THELEAPFROGGROUP

SECTION 6 NQF SAFE PRACTICES

GENERAL FREQUENTLY ASKED QUESTIONS (FAQS)

Please review the FAQs below before answering the question for each Safe Practice. The SPS section of The Leapfrog Group Hospital Survey is applicable for all hospitals unless noted in the Survey for those facilities that do not provide specific services. More detailed measure-specific FAQs are available in the hard copy of the survey at http://beta.leapfroggroup.org/survey-materials/survey-and-cpoe-materials.

1. **Why was the NQF Safe Practices report used for development and revisions of the survey?**
    The initial NQF Report and the first accompanying set of Safe Practices provided a comprehensive and accessible document addressing specific practices to improve patient safety and healthcare quality. Since that initial report, a Maintenance Committee was established by the NQF and a revised set of Safe Practices were endorsed in 2006, 2009, and 2010. The 2010 report details 34 Safe Practices that should be universally implemented in clinical care to reduce the risk of harm to patients. The practices address the first three "leaps" of the Leapfrog Group and continue to be assessed in separate survey sections. A subset of the remaining 34 practices is now addressed in the SPS survey section.

    The initial and subsequent NQF reports were developed using a consensus process by a committee representing some of the foremost thought leaders and stakeholders in patient safety. The initial committee and the maintenance committee included members of patient and consumer groups, healthcare purchasers, health plans, healthcare providers, and research and quality improvement organizations. In accordance with the National Technology Transfer Advancement Act of 1995 (P.L. 104-113), the federal government may use the information in the NQF report for standardization purposes. As such, the initial survey was designed to be based on and limited to the content, scope, and evidence provided by the NQF *Safe Practices for Better Healthcare: A Consensus Report* of May 2003; likewise, the current survey of safe practices is consistent with the content of the *2010 Update* released by NQF in April in 2010.

2. **How was the NQF Safe Practices survey section developed?**
    This updated survey section was developed based on advice from a 10 member Senior Advisory Board of patient safety and performance improvement national thought leaders. The Senior Advisory Board worked with input from more than 260 subject matter experts (SMEs) who have strong command of the medical literature and deep understanding of the best practices targeting the problem areas addressed in the NQF report. The SME frontline expertise includes the domains of medication management, ICU, surgery, healthcare law, administration, human factors, reliability science, culture and systems psychology. The SMEs contributed to the NQF practice and evidence

assessment. They also participated in the development of revised relative weights for each practice for 2007. In addition, several hospital industry associations and numerous individual hospital representatives provided input on the survey content. A number of our Leapfrog experts were former clinicians and administrative contributors to the original NQF report, and also served on the maintenance committee. For 2008, Leapfrog reduced the number and length of the survey, allowing hospitals to focus on the most heavily weighted practices for the survey. The number and length of the survey were reduced once again in 2012 to focus on those practices for which the outcome of the safe practice was being measured by Leapfrog or in other public reporting initiatives, and whether the practice, if fully implemented, was considered by experts to have a robust effect on safety in the hospital.

3. **How much time and effort is required to complete this part of the survey?**
The time and effort it will take a hospital to complete this section of the survey will vary based on a number of factors, including the number of persons in the organization involved in answering this section of the survey and accessibility to needed information. Leapfrog anticipates the level of burden to complete this section of the survey has been reduced by focusing on just eight of the 34 Safe Practices.

4. **The *NQF Safe Practices for Better Healthcare 2010 Update: A Consensus Report* was released in April of 2010. How does the survey deal with a report that is lacking detailed measures?**
The NQF report is an excellent publication. However, it is a set of standards and implementation suggestions; it is not an endorsed measure set. The measurement of adoption of the endorsed set of standards is done through this survey. However, the design of the survey is closely aligned with the implementation guidance in the report.

In order to create an effective survey instrument and relative weighting system, the following principles were followed**:**
- **4 A Framework:** The 4 A Adoption Framework (see below) was designed to measure progress on the problem being targeted by the practices. Over time, the questions in the survey have evolved based on experience and research, and now on the new set of Safe Practices. The 4 A Adoption Framework is still in place, but this set of survey questions is more specific than the survey designed for the first report, where more latitude was given to hospitals in terms of implementation strategies and the ability to make commitments for implementation.
- **Focus on Practices:** The evidence, practices, and implementation details have gone through a complete and comprehensive review by the NQF Maintenance Committee, and as a result the new report is more actionable than the initial report. The survey is still designed for a mid-level manager of a frontline community hospital to complete.
- **Systematic Application of 4 A Adoption Framework:** A framework defining dimensions of progress in patient safety of Awareness, Accountability, Ability, and Action was used in

formulation of survey questions. As a result of the changes to the practices, measures are more clearly aimed at specific processes and outcomes. Partial credit is still available for having completed some, but not all of the key strategies for implementing the Safe Practices.

