



**MICHIGAN HEALTH AND SAFETY COALITION
JOINT HOSPITAL SURVEY**

September 5, 2003

Michigan Health and Safety Coalition Joint Hospital Survey

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*Any sections B2(a-h) - B3 which do not apply will be marked N/A based on responses in section B1. Each section will be marked "Completed" when finished on-line.

This is a voluntary survey. All questions are optional, but survey results will not be publicly reported by The Leapfrog Group or the Michigan Health and Safety Coalition unless a minimum set of required questions are answered:

- For any Evidence-Based Hospital Referral results to be submitted to and publicly released by The Leapfrog, any sections B2: b, c, d, f, g and h which apply must all be completed.
- The MH&SC will collect and publicly report results from each MH&SC guideline section individually, for each section where all required MH&SC questions have been answered; this refers to all sections B2: a, c, d, e, g, h and B3 which apply.

After all applicable sections have been completed, or revised as needed, be sure to click on the **Submit Survey Results** button. If you do not, results of your survey responses **WILL NOT** be submitted and will not appear on the Leapfrog or MH&SC web sites.

Submit Survey Results
(Statement of accuracy required)

Save Work & Leave Survey
(Survey results not yet submitted)

- C. Glossary of Terms

Section A1: Preamble

The Michigan Health and Safety Coalition (MH&SC), in partnership with The Leapfrog Group (Leapfrog), requests your participation in its second annual survey of Michigan hospitals. Both Leapfrog and the MH&SC are committed to the improvement of patient safety in Michigan. The purpose of the 2003 partnership is to collect data needed by both organizations using one survey.



Note: This site is for hospitals to submit and update their survey responses. For publicly reported survey results, go to one of these sites:

[Michigan Health and Safety Coalition – Consumer Report](#)

[The Leapfrog Group Patient Safety Survey – Hospital Survey Results](#)

The groups share common organizational interests and values: an unwavering commitment to improve the safety of patient care; a desire to reduce preventable medical errors; a respect for evidence-based initiatives; reliance on valid data; dissemination of information as a catalyst for change and the importance of well-informed consumers.

Recognizing not only the differences, but also the similarities of the respective surveys, the MH&SC and the Leapfrog Group agreed on a collaborative and seamless approach to meet their objectives. By combining surveys, The Leapfrog Group will have comparative data across regions to share with national purchasers and the MH&SC can stimulate movement toward best practices in Michigan while helping to reduce requests for data. Hospitals will benefit by only having a single survey to complete. This survey combines questions related to both MH&SC hospital referral guidelines and Leapfrog safety practices. Questions unique to

MH&SC  or to Leapfrog  are marked with icons distinguishing them. Questions in common are not marked either way.

Participation in the 2003 joint hospital survey is voluntary, but your participation is strongly encouraged so that both the MH&SC and Leapfrog can better achieve their goal to improve the safety of patient care in Michigan hospitals. Both parties will respect the confidentiality of hospital-specific information and data will not be co-mingled between MH&SC and Leapfrog without permission of all parties.

The MH&SC has a diverse membership of key Michigan healthcare stakeholders, including provider organizations representing hospitals, physicians, nurses, and pharmacists; health plans, including HMOs and Blue Cross Blue Shield of Michigan; employer and union groups including the autos and the International Union, UAW; a consumer organization and the Michigan Department of Community Health.

The Leapfrog Group, a 501(c)(3) non-profit organization, has a purchaser base of over 140 organizations nationally, representing over \$59 billion in health care expenditures and 34 million Americans. The Center for Medicare and Medicaid Services (CMS), the Office of Personnel Management and the Department of Defense participate as liaison members. Of the more than 140 employer members, 49 have employees in Michigan.

Leapfrog is collecting data on its national patient safety practices through local Regional Roll-Outs. There are 22 Leapfrog designated Regional Roll-Outs. Michigan, with its strong commitment to patient safety through MH&SC activities, was selected as one of the Leapfrog Group's original Roll-Outs. The official Regional Roll-Out in Michigan, however, was postponed pending the work of the MH&SC's Expert Clinical Panels (ECPs), which produced the MH&SC Hospital Referral Guidelines in 2001. In 2002, the MH&SC asked hospitals to complete a survey based on those guidelines.

The Leapfrog Group is committed to improving the safety, quality and overall value of healthcare through a national movement stimulated by employer purchasing power. Because it is a national movement, there is a need to collect hospital information in a standardized way, using standardized methodology. The Leapfrog Group questions contained in the 2003 survey are the same as those answered by hospitals nation-wide. Hospital-specific results for the Leapfrog Group survey questions will be publicly displayed on The Leapfrog Group Web site (www.leapfroggroup.org). For The Leapfrog Group, you may respond to the survey at any time, although we encourage you to respond by September 30. However, if your hospital's status of

implementing Leapfrog's recommended patient safety practices should change, please update your responses to the survey and resubmit within 30 days of that change.

The 2003 MH&SC's survey results will be used to produce data that will assist the MH&SC and others to better understand how adoption of the patient safety guidelines have affected practices within Michigan hospitals and to develop guideline implementation approaches that balance cost, quality and access to care. Hospital-specific results from the MH&SC survey questions will be publicly posted on the MH&SC Web site (www.mihealthandsafety.org). Hospital-specific data will also be shared, upon authorization, with hospitals (in aggregate form) and health plans (for contracted hospitals in their networks) as was done with the first year's survey data and results. For the MH&SC, your hospital MUST respond to this survey no later than September 30, 2003 for your results to be included in the 2003 MH&SC reports that will be provided to hospitals, hospitals, health plans and consumers in November.

Medstat (<http://www.medstat.com>), a Thomson business, is providing data collection, analysis, and support services to the Michigan Health and Safety Coalition and The Leapfrog Group for this patient safety survey. Medstat is a health information company that provides decision support systems, market intelligence, benchmark databases, and research for managing the purchase, administration, and delivery of health services and benefits. It serves more than 1,000 organizations across the healthcare spectrum including hospitals, health systems, and integrated delivery networks as well as many of the nation's leading employers, health plans, pharmaceutical companies, and federal and state government organizations.

Section A2: General Information

Michigan Health and Safety Coalition Hospital Referral Guidelines Survey

Background

The MH&SC's mission is to help improve health care quality in Michigan through cost-effective improvements in patient safety, including reduced medical errors, across all health care settings. The Michigan Health and Safety Coalition (MH&SC) released the Hospital Referral Guidelines in December 2001. Michigan hospitals were sent a copy of the guidelines, along with an announcement, from the Michigan Health & Hospital Association (MHA), a Coalition member. The guidelines are also available on the Coalition's Web site at www.mihealthandsafety.org.

The Michigan guidelines focus on Intensive Care Unit Physician Staffing (IPS), care for low birthweight infants and infants with congenital anomalies in Neonatal Intensive Care Units, and the following procedures: abdominal aortic aneurysm repair, carotid endarterectomy surgery, esophagectomy for cancer, open heart surgery, and percutaneous coronary interventions. These areas of care and procedures were selected for guideline development based on evidence of a relationship between particular characteristics of a hospital and patient health outcomes, as well as significant employer interest in useful quality indicators in these areas.

Six Expert Clinical Panels, under the direction of the MH&SC, developed the guidelines using a rigorous, facilitated review process that included an assessment of currently available scientific evidence from published, peer-reviewed health services research and expert collaborative consensus opinion. These guidelines are based on the principles of continuous quality improvement and will evolve as new evidence is developed.

Last year, in the spring of 2002, the MH&SC conducted its first annual hospital survey based on the guidelines. This year, the MH&SC is conducting its second annual survey as a joint initiative with The Leapfrog group. One of the key benefits of this survey for hospitals is the opportunity to consolidate multiple data collection efforts. The MH&SC's hope is that the guidelines will be used to support continuous improvement in the safety and quality of health care in Michigan. The survey will help the MH&SC to identify gaps between the guidelines and actual practice.

Access to MH&SC Hospital Data and Survey Reports

Four levels of access to MH&SC data have been identified: consumers, health plans, hospitals, and the MH&SC's analytical team. Prior to the release of data and reports, the algorithms and weights used to score each report will be shared with hospitals. Permission to release the hospital-specific reports and data as detailed below will be sought from each hospital. No hospital-specific data will be shared without permission. Hospitals that elect not to participate in the survey or not to share their data will be denoted in the public report as choosing not to participate. (Note: responses to all Leapfrog Group questions will be reported publicly at www.leapfroggroup.org)

Consumers - the general public, employers, and non-hospital health care providers and clinicians – will be provided high-level aggregated data via the MH&SC Web site. Specifically, a one-item summary measure will be provided for IPS; and for the volume-based guidelines, raw volume data and a one-item measure that reflects appropriateness and other structure, process and outcome measures will be made available.

Health plans will have access to hospital-specific responses for each item in the survey instrument from all contracted hospitals in the health plan's network that grant approval for the data's release, and others with hospital permission. Making these data available should reduce the need for hospitals to collect and submit the required information separately. Health plans will have the opportunity to use this data to respond to multiple inquiries from purchasers on the performance of their contracted hospitals.

Each hospital will have access to its own responses to each item in the survey. Hospitals that authorize release of their hospital-specific reports will also have access to aggregated responses for each item in the

survey instrument. Aggregate reports will depict responses from all hospital participants and for respondents sorted by segments such as peer-group and geographic region.

The MH&SC's analytical staff will have access to all hospital-specific responses for each item in the survey. These data, and the analyses of them, will help the MH&SC identify issues that need to be addressed, such as funding and access to care in different geographic regions, before developing guideline implementation strategies. As we did last year, hospitals will be invited to participate in quality/safety workgroups to explore implementation issues and recommend next steps to the MH&SC.

The Leapfrog Group Hospital Patient Safety Survey

A 1999 report by the Institute of Medicine (IOM) found that up to 98,000 Americans die every year from preventable medical errors made in hospitals. The report recommended that large healthcare purchasers provide more market reinforcement for quality and safety. The Leapfrog Group is a growing consortium of over 140 Fortune 500 companies and other large private and public healthcare purchasers founded by The Business Roundtable. The Leapfrog Group launched a national effort in November 2000 to reward hospitals for advances in patient safety and quality and to educate employees, retirees, and families about the importance of hospitals' efforts in this area. Leapfrog purchasers provide health benefits to more than 34 million Americans and spend more than \$59 billion on healthcare annually.

The Leapfrog Group has identified three initial patient safety practices (Leaps) as the focus for hospital recognition and reward. They are Computer Physician Order Entry, ICU Physician Staffing, and Evidence-Based Hospital Referral. Research indicates that meeting these Leaps in non-rural hospitals could save upwards of 58,300 lives and prevent approximately 522,000 serious medication errors each year. Detail about the three Leaps is outlined throughout this hospital survey.

Leapfrog's initial efforts have a special focus on acute-care facilities in designated urban and suburban regions around the country, including Michigan. Leapfrog purchasers will use the survey responses to (1) educate and inform enrollees about patient safety and the importance of comparing provider performance on Leapfrog's three safety Leaps and (2) recognize and reward providers that meet the Leaps. This means that purchasers will share the survey responses with their employees. It also means that purchasers will use the survey results in their contracting discussions with health plans and providers. In addition, The Leapfrog Group will share the responses from all hospitals with the public to describe the progress that your hospital is making towards implementing the Leapfrog safety Leaps.

The Leapfrog Group is committed to presenting information that is as current and accurate as possible. For those hospitals that choose not to respond to a request to complete the survey, the publicly reported survey results will read: "Hospital did not disclose this information."

Background information about The Leapfrog Group and details about Leapfrog's three safety Leaps are available by clicking on the links below.

[The Leapfrog Group Fact Sheet](#)

[CPOE Fact Sheet](#)

[Evidence-Based Hospital Referral Fact Sheet](#)

[Evidence-Based Hospital Referral – Medical Coding for High-Risk Procedures and Conditions](#)

[ICU Physician Staffing Fact Sheet](#)

[Frequently Asked Questions about the Survey](#)

[How Results of the Survey are Publicly Reported](#)

If you have any questions, please call the survey help line at (734) 913-3030.

If you have additional questions about The Leapfrog Group, please visit www.leapfroggroup.org.

Section A3: Completing the Survey Online

Welcome!



The Michigan Health and Safety Coalition Joint Hospital Survey is divided into fourteen sections. The first section asks you to provide basic information about your hospital. The next ten sections ask questions specifically about your hospital's current practices compared to the guidelines for volume-based procedures, IPS, and CPOE. Each section follows a similar format. The last two sections are optional: one asks if your hospital is willing to participate in collaborative workgroups focused on issues related to implementation of one or more of the guidelines; the other offers hospitals an opportunity for a comparative self-assessment of patient safety readiness.

CEO's of all Michigan hospitals should have received an introductory letter requesting that their hospital complete the survey and containing a security code for completing the survey on-line. **If you do not have a security code**, call the Survey Help Desk to determine where the code was sent or to have another copy sent.

If you already have a security code, you can use it to complete the survey, or to review, revise, or resubmit the latest survey responses for your hospital. **Please review the instructions below before starting the survey.** Or [click here](#) if you're returning to update or review your responses to be taken to the survey now.

