



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

August 30, 2004

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 Group, 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 Group 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 third 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 2004 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](#)

To complete or update the NQF Safe Practices section of the survey, [go directly to that section.](#)

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. Additionally, in 2004, the national Leapfrog Hospital Quality and Patient Safety survey has added a survey section devoted to remaining safety practices included in the *National Quality Forum Safe Practices for Better Healthcare: A Consensus Report*, released in May 2003. MH&SC asks Michigan hospitals to continue to The Leapfrog Group survey to complete that additional section as well.

Participation in the 2004 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, is a growing consortium of Fortune 500 companies and other large private and public healthcare purchasers that provide health benefits to more than 34 million Americans in all 50 states; Leapfrog members and their employees spend tens of billions of dollars on health care annually. Leapfrog members have agreed to base their purchase of health care on principles that encourage provider quality improvement and consumer involvement.

Leapfrog is collecting data on its national patient safety practices through local Regional Roll-Outs. There are 24 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 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 2004 survey are the same as those answered by hospitals nationwide. Hospital-

specific results for The Leapfrog Group survey questions will be publicly displayed on The Leapfrog Group Web site (<http://www.leapfroggroupdata.org>). For The Leapfrog Group, you may respond to the survey at any time, although we encourage you to respond by October 1, 2004. If your hospital's status of implementing Leapfrog's recommended patient safety practices should change, please update your responses to the survey and resubmit them within 30 days of that change.

The 2004 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 (<http://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 previous years survey data and results. For the MH&SC, your hospital MUST respond to this survey no later than October 1, 2004 for your results to be included in the 2004 MH&SC reports that will be provided to hospitals, hospitals, health plans and consumers in November.

Medstat (<http://www.medstat.com>) 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 healthcare information company that provides market intelligence and benchmark databases, decision support solutions, and research services for managing the cost and quality of healthcare. The company applies these capabilities to improve policy and management decision making for many of the nation's leading employers, government agencies, health plans, hospitals and provider networks, and pharmaceutical companies. Medstat is a business within the Thomson Corporation (www.thomson.com). With 2003 revenues of \$7.6 billion, Thomson is a global leader in providing integrated information solutions to business and professional customers.

If you have any questions, please call the Survey Help Desk at 734-913-3030.

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 <http://www.mihealthandsafety.org/guidelines.html>.

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, 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 were reviewed in early 2004. Some updates were made based on Expert Clinical Panel recommendations and will continue to evolve as new evidence is developed.

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 third 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 <http://www.leapfroggroupdata.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 (Leapfrog), a growing consortium of over 150 Fortune 500 companies and other large private and public healthcare purchasers founded by The Business Roundtable, 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 billions on healthcare annually.

The Leapfrog Group initially identified three 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. Leapfrog's research indicates that implementing these leaps in non-rural hospitals could save more than 60,000 lives and prevent approximately 900,000 serious medication errors each year. Detail about the three leaps is outlined throughout this hospital survey.

In May 2003, the National Quality Forum (NQF) released *Safe Practices for Better Healthcare: A Consensus Report*, identifying 30 practices that, if adopted, would have major positive impact on the safety of patients in healthcare settings. These 30 practices include the original three leaps. The other 27 Safe Practices together form a new fourth leap, which Leapfrog has endorsed. This fourth leap is also applicable to rural acute care hospitals, but remains voluntary for this year.

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 quality and safety leaps and (2) recognize and reward providers that have implemented 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 submit this information."

Background information about The Leapfrog Group and details about Leapfrog's four quality 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](#)

[National Quality Forum Safe Practices \(NQF-SP\)](#)

[Frequently Asked Questions about the Survey](#)

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

Further information on the NQF Safe Practices leap can be found at The Leapfrog Group survey site, <https://leapfrog.medstat.com>.

If you have additional questions about The Leapfrog Group, please visit <http://www.leapfroggroup.org>.

If you have any questions, please contact the Survey Help Desk at 734-913-3030 or by e-mail at mhsc.medstat@thomson.com.

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 \(https://mihealthandsafety.medstat.com\)](https://mihealthandsafety.medstat.com) if you're returning to update or review your responses to be taken to the survey now. To complete or update responses to the new National Quality Forum Safe Practices survey section, [log-in here \(https://leapfrog.medstat.com/login_MI.aspx\)](https://leapfrog.medstat.com/login_MI.aspx).

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 on-line.**
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. **If data are submitted for multiple hospitals within one survey, the responses will not be reported by the MH&SC or Leapfrog.**
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 October 1, 2004 for your results to be included in the MH&SC reports that will be provided to hospitals, health plans and consumers in December 2004.**
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. After submitting this joint hospital survey, you are invited to complete the additional section at The Leapfrog Group survey site regarding your hospital's status relative to the other National Quality Forum Safe Practices for Better Healthcare. Leapfrog will report results from this new NQF Safe Practices section in its public results. MH&SC will use results for these other Safe Practices to implement improvement efforts, but does not plan to report results on its Web site this year.

You should review that section of the survey and order a full copy of the *National Quality Forum Safe Practices for Better Healthcare: A Consensus Report (May 2003)* in advance. See [ordering information](#) at The Leapfrog Group survey site (<https://leapfrog.medstat.com>) or the MH&SC Web site at (<http://www.mihealthandsafety.org>).
 10. For more information about the MH&SC and to review the hospital referral guidelines, visit the MH&SC Web site at <http://www.mihealthandsafety.org>.
 11. For more information about The Leapfrog Group's patient safety practices, visit their Web site at <http://www.leapfroggroup.org>.
 12. 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.
 13. [Click here to begin the survey now \(https://mihealthandsafety.medstat.com\)](https://mihealthandsafety.medstat.com) 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) at 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 <https://mihealthandsafety.medstat.com>. For technical questions, including questions about The Leapfrog Group content and access to the on-line survey, contact the Survey Help Desk at 734-913-3030 or by e-mail at mhsc.medstat@thomson.com.

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 licensed medical, surgical, and obstetrics beds	
9.	Number of staffed medical, surgical, and obstetric beds	
10.	Number of total acute-care admissions to your hospital for most recent 12 months available.	
11.	Number of licensed Intensive Care Unit (ICU) beds	
12.	Number of staffed ICU beds	
13.	Number of admissions to adult and pediatric general medical/surgical ICU(s) for most recent 12 months available.	
14.	Number of licensed Neonatal Intensive Care Unit beds	
15.	Is this hospital part of a healthcare system or Integrated Delivery Network (IDN)	Yes <input type="radio"/> No <input type="radio"/>
16.	If yes to #15, please enter the name of the healthcare system or IDN	
17.	Hospital's federal tax identification number (TIN)	

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 <u>adult or pediatric medical/surgical intensive care units</u> ?	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 (period must end within the last year)

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.



2004 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 style="text-align: center;">_____</p> <p style="text-align: center;"><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 heart 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>open heart surgeries</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></td> <td style="text-align: right;">Go to C1</td> </tr> <tr> <td colspan="3" style="text-align: center;"></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 colspan="3" style="text-align: center;"></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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<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 heart surgeries</u>?</p> <p style="margin-left: 20px;">a. Does your hospital collect <u>risk-adjusted mortality data</u>?</p> <p style="margin-left: 20px;">b. Does your hospital collect <u>risk-adjusted morbidity indicators</u>?</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%; 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></td> <td style="text-align: right;">Go to C2</td> </tr> <tr> <td colspan="3" style="text-align: center;"></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 colspan="3" style="text-align: center;"></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 colspan="3" style="text-align: center;"></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"/>	Skip C2a	Skip C2a					<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			
Yes	In Progress	No																										
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																										
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<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																										
Skip C2a	Skip C2a																											
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																										

Comment Box

Please briefly describe improvement activities most recently implemented or currently in progress pertaining to this guideline.



Section B2b: Coronary Artery Bypass Graft Surgery

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



[2004 Evidence-Based Hospital Referral \(EHR\) Leap for CABG](#)

<p>A. Volume</p> <p>1. How many <u>coronary artery bypass graft surgeries</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. 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. Has your hospital <u>participated in</u> the Society of Thoracic Surgeons (STS) performance reporting system for coronary artery bypass graft surgery and submitted data for all such procedures in the most recent 12-month period for which performance reports have been released?</p> <p>2. What is the most recent 12-month reporting period for which STS performance results are available? 12 months ending:</p> <p>3. For that time period, do those reports indicate that your hospital's performance is 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>	<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></td> <td style="text-align: center;">Go to C1</td> </tr> <tr> <td></td> <td style="text-align: center;">Participating but no reports yet available <input type="radio"/></td> </tr> <tr> <td></td> <td style="text-align: center;">Go to C1</td> </tr> <tr> <td></td> <td style="text-align: center;"></td> </tr> <tr> <td></td> <td style="text-align: center;">_____</td> </tr> <tr> <td></td> <td style="text-align: center;">MMYYYY</td> </tr> <tr> <td></td> <td style="text-align: center;"></td> </tr> <tr> <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;">Prefer not to respond <input type="radio"/></td> </tr> <tr> <td></td> <td style="text-align: center;"></td> </tr> </table>	Yes <input type="radio"/>	No <input type="radio"/>		Go to C1		Participating but no reports yet available <input type="radio"/>		Go to C1				_____		MMYYYY			<input type="radio"/>	<input type="radio"/>		Prefer not to respond <input type="radio"/>		
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	MMYYYY																						
<input type="radio"/>	<input type="radio"/>																						
	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.</p>																							
<p>1. Has your hospital:</p> <ul style="list-style-type: none"> • performed a medical record audit on <u>all cases (or a sufficient sample of them)</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>	<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></td> <td style="text-align: center;">Skip C2</td> </tr> <tr> <td></td> <td style="text-align: center;"></td> </tr> <tr> <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> </tr> </table>	Yes <input type="radio"/>	No <input type="radio"/>		Skip C2			<input type="radio"/>	<input type="radio"/>														
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	Skip C2																						
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Section B2c: Percutaneous Coronary Intervention

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








[2004 MH&SC PCI Guideline](#)

[2004 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;">_____</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;"> <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> </table> <p style="text-align: center;"></p>	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;"> <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> </table> <p style="text-align: center;"></p> <p style="text-align: center;"></p>	Yes	In Progress	No	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			Go to C1
Yes	In Progress	No								
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		Go to C1								

C. Structure, Process, Outcome Measures	Yes	In Progress	No
1. Does your hospital have a <u>risk-adjustment system</u> for <u>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 data</u> ?	<input type="radio"/>		<input type="radio"/>
b. Does your hospital collect physician-specific <u>risk-adjusted mortality data</u> ?	<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"/>
d. Does your hospital collect physician-specific <u>risk-adjusted morbidity indicators</u> ?	<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"/>







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. Has your hospital participated in the American College of Cardiology National Cardiovascular Data Registry (ACC-NCDR™) quality measurement program for percutaneous coronary interventions and submitted data for all such procedures in the most recent 12-month period for which performance reports have been released?	Yes <input type="radio"/>	No <input type="radio"/> Go to E1 Participating but no reports yet available <input type="radio"/> Go to E1 
2. What is the most recent 12-month reporting period for which ACC-NCDR™ performance results are available? 12 months ending:	<hr/> MMYYYY 	
3. For that time period, do those reports indicate that your hospital's performance is more favorable than the national ACC-NCDR™ average risk-adjusted mortality of participating U.S. hospitals for percutaneous coronary interventions?	<input type="radio"/>	<input type="radio"/> Prefer not to respond <input type="radio"/> 

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.

<p>1. Has your hospital:</p> <ul style="list-style-type: none">performed a medical record audit on <u>all cases (or a sufficient sample of them)</u> for percutaneous coronary interventions over at least a 12-month period, but excluding cases admitted more than 24 months ago; andmeasured 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>	<table><tr><td>Yes</td><td></td><td>No</td></tr><tr><td><input type="radio"/></td><td></td><td><input type="radio"/></td></tr><tr><td></td><td></td><td>Skip E2</td></tr><tr><td><input type="radio"/></td><td></td><td><input type="radio"/></td></tr></table>	Yes		No	<input type="radio"/>		<input type="radio"/>			Skip E2	<input type="radio"/>		<input type="radio"/>
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		Skip E2											
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Comment Box

Please briefly describe improvement activities most recently implemented or currently in progress pertaining to this guideline.



Section B2d: Abdominal Aortic Aneurysm Repair

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



[2004 MH&SC AAA Repair Guideline](#)







[2004 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%; 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></td> <td>Skip B2</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> </tbody> </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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<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> data 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</u> indicators 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%; 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></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> </tbody> </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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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.

<p>1. Has your hospital:</p> <ul style="list-style-type: none">performed a medical record audit on <u>all cases (or a sufficient sample of them)</u> for abdominal aortic aneurysm repairs over at least a 12-month period, but excluding cases admitted more than 24 months ago; andmeasured 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>	<table><tr><td>Yes <input type="radio"/></td><td></td><td>No <input type="radio"/></td></tr><tr><td><input type="radio"/></td><td></td><td><input type="radio"/></td></tr></table> <p>Skip D2</p>	Yes <input type="radio"/>		No <input type="radio"/>	<input type="radio"/>		<input type="radio"/>
Yes <input type="radio"/>		No <input type="radio"/>					
<input type="radio"/>		<input type="radio"/>					

Comment Box

Please briefly describe improvement activities most recently implemented or currently in progress pertaining to this guideline.



Section B2e: Carotid Endarterectomy

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



2004 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;">_____</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 No</p> <p><input type="radio"/> <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 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 of 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 of carotid endarterectomy surgeries</u>?</p>	<p>Yes In Progress No</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/></p> <p style="text-align: right;">Go to C1</p> <p style="text-align: center;"></p> <p><input type="radio"/> <input type="radio"/> <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: 40px;">a. Does your hospital collect <u>risk-adjusted mortality</u> data for <u>carotid endarterectomy surgeries</u>?</p> <p style="margin-left: 40px;">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: 40px;">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 In Progress No</p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/></p> <p style="text-align: right;">Go to C2</p> <p style="margin-left: 40px;"><input type="radio"/> <input type="radio"/> <input type="radio"/></p> <p style="margin-left: 40px;"><input type="radio"/> <input type="radio"/> <input type="radio"/></p> <p style="margin-left: 40px;"><input type="radio"/> <input type="radio"/> <input type="radio"/></p> <p><input type="radio"/> <input type="radio"/> <input type="radio"/></p> <p>Skip C2a Skip C2a</p> <p style="margin-left: 40px;"><input type="radio"/> <input type="radio"/> <input type="radio"/></p> <p style="margin-left: 40px;"><input type="radio"/> <input type="radio"/> <input type="radio"/></p> <p style="text-align: center;"></p>

Comment Box

Please briefly describe improvement activities most recently implemented or currently in progress pertaining to this guideline.



Section B2f: Pancreatic Resection

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



[2004 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

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



[2004 MH&SC Esophagectomy Guideline](#)

[2004 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> <p>1. How many <u>esophagectomies</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>esophagectomies</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>esophagectomies</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></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"/>
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C. Structure, Process, Outcome Measures	Yes	In Progress	No
1. Does your hospital have a <u>risk-adjustment system</u> for <u>esophagectomies</u> ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Go to C2
a. Does your hospital collect <u>risk-adjusted mortality data</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</u> to the <u>Society for Thoracic Surgeons Database</u> ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
a. Is your hospital and/or its surgeons willing to submit clinical data related to <u>esophagectomies</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</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

Please briefly describe improvement activities most recently implemented or currently in progress pertaining to this guideline.



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.




















[2004 MH&SC Guidelines for Low Birthweight Infants and Infants with Congenital Anomalies](#)

[2004 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> <ol style="list-style-type: none"> How many <u>low birthweight infants</u> (<1500 grams) were admitted to your hospital's <u>licensed neonatal intensive care unit</u> for the <reporting period> ending <MMYYYY>? For the <reporting period> ending <MMYYYY>, what is the <u>average daily census</u> in the neonatal ICU (counting all patients regardless of condition)? 	<div style="text-align: center;">  <hr/>  </div>																					
<p>B. Appropriateness</p> <ol style="list-style-type: none"> 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>? 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>? 	<table style="width: 100%; text-align: center;"> <thead> <tr> <th>Yes</th> <th>In Progress</th> <th>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></td> <td>Go to C1</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></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> <ol style="list-style-type: none"> Does your hospital <u>electively admit high-risk deliveries</u>? For high-risk deliveries, has your hospital: <ul style="list-style-type: none"> performed a medical record audit on <u>all cases (or a sufficient sample of them)</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 guideline for these high-risk deliveries (see Zynx.pdf)? If Yes, did your hospital exceed 80% adherence to this guideline? 	<table style="width: 100%; text-align: center;"> <thead> <tr> <th>Yes</th> <th></th> <th>No</th> </tr> </thead> <tbody> <tr> <td><input type="radio"/></td> <td></td> <td><input type="radio"/></td> </tr> <tr> <td></td> <td></td> <td>Go to D1</td> </tr> <tr> <td><input type="radio"/></td> <td></td> <td><input type="radio"/></td> </tr> <tr> <td></td> <td></td> <td>Skip C3</td> </tr> <tr> <td><input type="radio"/></td> <td></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td></td> <td><input type="radio"/></td> </tr> </tbody> </table>	Yes		No	<input type="radio"/>		<input type="radio"/>			Go to D1	<input type="radio"/>		<input type="radio"/>			Skip C3	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>		<input type="radio"/>
Yes		No																				
<input type="radio"/>		<input type="radio"/>																				
		Go to D1																				
<input type="radio"/>		<input type="radio"/>																				
		Skip C3																				
<input type="radio"/>		<input type="radio"/>																				
<input type="radio"/>		<input type="radio"/>																				

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 data</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"/>	<input type="radio"/>	<input type="radio"/>
	Skip D2a		Skip D2a
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 data</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"/>	<input type="radio"/>	<input type="radio"/>
	Skip E2a	Skip E2a	
			
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

Please briefly describe improvement activities most recently implemented or currently in progress pertaining to this guideline.



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.



[2004 MH&SC ICU Physician Staffing Guideline](#)

[2004 ICU Physician Staffing \(IPS\) Leap](#)







<p>A. General Relevance</p> <p>1. How many <u>intensive care units</u> does your hospital operate?</p>	<hr style="width: 100%;"/>																											
<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>ordinarily present</u> in each of these ICUs during <u>daytime hours for at least 8 hours per day, 7 days per week</u>, and do they provide clinical care <u>exclusively</u> in one ICU during these hours?</p> <p style="margin-left: 20px;">a. If you answered “Yes”, is intensivist “presence” accomplished in part via <u>telemedicine</u>?</p> <p>3. When these physicians are not present in these ICUs on-site or via telemedicine, 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 on-site in the ICU and not able to reach an ICU patient within 5 minutes, can they rely on a physician or FCCS-certified non-physician “effector” 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).

** The answers to Question 3 and 4 should be based on a quantified analysis of the pager response time. This percentage may exclude low-urgency pages, if the paging system can designate low-urgency pages or if the hospital has an alternative scientific method for documenting high-urgency pages that are not returned within 5 minutes.

C. Leapfrog Partial Credit for ICU Physician Staffing (IPS) Leap

If you answered "No" or "In Progress" to any of questions #1-4 in Section B, please answer the following questions for adult and pediatric general medical and/or surgical ICUs.

