PROPOSED CHANGES TO THE 2025 LEAPFROG HOSPITAL SURVEY

OPEN FOR PUBLIC COMMENT
Comments Accepted until midnight ET on December 13, 2024

Each year, The Leapfrog Group's research team reviews the literature and convenes expert panels to ensure the Leapfrog Hospital Survey aligns with the latest science and the public reporting needs of purchasers and consumers. Once the list of proposed changes is assembled for next year's Survey, Leapfrog releases that list for public comment. The public comments received are then reviewed by Leapfrog's research team and used to refine the Survey before it is finalized.

The proposed changes to the 2025 Leapfrog Hospital Survey are outlined below. To provide a public comment, please respond by completing the public comment form **here**. Comments will be accepted until midnight ET on **December 13, 2024.**

This year, we are requesting that commenters pay special attention to the following:

- Public Reporting: Proposal to update public reporting timeframe.
- Policy Update: Proposal to add questions regarding availability of data due to cybersecurity events, natural disasters, and changes in ownership.
- Section 2C: Bar Code Medication Administration (BCMA): Proposal to add separate questions to assess the utilization of BCMA in step-down/progressive units separately from med/surg units to align with other sections of the Survey where step-down/progressive units are not combined with med/surg units.
- Section 5: ICU Physician Staffing (IPS): Proposal to separate the current IPS questions into two subsections; one focused on adult ICUs and the other on pediatric ICUs, which will be scored and publicly reported separately to give consumers better information.
- Section 5C: Nursing Workforce: Request for information on evidence-based nursing structural measures for future consideration on the Survey and the short version of the Practice Environment Scale (PES-5), which measures the work environment of nurses.
- Section 6E: Emergency Department (ED) Boarding: Proposal to add new optional, fact-finding questions to assess boarding times for patients seen in the ED who have been admitted to the inpatient setting but don't yet have an inpatient bed.

We are grateful to those who take the time to submit comments each year. These comments bring enormous value to Leapfrog's team and our expert panel deliberations, and help ensure the Survey is valuable to hospitals, purchasers, and consumers.

For information on the 2024 Leapfrog Hospital Survey, visit www.leapfroggroup.org/survey.

DEADLINES AND REPORTING PERIODS FOR 2025

Review the 2025 Leapfrog Hospital Survey deadlines and anticipated reporting periods in Appendix I and II.

SCORING AND PUBLIC REPORTING FOR 2025

As in prior years, hospitals that submit a Leapfrog Hospital Survey by the June 30 Submission Deadline will have Survey Results available on their Hospital Details Page on July 12 and publicly reported at https://ratings.leapfroggroup.org on July 25. After July, Leapfrog is proposing to update the Survey Results within the first seven (7) business days of the month to reflect Surveys (re)submitted by the end of the previous month. Previously, results were published within the first five (5) business days of the month.

NEW REPORTING POLICY FOLLOWING CYBERSECURITY EVENTS, NATURAL DISASTERS, AND MERGERS/ACQUISITIONS

As the frequency of cybersecurity events, natural disasters, and changes in hospital ownership continues to grow, Leapfrog is proposing the following for hospitals that have limited data availability during the reporting period for specific sections of the Survey as the result of one of these three events:

- Hospitals missing data for less than 15 days during the reporting period due to a cybersecurity event or natural disaster will be able to report to the Leapfrog Hospital Survey and use the data they have available for the specified reporting periods to be scored and publicly reported. Survey Results will be used in Leapfrog's other programs, including the Leapfrog Hospital Safety Grade.
- Hospitals missing data for 15 or more days during the reporting period due to a cybersecurity event or natural disaster will be able to report to the Survey that (a) they had an event and (b) are missing 15 or more days of data during the reporting period. Survey Results will be reported as "Not available due to a cybersecurity event/natural disaster." For the purposes of the Leapfrog Hospital Safety Grade, Survey Results reported as "Not available due to a cybersecurity event/natural disaster" will be treated as "Declined to Respond" and Leapfrog's imputation methodology will apply.
- Hospitals missing data due to a change in ownership will be able to report to the Leapfrog Hospital Survey and will have results displayed along with the following note: "This hospital recently had a change in ownership." Hospitals will still be required to submit by all deadlines and will have results displayed as "Declined to Respond" if they elect not to report. Survey Results will be used in Leapfrog's other programs, including the Leapfrog Hospital Safety Grade.

The following questions will be added to Section 1A: Basic Hospital Information regarding the availability of data for reporting on the Leapfrog Hospital Survey:

1) Did your hospital experience a cybersecurity event, natural disaster, or change in ownership that resulted in limited data availability during the reporting period for any one of the following subsections of the Survey: • 4B Cesarean Birth • 4C Episiotomy • 4D Process Measures of Quality • 4E High-Risk Deliveries • 5C Nursing Workforce *If "no," skip the remaining questions in Section 1A and continue to the next subsection.*	○ Yes, due to a cybersecurity event ○ Yes, due to a natural disaster ○ Yes, due to a change of ownership ○ No

2) If "yes, due to a cybersecurity event" or "yes, due to a natural disaster," how long were you closed or had system downtime? If "15 or more days" to question #2, skip the remaining questions in the Survey. The hospital will be scored as "Not Available" for all Leapfrog Survey measures.	○ 14 or fewer days ○ 15 or more days

Leapfrog is also proposing to add the following information on its public reporting website when hospitals indicate having limited data availability:

"This hospital's quality and safety performance may have been impacted by a recent cybersecurity event, natural disaster, or change in ownership. We urge patients and family caregivers to ask the hospital for information on their recent performance and consider that information in combination with historical performance. Patients and family caregivers may benefit from discussing with their health care provider the disruptions this event may have caused on quality and safety of care."

STRUCTURAL CHANGES

Leapfrog will rename Section 5: ICU Physician Staffing (IPS) to Section 5: Staffing and Workforce and will move Section 6C: Nursing Workforce to Section 5C: Nursing Workforce. Section 5: Staffing and Workforce will include the following subsections:

- Section 5A: Adult ICU Physician Staffing
- Section 5B: Pediatric ICU Physician Staffing
- Section 5C: Nursing Workforce (previously Section 6C)

Section 6: Patient Safety Practices will include the following subsections:

- Section 6A: NQF Safe Practice #1 – Culture of Safety Leadership Structures and Systems
- Section 6B: NQF Safe Practice #2 – Culture Measurement, Feedback, and Intervention
- Section 6C: Hand Hygiene (previously Section 6D)
- Section 6D: Diagnostic Excellence (previously Section 6E)
- Section 6E: ED Boarding

PROPOSED CONTENT CHANGES

GENERAL

For greater ease of reporting, Leapfrog will update and align some of the unit definitions used throughout the Survey (which are provided in endnotes) and is proposing to include a table summarizing these unit types in the 2025 Survey.

Leapfrog will also remind hospitals throughout the Survey to only report on units that are currently open and that were consistently open during the entire reporting period.

The proposed table and updated endnotes can be reviewed in Appendix III.

HOSPITAL PROFILE

There are no proposed changes to the Hospital Profile.

SECTION 1: PATIENT RIGHTS AND ETHICS

SECTION 1A: BASIC HOSPITAL INFORMATION

Leapfrog will update and add new questions in Section 1A so hospitals can report on beds used to care for ICU patients that are not located in ICUs. First, Leapfrog will ask the following:

1) Does your hospital operate any general medical and/or surgical or neuro ICUs (adult and/or pediatric) or admit adult or pediatric general medical and/or surgical or neuro ICU patients? *If "no" to question #1, skip questions #2-3 and continue to question #4.*	○ Yes ○ No

Hospitals that report "yes" will be asked to report on beds and admissions in their ICUs, as well as in units used to care for ICU patients. The new and updated questions are below:

2) Total number of beds used to care for adult and pediatric general medical/surgical or neuro ICU patients in mixed-acuity or other units.	_____
3) Total number of ICU admissions to adult and pediatric general medical/surgical ICUs and neuro ICUs and units that include ICU and universal beds that can be converted to care for an ICU patient during the reporting period.	_____

Additionally, as noted above, Leapfrog will update unit description endnotes in Section 1A: Basic Hospital Information to add further clarification and alignment with reporting in other sections of the Survey.

The endnotes defining licensed acute-care beds and licensed ICU beds will also be updated to instruct hospitals to report the number of staffed beds if beds are currently staffed higher than licensed. The endnote for acute-care beds will also instruct hospitals to exclude swing beds.

The proposed updated endnotes can be reviewed in Appendix III.

Leapfrog will also clarify the reporting period used for Section 1A: Basic Hospital Information questions #13-16 which ask about board certification, inclusion of Leapfrog performance in performance reviews, rapid response teams, and patient-reported concerns, and will instruct hospitals to answer the questions based on the practices currently in place at the time they submit the section of the Survey.

In addition, Leapfrog will add two new FAQs to this section, to offer hospitals additional guidance in implementing a policy to empower patients to activate rapid response teams, and to follow up on patient-reported concerns:

- **Regarding clinicians' role in the rapid response team, can we require that activation of the rapid response team be mediated by a clinical professional, such as a nurse? What trainings do clinicians need to have to respond to a request for a rapid response team?**

The rapid response team should be able to be directly activated by the patient themselves, as opposed to through a clinical staff intermediary. Regarding the training program, Leapfrog only requires that clinicians be trained to recognize when a patient or family caregiver is asking for an evaluation by a rapid response team and be trained on how to conduct the evaluation if they are part of the rapid response team. The FAQ will also include references to two implemented examples at the University of Pittsburgh Medical Center (Condition Help) and MonHealth Medical Center.

- **What are some examples of a protocol to follow-up on patient-reported concerns?**
  Leapfrog's goal is to capture how hospitals are encouraging the submission of, and following up on, issues or complaints from patients that are specific to the care they received at the hospital. For example, hospitals could distribute a patient satisfaction survey with space to report concerns with their care, and a protocol in place to investigate these by following up with a family member and logging the incident. Another example is to notify patients on admission about their right to report concerns as part of their rights and responsibilities.

Lastly, as previously noted above, Leapfrog will add two new questions to Section 1A to assess data availability.

SECTION 1B: BILLING ETHICS

In response to feedback from hospitals participating in the Survey, an analysis of responses submitted in 2024, and new insights from researchers in the field, Leapfrog is proposing the following updates to Section 1B: Billing Ethics:

- Question #1, regarding the itemized billing statement, will be updated to clarify that the itemized billing statement will be provided based on the patient's choice of mail or electronically (via email or the patient portal).
- Question #4, regarding the presumptive screening of patients for financial assistance, will be updated to clarify that ALL patients should be included in the screening process. We will also be adding a response option for hospitals that only screen uninsured patients.
- Leapfrog will add an optional, fact-finding question regarding whether all clinicians are included in the hospital's financial assistance program and will add an FAQ with further information:

1) Does your hospital's financial assistance program apply to ALL clinician fees, in addition to facility fees, for clinicians with privileges at your hospital?	○ Yes ○ No

What does Leapfrog mean when asking if the hospital's financial assistance program includes ALL clinicians with privileges at the hospital?
Hospitals that offer a financial assistance program (FAP) or "charity care" should provide a list of any clinicians delivering emergency or other medically necessary care in the hospital facility, that specifies which clinicians are covered by the FAP and which are not to ensure that the patient is aware that they may receive a separate bill that they will be responsible for from any clinician who is not covered. More information about what should be included in your financial assistance policy is available here: https://www.irs.gov/charities-non-profits/financial-assistance-policy-and-emergency-medical-care-policy-section-501r4.

Additionally, Leapfrog will retain the optional, fact-finding questions regarding presumptive screening of patients for financial assistance and patient notification when financial assistance has been applied, for a second year with plans to incorporate into the national Billing Ethics Standard in 2026.

The optional, fact-finding questions will not be used in scoring or public reporting in 2025. There are no proposed changes to the scoring algorithm for Section 1B: Billing Ethics.

