



PROPOSED CHANGES TO THE 2026 LEAPFROG HOSPITAL SURVEY

OPEN FOR PUBLIC COMMENT Comments Accepted until midnight ET on December 18, 2025

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

The proposed changes to the 2026 Leapfrog Hospital Survey are outlined below. To provide a public comment, please respond by completing the public comment form [here](#). Comments will be accepted until midnight ET on **December 18, 2025**.

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

- [Section 1A: Basic Hospital Information](#): Proposal to add two fact-finding questions on the use of the National Association for Healthcare Quality's (NAHQ) Certified Professional in Healthcare Quality (CPHQ) certification for staff.
- [Section 1B: Billing Ethics](#): Proposal to require reporting of presumptive eligibility and financial assistance programs for patients; no scoring or public reporting.
- [Section 1C: Health Care Equity](#): Request for information on the Office of Management and Budget standards for maintaining, collecting and presenting data on race and ethnicity.
- [Section 3A: Hospital and Surgeon Volume](#): Proposal to add a new optional, fact-finding question to assess if the hospital has surgeons that perform both total knee and total hip replacement procedures.
- [Section 4A: Maternity Care Volume and Services](#): Request for information on the collection of data and calculation of rates for vaginal births after cesarean section (VBACs) for inclusion in the 2027 Leapfrog Hospital Survey.
- [Section 5C: Nursing Workforce](#): Proposal to no longer publicly report Nursing Skill Mix and include a new optional, fact-finding question to assess the use of virtual nursing.
- [6A NQF Safe Practice #1 – Culture of Safety Leadership Structures and Systems](#): Request for information on approaches to strengthen the participation of patients and/or care partners on hospital-wide safety and quality committees.
- [Section 6C: Hand Hygiene](#): Discussion of a request from the Association for Professionals in Infection Control and Epidemiology's (APIC) that Leapfrog considers changes to the Leapfrog hand hygiene standard, specifically regarding the monitoring of hand hygiene opportunities, and a request for public comment on strengthening all elements of the Hand Hygiene standard.
- [Section 6D: Diagnostic Excellence](#): Proposal to require reporting of the Diagnostic Excellence questions and the removal of several questions to focus quality improvement efforts on the most effective practices to reduce diagnostic errors. The subsection will not be scored or publicly reported in 2026.



- [Section 6E: Emergency Department \(ED\) Boarding](#): Proposal to refine the existing questions to also include reporting of the total boarding time for all ED visits with an inpatient admission or where the patient was placed in hospital observation status and clarifying that the stratification by patient age is based on the type of bed the patient is waiting to be admitted to. This subsection will remain optional and will not be scored or publicly reported in 2026.
- [Section 9C: Volume of Procedures](#): Proposal to allow hospitals to optionally report their outpatient procedure volumes.
- [Section 9F: CMS Measures](#): Proposal to rename Section 9F, obtain OAS CAHPS results directly from the CMS Provider Data Catalog, and reorganize the section to include CMS OP-32: Rate of Unplanned Hospital Visits After An Outpatient Colonoscopy, previously included in Section 9D.

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

For information on the 2025 Leapfrog Hospital Survey, visit www.leapfroggroup.org/survey.

DEADLINES AND REPORTING PERIODS FOR 2026

Review the 2026 Leapfrog Hospital Survey deadlines and anticipated reporting periods in [Appendix I](#) and [II](#).

PROPOSED CONTENT CHANGES

HOSPITAL PROFILE

There are no proposed changes to the Hospital Profile.

SECTION 1: PATIENT RIGHTS AND ETHICS

SECTION 1A: BASIC HOSPITAL INFORMATION

Leapfrog will update and add 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 will also update 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 be reporting on these questions.

In addition, Leapfrog will remove 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.



Lastly, Leapfrog will add two fact-finding questions asking hospitals to report on their use of the [National Association for Healthcare Quality's \(NAHQ\) Certified Professional in Healthcare Quality \(CPHQ\)](#) certification for their employed staff. The CPHQ program is the only accredited certification program in healthcare quality. It is designed to validate knowledge and competency against the industry-standard for delivering excellence in healthcare quality and safety. These fact-finding questions will be optional and will not be used in scoring or public reporting in 2026.

The proposed updated questions are available in [Appendix III](#).

