Summary of Changes to the 2026 Leapfrog Hospital Survey and Responses to Public Comments

Published March 11, 2026

THELEAPFROGGROUP

TABLE OF CONTENTS

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 the 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 Survey is then pilot tested with a diverse group of hospitals across the country. Following the pilot test, Survey content and scoring are finalized for launch on April 1.

Leapfrog received over 300 public comments in response to its proposed changes for the 2026 Leapfrog Hospital Survey. Those comments, as well as the results from the pilot test, were incorporated into the final content and scoring algorithms for the Survey. We have summarized the changes in this document and have included responses to public comments.

We offer our sincere gratitude to all commenters for the time and thought they gave to the 2026 Leapfrog Hospital Survey. The comments submitted are invaluable to the development of a high-quality Survey that serves our many constituents, including purchasers and payors, as well as hospitals and the public at large.

The 2026 Leapfrog Hospital Survey will open on April 1 and a PDF of the Survey will be available for download here.

DEADLINES AND REPORTING PERIODS FOR 2026

Review the 2026 Leapfrog Hospital Survey deadlines and reporting periods in Appendix I and II.

SCORING AND PUBLIC REPORTING FOR 2026

In 2026 Leapfrog is updating the "Declined to Respond" performance category to "Declined to Report" to more accurately reflect hospitals that do not submit a Survey or report on a measure. In addition, Leapfrog is adding a "Not Available" performance category for hospitals that do not have a CMS measure available to be reported.

For detailed information on Leapfrog's scoring algorithms that place hospitals into performance categories for the purposes of public reporting (e.g., Achieved the Standard, which represents the best performance), please visit our Hospital Scoring Results website.

CONTENT CHANGES

HOSPITAL PROFILE

There are no changes to the Hospital Profile.

SECTION 1: PATIENT RIGHTS AND ETHICS

SECTION 1A: BASIC HOSPITAL INFORMATION

Leapfrog is updating and adding two new questions in Section 1A: Basic Hospital Information, asking hospitals to report on adult and pediatric licensed and staffed ICU beds separately. The purpose of these adjusted questions

is to identify hospitals that are eligible to report on adult and/or pediatric ICU Physician Staffing in Section 5A: Adult ICU Physician Staffing and Section 5B: Pediatric ICU Physician Staffing.

Leapfrog is also updating the questions regarding the operations of and admissions to neonatal ICUs to clarify that only level II/III, level III, and level IV neonatal ICUs should be included in responses. This was previously clarified in the associated endnotes and does not reflect a change in how hospitals should report on these questions.

In addition, Leapfrog is removing question #18 which asks if hospitals have a protocol to follow up on patient-reported concerns, as performance has improved over time, with more than 99% of hospitals responding "yes" in 2025.

Finally, Leapfrog is persuaded by evidence that attainment of certifications related to improving quality and patient safety can lead to improved patient outcomes. Given the compelling public comments, it is clear that a number of such certifications are available to professionals, and more work is needed to study the evidence on impact to patient care. As a result, Leapfrog will form an advisory committee to explore the evidence on quality and patient safety certifications and delay for one year planned fact-finding questions about the National Association for Healthcare Quality's (NAHQ) Certified Professional in Healthcare Quality (CPHQ) certification.

The updated questions are available in Appendix III.

SECTION 1B: BILLING ETHICS

In response to feedback and responses from hospitals participating in the 2025 Leapfrog Hospital Survey, Leapfrog will make several updates to Section 1B: Billing Ethics.

First, Leapfrog is updating the response options in question #3, which asks if hospitals take legal action against patients for late or insufficient payments, to include an option for public hospitals that are required by state law to transfer unpaid medical bills to a state agency, similar to federal law requirements for Military Treatment Facilities. We anticipate that this updated response option will only apply to public hospitals in limited states (e.g., Illinois or New York). Leapfrog is also adding a FAQ with further information.

Hospitals eligible for this exception should maintain a copy of the state or federal legislation requiring the transfer of medical bills. As part of Leapfrog's Data Accuracy protocol, hospitals may be randomly selected for Leapfrog's monthly documentation requirement and will need to provide documentation supporting their Survey responses.

Second, we are retaining the four fact-finding questions regarding presumptive eligibility and financial assistance programs for patients for another year with plans to incorporate them into the Billing Ethics Standard in 2027. These fact-finding questions will now be required but will not be used in scoring or public reporting in 2026.

Finally, Leapfrog is adding two new FAQs to provide hospitals with additional clarification regarding screening methods and financial assistance application disclosures.

The updated question and new FAQs are available in Appendix IV. There are no changes to the scoring algorithm for Section 1B: Billing Ethics.

SECTION 1C: HEALTH CARE EQUITY

There are no changes to this subsection.

SECTION 1D: INFORMED CONSENT

Leapfrog is removing question #2, which asks if hospitals solicit feedback from patients/legal guardians about their hospital's informed consent process. As this question was neither scored nor publicly reported, there are no changes to the scoring algorithm for Section 1D: Informed Consent.

After additional research and consideration of public comments, Leapfrog is adding a new FAQ with guidance on how hospitals can assess the reading level of their Spanish-language consent forms. The reading level of consent forms in languages other than English is an important consideration for improving the accessibility of the informed consent process to all patients, so Leapfrog created an online calculator (available at: https://readability.leapfroggroup.org/) to assist hospitals in evaluating the reading level of their Spanish-language consent forms. In 2026, Leapfrog's standard will continue to focus on consent forms written in the English language, but we expect to extend the standard to Spanish as early as 2027.

In addition, Leapfrog is updating FAQ #28 in Section 1D to add additional information regarding strategies for optimizing the readability of consent forms using Large Language Models.

Both FAQs are available in Appendix V.

SECTION 2: MEDICATION SAFETY

SECTION 2A: COMPUTERIZED PHYSICIAN ORDER ENTRY (CPOE)

There are no changes to this subsection.

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

Leapfrog is continuing to ask questions about Artificial Intelligence (AI) applications used as part of a hospital's medication management and these questions will be required beginning in 2026. The responses will be used to research AI vendor influence on a hospital's CPOE Test score. Leapfrog is also updating the definition of AI included in the FAQs to provide more clarity. The updated questions and FAQ are provided in Appendix VI.

As a reminder, Section 2B: EHR Application Information is not scored or publicly reported.

CPOE EVALUATION TOOL (FOR ADULT AND GENERAL HOSPITALS ONLY)

The developers of the CPOE Evaluation Tool are revising the test medication scenarios to align with updated clinical guidelines and are removing medications that hospitals frequently report as not included in their formularies.

Lastly, after reviewing non-interruptive alerts, Leapfrog's CPOE Expert Panel found that these alerts have become less effective in alerting prescribers to important information about dangerous medication orders. To address this issue, Leapfrog is launching a multi-phase project to:

- Gather examples and references to strengthen guidance on non-interruptive alerts,

- Develop educational webinars for hospitals throughout 2026, and
- Prepare hospitals for updated expectations in the 2027 CPOE Tool.

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

SECTION 2C: BAR CODE MEDICATION ADMINISTRATION (BCMA)

In response to feedback from hospitals participating in the Survey, Leapfrog is updating two of the elements included for Section 2C: BCMA question #21, which asks about mechanisms used to reduce and understand potential BCMA system "workarounds." The implementation, monitoring, and evaluation of quality improvement projects focused on improving BCMA performance is no longer required for hospitals that have met Leapfrog's standard of 95% compliance with scanning the patient and medication prior to medication administration if this standard is met in ALL applicable units based on quarterly monitoring. To reflect this change, the response options for question #21f have been updated as outlined below and hospitals will not report on question #21g if they indicate "no" or "does not apply" to question #21f. The requirement of having 6 out of 8 processes/structures to reduce and understand potential BCMA system "workarounds" will be maintained and hospitals responding "does not apply" to question #21f will earn credit for both #21f and #21g for the purposes of scoring and public reporting.

Updates highlighted in yellow.

1)	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 (e.g., extra scanners, portable computers, batteries, and mice) 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 1a, 1d or 1e.* *If "no" or "does not apply, hospital has achieved 95% BCMA scanning compliance in all applicable units based on quarterly monitoring," skip question #1g and continue to question #1h.*	○ Yes ○ No ○ Does not apply, hospital has achieved 95% BCMA scanning compliance in **all** applicable units based on quarterly monitoring

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	○ 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 1a, 1d or 1e.*	○ Yes ○ No

There are no other changes to the scoring algorithm for Section 2C: BCMA.

SECTION 2D: MEDICATION RECONCILIATION

Leapfrog is updating the measure specifications to clarify that if a pharmacist, pharmacy resident, or certified pharmacy technician creates the pre-admission medication list (PAML) then a **different** (second) pharmacist, pharmacy resident, or certified pharmacy technician must collect the Gold Standard Medication History. This information was previously clarified in a FAQ.

For ease of reporting, we are providing a flow chart outlining the steps required for data collection which will be available on our Survey materials webpage.

As a reminder, hospitals can continue to use the 2025 Leapfrog Hospital Survey Measure Specifications for Section 2D: Medication Reconciliation to perform data collection in preparation for the 2026 Leapfrog Hospital Survey.

There are no changes to the scoring algorithm for Section 2D: Medication Reconciliation.

SECTION 3: ADULT AND PEDIATRIC COMPLEX SURGERY

SECTION 3A: HOSPITAL AND SURGEON VOLUME

Leapfrog's experts are reviewing the ICD-10 and CPT codes used for hospitals reporting on this subsection and any updates (i.e., additions and removals) will be published separately as their review is still ongoing.

Leapfrog is also adding an optional, fact-finding question to determine if the hospital has surgeons that perform both total knee replacement and total hip replacement procedures listed in Section 3A. Leapfrog is adding this question to evaluate how common it is to have the same surgeon performing both procedures given requests received from hospitals and ambulatory surgery centers to combine total hip and knee replacements into a single volume standard. The new question is available below:

1) Does your hospital have surgeons that perform both total knee replacement and total hip replacement procedures? *This question only applies to hospitals that perform both total knee replacement and total hip replacement procedures.* *Response will not be scored or publicly reported in 2026.*	○ Yes ○ No

This optional, fact-finding question will not be used in scoring or public reporting in 2026. There are no changes to the scoring algorithm for Section 3A: Hospital and Surgeon Volume.

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

There are no changes to this subsection.

SECTION 4: MATERNITY CARE

Leapfrog is updating the measure specifications from The Joint Commission for PC-02 Cesarean Birth (Section 4B) to reflect version 2026A1 for those hospitals that do not already submit data to The Joint Commission and therefore need to retrospectively collect data. We are also continuing to accept both data for the chart-abstracted measure (PC-02) and data collected using The Joint Commission'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 that data 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 using the data provided in their CMQCC reports when responding to subsections 4A: Maternity Care Volume and Services (volume only), 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

Maternity Care Volume

Leapfrog is updating the measure specifications used to report on the total number of live births (volume) in Section 4A: Maternity Care Volume and Services to indicate that hospitals participating in the California Maternal Quality Care Collaborative (CMQCC) Maternal Data Center may use the data provided in CMQCC reports when reporting on their live births. As in past Surveys, hospitals can alternatively continue to either use the data reported to their state or the Z codes provided in the measure specifications.

Maternity Care Services

Leapfrog is updating the existing Maternity Care Services questions to provide further clarity on the services provided at hospitals offering maternity care to ensure this data can continue to be used in a meaningful and useful way by hospitals, patients and their families, employers, purchasers, and other users of Leapfrog's data. Updates include a revised question and FAQ related to the type of breastfeeding/lactation support offered after

delivery and prior to hospital discharge. As a reminder, these questions are used in public reporting but are not scored.

The updated questions and new FAQ are available in Appendix VII.

Request for Information

As part of our request for public comments, Leapfrog included a request for information on the collection of data and calculation of rates for vaginal births after cesarean section (VBACs) in the 2027 Leapfrog Hospital Survey. Specifically, Leapfrog asked about the Agency for Healthcare Research and Quality (AHRQ)'s Inpatient Quality Indicator (IQI) 22: Vaginal Birth After Cesarean (VBAC) Delivery Rate, Uncomplicated measure which is currently used by both CMQCC and Cal Hospital Compare, as well as other states. Leapfrog appreciates all the comments that were received.

Several comments supported the inclusion of this measure and hospitals indicated that they are already collecting the data needed to report. A few comments explained that the exclusion criteria used in the measure does not fully account for clinically appropriate, guideline-supported indications for repeat cesarean delivery and urged Leapfrog to consider additional exclusions or other reporting metrics. One comment cautioned Leapfrog against unintentional consequences when evaluating the measure, such as encouraging inappropriate access rather than safe access. All comments will be reviewed with Leapfrog's Maternity Care Expert Panel as part of Leapfrog's regular standard review process.

While we continue to evaluate this information, we are removing the current maternity services question regarding whether hospitals offer patients the opportunity to attempt VBAC from the 2026 Leapfrog Hospital Survey.

SECTION 4B: CESAREAN BIRTH

Leapfrog is continuing to include questions on the collection of cesarean birth data (NTSV C-section measure) by race/ethnicity and is asking 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 and 2025 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 and 2025, these questions are 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 the U.S. News & World Report Maternity Services Survey may use the data provided to U.S. News & World Report when responding to these questions. Both can use the crosswalk provided in the measure specifications to aid in reporting. Otherwise, hospitals will continue to use The Joint Commission's PC-02 Cesarean Birth measure specifications (version 2026A1) and Leapfrog instructions to retrospectively review all cases and stratify by race/ethnicity.

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

SECTION 4C: EPISIOTOMY

There are no changes to this subsection.

SECTION 4D: PROCESS MEASURES OF QUALITY

Newborn Bilirubin Screening Prior to Discharge

There are no changes to this measure.

Appropriate DVT Prophylaxis in Women Undergoing Cesarean Section

In response to feedback and consultation with our Maternity Care Expert Panel, Leapfrog is updating the measure specifications for Appropriate Deep Vein Thrombosis (DVT) Prophylaxis in Women Undergoing Cesarean Delivery to remove credit for patients receiving heparin or heparinoid given the American College of Obstetricians and Gynecologists' clinical guidance that all patients should have pneumatic compressions devices placed prior to cesarean delivery. As such, only patients receiving pneumatic compression devices prior to surgery will be included in the numerator. However, clinical guidelines continue to recommend that patients at high- or moderate-risk for DVT should also receive appropriate pharmacological prophylaxis in addition to the placement of pneumatic compression devices. The target for this measure remains at 90%.

The updated measure specifications are available in Appendix VIII.

There are no changes to the scoring algorithms for Section 4D: Process Measures of Quality.

SECTION 4E: HIGH-RISK DELIVERIES

Based on a review of responses to the 2025 Leapfrog Hospital Survey, Leapfrog is updating question #1 in Section 4E: High Risk Deliveries to further clarify which hospitals are required to report on this subsection:

Updates highlighted in yellow.

1. Does your hospital admit high-risk deliveries? *If "no" or "yes, but only on an emergency basis or when a patient is too unstable for safe transfer," skip the remaining questions in Section 4E and go to the Affirmation of Accuracy. The hospital will be scored as "Does Not Apply."*	○ Yes ○ No ○ Yes, but only on an emergency basis or when a patient is too unstable for safe transfer.

This update will not impact reporting requirements for this subsection as the associated endnote previously indicated that hospitals must answer "yes" to electively admitting high-risk deliveries if they admit deliveries where the conditions (expected birth weight less than 1500 grams or gestational age at least 22 weeks but less than 32 weeks) are known prior to admission (e.g., not admitted on only an emergent basis).