SECTION 1C: HEALTH CARE EQUITY

Leapfrog will continue to score and publicly report the Health Care Equity standard and are proposing three updates:

- Question #1, regarding patient self-identified demographic data, will be updated to include a new response option for ability status. We will also add a new FAQ which will provide more information about ability status and examples of questions to ask patients:

  What does Leapfrog mean by "ability status"?
  As described by the CDC, a disability is any condition of the body or mind (impairment) that makes it more difficult for the person with the condition to do certain activities (activity limitation) and interact with the world around them (participation restrictions). More information is available on the CDC website at https://www.cdc.gov/ncbddd/disabilityandhealth/disability.html. Examples of questions that determine one's ability status can be found here:

  - https://www.cdc.gov/ncbddd/disabilityandhealth/datasets.html
  - https://torontohealthequity.ca/wp-content/uploads/2018/03/Measuring-Health-Equity-Participant-Manual-2018.pdf
  - https://ifdhe.aha.org/hretdisparities/how-to-ask-the-questions

- Leapfrog will add a new question asking hospitals to provide a link to where they publicly share their efforts to identify and reduce health care disparities. Only hospitals that answer "yes" to question #6 will be asked to provide the URL. This question, and the provided URL, will be used as part of Leapfrog's Data Verification Protocols and will be publicly reported. The new proposed question is available for review below:

1) Webpage URL where efforts to identify and reduce health care disparities and the impact of those efforts (based on the self-identified demographic data collected directly from patients (or patient's legal guardian)) are displayed:	_____

- Leapfrog will add an optional, fact-finding question to determine if hospitals have implemented (or have plans to implement) the new Office of Management and Budget standards for maintaining, collecting and presenting data on race and ethnicity:

2) Has your hospital combined race and ethnicity categories into a single question to align with the 2024 Office of Management and Budget (OMB) seven minimum reporting categories that allows patients (or the patient's legal guardian) to select one or multiple categories?	○ Yes ○ No ○ No, but plan to implement within the next 6 months

	○ No, but plan to implement within the next 7-12 months

This optional, fact-finding question will not be used in scoring or public reporting in 2025. There are no proposed changes to the scoring algorithm for Section 1C: Health Care Equity.

SECTION 1D: INFORMED CONSENT

Leapfrog has learned that hospitals in Georgia and Texas have a statutory protection facilitated by using consent forms at a ninth-grade reading level. Leapfrog proposes to maintain the current scoring algorithm for "Considerable Achievement" which requires having all consent forms written at a ninth-grade reading level, if additional criteria are also met. However, because 54% of Americans between the ages of 16 and 74 read below the equivalent of a sixth-grade level, hospitals will continue to be required to have all applicable consent forms written at a sixth-grade reading level or lower to "Achieve the Standard."

In response to questions and feedback from hospitals participating in the Survey, Leapfrog will clarify FAQ #21 and update as follows:

> **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: hospital leaders, physicians/independent nurse practitioners/independent physician assistants, nurses or other clinical staff, administrative staff in a patient-facing role, 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 hospital leaders, training on the definition and principles of informed consent and specifics on the hospital'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 in a patient-facing role and interpreters, participating in the informed consent process should also be trained in documentation.
>
> Staff that are not directly employed by the hospital (e.g., medical interpreters who are employed by a contractor) do not need to be trained by the hospital.
>
> Training does not need to be exclusive to informed consent and can be included as a component or module 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.

There are no proposed changes to the scoring algorithm for Section 1D: Informed Consent.

SECTION 2: MEDICATION SAFETY

SECTION 2A: COMPUTERIZED PHYSICIAN ORDER ENTRY (CPOE)

Leapfrog will update the measure specifications for question #3 to include medications ordered via text message in the denominator. Additionally, we will update the measure specifications for question #4 to indicate that medications ordered via text should be treated like verbal orders in that they should only be included in question #4 if alerts were read back to a licensed prescriber prior to ordering.

There are no proposed changes to the scoring algorithm for Section 2A: CPOE.

SECTION 2B: EHR APPLICATION INFORMATION (FOR ADULT AND GENERAL HOSPITALS ONLY)

Leapfrog will add optional fact-finding questions about Artificial Intelligence (AI) vendors. The responses will be used to research AI vendor influence on a hospital's CPOE Test score. The proposed questions are included below:

1) Does your hospital currently use an Artificial Intelligence (AI) application as part of your medication-related decision support systems? *If "no" to question #1, skip the remaining questions in Section 2B, and continue to Section 2C.*	○ Yes ○ No
2) Which Artificial Intelligence (AI) vendor source is your hospital currently using? *Select all that apply.* *If "AI Vendor" or "Homegrown AI Application" is selected, continue to question #3.*	**EHR Vendors** ☐ Epic ☐ Cerner ☐ Allscripts (Altera) ☐ Meditech ☐ Quadramed ☐ CPSI **Medication Safety Vendors** ☐ First Databank ☐ Medi-Span ☐ Multum ☐ Lexicomp ☐ Elsevier **Other** ☐ AI Vendor ☐ Homegrown AI Application
3) What are the names of the AI Vendors or Homegrown AI Applications that your hospital is currently using?	_____

Additionally, we will add an FAQ to define Artificial Intelligence:

What is the definition of Artificial Intelligence?
Artificial Intelligence (AI) includes advanced analytics and logic-based techniques, including machine learning, that are used to interpret events, support and automate decisions, and take actions.

These optional, fact-finding questions will not be used in scoring or public reporting in 2025. As a reminder, Section 2B: EHR Application Information is not scored or publicly reported.

CPOE EVALUATION TOOL (FOR ADULT AND GENERAL HOSPITALS ONLY)

The CPOE Evaluation Tool developers will update the test medication scenarios to reflect changes to clinical guidelines and to address medications that hospitals frequently reported as not being in their medication formulary.

The Test Patients PDF will include the date of birth for each patient so that hospitals no longer have to calculate a patient's date of birth based on the age provided. Patient allergies will also be removed as the Drug Allergy Order Checking Category was removed in 2023 and this information is no longer relevant.

Previously, the Excessive Dosing and Drug Route Order Checking Categories were indicated as scenario-specific clinical decision support, meaning that advice or information presented to the prescriber is related to the Test Order and the Test Patient, which includes specific patient demographics and clinical information. For the 2025 CPOE Test, the Excessive Dosing and Drug Route Order Checking Categories will be updated to indicate that the type of clinical decision support in these Order Checking Categories is medication-specific, meaning that it is specific to the medication and might appear any time the medication is ordered for any patient and is not specifically related to the Test Patient. This change will be reflected in the Orders and Observations Sheet.

Lastly, the Sample Test content will be updated to include one Test Order from each of the eight Order Checking Categories to give hospitals a preview of the response options that they will see on the Online Answer Form in the Adult Inpatient Test.

There are no proposed changes to the scoring algorithm for the CPOE Evaluation Tool.

SECTION 2C: BAR CODE MEDICATION ADMINISTRATION (BCMA)

Leapfrog will continue to ask hospitals about their utilization of BCMA in the following units: medical and/or surgical units (adult and/or pediatric), intensive care units (adult, pediatric, and/or neonatal), labor and delivery units, and pre-operative and post-anesthesia care units (adult and/or pediatric) but as described above, we will update the unit definitions to further align with other sections of the Survey. Previously, step-down/progressive units were included when reporting on medical and/or surgical units. For 2025, Leapfrog will add new questions to assess the utilization of step-down/progressive units separately. Telemetry units will continue to be reported with medical and/or surgical units. The updated unit definitions can be found in Appendix III, including updated definitions for pre-operative and post-anesthesia care units (PACUs). Updated questions can be found in Appendix IV.

Leapfrog will also update the measure specifications to note that hospitals should continue to count units as they do internally (i.e., if units are considered separate units despite sharing a space, report the units as two; if they are considered a single combined unit, report the unit as one). When reporting on compliance, Leapfrog will also clarify that medication administrations performed during a procedure should be excluded (i.e., if the hospital combines their procedural areas with their pre-operative or post-anesthesia care units and is able to distinguish between these medication administrations).

Leapfrog will make two updates to assist hospitals reporting on their mechanisms used to reduce and understand potential BCMA system "workarounds." First, Leapfrog will update one of the questions to ask about "back-up equipment" for BCMA hardware failures, instead of "back-up systems." Second, we will add a FAQ reminding hospitals that they should still implement or monitor a quality improvement program even if they are at 95% compliance to ensure that they can continue to improve and maintain high compliance.

There are no proposed changes to the Scoring Algorithm for Section 2C: BCMA.

SECTION 2D: MEDICATION RECONCILIATION

There are no proposed changes to this subsection. As a reminder, hospitals can continue to use 2024 Leapfrog Hospital Survey Measure Specifications for Section 2D: Medication Reconciliation to perform data collection in preparation for the 2025 Leapfrog Hospital Survey.

SECTION 3: ADULT AND PEDIATRIC COMPLEX SURGERY

SECTION 3A: HOSPITAL AND SURGEON VOLUME

For mitral valve repair and replacement, Leapfrog will update the questions and measure specifications to clarify that hospitals can only report on their Mitral Valve Repair/Replacement Composite Score if the score is publicly reported on the STS website at https://publicreporting.sts.org/search/acsd.

For Bariatric Surgery for Weight Loss, Leapfrog is proposing to add a number of ICD-10-CM procedure codes that bring greater alignment with the Centers for Medicare and Medicaid's payment policies for bariatric surgery. These additional codes expand on the current procedure code list, with a continued focus on the bypass of the stomach, but reflect additional tissue types and approach types. The proposed additions can be reviewed in Appendix V.

SECTION 3B: SAFE SURGERY CHECKLIST FOR ADULT AND PEDIATRIC COMPLEX SURGERY

To address hospital feedback, we will add a new response option to question #6 (which asks if the hospital performed an audit on patients who underwent a procedure included in Section 3A), for hospitals that perform fewer than 30 inpatient procedures under general anesthesia. Hospitals selecting this response option will be scored and publicly reported as "Unable to Calculate Score."

The proposed updated scoring algorithm is available in Appendix VI.

SECTION 4: MATERNITY CARE

Leapfrog will provide updated measure specifications from The Joint Commission for PC-02 Cesarean Birth (Section 4B) for those hospitals that do not already submit data to TJC and therefore need to retrospectively collect data. We will also continue to accept both data for the chart-abstracted measure (PC-02) and data collected using TJC's electronic clinical quality measure (eCQM) specifications (ePC-02). Hospitals measuring this quality indicator and reporting results to The Joint Commission should continue to use the data reported to TJC when responding to the questions in Section 4B: Cesarean Birth.

Hospitals participating in the California Maternal Quality Care Collaborative (CMQCC) Maternal Data Center may continue to use the data provided in their CMQCC reports when responding to subsections 4B: Cesarean Birth, 4C: Episiotomy, and 4D: Process Measures of Quality. Hospitals participating in the Michigan Obstetrics Initiative (OBI) may also continue to use the data provided in their OBI reports to report on Section 4B: Cesarean Birth.

SECTION 4A: MATERNITY CARE VOLUME AND SERVICES

Leapfrog will continue to include and require questions regarding service offerings and use them in public reporting only. For clarification, Leapfrog will add a reporting period for these questions and instruct hospitals to report on the services that are currently offered.

In addition, Leapfrog will update the policy question regarding the prevention of nonmedically indicated early elective deliveries to specify that the written protocols must be approved by the medical director or other designated physician (previously this was noted as other designated “clinician”).

SECTION 4B: CESAREAN BIRTH

Leapfrog will continue to include questions on the collection of cesarean birth data (NTSV C-section measure) by race/ethnicity and will ask hospitals to provide numerators and denominators for the NTSV C-section measure for each of the following races/ethnicities, which were also used in 2024 reporting: Non-Hispanic White, Non-Hispanic Black, Non-Hispanic American Indian or Alaska Native, Non-Hispanic Asian or Pacific Islander, Hispanic, and Non-Hispanic Other (including two or more races). Reporting this information requires that hospitals collect ethnicity and race, including if a patient identifies with multiple races. As in 2024, these questions will be required but will not be used in scoring or public reporting by hospital on the Survey Results website. Instead, cesarean birth rates stratified by race/ethnicity will continue to be confidentially shared with reporting hospitals on their Hospital Details Pages.