SECTION 1B: BILLING ETHICS

In response to feedback from hospitals participating in the Survey and an analysis of Survey responses submitted in 2025, Leapfrog is proposing two updates to Section 1B: Billing Ethics.

First, Leapfrog will update 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 hospitals that are required by state law to transfer unpaid medical bills to the Department of Treasury, similar to federal law requirements for Military Treatment Facilities. We anticipate this updated response option only applying to public hospitals in limited states such as Illinois.

Updates highlighted in **yellow**.

1) Does your hospital take legal action against patients for late payment or insufficient payment of a medical bill? <i>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.</i>	○ Yes ○ No ○ No, but required by state or federal law to transfer delinquent payments to the Department of Treasury for action
---	--

Second, we will retain 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.

There are no proposed changes to the scoring algorithm for Section 1B: Billing Ethics.

SECTION 1C: HEALTH CARE EQUITY

There are no proposed changes to this subsection. However, we are requesting input related to the revised standards for race and ethnicity data collection.

Request for Information

The Leapfrog Group is requesting feedback on the new [Office of Management and Budget standards](#) for maintaining, collecting and presenting data on race and ethnicity. While hospitals are not required to implement these updates to existing record keeping or data collection systems until 2029, we are interested in hearing feedback on the following three items:



- At what point is your hospital at in terms of implementing the new standards (e.g., discussing, planning, implementing, etc.)?
- When do you anticipate using the revised OMB Race and Ethnicity standards at your hospital?
- General thoughts, comments, and reactions to the revised standards.

SECTION 1D: INFORMED CONSENT

Leapfrog will remove question #2, which asks if hospitals solicit feedback from patients/legal guardians about their hospital's informed consent process, as the current resources available to health care organizations to collect this feedback are extremely limited. As this question was neither scored nor publicly reported, there are no proposed changes to the scoring algorithm for Section 1D: Informed Consent.

In addition, Leapfrog is exploring a new FAQ to provide guidance on how to assess the reading level of Spanish-language consent forms. If finalized, the new FAQ will be published in the Summary of Changes in March 2026.

SECTION 2: MEDICATION SAFETY

SECTION 2A: COMPUTERIZED PHYSICIAN ORDER ENTRY (CPOE)

There are no proposed changes to this subsection.

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

Leapfrog will continue to ask questions about Artificial Intelligence (AI) vendors 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 will update the definition of AI provided in the FAQs to provide more clarity:

What is the definition of Artificial Intelligence in Health Care?

Artificial Intelligence (AI) in health care 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, and administrative work. 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.

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.

In addition, the CPOE Tool Instructions are being updated to clarify that the term Medication-Specific Advice/Information refers to general information that applies any time the medication is ordered with the specific



dose, route and frequency. It is not specific to the Test Patient details. Advice or information that appears only because the medication is entered should not be recorded as such.

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 will launch 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 proposed 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 will update 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 will no longer be required and applicable for those hospitals that have met Leapfrog’s standard of 95% compliance with scanning the patient and medication during the administration of medications if this standard is met in all applicable units. As such, the response options for question #21f will be updated as outlined below and hospitals will not report on question #21g if they indicate “no” or “does not apply” to question #21f. The requirements 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 still 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	☐ Yes ☐ No ☐ Does not apply, hospital has achieved 95% BCMA scanning compliance in all applicable units
	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 <i>Cannot respond “yes” to this question, unless “yes” to either 21a, 21d or 21e.</i>	

	<i>If “no” or “does not apply, hospital has achieved 95% BCMA scanning compliance in all applicable units, skip question #21g and continue to question #21h.</i>	
g)	OR 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 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 <i>Cannot respond “yes” to this question, unless “yes” to either 21a, 21d or 21e.</i>	☐ Yes ☐ No

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

SECTION 2D: MEDICATION RECONCILIATION

Leapfrog will update 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, the measure specifications will also be updated to include a flow chart outlining the steps required for data collection.

As a reminder, hospitals can continue to use 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 proposed 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 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 will also add 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:

1) Does your hospital have surgeons that perform both total knee replacement and total hip replacement procedures? <i>This question only applies to hospitals that perform both total knee replacement and total hip replacement procedures.</i>	☐ Yes ☐ No
--	--

This optional, fact-finding question will not be used in scoring or public reporting in 2026. There are no proposed 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 proposed changes to this subsection.