<p>1. Are all patients in these ICUs managed or co-managed by one or more physicians certified in critical care medicine who are either:</p> <ul style="list-style-type: none"> • <u>ordinarily present</u> on-site in these units, • for at least 8 hours per day, 4 days per week, and • providing clinical care <u>exclusively</u> in one ICU during these hours? 	<p>Yes <input type="radio"/></p>		<p>No <input type="radio"/></p>
<p>OR</p> <ul style="list-style-type: none"> • present via <u>telemedicine</u> for 24 hours per day, 7 days per week when an intensivist is not present on-site, • meeting the other Leapfrog ICU requirements for intensivist presence in the ICU via <u>telemedicine</u>, • with an intensivist on-site at least 4 days per week to establish or revise daily care plans for each ICU patient? 			
<p>2. If not all patients are managed or co-managed by physicians certified in critical care medicine, are some patients managed by these physicians?</p>	<p><input type="radio"/></p>		<p><input type="radio"/></p>
<p>3. What is the date, if any, by which your hospital commits to meet the Leapfrog IPS leap fully?</p>		<p>(MMYYYY)</p>	
<p>4. Does your hospital have a board-approved budget that is adequate to meet this commitment?</p>	<p><input type="radio"/></p>		<p><input type="radio"/></p>
<p>5. Does a clinical pharmacist make daily rounds on patients in these ICUs?</p>	<p><input type="radio"/></p>		<p><input type="radio"/></p>
<p>6. Does a physician certified in critical care medicine lead daily multi-disciplinary rounds <i>on-site</i> on all patients in these ICUs?</p>	<p><input type="radio"/></p>		<p><input type="radio"/></p>
<p>7. When certified physicians are <i>on-site</i> in these ICUs, do they have responsibility for all ICU admission and discharge decisions?</p>	<p><input type="radio"/></p>		<p><input type="radio"/></p>









Comment Box

If your facility has used or is familiar with the ICU toolkit created by the Michigan Health and Safety Coalition (and found on its Web site at www.mihealthandsafety.org), please tell us 1) whether the ICU staff found the information useful, 2) describe how the ICU staff used the toolkit and 3) what, if any, safety improvements have been observed

If your facility is not familiar with the ICU toolkit, please briefly describe any other improvement activities recently implemented or currently in progress.



If you answered "No" to question 1, or less than 75% to question 2, please answer questions 4-11 below as a means of sharing the interim steps your hospital may be taking.

<p>4. 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>5. Do you have a written strategy for implementing CPOE?</p> <p>6. Have you defined a timeline and launched a CPOE implementation project?</p> <p>7. What is the date, if any, by which your hospital commits to meet the Leapfrog CPOE leap fully?</p> <p>8. 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>9. Do you have a physician champion who spearheads the CPOE initiative at your hospital?</p> <p>10. Is your CPOE strategy a component of a larger written strategy for a hospital information system?</p> <p>11. 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>No</p> <p><input type="radio"/></p> <p><input type="radio"/></p> <p>_____ MMYYYY</p> <p><input type="radio"/></p> <p><input type="radio"/></p> <p><input type="radio"/></p> <p><input type="radio"/></p> <p>N/A (<100 beds)</p> <p><input type="radio"/></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>No</p> <p><input type="radio"/></p>

Section B5: General Comments on Patient Safety Activities

What additional activities has your hospital implemented to promote improvement in patient safety? Please name (provide only the titles) your hospital's initiatives.



Section B6: Future Participation



Hospital Workgroups	Yes <input type="radio"/>	No <input type="radio"/>
<p>The Coalition may form workgroups to assess various issues related to implementation of the hospital referral guidelines such as access to care, costs of implementation, and funding.</p>		
a. Is your hospital willing to participate in one or more workgroups?	<input type="radio"/>	<input type="radio"/>
b. If yes, for which guideline or guidelines are you most interested in participating:	Check as many categories as interested	
1. Open Heart Surgery	<input type="radio"/>	
2. Percutaneous Coronary Intervention	<input type="radio"/>	
3. Abdominal Aortic Aneurysm Repair	<input type="radio"/>	
4. Carotid Endarterectomy Surgery	<input type="radio"/>	
5. Esophagectomy	<input type="radio"/>	
6. Low Birthweight Infants	<input type="radio"/>	
7. Infants with Congenital Anomalies	<input type="radio"/>	
8. Intensive Care Unit Physician Staffing (IPS)	<input type="radio"/>	
9. Small/Rural/Critical Access Hospitals	<input type="radio"/>	
10. If you answered "yes", please identify the person at your hospital the Coalition should contact for follow up.		
	Name _____ Phone _____ Email _____	

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.

We ask that you complete or update The Leapfrog Group's survey related to the other 27 National Quality Forum (NQF) Safe Practices. The Leapfrog Group will post results from that section on its Web site. The Michigan Health and Safety Coalition (MH&SC) will have access to the survey data and use the information to identify opportunities for improvement activities.

[Go to NQF Safe Practices survey section](#) (log-in required)

[Return to MH&SC Joint Hospital Survey Home Page](#)

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 Group survey. **These questions are entirely optional** and responses will not be released to, or used by, the Michigan Health and 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 implemented an automated events tracking system to monitor incidents and occurrences	0	0	0	0
7) We perform root cause analysis to explore possible reasons for high levels of patient errors.	0	0	0	0
8) We have reviewed and implemented patient safety protections from the JCAHO Sentinel Event Alerts.	0	0	0	0
9) Patient care quality assessment is supported by the following systems (choose all applicable):				
a) JCAHO ORYX™ Core Measures 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

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

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 or 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, 39.25, 39.51 or 39.71 (regardless of diagnosis codes). Note that, 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 cases (or a sufficient sample of them)

If you have fewer than 60 cases *that meet the criteria for inclusion in the denominator of the process measure*, include ALL of these cases in measuring adherence to the process indicators. You should report results for cases from at least a 12-month period (unless your hospital only recently started offering these services, in which case for the time period that you have offered those services.) You need NOT use more than 12 months of historical experience to increase the eligible cases beyond 60; just measure and report based on ALL eligible cases that you have in that period.

If you have more than 60 cases that meet those criteria during the time period of the audit, you may randomly sample 60 of them for the denominator of each indicator, and measure and report adherence based on that sample. When sampling from a larger population of cases, this is the minimum number of cases needed to make a statistically reliable statement of percentage adherence to the process guideline.

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.

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/>).

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.

If the NICU has been in operation for less than 12 months, compute the average daily census for the most recent 60 days of operations; do not report if fully operational less than 60 days. When the NICU reaches 12 months of full operations please re-submit the average daily census for all 12 months.

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."]

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.jcaho.org/>).

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, 38.32 or 38.42.

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 subspecialty 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 ACGME-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/>). 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/>).

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/>).

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.

Electively Admit High-Risk Deliveries

Includes deliveries with:

- expected birth weight <1500 grams;
- gestational age <32 weeks;
- pre-natal diagnosis of major congenital anomalies; or,
- any combination of these.

Not all women at risk for delivery of babies with these conditions are known beforehand to be at risk, e.g., an estimated 40% of mothers delivering babies with major congenital anomalies are identified at-risk prior to delivery. Therefore, deliveries in which these high-risk conditions were unknown prior to admission are not considered electively admitted high-risk deliveries.

If your hospital admits deliveries where these conditions are known prior to admission, then your hospital electively admits high-risk deliveries and you should answer Yes to Question C1; otherwise, answer No.

Esophagectomy

Surgical removal of the esophagus. Principle or secondary procedure code of 42.40-42.59, 42.61-42.69 43.99 (regardless of diagnosis code). 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.

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/education/fccs_courses/index.asp. 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.

Federal Tax Identification Number (TIN)

Enter the TIN that your hospital uses for billing purposes. The number is a nine-digit number with a hyphen between the second and third digits, e.g., 09-8765432. Enter any leading 0 and the hyphen. If your hospital has more than one TIN, use the one that would most typically be used for UB-92 claims filed with commercial health insurance plans for inpatient hospital stays.

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, 765.00, 765.01 - 765.05, 765.10 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 C2 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/003335.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/>).

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, 37.5X, 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.

Ordinarily Present in the ICU

"Ordinarily present in the ICU" refers to direct presence in the ICU (or presence via telemedicine) of an intensivist during the 8-hour period. While it need not be the same intensivist for the entire 8-hour duration, it is expected that the ICU(s) are primarily staffed by dedicated ICU intensivists who are ordinarily and exclusively present in the ICU(s). "Presence" does not mean staffed part-time by multiple physicians who are not ordinarily and exclusively dedicated to the ICU, nor does it mean the cumulative time that one or more intensivists spend in the unit visiting, rounding, consulting, or responding to pages.

The standard allows for normally expected intensivist activities outside of the ICU related to their responsibilities in the ICU (e.g. evaluating patients proposed for ICU admission), as long as intensivists are ordinarily present in the ICU and return immediately when paged. An intensivist present in one ICU immediately adjacent to another can be considered present in both units as long as s/he can respond to demands in both units as if s/he would if both units were one larger unit. While tele-intensivists can be used to meet the presence requirement, some on-site intensivist presence is still necessary to meet the Leapfrog specifications.

Pancreatic Resection

ICD9 Procedure Codes (regardless of diagnosis code): 52.51, 52.53, 52.6, 52.7

Exclude patients age 17 and younger.

Participated in STS/ACC Performance Measurement Systems

If your hospital currently participates and has begun submitting data for all such procedures but has not yet received any reports, you should indicate "Participating but no reports yet available" to get credit for participation. Return and update answers to the remaining questions when you receive your hospital's first reported results; if you show more favorable performance than average you can receive additional credit.

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, 36.06, 36.07, or 36.09. 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.

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.

Quantified Analysis of Page Response Times

Providers can monitor pager response times in multiple ways, as long as the data collection process is non-biased and scientific.

As an example . . .

Providers could maintain an exception log in the ICU(s) on six randomly sampled days per year. On those days, ICU nurses could record:

- the number of urgent pages made to intensivists when they are not present in the unit (whether on-site or via telemedicine);
- the number of urgent pages made to other physicians or FCCS-certified effectors when no physician or FCCS-certified effector is physically present in the unit; and
- the number of times that responses exceed 5 minutes for those respective pages.

Hospitals can then cost-effectively estimate whether they meet the 95% timely response standards by dividing the average number of log exceptions per day by the average number of pages per day.

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/>).

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 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/>).

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/>).

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. When an intensivist is not on-site in the ICU managing or co-managing all ICU patients, a tele-intensivist is monitoring and able to manage all ICU patients for the remaining 24 hours per day, 7 days per week. "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. "Manage" means authorized to diagnose, treat, and write orders for a patient in the ICU on his/her own authority.
3. A tele-intensivist has immediate access to key patient data, including:
 - a. physiologic bedside monitor data (in real-time);
 - b. laboratory orders and results;
 - c. medications ordered and administered; and,
 - d. notes, radiographs, ECGs, etc. on demand.
4. Data links between the ICU and the tele-intensivist are reliable (>98% up-time) and secure (HIPAA compliant).
5. Via 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://jcaho.org/>).

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>).



2004 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:
 2. For coronary artery bypass graft surgery (CABG) or percutaneous coronary intervention (PCI): Participates in and scores better than 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
- or
3. For CABG, 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 Leapfrog Expert Panel-Endorsed Procedure-Specific Process Measures of Quality).

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 criteria 1 and 2 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, or in the second quartile and meeting criterion 3 above.

Thus far, The Leapfrog Group has endorsed performance assessment systems for CABG mortality in CA, NJ, NY, and PA, and for PCI in NY. 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 or 400 PCIs 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).

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

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.

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 your hospital does not offer a procedure or service on an elective basis, the notation 'N/A' will be displayed on the public Web site indicating that the leap does not apply to your hospital.

Scoring Algorithm for EHR (Leapfrog - Michigan)

	EHR Credit				
	Full Credit (full circle)	¾ Circle	½ Circle	¼ 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, a hospital's score is based on its procedure volume (per questions A1 in sections B2b and B2c).
 - Additionally, hospitals that participate in STS/ACC receive additional credit of:
 - ¼-circle credit for participation in STS/ACC (per question B1 in section B2b or question D1 in section B2c) and
 - an additional ¼-circle credit if more favorable than the national average (per question B2 in section B2b or question D2 in section B2c).
 - Alternatively, hospitals not participating in STS/ACC receive additional credit of ¼-circle for adherence to process measure standards (per questions C1-C2 in section B2b, or questions E1-E2 in section B2c).
- For AAA and high-risk deliveries, hospitals get an additional ¼ circle credit by adherence to process measure standards (per questions (per questions D1-D2 in section B2d or questions C1-2 in section B1h).

The hospital's overall score is supplemented in the public results with more **additional detail**:

Volume

For each EHR procedure/condition, the volume of surgery procedures or the NICU census, relative to the volume thresholds (per questions 7-11, 33)

Outcomes Ranking

For CABG and PCI:

- Better than National Average (per question B2 in section B2b or question D2 in section B2c)
- Worse than National (per question B2 in section B2b or question D2 in section B2c)
- Data Not Yet Available (per question B1 in section B2b or question D1 in section B2c)
- Did Not Measure or Disclose (per questions B1-2 in section B2b or questions D1-2 in section B2c)

For all other EHR procedures/conditions, N/A to indicate that there are no Outcomes measures.

Process Excellence

For CABG, PCI, AAA and NICU (based on questions C1-C2 in section B2b, questions E1-E2 in section B2c, questions D1-D2 in section B2d, or questions C1-3 in section B1h):

(results not displayed for CABG or PCI if hospital's STS/ACC performance is better than national average)

- Higher Adherence to Clinical Guidelines
- Lower Adherence to Clinical Guidelines
- Did Not Measure

For all other EHR procedures/conditions, N/A to indicate that there are no Leapfrog-endorsed Outcomes or Process measures.

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.



2004 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 ordinarily present in the ICU (on-site, or via telemedicine that meets Leapfrog specifications) 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 analysis of pager response time;* 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 may exclude low-urgency pages, if the paging system can designate low-urgency pages or if the hospital has an alternative scientific method for documenting high-urgency pages that are not returned within 5 minutes.

If you have no licensed or staffed adult or pediatric general medical and/or surgical ICU beds, then this section does not apply to your hospital. Simply answer “No” to the first question and finish the section. 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 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.

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) when those physicians are present, whether on-site or via telemedicine (answered "Yes" to question B2); **and**
 2. The hospital commits to meet the Leapfrog IPS standard fully by 12/31/2004 (answered < 2005 to question C3); **and**
 3. The hospital has a board-approved budget that is adequate to meet the IPS commitment (answered "Yes" to question C4);
 4. The hospital has implemented either of the following practices:
 - a) Intensivists are present and manage or co-manage all patients in all ICUs either on-site at least 8 hours per day, 4 days per week or via telemedicine 24 hours per day, 4 days per week with on-site daily care planning at least 4 days per week (answered "Yes" to question C1); use of telemedicine requires that additional Leapfrog telemedicine specifications are met; **or**
 - b) 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 on-site (answered "Yes" to question C6), **or**
 - b) makes admission and discharge decisions when on-site (answered "Yes" to question C7).

Good early stage effort means:

1. The hospital commits to meet the Leapfrog IPS standard fully by 12/31/2005 (answered < 2006 to question C3); **and**
2. The hospital has a board-approved budget that is adequate to meet the IPS commitment (answered "Yes" to question C4); **and**
3. Some patients in the ICU(s) are managed or co-managed by an intensivist when present on-site or via telemedicine (answered "Yes" to question C2). Use of telemedicine requires that additional Leapfrog telemedicine specifications are met.

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.



2004 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 prescribers* enter hospital medication orders via a computer system that includes decision support software to reduce prescribing errors;
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 prescribers electronically document a reason for overriding an interception prior to doing so.

* "Prescribers" 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 \geq 75% for question 3*).

Good progress means:

1. Has a functioning CPOE system in at least one part of the hospital (*answered "Yes" to question 1*); **or**
2. The hospital is currently implementing or selecting a CPOE system (*checked "Currently selecting" or "Currently implementing" in question 4*); **or**
3. The hospital has a written strategy for implementing CPOE (*answered "Yes" to question 5*); **or**
4. The hospital has a defined timeline and already launched a CPOE implementation project (*answered "Yes" to question 6*).

AND all of the following:

5. 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 8*); **and**
6. The hospital has a physician champion who spearheads the hospital's CPOE initiative (*answered "Yes" to question 9*); **and**
7. The hospital commits to meet the Leap fully before 2005 (*answered $<$ 2005 or question 7*).

Good early stage effort means:

1. Hospital has a written strategy for implementing CPOE (*answered "Yes" to question 5*); **or**
2. The hospital has defined a timeline and has launched a CPOE implementation project (*answered "Yes" to question 6*).

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 8*).
4. The hospital has a physician champion who leads the hospital's CPOE initiative (*answered "Yes" to question 9*).

5. The hospital commits to meet the Leapfrog CPOE standard fully before 2006 (*answered < 2006 for question 7*).

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.

2004 National Quality Forum Safe Practices Leap (NQF-SP)

In May 2003, the National Quality Forum released its Safe Practices Consensus Report, a total of 30 practices that can have major impact on the safety of patients in healthcare settings. These 30 practices include Leapfrog's three initial Leaps (CPOE, IPS, and EHR) and those practices are reflected in other sections of this survey. This section focuses on the other 27 safe practices. The practices are numbered in the same order as found in the NQF documentation, thus three numbers (from the original Leaps) are skipped and covered in other sections of the survey.

Before completing this section of the survey, please review some important background information on the design of this section and how users can most easily complete it. **To complete this section, you should have a full copy of the NQF Safe Practices Consensus Report. See link to purchase a copy from NQF if you do not already have one.**

- [Suggestions for Reviewing and Completing This Section](#)
- [Background -- Guiding Principles in the Design of Survey Questions](#)
- National Quality Forum Safe Practices Consensus Report (May 2003):
 - [Executive Summary](#)
 - [Full Report \(ordering information\)](#)
- [Submitter's Checklist](#)
- [NQF Safe Practices Leap Development White Paper](#)
- [Glossary of Terms](#)
- [Frequently Asked Questions \(NQF-SP\)](#)
- [How Results Are Scored¹](#)

For each of the 27 NQF Safe Practices listed below, please review and check items, as appropriate. As you finish each practice, it will be marked "Completed" when you return to this page. When you have finished responding to all 27 Safe Practices, you will be able to Save & Affirm this section.

<i>Safe Practice</i>	<i>Weighting (pts)</i>
# <i>Enterprise-wide System</i>	
1 Create Safety Culture	263
3 Ensure Adequate Nursing Workforce	119
Subtotal	382
<i>Enterprise-wide Process</i>	
6 Verbal Order Readback	36
7 Standardized Abbreviations/Doses	17
8 No Pt Care Summaries from Memory	17
9 Pt Care Info/Orders to all Providers	84
Subtotal	154
TOTAL ENTERPRISE-WIDE	536
<i>Clinical Care Setting or Function-Specific</i>	
5 Pharmacist Active in Medication Use	32
10 Patient Readback of Informed Consent	8
11 Document Resuscitation/End of Life Directives	12
13 Prevention of Mislabeled Radiographs	16
14 Wrong-site/Wrong-patient Prevention	30
15 Prophylactic Beta Blockers for Elective Surgery	23

16	Pressure Ulcer Prevention	28
17	DVT/VTE- Risk Assessment & Prevention	27
18	Anticoagulation Services	39
19	Aspiration Prevention	24
20	Central Venous Line Sepsis Prevention	33
21	Surgical Site Infection/Antibiotic Prophylaxis	37
22	Contrast-induced Renal Failure Protocol	12
23	Malnutrition Prevention	12
24	Tourniquet -- Ischemia/Thrombosis Prevention	8
25	Hand Washing	33
26	Flu Vaccination for Healthcare Workers	11
27	Optimize Medication Workspaces	7
28	Optimize Medication Storage/Packaging/Labeling	22
29	Identify High Alert Medications	21
30	Medication Unit Dosing/Unit-of-Use Dispensing	29
	TOTAL CLINICAL CARE SETTING OR FUNCTION-SPECIFIC	464
	GRAND TOTAL	1,000

Return to Main Page

Leave section without finishing and return to other parts of the survey

Save & Affirm

Affirm this section as complete and return to other parts of the survey

1. **Carefully review the explanations provided in the Background-- [Guiding Principles in the Design of Survey Questions](#).** They provide Guiding Principles that were used for creation of the survey, including:
 - The rationale for providing partial credit for partial progress, partial credit for commitment to progress, and a short description of the systematic approach used to address patient safety problems and practices in an ever emerging area of science are provided.
 - The weighting of the relative practices was defined by an expert advisory group of 8 Patient Safety thought leaders and 67 subject matter experts. The relative weighting was based on the enterprise-wide impact of the problem area, impact of practices, and the relative impact of practices on specific care areas with emphasis on the frequency and severity of adverse events and the impact of readily available practices and performance improvement methods.
 - Rural organizations should note that, in Practice #5 of the NQF Safe Practices Report, there is an option for telephone pharmacy consultation rather than on-site services. In 2004, a rural task force will be examining the potential for alternative measures for the original Leapfrog leaps. Implementation would occur in the 2005 survey.
 - The focus of the survey is on adult acute care. See FAQs regarding applicability of these 27 Safe Practices to children's hospitals.