Hospitals participating in the California Maternal Quality Care Collaborative (CMQCC) Maternal Data Center may use the data provided in their CMQCC reports and hospitals reporting to U.S. News & World Report Maternity Services Survey may use the data provided to U.S. News & World Report when responding to these questions. Otherwise, hospitals will continue to use TJC’s PC-02 Cesarean Birth measure specifications and Leapfrog instructions to retrospectively review all cases and stratify by race/ethnicity.

There are no proposed changes to the scoring algorithm for Section 4B: Cesarean Birth.

SECTION 4C: EPISIOTOMY

There are no proposed changes to this subsection.

SECTION 4D: PROCESS MEASURES OF QUALITY

There are no proposed changes to this subsection.

SECTION 4E: HIGH-RISK DELIVERIES

There are no proposed changes to this subsection.

Neonatal Intensive Care Unit(s) – National Performance Measurement

Leapfrog will continue to obtain data directly from the Vermont Oxford Network (VON) for those hospitals that electively admit high-risk deliveries and opt to use VON's Death or Morbidity Outcome Measure when reporting on Section 4E: High-Risk Deliveries. Hospitals will still need to complete the following steps:

1. Complete a Data Sharing Authorization letter and submit it to VON by the dates listed in Appendix VII. (hospitals that successfully submitted a Data Sharing Authorization letter in prior years will not be required to submit another letter in 2025),
2. Select "VON National Performance Measure" in Section 4E: High-Risk Deliveries question #3,
3. Provide an accurate VON Transfer Code in the Hospital Profile of the Leapfrog Hospital Survey (this will be pre-populated if previously provided); and,
4. Submit the Leapfrog Hospital Survey by the dates listed in Appendix VII.

Hospitals that select "VON National Performance Measure" in question #3 of Section 4E: High-Risk Deliveries, but do not complete all the steps listed above will be scored and publicly reported as "Declined to Respond" for the High-Risk Deliveries measure.

SECTION 5: STAFFING AND WORKFORCE

SECTION 5A: ADULT ICU PHYSICIAN STAFFING AND SECTION 5B: PEDIATRIC ICU PHYSICIAN STAFFING

To ensure that consumers, employers and purchasers, health plans, and other stakeholders can clearly identify hospitals that have adult critical care units and/or pediatric critical care units, Leapfrog is proposing to divide Section 5: ICU Physician Staffing into two subsections: Section 5A: Adult ICU Physician Staffing and Section 5B: Pediatric ICU Physician Staffing. The questions themselves will only be updated to reference adult or pediatric units. No other updates are planned for the questions or endnotes. As always, hospitals are instructed to report on the applicable unit with the lowest level of staffing for both subsections.

The subsections 5A and 5B will be scored and publicly reported separately, but there will be no changes to the scoring algorithm. The standard for adult and pediatric medical and/or surgical intensive care units and neuro intensive care units will remain the same. See the 2024 Scoring Algorithm for more information. While both the adult and pediatric measures will be scored and publicly reported on Leapfrog's public reporting website and used in Leapfrog's Value-Based Purchasing Program, only the adult ICU Physician Staffing measure will be used in the Hospital Safety Grade methodology.

Leapfrog is also proposing the following updates to relevant endnotes for Section 5:

- The definition of co-management for critical care patients will be updated to provide more clarity and specificity.
- The definition of "Certified in Critical Care Medicine" will be updated to include those who are awarded certification by the American Osteopathic Association (AOA).
- The definition of "Certified in Critical Care Medicine" will also be updated to exclude physicians with certificates awarded from the Committee on Advanced Subspecialty Training (CAST) as the three-year grace period since CAST certificates have ceased being issued has expired.

The proposed updated questions and endnotes are available in Appendix VIII.

SECTION 5C: NURSING WORKFORCE

In response to feedback from hospitals participating in the Survey, an analysis of responses submitted in 2024, and close consultation with our Nursing Workforce Expert Panel, Leapfrog is proposing several updates to Section 5C: Nursing Workforce.

Updates to Applicable Units and Measure Specifications

Leapfrog will update question #2 to clarify that hospitals should only respond to the questions about mixed acuity units if the hospital does not operate any of the applicable single acuity units. Further clarification on single acuity medical, surgical and med-surg units to include or exclude, as well as additional clarification on the definition of acuity (i.e., level of care), will be added. Critical Access Units, defined as units where more than 10% of beds are for skilled nursing (swing beds), will be added as an exclusion for both single acuity and mixed acuity units.

The Midnight Census method for calculating the total number of patient days for each unit will include a clarification that observation patients must be included and short stay patients (who are in and out of the unit before the census is taken) must be included; otherwise, this method cannot be used for calculating patient days.

Leapfrog will update the measure specifications for total productive hours worked by employed and contracted nursing staff with direct patient care responsibilities to clarify that sitter hours can only be included if the sitter is authorized to physically touch the patient when providing direct patient care (i.e., does not need to call another staff member if physical intervention of any type is required).

Additionally, Press Ganey will waive custom report fees starting in 2025 for active National Database of Nursing Quality Indicators (NDNQI) clients with eligible data. Hospitals participating in NDNQI will be able to request reports to complete the Survey free of charge.

For NQF Safe Practice #9 on the 2025 Leapfrog Hospital Survey, Leapfrog will continue to accept 2020 American Nurses Credentialing Center (ANCC) Pathway to Excellence® criteria and will add 2024 ANCC Pathway to Excellence® criteria.

There are no proposed changes to the scoring algorithm for Section 5C: Nursing Workforce.

Request for Information

The Leapfrog Group recognizes that nursing models in U.S. hospitals continue to evolve quickly as hospitals adopt new technologies (e.g., virtual nurses) and research identifies advancements in care delivery that improve patient outcomes. To ensure our patient safety and quality standards always reflect the best science, we work with our national expert panels to refine and adapt them over time, and anticipate doing the same with our Nursing Staffing and Workforce standards. While Leapfrog has not identified a specific timeline for advancing the Nursing Workforce standard, we are interested in hearing feedback from interested parties on two potential areas for future measurement:

(1) **Request for information on hospitals reporting on the PES-5 (Nurse Work Environment)**

The Practice Environment Scale – Nursing Work Index (PES-NWI) is an instrument which measures the nursing practice environment - defined as factors that enhance or attenuate a nurse's ability to practice nursing skillfully

and deliver high quality care. Many studies have associated higher composite scores on the PES-NWI with better nurse-reported patient outcomes such as care quality, medication errors, and patient falls, as well as better patient reported experiences of care. The original PES-NWI instrument was developed in 2002 and includes 31 items across five domains.

In early 2024, a 5-item version of the instrument was released (known as the PES-5), which significantly reduces the length of the survey and the response burden. The PES-5 has one item for each of the five domains. The PES-5 maintains strong predictive validity with respect to nurse-reported work environments and patient outcomes.

The five items in the PES-5 are:

- Administration listens and responds to nurse concerns
- Our supervisor is a good manager and leader
- There is good teamwork between nurses and physicians
- There are enough staff to get work done
- There is a clear philosophy of nursing that pervades the patient care environment

Each item is scored on a 1-4 scale (1=strongly disagree, 2=disagree, 3=agree, 4=strongly agree).

Leapfrog is considering asking US hospitals to have their registered nurses (RNs) with direct patient care responsibilities complete the PES-5 at least once every two years, with overall composite scores reported to Leapfrog. The exact numerical composite scores would not be publicly reported, but hospitals would be compared and scored against the national median (e.g., bottom 25%, middle 50%, top 25%).

While the PES-5 is straightforward to administer, some hospitals find it helpful to use a survey vendor who can help facilitate the survey's completion.

(2) Request for information on structural measures linked to nurse staffing

For many years, Leapfrog has been asking hospitals to report on structural elements of the National Quality Forum's Safe Practice #9 that helps ensure nursing staff services and nursing leadership at all levels, including senior administrative and unit levels, are competent and adequate to provide safe care. An example of a structural element of the Safe Practice is nursing leadership is included as part of the hospital's senior leadership team.

Leapfrog is seeking suggestions and feedback on additional nurse staffing and nurse leadership-related structural measures that could help reflect distinct elements of high quality, safe care.

Potential structural measures include:

- Reporting structure: The Chief Nursing Office (CNO) is on the same organizational level as the Chief Medical officer (CMO)
- Education preparation of nurse managers: The percentage of the hospital's nurse managers that hold a Master's degree or higher
- Span of control for nurse managers: How many units (and/or beds) does each nurse manager oversee
- External recognition: If the hospital is a Magnet recognized organization or a Pathway to Excellence organization
- Board composition: The hospital Board includes at least one nurse

SECTION 6: PATIENT SAFETY PRACTICES

SECTION 6A: NQF SAFE PRACTICE #1 – CULTURE OF SAFETY LEADERSHIP STRUCTURES AND SYSTEMS

Leapfrog will add an FAQ for Safe Practice 1.1b to clarify that hospitals with a system-wide safety and quality committee must have one patient representative per campus on the system-wide safety and quality committee. Additionally, the definition of Board will be updated to clarify that a system-wide board that governs hospitals in the system would meet the criteria. The updated FAQ can be reviewed below:

1.1b: What is meant by "patients and/or families of patients are active participants in the hospital-wide safety and quality committee?"
To meet the intent of this element, hospitals must have patients and/or families of patients participate on the hospital-wide safety and quality committee. The safety and quality committee should have influence over hospital-wide quality and safety issues, not just a particular department or service line. Hospitals with a system-wide safety and quality committee must have one patient representative per campus on the system-wide safety and quality committee.

Meetings should be formal, and minutes should be taken. Topics covered should be related to broad oversight of hospital-wide patient safety and quality issues and what is being done to effect changes. An example would be tracking and preventing adverse events.

In most hospitals, due to the scope of issues discussed at Patient and Family Advisory Council (PFAC) meetings, having a PFAC would not meet the criteria for a safety and quality committee. If your hospital has a PFAC member on the hospital-wide patient safety and quality committee, then your hospital is meeting the intent of this safe practice.

Patients and/or families of patients can participate in these meetings in person, via conference call, or via video conference. Hospitals do not meet the intent of this element if the patients and/or families of patients are invited but do not regularly attend. It is the responsibility of the hospital to ensure that patients and/or families of patients can provide their perspectives to other committee members during meetings. Hospitals should identify people who are not Board members or employees to serve on the committee so the participant can represent the views of patients and without conflict. Board members have a fiduciary responsibility to the organization, and therefore may have a potential conflict representing the views of patients and/or families of patients.

Hospitals can document adherence to this element by maintaining committee rosters and meeting minutes with attendance and participation noted. Patients and/or families of patients should have the opportunity to present or co-present a topic, lead or co-lead a discussion, or co-chair the committee, and this should be noted in the meeting minutes. Patients and/or families should have attended at least one meeting prior to Survey submission.

Hospitals in the process of adding patients/families of patients to the hospital-wide safety and quality committee can refer to AHRQ's toolkit for engaging patients and families in hospital improvement work for more information at https://www.ahrq.gov/patient-safety/patients-families/engagingfamilies/index.html.

There are no proposed changes to the scoring algorithm for Section 6A: NQF Safe Practice #1 – Culture of Safety Leadership Structures and Systems.

SECTION 6B: NQF SAFE PRACTICE #2 – CULTURE MEASUREMENT, FEEDBACK, AND INTERVENTION

There are no proposed changes to this subsection.

SECTION 6C: HAND HYGIENE

Leapfrog will continue to add further clarification in the measure specifications regarding the units included when reporting on Section 6C Hand Hygiene, including reminding hospitals to exclude units that are not currently open and/or were not open consistently throughout the entire reporting period (i.e., most recent month or past three months based on responses selected in monitoring questions #8-10). As described above, the units will be updated to add further clarification and alignment with reporting in other sections of the Survey. They can be reviewed in Appendix III.

After a year of fact-finding, Leapfrog will remove the optional question asking about practices followed when a patient is suspected or confirmed with *C. difficile* given that the vast majority of hospitals were following all of the SHEA/IDSA/APIC Practice Recommendations.