SECTION 4: MATERNITY CARE

Leapfrog will provide updated measure specifications from The Joint Commission for PC-02 Cesarean Birth (Section 4B) for those hospitals that do not already submit data to The Joint Commission and therefore need to retrospectively collect data. We will also continue to accept both data for the chart-abstracted measure (PC-02) and data collected using 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 to use 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 will update 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 will also update 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 in the immediate postpartum period prior to delivery discharge. As a reminder, these questions are used in public reporting but are not scored.

The proposed updated questions and new FAQ are available in [Appendix IV](#).

Request for Information

Leapfrog is requesting information and feedback from hospitals and other interested parties regarding the collection of data and calculation of rates for vaginal births after cesarean section (VBACs) in the 2027 Leapfrog Hospital Survey. Specifically, Leapfrog is interested in using 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. This measure is important to both purchasers and consumers as providing patients with the option of VBAC, when safe and appropriate, can reduce unnecessary cesarean sections and their potential complications, as well as reduce costs.

This measure looks at the number of vaginal births by patients with a previous Cesarean delivery and excludes deliveries with complications such as abnormal presentation, preterm delivery, fetal death, multiple gestation, and breech presentation. The numerator and denominator are defined in the AHRQ [specifications](#) as follows:

- Numerator:
 - Number of vaginal deliveries among discharges meeting the inclusion and exclusion rules for the denominator.
 - Vaginal deliveries are identified by any listed ICD-10-PCS procedure code (see page 3 of AHRQ [specifications](#) for a list of procedure codes).
- Denominator:
 - Discharges with an ICD-10-CM diagnosis code for birth delivery outcome (see page 4 of AHRQ [specifications](#) for a list of Z codes) with any listed ICD-10-CM diagnosis code for previous Cesarean delivery (see page 5 of AHRQ [specifications](#) for a list of diagnosis codes)

The following discharges are excluded from the denominator:

- with any listed ICD-10-CM diagnosis code for abnormal presentation, preterm delivery, fetal death, multiple gestation, or breech presentation (see diagnosis codes provided in [Appendix A](#) of AHRQ specifications)
- with a principal ICD-10-CM diagnosis code assigned to MDC (Major Diagnostic Category) 15 Newborns & Other Neonates with Conditions Originating in Perinatal Period (see diagnosis codes provided in [Appendix B](#) of AHRQ specifications)
- with an ungroupable DRG (DRG=999)
- with missing sex (SEX=missing), age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing) or principal diagnosis (DX1=missing)
- with missing MDC (MDC=missing) when user indicates that MDC is provided

We are interested in understanding if hospitals are currently using and calculating the numerator and denominator for this measure and we are seeking feedback regarding any foreseeable challenges in self-reporting. The goal with collecting this data is to better understand both VBAC access and VBAC success.



While we collect more information, we will remove 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 will continue to include questions on the collection of cesarean birth data (NTSV C-section measure) by race/ethnicity and will ask hospitals to provide numerators and denominators for the NTSV C-section measure for each of the following races/ethnicities, which were also used in 2024 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 will be required but will not be used in scoring or public reporting by hospital on the Survey Results website. Instead, cesarean birth rates stratified by race/ethnicity will continue to be confidentially shared with reporting hospitals on their [Hospital Details Pages](#).

Hospitals participating in the California Maternal Quality Care Collaborative (CMQCC) Maternal Data Center may use the data provided in their CMQCC reports and hospitals reporting to 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 and Leapfrog instructions to retrospectively review all cases and stratify by race/ethnicity.

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

SECTION 4C: EPISIOTOMY

There are no proposed changes to this subsection.

SECTION 4D: PROCESS MEASURES OF QUALITY

Newborn Bilirubin Screening Prior to Discharge

There are no proposed 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 will update 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. As a reminder, the target for this measure is 90%.

The proposed updated measure specifications are available in [Appendix V](#).

There are no proposed 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 will update 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?	○ Yes ○ No ○ Yes, but only on an emergency basis or when a patient is too unstable for safe transfer.
<i>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.”</i>	

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

1. Complete a Data Sharing Authorization letter and submit it to VON by the dates listed in [Appendix VI](#). (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 VI](#).



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

SECTION 5: PHYSICIAN AND NURSE STAFFING

SECTION 5A: ADULT ICU PHYSICIAN STAFFING

There are no proposed changes to this subsection.