Neonatal Intensive Care Unit(s) - Volume

Based on feedback received from participating hospitals and in consultation with our experts, Leapfrog is updating the measure specifications used for those hospitals opting to report using their volume of very low birthweight

babies (i.e., less than 1500 grams) admitted to their neonatal intensive care unit(s) by removing the following two ICD-10-CM codes:

- P05.2: Newborn affected by fetal malnutrition not light or small for gestational age
- P05.9: Newborn affected by slow intrauterine growth, unspecified

Unlike the other codes provided, which reflect birth weights between 500 and 1500 grams, these two codes do not specify birthweight and our understanding is that newborns with very low birthweight are already captured via the other codes provided in the measure specifications. This update allows hospitals to pull the volume data using claims and without having to rely on chart review as the current criteria of excluding newborns weighing 1500 grams or more is no longer needed.

Neonatal Intensive Care Unit(s) – National Performance Measurement

Leapfrog is continuing 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 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 IX. (hospitals that successfully submitted a Data Sharing Authorization letter in prior years will not be required to submit another letter in 2026),
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 IX.

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 Report" for the High-Risk Deliveries measure.

SECTION 5: PHYSICIAN AND NURSE STAFFING

SECTION 5A: ADULT ICU PHYSICIAN STAFFING

There are no changes to this subsection.

SECTION 5B: PEDIATRIC ICU PHYSICIAN STAFFING

There are no changes to this subsection.

SECTION 5C: NURSING WORKFORCE

There are three major changes planned for 2026 and additional clarifications to the measure specifications regarding applicable units.

First, all hospitals will be required to report on whether they operate any mixed acuity medical, surgical and/or med-surg units, and if they do, the types of mixed acuity units (high, moderate and/or blended). Hospitals that

operate **both** single and mixed acuity units can then **optionally** report on nursing hours in their mixed acuity unit(s) but will continue to ONLY be scored on the **single** acuity units. An analysis of the data collected in 2026 and anticipated key informant interviews with Survey participants will help determine if additional updates to scoring and public reporting should be proposed for 2027. This change is the first step in responding to hospital requests to earn credit for their staffing of both single and mixed acuity units.

Hospitals that operate only **one** single acuity unit, but had fewer than 15 patient days per month for all 3 months of any quarter of the reporting period will be asked to report on their mixed acuity medical, surgical and/or med-surg units (if applicable) and will be scored and publicly reported on those units. The updated questions are available in Appendix X.

Second, Leapfrog is temporarily pausing public reporting of the Nursing Skill Mix measure (the proportion of total nursing hours worked by registered nurses), as the Nursing Workforce Expert Panel further examines the relationship between this measure and the Total Nursing Care Hours Per Patient Day and Total RN Hours Per Patient Day measures.

Third, Leapfrog is adding a new optional fact-finding question to assess hospital's use of virtual nursing models, which will not be scored or publicly reported in 2026. The new question and FAQ defining virtual nursing is available in Appendix X.

Leapfrog has also added a clarification to the measure specifications for hospitals that operate Single Acuity Med-Surg Units: OB and Med-Surg Units, which are defined as combination units in which greater than 50% of the patients are obstetric and the remaining percent are adult acute med-surg such as gynecological and/or pediatric acute med-surg, should be excluded.

For the 2027 Leapfrog Hospital Survey, Leapfrog and the National Database of Nursing Quality Indicators (NDNQI) are exploring options that would allow active NDNQI clients to authorize Leapfrog to access their data directly from the NDNQI database, eliminating the need for clients to request reports from NDNQI.

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

SECTION 6: PATIENT SAFETY PRACTICES

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

In consultation with Leapfrog's Patient and Family Caregiver Expert Panel, Leapfrog is updating the term used in Safe Practice 1.1b, from "patients and/or families of patients" to "patients and/or care partners," to be inclusive of a broader population of potential active participants to consider for inclusion in the hospital-wide safety and quality committee.

Leapfrog is updating FAQ #9 in Section 1.1b to define a "patient and/or care partner" as any patient who has currently, or in the past, received care at the hospital campus, as well as their family members or other trusted individuals navigating or participating in a patient's care at the hospital (e.g., facilitate communication, participate in consent process).

Leapfrog received extensive public comments regarding a potential update to the 2027 Hospital Survey to strengthen the participation of patients and/or care partners on the hospital-wide quality and safety committee by

requiring two or more patients and/or care partners on committees. Commenters across stakeholder groups consistently support incorporating patients and their care partners in quality and safety committees and specifically cite the valuable feedback they have provided to hospitals in that context and the role they've played as partners in improving clinical care delivery. However, hospitals cited obstacles to increasing the number of representative participants and recommended that Leapfrog pursue a standard to further incorporate patients' perspectives in quality and safety efforts that goes beyond participation in a specific committee, but instead reflects participation through other venues, including PFACs, structured post-care interviews, or other targeted ways to solicit patient feedback.

Finally, hospitals in a health system noted that because they convene individual hospital committees at each campus, they are already hearing from numbers of patients and families, including at network committees that already will have the benefit of multiple participating patients. All comments will be reviewed with Leapfrog's Expert Panel as part of Leapfrog's regular standard review process prior to announcing any potential changes for the 2027 Leapfrog Hospital Survey.

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

There are no changes to this subsection. As a reminder, the AHRQ Hospital Survey on Patient Safety Culture Version 1.0 can no longer be used for the purposes of reporting on the 2026 Leapfrog Hospital Survey. Only Version 2.0 may be used. Similarly, SCORE can no longer be used for the purposes of reporting on the 2026 Leapfrog Hospital Survey. Only SCORE II may be used. Please reference the Guidelines for a Culture of Safety Survey document available on our website.

SECTION 6C: HAND HYGIENE

There are no changes to this subsection for 2026.

Request for Information

As part of our request for public comments, Leapfrog included a request for information and recommendations on strengthening all elements of the Hand Hygiene standard, prompted by ongoing dialogue with the Association for Professionals in Infection Control and Epidemiology (APIC). Leapfrog appreciates the over one hundred commenters that submitted information. Some comments supported APIC's perspective that 50 observations are sufficient for monitoring. Several comments requested that Leapfrog consider alternatives to the monitoring requirements due to current burden and potential for reporting bias such as cumulative sampling and point prevalence models. Many also added that they encourage Leapfrog to maintain its current multimodal approach to hand hygiene and the five domains included while revisiting the monitoring requirements. Some commenters supported maintaining Leapfrog's standard as is. One commenter suggested that the hand hygiene measure be removed entirely given the inclusion of associated outcomes like the healthcare-associated infections.

Leapfrog and its Hand Hygiene Expert Panel continue to conclude that the current monitoring standard is necessary to ensure hospitals are using reliable data on both hand hygiene compliance and changes in compliance levels. This is based on a comprehensive literature review and statistical analysis. However, given the relatively limited body of literature available on this topic and the compelling comments, Leapfrog will continue working with APIC, World Health Organization, and others to test the standard and determine if changes are merited for the 2027 Leapfrog Surveys.

SECTION 6D: DIAGNOSTIC EXCELLENCE

To better assess overall national performance in this emerging area of patient safety, Leapfrog is requiring hospitals to report on Section 6D: Diagnostic Excellence beginning with the 2026 Leapfrog Hospital Survey. However, responses will not be scored or publicly reported.

Leapfrog is removing several questions in this subsection to focus on the most effective evidence-based practices to reduce diagnostic errors, including convening a multidisciplinary team; leveraging that team to collect and review data, encourage data submission, assess progress on the Safer Dx Checklist; training staff using AHRQ's TeamSTEPPS for Diagnosis Improvement, and convening emergency medicine staff, radiologists, and pathologists, to develop and implement protocols to reduce the incidence of diagnostic errors.

Progress on implementing these best practices will be assessed by eight questions, compared to 22 questions from the 2025 Hospital Survey. The updated questions are available in Appendix XI.

We removed the following questions:

- Questions #1 and #2, concerning hospital CEO or CMO commitment to reducing harm to patients due to diagnostic error and communicating specific actions as part of that commitment.
    - Note: The hospital's CEO or CMO is still required to formally sponsor the multidisciplinary team, as well as review quarterly reports from the team and facilitate a report-out to the hospital board every year. As such, the hospital CEO and CMO are still required to meaningfully and publicly engage with staff to reduce harm to patients from diagnostic error; this question is being removed to streamline reporting.
- Questions #3 and #4, concerning engaging with Patient and Family Advisory Councils (PFACs) on initiatives aimed at reducing errors in diagnosis.
    - Note: Leapfrog is adding a new requirement, that the hospital's multidisciplinary team must include at least one patient and/or care partner (for example, the patient and/or care partner currently serving on the patient safety committee). The Agency for Healthcare Research and Quality has specifically cited including patients as members of quality and safety committees as a "next step" beyond convening a patient and family advisory council, representing a progressive incremental step in patient and care partner engagement (AHRQ Working with Patients and Families as Advisors Implementation Handbook). A majority of hospitals that report to the Leapfrog Hospital Survey have incorporated patients and care partners in their hospital-wide quality and safety committees; hospitals that elect to use these committees as an opportunity to prioritize diagnosis work by dedicating specific time on their agenda to diagnosis can continue to use the same patient and/or care partners, or use this opportunity to engage additional individuals.
- Question #8, concerning whether the multidisciplinary team focused on diagnostic excellence has educated staff on their efforts to reduce errors in diagnosis.
- Question #10, concerning whether the multidisciplinary team conducted any analyses or case reviews within four weeks of a diagnostic error being identified and ensured the findings were communicated to the individuals involved in the patient's care and hospital leadership.
- Questions #12 and #14, concerning the multidisciplinary team convening emergency medicine staff to identify commonly misdiagnosed conditions in the emergency department, as well as convening radiologists and pathologists to discuss diagnosis related issues. Instead, questions #13 and #15 are updated to capture this information.

- Questions #17-22, assessing hospitals' processes for assessing whether certain cancer diagnoses were communicated to patients or the ordering provider of the diagnostic test (closing the loop on cancer diagnosis).

In addition, Leapfrog is updating the current question #1, regarding whether a hospital has convened a multidisciplinary team focused on diagnostic excellence, in two key aspects:

- First, Leapfrog is revising the guidance embedded in the question to read:
  "*The multidisciplinary team can be the established hospital-wide safety and quality committee if the committee has a dedicated agenda item at least quarterly to review efforts focused on reducing harm to patients from errors in the diagnostic process.*"

  In prior years, the guidance indicated that the multidisciplinary team should be a distinct entity and separate from the established hospital-wide safety and quality committee. However, in response to hospital feedback and in consultation with our Diagnostic Excellence Expert Panel, Leapfrog determined that a safety and quality committee with dedicated time for discussion meets the intent of the question.

- Second, Leapfrog is updating the wording of question #1 to read "does your hospital have a multidisciplinary team," a change from the previous "does your hospital convene a multidisciplinary team," to allow hospitals who belong to a system that has convened a system-level committee focused on diagnostic excellence to use that team to guide efforts at both a system level and on individual campuses. The FAQ offering guidance on this point is revised and available in Appendix XI.

- Third and finally, as indicated above, Leapfrog now requires that the multidisciplinary team include at least one patient and/or care partner.

Furthermore, Leapfrog is updating the response options to indicate that if a different team at the hospital met the requirements of current questions #3 and #4, that team must also present their findings to the multidisciplinary team.

To clarify the current question #6 and question #7, Leapfrog is adding a response option "Yes, but all practices are currently fully implemented" to question #6, and rephrasing question #7 to read "What steps has your hospital taken to implement one or more practices listed in the Safer Dx Checklist?".

To further clarify terminology used throughout this section, Leapfrog is replacing the term "errors in diagnosis" with "errors in the diagnostic process", where applicable.

Finally, although Leapfrog is removing former questions #3, #4, and #10 in this subsection, the underlying diagnostic safety concepts associated with these questions remain important and addressable by hospitals using resources created by Leapfrog as part of our Diagnostic Excellence initiative. As such, Leapfrog is adding two new FAQs to Section 6D: Diagnostic Excellence to direct hospitals to these resources. These new FAQs are available in Appendix XI.

SECTION 6E: HOSPITAL BOARDING IN THE EMERGENCY DEPARTMENT (ED) (OPTIONAL – NOT SCORED OR PUBLICLY REPORTED IN 2026)

In 2025, Leapfrog announced the decision to begin reporting on Emergency Department (ED) safety, recognizing the ED's essential role in patient outcomes and importance to consumers and purchasers. As the first step in that

reporting, the 2025 Leapfrog Hospital Survey introduced three fact-finding measures on hospital boarding in the ED. These included: the percentage of ED patients that are admitted to the hospital or for observation that had a boarding time greater than four hours, the median length of stay in the ED for patients admitted to the hospital or for observation, and the 90th percentile length of stay in the ED for patients admitted to the hospital or for observation. These measures excluded patients that were placed in ED observation status or transferred to another hospital.

Leapfrog is making several refinements to last year's questions and measure specifications and will add one new question for the 2026 Leapfrog Hospital Survey, aimed at standardizing data collection, improving clarity, and strengthening the foundation for future benchmarking and public reporting.

First, based on feedback from Leapfrog's Emergency Department Boarding Expert Panel, we are updating questions #4 and #5 and asking hospitals to additionally report the total boarding time (in hours) for all ED visits with an inpatient admission or where the patient was placed in hospital observation status. This will allow Leapfrog to understand the average hours patients admitted to the hospital boarded in the ED. This information will complement the existing data collected about patients that board for four or more hours.

Second, the notes and measure specifications will be updated for clarity and to support standardized data collection. Specifically, the definitions for boarding time, guidance for hospitals operating a single general ED that are admitting pediatric patients to adult inpatient beds or adult observation beds, and guidance for hospitals admitting patients to licensed detox beds.

Finally, four new FAQs will be added to provide additional clarification regarding reporting expectations and definitions.

These questions will remain optional and will not be used in scoring or public reporting in 2026. The updated questions and new FAQs are available in Appendix XII.

SECTION 7: MANAGING SERIOUS ERRORS

SECTION 7A: NEVER EVENTS

There are no changes to this subsection.

SECTION 7B: HEALTHCARE-ASSOCIATED INFECTIONS

Leapfrog downloads HAI data from the Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN) four times during the Survey Cycle for use in the Leapfrog Hospital Survey. Both Leapfrog and CMS currently use and publicly report data that is calculated using a 2015 Baseline (i.e., Standard Population Data Year). Starting in fall 2026, CMS plans to calculate HAI measures using NHSN's new 2022 Baseline for data publicly reported on the Care Compare website. Once CMS begins calculating and publicly reporting HAI measures on Care Compare using the 2022 Baseline, Leapfrog will also transition to using data calculated with the 2022 Baseline in a reasonable and feasible timeframe.

Leapfrog anticipates using 2015 Baseline CMS IPPS Reports for scoring in the first two NHSN data downloads (June and August), then 2022 Baseline CMS IPPS Reports for scoring in the next two NHSN data downloads

(October and December). However, this plan is subject to CMS' actual rollout of the new baseline on Care Compare.