Completing the Survey Online

Completing this survey will require a number of steps:

1. This survey requires information that you may not have readily available. We recommend that you print a hard copy of this survey. A printable version of the survey is available by clicking here: [View/Print survey](#). Once you have had a chance to review the survey, please assign survey completion to others in your organization as appropriate. This might include someone from your quality management area who regularly compiles data about your hospital, as well as representatives from your information technology group or medical staff. All survey responses must then be submitted through the online survey. **Each representative from your hospital must use the same security code given to your hospital when accessing the survey online.**
2. **Please respond to the survey for your hospital only.** If your hospital is part of a multi-hospital health care system, each individual hospital within the system will be invited to complete a separate survey using a unique security code.
3. Your hospital may begin the survey and if necessary, stop before finishing, save answers and return at a later time to complete the survey. Once completed, the survey must be affirmed and submitted for results to be released. Once you have completed the survey, you can visit this survey site at any time to review your responses or update them as needed. We invite you to update the information in this survey at least annually. Please update your information within 30 days of any change in status. We reserve the right to either omit or have disclaimers accompany information that is not current.
 - **The Leapfrog Group will update the public display of survey results monthly**, and results from your survey (re)submissions will appear on the site in the first week of the following month.
 - The MH&SC will update the public display of survey results bi-annually. **Your hospital MUST complete the survey by September 30, 2003 for your results to be included in the MH&SC reports that will be provided to hospitals, health plans and consumers in December 2003.**
4. This survey combines questions related to both MH&SC Hospital Referral guidelines and Leapfrog safety practices. Questions unique to MH&SC  or to Leapfrog  are marked with icons distinguishing them. Questions in common are not marked either way. All questions are optional. However, survey results will not be submitted to Leapfrog or MH&SC unless a minimum set of required questions have been answered.

- Upon completion of any section of the on-line survey, a list of unanswered questions necessary for Leapfrog submission will be noted, otherwise the section will be marked “complete” for Leapfrog submission when you return to the Table of Contents. All Evidence-Based Hospital Referral sections for which there are Leapfrog standards must be completed for any Evidence-Based Hospital Referral results to be released to Leapfrog.
 - Upon completion of any section of the on-line survey, a list of unanswered questions necessary for MH&SC submission will be noted, otherwise the section will be marked “complete” for MH&SC submission when you return to the Table of Contents. The MH&SC will collect and publicly report results from each MH&SC guideline section individually, for each section where all required MH&SC questions have been answered.
5. You must use the same reporting period for all data submitted for each section of the survey. Responses to all questions will be based on reporting periods of the most recent 12 month period or the annual average of the past 24 months.
 6. To help you better understand the questions, we have defined many of our terms in a glossary. Simply click on any underlined term within the survey to immediately view its definition.
 7. Your hospital's status on an item should be reported as “in progress” **only** if you would be able to provide written documentation to substantiate this assessment for that item. Examples of documents to support an “in progress” status include strategic plans with clear and defined timelines, approved budgets, leadership workgroups, training programs, and procurement of bids and pricing information.
 8. At the end of the survey, your organization’s CEO is asked to affirm that all information submitted by his/her authorized agent(s) in response to the survey is accurate.
 9. For more information about the MH&SC and to review the hospital referral guidelines, visit the MH&SC Web site at www.mihealthandsafety.org.
 10. For more information about the Leapfrog Group’s patient safety practices, visit their web site at www.leapfroggroup.org.
 11. You may return to this instruction page from any point in the survey by clicking on the "Return to Instructions" link located at the bottom of each page.
 11. [Click here to begin the survey now](#) and you will be prompted to enter your security code.

Additional Questions:

If you have general questions about the MH&SC survey content, please call Chris Goeschel of the Michigan Health & Hospital Association (MHA), (517) 323-3443 or by e-mail at cgoeschel@mha.org.



For information about the on-line survey, follow the link to the survey at mihealthandsafety.medstat.com. For technical questions, including questions about the Leapfrog Group content and access to the online survey, contact the Survey Help Desk at (734) 913-3030.

Section B1: Organization and Hospital Contact Information


A. Organization Information

If your hospital is part of a larger healthcare system, you should respond to this survey for your hospital only. Your hospital has been identified based on its separate designation as a Medicare-certified hospital. (If your hospital was not included in the roster derived from the Medicare Provider of Service directory, you have been assigned a special identification number through the form located on this site for the purposes of completing this survey only.)

Your hospital should reflect the status and information pertaining only to this hospital, as identified. If you are responding on behalf of a multi-hospital system, separate survey responses are required for each hospital based on their separate Medicare certification (or the special identifier assigned to your hospital through the form located on this site).

1.	Hospital name	
2.	Street address	
3.	City	
4.	State	
5.	Zip Code	
6.	Main phone number	
7.	Hospital web site address (So consumers can learn more about your hospital's efforts in the area of patient safety and quality improvement.) see: Tips for entering Web addresses	
8.	Number of <u>licensed medical, surgical, and obstetrics beds</u>	
9.	Number of <u>staffed medical, surgical, and obstetric beds</u>	
10.	Number of total acute-care admissions to your hospital for most recent 12 months available.	
11.	Number of <u>licensed Intensive Care Unit (ICU) beds</u>	
12.	Number of <u>staffed ICU beds</u>	
13.	Number of admissions to adult and pediatric general medical/surgical ICU(s) for most recent 12 months available.	
14.	Number of <u>licensed Neonatal Intensive Care Unit beds</u>	
15.	Is this hospital part of a healthcare system or Integrated Delivery Network (IDN)	
16.	If so, please enter the name of the healthcare system or IDN	

B. Contact Information

1.	Name of Chief Executive Officer (CEO) of your hospital	
2.	Name of Chief Medical Officer (CMO) of your hospital	
3.	Name of Chairman of Board of your hospital	
4.	Name of contact person for this survey	
5.	Contact's title	
6.	Contact's phone number	
7.	Contact's e-mail address	

C. Information about Evidence-Based Hospital Referral Procedures and Services at Your Hospital

Does your hospital perform these procedures on an <u>elective</u> basis?		
1) <u>Open heart surgery</u>	Yes <input type="radio"/>	No <input type="radio"/>
2) <u>Coronary artery bypass graft</u>	Yes <input type="radio"/>	No <input type="radio"/>
3) <u>Percutaneous coronary intervention</u>	Yes <input type="radio"/>	No <input type="radio"/>
4) <u>Abdominal aortic aneurysm repair</u>	Yes <input type="radio"/>	No <input type="radio"/>
5) <u>Carotid endarterectomy</u>	Yes <input type="radio"/>	No <input type="radio"/>
6) <u>Pancreatic resection</u>	Yes <input type="radio"/>	No <input type="radio"/>
7) <u>Esophagectomy</u>	Yes <input type="radio"/>	No <input type="radio"/>
8) Does your hospital have a <u>licensed neonatal intensive care unit</u> ?	Yes <input type="radio"/>	No <input type="radio"/>
9) Does your hospital operate any adult or pediatric medical/surgical intensive care units?	Yes <input type="radio"/>	No <input type="radio"/>
10) If you answered yes to any questions #1-8, indicate the time period for which volume and census data will be reported in later sections of this survey.	<input type="radio"/> 12-months ending: <input type="radio"/> 24-months ending:	_____ MMYYYY <i>(period must end within the last year)</i>

Specifications for using ICD-9 Codes to identify and count the procedures or conditions identified above: [VolumeStdCodes.pdf](#)

Section B2a: Open Heart Surgery

Complete this section only if your hospital performs these procedures on an elective basis.



[2003 MH&SC Open Heart Surgery Guideline](#)

An item should be reported as “in progress” only if you are able to provide written documentation to substantiate such an assessment.

<p>A. Volume</p> <p>1. How many <u>open heart surgeries</u> were performed in your hospital for the <reporting period> ending <MMYYYY>?</p>	<p><i>(Annual number of procedures for this period; annual average if 24 months of data)</i></p>																								
<p>B. Appropriateness</p> <p>1. Does your hospital's medical staff have <u>appropriateness criteria</u> for determining the <u>medical necessity of open heart surgeries</u>?</p> <p>2. Does your hospital require the medical staff to use the <u>appropriateness criteria for clinical case reviews of open heart surgeries</u>?</p>	<table style="width: 100%; text-align: center;"> <tr> <td>Yes</td> <td>In Progress</td> <td>No</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td></td> <td></td> <td>Go to C1</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> </table>	Yes	In Progress	No	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			Go to C1	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>												
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		Go to C1																							
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																							
<p>C. Structure, Process, Outcome Measures</p> <p>1. Does your hospital have a <u>risk-adjustment system for open heart surgeries</u>?</p> <p style="margin-left: 20px;">a. Does your hospital collect <u>risk-adjusted mortality</u>?</p> <p style="margin-left: 20px;">b. Does your hospital collect <u>risk-adjusted morbidity</u> indicators?</p> <p>2. Does your hospital and/or its cardiac surgeons submit clinical data related to <u>open heart surgeries</u> to the <u>Society of Thoracic Surgeons Database</u>?</p> <p style="margin-left: 20px;">a. Is your hospital and/or its cardiac surgeons willing to submit clinical data related to <u>open heart surgeries</u> to the <u>Society of Thoracic Surgeons Database</u>?</p>	<table style="width: 100%; text-align: center;"> <tr> <td>Yes</td> <td>In Progress</td> <td>No</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td></td> <td></td> <td>Go to C2</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td>Skip C2a</td> <td>Skip C2a</td> <td></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> </table>	Yes	In Progress	No	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			Go to C2	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Skip C2a	Skip C2a		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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Comment Box

If desired, please provide any additional comments on this section of the survey in the space provided.



Section B2b: Coronary Artery Bypass Graft Surgery

Complete this section only if your hospital performs these procedures on an elective basis.



[2003 Evidence-Based Hospital Referral \(EHR\) Leap for CABG](#)

<p>A. Volume</p> <ul style="list-style-type: none"> • How many <u>coronary artery bypass graft surgeries</u> were performed in your hospital for the <reporting period> ending <MMYYYY>? 	<p>_____</p> <p><i>(Annual number of procedures for this period; annual average if 24 months of data)</i></p>												
<p>B. Performance Measurement Indicate your hospital's participation, if any, in the following national performance measurement system if your hospital submitted data for all such procedures in the most recent 12-month period for which performance reports have been released.</p>													
<p>1. Based on participation in the Society of Thoracic Surgeons (STS) performance reporting system, is your hospital's performance for the most recent 12-month reporting period more favorable than the national average for participating U.S. hospitals on either risk-adjusted mortality or ratio of observed-to-expected mortality for coronary artery bypass graft surgery?</p> <p>2. Based on reporting period for 12 months ending:</p>	<table style="width: 100%; border: none;"> <tr> <td style="text-align: center;">Yes <input type="radio"/></td> <td style="text-align: center;">No <input type="radio"/></td> </tr> <tr> <td style="text-align: center;">Did not participate <input type="radio"/></td> <td style="text-align: center;">Participated but prefer not to respond <input type="radio"/></td> </tr> </table> <p style="text-align: center;">_____</p> <p style="text-align: center;">MMYYYY</p>	Yes <input type="radio"/>	No <input type="radio"/>	Did not participate <input type="radio"/>	Participated but prefer not to respond <input type="radio"/>								
Yes <input type="radio"/>	No <input type="radio"/>												
Did not participate <input type="radio"/>	Participated but prefer not to respond <input type="radio"/>												
<p>C. Procedure-Specific Process Measurement System Indicate your hospital's adherence to Leapfrog's expert panel-endorsed procedure-specific process measures of quality specific to this procedure (see Zynx.pdf), if measured, or your hospital's intent to measure and report results by year-end 2003.</p>													
<p>1. Has your hospital:</p> <ul style="list-style-type: none"> • performed a medical record audit on all cases, or on a random sample of at least 61 cases (<u>why 61 cases?</u>), for coronary artery bypass graft surgery over at least a 12-month period, but excluding cases admitted more than 24 months ago; and • measured adherence to at least two of Leapfrog's expert panel-endorsed clinical process guidelines for this procedure? <p>2. If Yes, did your hospital exceed 80% adherence to two or more of those guidelines?</p> <p>3. Does your hospital commit to performing such a medical record audit, measuring adherence to Leapfrog's expert panel-endorsed clinical process guidelines for this procedure, and reporting the results via an update of this survey no later than December 31, 2003?</p>	<table style="width: 100%; border: none;"> <tr> <td style="text-align: center;">Yes <input type="radio"/></td> <td style="text-align: center;">No <input type="radio"/></td> </tr> <tr> <td style="text-align: center;"></td> <td style="text-align: center;">Go to C3</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;">Skip C3</td> <td style="text-align: center;">Skip C3</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;"></td> <td style="text-align: center;"></td> </tr> </table>	Yes <input type="radio"/>	No <input type="radio"/>		Go to C3	<input type="radio"/>	<input type="radio"/>	Skip C3	Skip C3	<input type="radio"/>	<input type="radio"/>		
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Skip C3	Skip C3												
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Section B2c: Percutaneous Coronary Intervention

Complete this section only if your hospital performs these procedures on an elective basis.









[2003 MH&SC PCI Guideline](#)

[2003 Evidence-Based Hospital Referral \(EHR\) Leap for PCI](#)



An item should be reported as “in progress” only if you are able to provide written documentation to substantiate such an assessment.

