

Leapfrog Ambulatory Surgery Center Survey Hard Copy

QUESTIONS & REPORTING PERIODS

MEASURE SPECIFICATIONS

ENDNOTES

FAQS



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Welcome to the 2023 Leapfrog ASC Survey

<http://www.leapfroggroup.org/asc>

Important Notes about the 2023 Leapfrog ASC Survey

1. The Leapfrog ASC Survey is for ambulatory surgery centers (ASCs) and is not applicable to hospital outpatient departments (HOPDs). Most ambulatory surgery centers are certified by Medicare and assigned a 10-digit CMS Certification Number (nn-Cnnnnnnn). Surgery centers that operate as an outpatient department of a hospital and share a CMS Certification Number (nn-nnnn) with a hospital should submit a [2023 Leapfrog Hospital Survey](#). If you have questions about which Survey to submit, please contact the Leapfrog [Help Desk](#).
2. To participate in the Leapfrog ASC Survey, ASCs must currently be performing procedures in one or more of the following specialties:
 - Gastroenterology
 - General Surgery
 - Ophthalmology
 - Orthopedics
 - Otolaryngology
 - Urology
 - Neurological Surgery
 - Obstetrics and Gynecology
 - Plastic and Reconstructive SurgeryASCs that are not currently performing procedures in one or more of the specialties listed above, should not begin a Survey. After completing and submitting the Profile, please contact the [Help Desk](#) with information regarding the procedures performed by your facility and with any questions.
3. ASCs reporting on Section 4B: NHSN Outpatient Procedure Component Module are required to join Leapfrog's NHSN Group. More information, including instructions and important deadlines, is available on the [Join NHSN Group webpage](#).
4. Leapfrog ASC Survey Results will be available on the ASC Details Page beginning July 12 and publicly reported on our [public reporting website](#) on July 25. After July, the ASC Details Page and public reporting website will be refreshed monthly within the first five (5) business days of each month to reflect Surveys submitted or resubmitted between July 1 and November 30 and previously submitted Surveys corrected before January 31. Survey Results are frozen from February to July 25.
5. All questions regarding the Leapfrog ASC Survey should be submitted to the Help Desk at <https://leapfroghelpdesk.zendesk.com>. Questions submitted to the Help Desk will receive a response within 1-2 business days (see [Help Desk Holiday Schedule](#) on the Get Help webpage for planned closures).
6. Leapfrog is committed to verifying the accuracy of Leapfrog ASC Survey Results. Please review the information on the [Data Accuracy webpage](#).
7. The [Submission Deadline](#) for the 2023 Leapfrog ASC Survey is **June 30, 2023**, and the Late Submission and Performance Update Deadline is **November 30, 2023**. ASCs that do not submit a Survey before 11:59 pm Eastern Time on **November 30, 2023**, will have to wait until the launch of the 2024 Leapfrog ASC Survey on April 1, 2024.

Overview of the 2023 Leapfrog ASC Survey

The Leapfrog ASC Survey is divided into five sections. A description of each section is listed below. For a more detailed overview of the 2023 Leapfrog ASC Survey, including a crosswalk of nationally endorsed measures and a description of how measures are publicly reported, visit the [Survey Overview webpage](#).

Section Number	Section Title	Brief Description
	Profile	The ASC Profile includes questions about demographic and contact information. The Profile can be accessed and updated anytime throughout the year by logging into the ASC Survey Dashboard with your facility's security code.
1	Basic Facility Information	Section 1 includes questions about your facility's operating and procedure rooms, adult and pediatric patient discharges, teaching status, ownership, accreditation, and transfer agreements. The section also includes questions about two aspects of person-centered care: billing ethics and health equity. In 2023, the health equity questions will continue to not be scored or publicly reported.
2	Medical, Surgical, and Clinical Staff	Section 2 includes questions about your facility's medical, surgical, and clinical staff, including ACLS and PALS certification, and board certification.
3	Volume and Safety of Procedures	Section 3 includes questions about your facility's volume of adult and pediatric procedures, patient selection, and use of a safe surgery checklist. Questions about facility volume and surgeon privileging for total hip replacements and total knee replacements will continue to be scored and publicly reported. In 2023, a new set of questions on facility and surgeon volume of bariatric surgery for weight loss was added. These questions will not be scored or publicly reported in 2023. Two new CMS outcome measures (Hospital Visits After Orthopedic Ambulatory Surgical Center Procedures, and Hospital Visits After Urology Ambulatory Surgical Center Procedures) were also added and will be scored and publicly reported. The questions about informed consent (Section 3D) will be scored and publicly reported.
4	Patient Safety Practices	Section 4 includes questions about medication safety, the NHSN Outpatient Procedure Component Module reporting, hand hygiene, NQF Safe Practices, Never Events and nursing workforce at your facility. In 2023, NQF Safe Practice #4 Risks and Hazards and the percentage of RNs who are BSN-prepared will be scored and publicly reported.
5	Patient Experience (OAS CAHPS)	Section 5 includes questions about patient experience (OAS CAHPS).

All five sections must be completed to submit the Leapfrog ASC Survey via the Online ASC Survey Tool.

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

- **General information** about The Leapfrog Group's standard (included in the hard copy only).
- **Reporting periods** to provide facilities with specific periods of time for each set of questions.

- **Survey questions** which may include references to endnotes. The Survey questions and endnotes match the Online ASC Survey Tool exactly.
- **Affirmation of accuracy** by your facility's administrator or by an individual that has been designated by the administrator. These statements affirm the accuracy of your facility's responses.
- **Reference information** which includes "What's New" and "Change Summaries," important measure specifications, answers to frequently asked questions, and other notes that must be carefully reviewed before providing responses to any of the Survey questions (included in the hard copy only). ASCs must download the CPT Code Excel Workbook on the Survey Dashboard **prior** to completing Section 3 of the 2023 Leapfrog ASC Survey.

Any changes made to the measure specifications after April 1 will be reflected in the hard copy of the Survey in the Reference Information sections under the "Change Summary" header (see [Table of Contents](#)). In addition, the updates to the specifications will be highlighted in yellow. If the changes are substantial, we will email the Primary Survey Contact your facility indicated in the ASC Profile of the Online ASC Survey Tool. If the notification is sent before your facility submits a 2023 Leapfrog ASC Survey, the email will go to the Primary Survey Contact provided in the previous year's Survey.

The Leapfrog Group and its participating members are committed to presenting information that is as current as possible and therefore we allow facilities to update and resubmit their Survey until the **November 30** Late Submission and Performance Update Deadline. Please carefully review the reporting periods in each section before updating your Survey. Leapfrog ASC Survey Results are updated monthly beginning in July on Leapfrog's [public reporting website](#). Facilities are required to update the information in their Survey within 30 days of any change in status. We reserve the right to decertify information that is not current. More information on updating your Survey is available on the [Updating Your ASC Survey webpage](#).

The table below outlines which sections of the 2023 Leapfrog ASC Survey will be scored and publicly reported beginning in July.

Sect #	Measure	Scored and Publicly Reported?
1	Basic Facility Information	
	General Information	Not scored but publicly reported
	Accreditation	
	Transfer Agreements	
	Billing Ethics	Scored and results are publicly reported
	Health Equity	<i>Not scored or publicly reported</i>
2	Medical, Surgical, and Clinical Staff	
	Certified staff present when patients are recovering	Scored and results are publicly reported
	Board certification	Not scored but publicly reported
3	Volume and Safety of Procedures	
	Volume of Procedures	Not scored but publicly reported
	Facility and Surgeon Volume	Scored and results are publicly reported
	Patient Selection	Not scored but publicly reported
	Patient Follow-up	Scored and results are publicly reported

Sect #	Measure	Scored and Publicly Reported?
	Informed Consent	Scored and results are publicly reported
	Safe Surgery Checklist	Scored and results are publicly reported
4	Patient Safety Practices	
	Medication and Allergy Documentation	Scored and results are publicly reported
	NHSN Outpatient Procedure Component Module	Scored and results are publicly reported
	Hand Hygiene	Scored and results are publicly reported
	NQF SP1 – Leadership Structures and Systems	Scored and results are publicly reported
	NQF SP2 – Culture Measurement, Feedback, and Intervention	Scored and results are publicly reported
	NQF SP4 – Risks and Hazards	Scored and results are publicly reported
	Never Events	Scored and results are publicly reported
	Percentage of RNs who are BSN-Prepared	Scored and results are publicly reported
5	Patient Experience (OAS CAHPS)	
	OAS CAHPS	Scored and results are publicly reported

Download a copy of the 2023 Leapfrog ASC Scoring Algorithms on the [Scoring and Results webpage](#).

Pre-Submission Checklist

Before you complete and submit the Survey via the Online ASC Survey Tool, there are several steps you should complete:

- Ensure that your facility is currently performing procedures in one or more of the specialties listed in [Important Notes](#) about the 2023 Leapfrog ASC Survey.**
- Visit the ASC Survey website pages at <http://www.leapfroggroup.org/asc>.**
- Make sure you have a 16-digit security code.** If you don't, download a [Security Code Request](#) form.
- Download a hard copy of the Survey** (PDF or Word document) on the [Survey Materials webpage](#). Read through the [entire Survey document](#) to ensure that you understand what information is required.
- Review the reference information** in each section of the Survey document and **download [other supporting materials](#)**. These documents and tools contain information that you will need to accurately respond to the Survey questions.
- Accept the American Medical Association's Terms of Use and Download the CPT Code Workbook.** ASCs reporting on Section 3A: Volume of Procedures or Section 3B: Facility and Surgeon Volume must accept the American Medical Association's Terms of Use and download the CPT Code Workbook via the button on the [Survey Dashboard](#) in Section 3.
- Join Leapfrog's NHSN Group.** Joining Leapfrog's NHSN Group for ASCs is one of two options for authenticating your facility for the purpose of requesting a security code to access the Online ASC Survey Tool. Additionally, ASCs are required to join Leapfrog's NHSN Group (The Leapfrog Group – ASCs Group ID: 57193) for Leapfrog to download data that we collect in Section 4B: NHSN Outpatient Procedure Component Module. Download the instructions and review information about deadlines on the [Join NHSN Group webpage](#).
- Identify individuals from your ASC to help you** gather the data you will need to complete the various sections of the Survey.
- Complete a hard copy of the Survey before you log in to the Online ASC Survey Tool.** This will expedite the data entry into the Online ASC Survey Tool and help to avoid the Tool "timing out" after 20 minutes of idle time (a security precaution). Once all the information has been collected and recorded in the hard copy of the Survey, the Administrator or the Administrator's designee can typically complete the data entry online in less than an hour. Please note, responses must be entered into the Online Survey Tool to be submitted.
- Download and review a copy of the Online Survey Tool Guide** on the [Get Started webpage](#). This document includes important instructions on how to navigate the Online ASC Survey Tool, including instructions on how to verify your ASC has successfully submitted the Survey.

- Check Survey deadlines.** Carefully review Survey [deadlines](#) before you begin. Ensure that you have enough time to collect the data, complete a hard copy of the Survey, and complete and submit via the Online ASC Survey Tool. Make sure you have joined Leapfrog's NHSN Group by the appropriate [deadline](#).
- Download and review the 2023 Leapfrog ASC Survey [Scoring Algorithms](#).**
- Review Leapfrog's policies and procedures regarding data accuracy.** Detailed information can be found on the [Data Accuracy webpage](#).

The Leapfrog ASC Survey Binder can be used to organize the documentation used to complete the Survey. Download a copy of the binder on the [Survey Materials webpage](#).

Instructions for Submitting a Leapfrog ASC Survey

Important Notes:

Note 1: Please carefully review these instructions and the [Online Survey Tool Guide](#) before you begin.

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

Note 3: Facilities should review and confirm in the ASC Profile that they perform one or more of the procedures currently included on the Leapfrog ASC Survey. Facilities that do not perform one of the included procedures should complete the Profile Section but should not complete a 2023 Survey. Facilities should contact the [Help Desk](#) with questions.

- 1) Log into the [ASC Survey Dashboard](#) using your 16-digit security code.
- 2) The first time you log into the 2023 Leapfrog ASC Survey, you will need to complete and save your facility's Profile. The ASC Profile includes demographic and contact information. The ASC Profile should be updated throughout the year if any information changes. **Failure to maintain current contact information could result in important, time-sensitive information being sent to the wrong person.**
- 3) Once the ASC Profile has been completed and saved, you will be taken to the Online ASC Survey Tool.
- 4) You can navigate to sections of the Online ASC Survey Tool using the links on the ASC Survey Dashboard. More information about navigating within the Online ASC Survey Tool is available in the [Online Survey Tool Guide](#).
- 5) Enter responses to each section. The Online ASC Survey Tool will automatically save your responses as you enter them. There is no 'save' button.
- 6) Once you have completed each section of the Online ASC Survey Tool, you will need to return to the ASC Survey Dashboard to affirm each section of the Survey.
- 7) Before you can select the "submit affirmed sections" button on the ASC Survey Dashboard, you will need to "check for data review warnings." When you select the "check for data review warnings" button, the sections of your Survey that have been affirmed will be scanned for potential reporting errors. If any errors are identified, a data review warning message will be generated and will appear on the ASC Survey Dashboard.
- 8) If any [data review warnings](#) are generated, you will still be able to submit your Survey. However, you will need to address the potential reporting errors identified during the scan or risk having related sections of your Survey decertified. Please note that additional data review warnings may be sent via email.
- 9) Once you have checked for data review warnings, you can select the "submit affirmed sections" button. Remember that all five sections of the Survey must be completed and affirmed before you can submit the Survey.
- 10) Use the "Print Last Submitted Survey" button on the ASC Survey Dashboard to print a copy of your submitted Survey and review it for accuracy and completeness.
- 11) Review the 2023 Leapfrog ASC Survey [Scoring Algorithms](#) to see how your Survey responses will be scored and publicly reported by Leapfrog.
- 12) Review your Survey Results on the [ASC Details Page](#) or [public reporting website](#). Facilities that submit by June 30 can preview their Survey Results on the ASC Details Page beginning July 12, before Leapfrog [publicly reports](#) Survey Results beginning on July 25. After July, the ASC Details

Page and public reporting website will be refreshed monthly within the first five (5) business days of each month following your (re)submission.

- 13) Leapfrog is committed to ensuring the accuracy of Leapfrog ASC Survey responses. Please review our data accuracy protocols on the [Data Accuracy webpage](#).
- 14) Responses can be updated or corrected, and the Survey can be resubmitted at any point during the Survey Cycle (April 1 – November 30). Please remember that if you are making updates, all updated sections must be re-affirmed.

Verifying Survey Submission

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

- **Check the ASC Survey Dashboard:** Refer to the “Section Status” column on the ASC Survey Dashboard. All submitted sections will be marked as “Submitted.”
- **Check your email:** You will receive a survey submission confirmation email within five minutes of submitting a Survey. Please Note: This email will not specify what sections were submitted – you will need to use the other tips to determine which of the sections were submitted.
- **Print Last Submitted Survey:** The Survey submission date will be listed at the top of the page under “Submitted Survey.” Be sure to check the submission date, review each section for accuracy and completeness, and check that each affirmation is complete (Sections 1-5).
- **Review the ASC Details Page:** Your Survey Results will be available on July 12 via the ASC Details Page link on the [ASC Survey Dashboard](#). Carefully review your results.
- **Check your publicly reported results:** Always check your Leapfrog ASC Survey Results on the [public reporting website](#). Results are posted on July 25 and are updated within the first five (5) business days of the month following your submission starting in August.

Updating or Correcting a Previously Submitted Survey

Facilities can update or correct previously submitted Survey responses at any point during the Survey Cycle (April 1 – November 30). Please review the [Deadlines webpage](#). Most updates or corrections are made:

- At the request of Leapfrog:
 - Following Leapfrog’s [Extensive Monthly Data Verification](#), the Primary Survey Contact, Secondary Survey Contact, and Affiliation or Management Company Survey Contact will receive an email from the Help Desk detailing potential reporting errors.
- Following [Virtual On-Site Data Verification](#):
 - Facilities selected for Virtual On-Site Data Verification will receive a report which will indicate any responses that need to be updated or corrected.
- At the discretion of the ASC:
 - To correct a data entry or reporting error.
 - To reflect a change in status or performance on a measure (e.g., stopped performing a procedure or implemented a new policy).
 - To provide more current responses based on the reporting periods outlined in the hard copy of the Survey.

Updating a Survey after Receiving a Help Desk Email

Leapfrog conducts [Extensive Monthly Data Verification](#) of responses submitted to the Leapfrog ASC Survey starting with Surveys submitted by the June 30 Submission Deadline and monthly thereafter until the Online ASC Survey Tool is taken offline on January 31. Following the Extensive Monthly Data Verification, the **Primary Survey Contact, Secondary Survey Contact, and the Affiliation or Management Company Contact** are notified by email of any Survey responses that need to be reviewed and/or updated by the facility.

If you receive a Data Verification email, you are required to document that your original responses were correct or update/correct your previously submitted Leapfrog ASC Survey by the end of the month using the **original** reporting period that was used for that section of the Survey in the original submission. For example, if a facility submitted a Survey for the first time on August 20, 2023, and then received a Data Verification email at the beginning of September, they would update their responses based on the reporting period used in the August 20, 2023 submission.

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

If any Category A Data Verification messages are not resolved by January 31 (when the Online ASC Survey Tool is taken offline), the entire Survey will be decertified, and all measures will be publicly reported as “Declined to Respond.”

Updating a Survey following Virtual On-Site Data Verification

Facilities that are selected for Virtual On-Site Data Verification will receive a findings report. If the findings report details any responses that need to be updated or corrected, please contact the [Help Desk](#).

Making General Updates to the Survey (for ASCs that have not received a Help Desk Email)

Leapfrog offers facilities multiple reporting periods so that they can report the most current data. Except for Section 3C: Patient Follow-up, and Section 4B: NHSN Outpatient Procedure Component Module, updating a Survey is optional. However, we do recommend that if your performance or if a structure has changed significantly, you update your Survey within 30 days. In addition, facilities should update their Surveys if they become aware of any reporting errors or data inaccuracies in their previous submission.

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

General updates and corrections can be made at any point during the Survey Cycle (April 1 – November 30). The months of December and January are reserved for data entry corrections (i.e., correcting data entry errors) or reporting corrections (i.e., in response to Leapfrog’s Extensive Monthly Data Verification) to previously submitted sections of the Survey. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. **Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.**

ASCs that are submitting general updates should:

- Use the stated [reporting period](#) at the top of each section selected based on the date of your resubmission.

For information on Leapfrog's automatic updates to Section 4B: NHSN Outpatient Procedure Component Module or the CMS measures in Section 3C, please review the [Join NHSN Group webpage](#), and the [Section 3C Patient Follow-up Measure Specifications](#).

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

Deadlines

Deadlines for the 2023 Leapfrog ASC Survey

The 2023 Leapfrog ASC Survey opens on April 1 and has a Submission Deadline of **June 30, 2023**. The Late Submission and Performance Update Deadline is **November 30, 2023**. Surveys must be submitted before 11:59 pm Eastern Time on **November 30**.

Corrections to Surveys submitted by **November 30** must be submitted by the **January 31, 2024** Corrections Deadline. The Online ASC Survey Tool will not be available after **January 31, 2024**. Find detailed information about the 2023 Leapfrog ASC Survey Deadlines, including the deadline to be eligible for the 2023 Leapfrog Top ASC Awards, on the [Deadlines webpage](#).

Deadlines to Join Leapfrog's NHSN Group

ASC reporting on Section 4B: NHSN Outpatient Procedure Component Module are required to join Leapfrog's NHSN Group. More information, including instructions and important deadlines, is available on the [Join NHSN Group webpage](#).

Technical Assistance and Support

Help Desk

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

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

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

- **@leapfrog-group.org**
- **@leapfroghelpdesk.zendesk.com**
- **@em8434.leapfrog-group.org**
- **IP address: 159.183.167.150**

You may also create an account with Zendesk and log in there to correspond with the Help Desk.

Orientation and Technical Assistance Calls

Leapfrog offers 1:1 Orientation/Technical Assistance Calls for ASCs throughout the Survey Cycle (April 1 – November 30). To request an orientation or technical assistance call, contact the [Leapfrog Help Desk](#).

Reporting Periods

Important Note: Reporting periods should be selected based on the date of Survey or section submission. If no reporting period is listed (i.e., "N/A"), you should respond to the questions in that section based on the current structure or process your facility has in place at the time of the Survey submission.

	Survey Submitted Prior to September 1	Survey (Re-)Submitted On or After September 1
Survey Section	Reporting Period	Reporting Period
1A Basic Facility Information	12 months ending 12/31/2022	12 months ending 06/30/2023
1B Person-Centered Care: Billing Ethics and Health Equity	N/A	N/A
2 Medical, Surgical, and Clinical Staff	Latest 3 months prior to Survey submission	Latest 3 months prior to Survey submission
3A Volume of Procedures	12 months ending 12/31/2022	12 months ending 06/30/2023
3B Facility and Surgeon Volume	Volume: 12 months or 24 months ending 12/31/2022	Volume: 12 months or 24 months ending 06/30/2023
3C Patient Selection and Patient Follow-up*	Patient Selection: N/A	Patient Selection: N/A
	Patient Follow-up: Latest 24 or 36 months prior to Survey submission	Patient Follow-up: Latest 24 or 36 months prior to Survey submission
3D Informed Consent	N/A	N/A
3E Safe Surgery Checklist	Latest 3 months prior to Survey submission	Latest 3 months prior to Survey submission
4A Medication and Allergy Documentation	12 months ending 12/31/2022	12 months ending 06/30/2023
4B NHSN Outpatient Procedure Component Module**	Latest 6 months prior to Survey submission	Latest 6 months prior to Survey submission
4C Hand Hygiene	N/A	N/A
4D National Quality Forum (NQF) Safe Practices	Latest 12 or 24 months prior to Survey submission (see individual Safe Practice for specific reporting period)	Latest 12 or 24 months prior to Survey submission (see individual Safe Practice for specific reporting period)
4E Never Events	N/A	N/A
4F Nursing Workforce	N/A	N/A
5 Patient Experience (OAS CAHPS)	Latest 12 months prior to Survey submission	Latest 12 months prior to Survey submission

*Facilities reporting on Section 3C: Patient Follow-up are required to provide an accurate CMS Certification Number (CCN) and National Provider Identifier (NPI) in the ASC Profile. Leapfrog will update data 3 times per Survey Cycle for all facilities that have provided an accurate CCN and NPI in the ASC Profile and submitted a 2023 Leapfrog ASC Survey.

**Facilities reporting on Section 4B NHSN Outpatient Procedure Component Module are required to join Leapfrog's NHSN Group for ASCs. More information, including important deadlines, is available on the [Join ASC NHSN Group webpage](#). Leapfrog will download data 4 times per Survey Cycle for all current members of our NHSN Group for ASCs that have provided an accurate NHSN ID in the Profile and submitted a 2023 Leapfrog ASC Survey.

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ASC PROFILE

Facilities must complete and submit an ASC Profile via the Online ASC Survey Tool before accessing the ASC Survey Dashboard for the first time. The Profile is available year-round and should be updated as needed.

ASC Profile

The ASC Profile includes questions about demographic and contact information. The Profile can be accessed and updated anytime throughout the year by logging into the [Online ASC Survey Tool](#) with your facility's security code.

The ASC Profile must be completed and submitted before you can access the Survey Dashboard.

ASC Profile

Important Notes:

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

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

Facility Information

Facility Name	CMS Certification Number (CCN)¹ If the CCN displayed in the Online ASC Survey Tool is not correct, contact the Leapfrog Help Desk immediately.
	Does your facility share this CCN with another facility?
	<input type="checkbox"/> Yes
	<input type="checkbox"/> No
	NHSN ID²
	Federal Tax Identification Number (TIN)³
	National Provider Identifier (NPI)⁴ If the NPI displayed in the Online ASC Survey Tool is not correct, contact the Leapfrog Help Desk immediately.
	Does your facility share this NPI with another facility?
	<input type="checkbox"/> Yes
	<input type="checkbox"/> No

Demographic Information

Physical Address	Mailing Address (used to send important communications)
Street Address	Street Address or P.O. Box
City	City
State	State
Zip Code	Zip Code
Zip Code Suffix	Zip Code Suffix
Main Phone Number	
Facility Website Address⁵	

Contact Information

Administrator	Chairperson of the Board
First Name	First Name
Last Name	Last Name
Title	
Email Address	

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

Public Relations Contact
First Name
Last Name
Phone Number
Phone Number Extension
Email Address

Affiliation or Management Company Information

Is your facility affiliated with a hospital or management company ⁶ ? If so, and you would like to designate a contact who may be organizing Survey submissions for several facilities, select “yes” and complete the fields below. <input type="checkbox"/> Yes <input type="checkbox"/> No	Affiliation/Management Company Public Relations Contact
	Affiliation/Management Company Public Relations Contact First Name

If "yes", provide contact information.	
Name of the Affiliation/ Management Company	Affiliation/Management Company Public Relations Contact Last Name
Affiliation/Management Company Contact First Name	Affiliation/Management Company Public Relations Contact Phone Number
Affiliation/Management Company Contact Last Name	Affiliation/Management Company Public Relations Contact Phone Number Extension
Affiliation/Management Company Contact Email Address	Affiliation/Management Company Public Relations Contact Email Address

Opt-Out Opt-out of having information in the "Contact Information" subsection shared with third parties.	<input type="checkbox"/> Opt-out
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Eligibility

<p>Does your facility currently perform procedures in one or more of the following specialties?</p> <p>Gastroenterology General Surgery Ophthalmology Orthopedics Otolaryngology Urology Neurological Surgery Obstetrics and Gynecology Plastic and Reconstructive Surgery</p>	<p>If "no," which specialties are performed at your facility?</p> <p>Information provided here will inform future versions of the Leapfrog ASC Survey.</p>
<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><i>If "no," then your facility should not complete the Leapfrog ASC Survey. After completing and submitting the Profile, contact the Help Desk with any questions.</i></p>	<p><input type="checkbox"/> Cardiothoracic Surgery <input type="checkbox"/> Oral and Maxillofacial Surgery <input type="checkbox"/> Vascular Surgery <input type="checkbox"/> Podiatry <input type="checkbox"/> Other</p> <p><input type="checkbox"/> If "other," which specialty? _____</p>

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SECTION 1: BASIC FACILITY INFORMATION

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

Section 1: Basic Facility Information

Person-Centered Care: Billing Ethics Fact Sheet and Bibliography:

<https://ratings.leapfroggroup.org/measure/asc/2023/billing-ethics>

Person-Centered Care: Health Equity Bibliography:

<https://ratings.leapfroggroup.org/measure/asc/2023/whats-new-2023>

Section 1 includes questions about your facility's operating and procedure rooms, adult and pediatric patient discharges, teaching status, ownership, accreditation, and transfer agreements. The section also includes questions about two aspects of person-centered care: billing ethics and health equity. In 2023, the health equity questions will continue to not be scored or publicly reported.

Each facility achieving the standard for Billing Ethics:

- 1) Provides EITHER payer-specific negotiated charges or cash prices on their website for commonly performed procedures, **and**
- 2) Provides every patient with a billing statement and/or master itemized bill within 30 days of final claims adjudication that includes all 10 required elements listed in question #3, **and**
- 3) Gives patients instructions for contacting a billing representative with access to an interpretation service to communicate in the patient's preferred language and has the authority to do all three required elements in question #4, **and**
- 4) Does NOT take legal action against patients for late or insufficient payment of a medical bill.

1A: Basic Facility Information

Important Note: This subsection will not be scored but will be used in public reporting (e.g., Leapfrog may display the number of operating and/or procedure rooms on individual ASC Summary Pages).