In order to ensure that hospitals have adequate time to review updates to the scoring algorithm for these five measures, Leapfrog plans to download 2022 Baseline CMS IPPS Reports, with the reporting period of 01/01/2025 – 12/31/2025, in June to model a new scoring algorithm for Section 7B: Healthcare-Associated Infections (HAIs). The new scoring algorithm will be available for public comment and finalized prior to its anticipated use in October 2026.

The deadlines to join Leapfrog's NHSN Group and anticipated use of the 2022 Baseline can be found in Appendix XIII.

SECTION 8: PEDIATRIC CARE

Leapfrog is adding Section 8: Pediatric Care as a minimum required section for Survey submission for pediatric hospitals ONLY. Pediatric hospitals that respond in Section 8A: Patient Experience that they did not administer the CAHPS Child Hospital Survey and/or in Section 8B: Pediatric Computed Tomography (CT) Radiation Dose that they did not calculate their distribution of CT radiation doses will be publicly reported as "Did Not Measure."

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

There are no changes to this subsection.

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

There are no changes to this subsection.

SECTION 9: OUTPATIENT PROCEDURES

Leapfrog is renaming Section 9F: OAS CAHPS to Section 9F: CMS Measures and moving Patient Follow-up within Section 9D: Safety of Procedures into Section 9F.

SECTION 9A: BASIC OUTPATIENT DEPARTMENT INFORMATION

Leapfrog is adding a new question to capture surgical specialties performed by hospitals. This information will be used to inform the search function on the Leapfrog Ratings website and will display the surgical specialties selected within the question. Leapfrog will not ask about volume for these additional surgical specialties. These questions will continue to be used in public reporting but are not scored.

1. Which of the following procedure specialties does your hospital perform on an outpatient basis? *Cardiothoracic Surgery, Oral and Maxillofacial Surgery, Pain Management, Podiatry, and Vascular Surgery apply to adult patients*	☐ Cardiothoracic Surgery ☐ Gastroenterology ☐ General Surgery ☐ Neurological Surgery

only. All other surgical specialties apply to adult or adult/pediatric patients. *Select all that apply.*	☐ Obstetrics and Gynecology ☐ Ophthalmology ☐ Oral and Maxillofacial Surgery ☐ Orthopedics ☐ Otolaryngology ☐ Pain Management ☐ Plastic and Reconstructive Surgery ☐ Podiatry ☐ Urology ☐ Vascular Surgery

SECTION 9B: MEDICAL, SURGICAL, AND CLINICAL STAFF

There are no changes to this subsection.

SECTION 9C: VOLUME OF PROCEDURES (OPTIONAL – NOT SCORED BUT PUBLICLY REPORTED IN 2026)

Beginning in 2026 Leapfrog is no longer requiring hospitals to report their outpatient procedure volume. Instead, this section is optional, and results will not be scored but will continue to be used in public reporting for those who submit this subsection. For those hospitals opting to report their volumes, updated CPT Codes will be provided within the Online Survey Tool when the Survey launches on April 1.

SECTION 9D: SAFETY OF PROCEDURES

Patient Follow-Up

Leapfrog is moving OP-32 Rate of Unplanned Hospital Visits After An Outpatient Colonoscopy to Section 9F: CMS Measures.

Data download dates for this measure are available in Appendix XIV.

Safe Surgery Checklist for Adult and Pediatric Outpatient Procedures

There are no changes to these questions.

SECTION 9E: MEDICATION SAFETY FOR OUTPATIENT PROCEDURES

There are no changes to this subsection.

SECTION 9F: CMS MEASURES

Leapfrog is no longer asking hospitals to report their OAS CAHPS Top Box scores. Instead, Leapfrog will obtain these data directly from the CMS Provider Data Catalog:

- Patient Experience Top Box Scores (OAS CAHPS)
    a) Facilities and Staff
    b) Communication About Your Procedure
    c) Patients' Rating of the Facility
    d) Patients Recommending the Facility

Additionally, as described above, Leapfrog is also obtaining data for OP-32: Rate of Unplanned Hospital Visits After an Outpatient Colonoscopy directly from the CMS Provider Data Catalog.

For hospitals that provide a valid CMS Certification Number (CCN) in the Hospital Profile and report performing outpatient procedures in Section 9A: Basic Outpatient Department Information of the Leapfrog Hospital Survey, data will be downloaded three times per Survey cycle: June 30, August 31, and November 30.

The top quartiles used in the 9F: Patient Experience (OAS CAHPS) scoring algorithm will be calculated using results published by CMS for both Ambulatory Surgery Centers (ASCs) and hospitals on June 30, 2026.

Anticipated reporting periods and data download dates for the CMS measure and new FAQs are available in Appendix XIV.

More information about the 2026 Leapfrog Hospital Survey is available on our website at http://www.leapfroggroup.org/hospital.

RESPONSES TO PUBLIC COMMENTS

Leapfrog was grateful to receive over 300 public comments in response to the proposed changes to the 2026 Leapfrog Hospital Survey. Comments were received from a diverse range of stakeholders, including health care organizations, as well as health care experts, patient advocates, purchasers, and patients themselves.

As a result of this robust set of comments, Leapfrog was able to make a significant number of meaningful improvements to our planned changes to the 2026 Survey, and we are grateful to commenters for their insights.

Responses to the public comments are organized by Survey section below. If you submitted a comment and do not see a response, or if you have additional questions, please contact the Help Desk at https://leapfroghelpdesk.zendesk.com.

REQUESTS FOR INFORMATION

Several commenters provided feedback in response to various requests for information.

We thank those who took the time to provide additional comments. This feedback will be reviewed and used to inform proposed updates to the 2027 Leapfrog Hospital Survey.

SECTION 1: PATIENT RIGHTS AND ETHICS

BASIC HOSPITAL INFORMATION

A couple of commenters supported the changes proposed for counting ICU beds and NICUs in Section 1A, citing that these changes meaningfully enhance data integrity and improve hospital-reporting.

We appreciate this feedback.

One hospital supported the removal of patient-reported concerns.

We appreciate this feedback.

Over seventy commenters supported Leapfrog's proposal to include a question on the CPHQ certification, but requested that Leapfrog include other certifications as well such as the following: Certification in Infection Control (CIC), Certified Professional in Patient Safety (CPPS), Certified Professional in Human Factors in Health Care (CPHFH), Certified Professional in Age Friendly Health Care (CPAFH), Certified Professional in Clinical Health Equity (CPCHE), Certified Professional Ergonomist (CPE), Certified Human Factors Professional (CHFP), Certified Professional in Healthcare Risk Management (CPHRM), Certified Six Sigma Black Belt (CSSBB), Graduate Certificate in Healthcare Quality and Safety (GCHQS), and Master of Science in Healthcare Quality and Safety (MSHQS).

As noted above, Leapfrog has delayed its plan to ask about the CPHQ certification in the 2026 Leapfrog Hospital Survey until the 2027 Survey, and will form an advisory committee to explore the range of certifications related to quality and patient safety and correlated with patient outcomes. Those certifications with evidence of positive impact on patient outcomes will be considered for inclusion in the 2027 Survey.

A couple commenters raised concerns that asking about the CPHQ credential for hospital-based employees will not be an accurate assessment for health systems that employ those staff at the system level.

We appreciate this feedback which will be brought to an advisory committee in advance of the 2027 Leapfrog Hospital Survey.

One hospital requested a multi-year phased-in approach if there is a plan to score and publicly report CPHQ certification in the future.

As with other information in this subsection, this information would likely be publicly reported but not scored.

A couple of commenters expressed that staff do not need to have a CPHQ to do effective quality work.

We appreciate this feedback which will be brought to an advisory committee in advance of the 2027 Leapfrog Hospital Survey.

One commenter suggested that the questions should specify that certifications should specifically target staff within quality and safety departments.

We appreciate this feedback which will be brought to an advisory committee in advance of the 2027 Leapfrog Hospital Survey.

A few commenters indicated that there is no process among their system for collecting information regarding use of CPHQ certification among staff and expressed that reporting would be burdensome and potentially inaccurate, particularly for those that do not require certification.

We appreciate this feedback which will be brought to an advisory committee in advance of the 2027 Leapfrog Hospital Survey.

One commenter requested that Leapfrog obtain certification information by role of provider.

We appreciate this feedback which will be brought to an advisory committee in advance of the 2027 Leapfrog Hospital Survey.

BILLING ETHICS

Leapfrog continues to receive strong support for our Billing Ethics Standard.

We appreciate this feedback.

In addition, we would like to highlight Healthcare Financial Management Association's support for our Billing Ethics Standard. HFMA's report, *Advancing Healthcare Access*, developed in collaboration with national experts, closely aligns with Leapfrog's ongoing efforts to promote responsible financial assistance, billing, and collection practices.

Leapfrog values HFMA's engagement and shares its commitment to transparency, patient engagement, and equitable access to care.

Two commenters expressed support for the update to the response options in question #3 regarding legal action.

We appreciate this feedback.

One commenter expressed concerns with the update to the response option in question #3 only including the Department of Treasury.

Leapfrog has updated the response options for this question to include state and federal agencies (e.g., Department of Treasury, Attorney General, etc.).

One commenter suggested clarification on how state-mandated collection practices will be considered.

These requirements generally apply to public or state-owned hospitals, including hospitals operated by public universities or state health systems, in certain states (e.g., Illinois or New York). The obligation is tied to the hospital's public ownership or operation, rather than hospital status alone. Private hospitals are generally not required to transfer delinquent patient accounts to a state or federal agency for collection.

Leapfrog has updated the response options for this question to include state and federal agencies (e.g., Department of Treasury, Attorney General, etc.) as well as added a new FAQ to the 2026 Survey to clarify.

One commenter did not support the proposal to require the four fact-finding questions regarding presumptive eligibility and financial assistance programs for patients and encouraged Leapfrog to maintain these questions as optional, expressing concern with the amount of time and resources it takes to complete required questions that are not included in scoring or public reporting.

Leapfrog appreciates this feedback and recognizes the effort required of hospitals to complete these questions. Leapfrog strives to maintain the highest standards pertaining to billing ethics, and the fact-finding questions are intended to provide important contextual information about hospital practices related to financial assistance and presumptive eligibility. While they are not currently included in scoring or public reporting, they help inform Leapfrog's understanding of hospital policies and practices and support ongoing evaluation of patient financial protections and will likely be scored and publicly reported in 2027. Responses this year will enable us to publish aggregated benchmarking as we have done in the past for new questions that will be scored.

Leapfrog remains mindful of this burden and will continue to consider hospital feedback when determining whether questions are required or optional and how collected information is used in future Survey updates.

HEALTH CARE EQUITY

Several commenters provided feedback in response to our request for information on the Office of Management and Budget standards for maintaining, collecting and presenting data on race and ethnicity.

Most commenters shared their support of the updated standards but noted their organizations are in preliminary discussions about how to implement them within their current workflows and data collection practices. One commenter asked for clarification if the implementation of the new standards is warranted as it only impacts federal agencies. A couple commenters noted they do not have plans to update their standards, with one commenter citing an inability to update because of their EHR vendor. One commenter encouraged Leapfrog to reduce any additional work or data collection for the Health Care Equity question set. Another commenter requested Leapfrog ask hospitals if they perform community health needs assessments (CHNA), and to identify who is involved in that process (e.g., local, state, or tribal public health department for that jurisdiction).

We appreciate those who took the time to submit feedback. Leapfrog currently uses the Office of Management and Budget (OMB) race and ethnicity reporting categories and therefore these changes may result in updates to the Survey. However, we will review this feedback and continue to engage stakeholders to inform whether updates are warranted.

No other comments were submitted.

INFORMED CONSENT

One commenter cautioned against establishing additional guidance in the informed consent standard specific to Spanish-language consent forms, without also extending that guidance to other common non-English languages. The commenter also noted that applying readability measures specific to the English language to other languages would not be appropriate. Finally, the commenter emphasized that translated consent forms are not a replacement for a medical interpreter.

Leapfrog has conducted additional research and has developed an online calculator (available at: https://readability.leapfroggroup.org/) to assist hospitals with evaluating the readability of their Spanish-language consent forms. The customized tool will facilitate review of consent forms by hospitals, as it can accept text pasted directly into the tool, or parse text from an MS Word document. However, in 2026, Leapfrog's reading level standard will continue to focus on consent forms written in the English language, but we expect to extend the standard to Spanish as early as 2027.

Unfortunately, there is a lack of available tools to assess the readability of medically-oriented documents in languages other than English and Spanish, Leapfrog welcomes additional feedback throughout the Survey Cycle to help us identify additional resources to broaden the standard for consent forms languages other than English and Spanish.

Leapfrog concurs that translated consent forms are not a replacement for an interpreter. In question #6 in this section, Leapfrog continues to require the use of a medical interpreter, and the formal documentation that this took place.

SECTION 2: MEDICATION SAFETY

COMPUTERIZED PHYSICIAN ORDER ENTRY (CPOE)

No comments were submitted.

EHR APPLICATION INFORMATION

A few commenters expressed support for the proposed addition of a question on the use of Artificial Intelligence in medication management.

We appreciate this feedback.

CPOE EVALUATION TOOL

One commentor suggested that medications that are commonly reported as not in formulary should not be removed from the CPOE Test because different hospital policies and pharmacy operations may allow a patient's own medications to be prescribed and used on the inpatient side.

Leapfrog will continue to review the list of medications that hospitals commonly report as not on formulary and either update test medication orders to include alternatives or in some cases replace medications included in test medication orders.

If the prescriber can enter the Test Order even though the medication is not on the hospital's formulary, then the prescriber should do so and proceed with ordering when conducting the CPOE Test.

Several commenters expressed support for removing medications from the CPOE Test that are commonly reported as not in formulary but requested that the CPOE Test be updated to dynamically add additional Test Orders to replace Test Orders that could not be ordered due to a non-formulary medication.

Leapfrog will continue to explore ways to update the test to include this option. However, this will not be implemented in 2026.

Several commenters expressed challenges with staff time and resources required to complete the CPOE Test and recommended that Leapfrog develop 1) a single CPOE Test for hospitals in the same health system that utilize the same EMR and version, and 2) a Leapfrog-certified EMR vendor build to receive automatic credit for the CPOE Test.

Due to differences in implementation and usage between separate hospital locations, Leapfrog continues to require the test be taken by each hospital consistent with Leapfrog's policy on multi-campus hospital systems. Leapfrog consistently observes variation in responses to the same testing scenarios among hospitals within the same system.

If needed, each separate test can be conducted at a central location if the clinical decision support and other CPOE settings being used mirror the local hospital's instance exactly and a local prescriber who regularly orders inpatient medications completes the order entry part of the test (Step 4). Again, a CPOE Test would still need to be completed for each campus.

Leapfrog appreciates the recommendation of developing a certified EMR build. However, the CPOE Evaluation Tool developers research and analysis continues to demonstrate that vendor deployed software is routinely customized at the local level.

Several commenters noted that the CPOE Test does not account for safety interventions that occur outside of CPOE, such as pharmacy- or nursing-facing alerts, which can reduce the need for provider-facing alerts.

The current CPOE Test includes a response option to account for new lab orders and monitoring for medications that are always managed by pharmacy per protocol. However, other scenarios where the CPOE system sends advice or information directly to a pharmacist or nurse, bypassing the prescriber, should not be recorded as an alert for the CPOE Test.

According to the medication safety experts who design and update the test, seven of the eight order checking categories included in the CPOE Evaluation Tool represent an area where a serious adverse drug event (ADE)

could occur if the CPOE system's clinical decision support fails to alert the prescriber. The eighth order checking category includes test orders that, if presented interruptedly, could contribute to over-alerting, which has been shown to contribute to alert fatigue and physician burnout. More information and guidance for reporting hospitals is available here: http://www.leapfroggroup.org/survey-materials/survey-and-cpoe-materials.