<p>A. Volume</p> <p>1. How many <u>percutaneous coronary interventions</u> were performed in your hospital for the <reporting period> ending <MMYYYY>?</p> <p>2. The <u>American College of Cardiology</u> recommends that physician/operators perform at least 75 <u>percutaneous coronary interventions</u> per year. Does your hospital collect data regarding total volume of interventions performed by physician/operators (at your hospital and elsewhere) as part of its credentialing process?</p>	<p style="text-align: center;"><i>(Annual number of procedures for this period; annual average if 24 months of data)</i></p> <table style="width: 100%; text-align: center;"> <thead> <tr> <th style="width: 33%;">Yes</th> <th style="width: 33%;">In Progress</th> <th style="width: 33%;">No</th> </tr> </thead> <tbody> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td></td> <td style="text-align: center;"></td> <td></td> </tr> </tbody> </table>	Yes	In Progress	No	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>									
Yes	In Progress	No														
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>														
<p>B. Appropriateness</p> <p>1. Does your hospital's medical staff have <u>appropriateness criteria</u> for determining the <u>medical necessity</u> of <u>percutaneous coronary interventions</u>?</p> <p>2. Does your hospital require the medical staff to use the <u>appropriateness criteria</u> for <u>clinical case reviews</u> of <u>percutaneous coronary interventions</u>?</p>	<table style="width: 100%; text-align: center;"> <thead> <tr> <th style="width: 33%;">Yes</th> <th style="width: 33%;">In Progress</th> <th style="width: 33%;">No</th> </tr> </thead> <tbody> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td></td> <td style="text-align: center;"></td> <td style="text-align: center;">Go to C1</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td></td> <td style="text-align: center;"></td> <td></td> </tr> </tbody> </table>	Yes	In Progress	No	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			Go to C1	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
Yes	In Progress	No														
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>														
		Go to C1														
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>														

C. Structure, Process, Outcome Measures	Yes	In Progress	No
1. Does your hospital have a <u>risk-adjustment system for percutaneous coronary interventions</u> ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Go to C2
a. Does your hospital collect hospital-specific <u>risk-adjusted mortality</u> ?	<input type="radio"/>	<input type="radio"/> 	<input type="radio"/>
b. Does your hospital collect physician-specific <u>risk-adjusted mortality</u> ?	<input type="radio"/>	<input type="radio"/> 	<input type="radio"/>
c. Does your hospital collect hospital-specific <u>risk-adjusted morbidity indicators</u> ?	<input type="radio"/>	<input type="radio"/> 	<input type="radio"/>
d. Does your hospital collect physician-specific <u>risk-adjusted morbidity indicators</u> ?	<input type="radio"/>	<input type="radio"/> 	<input type="radio"/>
2. Does your hospital and/or its physician/operators submit clinical data related to <u>percutaneous coronary interventions</u> to a <u>comprehensive statewide database</u> ?	<input type="radio"/> Skip C2a	<input type="radio"/> Skip C2a 	<input type="radio"/>
a. Is your hospital or its physician/operators willing to submit clinical data related to <u>percutaneous coronary interventions</u> to a <u>comprehensive statewide database</u> ?	<input type="radio"/>	<input type="radio"/> 	<input type="radio"/>










D. Performance Measurement

Indicate your hospital's participation, if any, in the following national performance measurement system if your hospital submitted data for all such procedures in the most recent 12-month period for which performance reports have been released.

1. Based on participation in the American College of Cardiology National Cardiovascular Data Registry (ACC-NCDR™) quality measurement program, is your hospital's performance for the most recent 12-month reporting period more favorable than the national NCDR average risk-adjusted mortality of participating U.S. hospitals for percutaneous coronary interventions?	<table> <tr> <td data-bbox="1114 1230 1279 1289">Yes <input type="radio"/></td> <td data-bbox="1279 1230 1502 1289">No <input type="radio"/></td> </tr> <tr> <td data-bbox="1114 1331 1279 1409">Did not participate <input type="radio"/></td> <td data-bbox="1279 1310 1502 1409">Participated but prefer not to respond <input type="radio"/></td> </tr> </table> 	Yes <input type="radio"/>	No <input type="radio"/>	Did not participate <input type="radio"/>	Participated but prefer not to respond <input type="radio"/>
Yes <input type="radio"/>	No <input type="radio"/>				
Did not participate <input type="radio"/>	Participated but prefer not to respond <input type="radio"/>				
2. Based on reporting period for 12 months ending:	<hr/> <p data-bbox="1247 1535 1365 1560">MMYYYY</p> 				

E. Performance Measurement

Indicate your hospital's adherence to Leapfrog's expert panel-endorsed procedure-specific process measures of quality specific to this procedure (see [Zynx.pdf](#)), if measured, or your hospital's intent to measure and report results by year-end 2003.

<p>1. Has your hospital:</p> <ul style="list-style-type: none"> performed a medical record audit on all cases, or on a random sample of at least 61 cases (<i>why 61 cases?</i>), for percutaneous coronary interventions over at least a 12-month period, but excluding cases admitted more than 24 months ago; and measured adherence to the Leapfrog expert panel-endorsed clinical process guidelines for this procedure? <p>2. If Yes, did your hospital exceed 80% adherence to each of the two guidelines?</p> <p>3. Does your hospital commit to performing such a medical record audit, measuring adherence to Leapfrog's expert panel-endorsed clinical process guidelines for this procedure, and reporting the results via an update of this survey no later than December 31, 2003?</p>	<table> <tr> <td>Yes <input type="radio"/></td> <td></td> <td>No <input type="radio"/> Go to E3</td> </tr> <tr> <td><input type="radio"/> Skip E3</td> <td></td> <td><input type="radio"/> Skip E3</td> </tr> <tr> <td><input type="radio"/></td> <td></td> <td><input type="radio"/></td> </tr> </table>	Yes <input type="radio"/>		No <input type="radio"/> Go to E3	<input type="radio"/> Skip E3		<input type="radio"/> Skip E3	<input type="radio"/>		<input type="radio"/>
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Comment Box

If desired, please provide any additional comments on this section of the survey in the space provided.



Section B2d: Abdominal Aortic Aneurysm Repair

Complete this section only if your hospital performs these procedures on an elective basis.



[2003 MH&SC AAA Repair Guideline](#)










[2003 Evidence-Based Hospital Referral \(EHR\) Leap for AAA Repair](#)

An item should be reported as “in progress” only if you are able to provide written documentation to substantiate such an assessment.

<p>A. Volume</p> <p>1. How many <u>abdominal aortic aneurysm repairs</u> were performed in your hospital for the <reporting period> ending <MMYYYY>?</p>	<p>_____</p> <p><i>(Annual number of procedures for this period; annual average if 24 months of data)</i></p>																														
<p>B. Appropriateness</p> <p>1. Does your hospital's medical staff have <u>appropriateness criteria</u> for determining the <u>medical necessity</u> of <u>open and/or closed abdominal aortic aneurysm repairs</u>?</p> <p>2. Does your hospital require the medical staff to use the <u>appropriateness criteria</u> for <u>clinical case reviews</u> of <u>open and/or closed abdominal aortic aneurysm repairs</u>?</p>	<table style="width: 100%; border: none;"> <tr> <td style="text-align: center;">Yes</td> <td style="text-align: center;">In Progress</td> <td style="text-align: center;">No</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td></td> <td style="text-align: center;"></td> <td style="text-align: center;">Skip B2</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td></td> <td style="text-align: center;"></td> <td></td> </tr> </table>	Yes	In Progress	No	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			Skip B2	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																		
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		Skip B2																													
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																													
<p>C. Structure, Process, Outcome Measures</p> <p>1. Does your hospital have a <u>risk-adjustment system</u> for <u>open and/or closed abdominal aortic aneurysm repairs</u>?</p> <p style="margin-left: 20px;">a. Does your hospital collect <u>risk-adjusted mortality</u> for <u>open and/or closed abdominal aortic aneurysm repairs</u>?</p> <p style="margin-left: 20px;">b. Does your hospital collect <u>risk-adjusted morbidity indicators</u> for <u>open and/or closed abdominal aortic aneurysm repairs</u>?</p> <p>2. Does your hospital and/or its vascular surgeons submit clinical data related to <u>open and/or closed abdominal aortic aneurysm repairs</u> to a <u>comprehensive statewide database</u>?</p> <p style="margin-left: 20px;">a. Is your hospital and/or its vascular surgeons willing to submit clinical data related to <u>open and/or closed abdominal aortic aneurysm repairs</u> to a <u>comprehensive statewide database</u>?</p>	<table style="width: 100%; border: none;"> <tr> <td style="text-align: center;">Yes</td> <td style="text-align: center;">In Progress</td> <td style="text-align: center;">No</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td></td> <td style="text-align: center;"></td> <td style="text-align: center;">Go to C2</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td></td> <td style="text-align: center;"></td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;">Skip C2a</td> <td style="text-align: center;">Skip C2a</td> <td></td> </tr> <tr> <td></td> <td style="text-align: center;"></td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td></td> <td style="text-align: center;"></td> <td></td> </tr> </table>	Yes	In Progress	No	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			Go to C2	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Skip C2a	Skip C2a					<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
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D. Performance Measurement

Indicate your hospital's adherence to Leapfrog's expert panel-endorsed procedure-specific process measures of quality specific to this procedure (see [Zynx.pdf](#)), if measured, or your hospital's intent to measure and report results by year-end 2003.

<p>1. Has your hospital:</p> <ul style="list-style-type: none"> performed a medical record audit on all cases or on a random sample of at least 61 cases (<u>why 61 cases?</u>), for abdominal aortic aneurysm repairs over at least a 12-month period, but excluding cases admitted more than 24 months ago; and measured adherence to the Leapfrog expert panel-endorsed clinical process guidelines for this procedure? <p>2. If Yes, did your hospital exceed 80% adherence to each of the two guidelines?</p> <p>3. Does your hospital commit to performing such a medical record audit, measuring adherence to Leapfrog's expert panel-endorsed clinical process guidelines for this procedure, and reporting the results via an update of this survey no later than December 31, 2003?</p>	<table> <tr> <td>Yes <input type="radio"/></td> <td></td> <td>No <input type="radio"/> Go to D3</td> </tr> <tr> <td><input type="radio"/> Skip D3</td> <td></td> <td><input type="radio"/> Skip D3</td> </tr> <tr> <td><input type="radio"/></td> <td></td> <td><input type="radio"/></td> </tr> </table>	Yes <input type="radio"/>		No <input type="radio"/> Go to D3	<input type="radio"/> Skip D3		<input type="radio"/> Skip D3	<input type="radio"/>		<input type="radio"/>
Yes <input type="radio"/>		No <input type="radio"/> Go to D3								
<input type="radio"/> Skip D3		<input type="radio"/> Skip D3								
<input type="radio"/>		<input type="radio"/>								

Comment Box

If desired, please provide any additional comments on this section of the survey in the space provided.



Section B2e: Carotid Endarterectomy

Complete this section only if your hospital performs these procedures on an elective basis.



[2003 MH&SC Carotid Endarterectomy Guideline](#)

An item should be reported as “in progress” only if you are able to provide written documentation to substantiate such an assessment.

<p>A. Volume</p> <p>1. How many <u>carotid endarterectomy surgeries</u> were performed in your hospital for the <reporting period> ending <MMYYYY>?</p> <p>2. Did your hospital perform fewer than 50 surgeries for the past two years?</p> <p>3. What was your hospital's <u>combined morbidity and mortality rate</u> for these surgeries for the past two years?</p>	<p style="text-align: center;"><i>(Annual number of procedures for this period; annual average if 24 months of data)</i></p> <p style="text-align: center;"></p> <p>Yes <input type="radio"/> No <input type="radio"/></p> <p style="text-align: right;">Go to B1</p> <p style="text-align: center;"></p> <p style="text-align: center;"></p>
<p>B. Appropriateness</p> <p>1. Does your hospital's medical staff have <u>appropriateness criteria</u> for determining the <u>medical necessity</u> of <u>carotid endarterectomy surgeries</u>?</p> <p>2. Does your hospital require the medical staff to use the <u>appropriateness criteria</u> for <u>clinical case reviews</u> of <u>carotid endarterectomy surgeries</u>?</p>	<p>Yes <input type="radio"/> In Progress <input type="radio"/> No <input type="radio"/></p> <p style="text-align: right;">Go to C1</p> <p style="text-align: center;"></p> <p>Yes <input type="radio"/> In Progress <input type="radio"/> No <input type="radio"/></p> <p style="text-align: center;"></p>
<p>C. Structure, Process, Outcome Measures</p> <p>1. Does your hospital have a <u>risk-adjustment system</u> for <u>carotid endarterectomy surgeries</u>?</p> <p style="margin-left: 20px;">a. Does your hospital collect <u>risk-adjusted mortality</u> for <u>carotid endarterectomy surgeries</u>?</p> <p style="margin-left: 20px;">b. Does your hospital collect <u>risk-adjusted morbidity indicators</u> for <u>carotid endarterectomy surgeries</u>?</p> <p>2. Does your hospital and/or its vascular surgeons submit clinical data related to <u>carotid endarterectomy surgeries</u> to a <u>comprehensive statewide database</u>?</p> <p style="margin-left: 20px;">a. Is your hospital and/or its vascular surgeons willing to submit clinical data related to <u>carotid endarterectomy surgeries</u> to a <u>comprehensive statewide database</u>?</p>	<p>Yes <input type="radio"/> In Progress <input type="radio"/> No <input type="radio"/></p> <p style="text-align: right;">Go to C2</p> <p>Yes <input type="radio"/> In Progress <input type="radio"/> No <input type="radio"/></p> <p>Yes <input type="radio"/> In Progress <input type="radio"/> No <input type="radio"/></p> <p>Yes <input type="radio"/> In Progress <input type="radio"/> No <input type="radio"/></p> <p>Skip C2a <input type="radio"/> Skip C2a <input type="radio"/></p> <p>Skip C2a <input type="radio"/> Skip C2a <input type="radio"/></p> <p>Yes <input type="radio"/> In Progress <input type="radio"/> No <input type="radio"/></p> <p style="text-align: center;"></p> <p style="text-align: center;"></p>

Comment Box

If desired, please provide any additional comments on this section of the survey in the space provided.



Section B2f: Pancreatic Resection

Complete this section only if your hospital performs these procedures on an elective basis.



[2003 Evidence-Based Hospital Referral \(EHR\) Leap for Pancreatic Resection](#)

A. Volume

1. How many pancreatic resections were performed in your hospital for the <reporting period> ending <MMYYYY>?

*(Annual number of procedures
for this period; annual average if 24
months of data)*



Section B2g: Esophagectomy for Cancer

Complete this section only if your hospital performs these procedures on an elective basis.



[2003 MH&SC Esophagectomy for Cancer Guideline](#)

[2003 Evidence-Based Hospital Referral \(EHR\) Leap for Esophagectomy](#)


An item should be reported as “in progress” only if you are able to provide written documentation to substantiate such an assessment.