2. **Review the survey questions along with a copy of the full National Quality Forum Safe Practices Consensus Report (May 2003).**
 - The format of the excellent NQF report was explicitly followed. The report is easy to read and provides a critical context to the patient safety practices, objectives, and problems being targeted.
 - The report provides “additional specifications” and “implementation examples” that include activities that hospital organizations may undertake to earn credit for the survey questions defined in this document. These specifications and implementation examples have been included in the survey question information exactly as written in the NQF report for reference purposes.
 - The report cites references in the literature that would complement a review undertaken today.
 - Also see the FAQs and on-line help text for further guidance in interpreting the survey questions.

3. **Mark up a hardcopy of the survey before responding to the on-line survey.**
 - Reading the survey text in hardcopy will be easier than reviewing it on-line.
 - For security reasons, the on-line survey times out after approximately 20 minutes of inactivity, i.e., if the user does not submit a page of responses. Work on that page will be lost and the user will need to log in again with hospital ID and password then navigate back to the page to start again.

4. **Hospital Requirements to Submit Survey:**
 - ✓ **3 Days Research:** It is hoped that research of answers to submit this section of the survey should take a hospital about 3 days. Given that JCAHO requires that all hospitals appoint a Patient Safety Officer and that this is usually someone senior with a staff, a progressive hospital should be able to complete the survey very rapidly. Those behind the curve on safety may take longer.
 - ✓ **1 Hour Submission (with answers in hand):** It is expected that a user with answers in hand should be able to complete this section of the on-line survey in approximately one hour.

5. **Mechanism to provide your highly valued input to the survey design:**
 - This survey section will continue to undergo refinement in future versions of The Leapfrog Hospital Patient Safety Survey with input from subject matter experts, hospital collaborators, and the healthcare industry. Comment periods will be provided.

The Leapfrog Group would like to acknowledge the outstanding work of the authors -- Charles Denham and Franck Guilloteau of the Texas Medical Institute of Technology (TMIT) -- for this portion of the survey. Countless hours of development, consultation, and testing were provided by them and by their "expert panels." Leapfrog also thanks the many contributors to the NQF process for development of the practices and The Medstat Group for integrating this new effort into the 2004 survey,

1. **Complement the NQF Safe Practices Report (May 2003):** The survey, weighting system, and ranking system designs are explicitly tied to the problem areas and practices defined by the NQF report. Recognizing the challenges of tying standards, measures, or practices to a report that is written at a snapshot in time, the survey, weighting, and ranking systems take into account that new evidence and refinement of performance improvement methods are being generated all the time. Patient safety is an emerging science and is constantly evolving. Therefore, the guiding principles included focus on the excellent list of safety problems being targeted by NQF practices and apply the "4 A Framework" below. The "4 A Framework" provides real flexibility of interpretation and provides a means of providing partial credit for partial progress and partial credit for commitment to progress.

Although the survey will undergo annual refinement through public review and optimization by our subject matter experts, the design will be kept intact in order to make the survey fair and reasonable. The goal is to neutralize the challenges of explicitly tying questions to specific language of practices that are evolving while staying well within the scope of the NQF report.

2. **Partial Credit for Partial Progress:** The questions were designed using a "select any that apply" response giving hospitals numerous opportunities for partial credit. A set of FAQs and context sensitive help text are provided to assure that respondents will have clarity regarding what will qualify for credit on a question-specific basis.
3. **Partial Credit for Commitment:** Many of the questions provide partial credit to organizations that make substantial commitment to get started. This will help those that may be "behind the safety curve". The intent is to provide a clear roadmap to organizations that have heretofore not prioritized safety. These questions are also intended to provide fairness in areas where patient safety issues have not been well publicized.
4. **Systematic Application of 4A Framework:** The 4A framework recognizes the sequential and interdependent nature of *awareness* of our performance opportunities, *accountability* of leadership, the *ability* to employ practices, and measurable *action* towards closing performance gaps. This "4A Framework" (updated from a 3A framework published by C. Denham in 2001) was used as an organizational structure to allow systematic customization of survey questions. (See: Chip Caldwell & Charles Denham, M.D. *Medication Safety and Cost Recovery: A Four-Step Approach for Executives*. Health Administration Press, Chicago, 2001.)

- √ **Awareness:** Clearly, the leaders of an organization must be aware of performance problems before they can make any impact on them. The concept of THE problem or performance opportunity addresses the awareness by hospitals that there is evidence to support a common problem across all hospitals. The concept of OUR problem addresses awareness of the frequency and severity of adverse events to our patient population within our organization **and** recognition of the impact that practices or performance improvement methods can have on those adverse events. Awareness of THE performance opportunities and OUR performance opportunities are addressed in a relatively standardized manner in each survey question, however they were customized to each problem depending on the current state of awareness in the community.
- √ **Accountability:** A critical success factor to patient safety is accountability of the leadership to performance. Whether the mechanisms of personal performance reviews or performance compensation incentives are used, sustained gains in patient safety frequently do not occur without personal accountability of the leaders. This issue was addressed in a relatively standardized way throughout the survey; however the questions were fine tuned to the scope or care setting addressed by the practice.
- √ **Ability:** An organization may be aware of THE problem – a performance gap common to most hospitals. In fact they may be aware of OUR problem (their own) with clear evidence of frequency and severity of adverse events in their own patient population. They may even have awareness of the impact of a given practice, however if they do not invest in education or skill development and more importantly allocate real protected staff time and dollars to a given problem, the impact on safety is modest at best. Adding a patient safety responsibility to an already overloaded employee without carving out the time and providing them the necessary financial resources to make an impact sends a clear message to the organization. The "ability" related survey questions employ a graduated set of investment levels ranging from investment in education, skill development (training regarding the application of

practices or performance improvement methods), compensated caregiver staff time, and dedicated line item budget allocations.

- √ **Actions:** Action activities were tied to the NQF cited best practices language as appropriate. Where there have been great strides in best practices, the survey questions provide latitude for activities deserving credit. A set of FAQs will be tied to each survey question that will provide guidance as to what activities may qualify for credit, especially if certain developments in patient safety have been substantiated in the literature after publication of the NQF report. Performance Improvement programs and project actions were given high emphasis, as such, these programs will require thorough literature reviews and examination of readily available practices be undertaken. Such initiatives would include but not limited to the NQF practices especially if there were new high impact actions that target the problems listed in the NQF report. Far more important than attestations of compliance to procedures, policies, and protocols are ongoing programs that have regular measurement and process improvement elements.
5. **Sensitivity to use of the word “Problem”:** Risk managers at hospital organizations have expressed concern over the use of the word “problem”, therefore wherever possible the term “performance opportunity” was used in the survey in place of the word “problem”. That is not to say the word problem is not used appropriately in the NQF report. It is.
 6. **“Practices” defined as readily available to mid-level manager at 350 bed frontline community hospital:** Recognizing the continuing evolution of practices a guiding principle to be followed in interpreting the survey questions is that it is expected that performance improvement programs or projects would require that hospitals to evaluate performance improvement methods or practices that would *“be currently and readily available to a mid-level manager at a frontline urban community hospital”*. This principle allowed the survey, weighting system, and ranking system to be normalized to the most representative case of hospitals across the country. It also limited confusion around currently published studies and opened the field of review to literature, internet resources, and readily available expert opinion from quality improvement groups. This did not violate the principle of operating within the scope of the NQF Safe Practices Report.
 7. **Adjustable Question Design:** Questions will be updated and weights may be adjusted on an annual basis. ”given new evidence, changes to the NQF practices, or substantive feedback from users. The graduated framework will allow questions to be made tougher or easier without dramatically impacting the coherence of the entire question set.
 8. **Emphasize Performance Improvement Projects/Programs:** The greatest sustained improvement and cost savings have been achieved by hospitals that have undertaken formal Performance Improvement Programs with measurement and process improvement features that tie to explicit procedures and protocols. They also allow us to avoid measuring action against dated or less effective methods than those now readily available to frontline hospitals.
 9. **Allow Flexibility in Interpretation:** The questions offer some flexibility for partial credit due to the limitations of typical practices language. This also allows a variety of practices that impact a patient safety area to generate credit.
 10. **Stratify Hospitals Through Partial Credit:** The answers for each question were designed to stratify respondents based on our experts' best understanding of the current status of frontline hospitals.
 11. **Comprehensive Questions for High Impact Areas:** A more comprehensive question set was used for high weight/high impact areas such as Culture. The goal here was to help stratify respondents and give them ample opportunity for partial credit.
 12. **Common Sense Test:** In all cases the attempt was to apply a “common sense” test to the questions from the perspective of a frontline mid level manager – did they make sense and relate well to the practices and verbiage in the NQF report.
 13. **Hawthorne Effect:** One objective was to create an opportunity for hospitals to recognize the potential benefit of partial credit for commitment and that just the process developing answers for the survey would cause frontline leaders to make a course change and invest in patient safety “on the spot”.

Practice #1

Create a Healthcare Culture of Safety

Safety Objective 1

To have a healthcare culture of safety.

The Problem

None.

Additional Specifications

In a healthcare culture of safety, at a minimum, standardized policies and procedures are in place to:

- prioritize patient safety events and situations that should be reported
- analyze the patient safety events and situations that are reported
- verify that the remedial actions identified through analysis of reported patient safety events are implemented and effective and do not cause unintended adverse consequences
- ensure that organizational leadership is kept knowledgeable about patient safety issues present within the organization and is continuously involved in processes to assure that the issues are appropriately addressed and that patient safety is improved
- provide oversight and coordination of patient safety activities
- provide feedback to frontline healthcare providers about lessons learned
- publicly disclose implementation of or compliance with all NQF endorsed safe practices applicable to the facility
- train all staff in techniques of teamwork-based problem solving and management.

Example Implementation Approaches

- Ensure incident reporting is conducted in a timely fashion.
- Implement a non-punitive "close call" reporting system.
- Establish an external multidisciplinary committee that reviews all incidents.
- Implement and utilize "trigger tools" (i.e., reminders) to identify harm and subsequent improvement.
- Designate a certain amount of the executive leadership's time for patient safety activities, e.g., weekly walk-arounds, regular patient safety-related sessions at executive staff and Board of Trustee meetings.
- Employ a patient safety officer who is the single point of contact for questions about safety, for education, and for deployment of system changes.
- Convene an interdisciplinary patient safety improvement committee that is responsible for creating, implementing, and overseeing mechanisms to:
 - ✓ oversee root cause analyses of every incident and provide feedback to frontline workers about lessons learned;
 - ✓ disclose the organization's progress toward implementing safe practices; and
 - ✓ provide professional training and practice in teamwork techniques (e.g., anesthesia crisis management, aviation-style crew resource management, medical team management).

Weighting for Safe Practice

Weighting Out of 1000 Points = 263

Check all boxes that apply.

In regard to creating a culture of safety as described in Chapter 2 of the NQF Safe Practices report our organization is:

Aware of the importance of this patient safety issue and has acknowledged it:

1.1	<input type="checkbox"/> by making efforts to become aware of THE common performance improvement opportunities through at least one educational meeting for administrative or clinical personnel addressing certain subjects defined in the safety culture section of the NQF report within the last 12 months as evidenced by meeting documentation/attendance records.
1.2	<input type="checkbox"/> by making efforts to become aware of OUR performance opportunities in creating a culture of safety in that senior management has received a formal written report within the last 12 months addressing subjects included in Chapter 2 of the NQF report regarding culture. OR <input type="checkbox"/> by having undertaken a cultural survey of employees across a clinical functional unit, department, or clinical service line within the last 12 months.
1.3	<input type="checkbox"/> by regular participation by senior executives in executive walk-arounds whereby patient safety issues are discussed with frontline staff.
1.4	<input type="checkbox"/> by regular active involvement by senior executive staff and/or trustees/board of directors in patient safety meetings or sessions.
1.5	<input type="checkbox"/> by establishing certain specific policies and procedures to ensure that the organizational leadership is kept knowledgeable about patient safety issues present within the organization and continuously involved in processes to assure that the issues are appropriately addressed and that patient safety is improved.
1.6	<input type="checkbox"/> by establishing polices and procedures to provide feedback to the frontline healthcare providers about lessons learned from incidents and reported events.
1.7	<input type="checkbox"/> as evidenced by the issue of creating culture of safety already specifically addressed in our existing strategic or operational plan. OR <input type="checkbox"/> by our organization making a commitment to add the issue of creating a culture of safety to our strategic or operational plan within six months of survey submission <i>Check one or neither, but not both.</i>

Accountable to it as evidenced by:

1.8	<input type="checkbox"/> our departmental and/or clinical service line managers being accountable to creating a culture of safety (such as subjects included in "Additional Specifications" and "Example Implementation Approaches" as defined in Chapter 2 of the NQF Safe Practices Report) through personal performance reviews or personal compensation incentives.
1.9	<input type="checkbox"/> our senior executives being directly accountable to creating a culture of safety through personal performance reviews or personal compensation incentives.
1.10	<input type="checkbox"/> our CEO and officers being already directly accountable to the patient safety areas addressed in creating a culture of safety through personal performance reviews or personal compensation incentives. OR <input type="checkbox"/> our CEO making a commitment to be directly accountable and assigning direct accountability of the organization's officers to the patient safety areas addressed in creating a culture of safety within six months of submitting this survey. <i>Check one or neither, but not both.</i>

<input type="checkbox"/> 1.11	direct and regular briefings of our trustees/board of directors being made by a Patient Safety Officer that include performance metrics addressing subjects included in “Additional Specifications” and “Example Implementation Approaches”. <u>OR</u> by committing to establish direct and regular briefings of our trustees/board of directors by a Patient Safety Officer that includes performance metrics addressing subjects included in “Additional Specifications” and “Example Implementation Approaches”. <i>Check one or neither, but not both.</i>
<input type="checkbox"/> 1.12	by publicly disclosing implementation of (or compliance with) NQF safe practices applicable to the organization or facility. <u>OR</u> by committing to publicly disclose implementation of (or compliance with) NQF safe practices applicable to the organization or facility. <i>Check one or neither, but not both.</i>

Investing in our **ability** to develop a culture of safety by:

<input type="checkbox"/> 1.13	having undertaken formal staff education programs as evidenced by meeting documentation/attendance records during the 12 months prior to submitting the survey.
<input type="checkbox"/> 1.14	having invested in staff skill development programs (applying practices or performance improvement tools such as the use of culture surveys or other tools addressed in the NQF report) as evidenced by meeting reports/attendance records reports during the 12 months prior to submitting the survey.
<input type="checkbox"/> <input type="checkbox"/> 1.15	having formally allocated compensated caregiver staff time to creating a culture of safety as evidenced by such staff resources actively involved in leading or developing programs defined or included in the culture section of the NQF Safe Practices Report. <u>OR</u> the organization making a commitment to formally allocate compensated caregiver staff time and dedicated line item budget allocations to implement policies and procedures such as those defined in the “additional specifications” and “implementation examples” sections of Chapter 2 of the NQF Safe Practices Report NQF report. <i>Check one or neither, but not both.</i>
<input type="checkbox"/> 1.16	having employed a full time patient safety officer who is responsible for answering patient safety questions, supervision of patient safety education, and deployment of system changes.
<input type="checkbox"/> 1.17	having made an explicit dedicated line item budget allocation to this area of patient safety addressing issues discussed in the NQF Safe Practices Report.

Has taken **action** to address it by:

<input type="checkbox"/> 1.18	implementation of ongoing automated or manual chart review or use of trigger tools that increase awareness of specific performance improvement areas.
<input type="checkbox"/> 1.19	having established or actively participating in a non-punitive “close call” or “near miss” reporting system.
<input type="checkbox"/> 1.20	having implemented a multi-disciplinary committee that reviews all incidents and errors that are reported.
<input type="checkbox"/> 1.21	having implemented clinical functional unit-wide, department-wide, or clinical service line-wide teamwork development training programs similar to the examples of anesthesia crisis management or aviation-style crew resource management or medical team management programs as evidenced by program/meeting documentation/ attendance records.
<input type="checkbox"/> 1.22	having implemented enterprise-wide teamwork development training programs similar to the examples of anesthesia crisis management or aviation-style crew resource management or medical team management programs as evidenced by program/meeting documentation/attendance records.

<input type="checkbox"/> 1.23	having implemented a formal performance improvement project/program of some type (with regular measurement and process improvement elements) addressing this area.
a <input type="checkbox"/> b <input type="checkbox"/> 1.24	having implemented a formal clinical unit-wide, department-wide, or clinical service line-wide performance improvement project/program in this area (with regular measurement and process improvement elements). <p style="text-align: center;">OR</p> the organization committing to undertake a formal clinical unit-wide, department-wide or clinical service line-wide performance improvement project/program in this safety area. <i>Check one or neither, but not both. You must successfully complete 1.23 before checking either item.</i>
<input type="checkbox"/> <input type="checkbox"/> 1.25	having implemented an enterprise-wide formal performance improvement project/program (with regular performance measurement and process improvement elements) within 12 months prior to submitting this survey. <p style="text-align: center;">OR</p> the organization committing to undertake a literature review and implement the latest best practices with a tightly coupled enterprise-wide performance improvement project/program (with regular measurement and process improvement elements) within six months of submitting this survey. <i>Check one or neither, but not both. You must successfully complete 1.24a before checking either item.</i>

Finished

Record answers, mark this Practice as Completed, and return to list of Practices.

Save Work

Save answers and return to list of Practices. I will return later to complete responses for this Practice.

Reset Page

Clear all answers on this page so I can start over with responses for this Practice.

Note: This button convention is repeated in the on-line survey at the end of each Practice

Practice #3

Specify an explicit protocol to be used to ensure an adequate level of nursing care based on the institution's usual patient mix and the experience and training of its nursing staff.

Safety Objective 3

Ensure nursing staff is adequate for providing safe care.

The Problem

Numerous studies have demonstrated that the level of nurse staffing in a healthcare institution, i.e., the ratio of nurses to patients, is strongly associated with the risk of adverse events encountered by patients. Specifically, lower staffing rates are associated with increased risk of adverse events. The level of education and training of the nursing staff is also a factor, with more adverse events typically being found in hospitals that have a lower proportion of registered nurses.

Despite the demonstrated relationship between nurse staffing and adverse events, a specific ratio of skilled nurses to patients that improves patient safety for each care setting or type of patient has not yet been identified. The evidence strongly suggests, however, that at current overall staffing levels, institutions that attract and retain more skilled nurses per patient, and that give careful thought to appropriate staffing, are safer institutions as measured by the occurrence of adverse events.