There are no proposed changes to the scoring algorithm for Section 6C: Hand Hygiene.

SECTION 6D: DIAGNOSTIC EXCELLENCE (OPTIONAL – NOT SCORED OR PUBLICLY REPORTED IN 2025)

Based on an analysis of responses submitted to the 2024 Leapfrog Hospital Survey and consultation with Leapfrog's Diagnostic Excellence Expert Panel, Leapfrog will not score or publicly report Section 6D: Diagnostic Excellence in 2025. Instead, Leapfrog proposes to make several revisions to the question set, and add new FAQs, to ensure responses accurately reflect the intent of the new subsection.

Leapfrog is proposing the following updates to Section 6D: Diagnostic Excellence:

- Question #1, regarding the CEO's commitment to diagnostic excellence, will be updated to specify that the commitment must specifically focus on errors in diagnosis, and to indicate that the commitment must have been made by the hospital's current CEO or CMO.
- Questions #3 and #4, regarding patient engagement, will be updated to specify a timeframe for PFAC meetings and clarify that PFAC activities should focus on diagnosis in the hospital.
- Question #5 and #6, regarding risk assessment and mitigation, will be updated to specify that hospitals should use the Safer Dx Checklist to identify at least one practice not currently fully implemented and to clarify the specific steps the hospital is taking to close those gaps.
- Questions #7-15, regarding convening a multidisciplinary team focused on diagnostic excellence, will be updated to confirm that the multidisciplinary team should be a distinct entity at the hospital, not the established patient safety committee, as well as specifying specific timeframes for activities. A new FAQ will clarify that multidisciplinary teams should be hospital-specific, not system-level.

- Question #16, regarding training and education, will be updated to specify that the AHRQ TeamSTEPPS for Diagnosis Improvement program is the training hospitals should be using to improve communication among members of the care team within the context of the diagnostic process.
- Questions #17-22, regarding closing the loop on cancer diagnosis, will include new FAQs to clarify which reports should be included, and how patients should be tabulated.

The proposed updated questions and new FAQs are available in Appendix IX.

SECTION 6E: EMERGENCY DEPARTMENT (ED) BOARDING (OPTIONAL – NOT SCORED OR PUBLICLY REPORTED IN 2025)

Over the next few years, Leapfrog plans to grow its hospital reporting to include emergency department (ED) safety. This is consistent with our expansion of ratings beyond the inpatient setting to include outpatient surgery in hospitals and ambulatory surgery centers. Our first approach to measuring and establishing standards of performance for ED safety began with our focus on harm to patients from diagnostic errors on the 2024 Leapfrog Hospital Survey, where a new subsection focused on Diagnostic Excellence included a set of fact-finding questions to assess hospital's adoption of targeted best practices.

In consultation with subject matter experts and own independent literature review, an urgent patient safety risk has been identified: emergency department (ED) boarding.

Boarding ED patients in the ED after the decision to admit them to an inpatient bed is a long-standing yet increasingly common quality and safety issue[1]. Studies suggest ED boarding is associated with delayed and missed care, medication errors, higher morbidity, in-hospital mortality, extended hospital length of stay, and poor patient satisfaction.[2-11] According to the Association of Academic Chairs of Emergency Medicine, ED boarding rose nearly 130% from 2012 to 2019, and further increased after COVID-19[12].

We recognize that this problem is complex and often difficult for hospitals to address. But for patients and payors, the risk of ED boarding would be a critical factor in evaluating the safety of a hospital. Leapfrog proposes asking hospitals to report on two measures which will be used for fact-finding only in 2025:

- The percentage of ED patients admitted to the hospital that had an ED Boarding time of 4 hours or less (where lower percentages are desirable)
- The average length of stay in the ED for patients admitted to the hospital (where lower averages are desirable)

Patients that are admitted to observation status, but not the inpatient setting, are excluded from reporting.

The proposed questions are available for review in Appendix X and will not be scored or publicly reported in 2025.

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[12] Kelen GD, Wolfe R, D'Onofrio G, Mills AM, Diercks D, Stern SA, Wadman MC, Sokolove PE. Emergency department crowding: the canary in the health care system. NEJM Catalyst Innovations in Care Delivery. 2021 Sep 28;2(5).

SECTION 7: MANAGING SERIOUS ERRORS

SECTION 7A: NEVER EVENTS

There are no proposed changes to this subsection.

SECTION 7B: HEALTHCARE-ASSOCIATED INFECTIONS

Leapfrog will continue to obtain healthcare-associated infection (HAI) data directly from the CDC's National Healthcare Safety Network (NHSN). Additionally, Leapfrog will add one new question to Section 7B to confirm that hospitals have completed all the required steps in order for their HAI data to be scored and publicly reported, which include: joining Leapfrog's NHSN Group, entering a valid NHSN ID in the Profile of the Leapfrog Hospital Survey, and submitting the 2025 Leapfrog Hospital Survey.

The proposed new question and deadlines to join Leapfrog's NHSN Group are available in Appendix XI.

SECTION 8: PEDIATRIC CARE

SECTION 8A: PATIENT EXPERIENCE (CAHPS CHILD HOSPITAL SURVEY)

There are no proposed changes to this subsection.

SECTION 8B: PEDIATRIC COMPUTED TOMOGRAPHY (CT) RADIATION DOSE

There are no proposed changes to this subsection.

SECTION 9: OUTPATIENT PROCEDURES

SECTION 9A: BASIC OUTPATIENT DEPARTMENT INFORMATION

There are no proposed changes to this subsection.

SECTION 9B: MEDICAL, SURGICAL, AND CLINICAL STAFF

In response to feedback from participating hospitals and ASCs, Leapfrog is proposing the following update to Section 9B: Medical, Surgical, and Clinical Staff:

- Question #2, regarding the presence of clinicians trained in Pediatric Advanced Life Support (PALS), will be updated to include a new response option of "Not applicable; pediatric patients are all aged 13-17" to clarify that all pediatric procedures reported on in Section 9C during the reporting period were performed on patients 13 years and older. The updated question is available for review below:

  Updates highlighted in yellow

1) Is there a Pediatric Advanced Life Support (PALS) trained clinician, as well as a second clinician**Error! Bookmark not defined.** (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 hospital outpatient department? *Hospitals that do not care for pediatric patients should select "Not Applicable; adult patients only" and hospitals that only performed applicable pediatric procedures on pediatric patients 13 years and older during the reporting period should select "Not applicable; pediatric patients are all aged 13-17," regardless of the presence of clinicians trained in PALS. These hospitals will be scored as "Does Not Apply".*	○ Yes ○ No ○ Not applicable; adult patients only ○ Not applicable; pediatric patients are all aged 13-17

There are no proposed changes to the scoring algorithm for Section 9B: Medical, Surgical, and Clinical Staff.

SECTION 9C: VOLUME OF PROCEDURES

There are no proposed changes to this subsection.

SECTION 9D: SAFETY OF PROCEDURES

Patient Follow-Up

There are no proposed changes to these questions.

Data download dates for OP-32 Rate of Unplanned Hospital Visits After an Outpatient Colonoscopy are available in Appendix XII.

Safe Surgery Checklist for Adult and Pediatric Outpatient Procedures

There are no proposed changes to these questions.

SECTION 9E: MEDICATION SAFETY FOR OUTPATIENT PROCEDURES

There are no proposed changes to this subsection.

SECTION 9F: PATIENT EXPERIENCE (OAS CAHPS)

There are no proposed changes to this subsection. However, Leapfrog would like to inform hospitals that they will still be required to report OAS CAHPS results in the Online Survey Tool, despite the data being publicly reported by CMS at data.cms.gov. Current benchmarks used by Leapfrog to score Top Box Scores from four domains included on the OAS CAHPS Survey are based on data from both ASCs and HOPDs. ASCs are not yet required to report their OAS CAHPS results to CMS. Leapfrog plans to incorporate the CMS publicly reported datasets in the future once ASCs are fully included in adjustments of the Top Box Scores.

Thank you for your interest in the Leapfrog Hospital Survey. To provide a public comment, please respond by completing the public comment form **here**. Comments will be accepted until midnight ET on **December 13, 2024.** The Leapfrog Group and our experts will consider comments carefully in finalizing the 2025 Leapfrog Hospital Survey. Leapfrog will publish responses to public comments and a summary of changes in March 2025.

APPENDIX I

Timeline for the 2025 Leapfrog Hospital Survey

Date	Deadline
March	Summary of Changes to the 2025 Leapfrog Hospital Survey and Responses to Public Comments will be published at www.leapfroggroup.org/hospital.
April 1	**2025 LEAPFROG HOSPITAL SURVEY LAUNCH** The hard copy of the 2025 Leapfrog Hospital Survey and supporting materials are available for download on the Survey Materials webpage. The Online Hospital Survey Tool is available.
June 19	**FIRST NHSN GROUP DEADLINE:** Hospitals that join Leapfrog's NHSN Group by June 19, provide a valid NHSN ID in the Profile, and submit the Leapfrog Hospital Survey by June 30, will have data available prior to public reporting on their Hospital Details Page starting on July 12. Results will be publicly reported on July 25. Please see Appendix XII for instructions and other 2025 NHSN deadlines.
June 30	**SUBMISSION DEADLINE:** Hospitals that submit a Survey (and CPOE Evaluation Tool if applicable) by June 30 will have their Leapfrog Hospital Survey Results available prior to public reporting on their Hospital Details Page starting July 12. Results will be publicly reported on Leapfrog's website starting on July 25. Hospitals that do not submit a Survey by June 30 will be publicly reported as "Declined to Respond" until a Survey has been submitted. Competitive Benchmarking Reports: Hospitals that would like to receive a free Summary Report must submit a Survey by June 30. The free Summary Report will be emailed to each hospital's CEO and Primary Survey Contact in September.
July 12	The first set of Leapfrog Hospital Survey Results, which reflect Surveys submitted by June 30, will be privately available for hospitals to view on July 12 via the Hospital Details Page link on the Survey Dashboard. In addition, Leapfrog will send out its first round of monthly data verification emails and documentation requests.
July 25	The first set of Leapfrog Hospital Survey Results, which reflect Surveys submitted by June 30, are published. After July, Survey Results are updated on the seventh (7) business day of the month to reflect Surveys (re)submitted by the end of the previous month.

Date	Deadline
August 31	**TOP HOSPITAL DEADLINE:** Submission deadline for hospitals to be eligible to receive a Leapfrog Top Hospital Award. Hospitals are encouraged to submit their Survey by June 30 in order to resolve any data entry or reporting errors identified by Leapfrog through its monthly data verification and documentation requests. **DATA SNAPSHOT DATE FOR THE FALL 2025 HOSPITAL SAFETY GRADE:** Adult and general hospitals that would like Leapfrog Hospital Survey Results included in the fall 2025 Leapfrog Hospital Safety Grade must submit a Survey and CPOE Evaluation Tool by August 31. Hospitals are encouraged to submit their Survey by June 30 in order to resolve any data entry or reporting errors identified by Leapfrog through its monthly data verification and documentation requests. Find more information about the Leapfrog Hospital Safety Grade here.
November 30	**LATE SUBMISSION DEADLINE:** The 2025 Leapfrog Hospital Survey will close to new submissions at 11:59 pm ET on November 30. No new Surveys, new Survey sections, or CPOE Evaluation Tool Tests can be submitted after this deadline. Only hospitals that have submitted a Survey by November 30 will be able to log into the Online Survey Tool to make corrections to previously submitted sections during the months of December and January. Survey updates reflecting a change in performance must be made prior to November 30. Performance updates made after November 30 will not be scored or publicly reported. Adult and general hospitals that would like Leapfrog Hospital Survey Results included in the spring 2026 Leapfrog Hospital Safety Grade must submit a Survey and CPOE Evaluation Tool by November 30 to have Leapfrog Hospital Survey Results available for the January 31 Data Snapshot Date. Find more information about the Leapfrog Hospital Safety Grade here.
January 31, 2026	**CORRECTIONS DEADLINE:** Hospitals that need to make corrections to previously submitted 2025 Leapfrog Hospital Surveys must make necessary updates and re-submit the entire Survey by January 31, 2026. Hospitals will not be able to make changes or re-submit their Survey after this date. Survey updates reflecting a change in performance must be made prior to November 30. Performance updates made after November 30 will not be scored or publicly reported. **DATA SNAPSHOT DATE FOR THE SPRING 2026 HOSPITAL SAFETY GRADE:** Adult and general hospitals that would like Leapfrog Hospital Survey Results included in the spring 2026 Leapfrog Hospital Safety Grade must submit a Survey and CPOE Evaluation Tool by November 30 to have Leapfrog Hospital Survey Results available for the January 31 Data Snapshot Date. Find more information about the Leapfrog Hospital Safety Grade here.