<p>A. Volume</p> <ul style="list-style-type: none"> • How many <u>esophagectomies for cancer</u> were performed in your hospital for the <reporting period> ending <MMYYYY>? 	<p>_____</p> <p><i>(Annual number of procedures for this period; annual average if 24 months of data)</i></p>												
<p>B. Appropriateness</p> <p>1. Does your hospital's medical staff have <u>appropriateness criteria</u> for determining the <u>medical necessity of esophagectomies for cancer</u>?</p> <p>2. Does your hospital require the medical staff to use the <u>appropriateness criteria for clinical case reviews of esophagectomies for cancer</u>?</p>	<table style="width: 100%; border: none;"> <tr> <td style="width: 33%; text-align: center;">Yes</td> <td style="width: 33%; text-align: center;">In Progress</td> <td style="width: 33%; text-align: center;">No</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td></td> <td></td> <td style="text-align: right;">Go to C1</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> </table>	Yes	In Progress	No	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			Go to C1	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Yes	In Progress	No											
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>											
		Go to C1											
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>											

C. Structure, Process, Outcome Measures	Yes	In Progress	No
1. Does your hospital have a <u>risk-adjustment system</u> for <u>esophagectomies for cancer</u> ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Go to C2
a. Does your hospital collect <u>risk-adjusted mortality</u> ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Does your hospital collect <u>risk-adjusted morbidity indicators</u> ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Does your hospital and/or its surgeons submit clinical data related to <u>esophagectomies for cancer</u> to the <u>Society for Thoracic Surgeons Database</u> ?	<input type="radio"/> Skip C2a	<input type="radio"/> Skip C2a	<input type="radio"/>
a. Is your hospital and/or its surgeons willing to submit clinical data related to <u>esophagectomies for cancer</u> to the <u>Society for Thoracic Surgeons Database</u> ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Are all of the surgeons who perform <u>esophagectomies for cancer</u> in your hospital certified by the <u>American Board of Thoracic Surgery</u> to perform this procedure?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Does your hospital have a multidisciplinary <u>tumor board</u> that meets on a regular basis?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Does your hospital provide post-operative care that includes <u>chemotherapy</u> ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Does your hospital provide post-operative care that includes <u>radiation therapy</u> ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comment Box

If desired, please provide any additional comments on this section of the survey in the space provided.



Section B2h: Low Birthweight Infants and Infants with Congenital Anomalies in NICUs


















Complete this section only if your hospital operates one or more licensed neonatal intensive care units.












[2003 MH&SC Guidelines for Low Birthweight Infants and Infants with Congenital Anomalies](#)

[2003 Evidence-Based Hospital Referral \(EHR\) Leap for High-Risk Deliveries](#)

An item should be reported as “in progress” only if you are able to provide written documentation to substantiate such an assessment.

<p>A. Volume</p> <p>1. How many low birthweight infants (<1500 grams) were admitted to your hospital's licensed neonatal intensive care unit for the <reporting period> ending <MMYYYY>?</p> <p>2. For the <reporting period> ending <MMYYYY>, what is the average daily census in the neonatal ICU (counting all patients regardless of condition)?</p>	<p style="text-align: center;">_____</p> <p style="text-align: center;"></p> <p style="text-align: center;">_____</p> <p style="text-align: center;"></p>																								
<p>B. Appropriateness</p> <p>1. Does your hospital's medical staff have <u>appropriateness criteria</u> for determining the <u>medical necessity</u> of all admissions to the <u>neonatal intensive care unit</u>?</p> <p>2. Does the hospital require the medical staff to use the <u>appropriateness criteria</u> for <u>clinical case reviews</u> of all admissions to the <u>neonatal intensive care unit</u>?</p>	<table style="width: 100%; border: none;"> <thead> <tr> <th style="text-align: center;">Yes</th> <th style="text-align: center;">In Progress</th> <th style="text-align: center;">No</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td></td> <td></td> <td style="text-align: right;">Go to C1</td> </tr> <tr> <td></td> <td style="text-align: center;"></td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td></td> <td style="text-align: center;"></td> <td></td> </tr> </tbody> </table>	Yes	In Progress	No	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			Go to C1				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>									
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		Go to C1																							
																									
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																							
																									
<p>C. Structure, Process, Outcome Measures</p> <p>This portion of the survey applies to low birthweight infants and deliveries <32 weeks gestational age. (see Zynx.pdf for clinical definitions)</p> <p>1. For high-risk deliveries and complicated newborns, has your hospital:</p> <ul style="list-style-type: none"> • performed a medical record audit on all cases or on a random sample of at least 61 cases (<u>why 61 cases?</u>) over at least a 12-month period, but excluding cases admitted more than 24 months ago; and • measured adherence to the expert panel-endorsed clinical process guidelines for these high-risk deliveries (see Zynx.pdf)? <p>2. If Yes, did your hospital exceed 80% adherence to each of those guidelines which apply?</p> <p>3. Does your hospital commit to performing such a medical record audit, measuring adherence to Leapfrog's expert panel-endorsed clinical process guidelines applicable to high-risk deliveries and complicated newborns, and reporting the results via an update of this survey no later than December 31, 2003?</p>	<table style="width: 100%; border: none;"> <thead> <tr> <th style="text-align: center;">Yes</th> <th></th> <th style="text-align: center;">No</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;"><input type="radio"/></td> <td></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td></td> <td style="text-align: center;"></td> <td style="text-align: right;">Go to C3</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td></td> <td style="text-align: center;">Skip C3</td> <td style="text-align: right;">Skip C3</td> </tr> <tr> <td></td> <td style="text-align: center;"></td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td></td> <td style="text-align: center;"></td> <td></td> </tr> </tbody> </table>	Yes		No	<input type="radio"/>		<input type="radio"/>			Go to C3	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		Skip C3	Skip C3				<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
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D. Structure, Process, Outcome Measures (continued) This portion of the survey applies to low birthweight infants	Yes	In Progress	No
1. Does your hospital have a <u>risk-adjustment system</u> for <u>low birthweight infants</u> (<1500 grams)?	<input type="radio"/>	<input type="radio"/> 	<input type="radio"/> Go to D2
a. Does your hospital collect <u>risk-adjusted mortality</u> ?	<input type="radio"/>	<input type="radio"/> 	<input type="radio"/>
b. Does your hospital collect <u>risk-adjusted morbidity indicators</u> ?	<input type="radio"/>	<input type="radio"/> 	<input type="radio"/>
2. Does your hospital and/or its neonatologists submit clinical data for <u>low birthweight Infants</u> (<1500 grams) admitted to the <u>neonatal intensive care unit</u> to the <u>Vermont Oxford Network Database</u> ?	<input type="radio"/> Skip D2a	<input type="radio"/> Skip D2a 	<input type="radio"/>
a. Is your hospital and/or its neonatologists willing to submit clinical data for <u>low birthweight infants</u> (<1500 grams) admitted to the <u>neonatal intensive care unit</u> to the <u>Vermont Oxford Network Database</u> ?	<input type="radio"/>	<input type="radio"/> 	<input type="radio"/>
3. Does your hospital have a <u>board-certified or board-eligible</u> neonatologist who directs the <u>neonatal intensive care unit</u> ?	<input type="radio"/>	<input type="radio"/> 	<input type="radio"/>
4. Does your hospital provide 24-hour in-house coverage by a <u>board-certified or board-eligible</u> neonatologist qualified in the intensive care of newborn infants?	<input type="radio"/>	<input type="radio"/> 	<input type="radio"/>
5. Does your hospital provide 24-hour in-house coverage by a <u>nurse practitioner</u> or <u>physician extender</u> certified in the intensive care of newborn infants?	<input type="radio"/>	<input type="radio"/> 	<input type="radio"/>
6. Does your hospital have on-site physician backup (board-certified or board-eligible neonatologist in the neonatal intensive care unit) to the nurse practitioner or physician extender available within 30 minutes?	<input type="radio"/>	<input type="radio"/> 	<input type="radio"/>

E. Structure, Process, Outcome Measures (continued) This portion of the survey applies to infants with congenital anomalies	Yes	In Progress	No
1. Does your hospital have a <u>risk-adjustment system</u> for <u>infants with congenital anomalies</u> ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Go to E2
a. Does your hospital collect <u>risk-adjusted mortality</u> ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Does your hospital collect <u>risk-adjusted morbidity indicators</u> ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Does your hospital and/or its neonatologists submit clinical data for <u>infants with congenital anomalies</u> admitted to the <u>neonatal intensive care unit</u> to the <u>Vermont Oxford Network Database</u> ?	<input type="radio"/> Skip E2a	<input type="radio"/> Skip E2a	<input type="radio"/>
a. Is your hospital and/or its neonatologists willing to submit clinical data for <u>infants with congenital anomalies</u> admitted to the <u>neonatal intensive care unit</u> to the <u>Vermont Oxford Network Database</u> ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Does your hospital have <u>established networks</u> for <u>rapid referral</u> to medical subspecialists?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Does your hospital have <u>established networks</u> for <u>rapid referral</u> to surgical subspecialists?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Does your hospital have <u>established networks</u> for <u>rapid referral</u> to pediatric subspecialists?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comment Box

If desired, please provide any additional comments on this section of the survey in the space provided.



Section B3: Intensive Care Unit Physician Staffing

Complete this section only if your hospital has one or more adult or pediatric medical/surgical intensive care units.



[2003 MH&SC ICU Physician Staffing Guideline](#)

[2003 ICU Physician Staffing \(IPS\) Leap](#)

<p>A. General Relevance</p> <p>1. How many <u>intensive care units</u> does your hospital operate?</p>	<p>_____</p>																											
<p>B. Structure, Process, Outcome Measures</p> <p>1. Are all patients in these ICUs <u>managed or co-managed</u> by one or more physicians who are <u>certified in critical care medicine</u>?</p> <p style="margin-left: 20px;">a. If you answered “Yes”, are some of those physicians considered certified under the <u>expanded definition of “certified”</u>?</p> <p style="margin-left: 20px;">b. Do these <u>ICUs</u> encourage <u>concurrent care</u> delivered by the <u>primary medical or surgical attending physician</u>?</p> <p style="margin-left: 20px;">c. Do these <u>ICUs</u> require that <u>admission and discharge criteria</u> are monitored by physicians who are certified in critical care medicine?</p> <p style="margin-left: 20px;">d. Do these <u>ICUs</u> require that implementation of care protocols be monitored by physicians who are certified in critical care medicine?</p> <p>2. Is one or more of these physicians <u>present</u> in each of these ICUs during daytime hours for at least 8 hours per day, 7 days per week, and do they provide clinical care <u>exclusively</u> in the ICU during these hours?</p> <p style="margin-left: 20px;">a. If you answered “Yes”, is intensivist “presence” accomplished in part via telemedicine?</p> <p>3. When these physicians are not present in these ICUs, does one of them return more than 95% of pages from these units within 5 minutes?*</p> <p>4. When these physicians are not present in the ICU and not able to reach an ICU patient within 5 minutes, can they rely on a physician or <u>FCCS-certified non-physician “effector”</u> who is in the hospital and able to reach these ICU patients within five minutes in more than 95% of the cases?*</p>	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 33%; text-align: center;">Yes</th> <th style="width: 33%; text-align: center;">In Progress*</th> <th style="width: 33%; text-align: center;">No</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Skip B1a</td> <td style="text-align: center;"><input type="radio"/> Skip B1a</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> </td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> </td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> </td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/> Skip B2a</td> <td style="text-align: center;"><input type="radio"/> Skip B2a</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> </tbody> </table>	Yes	In Progress*	No	<input type="radio"/>	<input type="radio"/> Skip B1a	<input type="radio"/> Skip B1a	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> 	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> 	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> 	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Skip B2a	<input type="radio"/> Skip B2a	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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* Only select “in progress” if you can provide documentation (should you be asked) that supports the “in progress” status for this ICU (e.g. a board-approved budget or strategic plan for increasing access to intensivist care, a system to track the actual number of hours ICU care is managed and directed by an intensivist, the percent of time on-call intensivists return pages to the ICU within five minutes, and the use of appropriately qualified physician extenders).

Section B4: 2003 Computer Physician Order Entry (CPOE)











2003 Computer Physician Order Entry (CPOE) Leap

<p>1. Does your hospital have a functioning CPOE system in at least one unit of the hospital?</p>	<table style="width: 100%; border: none;"> <tr> <td style="text-align: center;">Yes <input type="radio"/></td> <td style="text-align: center;">No <input type="radio"/></td> </tr> <tr> <td colspan="2" style="text-align: center;">Go to Question 7</td> </tr> </table>	Yes <input type="radio"/>	No <input type="radio"/>	Go to Question 7	
Yes <input type="radio"/>	No <input type="radio"/>				
Go to Question 7					

If Yes, continue:

<p>2. For units in which CPOE is implemented, does your hospital require all physicians to enter hospital medication orders via a computer system linked to prescribing error prevention software?</p> <p>3. Does your hospital's CPOE system require physicians to document a reason if they override a CPOE-generated warning of a potentially dangerous prescribing error prior to overriding the order?</p> <p>4. Is your CPOE system integrated with the pharmacy, laboratory, and admitting-discharge-transfer (ADT) systems of your hospital?</p> <p>5. What percent of inpatients have the majority of their medication orders entered by a physician via a CPOE system?</p> <p>6. What percent of your hospital's total medication orders (including orders made in units which do NOT have a functioning CPOE) do physicians enter via a CPOE system that:</p> <ul style="list-style-type: none"> • includes prescribing error prevention software; and, • requires that they document electronically a reason for overriding an interception prior to doing so? 	<table style="width: 100%; border: none;"> <tr> <td style="text-align: center;">Yes <input type="radio"/></td> <td style="text-align: center;"></td> <td style="text-align: center;">No <input type="radio"/></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td></td> <td style="text-align: center;">_____% </td> <td></td> </tr> <tr> <td></td> <td style="text-align: center;">_____% </td> <td></td> </tr> </table>	Yes <input type="radio"/>		No <input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>		<input type="radio"/>		_____% 			_____% 	
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<input type="radio"/>		<input type="radio"/>														
<input type="radio"/>		<input type="radio"/>														
	_____% 															
	_____% 															

If you answered "No" to question 1, or less than 75% to question 6, please answer questions 7-14 below as a means of sharing the interim steps your hospital may be taking.