Reporting Period: 12 months

- Surveys submitted prior to September 1:
 - 01/01/2022 – 12/31/2022
- Surveys (re)submitted on or after September 1:
 - 07/01/2022 – 06/30/2023

Note: As a reminder, the [Corrections Period](#) (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

1) 12-month reporting period used:	01/01/2022 – 12/31/2022 07/01/2022 – 06/30/2023
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General Information

2) Total number of operating rooms ⁷ .	_____
3) Total number of endoscopic procedure rooms ⁸ .	_____
4) Total number of adult patient discharges from your facility during the reporting period.	_____
5) Total number of pediatric patient discharges (17 years of age and younger) from your facility during the reporting period.	_____
6) Does your facility have a formal teaching agreement with a training institution (e.g., academic medical center)?	Yes No
7) Which best describes your facility's ownership status? <i>Select one.</i>	<input type="checkbox"/> Single Physician Owner <input type="checkbox"/> Multiple Physician Owner <input type="checkbox"/> Management Company <input type="checkbox"/> Hospital Owner <input type="checkbox"/> Physician and Management Company Joint Venture <input type="checkbox"/> Physician and Hospital Joint Venture <input type="checkbox"/> Physician and Management Company and Hospital Joint Venture <input type="checkbox"/> Management Company and Hospital Joint Venture

	<input type="checkbox"/> Government <input type="checkbox"/> Other
8) If your facility is wholly or in part owned by physician(s), does the facility have a written policy to ensure disclosure of potential conflicts of interest?	Yes No <i>Not wholly or in part owned by physician(s)</i>

Accreditation

9) Is your facility nationally accredited by one of the following organizations? Select one.	<i>The Accreditation Association for Ambulatory Health Care (AAAHC)</i> <i>The American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF) Healthcare Facilities Accreditation Program (HFAP)</i> <i>Institute for Medical Quality (IMQ)</i> <i>The Joint Commission (TJC)</i> Not nationally accredited Other_____
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Transfer Agreements

10) Does your facility have a written transfer agreement ⁹ with a pediatric or general acute care hospital for patients who require a higher level of care?	Yes No
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Additional Question (Optional – Fact Finding Only)

<p>11) How are environmental services (EVS) and facilities engineering integrated into your ASC's quality and safety structures?</p> <p><i>Select all that apply.</i></p>	<ul style="list-style-type: none"> <input type="checkbox"/> EVS (employed or contracted) reports data and relevant information to the primary point of contact for the ASC's integrated patient safety program (i.e., risk manager) <input type="checkbox"/> Facilities engineering (employed or contracted) reports data and relevant information to the primary point of contact for the ASC's integrated patient safety program (i.e., risk manager) <input type="checkbox"/> Other <input type="checkbox"/> Not applicable; EVS and facilities engineering are not integrated into the ASC's quality and safety structures
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1B: Person-Centered Care: Billing Ethics and Health Equity

Important Notes:

Note 1: Health Equity (questions #8-20) will not be scored or publicly reported.

Note 2: Hyperlinks throughout this subsection refer to the [Person-Centered Care: Billing Ethics and Health Equity FAQs](#) beginning on page 39, not to endnotes. These hyperlinks are not included in the Online Survey Tool.

Reporting Period: Answer questions #1-20 based on the practices currently in place at the time you submit this section of the Survey.

Note: As a reminder, the [Corrections Period](#) (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

Billing Ethics

Price Transparency	
<p>1) What pricing information is displayed on your facility’s website for commonly performed procedures? Select all that apply.</p> <p><i>If “none of the above”, skip question #2 and continue to question #3.</i></p>	<p><input type="checkbox"/> Payer-specific negotiated charges</p> <p><input type="checkbox"/> Cash prices</p> <p><input type="checkbox"/> None of the above</p>
<p>2) Webpage⁵ URL where payer-specific negotiated charges or cash prices are displayed for consumers:</p> <p><i>The http:// prefix needs to be included.</i></p>	<p>_____</p>
Billing Ethics	
<p>3) Within 30 days of the final claims adjudication (or within 30 days from date of service for patients without insurance), does your facility provide every patient, either by mail or electronically, with a billing statement and/or master itemized bill for facility services that includes ALL the following?</p> <ul style="list-style-type: none"> a) Name and address of the facility where billed services occurred b) Date(s) of service c) An individual line item for each service or bundle of services performed d) Description of services billed that accompanies each line item or bundle of services performed e) Amount of any principal, interest, or fees (e.g., late or processing fees), if applicable f) Amount of any adjustments to the bill (e.g., health plan payment or discounts), if applicable g) Amount of any payments already received (from the patient or any other party), if applicable h) Instructions on how to apply for financial assistance 	<p>Yes</p> <p>No</p> <p><i>Only upon request</i></p>

<p>i) Instructions in the patient's preferred language on how to obtain a written translation or oral interpretation of the bill.</p> <p>j) Notification that physician services will be billed separately, if applicable</p> <p><i>If any one of the elements above are only provided upon request, select "Only upon request." If any one of the elements above are not ever provided, select "No."</i></p>	
<p>4) Does your facility give patients instructions for contacting a billing representative with:</p> <ul style="list-style-type: none"> • access to an interpretation service to communicate in the patient's preferred language and • the authority to (a) initiate an investigation into errors on the bill, (b) offer a price adjustment or debt forgiveness based on facility policy, and (c) offer a payment plan within 10 business days of being contacted by the patient or patient representative? <p><i>If "no" to question #4, skip question #6.</i></p>	<p>Yes No</p>
<p>5) Does your facility take legal action against patients for late payment or insufficient payment of a medical bill?</p> <p><i>This question does not include patients with whom your facility has entered into a written agreement specifying a good faith estimate for a medical service.</i></p>	<p>Yes No</p>

Additional Questions (Optional – Fact Finding Only)

<p>6) Based on a quantified analysis of response times, do the billing representatives from question #4 (a) initiate investigations into errors on the bill, (b) offer a price adjustment or debt forgiveness based on facility policy, and (c) offer payment plans within 10 business days at least 95% of the time?</p>	<p>Yes No <i>Not applicable, our facility did not conduct a quantified analysis of response times</i></p>
<p>7) Does your facility notify patients when their outstanding unpaid balance is closed (e.g., due to the facility's charity care program, or the bill having been written off as unrecoverable debt), within 30 days?</p>	<p>Yes No <i>Not applicable, our facility does not close outstanding unpaid balances</i></p>

Health Equity

<p>8) Which of the following patient self-identified demographic data does your facility collect directly from its patients (or patient's legal guardian) prior to or while registering a patient for a facility visit?</p> <p><i>Select all that apply.</i></p> <p><i>If "none of the above," skip the remaining questions in Section 1 and go to the Affirmation of Accuracy.</i></p>	<input type="checkbox"/> Race <input type="checkbox"/> Ethnicity <input type="checkbox"/> Spoken language preferred for healthcare (patient or legal guardian) <input type="checkbox"/> Written language preferred for healthcare (patient or legal guardian) <input type="checkbox"/> Sexual orientation <input type="checkbox"/> Gender identity <input type="checkbox"/> None of the above
<p>9) Which of the following methods does your facility use to collect the demographic data in question #8 directly from patients (or patient's legal guardian)?</p> <p><i>Select all that apply.</i></p>	<input type="checkbox"/> Online Patient Portal <input type="checkbox"/> Paper Registration Forms <input type="checkbox"/> Over the Phone <input type="checkbox"/> At Registration (in-person)
<p>10) Does your facility train staff responsible for registering patients either in-person or over the phone on how to collect self-identified demographic data in question #8 from its patients (or patient's legal guardian) at both:</p> <ul style="list-style-type: none"> • the time of onboarding, and • annually thereafter? 	<p style="text-align: center;">Yes No</p>
<p>11) Does your facility routinely take any of the following steps to ensure the accuracy of the patient self-identified demographic data collected directly from its patients (or patient's legal guardian) in question #8?</p> <p><i>Select all that apply.</i></p>	<input type="checkbox"/> Ensure appropriate data collection fields are available in the online patient portal or paper registration form <input type="checkbox"/> Compare data collected from patient experience surveys with data collected directly from patients by the facility <input type="checkbox"/> Compare data collected with community data provided by state or county or Community Health Needs Assessment (CHNA) <input type="checkbox"/> Compare data collected to census data for the facility's service area <input type="checkbox"/> Other <input type="checkbox"/> None of the above

<p>12) Does your facility use the patient self-identified demographic data it collects directly from patients (or patient's legal guardian) in question #8 to stratify <u>any</u> quality measure(s) with the aim of identifying <u>health care disparities</u>?</p> <p><i>If "no" to question #12, skip questions #13-17, and continue to question #18.</i></p>	<p>Yes No</p>
<p>13) Which type(s) of quality measure(s) does your facility stratify?</p> <p><i>Select all that apply.</i></p>	<p><input type="checkbox"/> Clinical process measures</p> <p><input type="checkbox"/> Clinical outcome measures</p> <p><input type="checkbox"/> OAS CAHPS</p> <p><input type="checkbox"/> Other patient experience measures</p> <p><input type="checkbox"/> Other</p>
<p>14) What types of patient self-identified demographic data selected in question #8 did your facility use to stratify the quality measures selected in question #13?</p> <p><i>Select all that apply based on items that were also selected in question #8.</i></p>	<p><input type="checkbox"/> Race</p> <p><input type="checkbox"/> Ethnicity</p> <p><input type="checkbox"/> Spoken language preferred for healthcare (patient or legal guardian)</p> <p><input type="checkbox"/> Written language preferred for healthcare (patient or legal guardian)</p> <p><input type="checkbox"/> Sexual orientation</p> <p><input type="checkbox"/> Gender identity</p>
<p>15) Prior to using the patient self-identified demographic data selected in question #14 to stratify quality measures, did your facility do any of the following to ensure the quality of the data?</p> <p><i>Select all that apply.</i></p>	<p><input type="checkbox"/> Periodically (e.g., monthly for first six months, and quarterly thereafter) review data set to identify critical issues with data quality</p> <p><input type="checkbox"/> Set targets for missing data (e.g., 10%) to use as a benchmark for performance</p> <p><input type="checkbox"/> Monitor "other" response rates to identify issues with existing data collection categories or methods</p> <p><input type="checkbox"/> Include the data collection team (i.e., registration team) when addressing data quality issues</p> <p><input type="checkbox"/> None of the above</p>
<p>16) By stratifying the measure(s) selected in question #13, has your facility identified any disparities among its patients based on the demographic data selected in question #14?</p> <p><i>If "no, disparities were not identified" or "inadequate data available to</i></p>	<p><i>Yes, disparities were identified</i></p> <p><i>No, disparities were not identified</i></p>

<i>determine if disparities exist,” skip question #17 and continue to question #18.</i>	<i>Inadequate data available to determine if disparities exist</i>
<p>17) In the past 12 months, has your facility used the data and information obtained through question #16 to update or revise its policies or procedures?</p> <p>OR</p> <p>In the past 12 months, has your facility developed a written action plan that describes how it will address at least one of the health care disparities identified through question #16?</p>	<p>Yes No</p>
18) Does your facility share information on its efforts to identify and reduce health care disparities based on <i>race, ethnicity, spoken language preferred for healthcare (patient or legal guardian), written language preferred for healthcare (patient or legal guardian), sexual orientation, or gender identity</i> and the impact of those efforts on its public website?	<p>Yes No</p>
19) Does your facility report out and discuss efforts related to identifying and addressing disparities with your facility’s governance and leadership at least annually?	<p>Yes No</p>
20) Does your facility make unconscious and implicit bias training available to all facility staff?	<p>Yes No</p>

Affirmation of Accuracy

As the administrator of the Ambulatory Surgery Center (ASC) or as an employee of the ASC to whom the ASC administrator has delegated responsibility, I have reviewed this information pertaining to the Basic Facility Information Section at our ASC, and I hereby certify that this information is true, accurate, and reflects the current, normal operating circumstances at our ASC. I am authorized to make this certification on behalf of our ASC.

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

Affirmed by _____, the ASC's _____,
(First Name, Last Name) (Title)

On _____.
(Date)

Section 1: Basic Facility Information Reference Information

What's New in the 2023 Survey

Section 1A: Basic Facility Information

In recognition of the published evidence and guidelines documenting the importance of environmental hygiene on infection prevention, Leapfrog is exploring the development of a new standard around environmental hygiene and will be consulting with experts in advance of the 2024 Leapfrog ASC Survey. Environmental hygiene topics under consideration include cleaning and disinfecting surfaces, air-handling, ventilation, and water quality. For the 2023 Leapfrog ASC Survey, we are adding an optional, fact-finding question to 1A: Basic Facility Information to assess how ASCs are integrating environmental services and facilities engineering into their quality and safety structures.

Section 1B: Person-Centered Care: Billing Ethics

In response to feedback from participating ASCs, an analysis of responses submitted to the 2022 Leapfrog ASC Survey, and feedback from researchers in the field, Leapfrog is making the following updates to Section 1B: Billing Ethics:

- Updating question #3, regarding a master itemized bill, to clarify that facilities must provide instructions on how to obtain a written translation or oral interpretation of the bill in the patient's preferred language.
- Updating question #4, regarding access to billing representatives and timely resolution of billing issues, to give billing representatives 10 days, rather than 5 days, to initiate an investigation into errors on a bill, offer a price adjustment or debt forgiveness based on facility policy, or offer a payment plan. We are also updating question #4 to require that billing representatives have access to a translation service to help communicate information in the patient's preferred language.
- Leapfrog is also adding two optional fact-finding questions regarding additional aspects of facilities' billing practices that will not be used in scoring or public reporting in 2023.

Additionally, we are adding Frequently Asked Questions (FAQs) regarding alternatives to taking legal action against patients and defining a "good faith estimate." There are no changes to the scoring algorithm.

Section 1B: Person-Centered Care: Health Equity

To date, Leapfrog has focused questions in this subsection on the collection of patient self-reported demographic information. Based on feedback from Leapfrog's National Advisory Committee and an analysis of responses submitted to the 2022 Leapfrog ASC Survey, Leapfrog is revising the questions to focus on methods that facilities are using to stratify measures by race, ethnicity, preferred language, sexual orientation, and gender identity. These questions are required, but responses will not be scored or publicly reported in 2023.

Change Summary Since Release

None. If substantive changes are made to this section of the Survey after release on April 1, 2023, they will be documented in this Change Summary section.

Basic Facility Information Frequently Asked Questions (FAQs)

Basic Facility Information

1) How does Leapfrog define an academic medical center?

Leapfrog aligns with The Joint Commission's (TJC) definition of an Academic Medical Center, which states: "An Academic Medical Center is a tertiary care hospital that is organizationally and administratively integrated with a medical school. The hospital is the principal site for the education of both medical students and postgraduate medical trainees from the affiliated medical school; it conducts medical, academic, and/or commercial human subjects research under multiple approved protocols involving patients of the hospital." This definition and more information may be found at <https://www.jointcommissioninternational.org/en/accreditation/accreditation-programs/academic-medical-center/>.

2) Why is Leapfrog still asking about written transfer agreements when they are no longer a CMS requirement for ASCs?

While CMS establishes minimum requirements for the purposes of participation in the Medicare Program, Leapfrog aims to establish national standards that help healthcare consumers identify the safest places to receive care. Healthcare consumers want information on what would happen in the case of an emergency.

Person-Centered Care: Billing Ethics

3) What does Leapfrog mean by "payer-specific negotiated charges?"

The "payer-specific negotiated charge" is the rate that an ASC has negotiated with a third-party payer. Each payer-specific negotiated charge should be clearly associated with the name of the third-party payer if charges differ by payer. Payer-specific negotiated charges are often found in rate sheets. Such rate sheets typically contain a list of common billing codes for items and services provided by the ASC along with the associated payer-specific negotiated charge or rate. This is NOT the "chargemaster" price.

4) What does Leapfrog mean by "cash prices?"

The charge that applies to an individual who pays cash, or cash equivalent, for the procedure. If the facility offers a discounted cash price for any procedure, the facility can list both discounted and undiscounted prices for the procedure (and any corresponding ancillary services).

5) If our facility has a price calculator on our website that lists prices for a specific procedure after a user inputs some parameters to calculate the cost, what should we select?

Select either "cash prices", "payer-specific negotiated charges", or "both", depending on what values your online price calculator outputs.

6) To meet the criteria for item "i" in question #3, does our facility have to translate the billing statement and/or master itemized bill to every language spoken by our patients?

Facilities must provide instructions, in the patient's primary language, on how to obtain a written translation or oral interpretation of the bill if the language constitutes 5% (and at least 50 patients) or 1,000 patients (whichever is less) of the population eligible to be served or likely to be encountered.

7) If our facility does not offer financial assistance, price adjustments, debt forgiveness, or payment plans as described in questions #1 and #4, how can we provide information to patients about these in the billing statement or via the billing statement?

If your facility does not offer financial assistance, price adjustments, debt forgiveness, or payment plans, then the elements of questions #1 and #4 that refer to these items do not apply to your facility. For example, if your facility does not offer price adjustments, item (b) in question #4 that refers to price adjustments does not need to be under the authority of your billing representatives to offer.

8) What does Leapfrog mean by “legal action” in question #5?

Legal action can include, but is not limited to, a lawsuit, wage garnishment, filing to take a patient’s money out of their tax return, seizing or placing a lien on a patient’s personal property, and selling or transferring a patient’s debt to a debt collection agency that will take legal action against the patient. If the debt collection agency is prevented from taking legal action against patients by their contract with the facility, selling or transferring a patient’s debt to that debt collection agency would not be considered legal action.

Patients with whom your facility has entered into a written agreement specifying a good faith estimate for a medical service would not be included in this question. A patient’s insurance being accepted by the facility, or publicly available prices for a procedure, do NOT constitute a written agreement specifying a set price for a procedure.

In addition, other legal proceedings where patients may be named as defendants for causes other than late or non-payment of a medical bill are not included in this standard (e.g., filing a lien after an auto accident, or misappropriation of an insurance reimbursement).

9) What are alternatives to legal action against patients?

To ensure that patients are not being pursued when they no longer have the means to pay, some healthcare providers partner with nonprofits such as RIP Medical Debt, a nonprofit that uses philanthropically raised funds to acquire bad debt from health systems solely for the purpose of debt relief. They use credit analytics to locate patients with financial hardship and help notify the patient that the debt is abolished. Facilities can contact RIP Medical Debt here:

<https://ripmedicaldebt.org/hospitals/>.

10) What is a “good faith estimate” as referred to in question #5?

A good faith estimate includes an itemized list of expected charges for the primary item or service the patient will receive, and any other items or services provided as part of the same scheduled episode of care. The final bill must be no more than \$400 over the amount of the good faith estimate. The Centers for Medicare and Medicaid Services have published an example template for providing good faith estimates: <https://www.cms.gov/files/document/good-faith-estimate-example.pdf>.

11) What procedure should we follow to conduct the quantified analysis of response times for billing representatives as described in question #6?

Although this question is not scored or publicly reported this year, Leapfrog has identified preliminary parameters for conducting the audit of response times. First, a minimum of 30 patient contacts with the facility billing department should be evaluated against the standard. Facilities can begin logging patient contacts (either by phone or email) with the billing department until at least 30 contacts from patients have been identified. Exclude patient contacts that are unrelated to errors on the bill, or where the patient is not asking for a payment plan or a price adjustment or debt forgiveness. Also

exclude contacts where the patient was determined to be ineligible for any price adjustment or payment plan, or if the patient withdrew their request. To calculate whether the timeframe was met, count the number of business days in between when the patient first contacted the billing department, and when an investigation was initiated into errors on the bill, or when a payment plan, price adjustment, or debt forgiveness was first offered to the patient, as applicable. If the interval is under 10 days, the billing representative met the required timeframe.

Person-Centered Care: Health Equity

12) Our facility is just starting to explore the collection and use of demographic data. What are some resources or tools we can use to collect demographic data?

Facilities that are starting their data collection journey can refer to the Toronto Measuring Health Equity [website](#) which includes training videos, manuals and presentations on how to collect demographic data from patients, including the modeling of interactions between health-care staff and patients. Additional resources such as scripting for staff and addressing patient concerns can be found here: <https://ifdhe.aha.org/hretdisparities/how-use-hret-disparities-toolkit>.

13) What types of demographic data should facilities be collecting?

Regarding patient self-identified race and ethnicity, at a minimum, facilities should collect ethnic and racial categories as outlined by the Office of Management and Budget (OMB) in their Standards for the Classification of Federal Data on Race and Ethnicity. Ethnic categories include Hispanic or Other Latino. Racial categories include American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, and White. If your facility has their own categories that go above and beyond OMB classifications, you can still answer question #8.

In addition, the race and ethnic categories should be presented as separate questions, and patients should be able to select multiple racial categories. More information is available at <https://www.govinfo.gov/content/pkg/FR-1997-10-30/pdf/97-28653.pdf>.

Regarding patient self-identified gender identity and sexual orientation, the Centers for Disease Control and Prevention has issued helpful guidance for providers and facilities, including a list of questions that can be asked at registration. More information is available at <https://www.cdc.gov/hiv/clinicians/transforming-health/health-care-providers/collecting-sexual-orientation.html>.

14) To select any of the patient self-identified demographic data in question #8, does a facility need to collect the data in a particular way?

To select patient self-identified data in question #8, facilities should be collecting the data directly from the patient or, for pediatric and other patients who cannot communicate the information themselves, the legal guardian present. Patients or their legal guardians should have the opportunity to provide the information either verbally (in-person or over the phone) or via a paper form or online portal. Information should NOT be collected through observation or other documents (i.e., state issue ID).

15) Does Leapfrog have a definition of sexual orientation or an example of what needs to be reflected in the data to select “sexual orientation” in question #8?

If your facility does not have an established set of questions to use to collect patient self-identified sexual orientation information at registration or during the visit, we would recommend that you refer to information on the CDC’s webpage – Collecting Sexual Orientation and Gender Identity Information at <https://www.cdc.gov/hiv/clinicians/transforming-health/health-care-providers/collecting-sexual-orientation.html>.

This webpage includes a list of questions that can be asked to obtain the information, and some helpful tips on collecting and using the data you collect.

16) What are some ways in which facilities can ensure the accuracy of the demographic data they collect from patients?

One method to ensure accuracy of demographic data is to compare a patient's self-reported demographic information in the "About You" of OAS CAHPS to the patient's demographic data collected by the facility (e.g., via online patient portal or paper forms). Facilities that offer patients self-check-in available through "kiosks" can ask the patient to confirm their demographic data and offer the opportunity to update it. In addition, CAHPS vendors such as Press Ganey offer free tools and resources to their clients. More information is available at <https://info.pressganey.com/cahps-regulatory>.

17) How does Leapfrog define "health care disparities"?

Leapfrog defines health care disparities as differences in the quality of health care that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention. More information is available at <http://www.ihl.org/communities/blogs/making-sense-of-health-equity-terminology#:~:text=Health%20care%20disparity%3A%20%E2%80%9CRacial%20or,by%20the%20Institute%20of%20Medicine>.

18) In question #16, what does Leapfrog mean by "inadequate data available to determine if disparities exist"?

Facilities may find that they cannot determine if a health care disparity exists due to small sample sizes (i.e., fewer than 25 patients able to be measured) or not enough additional data such as data on income or education.

19) Can we report on network level data in question #16 if we do not have adequate data to determine if disparities exist?

Yes, individual facilities that do not have enough data to identify disparities among their patients based on the demographic data selected in question #14, can answer "yes" to question #16 if they are aggregating their data for the purposes of analysis with other facilities that are part of their affiliation or management company.

20) In question #18, is Leapfrog asking whether our facility is publicly reporting the measures we stratify in question #13 on our website?

No. We are trying to assess the extent to which facilities are sharing any information on their efforts to identify and reduce health care disparities (based on race, ethnicity, spoken language preferred for healthcare (patient or legal guardian), written language preferred for healthcare (patient or legal guardian), sexual orientation, and gender identity) and the impact of those efforts. This may take the form of sharing quantitative or qualitative data. It may also include a description of types of demographic data collected and the analysis performed, which in some cases demonstrated no apparent health care disparities.

21) What does Leapfrog mean by unconscious and implicit bias training in question #20?

Unconscious or implicit bias is generally understood to mean the unintentional and unconscious bias in your behaviors, attitudes or beliefs towards a group of people. More specifically, implicit or unconscious bias is defined as "the bias in judgment and/or behavior that results from subtle cognitive processes (e.g., implicit attitudes and implicit stereotypes) that often operate at a level below conscious awareness and without intentional control", as defined in [Achieving Health Equity: A guide for Health Care Organizations](#). Your facility should offer some form of training to staff that addresses an implicit bias such as race, gender, sexual orientation, or gender identity.

22) Can we answer “yes” to question #20 even if unconscious and implicit bias training isn’t mandatory for all facility staff?

Yes. Leapfrog is not asking if facilities require unconscious and implicit bias training. Facilities should, however, provide staff with an opportunity or option to take unconscious and implicit bias training.

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SECTION 2: MEDICAL, SURGICAL, AND CLINICAL STAFF

This section includes questions and reference information for Section 2: Medical, Surgical, and Clinical Staff. Please carefully review the questions, endnotes, and reference information (e.g., measure specifications, notes, and frequently asked questions) before you begin. Failure to review the reference information could result in inaccurate responses.

Section 2: Medical, Surgical, and Clinical Staff

Outpatient Procedures Fact Sheet and Bibliography:

<https://ratings.leapfroggroup.org/measure/asc/asc-survey-measures>

Section 2 includes questions about your facility's medical, surgical, and clinical staff, including ACLS and PALS certification, and board certification.

Each facility achieving the standard for Medical, Surgical, and Clinical Staff:

1) For adult patients:

- a. Has an ACLS certified clinician, plus a second clinician, present at all times and immediately available in the building while adult patients are present in the facility; and
- b. Has a physician or CRNA present at all times and immediately available in the building until all adult patients are physically discharged from the facility

For pediatric patients:

- a. Has a PALS certified clinician, plus a second clinician, present at all times and immediately available in the building while pediatric patients are present in the facility; and
- b. Has a physician or CRNA present at all times and immediately available in the building until all pediatric patients are physically discharged from the facility

Download the 2023 Leapfrog ASC Survey Scoring Algorithms on the [Scoring and Results webpage](#).

2: Medical, Surgical, and Clinical Staff

Reporting Period: Answer questions #1-5 based on the staffing structure currently in place at the time that you submit this section of the Survey. The staffing structure should have been in place for at least the past 3 months and reflect the ordinary staffing structure for the facility.

Note: As a reminder, the [Corrections Period](#) (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

<p>1) Is there an Advanced Cardiovascular Life Support (ACLS) trained clinician¹⁰, as well as a second clinician¹⁰ (regardless of ACLS training), present at all times and immediately available in the building while an adult patient (13 years and older) is present in the facility?</p> <p><i>Facilities that did not perform any applicable procedures on patients 13 years and older during the reporting period should select “not applicable; pediatric patients only,” skip question #2, and continue to question #3. These facilities will be scored as “Does Not Apply”.</i></p>	<p>Yes No Not applicable; pediatric patients only</p>
<p>2) Is there a physician or CRNA present at all times and immediately available in the building until all adult patients (13 years and older) are physically discharged from the facility?</p> <p><i>Facilities that have a physician or CRNA serving as their ACLS trained clinician in question #1 may respond “yes” to question #2 if the physician/CRNA is present until all adult patients are physically discharged from the facility.</i></p>	<p>Yes No</p>
<p>3) Is there a Pediatric Advanced Life Support (PALS) trained clinician¹⁰, as well as a second clinician¹⁰ (regardless of PALS training), present at all times and immediately available in the building while a pediatric patient (infant through 12 years) is present in the facility?</p> <p><i>Facilities that did not perform any applicable procedures on pediatric patients (infant through 12 years) during the reporting period should select “not applicable; adult patients only,” skip question #4, and continue to question #5. These facilities will be scored as “Does Not Apply”.</i></p>	<p>Yes No Not applicable; adult patients only</p>
<p>4) Is there a physician or CRNA present at all times and immediately available in the building until all pediatric patients (infant through 12 years) are physically discharged from the facility?</p>	<p>Yes No</p>

<p><i>Facilities that have a physician or CRNA serving as their PALS trained clinician in question #3 may respond “yes” to question #4 if the physician/CRNA is present until all pediatric patients are physically discharged from the facility.</i></p>	
<p>5) To help ensure that patients are cared for by well-trained physicians and anesthesia providers (e.g., anesthesiologists and certified registered nurse anesthetists), do your medical staff by-laws or facility-wide policies require all physicians and anesthesia providers who have privileges to provide care at your facility to be board certified or board eligible?</p>	<p>Yes No</p>

Section 2: Medical, Surgical, and Clinical Staff Reference Information***What's New in the 2023 Survey***

Leapfrog is removing questions #5 and #6, which asked for the percent of physicians and anesthesia professionals that are board certified or board eligible. We are replacing these two questions with a single yes/no question asking whether an ASC's medical staff by-laws or facility-wide policies require all physicians and anesthesia providers to be board certified or board eligible. This question will not be scored but will be publicly reported.

Change Summary Since Release

None. If substantive changes are made to this section of the Survey after release on April 1, 2023, they will be documented in this Change Summary section.

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

1) How does Leapfrog define “immediately available” as it pertains to ACLS and/or PALS trained clinicians?

“Immediately available” is defined as being physically present in the facility and not engaged in an activity or procedure that cannot be interrupted if hands-on intervention is needed for a patient.

