Proposed Changes to the 2015 Leapfrog Hospital Survey

Open for Public Comment

The proposed changes to the Leapfrog Hospital Survey in 2015 are outlined below. To provide public comment, please respond by completing the public comment form here. Comments will be accepted until COB on **December 19, 2014**. Thank you for your interest in the Leapfrog Hospital Survey.

SECTION 1: DEMOGRAPHICS

The Leapfrog Group will include fields for both a mailing address (e.g. post office box) and a physical address in Section 1 Demographics. The mailing address will be used for communications (e.g. security code mailing) to hospital administrators and survey contacts, and the physical address will be used for public reporting.

SECTION 2: COMPUTERIZED PHYSICIAN ORDER ENTRY (CPOE)

Hospitals that report having a functioning computerized physician order entry (CPOE) system in at least one inpatient unit will be asked to report on:

- The total number of inpatient medication orders inpatients across all units, and
- The total number of inpatient medication orders across all units that were entered through the CPOE system.

Previously, Leapfrog asked hospitals to report on the percentage of inpatient orders administered through the CPOE system. Leapfrog will provide some additional guidance in the survey reference book to assist hospitals in responding to the new questions.

There are no proposed changes to the scoring algorithm.

SECTION 3: HIGH-RISK SURGERIES AND CONDITIONS (EVIDENCE-BASED HOSPITAL REFERRAL)

No substantive changes proposed to this section.

SECTION 4: MATERNITY CARE

NTSV CESAREAN SECTION MEASURE

In recognition of the importance of maternity care outcomes data to employers, purchasers, consumers, Leapfrog added The Joint Commission's NTSV Cesarean Section Measure to the Leapfrog Hospital Survey in 2014. Hospitals were instructed to report on the measure using eight separate maternal age stratums. Leapfrog then calculated an adjusted rate (using a method of direct standardization where stratum-specific rates were given a weight derived from the distribution of maternal ages for first births from the NCHS) and an unadjusted NTSV Cesarean Section rate. Hospitals that submitted a 2014 survey were able to view their adjusted and unadjusted rates on a password-protected website. These results were not measured against a target rate, nor were they publicly reported.

Target Rate Established
This summer, Leapfrog convened an eight-member national expert panel of academic physicians and other academic clinicians to perform an extensive review of the literature related to NTSV cesarean sections and recommend a target rate to measure hospitals against in 2015. The panel met several times, and, based on their recommendation, hospitals will be measured against a target rate of 23.9% (which is the HealthyPeople 2020 objective). A hospital's performance for this measure will be publicly reported with the first set of 2015 Leapfrog Hospital Survey Results in July 2015 at www.leapfroggroup.org/cp.

Given the lack of immediate evidence of the potential benefits and harms of extremely low cesarean section rates, the panel took a conservative approach in setting an initial target rate for NTSV cesarean sections. The target rate for this measure will be revisited annually by the panel. Given the national goal to reduce primary cesarean sections, it is anticipated that the target rate will be lowered over time.

Proposed scoring algorithm for hospital rate of NTSV Cesarean Section:

- Fully meets the standard: rate ≤23.9%
- Substantial progress: >23.9% and ≤27.0%
- Some progress: >27.0% and ≤33.3%
- Willing to report: >33.3%
- Unable to calculate score: Hospitals that do not meet the minimum reporting size (n <10)
- Declined to respond: Hospital did not submit a Leapfrog Hospital Survey or did not submit Section 4 of the Leapfrog Hospital Survey.

Maternal-Age Stratums Eliminated
In addition, the expert panel recommended that hospitals no longer report on the measure by maternal age stratums, and that Leapfrog no longer calculate an adjusted NTSV Cesarean Section rate. Research has shown that the age effect disappears when you include BMI in the model and that further adjustments for case mix do not add explanatory value. In 2015, hospitals will report a numerator and denominator using The Joint Commission's measure specifications for PC-02 NTSV Cesarean Section (https://manual.jointcommission.org/releases/TJC2014A/MIF0167.html).

EPISIOTOMY MEASURE
Following a review of the 2014 Leapfrog Hospital Survey Results, where over 60% of hospitals were meeting the previous target rate for this measure of 12%, and a discussion regarding clinical practice trends, the Maternity Care Expert Panel recommended that Leapfrog lower the target rate for hospitals to "fully meet" the Episiotomy standard in order to continue to encourage hospitals to improve.

Proposed scoring algorithm for hospital rate of Episiotomy:

- Fully meets the standard: rate ≤5%
- Substantial progress: >5% and ≤10%
- Some progress: >10% and ≤15%
- Willing to report: >15%
- Unable to calculate score: Hospitals that do not meet the minimum reporting size (n <10)
- Declined to respond: Hospital did not submit a Leapfrog Hospital Survey or did not submit Section 4 of the Leapfrog Hospital Survey.

SECTION 5: ICU PHYSICIAN STAFFING (IPS)

Expansion of criteria for physicians to be considered "certified in critical care"
Beginning in 2015, physicians who are board-certified in their primary specialty and who are additionally certified in the subspecialty of Neurocritical Care Medicine through the completion of the Society of Neurological Surgeon's CAST fellowship, with subsequent passage of the associated ABNS exam will be considered "certified in critical care." In addition, 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 for the purposes of meeting this standard. (These six weeks need not be consecutive.) This category of intensivists applies only to neuro ICUs. Neurointensivists qualify as "intensivists" only for coverage in neuro ICUs, not in other ICUs.