The CPOE Expert Panel has concluded that the evidence does not support sending alerts only to pharmacists while bypassing the prescriber, and recommended that Leapfrog maintain the current structure of the CPOE Evaluation Tool.

You can find more information on Leapfrog's CPOE Standard and supporting evidence by reviewing the Fact Sheet and Bibliography available for download here: https://ratings.leapfroggroup.org/measure/hospital/2025/safe-medication-ordering.

One commentor expressed concern that updates and revisions to the CPOE Evaluation Tool could delay testing and negatively impact future scoring.

Leapfrog plans to present webinars on updates and revisions in the fall of 2026 so that hospitals can prepare for the 2027 CPOE Test when the 2027 Leapfrog Hospital Survey opens in April 2027.

BAR CODE MEDICATION ADMINISTRATION (BCMA)

Several commenters supported Leapfrog's proposal to no longer require quality improvement projects if all applicable units achieve 95% compliance with BCMA scanning.

We appreciate this feedback.

One commenter did not support the requirement that compliance be met at the unit level in order to forego quality improvement projects. They also requested more information on the timeframe.

While a hospital may be meeting overall compliance at the hospital-level, there may be certain units that fall below that threshold and that would benefit from the implementation of a quality improvement project. Leapfrog is updating the response option to clarify that quarterly monitoring at the unit-level is required at a minimum if a hospital wants to forego any quality improvement projects related to improving BCMA compliance.

MEDICATION RECONCILIATION

No comments were submitted.

SECTION 3: ADULT AND PEDIATRIC COMPLEX SURGERY

HOSPITAL AND SURGEON VOLUME

One commenter suggested that the new question doesn't account for the fact that most surgeons perform both hip and knee procedures, but generally specialize in one leading to vastly different volumes and skill level. The commenter suggested that the standards be maintained separately as a result.

Thank you for that comment. Based on hospital responses to the new question, Leapfrog will be able to do some targeted follow-up with hospitals to understand the distribution of the surgical cases.

One commenter agreed that total hip and total knee volume standards should be combined as the surgeons and the staff are the same for both procedures.

Thank you for that comment. The addition of the fact-finding question is to better understand the frequency of overlap of these two procedures in reporting hospitals.

SAFE SURGERY CHECKLIST FOR ADULT AND PEDIATRIC COMPLEX SURGERY

No comments were submitted.

SECTION 4: MATERNITY CARE

MATERNITY CARE VOLUME AND SERVICES

One commenter expressed that well-trained nurses also work well with new moms and don't need to be Certified Lactation Consultants.

The updated response options in Section 4A allow hospitals to choose multiple options including "education and counseling provided by other lactation consultants, educators, and/or specialists" in addition to clinical lactation care, education, and support provided by an International Board-Certified Lactation Consultant (IBCLC®). A FAQ is provided to further clarify the distinction between these two response options and is available in Appendix VII for review below.

Leapfrog received several comments regarding our request for information on collecting and reporting a VBAC rate.

Most commenters supported the addition of VBAC reporting, and specifically the proposed use of the IQI-22 measure for VBAC reporting and many noted that the data was already collected by their hospital. A couple of commenters noted that the exclusion criteria for the proposed measure does not fully account for clinically appropriate, guideline-supported indications for repeat cesarean delivery and asked Leapfrog to consider adding additional exclusions or instead report the VBAC success rate for those that elect to have a trial of labor after cesarean delivery. One commenter cautioned Leapfrog against including IQI-22 as a standalone quality metric as it could incentivize inappropriate access to VBAC as opposed to safe access and could lead to an increase in complication rates.

We appreciate the information submitted by each commenter. All comments will be reviewed with Leapfrog's Maternity Care Expert Panel as part of Leapfrog's regular standard review process.

CESAREAN BIRTH

No comments were submitted.

EPISIOTOMY

No comments were submitted.

PROCESS MEASURES OF QUALITY

One commenter asked Leapfrog to consider pharmacologic prophylaxis in addition to mechanical prophylaxis for the prevention of DVT.

As noted above, the update to remove pharmacologic prophylaxis aligns with the American College of Obstetricians and Gynecologists' clinical guidance that all patients should have pneumatic compressions devices placed prior to cesarean delivery. Clinical guidelines continue to recommend that patients at high- or moderate-risk for DVT should also receive appropriate pharmacological prophylaxis in addition to the placement of pneumatic compression devices. As a reminder, the target for this measure is 90%.

One commenter requested that the change to the requirements for DVT prophylaxis be made in 2027 to allow hospitals time to revise their nursing workflows.

This change was originally previewed in the Proposed Changes to the 2025 Leapfrog Hospital Survey and aligns with current evidence.

HIGH-RISK DELIVERIES

One commenter requested that Leapfrog change the name of this measure for additional clarity.

While we appreciate this feedback, Leapfrog has reviewed the name previously and it aligns with terms used by other organizations and health care entities. The use of the term refers to pregnancies where the mother and/or fetus face increased risks for complications during birth due to pre-existing conditions, including low birth weight.

SECTION 5: PHYSICIAN AND NURSE STAFFING

ADULT ICU PHYSICIAN STAFFING

No comments were submitted.

PEDIATRIC ICU PHYSICIAN STAFFING

No comments were submitted.

NURSING WORKFORCE

TOTAL NURSING CARE HOURS PER PATIENT DAY AND RN HOURS PER PATIENT DAY

A couple of commenters supported Leapfrog's proposal to collect nursing hours per patient day from hospitals with both single and mixed acuity adult and/or pediatric Medical, Surgical, and/or Med-Surg Units.

We appreciate this feedback.

A couple of commenters supported exploring options for active NDNQI clients to authorize Leapfrog to directly access NDNQI data beginning in 2027.

We appreciate this feedback.

Several commenters supported Leapfrog's proposal to add a question asking whether virtual nursing is used in direct patient care.

We appreciate this feedback.

A couple of commenters requested additional clarity on the definition of virtual nursing in terms of where it is used.

Leapfrog has updated the term used in the question about virtual nursing from "engage" to "utilize" to clarify that the question is asking if hospitals use virtual nursing in direct patient care.

The purpose of the new optional fact-finding question in 2026 is to assess the use of virtual nursing models when providing direct patient care at hospitals. The results will not be scored or publicly reported in 2026, but Leapfrog's Nursing Workforce Expert Panel will evaluate responses to inform future Survey updates. For 2026, virtual nursing hours should continue to be excluded. As a reminder, direct patient care responsibilities are defined as patient centered nursing activities by hospital unit-based staff in the presence of the patient and activities that occur away from the patient that are patient related:

- Medication administration
- Nursing treatments
- Nursing rounds
- Admission, transfer, discharge activities
- Patient teaching
- Patient communication
- Coordination of patient care
- Documentation time
- Treatment planning
- Patient screening (e.g., fall risk) and assessment

NURSING SKILL MIX

Several commenters supported Leapfrog's proposal to no longer publicly report the Nursing Skill Mix measure.

We appreciate this feedback.

PERCENTAGE OF RNS WHO ARE BSN-PREPARED

No comments were submitted.

SECTION 6: PATIENT SAFETY PRACTICES

NQF SAFE PRACTICE #1 – CULTURE OF SAFETY LEADERSHIP STRUCTURES AND SYSTEMS

Public commenters offered Leapfrog insights into a potential update to the 2027 Hospital Survey to strengthen the participation of patients and/or care partners on the hospital-wide quality and safety committee by adding additional patients and/or care partners.

Leapfrog received nearly two dozen comments on our request for public comment regarding a possible change to the inclusion of patients and/or care partners in the hospital's quality and safety committee. Commenters across stakeholder groups consistently support incorporating patients and their care partners in quality and safety committees, and specifically cite the valuable feedback they have provided to hospitals in that context and the role they've played as partners in improving clinical care delivery. However, hospitals cited obstacles to increasing the number of representative participants, including (a) a limited number of available and willing participants, including participants willing to agree to confidentiality agreements and other legal structures to allow sharing of quality and safety data, (b) travel distances and other obstacles to convening in rural areas. Hospitals gave examples of recruiting efforts that had not succeeded, including reaching out to participants on existing PFACs.

Commenters recommended that Leapfrog pursue a standard to further incorporate patients' perspectives in quality and safety efforts that goes beyond participation in the specific committee, but instead reflect participation through other venues, including an empowered patient and family caregiver advisory council (PFAC), or even structured post-care interviews or other targeted ways to solicit patient feedback.

Finally, hospitals in a health system noted that because they convene individual hospital committees at each campus, they are already hosting a number of participants, including at network committees that already will have the benefit of multiple participating patients.

No other comments were submitted.

NQF SAFE PRACTICE #2 – CULTURE MEASUREMENT, FEEDBACK, AND INTERVENTION

No comments were submitted.

HAND HYGIENE

Leapfrog received over 100 comments in response to our request for information on ways Leapfrog could further strengthen our Hand Hygiene Standard.

These comments mainly included support for reducing the number of hand hygiene opportunities required for monitoring or moving to quarterly monitoring with some suggestions of using representative sampling or cumulative sampling and point prevalence models or a risk-based approach which prioritizes monitoring in high-risk units (e.g., units with historically low compliance or high infection rates). Main concerns cited with the current monitoring standard were the burden on hospitals, potential misdirection of resources from other important infection prevention activities, and the potential for poor quality and biased compliance data. Some comments supported that Leapfrog maintain the alternative scoring for Achieved the Standard which only requires monitoring of 100 hand hygiene opportunities if all other domains are met. A couple commenters suggested that Leapfrog give more credit to hospitals that are utilizing an electronic compliance monitoring system to help incentivize adoption of this technology and a couple suggested that those using an electronic compliance system that provides immediate feedback need not do additional direct observations.

Most comments suggested that Leapfrog focus on the quality of observations, feedback, training, and culture as opposed to quantity. Other suggestions included enhancing the training and education domain by requiring monthly education and related activities; proof of educational programming for patients, residents, and visitors; strategic placement of hand sanitizer; staff input and buy-in on hand hygiene products; monitoring product volume; reviewing correlations with infection rates; focusing on hand hygiene compliance for various procedures; adopting a patient-centered approach. Several commenters also noted that they support maintaining Leapfrog's

multimodal approach which focuses not only on monitoring, but also on training and education, infrastructure, feedback, and culture. A couple commenters supported maintaining the monitoring requirements and suggested that Leapfrog also report on action plans implemented to encourage improvements in hand hygiene.

We appreciate the information submitted by each commenter. Given the relatively limited body of literature available on this topic and the compelling comments, Leapfrog will continue working with APIC, the World Health Organization, and others to review the standard and determine if changes are merited for the 2027 Leapfrog Surveys.

No other comments were submitted.

DIAGNOSTIC EXCELLENCE

Commenters were divided on the merits of the diagnostic excellence section in the Leapfrog Hospital Survey. While many agreed that diagnostic errors are an important patient safety priority, several noted that operational constraints could challenge hospitals with adopting the practices Leapfrog asks about in Section 6D: Diagnostic Excellence.

In setting national standards for achieving diagnostic excellence, our focus is evidence-based best practices to reduce harm to patients from diagnostic errors and putting standards in place that help hospitals benchmark and improve while being valuable to patients and purchasers. Diagnostic errors dominate malpractice lawsuits in most specialties and cause the most harm to patients.[1] A systematic review of diagnostic errors involving hospital inpatients found a quarter million will experience a harmful diagnostic error annually in the United States,[2] and the most recent analysis estimated that some 550,000 patients suffer permanent disability or death every year from diagnostic error.[3] The problem is deeply concerning.

As a result of emerging evidence on the significant harm associated with diagnostic error, over the past five years Leapfrog led a comprehensive project to build national consensus around practices hospitals can adopt to improve diagnostic safety and quality, as well as develop resources to guide hospitals in their implementation. Leapfrog has provided publications, research, guidance, and webinars, and recognizes that hundreds of hospitals nationwide have used these and other guidance offered by the Agency for Healthcare Research and Quality, the Community Improving Diagnosis in Medicine, and the UCSF Coordinating Center for Diagnostic Excellence, among others.

[1] Newman-Toker DE, Schaffer AC, Yu-Moe CW, et al. Serious misdiagnosis-related harms in malpractice claims: The "Big Three" - vascular events, infections, and cancers [published correction appears in Diagnosis (Berl). 2020 May 16;8(1):127128]. Diagnosis (Berl). 2019;6(3):227-240. doi:10.1515/dx-2019-0019

[2] Gunderson CG, Bilan VP, Holleck JL, et al. Prevalence of harmful diagnostic errors in hospitalised adults: a systematic review and meta-analysis. BMJ Qual Saf. 2020;29(12):1008-1018. doi:10.1136/bmjqs-2019-010822

[3]Newman-Toker, D., et al., Burden of serious harms from diagnostic error in the USA. BMJ Qual Saf, 2023. doi: 10.1136/bmjqs-2021-014130.

Commenters were divided on Leapfrog's proposed timeframe to move to scoring and public reporting. Some recommended an additional year of optional reporting on diagnostic excellence, while others recommended moving immediately to scoring and public reporting of the section.

Although the 2026 Survey will be the third year that Section 6D: Diagnostic Excellence is unscored, the section saw significant revisions in between the first and second year, and in this third year is once again being substantially revised. This reflects the fact that diagnostic excellence is a relatively new area of research and evidence.

Our goal with moving to requiring the section, without scoring and publicly reporting the results, is to collect sufficient data from all participating hospitals on our revised questions set, and align with best evidence, so we can be confident with scoring and publicly reporting the results in 2027.

Some commenters, including both representatives from hospitals and health systems, as well as leaders in the diagnostic excellence research community, and leaders representing patients and family caregivers, recommended retaining questions #1 and #2, concerning hospital CEO or CMO commitment to reducing harm to patients due to diagnostic error and communicating specific actions as part of that commitment, as well as questions #3 and #4, concerning engaging with Patient and Family Advisory Councils (PFACs) on initiatives aimed at reducing errors in diagnosis.

After considering the comments and rationale presented by a wide variety of stakeholders, Leapfrog believes that the core concepts underlying these practices can be retained in the Diagnostic Excellence Section of the Hospital Survey by strengthening the question requiring hospitals to convene a multidisciplinary team focused on diagnostic excellence. As a result, Leapfrog will update current question #1 in the section to add a new requirement that a patient or care partner be included as a participant in the multidisciplinary team.

The Agency for Healthcare Research and Quality has specifically cited including patients as members of quality and safety committees as a “next step” beyond convening a patient and family advisory council, representing a progressive incremental step in patient and care partner engagement (AHRQ Working with Patients and Families as Advisors Implementation Handbook).

A majority of hospitals that report to the Leapfrog Hospital Survey have incorporated patients and care partners in their hospital-wide quality and safety committees; hospitals that elect to use these committees as an opportunity to prioritize diagnosis work by dedicating specific time on their agenda to diagnosis can continue to use the same patient and/or care partners, or use this opportunity to engage additional individuals.

We also note that the multidisciplinary team must be sponsored by either the CEO or CMO of the hospital. By sponsoring the multidisciplinary committee, hospital leadership is sending a documented signal of support for the pursuit of diagnostic excellence, both as an explicit endorsement of the quality improvement effort and in the resources needed to convene this committee, as well as facilitate their reporting to senior leaders and the hospital’s Board of Directors.