2) If an ASC did not perform any pediatric procedures during the reporting period selected in Section 3, should they still report on PALS trained clinicians in Section 2 questions #3-4?

No. If your facility did not report any pediatric discharges for the procedures listed in Section 3 during the reporting period, then you should select “not applicable; adult patients only” in question #3.

3) Is the PEARS certification the equivalent of PALS certification for the purposes of responding to question #3?

No. PEARS is not the equivalent of or substitution for PALS certification. The PEARS curriculum is focused on recognition of and steps to mitigate pediatric respiratory emergencies, whereas the PALS curriculum informs clinicians how to manage these emergencies, with emphasis on leadership of the care team, and how to perform key air management techniques. Additionally, the PALS curriculum instructs providers on multiple ways to obtain IV access to improve circulatory issues.

4) If a pediatric ASC has clinicians trained in PALS, but a small percentage of the patient population is over 13, should these clinicians also have ACLS training or would the PALS training be sufficient?

If your facility is performing procedures on both adult and pediatric patients, there should be at least one clinician with ACLS training when adult patients (13 years and older) are recovering and one clinician with PALS training when pediatric patients (infant to 12 years) are recovering. This could mean that some clinicians maintain both certifications or some maintain ACLS and others maintain PALS.

5) How does Leapfrog define board certified and board eligible?

For physicians:

- **Board certified** means that the physician has been awarded certification from the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA).
- **Board eligible** indicates that the physician has completed their initial training/fellowship but has not yet passed an existing board-certifying exam in a specialty. Leapfrog adheres to the ABMS and AOA Board Eligibility Policies for all specialties, which may be reviewed at <https://www.abms.org/wp-content/uploads/2020/10/abms-board-eligibility-faq-rev-may-2020-abms-org.pdf> and <https://certification.osteopathic.org/about/>, respectively. These eligibility periods provide the physician with an adequate window to take the boards and re-take if necessary.

For CRNAs:

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

Section 2 question #5 is only referring to CRNAs that are board certified, as board eligible CRNAs are not licensed and are not yet able to provide clinical care in facilities.

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SECTION 3: VOLUME AND SAFETY OF PROCEDURES

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

Section 3: Volume and Safety of Procedures

Outpatient Procedures Fact Sheet and Bibliography:

<https://ratings.leapfroggroup.org/measure/asc/asc-survey-measures>

Facility and Surgeon Volume Fact Sheet and Bibliography:

<https://ratings.leapfroggroup.org/measure/asc/2023/total-joint-replacement>

Informed Consent Fact Sheet and Bibliography:

<https://ratings.leapfroggroup.org/measure/asc/2023/informed-consent>

Section 3 includes questions about your facility's volume of adult and pediatric procedures, patient selection, and use of a safe surgery checklist. Questions about facility volume and surgeon privileging for total hip replacements and total knee replacements will continue to be scored and publicly reported. In 2023, a new set of questions on facility and surgeon volume of bariatric surgery for weight loss was added. These questions will not be scored or publicly reported in 2023. Two new CMS outcome measures (Hospital Visits After Orthopedic Ambulatory Surgical Center Procedures, and Hospital Visits After Urology Ambulatory Surgical Center Procedures) were also added and will be scored and publicly reported. The questions about informed consent (Section 3D) will be scored and publicly reported.

ASCs will not be able to access Section 3 until the American Medical Association's Terms of Use are completed via the CPT Code Workbook button on the Survey Dashboard, and the appropriate CPT Code Workbook is downloaded.

Each facility achieving the Facility and Surgeon Volume standard for Total Hip Replacement and/or Total Knee Replacement:

- 1) Meets the minimum facility volume standard for each applicable procedure; and
- 2) The facility's process for privileging surgeons includes meeting or exceeding the minimum annual surgeon volume standard for each applicable procedure.

Each facility achieving the Patient Follow-up standard (ASC-12, ASC-17, and ASC-18):

- 1) Provided an accurate CCN and NPI in the Profile Section, reported volume for adult lower gastrointestinal endoscopy procedures in Section 3A, and is in the top quartile of performance on the CMS measure ASC-12, Rate of Unplanned Hospital Visits After Colonoscopy based on responses to the 2022 Leapfrog ASC Survey and Section 10 of the 2022 Leapfrog Hospital Survey (OP-32) submitted by June 30, 2022.
- 2) Provided an accurate CCN and NPI in the Profile Section, reported volume for adult orthopedic procedures in Section 3A and/or 3B, and is in the top quartile of performance on the CMS measure ASC-17, Hospital Visits After Orthopedic Ambulatory Surgical Center Procedures based on scores published by CMS as of June 30, 2023.
- 3) Provided an accurate CCN and NPI in the Profile Section, reported volume for adult urology procedures in Section 3A, and is in the top quartile of performance on the CMS measure ASC-18, Hospital Visits After Urology Ambulatory Surgical Center Procedures based on scores published by CMS as of June 30, 2023.

Each facility achieving the standard for Informed Consent:

- 1) Has a training program on informed consent that tailors different training topics to different staff roles and has made the training required for newly hired staff and existing staff who were not trained, **and**

- 2) Ensures that as part of the process for obtaining informed consent, clinicians explain expected difficulties, recovery time, pain management, and restrictions after a test, treatment, or procedure, and give the patient an opportunity to ask questions, **and**
- 3) Ensures every consent form used by the facility includes the name of the clinician performing the test, treatment, or procedure, whether the clinician is expected to be absent, and whether any assistants or trainees will be involved, **and**
- 4) Ensures every consent form is written at a 6th grade reading level or lower, **and**
- 5) Prior to conducting the informed consent discussion, identifies the patient/legal guardian's preferred language and provides a medical interpreter, and has a place in the consent form or electronic medical record that indicates whether an interpreter was used, **and**
- 6) Requires clinicians at the facility to use the “teach back method” with patients/legal guardians.

Each facility achieving the Safe Surgery Checklist standard:

- 1) Uses a safe surgery checklist on **all** patients undergoing an applicable procedure (reported on in Sections 3A and 3B, if applicable) that includes **all** safe surgery checklist elements; and
- 2) Verbalizes **all** safe surgery checklist elements in the presence of the appropriate personnel; and
- 3) Completes an audit of at least 30 patients to document adherence to the checklist; and
- 4) Has documented adherence to the checklist for at least 90% of the patients included in the audit.

Download the 2023 Leapfrog ASC Survey Scoring Algorithms on the [Scoring and Results webpage](#).

3A: Volume of Procedures

Important Notes:

Note 1: In order to access this section in the [Online Survey Tool](#), facilities must complete the American Medical Association's Terms of Use via the CPT Code Workbook button next to Section 3 on the [Survey Dashboard](#) and download the appropriate CPT Code Workbook. Instructions for downloading the CPT Code Workbook are available in the [Volume of Procedures Measure Specifications](#). Each facility must complete these steps even if they are part of a network.

Note 2: This subsection (questions #2-19) will not be scored but will be used in public reporting to inform purchasers and consumers about the facility's experience with the procedure. Additionally, this information will be used to facilitate the search functionality on Leapfrog's [public reporting website](#) (e.g., allowing users to search for facilities that perform the procedure they need).

Specifications: See [Volume of Procedures Measure Specifications](#) in the Reference Information beginning on page 75.

Reporting Period: 12 months

- Surveys submitted prior to September 1:
 - 01/01/2022 – 12/31/2022
- Surveys (re)submitted on or after September 1:
 - 07/01/2022 – 06/30/2023

Note: As a reminder, the [Corrections Period](#) (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

1) 12-month reporting period used:	01/01/2022 – 12/31/2022 07/01/2022 – 06/30/2023
2) During the reporting period, were one or more of the following gastroenterology procedures performed at your facility on <u>adult</u> or <u>pediatric</u> patients: <ul style="list-style-type: none"> • Upper GI endoscopy • Other upper GI procedures • Lower GI endoscopy <p><i>If "no" or "yes, but no longer performs these procedures," skip question #11 below.</i></p>	<p style="text-align: center;">Yes Yes, but no longer performs these procedures No</p>
3) During the reporting period, were one or more of the following general surgery procedures performed at your facility on <u>adult</u> or <u>pediatric</u> patients: <ul style="list-style-type: none"> • Cholecystectomy and common duct exploration • Hemorrhoid procedures • Inguinal and femoral hernia repair • Other hernia repair 	<p style="text-align: center;">Yes Yes, but no longer performs these procedures No</p>

<ul style="list-style-type: none"> • Laparoscopy • Lumpectomy or quadrantectomy of breast • Mastectomy <p><i>If “no” or “yes, but no longer performs these procedures,” skip question #12 below.</i></p>	
<p>4) During the reporting period, were one or more of the following ophthalmology procedures performed at your facility on <u>adult</u> or <u>pediatric</u> patients:</p> <ul style="list-style-type: none"> • Anterior segment eye procedures • Posterior segment eye procedures • Ocular adnexa and other eye procedures <p><i>If “no” or “yes, but no longer performs these procedures,” skip question #13 below.</i></p>	<p style="text-align: center;">Yes Yes, but no longer performs these procedures No</p>
<p>5) During the reporting period, were one or more of the following orthopedic procedures performed at your facility on <u>adult</u> or <u>pediatric</u> patients:</p> <ul style="list-style-type: none"> • Finger, hand, wrist, forearm, and elbow procedures • Shoulder procedures • Spine procedures • Hip procedures • Knee procedures • Toe, foot, ankle, and leg procedures • General orthopedic procedures <p><i>If “no” or “yes, but no longer performs these procedures,” skip question #14 below.</i></p>	<p style="text-align: center;">Yes Yes, but no longer performs these procedures No</p>
<p>6) During the reporting period, were one or more of the following otolaryngology procedures performed at your facility on <u>adult</u> or <u>pediatric</u> patients:</p> <ul style="list-style-type: none"> • Ear procedures • Mouth procedures • Nasal/sinus procedures • Pharynx/adenoid/tonsil procedures <p><i>If “no” or “yes, but no longer performs these procedures,” skip question #15 below.</i></p>	<p style="text-align: center;">Yes Yes, but no longer performs these procedures No</p>
<p>7) During the reporting period, were one or more of the following urology procedures performed at your facility on <u>adult</u> patients:</p> <ul style="list-style-type: none"> • Circumcision • Cystourethroscopy • Male genital procedures • Urethra procedures 	<p style="text-align: center;">Yes Yes, but no longer performs these procedures No</p>

<ul style="list-style-type: none"> Vaginal repair procedures <p><i>If “no” or “yes, but no longer performs these procedures,” skip question #16 below.</i></p>	
<p>8) During the reporting period, was the following neurological surgery procedure performed at your facility on <u>adult</u> patients:</p> <ul style="list-style-type: none"> Spinal fusion procedures <p><i>If “no” or “yes, but no longer performs this procedure,” skip question #17 below.</i></p>	<p>Yes Yes, but no longer performs this procedure No</p>
<p>9) During the reporting period, were one or more of the following obstetrics and gynecology procedures performed at your facility on <u>adult</u> patients:</p> <ul style="list-style-type: none"> Cervix procedures Hysteroscopy Uterus and adnexa laparoscopies <p><i>If “no” or “yes, but no longer performs these procedures,” skip question #18 below.</i></p>	<p>Yes Yes, but no longer performs these procedures No</p>
<p>10) During the reporting period, were one or more of the following plastic and reconstructive surgery procedures performed at your facility on <u>adult</u> patients:</p> <ul style="list-style-type: none"> Breast repair or reconstruction Skin graft/reconstruction procedures <p><i>If “no” or “yes, but no longer performs these procedures,” skip question #19 below.</i></p>	<p>Yes Yes, but no longer performs these procedures No</p>

Gastroenterology

<p>11) Total adult and/or pediatric volume for each of the following applicable procedures performed at your facility during the reporting period.</p> <p><i>You cannot leave any blank. If you did not perform one or more of the procedures listed below enter 0 (zero). If you had zero volume for all procedures, go back to question #2 and update your response from “yes” to “no.”</i></p>		
	(a) Adult Volume	(b) Pediatric Volume
Upper GI endoscopies	_____	_____
Other upper GI procedures	_____	_____
Lower GI endoscopies	_____	_____

General Surgery

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

*You cannot leave any blank. If you did not perform one or more of the procedures listed below enter 0 (zero). If you had zero volume for **all** procedures, go back to question #3 and update your response from “yes” to “no.”*

	(a) Adult Volume	(b) Pediatric Volume
Cholecystectomies and common duct explorations	_____	
Hemorrhoid procedures	_____	
Inguinal and femoral hernia repairs	_____	_____
Other hernia repairs	_____	_____
Laparoscopies	_____	
Lumpectomies or quadrantectomy of breast procedures	_____	
Mastectomies	_____	

Ophthalmology

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

*You cannot leave any blank. If you did not perform one or more of the procedures listed below enter 0 (zero). If you had zero volume for **all** procedures, go back to question #4 and update your response from “yes” to “no.”*

	(a) Adult Volume	(b) Pediatric Volume
Anterior segment eye procedures	_____	_____
Posterior segment eye procedures	_____	_____
Ocular adnexa and other eye procedures	_____	_____

Orthopedics

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

*You cannot leave any blank. If you did not perform one or more of the procedures listed below enter 0 (zero). If you had zero volume for **all** procedures, go back to question #5 and update your response from “yes” to “no.”*

	(a) Adult Volume	(b) Pediatric Volume
Finger, hand, wrist, forearm, and elbow procedures	_____	_____
Shoulder procedures	_____	_____
Spine procedures	_____	
Hip procedures	_____	
Knee procedures	_____	_____
Toe, foot, ankle, and leg procedures	_____	_____
General orthopedic procedures	_____	_____

Otolaryngology

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

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

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

Urology

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

*You cannot leave any blank. If you did not perform one or more of the procedures listed below enter 0 (zero). If you had zero volume for **all** procedures, go back to question #7 and update your response from “yes” to “no.”*

	(a) Adult Volume	(b) Pediatric Volume

Circumcisions	_____	
Cystourethroscopies	_____	
Male genital procedures	_____	
Urethra procedures	_____	
Vaginal repair procedures	_____	

Neurological Surgery

<p>17) Total adult volume for the following procedure performed at your facility during the reporting period.</p> <p><i>You cannot leave any blank. If you did not perform the procedure listed below, go back to question #8 and update your response from “yes” to “no.”</i></p>		
	(a) Adult Volume	(b) Pediatric Volume
Spinal fusion procedures	_____	

Obstetrics and Gynecology

<p>18) Total adult volume for each of the following applicable procedures performed at your facility during the reporting period.</p> <p><i>You cannot leave any blank. If you did not perform one or more of the procedures listed below enter 0 (zero). If you had zero volume for all procedures, go back to question #9 and update your response from “yes” to “no.”</i></p>		
	(a) Adult Volume	(b) Pediatric Volume
Cervix procedures	_____	
Hysteroscopies	_____	
Uterus and adnexa laparoscopies	_____	

Plastic and Reconstructive Surgery

<p>19) Total adult volume for each of the following applicable procedures performed at your facility during the reporting period.</p> <p><i>You cannot leave any blank. If you did not perform one or more of the procedures listed below enter 0 (zero). If you had zero volume for all procedures, go back to question #10 and update your response from “yes” to “no.”</i></p>		
	(a) Adult Volume	(b) Pediatric Volume
Breast repair or reconstructive procedures	_____	
Skin graft/reconstruction procedures	_____	

3B: Facility and Surgeon Volume

Important Notes:

Note 1: Information for Bariatric Surgery for Weight Loss will not be scored or publicly reported.

Note 2: Information regarding appropriateness criteria for total knee replacement and total hip replacement (questions #5-9) will not be scored, but will be used in public reporting (i.e., Leapfrog will include a statement indicating whether the facility “does” or “does not” have protocols in place to ensure surgeries are only performed on patients that meet defined criteria for the applicable procedures).

Note 3: As described in the [Facility and Surgeon Volume Measure Specifications](#), ASCs must download the appropriate CPT Code Workbook via the CPT Code Workbook button on the [Survey Dashboard](#) prior to answering the questions in this subsection.

Specifications: See [Facility and Surgeon Volume Measure Specifications](#) in the Reference Information beginning on page 82.

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

- Surveys submitted prior to September 1:
 - 01/01/2022 – 12/31/2022 (12-month count)
 - 01/01/2021 – 12/31/2022 (24-month annual average)
- Surveys (re)submitted on or after September 1:
 - 07/01/2022 – 06/30/2023 (12-month count)
 - 07/01/2021 – 06/30/2023 (24-month annual average)

Note: As a reminder, the [Corrections Period](#) (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

1) 12-month or 24-month reporting period used:	01/01/2022 – 12/31/2022 (12-month count) 01/01/2021 – 12/31/2022 (24-month annual average) 07/01/2022 – 06/30/2023 (12-month count) 07/01/2021 – 06/30/2023 (24-month annual average)
2) Check all procedures that your facility performs: <i>If “none of the above,” skip the remaining questions in Section 3B and continue to the next subsection. The facility will be scored as “Does Not Apply.”</i>	<input type="checkbox"/> Total knee replacement <input type="checkbox"/> Total hip replacement <input type="checkbox"/> Bariatric surgery for weight loss <input type="checkbox"/> None of the above

Respond to questions #3-9 based on the procedures selected in question #2.

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

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

<i>Procedure</i>	<i>Facility Volume Standard</i>	<i>Number of Procedures Performed (12-month count or 24-month annual average) Format: Up to one decimal place (e.g., 10.5)</i>
Total knee replacement	50	_____
Total hip replacement	50	_____
Bariatric surgery for weight loss	50	_____

4) Does your facility's privileging process include the surgeon meeting or exceeding the minimum annual surgeon volume standard listed below?

<i>Procedure</i>	<i>Annual Surgeon Volume Standard</i>	
Total knee replacement	25	Yes No
Total hip replacement	25	Yes No
Bariatric surgery for weight loss	20	Yes No

5) Does your facility have appropriateness criteria ¹¹ for <u>any</u> of the following procedures: <i>If "none of the above," skip questions #5b-9 and continue to the next subsection.</i>	<input type="checkbox"/> Total knee replacement <input type="checkbox"/> Total hip replacement <input type="checkbox"/> Bariatric surgery for weight loss <input type="checkbox"/> None of the above
5b) Did your facility do <u>any</u> of the following in developing the appropriateness criteria:	<input type="checkbox"/> Use the latest evidence and clinical guidelines <input type="checkbox"/> Solicit input from employed surgeons, and if applicable, non-employed surgeons <input type="checkbox"/> Incorporate relevant Choosing Wisely lists <input type="checkbox"/> Review, and if appropriate, update the criteria on an annual basis <input type="checkbox"/> None of the above
6) Does your facility have processes or structures in place to promote ongoing adherence to the appropriateness criteria for <u>any</u> of the following procedures:	<input type="checkbox"/> Total knee replacement <input type="checkbox"/> Total hip replacement <input type="checkbox"/> Bariatric surgery for weight loss <input type="checkbox"/> None of the above

7) Does your facility conduct regular retrospective reviews of surgical cases to evaluate the extent to which your appropriateness criteria are met or not met by each surgeon for <u>any</u> of the following procedures:	<input type="checkbox"/> Total knee replacement <input type="checkbox"/> Total hip replacement <input type="checkbox"/> Bariatric surgery for weight loss <input type="checkbox"/> None of the above
8) Does your facility have a process in place for communicating with surgeons, surgical leadership, and administrative leadership when a surgeon's trend or pattern suggests challenges to adhering to your appropriateness criteria and work to understand potential barriers to meeting the criteria for <u>any</u> of the following procedures:	<input type="checkbox"/> Total knee replacement <input type="checkbox"/> Total hip replacement <input type="checkbox"/> Bariatric surgery for weight loss <input type="checkbox"/> None of the above
9) Does your facility report annually to its governance and leadership the findings from the retrospective reviews and plans to improve adherence to the appropriateness criteria for <u>any</u> of the following procedures:	<input type="checkbox"/> Total knee replacement <input type="checkbox"/> Total hip replacement <input type="checkbox"/> Bariatric surgery for weight loss <input type="checkbox"/> None of the above

3C: Patient Selection and Patient Follow-up

Important Note: Patient Selection (questions #1-4) will not be scored, but will be used in public reporting (e.g., Leapfrog will display the components of a facility's patient screening tool on individual ASC Summary Pages).

Specifications: See the [Patient Follow-up Measure Specifications](#) in the Volume and Safety of Procedures Reference Information beginning on page 84.

Reporting Period: Answer questions #1-4 based on the practices currently in place at the time you submit this section of the Survey.

Note: As a reminder, the [Corrections Period](#) (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

Patient Selection

<p>1) Does your facility have a standard, written screening protocol to determine whether a patient's procedure can safely be performed at the facility?</p> <p><i>If "no" to question #1, skip questions #2-4 and continue to question #5.</i></p>	<p style="text-align: center;">Yes No</p>
<p>2) Which of the following components are included in your facility's standard, written screening protocol:</p> <p><i>Select all that apply.</i></p>	<ul style="list-style-type: none"> <input type="checkbox"/> History of difficult intubation <input type="checkbox"/> Difficult airway/aspiration risk <input type="checkbox"/> Body Mass Index (BMI) <input type="checkbox"/> American Society of Anesthesiologists (ASA) Physical Status Classification <input type="checkbox"/> Recent Medical History (within 30 days of scheduled procedure) <input type="checkbox"/> Cognitive Assessment <input type="checkbox"/> Sleep Apnea Assessment <input type="checkbox"/> Availability of transportation following discharge <input type="checkbox"/> Availability of a caregiver following discharge
<p>3) Who completes the standard, written screening protocol to determine whether a patient's procedure can safely be performed at the facility?</p> <p><i>Select all that apply.</i></p>	<ul style="list-style-type: none"> <input type="checkbox"/> Anesthesiologist <input type="checkbox"/> Certified Registered Nurse Anesthetist (CRNA) <input type="checkbox"/> Physician <input type="checkbox"/> Nurse (RN or MSN)

	<input type="checkbox"/> Physician Assistant (PA) <input type="checkbox"/> Nurse Practitioner (NP) <input type="checkbox"/> Other
4) When patients are identified through your facility's screening protocol as high-risk, does an anesthesiologist, certified registered nurse anesthetist, or Medical Director complete an additional medical review to determine whether the patient's procedure can safely be performed at the facility?	<p style="text-align: center;">Yes No</p>

Patient Follow-up

ASC-12: Rate of Unplanned Hospital Visits After an Outpatient Colonoscopy

Reporting Period:

- Most recent 36-month reporting period published by CMS

ASC-17: Hospital Visits After Orthopedic Ambulatory Surgical Center Procedures

Reporting Period:

- Most recent 24-month reporting period published by CMS

ASC-18: Hospital Visits After Urology Ambulatory Surgical Center Procedures

Reporting Period:

- Most recent 24-month reporting period published by CMS

Leapfrog will update data three times per Survey Cycle for facilities that have provided an accurate CCN and NPI in the Profile and submitted a Leapfrog ASC Survey.

Leapfrog obtains data for three CMS Ambulatory Surgical Center Quality Reporting (ASCQR) measures directly from CMS' [website](#):

- ASC-12: Rate of Unplanned Hospital Visits After an Outpatient Colonoscopy
- ASC-17: Hospital Visits After Orthopedic Ambulatory Surgical Center Procedures
- ASC-18: Hospital Visits After Urology Ambulatory Surgical Center Procedures

In order for Leapfrog to obtain the data for each applicable ASCQR measure, facilities must provide a valid CMS Certification Number (CCN) and National Provider Identifier (NPI) in the Profile Section of the Online Survey Tool and submit the Leapfrog ASC Survey.

Facilities that do not perform applicable procedures will be scored and publicly reported as "Does Not Apply." Facilities that do not provide an accurate CCN and NPI in the Profile or do not report applicable data to CMS will be scored and publicly reported as "Unable to Calculate Score." Facilities that do not submit a Leapfrog ASC Survey will be scored and publicly reported as "Declined to Respond."

Please refer to the "[Deadlines and Reporting Periods](#)" table in the [Patient Follow-Up Measure Specifications](#).

3D: Informed Consent

Important Notes:

Note 1: In this subsection, questions regarding the informed consent process and consent forms concern ALL tests, treatments, and procedures for which your facility obtains consent, EXCEPT anesthesia.

Note 2: Hyperlinks throughout this subsection refer to the [Informed Consent FAQs](#) beginning on page 89, not to endnotes. These hyperlinks are not included in the Online Survey Tool.

Reporting Period: Answer questions #1-6 based on the practices currently in place at the time you submit this section of the Survey.

Note: As a reminder, the [Corrections Period](#) (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

Policies and Training

<p>1) Does your facility have a training program on informed consent that tailors different training topics to different staff roles (including facility leaders, MD/NP/PA, nurses and other clinical staff, administrative staff, and interpreters) and has your facility made the training:</p> <ul style="list-style-type: none"> • a required component of onboarding for the appropriate newly hired staff, and • required for the appropriate existing staff who were not previously trained 	<p>Yes No</p>
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Content of Informed Consent Forms

<p>2) As part of your facility's process for obtaining informed consent, does:</p> <ul style="list-style-type: none"> • the clinician explain expected difficulties, recovery time, pain management, and restrictions after a test, treatment, or procedure, in the facility and post-discharge, if applicable, • the patient have the opportunity to ask questions, and • the consent form document that these two elements of the process have taken place? 	<p>Yes No</p>
<p>3) Do ALL of your facility's consent forms include:</p> <ul style="list-style-type: none"> • the name(s) of the clinician(s) performing the test, treatment, or procedure, • whether the clinician is expected to be absent from portions of the test, treatment, or procedure (e.g., opening, closing), and • whether any assistants or trainees will be involved in the test, treatment, or procedure? 	<p>Yes No</p>
<p>4) Are ALL your facility's consent forms written at a 6th grade reading level or lower?</p>	<p><i>Yes, all forms are written at a 6th grade reading level or lower</i></p>

<i>The procedure name and description can be excluded from the reading level assessment.</i>	At least one form is written at a 6th grade reading level or lower No forms are written at a 6th grade reading level or lower
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Process for Gaining Informed Consent

<p>5) Prior to the informed consent discussion, does your facility:</p> <ul style="list-style-type: none"> • ask what the patient/legal guardian’s preferred language for medical decision-making is, • where needed, provide the patient/legal guardian access to a qualified medical interpreter, • use a consent form or notation in the medical record to document whether a qualified medical interpreter was used to conduct the informed consent process, and • have the medical interpreter sign the consent form (either in-person, electronically, or by documenting the use of an interpreter in the medical record)? <p><i>If anyone other than a qualified medical interpreter is ever used to translate (e.g., caregiver or family member), answer “no” to this question.</i></p>	<p>Yes No</p>
<p>6) As part of the informed consent discussion, do clinicians at your facility use the “teach back method” with patients/legal guardians, where patients/legal guardians are asked to describe, in their own words, what they understand will be performed, why it will be performed, and what are the primary risks?</p>	<p>Yes No</p>

Additional Questions (Optional – Fact Finding Only)

<p>7) As part of your facility’s process for obtaining informed consent, does:</p> <ul style="list-style-type: none"> • the clinician explain all the patient’s test or treatment choices (including the choice of declining to go through with the test, treatment, or procedure), including the severity and probability of the risks and benefits of each choice, if applicable, and • the patient have the opportunity to ask questions, and • the consent form document that these two elements of the process have taken place? 	<p>Yes No</p>
<p>8) As part of your facility’s process for obtaining informed consent, does:</p> <ul style="list-style-type: none"> • the clinician explain the clinical rationale (i.e., condition-specific justification) for why the test, treatment, or procedure is being performed, • the patient have the opportunity to ask questions, and • the consent form document that these two elements of the process have taken place? 	<p>Yes No</p>

9) Which clinician is responsible for conducting the informed consent process at your facility?	<p><i>The clinician primarily responsible for performing the procedure</i></p> <p><i>Another clinician on the procedure team</i></p> <p><i>A clinician not involved with performing the procedure</i></p> <p><i>Other</i></p>
10) As part of the informed consent discussion, do clinicians at your facility tell patients/legal guardians how many times a year, on average, they perform the test, treatment, or procedure?	<p>Yes</p> <p>No</p>
11) For tests, treatments, and procedures that are scheduled a week (i.e., seven calendar days) or more in advance, is the consent form shared with the patient at least three calendar days before the patient's test, treatment, or procedure?	<p>Yes</p> <p>No</p>
12) For tests, treatments, and procedures that are scheduled a week (i.e., seven calendar days) or more in advance, do clinicians discuss the consent form with the patient/legal guardian at least one calendar day before the patient's test, treatment, or procedure, and is the patient/legal guardian provided with an opportunity to ask questions?	<p>Yes</p> <p>No</p>
13) At least once a year, does your facility solicit feedback from patients/legal guardians about your facility's informed consent process to understand how it can be improved over time?	<p>Yes</p> <p>No</p>
14) At least once a year, does your facility complete an audit of the informed consent process to evaluate its efficacy and provide feedback to staff on opportunities for improvement?	<p>Yes</p> <p>No</p>

3E: Safe Surgery Checklist for Adult and Pediatric Outpatient Procedures

Important Notes:

Note 1: The elements required for each stage of the safe surgery checklist in the questions below are adapted from the [WHO Surgical Safety Checklist](#) and the [AHRQ Endoscopy Checklist](#).