- **Define practices as readily available to mid-level manager at frontline community hospital:** The Medical Advisory Board and Subject Matter Experts were asked to focus on the problem cited in the NQF report and emphasize the impact of best practices "**currently and readily available to a mid-level manager at a frontline urban community hospital"** on the problem including, but not limited to, the specifications and implementation approaches cited**.** This allowed the weighting, survey, and ranking system to be normalized to the most representative case of hospitals across the country. It also limited confusion around currently published studies and opened the field of review to the medical literature, Internet resources, and readily available expert opinion from quality improvement groups. This did not violate the principle of operating within the scope of the NQF report.

5. **Why is each practice area broken down into the 4 A' 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.

- **Awareness:** Most of the NQF Safe Practices are defined with a safety objective addressing the nature of a preventable adverse event. The cause of these adverse events are fairly well understood and well known. Each NQF Practice was treated individually depending on how well understood THE performance opportunities are and how well a hospital can address their – OUR performance opportunities. Although all questions were developed custom designed to the safety objective/practice, a standardized guide was developed to assist in the process.
- **Accountability:** Accountability addresses direct accountability of the appropriate leaders to the adverse event area.
- **Ability:** A graduated set of investment levels were used ranging from investment in education, skill development, allocated human resources, and line item budget allocations. These were adjusted in a safety objective/practice specific way.
- **Actions:** Action levels were tied to NQF language as well as they could be. Performance Improvement programs and projects were tied to actions, as they are recognized as critical to sustained performance.

6. **This part of the survey places significant emphasis on Performance Improvement Projects/ Programs. Why?**
   The greatest sustained improvement and cost savings have been achieved by hospitals that have undertaken formal Performance Improvement Programs with measurement and process improvement features that are tied to explicit procedures and protocols (as cited in some but not all of the NQF Safe Practices).

7. **There are many types of Performance Improvement Programs and project methodologies. What elements are required to satisfy the requirements for credit for such programs or projects?**
   Generally, five elements must be present (and are typically present in most such programs or projects):
   - **Education:** Staff and caregivers should be educated regarding the nature of the adverse events being targeted and the impact of better or best practices.
   - **Skill Development:** Staff and caregivers should be briefed and equipped to have the skills necessary to undertake a performance improvement project.
   - **Measurement:** Process measures or outcome measures should be assessed and tracked.
   - **Process Improvement:** A feedback process improvement component should be employed to improve processes, test the change, and then provide feedback through measurement to improve outcomes.
   - **Reporting:** Results of performance improvement projects or programs should be reported to the administrative leadership and caregivers.

8. **What Guiding Principles were followed to design the relative Weighting System?**
   Below we describe how the weights (which are still applied) were developed.
   - **Enterprise-wide Systems & Process Areas Prioritized:** In preparation for the formal voting process, all Advisory Board members were presented with the concept of allocating weighting to enterprise-wide systems focus areas and enterprise-wide process focus areas as a first step, followed by allocating weight to care setting-specific areas. All were in agreement and this process was followed. Weighting was made to an agreed set of enterprise-wide problems/practices and the balance of the points allocated by a relative weighting vote.
   - **Neutralize NQF Report Limitations:** As with the survey question design process, the limitations of the NQF report were neutralized by emphasis on the problem cited by the NQF, rather than the practices and by employment of the 4 A framework of patient safety progress.
   - **Focus on Safety Objectives (cited by NQF) and Practices:** The Safety Objectives and cited adverse events addressed in the NQF report were entirely satisfactory and the "right list" as evaluated by the Medical Advisory Board.
   - **Emphasize Impact (Frequency x Severity x Practice Impact):** The Advisory Board was provided with resources of prior incidence studies (Utah-Colorado and others) and

weighting systems used by organizations such as the Veterans Healthcare Administration. The common approach patient safety researchers use is the factor frequency (prevalence), severity of the problem, and impact of readily available practices. A global relative weighting approach was determined to be the most appropriate for this survey.

- **Use Transparent Multi-round Multi-voting:** A rapid cycle transparent, multi-round voting method was used to allow the Advisory Board to vote, discuss their votes, review individual practices and problems, evaluate point spread across voters and across voting rounds. All practices were individually reviewed and discussed before and after each voting round. Only two voting rounds were required for consensus.

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