Commenters generally supported Leapfrog’s proposed changes to the acceptable configurations of the multidisciplinary team, as well as Leapfrog’s approach to removing several questions in the section.

We appreciate this feedback.

Some commenters recommended updating question #6, regarding the implementation of the Safer Dx Checklist, to reduce ambiguity.

Leapfrog has revised current question #6 to add a response option for cases where all practices have been implemented, as well as reworded the subsequent question #7 to clarify that hospitals can respond based on multiple practices they are implementing from the Safer Dx Checklist.

Some commenters recommended that Leapfrog broaden question #6 on whether hospitals have trained staff on AHRQ's TeamSTEPPS for Diagnosis Improvement, to include other evidence-based programs to improve communication among members of the care team. Others suggested that the evidence base supporting TeamSTEPPS is insufficient to support a national best practice recommendation.

Leapfrog is committed to continuing our research into possible resources and models in this area. To date, only AHRQ's TeamSTEPPS for Diagnosis Improvement has distinguished itself as an appropriate resource, and includes a rigorous evidence base as compiled by AHRQ: https://www.ahrq.gov/teamstepps-program/evidence-base/hospital.html. However, researchers and clinicians are strongly encouraged to contact the Leapfrog Help Desk to propose alternative resources or models of effective team-based communication training with a specific emphasis on the diagnostic process for consideration for the future.

HOSPITAL BOARDING IN THE EMERGENCY DEPARTMENT (ED)

One commenter suggested that the Frequently Asked Questions (FAQs) should explicitly address scenarios where patients are awaiting clearance and bed placement at another facility (e.g., a psychiatric unit), noting that in these cases no inpatient order is placed at the reporting hospital and the patient remains under ED observation.

This is clarified in the measure specifications. Patients transferred to a separate facility or who remain only under ED observation and are never admitted should be excluded from Section 6E.

One commenter asked how a pediatric hospital co-located within an adult hospital, sharing a single Emergency Department that serves both pediatric and adult patients, should respond to this section, and noted that additional guidance for "hospital-within-a-hospital" arrangements would be helpful.

We will add a FAQ clarifying how co-located pediatric hospitals within adult hospitals should complete this section. Hospitals should report on operating a pediatric emergency department in question #3 and then respond to question #5, where hospitals report on ED visits with an admission to a pediatric inpatient non-psychiatric or psychiatric bed (including ED visits where the patient was placed in hospital observation status).

One commenter noted that the language describing the data requested in columns C, D, and E is unclear and could be misinterpreted, pointing out that the repeated verbiage obscures the fact that column C (total boarding time) is a different data request than columns D and E (hours spent in the ED).

We have updated the question wording to column C and defined total boarding time (in hours) in the measure specifications for additional clarity. In 2026, the goal is to not only capture the total number of ED visits with a boarding time greater than 4 hours but to also capture the total boarding time for all ED patients that were admitted to the hospital (including patients placed in hospital observation status) to understand the average boarding time.

One commenter asked whether Leapfrog's Hospital Boarding in the Emergency Department measure aligns with the Centers for Medicare and Medicaid Services (CMS) proposed Emergency Care Access & Timeliness (ECAT) eCQM, proposed for inclusion in the 2026 OPPS quality reporting programs.

The Hospital Boarding in the Emergency Department measure included in the Leapfrog Hospital Survey differs from CMS's Emergency Care Access & Timeliness (ECAT) eCQM. The ECAT is a new composite measure that broadly evaluates ED timeliness across all emergency encounters. The CMS measure evaluates four gaps in ED

access including: patient wait times, patients leaving without being seen, patient boarding time in the ED, and overall length of stay in the ED. Though aligned with the CMS purpose, Leapfrog's approach seeks to capture more granular, descriptive insight into boarding, a specific problem that evidence suggests presents an exceptionally high risk to patients. We believe our approach complements the CMS measure to the benefit of patients, and will ultimately give hospitals themselves clear, actionable insight to address their boarding and throughput safety challenges.

Presented together, these approaches highlight complementary—but distinct—perspectives on hospital boarding in the ED. The following table outlines the differences between the two.

	CMS ECAT eCQM	**Leapfrog Hospital Survey Questions**
Primary Purpose	Looks at four gaps in ED access, including: patient wait times, patients leaving before being seen, boarding in the ED, and overall length of stay in the ED.	Focuses only on hospital boarding in the ED (and ED length of stay, as a balancing measure) with more detailed understanding of that particular risk to patients
Patient Population	All ED encounters (discharged, admitted, observation, left before evaluation)	ED patients with an inpatient admission or where the patient was placed in hospital observation status.
Key Measurements	Composite of four possible failures: • >1 hour to evaluation, • left without being evaluated, • boarding >4 hours, or • ED Length of Stay > 8 hours	• Total number of ED visits with an inpatient admission, or where the patient was placed in hospital observation status, • number of admissions boarding >4 hours, • total boarding time, • median ED length of stay, • 90th percentile ED length of stay

Two commenters requested clarification on inclusion criteria and advocated for methods of measurement that reflect evolving current healthcare landscape, noting that using Emergency Department boarding time as a hospital quality indicator does not accurately reflect quality of care due to factors outside of the hospital's control.

Leapfrog agrees that clear, standardized definitions of Emergency Department (ED) boarding time are essential to ensure fairness and comparability across hospitals nationwide. With guidance from a national Expert Panel, the

survey includes detailed specifications on inclusion and exclusion criteria, including how observation status and behavioral health patients are addressed, to support consistent interpretation and reporting.

Leapfrog recognizes that hospital boarding in the emergency department is influenced by national, state, community, and system-level factors such as policies affecting access, regional capacity constraints, demand surges, hospital closures, and behavioral health bed shortages, which may disproportionately affect large or referral hospitals. However, prolonged hospital boarding in the ED remains a well-established patient safety and quality concern, and patients deserve to know their risk of boarding at hospitals in their community regardless of why the problem exists. Where appropriate, Leapfrog continues to work with hospitals to advocate for policies that allow hospitals to reduce or eliminate boarding.

Leapfrog relies on standardized definitions of boarding to assure accurate comparative data and will continue to refine the measure as part of our ongoing Survey research and development process.

One commenter suggested Leapfrog adjust the definition of "boarding time" to start one hour after a patient is admitted accounting for potential handoff time delays, transport coordination, and communication with family.

We recognize that important clinical and operational steps occur after an admission order is entered, but those important steps are critical to patient safety. Based on guidance from our national Expert Panel, boarding time should be measured from the decision to admit (e.g., admission order) until the patient's final departure from the ED.

A commenter applauded Leapfrog's ongoing dedication to measuring Hospital Boarding in the Emergency Department by enhancing reporting and data collection.

We appreciate this feedback.

One commenter recommended several updates to Hospital Boarding in the Emergency Department including: redefining the reporting period, adding a 75th-percentile measure, including transfer and social holds, adding behavioral health observation patients, and clarifying that start and stop times apply to all boarders.

Leapfrog will not change the reporting period for this measure and will not be adding a 75th percentile because the median and 90th percentile already provide meaningful insight into performance distribution. Transfer holds were not included based on the recommendations of our national Expert Panel. Behavioral health observation patients will continue to be included when they meet the established definition of hospital boarding in the ED (i.e., once an admission or hospital observation order has been placed and they are admitted to an inpatient psychiatric/non-psychiatric bed). Patients under a social hold are included in the measures if they are admitted to an inpatient bed or placed in hospital observation status, and the time the patient waits before leaving the ED should still be captured. Leapfrog did, however, revise the definition of boarding time so that the final timestamp reflects the patient's final departure from the ED.

One commenter recommended expanding Hospital Boarding in the Emergency Department evaluation by adding balancing measures for operational context, collecting information on mitigation practices, clarifying accountability for admitted patient care in the ED, recognizing best practices in addition to raw performance, allowing credit for relevant external certifications, and providing flexibility in data submission for complex and academic settings.

Leapfrog will not be adding additional elements for evaluation due to concerns about reporting and the effort required to collect multiple data elements. We will continue to evaluate this measure with our national Expert Panel and find ways to enhance the measure while reducing the reporting burden.

One commenter mentioned that it may be difficult to sustain high performance for the Hospital Boarding in the Emergency Department measure for hospitals undergoing renovations or without functioning patient rooms within the Emergency Department.

Leapfrog recognizes that physical constraints like renovations or temporarily closed patient rooms can make hospital boarding in the ED more challenging in the short term. However, prolonged boarding in the ED is a patient safety issue and patients deserve to be made aware of the risk regardless of the reason for it. Extended hospital boarding in the ED is associated with delays in care, increased medical errors, and worse outcomes, which is why it remains a critical focus of Leapfrog going forward.

SECTION 7: MANAGING SERIOUS ERRORS

NEVER EVENTS

No comments were submitted.

HEALTHCARE-ASSOCIATED INFECTIONS

No comments were submitted.

SECTION 8: PEDIATRIC CARE

One commenter supported Leapfrog's requirement that pediatric hospitals submit the pediatric care section of the Survey.

We appreciate this feedback.

PATIENT EXPERIENCE (CAHPS CHILD HOSPITAL SURVEY)

No comments were submitted.

PEDIATRIC COMPUTED TOMOGRAPHY (CT) RADIATION DOSE

No comments were submitted.

SECTION 9: OUTPATIENT PROCEDURES

BASIC OUTPATIENT DEPARTMENT INFORMATION

No comments were submitted.

MEDICAL, SURGICAL, AND CLINICAL STAFF

No comments were submitted.

VOLUME OF PROCEDURES

One commenter expressed support for allowing hospitals to optionally report on outpatient procedure volumes.

We appreciate this feedback.

SAFETY OF PROCEDURES

SAFE SURGERY CHECKLIST FOR ADULT AND PEDIATRIC OUTPATIENT PROCEDURES

One commenter requested that this section be optional since hospitals are no longer required to report on volumes in Section 9C and most hospitals are utilizing data from Section 9C to complete retrospective audits using the Safe Surgery Checklist.

Leapfrog continues to see significant variation in hospital's reported use of a safe surgery checklist for patients undergoing outpatient procedures. Therefore, we will continue to require this subsection. Hospitals that have not reviewed a random sample of patients, should respond "did not measure."

MEDICATION SAFETY FOR OUTPATIENT PROCEDURES

One commenter requested that this section be optional since hospitals are no longer required to report on volumes in Section 9C and most hospitals are utilizing data from Section 9C to measure adherence to medication documentation guidelines.

Leapfrog continues to see significant variation in hospital results related to documenting home medications, visit medications, and allergies for patients undergoing outpatient procedures. Therefore, we will continue to require this subsection. Hospitals that have not reviewed a random sample of patients, should respond "did not measure."

CMS MEASURES

One commenter expressed support for the transition from self-reported OAS CAHPS results to CMS publicly reported OAS CAHPS results.

We appreciate this feedback.

One commenter noted that CMS has recently reintroduced "Preparations for Discharge and Recovery" OAS CAHPS domain to hospital public reporting.

We are aware that this measure is currently publicly reported by CMS for hospital outpatient departments, but it is not yet available for ASCs. Leapfrog aligns the public reporting of OAS CAHPS measures for both hospitals and ASCs to allow for reliable comparisons between sites of surgery. We plan to add this measure to future Surveys. Leapfrog has updated the FAQ to clarify this plan.

One commenter expressed concern about the reporting period being older for CMS OAS CAHPS data, compared to self-reported data.

The Survey previously asked hospitals to report their most recent 12-month reporting period for OAS CAHPS. If a hospital submitted the 2025 Leapfrog Hospital Survey in June 2025, to meet the submission deadline of June 30, their reporting period was 06/01/2024 - 05/30/2025. Alternatively, the reporting period for CMS data available in November 2025 was 1/1/2024 - 12/31/2024. If Leapfrog had utilized CMS data for these hospitals in the final scoring, the data reported by Leapfrog for this hospital would have had a 6-month difference, which is not substantial. While we are committed to capturing current data, this change has allowed us to ensure OAS CAHPS reporting periods, adjustment methods, and data verification are aligned among all hospital outpatient departments (HOPDs) and ASCs for each Survey Cycle. Improving these elements allows for improved benchmarking and data confidence.

One commenter noted that CMS data results are not facility-specific among hospitals that share a CCN, which is contrary to Leapfrog's Multi-Campus Reporting Policy.

Leapfrog is the nation's most vocal advocate that CMS should discontinue its policy of permitting individual facilities within health systems to share the same CCN. Providing data by facility maximizes transparency and aids consumers in choosing the best hospital. We recommend that all hospitals that currently share CCNs consider registering with CMS as separate facilities and reporting under distinct CCNs. Leapfrog has updated the FAQ to address this concern.

APPENDIX I: TIMELINE FOR THE 2026 LEAPFROG HOSPITAL SURVEY

Date	Deadline
March	Summary of Changes to the 2026 Leapfrog Hospital Survey and Responses to Public Comments will be published at www.leapfroggroup.org/hospital.
April 1	**2026 LEAPFROG HOSPITAL SURVEY LAUNCH** The hard copy of the 2026 Leapfrog Hospital Survey and supporting materials are available for download on the Survey Materials webpage. The Online Hospital Survey Tool is available.
June 22	**FIRST NHSN GROUP DEADLINE:** Hospitals that join Leapfrog's NHSN Group by June 22, 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 XIII for instructions and other 2026 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 Report" until a Survey has been submitted. Custom 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 confidentially available for hospitals to view on July 12 via the Hospital Details Page. 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.
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 2026 HOSPITAL SAFETY GRADE:** Adult and general hospitals that would like Leapfrog Hospital Survey Results included in the fall 2026 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.