APPENDIX II

Anticipated Reporting Periods for the 2025 Leapfrog Hospital Survey

	Survey Submitted Prior to September 1	Survey (Re)Submitted on or after September 1
Survey Section	**Reporting Period**	**Reporting Period**
1A Basic Hospital Information	12 months ending 12/31/2024	12 months ending 06/30/2025
1B Billing Ethics	N/A	N/A
1C Health Care Equity	N/A	N/A
1D Informed Consent	N/A	N/A
2A Computerized Physician Order Entry (CPOE)	Latest 3 months prior to Survey submission	Latest 3 months prior to Survey submission
2B EHR Application Information	N/A	N/A
2C Bar Code Medication Administration (BCMA)	Latest 3 months prior to Survey submission	Latest 3 months prior to Survey submission
2D Medication Reconciliation	Latest 6 months prior to survey submission	Latest 6 months prior to survey submission
3A Hospital and Surgeon Volume	Volume: 12 months or 24 months ending 12/31/2024	Volume: 12 months or 24 months ending 06/30/2025
	STS MVRR Composite Score: Latest 36-month report	STS MVRR Composite Score: Latest 36-month report
3B Safe Surgery Checklist for Adult and Pediatric Complex Surgery	Latest 12 months prior to Survey submission	Latest 12 months prior to Survey submission
4A Maternity Care Volume and Services	12 months ending 12/31/2024	12 months ending 06/30/2025
4B Cesarean Birth	12 months ending 12/31/2024	12 months ending 06/30/2025
4C Episiotomy	12 months ending 12/31/2024	12 months ending 06/30/2025
4D Process Measures of Quality	12 months ending 12/31/2024	12 months ending 06/30/2025
4E High-Risk Deliveries	Volume: 12 months ending 12/31/2024	Volume: 12 months ending 06/30/2025
	VON: 2023 report	VON: 2024 report
5A Adult ICU Physician Staffing	Latest 3 months prior to Survey submission	Latest 3 months prior to Survey submission
5B Pediatric ICU Physician Staffing	Latest 3 months prior to Survey submission	Latest 3 months prior to Survey submission
5C Nursing Workforce	Nurse Staffing and Skill Level: 12 months ending 12/31/2024	Nurse Staffing and Skill Level: 12 months ending 06/30/2025
	NQF Safe Practice #9: Latest 12 months prior to Survey submission	NQF Safe Practice #9: Latest 12 months prior to Survey submission

Survey Section	Survey Submitted Prior to September 1 Reporting Period	Survey (Re)Submitted on or after September 1 Reporting Period
	Percentage of RNs who are BSN-Prepared: 12 months ending 12/31/2024	Percentage of RNs who are BSN-Prepared: 12 months ending 06/30/2025
6A NQF Safe Practice #1 – Culture of Safety Leadership Structures and Systems	Latest 12 months prior to Survey submission	Latest 12 months prior to Survey submission
6B NQF Safe Practice #2 – Culture Measurement, Feedback, and Intervention	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)
6C Hand Hygiene	N/A	N/A
6D Diagnostic Excellence	CEO Commitment to Diagnostic Excellence, Patient Engagement, Risk Assessment and Mitigation, Convening a Multidisciplinary Team Focused on Diagnostic Excellence, Training and Education: N/A	CEO Commitment to Diagnostic Excellence, Patient Engagement, Risk Assessment and Mitigation, Convening a Multidisciplinary Team Focused on Diagnostic Excellence, Training and Education: N/A
	Closing the Loop on First-Time Cancer Diagnosis: 12 months ending 12/31/2024	Closing the Loop on First-Time Cancer Diagnosis: 12 months ending 06/30/2025
6E Emergency Department (ED) Boarding	12 months ending 12/31/2024	12 months ending 06/30/2025
7A Never Events	N/A	N/A
7B Healthcare-Associated Infections (HAIs)	June and August Data Downloads: 01/01/2024 – 12/31/2024	October and December Data Downloads: 07/01/2024 – 06/30/2025
8A Patient Experience (CAHPS Child Hospital Survey)	Latest 12 months prior to Survey submission	Latest 12 months prior to Survey submission
8B Pediatric Computed Tomography (CT) Radiation Dose	12 months ending 12/31/2024	12 months ending 06/30/2025
9A Basic Outpatient Department Information	12 months ending 12/31/2024	12 months ending 06/30/2025
9B Medical, Surgical, and Clinical Staff	Latest 3 months prior to Survey submission	Latest 3 months prior to Survey submission
9C Volume of Procedures	12 months ending 12/31/2024	12 months ending 06/30/2025
9D Safety of Procedures	Patient Follow-up: Latest 24 months prior to Survey submission	Patient Follow-up: Latest 24 months prior to Survey submission
	Safe Surgery Checklist:	Safe Surgery Checklist:

	Survey Submitted Prior to September 1	Survey (Re)Submitted on or after September 1
Survey Section	**Reporting Period**	**Reporting Period**
	Latest 12 months prior to Survey submission	Latest 12 months prior to Survey submission
9E Medication Safety for Outpatient Procedures	12 months ending 12/31/2024	12 months ending 06/30/2025
9F Patient Experience (OAS CAHPS)	Latest 12 months prior to Survey submission	Latest 12 months prior to Survey submission

APPENDIX III

General: Units by Survey Section

Hyperlinks to unit definitions are provided below in the General – Proposed Endnotes for 2025 Units

Survey Section/ Measure	Units
1A Basic Hospital Information	• Acute-Care Units(adult and/or pediatric) • General Medical/Surgical ICUs and Neuro ICUs (adult and/or pediatric) • Specialty ICUs • Neonatal ICUs
1B Billing Ethics	N/A
1C Health Care Equity	N/A
1D Informed Consent	N/A
2A Computerized Physician Order Entry (CPOE)	N/A
2B EHR Application Information	N/A
2C Bar Code Medication Administration (BCMA)	• General Medical/Surgical ICUs and Neuro ICUs (adult and/or pediatric) • Neonatal ICUs • Specialty ICUs (adult and/or pediatric) • Medical and/or Surgical Units (including Telemetry)(adult and/or pediatric) • Step-down/Progressive Units • Pre-operative and Post-anesthesia Care Units (adult and/or pediatric) • Labor and Delivery Units
2D Medication Reconciliation	• Medical and/or Surgical Units (including Telemetry) (adult only) • Step-down/Progressive Units
3A Hospital and Surgeon Volume	N/A

Survey Section/ Measure	Units
3B Safe Surgery Checklist for Adult and Pediatric Complex Surgery	N/A
4A Maternity Care Volume and Services	N/A
4B Cesarean Birth	N/A
4C Episiotomy	N/A
4D Process Measures of Quality	N/A
4E High-Risk Deliveries	• Neonatal ICUs
5A Adult ICU Physician Staffing	• General Medical/Surgical ICUs and Neuro ICUs (adult)
5B Pediatric ICU Physician Staffing	• General Medical/Surgical ICUs and Neuro ICUs (pediatric)
5C Nursing Workforce	Nurse Staffing and Skill Level: • Single Acuity Medical Units (adult and/or pediatric) • Single Acuity Surgical Units (adult and/or pediatric) • Single Acuity Med-Surg Combined Units (adult and/or pediatric) • Mixed Acuity Medical, Surgical and Med-Surg Units (adult and/or pediatric) Percentage of RNs who are BSN-Prepared: • N/A For more information, refer to the Section 5C: Nursing Workforce Measure Specifications.
6A NQF Safe Practice #1 – Culture of Safety Leadership Structures and Systems	N/A

Survey Section/ Measure	Units
6B NQF Safe Practice #2 – Culture Measurement, Feedback, and Intervention	N/A
6C Hand Hygiene	• Medical and/or Surgical Units (including Telemetry) (adult and/or pediatric) • Step-down/Progressive Units (adult and/or pediatric) • Obstetrical Units (Labor and Delivery Units, nursery, etc., excluding procedural areas) • General Medical/Surgical ICUs and Neuro ICUs (adult and/or pediatric) • Neonatal ICUs • Specialty ICUs (adult and/or pediatric) • Pre-operative and Post-anesthesia Care Units (adult and/or pediatric) • Observation units • Dedicated Emergency Department Units
6D Diagnostic Excellence	N/A
6E Emergency Department (ED) Boarding	• Dedicated Emergency Department Units
7A Never Events	N/A
7B Healthcare-Associated Infections (HAIs)	N/A
8A Patient Experience (CAHPS Child Hospital Survey)	N/A
8B Pediatric Computed Tomography (CT) Radiation Dose	N/A
9A Basic Outpatient Department Information	N/A
9B Medical, Surgical, and Clinical Staff	N/A

Survey Section/ Measure	Units
9C Volume of Procedures	N/A
9D Safety of Procedures***	N/A
9E Medication Safety for Outpatient Procedures	N/A
9F Patient Experience (OAS CAHPS)	N/A

General – Proposed Endnotes for 2025 Units

Updates highlighted in yellow

Acute-Care Units

Include units used for short-term, acute-care medical, surgical, medical/surgical, obstetrical, and intensive care, as well as telemetry/step-down/progressive care. Exclude units used for short and long-term psychiatric care, rehabilitation, observation, or sub-acute care (e.g., skilled nursing facility, hospice extended care, sub-acute eating disorder treatment, extended care facility, or residential substance abuse treatment), and swing units.

General Medical and/or Surgical or Neuro ICUs

Include general medical and/or surgical ICUs and neuro ICUs (medical and surgical). Exclude units "dedicated exclusively" to patients with specialized conditions (e.g., cardiac, burn, trauma, neonatal, etc.) that are distinct and separate from other adult or pediatric general medical and/or surgical ICUs or neuro ICUs unless the same ICU is used for both specialized intensive care patients as well as general medical and/or surgical or neuro intensive care patients. "Dedicated exclusively" means that general medical and/or surgical or neuro patients are not also cared for in these specialized units (except in rare overflow situations). Ignore intermediate care or telemetry/step-down/progressive units.

For the purposes of reporting on admissions In Section 1A: Basic Hospital Information, include admissions to general medical and/or surgical ICUs and neuro ICUs (medical and surgical), as well as ICU admissions to mixed acuity and other units, whether directly admitted to the unit or transferred to the unit from another area of your hospital (e.g., post-operatively). Include transfers from other hospitals as admissions to your hospital. Count the number of hospitalizations that include an ICU stay, not the number of patient trips to the ICU.

For the purposes of reporting on Section 5: ICU Physician Staffing, cardiac critical care patients in a general medical or surgical ICU beds being cared for by general medical or surgical critical care physicians and nursing staff are included in the standard and need to be managed/co-managed by the intensivist. Cardiac critical care patients in a general medical or surgical ICU that are in beds dedicated to cardiac critical care patients and being

cared for by dedicated cardiac physicians (e.g., cardiologist or cardiac surgeon) and nursing staff are not included in Leapfrog's ICU Physician Staffing standard and do not need to be managed/co-managed by the intensivist.

For hospitals that have more than one type of ICU included in the ICU Physician Staffing standard, where the ICU physician staffing structure may differ among ICU types, hospitals are instructed to report on the ICU with the lowest level of staffing by physicians certified in critical care medicine when responding to questions #1-15 in Section 5A: Adult ICU Physician Staffing and Section 5B: Pediatric ICU Physician Staffing. For example, if the adult medical ICU is staffed by intensivists at least 8 hours/day, 7 days/week, but the adult surgical ICU is not, the hospital would respond to questions #1-15 based on the adult surgical ICU.