<p>7. If your hospital does not have a CPOE system installed that meets the Leapfrog CPOE Leap, please check the box at right that best describes your current stage in CPOE planning and implementation:</p>	<p> <input type="radio"/> Planning for CPOE <input type="radio"/> Currently selecting CPOE system (at a minimum, RFP has been released) <input type="radio"/> Currently implementing a CPOE system <input type="radio"/> None of the above </p> 		
<p>8. Do you have a written strategy for implementing CPOE?</p> <p>9. Have you defined a timeline and launched a CPOE implementation project?</p> <p>10. What is the date, if any, by which your hospital commits to meet the Leapfrog CPOE Leap fully?</p> <p>11. Has your hospital's board approved a dedicated budget for CPOE for the latest fiscal year for which it approved a final budget?</p> <p>12. Do you have a physician champion who spearheads the CPOE initiative at your hospital?</p> <p>13. Is your CPOE strategy a component of a larger written strategy for a hospital information system?</p> <p>14. For hospitals with 100 or more licensed beds: Does your hospital have an in-house pharmacist available 24hrs/day, seven days/week, to review orders prior to initial dispensing of medications?</p>	<p>Yes</p> <p><input type="radio"/></p> <p><input type="radio"/></p> <p><input type="radio"/></p> <p><input type="radio"/></p> <p><input type="radio"/></p> <p><input type="radio"/></p> <p>Yes</p> <p><input type="radio"/></p>	<p></p> <p></p> <p>_____ MMYYYY</p> <p></p> <p></p> <p></p> <p></p> <p>N/A (<100 beds)</p> <p><input type="radio"/></p> <p></p>	<p>No</p> <p><input type="radio"/></p> <p><input type="radio"/></p> <p><input type="radio"/></p> <p><input type="radio"/></p> <p><input type="radio"/></p> <p><input type="radio"/></p> <p>No</p> <p><input type="radio"/></p>

Statement of Accuracy

These statements pertaining to the Michigan Health and Safety Hospital Referral Guidelines for ICU physician staffing and selected volume-based procedures, and the Leapfrog requirements for CPOE at our hospital are accurate and reflect the current normal operating circumstances at our hospital, and I am authorized to make these statements on behalf of our hospital. We understand that the Michigan Health and Safety Coalition and/or The Leapfrog Group will make this information public and they reserve the right to omit or disclaim information that is not current.

Affirmed by the Hospital's Chief Executive Officer, _____ (name), on _____(mm/day/year).

Note:

- Survey responses will be released to the Michigan Health and Safety Coalition (MH&SC) only if the sections are sufficiently complete for MH&SC survey purposes, and only responses that are specific to MH&SC or common to both MH&SC and Leapfrog will be included in that release.
- Survey responses will be released to The Leapfrog Group (LFG) only if the sections are sufficiently complete for LFG survey purposes, and only responses that are specific to LFG or common to both LFG and MH&SC will be included in that release.

Section B7: Optional Survey Questions from Medstat

In order to help hospitals understand their organization's performance in the area of patient safety compared to their peers, Medstat has included the following optional survey questions for hospitals completing the Leapfrog survey. **These questions are entirely optional** and responses will not be released to, or used by, the Michigan Health & Safety Coalition or The Leapfrog Group for any purpose.

Hospitals that elect to complete these optional questions will receive a summary report of their responses, compared to the range of responses from other hospitals, both nationally and in the local area. If you wish to receive this report, please enter below the e-mail address where you would like this report sent. (If response rates are insufficient to preclude identification of your institution or others within your local area, the local comparisons will be suppressed.)

Please e-mail my summary report to me at: _____
(E-mail address)

Hospital-specific responses to these optional questions are confidential, will not be released publicly, and will not be used for purposes of marketing to individual hospital respondents. To learn more about how Medstat will and will not use your responses to these optional questions, see [Use of Optional Survey Questions and Privacy Policy](#) at the end of this section.

Medstat, a Thomson business, is providing data collection, analysis, and support services to the Michigan Health and Safety Coalition for this patient safety survey.

Medstat is a health information company that provides decision support systems, market intelligence, benchmark databases, and research for managing the purchase, administration, and delivery of health services and benefits. It serves more than 1,000 organizations across the healthcare spectrum including hospitals, health systems, integrated delivery networks, and other provider organizations.

Section B7: Optional Survey Questions from Medstat (*continued*)

Patient Safety Reporting Systems

Today, hospitals are conducting both assessment and improvement activities in the areas of patient safety and quality. Many hospitals have in place, or are considering implementing, a patient safety reporting system. The following questions are about these types of systems.

	<i>Now</i>	<i>Planned within:</i>		<i>No plans/ Unknown</i>
		<i>12 mos.</i>	<i>24 mos.</i>	
1) Our hospital has a non-punitive hazard and error-reporting system in place, with all personnel expected and encouraged to report errors, hazards, and near misses.	0	0	0	0
2) The system is voluntary, open to all employees, confidential, non-punitive, and objective.	0	0	0	0
3) Our Board of Trustees receives and acts on periodic reports on patient safety.	0	0	0	0
4) Processes are in place for investigation, review, and analysis of errors and near misses to identify patterns of hazard and vulnerable designs, root cause analysis, and trends.	0	0	0	0
5) Reporting of errors and near misses is encouraged and used for process improvement initiatives.	0	0	0	0
6) Our hospital has reviewed and assessed its level of compliance with the new JCAHO 2001 patient safety standards.	0	0	0	0
7) We have reviewed and implemented patient safety protections from the JCAHO Sentinel Event Alerts.	0	0	0	0
8) Patient care quality assessment is supported by the following systems (choose all applicable):				
a) JCAHO ORYX™ reporting	0	0	0	0
b) Hospital-wide balanced scorecard reporting	0	0	0	0
c) Reports for regular committee meetings (e.g., morbidity and mortality, infection control, etc.)	0	0	0	0
d) Structured data mining of administrative data (UB-92 and related detailed billing)	0	0	0	0
e) Other _____	0	0	0	0

	<i>Now</i>	<i>Planned within:</i>		<i>No plans/ Unknown</i>
		<i>12 mos.</i>	<i>24 mos.</i>	
9) Patient safety assessment is supported by the following system (choose all applicable):				
a) JCAHO ORYX™ reporting	0	0	0	0
b) Medication error/near-miss reporting	0	0	0	0
c) Risk management / incident reporting	0	0	0	0
d) Regular meetings of patient safety committee(s)	0	0	0	0
e) Other _____	0	0	0	0
10) Our hospital has available the required information for performing the following activities across the organization: (choose all applicable)				
a) Patient care quality assessment	0	0	0	0
b) Patient care quality improvement	0	0	0	0
c) Patient safety assessment	0	0	0	0
d) Patient safety improvement	0	0	0	0

ORYX is a registered trademark of the Joint Commission on Accreditation of Health Care Organizations.

Use of Optional Survey Questions and Privacy Policy

1. THIS POLICY RELATES ONLY TO THE OPTIONAL (MEDSTAT) PORTION OF THE SURVEY.
2. "Hospital-specific survey information" means responses or other information provided by hospital-respondent in this OPTIONAL survey section that is readily identifiable to that hospital.
3. Medstat will not release any hospital-specific survey information to any party other than that hospital respondent nor any aggregate information from which such hospital-specific survey information could reasonably be inferred and attributed specifically to a hospital respondent.
4. Medstat will pool hospital-specific information and may release summaries of information from this optional survey section to hospitals or other parties.
5. Medstat may link the hospital-specific survey information with either public data or private data collected by, purchased by, or licensed to Medstat, or both, to create derivative information products that it may market to hospitals and other parties. These derivative products will not include hospital-specific survey information or information from which such hospital-specific survey information could reasonably be inferred and attributed specifically to a hospital respondent.
6. Medstat may use hospital-specific responses to guide its product development and marketing strategies.
7. Medstat will not use hospital-specific information to market products or services directly to the hospital.

Section C. GLOSSARY OF TERMS

Abdominal Aortic Aneurysm Repair

Abdominal aortic aneurysm (AAA) repairs refer to the open surgical procedures used to treat AAAs and the closed procedures used to treat AAAs including all types of endovascular approaches. An aneurysm is an abnormal dilation of the abdominal portion of the aorta (the major artery from the heart). (MEDLINEplus Encyclopedia <http://www.nlm.nih.gov/medlineplus/ency/article/000162.htm>).

The goal of this standard is to increase the number of patients who have ELECTIVE abdominal aortic aneurysm repair at high volume hospitals. The standard focuses on elective procedures because patients whose AAA's have already ruptured (who need emergency surgery) cannot necessarily be safely transferred to another hospital. In addition, there is less evidence that the choice of hospital matters for emergency AAA (getting the operation as fast as possible may be more important).

The measurement of a hospital's annual volume, however, includes both its elective cases and its emergency cases (since they are all AAA repairs). Thus, a hospital's annual volume is determined by adding up all procedures coded 38.34, 38.44, 38.64, or 39.71 (regardless of diagnosis codes) PLUS all procedures coded 39.25, 39.51 or 39.52 for which there was an accompanying diagnosis code of: 441.0, 441.02, 441.03, 441.3, 441.4, 441.5, 441.6, 441.7, and 441.9. Note that, as above, only one occurrence of a given procedure is counted on a given day. So, if a patient goes to the operating room one day and has coded both a 38.34 "resection of vessel with replacement, abdominal aorta" and 39.25 "aorto-iliac-femoral bypass", this is counted as a single procedure. Exclude patients age 17 and younger.

Admission and Discharge Criteria

In the case of the ICU, the term "admission and discharge criteria" refers to the indicators, generally physiological parameters, used by an intensivist or other physician and clinical staff to determine the appropriateness of admitting or discharging patients.

All elements of the IPS Leap

Patients in adult or pediatric general medical and/or surgical ICU(s) are managed or co-managed by physicians certified (or eligible for certification) in critical care medicine who:

- Are present in the ICU during daytime hours a minimum of 8 hours per day, 7 days per week, and during this time provide clinical care exclusively in the ICU; and,
- At other times . . .
 - ✓ Return more than 95% of ICU pages within 5 minutes (based on a quantified hospital analysis of pager response time). This excludes low-urgency pages, if the paging system can designate low-urgency pages; and,
 - ✓ Can rely on a physician or FCCS-certified non-physician "effector" 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 pager response time). This excludes low-urgency pages, if the paging system can designate low-urgency pages.

American Board of Thoracic Surgery (ABTS)

An active member of the American Board of Medical Specialties. The Board also functions in close cooperation with the Residency Review Committee for Thoracic Surgery, and through it, with the Accreditation Council for Graduate Medical Education and the Council for Medical Affairs (CFMA). The Board also maintains close liaison with the Thoracic Surgery Directors Association.

The primary purpose and most essential function of the Board is to protect the public by establishing and maintaining high standards in thoracic surgery. To achieve these objectives, the Board has established qualifications for examination and procedures for certification and recertification. Its requirements and procedures are reviewed regularly and modified as necessary.

Board certification in a medical specialty is evidence that a physician's qualifications for specialty practice are recognized by his or her peers. It is not intended to define the requirements for membership on hospital staffs, to gain special recognition or privileges for its Diplomats, to define the scope of specialty practice, or to state who may or may not engage in the practice of the specialty.

Specialty certification of a physician does not relieve a hospital's governing body from responsibility in determining the hospital privileges of such specialist.

American College of Cardiology (ACC)

A professional society of over 25,000 cardiovascular physicians and scientists from around the world that support ACC's mission "to foster optimal cardiovascular care and disease prevention through professional education, promotion of research, leadership in the development of standards and guidelines and the formulation of health care policy."

Membership in ACC is open only to those physicians and scientists who meet specific educational and or certification criteria and have high ethical standards as determined by their peers. Members who are both board certified in internal medicine and cardiovascular disease by the American Board of Internal Medicine and devote 75% of their time to the practice of cardiology are eligible for the most prestigious category of Fellow of the American College of Cardiology.

Ancillary (non-physician) Staff

Staff other than physicians and nurses who provide patient care services. Examples of ancillary services include diagnostic imaging, pharmacy, laboratory and therapy services. Ancillary staff are distinguished from support staff by the relationship of their activities to the patient. Support staff activities provide infrastructure support. Examples of support staff include central supply, security, materials management, food service, housekeeping and laundry. (JCAHO Lexicon 1998).

Appropriately Qualified Physician

For the purposes of this survey, an appropriately qualified physician is defined as a physician who is certified, or eligible for certification, in critical care medicine. House officer physicians (intern, resident, or fellow) should be supervised by an intensivist who is board-certified or board-eligible in critical care medicine.

Appropriateness Criteria

Indicators that reflect the degree to which the care and services provided are relevant to an individual's clinical need, given the current state of knowledge.
(http://www.jcaho.org/standard/disease_fr_std.html).

Board-certified or Board-eligible

The American Board of Medical Specialties (ABMS) is the umbrella organization for the 24 approved medical specialty boards in the United States. Established in 1933, the ABMS serves to coordinate the activities of its Member Boards and to provide information to the public, the government, the profession and its Members concerning issues involving specialization and certification in medicine. The mission of the ABMS is to maintain and improve the quality of medical care in the United States by assisting the Member Boards in their efforts to develop and utilize professional and educational standards for the evaluation and certification of physician specialists.