Additional Specifications

- Implement explicit organizational policies and procedures regarding use of the nurse staffing protocol.
- Regularly document the degree to which the predetermined staff-patient number and mix is achieved.

Weighting for Safe Practice

Weighting Out of 1000 Points = 119

Check all boxes that apply.

In regard to adequate nursing staff to patient levels our organization is:

Aware of the critical importance of nursing staff levels and OUR performance as evidenced by:

3.1	<input type="checkbox"/> at least one educational meeting for nurses, clinicians, and or administrators specifically related to patient safety and adequate nursing staff levels with in the 12 months prior to submitting this survey as evidenced by meeting documentation/attendance records.
3.2	<input type="checkbox"/> our organization has undertaken an evaluation of the frequency and severity of adverse events that can be related to staffing and skill levels in our patient population. An assessment of the potential impact that improved staffing levels can have as well as recommendations were included in a report to administration in the 12 months prior to submission of this survey. OR <input type="checkbox"/> our organization commits to undertake an evaluation of the frequency and severity of adverse events that can be related to staffing and skill levels that will include an assessment of the potential impact that improved staffing levels can have on adverse events in our patient population within six months of submitting this survey. <i>Check one or neither, but not both.</i>
3.3	<input type="checkbox"/> staffing level and or skill level goals being already specifically addressed in our existing strategic or operational plan. OR <input type="checkbox"/> our organization commits to add the issue of maintaining target nursing staff levels and or skill development to the enterprise strategic or operational plan within six months of survey submission. <i>Check one or neither, but not both.</i>

Accountable to optimizing staffing levels related to patient safety as evidenced by:

3.4	<input type="checkbox"/> certain departmental/clinical service line managers are directly accountable to maintaining adequate nursing staffing levels through personal performance reviews or personal compensation incentives. OR certain departmental/clinical service line managers are directly accountable to minimizing the impact of low workforce staffing levels on patient safety by performance improvement methods. They are accountable through personal performance reviews or compensation incentives.
3.5	<input type="checkbox"/> our CEO, our officers/Senior executives, and pertinent departmental/clinical service line managers are all directly accountable to the patient safety area through personal performance reviews or personal compensation incentives. OR <input type="checkbox"/> our organization commits to assigning direct accountability of adequate staffing levels and related adverse event evaluation to the CEO and senior executives through performance reviews or compensation incentives within six months of submitting this survey. <i>Check one or neither, but not both.</i>
3.6	<input type="checkbox"/> direct and regular briefings of our trustees/board of directors by a Patient Safety Officer that includes staffing level related performance metrics.

Focused on our **ability** to improve staff level and skill level related adverse events by:

3.7	<input type="checkbox"/> investing in staff education/knowledge transfer or recruitment and retention efforts as evidenced by meeting documentation/attendance records or project documentation.
3.8	<input type="checkbox"/> investing in staff skill development (improving practice competencies that reduce adverse event rates related to staffing levels) as evidenced by meeting documentation/attendance records or project documentation.

<input type="checkbox"/> 3.9	<p>having formally allocated compensated caregiver staff time to this patient safety issue. Examples of such programs may take the form of education or program development to minimize the risks associated with less than optimal staffing levels or skill levels of staff.</p> <p style="text-align: center;">OR</p> <p>making a commitment to allocate dedicated compensated caregiver staff time AND a line item budget allocation to this area of patient safety.</p> <p><i>Check one or neither, but not both.</i></p>
3.10	<input type="checkbox"/> <p>having made a dedicated line item budget allocation to improve performance and reduce risk to patients by optimizing staffing levels and skill levels and adhering to the appropriate protocols in this area of patient safety.</p>

Is taking **actions** to address adequate nursing staff levels by:

<input type="checkbox"/> 3.11	<p>having implemented explicit protocols to ensure adequate nursing staff to patient levels are achieved with regular documentation as to the degree to which the predetermined staff levels are maintained (i.e., step-by-step process that assists in determining daily safe staffing levels in order to correctly deploy staff and determine long term needs to maintain those safe levels).</p>
<input type="checkbox"/> 3.12	<p>having implemented some kind of performance improvement project (with regular measurement and process improvement methods) that minimize the risk to patients of less than optimal nursing staff levels or raise staffing levels in high risk areas within the 12 months prior to submitting this survey.</p>
<input type="checkbox"/> <input type="checkbox"/> 3.13	<p>having implemented an enterprise-wide performance improvement program or project (with regular measurement and process improvement methods) that minimize the risk to patients of less than optimal nursing staff levels within the 12 months prior to submitting this survey.</p> <p style="text-align: center;">OR</p> <p>the organization committing to implement an enterprise-wide performance improvement program or project (with regular measurement and process improvement methods) intended to minimize the risk to patients of less than optimal nursing staff levels or skill levels within six months of submitting this survey.</p> <p><i>Check one or neither, but not both. You must successfully complete 3.12 before checking either item.</i></p>
<input type="checkbox"/> 3.14	<p>having established target staffing levels and then successfully achieved the targets during the 12 months prior to survey submission as evidenced by project, meeting, or planning/measures documentation.</p>

Practice #5

Pharmacists should actively participate in the medication-use process, including, at a minimum, being available for consultation with prescribers on medication ordering, interpretation and review of medication orders, preparation of medications, dispensing of medications, and administration and monitoring of medications.

Safety Objective 5

Ensure that medications are used in safe and effective ways.

The Problem

Nearly half of preventable adverse drug events (ADEs) result from a problem in medication ordering. It has been demonstrated in inpatient settings that having a pharmacist review medication orders before administration is associated with a significant decrease in preventable ADEs. Similar findings have been found in ambulatory settings. Including pharmacists on clinical rounds also can reduce medication errors.

Additional Specifications

- Pharmacists should review all medication orders and the complete patient medication profile before medications are dispensed or made available for administration except in those instances when review would cause a medically unacceptable delay.
- The review of medication orders should be documented in the patient's record.
- There should be explicit organizational policies and procedures regarding the role of pharmacists in the medication-use process.
- This practice shall be done in accordance with applicable state and federal laws.
- When a full-time pharmacist is not available onsite, then a pharmacist should be available by telephone or accessible at another location that has 24-hour pharmacy services*.

* NQF included the option for telephone pharmacy consultation in lieu of on-site access to extend this Practice to hospitals in rural areas.

Weighting for Safe Practice

Weighting Out of 1000 Points = 32

Check all boxes that apply.

In regard to adverse drug events and active pharmacist participation in the medication-use process, our organization is:

<p>5.1</p>	<p><input type="checkbox"/> Aware of OUR performance improvement opportunity in this area in that . . . the organization has undertaken an evaluation of the frequency and severity of adverse drug events in our patient population that includes an assessment of the potential impact of pharmacist consultations and the processes of improving accuracy in ordering and the medication use process,</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> the organization commits to undertake a thorough review of the pertinent medication management literature and undertake an enterprise-wide comprehensive evaluation of the frequency and severity of adverse events medication use process in our patient population. A summary of the opportunity for improvement including optimizing the use of pharmacists will be reported to the administration within six months of submitting this survey.</p> <p><i>Check one or neither, but not both.</i></p>
<p>5.2</p>	<p><input type="checkbox"/> Accountable to the issue of adverse drug events as evidenced by . . . our CEO, our officers, senior executives (COO), and pertinent departmental/clinical service line managers being directly accountable through personal performance reviews or personal compensation incentives,</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> the Patient Safety Officer regularly reports performance metrics related to this area of the medication use process to the trustees/board of directors and is directly accountable to this area through performance reviews or compensation.</p>
<p>5.3</p>	<p><input type="checkbox"/> Invested in our ability to deal with this issue of adverse drug events in that . . . the organization is conducting staff education/knowledge transfer (of actionable information) and/or skill development (staff's ability to apply practices or tools in performance improvement) in the area of reducing adverse drug events related to ordering accuracy,</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> the organization commits to make a dedicated budget allocation to this reducing adverse drug events including consideration of improving the utilization of pharmacists in the medication use process within six months of completing the survey.</p> <p><i>Check one or neither, but not both.</i></p>
<p>5.4</p>	<p><input type="checkbox"/> Taking action in this area in that pharmacists currently review all medication orders and complete medication profiles before medications are dispensed or made available for administration except in those instances when review would cause a medically unacceptable delay to address this issue by implementing a formal performance improvement project/program (with regular measurement and process improvement elements) addressing this area.</p>

Practice #6

Verbal or telephone orders or critical test results should be recorded whenever possible and immediately read back to the prescriber, i.e., a healthcare provider receiving a verbal or telephone order should read or repeat back the information the prescriber conveys in order to verify the accuracy of what was heard.

Safety Objective 6

Promote accurate communication about treatments and procedures.

The Problem

Safe and effective healthcare delivery depends to a large extent on accurate and timely communication among care-givers. The need for clear, unambiguous communication of orders cannot be overstated; a lapse in communication at any step can result in an error that can cause serious illness or injury long-term disability, or death.

Additional Specifications

- Explicit organizational policies and procedures should be in place regarding verbal orders.
- Verbal orders should never be used for chemotherapy.

Example Implementation Approaches

The healthcare provider receiving the order should immediately write the order down or enter it into a computer immediately following read-back.

Weighting for Safe Practice

Weighting Out of 1000 Points = 36

In regard to communication issues related to verbal orders or critical test results, our organization is:

<p><input type="checkbox"/></p> <p>6.1</p>	<p><u>Aware</u> of OUR performance improvement opportunity in that . . . the hospital has undertaken an enterprise-wide educational effort addressing improvement in communication including the area of verbal read backs of orders and critical test results as evidenced by meeting or program documentation/attendance records,</p> <p style="text-align: center;"><u>OR</u></p> <p>the organization has undertaken an evaluation of the frequency and severity of adverse events resulting from miscommunication including breakdowns in transmission of verbal orders or critical test results in our patient population and has identified optimal polices and procedures to optimize performance,</p> <p style="text-align: center;"><u>OR</u></p> <p>the organization commits to undertake a thorough literature review and a comprehensive enterprise-wide evaluation of the frequency and severity of adverse events resulting from communication breakdowns including those related to verbal orders or critical test results in our patient population. A report with a summary of the opportunity for improvement in this area will be reported to administration within 12 months of submitting this survey.</p> <p><i>Check one or neither, but not both.</i></p>
<p><input type="checkbox"/></p> <p>6.2</p>	<p><u>Accountable</u> to this issue as evidenced by our senior executives and pertinent departmental/clinical service line managers being directly accountable to the patient safety area (communication improvement) through personal performance reviews or personal compensation incentives.</p>
<p><input type="checkbox"/></p> <p>6.3</p>	<p>Invested in our <u>ability</u> to deal with the issue of conducting staff education/knowledge transfer and skill development programs as evidenced by meeting reports/attendance records for educational programs (in communication improvement) and/or project reports during the 12 months prior to submitting this survey.</p>
<p><input type="checkbox"/></p> <p>6.4</p>	<p>Taking <u>actions</u> to address this issue . . .</p> <p>by already having actively implemented explicit organizational policies and procedures, which include writing the verbal order down and reading it back to the prescriber, to prevent the occurrence of adverse events resulting from miscommunication due to verbal orders or critical test results,</p> <p style="text-align: center;"><u>OR</u></p> <p>by having implemented a formal performance improvement project/program (with regular measurement and process improvement elements) addressing communication in this area within the 12 months prior to submitting this survey.</p> <p style="text-align: center;"><u>OR</u></p> <p>by making the commitment to undertake a formal enterprise-wide performance improvement project/program to promote accurate read back of verbal orders</p> <p><i>Check one or neither, but not both.</i></p>

Practice #7

Use only standardized abbreviations and dose designations.

Safety Objective 7

Promote accurate communication about treatments and procedures.

The Problem

The use of non-standardized abbreviations and dose designations is a demonstrated cause of medication errors. Although the use of abbreviations and dose designations is reputed to save time and make order writing more efficient, illegible handwriting and the use of abbreviations or dose designations that are unfamiliar or that have multiple meanings may lead to confusion and errors. For example, the use of "U" for "units" is especially problematic because when handwritten, "U" often looks like a zero. Numerous case reports document that errors related to insulin dosage have occurred because of this. Likewise, using handwritten trailing zeros or a leading decimal point without a leading zero are dangerous order writing practices because the decimal point is sometimes not seen, and misinterpretation of such orders can lead to as much as a 10-fold dosing error. Experiential data show that using standardized abbreviations and symbols and standardized phraseology reduces medication errors.

Additional Specifications

- Explicit organizational policies and procedures should be in place regarding the use of only standardized abbreviations and dose designations.
- Organizations should maintain an up-to-date list of abbreviations and dose designations that should never be used.

Example Implementation Approaches

- Establish and rigorously adhere to a list of standardized phraseology and agreed-upon abbreviations and dose designations.
- Rigorously prohibit the use of abbreviations known to have multiple meanings (e.g., u, qd, hs) and methods of expressing doses known to lead to misinterpretation (e.g., volume without metric weight of the dose, use of trailing zeros for whole numbers, not using a leading zero for doses less than one).
- Use the metric system to express all doses on prescription orders except for therapies that use standard units, such as insulin and vitamins.

Weighting for Safe Practice

Weighting Out of 1000 Points = 17

Check all boxes that apply.

In regard to adverse events resulting from lack of standardization abbreviations and dose designations, our organization is:

<p>7.1</p>	<p><input type="checkbox"/> Aware of THE performance improvement opportunity in that . . . the organization has undertaken an educational initiative to make clinicians and administration aware of the frequency and severity of adverse events that can be impacted by performance improvement practices of standardization of abbreviations and dose designations within the 12 months prior to submitting this survey as evidenced by meeting attendance records and documentation.</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> the organization commits to evaluate OUR performance improvement opportunity in this area by undertaking an evaluation of the frequency and severity of adverse events and potential impact of performance improvement practices of standardization of abbreviations and dose designations and the creation of a “Do Not Use” list of abbreviations, acronyms and symbols for our patient population within six months of submitting the survey.</p> <p><i>Check one or neither, but not both.</i></p>
<p>7.2</p>	<p><input type="checkbox"/> Accountable to it as evidenced by our senior executives and pertinent departmental/clinical service line managers being directly accountable to ensure that policies and procedures that address this issue are being rigorously followed through personal performance reviews or personal compensation incentives.</p>
<p>7.3</p>	<p><input type="checkbox"/> Invested in our ability to deal with the issue . . . by having invested in staff education/knowledge transfer and/or skill development programs as evidenced by meeting reports/attendance records within the 12 months prior to submitting this survey,</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> by having allocated compensated caregiver staff time to ensuring protocols are in place and adhered to during the 12 months prior to submitting the survey.</p>
<p>7.4</p>	<p>Taking action to address the issue . . .</p> <p><input type="checkbox"/> by already actively implementing explicit organizational polices and procedures to standardize abbreviations and doses designation in place and by creating a “Do Not Use” list of abbreviations, acronyms and symbols (as described in the NQF Safe Practices Consensus report).</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> by making the commitment to undertake a formal enterprise-wide performance improvement project/program (with regular measurement and process improvement elements) addressing this area and implementing explicit organizational polices and procedures to standardize abbreviations and doses and by creating a “Do Not Use” list of abbreviations, acronyms and symbols (as designation within 12 months of submitting this survey).</p> <p><i>Check one or neither, but not both.</i></p>

Practice #8

Patient care summaries or other similar records should not be prepared from memory.

Safety Objective 8

Promote accurate communication about treatments and procedures.

The Problem

When relying on memory to transcribe medical records, natural human limitations, often exacerbated by environmental circumstances, can result in errors of recall, increasing the risk of error and of an adverse event.

Additional Specifications

The original source documents (e.g., laboratory or radiology reports or medication administration records) should be in the transcriber's immediate possession and be visible when it is necessary to transcribe information from one document to another.

Weighting for Safe Practice

Weighting Out of 1000 Points = 17

Check all boxes that apply.

In regard to adverse events resulting from patient care summaries or other similar records prepared only from memory, our organization is:

<input type="checkbox"/> 8.1	<p><u>Aware</u> of THE performance improvement opportunity in that . . .</p> <p>the organization has addressed this issue as part of an educational initiative to make clinicians and administration aware of the frequency and severity of adverse events resulting from errors in communication of patient information including recording patient care information, as evidenced by meeting documentation/attendance records during the 12 months prior to submitting the survey.</p> <p style="text-align: center;"><u>OR</u></p> <p>the organization commits to evaluate OUR performance improvement opportunity in the area of accuracy of transcription of patient care information in our patient population within the next six months.</p> <p><i>Check one or neither, but not both.</i></p>
<input type="checkbox"/> 8.2	<p><u>Accountable</u> to it as evidenced by the pertinent departmental/clinical service line managers being directly accountable to the patient safety area through personal performance reviews or personal compensation incentives.</p>
<input type="checkbox"/> 8.3	<p>Invested in our <u>ability</u> to deal with the issue . . .</p> <p>by having invested in relevant skill development programs (application of performance improvement tools) that address this issue in whole or in part as evidenced by meeting reports/attendance records for educational programs and project reports during the 12 months prior to submitting the survey,</p> <p style="text-align: center;"><u>OR</u></p> <p>by having allocated compensated caregiver staff time or dedicated line item budget resources to improve accuracy in transcription documentation through investment in best practices development.</p>
<input type="checkbox"/> 8.4	<p>Taking <u>action</u> to address the issue . . .</p> <p>by already actively implementing policies that require the transcriber to have the original source documents in their immediate possession when preparing patient care summaries</p> <p style="text-align: center;"><u>OR</u></p> <p>by undertaking a formal performance improvement project/program (with regular measurement and process improvement elements) addressing this area.</p>

Practice #9

Ensure that care information, especially changes in orders and new diagnostic information, is transmitted in a timely and clearly understandable form to all of the patient's healthcare providers/professionals who need that information to provide care.

Safety Objective 9

Promote accurate communication about treatments and procedures.

The Problem

Changes in medications that occur during one care setting are often not communicated to healthcare providers in other care settings. As a result, professionals often lack important information when making treatment decisions. This lack of information is a frequent cause of medication prescribing errors.

Additional Specifications

- Providers/professionals should request that the patient bring the full names, addresses, and phone numbers of all other physicians that he/she is seeing as well as pharmacy(ies) being used prior to commencing treatment.
- Providers/professionals should encourage patients to maintain a list of current medications and their list of current medications and their intended purpose as well as a list of any medications to which they are allergic or have had idiosyncratic or other untoward reactions.
- Providers/professionals should review the patient's lists of medications with the patient at each encounter.
- This practice shall be done in accordance with applicable state and federal laws and with the patient's consent.

Example Implementation Approaches

Following hospitalization, send a standardized, structured discharge summary to all the patient's healthcare providers.

Weighting for Safe Practice

Weighting Out of 1000 Points = 84

Check all boxes that apply.