SECTION 5B: PEDIATRIC ICU PHYSICIAN STAFFING

There are no proposed changes to this subsection.

SECTION 5C: NURSING WORKFORCE

First, based on hospital feedback and in consultation with our [Nursing Workforce Expert Panel](#), Leapfrog will add a reporting option for hospitals that operate single and mixed acuity medical, surgical and/or med-surg units. Hospitals will continue to ONLY be scored on the **single** acuity unit. However, they can optionally report on their mixed acuity unit(s) and based on an analysis of the data collected in 2026 and anticipated key informant interviews with Survey participants, additional updates to scoring and public reporting may be proposed for 2027. This change is the first step in responding to hospital requests to earn credit for both their staffing of single and mixed acuity units.

In addition, 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 proposed updated questions are available in [Appendix VII](#).

Second, Leapfrog will temporarily pause 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.

Finally, Leapfrog will add 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 proposed question and new FAQ defining virtual nursing is available in [Appendix VII](#).

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 proposed 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

First, in consultation with Leapfrog’s [Patient and Family Caregiver Expert Panel](#), Leapfrog proposes to update 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.

Second, Leapfrog is considering approaches to strengthen the participation of patients and/or care partners on the hospital-wide safety and quality committee. One update under consideration is to require adding an additional patient and/or care partner on the quality and safety committee, for a total of two. The Expert Panel has noted the potential for a second voice to serve as a more effective vehicle for the patient and/or care partner’s perspective on the committee, as well as ensure that at least one patient or care partner is present at every meeting in the event of an unplanned absence. Leapfrog is not proposing this change for the 2026 Leapfrog Hospital Survey but invites public comment on this approach for potential inclusion in the 2027 Leapfrog Hospital Survey. Leapfrog also invites recommendations for other possible approaches to ensure the patient and/or care partner’s presence on the hospital-wide safety and quality committee is active, effective, and meaningful to all stakeholders.

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

There are no proposed changes to this subsection.

SECTION 6C: HAND HYGIENE

There are no proposed changes to this subsection for 2026.

Request for Information

The Leapfrog Group requests comments 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’s (APIC).

The Leapfrog hand hygiene standard consists of five domains:

1. Monitoring
2. Feedback
3. Training and Education
4. Infrastructure
5. Culture

In an August 20, 2025, letter to Leapfrog CEO Leah Binder, Dr. Devin Jopp, CEO of the Association for Professionals in Infection Control and Epidemiology’s (APIC), requested that Leapfrog consider changes to the Leapfrog hand hygiene standard. Specifically, APIC is concerned with a provision in the “Monitoring” domain that requires hospitals to conduct 200 observations per month per unit. APIC points to a new peer-reviewed study suggesting the number of observations could be limited to 50 per unit per month while still providing an accurate



and reliable assessment of performance. APIC also asserts that the Leapfrog standard on the number of observations contradicts the World Health Organization (WHO) Hand Hygiene Self-Assessment Framework.

Leapfrog launched an intensive review of the hand hygiene standard in light of this correspondence. This included updated research on the literature including the referenced [Reese et al 2024 Am J Infect Control study](#), consultation with key experts, an interview with World Health Organization officials, and review by Leapfrog's national [Hand Hygiene Expert Panel](#) and other scientific advisors.

The Leapfrog hand hygiene standard is adapted from the World Health Organization (WHO) Hand Hygiene Self-Assessment Framework, so we investigated the concern expressed by APIC that Leapfrog may have contradicted that Framework. Our experts interviewed WHO Infection Prevention and Control Unit leaders to investigate this issue. According to WHO representatives, the WHO framework aligns with Leapfrog in most respects, including its recommendation for regular data collection over time, and collection of data monthly at the unit-level. However, WHO representatives reinforced that the WHO framework does not specify a recommended number of observations. Thus, WHO agreed that Leapfrog's assignment of a target number does not contradict the WHO framework, because the framework is silent on the issue.

Our experts studied the Reese et al study that the letter from APIC cited. The panel noted the sampling methodology that was used for the study was problematic – to test different sample sizes, the authors pulled subsets of observations from the exact same stratum, where one would expect any differences to be due to random variation. The sampling approach used weakens their conclusion that smaller subsets (50 observations) are equally reliable as largest subsets (100 or 200 observations). A more reliable methodology would build on separate observation periods with differing sample sizes, not portions of the same observation sample.