The governing body of each Member Board is comprised of specialists qualified in the specialty represented by the board. The individual Member Boards evaluate physician candidates who voluntarily seek certification by a Member Board of the ABMS. To accomplish this function, the Member Boards determine whether candidates have received appropriate preparation in approved residency training programs in accordance with established educational standards, evaluate candidates with comprehensive examinations, and certify those candidates who have satisfied the board requirements.

What does it mean for a doctor to be board certified? A board certified physician has completed an approved educational training program and an evaluation process including an examination designed to assess the knowledge, skills and experience necessary to provide quality patient care in that specialty.

What does it mean if a doctor states he/she is "board eligible"? There could be a variety of meanings and you should contact the specialty board directly to verify their status. Most of the boards have not used this term for twenty years because of the variety of interpretations and the tendency of some individuals to call themselves "board eligible" indefinitely. [You can read and/or download the ABMS policy statement on "board eligible."]

American Board of Medical Specialties Statement on "Board Eligible"

Because of continuing confusion about the term "board eligible", the American Board of Medical Specialties (ABMS) wishes to reiterate its position about that term. The specific term "board eligible" has been given such diverse meanings by different agencies that it has lost its usefulness as an indicator of a physician's progress toward certification by a specialty board. Furthermore, because some candidates have used the term year after year while making no perceptible progress toward certification, it has sometimes been accepted improperly as a permanent alternative to certification. The requirements for admission to the certification process change from time to time, making the term "board eligible" equally susceptible to changes in meaning. For these reasons, the ABMS recommends to its Member Boards that the use of the term "board eligible" be disavowed. Instead, the Boards are urged to respond to inquiries by stating an individual's precise position in the certifying process.

Average Daily Census in NICU

Compute the average daily census for ALL newborns in the NICU, regardless of the newborns' medical condition. (Do not use the medical coding criteria in [VolumeStdCodes.pdf](#) to determine the average daily census, since the census should count newborns regardless of condition.)

Round the census to the nearest whole number, e.g., 14.4999 rounds to 14; 14.500 rounds to 15.

Care Protocols

The term "care protocols" refers to a variety of tools used by clinicians and others that are designed to improve the quality of patient care by aiding clinical decision making. It may refer to the use of standing orders, critical pathways, practice guidelines and other documents that identify an agreed upon and evidence-based general course of care expected for a particular group of patients.

Clinical practice guidelines describe the processes used to evaluate and treat a patient having a specific diagnosis, condition, or symptom. Clinical practice guidelines are found in the literature under many names – practice parameters, practice guidelines, patient care protocols, standards of practice, clinical pathways or highways, care maps, and other descriptive names. "Guidelines" should be evidence-based, authoritative, efficacious and effective within the targeted patient populations. (http://www.icaho.org/standard/disease_fr_std.html).

Carotid Endarterectomy Surgery

Carotid artery surgery is a surgical procedure to remove fat and cholesterol build-up (plaque) from inside the carotid artery in the neck and restore adequate blood flow to the brain. (MEDLINEplus Encyclopedia <http://www.nlm.nih.gov/medlineplus/ency/article/002951.htm>). The procedures to treat carotid artery disease can be open surgical repairs or other closed procedures including endarterectomies, angioplasties, and insertion of stents (Michigan Health and Safety Coalition Expert Clinical Panel on Vascular Surgery, 2001). Procedure codes equal 38.12.

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 and Pediatrics.

Because sub-specialty certification is not offered in emergency medicine, emergency medicine physicians will be considered "certified in Critical Care Medicine" if they are board-certified in emergency medicine and have completed a critical care fellowship at an ACEP-accredited program.

On an interim basis, two other categories of physicians are considered by Leapfrog to be "certified in Critical Care Medicine":

- Physicians who completed training prior to availability of subspecialty certification in critical care in their specialty (1987 for Medicine, Anesthesiology, Pediatrics and Surgery), who are board-certified in one of these four specialties, and who have provided at least six weeks of full-time ICU care annually since 1987. (The weeks need not be consecutive weeks.)
- Physicians board-certified in Medicine, Anesthesiology, Pediatrics or Surgery who have completed training programs required for certification in the subspecialty of Critical Care Medicine but are not yet certified in this subspecialty.

Chemotherapy

Chemotherapy refers to drugs that are used to kill microorganisms (bacteria, viruses, fungi) and cancer cells. Most commonly the term is used to refer to "cancer-fighting" drugs. (MEDLINEplus Encyclopedia <http://www.nlm.nih.gov/medlineplus/ency/article/002324.htm>).

The treatment of disease by means of chemicals that have a specific toxic effect upon the disease producing microorganisms. (Medline Plus Health Information).

Clinical Case Review

Typically, this activity involves periodic and regularly scheduled concurrent and/or retrospective reviews of particular patient cases and records by a designated multidisciplinary group within a given hospital.

Clinical record is the account, compiled by health care professionals, of an individual's history, present illness, findings on examination, details of care and services, and notes on progress.

(http://www.jcaho.org/standard/disease_fr_std.html).

Combined Morbidity and Mortality Rate

As related to performance of carotid endarterectomy, morbidity is defined as stroke; any neurological deficit not present at the time of admission. The combined morbidity and mortality rate is 1) the total number of patients who underwent open carotid endarterectomy surgery or a closed carotid endarterectomy procedure and who experienced death or stroke 2) divided by the total number of patients who underwent open carotid endarterectomy surgery or a closed carotid endarterectomy procedure. (Michigan Health and Safety Coalition Expert Clinical Panel on Vascular Surgery, 2001). Please calculate this rate using data from the past two years: October 1, 1999 to September 30, 2001.

Comprehensive Statewide Database

An organized, comprehensive collection of data elements (variables) and their values (<http://www.jcaho.org/perfmeas/glossry.html>). The collected data needs to be in an analyzable format that documents the structures, processes, and outcomes of care for a particular patient population within a state.

Databases should facilitate performance improvement in health care organizations through the collection and dissemination of process and/or outcome measures of performance. Measurement systems must be able to generate internal comparisons of organizational performance over time, and external comparisons of performance among participating organization at comparable times.

(http://www.jcaho.org/permeas/coremeas/cm_gloss.html).

Concurrent Care

In this situation, concurrent care refers to the situation in an Intensive Care Unit (ICU) where the intensivist works with the primary medical attending and/or primary surgical attending to develop, monitor, and evaluate the patient's plan of care and responses to that plan of care. (Michigan Health and Safety Coalition, Intensive Care Unit Physician Staffing Expert Clinical Panel, 2001).

Conflicting Responsibilities

With respect to the intensivist, providing care to Intensive Care Unit (ICU) patients without "conflicting responsibilities", this term means that the intensivist will not be away from the hospital or holding clinic elsewhere in the hospital. It does not, however, preclude the intensivist's ability to evaluate patients elsewhere in the hospital for the appropriateness of admission to the ICU or to provide suggestions for stabilizing patients considered for ICU admission in order to avoid a potentially unnecessary ICU admission. (Michigan Health and Safety Coalition, Intensive Care Unit Physician Staffing Expert Clinical Panel, 2001).

Coronary Artery Bypass Graft Surgeries

ICD-9-CM procedure code of 36.1x. Exclude patients age 17 and younger.

When calculating hospital volumes, only one occurrence of the surgery is counted on a given day. For example, if a patient is coded for both 36.12 (2 vessel bypass) and 36.13 (3 vessel bypass) on the same day, it should be counted as a single procedure.

Data Sources

The primary source document(s) used for data collection and may include administrative/billing data, clinical reviews, medical records, patient surveys, provider data and registry/log data. (http://www.jcaho.org/standard/disease_fr_std.html).

The materials, items, or facts on which hospital performance is assessed and inferences are based.

Diagnostic Radiology

The subspecialty concerned with or aiding in diagnosis using radiology. (American College of Radiology).

Diagnostic Ultrasound

Also called ultrasound scanning or sonography, diagnostic ultrasound is a method of obtaining images from inside the human body through the use of high frequency sound waves and using them to aid in diagnosis. The sound wave's echoes are recorded and displayed as a real-time, visual image. No radiation is involved in ultrasound imaging. Because US images are captured in real time, they can show movement of internal tissues and organs and enable physicians to see blood flow. This can help to diagnose a variety of conditions and to assess damage caused by illness.

An ultrasound creates images that allow various organs in the body to be examined. The ultrasound machine sends out high-frequency sound waves, which reflect off body structures to create a picture. There is no ionizing radiation exposure with this test. (MEDLINEplus Encyclopedia <http://www.nlm.nih.gov/medlineplus/ency/article/003336.htm>).

Elective Basis, High-risk Procedures Performed on an . . .

If your hospital does not perform the procedure or ONLY does so when a patient is too unstable for safe transfer, answer no.

Esophagectomy for Cancer

Surgical removal of the esophagus due to cancer. Principle diagnosis 150.0 - 151.0 (must be tied to one of the following ICD9 procedure codes) and procedure code equals 42.4, 42.4X, 42.5, 42.5X, or 42.6, 42.6X (must be tied to one of the ICD9 diagnostic codes listed above). Exclude patients age 17 and younger.

Established Networks

With respect to care provided to infants born with major congenital anomalies, having an "established network" means that a hospital has existing agreements with medical, surgical, and pediatric subspecialists to provide care that is not otherwise available and is appropriate for the infant's particular anomaly.

Exclusively providing care in the ICU

"**Exclusively**" means that when the physician is in the ICU, s/he has no concurrent clinical responsibilities to non-ICU patients. The standard does not specify how frequently the physician must work in the ICU.

Expanded definition of "certified"

On an interim basis, two other categories of physicians are considered by Leapfrog to be "certified in Critical Care Medicine":

- Physicians who completed training prior to availability of subspecialty certification in critical care in their specialty (1987 for Medicine, Anesthesiology, Pediatrics and Surgery), who are board-certified in one of these four specialties, and who have provided at least six weeks of full-time ICU care annually since 1987. (The weeks need not be consecutive weeks.)
- Physicians board-certified in Medicine, Anesthesiology, Pediatrics or Surgery who have completed training programs required for certification in the subspecialty of Critical Care Medicine but are not yet certified in this subspecialty.

FCCS Certified

Fundamental Critical Care Support Certification (FCCS) – Documentation of successful completion of a 2 day comprehensive course addressing fundamental management principals for the first 24 hours of critical care. The course is intended to better prepare the non-intensivist for management of the

critically ill patient until transfer or appropriate critical care consultation can be arranged. In addition, the certification is intended to:

- assist the non-intensivist in dealing with sudden deterioration of the critically ill patient;
- prepare house staff for ICU coverage; and
- prepare nurses to deal with acute deterioration in the critically ill patient.

(Society of Critical Care Medicine).

FCCS-certified non-physician “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/edu/fccscourses.html>. At present, this is the only such course recommended by The Leapfrog Group’s expert advisory panel. Intensivists or any other physicians who are certified in critical care medicine (or eligible based on residency training or fellowship) need not also be FCCS certified.

In Progress

The term “in progress” means that the hospital is making documentable changes toward addressing the recommendations contained in a guideline. In the case of IPS, a hospital should only mark the “in progress” status if they can provide documentation (should they be asked) that supports the “in progress” status of a particular ICU. Examples of criteria to assess “in progress” include a board-approved budget or strategic plan for increasing access to intensivist care, a system to track actual number of hours ICU care is managed and directed by an intensivist, the percent of time on-call intensivists return pages to the ICU within five minutes, and the use of appropriately qualified physician extenders.

Intensive Care Unit

Organizational setting where professional and supportive services are concentrated for the purpose of providing continuous health services to critically ill patients with life-threatening conditions. (JCAHO Lexicon 1998). In this case, consider general adult or pediatric medical/surgical ICUs, but exclude neonatal ICUs, specialty ICUs such as trauma or burn units, or transitional or step-down units. Also ignore Coronary Care Units (CCUs) if they are physically distinct from other ICUs. (If the same ICU beds are used for both coronary intensive care as well as other medical-surgical conditions, include these as ICUs in your responses.) Ignore transitional or step-down units.

Administrative management of an ICU by an intensivist may include activities related to budget, staffing, and selection of care protocols to be used within the ICU. Administrative management does not necessarily imply that the intensivist is engaging in direction of clinical care in the ICU.

Direction of clinical care within an ICU by an intensivist means that the intensivist monitors use of admission and discharge criteria, implementation of care protocols, and supervision of all house staff and physician extenders. Direction of clinical care does not necessarily imply that the intensivist is engaging in administrative management of the ICU.

Licensed Intensive Care Unit (ICU) beds

Include adult and pediatric general medical and surgical ICU beds, but exclude Coronary Care Unit (CCU) beds if they are separately licensed and operated. Do not include Neonatal Intensive Care Units, separate Trauma or Burn units, or beds in intermediate care or step-down units. (If the same licensed ICU beds are used for both coronary intensive care as well as other medical-surgical conditions, include them.)

If the number licensed has changed over the last year, indicate the most recent number for which it is licensed. When responding to this section, exclude any Coronary Care Unit (CCU) that is distinct and separate from other adult/pediatric general medical/surgical ICUs. (If the same ICU is used for both coronary intensive care as well as other general medical-surgical conditions, include this unit in your responses.) Also exclude Neonatal Intensive Care Units, separate Trauma or Burn units, or beds in intermediate care or step-down units when responding to this section.

Licensed medical, surgical, and obstetrics beds

Include short-term, acute-care medical, surgical, and obstetrical beds as licensed by the state. Exclude beds licensed or used for long-term rehabilitation or psychiatric care, or sub-acute care, (e.g., skilled

nursing facility (SNF), 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.