In regard to timely and understandable communication of patient care information to the patient's care providers our organization is:

Aware of the patient safety performance issue as evidenced by:

<p><input type="checkbox"/></p> <p>9.1</p>	<p>making efforts to become aware of THE common performance improvement opportunity in this area of care as evidenced by . . .</p> <p>an educational meeting for administrative or clinical personnel addressing the area within 12 months prior to submitting this survey as supported by meeting documentation/ attendance records.</p> <p style="text-align: center;">OR</p> <p>the organization commits to undertake a thorough literature search and identification of readily available best practices and evaluation of the frequency and severity of adverse events related to communication of patient care information in our patient population within the constraints of federal and state HIPPA requirements. The effort will include an assessment of the potential impact of performance improvement practices with a report of recommendations to administration during the six months following submission of this survey.</p> <p><i>Check one or neither, but not both.</i></p>
<p><input type="checkbox"/></p> <p>9.2</p>	<p>making efforts to become aware of OUR performance improvement opportunity in this area by undertaking an evaluation of the pertinent frequency and severity of adverse events and potential impact of performance improvement practices in our patient population within the 12 months prior to submitting this survey.</p>
<p><input type="checkbox"/></p> <p>9.3</p>	<p>accurate communication of patient care information being already specifically addressed in some specific way in our existing strategic or operational plan.</p> <p style="text-align: center;">OR</p> <p>making a commitment to add the issue of accurate communication of patient care information to our strategic or operational plan within six months of survey submission if it is not already in our strategic or operational plan.</p> <p><i>Check one or neither, but not both.</i></p>

Accountable to it as evidenced by:

<p><input type="checkbox"/></p> <p>9.4</p>	<p>our pertinent departmental and/or clinical service line managers being accountable to this patient safety area through personal performance reviews or personal compensation incentives.</p>
<p><input type="checkbox"/></p> <p>9.5</p>	<p>our senior executives and pertinent departmental/clinical service line managers all being directly accountable to the patient safety area through personal performance reviews or personal compensation incentives.</p>
<p><input type="checkbox"/></p> <p>9.6</p>	<p>our CEO, our officers/Sr. executives, and pertinent departmental/clinical service line managers are currently directly accountable to the patient safety area through personal performance reviews or personal compensation incentives.</p> <p style="text-align: center;">OR</p> <p>the organization making the commitment to assign direct accountability of performance in this area to our CEO, our officers/Sr. executives, and pertinent departmental/clinical service line managers through personal performance reviews or personal compensation incentives within six months of completing this survey.</p> <p><i>Check one or neither, but not both.</i></p>

<input type="checkbox"/> 9.7	the direct and regular briefings of our trustees/board of directors by a Patient Safety Officer that includes performance metrics in this area.
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Invested in our **ability** to deal with the issue by:

<input type="checkbox"/> 9.8	having undertaken staff education/knowledge transfer programs addressing communication of patient information to and between caregivers within the constraints of federal and state HIPPA requirements as evidenced by meeting reports/attendance records during the 12 months prior to submitting the survey.
<input type="checkbox"/> 9.9	having invested in skill development programs (application of practices or performance improvement tools) as evidenced by meeting reports/attendance records for such programs and project reports during the 12 months prior to submitting the survey.
<input type="checkbox"/> 9.10	having formally allocated compensated caregiver staff time to this area.
<input type="checkbox"/> 9.11	having made an explicit dedicated line item budget allocation to this patient safety area. <p style="text-align: center;"><u>OR</u></p> making a commitment to make a formal line item budget allocation to this specific area within six months of submitting this survey. <i>Check one or neither, but not both.</i>

Has taken **actions** to address it by:

<input type="checkbox"/> 9.12	having evaluated in some way its performance in this area within the last 12 months of taking this survey.
a <input type="checkbox"/> b <input type="checkbox"/> 9.13	having implemented a formal performance improvement project/program of some type (with regular measurement and process improvement elements) addressing this area. <p style="text-align: center;"><u>OR</u></p> making a commitment to a formal performance improvement project/ program (with regular measurement and process improvement elements) of some type addressing this area within six months of completing this survey. <i>Check one or neither, but not both. You must successfully complete 9.12 before checking either item.</i>
a <input type="checkbox"/> b <input type="checkbox"/> 9.14	having implemented a formal clinical unit-wide, department-wide, or clinical service line-wide performance improvement project/program (with regular measurement and process improvement elements). <p style="text-align: center;"><u>OR</u></p> the organization commits to undertake a formal clinical unit-wide, department-wide or clinical service line-wide performance improvement project/program in this safety area within six months of submitting this survey. <i>Check one or neither, but not both. You must successfully complete 9.13a before checking either item.</i>
<input type="checkbox"/> <input type="checkbox"/> 9.15	having implemented an enterprise-wide formal performance improvement project/program (with regular performance measurement and process improvement elements) addressing this area. <p style="text-align: center;"><u>OR</u></p> the organization commits to undertaking a thorough literature review and implement certain of the latest readily available best practices through an enterprise-wide performance improvement project/program (with regular measurement and process improvement elements) within six months of submitting this survey. <i>Check one or neither, but not both. You must successfully complete 9.14a before checking either item.</i>

Practice #10

Ask each patient or legal surrogate to recount what he or she has been told during the informed consent discussion.

Safety Objective 10

Ensure that patients or legal surrogate understand the proposed treatment and its potential complications.

The Problem

Obtaining informed consent has become an essential part of the healthcare process. The use of a written informed consent form is undertaken prior to major procedures including, but not limited to, surgery and other invasive procedures.

The primary purpose of the informed consent process is to ensure that the patient can make an informed decision about whether to undergo a proposed treatment or procedure. The informed consent process involves the patient as a collaborator with the provider in developing and evaluating treatment options. Properly executed informed consent leads to shared decision-making, i.e., the more knowledgeable a patient is, the greater the likelihood that she or he can provide an additional layer of protection and decrease the potential for medical errors.

In recent years, informed consent forms have largely become legal documents that protect institutions rather than provide information for shared decision-making. Because an estimated 40 million people in the United States are marginally or functionally illiterate and a much larger number are medically illiterate, policies should be implemented to ensure the use of clear informed consent forms that most patients and their families can readily understand. Similarly, providing informed consent should be viewed as an interactive process between healthcare providers and patients, not merely a form for which a signature must be obtained.

Additional Specifications

- Use informed consent forms written in simple sentences and in the primary language of the patient.
- Engage the patient in a dialogue about the nature and scope of the procedure covered by the consent form.
- Provide an interpreter or reader to assist non-English speaking patients, visually or hearing-impaired patients, and low-literacy patients.
- Convey the higher risk associated with suboptimal volumes for select high-risk surgeries and procedures specified in Practice 2 (see survey Section 3: Evidence-Based Hospital Referral).

Weighting for Safe Practice

Weighting Out of 1000 Points = 8

Check all boxes that apply.

In regard to the quality of the Informed consent process for all patients, our organization is:

<p>10.1</p>	<p><input type="checkbox"/> Aware of THE problem in that . . . the organization has undertaken an educational initiative to make clinicians and administration aware of the frequency and severity of poor quality informed consent episodes and has identified the opportunities for improvement in this area within the past 12 months as evidenced by meeting attendance records and documentation of meeting minutes.</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> the organization commits to evaluate OUR problem in this area by undertaking an evaluation of the frequency and severity of poor quality informed consent episodes, in our patient population within the next six months.</p> <p><i>Check one or neither, but not both.</i></p>
<p>10.2</p>	<p><input type="checkbox"/> Accountable to this issue as evidenced by . . . our pertinent departmental/clinical service line managers being directly accountable to this patient safety area through personal performance reviews or personal compensation incentives,</p> <p style="text-align: center;">OR</p> <p>the Patient Safety Officer or a senior leader in the organization regularly reports performance metrics related to improvement of the informed consent process to the CEO and the Board of Directors (or a sub-committee of governance) and is directly accountable to this area through performance reviews or compensation.</p>
<p>10.3</p>	<p><input type="checkbox"/> Invested in our ability to deal with this issue by conducting staff education/knowledge transfer and skill development programs as evidenced by meeting reports/attendance records for educational programs and project reports during the 12 months prior to submitting the survey,</p> <p style="text-align: center;">OR</p> <p>Invested in our ability to improve the quality of the informed consent process having revised all consent forms to simple sentences in the primary language of the patient AND provided a language/hearing interpreter when English is not the patient's primary language or they are hearing impaired during the 12 months prior to submitting the survey.</p>
<p>10.4</p>	<p><input type="checkbox"/> Taking action to address this issue . . . by implementing a formal performance improvement project (with regular measurement and process improvement elements) addressing this area.</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> the organization commits to undertake a formal enterprise-wide performance improvement project/program in the area of informed consent within six months of submitting the survey.</p> <p><i>Check one or neither, but not both.</i></p>

Practice #11

Ensure that written documentation of the patient's preference for life-sustaining treatments is prominently displayed in his or her chart.

Safety Objective 11

Ensure that the patient receives only the life-sustaining treatments that he or she desires.

The Problem

A patient's preferences for life-sustaining treatment are often not known by his or her caregivers. The published literature demonstrates that there are significant problems in all areas relevant to advance planning, i.e., in determining a patient's preferences, in transmitting this information to the care setting, and in respecting the patient's preferences when life-sustaining treatment decisions are made and carried out.

The provision of unwanted end-of-life care is an adverse event that can be avoided by the implementation of effective patient communication. Written documentation about patient preferences indicates that the patient and his or her family have given thought to this important issue and have stated preferences in the form of a written advance directive.

Additional Specifications

Explicit organizational policies and procedures should be in place regarding patient preference for life-sustaining treatments.

Example Implementation Approaches

Include the patient's preferences for resuscitation, use of intravenous fluids, and nutrition.

Weighting for Safe Practice

Weighting Out of 1000 Points = 12

Check all boxes that apply.

In regard to performing unwanted life sustaining treatment our organization is:

<p>11.1</p>	<p><input type="checkbox"/> Aware of THE performance improvement opportunity in that . . . the organization has undertaken an educational initiative to make clinicians and administration aware of the frequency and severity of performing unwanted life sustaining treatment and has identified the opportunities for improvement in this area within the past 12 months as evidenced by meeting attendance records and documentation of meeting minutes.</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> the organization commits to evaluate OUR performance in this area by undertaking an evaluation of the frequency and severity of performing unwanted life sustaining treatment and will undertake a thorough literature search and identify the readily available best practices that can be applied to our patient population within the next six months. Further we will make recommendations to administration regarding implementation of such practices.</p> <p><i>Check one or neither, but not both.</i></p>
<p>11.2</p>	<p><input type="checkbox"/> Accountable to this issue as evidenced by . . . our pertinent departmental and/or clinical service line managers are held accountable to this patient safety area through personal performance reviews or personal compensation incentives.</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> our organization commits to begin having our Patient Safety Officer regularly report performance metrics in this area of unwanted life sustaining treatment episodes to the CEO and Board of Directors within the next six months after submitting this survey.</p> <p><i>Check one or neither, but not both.</i></p>
<p>11.3</p>	<p><input type="checkbox"/> Invested in our ability to deal with the issue by conducting staff education/knowledge transfer and skill development programs as evidenced by meeting reports/attendance records for educational programs and project reports during the 12 months prior to submitting the survey,</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> our organization has developed explicit organizational policies and procedures regarding life-sustaining treatments are in place across the entire enterprise.</p>
<p>11.4</p>	<p>Taking action to address this issue in that . . .</p> <p><input type="checkbox"/> the organization has developed procedures to assure that the most current copy of the patient's preferences for life sustaining treatments are a part of the active medical record.</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> the organization commits to conduct a review of the medical literature in this area and to implement the readily available best practices through an enterprise-wide performance improvement project/program (with regular measurement and process improvement elements) within six months of submitting this survey.</p> <p><i>Check one or neither, but not both.</i></p>

Practice #13

Implement a standardized protocol to prevent the mislabeling of radiographs.

Safety Objective 13

Reduce misinterpretation of radiographs resulting from the miscommunication of critical information.

The Problem

In both inpatient and outpatient settings, the potential exists for radiographs to be mislabeled, or not completely labeled, and consequently misinterpreted.

Additional Specifications

Explicit organizational policies and procedures should be in place regarding labeling of radiographs.

Example Implementation Approaches

- Flash/mark x-ray images with the correct patient information in the darkroom;
- Mark "left" or "right" on each radiographic image to prevent misinterpretation on the light box.

Weighting for Safe Practice

Weighting Out of 1000 Points = 16

Check all boxes that apply.

In regard to adverse events related to misinterpretation of radiographs resulting from mislabeled radiographs and subsequent miscommunication of critical information, our organization is:

<p>13.1</p>	<p><input type="checkbox"/> Aware of THE performance improvement opportunity in that . . . the organization has addressed this issue as part of an educational initiative to make clinicians and administration aware of the frequency and severity of adverse events resulting from communication breakdowns in imaging services including mislabeled radiographs, and has identified the opportunities and practices for improvement in this area within the past 12 months prior to submitting this survey. This is evidenced by meeting documentation/ attendance records.</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> the organization commits to evaluate OUR performance improvement opportunity in this area by undertaking an evaluation of the frequency and severity of adverse events and readily available improvement methods related to mislabeled radiographs in our patient population with a report to administration within six months of submitting this survey.</p> <p><i>Check one or neither, but not both.</i></p>
<p>13.2</p>	<p><input type="checkbox"/> Accountable to this issue as evidenced by our senior executives, and pertinent departmental/clinical service line managers all being directly accountable to this patient safety issue through personal performance reviews or personal compensation incentives.</p>
<p>13.3</p>	<p><input type="checkbox"/> Invested in our ability to deal with the issue by . . . conducting staff education/knowledge transfer and/or skill development programs (staff's ability to apply tools in performance improvement) as evidenced by meeting reports/attendance records for educational programs and project reports during the 12 months prior to submitting this survey,</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> having allocated compensated caregiver staff time to ensure the standardized protocols are in place and adhered to during the 12 months prior to submitting the survey.</p>
<p>13.4</p>	<p>Taking actions to address this issue . . .</p> <p><input type="checkbox"/> by already actively implementing standardized protocols and explicit organizational policies and procedures to prevent the mislabeling of radiographs.</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> by committing to undertake formal clinical unit-wide, department-wide or clinical service line-wide performance improvement project/program in imaging that includes this safety area (with regular performance measurement and process improvement elements) and by committing to implement explicit organizational polices and procedures within six months of submitting this survey.</p> <p><i>Check one or neither, but not both.</i></p>

Practice #14

Implement standardized protocols to prevent the occurrence of wrong-site procedures or wrong-patient procedures.

Safety Objective 14

Prevent wrong-site procedures and wrong-patient procedures.

The Problem

Similarity of patient names and other characteristics and symmetry between the two sides of the body present many opportunities for wrong-site errors or wrong-patient errors. These errors often result in significant adverse events, events that are now believed to be far more common than previously recognized.

A number of factors are believed to increase the risk of wrong-site surgery, including having more than one surgeon involved with the patient's care, having multiple procedures performed during a single setting, and time pressures.

Additional Specifications

- The surgeon or other relevant healthcare provider should clearly document the intended operative or intervention site in the patient record, and this record should accompany the patient to the operating room (OR) or procedure room.
- The OR or procedure team should use a standardized checklist, to verify the operative site before in the surgical suite before surgery commences.
- Document the verification of the operative site by the OR/procedure team in the patient's record.
- Whenever possible, document the patient's pre-operative verification in the OR record.
- The patient or someone who has first hand knowledge of the proposed procedure and the informed consent discussion should clearly mark the operative or intervention site.

Weighting for Safe Practice

Weighting Out of 1000 Points = 30

In regard adverse events related to wrong-site and wrong-patient procedures our organization is:

<p>14.1</p>	<p><input type="checkbox"/> Aware of OUR performance improvement opportunity in that . . . the organization has undertaken an enterprise-wide (pertinent departments) educational effort addressing the frequency and severity of adverse events related to wrong-site and wrong-patient procedures and importance of protocols for our patient population,</p> <p style="text-align: center;">OR</p> <p>the organization has undertaken an evaluation of the frequency and severity of adverse events resulting from wrong-site and wrong-patient procedures in our patient population and has identified polices and procedures to optimize performance.</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> the organization commits to undertake a thorough literature review and a comprehensive enterprise-wide evaluation of the frequency and severity of adverse events related to wrong-site and wrong-patient procedures in our patient population. A report with a summary of the readily available improvement opportunities in this area will be reported to administration within six months of submitting this survey.</p> <p><i>Check one or neither, but not both.</i></p>
<p>14.2</p>	<p><input type="checkbox"/> Accountable to this issue as evidenced by . . . direct and regular briefings to our trustees/board of directors by a Patient Safety Officer or leader that include performance metrics in this area (process measures related to compliance to protocols),</p> <p style="text-align: center;">OR</p> <p>our CEO, our officers/Sr. executives, and pertinent departmental/clinical service line managers are directly accountable to the issue of wrong-site and wrong-patient procedures through personal performance reviews or personal compensation incentives.</p>
<p>14.3</p>	<p><input type="checkbox"/> Invested in our ability to deal with the issue by having invested in staff education/ knowledge transfer and/or skill development programs (staff’s ability to apply practices or tools in performance improvement, including direct patient or person knowledgeable of the informed consent discussion, involved in marking the site, and taking a “time out” period before beginning the procedure with the surgical team to check that it is the correct patient, procedure and site) as evidenced by meeting reports/ attendance records and/or project reports AND having allocated compensated caregiver staff time to ensure the standardized protocols are in place and adhered to during the 12 months prior to submitting the survey.</p>

<input type="checkbox"/>	<p>Taking additional actions to ensure that explicit standardized protocols are in place across the entire enterprise to prevent the occurrence of wrong site procedures or wrong patient procedures with routine measurement and process improvement elements addressing adherence policies and procedures within the last 12 months,</p> <p style="text-align: center;"><u>OR</u></p> <p>by having implemented a formal performance improvement project/program addressing OR procedures (with regular measurement and process improvement elements) including this area within the 12 months prior to submitting this survey.</p> <p style="text-align: center;"><u>OR</u></p> <p><input type="checkbox"/> by making the commitment to undertake a formal enterprise-wide performance improvement project/program addressing OR procedures that includes this safety area (with regular performance measurement and process improvement elements) and implementing explicit organizational policies and procedures within six months of submitting this survey.</p> <p><i>Check one or neither, but not both.</i></p>
14.4	

Practice #15

Evaluate each patient undergoing elective surgery for risk of an acute ischemic cardiac event during surgery, and provide prophylactic treatment of high-risk patients with beta blockers.

Safety Objective 15

Prevent intra-operative myocardial ischemia/infarction.

The Problem

Surgery is physiologically stressful and may precipitate myocardial infarction in patients before, during, or after the procedure. As many as 75 percent of high-risk patients (e.g., those with pre-existing heart disease) suffer heart attacks during or immediately after surgery. Short-term administration of beta-blocker medications can substantially reduce the risk of this adverse event, particularly in high-risk patients. Unfortunately, the evidence suggests that nearly 67 percent of those who should be treated in this manner are not.

Additional Specifications

- Document the acute cardiac risk assessment and findings in the patient's record;
- Explicit organizational policies and procedures should be in place regarding the prevention of intra-operative myocardial ischemia.

Example Implementation Approaches

Develop a standard cardiac risk assessment instrument to assess and document the risk of acute cardiac ischemia. In patients for whom prophylactic beta-blockers are determined to be beneficial:

- Administer a therapeutic dose of the chosen beta-blocker prior to introduction of anesthesia,
- Use beta-blockers through the operation and during the postoperative period.

Weighting for Safe Practice

Weighting Out of 1000 Points = 23

Check all boxes that apply.