Neonatal ICUs

Include any level neonatal ICU (NICU), i.e., Level II/III, Level III, or Level IV. Exclude neonatal nurseries (Level I and Level II). For more information about what is considered a NICU, please refer to the CDC's definitions of Neonatal Units on p. 15-12 to 15-15 of the following document: http://www.cdc.gov/nhsn/PDFs/pscManual/15LocationsDescriptions_current.pdf.

For the purposes of reporting on NICU admissions in Section 1A: Basic Hospital Information, include admissions to any level NICU, even if counted in question #5. Include transfers from other hospitals as admissions to your hospital. Exclude admissions for patients that were transferred to another facility.

Medical and/or Surgical Units

An exact definition on which units would be included in general medical, surgical, or medical/surgical cannot be provided because each hospital is laid out differently. For information about what is considered a general medical, surgical, or medical/surgical unit, please refer to the CDC's definitions of Medical Ward, Medical/Surgical Ward, and Surgical Ward on p. 15-17 to 15-20 of the following document: http://www.cdc.gov/nhsn/PDFs/pscManual/15LocationsDescriptions_current.pdf. The flowchart on p. 15-3 can also be used to help define units in your hospital. Units for patients from a specific service type (e.g., burn, cardiac) and observation units should be excluded. Include telemetry units.

For the purposes of reporting on Sections 2C: BCMA and 6C: Hand Hygiene, include both mixed acuity and single acuity medical and/or surgical units.

For the purposes of reporting on Section 5C: Nursing Workforce, hospitals must reference the unit definitions and acuity definitions in the measure specifications.

Step-Down/Progressive Unit

A single acuity unit in which at least 90% of the patients are at a lower level of acuity than patients in a critical care unit, yet at a higher level of acuity than that which is provided in a general care unit. These units may be called progressive care, intermediate care, direct observation, or transitional care units. Telemetry alone is not an indicator of acuity level. Telemetry patients must require a higher level of nursing intensity than is available on medical-surgical units to be classified as step-down.

Pre-Operative or Post-Anesthesia Care Units

Include all pre-operative and post-anesthesia care units (PACUs) located in or co-located with your hospital. This includes combined pre-operative and post-anesthesia care units as well. If the hospital distinguishes between

post-anesthesia phases within its PACU(s) (i.e., Phase I, Phase II, and Phase III recovery), all phases must be included when reporting.

Pre-operative units include areas where patients are prepared for an inpatient or outpatient surgical or diagnostic procedure, (i.e., where patients have their medical histories reviewed with their care team and receive physical examinations to determine risk factors and other information relevant to the surgery or procedure).

PACUs include areas where patients are watched after an inpatient or outpatient surgical or diagnostic procedure that required anesthesia or sedation and where hospital staff (e.g., nurses, anesthesiologists, and other support services) monitor patient recovery from anesthesia or sedation by keeping track of vitals and providing pain management.

Labor and Delivery Units

Include all antepartum and postpartum units. Nursery units, OR units, and procedural areas should be excluded.

Dedicated Emergency Department Units

A dedicated emergency department is an area of the hospital that meets any one of the following criteria:

- Licensed by the state as an emergency department,
- Holds itself out to the public as providing emergency care, or
- During the preceding calendar year, at least one-third of its outpatient visits were for the treatment of emergency medical conditions.

APPENDIX IV

Section 2C: Bar Code Medication Administration (BCMA) – Proposed Questions for 2025

Updates highlighted in yellow.

1) What is the latest 3-month reporting period for which your hospital is submitting responses to questions #2-21? 3-month reporting period ending:	_____ *Format: Month/Year*
2) Does your hospital use a Bar Code Medication Administration (BCMA) system that is linked to the electronic medication administration record (eMAR) when administering medications at the bedside in at least one of the following units: • General Medical/Surgical ICUs and Neuro ICUs (adult and/or pediatric), Neonatal ICUs, and Specialty ICUs (adult and/or pediatric), • Medical and/or Surgical Units (including telemetry units) (adult and/or pediatric), • Step-down/Progressive units (adult and/or pediatric) • Labor and Delivery Unit, or • Pre-operative and Post-anesthesia Care Units (adult and/or pediatric)? *If "no" to question #2, skip questions #3-21 and continue to the next subsection. The hospital will be scored as "Limited Achievement."*	○ Yes ○ No
3) Does your hospital operate General Medical/Surgical ICUs and Neuro ICUs (adult and/or pediatric), Neonatal ICUs, or Specialty ICUs (adult and/or pediatric)? *If "no" to question #3, skip questions #4-5 and continue to question #6.*	○ Yes ○ No
4) If "yes," how many of this type of unit are open and staffed in the hospital?	_____
5) How many of the units in question #4 utilized the BCMA/eMAR system when administering medications at the bedside?	_____
6) Does your hospital operate Medical and/or Surgical Units (including telemetry units) (adult and/or pediatric)? *If "no" to question #6, skip questions #7-8 and continue to question #9.*	○ Yes ○ No
7) If "yes," how many of this type of unit were open and staffed in the hospital?	_____
8) How many of the units in question #7 utilized the BCMA/eMAR system when administering medications at the bedside?	_____
9) Does your hospital operate Step-down/Progressive units (adult and/or pediatric)? *If "no" to question #9, skip questions #10-11 and continue to question #12.*	○ Yes ○ No

10) If "yes," how many of this type of unit were open and staffed in the hospital?	_____
11) How many of the units in question #10 utilized the BCMA/eMAR system when administering medications at the bedside?	_____
12) Does your hospital operate a Labor and Delivery Unit? *If "no" to question #12, skip questions #13-14 and continue to question #15.*	○ Yes ○ No
13) If "yes," how many of this type of unit were open and staffed in the hospital?	_____
14) How many of the units in question #13 utilized the BCMA/eMAR system when administering medications at the bedside?	_____
15) Does your hospital operate Pre-operative and Post-anesthesia Care Units (adult and/or pediatric)? *If "no" to question #15, skip questions #16-17 and continue to question #18.*	○ Yes ○ No
16) If "yes," how many of this type of unit are open and staffed in the hospital?	_____
17) How many of the units in question #16 utilized the BCMA/eMAR system when administering medications at the bedside?	_____

If "no" to questions #3, #6, #9, #12, and #15 above, update your response to question #2.

18) The number of scannable medication administrations during the reporting period in those units that utilize BCMA as indicated in questions #5, #8, #11, #14, and #17 above:	_____
19) The number of medication administrations from question #18 that had both the patient and the medication scanned during administration with a BCMA system that is linked to the electronic medication administration record (eMAR):	_____

20) What types of decision support does your hospital's BCMA system provide to users of the system?		
a)	Wrong patient	○ Yes ○ No
b)	Wrong medication	○ Yes ○ No
c)	Wrong dose	○ Yes ○ No

d)	Wrong time (e.g., early/late warning; warning that medication cannot be administered twice within a given window of time)	○ Yes ○ No
e)	Second nurse check needed	○ Yes ○ No

21)	Which of the following mechanisms does your hospital use to reduce and understand potential BCMA system "workarounds"?	
a)	Has a formal committee that meets routinely to review data reports on BCMA system use	○ Yes ○ No
b)	Has back-up equipment for BCMA hardware failures	○ Yes ○ No
c)	Has a Help Desk that provides timely responses to urgent BCMA issues in real-time	○ Yes ○ No
d)	Conducts real-time observations of users at the unit level using the BCMA system	○ Yes ○ No
e)	Engages nursing leadership at the unit level on BCMA use	○ Yes ○ No
f)	In the past 12 months used the data and information obtained through items a-e to implement quality improvement projects that have focused on improving the hospital's BCMA performance **OR** In the past 12 months used the data and information obtained through items a-e to monitor a previously implemented quality improvement project focused on improving the hospital's BCMA performance *Cannot respond "yes" to this question, unless "yes" to either 21a, 21d or 21e.*	○ Yes ○ No

g)	In the past 12 months evaluated the results of the quality improvement projects (from f) and demonstrated that these projects have resulted in higher adherence to your hospital's standard medication administration process **OR** In the past 12 months evaluated the results of the quality improvement projects (from f) and demonstrated continued adherence to your hospital's standard medication administration process *Cannot respond "yes" to this question, unless "yes" to 21f.*	○ Yes ○ No
h)	Communicated back to end users the resolution of any system deficiencies and/or problems that may have contributed to workarounds *Cannot respond "yes" to this question, unless "yes" to either 21a, 21d or 21e.*	○ Yes ○ No

APPENDIX V

Section 3A: Adult and Pediatric Complex Surgery – Proposed Additional Codes for Bariatric Surgery for Weight Loss

ICD-10 CM Procedure Code	Description
0D164J9	Bypass Stomach to Duodenum with Synthetic Substitute, Percutaneous Endoscopic Approach
0D164K9	Bypass Stomach to Duodenum with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0D160J9	Bypass Stomach to Duodenum with Synthetic Substitute, Open Approach
0D160K9	Bypass Stomach to Duodenum with Nonautologous Tissue Substitute, Open Approach
0D16879	Bypass Stomach to Duodenum with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D168J9	Bypass Stomach to Duodenum with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic
0D168K9	Bypass Stomach to Duodenum with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D168Z9	Bypass Stomach to Duodenum, Via Natural or Artificial Opening Endoscopic
0D164JA	Bypass Stomach to Jejunum with Synthetic Substitute, Percutaneous Endoscopic Approach
0D164KA	Bypass Stomach to Jejunum with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0D160JA	Bypass Stomach to Jejunum with Synthetic Substitute, Open Approach
0D160KA	Bypass Stomach to Jejunum with Nonautologous Tissue Substitute, Open Approach
0D1687A	Bypass Stomach to Jejunum with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D168JA	Bypass Stomach to Jejunum with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic
0D168KA	Bypass Stomach to Jejunum with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D168ZA	Bypass Stomach to Jejunum, Via Natural or Artificial Opening Endoscopic
0D164JB	Bypass Stomach to Ileum with Synthetic Substitute, Percutaneous Endoscopic Approach
0D164KB	Bypass Stomach to Ileum with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0D160JB	Bypass Stomach to Ileum with Synthetic Substitute, Open Approach

ICD-10 CM Procedure Code	Description
0D160KB	Bypass Stomach to Ileum with Nonautologous Tissue Substitute, Open Approach
0D1687B	Bypass Stomach to Ileum with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D168JB	Bypass Stomach to Ileum with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic
0D168KB	Bypass Stomach to Ileum with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D168ZB	Bypass Stomach to Ileum, Via Natural or Artificial Opening Endoscopic

APPENDIX VI

Section 3B: Safe Surgery Checklist for Adult and Pediatric Complex Surgery – Proposed Scoring Algorithm for 2025

Updates highlighted in yellow.

Safe Surgery Checklist Score (Performance Category)	Meaning that…
Achieved the Standard **(4 bars)**	• The hospital uses a safe surgery checklist on **all** patients undergoing an applicable procedure, • The checklist includes **all** safe surgery checklist elements, and these elements were verbalized in the presence of the appropriate personnel (i.e., hospital responded "yes" to questions #3, #4, and #5), • The hospital completed an audit of 15 or 30 patients, as applicable, and documented adherence to the checklist, and • Based on the audit, has documented adherence to the checklist for **at least 90%** of the patients included in the audit.
Considerable Achievement **(3 bars)**	• The hospital uses a safe surgery checklist on **all** patients undergoing an applicable procedure, • The checklist includes **all** safe surgery checklist elements, and these elements were verbalized in the presence of the appropriate personnel (i.e., hospital responded "yes" to questions #3, #4, and #5), • The hospital completed an audit of 15 or 30 patients, as applicable, and documented adherence to the checklist, and • Based on the audit, has documented adherence to the checklist for **at least 75%** of the patients included in the audit.
Some Achievement **(2 bars)**	• The hospital uses a safe surgery checklist on **all** patients undergoing an applicable procedure, • The checklist includes **all** safe surgery checklist elements, and these elements were verbalized in the presence of the appropriate personnel (i.e., hospital responded "yes" to questions #3, #4, and #5), • The hospital completed an audit of 15 or 30 patients, as applicable, and documented adherence to the checklist, and • Based on the audit, has documented adherence to the checklist for **at least 50%** of the patients included in the audit.
Limited Achievement **(1 bar)**	The hospital responded to the questions in this section, but it does not yet meet the criteria for Some Achievement.