Date	Deadline
November 30	**LATE SUBMISSION DEADLINE:** The 2026 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 2027 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, 2027	**CORRECTIONS DEADLINE:** Hospitals that need to make corrections to previously submitted 2026 Leapfrog Hospital Surveys must make necessary updates and re-submit the entire Survey by January 31, 2027. 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 2027 HOSPITAL SAFETY GRADE:** Adult and general hospitals that would like Leapfrog Hospital Survey Results included in the spring 2027 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: REPORTING PERIODS FOR THE 2026 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 12/31/2025	12 months ending 06/30/2026
1B Billing Ethics	Based on the practices currently in place at the time of Survey submission	Based on the practices currently in place at the time of Survey submission
1C Health Care Equity	Based on the practices currently in place at the time of Survey submission	Based on the practices currently in place at the time of Survey submission
1D Informed Consent	Based on the practices currently in place at the time of Survey submission	Based on the practices currently in place at the time of Survey submission
2A Computerized Physician Order Entry (CPOE)	Latest 3 months prior to Survey submission	Latest 3 months prior to Survey submission
2B EHR Application Information	Based on the EHR application currently in place at the time of Survey submission	Based on the EHR application currently in place at the time of Survey submission
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 12/31/2025	Volume: 12 months or 24 months ending 06/30/2026
	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	Volume: 12 months ending 12/31/2025	Volume: 12 months ending 06/30/2026
	Services: Based on the practices currently in place at the time of Survey submission	Services: Based on the practices currently in place at the time of Survey submission
4B Cesarean Birth	12 months ending 12/31/2025	12 months ending 06/30/2026
	Cesarean Birth Stratified by Race/Ethnicity: 24 months ending 12/31/2025	Cesarean Birth Stratified by Race/Ethnicity: 24 months ending 06/30/2026
4C Episiotomy	12 months ending 12/31/2025	12 months ending 06/30/2026
4D Process Measures of Quality	12 months ending 12/31/2025	12 months ending 06/30/2026

Survey Section	Survey Submitted Prior to September 1 Reporting Period	Survey (Re)Submitted on or After September 1 Reporting Period
4E High-Risk Deliveries	Volume: 12 months ending 12/31/2025	Volume: 12 months ending 06/30/2026
	VON: 2024 report	VON: 2025 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: 12 months ending 12/31/2025	Nurse Staffing: 12 months ending 06/30/2026
	NQF Safe Practice #9: Latest 12 months prior to Survey submission	NQF Safe Practice #9: Latest 12 months prior to Survey submission
	Percentage of RNs who are BSN-Prepared: Based on the most recent day within the last 12 months for which you have complete data	Percentage of RNs who are BSN-Prepared: Based on the most recent day within the last 12 months for which you have complete data
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	Based on the practices currently in place at the time of Survey submission	Based on the practices currently in place at the time of Survey submission
6D Diagnostic Excellence	Based on the practices currently in place at the time of Survey submission	Based on the practices currently in place at the time of Survey submission
6E Hospital Boarding in the Emergency Department (ED)	12 months ending 12/31/2025	12 months ending 06/30/2026
7A Never Events	Based on the principles currently included in your hospital's never events policy at the time of Survey submission	Based on the principles currently included in your hospital's never events policy at the time of Survey submission
7B Healthcare-Associated Infections	June and August Data Downloads: 01/01/2025 – 12/31/2025	October and December Data Downloads: 07/01/2025 – 06/30/2026

Survey Section	Survey Submitted Prior to September 1 Reporting Period	Survey (Re)Submitted on or After September 1 Reporting Period
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 12/31/2025	12 months ending 06/30/2026
9A Basic Outpatient Department Information	12 months ending 12/31/2025	12 months ending 06/30/2026
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 12/31/2025	
9D Safety of Procedures	Latest 12 months prior to Survey submission	Latest 12 months prior to Survey submission
9E Medication Safety for Outpatient Procedures	12 months ending 12/31/2025	12 months ending 06/30/2026
9F CMS Measures	June CMS Data Download: OP-32: 1/1/2022 - 12/31/2024 OAS CAHPS: 7/1/2024 - 6/30/2025 August CMS Download: OP-32: 1/1/2022 - 12/31/2024 OAS CAHPS: 10/1/2024 - 9/30/2025	November CMS Data Download: OP-32: 1/1/2022 - 12/31/2024 OAS CAHPS: 1/1/2025 - 12/31/2025

APPENDIX III: BASIC HOSPITAL INFORMATION QUESTIONS

Updates highlighted in yellow.

General Information

1) Reporting period used:	○ 01/01/2025 – 12/31/2025 ○ 07/01/2025 – 06/30/2026
2) Total number of licensed acute-care beds.	_____
3) Total number of staffed acute-care beds.	_____
4) Total number of adult acute-care admissions to your hospital during the reporting period.	_____
5) Total number of pediatric acute-care admissions to your hospital during the reporting period.	_____
6) Does your hospital operate any adult and/or pediatric general medical, surgical, medical/surgical, or neuro ICUs? *If "yes, adult only" to question #6, skip questions #10-13 below.* *If "yes, pediatric only" to question #6, skip questions #7-9 and #13 below.* *If "yes, adult and pediatric" to question #6, skip question #13 below.* *If "no" to question #6, skip questions #7-12 and continue to question #13.*	○ Yes, adult only ○ Yes, pediatric only ○ Yes, adult and pediatric ○ No
7) Total number of licensed adult general medical, surgical, medical/surgical, and neuro ICU beds.	_____
8) Total number of staffed adult general medical, surgical, medical/surgical, and neuro ICU beds.	_____
9) Total number of adult general medical, surgical, medical/surgical, and neuro ICU admissions during the reporting period.	_____
10) Total number of licensed pediatric general medical, surgical, medical/surgical, and neuro ICU beds.	_____
11) Total number of staffed pediatric general medical, surgical, medical/surgical, and neuro ICU beds.	_____
12) Total number of pediatric general medical, surgical, medical/surgical, and neuro ICU admissions during the reporting period.	_____

13) If your hospital does not operate dedicated adult or pediatric general medical, surgical, medical/surgical, or neuro ICUs, does your hospital admit adult and/or pediatric general medical, surgical, medical/surgical or neuro ICU patients to mixed acuity units?	○ Yes ○ No
14) Does your hospital operate any of the following specialty ICUs: medical cardiac, respiratory, surgical cardiothoracic, burn, trauma, pediatric cardiothoracic, oncology, Level II/III neonatal ICU, Level III neonatal ICU, or Level IV neonatal ICU? *If "no" to question #14, skip question #15 and continue to question #16.*	○ Yes ○ No
15) Total number of admissions to a Level II/III, Level III, or Level IV neonatal ICU during the reporting period.	_____
16) Is your hospital a Major or Graduate teaching hospital (based on NHSN's definitions) for physicians and/or physicians-in-training or nursing students?	*No response required here. Determined automatically based on NHSN 2025 Patient Safety Component – Annual Hospital Survey.*

General Hospital Policies

17) To help ensure that patients are cared for by well-trained physicians and other providers (e.g., certified registered nurse anesthetists, certified midwives, or certified nurse-midwives, etc.), do your medical staff by-laws or hospital-wide policies require all physicians and providers who have privileges to provide care at your hospital to be board certified or board eligible?	○ Yes ○ No
18) Does your hospital include performance on the Leapfrog Hospital Survey, Leapfrog Hospital Safety Grade, or Leapfrog Top Hospital in performance reviews and/or compensation incentives for senior administrative leadership?	○ Yes ○ No
19) Does your hospital have a policy and protocol that empowers patients, or their family caregivers, to activate a rapid response team (RRT) to evaluate the patient for possible escalation of care, that includes **all** the following elements: • A process to notify patients and family caregivers, verbally or in writing, about how to activate the rapid response team; • A process to ensure clinicians are trained to recognize when a patient or family caregiver is asking for an evaluation by a rapid response team; and • A process to ensure clinicians are trained on how to conduct the evaluation if they are part of the rapid response team?	○ Yes ○ No

APPENDIX IV: BILLING ETHICS QUESTIONS AND FAQS

Section 1B: Billing Ethics – Questions for 2026

Updates highlighted in yellow.

1) Within 30 days of the final claims adjudication (or within 30 days from date of service for patients without insurance), does your hospital provide every patient with a billing statement and/or master itemized bill for facility services, either by mail or electronically (via email or the patient portal), that includes ALL the following: a. Name and address of the facility where billed services occurred; b. Date(s) of service; c. An individual line item for each service or bundle of services performed; d. Description of services billed that accompanies each line item or bundle of services performed; e. Amount of any principal, interest, or fees (e.g., late or processing fees), if applicable; f. Amount of any adjustments to the bill (e.g., health plan payment or discounts), if applicable; g. Amount of any payments already received (from the patient or any other party), if applicable; h. Instructions on how to apply for financial assistance, if applicable; i. Instructions in the patient's preferred language on how to obtain a written translation or oral interpretation of the bill; and j. Notification that physician services will be billed separately, if applicable? *If any one of the elements above is only provided upon request, select "only upon request." If any one of the elements above is not ever provided, select "no."*	○ Yes ○ No ○ Only upon request
2) Does your hospital give patients instructions for contacting a billing representative: • Who has access to an interpretation service to communicate in the patient's preferred language, **and** • Who has the authority to do all the following within 10 business days of being contacted by the patient or patient representative: i. initiate an investigation into errors on the bill, ii. offer a price adjustment or debt forgiveness based on hospital policy, and iii. offer a payment plan?	○ Yes ○ No

3) Does your hospital take legal action against patients for late payment or insufficient payment of a medical bill? *This question does not include patients with whom your hospital has entered into a written agreement specifying a good faith estimate for a medical service.*	○ Yes ○ No ○ No, but required by state or federal law to transfer delinquent payments to a state or federal agency (e.g., Department of Treasury, Attorney General, etc.) for action
4) Does your hospital screen ALL patients to determine if they are eligible for your hospital's financial assistance program, regardless of whether they apply for financial assistance? *If "no, we only screen uninsured patients for financial assistance eligibility" or "no, we only screen patients who have applied for financial assistance," skip question #5 and continue to question #6.* *If "no, our hospital does not have a financial assistance program," skip questions #5-7 and continue to the next subsection.*	○ Yes, using a presumptive eligibility tool licensed from a third-party ○ Yes, using our hospital's own approach to assessing financial assistance eligibility ○ No, we only screen uninsured patients for financial assistance eligibility ○ No, we only screen patients who have applied for financial assistance ○ No, our hospital does not have a financial assistance program
5) Does your hospital notify ALL patients who were determined to be eligible for your hospital's financial assistance program that they have qualified for the program within 30 days of the determination?	○ Yes ○ No
6) 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 ○ No, but we include a list of covered clinicians and services in our financial assistance application
7) Does your hospital's financial assistance application include notification that some services, including physician services, may be billed separately?	○ Yes ○ No

Section 1B: Billing Ethics – FAQs for 2026

1. **How do I know if a state or federal law requires my hospital to transfer delinquent payments to a state or federal agency (e.g., Department of Treasury, Attorney General, etc.)?**
   These requirements generally apply to public or state-owned hospitals, including hospitals operated by public universities or state health systems, in certain states (e.g., Illinois or New York). The obligation is tied to the hospital's public ownership or operation, rather than hospital status alone.

   Private hospitals are generally not required to transfer delinquent patient accounts to a state or federal agency for collection.

2. **Our organization uses more than one method for screening patients for financial assistance eligibility, how should we respond to question #4?**
   When more than one option is applicable, hospitals should select the option that is primarily used for screening patients.

3. **Our organization currently lists the notification regarding some services being billed separately in the Frequently Asked Questions on our medical bills. Does this still need to be added to the financial assistance application?**
   Yes, the disclosure should still be included in the financial assistance application itself. The intent of this question is to ensure patients are notified at the point of applying for financial assistance, not just somewhere else in the billing materials.

APPENDIX V: INFORMED CONSENT FAQS

Section 1D: Informed Consent – FAQs for 2026

1. **How should the reading level of consent forms be assessed in languages other than English?**
   To date, Leapfrog has only developed readability guidance for Spanish-language consent forms. For the Spanish language, Leapfrog considers a score of 55 or above on the INFLESZ Scale to be written at a sixth-grade reading level or below. The INFLESZ Scale, developed and validated in 2008 by Barrio-Cantalejo et al, is the most widely used in academic research on readability of Spanish-language consent forms (Aponte 2025). The INFLESZ scale is calculated as 206.835 − 62.35 × (total syllables/total words) − (total words/total sentences). A minimum threshold of 55 and above on the INFLESZ scale is considered to be readable by most patients.

   To calculate an INFLESZ score, Leapfrog has provided an online calculator (available at: https://readability.leapfroggroup.org/). You may paste in the text of your consent form or upload a Microsoft Word 365 file: the calculator will provide a score, an indication of pass/fail, and details on the calculation.

   For languages other than English and Spanish, Leapfrog has not yet established a scoring methodology.

   Barrio-Cantalejo IM, Simón-Lorda P, Melguizo M, Escalona I, Marijuán MI, Hernando P. Validación de la Escala INFLESZ para evaluar la legibilidad de los textos dirigidos a pacientes [Validation of the INFLESZ scale to evaluate readability of texts aimed at the patient]. An Sist Sanit Navar. 2008;31(2):135-152. doi:10.4321/s1137-66272008000300004

   Aponte J, Tejada K, Figueroa K. Readability Level of Spanish Language Online Health Information: A Systematic Review. Hisp Health Care Int. 2025;23(2):107-122. doi:10.1177/15404153241286720.

2. **Why has Leapfrog selected a 6th-grade reading level target for consent forms, and what are some strategies we can use to meet this?**
   Just over half of U.S. adults have a reading level that permits them to understand and synthesize information from a complex text. According to a Gallup analysis, 54% of Americans between the ages of 16 and 74 read below the equivalent of a sixth-grade level. A more recent survey by the Organization for Economic Development and Cooperation (OECD) indicates that literacy in the U.S. has gradually declined since that Gallup analysis, suggesting a still-greater proportion of the population reads below a sixth-grade level today.

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

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

   In addition, recent research suggests that Large Language Models (e.g. ChatGPT) can be leveraged to optimize the reading level of consent forms, while retaining the accuracy and completeness of the medical terminology and descriptions used.

Ramanathan, Rahul & Kelly, Ryan & Shaw, Jeremy & Gopakumar, Adway & Shannon, Michael & Gonzalez, Christopher & Weinberg, Jacob & Bonamer, John & Wawrose, Richard & Spitnale, Michael & Lee, Joon & Weddle, John. (2026). Reducing Complexity in Surgical Consents: The Role of AI in Patient Communication. Medical Research Archives. 13. 10.18103/mra.v13i12.7178.

APPENDIX VI: EHR APPLICATION INFORMATION QUESTIONS AND FAQS

Section 2B: EHR Application Information – Questions for 2026

Updates highlighted in yellow.

1) Which EHR source is your hospital currently using? *If your hospital purchased a third-party vendor system and substantially altered it on implementation, select "Homegrown App," skip questions #2-4, and continue to question #5.*	○ Vendor Application ○ Homegrown Application
2) Which EHR vendor is your hospital currently using?	○ Altera/Allscripts ○ Altera/Digital Health ○ Allscripts/Eclipsys ○ Altera/Paragon ○ CareCast ○ Cerner ○ CPSI ○ Epic ○ MEDHOST ○ MEDITECH ○ Quadramed ○ Other (please specify): _____
3) What EHR version is your hospital currently using?	_____
4) What is the name of the EHR product that your hospital is currently using?	_____
5) When was the EHR initially installed at the hospital? *Enter the month and year the EHR was installed at the hospital.*	_____ *Format: Month/Year*
6) Which EHR Medication Reference Database is your hospital currently using?	○ Homegrown ○ First DataBank (FDB) ○ Gold Standard / Elsevier ○ Lexicomp ○ Medi – Span ○ Micromedex ○ Multum ○ Other (please specify): _____

7) Does your hospital currently use Artificial Intelligence (AI) applications in its medication management process (including medication-related clinical decision support, medication ordering, BCMA, and medication reconciliation)? *If "no" to question #7, skip the remaining questions in Section 2B, and continue to Section 2C.*	○ Yes ○ No
8) In which areas of the medication management process are Artificial Intelligence (AI) applications used? *Select all that apply.*	☐ Medication-related Clinical Decision Support ☐ Medication Ordering ☐ Bar Code Medication Administration (BCMA) ☐ Medication Reconciliation
9) Are the vendors of these AI applications the same as your EHR and medication reference database systems? *Select all that apply.* *If "Other Vendors" is selected, continue to question #10. Otherwise, skip question #10 and continue to Section 2C.*	☐ Same as EHR ☐ Same as Medication Safety Reference Database ☐ Homegrown ☐ Other Vendors
10) What are the names of the Other Vendors that your hospital is currently using in its medication management process from question #8? *If entering multiple Other Vendors, separate each by a comma.*	_____

Section 2B: EHR Application Information – FAQ for 2026

1. **What is the definition of Artificial Intelligence in Health Care?**
   Artificial Intelligence (AI) in healthcare is the use of machine learning, AI Algorithms, large language models, AI Agents, agentic AI, chatbots, and other related technologies to analyze health data and assist clinicians in tasks like diagnosis, treatment (including clinical decision support), patient monitoring, administrative work, and automated workflows. Its goal is to improve patient outcomes, increase efficiency, and personalize care by providing tools that can identify diseases, streamline workflows, and help predict patient needs.