In regard to surgery-related acute ischemic cardiac events in patients undergoing elective surgery, our organization is:

15.1	<p><input type="checkbox"/> Aware of THE performance improvement opportunity in that . . . the organization has undertaken an educational effort of some type to make clinicians and administration aware of the frequency and severity of surgery-related acute ischemic cardiac events in patients undergoing elective surgery, and has identified the opportunities for improvement in this area, within the past 12 months, as evidenced by meeting documentation/attendance records.</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> the organization commits to evaluate OUR performance opportunity in this area by undertaking a thorough literature search and an evaluation of the frequency and severity of surgery-related acute ischemic cardiac events in patients undergoing elective surgery in our patient population and will identify and implement the readily available best practices within the next six months.</p> <p><i>Check one or neither, but not both.</i></p>
15.2	<p><input type="checkbox"/> Accountable to this issue as evidenced by . . . our pertinent departmental and/or clinical service line managers being held accountable to this patient safety area through personal performance reviews or personal compensation incentives.</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> our organization commits to begin to have our Patient Safety Officer regularly report performance metrics (i.e. documentation of risk assessments for acute ischemic cardiac events in the medical record) to the CEO and Board of Directors within six months following submission of this survey.</p> <p><i>Check one or neither, but not both.</i></p>
15.3	<p><input type="checkbox"/> Invested in our ability to deal with this issue by conducting staff education/knowledge transfer as evidenced by meeting reports/attendance records for educational programs and project reports during the 12 months prior to submitting the survey.</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> our organization commits to invest dedicated compensated caregiver staff time over the next six months following submission of this survey to develop a standard cardiac risk assessment instrument to assess and document the risk of acute ischemia in patients for whom prophylactic beta blockers are determined to be beneficial.</p> <p><i>Check one or neither, but not both.</i></p>
15.4	<p><input type="checkbox"/> Taking action to address this issue . . . by having clearly documented evidence that 80% of all elective surgery patients are evaluated for the risk an acute ischemic cardiac event and are treated with beta blockers when appropriate.</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> by committing to undertake a formal clinical unit-wide, department-wide or clinical service line-wide performance improvement project/program (with regular measurement and process improvement elements) in this safety area within six months of submitting this survey.</p> <p><i>Check one or neither, but not both.</i></p>

Practice #16

Evaluate each patient upon admission, and regularly thereafter, for the risk of developing pressure ulcers. This evaluation should be repeated at regular intervals during care. Clinically appropriate preventative methods should be implemented consequent to the evaluation.

Safety Objective 16

Reduce the occurrence of pressure ulcers.

The Problem

All patients are at risk of developing pressure ulcers when seriously ill, immobile for a prolonged period, or unable to respond to pressure discomforts. The occurrence of pressure ulcers for patients entering acute care facilities and nursing homes ranges from 7 to 25 percent. When they occur, pressure ulcers increase the morbidity of patients who are already ill and may delay recovery. The evidence shows that risk assessment for pressure ulcers is not performed in a consistent or predictable manner.

Prevention is the key to reducing the prevalence of pressure ulcers. Appropriate prevention methods are known and widely available, although substantially underused. Preventive strategies are generally prescribed based on clinical assessment by nurses. Several scoring systems exist that can be used to reliably assess the risk of pressure ulcer development (e.g., Braden scale, Norton scale).

Additional Specifications

- Document the pressure ulcer risk assessment and prevention plan in the patient's record.
- Explicit organizational policies and procedures should be in place regarding the prevention of pressure ulcers.

Example Implementation Approaches

Appropriate preventative methods include the use of fire-code compliant pads (e.g., "egg-crate" mattresses or sheepskins); the use of plastic polymer pressure-relieving pads; regular changes in the position of an immobile patient; the use of nutritional assessments and supplements when indicated; and the use of incontinence prevention management programs.

Weighting for Safe Practice

Weighting Out of 1000 Points = 28

Check all boxes that apply.

In regard to the occurrence pressure ulcers, our organization is:

<p>16.1</p>	<p><input type="checkbox"/> Aware of OUR performance improvement opportunity in that . . . the organization has undertaken an evaluation of the frequency and severity of the occurrence of pressure ulcers in our patient population and has identified best practices to optimize care.</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> the organization commits to undertake a thorough literature review and a comprehensive enterprise-wide evaluation of the frequency and severity of pressure ulcers in our patient population. A report with a summary of the readily available improvement opportunities in this area will be provided to administration within 12 months of submitting this survey.</p> <p><i>Check one or neither, but not both.</i></p>
<p>16.2</p>	<p><input type="checkbox"/> Accountable to this issue as evidenced . . . by pertinent departmental/clinical service line managers all being directly accountable to the patient safety area through personal performance reviews or personal compensation incentives.</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> by our organization's commitment to assign accountability to our senior executives and pertinent departmental/clinical service line managers to the patient safety area through personal performance reviews or personal compensation incentives.</p> <p><i>Check one or neither, but not both.</i></p>
<p>16.3</p>	<p><input type="checkbox"/> Invested in our ability to deal with this issue by conducting staff education/knowledge transfer and skill development programs (training staff in application of practices or performance improvement tools) as evidenced by meeting reports/attendance records and/or project reports during the 12 months prior to submitting this survey.</p>
<p>16.4</p>	<p><input type="checkbox"/> Has taken action to address this issue . . . by already actively implementing explicit organizational policies and procedures concerning documented risk assessment and prevention plan to reduce the occurrence of pressure ulcers compatible with those outlined in the NQF Implementation Approaches for this practice,</p> <p style="text-align: center;">OR</p> <p>by currently implementing a formal performance improvement project/program (with regular measurement and process improvement elements) addressing prevention of decubitus ulcers.</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> by committing to undertake a formal enterprise-wide performance improvement project/program in this safety area (with regular performance measurement and process improvement elements) and implementing explicit organizational polices and procedures within six months of submitting this survey.</p> <p><i>Check one or neither, but not both.</i></p>

Practice #17

Evaluate each patient upon admission, and periodically thereafter, for the risk of developing DVT/VTE. Utilize clinically appropriate methods to prevent DVT/VTE.

Safety Objective 17

Reduce the occurrence of venous thromboembolism.

The Problem

It is estimated that 2 million Americans are afflicted with deep vein thrombosis (DVT) each year and that as many as 600,000 of these patients subsequently develop a pulmonary embolism (PE). In about 200,000 persons the PE proves to be fatal. Pulmonary thromboembolism is the third most common cause of hospital-related deaths in the United States and the most common preventable cause of hospital death.

Several clinical interventions are known to effectively prevent DVT or other venous thromboembolism (VTE), including intermittent calf compression devices, graduated compression stockings, subcutaneous administration of low molecular weight heparin, and oral administration of aspirin or warfarin. The most appropriate specific intervention will depend on the thrombotic risk, the clinical setting, and other factors.

Despite widespread education about the need for preventive intervention and the publication of clinical guidelines for VTE prevention, appropriate prophylaxis continues to be substantially underused, especially in patients at low or moderate risk of venous thrombosis.

Additional Specifications

- Document the VTE risk assessment and prevention plan in the patient's record.
- Explicit organizational policies and procedures should be in place for the prevention of VTE.

Example Implementation Approaches

Depending on the level of risk, different specific methods may be more appropriate or more effective than other methods. For example, in postoperative patients, mechanical methods such as graduated compression stockings or intermittent calf compression may be preferred over anticoagulants.

Weighting for Safe Practice

Weighting Out of 1000 Points = 27

In regard to the problem of developing deep vein thrombosis (DVT), other venous thromboembolism (VTE), and subsequent pulmonary embolism, our organization is:

<p>17.1</p>	<p><input type="checkbox"/> Aware of OUR performance opportunity in this area in that . . . the organization has undertaken an evaluation of the frequency and severity of cases of deep vein thrombosis (DVT), venous thromboembolism (VTE), and pulmonary embolism in our patient population and has implemented risk assessment protocols with clinician and staff education programs.</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> the organization commits to undertake a thorough literature review for readily available best practices and undertake a comprehensive enterprise-wide evaluation of the frequency and severity of developing deep vein thrombosis (DVT), other venous thromboembolism (VTE), and pulmonary embolism in our patient population and we will identify opportunities for improvement in a report to administration within 12 months of submitting this survey.</p> <p><i>Check one or neither, but not both.</i></p>
<p>17.2</p>	<p><input type="checkbox"/> Accountable to this issue as evidenced by our pertinent departmental and/or clinical service line managers being held accountable to this patient safety area including risk assessments for DVT/VTE through personal performance reviews or personal compensation incentives.</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> our organization commits to begin having our Patient Safety Officer regularly report performance metrics in this area including addressing risk assessments for the development of DVT/VTE on 80% of all patients to the CEO and Board of Directors within the six months of submitting this survey.</p> <p><i>Check one or neither, but not both.</i></p>
<p>17.3</p>	<p><input type="checkbox"/> Invested in our ability to deal with the issue . . . by conducting staff education/knowledge transfer and skill development programs (training regarding application of practices or performance improvement and protocol tools) as evidenced by meeting reports/attendance records and project reports during the 12 months prior to submitting the survey,</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> by having allocated dedicated HR resources and allocated dedicated budget to address anticoagulation issues and DVT/VTE prevention.</p>
<p>17.4</p>	<p>Taking actions to address this issue . . .</p> <p><input type="checkbox"/> by having clearly documented evidence that 80% all of the appropriate patients are being assessed and treated according to explicit organizational policies and procedures addressing this area.</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> by committing to undertake a formal clinical unit-wide, department-wide or clinical service line-wide performance improvement project/program (with regular measurement and process improvement elements) in this safety area within six months of submitting this survey.</p> <p><i>Check one or neither, but not both.</i></p>

Practice #18

Utilize dedicated anti-thrombotic (anticoagulation) services that facilitate coordinated care management.

Safety Objective 18

Ensure the anti-thrombotic (anticoagulation) therapy is effective and safe.

The Problem

Anti-thrombotic therapy is a complex and labor-intensive intervention for which success depends upon correct dosing decisions, close attention to many details, and good communication among all parties involved. Optimal anticoagulation management occurs when a systematic and coordinated process is used that includes dedicated management by a qualified healthcare professional that ensures reliable patient scheduling and tracking; accessible, accurate, and frequent Prothrombin Time (PT)/Independent Normalized Ratio (INR) testing; patient-specific decision support and interaction; and ongoing patient education.

Additional Specifications

Explicit organizational policies and procedures should be in place regarding anti-thrombotic services.

Example Implementation Approaches

- Ensure that staff are dedicated and experienced in monitoring anticoagulant therapy.
- Implement reliable patient scheduling and tracking.
- Employ accessible, accurate, and frequent PT/INR testing.
- Utilize patient-specific decision support and interaction.
- Implement ongoing patient education.

Weighting for Safe Practice

Weighting Out of 1000 Points = 39

Check all boxes that apply.

In regard to anticoagulation services and coordinated care our organization is:

Aware of the importance of this specific patient safety issue and has acknowledged it:

18.1	<input type="checkbox"/> by taking efforts to become aware of THE common performance improvement opportunity through an educational initiative to make clinicians and administration aware of the frequency and severity of anticoagulation related adverse events and identified opportunities for impact by improvement practices in this area within 12 months prior to submitting this survey as evidenced by meeting documentation/attendance records.
18.2	<input type="checkbox"/> by making efforts to become aware of OUR performance improvement opportunity by undertaking an evaluation of the frequency and severity of anticoagulation related adverse events, and the potential impact of performance improvement practices in our patient population within 12 months prior to submitting the survey. <p style="text-align: center;"><u>OR</u></p> <input type="checkbox"/> by making the commitment to undertake a thorough literature review and comprehensive enterprise-wide evaluation of the frequency and severity of adverse events related to anticoagulation in our patient population including continuity of care following discharge. A report with a summary of the readily available improvement opportunities in this area will be provided to administration within six months of submitting this survey. <i>Check one or neither, but not both.</i>
18.3	<input type="checkbox"/> as evidenced by it being already specifically addressed in our existing strategic or operational plan. <p style="text-align: center;"><u>OR</u></p> <input type="checkbox"/> by making a commitment to add this issue to our strategic or operational plan within six months of survey submission if it is not already in our strategic or operational plan. <i>Check one or neither, but not both.</i>

Accountable to it as evidenced by:

18.4	<input type="checkbox"/> our pertinent departmental and/or clinical service line managers being accountable to this patient safety area through personal performance reviews or personal compensation incentives, <p style="text-align: center;"><u>OR</u></p> <input type="checkbox"/> having a designated one or more senior managers in charge of anticoagulation services and coordinated care who are accountable for the performance of the patient safety area through personal performance reviews or personal compensation incentives
18.5	<input type="checkbox"/> our senior executives being directly accountable to performance in this patient safety area through personal performance reviews or personal compensation incentives.
18.6	<input type="checkbox"/> our CEO and officers are directly accountable to performance in this patient safety area through personal performance reviews or personal compensation incentives.
18.7	<input type="checkbox"/> the direct and regular briefings of our trustees/board of directors by a Patient Safety Officer that include performance metrics in this area.

Investing in our **ability** to deal with the issue by:

18.8	<input type="checkbox"/> having undertaken staff education programs regarding anticoagulation management as evidenced by meeting reports/attendance records during the 12 months prior to submitting the survey.
18.9	<input type="checkbox"/> having invested in staff skill development programs (training in the application of practices or tools used for anticoagulation management or optimization) as evidenced by meeting reports/attendance records and/or project reports during the 12 months prior to submitting the survey.
18.10	<input type="checkbox"/> having formally allocated compensated caregiver staff time to this area.
18.11	<input type="checkbox"/> having made dedicated explicit line item budget allocations to this area of patient safety during the 12 months prior to submitting the survey.

Has taken **action** to address it by:

18.12	<input type="checkbox"/> establishing explicit protocols and policies to ensure anticoagulation management and coordinated care occurs in the inpatient population and at discharge with routine measurement and process improvement elements addressing adherence to policies and procedures in acute care settings and at discharge.
18.13	a <input type="checkbox"/> having implemented a formal performance improvement project/program (with regular measurement and process improvement elements) addressing anticoagulation services and coordinated care delivered to patients in acute care settings and at discharge.
18.14	a <input type="checkbox"/> having implemented a formal clinical unit-wide, department-wide, or clinical service line-wide performance improvement project/program (with regular measurement and process improvement elements) addressing anticoagulation services and coordinated care in the 12 months prior to submitting this survey.
	b <input type="checkbox"/> making the commitment to undertake a formal clinical unit-wide, department-wide or clinical service line-wide performance improvement project/program (with regular measurement and process improvement elements) that address anticoagulation services and coordinated care within six months of submitting this survey. <i>Check one or neither, but not both. You must successfully complete 18.13 before checking either item.</i>
18.15	<input type="checkbox"/> having implemented an enterprise-wide formal performance improvement project/program (with regular performance measurement and process improvement elements) that addresses anticoagulation services and coordinated care and implemented explicit organizational polices and procedures.
	<input type="checkbox"/> making the commitment to undertake a formal enterprise-wide performance improvement project/program addressing anticoagulation services and coordinated care (with regular performance measurement and process improvement elements) and implementing explicit organizational polices and procedures within six months of submitting this survey <i>Check one or neither, but not both. You must successfully complete 18.14a before checking either item.</i>

Practice #19

Upon admission, and periodically thereafter, evaluate each patient for the risk of aspiration.

Safety Objective 19

Prevent hospital acquired respiratory infections.

The Problem

Hospital-acquired respiratory infections account for about 15 percent of nosocomial infections. General hygiene measures such as hand disinfection, the use of gloves, and the use of sterile equipment remain the cornerstone of infection prevention and should be standard practice in all healthcare facilities. Additionally, the semi-recumbent body position has been shown to reduce the frequency and risk of hospital-acquired pneumonia, especially in patients who receive enteral nutrition.

Additional Specifications

- Document the aspiration risk assessment and prevention plan in the patient's record.
- Explicit organizational policies and procedures should be in place regarding the prevention of aspiration.

Example Implementation Approaches

Elevate the head of the bed at an angle of 30 to 45 degrees for all patients on ventilators to reduce the likelihood of aspiration.

Weighting for Safe Practice

Weighting Out of 1000 Points = 24

Check all boxes that apply.

In regard to aspiration related hospital-acquired respiratory infections, our organization is:

<p>19.1</p>	<p><input type="checkbox"/> Aware of OUR performance improvement opportunity in that . . . the organization has undertaken an evaluation of the frequency and severity of hospital-acquired respiratory infections in our patient population and has evaluated the potential impact of performance improvement practices within the 12 months prior to submitting this survey.</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> the organization commits to undertake a thorough literature review and comprehensive enterprise-wide evaluation of the frequency, severity, and potential impact of performance improvement practices on hospital-acquired respiratory infections in our patient population within six months of submitting this survey.</p> <p><i>Check one or neither, but not both.</i></p>
<p>19.2</p>	<p><input type="checkbox"/> Accountable to this issue as evidenced by . . . our senior executives and pertinent departmental/clinical service line managers are directly accountable to performance in this patient safety issue through personal performance reviews or personal compensation incentives.</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> the organization commits to having the patient safety officer report performance in this area to the CEO trustees/board of directors on a regular basis and assign accountability to the appropriate department or service line managers.</p> <p><i>Check one or neither, but not both.</i></p>
<p>19.3</p>	<p><input type="checkbox"/> Invested in our ability to deal with the issue by conducting staff education/ knowledge transfer and skill development programs (training regarding application of practices or tools in performance improvement) as evidenced by meeting reports/attendance records for educational programs and project reports during the 12 months prior to submitting the survey.</p>
<p>19.4</p>	<p>Taking actions to address this issue . . .</p> <p><input type="checkbox"/> by having clearly documented evidence that 80% of all patients are assessed for risk of aspiration and the prevention plan for high risk patients is clearly documented in the medical record according to explicit organizational policies and procedures.</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> by committing to undertake a formal clinical unit-wide, department-wide or clinical service line-wide performance improvement project/program (with regular measurement and process improvement elements) for this issue within six months of submitting this survey.</p> <p><i>Check one or neither, but not both.</i></p>

Practice #20

Adhere to effective methods of preventing central venous catheter-related blood stream infections.

Safety Objective 20

Prevent central venous catheter-related infections.

The Problem

Central venous catheters are essential devices for the management of critically ill and/or chronically ill patients because they provide access to the central venous circulation for administering fluids, drugs, and nutrition, as well as for hemodynamic monitoring. Vascular catheter-related infections are the leading cause of hospital-acquired blood stream infections and are associated with significant morbidity in critically ill patients. Most central venous catheter-related infections are considered preventable.

The evidence shows that most central venous catheter-related infections are caused by organisms that colonize the skin at the insertion site and migrate down the extraluminal surface of the catheter through the transcutaneous tract created at the time of insertion. Other sources of infection are contamination of the catheter hub and blood-borne seeding from a remote source to the catheter.

Additional Specifications

Explicit organizational policies and procedures should be in place regarding the prevention of central venous catheter related infections.

Example Implementation Approaches

- Use aseptic technique during central venous catheter insertion, including cap, mask, sterile gown, sterile gloves, and sterile drapes.
- Disinfect skin with an appropriate antiseptic before catheter insertion and at the time of dressing changes (preferably with a 2% chlorhexidine-based preparation; alternatively use tincture of iodine, an iodophor, or 70% alcohol).
- Promptly remove the catheter as soon as it is no longer essential.
- Implement a central catheter insertion and care protocol that addresses evidence-based strategies for infection reduction, and monitor compliance and infection rates.

Weighting for Safe Practice

Weighting Out of 1000 Points = 33

Check all boxes that apply.