Several other studies have reached different conclusions on the number of hand hygiene observations that are needed to reliably assess meaningful differences in performance over time. These studies have found that the number of hand hygiene observations needed range from 61 to 783, depending on assumptions of baseline hand hygiene adherence and the desired precision to detect change over time (e.g., a 5% difference, a 10% difference).¹⁻³ The Expert Panel noted that the key issue in setting the target number of observations needed for patient safety is whether the monthly observations are adequate to assess *changes* in compliance over time. This is especially true when observations that are collected manually are typically not independent of each other, but clustered by health care worker, location, and shift - so results from the same cluster are more alike. This clustering approach further erodes statistical reliability about adherence and suggests the need to err on the side of more, not fewer, observations to reliably assess progress over time.

Thus, it remains our conclusion that the evidence and statistical analysis to date support Leapfrog's standard for 200 observations per month per unit. However, we recognize that in practice this level of observation has been challenging for some. As a result of that concern, Leapfrog updated its scoring algorithm in 2022 to allow hospitals to meet Leapfrog's hand hygiene standard with a reduced number of observations, if they fully meet the requirements in the other four domains that are part of the hand hygiene standard. That means a hospital can meet the standard by collecting as few as 100 observations per month per unit, if they also meet the requirements within the domains of feedback, training and education, infrastructure, and culture. For hospitals not meeting some of the domains of the standard, the full 200 observations is critical to ensure transparency and accountability, and reliably monitor progress on improvement.

While a strong majority of hospitals are meeting Leapfrog's Hand Hygiene standard, Leapfrog is not yet persuaded that hand hygiene compliance is where it needs to be. Leapfrog would welcome recommendations on



how Leapfrog can further enhance all five domains of its hand hygiene standard to ensure the safest care possible for our patients.

The Leapfrog Group wishes to thank Devin Jopp and the membership of APIC for ensuring this standard is as strong as possible, and most of all for their ongoing leadership on infection control in U.S. hospitals. Health care acquired infections are trending down nationally, and we look forward to working together to accelerate that important progress.

References:

1. Sax H, Allegranzi B, Chraïti MN, Boyce J, Larson E, Pittet D. The World Health Organization hand hygiene observation method. *Am J Infect Control*. 2009;37(10):827-34.
2. Yin J, Reisinger HS, Vander Weg M, et al. Establishing evidence-based criteria for directly observed hand hygiene compliance monitoring programs: a prospective, multicenter cohort study. *Infect Control Hosp Epidemiol*. 2014;35(9):1163-8.
3. Park SY, Park S, Hwang BS, Lee E, Kim TH, Won S. Appropriate number of observations for determining hand hygiene compliance among healthcare workers. *Antimicrob Resist Infect Control*. 2021;10(1):167.

SECTION 6D: DIAGNOSTIC EXCELLENCE

To better assess overall national performance in this emerging area of patient safety, Leapfrog will require 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 will also remove 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, as well as 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 proposed updated questions are available in [Appendix VIII](#).

The following questions will be removed:

- 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.
- Questions #3 and #4, concerning engaging with Patient and Family Advisory Councils (PFACs) on initiatives aimed at reducing errors in diagnosis.
- 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 will be 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 will update question #7, regarding whether a hospital has convened a multidisciplinary team focused on diagnostic excellence, in two key aspects:

- First, Leapfrog will revise the guidance embedded in the question to read:
"The multidisciplinary team can be the established patient safety committee if the patient safety committee has a dedicated agenda item at least quarterly to review diagnostic excellence initiatives."

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

- Second, Leapfrog will update the wording of question #7 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 will be revised as follows:

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.

Furthermore, Leapfrog will update the response options to indicate that if a different team at the hospital has met the requirements of questions #9, #13, and #15, that team must also present their findings to the multidisciplinary team.

Finally, although Leapfrog proposes to remove 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 will add two new FAQs to Section 6D: Diagnostic Excellence to direct hospitals to these resources:

As our hospital reviews clinical or administrative data, patient experience or patient reported data, or incident reports to identify or track errors in diagnosis, as described in question #2, what specific methodology should be used to conduct a root cause analysis of these errors in diagnosis?

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.



As our hospital pursues initiatives aimed at reducing harm to patients from errors in diagnosis, how can patients and family caregivers be engaged in that effort?

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.