Note 2: Hyperlinks throughout this subsection refer to the [Safe Surgery Checklist for Adult and Pediatric Outpatient Procedures FAQs](#) beginning on page 91, not to endnotes. These hyperlinks are not included in the Online Survey Tool

Specifications: See the [Safe Surgery Checklist for Adult and Pediatric Outpatient Procedures Measure Specifications](#) in the Volume and Safety of Procedures Reference Information beginning on page 85.

Reporting Period: 3 months

Answer questions #1-8 for the latest 3-month period prior to submission of this section of the Survey.

Note: As a reminder, the [Corrections Period](#) (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

Sufficient Sample: See [Safe Surgery Checklist for Adult and Pediatric Outpatient Procedures Measure Specifications](#) for instructions on identifying a sufficient sample for question #6.

1) What is the latest 3-month reporting period for which your facility is submitting responses to questions #2-8? 3-month reporting period ending:	<hr/> <i>Format: Month/Year</i>
2) Does your facility utilize a safe surgery checklist on <u>every</u> patient <u>every</u> time one of the applicable procedures in Section 3A and 3B (if applicable) is performed? <i>If “no” to question #2, skip the remaining questions in Section 3E and go to the Affirmation of Accuracy. The facility will be scored as “Limited Achievement.”</i>	Yes No
3) Before the induction of anesthesia , is a safe surgery checklist that includes <u>all</u> the following elements <u>read aloud</u> in the presence of the <u>anesthesia professional and nursing personnel</u> : <ul style="list-style-type: none"> • Patient ID • Confirmation of procedure • Patient consent • Site marked, if applicable • Anesthesia/medication check • Allergies assessed • Difficult airway/aspiration risk • Risk of blood loss, (only applicable risk of blood loss is >500ml for adults or >7ml/kg for children) • Availability of devices on-site, if applicable? 	Yes No

<p>4) Before the skin incision and/or before the procedure begins, is a safe surgery checklist that includes <u>all</u> the following elements <u>read aloud</u> in the presence of the <u>whole surgical team</u>:</p> <ul style="list-style-type: none"> • Clinical team introduction • Confirmation of patient name, procedure, and, if applicable, surgical/incision site • Antibiotic prophylaxis, if applicable • Anticipated Critical Events (i.e., non-routine steps, length of procedure, blood loss, patient-specific concerns, sterility) • Equipment check/concerns • Essential imaging available, if applicable 	<p>Yes No</p>
<p>5) Before the patient leaves the operating room and/or procedure room, is a safe surgery checklist that includes <u>all</u> the following elements <u>read aloud</u> in the presence of the <u>whole surgical team</u>:</p> <ul style="list-style-type: none"> • Confirmation of procedure performed • Instrument/supply counts, if applicable • Specimen labeling, if applicable • Equipment concerns • Patient recovery/management concerns? 	<p>Yes No</p>

If “no” to question #3, #4, or #5, skip the remaining questions in Section 3E, and go to the Affirmation of Accuracy. The facility will be scored as “Limited Achievement.”

<p>6) Did your facility perform an audit (either in-person or via the medical record or other EHR data) on at least 30 cases of patients who underwent a procedure included in Section 3A and 3B, if applicable and measure adherence to the safe surgery checklist?</p> <p><i>If “no” to question #6, skip the remaining questions in Section 3E and go to the Affirmation of Accuracy. The facility will be scored as “Limited Achievement.”</i></p>	<p>Yes No</p>
<p>7) Which method was used to perform the audit on at least 30 cases of patients who underwent a procedure in Section 3A and 3B?</p>	<p><i>In-person observational audit</i> <i>Retrospective audit of medical records or EHR data</i> <i>Both</i></p>
<p>8) Based on your facility’s audit (either in-person or via the medical record or other EHR data) on at least 30 cases of patients who underwent an applicable procedure included in Section 3A and 3B, what was your facility’s documented rate of adherence to the safe surgery checklist (e.g., what percentage of the sampled cases had all elements in questions #3, #4, and #5 completed)?</p>	<p>90%-100% 75%-89% 50%-74% Less than 50%</p>

Affirmation of Accuracy

As the administrator of the Ambulatory Surgery Center (ASC) or as an employee of the ASC to whom the ASC administrator has delegated responsibility, I have reviewed this information pertaining to the Volume and Safety of Procedures Section at our ASC, and I hereby certify that this information is true, accurate, and reflects the current, normal operating circumstances at our ASC. I am authorized to make this certification on behalf of our ASC.

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

Affirmed by _____, the ASC's _____,
(First Name, Last Name) (Title)

On _____.
(Date)

Section 3: Volume and Safety of Procedures Reference Information

What's New in the 2023 Survey

Section 3B: Facility and Surgeon Volume

Based on feedback from participating ASCs and guidance from Leapfrog's [Complex Surgery Expert Panel](#), Leapfrog will add Bariatric Surgery for Weight Loss to Section 3B: Facility and Surgeon Volume. Leapfrog will ask facilities that perform the procedures to report facility volume, whether the facility's process for privileging includes the surgeon meeting or exceeding Leapfrog's minimum annual surgeon volume standard, and whether they have appropriateness criteria for Bariatric Surgery for Weight Loss. Leapfrog's facility volume standard for this procedure is 50 and the annual surgeon volume is 20. However, Leapfrog will not score or publicly report Bariatric Surgery for Weight Loss until 2024.

The Current Procedural Terminology (CPT) codes used to calculate total facility volume and annual surgeon volume for this procedure will be available via the Online Survey Tool when the Survey opens on April 1, 2023. Due to the American Medical Association's Terms of Use, ASCs must complete the Terms of Use via the Online Survey Tool to access the CPT codes.

In addition, Leapfrog plans to incorporate the surgical appropriateness questions into scoring and public reporting beginning in 2024 for all three procedures in this subsection: Total Hip Replacement Surgery, Total Knee Replacement Surgery, and Bariatric Surgery for Weight Loss. We also plan to add a new question in 2024 to assess the extent to which an ASC's appropriateness criteria are being utilized by asking ASCs to report on their findings from the retrospective reviews completed in question #7. An updated scoring algorithm will be published with the Proposed Changes to the 2024 Leapfrog ASC Survey. There are no changes to the public reporting of the surgical appropriateness questions for Total Hip Replacement Surgery or Total Knee Replacement Surgery for 2023. There are no changes to the questions or scoring algorithm for Total Knee Replacement Surgery or Total Hip Replacement Surgery.

Section 3C: Patient Follow-up

Leapfrog is removing ASC-11 Improvement in Patients Visual Function Following Cataract Surgery since CMS has made this measure voluntary through the 2023 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule. We are adding two new outcome measures published by CMS: ASC-17 Hospital Visits After Orthopedic Ambulatory Surgical Center Procedures and ASC-18 Hospital Visits After Urology Ambulatory Surgical Center Procedures. Leapfrog will score and publicly report both measures in 2023.

There are no changes to the scoring algorithm for ASC-12 Rate of Unplanned Hospital Visits after an Outpatient Colonoscopy. Data download dates and reporting periods for ASC 12, ASC-17, and ASC-18, are available in the [Deadlines and Reporting Period table](#) below.

Section 3D: Informed Consent

Based on an analysis of responses submitted to the 2022 Leapfrog ASC Survey and consultation with Leapfrog's [Patient and Family Caregiver Expert Panel](#), Leapfrog will score and publicly report Section 3D: Informed Consent in 2023. We are updating Section 3D as follows:

First, the following six questions, identified by the expert panel as being the most relevant to patients and family caregivers, will be scored and publicly reported in 2023:

- One (1) question from the Policies and Training domain that focuses on staff training on the facilities' informed consent policies.

- Three (3) questions from the Content of the Informed Consent Forms domain that focus on detailing expected difficulties with the procedure; naming individuals who will be involved with the procedure, including trainees and assistants; and ensuring consent forms are at a 6th grade reading level or lower.
- Two (2) questions from the Processing for Gaining Informed Consent domain that focus on providing medical interpretation in the patient/legal guardian’s preferred language, where needed, when discussing informed consent and using the “teach back method” with patients to ensure they understand what is being explained to them.

Second, we are removing questions focused on the facility having a written policy on informed consent, the facility explicitly offering patients the opportunity for a care partner to participate in the informed consent process, and the use of high-quality decision aids when discussing treatment options.

Finally, we are retaining several questions from the 2022 Leapfrog ASC Survey but making them optional for fact finding purposes only; they will not be scored or publicly reported in 2023. As we conduct additional research on these and other important, evidence-based practices related to the informed consent process, additional questions may be scored and publicly reported in the future.

Section 3E: Safe Surgery Checklist

Leapfrog is making two updates to Section 3E: Safe Surgery Checklist for Adult and Pediatric Outpatient Procedures. First, Leapfrog is increasing the audit requirement in question #6 from 15 sampled cases to 30 sampled cases for facilities who perform any of the procedures included in Section 3A Volume of Procedures or 3B Facility and Surgeon Volume. Facilities should randomly sample 30 cases across all the procedures reported in Sections 3A and 3B.

Second, for ASCs conducting the audit to assess compliance with the Safe Surgery Checklist, Leapfrog is adding a question asking if the ASC performed an in-person observational audit, a retrospective audit of medical records or EHR data, or both.

There are no changes to the scoring algorithm for Section 3E: Safe Surgery Checklist for Adult and Pediatric Outpatient Procedures.

Change Summary Since Release

June 12, 2023 – Section 3A Volume of Procedures: Added 14 adult and 18 pediatric CPT Codes used to identify Other Hernia Repairs and added one adult and one pediatric CPT Code used to identify Nasal/Sinus Procedures that were previously noted as removed. Updates are reflected in the Outpatient Procedure CPT Code workbook for Other Hernia Repair in the Adult and Pediatric General Surgery tab and for Nasal/Sinus Procedure in the Otolaryngology tab.

Please download an updated copy of the Outpatient Procedure CPT Code workbook from the [Survey Dashboard](#). Instructions for downloading the workbook are available in the [Volume of Procedures Measure Specifications](#).

Section 3A: Volume of Procedures Measure Specifications

Important Note: CPT codes are provided in downloadable Excel files on the Survey Dashboard. To access the files, click the CPT Code Workbook button next to Section 3. You will be required to complete the American Medical Association's Terms of Use before downloading the Excel file and using the individual CPT codes to query your EHR or billing system. You are only required to complete the Terms of Use once per Survey Cycle (April 1 – November 30).

The CPT Code Workbooks (Excel files) are labeled for Section 3A: Volume of Procedures and Section 3B: Facility and Surgeon Volume. Please note, if you are part of a network, each ASC will need to complete the Terms of Use. This is a requirement of the American Medical Association.

<p>Source: The Leapfrog Group, American Medical Association, The Health Care Cost Institute</p>
<p>Reporting Period: 12 months</p> <ul style="list-style-type: none"> • Surveys submitted prior to September 1: <ul style="list-style-type: none"> ○ 01/01/2022 – 12/31/2022 • Surveys (re)submitted on or after September 1: <ul style="list-style-type: none"> ○ 07/01/2022 – 06/30/2023
<p>Questions #2-10: Respond “yes” or “no” based on whether your facility performed any of the procedures during the reporting period on adult and/or pediatric patients. The procedures fall within 9 specialty areas:</p> <p><i>Adult Procedures</i></p> <p>Gastroenterology procedures: upper GI endoscopy; other upper GI procedures; and lower GI endoscopy</p> <p>General surgery procedures: cholecystectomy and common duct exploration; hemorrhoid procedures; inguinal and femoral hernia repairs; other hernia repairs; laparoscopy; lumpectomy or quadrantectomy of breast; and mastectomy</p> <p>Ophthalmology procedures: anterior segment eye procedures; posterior segment eye procedures; and ocular adnexa and other eye procedures</p> <p>Orthopedic procedures: finger, hand, wrist, forearm, and elbow procedures; shoulder procedures; spine procedures; hip procedures; knee procedures; toe, foot, ankle, and leg procedures; and general orthopedic procedures</p> <p>Otolaryngology procedures: ear procedures; mouth procedures; and nasal/sinus procedures</p> <p>Urology procedures: circumcisions; cystourethroscopy; male genital procedures; urethra procedures; and vaginal repair procedures</p> <p>Neurological surgery procedures: spinal fusion procedures</p> <p>Obstetrics and gynecology procedures: cervix procedures; hysteroscopy; and uterus and adnexa laparoscopies</p> <p>Plastic and reconstructive surgery procedures: breast repair or reconstructive procedures; and skin graft/reconstruction procedures</p> <p><i>Pediatric Procedures</i></p> <p>Gastroenterology procedures: upper GI endoscopy; other upper GI procedures; and lower GI endoscopy</p>

[General surgery procedures](#): inguinal and femoral hernia repairs; and other hernia repairs

[Ophthalmology procedures](#): anterior segment eye procedures; posterior segment eye procedures; and ocular adnexa and other eye procedures

[Orthopedic procedures](#): finger, hand, wrist, forearm, and elbow procedures; shoulder procedures; knee procedures; toe, foot, ankle, and leg procedures; and general orthopedic procedures

[Otolaryngology procedures](#): ear procedures; mouth procedures; nasal/sinus procedures; pharynx/adenoid/tonsil procedures

Respond “yes” if:

- Your facility performed the procedure for the entire reporting period (12 months) and continues to do so
- Your facility performed the procedure during part of the reporting period (less than 12 months) and continues to perform the procedure

Respond “yes, but no longer perform these procedures” if:

- Your facility performed the procedure for all or some of the reporting period, but NO longer performs the procedure

Respond “no” if:

- Your facility does not perform the procedure

Questions #11-19: Based on your responses to questions #2-10, report on the total (a) adult and/or (b) pediatric volume for each procedure (from questions #2-10) during the reporting period:

Adult Procedures

[Gastroenterology procedures](#): upper GI endoscopy; other upper GI procedures; and lower GI endoscopy

[General surgery procedures](#): cholecystectomy and common duct exploration; hemorrhoid procedures; inguinal and femoral hernia repairs; other hernia repairs; laparoscopy; lumpectomy or quadrantectomy of breast; and mastectomy

[Ophthalmology procedures](#): anterior segment eye procedures; posterior segment eye procedures; and ocular adnexa and other eye procedures

[Orthopedic procedures](#): finger, hand, wrist, forearm, and elbow procedures; shoulder procedures; spine procedures; hip procedures; knee procedures; toe, foot, ankle, and leg procedures; and general orthopedic procedures

[Otolaryngology procedures](#): ear procedures; mouth procedures; and nasal/sinus procedures

[Urology procedures](#): circumcisions; cystourethroscopy; male genital procedures; urethra procedures; and vaginal repair procedures

[Neurological surgery procedures](#): spinal fusion procedures

[Obstetrics and gynecology procedures](#): cervix procedures; hysteroscopy; and uterus and adnexa laparoscopies

[Plastic and reconstructive surgery procedures](#): breast repair or reconstructive procedures; and skin graft/reconstruction procedures

Pediatric Procedures

[Gastroenterology procedures](#): upper GI endoscopy; other upper GI procedures; and lower GI endoscopy

[General surgery procedures](#): inguinal and femoral hernia repairs; and other hernia repairs

[Ophthalmology procedures](#): anterior segment eye procedures; posterior segment eye procedures; and ocular adnexa and other eye procedures

[Orthopedic procedures](#): finger, hand, wrist, forearm, and elbow procedures; shoulder procedures; knee procedures; toe, foot, ankle, and leg procedures; and general orthopedic procedures

[Otolaryngology procedures](#): ear procedures; mouth procedures; nasal/sinus procedures; and pharynx/adenoid/tonsil procedures

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

- Count the number of **patients** discharged from your facility within the reporting period with any one or more of the codes specified for each procedure, subject to the criteria below:
 - Only the procedure codes provided by Leapfrog should be used to report on the questions in Section 3A.
 - If a patient had more than one of the listed procedures performed on the same visit (i.e., repair of dislocating kneecap (CPT: 27422) and repair of superior labrum anterior/posterior (SLAP) lesion (CPT: 29807)), include the patient in the total volume for both procedures.

See [FAQs](#) for additional information about responding to questions in this section.

Gastroenterology Measure Specifications

For gastroenterology procedures, use the CPT codes available in the Library on the [Survey Dashboard](#) to count **patients** discharged from your facility who have undergone any of the 3 procedures during the reporting period.

All three procedures apply to **both adult and pediatric patients**:

- Upper GI endoscopy
- Other upper GI procedure
- Lower GI endoscopy

Using the “Gastroenterology_adult” sheet, count the total number of adult (18 years of age or older) patients discharged for each procedure with any of the CPT codes listed. The CPT code can be in any procedure field.

Using the “Gastroenterology_peds” sheet, count the total number of pediatric (17 years of age and younger) patients discharged for each procedure with any of the CPT codes listed. The CPT code can be in any procedure field.

General Surgery Measure Specifications

For general surgery procedures, use the CPT codes available in the Library on the [Survey Dashboard](#) to count **patients** discharged from your facility who have undergone any of the 7 procedures during the reporting period.

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

- Cholecystectomy and common duct exploration
- Hemorrhoid procedures
- Laparoscopy
- Lumpectomy or quadrantectomy of breast
- Mastectomy

Two procedures apply to **both adult and pediatric patients**:

- Inguinal and femoral hernia repairs
- Other hernia repairs

Using the “General surgery_adult” sheet, count the total number of adult (18 years of age or older) patients discharged for each procedure with any of the CPT codes listed. The CPT code can be in any procedure field.

Using the “General surgery_ped” sheet, count the total number of pediatric (17 years of age and younger) patients discharged for each procedure with any of the CPT codes listed. The CPT code can be in any procedure field.

Ophthalmology Measure Specifications

For ophthalmology procedures, use the CPT codes available in the Library on the [Survey Dashboard](#) to count **patients** discharged from your facility who have undergone either of the 3 procedures during the reporting period.

All three procedures apply to **both adult and pediatric patients**:

- Anterior segment eye procedures
- Posterior segment eye procedures

- Ocular adnexa and other eye procedures

Using the “Ophthalmology_adult” sheet, count the total number of adult (18 years of age or older) patients discharged for each procedure with any of the CPT codes listed. The CPT code can be in any procedure field.

Using the “Ophthalmology_ped” sheet, count the total number of pediatric (17 years of age and younger) patients discharged for each procedure with any of the CPT codes listed. The CPT code can be in any procedure field.

Orthopedic Measure Specifications

For orthopedic procedures, use the CPT codes available in the Library on the [Survey Dashboard](#) to count **patients** discharged from your facility who have undergone any of the 7 procedures during the reporting period.

Five procedures apply to **both adult and pediatric patients**:

- Finger, hand, wrist, forearm, and elbow procedures
- Shoulder procedures
- Knee procedures
- Toe, foot, ankle, and leg procedures
- General orthopedic procedures

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

- Spine procedures
- Hip procedures

Using the “Orthopedic_adult” sheet, count the total number of adult (18 years of age or older) patients discharged for each procedure with any of the CPT codes listed. The CPT code can be in any procedure field.

Using the “Orthopedic_ped” sheet, count the total number of pediatric (17 years of age and younger) patients discharged for each procedure with any of the CPT codes listed. The CPT code can be in any procedure field.

Otolaryngology Measure Specifications

For otolaryngology procedures, use the CPT codes available in the Library on the [Survey Dashboard](#) to count **patients** discharged from your facility who have undergone any of the 4 procedures during the reporting period.

Three procedures apply to **both adult and pediatric patients**:

- Ear procedures
- Mouth procedures
- Nasal/sinus procedures

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

- Pharynx/adenoid/tonsil procedures

Using the “Otolaryngology_adult” sheet, count the total number of adult (18 years of age or older) patients discharged for each procedure with any of the CPT codes listed. The CPT code can be in any procedure field.

Using the “Otolaryngology_ped” sheet, count the total number of pediatric (17 years of age and younger) patients discharged for each procedure with any of the CPT codes listed. The CPT code can be in any procedure field.

Urology Measure Specifications

For urology procedures, use the CPT codes available in the Library on the [Survey Dashboard](#) to count **patients** discharged from your facility who have undergone any of the 5 procedures during the reporting period.

All five procedures apply to **adult patients only**:

- Circumcision
- Cystourethroscopy
- Male genital procedures
- Urethra procedures
- Vaginal repair procedures

Using the “Urology_adult” sheet, count the total number of adult (18 years of age or older) patients discharged for each procedure with any of the CPT codes listed. The CPT code can be in any procedure field.

Neurological Surgery Measure Specifications

For neurological surgery procedures, use the CPT codes available in the Library on the [Survey Dashboard](#) to count **patients** discharged from your facility who have undergone the procedure during the reporting period.

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

- Spinal fusion procedures

Using the “Neurological surgery_adult” sheet, count the total number of adult (18 years of age or older) patients discharged with any of the CPT codes listed. The CPT code can be in any procedure field.

Obstetrics and Gynecology Measure Specifications

For obstetrics and gynecology procedures, use the CPT codes available in the Library on the [Survey Dashboard](#) to count **patients** discharged from your facility who have undergone any of the 3 procedures during the reporting period.

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

- Cervix procedures
- Hysteroscopy
- Uterus and adnexa laparoscopies

Using the “Obstetrics and gynecology_adult” sheet, count the total number of adult (18 years of age or older) patients discharged for each procedure with any of the CPT codes listed. The CPT code can be in any procedure field.

Plastic and Reconstructive Surgery Measure Specifications

For plastic and reconstructive surgery procedures, use the CPT codes available in the Library on the [Survey Dashboard](#) to count **patients** discharged from your facility who have undergone either of the 2 procedures during the reporting period.

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

- Breast repair or reconstruction
- Skin graft/reconstruction procedures

Using the “Plastic_reconstruct surg_adult” sheet, count the total number of adult (18 years of age or older) patients discharged for each procedure with any of the CPT codes listed. The CPT code can be in any procedure field.

Section 3B: Facility and Surgeon Volume Measure Specifications

Important Note: CPT codes are provided in downloadable Excel files on the Survey Dashboard. To access the files, click the CPT Code Workbook button next to Section 3. You will be required to complete the American Medical Association's Terms of Use before downloading the Excel file and using the individual CPT codes to query your EHR or billing system. You are only required to complete the Terms of Use once per Survey Cycle (April 1 – November 30).

The CPT Code Workbooks (Excel files) are labeled for Section 3A: Volume of Procedures and Section 3B: Facility and Surgeon Volume. Please note, if you are part of a network, each ASC will need to complete the Terms of Use. This is a requirement of the American Medical Association.

<p>Source: The Leapfrog Group, American Medical Association</p>
<p>Reporting Period: 12 months or <i>optionally</i> 24 months (annual average)</p> <ul style="list-style-type: none"> • Surveys submitted prior to September 1: <ul style="list-style-type: none"> ○ 01/01/2022 – 12/31/2022 (12-month count) or 01/01/2021 – 12/31/2022 (24-month annual average) • Surveys (re)submitted on or after September 1: <ul style="list-style-type: none"> ○ 07/01/2022 – 06/30/2023 (12-month count) or 07/01/2021 – 06/30/2023 (24-month annual average)
<p>Question #2: Check all procedures that your facility has performed during the reporting period on adult patients (ages 18 years or older).</p> <p style="padding-left: 40px;">Total knee replacement (Facility Volume Standard: 50) Total hip replacement (Facility Volume Standard: 50) Bariatric surgery for weight loss (Facility Volume Standard: 50)</p> <p><u>Do not</u> check the box for the procedure if:</p> <ul style="list-style-type: none"> • Your facility has started to perform the procedure in the last 18 months. Leapfrog gives ASCs an 18-month grace period before having to report on facility volume and process for privileging surgeons for new service lines. <p><u>Do</u> check the box for the procedure if:</p> <ul style="list-style-type: none"> • Your facility electively performs the procedure but has zero cases during the reporting period. Select the procedure and indicate a facility volume of zero in question #3. Please note that facilities can elect to report on a 24-month annual average. • Your facility has reached the end of the 18-month grace period for a new service line. You will now have to report on both facility volume and your process for privileging surgeons for this procedure.
<p>Question #3: Total facility volume for each selected procedure during the reporting period:</p> <p>When calculating total facility volume for total knee replacement or total hip replacement:</p> <ul style="list-style-type: none"> • Count the number of patients discharged from your facility within the reporting period with the CPT codes specified for each procedure, subject to the inclusion criteria below: <ul style="list-style-type: none"> ○ Only the CPT codes provided by Leapfrog should be used to report on the questions in Section 3B: Facility and Surgeon Volume. ○ The CPT code can be in any procedure field. <p>When calculating total facility volume for bariatric surgery for weight loss:</p> <ul style="list-style-type: none"> • Count the number of patients discharged from your facility within the reporting period with the CPT and ICD-10 codes specified for this procedure, subject to the inclusion criteria below:

- Only the CPT and ICD-10 codes provided by Leapfrog should be used to report on the questions in Section 3B: Facility and Surgeon Volume. ICD-10 codes are provided below.
- This procedure includes TWO sets of codes (one set of CPT procedure codes and one set of ICD-10 diagnosis codes), both sets of codes must be used for counting patient discharges (e.g., at least one procedure code AND one diagnosis code must be present).
- The CPT code can be in any procedure field. The ICD-10 diagnosis code must be the primary diagnosis.

ICD-10 Diagnosis Codes for Bariatric Surgery for Weight Loss

ICD-10 Diagnosis Code	Code Description
E66.01	Morbid (severe) obesity due to excess calories
E66.09	Other obesity due to excess calories
E66.8	Other obesity
Z68.35	Body mass index (BMI) 35.0-35.9, adult
Z68.36	Body mass index (BMI) 36.0-36.9, adult
Z68.37	Body mass index (BMI) 37.0-37.9, adult
Z68.38	Body mass index (BMI) 38.0-38.9, adult
Z68.39	Body mass index (BMI) 39.0-39.9, adult
Z68.41	Body mass index (BMI) 40.0-44.9, adult
Z68.42	Body mass index (BMI) 45.0-49.9, adult
Z68.43	Body mass index (BMI) 50-59.9, adult
Z68.44	Body mass index (BMI) 60.0-69.9, adult
Z68.45	Body mass index (BMI) 70 or greater, adult

Question #4: Does your facility's privileging process include the surgeon meeting or exceeding the minimum annual surgeon volume standard listed below?

Total knee replacement: 25
 Total hip replacement: 25
 Bariatric surgery for weight loss: 20

When determining whether surgeons have met or exceeded Leapfrog's minimum annual surgeon volume standards for the purposes of privileging, only refer to the CPT codes included in the CPT Code Workbooks provided by Leapfrog – **diagnosis** codes (if provided) can be ignored.

See [FAQs](#) for additional information about responding to the questions in this section.

Section 3C: Patient Follow-up Measure Specifications

Leapfrog obtains data for three CMS Ambulatory Surgical Center Quality Reporting (ASCQR) measures directly from CMS' [website](#):

- ASC-12: Rate of Unplanned Hospital Visits After an Outpatient Colonoscopy
- ASC-17: Hospital Visits After Orthopedic Ambulatory Surgical Center Procedures
- ASC-18: Hospital Visits After Urology Ambulatory Surgical Center Procedures

In order for Leapfrog to obtain the data for each applicable ASCQR measure, facilities must provide a valid CMS Certification Number (CCN) and National Provider Identifier (NPI) in the Profile Section of the Online Survey Tool and submit the Leapfrog ASC Survey.