In regard to central venous catheter-related infections, our organization is:

<input type="checkbox"/> 20.1	<p><u>Aware</u> of OUR performance improvement opportunity having undertaken an evaluation of the frequency, severity, and potential impact of performance improvement practices on central venous catheter-related blood stream infections in our patient population within 12 months prior to submitting the survey.</p> <p style="text-align: center;"><u>OR</u></p> <p><input type="checkbox"/> the organization commits to undertake a thorough literature review and an enterprise-wide comprehensive evaluation of the frequency, severity, and potential impact of performance improvement practices on central venous catheter-related infections in our patient population with a report to administration within six months of submitting this survey.</p> <p><i>Check one or neither, but not both.</i></p>
<input type="checkbox"/> 20.2	<p><u>Accountable</u> to this issue as evidenced by . . .</p> <p><input type="checkbox"/> our senior executives and pertinent departmental/clinical service line managers being directly accountable to the performance in reducing central venous line infections through personal performance reviews or personal compensation incentives.</p> <p style="text-align: center;"><u>OR</u></p> <p><input type="checkbox"/> our organization commits to having our Patient Safety Officer regularly report performance metrics (such as compliance to protocols and catheter related infections) to the CEO and Board of Directors (or sub-committee of the board) within six months of submitting this survey.</p> <p><i>Check one or neither, but not both.</i></p>
<input type="checkbox"/> 20.3	<p><input type="checkbox"/> Invested in our <u>ability</u> to reduce the impact of central venous line infections by conducting staff education/knowledge transfer and skill development programs (training regarding application of practices or tools in performance improvement) as evidenced by meeting reports/attendance records for educational programs and project reports during the 12 months prior to submitting this survey.</p> <p style="text-align: center;"><u>OR</u></p> <p><input type="checkbox"/> the organization commits to allocate compensated caregiver staff time to develop specific protocols and allocate dedicated line item budget resources to this area within six months of submitting this survey.</p> <p><i>Check one or neither, but not both.</i></p>
<input type="checkbox"/> 20.4	<p>Taking <u>actions</u> to address central venous catheter infections . . .</p> <p><input type="checkbox"/> by having actively implemented explicit organizational policies and procedures to prevent the occurrence of catheter-related infections,</p> <p style="text-align: center;"><u>OR</u></p> <p><input type="checkbox"/> by having implemented a formal performance improvement project/program (with regular measurement and process improvement elements) addressing this issue.</p> <p style="text-align: center;"><u>OR</u></p> <p><input type="checkbox"/> by committing to undertake a formal clinical unit-wide, department-wide or clinical service line-wide performance improvement project/program in this safety area within six months of submitting this survey.</p> <p><i>Check one or neither, but not both.</i></p>

Practice #21

Evaluate each pre-operative patient in light of his or her planned surgical procedure for the risk of SSI, and implement appropriate antibiotic prophylaxis and other preventative measures based on that evaluation.

Safety Objective 21

Reduce surgical site infections (SSIs).

The Problem

SSIs account for 14 percent of hospital-acquired infections. Studies estimate that SSIs, on average, increase the hospital length of stay by seven days. Death may occur from sepsis secondary to SSI.

The essential foundation of infection control for patients undergoing surgery includes operating room (OR) practices for preparing and maintaining an aseptic surgical field within a controlled environment that minimizes contamination; proper sterilization of surgical instruments, attire, and surgical scrub of the OR team; meticulous surgical technique; and careful postoperative wound care. The effectiveness of these practices has been demonstrated over time.

Strategies to reduce infection in certain patients who have an increased risk of SSI include controlling blood glucose levels in diabetic patients to avoid preoperative hyperglycemia, encouraging tobacco cessation for 30 days pre-operatively, and treating infections remote from the surgical site before performing elective surgery.

Many surgical procedures have shown a reduction in SSIs through the use of prophylactic antibiotics that are given prior to surgery in order to establish tissue levels at the time of incision and that are maintained throughout the operation. The medical literature regularly publishes recommendations and updates for prophylactic antibiotics for various surgical procedures. Antibiotic prophylaxis should be given for the duration of the operation only. Bowel preparation for elective colorectal surgery is also recommended. Feedback to the surgical team and OR staff of surgical infection rates is important for ongoing infection-reduction efforts.

Additional Specifications

- Document SSI assessment and prevention plan in the patient's record.
- Explicit organizational policies and procedures should be in place regarding the prevention of SSIs, including selection, timing and discontinuation of antibiotics.

Example Implementation Approaches

- Identify and treat all infections remote and to the surgical site before elective operation, and postpone elective operations until the infection has resolved.
- Utilize mechanical and intraluminal antibiotic bowel preparation for patients undergoing elective colorectal surgery.
- Remove hair from the incision site only if the hair interferes with the operation by clipping (not shaving) immediately before the operation,
- Administer prophylactic antimicrobial agent to patients based on published guidelines and recommendations targeting the most common pathogens for the planned procedure.
- Utilize intravenous route to administer the prophylactic antimicrobial agent and to administer the antibiotic so that a bactericidal concentration is established in the serum and tissues when the incision is made (except for Caesarian delivery, when antibiotics should be administered after cord clamp)
- Maintain therapeutic levels of the agent in serum and tissues throughout the operation and until, at most, a few hours after the incision is closed.
- Regularly calculate operation-specific SSI rates and report these to surgical team members.
- Utilize other surgical infection prevention methods in accordance with the patient's specific clinical situation.

Weighting for Safe Practice

Weighting Out of 1000 Points = 37

Check all boxes that apply.

In regard to surgical site infections, our organization is:

<p>21.1</p>	<p><input type="checkbox"/> Aware of OUR performance improvement opportunity by undertaking an evaluation of the frequency, severity, and potential impact of performance improvement practices on surgical site infections in our patient population within the last 12 months.</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> the organization commits to undertake a thorough literature review and comprehensive enterprise-wide evaluation of the frequency, severity, and potential impact of performance improvement practices on surgical site infections in our patient population with a report to administration within six months of submitting this survey.</p> <p><i>Check one or neither, but not both.</i></p>
<p>21.2</p>	<p><input type="checkbox"/> Accountable to this issue as evidenced by our senior executives and pertinent departmental/clinical service line managers all being held directly accountable to performance in this patient safety area through personal performance reviews or personal compensation incentives.</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> our organization commits to having our Patient Safety Officer regularly report to the CEO and Board of Directors (or sub-committee of the board) pertinent performance metrics associated with the reduction of surgical site infections within six months of submitting this survey.</p> <p><i>Check one or neither, but not both.</i></p>
<p>21.3</p>	<p><input type="checkbox"/> Invested in our ability to deal with this issue by conducting staff education/knowledge transfer and skill development programs as evidenced by meeting reports/attendance records for educational programs and project reports during the 12 months prior to submitting this survey.</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> commits to invest compensated caregiver staff time to develop a standard protocol including specific risk reduction interventions (i.e. use of prophylactic IV antibiotics) and documentation of implementation of the protocols in the medical records of surgical patients within six months of submitting this survey.</p> <p><i>Check one or neither, but not both.</i></p>
<p>21.4</p>	<p>Taking action to address this issue . . .</p> <p><input type="checkbox"/> by having already actively implemented explicit polices and procedures for documented risk assessment and prevention plans for reducing surgical site infections,</p> <p style="text-align: center;">OR</p> <p>by having implemented a formal performance improvement project/program (with regular measurement and process improvement elements) addressing reduction in surgical site infections and implementation of specific protocols as documented in the medical record.</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> by committing to undertake a formal clinical unit-wide, department-wide or clinical service line-wide performance improvement project/program (with regular measurement and process improvement elements) in this safety area within six months of submitting this survey.</p> <p><i>Check one or neither, but not both.</i></p>

Practice #22

Utilize validated protocols to evaluate patients who are at risk for contrast media-induced renal failure, and utilize a clinically appropriate method for reducing risk of renal injury based on the patient's kidney function evaluation.

Safety Objective 22

Reduce adverse events resulting from administration of intravenous contrast dye in patients with diminished renal function.

The Problem

Many radiologic procedures (e.g., angiography, intravenous pyelograms, and computerized tomography scans) utilize iodine-containing contrast media. Adverse events resulting from the intravenous administration of contrast dye include allergic reactions, anaphylaxis, and kidney damage. Contrast media-induced renal failure rarely occurs in patients with normal kidney function, but patients with pre-existing renal insufficiency or other conditions (e.g., diabetic nephropathy, dehydration, congestive heart failure, or concurrent administration of nephrotoxic drugs) are at risk for renal failure when given iodine-containing contrast media.

Screening protocols have been developed to identify patients who need baseline kidney function assessment (e.g., serum creatinine testing) and risk-reduction precautions such as the use of low osmolar contrast media.

Additional Specifications

- Document the contrast media-induced renal failure risk assessment and renal failure prevention plan in the patient's record.
- Explicit organizational policies and procedures should be in place regarding the prevention of contrast media-induced nephropathy.

Example Implementation Approaches

- Ensure that the patient undergoing intravenous contrast procedures is hydrated sufficiently according to standard protocol.
- Use low osmolar contrast media to prevent contrast media-induced renal failure in a patient with impaired renal function
- Check the serum creatinine level prior to scheduling a contrast study in a patient who has uncertain kidney function.

Weighting for Safe Practice

Weighting Out of 1000 Points = 12

Check all boxes that apply.

In regard to adverse events resulting from administration of intravenous contrast dye in patients with diminished renal function, our organization is:

<p>22.1</p>	<p><input type="checkbox"/> Aware of THE performance improvement opportunity in that . . . the organization has undertaken some kind of an educational initiative to make clinicians and administration aware of the frequency, severity, and opportunity for impact of improvement practices that included IV contrast related adverse events within the past 12 months as evidenced by meeting/ attendance records.</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> the organization commits to evaluate OUR performance improvement opportunity in this area by undertaking an evaluation of the frequency, severity, and opportunity potential for impact of readily available performance improvement practices for IV contrast related adverse events in our patient population within the next six months of submitting the survey.</p> <p><i>Check one or neither, but not both.</i></p>
<p>22.2</p>	<p><input type="checkbox"/> Accountable to it as evidenced by our pertinent departmental/clinical service line managers being directly accountable to the patient safety area through personal performance reviews or personal compensation incentives.</p>
<p>22.3</p>	<p><input type="checkbox"/> Invested in our ability to deal with the issue by having invested in staff education/ knowledge transfer and/or skill development programs (staff's ability to apply tools in performance improvement or implementation of appropriate procedures/ protocols/ policies) as evidenced by meeting reports/attendance records for educational programs and/or project reports during the 12 months prior to submitting the survey.</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> the organization commits to invest in staff education/knowledge transfer and/or skill development programs (staff's ability to apply tools in performance improvement or implementation of appropriate procedures/protocols/policies) and allocate compensated caregiver staff time and make a dedicated budget allocation to implement protocols or procedures to minimize contrast related adverse events within six months of submitting this survey.</p> <p><i>Check one or neither, but not both.</i></p>
<p>22.4</p>	<p>Taking action to address the issue . . .</p> <p><input type="checkbox"/> by already actively implemented explicit organizational polices and procedures regarding documented risk assessment and prevention plans for contrast-related renal failure.</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> by committing to undertake a formal clinical unit-wide, department-wide or clinical service line-wide performance improvement project/program in imaging that includes this safety area (with regular performance measurement and process improvement elements) AND implementing explicit organizational polices and procedures within six months of submitting this survey.</p> <p><i>Check one or neither, but not both.</i></p>

Practice #23

Evaluate each patient upon admission, and periodically thereafter, for risk of malnutrition. Employ clinically appropriate strategies to prevent malnutrition.

Safety Objective 23

Reduce adverse events resulting from malnutrition.

The Problem

Persons with chronic disease are frequently malnourished or may become malnourished during hospitalization, especially if the hospital course is complicated. Malnourished patients experience increased morbidity and mortality and prolonged hospital stays. Malnutrition in hospitalized patients frequently is not recognized. Providing nutritional support to patients, either malnourished or at risk of malnutrition, can result in improved clinical outcomes and fewer adverse events.

Additional Specifications

- Document the malnutrition risk assessment and prevention plan in the patient's record.
- Explicit organizational policies and procedures should be in place regarding the prevention of malnutrition.

Example Implementation Approaches

- Implement a malnutrition evaluation instrument to screen and identify those at risk for malnutrition.
- Implement clinically appropriate strategies, including screening, assessment, and nutritional interventions, to prevent malnutrition-related morbidity and mortality.
- Ensure that food is appropriate to the patient's ability to masticate.

Weighting for Safe Practice

Weighting Out of 1000 Points = 12

Check all boxes that apply.

In regard to the potential for patients to experience malnutrition, our organization is:

<p>23.1</p>	<p><input type="checkbox"/> Aware of THE performance improvement opportunity in that . . . the organization has undertaken an educational initiative to make clinicians and administration aware of the frequency, severity, and opportunity for impact of improvement practices to prevent malnutrition within the past 12 months as evidenced by meeting documentation and attendance records.</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> the organization commits to evaluate OUR performance improvement opportunity by undertaking a thorough literature review for readily available best practices and an evaluation of preventable malnutrition in our patient population. The evaluation will include the frequency and severity of preventable malnutrition and the potential impact of the performance improvement practices. It will be undertaken within six months of submitting this survey.</p> <p><i>Check one or neither, but not both.</i></p>
<p>23.2</p>	<p><input type="checkbox"/> Accountable to this issue as evidenced by the fact that . . . senior executives and pertinent departmental/clinical service line managers are directly accountable to this patient safety area through personal performance reviews.</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> our organization commits to begin to have the Patient Safety Officer regularly report performance in this area to the CEO and trustees/board of directors within six months of submitting this survey. Such reports should include metrics such as measures to implement a malnutrition risk assessment of the patient population.</p> <p><i>Check one or neither, but not both.</i></p>
<p>23.3</p>	<p><input type="checkbox"/> Invested in our ability to deal with the issue by conducting staff education/knowledge transfer and skill development programs (such as skill in assessing patients risk for malnutrition and performance improvement) as evidenced by meeting reports/attendance records for educational programs and project reports during the 12 months prior to submitting the survey.</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> the organization commits to allocate compensated caregiver staff time to develop a risk assessment instrument specific to malnutrition and demonstrate implementation through documentation in patient medical records during the six months following submission of this survey.</p> <p><i>Check one or neither, but not both.</i></p>
<p>23.4</p>	<p><input type="checkbox"/> Taking action to address this issue already . . . by having clearly documented evidence that 80% of all patients admitted to our organization are assessed for the risk of malnutrition; the prevention plan for high risk patients is clearly documented in the medical record according to explicit organizational policies and procedures.</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> by committing to undertake a formal clinical unit-wide, department-wide or clinical service line-wide performance improvement project/program addressing this issue within six months of submitting this survey.</p> <p><i>Check one or neither, but not both.</i></p>

Practice #24

Whenever a pneumatic tourniquet is used, evaluate the patient for risk of ischemia and/or thrombotic complication and utilize appropriate prophylactic measures.

Safety Objective 24

Prevent pneumatic tourniquet-related complications.

The Problem

Pneumatic tourniquets are sometimes used to create a bloodless surgical field (e.g., to improve visualization for orthopedic and plastic surgery on the extremities) or for the instillation of regional anesthesia to the limb. Ischemic neuromuscular injury may occur if the tourniquet remains inflated too long. Direct pressure injury to nerves may also occur. Additionally, tourniquet inflation and deflation may depress cardio-respiratory function in the peri-operative period, including causing "showers" of embolic debris to the heart, which may in turn cause pulmonary embolism.

Additional Specifications

- Document the pneumatic tourniquet complication risk of an ischemic and/or thrombotic complication prevention plan in the patient's chart.
- Explicit organizational policies and procedures should be in place for the proper use and maintenance of pneumatic tourniquets.

Example Implementation Approaches

- Provide training in the proper use of the pneumatic tourniquet device for all peri-operative staff.
- Perform regular inspection of the device according to manufacturer's written instructions.
- Ensure proper fit of the device by selecting the proper size and appropriate positioning of the tourniquet cuff.
- Keep tourniquet inflation time to a minimum.
- Keep tourniquet inflation pressure to a minimum (I.e. Only that required to suppress arterial circulation)
- Follow inflation and deflation procedures as recommended by the manufacturer.
- Perform continuous monitoring of the tourniquet inflation time and pressure display.

Weighting for Safe Practice

Weighting Out of 1000 Points = 8

Check all boxes that apply.

In regard to complications related to the use of pneumatic tourniquets, our organization is:

<p>24.1</p>	<p><input type="checkbox"/> Aware of THE performance improvement opportunity in that . . . the organization has, undertaken an educational initiative to make clinicians and administration aware of the frequency and severity of complications related to the use of pneumatic tourniquets and opportunity for performance improvement impact in this area, within the past 12 months, as evidenced by meeting documentation/ attendance records.</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> the organization commits to evaluate OUR performance opportunity in this area by undertaking an evaluation of the frequency, severity, and potential impact of performance readily available performance improvement practices in our patient within six months following survey submission.</p> <p><i>Check one or neither, but not both.</i></p>
<p>24.2</p>	<p><input type="checkbox"/> Accountable to this issue as evidenced by . . . having the pertinent departmental/clinical service line managers directly accountable to this issue through personal performance reviews or personal compensation incentives.</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> our commitment to make pertinent departmental/clinical service line managers directly accountable to this issue through personal performance reviews or personal compensation incentives within six months of submitting this survey.</p> <p><i>Check one or neither, but not both.</i></p>
<p>24.3</p>	<p><input type="checkbox"/> Invested in our ability to deal with the issue by conducting staff education/knowledge transfer and skill development programs (training regarding application of practices or protocols or staff's ability to apply tools in performance improvement) as evidenced by meeting reports/attendance records for educational programs and/or project reports during the six months prior to submitting the survey.</p>
<p>24.4</p>	<p>Taking action to address this issue . . .</p> <p><input type="checkbox"/> by already having implemented explicit organizational polices and procedures to reduce the risk of pneumatic tourniquet-related complications.</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> by making a commitment to undertake a formal clinical unit-wide, department-wide or clinical service line-wide performance improvement project/program in this safety area (with regular performance measurement and process improvement elements) AND making a commitment to implement explicit organizational polices and procedures within six months of submitting this survey.</p> <p><i>Check one or neither, but not both.</i></p>

Practice #25

Decontaminate hands with either a hygienic hand rub or by washing with a disinfectant soap prior to and after direct contact with the patient or objects immediately around the patient.

Safety Objective 25

Prevent person to person transmission of infections.

The Problem

Up to 10 percent of hospitalized patients suffer from an infection acquired while they are in the hospital. Many of these infections are transmitted via the hands of healthcare workers. Pathogenic gram-negative bacilli may survive on the hands for over two hours. The increase in antibiotic-resistant pathogens makes prevention of person-to-person transmitted infections especially important. Although hand washing has been shown to be highly effective in preventing the transmission of pathogens within a hospital, studies have repeatedly shown that hand washing compliance rates are generally less than 50 percent. Studies suggest that healthcare-acquired (nosocomial) infections are the primary cause of about 1 percent of in-hospital deaths and are a significant contributing factor to another 3 percent of deaths in hospitals. The burden of nosocomial infection adds dramatically to morbidity resulting from the underlying diseases and generally increases hospital costs because of extended hospital stays. Although most studies of hand washing have been performed in hospital settings, nosocomial infections remain a problem in all healthcare settings.

Additional Specifications

Explicit organizational policies and procedures should be in place regarding hand decontamination and the prevention of nosocomial infection.

Weighting for Safe Practice

Weighting Out of 1000 Points = 33

Check all boxes that apply.