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

In 2025, Leapfrog began expanding hospital reporting to include Emergency Department (ED) safety, recognizing the ED's essential role in patient outcomes. The 2025 Leapfrog Hospital Survey introduced three fact-finding measures on hospital boarding in the ED with the aim of developing future performance standards: 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 proposes several refinements to last year's questions and measure specifications and 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 will update questions #4 and #5 and ask hospitals to additionally report the total boarding time for all ED visits with an inpatient admission or where the patient was placed in hospital observation status.

Second, the measure specifications will be updated for clarity and to support standardized data collection. Specifically, the definitions for boarding time, additional guidance on when that boarding time starts and ends, and guidance for hospitals operating a single general ED that are admitting pediatric patients to the hospital or placing them in observation status, and guidance for hospitals admitting patients to licensed detox beds. Leapfrog will also provide additional information on how to calculate the 90th percentile of hours spent in the ED to clarify that it represents a long boarding time, and an example will be added to the Measure Specifications to help hospitals understand how this calculation should be performed.

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 proposed updated questions and new FAQs are available in [Appendix IX](#).

SECTION 7: MANAGING SERIOUS ERRORS

SECTION 7A: NEVER EVENTS



There are no proposed changes to this subsection.

SECTION 7B: HEALTHCARE-ASSOCIATED INFECTIONS

Leapfrog downloads HAI data from 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 downloading and using 2015 Baseline CMS IPPS Reports in the first two NHSN data downloads (June and August), then 2022 Baseline CMS IPPS Reports 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.

Once the 2022 Baseline CMS IPPS Reports are downloaded by Leapfrog, Leapfrog will reestablish cut-points used for the performance categories in Section 7B: Healthcare-Associated Infections (HAIs). The updated scoring algorithm will be republished to <https://www.leapfroggroup.org/survey-materials/scoring-and-results> and the new HAI data and scoring designations will be reported on Leapfrog's [public reporting website](#) within the first seven (7) business days of the month following the NHSN download.

The deadlines to join Leapfrog's NHSN Group and anticipated use of the 2022 Baseline can be found in [Appendix X](#).

SECTION 8: PEDIATRIC CARE

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

There are no proposed changes to this subsection.

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

There are no proposed changes to this subsection.

SECTION 9: OUTPATIENT PROCEDURES

Leapfrog will rename Section 9F: OAS CAHPS to Section 9F: CMS Measures and will move Patient Follow-up within Section 9D: Safety of Procedures into Section 9F.

SECTION 9A: BASIC OUTPATIENT DEPARTMENT INFORMATION

There are no proposed changes to this subsection.

SECTION 9B: MEDICAL, SURGICAL, AND CLINICAL STAFF



There are no proposed changes to this subsection.

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

Beginning in 2026 Leapfrog will no longer require hospitals to report their outpatient procedure volume. Instead, this section will be 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.

Additionally, we will expand and restructure the surgical specialty questions to include the following:

- General Surgical Procedures
- Integumentary System
- Musculoskeletal System
- Respiratory System
- Cardiovascular System
- Hemic and Lymphatic Systems
- Mediastinum and Diaphragm
- Digestive System
- Urinary System
- Male Genital System
- Female Genital System
- Maternity Care and Delivery
- Endocrine System
- Nervous System
- Eye and Ocular Adnexa
- Auditory System

These updates align with revisions to the Leapfrog Ambulatory Surgery Center (ASC) Survey and allow for better comparison between ASCs and hospital outpatient departments on Leapfrog's [public reporting website](#).

SECTION 9D: SAFETY OF PROCEDURES

Patient Follow-Up

Leapfrog will move 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 XI](#).

Safe Surgery Checklist for Adult and Pediatric Outpatient Procedures

There are no proposed changes to these questions.

SECTION 9E: MEDICATION SAFETY FOR OUTPATIENT PROCEDURES



There are no proposed changes to this subsection.

SECTION 9F: CMS MEASURES

Leapfrog no longer ask 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 will also obtain 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 OP-32 Rate of Unplanned Hospital Visits After An Outpatient Colonoscopy and OAS CAHPS Top Box Scores are available in [Appendix XI](#).



Thank you for your interest in the Leapfrog Hospital Survey. The Leapfrog Group and our experts will consider comments carefully in finalizing the 2026 Leapfrog Hospital Survey. Leapfrog will publish responses to public comments and a summary of changes in March 2026.

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 X 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 Respond" 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.