Deadlines and Reporting Period

Data downloaded from CMS will be scored and publicly reported for ASCs that have submitted a Survey by	CMS Reporting Period	Available on ASC Details Page	Available on the Public Reporting Website
June 30, 2023	ASC-12: Most recent 36 months ASC-17: Most recent 24 months ASC-18: Most recent 24 months	July 12, 2023	July 25, 2023
August 31, 2023	ASC-12: Most recent 36 months ASC-17: Most recent 24 months ASC-18: Most recent 24 months	September 8, 2023	September 8, 2023
November 30, 2023	ASC-12: Most recent 36 months ASC-17: Most recent 24 months ASC-18: Most recent 24 months	December 7, 2023	December 7, 2023

Review your CMS data for ASC-12, ASC-17, and ASC-18

- Once Leapfrog has published your facility's Survey Results on the [ASC Details Page](#), ASCs are urged to compare the CMS data Leapfrog has obtained with the data published for each applicable measure on CMS' [website](#).
- Dates on which the Survey Results will be available on the ASC Details page are listed in the "Deadlines and Reporting Periods" table above.

If, while comparing your facility's data published on the CMS [website](#) to the data published on the ASC Details page, you find a discrepancy, contact Leapfrog's Help Desk immediately.

Section 3E: Safe Surgery Checklist for Adult and Pediatric Outpatient Procedures Measure Specifications

Source: The Leapfrog Group, WHO Surgical Safety Checklist, AHRQ Endoscopy Checklist
Reporting Period: Latest 3-month period prior to submission of this section of the Survey
<p>Safe Surgery Checklist Workbook (Excel)</p> <p>To complete the data collection and respond to questions #6-8, facilities should download the Safe Surgery Checklist Workbook (Excel). This workbook includes five tabs: Instructions, Before Anesthesia, Before Procedure Begins, Before Patient Leaves, and Data Entry; these tabs can be used to complete the safe surgery checklist audits for this subsection and to calculate the response to select in the Online Survey Tool for question #8.</p> <p>The workbook is available on the Survey Materials Webpage.</p>
<p>Sampling: Facilities can randomly sample 30 patients (who had one of the procedures included in Section 3A and/or 3B, if applicable) and measure and report adherence to the safe surgery checklist based on that sample.</p> <p>Facilities that only perform the procedures in Section 3A, or that only perform the procedures in Section 3B, must randomly sample 30 patients who had one of the procedures from the appropriate section and measure and report adherence to the safe surgery checklist based on that sample.</p> <p>When sampling from a larger population of cases, facilities that perform procedures across multiple surgical specialties (e.g., general surgery, orthopedics, urology, etc.) included in Section 3A and 3B, and facilities that perform procedures for both adult and pediatric patients, should obtain a representative sample (i.e., include patients who underwent procedures in different surgical specialties and include both adult and pediatric patients, if applicable).</p>
<p>Question #6: Did your facility perform an audit (either in-person or via the medical record or other EHR data) on at least 30 cases of patients who underwent a procedure included in Section 3A and/or 3B and measure adherence to the safe surgery checklist?</p> <p>To respond “yes” to question #6, facilities must measure and document whether all the elements in questions #3, #4, and #5 were verbalized in the presence of the appropriate personnel for each sampled case. Facilities that completed the audit should respond “yes” to this question regardless of whether the adherence to the checklist was 100%. Facilities will report on adherence to the checklist in question #8.</p>
<p>Question #7: What method was used to perform the audit on at least 30 cases of patients who underwent a procedure in Section 3A and 3B?</p> <p>Facilities can only perform a retrospective audit by reviewing medical records or EHR data if adherence to the safe surgery checklist is clearly documented in the medical record or EHR and the documentation clearly demonstrates that each element was verbalized in the presence of the appropriate personnel. If facilities cannot clearly determine whether (a) the checklist element was verbalized and (b) the appropriate personnel were present via a retrospective audit, an in-person observational audit must be completed.</p> <p>Facilities can perform the in-person audits up to six months prior to and during the reporting period.</p>

Question #8: Based on your facility’s audit (either in-person or via the medical record or other EHR data) on at least 30 cases of patients who underwent an applicable procedure included in Section 3A and 3B, what was your facility’s documented rate of adherence to the safe surgery checklist (i.e., what percentage of the sampled cases had all elements in questions #3, #4, and #5 completed)?

Based on the audit completed for question #6, determine the total number of patient audits where **all** elements of the safe surgery checklist (included in questions #3, #4, and #5) were read aloud in the presence of the appropriate personnel 1) before the induction of anesthesia, 2) before the skin incision and/or the procedure began, and 3) before the patient left the operating and/or procedure room.

Included cases:

- The patient audit shows that **all** elements of the safe surgery checklist, at **all** three time points, were read aloud in the presence of the appropriate personnel.

Excluded cases:

- The patient audit does **not** demonstrate that all elements of the safe surgery checklist were read aloud in the presence of the appropriate personnel (i.e., one or more elements of the checklist were not read aloud or the appropriate personnel were not present during the checklist).
- The patient audit does **not** demonstrate that the safe surgery checklist was read aloud in the presence of the appropriate personnel at all three time points (i.e., before anesthesia, before the skin incision and, and before the patient leaves).

Important Note: If a Safe Surgery Checklist element includes the qualifier “if applicable,” facilities should determine if that element of the checklist was applicable to the patient and procedure being performed. If the element was determined to be “not applicable” to the patient and procedure, it does not count against the total adherence. For example, if your facility performed a hernia repair, the availability of a device on-site would not be applicable. Therefore, when completing the Safe Surgery Checklist Workbook for this patient, indicate N/A for that element (device on-site) and your facility would be able to count that case as adherent.

See [FAQs](#) for additional information about responding to questions in this section.

Volume and Safety of Procedures Frequently Asked Questions (FAQs)

Volume of Procedures

1) How did Leapfrog select the 9 specialties and the procedures in this section of the survey?

Leapfrog worked with the Healthcare Cost Institute (HCCI) to identify the most commonly billed surgical procedures in ambulatory surgery centers and hospital outpatient departments for commercially insured adult and pediatric patients. Leapfrog's technical experts then assessed the list of procedures based on their frequency and type of anesthesia used during the procedure. Those selected for the Survey represent the highest volume procedures nationally requiring moderate to general anesthesia (including nerve blocks).

Please reach out to the [Leapfrog Help Desk](#) if you believe additional CPT codes should be added to the Survey; Leapfrog will take these suggestions to our technical experts.

2) Should we count patients discharged with a G code for colonoscopy?

No. A "G" (HCPCS II) code is used to differentiate between colonoscopies performed for screening purposes rather than for a diagnostic or therapeutic procedure. The Survey only includes major diagnostic and therapeutic procedures.

Facility and Surgeon Volume

3) How should facilities calculate volume using a 24-month annual average?

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

4) If an ASC elects to begin a new service line of procedures, how should the facility report its volume and annual surgeon volumes while establishing the new line?

Leapfrog gives ASCs an 18-month grace period before having to report on the facility and annual surgeon volume for a new procedure. From the day that the ASC performs the procedure for the first time, the ASC and its surgeons will have 18 months to reach the annual volume standard. During this period, the ASC does not have to report its procedure volumes for the ASC or surgeons. However, once the ASC reaches the end of the 18-month grace period, it must report its facility and annual surgeon procedure volume.

5) How should we deal with a temporary drop in volume due to losing a surgeon's service?

To accommodate fluctuations in facility volumes, ASCs have the option of reporting on their average case volumes over a 24-month period.

6) When counting surgeon volume for the purposes of privileging, should we consider procedures performed by the surgeon at other facilities?

When determining whether a surgeon has met or has exceeded Leapfrog's minimum annual surgeon volume standard, we expect that ASCs will consider total experience in the privileging process – this would include procedures performed within the reporting period at the ASC and at any hospitals with which the surgeon is also affiliated.

7) For determining surgeon volume for the purposes of our ASC's privileging policy, how should we count procedures that involve surgeons who have just finished training and are building up their experience?

Surgeons who have just finished their training should receive a 24-month grace period to build up their experience. After that point, the surgeon's volume should be tracked and included in privileging decisions. The procedures performed by this surgeon during the reporting period should still be counted towards the facility's volume total, as the broader staff still had the experience with the procedure.

8) If a surgeon was not 'active' during the entire reporting period (e.g., just hired, sabbatical, illness, etc.), how should this surgeon's procedures be reported?

If a surgeon was absent for an extended time during the reporting period, the procedures performed by this surgeon during the reporting period should still be counted towards the ASC's procedure total (question #3). However, the surgeon would not need to be considered when responding to question #4 regarding whether or not your ASC's process for privileging includes the surgeon having to meet Leapfrog's minimum annual surgeon volume standards until they have been active again for an entire reporting period (likely the next year).

9) Does the specific procedure and minimum annual surgeon volume standard listed, need to be included in our process for privileging surgeons?

Yes. ASCs must ensure that the specific procedure and minimum annual surgeon volume standard are included in your process for privileging surgeons.

10) Does our privileging process for surgeons have to include the annual surgeon volume standard for initial privileging only or ongoing/renewal of privileging as well?

Both. Leapfrog's minimum annual surgeon volume standards should be fully integrated into your facility's process for privileging surgeons, including both initial and ongoing privileging. There are two exceptions:

- a. Surgeons who have just finished training: see [FAQ #7](#) above.
- b. Surgeons who were not active for the entire reporting period: see [FAQ #8](#) above.

Surgical Appropriateness

11) What documents can be used as supporting evidence of an ASC's implementation of surgical appropriateness?

ASCs may use facility meeting minutes, retrospective reviews of surgical cases, or any other materials that show that there are surgical appropriateness standards of care.

12) How often do we need to perform "regular retrospective reviews" as described in question #6 in Section 3B?

More than once per year. Some ASCs may decide to review quarterly or even monthly, depending on the size of the service.

Patient Selection

13) What are examples of appropriate tools for assessing cognition as part of patient screening and selection?

Examples of tools that may be used to assess cognition include the Montreal Cognitive Assessment (MOCA), Mini-Mental State Exam (MMSE), and Mini-Cog. More information on these cognitive assessments, as well as other commonly used tools, may be found here:

https://www.americangeriatrics.org/sites/default/files/inline-files/kkaycee_sink.pdf, as well as here: <https://www.aafp.org/family-physician/patient-care/care-resources/cognitive-care.html>.

14) Why does a Medical Director need to perform a second screening of high-risk patients?

If an anesthesiologist and/or CRNA performs the initial screening for high-risk patients, then the second screening should be conducted by a Medical Director, as the Medical Director should take ownership of how the facility screens patients. The Medical Director should also have the clinical expertise to determine whether it is safe and appropriate for a patient to have an invasive procedure or surgery performed at the facility.

Patient Follow-Up**15) Do ASCs need to do anything for Leapfrog to obtain data for the CMS measures?**

No, Leapfrog will use your ASCs data that are reported to CMS, if you provide your CCN and NPI in the Profile, as applicable, to determine your score on the three ASCQR measures. If your ASC does not perform any applicable procedures, your ASC will be scored as “Does Not Apply”. More information on how your ASC will be scored is available in the [ASC Scoring Algorithm](#).

Informed Consent**16) In cases where facilities do not have information about informed consent processes that take place at a clinician’s (e.g., surgeon’s) office, and/or informed consent processes are conducted by clinicians that are not employed by the facility, or in other cases where the facility does not have visibility into the informed consent process, how should facilities respond to questions in this Section?**

Facilities that do not have input over the consent form or visibility into the informed consent process for tests, treatments, and procedures performed at a facility, should select “No” for the questions in this section.

If the facility does have input over the consent form and visibility into the informed consent process for tests, treatments, and procedures performed at the facility, but the consent forms and the consent process are being completed at the clinician(s)’s office, the facility can work with those offices to implement the requirements outlined in the questions and, via an annual audit, verify that the forms and process meet the criteria to respond “Yes” to the questions in this section. All documentation should be maintained throughout the Survey Cycle.

17) Are there any examples of patients for whom the informed consent questions would not apply?

When responding to the questions in this subsection, you can exclude patients who are unable to communicate and for whom no family member or medical proxy has been identified at least one week prior to the test, treatment, or procedure being performed.

18) When answering questions that ask about “all your facility’s consent forms,” are any consent forms excluded?

Facilities can exclude their general consent to treat and anesthesia consent forms when responding to questions regarding “all your facility’s consent forms.”

19) What roles and staff levels need to be included in the training program on informed consent included in question #1? What types of training can we use?

As described on page 98 of the [AHRQ’s Making Informed Consent an Informed Choice – Training for Health Care Leaders](#), the appropriate roles for training include all the following: facility leaders, physicians/independent nurse practitioners/independent physician assistants, nurses or other clinical staff, administrative staff, and interpreters. The training may be tailored to only include relevant

materials based on the staff role. The goal is for each responsible staff person to be trained in their applicable domains. For example:

- For facility leaders, training on the definition and principles of informed consent and specifics on the facility's informed consent policy is appropriate.
- Clinical staff such as physicians and nurses should also be trained in strategies for clear communication, for presenting choices, and for documentation.
- For administrative staff and interpreters, participating in the informed consent process should also be trained in documentation.

Staff that are not directly employed by the facility (e.g., medical interpreters who are employed by a contractor) do not need to be trained by the facility.

Trainings do not need to be exclusive to informed consent and can be included as components or modules in other trainings. Examples of trainings include computer-based training, one-on-one precepting, webinars, and staff meeting presentations, as well as other modalities where learning can be assessed after the content is delivered to the trainee.

20) Why has Leapfrog selected a 6th-grade reading level target for consent forms, and what are some strategies we can use to meet this?

Just over half of U.S. adults have a reading level that permits them to understand and synthesize information from a complex text. According to [a Gallup analysis](#), 54% of Americans between the ages of 16 and 74 read below the equivalent of a sixth-grade level. Leapfrog has included an exemption in the standard for the procedure name and description, that may include highly technical language that would affect the reading level.

Leapfrog hosted two Town Hall Calls last year led by AHRQ describing techniques for reducing the written complexity of consent forms. The slides are available on Leapfrog's [Town Hall Calls webpage](#); please refer to slide 40-47 for more information in the "Informed Consent" slide deck and slides 40-45 in the "Health Literacy" deck. Additional resources include:

- [AHRQ Training Module](#)
- The Patient Education Materials Assessment Tool ([PEMAT](#))
- Clear Communication Index ([CCI](#))
- [CMS Toolkit for Making Written Material Clear and Effective](#)

21) Should each consent form be customized to include patient- and procedure-specific details to explain expected difficulties and recovery time (question #2), treatment choices (question #8), or the clinical rationale (question #9)?

No. Instead, the consent form must document that the conversation between the patient and the clinician that covered these topics took place, and that the patient had the opportunity to ask questions. For example, such language might read: "I acknowledge my treatment choices, including the severity and probability of the risks and benefits of each choice were explained to me, and that expected difficulties as a result of undergoing the Procedure were explained to me, including recovery time, pain management, and restrictions in the facility and after I leave the facility. I also acknowledged that I understand why the Procedure is being performed."

22) How should the reading level of the consent form be assessed?

There are software tools available to assess reading level. For example, consent forms can be edited in Microsoft Word, where a readability tool can be used to make this assessment by: (1) on the "File" tab, click the "Options" button; (2) on the "Proofing" tab, under "When correcting spelling and grammar in Word", make sure "Check grammar with spelling" is selected; (3) under "When correcting

spelling and grammar in Word”, select the “Show readability statistics” check box. After the grammar check is complete, Word displays a message box showing you the readability grade-level.

23) Regarding the process for soliciting patient feedback in question #14, or the audit included in question #15, what parameters should these processes follow? Are there a minimum number of instances that should be audited, or a patient feedback evaluation form?

Leapfrog has not established any specific requirements or forms for either the process audit, or the solicitation of patient feedback. Results from both activities can be used to improve processes.

Safe Surgery Checklist for Adult and Pediatric Outpatient Procedures

24) Does the safe surgery checklist referenced in Section 3E, questions #1-8 apply to all procedures, including colonoscopies, endoscopies, etc.?

Yes, it applies to all procedures in Section 3A and 3B, if applicable. If your facility does not utilize a safe surgery checklist for colonoscopy and/or endoscopy, respond “no” to question #2.

25) Can different elements of the “Before the induction of anesthesia” checklist (question #3) be performed in different places?

Yes, facilities may perform some elements of the pre-anesthesia checklist outside of the operating room. A facility may read aloud the following elements in a pre-procedure (preop) area: Patient ID, Confirmation of procedure, Patient consent, Site marked, if applicable, and Allergies assessed.

Facilities should not remove conversation prompts as it is harmful to the purpose of the checklist and should continue debriefing and requiring participation of the surgical team members in key moments.

26) Do the Safe Surgery Checklist components included in questions #3, #4, and #5 need to be in one document that would align with the WHO example, or can they be in different documents (i.e., pre-anesthesia notes, surgeon H&P, and pre-surgical checklists, etc.)?

It is possible to have separate checklists for each phase of the surgical procedure (i.e., before the induction of anesthesia, before the skin incision and/or before the procedure begins, and before the patient leaves the operating or procedure room). However, each individual component included in questions #3, #4, and #5 should be listed on the checklist(s) and facilities should document whether the components were read aloud at the appropriate time with the appropriate members of the surgical team present.

27) How is the “whole surgical team” defined?

“Whole surgical team” is comprised of the surgeons, anesthesia professionals, nurses, technicians, and other operating room personnel involved in surgery. Based off the World Alliance for Patient Safety “Implementation Manual Surgical Safety Checklist (First Edition)”:

<https://apps.who.int/iris/handle/10665/70046>.

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SECTION 4: PATIENT SAFETY PRACTICES

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

Section 4: Patient Safety Practices

Hand Hygiene Fact Sheet and Bibliography:

<https://ratings.leapfroggroup.org/measure/asc/2023/handwashing>

NQF Safe Practices Fact Sheet: <https://ratings.leapfroggroup.org/measure/asc/2023/preventing-and-responding-patient-harm>

Never Events Fact Sheet: <https://ratings.leapfroggroup.org/measure/asc/2023/responding-never-events>

Nursing Workforce Bibliography: <https://ratings.leapfroggroup.org/measure/asc/2023/nursing-workforce>

Section 4 includes questions about medication safety, the NHSN Outpatient Procedure Component Module reporting, hand hygiene, NQF Safe Practices, Never Events and nursing workforce at your facility. In 2023, NQF Safe Practice #4 Risks and Hazards and the percentage of RNs who are BSN-prepared will be scored and publicly reported.

Each facility achieving the Medication and Allergy documentation standard:

Has met the 90% target for documenting all three components: home medications, visit medications, and allergies/ adverse reaction(s) in the clinical record.

Each facility achieving the NHSN Outpatient Procedure Component Module standard;

- 1) Has joined Leapfrog's NHSN group;
- 2) Has provided a valid NHSN ID in the Profile Section
- 3) Is enrolled in the NHSN OPC Module;
- 4) Completed the 2022 OPC Annual Facility Survey;
- 5) Has a Monthly Reporting Plan and Summary Data in place for each month of the reporting period (six months) for all four Same Day Outcome Measures; and
- 6) Has a Monthly Reporting Plan in place for each month of the reporting period (six months) for all applicable Surgical Site Infection Measures.

Each facility achieving the Hand Hygiene standard:

Has met all elements for the Monitoring domain, including collecting compliance data on at least 200 hand hygiene opportunities* each month. Has also met all elements for the Feedback domain, as well as **2 of the 3** remaining domains for hand hygiene:

- Training and Education Domain
- Infrastructure Domain
- Culture Domain

**or at least the number of hand hygiene opportunities outlined based on [Table 1](#).*

OR

Has met all elements for the Monitoring domain, including collecting compliance data on at least 100 hand hygiene opportunities** each month, as well as **all 4** remaining domains for hand hygiene:

- Feedback Domain
- Training and Education Domain
- Infrastructure Domain
- Culture Domain

***or at least the number of hand hygiene opportunities based on [Table 2](#).*

Each facility achieving the standard for NQF Safe Practice #1- Culture of Safety Leadership Structures and Systems, NQF Safe Practice #2- Culture Measurement, Feedback, and Intervention, and NQF Safe Practice #4 – Risks and Hazards:

Has earned 100% of points (adopted all elements) for that NQF Safe Practice

Each facility achieving the standard for Never Events Policy:

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

Each facility achieving the standard for Nursing Workforce:

Has a percentage of RNs who are BSN-prepared that is greater than or equal to 80%.

Download the 2023 Leapfrog ASC Survey Scoring Algorithms on the [Scoring and Results webpage](#).

4A: Medication Safety

Medication and Allergy Documentation

Specifications: See [Medication Safety Measure Specifications](#) in the Reference Information beginning on page 118.

Reporting Period: 12 months

Answer questions #2-7 based on all cases (or a [sufficient sample](#) of them)

- Surveys submitted prior to September 1:
 - 01/01/2022 – 12/31/2022
- Surveys (re)submitted on or after September 1:
 - 07/01/2022 – 06/30/2023

Note: As a reminder, the [Corrections Period](#) (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission

Sufficient Sample: See [Medication Safety Measure Specifications](#) for instructions on identifying a sufficient sample for questions #2-7.

1) 12-month reporting period used:	01/01/2022 – 12/31/2022 07/01/2022 – 06/30/2023
2) Did your facility perform an audit of clinical records for all patients (or a sufficient sample of them) discharged for the reporting period selected and measure adherence to medication documentation guidelines regarding home medications, medications administered during the visit or prescribed at discharge, and medication allergies? <i>If “no” to question #2, skip the remaining questions in Section 4A and continue to Section 4B. The facility will be scored as “Limited Achievement.”</i> <i>If “yes, but there were fewer than 30 patients discharged for the reporting period,” skip the remaining questions in Section 4A and continue to Section 4B. The facility will be scored as “Unable to Calculate Score.”</i>	Yes No Yes, but there were fewer than 30 patients discharged for the reporting period
3) Number of cases measured (either all cases or a sufficient sample of them).	_____
4) Number of cases in question #3 with a list of all home medication(s) , including dose, route, and frequency, documented in the clinical record.	_____
5) Number of cases in question #3 with a list of all medication(s) administered during the visit and/or new medications prescribed at discharge , including the strength, dose, route, date, and time of administration, documented in the clinical record.	_____
6) Number of cases in question #3 with a list of all medication allergies and adverse reaction(s) documented in the clinical record.	_____

7) Do the responses in questions #3-6 represent a sample of cases?	Yes No
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4B: NHSN Outpatient Procedure Component Module

Important Note: Leapfrog will be obtaining data for the Outpatient Procedure Component (OPC) modules listed below directly from the CDC’s National Healthcare Safety Network (NHSN).

Please be sure you have followed the instructions provided online and have joined Leapfrog’s NHSN group for ASCs by the specified deadlines. In addition to joining Leapfrog’s NHSN group, facilities must provide an accurate NHSN ID in the Profile section of the Online ASC Survey Tool and submit a 2023 Leapfrog ASC Survey. ASCs that join Leapfrog’s NHSN group, but do not provide an accurate NHSN ID in their Profile or do not submit the 2023 Leapfrog ASC Survey by June 30 will not have their NHSN data scored and publicly reported on Leapfrog’s [public reporting website](#) when results first become available in July. The join by deadline for the first June NHSN data download date is June 22 and NHSN data will be downloaded on June 23.

For all other deadlines, please refer to the “Deadlines and Reporting Periods” table provided in the [Section 4B Measure Specifications](#), as well as [online](#).

Specifications: See [NHSN Outpatient Procedure Component Module Measure Specifications](#) in the Reference Information beginning on page 121.

Reporting Period: 6 months

Answer questions #1-17 for the latest 6-month period prior to the submission of this section of the Survey.

Visit the [Join NHSN Group](#) webpage for important information on deadlines for joining Leapfrog’s NHSN Group.

1) What is the latest 6-month reporting period for which your facility is submitting responses to this section? 6-month reporting period ending:	<hr/> <i>Format: Month/Year</i>
2) Does your facility participate in NHSN’s Outpatient Procedure Component (OPC) Module? <i>If “no” to question #2, skip the remaining questions in Section 4B and continue to Section 4C. The facility will be scored as “Limited Achievement.”</i>	Yes No
3) Did your facility complete the 2022 Outpatient Procedure Component – Annual Facility Survey?	Yes No
4) During the reporting period, did your facility have a Monthly Reporting Plan in place with NHSN for the Same Day Outcome Measures (SDOM) Module and submit associated Summary Data? <i>The SDOM Module includes information on patient burns, falls, “wrong” event, and all-cause hospital transfer/admission. Summary Data refers to the numerator (if applicable) and denominator information for the SDOM measure.</i>	Yes No

<p>If "no" to question #4, skip question #5 and continue to question #6.</p>	
<p>5) For how many months during the reporting period did your facility have a Monthly Reporting Plan and Summary Data in place with NHSN for the Same Day Outcome Measures (SDOM) Module?</p>	<p>Format: _____ Whole numbers only</p>
<p>6) During the reporting period, did your facility perform breast surgeries?</p> <p>If "no" to question #6, skip questions #7-8 and continue to question #9.</p>	<p>Yes No</p>
<p>7) During the reporting period, did your facility have a Monthly Reporting Plan in place with NHSN for the Breast Surgery (BRST) Procedure SSI Outcome Measure?</p> <p>If "no" to question #7, skip question #8 and continue to question #9.</p>	<p>Yes No</p>
<p>8) For how many months during the reporting period did your facility have a Monthly Reporting Plan in place with NHSN for the Breast Surgery (BRST) Procedure SSI Outcome Measure?</p>	<p>Format: _____ Whole numbers only</p>
<p>9) During the reporting period, did your facility perform herniorrhaphy procedures?</p> <p>If "no" to question #9, skip questions #10-11 and continue to question #12.</p>	<p>Yes No</p>
<p>10) During the reporting period, did your facility have a Monthly Reporting Plan in place with NHSN for the Herniorrhaphy (HER) Procedure SSI Outcome Measure?</p> <p>If "no" to question #10, skip question #11 and continue to question #12.</p>	<p>Yes No</p>
<p>11) For how many months during the reporting period did your facility have a Monthly Reporting Plan in place with NHSN for the Herniorrhaphy (HER) Procedure SSI Outcome Measure?</p>	<p>Format: _____ Whole numbers only</p>
<p>12) During the reporting period, did your facility perform knee prosthesis procedures?</p> <p>If "no" to question #12, skip questions #13-14 and continue to question #15.</p>	<p>Yes No</p>
<p>13) During the reporting period, did your facility have a Monthly Reporting Plan in place with NHSN for the Knee Prosthesis (KPRO) Procedure SSI Outcome Measure?</p> <p>If "no" to question #13, skip question #14 and continue to question #15.</p>	<p>Yes No</p>

<p>14) For how many months during the reporting period did your facility have a Monthly Reporting Plan in place with NHSN for the Knee Prosthesis (KPRO) Procedure SSI Outcome Measure?</p>	<p>_____</p> <p><i>Format: Whole numbers only</i></p>
<p>15) During the reporting period, did your facility perform laminectomies?</p> <p><i>If "no" to question #15, skip questions #16-17 and continue to the next subsection.</i></p>	<p>Yes No</p>
<p>16) During the reporting period, did your facility have a Monthly Reporting Plan in place with NHSN for the Laminectomy (LAM) Procedure SSI Outcome Measure?</p> <p><i>If "no" to question #16, skip question #17 and continue to the next subsection.</i></p>	<p>Yes No</p>
<p>17) How many months during the reporting period did your facility have a Monthly Reporting Plan in place with NHSN for the Laminectomy (LAM) Procedure SSI Outcome Measure?</p>	<p>_____</p> <p><i>Format: Whole numbers only</i></p>

4C: Hand Hygiene

Important Notes:

Note 1: Question #22 will not be scored or publicly reported.

Note 2: Hyperlinks, not followed by a superscript, throughout this subsection refer to the [Patient Safety Practices FAQs](#) beginning on page 130. These hyperlinks are not included in Online Survey Tool.

Note 3: The framework and questions in Section 4C are modeled after the World Health Organization's [Hand Hygiene Self-Assessment Framework](#).

Note 4: Facility responses should include surgical or treatment areas, which include pre-operative rooms, operating and procedure rooms, and post-operative rooms.

Specifications: See [Hand Hygiene Measure Specifications](#) in the Reference Information beginning on page 122.

Reporting Period: Answer questions #1-22 based on the practices currently in place at the time you submit this section of the Survey.