Licensed Neonatal Intensive Care Unit

A neonatal intensive care unit that is licensed by the State of Michigan to provide care to at-risk newborn infants.

Low Birthweight Infants

Low, very low, and extremely low birth weight are measured by the percent of infants who are below a specific weight at birth: 2,500 grams for low birth weight (LBW); 1,500 grams for very low birth weight (VLBW); and 1,000 grams for extremely low birth weight (ELBW). (US Department of Health & Human Services). For the purposes of this survey, low birthweight infants are defined as those who weigh less than 1500 grams at birth. Diagnosis codes equal Major Diagnostic Code 15 combined with 764.01 - 764.05, 764.11 - 764.15, 764.21 - 764.25, 764.91 - 764.95, 765.01 - 765.05, or 765.11 - 765.15.

Managed or Co-managed (by Intensivist)

The intensivist, when present, 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-staff to meet this requirement.

“All patients” means any patient in the ICU. (Please see Question 5 if you answer No to this question because not **all** patients are managed/co-managed by the intensivist when present.)

Medical Necessity

A treatment or service that is appropriate and consistent with diagnoses and which, in accordance with local accepted standards of practice, cannot be omitted without adversely affecting the patient's condition or the quality of care. (JCAHO Lexicon 1998).

Michigan Health and Safety Coalition

The Michigan Health and Safety Coalition (MH&SC) is a collaborative quality improvement effort focused on improving patient safety in Michigan. Its mission is to help improve health care quality in Michigan through cost-effective improvements in patient safety, including medical errors, across all health care settings. Its goals are to: 1) provide leadership and share knowledge on patient safety issues in Michigan; 2) develop and/or support systemic approaches to identifying and learning from errors with a focus on continuous improvement; 3) encourage the establishment of performance standards for patient safety, medical error reporting and continuous improvement; and encourage the provision of positive incentives for improved performance; and 4) support a culture of safety by encouraging the implementation of safety systems in health care organizations. Its membership is diverse and includes representatives from health care plans, health care providers, and employer and union groups and it anticipates the need to work with other entities and experts (academics, legislators, legal, systems, and data analysts) to carry out the actions specified by the Coalition. (<http://www.mihealthandsafety.org>).

MRI Capabilities

MRI is a non-invasive procedure that uses powerful magnets and radio waves to construct pictures of the body.

Unlike conventional radiography and Computed Tomographic (CT) imaging, which make use of potentially harmful radiation (X-rays), MRI imaging is based on the magnetic properties of atoms. A powerful magnet generates a magnetic field roughly 10,000 times stronger than the natural background magnetism from the earth. A very small percentage of hydrogen atoms within a human body will align with this field.

When focused radio wave pulses are broadcast towards the aligned hydrogen atoms in tissues of interest, they will return a signal. The subtle differences in that signal from various body tissues enables MRI to differentiate organs, and potentially contrast benign and malignant tissue.

Any imaging plane (or "slice") can be projected, stored in a computer, or printed on film. MRI can easily be performed through clothing and bones. However, certain types of metal in the area of interest can cause significant errors in the reconstructed images. (MEDLINEplus Encyclopedia <http://www.nlm.nih.gov/medlineplus/ency/article/0003335.htm>).

The term "MRI capabilities" refers to whether or not a hospital can provide the type of MRI services required to clinically assess infants born with major congenital anomalies.

Neonatal Intensive Care Unit

A unit of a hospital for the treatment and continuous monitoring of infants with life threatening conditions who are generally less than 23 days old on admission to the unit. (JCAHO Lexicon 1998).

Nurse Practitioner

A nurse practitioner (NP) is a registered nurse with advanced academic and clinical experience, which enables him or her to diagnose and manage most common and many chronic illnesses, either independently or as part of a health care team. A nurse practitioner provides some care previously offered only by physicians and in most states has the ability to prescribe medications. Nurse practitioners are educated through programs that grant either a certificate or a master's degree. Lastly, the scope of an NP's practice varies depending upon each state's regulations. (<http://www.aanp.org/nurse.htm>).

Open Heart Surgery (Including CABG)

Any surgery where the chest is opened and surgery is performed on the heart is called an open heart surgery. The term "open" refers to the chest, not the heart itself (which may or may not be opened depending on the type of surgery). Open heart surgery includes surgery on the heart muscle, valves, arteries, or other structures. Coronary artery bypass graft surgery (CABG) is one example of an open heart surgery procedure. A heart-lung machine (also called heart-lung bypass) is usually used to help provide oxygen-rich blood to the brain, heart muscle, and other vital body areas. It pumps the blood, supplies oxygen to the blood, and removes carbon dioxide from the blood.

There are some new surgical procedures being performed that are done with the heart still beating. The procedures are referred to as minimally invasive heart surgery or limited access coronary artery surgery. These procedures are being evaluated in several medical centers as an alternative to the standard methods using the heart-lung machine. (MEDLINEplus Encyclopedia <http://www.nlm.nih.gov/medlineplus/ency/article/002950.htm>).

For the purposes of this survey, an open heart procedure includes coronary artery bypass graft surgeries as well as other open heart surgeries. A coronary artery bypass surgery is defined by the following ICD-9 codes: 36.10, 36.11, 36.12, 36.13, 36.14, 36.15, 36.16, 36.17, or 36.19. Other (non-CABG) open heart surgeries are defined by the following ICD-9 codes: 33.6, 35.10, 35.11, 35.12, 35.13, 35.14, 35.20, 35.21, 35.22, 35.23, 35.24, 35.25, 35.26, 35.27, 35.28, 35.31, 35.32, 35.33, 35.34, 35.35, 35.39, 35.50, 35.51, 35.52, 35.53, 35.54, 35.60, 35.61, 35.62, 35.63, 35.70, 35.71, 35.72, 35.81, 35.95, 35.98, 35.99, 36.03, 36.31, 36.39, 36.91, 36.99, 37.10, 37.11, 37.12, 37.31, 37.32, 37.33, 37.35, 37.4, 37.5, 37.62, 37.63, 37.64, 37.65, 37.66, or 37.67. For both CABG and other open heart procedures, include only those cases where age was greater than 17 years of age at the time of surgery.

Pancreatic resection

ICD9 Diagnostic Codes (must be tied to one of the ICD9 procedures codes listed): 152.0, 156.1, 156.2, 157, 157.0, 157.1, 157.2, 157.3, 157.4, 157.8, 157.9

ICD9 Procedure Codes (must be tied to one of the above ICD9 diagnostic codes): 52.51, 52.53, 52.6, 52.7

Exclude patients age 17 and younger.

Percutaneous Coronary Interventions

These interventions include transluminal percutaneous coronary angioplasty as well as rotational atherectomy, directional atherectomy, extraction atherectomy, laser angioplasty, implantation of intracoronary stents and other catheter devices used to treat coronary atherosclerosis. (Michigan

Health and Safety Coalition Expert Clinical Panel on Cardiology, 2001). Procedure codes for PCI equal 36.01, 36.02, 36.05, or 36.06. Exclude patients age 17 and younger.

Physician Extender

The terms "physician extender" (PE) and "mid-level provider" are interchangeable catchall phrases used to refer most often to physician's assistants (PAs) and nurse practitioners, as well as to nurse-midwives and other allied health professionals. An appropriately qualified physician extender is defined as a physician assistant or a mid-level practitioner such as a nurse practitioner or a clinical nurse specialist who is FCCS certified and meets the competencies required by the hospital's credentialing committee.

Present in the ICU

The 8-hour period refers to direct presence in the ICU of an intensivist, and it need not be the same intensivist for the entire 8-hour duration. 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, i.e., as if both units were one larger unit.

Primary Medical or Surgical Attending Physician

In relationship to care provided by an intensivist in an ICU, a patient's primary medical attending physician may be the general practitioner or specialist in cardiology or internal medicine who routinely provides care to the patient in the ambulatory setting. The primary surgical attending is the surgeon who performed an operation or procedure upon the patient.

Radiation Therapy

A treatment approach that uses radiation to destroy cancer cells. Radiation therapy is used to fight many types of cancer. Often it is used to shrink the tumor, which is then removed during surgery, or given after surgery to prevent tumor recurrence. Sometimes it is the only treatment needed to cure certain types of cancer. It may also be used to provide temporary relief of symptoms, or to treat malignancies that are not amenable to surgery. (MEDLINEplus Encyclopedia <http://www.nlm.nih.gov/medlineplus/ency/article/001918.htm>).

Rapid Referral

In relation to the provision of care to infants born with major congenital anomalies, "rapid referral" means that the infant is transferred to an appropriate medical, surgical, or pediatric subspecialist or facility in a prompt manner that does not further compromise the infant's health.

Risk-Adjusted Morbidity Indicators

Morbidity indicators/rates that take into account differences in case mix to allow for more valid comparisons between groups. Indicators are 1) measures used to determine, over time, performance of functions, processes, and outcomes and 2) statistical values that provide an indication of the condition or direction over time of performance of a defined process or achievement of a defined outcome. (http://www.jcaho.org/perrmeas/coremeas/cm_gloss.html). (http://www.jcaho.org/sentinel/se_glsry.html).

Examples of morbidity indicators include: For open heart surgery: re-operation for post-operative bleeding, deep sternal infection, permanent stroke, prolonged ventilation, and post-operative renal failure. For carotid endarterectomy surgery, one measure of morbidity is stroke, which is defined as any neurological deficit not present at the time of admission. For abdominal aortic aneurysm repair consider graft infection, renal failure, subsequent amputation, and leaks. For esophagectomies for cancer consider respiratory complications, anastomotic leak rates, dysphagia, post-operative dilatation, regurgitation, and dumping symptoms. (Michigan Health and Safety Coalition Cardiothoracic Surgery, Vascular Surgery, and Thoracic Surgery Expert Panels, 2001).

Risk-Adjusted Mortality

A mortality rate that takes into account differences in case mix to allow for more valid comparisons between groups (http://www.jcaho.org/perrmeas/coremeas/cm_gloss.html).

Mortality could include not only risk-adjusted death rates, but observed to expected mortality ratios. For low birthweight infants and infants with congenital anomalies admitted to the NICU consider neonatal survival statistics adjusted by weight and gestational age.

Risk-Adjusting

A statistical process for reducing, removing, or clarifying the influences of confounding factors that differ among comparison groups (e.g., logistic regression, stratification). (JCAHO Lexicon 1998 and http://www.jcaho.org/perrmeas/coremeas/cm_gloss.html).

Risk-adjustment System

The statistical algorithm that specifies the numerical values and the sequence of calculations used to risk-adjust performance measures. (JCAHO Lexicon 1998). An example of an algorithm is the Risk Adjusted Mortality Index (RAMI), a model for measuring the risk of death during a hospital stay for specific diagnoses and procedures. The following variables are used: the patient's age, race, sex and DRG cluster; the presence or absence of comorbidities; the presence of any secondary diagnosis of cancer (other than skin cancer); and total number of morbidities. (JCAHO Lexicon 1998).

Society of Thoracic Surgeons (STS) Database

The STS National Cardiac Surgery Database is pooled case-specific anonymous clinical information from over 1.2 million surgical case records. The data collection is a collaborative effort of surgeons across the United States and Canada (<http://www.sts.org>).

Staffed ICU beds

Include ICU 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 ICU capacity over the last year.

Include adult and pediatric general medical and surgical ICU beds, but exclude Coronary Care Unit (CCU) beds if they are separately licensed and operated. Do not include Neonatal Intensive Care Units, separate Trauma or Burn units, or beds in intermediate care or step-down units. (If the same licensed ICU beds are used for both coronary intensive care as well as other medical-surgical conditions, include them.) If the number has changed over the last year, indicate the average or other number most representative of your operating bed capacity in these units over the last year.

Staffed medical, surgical, and obstetric 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.

Telemedicine

The use of real-time video transmissions and stored electronic data to facilitate health care delivery between distant locations. A method of providing medical care through a video communications interface with the physician at one site and the patient at another site.

Telemedicine, Intensivist Presence via . . .

To meet the Leapfrog ICU standard via telemonitoring, a hospital must affirm that its telemonitoring intensivist presence fulfills the following 10 key features 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. An intensivist who is physically present in the ICU ("onsite intensivist") performs a comprehensive review of each ICU patient each day and establishes and/or revises the care plan. A tele-intensivist has immediate access to information regarding the onsite intensivist's care plan at the time monitoring responsibility is transferred to him or her by the onsite intensivist. When care is transferred back to the onsite intensivist, the tele-intensivist communicates (rounds) with the onsite intensivist to review the patient's progress and set direction.
2. A tele-intensivist is monitoring all ICU patients on a 7-day, 24-hour basis, except when an intensivist is onsite in the ICU managing or co-managing all ICU patients "Monitoring" means the tele-intensivist has

no other concurrent responsibilities, is immediately available to communicate with ICU staff, and is in the physical presence of the tele-ICU's patient monitoring and communications equipment.

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 A-V support, tele-intensivists are able to visualize patients with sufficient clarity to assess breathing pattern, and communicate with onsite 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 onsite 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. A tele-intensivist's patient workload ordinarily permits him or her to complete a comprehensive assessment of any patient within five minutes of the request for assistance being initiated by hospital staff.
9. There is an established written process to ensure effective communication between the onsite care team and the tele-intensivist.
10. The tele-intensivist documents patient care activities and this documentation is incorporated into the patient record.

Tips for entering Web addresses

- Do not exit the survey 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. **Remove the http:// prefix from the address!**
- 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.
- Make sure to use .org, rather than .com, if that's the domain for your hospital's Web site. Remember to **remove the http:// prefix from the address!** Test the address with the button in the survey form just below the entry.
- Although many hospitals elect to enter the address for the home page of their hospital Web site, consider pointing it to a page specific to patient safety, the Leapfrog safety practices, or other quality improvement activities about which you want to communicate to your community.