Unable to Calculate Score	The hospital performs fewer than 30 total inpatient procedures under general anesthesia.
Does Not Apply	The hospital does not perform any of the adult or pediatric complex procedures.

APPENDIX VII

VON Reporting Periods and Deadlines for 2025

Complete and submit Data Sharing Authorization to VON by*	VON data will be scored and publicly reported for hospitals that have submitted Section 4 by	VON Reporting Period	Available on Hospital Details Page and Public Reporting Website
June 16, 2025	June 30, 2025	2023	July 12, 2025 Hospital Details Page July 25, 2025 Public Reporting Website
August 15, 2025	August 31, 2025	2024**	September 10, 2025***
November 14, 2025	November 30, 2025	2024	December 9, 2025***

* Hospitals that successfully submitted a Data Sharing Authorization letter in previous years will not be required to submit another letter in 2025.
**Anticipated release of 2024 VON data.
*** Available on Hospital Details Page on the same date as public release of Survey Results

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APPENDIX VIII

Section 5B: Pediatric ICU Physician Staffing – Proposed Questions for 2025

Updates highlighted in yellow.

1) What is the latest 3-month reporting period for which your hospital is submitting responses to this section? 3 months ending:	_____ *Format: Month/Year*
2) Does your hospital operate any pediatric general medical and/or surgical ICUs or neuro ICUs? *If your hospital has more than one applicable pediatric ICU, respond to all questions in this section based on the pediatric ICU that has the lowest level of staffing by physicians certified in critical care medicine (More Information).* *If your hospital does not operate an applicable pediatric ICU but regularly admits critical care pediatric patients to non-critical care or mixed acuity units, select "yes" and respond to the remaining questions in Section 5B.* *If "no" to question #2, skip the remaining questions in Section 5B: Pediatric ICU Physician Staffing and go to the Affirmation of Accuracy. The hospital will be scored as "Does Not Apply."*	○ Yes ○ No
3) Is the ICU staffed with physicians who are certified in critical care medicine and present on-site or via telemedicine? *If "no" to question #3, skip the remaining questions in Section 5B: Pediatric ICU Physician Staffing and go to the Affirmation of Accuracy. This hospital will be scored as "Limited Achievement."*	○ Yes, the ICU is staffed with physicians certified in critical care medicine ○ Yes, the ICU is staffed with physicians certified in critical care medicine based on Leapfrog's expanded definition ○ No, the ICU is not staffed with any physicians certified in critical care medicine
4) Do the physicians who are certified in critical care medicine (whether present on-site or via telemedicine) manage or co-manage all critical care patients in the ICU? *If "no" to question #4, skip questions #5-11 and continue to question #12.*	○ Yes, all patients are managed or co-managed by a physician certified in critical care medicine when the physician is present (on-site or via telemedicine) ○ No, not all patients are managed or co-managed by a physician certified in critical care medicine when

	the physician is present (on-site or via telemedicine)
5) Are all critical care patients in the ICU managed or co-managed by one or more physicians certified in critical care medicine who meet **all** the following criteria: • ordinarily present **on-site** in the ICU during daytime hours; • for at least **8 hours per day, 7 days per week**; and • providing clinical care exclusively in the ICU during these hours? *If "yes" to question #5, skip question #6 and continue to question #7.*	○ Yes ○ No
6) Are all critical care patients in the ICU managed or co-managed by one or more physicians certified in critical care medicine who meet **all** the following criteria: • present via telemedicine, in combination with on-site intensivist coverage, for a total of **24 hours per day, 7 days per week**; • meet all of Leapfrog's ICU requirements for intensivist presence in the ICU via telemedicine (More Information); and • supported by an on-site intensivist who establishes and revises the daily care plan for each ICU patient?	○ Yes ○ No
7) When the physicians (from question #3) are not present in the ICU on-site or via telemedicine, do they return more than 95% of calls/pages/texts from these units within five minutes, based on a quantified analysis of notification device response time? (More information on the use of telemedicine to cover calls)	○ Yes ○ No ○ Not applicable; intensivists are present on-site 24/7
8) When the physicians (from question #3) are not present on-site in the ICU or not able to physically reach an ICU patient within 5 minutes, can they rely on a physician, physician assistant, nurse practitioner, or FCCS-certified nurse or intern "effector" who is in the hospital and able to reach these ICU patients within five minutes in more than 95% of the cases, based on a quantified analysis of response time of the effector reaching the patient?	○ Yes ○ No Not applicable; intensivists are present on-site 24/7
9) Are all critical care patients in the ICU managed or co-managed by one or more physicians certified in critical care medicine who meet all the following criteria: • ordinarily present on-site in the ICU during daytime hours; • for at least 8 hours per day, 4 days per week or 4 hours per day, 7 days per week; and • providing clinical care exclusively in the ICU during these hours?	○ Yes ○ No

10) Are all critical care patients in the ICU managed or co-managed by one or more physicians certified in critical care medicine who meet all the following criteria: • present via telemedicine for 24 hours per day, 7 days per week; • meet all of Leapfrog's modified ICU requirements for intensivist presence in the ICU via telemedicine (More Information); and • supported in the establishment and revision of daily care planning for each ICU patient by an on-site intensivist, hospitalist, anesthesiologist, or physician trained in emergency medicine?	○ Yes ○ No
11) Are all critical care patients in the ICU managed or co-managed by one or more physicians certified in critical care medicine who are: • on-site at least 4 days per week to establish or revise daily care plans for each critical care patient in the ICU?	○ Yes ○ No
12) If not all critical care patients are managed or co-managed by physicians certified in critical care medicine, either on-site or via telemedicine, are some critical care patients managed or co-managed by these physicians who are: • ordinarily present on-site in the ICU during daytime hours; • for at least 8 hours per day, 4 days per week or 4 hours per day, 7 days per week; and • providing clinical care exclusively in the ICU during these hours?	○ Yes ○ No
13) Does an on-site clinical pharmacist do all the following: • at least 5 days per week, makes daily on-site rounds on all critical care patients in the ICU; and • on the other 2 days per week, returns more than 95% of calls/pages/texts from the unit within 5 minutes, based on a quantified analysis of notification device response time; OR • makes daily on-site rounds on all critical care patients in the ICU 7 days per week?	○ Yes ○ No ○ Clinical pharmacist rounds 7 days per week
14) Does a physician certified in critical care medicine lead daily interprofessional rounds on-site on all critical care patients in the ICU 7 days per week?	○ Yes ○ No
15) Are physicians certified in critical care medicine responsible for all ICU admission and discharge decisions when they are: • present on-site for at least 8 hours per day, 4 days per week or 4 hours per day, 7 days per week?	○ Yes ○ No

Section 5A: Adult ICU and Section 5B: Pediatric ICU – Proposed Endnotes for 2025

Updates highlighted in yellow.

Managed or Co-Managed

The intensivist, when present (whether on-site or via telemedicine), is authorized to diagnose, treat, and write orders for a patient in the ICU on the intensivist's own authority. Specific examples of co-management include but are not limited to: communication on patient status between the intensivist and primary care team on a daily basis, briefed on new admissions to the ICU from the primary service team, and develop care plans with the primary service team. Mandatory consults or daily rounds by an intensivist are not sufficient to meet the managed/co-managed requirement. However, an ICU need not be closed to meet this requirement.

Certified in Critical Care Medicine

A physician who is "certified in Critical Care Medicine" is a board-certified physician who is additionally certified in the subspecialty of Critical Care Medicine. Certification in Critical Care Medicine is awarded by the American Boards of Internal Medicine, Surgery, Anesthesiology, Pediatrics, and Emergency Medicine. Additionally, physicians who are awarded certification in Critical Care Medicine from the American Osteopathic Board (AOA) will also be considered "Certified in Critical Care Medicine".

"Neurointensivists" include any physician that meets at least one of the following paths:

- Physicians who are board-certified in their primary specialty and who are additionally certified in the subspecialty of Neurocritical Care Medicine. Certification in Neurocritical Care Medicine is awarded by the United Council for Neurologic Subspecialties (UCNS) or by the American Board of Psychiatry and Neurology, Inc. (ABPN). Physicians who have not yet passed a certifying exam, either through UCNS or ABPN, are considered to be equivalent to a physician "certified in Neurocritical Care Medicine" for up to 3 years after they are eligible to take either: (1) the UCNS exam (UCNS currently offers a "grandfathering" option for their "Practice Track" for exam eligibility) or (2) the ABPN exam (ABPN currently offers a "grandfathering" or practice pathway track for exam eligibility, which will last until 2026). These options provide a 3-year grace period for clinicians to take and pass the necessary exams. To qualify for the grace period, hospitals and/or clinicians will need to provide clear documentation of what their eligibility dates were to sit for one or both of these exams.
- Physicians who are board-certified in their primary specialty and who are additionally credentialed by the American Board of Neurological Surgery (ABNS) through their Recognition of Focused Practice in Neurocritical Care. Physicians who have not yet passed the ABNS Neurocritical Care RFP exam are considered to be equivalent to a physician "certified in Neurocritical Care Medicine" for up to 3 years after they are eligible to take the exam. This provides a 3-year grace period for clinicians to take and pass the necessary exam. To qualify for the grace period, hospitals and/or clinicians will need to provide clear documentation of what their eligibility dates were to sit for the exam.

APPENDIX IX

Section 6D: Diagnostic Excellence Proposed Questions for 2025 (Optional – Fact-Finding Only)

Updates highlighted in yellow

CEO Commitment to Diagnostic Excellence

1) In the past 36 months, has your hospital's current CEO or CMO made a formal commitment (verbally or in writing) to **all staff** to make reducing harm to patients from errors in diagnosis an organizational priority, and communicated at least one specific action the hospital will take to further the commitment? **The commitment must specifically focus on errors in diagnosis.** *If "no" to question #1, skip question #2 and continue question #3.*	○ Yes ○ No
2) What specific actions were communicated by your hospital's CEO or CMO as part of their formal commitment to reducing harm to patients from errors in diagnosis? *Select all that apply.*	☐ Designated a senior leader or clinician champion ☐ Formed a committee ☐ Implemented a performance measure ☐ Implemented a QI project ☐ None of the Above

Patient Engagement

3) Does your hospital have a Patient and Family Advisory Council (PFAC) that meets at least quarterly? *If "no" to question #3, skip question #4 and continue to question #5.*	○ Yes ○ No
4) In the past 36 months, has your hospital's PFAC: • received education regarding errors in diagnosis or the diagnostic process in the hospital, • had input into any initiatives aimed at reducing errors in diagnosis in the hospital, or • led any initiatives aimed at reducing errors in diagnosis in the hospital?	○ Yes ○ No

Risk Assessment and Mitigation

5) In the past 36 months, has your hospital used the Safer Dx Checklist to identify at least one high-priority practice that is not currently at "full" implementation? *If "no" to question #5, skip question #6 and continue to question #7.*	○ Yes, led by our multidisciplinary team ○ Yes, led by a different entity at the hospital (please specify): _____ ○ No

6) What steps has your hospital taken to fully implement that practice? *Select all that apply.*	☐ Allocated budget ☐ Appointed a responsible person ☐ Set a date for full implementation ☐ None of the above