   Examples of AI applications used in medication management processes are as follows:
   - AI algorithms that suggest a new medication order's dosage, frequency, or duration of therapy.
   - AI algorithms that suggest a new medication for a patient based on an analysis of the patient's medical record.
   - AI algorithms that suggest changes to an existing medication the patient is on based on an analysis of the patient's medical records.

APPENDIX VII: MATERNITY CARE VOLUME AND SERVICES QUESTIONS AND FAQS

Section 4A: Maternity Care Volume and Services – Questions for 2026

Updates highlighted in yellow.

Maternity Care Services

1) Do certified nurse-midwives and/or certified midwives offer care for labor and delivery at your hospital?	○ Yes ○ No
2) Do doulas offer care for labor and delivery at your hospital? *Select all that apply.*	☐ Yes, the hospital employs or contracts with doulas ☐ Yes, patients can bring their own doulas ☐ No
3) What breastfeeding/lactation support is provided in your hospital after delivery and prior to hospital discharge? *Select all that apply.*	☐ Clinical lactation care, education, and support provided by an International Board Certified Lactation Consultants® (IBCLCs®) ☐ Education and counseling provided by other lactation consultants, counselors, educators, and/or specialists ☐ None of the above
4) Which of the following does your hospital offer patients after delivery and prior to hospital discharge? *Select all that apply.*	☐ Tubal ligation ☐ Bilateral salpingectomy ☐ Long-acting reversible contraception (LARC) (e.g., IUDs) ☐ None of the above
5) Has your hospital adopted a policy that prevents nonmedically indicated early elective deliveries (before 39 completed weeks gestation) that includes all the following: • Written standards for when an early elective delivery is, and is not, appropriate based on ACOG and national guidelines (i.e., The Joint Commission), • Written protocols for the medical director, or other designated physician, to review and approve an early elective delivery when medically indicated based on ACOG and national guidelines, and • Written protocols for staff to follow when scheduling an early elective delivery if approved by the medical director or other designated physician?	○ Yes ○ No

Section 4A: Maternity Care Services – FAQ for 2026

1. **For the purposes of Section 4A question #3, what qualifies for the different categories of lactation personnel?**
   The National Lactation Consultant Alliance has categories for lactation personnel, with specific qualifications based upon the extent of their education and training.

   1) International Board Certified Lactation Consultants® (IBCLCs®) are individuals that are board certified by the International Board of Lactation Consultant Examiners® to provide ***clinical lactation care*** (e.g., clinical assessments, lactation management and feeding plans, referrals to other healthcare practitioners, etc.), as well as education and support to postpartum patients.

   2) Lactation consultants, counselors, educators, and/or specialists are individuals that provide basic breastfeeding and lactation teaching, as well as support to postpartum patients. This would include approximately 20 different designations, with an array of lactation-specific education requirements.

   More information on the differing types of personnel can be found here.

APPENDIX VIII: PROCESS MEASURES OF QUALITY MEASURE SPECIFICATIONS

Updates highlighted in yellow.

Appropriate DVT Prophylaxis in Women Undergoing Cesarean Delivery

Source: National Quality Forum #0473

Reporting Period: 12 months
• Surveys submitted prior to September 1:
  ○ 01/01/2025 – 12/31/2025
• Surveys (re)submitted on or after September 1:
  ○ 07/01/2025 – 06/30/2026
 	
Note: The discharge date must be used to determine whether a case falls within the reporting period specified.

Hospitals participating in the California Maternal Quality Care Collaborative (CMQCC) Maternal Data Center may use the data provided in CMQCC reports when responding to this subsection of the Survey. Download instructions for using the CMQCC reports on the Survey and CPOE Materials webpage.
Sampling: If you have fewer than 30 cases that meet the criteria for inclusion in the denominator of the process measure during the time period of the medical record audit, include ALL of these cases in measuring adherence to the process guidelines. You need NOT use more than 12 months of historical data to increase the eligible cases beyond 30; just measure and report on ALL eligible cases that you have in that reporting period. If you have more than 30 cases that meet the criteria for inclusion in the denominator of the process measure during the time period of the medical record audit, you may randomly sample at least 30 of them for the denominator of each guideline, and measure and report adherence based on that sample.
Question #7 (denominator): Eligible cases include all women undergoing cesarean delivery during the reporting period. Include cases with one of the following MS-DRG codes: • 783: Cesarean section with sterilization with MCC • 784: Cesarean section with sterilization with CC • 785: Cesarean section with sterilization without CC/MCC • 786: Cesarean section without sterilization with MCC • 787: Cesarean section without sterilization with CC • 788: Cesarean section without sterilization without CC/MCC The following APR-DRGs should also be used to identify a cesarean delivery if your hospital uses APR-DRG coding: • 539: Cesarean section with sterilization • 540: Cesarean section without sterilization The following Tricare DRGs should also be used to identify a cesarean delivery if your hospitals uses Tricare DRG coding: • 771 Cesarean section without sterilization with MCC • 772 Cesarean section without sterilization with CC • 773 Cesarean section without sterilization without CC/MCC • 783 Cesarean section with sterilization with MCC • 784 Cesarean section with sterilization with CC • 785 Cesarean section with sterilization without CC/MCC

Excluded Populations: None.
Question #8 (numerator) Number of eligible cases included in the denominator who received pneumatic compression devices prior to surgery. Note 1: Use of a pneumatic compression device may be documented in the OR log but must be placed pre-operatively to qualify for inclusion in the numerator. Note 2: Clinical guidelines continue to recommend that patients at high or moderate risk for DVT should also receive appropriate pharmacological prophylaxis in addition to the placement of pneumatic compression devices. For a list of approved pneumatic compression devices, see the devices listed under “Intermittent Pneumatic Compression Device (IPC)” in Table 2.1 VTE Prophylaxis Inclusion Table.

APPENDIX IX: VON REPORTING PERIODS AND DEADLINES

VON Deadline	VON Reporting Period	Leapfrog Survey Submission Date	Review Results
*Hospitals must complete and submit their Data Sharing Authorization letter to VON before this date**		*VON data will not be publicly reported if hospitals have not submitted by this date*	*Data received from VON will be available to review on the Hospital Details Page or Public Reporting Website by these dates*
June 15, 2026	2024	June 30, 2026	July 12, 2026**
August 14, 2026	2025***	August 31, 2026	September 10, 2026
November 16, 2026	2025	November 30, 2026	December 9, 2026

* Hospitals that successfully submitted a Data Sharing Authorization letter in previous years will not be required to submit another letter in 2026.
**Data will be published on the Public Reporting Website starting on July 25, 2026.
***Anticipated release of 2025 VON data.

APPENDIX X: NURSING WORKFORCE QUESTIONS AND FAQS

Section 5C: Nursing Workforce – Questions for 2026

Updates highlighted in yellow.

Total Nursing Care Hours per Patient Day and RN Hours per Patient Day

Important Notes:

Note 1: If a hospital operates single acuity Medical, Surgical, or Med-Surg units, but all of these units had fewer than 15 patient days per month for all 3 months of any quarter of the reporting period, then the hospital should respond "yes, but had fewer than 15 patient days per month for all 3 months of any quarter of the reporting period" in questions #4, #6 and #8, and then report on mixed acuity Medical, Surgical and Med-Surg units, if applicable, in questions #10-12.

Note 2: Hospitals that operate at least one single acuity Medical, Surgical, or Med-Surg unit **AND** at least one mixed acuity Medical, Surgical, or Med-Surg Unit have the option to respond to question #13 to report on their mixed acuity units. Responses to these questions are optional and will not be scored or publicly reported.

1) 12-month reporting period used:	○ 01/01/2025 – 12/31/2025 ○ 07/01/2025 – 06/30/2026
2) Did your hospital calculate total number of patient days, total number of productive hours worked by employed and contracted nursing staff with direct patient care responsibilities (RN, LPN/LVN, and UAP), and total number of productive hours worked by RN nursing staff with direct patient care responsibilities for the reporting period in single or mixed acuity Medical, Surgical, and/or Med-Surg Units, and do you choose to report those data to this Survey? *If "no" to question #2, skip questions #3-16 and continue to question #17. The hospital will be scored as "Did Not Measure."* *If "does not apply; hospital does not operate applicable units," skip questions #3-16 and continue to question #17. The hospital will be scored as "Does Not Apply."*	○ Yes ○ No ○ Does not apply; hospital does not operate applicable units
3) Which method did your hospital use to calculate the total number of patient days for each single acuity Medical, Surgical, Med-Surg or mixed acuity Medical, Surgical or Med-Surg Unit?	○ Midnight census (including observation patients) ○ Midnight census and patient days from actual hours for short stay patients ○ Patient days from actual hours ○ Patient days from multiple census reports

4) Does your hospital operate any adult or pediatric single acuity Medical Units? *A single acuity unit is defined as a unit where at least 90% of the patients receive the same level of care.* *If "no" or "yes, but had fewer than 15 patient days per month for all 3 months of any quarter of the reporting period" to question #4, skip question #5 and continue to question #6.*	○ Yes ○ No ○ Yes, but had fewer than 15 patient days per month for all 3 months of any quarter of the reporting period

5) Enter your hospital's responses for each quarter for all adult and pediatric single acuity Medical Units for the reporting period selected in question #1:

	(a) Total number of patient days:	**(b)** Total number of productive hours worked by employed and contracted **nursing staff (RN, LPN/LVN, and UAP)** with direct patient care responsibilities:	**(c)** Total number of productive hours worked by **RN nursing staff** with direct patient care responsibilities:
Quarter 1			
Quarter 2			
Quarter 3			
Quarter 4			

6) Does your hospital operate any adult or pediatric single acuity Surgical Units? *A single acuity unit is defined as a unit where at least 90% of the patients receive the same level of care.* *If "no" or "yes, but had fewer than 15 patient days per month for all 3 months of any quarter of the reporting period," skip question #7 and continue to question #8.*	○ Yes ○ No ○ Yes, but had fewer than 15 patient days per month for all 3 months of any quarter of the reporting period

7) Enter your hospital's responses for each quarter for all adult and pediatric single acuity Surgical Units for the reporting period selected in question #1:

	(a) Total number of patient days:	**(b)** Total number of productive hours worked by employed and contracted **nursing staff (RN, LPN/LVN, and UAP)** with direct patient care responsibilities:	**(c)** Total number of productive hours worked by **RN nursing staff** with direct patient care responsibilities:
Quarter 1			
Quarter 2			
Quarter 3			
Quarter 4			

8) Does your hospital operate any adult or pediatric single acuity Med-Surg Units? *A single acuity unit is defined as a unit where at least 90% of the patients receive the same level of care.* *If "no" or "yes, but had fewer than 15 patient days per month for all 3 months of any quarter of the reporting period," skip question #9 and continue to question #10.*	○ Yes ○ No ○ Yes, but had fewer than 15 patient days per month for all 3 months of any quarter of the reporting period

9) Enter your hospital's responses for each quarter for all adult and pediatric single acuity Med-Surg Units for the reporting period selected in question #1:

	(a) Total number of patient days:	**(b)** Total number of productive hours worked by employed and contracted **nursing staff (RN, LPN/LVN, and UAP)** with direct patient care responsibilities:	**(c)** Total number of productive hours worked by **RN nursing staff** with direct patient care responsibilities:
Quarter 1			
Quarter 2			
Quarter 3			
Quarter 4			

10) Does your hospital operate at least one adult or pediatric mixed acuity Medical, Surgical or Med-Surg Unit? *A mixed acuity unit is defined as a unit where more than 10% of patients receive varying levels of care.* *If "no" or "yes, but had fewer than 15 patient days per month for all 3 months of any quarter of the reporting period," skip questions #11-13.*	○ Yes ○ No ○ Yes, but had fewer than 15 patient days per month for all 3 months of any quarter of the reporting period

If "yes, but had fewer than 15 patient days per month for all 3 months of any quarter of the reporting period" to questions #4, #6, and #8 and "yes" to question #10, continue to questions #11-12 and report on your mixed acuity unit(s).

Hospitals that operate both single and mixed acuity units can optionally report on their mixed acuity units in question #14.

11) What type(s) of adult or pediatric mixed acuity Medical, Surgical, or Med-Surg Units does your hospital operate? *Select all that apply.* *A High Acuity Unit is a mixed acuity unit in which 50-89% of the patients are critical care **and** the remaining 11-49% can be any other acuity level.*	☐ High Acuity ☐ Moderate Acuity ☐ Blended Acuity

*A Moderate Acuity Unit is a mixed acuity unit in which 25-49% of the patients are critical care **OR** 50-89% of the patients are step down care. The remaining percentage can be any other acuity level.* *A Blended Acuity Unit is a mixed acuity acute care unit in which less than 90% of the patients receive a single acuity level of care, less than 50% receive step down care, **and** less than 25% receive critical care.*	

12) Enter your hospital's responses for each quarter for all adult and pediatric mixed acuity Medical, Surgical, and Med-Surg Units for the reporting period selected in question #1:

	(a) Total number of patient days:	**(b)** Total number of productive hours worked by employed and contracted **nursing staff (RN, LPN/LVN, and UAP)** with direct patient care responsibilities:	**(c)** Total number of productive hours worked by **RN nursing staff** with direct patient care responsibilities:
Quarter 1			
Quarter 2			
Quarter 3			
Quarter 4			

Additional Questions (Optional – Fact-Finding Only)

13) Does your hospital currently utilize virtual nursing to perform direct patient care responsibilities in the units from questions 4-13?	○ Yes ○ No

*Hospitals that operate Adult or Pediatric **Single** Acuity Medical, Surgical, or Med-Surg Units will be scored and publicly reported based on questions #4, #6, and/or #8.*

Reporting on Mixed Acuity units in question #14 is optional and will not be scored or publicly reported in 2026; however, responses will be used to inform potential updates for 2027.