Update to criteria for physicians to be considered "certified in critical care"
In addition, due to the recent availability of subspecialty certification in critical care for physicians board-certified in Emergency Medicine, only Emergency Medicine physicians who completed their training prior to 2013 will be considered by Leapfrog to be equivalent to a physician "certified in Critical Care Medicine" for the purpose of meeting the standard. Emergency Medicine physicians who completed training prior 2013 must have provided at least six weeks of full-time ICU care annually. (These six weeks need not be consecutive.)

SECTION 6: NQF SAFE PRACTICES SCORE

New standard for Culture of Safety
Since introducing the NQF Safe Practices to the Leapfrog Hospital Survey in 2004, Leapfrog has asked hospitals if they conduct a culture of safety survey for their units using a nationally recognized tool. Given research that shows a relationship between performance on specific domains on these national surveys and better patient outcomes, Leapfrog added a set of unscored, detailed questions about the culture of safety survey instruments on the 2014 Leapfrog Hospital Survey. Based on the results from these detailed questions, Leapfrog is proposing a new standard focused on culture of safety.

The new standard includes four key elements. Hospitals would earn a ¼ credit for each of the four elements listed below:

1) The hospital conducted a survey using a national standardized tool (e.g. HSOPS, SAQ, PSCHO, Zohar, etc.) in the past 24 months.

2) The hospital used the results of the survey in a "meaningful way" (e.g. implemented all elements of NQF Safe Practice 2 from the Leapfrog Hospital Survey)

3) The hospital publicly reports its data. (For an example, see http://www.uofmhealth.org/quality-safety/patient-safety-culture)

4) The hospital met (or exceeded) a specific score threshold on a valid safety culture survey (e.g. HSOPS, SAQ, PSCHO, Zohar, etc.)

This new standard would give hospitals credit for collecting data on culture of safety, acting on the findings, and making the findings transparent. Hospitals would need to meet or exceed a specific score threshold on a valid culture of safety survey (element #4) to "fully meet the standard."

Proposed Scoring Algorithm for Culture of Safety standard:
- Fully meets the standard: Hospital implements elements #1-4.
- Substantial Progress: Hospital implements elements #1-3 or #1, 2, and 4
- Some Progress: Hospital implements elements #1-2

- Willing to Report: Hospital implements element #1 only or hospital did not administer a culture of safety survey in the past 24 months.
- Declined to respond: Hospital did not submit a Leapfrog Hospital Survey or did not submit Section 6 of the Leapfrog Hospital Survey.

As this is a newly developed standard, Leapfrog is seeking comment from hospitals on the feasibility of reporting on this measure. Initially, Leapfrog would ask hospitals to report on this new standard in 2015, but results would not be publicly reported. In 2016, this new standard would replace Safe Practice 2 Culture, Measurement, Feedback, and Intervention, meaning that Safe Practice 2 would be retired from the Leapfrog Hospital Survey.

SECTION 7: MANAGING SERIOUS ERRORS

No substantive changes proposed to this section.

SECTION 8: SAFETY-FOCUSED SCHEDULING (UTILIZATION AND ACCESS)

Retiring the Safety-Focused Scheduling Section
Although the benefits of applying operations management methods to smooth patient flow in operating rooms that service inpatients are well-documented, efforts to develop a standard and measure hospitals' performance against the standard have not yielded the anticipated results. Despite serial refinements of the survey questions and measure specifications, hospitals continue to be challenged in respect to accurate data collection. Leapfrog feels strongly that including this measure on the survey for the past several years succeeded in awakening US hospitals to this previously invisible opportunity to lower surgical complications and the cost of surgical care, and many hospitals have capitalized on this opportunity to the great benefit of their patients and other purchasers of care. However, until such time as we find a source for more valid survey questions, we will retire Section 8 Safety-focused Scheduling from the survey.

SECTION 9: RESOURCE USE

LENGTH OF STAY FOR AMI, HEART FAILURE, AND PNEUMONIA PATIENTS
Patients with >120 inpatient days will be excluded from the measure.

NEW SECTION: BAR CODE MEDICATION ADMINISTRATION (BCMA)

To better recognize hospitals for effective efforts to prevent medication errors, Leapfrog proposes a new standard to the 2015 Leapfrog Hospital Survey focused on hospitals use of BCMA in inpatient units. Bar coded medication administration systems (BCMAs) are one of the proposed solutions to medication administration errors and may reduce reported medication errors by as much as 86% (Baldwin, 2002; Bates, et al., 2001; Cipriano, 2002; Crane & Crane, 2006; Cummings, Bush, Smith, & Matuszewski, 2005; Johnson, Carlson, Tucker, & Willette, 2002; Paoletti, et al., 2007; Rivish & Modeda, 2010).

The new section will include three questions in 2015:

1. Does your hospital use a BCMA system in administering medications at least one inpatient unit?
2. What is the total number of inpatient medication orders across all inpatient units?
3. What is the total number of inpatient medication orders administered using a BCMA system?

Results for this section of the survey will not be publicly reported in 2015. Results will be publicly reported in 2016. Leapfrog has convened a national expert panel that will develop recommendations for performance category cut-points over the next year. In addition, the expert panel will develop additional components to this standard to ensure that work-arounds created by clinicians in the execution of the required processes, and that often lead to

medication errors, aren't taking place in inpatient units where BCMA is being utilized. Public comments with recommendations for the Expert Panel on additional components to ensure walk-arounds are not taking place are also welcomed.

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