Tumor Board

A multidisciplinary group of medical and surgical specialists within a given hospital who review the clinical records of patients with cancer. For purposes of this survey, tumor boards would review

clinical records of patients with cancer of the esophagus and evaluate treatment options in light of the clinical condition and make recommendations regarding treatment options.

The term “multidisciplinary” refers to a group of clinical staff members composed of representatives of a range of professions, disciplines, or service areas.

(http://222.jcaho.org/standard/disease_fr_std.html).

Vermont Oxford Network Database

The Network maintains a Database for infants 401 to 1500 grams who are born at participating hospitals or admitted to them within 28 days of birth. Member institutions also have the option of submitting data for infants weighing over 1500 grams at birth, who are admitted to a participating hospital neonatal intensive care unit or who die within 28 days of birth. Infants transferred to another hospital prior to final discharge to home are tracked and their survival status is determined. The Database is used to provide comprehensive, confidential reports to participating hospitals, which serve as the foundation for local quality improvement projects, internal audit, and peer review. The Database also provides information for use in outcomes research. Members have the option of submitting data for very low birth weight infants on paper forms or electronically. Members participating in the expanded Database for all NICU infants must submit all data electronically.

(<http://www.vtoxford.org>).

Why 61 cases?

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.



2003 Evidence-Based Hospital Referral (EHR) Leap

Note: This section provides the scoring algorithms that will be used by The Leapfrog Group. The MH&SC scoring information can also be accessed at the MH&SC Web site at: <http://www.mihealthandsafety.org/survey.html>

Each hospital fulfilling one or more of these Leaps:

1. Achieves one or more of the favorable hospital volume characteristics listed below, **and also** either:
 - a. For coronary artery bypass graft surgery (CABG), percutaneous coronary intervention (PCI), abdominal aortic aneurysm repair (AAA) or high-risk deliveries: Achieves more than 80% adherence to two or more expert panel-endorsed procedure-specific process measures of quality (See [Zynx.pdf](#)); **or**,
 - b. For CABG or PCI: Participates in and scores above the national average for participating U.S. hospitals in risk-adjusted mortality or ratio of observed-to-expected mortality in the procedure-specific measurement systems operated by the Society of Thoracic Surgeons (STS) or the American College of Cardiology (ACC).

For more information, see:

STS-Adult Cardiac Care: www.sts.org

ACC-NCDR™: www.acc.org/ncdr/index.htm

When a hospital's performance is publicly reported via scientifically rigorous¹, audited, comparable and commonly utilized performance assessment systems endorsed by The Leapfrog Group, fulfillment of the Leap will be defined by favorable performance rather than the criteria above so long as a hospital's sample sizes are sufficient to produce a statistically stable result. Favorable performance is defined as ranking in the most favorable quartile for risk-adjusted mortality or observed-to-expected mortality.

Thus far, The Leapfrog Group has endorsed performance assessment systems for CABG mortality in CA, NJ, NY, and PA. To qualify for assessment by performance instead of volume and the additional measures indicated above, a hospital's results must be based on at least 350 CABGs as reported in its state's most recent publicly-reported results.

Treatments (See specifications below)	Favorable Hospital Volume Characteristic*
Coronary artery bypass graft**	450 or more procedures/year
Percutaneous coronary intervention	400 or more procedures/year
Abdominal aortic aneurysm repair	50 or more procedures/year
Pancreatic resection	11 or more procedures/year
Esophagectomy	13 or more procedures/year
High-risk deliveries: Delivery with gestational age <32 weeks or expected birth weight <1500 grams Delivery with prenatal diagnosis of major congenital anomalies	Average daily neonatal ICU census ≥ 15 for all babies regardless of diagnosis

* Annual volume calculated for most recent 12 months available or as annual average over most recent 24 months available, for a period ending within the last year.

** Except hospitals in CA, NJ, NY and PA with adequate publicly-reported sample sizes (see additional information on publicly reported performance information above).

For hospitals that do not perform these procedures or treat these high-risk deliveries, or refer/transfer all safely and legally transferable patients for such high-risk procedures or conditions, the Leap does not apply for that procedure or condition. If you answer 'No' to any of the procedures listed in questions 1-5 below, the notation 'N/A' will be displayed on the public Web site.

¹ Scientifically Rigorous, Audited, and Comparable Performance Assessment Systems

"Scientifically rigorous" indicates a measurement reporting system in which 1) all cases are reported; 2) there is a third party audit to affirm accuracy of submitted clinical data; 3) there is supplementary collection of clinical variables present upon admission that, when combined with routinely collected administrative data, predict a large portion of inter-hospital mortality differences; 4) data cover at least a 12-month period; and, 5) sample sizes per hospital are adequate to achieve statistically stable results.

Scoring Algorithm for EHR (Leapfrog - Michigan)

	EHR Credit				
	Full Credit (full circle)	$\frac{3}{4}$ Circle	$\frac{1}{2}$ Circle	$\frac{1}{4}$ Circle	No Credit (empty circle)
CABG see Notes 1 below			450+	<450	Did not disclose
PCI see Note 1 below			400+	<400	Did not disclose
AAA Repair see Note 2 below		50+	17-49	<17	Did not disclose
Esophagectomy	13+	8-12	5-7	<5	Did not disclose
Pancreatic resection	11+	6-10	3-5	<3	Did not disclose
High Risk Deliveries see Note 2 below		Average daily NICU census ≥ 15		NICU with average daily census <15 or High-risk deliveries but no NICU	Did not disclose

Scoring modifications:

- For CABG and PCI, hospitals get additional $\frac{1}{4}$ -circle credit by:
 - participation in STS/ACC, plus another $\frac{1}{4}$ -circle credit by above the national average (per questions B1-B2 in section B2b, or questions D1-D2 in section B2c);
or
 - adherence to process measure standards or commitment to measure adherence and report results by December 31, 2003 (per questions C1-C3 in section B2b, or questions E1-E3 in section B2c).
- For AAA and high-risk deliveries, hospitals get an additional $\frac{1}{4}$ circle credit by adherence to process measure standards or commitment to measure adherence and report results by December 31, 2003 (per questions D1-D3 in section B2d).

Did not disclose this information means:

The hospital did not respond to this section of the survey, or the hospital was asked to complete the survey but has not submitted one.

N/A -- Standard does not apply means:

High-risk procedure(s): The hospital does not perform this procedure on an elective basis.

High-risk deliveries: The hospital does not have a neonatal intensive care unit and does not electively admit high-risk deliveries.



2003 ICU Physician Staffing (IPS) Leap

Note: This section provides the scoring algorithms that will be used by The Leapfrog Group. The MH&SC scoring information can also be accessed at the MH&SC Web site at: <http://www.mihealthandsafety.org/survey.html>

A hospital fulfilling this Leap assures that all patients in its adult or pediatric general medical and/or surgical ICUs are managed or co-managed by physicians certified in critical care medicine who:

- Are present in the ICU during daytime hours a minimum of 8 hours per day, 7 days per week, and during this time provide clinical care exclusively in the ICU; and
- At other times . . . ;
 - Return more than 95% of ICU pages within 5 minutes (based on a quantified hospital analysis of pager response time). This excludes low-urgency pages, if the paging system can designate low-urgency pages; and
 - Can rely on a physician or FCCS-certified non-physician “effector” 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 pager response time). This excludes low-urgency pages, if the paging system can designate low-urgency pages.

If you have no licensed or staffed adult or pediatric general medical and/or surgical ICU beds (and indicated so in the Organization Information section of this survey), then this section does not apply to your hospital. Your results will be displayed as ‘N/A’ on the public web site.

Notes:

1. When a hospital publicly documents favorable ICU performance via scientifically rigorous and comparable performance assessment systems endorsed by The Leapfrog Group, favorable performance will replace or supplement the physician staffing Leap. The Leapfrog Group is currently collaborating with JCAHO and operators of ICU performance measurement systems to specify the terms “favorable performance,” “scientifically rigorous,” “publicly document,” and “comparable.”
2. Intensivist “presence” may be partially accomplished via telemedicine per Leapfrog’s specifications.
3. On an interim basis, other categories of physicians may be considered by Leapfrog to be “certified in Critical Care Medicine” under an expanded definition.

Additional Information about the Leap:

Fact Sheet: [FactSheetICU.pdf](#)

Bibliography: [BibliolCU.pdf](#)

Scoring Algorithm for Leapfrog IPS

(References are to questions in Section B3 of survey.)

Fully implemented means:

1. All patients in adult and pediatric general medical and surgical ICU(s) are managed or co-managed by one or more physicians who are certified in critical care medicine (intensivists); **and**
2. One or more intensivist(s) is/are present in each ICU during daytime hours for at least 8 hours per day, 7 days per week, and provide(s) clinical care exclusively in this ICU during these hours; **and**
3. When intensivists are not present in these ICUs, one of them returns more than 95% of pages from these units within five minutes (based on a quantified hospital analysis of pager response time). This excludes low-urgency pages if the paging system can designate low-urgency pages; **and**
4. When an intensivist is not present in the ICU, another physician or FCCS-certified non-physician “effector” is on-site at the hospital and able to reach ICU patients within five minutes in more than 95% of the cases (based on a quantified hospital analysis of pager response time). This excludes low-urgency pages, if the paging system can designate low-urgency pages.

(Answered “Yes” to all of questions B1 – B4.)

Good progress means:

1. All patients in adult/pediatric medical ICU(s) are managed or co-managed by one or more physicians who are certified in critical care medicine (intensivists) (*answered "Yes" to question B2*); **and**
 2. The hospital commits to meet the Leapfrog IPS standard fully before 2004 (*answered < 2004 for question C2*); **and**
 3. The hospital has a board-approved budget that is adequate to meet the IPS commitment (*answered "Yes" to question C3*); **and**
 4. The hospital has implemented one of the following three practices:
 - a) ICU care of at least 50% of patients fully meets the standard (*answered ≥50% to question C1*); **or**
 - b) Meets the IPS leap for more than 28 hours per week (*answered > 28 hours on question C4*); **or**
 - c) Clinical pharmacists make daily rounds on adult medical/surgical ICU patients (*answered "Yes" to question C5*);
- and**
5. An intensivist:
 - a) leads daily, multi-disciplinary team rounds (*answered "Yes" to question C6*), **or**
 - b) makes weekday admission and discharge decisions (*answered "Yes" to question C7*).

Good early stage effort means:

1. The hospital commits to meet the Leapfrog IPS standard fully before 2005 (*answered < 2005 for question C2*); **and**
2. The hospital has a board-approved budget that is adequate to meet the IPS commitment (*answered "Yes" to question C3*).

Willing to report publicly means:

The hospital responded to all the Leapfrog survey questions, but it does not yet meet the criteria for a good early stage effort.

Did not disclose this information means:

The hospital did not respond to this section of the survey, or the hospital was asked to complete the survey but has not submitted one.

N/A -- Standard does not apply means:

The hospital does not operate an adult or pediatric general medical or surgical intensive care unit.



2003 Computer Physician Order Entry (CPOE) Leap

Note: This section provides the scoring algorithms that will be used by The Leapfrog Group. The MH&SC scoring information can also be accessed at the MH&SC Web site at: <http://www.mihealthandsafety.org/survey.html>

Each hospital fulfilling this Leap:

1. Assures that physicians* enter hospital medication orders via a computer system that includes prescribing error prevention software;
2. Demonstrates, via a test (now [under development](#) by the First Consulting Group and the Institute for Safe Medication Practices), that their inpatient CPOE system can alert physicians to at least 50% of common serious prescribing errors. *This criterion for the Leap will not count towards your hospital's publicly reported status on this Leap until the test is available;* and,
3. Requires that physicians electronically document a reason for overriding an interception prior to doing so.

* "Physicians" used throughout this section refers to all clinicians authorized by the hospital to order pharmaceuticals for patients.

Additional Information about the Leap:

Fact Sheet: [FactSheetCPOE.pdf](#)

Bibliography: [BiblioCPOE.pdf](#)

Scoring Algorithm for CPOE

(References are to questions in Section B4 of survey.)

Fully implemented means:

Prescribers enter at least 75% of all medication orders via a CPOE system that fulfills the Leap (*answered >= 75% for question 6*).

Good progress means:

Has a functioning CPOE system in at least one part of the hospital (*answered "Yes" to question B1*);

OR:

1. The hospital is currently implementing or selecting a CPOE system (*checked "Currently selecting" or "Currently implementing" in question 7*); **or**
 2. The hospital has a written strategy for implementing CPOE (*answered "Yes" to question 8*); **or**
 3. The hospital has a defined timeline and already launched a CPOE implementation project (*answered "Yes" to question 9*).
- And** all of the following:
4. The hospital board approved a dedicated budget for CPOE for the latest fiscal year for which it approved a final budget (*answered "Yes" to question 11*); **and**
 5. The hospital has a physician champion who spearheads the hospital's CPOE initiative (*answered "Yes" to question 12*); **and**
 6. The hospital commits to meet the Leap fully before 2005 (*answered < 2005 or question 10*).

Good early stage effort means:

1. Hospital has a written strategy for implementing CPOE (*answered "Yes" to question 8*); **or**
2. The hospital has defined a timeline and has launched a CPOE implementation project (*answered "Yes" to question 9*).

And all of the following:

3. The hospital board approved a dedicated budget for CPOE for the latest fiscal year for which it approved a final budget (*answered "Yes" to question 11*).

4. The hospital has a physician champion who leads the hospital's CPOE initiative (*answered "Yes" to question 12*).
5. The hospital commits to meet the Leapfrog CPOE standard fully before 2006 (*answered < 2006 for question 10*).

Willing to report publicly means:

The hospital responded to all Leapfrog survey questions, but does not yet meet the criteria for a good early stage effort.

Did not disclose this information means:

The hospital did not respond to this section of the survey, or the hospital was asked to complete the survey but has not submitted one.