Convening a Multidisciplinary Team Focused on Diagnostic Excellence

7) Has your hospital convened a multidisciplinary team that meets all the following requirements: • Solely focused on reducing harm to patients from errors in diagnosis; • Sponsored by either the CEO or CMO; • Includes, at a minimum, representatives from nursing, pharmacy, laboratory medicine, radiology, pathology, hospital medicine or inpatient care specialists, emergency medicine, and quality or risk management; • Meets at least quarterly; • Reports to senior leaders quarterly; and • Reports to the Board annually? *The multidisciplinary team should be a **distinct entity** at your hospital, not the established patient safety committee.*	○ Yes ○ No
8) As a standing agenda item of regular meetings, has the multidisciplinary team reviewed any clinical or administrative data, patient experience or patient reported data, or incident reports to identify or track errors in diagnosis? *If "no" to question #8, skip question #9 and continue to question #10.*	○ Yes ○ No ○ No, but a different team at the hospital has reviewed data or incident reports to identify or track errors in diagnosis
9) If an error in diagnosis was identified through the review of any of the data sources used in question #8, did the team conduct any analyses or case reviews within four weeks of the error being identified and ensure the findings were communicated to the individuals involved in the patient's care and hospital leadership?	○ Yes ○ No ○ No, but a different team at the hospital has conducted at least one root cause analysis or case review of a diagnostic error
10) In the past 24 months, has the multidisciplinary team encouraged all staff (verbally or in writing), including all clinicians who participate in the diagnostic process, to report errors in diagnosis via the hospital's incident or event reporting system?	○ Yes ○ No ○ No, but a different team at the hospital has encouraged all staff to report errors in diagnosis
11) In the past 24 months, has the multidisciplinary team convened emergency medicine staff to identify commonly misdiagnosed conditions (e.g., stroke, heart attack, VTE) in the emergency department? *If "no" to question #11, skip question #12 and continue to question #13.*	○ Yes ○ No ○ No, but the emergency medicine staff independently meet to

	identify commonly misdiagnosed conditions
12) In the past 24 months, has the multidisciplinary team worked with the emergency medicine staff to develop or implement any initiatives aimed at improving accurate and timely diagnosis of these commonly misdiagnosed conditions?	○ Yes ○ No ○ No, but the emergency medicine staff have independently implemented at least one such initiative
13) In the past 24 months, has the multidisciplinary team convened radiologists and pathologists to discuss diagnosis related issues, including potential discrepancies, and analyze cases where there is a discrepancy between radiology and pathology findings? *If "no" to question #13, skip question #14 and continue to question #15.*	○ Yes ○ No ○ No, but radiologists and pathologists independently meet to discuss diagnosis-related issues
14) In the past 24 months, has the multidisciplinary team worked with the pathologists and radiologists to develop or implement protocols to ensure timely review and resolution of discrepancies, and timely communication of diagnoses to patients and their families?	○ Yes ○ No ○ No, but radiologists and pathologists independently developed or implemented at least one such protocol
15) In the past 24 months, has the multidisciplinary team helped to educate staff on their work on reducing errors in diagnosis?	○ Yes ○ No

Training and Education

16) In the past 36 months, has your hospital trained any staff using AHRQ's TeamSTEPPS for Diagnosis Improvement program to improve communication among members of the care team (including nurses, pharmacists, and other allied health professionals), within the context of the diagnostic process or in reducing errors in diagnosis)?	○ Yes ○ No

Closing the Loop on Cancer Diagnosis

17) 12-month reporting period used:	○ 01/01/2024 – 12/31/2024 ○ 07/01/2024 – 06/30/2025
18) Do pathologists at your hospital routinely document the date in which they communicate pathology reports indicating a diagnosis of colon, lung, or breast cancer to a patient or a patient's ordering physician? *If "no" or "our hospital does not operate an on-site pathology service" to question #18, skip the remaining questions in Section 6D and continue to the Affirmation of Accuracy.*	○ Yes ○ No ○ Our hospital does not operate an on-site pathology service

19) Did your hospital calculate the proportion of colon, lung, or breast cancer diagnoses in which the patient or patient's ordering physician was notified within five business days of the report being signed by the pathologist, and do you choose to report those data to this Survey? *If "no" or "yes, but fewer than 30 cases met the inclusion criteria for the denominator," skip the remaining questions in Section 6D and continue to the Affirmation of Accuracy.*	○ Yes ○ No ○ Yes, but fewer than 30 cases met the inclusion criteria for the denominator
20) Total number of patients (18 years or older) with a diagnosis of colon, lung, or breast cancer:	_____
21) Total number of patients from question #22 with documented communication between the pathologist and the patient or patient's ordering physician within five business days of the report being signed by the pathologist: *Documented communication includes:* • *A documented phone call between the pathologist and patient or patient's ordering physician of the diagnosis, and* • *A timestamp, read receipt, or email response indicating that the patient or patient's ordering physician read an electronic communication of the diagnosis.*	_____
22) Total number of patients from question #22 who were notified, either by phone or electronically, that the pathology report with their diagnosis was uploaded to the patient portal and ready for review: *Hospitals that do not upload pathology reports to the patient portal or notify patients when reports are uploaded, should enter "0."*	_____

Section 6D: Diagnostic Excellence – Proposed FAQs for 2025

1. **What are examples of a CEO or CMO commitment to reducing errors in diagnosis?**
   Examples of a CEO or CMO commitment include verbal remarks at an all-staff "town hall" or "all-hands" meeting, or a segment in an annual report or other publication disseminated to all staff that specifically mentions reducing diagnostic errors.

2. **What are examples of a PFAC having input in or leading initiatives aimed at reducing errors in diagnosis?**
   Hospitals can refer to the Patient and Family Advisory Council (PFAC) Toolkit for Exploring Diagnostic Quality for detailed guidance. One common example of an initiative is to consult with the PFAC for input on materials for admitted patients pertaining to diagnosis, such as a resource developed based on needs identified in a patient survey, or a sepsis education campaign targeted at patients visiting the emergency room.

3. **Can our hospital system convene a multidisciplinary team at the system level, instead of individual hospitals assembling teams at their respective facilities?**
   Multidisciplinary teams convened to solely focus on reducing diagnostic errors should be specific to individual hospitals in order to closely oversee case analyses, review data specific to individual sites, and be responsive to the individual hospital's leadership.

4. **What pathology reports should be included in our response to question #19? Are inpatient and outpatient reports included?**
A “pathology report” refers to any report that would be signed by a pathologist that diagnoses cancer. In other words, both the first diagnosis of malignancy reports, or a finalized report where resection specimens were examined and included in a signed report, would be included in the assessment of whether there was documented communication between the pathologist and the patient or patient's ordering physician. This applies to inpatients and outpatients alike, as long as the pathologist practicing at your hospital signed the report. If multiple signed reports are issued for a patient in a single year, they should all be included.

5. **What ICD-10 codes should we use to identify diagnoses of colon, lung, or breast cancer?**
Leapfrog has not identified a specific set of ICD-10 codes to use to select these cases.

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APPENDIX X

Section 6E: ED Boarding – Proposed Questions for 2025 (Optional – Fact-Finding Only)

Questions #3 (denominator) and #4 (numerator) are used to calculate ED Boarding Longer than 4 Hours and questions #3 (denominator) and #5 (numerator) are used to calculate Average ED Length of Stay (LOS) for Admitted Patients.

1) 12-month reporting period used:	○ 01/01/2024 – 12/31/2024 ○ 07/01/2024 – 06/30/2025
2) Did your hospital operate a dedicated emergency department (ED)* during the reporting period?	○ Yes ○ No ○ Yes, but ED is now closed or wasn't open for the entire reporting period
3) Total number of emergency department (ED) visits (of patients of any age) during the reporting period that were admitted to the hospital's inpatient setting, with **Excluded Populations**** removed:	_____
4) Total number of ED visits indicated in question #2 that had a boarding time*** that was longer than 4 hours:	_____
5) Total number of hours spent**** in the ED for ED visits indicated in question #2:	_____

*A dedicated emergency department is an area of the hospital that meets any one of the following criteria:

- Licensed by the state as an emergency department,
- Holds itself out to the public as providing emergency care, or
- During the preceding calendar year, at least one-third of its outpatient visits were for the treatment of emergency medical conditions.

**Patients with an ED visit that are admitted to observation status, but not the inpatient setting, are excluded from the denominator (question #3).

Note: A patient can have multiple ED visits with a hospital admission during the performance period so each patient ED visit with an inpatient admission is included in the denominator (question #3).

***Boarding time is defined as the difference between the “time from the admission order” to “patient departure from the ED for admitted patients.”

****Hours spent in the ED is defined as the difference between the “patient arrival time at the ED” to “patient departure from the ED for admitted patients.”

APPENDIX XI

Section 7B: Healthcare-Associated Infections – Proposed Question for 2025

Hospitals that join* Leapfrog's NHSN Group by the join-by dates**, enter a valid*** NHSN ID in the Profile of the Leapfrog Hospital Survey, and submit the 2025 Leapfrog Hospital Survey will have their data scored and publicly reported.

1) Hospitals that join Leapfrog's NHSN Group, enter a valid NHSN ID in the Profile, and submit the Leapfrog Hospital Survey will have their standardized infection ratios (SIRs) for each of the following applicable infection measures downloaded directly from the CDC's National Healthcare Safety Network (NHSN): • CLABSI in ICUs and select wards, • CAUTI in ICUs and select wards, • Facility-wide inpatient MRSA Blood Laboratory-identified Events, • Facility-wide inpatient C. diff. Laboratory-identified Events, and • SSI: Colon. Select a response:	○ The hospital has joined Leapfrog's NHSN Group, accepted Leapfrog's Rights Acceptance Report/Data Rights Template, and entered a valid NHSN ID in the Profile ○ The hospital has not joined Leapfrog's NHSN Group, accepted Leapfrog's Rights Acceptance Report/Data Rights Template, or entered a valid NHSN ID in the Profile and acknowledges that the hospital will be reported as "Declined to Respond" for all five infection measures in Section 7B

*Instructions for joining or verifying that you are in Leapfrog's NHSN Group are available in the "NHSN Guidance: Join the Group, Review/Accept Data Rights Template, and Download Reports" document on our Join NHSN Group webpage.
**Join-by dates are listed in the "Deadlines and Reporting Periods" table below.
***Hospitals that share a CMS Certification Number must have a unique NHSN ID as required by NHSN. Please carefully review Leapfrog's Multi-Campus Reporting Policy on the Join NHSN Group webpage.

NHSN Reporting Periods and Deadlines for 2025

The NHSN reporting periods and deadlines for the 2025 Leapfrog Hospital Survey are as follows:

Join Leapfrog's NSHN Group by	Leapfrog will download data from NHSN for all current group members	Data downloaded from NHSN will be scored and publicly reported for hospitals that have submitted Section 7 by	HAI Reporting Period	Available on Hospital Details Page and Public Reporting Website
June 19, 2025	June 20, 2025	June 30, 2025	01/01/2024 – 12/31/2024	July 12, 2025 Details Page July 25, 2025 Public Reporting Website

August 21, 2025	August 22, 2025	August 31, 2025	01/01/2024 – 12/31/2024	September 10, 2025*
October 22, 2025	October 23, 2025	October 31, 2025	07/01/2024 – 06/30/2025	November 12, 2025*
December 17, 2025	December 18, 2025**	November 30, 2025	07/01/2024 – 06/30/2025	January 12, 2026*

Leapfrog will provide step-by-step instructions for hospitals to download the same reports that Leapfrog downloads for each of the NHSN data downloads on our website by April 1.

* Available on Hospital Details Page on the same date as public release of Survey Results

** The Leapfrog Hospital Survey closes on November 30, 2025. The last NHSN data download is on December 18, 2025 to incorporate any facilities and corrections from facilities that joined by the last join date of December 17, 2025.

APPENDIX XII

OP-32 Rate of Unplanned Hospital Visits After an Outpatient Colonoscopy Reporting Periods and Deadlines for 2025

CMS data will be scored and publicly reported for Hospitals that have submitted Section 9 by	CMS Reporting Period	Available on Hospital Details Page	Available on the Public Reporting Website
June 30, 2025	OP-32: Most recent 24 months	July 12, 2025	July 25, 2025
August 31, 2025	OP-32: Most recent 24 months	September 10, 2025	September 10, 2025
November 30, 2025	OP-32: Most recent 24 months	December 9, 2025	December 9, 2025

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