Note: As a reminder, the [Corrections Period](#) (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

Training and Education

<p>1) Do individuals who touch patients or who touch items that will be used by patients¹² in your facility receive hand hygiene training from a professional with appropriate training and skills¹³ at both:</p> <ul style="list-style-type: none"> • the time of onboarding, and • annually thereafter? <p><i>If "no" to question #1, skip questions #2-3 and continue to question #4.</i></p>	<p style="text-align: center;">Yes No</p>
<p>2) In order to pass the initial hand hygiene training, do individuals who touch patients or who touch items that will be used by patients¹² need to physically demonstrate proper hand hygiene with soap and water and alcohol-based hand sanitizer?</p>	<p style="text-align: center;">Yes No</p>
<p>3) Are all six of the following topics included in your facility's initial and annual hand hygiene training?</p> <ul style="list-style-type: none"> • Evidence linking hand hygiene and infection prevention • When individuals who touch patients or who touch items that will be used by patients¹² should perform hand hygiene (e.g., WHO's 5 Moments for Hand Hygiene, CDC's Guideline for Hand Hygiene) • How individuals who touch patients or who touch items that will be used by patients¹² should clean their hands with alcohol-based hand sanitizer and soap 	<p style="text-align: center;">Yes No</p>

<p>and water as to ensure they cover all surfaces of hands and fingers, including thumbs and fingernails</p> <ul style="list-style-type: none"> • When gloves should be used in addition to hand washing (e.g., caring for <i>C. diff.</i> patients) and how hand hygiene should be performed when gloves are used • The minimum time that should be spent performing hand hygiene with soap and water and alcohol-based hand sanitizer • How hand hygiene compliance is monitored 	
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Infrastructure

<p>4) Does your facility have a process in place to ensure that all the following are done, as necessary, and quarterly audits are conducted on a sample of dispensers to ensure that the process is followed?</p> <ul style="list-style-type: none"> • Refill paper towels, soap dispensers, and alcohol-based hand sanitizer dispensers when they are empty or near empty • Replace batteries in automated paper towel dispensers, soap dispensers, and alcohol-based hand sanitizer dispensers (if automated dispensers are used in the facility) 	<p>Yes No</p>
<p>5) Do all rooms and bed spaces in your surgical and treatment areas have</p> <ul style="list-style-type: none"> • an alcohol-based hand sanitizer dispenser located at the entrance to the room or bed space, and • alcohol-based hand sanitizer dispenser(s) located inside the room or bed space that are equally accessible to the location of all patients in the room or bed space? 	<p>Yes No</p>
<p>6) Does your facility conduct audits of the volume of alcohol-based hand sanitizer that is delivered with each activation of a wall-mounted dispenser (manual and automated) on a sample of dispensers in your facility at all the following times:</p> <ul style="list-style-type: none"> • upon installation, • whenever the brand of product or system changes, and • whenever adjustments are made to the dispensers. <p>OR</p> <p>Has your facility conducted an audit of the volume of alcohol-based hand sanitizer that is delivered with each activation of a wall-mounted dispenser (manual and automated) on a sample of your facility's <u>existing</u> dispensers if there have been no changes to any dispensers?</p> <p><i>If "no" or "does not apply, wall-mounted dispensers are not used," skip question #7 and continue to question #8.</i></p>	<p>Yes No <i>Does not apply, wall-mounted dispensers are not used</i></p>
<p>7) Do all the audited dispensers deliver, with one activation, 1.0 mL of alcohol-based hand sanitizer OR a volume of alcohol-</p>	<p>Yes No</p>

based sanitizer that covers the hands completely and requires 15 or more seconds for hands to dry (on average)?	
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Monitoring

<p>8) Does your facility collect hand hygiene compliance data on at least 200 hand hygiene opportunities, or at least the number of hand hygiene opportunities outlined in Table 1, each month?</p> <p><i>If “yes” to question #8, skip questions #9-10 and continue to question #11.</i></p>	<p><i>Yes, using an electronic compliance monitoring system throughout the facility</i></p> <p><i>Yes, using an electronic compliance monitoring system throughout some areas and only direct observation in all other areas</i></p> <p><i>Yes, using only direct observation throughout the facility</i></p> <p><i>No</i></p>
<p>9) Does your facility collect hand hygiene compliance data on at least 100 hand hygiene opportunities, or at least the number of hand hygiene opportunities outlined in Table 2, each month?</p> <p><i>If “yes” to question #9, skip question #10 and continue to question #11.</i></p>	<p><i>Yes, using an electronic compliance monitoring system throughout the facility</i></p> <p><i>Yes, using an electronic compliance monitoring system throughout some areas and only direct observation in all other areas</i></p> <p><i>Yes, using only direct observation throughout the facility</i></p> <p><i>No</i></p>
<p>10) Does your facility collect hand hygiene compliance data on at least 100 hand hygiene opportunities each quarter?</p> <p><i>If “no” to question #10, skip questions #11-19 and continue to question #20.</i></p>	<p><i>Yes, using an electronic compliance monitoring system throughout the facility</i></p> <p><i>Yes, using an electronic compliance monitoring system throughout some areas and only direct observation in all other areas</i></p> <p><i>Yes, using only direct observation throughout the facility</i></p> <p><i>No</i></p>
<p>11) Does your facility use hand hygiene coaches or compliance observers to provide individuals who touch patients or who touch items that will be used by patients¹² with feedback on both when they are and are not compliant with performing hand hygiene?</p>	<p><i>Yes</i></p> <p><i>No</i></p>

Direct Monitoring – Electronic Compliance Monitoring System

If “yes, using an electronic compliance monitoring system throughout the facility” or “yes, using an electronic compliance monitoring system throughout some areas and only direct observation in all other areas” to question #8, question #9 or question #10, answer questions #12-13 based on the surgical or treatment areas that use an electronic compliance monitoring system.

<p>12) In those surgical or treatment areas where an electronic compliance monitoring system is used, does the monitoring system used meet both of the following criteria?</p> <ul style="list-style-type: none"> • The system can identify both opportunities for hand hygiene and that hand hygiene was performed • The facility itself has validated the accuracy of the data collected by the electronic compliance monitoring system 	<p>Yes No</p>
<p>13) In those surgical or treatment areas where an electronic compliance monitoring system is used, are direct observations also conducted for coaching and intervention purposes that meet all the following criteria?</p> <ul style="list-style-type: none"> • Observers immediately intervene prior to any harm occurring to provide non-compliant individuals with immediate feedback • Observations identify both opportunities for hand hygiene and compliance with those opportunities • Observations determine who practiced hand hygiene, verify when they practiced it, and whether their technique was correct • Observations are conducted weekly or monthly across all shifts and on all days of the week proportional to the number of individuals who touch patients or who touch items that will be used by patients¹² on duty for that shift • Observations capture a representative sample of the different roles of individuals who touch patients or who touch items that will be used by patients¹² (e.g., nurses, physicians, techs, environmental services workers) 	<p>Yes No</p>

Direct Monitoring – Direct Observation

If “yes, using an electronic compliance monitoring system throughout some areas and only direct observation in all other areas” or “yes, using only direct observation throughout the facility” to question #8, question #9, or question #10, answer questions #14-15 based on the surgical or treatment areas that do NOT use an electronic compliance monitoring system.

<p>14) In those surgical or treatment areas where an electronic compliance monitoring system is NOT used, do the direct observations meet all the following criteria?</p> <ul style="list-style-type: none"> • Observations identify both opportunities for hand hygiene and compliance with those opportunities • Observations determine who practiced hand hygiene, verify when they practiced it, and whether their technique was correct • Observations are conducted weekly or monthly across all shifts and on all days of the week proportional to the number of individuals who touch patients or who touch items that will be used by patients¹² on duty for that shift 	<p>Yes No</p>
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<ul style="list-style-type: none"> Observations are conducted to capture a representative sample of the different roles of individuals who touch patients or who touch items that will be used by patients¹² (e.g., nurses, physicians, techs, environmental services workers) 	
15) Does your facility have a system in place for both the initial and recurrent training and validation of hand hygiene compliance observers?	Yes No

Feedback

16) Are hand hygiene compliance data fed back to individuals who touch patients or who touch items that will be used by patients ¹² at least monthly for improvement work?	Yes No
17) Are hand hygiene compliance data used for creating action plans?	Yes No
18) Is regular (at least every 6 months) feedback of hand hygiene compliance data, with demonstration of trends over time, given to: <ul style="list-style-type: none"> ASC leadership, and ASC governance? <p><i>If "no" to question #18, skip question #19 and continue to question #20.</i></p>	Yes No
19) If "yes" to question #18, is ASC leadership held directly accountable for hand hygiene performance through performance reviews or compensation?	Yes No

Culture

20) Are patients and visitors invited to remind individuals who touch patients or who touch items that will be used by patients ¹² to perform hand hygiene?	Yes No
21) Has ASC leadership demonstrated a commitment to support hand hygiene improvement in the last year (e.g., a written or verbal commitment delivered to those individuals who touch patients or who touch items that will be used by patients ¹²)?	Yes No
22) Do all rooms and bed spaces in your surgical and treatment areas have a sink for hand washing within 20 feet of the patient's bed that is easily accessible to individuals who touch patients or who touch items that will be used by patients ¹² ?	Yes No

Instructions for Reporting on Section 4D: National Quality Forum (NQF) Safe Practices

1. **Prepare:**
 - a. Download and review a copy of the National Quality Forum's *Safe Practices for Better Healthcare – 2010 Update* report for reporting on subsection 4D (see link on <https://www.leapfroggroup.org/asc-survey-materials/survey-materials>)
 - b. Print and review a hard copy of (1) the Survey questions, (2) practice-specific FAQs, and (3) the scoring algorithm
2. **Identify Individuals to Assist:** Decide who should participate on your team to assist in collection of the documentation for assessment.
3. **Plan:** The team should be briefed and assigned duties to help capture the key information necessary for submission of this section.
4. **Collect and Maintain:** Key documentation must be collected to support answering the questions in this section of the Survey. Please refer to the [Survey Binder](#) for examples of acceptable documentation. Documentation should be maintained to ensure that your ASC can respond to Leapfrog's request for documentation should you be selected for our [random monthly review](#). Reviews are performed every month during the Survey Cycle (April 1 to November 30) and throughout the Corrections Period). In addition, the documentation can be helpful if your facility is planning to update and resubmit this section of the Survey prior to November 30.
5. **Assess:** When all the supporting documents are assembled, it is recommended that ASCs review their final responses to Section 4D with their responsible leadership. ASCs should update their answers online as they adopt additional practices throughout the Survey Cycle (April 1 to November 30). As a reminder, the [Corrections Period](#) (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.
6. **Submit:** Section 4 must be completed and affirmed before it can be submitted with the Survey.

Important Note: In the Online ASC Survey Tool, make sure to click the “**Review of this Practice Complete**” checkbox at the bottom of each safe practice even if no items are checked, to mark the Safe Practice as complete. This checkbox must be checked for each NQF-endorsed Safe Practice in order to affirm Section 4 in the Online ASC Survey Tool.

NQF Safe Practice #1 – Culture of Safety Leadership Structures and Systems

Important Notes:

Note 1: Page numbers in Section 4D refer to the [NQF Safe Practices for Better Healthcare – 2010 Update](#) report, not this document.

Note 2: Hyperlinks throughout Section 4D refer to [practice-specific FAQs](#) beginning on page 133, not to endnotes. These hyperlinks are not included in the Online Survey Tool.

Check all boxes that apply.

AWARENESS	<p>1.1 Within the last 12 months, in regard to raising the awareness of key stakeholders to our facility’s efforts to improve patient safety, the following actions related to the identification and mitigation of risks and hazards have been taken:</p> <p>a <input type="checkbox"/> governance meeting minutes reflect regular communication regarding all three of the following:</p> <ul style="list-style-type: none"> • risks and hazards (as defined by Safe Practice #4, Identification and Mitigation of Risks and Hazards); • culture measurement (as defined by Safe Practice #2, Culture Measurement, Feedback, and Intervention); and • progress towards resolution of safety and quality problems. (p.75) <p>b <input type="checkbox"/> steps have been taken to report ongoing efforts to improve safety and quality in the facility and the results of these efforts to the community. (p.75)</p> <p>c <input type="checkbox"/> all staff and independent practitioners were made aware of ongoing efforts to reduce risks and hazards and to improve patient safety and quality in the facility. (p.75)</p>
ACCOUNTABILITY	<p>1.2 Within the last 12 months, in regard to holding governance and leadership directly accountable for results related to the identification and mitigation of risks and hazards, the facility has done the following:</p> <p>a <input type="checkbox"/> an integrated patient safety program has been in place for the entire reporting period providing oversight and alignment of safe practice activities. (p.76)</p> <p>b <input type="checkbox"/> a Risk Manager or Quality Coordinator has been appointed and communicates regularly with governance and leadership; the Risk Manager or Quality Coordinator is the primary point of contact of the integrated patient safety program. (p.76)</p> <p>c <input type="checkbox"/> performance has been documented in performance reviews and/or compensation incentives for leadership and ASC-employed caregivers. (p.76)</p>

	<p>d <input type="checkbox"/> the patient safety team, Risk Manager, or Quality Coordinator communicated regularly with leadership regarding both of the following and documented these communications in meeting minutes (p. 76-77):</p> <ul style="list-style-type: none"> • progress in meeting safety goals; and • provide team training to caregivers. <p>e <input type="checkbox"/> the facility reported adverse events to external mandatory or voluntary programs. (p.77)</p>
<p style="writing-mode: vertical-rl; transform: rotate(180deg);">ABILITY</p>	<p>1.3 Within the last 12 months, in regard to implementation of the patient safety program, governance and leadership have provided resources to cover the implementation, as evidenced by:</p> <p>a <input type="checkbox"/> dedicated patient safety program budgets to support the program, staffing, and technology investment. (p.77)</p>
<p style="writing-mode: vertical-rl; transform: rotate(180deg);">ACTION</p>	<p>1.4 Within the last 12 months, structures and systems have been in place to ensure that leadership is taking direct action, as evidenced by:</p> <p>a <input type="checkbox"/> leadership is personally engaged in reinforcing patient safety improvements (e.g., holding patient safety meetings and reporting to governance). Calendars reflect allocated time. (p.78)</p> <p>b <input type="checkbox"/> facility has established a structure for input into the patient safety program by licensed independent practitioners and the organized medical staff and physician leadership. Input documented in meeting minutes or materials. (p.79)</p>
<p>1.5</p>	<p><input type="checkbox"/> Review of this Safe Practice is complete.</p> <p><i>This check box is in the Online ASC Survey Tool to ensure that your facility has reviewed the data entry for the above questions. This question must be marked, even if no items are checked.</i></p>

NQF Safe Practice #2 – Culture Measurement, Feedback, and Intervention

2.1	<p>Does your facility currently have 20 or more employees?</p> <p><i>If “no” to question #2.1, skip the remaining questions in NQF Safe Practice #2 and continue to the next subsection. The facility will be scored as “Does Not Apply.”</i></p>	<p>Yes No</p>
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Check all boxes that apply.

2.2	AWARENESS	<p>Within the last 24 months, in regard to culture measurement, our facility has done the following:</p> <p>a <input type="checkbox"/> Administered one of the following culture of safety surveys to employees:</p> <ul style="list-style-type: none"> • AHRQ Survey on Patient Safety (SOPS), • Glint Patient Safety Pulse, • Press Ganey Safety Culture Survey, or • Safety, Communication, Organizational Reliability, Physician & Employee Burnout and Engagement (SCORE) Survey <p><i>If item ‘a’ is not checked, no other items in Practice #2 may be checked.</i></p> <p>b <input type="checkbox"/> benchmarked results of the culture of safety survey against external organizations, such as “like” ASCs or other comparable facilities within the same health system.</p> <p>c <input type="checkbox"/> Risk Manager, Quality Coordinator, or leadership used the results of the culture of safety survey to debrief staff using semi-structured approaches for the debriefings and presenting results in aggregate form to ensure the anonymity of survey respondents.</p>
2.3	ACCOUNTABILITY	<p>Within the last 24 months, in regard to accountability for improvements in culture measurement, our facility has done the following:</p> <p>a <input type="checkbox"/> shared the results of the culture of safety survey with governance and leadership in a formal report and discussion. (p.88)</p> <p>b <input type="checkbox"/> included in performance evaluation criteria for leadership, both the response rates to the culture of safety survey and the use of the culture of safety survey results in the improvement efforts.</p>
2.4	ABILITY	<p>Within the last 12 months, in regard to culture measurement, the facility has done the following (or has had the following in place):</p> <p>a <input type="checkbox"/> conducted staff education program(s) on methods to improve the culture of safety, tailored to the facility’s culture of safety survey results.</p>

	<p>b <input type="checkbox"/> included the costs of culture measurement/follow-up activities in the patient safety program budget.</p>
2.5	<p>Within the last 12 months, in regard to culture measurement, feedback, and interventions, our facility has done the following (or has had the following in place):</p> <p>a <input type="checkbox"/> developed or implemented explicit, facility-wide organizational policies and procedures for regular culture measurement. (p.88)</p> <p>b <input type="checkbox"/> identified performance improvement interventions based on the culture of safety survey results, which were shared with leadership and subsequently measured and monitored. (p.88)</p>
2.6	<p><input type="checkbox"/> Review of this Safe Practice is complete.</p> <p><i>This check box is in the Online ASC Survey Tool to ensure that your facility has reviewed the data entry for the above questions. This question must be marked, even if no items are checked.</i></p>

Additional Question (Optional – Fact Finding Only)

2.7	<p>What was the response rate (i.e., rate of returned surveys) among employees that were administered the culture of safety survey within the past 36 months?</p>	<p>>= 75%</p> <p>50-74%</p> <p>25-49%</p> <p><25%</p>
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4.4	<p><input type="checkbox"/> Review of this safe practice is complete.</p> <p><i>This check box is in the Online ASC Survey Tool to ensure that your facility has reviewed the data entry for the above questions. This question must be marked, even if no items are checked.</i></p>
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4E: Never Events

Important Note: To earn credit for these questions, facilities must have a policy in place that addresses the National Quality Forum's list of 25 Serious Reportable Events that are applicable to Ambulatory Practice Settings/Office-based Practices. All references to "never event" or "serious reportable event" are specific to the National Quality Forum list available at

https://www.qualityforum.org/topics/sres/serious_reportable_events.aspx.

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

Note: As a reminder, the [Corrections Period](#) (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

Below are the nine elements which make up The Leapfrog Group's Policy Statement regarding [never events](#).¹⁴ Indicate which of the following principles are included in your facility's current never events policy.

1) We apologize to the patient ¹⁵ and/or family affected by the never event ¹⁴ .	Yes No
2) We report the event to at least one of the following external agencies ¹⁶ within 15 business days of becoming aware that the never event ¹⁴ has occurred: <ul style="list-style-type: none"> √ State reporting program for medical errors √ Patient Safety Organization (as defined in The Patient Safety and Quality Improvement Act of 2005) √ Accreditation Organizations (i.e., TJC, AAAHC, AAAASF, HFAP, etc.) 	Yes No
3) We perform a root cause analysis ¹⁷ which at a minimum, includes the elements required by the chosen external reporting agency.	Yes No
4) We waive all costs directly related to the never event ¹⁴ . <i>In order to respond "yes" to this question, all costs directly related to the never event must be waived to both the patient and the payor.</i>	Yes No
5) We make a copy of this policy available to patients, patients' family members, and payers upon request.	Yes No
6) We interview patients and/or families who are willing and able, to gather evidence for the root cause analysis ¹⁷ .	Yes No
7) We inform the patient and/or the patient's family of the action(s) that our facility will take to prevent future recurrences of similar events based on the findings from the root cause analysis ¹⁷ .	Yes No

<p>8) We have a protocol in place to provide support for caregivers involved in never events¹⁴ and make that protocol known to all caregivers and affiliated clinicians.</p>	<p>Yes No</p>
<p>9) We perform an annual review to ensure compliance with each element of Leapfrog’s Never Events Policy for each never event¹⁴ that occurred.</p> <p><i>Cannot respond “yes” to this question, unless “yes” to questions #1-8.</i></p>	<p>Yes No</p>

4F: Nursing Workforce

Specifications: See [Nursing Workforce Measure Specifications](#) in the Reference Information beginning on page 129.

Reporting Period: 12 months

Answer questions #1-3 based on the most recent day within the last 12-months for which you have complete data.

Note: As a reminder, the [Corrections Period](#) (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or

Percentage of RNs who are BSN-Prepared

<p>1) Did your facility calculate the BSN-prepared measure for the reporting period, and do you choose to report those data to this Survey?</p> <p><i>If “no” to question #1, skip questions #2-3 and continue to the Affirmation of Accuracy. The facility will be scored as “Limited Achievement.”</i></p>	<p>Yes No</p>
<p>2) Total number of employed RN nursing staff at the facility with direct patient care responsibilities.</p>	<p>_____</p>
<p>3) Total number of employed RN nursing staff at the facility with direct patient care responsibilities who have a BSN degree or higher (e.g., MSN, DNP, or PhD).</p>	<p>_____</p>

Section 4: Patient Safety Practices Reference Information

What's New in the 2023 Survey

Section 4A: Medication Safety

Leapfrog is updating the specifications to clarify that only medications newly prescribed at discharge should be counted as medications prescribed at discharge and/or administered during the visit. We are also adding intra-op irrigation solutions to the list of excluded medications and updating the measure specifications to exclude the dose requirement for lidocaine jelly.

There are no changes to the scoring algorithm for Section 4A: Medication Safety.

Section 4B: NHSN Outpatient Procedure Component Module

The deadlines to join Leapfrog's NHSN Group and associated reporting periods for all four NHSN data downloads for the 2023 Survey Cycle are available in the [Deadlines and Reporting Period table](#).

There are no changes to the scoring algorithm for Section 4B: NHSN Outpatient Procedure Component Module.

Section 4D: National Quality Forum (NQF) Safe Practices

NQF Safe Practice #2 – Culture Measurement, Feedback, and Intervention

Leapfrog is adding the Safety, Communication, Organizational Reliability, Physician & Employee Burnout and Engagement (SCORE) Survey, developed by Safe & Reliable, to the list of valid and reliable culture of safety surveys ASCs can administer to meet the requirement of practice element 2.2a.

There are no changes to the scoring algorithm for Section 4D: NQF Safe Practice #2.

NQF Safe Practice #4 – Risks and Hazards

Leapfrog will score and publicly report NQF Safe Practice #4, which asks ASCs if they have implemented six key elements outlined in the National Quality Forum's [Safe Practices for Better Healthcare – 2010 Update](#). ASCs will be scored based on how many elements they have adhered to within the last 12 months.

Section 4E: Never Events

Leapfrog is clarifying question #4, which asks if facilities waive all costs related to all [never events](#), by stating that costs must be waived to both the patient and the payor.

Section 4F: Nursing Workforce

Leapfrog will score responses and publicly report results for the Percentage of RNs who are BSN-prepared measure.

Change Summary Since Release

None. If substantive changes are made to this section of the Survey after release on April 1, 2023, they will be documented in this Change Summary section.

Section 4A: Medication Safety Measure Specifications

Medication and Allergy Documentation

<p>Source: The Leapfrog Group</p>
<p>Reporting Period: 12 months</p> <ul style="list-style-type: none"> • Surveys submitted prior to September 1: <ul style="list-style-type: none"> ▪ 01/01/2022 – 12/31/2022 • Surveys (re)submitted on or after September 1: <ul style="list-style-type: none"> ▪ 07/01/2022 – 06/30/2023
<p>Medication Safety Documentation Workbook (Excel)</p> <p>To complete the data collection for this subsection and respond to questions #3-7, facilities should download the Medication Safety Documentation Workbook (Excel). This workbook includes seven tabs: Instructions, 2022 Sampling, 2023 Sampling, Home Meds, Visit Meds, Allergies, and Data Entry and can be used to identify patients to sample in order to complete the three clinical record audits, as well as calculate the responses to enter into the Online ASC Survey Tool for each of the audits.</p> <p>This workbook is available on the Survey Materials webpage and should be used when completing this subsection.</p>
<p>Sampling: If you have more than 30 cases that meet the criteria for inclusion in the denominator of the process measures during the time period of the clinical record audit, you may randomly sample 30 of them for the denominator of each documentation guideline, and measure and report adherence based on that sample. When sampling from a larger population of cases, this is the minimum number of cases needed to make a statistically reliable statement of percent adherence to the process guidelines.</p>
<p>Medications: For the purposes of this measure, a medication is a substance that is taken into, or placed onto, the body of a person for one or more of the following reasons:</p> <ul style="list-style-type: none"> • as a placebo • to prevent a disease (e.g., flu vaccine) • to make a diagnosis (e.g., contrast dye) • to test for the possibility of an adverse effect • to modify a physiological, biochemical, or anatomical function or abnormality (e.g., heparin/heparin flushes, statins, antihypertensives, etc.) • to replace a missing factor (e.g., blood product) • to ameliorate a symptom (e.g., aspirin) • to treat a disease or condition (including topicals, nasal sprays, eye drops, compounds, inhalants, injectables, patches, etc.) • to induce anesthesia • to stabilize or hydrate during medical treatment or procedures (e.g., IV fluids, normal saline, lactated ringers, etc.) • to provide nutrition (e.g., enteral nutrition products, parenteral nutrition products) • as a supplement (e.g., iron for a patient with iron deficiency anemia or calcium/vitamin D for a patient with osteoporosis) <p>For the purpose of this measure, the following are not considered medications:</p> <ul style="list-style-type: none"> ▪ Pre-filled saline flushes and pre-filled heparin flushes ▪ Chlorhexidine and alcohol preparation pads ▪ Intra-op irrigation solutions

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

Your facility should perform a clinical record audit of either all adult and/or pediatric patients undergoing those procedures included in Section 3A discharged during the reporting period or a sufficient sample of those patients discharged during the reporting period as described above.

This audit of clinical records can be done retrospectively (anytime during the Survey Cycle of April 1 – November 30).

The total number of clinical records included in your audit is reported in question #3.

Excluded cases:

- Patients discharged from the facility without having one of the procedures included in Section 3A performed during the reporting period.

Question #4 (numerator): Number of cases in question #3 with a list of all home medication(s), including dose, route, and frequency, documented in the clinical record.

Determine the total number of clinical records included in the audit (in question #3), where a list of all home medication(s), including dose, route, and frequency, was documented in the clinical record either on the day of the procedure or after a pre-screening phone call (i.e., 1-2 days in advance of the procedure). Records that include documentation that the patient had no home medications should be included.

“Home medications” are defined as medications that the patient was taking prior to admission.

The following home medications may be excluded from the clinical record unless they are clinically relevant (e.g., herbal supplement that is known to interact with anesthesia):

- as needed (PRN) medications
- topical lotions/creams
- saline nasal spray and artificial tear eye drops
- herbals and supplements and vitamins

The following home medications must be included in the clinical record:

- clinically relevant PRN medications such as inhalers, nitroglycerin, analgesics (opioid and non-opioid), muscle relaxants, and sedatives
- clinically relevant is defined as any PRN medication that treats a medical condition on the patient’s problem list and/or condition they are being treated for during the visit (i.e., reason for the procedure)

Included cases:

- The clinical record includes documentation that the patient has no home medications.

Excluded cases:

- The clinical record is missing a list of all home medication(s).
- The clinical record is missing dose, route, or frequency for a home medication.

Question #5 (numerator): Number of cases in question #3 with a list of all medication(s) administered during the visit and/or new medications prescribed at discharge, including the strength, dose, route, date, and time of administration, documented in the clinical record.

Determine the total number of clinical records included in the audit (question #3), where a list of all medication(s) administered during the visit and/or new medications prescribed at discharge, including the strength, dose, route, date, and time of administration, was documented in the clinical record on the day of the procedure.

Local, regional, and general anesthesia medications must only **have total dose, date, and time of administration** documented in the clinical record to be considered complete.

IV solutions must have **strength, dose, route, date, and time of administration** documented in the clinical record to be considered complete. However, if the IV solution only comes in one concentration/strength (such as the LR Injection), the strength can be entered as N/A and the start time and volume of the bag can be documented for dose in order to be considered complete.

New medications prescribed at discharge, but not administered at the facility must only have **strength, dose, route, and date the medication was prescribed** documented in the clinical record to be considered complete.

Excluded cases:

- The clinical record is missing a medication that was administered or prescribed during the visit or at discharge.
- The clinical record is missing strength, dose, route, date, **or** time of administration for a medication administered or prescribed during the visit or at discharge except as described above for anesthesia medications, IV solutions, and prescribed medications.
- The clinical record is missing dose for lidocaine jelly.

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

Determine the total number of clinical records included in the audit (question #3), where a list of all medication allergies and adverse reaction(s) was documented in the clinical record. Facilities should only assess medication allergies (i.e., facilities do not need to assess food or environmental allergies).

Included cases:

- The clinical record includes documentation that the patient reported no known allergies.

Excluded cases:

- The clinical record does **not** include either a list of allergies and adverse reaction(s) **nor** documentation of no known allergies.
- The clinical record does include a list of allergies but does not include documentation of the adverse reaction(s) for each allergy.