Date	Deadline
August 31	TOP HOSPITAL DEADLINE: Submission deadline for hospitals to be eligible to receive a Leapfrog Top Hospital Award. Hospitals are encouraged to submit their Survey by June 30 in order to resolve any data entry or reporting errors identified by Leapfrog through its monthly data verification and documentation requests. DATA SNAPSHOT DATE FOR THE FALL 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.
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

Anticipated Reporting Periods for the 2026 Leapfrog Hospital Survey

	Survey Submitted <u>Prior to</u> September 1	Survey (Re)Submitted <u>on or</u> <u>After</u> 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	N/A	N/A
1C Health Care Equity	N/A	N/A
1D Informed Consent	N/A	N/A
2A Computerized Physician Order Entry (CPOE)	Latest 3 months prior to Survey submission	Latest 3 months prior to Survey submission
2B EHR Application Information	N/A	N/A
2C Bar Code Medication Administration (BCMA)	Latest 3 months prior to Survey submission	Latest 3 months prior to Survey submission
2D Medication Reconciliation	Latest 6 months prior to Survey submission	Latest 6 months prior to Survey submission
3A Hospital and Surgeon Volume	Volume: 12 months or 24 months ending 12/31/2025	Volume: 12 months or 24 months ending 06/30/2026
	STS MVR Composite Score: Latest 36-month report	STS MVR Composite Score: Latest 36-month report
3B Safe Surgery Checklist for Adult and Pediatric Complex Surgery	Latest 12 months prior to Survey submission	Latest 12 months prior to Survey submission
4A Maternity Care Volume and Services	12 months ending 12/31/2025	12 months ending 06/30/2026
4B Cesarean Birth	12 months ending 12/31/2025	12 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
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

	Survey Submitted <u>Prior to</u> September 1	Survey (Re)Submitted <u>on or</u> <u>After</u> September 1
Survey Section	Reporting Period	Reporting Period
	Percentage of RNs who are BSN-Prepared: N/A	Percentage of RNs who are BSN-Prepared: N/A
6A NQF Safe Practice #1 – Culture of Safety Leadership Structures and Systems	Latest 12 months prior to Survey submission	Latest 12 months prior to Survey submission
6B NQF Safe Practice #2 – Culture Measurement, Feedback, and Intervention	Latest 12 or 24 months prior to Survey submission (see individual safe practice for specific reporting period)	Latest 12 or 24 months prior to Survey submission (see individual safe practice for specific reporting period)
6C Hand Hygiene	N/A	N/A
6D Diagnostic Excellence	N/A	N/A
6E Hospital Boarding in the Emergency Department (ED)	12 months ending 12/31/2025	12 months ending 06/30/2026
7A Never Events	N/A	N/A
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
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	Safe Surgery Checklist: Latest 12 months prior to Survey submission	Safe Surgery Checklist: 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

Section 1A: Basic Hospital Information – Proposed Questions for 2026

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? <i>If “yes, adult only” to question #6, skip questions #10-14 below.</i> <i>If “yes, pediatric only” to question #6, skip questions #7-9 and #13 below.</i> <i>If “yes, adult and pediatric” to question #6, skip question #13 below.</i> <i>If “no” to question #6, skip questions #7-12 and continue to question #13.</i>	☐ 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? <i>If "no" to question #14, skip question #15 and continue to question #16.</i>	☐ 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?	<i>No response required here. Determined automatically based on NHSN 2025 Patient Safety Component – Annual Hospital Survey.</i>

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



Additional Questions (Optional – Fact-Finding Only)

20)	Does your hospital require employed staff in any role to hold the Certified Professional in Healthcare Quality (CPHQ®) credential?	☐ Yes ☐ No
21)	How many employed staff members at your hospital currently hold the Certified Professional in Healthcare Quality (CPHQ®) credential?	☐ 0 ☐ 1 - 5 ☐ 6 - 10 ☐ 11 - 15 ☐ 16 - 20 ☐ More than 20 ☐ Unknown

APPENDIX IV

Section 4A: Maternity Care Volume and Services – Proposed 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 in the immediate postpartum period before delivery 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 in the immediate postpartum period before delivery 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 – Proposed FAQ for 2026

1. For the purposes of Section 4A question #4, 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 V

Section 4D: Process Measures of Quality – Proposed Measure Specifications for 2026

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 <u>fewer than 30 cases</u> 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 <u>more than 30 cases</u> 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 VI

VON Reporting Periods and Deadlines for 2026

VON Deadline	VON Reporting Period	Leapfrog Survey Submission Date	Review Results
<i>Hospitals must complete and submit their Data Sharing Authorization letter to VON before this date*</i>		<i>VON data will not be publicly reported if hospitals have not submitted by this date</i>	<i>Data received from VON will be available to review on the Hospital Details Page or Public Reporting Website by these dates</i>
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 VII

Section 5C: Nursing Workforce – Proposed Questions for 2026

Updates highlighted in yellow.

