number of operating rooms 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.

[50] ***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. If your state does not designate and license procedure rooms, enter the number of procedure rooms that are used for endoscopies 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.

[51] ***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.

[52] ***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.

[53] ***Clinician***
A clinician here refers to a physician, physician assistant (PA), nurse practitioner (NP), nurse anesthetist (CRNA), or nurse (RN or MSN).

[54] ***Time-Out***
Time-outs are short meetings with the entire operating team immediately before an incision to verify, at minimum, the patient's identity, procedure site, procedure to be performed, and any anticipated concerns or critical events. The time-out should be led by a single individual on the surgical team, should be clearly documented, and all questions and/or concerns brought up during the time-out should be addressed prior to beginning the invasive procedure.

More information about time-outs may be reviewed in The Joint Commission's 'The Universal Protocol,' which is summarized here: https://www.jointcommission.org/assets/1/18/UP_Poster1.PDF, as well as in the World Health Organization's 'Surgical Safety Checklist,' which may be reviewed here: https://www.who.int/patientsafety/safesurgery/tools_resources/SSSL_Checklist_finalJun08.pdf.

[55] ***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 3.0 at https://oascahps.org/Survey-Materials.