Important Note: In addressing allergies and adverse reaction statuses noted as “unknown” in the clinical record, facilities should assess if:

1) “unknown” is used to indicate that the patient (or patient’s family) was asked for the adverse reaction status, but they indicated it was not known, in which situation the case should be included in the numerator (question #6); or

2) “unknown” is used in the clinical record to indicate that the information is not available because it was not requested or documented by the clinician, in which situation the case should be excluded from the numerator (question #6)

See [FAQs](#) for additional information about responding to questions in this section.

Section 4B: NHSN Outpatient Procedure Component Module Measure Specifications

Important Notes:

Note 1: Facilities must provide an accurate NHSN ID in the Profile section of their Survey.

Note 2: Data is obtained directly from CDC's National Healthcare Safety Network (NHSN). Data will be available on the ASCs Details Page, as well as scored and publicly reported by Leapfrog, in July for facilities that:

1. Join Leapfrog's NHSN Group for ASCs by June 22,
2. Enter a valid NHSN ID in the Profile Section of their 2023 Leapfrog ASC Survey, and
3. Complete, affirm, and submit the 2023 Leapfrog ASC Survey by June 30.

For instructions and all other deadlines and release dates, please refer to the "ASC NHSN Guidance: Join the Group, Review/Accept Data Rights Template, and Download Reports" and the "Deadlines and Reporting Periods" table (below), which are also provided on the [Join ASC NHSN Group webpage](#).

Join Leapfrog's NHSN group by	Leapfrog will download data from NHSN for all current group members on	Data downloaded from NHSN will be scored and publicly reported for ASCs that have submitted a Survey by	SDOM and SSI Reporting Period	Available on ASC Details Page and Public Reporting Website on
June 22, 2023	June 23, 2023	June 30, 2023	Latest 6 months prior to Survey submission	July 12, 2023 Details Page July 25, 2023 Public Reporting Website
August 23, 2023	August 24, 2023	August 31, 2023	Latest 6 months prior to Survey submission	September 8, 2023
October 23, 2023	October 24, 2023	October 31, 2023	Latest 6 months prior to Survey submission	November 7, 2023
December 20, 2023	December 21, 2023*	November 30, 2023	Latest 6 months prior to Survey submission	January 8, 2024

Leapfrog will provide step-by-step instructions for ASCs to download the same reports that Leapfrog downloads for each of the NHSN data downloads on our [website](#) by April 1.

* The Leapfrog ASC Survey closes on November 30, 2023. The last NHSN data download is on December 21, 2023, to incorporate any facilities and corrections from facilities that joined by the last join date of December 20, 2023.

Section 4C: Hand Hygiene Measure Specifications

Source: The framework and questions in this subsection are modeled after the World Health Organization's [Hand Hygiene Self-Assessment Framework](#).

Reporting Period: Answer questions #1-22 based on the practices currently in place at the time you submit this section of the Survey.

Note: For monitoring, this means that the monthly sample size (or quarterly sample size if answering question #10) would need to be met at least once the month (or quarter) preceding the time of the submission of the Survey and there must be a process in place to meet the monthly (or quarterly) sample size thereafter every month/quarter.

If the monitoring sample size is not met at any point after submission, the Survey must be updated and re-submitted. More information about updating a Survey can be found at <https://www.leapfroggroup.org/asc-survey-materials/updating-your-asc-survey>.

Areas: Facility responses should reflect surgical or treatment areas, which include pre-operative rooms, operating and procedure rooms, post-operative rooms.

Infrastructure

Question #4: Does your facility have a process in place to ensure that **all** the following are done, as necessary, and quarterly audits are conducted on a sample of dispensers to ensure that the process is followed?

- Refill paper towels, soap dispensers, and alcohol-based hand sanitizer dispensers when they are empty or near empty
- Replace batteries in automated paper towel dispensers, soap dispensers, and alcohol-based hand sanitizer dispensers (if automated dispensers are used in the facility)

In order to respond “yes” to question #4, a process must be in place to ensure that paper towel, soap, and alcohol-based hand sanitizer dispensers are refilled when they are empty or near empty and batteries are replaced in automated paper towel, soap, and alcohol-based hand sanitizer dispensers (if automated dispensers are used in the facility).

In addition, a quarterly audit must be conducted on a sample of paper towel, soap, and alcohol-based hand sanitizer dispensers to include checking that dispensers are refilled and that batteries in automated dispensers are replaced. The quarterly audit should be a supplement to a system that checks these supplies on a routine basis (e.g., environmental services check with their regular cleaning).

Sampling Instructions: The sample must be based on a random or systematic sampling procedure, where the sampling plan assures wide sampling (i.e., the same places would not always be monitored) and includes at least 5% of the dispensers.

Question #6: Does your facility conduct audits of the volume of alcohol-based hand sanitizer that is delivered with each activation of a wall-mounted dispenser (manual and automated) on a sample of dispensers in your facility at **all** the following times:

- upon installation
- whenever the brand of product or system changes; and
- whenever adjustments are made to the dispensers

OR

Has your facility conducted an audit of the volume of alcohol-based hand sanitizer that is delivered with each activation of a wall mounted dispenser (manual and automated) on a sample of your facility's existing dispensers if there have been no changes to any dispensers?

In order to respond "yes" to question #6, a volume audit on a sample of wall-mounted alcohol-based hand sanitizer dispensers (manual and automated) in your facility must be conducted **at least** once (upon installation, whenever the brand of product or system changes, and whenever adjustments are made to the dispensers) using one of the below methods. Prior volume audits are acceptable if they were conducted using the instructions in Leapfrog's 2019-2022 Surveys, documentation has been maintained, and no changes have been made to the dispensers since the audit.

Sampling Instructions: The sample must be based on a random or systematic sampling procedure, where the sampling plan assures wide sampling (i.e., the same places would not always be monitored) and includes at least 5% of the dispensers.

Method #1 – Auditing Liquid Volume: To audit the *liquid volume* of alcohol-based hand sanitizer that is delivered with each activation of a wall-mounted dispenser (manual and automated), use the following process:

1. Select a sample of dispensers based on a random or systematic sampling procedure.
2. Take a small, graduated plastic medicine cup and have the dispenser deliver 10 doses of alcohol-based hand sanitizer.
3. Divide the total volume dispensed by 10 to get an average of the amount dispensed.

NOTE: ASCs using foam alcohol-based hand sanitizer will need to follow the steps above, but will instead need to weigh the sample, divide the results by 10 to obtain the average output of the sample, and then convert the weight in grams to milliliters by dividing the weight by the density (which can be provided by your vendor for your specific product).

Method #2 – Auditing Average Hand Rubbing Time: To audit the *average hand rubbing time* of alcohol-based hand sanitizer that is delivered with each activation of a wall-mounted dispenser (manual and automated), use the following process:

1. Select a sample of dispensers based on a random or systematic sampling procedure.
2. Identify multiple individuals (at least 10) with varying hand sizes (by quick observation).
3. For each sampled dispenser, have each of the individuals identified in step #1 dispense a volume of alcohol-based hand sanitizer dispenser.
4. For each individual, have a separate individual time the amount of hand rubbing time required for hands to dry completely.
5. Repeat this process for each individual and calculate an **average** time based on the ten observations conducted.
6. Repeat this process for each sampled dispenser.

Question #7: Do all the audited dispensers deliver, with one activation, 1.0 mL of alcohol-based hand sanitizer OR a volume of alcohol-based hand sanitizer that covers the hands completely and requires 15 or more seconds for hands to dry (on average)?

In order to respond "yes" to question #7, the **average** liquid volume for **each** sampled dispenser needs to be at least 1.0 mL (if using method #1) or the **average** hand rubbing time for **each** sampled dispenser needs to be at least 15 seconds (if using method #2).

Monitoring

Hand hygiene opportunities: Hand hygiene opportunities are the number of times that an individual who touches patients or who touches items used by patients should have cleaned their hands given the hand hygiene framework your ASC has adopted (e.g., WHO's "5 moments", Ontario's 4 moments, CDC's

guidelines, etc.). In terms of determining opportunities to monitor, this would depend on the guidelines the ASC chooses to follow.

For example, many facilities choose to audit before and after patient contact or room entry and exit because this is operationally the simplest method. Auditing opportunities before and after dirty tasks is operationally difficult. There is some evidence that measuring adherence on room entry and exit may be an acceptable stand-in for other opportunities within the patient encounter.

Question #8: Does your facility collect hand hygiene compliance data on at least **200 hand hygiene opportunities**, or at least the number of hand hygiene opportunities outlined in Table 1, **each month**?

In order to respond “yes” to question #8, your facility must monitor at least **200 hand hygiene opportunities**, or at least the number of hand hygiene opportunities outlined in Table 1, **each month** using either:

- An electronic compliance monitoring system throughout the facility
- An electronic compliance monitoring system throughout some areas and only direct observation in all other areas
- Only direct observation throughout the facility

Refer to the following table to determine how many hand hygiene opportunities must be monitored throughout the facility on a monthly basis for question #8. **Historical data** (e.g., past 3 months, 6 months, 12 months, etc.) on the monthly procedure volume should be used.

Table 1:

If your facility’s average number of procedures in a month is...	Your facility needs to collect hand hygiene compliance data for <u>at least</u> this number of <u>hand hygiene opportunities per month</u> for question #8...
400 procedures or greater	200
320-399 procedures	150
240-319 procedures	100
160-239 procedures	75
120-159 procedures	50
60-119 procedures	30
30-59 procedures	15
<30 procedures	5

Question #9: Does your facility collect hand hygiene compliance data on at least **100 hand hygiene opportunities**, or at least the number of hand hygiene opportunities outlined in Table 2, **each month**?

In order to respond “yes” to question #9, your facility must monitor at least **100 hand hygiene opportunities**, or at least the number of hand hygiene opportunities outlined in Table 2, **each month** using either:

- An electronic compliance monitoring system throughout the facility
- An electronic compliance monitoring system throughout some areas and only direct observation in all other areas
- Only direct observation throughout the facility

Refer to the following table to determine how many hand hygiene opportunities must be monitored throughout the facility on a monthly basis for question #9. **Historical data** (e.g., past 3 months, 6 months, 12 months, etc.) on the monthly procedure volume should be used.

Table 2:

If your facility's average number of procedures in a month is...	Your facility needs to collect hand hygiene compliance data for <u>at least this number of hand hygiene opportunities per month</u> for question #9...
400 procedures or greater	100
320-399 procedures	75
240-319 procedures	50
160-239 procedures	37
120-159 procedures	25
60-119 procedures	15
30-59 procedures	7
<30 procedures	2

Question #10: Does your facility collect hand hygiene compliance data on at least **100 hand hygiene opportunities each quarter**?

In order to respond "yes" to question #10, your facility must monitor at least **100 hand hygiene opportunities each quarter** using either:

- An electronic compliance monitoring system throughout the facility
- An electronic compliance monitoring system throughout some areas and only direct observation in all other areas
- Only direct observation throughout the facility

There are no alternate sample sizes for the quarterly requirement. Facilities trying to meet the quarterly requirement in question #10 will need to still monitor 100 hand hygiene opportunities a quarter.

Question #12: In those surgical or treatment areas where an electronic compliance monitoring system is used, does the monitoring system used meet **both** of the following criteria?

- The system can identify both opportunities for hand hygiene and that hand hygiene was performed
- The facility itself has validated the accuracy of the data collected by the electronic compliance monitoring system

In order to respond "yes" to question #12, the electronic monitoring system in use must identify both opportunities and that hand hygiene was performed, which could include both group monitoring systems and badge-based systems.

For example, an electronic monitoring system that records when an individual (not identified) enters and exits a room and also records if a dispenser was used within the same time frame, would qualify as the entry and exit is used as a proxy for a hand hygiene opportunity (before and after touching a patient) and the dispenser use is used as a proxy for a hand hygiene event. This data can be adjusted to take visitors into account and used to estimate hand hygiene compliance. Another example would be a badge-based system where individuals or their roles can be identified.

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

Question #13: In those surgical or treatment areas where an electronic compliance monitoring system is used, are direct observations also conducted for coaching and intervention purposes that meet **all** the following criteria?

- Observers immediately intervene prior to any harm occurring to provide non-compliant individuals with immediate feedback
- Observations identify both opportunities for hand hygiene and compliance with those opportunities
- Observations determine who practiced hand hygiene, verify when they practiced it, and whether their technique was correct
- Observations are conducted weekly or monthly across all shifts and on all days of the week proportional to the number of [individuals who touch patients or who touch items that will be used by patients](#)¹² on duty for that shift
- Observations capture a representative sample of the different roles of [individuals who touch patients or who touch items that will be used by patients](#)¹² (e.g., nurses, physicians, techs, environmental services workers)

In order to respond “yes” to question #13, direct observations must be conducted for coaching and intervention purposes and meet the following sample sizes at a minimum:

In facilities with low hand hygiene compliance*:

- On a monthly basis, the facility will need to perform 20 direct observations.
- If after collecting those observations, more than 50% of the observations were NOT compliant and/or did NOT demonstrate proper technique, the facility will need to perform an additional 20 observations the following month (40 total observations).
- The facility must continue to collect 40 observations per month until the number of observations that are NOT compliant and/or did not demonstrate proper technique is reduced to less than 50%.

Compliance rates must be assessed at least quarterly and additional observations need to be collected on a monthly basis for the entire quarter if warranted based on the above rules.

**Low hand hygiene compliance is defined as two or more standard deviations below the facility’s historical mean hand hygiene compliance rate, i.e., average from the prior 12 months.*

In all other facilities:

- On a quarterly basis, facilities using ECM need to perform 10% of the observations noted in Table 1 (e.g., if the facility would require 200 direct observations without ECM, then with the use of ECM, they need to collect 20 direct observations).

- Facilities in which direct observation data is being collected monthly (i.e., facilities with low hand hygiene compliance rates) do not require the additional quarterly data collection.

All direct observations conducted must meet the following criteria:

- Observers immediately intervene prior to any harm occurring to provide non-compliant individuals with immediate feedback
- Observations identify both opportunities for hand hygiene and compliance with those opportunities
- Observations determine who practiced hand hygiene, verify when they practiced it, and whether their technique was correct
- Observations are conducted weekly or monthly across all shifts and on all days of the week proportional to the number of [individuals who touch patients or who touch items that will be used by patients](#)¹² on duty for that shift
- Observations capture a representative sample of the different roles of [individuals who touch patients or who touch items that will be used by patients](#)¹² (e.g., nurses, physicians, techs, environmental services workers)

Observers must record at least the following:

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

Question #14: In those surgical or treatment areas where an electronic monitoring system is NOT used, do the direct observations meet all the following criteria?

- Observations identify both opportunities for hand hygiene and compliance with those opportunities
- Observations determine who practiced hand hygiene, verify when they practiced it, and whether their technique was correct
- Observations are conducted weekly or monthly across all shifts and on all days of the week proportional to the number of [individuals who touch patients or who touch items that will be used by patients](#)¹² on duty for that shift
- Observations capture a representative sample of the different roles of [individuals who touch patients or who touch items that will be used by patients](#)¹² (e.g., nurses, physicians, techs, environmental services workers)

In order to respond “yes” to question #14, direct observations must be conducted in areas that do not use an electronic compliance system and must meet the following criteria:

- Observations identify both opportunities for hand hygiene and compliance with those opportunities
- Observations determine who practiced hand hygiene, verify when they practiced it, and whether their technique was correct
- Observations are conducted weekly or monthly across all shifts and on all days of the week proportional to the number of [individuals who touch patients or who touch items that will be used by patients](#)¹² on duty for that shift

- Observations capture a representative sample of the different roles of [individuals who touch patients or who touch items that will be used by patients](#)¹² (e.g., nurses, physicians, techs, environmental services workers)

Observers must record at least the following:

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

Question #15: Does your facility have a system in place for both the initial and recurrent training and validation of hand hygiene compliance observers?

In order to respond “yes” to question #15, your facility must regularly monitor the quality and accuracy of observations that are collected by each observer through initial and recurrent validation (at least once a year) of hand hygiene compliance observers. This would include having an individual trained in infection control simultaneously collecting data with the hand hygiene compliance observers and comparing results. Alternatively, videos which include an interactive assessment and completion of an observation form, such as the [WHO Hand Hygiene Training Film](#) and [Slides Accompanying the Training Films, Videos from Hand Hygiene Australia](#), or internally developed videos with assessment, would also be sufficient for validating hand hygiene compliance observers. ASCs must expand the testing scenarios that are included in the videos (i.e., the videos should be expanded to include: various types of individuals who touch patients or who touch items that will be used by patients, a larger number of scenarios where individuals are adherent and non-adherent, the inclusion of all moments observed, etc.).

See [FAQs](#) for additional information about responding to questions in this section.

Section 4F: Nursing Workforce Measure Specifications

Percentage of RNs who are BSN-Prepared

<p>Source: The Leapfrog Group</p>
<p>Reporting Period: Answer questions #1-3 based on the most recent day within the last 12-months for which you have complete data.</p>
<p>Question 2 (denominator): Total number of employed RN Nursing Staff at the ASC with direct patient care responsibilities.</p> <p>RN Nursing Staff include staff employed by the facility but exclude temporary staff who are not employed by the facility (i.e., contracted/agency staff).</p> <p>Included employed RN Nursing Staff who:</p> <ul style="list-style-type: none"> • Are counted in the facility's staffing schedule • Are replaced if they call in sick, and • Whose work hours are included in the facility's budget <p>Excluded RN Nursing Staff who:</p> <ul style="list-style-type: none"> • Are not employed by the facility (i.e., contracted/agency staff) • Are primarily responsible for administrative tasks (at least 50% of their time is administrative) • Are facility secretaries or clerks and others with no direct patient care responsibilities <p><u>Direct Patient Care Responsibilities</u> are defined as patient centered nursing activities by facility staff in the presence of the patient and activities that occur away from the patient that are patient related:</p> <ul style="list-style-type: none"> • Medication administration • Nursing treatments • Nursing rounds • Admission, transfer, discharge activities • Patient teaching • Patient communication • Coordination of patient care • Documentation time • Treatment planning • Patient screening (e.g., risk) and assessment
<p>Question 3 (numerator): Total number of employed RN nursing staff at the facility with direct patient care responsibilities who have a BSN degree or higher (e.g., MSN, DNP, and PhD).</p> <p>Note: Facilities can use any method to identify RN nursing staff who have a BSN degree or higher, including:</p> <ul style="list-style-type: none"> • Contacting HR or credentialing office, or • Surveying staff via SurveyMonkey or other free data collection tool.

Patient Safety Practices Frequently Asked Questions (FAQs)

Medication and Allergy Documentation

1) How often do home medications need to be updated in the clinical record for Section 4A question #4?

Home medications must be recorded in a pre-screening phone call 1-2 days in advance of the procedure or updated on the day of the clinical procedure (for all procedures included in Section 3A of the 2023 Leapfrog ASC Survey).

Patients who are returning for a second or follow-up procedure within 12 months of the initial procedure are not required to have an updated home medication list in their clinical record in order for the record to be counted in the numerator of the home medication audit (i.e., included in the count in question #4). However, in cases of frequent repeated clinical visits, the home medications list should be updated at least once every 12 months.

2) For medications that only ever have a single route of administration (e.g., orally only), does route have to be documented in the clinical record for questions #4 and #5?

No. If there is a medication that can only ever be given via a single route, route does not have to be documented to count the case when responding to questions #4 and #5.

Hand Hygiene Frequently Asked Questions

General

3) For the purposes of reporting on Section 4C Hand Hygiene Practices of the Leapfrog ASC Survey:

- **Governance** should be considered to be the person or persons who:
 - Are fully and legally responsible, either directly or by appropriate professional delegation, for the operations and performance of the facility
 - Identify and hold accountable those responsible for planning, management, and operational activities, including the provision of care, treatment, or services
- **Leadership** should be considered to be the person or persons who:
 - Are responsible for planning, management, and operational activities
 - Are a physician leader, nurse leader, or administrative leader
 - Guide the facility on a day-to-day basis

Training and Education

4) Are online training modules acceptable for the purposes of question #1 and question #3?

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

For question #1, the online training must be done at the frequency specified and would need to be delivered and/or developed by a [professional with appropriate training and skills](#).¹³ For question #3, the online training must meet all six topics outlined in the question.

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

5) What are examples of what can count as “physically demonstrating” proper hand hygiene during the initial hand hygiene training?

Before new individuals to your facility have contact with patients and the patient care space, they will need to demonstrate proper hand hygiene with soap and water and alcohol-based hand sanitizer. This demonstration could be done as part of other onboarding activities, during occupational health activities as part of the TB test, during facility orientations, in small groups, etc. A group “teach-back” would be acceptable, but with no more than 10 students per one trainer/monitor. An online or in-person “simulation” would not be sufficient for this purpose. Computer-based assessments of technique are acceptable if the assessment is done without providing instructions to the individual during the assessment and feedback is given to them at the end.

Facilities that are starting to implement this component should add physical demonstration to their **initial** training for any **new hires**. Leapfrog is not asking facilities to retroactively train individuals.

Infrastructure

6) What does Leapfrog mean by “equally accessible to the location of all patients in the room or bed space” for the purposes of question #5?

Equally means the same distance from any patient’s bed, which can be measured in steps. Leapfrog is not looking for an exact distance, but rather the goal is to ensure that hand hygiene can be easily performed regardless of the location of the patient being cared for in the room or bed space.

Monitoring

7) Why did Leapfrog select 200 hand hygiene opportunities for monthly monitoring in question #8?

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

References:

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

Jun Yin MS, Heather Schacht Reisinger PhD, Mark Vander Weg PhD, Marin L. Schweizer PhD, Andrew Jesson, Daniel J. Morgan MD MS, Graeme Forrest MD, Margaret Graham, Lisa Pineles MA and Eli N. Perencevich MD MS Infection Control and Hospital Epidemiology Vol. 35, No. 9 (September 2014), pp. 11631168

8) My facility uses an electronic compliance monitoring system, but it does not meet all the criteria outlined in question #12-13. Can I report on the hand hygiene compliance data we collect via direct observation instead?

Yes. If your facility also uses direct observation to collect hand hygiene compliance data (not just for coaching/intervention) throughout the facility, you can select “yes, using only direct observation” in either question #8, question #9, or question #10 and report on your adherence to the direct observation criteria only. Otherwise, you will need to respond “no” to question #12.

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

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

We anticipate that electronic compliance monitoring technology will improve over time and become an important component of a comprehensive hand hygiene program. Electronic monitoring is a routine component of public safety in other industries where compliance is critical, so health care can and should achieve those standards for its patients.

All items included in Section 4C are based on the evidence review and recommendations from Leapfrog's national [Hand Hygiene Expert Panel](#) and others. We have included in the Hand Hygiene bibliography several peer-reviewed studies that have examined the benefits of using electronic monitoring systems over direct observation. The bibliography is available at <http://www.leapfroggroup.org/ratings-reports/hand-hygiene>.

10) Are online training modules acceptable for the purposes of training hand hygiene compliance observers in question #15?

Online training can be used for the initial and recurrent training of hand hygiene compliance observers. Please refer to the Hand Hygiene Measure Specifications for more information on the requirements for the validation of hand hygiene compliance observers.

Feedback

11) For the purposes of responding to question #19, what are some examples of how facility leadership can be held accountable through performance reviews or compensation?

A performance review or compensation plan should include specific language about hand hygiene performance. A list of hand hygiene practices and related goals may be incorporated into the performance review and/or compensation plan or formalized programs whereby a measure of success of those activities or programs is tied to individual performance reviews or compensation incentive plans of executives. Examples include meeting targets for hand hygiene compliance rates, having bonuses tied to structural changes like the implementation of electronic compliance monitoring systems, etc. Language pertaining solely to infection control practices and performance would NOT be sufficient.

Culture

12) What are some examples of how patients and visitors can be invited to remind individuals who touch patients or who touch items that will be used by patients to perform hand hygiene?

Patients and visitors can be invited to remind individuals who touch patients or who touch items that

will be used by patients to perform hand hygiene with posters placed in surgical or treatment areas, bedside placards, buttons worn by the staff, etc.

13) What are some examples of demonstrating a commitment to hand hygiene improvement as referenced in question #21?

Some examples of how individuals can demonstrate a commitment to support hand hygiene improvement are written or verbal commitments given during town hall meetings, videos, e-mails from leadership, public comments to staff, etc. This needs to be a verbal or written commitment that is delivered to those individuals who touch patients or who touch items that will be used by patients.

NQF Safe Practices Frequently Asked Questions (FAQs)

General

14) Why is each practice area broken down into the 4A Framework: Awareness, Accountability, Ability, and Action?

Organizations must have awareness of performance gaps and through direct measurement, they must be aware of their own performance gaps. Accountability of leadership to improve performance is critical to accelerate innovation adoption. An organization may be aware, and the leadership accountable, however if the staff do not have the ability to employ new practices, meaning the capacity and resources to do so, success is at risk. Finally, action must be taken with discipline over time that is measurable both by process measures and outcome measures that clearly tie to closing performance gaps.

15) For the purposes of reporting on Section 4D: NQF Safe Practices of the Leapfrog ASC Survey:

- **Governance** should be the person or persons who:
 - Are fully and legally responsible, either directly or by appropriate professional delegation, for the operations and performance of the facility
 - Identify and hold accountable those responsible for planning, management, and operational activities, including the provision of care, treatment, or services
- **Leadership** should be the person or persons who:
 - Are responsible for planning, management, and operational activities
 - Are a physician leader, nurse leader, or administrative leader
 - Guide the facility on a day-to-day basis
- **Risk Manager or Quality Coordinator** refers to the patient safety leader (who may or may not have these titles) who has responsibility for multiple and integrated areas of patient safety.
 - The facility may appoint a Risk Manager or Quality Coordinator who may have other assigned duties or may specifically employ a Risk Manager or Quality Coordinator designated with this responsibility.
 - Multiple executives who are responsible for individual areas (i.e., risk, quality, infection prevention, etc.), but do not assess the integrated safety issues, would not qualify.
- **Caregivers** include, but are not necessarily limited to the following:
 - Employed physicians, mid-levels (NPs, PAs), nurses, surgical assistants, and other clinicians involved in pre-operative, intraoperative, and post-operative care of the patient.

16) There are several references to communicating and reporting to the governance throughout Section 4. How can ASCs meet the intent of these elements?

Reporting on each specific Safe Practice element as described in the Safe Practice should occur and be documented within the reporting period. Communications and reporting must occur to the facility's governance, and reporting to internal staff committees (i.e., performance improvement committee, risk mitigation committee, safety team meeting, etc.) would not meet the intent of these elements.

17) The phrase "performance reviews or compensation" is used throughout Section 4. Do performance reviews and compensation plans need to have specific language about the Safe Practice, or can a set of patient safety goals related to the specific Safe Practice be attached?

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

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

18) There are several references to ASC budgets throughout Section 4. How can ASCs meet the intent of these elements?

The intent of these elements is to verify that actions specific to the Safe Practices have been included in ASC budgets. To meet the intent of these elements, ASCs should ensure that these actions can be identified within the facility's budget. If the budget includes categories which address the Safe Practice, but do not specifically name the Safe Practice, then the intent of the element is met.

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

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

ASCs that have invested in in-house staff educators and who include in their job descriptions the coordination and delivery of training and education to appropriate facility staff on specific Safe Practices meet the intent of this element. For example, if the position description for the Clinical Nurse Educator includes the coordination and delivery of in-service training and educational sessions related to preventing infections by improving hand hygiene, the intent of this practice is met. Training can be in-person or virtual/ computer-based.

19) How should staff education be measured?

Educational meetings should clearly address the subject matter pertinent to adverse events and performance improvement targeted by the specific Safe Practice. ASCs should track meeting dates, frequency of training sessions provided, attendance records or completion records, and the percentage of the total staff who received the information. Training can be in-person or virtual/ computer-based.

NQF Safe Practice #1 – Leadership Structures and Systems

20) 1.1a, 1.2b, and 1.2d: Several elements within Safe Practice 1 mention that “regular communication” is required. How does Leapfrog define “regular communication?”

Regular communication means more than once a year. Some facilities may discuss these items quarterly or even monthly. ASCs can document these communications took place through dated meeting minutes. We would urge ASCs to improve the detail of their governance and other meeting minutes to ensure they are able to clearly document that the issues were discussed.

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

21) 1.1b: How can an ASC document the steps that it has taken to report to the community ongoing efforts and results of these efforts to improve safety and quality?

ASCs can utilize several communication vehicles, including: webpages that are prominent from the facility’s homepage, electronic newsletters, mailings or annual reports, or an ad in the local paper. The communication must include **both** efforts the ASC is taking to improve and the results of those efforts.