In regard nosocomial infections related to inadequate hand washing, our organization is:

<p>25.1</p>	<p><input type="checkbox"/> Aware of OUR performance improvement opportunity in this area in that . . . we have undertaken an enterprise-wide educational effort addressing the frequency and severity of nosocomial infections within our patient population and potential impact of performance improvement practices related to the absence of or inadequate hand washing within the last 12 months as evidenced by meeting documentation/ attendance records.</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> the organization commits to undertake a thorough literature review and comprehensive enterprise-wide evaluation of the frequency and severity of nosocomial infections related to the inadequate hand washing. A report with a summary of the readily available improvement opportunities and recommendations in this area will be provided to administration within six months of submitting this survey.</p> <p><i>Check one or neither, but not both.</i></p>
<p>25.2</p>	<p><input type="checkbox"/> Accountable to this issue as evidenced . . . by pertinent departmental/clinical service line managers all being directly accountable to the patient safety area through personal performance reviews or personal compensation incentives.</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> by our organization committing to assign accountability to our senior executives and pertinent departmental/clinical service line managers for this safety patient safety area through personal performance reviews or personal compensation incentives within six months of submitting this survey.</p> <p><i>Check one or neither, but not both.</i></p>
<p>25.3</p>	<p><input type="checkbox"/> Invested in our ability to deal with this issue by conducting staff education/knowledge transfer and skill development programs (training regarding implementation of practices or application of tools in performance improvement) as evidenced by meeting reports/attendance records for educational programs.</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> our organization commits to make an explicit dedicated line item budget allocation for regular in-service educational programs during the six months following submission of this survey.</p> <p><i>Check one or neither, but not both.</i></p>
<p>25.4</p>	<p><input type="checkbox"/> Taking additional actions to ensure that explicit organizational policies and procedures are in place across the entire enterprise to prevent nosocomial infections due to inadequate hand washing techniques with routine measurement of compliance and process improvement elements addressing adherence to policies and procedures within the last 12 months,</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> by having implemented a formal performance improvement project/program addressing nosocomial infections (with regular measurement and process improvement elements) including hand washing techniques and compliance within the 12 months prior to submitting this survey.</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> by making the commitment to undertake a formal enterprise-wide performance improvement project/program addressing nosocomial infections that includes hand washing techniques and compliance (with regular performance measurement and process improvement elements) and implementing explicit organizational polices and procedures within six months of submitting this survey.</p> <p><i>Check one or neither, but not both.</i></p>

Practice #26

Vaccinate healthcare workers against influenza to protect both them and patients from influenza.

Safety Objective 26

Prevent person to person transmission of infections.

The Problem

Many high-risk elderly patients do not receive influenza vaccinations or are incompletely immunized from the vaccine because of weakened immune systems. Influenza, and the pneumonia that often follows it, are major problems in

institutional care settings, where the number of frail elderly people creates an environment that is likely to allow the rapid spread of such infections. Influenza causes at least 20,000 deaths each year in the United States.

Healthcare workers in close contact with high-risk patients may be infected with influenza and spread the infection to other workers or patients. Vaccination of health-care workers can prevent worker infection and worker-mediated transmission of disease among patients, but evidence shows that only about one-third of hospital workers have current vaccinations against influenza.

Additional Specifications

- Document the vaccination status of all employees, subject to collective bargaining, labor law, and privacy law. Employees refusing vaccinations should have this refusal noted.
- Explicit organizational policies and procedures should be in place regarding immunization against influenza.

Weighting for Safe Practice

Weighting Out of 1000 Points = 11

Check all boxes that apply.

In regard to person-to-person transmission of influenza infections from unvaccinated healthcare workers to patients, our organization is:

<p>26.1</p>	<p><input type="checkbox"/> Aware of THE performance improvement opportunity in that the organization . . . has undertaken an educational initiative to make clinicians and administration aware of the frequency and severity of transmission of influenza infections from unvaccinated healthcare workers and have identified the opportunities for improvement in this area, within the past 12 months, as evidenced by meeting attendance records and documentation of meeting minutes.</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> commits to evaluate OUR performance improvement opportunity in this area by undertaking an evaluation of the frequency and severity of transmission of influenza infections within our organization within the next six months.</p> <p><i>Check one or neither, but not both.</i></p>
<p>26.2</p>	<p><input type="checkbox"/> Accountable to this issue as evidenced by . . . our senior executives and pertinent departmental/clinical service line managers being directly accountable to this patient safety issue through personal performance reviews or personal compensation incentives.</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> our organization will assign accountability to our senior executives and pertinent departmental/clinical service line managers for this patient safety issue through personal performance reviews or personal compensation incentives within six months of submitting this survey.</p> <p><i>Check one or neither, but not both.</i></p>
<p>26.3</p>	<p><input type="checkbox"/> Invested in our ability to deal with the issue by . . . formally allocating HR resources to administer the vaccinations (compensated staff time), and having a dedicated budget allocation for an employee influenza vaccination program.</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> committing to invest in this issue by formally allocating compensated caregiver staff time to administer the vaccinations, and making a dedicated budget allocation for an employee influenza vaccination program within the 12 months of submitting the survey.</p> <p><i>Check one or neither, but not both.</i></p>
<p>26.4</p>	<p>Taking action to address this issue . . .</p> <p><input type="checkbox"/> by having already implemented a formal enterprise-wide program to vaccinate all employees, except those that formally refuse vaccination (and documentation of the refusal) as per explicit organizational polices and procedures.</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> by committing to implement the best practices to vaccinate all healthcare workers within six months of submitting this survey.</p> <p><i>Check one or neither, but not both.</i></p>

Practice #27

Keep workspaces where medications are prepared clean, orderly, well lit, and free of clutter, distraction and noise.

Safety Objective 27

Provide a work environment that facilitates attention to detail and promotes the accurate filling and dispensing of medication orders.

The Problem

Although many medication errors have no or minor consequences for patients, others may cause serious morbidity or even death. Errors related to dispensing medications are common, occurring at rates ranging up to 24 percent of medications dispensed. A number of environmental factors in the medication dispensing area itself are known to increase the occurrence of errors, including heavy workload, cluttered workspace, noise, and poor lighting. Having an organized and well-lit workspace has been shown to both decrease errors and increase efficiency.

Additional Specifications

Explicit organizational policies and procedures should be in place for the pharmacy and nursing work environment and should include the specific implementation guidelines.

Example Implementation Approaches

Conduct frequent and regular monitoring of the work environment to ensure that guidelines are followed.

Weighting for Safe Practice

Weighting Out of 1000 Points = 7

Check all boxes that apply.

In regard to medication errors related to poor and disorganized environmental factors in medication preparation workspaces, our organization is:

<p>27.1</p>	<p><input type="checkbox"/> Aware of THE performance improvement opportunity in that the organization . . . has undertaken an educational initiative to make clinicians or administration aware of the frequency and severity of medication errors related to work area environmental factors in medication preparation workspaces and have identified the opportunities for improvement in this area, within the past 12 months, as evidenced by meeting documentation.</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> commits to evaluate OUR performance improvement opportunity in this area by undertaking an evaluation of the frequency and severity of medication errors that could be related to work area environmental factors in medication preparation workspaces within the next six months. A formal evaluation of pharmacy related ADEs that includes such an analysis will suffice.</p> <p><i>Check one or neither, but not both.</i></p>
<p>27.2</p>	<p><input type="checkbox"/> Accountable to this area as evidenced by . . . pertinent departmental/clinical service line managers being directly accountable to this patient safety area through personal performance reviews or personal compensation incentives.</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> our commitment to make pertinent departmental/clinical service line managers directly accountable to this patient safety area through personal performance reviews or personal compensation incentives within six months of submitting this survey. This may be part of accountability to medication management performance.</p> <p><i>Check one or neither, but not both.</i></p>
<p>27.3</p>	<p><input type="checkbox"/> Invested in our ability to deal with the issue . . . by a formal specific budget allocation and compensated caregiver staff time to evaluate and develop an improvement plan for the facilities and conditions of medication dispensing workspaces.</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> by committing to formal specific budget and compensated caregiver staff time allocation to address this safety issue within six months of submitting this survey</p> <p><i>Check one or neither, but not both.</i></p>
<p>27.4</p>	<p><input type="checkbox"/> Taking action to ensure that frequent and regular monitoring of medication workspaces is conducted according to explicit organizational polices and procedures for the pharmacy and nursing work environments.</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> by committing to frequent and regular monitoring of medication workspaces according to explicit organizational polices and procedures for the pharmacy and nursing work environments within six months of submitting this survey</p> <p><i>Check one or neither, but not both.</i></p>

Practice #28

Standardize the methods of labeling, packaging, and storing medications.

Safety Objective 28

Reduce adverse events resulting from improper labeling, packaging, and/or storage of medications.

The Problem

Improper labeling and packaging of medications are well-known causes of serious medication errors. For example, one study of 334 errors causing 264 adverse drug events over six months in two tertiary care hospitals found that 11 percent of the preventable adverse events reflected problems with pharmacy dispensing. The evidence shows that there are effective methods for simplifying pharmacy dispensing by standardizing the labeling of medication containers and drawn-up syringes and the packaging of medications.

Additional Specifications

Standardized methods for labeling, packaging, and storing medications should be utilized institution-wide and should include, at a minimum, requirements for:

- labeling of all medications until they are administered to the patient, and
- ensuring compliance with the policies and procedures for medication labeling, packaging, and storage.

Example Implementation Approaches

- Implement organizational protocols that require standardized labeling of all medications (e.g. color-coding of medications and typed labels)
- Store drugs with similar names and strengths in physically separate locations,
- Document the lot number of the medication, the expiration

Weighting for Safe Practice

Weighting Out of 1000 Points = 22

Check all boxes that apply.

In regard to adverse drug events resulting from improper labeling, packaging, and/or storing of medications, our organization is:

<p>28.1</p>	<p><input type="checkbox"/> Aware of THE performance improvement opportunity in that . . . the organization has undertaken an educational initiative to make clinicians and administration aware of the frequency and severity of adverse drug events resulting from improper labeling, packaging, and/or storing of medications and have identified the opportunities for improvement in this area, within the past 12 months, as evidenced by meeting documentation and attendance records.</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> the organization commits to evaluate OUR performance improvement opportunity in this area by undertaking an evaluation of the frequency and severity of adverse drug events resulting from improper labeling, packaging, and/or storing of medications within the next 6 months</p> <p><i>Check one or neither, but not both.</i></p>
<p>28.2</p>	<p><input type="checkbox"/> Accountable to this issue as evidenced by our senior executives, and pertinent departmental/clinical service line manager, who are held directly accountable to this patient safety area through personal performance reviews or personal compensation incentives.</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> the organization commits to having our Patient Safety Officer include this issue as part of a formal regular presentation regarding all areas of adverse drug events to the CEO and trustees/board of directors.</p> <p><i>Check one or neither, but not both.</i></p>
<p>28.3</p>	<p><input type="checkbox"/> Invested in our ability to deal with the issue by conducting staff education/knowledge transfer (of actionable information) and skill development (staff's ability to apply practices and tools in performance improvement), AND by formally allocating compensated caregiver staff time to evaluate and address the severity of the issue (compensated staff time), AND by dedicated budget allocation to this specific issue.</p>
<p>28.4</p>	<p><input type="checkbox"/> Taking action to address this issue as evidenced by . . . implementation of enterprise-wide implementation of standardization of labeling and storage of 80% of all medications possible,</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> having undertaken a formal clinical unit-wide, department-wide, or clinical service line-wide performance improvement project/program (with regular measurement and process improvement elements) within the last 12 months.</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> committing to undertake a review of the medical literature surrounding this issue and to implement the most pertinent and timely best practices with a tightly coupled enterprise-wide performance improvement project/program (with regular measurement and process improvement elements) within six months of submitting this survey.</p> <p><i>Check one or neither, but not both.</i></p>

Practice #29

Improve the safety of using high-alert medications (e.g., intravenous adrenergic agonists and antagonists, chemotherapy agents, anticoagulants and anti-thrombotics, concentrated parenteral electrolytes, general anesthetics, neuromuscular blockers, insulin and oral hypoglycemics, narcotics and opiates).

Safety Objective 29

Ensure the safe use of "high-alert" drugs.

The Problem

Certain classes of medications have been repeatedly shown to cause adverse drug events and should be viewed as particularly serious threats to patient safety. These "high-alert" medications include concentrated electrolyte solutions (e.g., concentrated potassium chloride solution), insulin, chemotherapeutic agents, intravenous opiate solutions, and anticoagulants such as heparin and warfarin.

Additional Specifications

- Designate protocols, guidelines, dosing scales, and/or checklists for each "high-alert" drug, and communicate this information to all relevant healthcare providers.
- Explicit organizational policies and procedures should be in place for the management of "high-alert" drugs.

Example Implementation Approaches

- Make a list of "high-alert" drugs available to all workers at the facility,
- Implement a process to identify new medications for addition to the "high-alert" list.
- Designate protocols, guidelines, dosing scales, and/or checklists for each "high-alert" drug (e.g. nomograms for heparin, standardized order forms for antineoplastic drugs) and make these available to relevant caregivers.
- Implement a process to audit compliance with these protocols and guidelines by all relevant caregivers.
- Utilize a multidisciplinary team to identify and regularly review safeguards for all "high-alert" drugs.

Weighting for Safe Practice

Weighting Out of 1000 Points = 21

Check all boxes that apply.

In regard to adverse drug events related to high alert medications, our organization is:

<p>29.1</p>	<p><input type="checkbox"/> Aware of THE performance improvement opportunity through an educational initiative or meetings to make clinicians and administration aware of the frequency and severity of adverse drug events related to high alert medications specified in the NQF report within the 12 months prior to submitting the survey. This should have included an assessment of the potential opportunities for improvement and be evidenced by meeting documentation/attendance records.</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> the organization commits to evaluate OUR performance improvement opportunity in this area by undertaking an evaluation of the frequency and severity of adverse drug events related to high alert medications in our patient population and make a report available to administration within the next six months.</p> <p><i>Check one or neither, but not both.</i></p>
<p>29.2</p>	<p><input type="checkbox"/> Accountable to this issue by senior executives and pertinent departmental/clinical service line managers directly accountable to this patient safety area through personal performance reviews or personal compensation incentives.</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> by committing to make senior executives and pertinent departmental/clinical service line managers directly accountable to this patient safety area through personal performance reviews or personal compensation incentives within six months of submitting this survey.</p> <p><i>Check one or neither, but not both.</i></p>
<p>29.3</p>	<p><input type="checkbox"/> Invested in our ability to deal with the issue . . . by conducting staff education and skill development (training of staff regarding application of practices or tools in performance improvement),</p> <p style="text-align: center;">AND</p> <p>by formally allocating compensated caregiver staff time to this area.</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> by committing to make a formal budget allocation to this specific area and allocating compensated caregiver staff time within six months of submitting this survey</p> <p><i>Check one or neither, but not both.</i></p>
<p>29.4</p>	<p><input type="checkbox"/> Taking action to address this issue . . . by already having actively implemented explicit organizational policies and procedures for the management of high alert drugs, including removal of concentrated electrolytes from patient care units and limiting and standardizing the number of drug concentrations available in the organization.</p> <p style="text-align: center;">OR</p> <p>by having implemented a formal performance improvement project/program (with regular measurement and process improvement elements) addressing this area.</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> by committing to undertake a formal enterprise-wide performance improvement project/program (with measurement and process improvement elements) in this safety area within six months of submitting this survey.</p> <p><i>Check one or neither, but not both.</i></p>

Practice #30

Dispense medications in unit-dose or when appropriate unit-of-use form, whenever possible.

Safety Objective 30

Reduce adverse events resulting from bulk packaging of medications.

The Problem

Hospitals purchase oral dosage (i.e., tablets, caplets, capsules) medications in two forms: bulk or commercially prepared, prepackaged dosages referred to as unit-of-use or unit dose. When purchased in bulk the medications must be repackaged into unit-dose aliquots.

The evidence shows that unit-dose packaging reduces the number of medication errors and appears to be widely used in most general medical and surgical wards. However, it is not used as much as it could be in other locations such as intensive care units, operating rooms, and emergency departments.

Additional Specifications

- Medications should be contained in unit-dose (single-unit) packages.
- Medications should be dispensed in as ready-to-administer form.
- Every unit-dose package label should contain a machine-readable code identifying the product name, strength, manufacturer, expiration date and lot number.
- For most medications, no more than a 24-hour supply of doses should be delivered to or be available at the patient care area at any time.
- There should be an established ongoing organizational process to monitor and improve the performance of the unit-dose drug distribution system.

Example Implementation Approaches

- Purchase medications in prepackaged unit-of-use packaging whenever available
- When prepackaged unit dose or unit-of-use is not commercially available, prepare and supply daily unit doses of medications for individual patients under the purview of pharmacists

Weighting for Safe Practice

Weighting Out of 1000 Points = 29

Check all boxes that apply.

In regard to adverse drug events resulting from bulk packaging of medications, our organization is:

<p>30.1</p>	<p><input type="checkbox"/> Aware of OUR performance improvement opportunity in this area in that . . . the organization has undertaken an evaluation of the frequency and severity adverse drug events and the opportunity for improvement related to the lack of unit dose and unit-of-use packaging of medications in our organization in the past 12 months.</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> our organization commits to evaluate OUR performance improvement opportunity in this area within the next six months.</p> <p><i>Check one or neither, but not both.</i></p>
<p>30.2</p>	<p><input type="checkbox"/> Accountable to this issue as evidenced by . . . pertinent senior executives and departmental/clinical service line managers are directly accountable to adverse drug events reduction through personal performance reviews or personal compensation incentives.</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> our commitment to make pertinent senior executives, and pertinent departmental/clinical service line managers directly accountable to adverse drug events reduction through personal performance reviews or personal compensation incentives within six months of submitting the survey.</p> <p><i>Check one or neither, but not both.</i></p>
<p>30.3</p>	<p><input type="checkbox"/> Invested in our ability to deal with the issue . . . by conducting staff education/knowledge transfer (of actionable information) and skill development (staff's ability to apply practices or tools in performance improvement),</p> <p style="text-align: center;">AND</p> <p>by formally allocating compensated caregiver staff time to this area.</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> by committing to make a dedicated formal budget allocation to this specific area within six months of submitting this survey and allocation compensated caregiver staff time.</p> <p><i>Check one or neither, but not both.</i></p>
<p>30.4</p>	<p><input type="checkbox"/> Taking actions to address this issue . . . by already actively implementing medication dispensing in unit-dose or unit-of-use form whenever possible that is monitored on a regular basis,</p> <p style="text-align: center;">OR</p> <p>by having implemented a formal clinical unit-wide, department-wide, or clinical service line-wide performance improvement project/program with regular measurement and process improvement elements addressing this area within the 12 months prior to submitting this survey.</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> by committing to undertake a review of the medical literature surrounding this issue and to implement the most pertinent and timely best practices regarding this issue within six months of submitting this survey.</p> <p><i>Check one or neither, but not both.</i></p>

Scoring Algorithm for NQF-SP

Hospital's responses are scored based on a best practices benchmarking process:

1. Each Practice has a weight -- the number of possible points earned for that Practice, out of a total 1000 for all 27 Practices. Each Practice indicates its weighting.
2. In the initial implementation of scoring, points are awarded within each Practice pro rata, based on the number of checked items in that Practice as a proportion of total number of questions for that Practice.
3. Points awarded for each Practice are summed to a total point value for the NQF-SP section.
4. A ratio of checked action items versus checked commitment items is created.
5. Hospitals are ranked into four groups based on total points earned by their responses and the ratio of action versus commitment:
 - Fully meets (full circle): Highest decile
 - Good progress (3/4-circle): Above median, but not top decile
 - Good early stage effort (1/2-circle): Below median, but not bottom decile
 - Willing to report (1/4-circle): Lowest decile

Decile and median cutpoints are based on the distribution of total-point scores in the initial round of 2004 survey submissions.

6. Recalibration during the 2004 survey cycle:
 - Decile and median cutpoints will be reviewed to determine if a recalibration is warranted and hospital scores in public results may change as a consequence.
 - Since it is unlikely and perhaps impractical for hospitals to meet all of the items identified within a Practice, the frequency and distribution of checked items within Practice will be reviewed to identify "best achievable" practice. E.g., results across hospital may indicate that hospitals rarely if ever check ALL possible items within a Practice. The points earned per checked item may then be adjusted so that:
 - (a) a hospital may earn ALL points for the Practice by checking fewer than all possible items, and
 - (b) points earned for any specific check-off item could be changed from the initial pro-rata assignment to a value proportionate to the impact that the item is expected to have in meeting the overall Practice.