14) Enter your hospital's responses for each quarter for all adult and pediatric mixed acuity Medical, Surgical, and Med-Surg Units for the reporting period selected in question #1:

	(a) Total number of patient days:	**(b)** Total number of productive hours worked by employed and contracted **nursing staff (RN, LPN/LVN, and UAP)** with direct patient care responsibilities:	**(c)** Total number of productive hours worked by **RN nursing staff** with direct patient care responsibilities:
Quarter 1			
Quarter 2			
Quarter 3			
Quarter 4			

NQF Safe Practice #9 – Nursing Workforce

15) Is your hospital currently recognized as an American Nurses Credentialing Center (ANCC) Magnet® organization or a 2020 or 2024 Pathway to Excellence® organization? *If "yes, our hospital is a current American Nurses Credentialing Center (ANCC) Magnet® organization" or "yes, our hospital is a 2020 or 2024 Pathway to Excellence® organization," skip question #16, and continue to question #17.* *Pathway to Excellence® hospitals that have not received either the 2020 or 2024 designation must select "no."*	○ Yes, our hospital is a current American Nurses Credentialing Center (ANCC) Magnet® organization ○ Yes, our hospital is a 2020 or 2024 Pathway to Excellence® organization ○ No
16) Within the last 12 months, to ensure adequate and competent nursing staff service and nursing leadership at all levels, our organization has:	
a. held nursing leadership directly accountable for improvements in performance through performance reviews or compensation.	○ Yes ○ No
b. included nursing leadership as part of the hospital senior administrative leadership team.	○ Yes ○ No
c. held the board (governance) and senior administrative leadership accountable for the provision of financial resources to ensure adequate nurse staffing levels.	○ Yes ○ No
d. budgeted financial resources for balancing staffing levels and skill levels to improve performance.	○ Yes ○ No
e. developed a staffing plan, with input from nurses, to ensure that adequate nursing staff-to-patient ratios are achieved.	○ Yes ○ No

Percentage of RNs who are BSN-Prepared

17) Did your hospital calculate the Percentage of RNs who are BSN-Prepared measure for the reporting period, and do you choose to report those data to this Survey? *If "no" to question #17, skip the remaining questions in Section 5C and go to the Affirmation of Accuracy. The hospital will be scored as "Did Not Measure."*	○ Yes ○ No
18) Total number of employed RN nursing staff at the hospital with direct patient care responsibilities:	_____

19) Total number of employed RN nursing staff at the hospital with direct patient care responsibilities who have a BSN degree or higher (e.g., MSN, DNP, PhD):	_____

Section 5C: Nursing Workforce – FAQ for 2026

1. What is the definition of virtual nursing?

Virtual nursing is defined using the American Nursing Association (ANA)'s definition: leveraging remote technology and tools to provide safe and quality patient care through application of the nursing process by emphasizing communication, compassion, and collaboration throughout the continuum of care.

Leapfrog is specifically asking if virtual nurses are used to perform direct patient care responsibilities, which are defined as patient centered nursing activities by hospital unit-based staff in the presence of the patient and activities that occur away from the patient that are patient related:

- Medication administration
- Nursing treatments
- Nursing rounds
- Admission, transfer, discharge activities
- Patient teaching
- Patient communication
- Coordination of patient care
- Documentation time
- Treatment planning
- Patient screening (e.g., fall risk) and assessment

APPENDIX XI: DIAGNOSTIC EXCELLENCE QUESTIONS

Updates highlighted in yellow.

Convening a Multidisciplinary Team Focused on Diagnostic Excellence

1) Does your hospital have a multidisciplinary team that meets all the following requirements: • Focused on reducing harm to patients from errors in the diagnostic process; • 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 • Reports to the Board annually; and • Includes at least one patient and/or care partner? *The multidisciplinary team can be the established hospital-wide safety and quality committee if the committee has a dedicated agenda item at least quarterly to review efforts focused on reducing harm to patients from errors in the diagnostic process.* *If "no" to question #1, skip questions #2-5 and continue to question #6.*	○ Yes ○ No ○ Yes, but our multidisciplinary team does not yet include a patient and/or care partner
2) As a standing agenda item of at least quarterly 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 the diagnostic process?	○ Yes ○ No
3) In the past 24 months, has the multidisciplinary team convened the emergency medicine staff to develop or implement any initiatives aimed at improving accurate and timely diagnosis of commonly misdiagnosed conditions?	○ Yes ○ No ○ No, but the emergency medicine staff have independently implemented at least one such initiative, and presented their initiative to the multidisciplinary team

4) In the past 24 months, has the multidisciplinary team convened 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, and presented their protocol to the multidisciplinary team
5) 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 the diagnostic process via the hospital's incident or event reporting system?	○ Yes ○ No
6) 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 "Yes, but all practices are currently fully implemented," or "no" to question #6, skip question #7 and continue to question #8.*	○ Yes, led by our multidisciplinary team ○ Yes, led by a different team at the hospital ○ Yes, but all practices are currently fully implemented ○ No
7) What steps has your hospital taken to implement one or more practices listed in the Safer Dx Checklist? *Select all that apply.*	☐ Allocated budget ☐ Appointed an individual or team responsible for implementation ☐ Set a date for full implementation ☐ None of the above

Training on Communication to Reduce Errors in the Diagnostic Process

8) 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 the diagnostic process?	○ Yes ○ No

Section 6D: Diagnostic Excellence – Updated FAQs for 2026

1. **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 can be convened at the system level. However, each meeting must include specific discussion of each individual hospital in the system, in order to closely **oversee** case analyses, review data specific to individual sites, and be responsive to the individual hospital's leadership.

2. **As our hospital reviews clinical or administrative data, patient experience or patient reported data, or incident reports to identify or track errors in the diagnostic process, as described in question #2, what specific methodology should be used to conduct a root cause analysis of these errors in the diagnostic process?**
   Together with a team of leading experts, Leapfrog has published Root Cause Analysis of Cases Involving Diagnosis: A Handbook for Healthcare Organizations. This resource offers authoritative guidance on how to modify existing approaches to conducting a RCA to study cases involving diagnosis. Guidance covers the process for finding cases of diagnostic error and how to convene an RCA team, map problems with the diagnostic process, use fishbone diagrams to consider possible domains of causes, and select appropriate interventions.

   The Agency for Healthcare Research and Quality has also published Measure Dx: A Resource to Identify, Analyze, and Learn from Diagnostic Safety Events, that can be further leveraged as resource. The toolkit is open access, and includes strategies and resources (e.g. infographics, checklists, case review tools) that can be used to set a baseline for implementation, conduct a self-assessment, implement strategies, and reviewing and analyzing case data to identify actionable insights to improve patient safety and reduce diagnostic errors.

3. **As our hospital pursues initiatives aimed at reducing harm to patients from errors in the diagnostic process, how can patients and/or care partners be engaged in that effort?**
   In addition to including a patient and/or care partner on the multidisciplinary team focused on reducing harm to patients from errors in the diagnostic process, hospitals can work with their PFACs to reduce errors in the diagnostic process. Leapfrog has created a Patient and Family Advisory Council (PFAC) Toolkit for Exploring Diagnostic Quality, which offers specific guidance for hospitals and PFAC members who look to partner in designing and deploying initiatives to push for diagnostic safety. This web-based tool includes overall introductions to patient and family engagement and convening a PFAC, detailed information and educational materials on the diagnostic process aimed at a lay audience, and specific examples of model PFAC initiatives focused on diagnostic safety and quality.

APPENDIX XII: HOSPITAL BOARDING IN THE EMERGENCY DEPARTMENT (ED) QUESTIONS AND FAQS

Section 6E: Hospital Boarding in the Emergency Department (ED) – Questions for 2026 (Optional – Fact-Finding Only)

Updates highlighted in yellow.

1) 12-month reporting period used:	○ 01/01/2025 – 12/31/2025 ○ 07/01/2025 – 06/30/2026
2) Did your hospital operate a dedicated emergency department (ED) during the reporting period? *If "no" or "yes, but ED is now closed or wasn't open for the entire reporting period," skip questions #3-5 and go to the Affirmation of Accuracy.*	○ Yes ○ No ○ Yes, but ED is now closed or wasn't open for the entire reporting period
3) What type(s) of dedicated emergency department(s) did your hospital operate? *Select all that apply.*	☐ Adult only ☐ Pediatric only ☐ Adult/Pediatric combined

If "Adult only" or "Adult/Pediatric combined" to question #3, answer question #4 based on the patients admitted to adult inpatient non-psychiatric and psychiatric beds (including ED visits where the patient was placed in hospital observation status).

4) Enter your hospital's total number of emergency department (ED) visits with an admission to an adult inpatient non-psychiatric or psychiatric bed (including ED visits where the patient was placed in hospital observation status) in column (a), the number of those ED visits indicated in column (a) with a boarding time greater than 4 hours, the total boarding time (in hours) for ED visits indicated in column (a), the median number of hours spent in the ED for ED visits indicated in column (a), and the 90th percentile of hours spent in the ED for ED visits indicated in column (a).

If the number of visits for an adult admission type is less than 10 (in column a), skip columns b, c, d, and e and then move to the next admission type.

For columns c, d, and e, enter hours and minutes up to one decimal place (e.g., enter 1.5 to denote 1 hour and 30 minutes).

Admission Type	ED Visits, Boarding Time, and Time Spent in the ED				
	(a) Total number of ED visits with an inpatient admission or where the patient was placed in hospital observation status	**(b) Number of ED visits indicated in column (a) with a boarding time greater than 4 hours**	**(c) Total boarding time (in hours) for ED visits indicated in column (a)**	**(d) Median number of hours spent in the ED for ED visits indicated in column (a)**	**(e) 90th percentile of hours spent in the ED for ED visits indicated in column (a)**

Admitted to an adult inpatient **non-psychiatric bed**					
Admitted to an adult inpatient **psychiatric bed**					

If "Pediatric only" or "Adult/Pediatric combined" to question #3, answer question #5 based on the patients admitted to pediatric inpatient non-psychiatric and psychiatric beds (including ED visits where the patient was placed in hospital observation status).

5) Enter your hospital's total number of emergency department (ED) visits with an admission to a pediatric inpatient non-psychiatric or psychiatric bed (including ED visits where the patient was placed in hospital observation status) in column (a), the number of those ED visits indicated in column (a) with a boarding time greater than 4 hours, the total boarding time (in hours) for ED visits indicated in column (a), the median number of hours spent in the ED for ED visits indicated in column (a), and the 90th percentile of hours spent in the ED for ED visits indicated in column (a).

If the number of visits for an adult admission type is less than 10 (in column a), skip columns b, c, d, and e and then move to the next admission type.

For columns c, d, and e, enter hours and minutes up to one decimal place (e.g., enter 1.5 to denote 1 hour and 30 minutes).

Admission Type	**ED Visits, Boarding Time, and Time Spent in the ED**				
	(a) Total number of ED visits with an inpatient admission or where the patient was placed in hospital observation status	**(b) Number of ED visits indicated in column (a) with a boarding time greater than 4 hours**	**(c) Total boarding time (in hours) for ED visits indicated in column (a)**	**(d) Median number of hours spent in the ED for ED visits indicated in column (a)**	**(e) 90th percentile of hours spent in the ED for ED visits indicated in column (a)**
Admitted to a pediatric inpatient **non-psychiatric bed**					
Admitted to a pediatric inpatient **psychiatric bed**					

Section 6E: Hospital Boarding in the Emergency Department (ED) – FAQs for 2026

1. **Can facilities use patient sampling to report data for Section 6E?**
   No, hospitals are required to report on all applicable ED visits and cannot report using a sample.

2. **How should a co-located pediatric hospital within an adult hospital, sharing a single ED that treats both adult and pediatric patients, respond to this section?**

Hospitals should report on operating a pediatric emergency department in question #3 and then respond to question #5, where hospitals report on ED visits with an admission to a pediatric inpatient non-psychiatric or psychiatric bed (including ED visits where the patient was placed in hospital observation status).

3. **How should boarding time be calculated for ED patients who are admitted to the hospital but transferred from the ED to the cardiac catheterization lab or another diagnostic or procedural area before being transferred to the inpatient unit?**
   Boarding time is calculated using the final departure time from the ED. If a patient leaves the ED for a test, treatment, or procedure, but then returns to the ED prior to being transferred to the inpatient bed, boarding time will continue and include the time spent in the test, treatment, or procedural area.

4. **How should boarding time be calculated for ED patients who are admitted to the hospital but transferred from the ED to an operating room for a surgical procedure before being transferred to the inpatient unit?**
   Boarding time is calculated using the final departure time from the ED. If a patient leaves the ED for a surgical procedure, boarding time will end when they are transferred to the operating room if they do not return to the ED.

APPENDIX XIII: HEALTHCARE-ASSOCIATED INFECTIONS REPORTING PERIODS AND DEADLINES

NHSN Download Date	NHSN Baseline	HAI Reporting Period	Leapfrog Survey Submission Date	Verify Results
Hospitals must be in the Leapfrog NHSN group before this date	*Hospitals should download reports with this baseline on the NHSN Download Date*	*Hospitals should download reports with this reporting period on the NHSN Download Date*	*HAI data will not be publicly reported if hospitals have not submitted and provided a valid NHSN ID by this date*	*Data pulled by Leapfrog will be available to review on the Hospital Details Page or Public Reporting Website by these dates*
June 22, 2026	**2015 Baseline**	01/01/2025 – 12/31/2025	June 30, 2026	July 12, 2026**
Aug 20, 2026	**2015 Baseline**	01/01/2025 – 12/31/2025	Aug 31, 2026	Sep 10, 2026
Oct 22, 2026	**2022 Baseline***	07/01/2025 – 06/30/2026	Oct 31, 2026	Nov 10, 2026
Dec 17, 2026***	**2022 Baseline***	07/01/2025 – 06/30/2026	Nov 30, 2026	Jan 12, 2027

*If CMS does not use the 2022 Baseline for the HAI data published in the October 2026 update to Care Compare, then Leapfrog will continue to use the 2015 Baseline for the NHSN Download Date.

**Data will be published on the Public Reporting Website starting on July 25, 2026.

***The Leapfrog Hospital Survey closes on November 30, 2026. The last NHSN data download is on December 17, 2026, to incorporate any facilities and corrections from facilities that joined prior to this last download date.

APPENDIX XIV: CMS MEASURES REPORTING PERIODS AND DEADLINES AND FAQS

Section 9F: CMS Measures – Reporting Periods and Deadlines for 2026: OP-32 Rate of Unplanned Hospital Visits After an Outpatient Colonoscopy and OAS CAHPS Top Box Scores

CMS Download Date	CMS Reporting Period	Review Results
Leapfrog will download the dataset from the CMS Provider Data Catalog on these dates	*These reporting periods are subject to CMS data availability on the download date and may change.*	*Data pulled by Leapfrog will be available to review on the Hospital Details Page or Public Reporting Website by these dates*
June 30, 2026	OP-32: 1/1/2022 - 12/31/2024 OAS CAHPS: 7/1/2024 - 6/30/2025	July 12, 2026*
August 31, 2026	OP-32: 1/1/2022 - 12/31/2024 OAS CAHPS: 10/1/2024 - 9/30/2025	September 10, 2026
November 30, 2026*	OP-32: 1/1/2022 - 12/31/2024 OAS CAHPS: 1/1/2025 - 12/31/2025	December 9, 2026

*Data will be published to the Public Reporting Website starting on July 25, 2026.

Section 9F: CMS Measures – FAQs for 2026

1. **We share a CMS Certification Number (CCN) with another hospital that participates in the OAS CAHPS Survey. How can we report on results from the OAS CAHPS Survey that are specific to our outpatient department?**
   Since OAS CAHPS data is now pulled on behalf of hospitals using CCNs, Leapfrog can no longer report OAS CAHPS data by individual facilities when CCNs are shared. Leapfrog has cautioned against hospitals located on separate campuses sharing CCNs since results will be aggregated and publicly reported on information tools, such as CMS Care Compare and the Leapfrog Hospital Safety Grade. While Leapfrog is committed to making differences among facilities known to patients and their families, Leapfrog made this change to minimize administrative burden associated with completing the Survey.

2. **Why does Leapfrog not publicly report the "Preparations for Discharge and Recovery" OAS CAHPS domain for hospitals?**
   Leapfrog plans to publicly report the "Preparations for Discharge and Recovery" OAS CAHPS domain for both ASCs and hospitals in future Surveys. The scores for this domain are not expected to be publicly available for ASCs until late 2026, and Leapfrog aligns with the public reporting of OAS CAHPS measures for both HOPDs and ASCs.

END OF DOCUMENT