22) 1.1c: How can an ASC document that all staff and independent practitioners were “made aware” of ongoing efforts to reduce risks and hazards and to improve patient safety and quality?

ASCs can share information via email or intranet, reports or presentations at meetings with meeting attendance recorded. If utilizing an intranet, ASCs must ensure that non-employed practitioners have access to the information.

23) 1.2a, 1.3a, 1.4b: What are the minimum requirements to qualify as a “patient safety program?”

As part of accreditation through The Joint Commission, ASCs are required to meet standard LD.03.09.01, which identifies the elements that must be included in an integrated patient safety program (see pages PS-32 to PS-33 in Patient Safety Systems chapter of the CAMAC). ASCs that are not accredited by The Joint Commission can use these elements as a guide as well.

24) 1.2d: What is the role of an interdisciplinary patient safety committee?

An interdisciplinary patient safety committee is an internal ASC committee that oversees the activities defined in the NQF Safe Practice #1 Practice Element Specifications and develops action plans to create solutions and changes in performance.

25) 1.2d: What is an example of team training that is appropriate for caregivers?

ASCs can utilize [TeamSTEPPS](https://www.leapfroggroup.org/asc-survey-materials/survey-materials), a comprehensive, evidence-based training program for healthcare professionals. At a minimum, the elements of basic teamwork training should be met as described on page 96 of the Safe Practices for Better Healthcare– 2010 Update, which is available for download at <https://www.leapfroggroup.org/asc-survey-materials/survey-materials>.

Team training to caregivers would need to be provided and then reported to leadership by the interdisciplinary patient safety team, Risk Manager, or Quality Coordinator to meet the intent of Safe Practice 1.2d.

26) 1.2e: How can ASCs that have not had any adverse events during the reporting period earn credit for this element?

First, we urge your ASC to reassess its conclusion that no adverse events occurred. Following the reassessment, if no adverse events were identified and the ASC can document that it has policies in place to report such events when they do occur (to a mandatory or voluntary program), the facility

would meet the intent of this element. Please see Section 4E Never Events for a list of adverse events and components of a Never Events Policy.

27) 1.4b: What are some examples of how ASCs can engage the medical staff as direct contributors to the patient safety program?

Examples may include:

- Leadership requests time on Medical Staff standing agendas to provide patient safety updates and elicit direct feedback on specific areas.
- Medical staff are invited and encouraged to be active participants in clinical meetings where patient safety is addressed.
- Governance appoints a community-based active medical staff member to represent the facility on a regional patient safety initiative.

28) 1.4b: In an ASC where all medical staff is employed, how do we answer this question?

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

NQF Safe Practice #2 – Culture Measurement, Feedback, and Intervention

29) 2.2a: Why does Leapfrog require that we administer one of these four culture of safety surveys: 1) AHRQ Survey on Patient Safety (SOPS), 2) the Glint Patient Safety Pulse, and 3) the Press Ganey Safety Culture Survey or 4) the Safety, Communication, Organizational Reliability, Physician & Employee Burnout and Engagement (SCORE) Survey?

These four culture of safety surveys have demonstrated validity, consistency, and reliability. If your facility does not administer one of these four surveys, then you should not check the box for 2.2a.

More information on these Surveys may be found:

- 1) AHRQ Survey on Patient Safety (SOPS): <https://www.ahrq.gov/sops/index.html>
- 2) the Glint Patient Safety Pulse: <https://www.glintinc.com/resource/datasheet-glint-patient-safety-pulse/>
- 3) the Press Ganey Safety Culture Survey: <https://www.pressganey.com/solutions/patient-workforce-safety/>
- 4) the SCORE Survey: <https://www.safeandreliablecare.com/score-survey>

30) 2.2a: For purposes of culture safety measurement, who should we consider to be "employees?"

The survey should be administered to all staff (clinical and nonclinical) who have worked at the ASC at least four times in the past month AND have been working at the ASC for at least six months. All staff asked to complete the survey should have enough knowledge about your ASC and its operations to provide informed answers to the survey questions. In general, include staff and doctors who interact with others working at the facility and do so often enough to be able to report on the topics assessed in the survey. Overall, when considering who should complete the survey, ask yourself:

- Does this person know about day-to-day activities at this ASC?
- Does this person interact regularly with staff working at this ASC?

The survey should be administered to full- or part-time employees, per diem employees, and those who work in the facility on a contract basis but may not be employees. Include doctors, nurses, certified registered nurse anesthetists (CRNAs), physician assistants (PAs), nurse practitioners (NPs),

technicians, management staff (facility directors, medical directors, nurse managers, office managers, etc.), and administrative, clerical, or business staff (schedulers, billing staff, receptionists, medical records, etc.). Some doctors or staff may work at more than one ASC, so distribute the survey in the facility where they spend most of their time and instruct them to answer about that ASC only. If they spend an equal amount of time at multiple ASCs, choose one facility and instruct them to answer the survey only for that facility.

31) 2.2b: What would constitute an “external organization” for benchmarking culture of safety survey results?

Although ASCs can have a variety of ownership and management arrangements, the patient safety culture survey was designed to measure patient safety at a single ASC facility. We consider each unique facility to be a separate facility for the purposes of survey administration and providing facility-specific feedback. ASCs should benchmark themselves against other facilities that have administered the same culture of safety survey.

32) 2.3b: Does performance evaluation criteria for leadership need to include the actual targeted response rate to the culture of safety survey?

Yes. The facility’s targeted response rate to the culture of safety survey should be included in performance evaluation criteria for senior administrative leadership. Criteria for using the survey results in improvement efforts should also be included to meet the intent of this element.

33) 2.4a: Which employees should be included in the staff education program?

Staff education needs to include education for all levels of staff, from leadership to frontline caregivers.

34) Why are two different reporting periods used in NQF Safe Practice #2?

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

NQF Safe Practice #4 – Risks and Hazards

35) 4.1a: Do ASCs need to have a list of recommendations for improvement based on the analysis of multiple retrospective sources?

Yes, after assessing risks and hazards to patient safety by reviewing multiple retrospective sources, ASCs should develop a list of recommendations for improvement. ASCs may find it helpful to use a severity/frequency/risk assessment grid to identify which risks and hazards the facility needs to focus on.

36) 4.1b: What is meant by “prospective identification methods?”

Proactive identification of risks and hazards to patient safety involves the use of Failure Modes and Effects Analysis (FMEA) and/or Probabilistic Risk Assessment (PRA). Facilities are most likely most familiar and have some experience with the FMEA process in conjunction with current Joint Commission standards requirements. The [NQF Safe Practices for Better Healthcare 2010 Update](#) includes several references that further illustrate how to employ use of these tools as a means to systematically identify possible failure areas before these events occur.

37) 4.1d: What are the minimum requirements for a “risk mitigation plan?”

For each patient safety risk identified from retrospective sources (4.1a) and prospective sources (4.1b), the ASC should:

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

Never Events Frequently Asked Questions (FAQs)

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

39) What if there is no “state reporting program for medical errors” in my state? Do we still have to report Never Events to meet Leapfrog principles for this policy? To whom?

Facilities in states that do not have a state reporting program or requirement in effect can meet the reporting requirement of Leapfrog’s principles for implementation of a Never Events policy by reporting all Never Events voluntarily to either an accrediting organization or a Patient Safety Organization.

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

40) The reportable adverse events defined by our state’s reporting program don’t include all twenty-five (25) Never Events endorsed by the National Quality Forum (NQF) and adopted in the Leapfrog policy. Will reporting only the state-required reportable events to the state agency suffice for meeting Leapfrog’s requirement for reporting Never Events to an external agency? Does our facility have to report other Never Events, as defined by NQF/Leapfrog, to that state agency even though not required by our state’s reporting program?

Facilities should report all of their state-required reportable events to the state agency. All other Never Events, as defined by NQF’s list of Serious Reportable Events, that cannot be reported to the state agency, should be reported to another external agency (e.g., accreditor, Patient Safety Organization), if possible. If reporting those events to another external agency is not possible, the final option is to report those events to the facility’s governance board.

41) Won’t Leapfrog’s request to have facilities apologize to the patient put the facility at risk for liability?

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

42) How does Leapfrog define “waive cost”?

At its core, Leapfrog’s approach to never events is about improving patient care. While the policy asks facilities to refrain from billing either the patient or a third-party payer, such as a health plan or employer company, for any costs directly related to a serious reportable adverse event, Leapfrog understands that, due to the wide array of circumstances surrounding never events, specific details of what constitutes “waiving cost” should be handled on a case-by-case basis by the parties involved.

43) Does Leapfrog recommend any resources for facilities looking to adhere to Leapfrog’s Never Events principles?

Yes, the Agency for Healthcare Research and Quality (AHRQ) has developed and tested the [Communication and Optimal Resolution \(CANDOR\) Toolkit](#), which outlines a process for facilities and practitioners to respond to unexpected events in a timely, thorough, and just way. The National Patient Safety Foundation (NPSF) has issued a report titled [RCA²: Improving Root Cause Analyses and Actions to Prevent Harm](#), which examines best practices and provides guidelines to help standardize and improve Root Cause Analysis. In addition, facilities can download tips and tools for interviewing patients and families for the Root Cause Analysis on the [Survey Materials webpage](#).

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SECTION 5: PATIENT EXPERIENCE (OAS CAHPS)

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

Section 5: Patient Experience (OAS CAHPS)

Outpatient Procedures Fact Sheet and Bibliography:

<https://ratings.leapfroggroup.org/measure/asc/asc-survey-measures>

Section 5 includes questions about patient experience (OAS CAHPS).

Each facility achieving the Patient Experience Standard:

Performed in the top quartile based on responses to the 2020 Leapfrog ASC Survey and Section 10 of the 2020 Leapfrog Hospital Survey submitted by August 31, 2020, for the four OAS CAHPS domains, listed below:

- a) Facilities and Staff
- b) Communication About Your Procedure
- c) Patients' Rating of the Facility
- d) Patients Recommending the Facility

Download the 2023 Leapfrog ASC Survey Scoring Algorithms on the [Scoring and Results webpage](#).

5: Patient Experience (OAS CAHPS)

Specifications: See [Patient Experience \(OAS CAHPS\) Measure Specifications](#) in the Reference Information beginning on page 147.

Reporting Period: 12 months

Answer questions #1-9 for the latest 12-month period prior to the submission of this section of the Survey.

Note: As a reminder, the [Corrections Period](#) (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

1) What is the latest 12-month reporting period for which your facility is submitting responses to this section? 12-month reporting period ending:	_____ Format: Month/Year
2) Did your facility have at least 300 eligible discharges ¹⁸ during the 12-month period referenced above? <i>If “no” to question #2, skip the remaining questions in Section 5 and go to the Affirmation of Accuracy. The facility will be scored as “Does Not Apply.”</i>	Yes No
3) Has your facility administered, or started to administer, the entire OAS CAHPS Survey during the reporting period? <i>Facilities not currently administering the OAS CAHPS Survey should answer “no” to question #3, skip the remaining questions in Section 5, and continue to the Affirmation of Accuracy. The facility will be scored as “Limited Achievement.”</i>	Yes No
4) Total number of months in which your facility administered the OAS CAHPS Survey during the reporting period.	_____ Format: Whole numbers only
5) Total number of returned surveys during the reporting period. <i>If less than 100, skip the remaining questions in Section 5 and go to the Affirmation of Accuracy. The facility will be scored as “Unable to Calculate Score.”</i>	_____

In questions #6-9, report your facility's [Top Box Score](#)¹⁹ (rounded to the nearest whole number) from each of the following patient experience **domains** from your 12-month vendor report that matches the reporting period selected in question #1.

6) Facilities and Staff	_____ Format: Whole numbers only
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7) Communication About Your Procedure	<p style="text-align: center;">_____</p> <p><i>Format: Whole numbers only</i></p>
8) Patients' Rating of the Facility	<p style="text-align: center;">_____</p> <p><i>Format: Whole numbers only</i></p>
9) Patients Recommending the Facility	<p style="text-align: center;">_____</p> <p><i>Format: Whole numbers only</i></p>

Affirmation of Accuracy

As the administrator of the Ambulatory Surgery Center (ASC) or as an employee of the ASC to whom the ASC administrator has delegated responsibility, I have reviewed this information pertaining to the Patient Experience (OAS CAHPS) Section at our ASC, and I hereby certify that this information is true, accurate, and reflects the current, normal operating circumstances at our ASC. I am authorized to make this certification on behalf of our ASC.

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

Affirmed by _____, the ASC's _____,
(First Name, Last Name) (Title)

On _____.
(Date)

Section 5: Patient Experience (OAS CAHPS) Reference Information

What's New in the 2023 Survey

Leapfrog is clarifying that ASCs must currently be administering the OAS CAHPS Survey to respond “yes” to question #3, which asks if the ASC administers, or has started to administer, the OAS CAHPS Survey.

There are no changes to the scoring algorithm for Section 5: Patient Experience (OAS CAHPS).

Change Summary Since Release

None. If substantive changes are made to this section of the Survey after release on April 1, 2023, they will be documented in this Change Summary section.

Section 5: Patient Experience (OAS CAHPS) Measure Specifications

Source: Developed by Centers for Medicare and Medicaid Services (CMS) using Agency for Healthcare Quality and Research (AHRQ) guidelines. More information available at <https://oascahps.org/General-Information/About-OAS-CAHPS-Survey>.

Reporting Period: 12 months

Report on the latest 12-month period prior to the submission of this section of the Survey.

This section of the Survey asks ASCs about their results from the [OAS CAHPS Survey](#). The first several questions are designed to learn more about the current administration of the survey. The last four questions collect the "[Top Box Score](#)"¹⁹ for each of the following four domains:

- Facilities and Staff
- Communication About Your Procedure
- Patient's Rating of the Facility
- Patients Recommending the Facility

ASCs using Press Ganey, NRC, or PRC to administer the [OAS CAHPS Survey](#) can use the CMS OAS CAHPS crosswalk below to ensure they are reporting on the correct domains. The crosswalk is designed to help translate the standard vendor report to the CMS domains used in questions #6-9.

CMS OAS CAHPS Crosswalk

CMS Domain Name	Press Ganey Domain Name	NRC Domain Name	PRC Domain Name
Facilities and Staff	Facility/Personal Treatment	About Facilities and Staff	Facility and Staff
Communication About Your Procedure	Communication	Communications About Your Procedure	Communication
Patient's Rating of the Facility	Facility Rating 0-10	Overall Rating of Facility	Overall Facility Rating
Patients Recommending the Facility	Recommend the Facility	Would Recommend Facility	Would Recommend

Question #2: Did your facility have at least 300 [eligible discharges](#)¹⁸ during the 12-month reporting period?

This section of the Survey is designed for facilities that discharged at least 300 eligible patients during the reporting period. Facilities that discharged fewer than 300 eligible patients should respond "no," skip the rest of the questions, and move on to the Affirmation of Accuracy.

Eligible discharges include discharges for adult patients (ages 18 years and older) who had both medically and non-medically necessary outpatient surgeries and/or procedures. A detailed description of patient sampling criteria, including a list of OAS CAHPS-eligible surgeries and procedures, is available in the Protocols and Guidelines Manual, version 7.0 at <https://oascahps.org/Survey-Materials>.

Question #3: Has your facility administered, or started to administer, the entire OAS CAHPS Survey, during the reporting period?

The OAS CAHPS survey includes questions about patients' experiences with their preparation for the surgery or procedure, check-in processes, cleanliness of the facility, communications with the facility staff, discharge from the facility, and preparation for recovering at home. The survey also includes questions about whether patients received information about what to do if they had possible side effects during their recovery. OAS CAHPS is designed to be national in scope and requires standardized administration protocols.

If your facility is not currently administering the OAS CAHPS Survey, a list of approved vendors is available at <https://oascahps.org/General-Information/Approved-Survey-Vendors>.

Question #4: Total number of months in which your facility administered the OAS CAHPS Survey during the reporting period.

It is recommended that facilities (or their survey vendor) sample over a 12-month period and ensure an even distribution of patients is sampled over the 12-month period. However, Leapfrog will accept OAS CAHPS results from facilities that have administered the survey over a period of time less than 12 months if they have at least 100 returned surveys.

Question #5: Total number of returned surveys during the reporting period.

It is recommended that facilities (or their survey vendor) administer the survey to a large enough sample in order to achieve 300 returned surveys in a 12-month reporting period. However, Leapfrog will accept OAS CAHPS results from facilities that have at least 100 returned surveys.

Questions #6-9: In questions #6-9, report your facility's [Top Box Score](#)¹⁹ (rounded to the nearest whole number) from each of the following patient experience domains from your 12-month vendor report that matches the reporting period selected in question #1. Facilities should not use domain scores that are publicly reported on the CMS [website](#) as these scores have been risk adjusted.

These four questions capture the Top Box Score for each of the four domains of patient experience: facilities and staff, communication about your procedure, patients' rating of the facility, and patients recommending the facility.

The following questions from the OAS CAHPS Survey are included in each domain:

Facilities and Staff

Q3: Did the check-in process run smoothly?

Q4: Was the facility clean?

Q5: Were the clerks and receptionists at the facility as helpful as you thought they should be?

Q6: Did the clerks and receptionists at the facility treat you with courtesy and respect?

Q7: Did the doctors and nurses treat you with courtesy and respect?

Q8: Did the doctors and nurses make sure you were as comfortable as possible?

Communication About Your Procedure

Q1: Before your procedure, did your doctor or anyone from the facility give you all the information you needed about your procedure?

Q2: Before your procedure, did your doctor or anyone from the facility give you easy to understand instructions about getting ready for your procedure?

Q9: Did the doctors and nurses explain your procedure in a way that was easy to understand?

Q10: Anesthesia is something that would make you feel sleepy or go to sleep during your procedure. Were you given anesthesia?

Q11: (If "yes" to Q10) Did your doctor or anyone from the facility explain the process of giving anesthesia in a way that was easy to understand?

Q12: (If “yes” to Q10) Did your doctor or anyone from the facility explain the possible side effects of the anesthesia in a way that was easy to understand?

Patients' Rating of the Facility

Q23: Using any number from 0 to 10, where 0 is the worst facility possible and 10 is the best facility possible, what number would you use to rate this facility?

Patients Recommending the Facility

Q24: Would you recommend this facility to your friends and family?

Please note that question numbers are taken from the OAS CAHPS Survey, which you can download at <https://oascahps.org/Survey-Materials>

See [FAQs](#) for additional information about responding to questions in this section.

Patient Experience (OAS CAHPS) Frequently Asked Questions (FAQs)

1) Can we report OAS CAHPS results to Leapfrog if we don't currently report our results to CMS?
Yes, ASCs can report OAS CAHPS results to Leapfrog even if they are not reporting OAS CAHPS results to CMS.

2) Isn't 300 returned surveys the minimum sample size recommended by CMS?
Yes, however, Leapfrog has received feedback that many hospitals and ambulatory surgery centers have only recently started to administer the survey. To ensure as many hospitals and ambulatory surgery centers as possible are able to report on this subsection, we have reduced the minimum sample size for reporting results to the Leapfrog Hospital and ASC Surveys to 100 returned surveys. This will help ensure that hospitals and ASCs that have made the investment to administer the Survey are able to earn credit for doing so.

If possible, however, it is recommended that facilities (or their survey vendor) administer the survey to a large enough sample in order to achieve 300 returned surveys in a 12-month reporting period.

3) We administer our own patient experience survey to collect specific information about our patient's experience. Can we report the results from our facility's patient experience survey?
No; facilities can only report the results of the official OAS CAHPS Survey on Section 5 of the Leapfrog ASC Survey.

However, according to the OAS CAHPS Protocols and Guidelines Manual, survey vendors and ASCs/HOPDs may choose to add up to 15 supplemental questions after the 'core' OAS CAHPS Survey questions that are personalized to the facility/vendor. More information on these supplemental questions, including restrictions and required approval, may be reviewed on pages 18-20 of the CMS OAS CAHPS Survey Protocols and Guidelines Manual, which is available for download at <https://oascahps.org/Survey-Materials>. Please note, the responses to these supplemental questions will not be reported on the Leapfrog ASC Survey.

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Endnotes

¹ **CMS Certification Number (CCN)**

A CMS Certification Number (CCN) is issued by the Centers for Medicare and Medicaid Services (CMS) to financial reporting entities for the purpose of reimbursement. CCNs are ten digits; with the first two digits representing the state in which the facility is located. Facilities that do not receive Medicare reimbursement may not have a CCN and should not have a CCN reported in this field. Leapfrog pre-populates this field in the Online ASC Survey Tool. If the facility's CCN is different from the one shown online, please contact the Help Desk.

² **National Health Safety Network (NHSN) ID**

A NHSN ID is issued by the Centers for Disease Control and Prevention and is used as a unique identifier for facilities participating in NHSN surveillance activities. Each facility within a network, even if they share a CCN, should report separately to NHSN and should have their own NHSN ID if they are located separately. Please see the NHSN instructions available at <http://www.leapfroggroup.org/asc-survey-materials/join-asc-nhsn-group>. NHSN IDs are five digits. Leapfrog pre-populates this field in the Online ASC Survey Tool for facilities that provided a valid NHSN ID, joined our NHSN Group for ASCs, and submitted the Leapfrog ASC Survey in 2019, 2020, 2021, or 2022. If the facility NHSN ID is different from the one shown online, please update accordingly.

³ **Federal Tax Identification Number (TIN)**

Enter the TIN that your facility uses for billing purposes. *The TIN is a nine-digit number (e.g., 098765432) and must conform precisely to this format – be sure to enter any leading 0.*

⁴ **National Provider Identifier (NPI)**

The NPI is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number of covered health care providers. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or medical specialty. If there is more than one NPI associated with your facility, please enter the NPI associated with the highest amount of charges for the most recent year. Leapfrog pre-populates this field in the Online ASC Survey Tool. If the facility's NPI is different from the one shown online, please contact the Help Desk.

⁵ **Tips for entering Web addresses**

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

⁶ Affiliation or Management Company

For the purpose of participating in the Leapfrog ASC Survey, some hospitals or health systems, health care networks, or management companies may want to coordinate Survey submissions among several facilities or ensure that communications regarding a facility's submission are shared with someone at the hospital, health system, health care network, or management company.

Facilities should only complete this section of the Profile regarding an affiliation with a hospital or health system, or health care network, or list their management company (including joint ventures) if they want information about the Survey submission shared with those individuals.

Facilities that are part of a joint venture with a hospital, health system, or health care network, as well as facilities that are partly or wholly owned by a management company, may consider completing this section of the Profile.

⁷ Operating Rooms

If your state designates and licenses operating rooms, enter the number of operating rooms licensed by your state. If your state does not designate and license operating rooms, enter the number of operating rooms that meet the following definition from the 2018 FGI Guidelines: a room that meets the requirements of a restricted area, is designated and equipped for performing surgical or other invasive procedures, and has the environmental controls for an OR as indicated in ASHRAE 170. An aseptic field is required for all procedures performed in an OR.

More information about the 2018 FGI Guidelines can be found at https://www.fgiguideines.org/wp-content/uploads/2017/08/SLS17_FGI_ExamProcedureOperatingImaging_170721.pdf.

⁸ Endoscopic Procedure Rooms

If your state designates and licenses procedure rooms, enter the number of procedure rooms licensed by your state that are used for endoscopies. If your state does not designate and license procedure rooms, enter the number of procedure rooms that are used for endoscopies that meet the following definition from the 2018 FGI Guidelines: a room designated for the performance of patient care that requires high-level disinfection or sterile instruments and some environmental controls but is not required to be performed with the environmental controls of an operating room.

More information about the 2018 FGI Guidelines can be found at https://www.fgiguideines.org/wp-content/uploads/2017/08/SLS17_FGI_ExamProcedureOperatingImaging_170721.pdf.

⁹ Written Transfer Agreement

A written agreement between an ambulatory surgery center and a receiving hospital that describes the transfer of patients, patient care, and clinical information in circumstances of varying acuity where a higher level of care is needed by patients. The transfer agreement should be formalized in advance of any patient care being initiated at an ASC and should be applicable to and immediately enacted in any case when a higher level of patient care is necessary.

¹⁰ Clinician

A clinician refers to a physician, physician assistant (PA), nurse practitioner (NP), certified registered nurse anesthetist (CRNA), nurse (RN or MSN), or respiratory therapist.

¹¹ Appropriateness Criteria

A procedure-specific set of criteria developed and implemented at the facility that surgeons use to evaluate whether the patient is appropriate for surgery. These criteria should not be surgeon-specific, but

procedure-specific. These criteria should be developed by those performing the procedure at the ASC and are not solely the product of a payment or reimbursement program.

¹² ***Individuals who touch patients or who touch items that will be used by patients***

This would include individuals who are formally engaged by the facility to help support the patient care process. This would include both direct and indirect care providers that are likely to have contact with patients, enter a surgical or treatment area, touch items that will be used by patients, or interact with patient fluids (e.g., blood, specimens), such as doctors, mid-levels, nurses, pharmacists, environmental services staff, phlebotomists, laboratory techs, etc. This would also include students and volunteers. These individuals should be trained to identify and perform proper hand hygiene for the specific indications/moments (see [WHO's 5 Moments for Hand Hygiene](#), [CDC's Guideline for Hand Hygiene](#)) that are relevant to their work.

Administrative workers that only perform office duties and do not touch patients or touch items that will be used by patients would not be included in this definition. Patients and their visitors would also not be included in this definition. While patients and their loved ones are important parts of the patient care process, they are not formally engaged by the facility for this work. Vendors would also not be included.

¹³ ***Professional with Appropriate Training and Skills***

This would include staff formally trained in Infection Control or Infectious Diseases, whose tasks include dedicated time for staff training. In some settings, this could also be medical or nursing staff involved in clinical work, with dedicated time to acquire thorough knowledge of the evidence for and correct practice of hand hygiene.

The minimum required knowledge of the trainer can be found in the [WHO Guidelines on Hand Hygiene in Health Care](#) and the [Hand Hygiene Technical Reference Manual](#).

¹⁴ ***Never Event***

In 2011, the National Quality Forum released a list of 25 events that they termed “serious reportable events,” extremely rare medical errors that should never happen to a patient in an ambulatory setting. Often termed “never events,” these include errors such as surgery performed on the wrong body part or on the wrong patient or leaving a foreign object inside a patient after surgery. Please see NQF’s “Never Events” list at https://www.qualityforum.org/topics/sres/serious_reportable_events.aspx.

¹⁵ ***Apology to the Patient***

While Leapfrog recognizes that on very rare occasions “never events” can occur that are not the fault of care systems or clinical care staff, given the high level of trust patients place in health care providers, Leapfrog feels it is appropriate for caregivers to apologize when a patient within their care setting suffers a serious event.

As the National Quality Forum identified in their 2002, 2006, and 2011 Serious Reportable Events Report, given the serious nature of these events, it is reasonable for facilities to initially assume that the adverse event was due to the referenced course of care. And while further investigation and/or root cause analysis of the unplanned event may be needed to confirm or refute the presumed relationship, delaying an apology to the patient is not treating the patient with compassion and sympathy.

¹⁶ ***Reporting Never Events to External Agencies***

If your facility is not accredited, is located in a state without a state-wide reporting program for medical errors, AND there is no available Patient Safety Organization to which your facility can report medical errors, the facility should report the event to the Board of Trustees. Full implementation of the Never Events policy still requires the facility to conduct a root cause analysis of the event.

¹⁷ Root Cause Analysis

The National Patient Safety Foundation published a set of best practices and guidelines in its report “RCA² Improving Root Cause Analysis and Action to Prevent Harm.” The report can be found at <http://www.ih.org/resources/Pages/Tools/RCA2-Improving-Root-Cause-Analyses-and-Actions-to-Prevent-Harm.aspx>.

¹⁸ Eligible Discharges

Discharged adult patients (ages 18 years and older) who had both medically and non-medically necessary surgeries and/or procedures are eligible to complete the OAS CAHPS Survey. A detailed description of patient sampling criteria, including a list of OAS CAHPS-eligible surgeries and procedures is available in the Protocols and Guidelines Manual, version 7.0 at <https://oascahps.org/Survey-Materials>.

¹⁹ Top Box Score

The percent of survey respondents who chose the most positive score for a given item. Looking at the **top box** is an approach to understand the number of responses with a strong sentiment. For the OAS CAHPS Survey “Patients’ Rating of the Facility” domain, responses of 9 or 10 are included in the top box score. For the “Patients Recommending the Facility” domain, responses of “Definitely yes” are included in the top box score. For all other domains included in Section 5, the top box score is the percent of survey respondents choosing “Yes, definitely.”

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