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

Important Notes:

Note 1: Hospitals should respond to questions #1-5 and #6-11 if they operate at least one adult or pediatric **single** acuity Medical, Surgical, or Med-Surg unit, defined as a unit where at least 90% of patients in the unit receive the same level of care. If responding to questions #6-11, skip questions #12-13.

Note 2: Hospitals should respond to questions #1-5 and #12-**13** if they:

- operate at least one adult or pediatric **mixed** acuity Medical, Surgical, or Med-Surg Unit, defined as a unit where more than 10% of the patients in the unit receive varying levels of care (e.g., general medical care and progressive care or intensive care), **and either**
 - a. **do not** operate any adult or pediatric **single** acuity Medical, Surgical, or Med-Surg Units, **or**
 - b. operate an adult or pediatric **single** acuity Medical, Surgical, or Med-Surg unit, but it had fewer than 15 patient days per month for all 3 months of any quarter of the reporting period.

Note 3: Single or mixed acuity Medical, Surgical, or Med-Surg Units that had fewer than 15 patient days per month for all 3 months of any quarter of the reporting period should be excluded in questions #6-11 or #12-**13**.

Note 4: Single or mixed acuity Medical, Surgical, or Med-Surg Units that transitioned to an excluded unit type during the reporting period should be excluded in questions #6-11 or #12-**13**. For example, if a single acuity Medical Unit transitioned to an ICU during the reporting period, the unit should be excluded when responding to questions #6-11.

Note 5: Hospitals that operate at least one adult or pediatric 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 questions #14-15 to report on their mixed acuity units. Responses to these questions are optional (for fact-finding only) 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) Does your hospital operate at least one adult or pediatric single acuity Medical, Surgical, or Med-Surg Unit? <i>A single acuity unit is defined as a unit where at least 90% of the patients receive the same level of care.</i>	☐ Yes ☐ No ☐ Yes, but had fewer than 15 patient days per month for all 3 months of any quarter of the reporting period

3) Does your hospital operate at least one adult or pediatric mixed acuity Medical, Surgical or Med-Surg Unit? <i>A mixed acuity unit is defined as a unit where more than 10% of patients receive varying levels of care.</i> <i>If “no” to questions #2 and #3, skip questions #4-17 and continue to question #18. The hospital will be scored as “Does Not Apply.”</i> <i>If “yes, but had fewer than 15 patient days per month for all 3 months of any quarter of the reporting period” to questions #2 and #3, skip questions #4-17 and continue to question #18. The hospital will be scored as “Unable to Calculator Score.”</i> <i>If “yes, but had fewer than 15 patient days per month for all 3 months of any quarter of the reporting period” to question #2 and “no” to question #3, skip questions #4-17 and continue to question #18. The hospital will be scored as “Unable to Calculate Score.”</i> <i>If “no” to question #2 and “yes, but had fewer than 15 patient days per month for all 3 months of any quarter of the reporting period” to question #3, skip questions #4-17 and continue to question #18. The hospital will be scored as “Unable to Calculator Score.”</i>	○ Yes ○ No ○ Yes, but had fewer than 15 patient days per month for all 3 months of any quarter of the reporting period
4) 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, and do you choose to report those data to this Survey? <i>If “no” to question #4, skip questions #5-17 and continue to question #18. The hospital will be scored as “Did Not Measure.”</i>	○ Yes ○ No
5) 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



If your hospital operates single acuity units, continue to question #6. If your hospital only operates mixed acuity units, skip questions #6-11, and continue to question #12. If your hospital operates both single acuity units and mixed acuity units, continue to questions #6-11 and optionally complete questions #14 and #15.

For Hospitals that Operate At Least One Adult or Pediatric Single Acuity Medical, Surgical, or Med-Surg Unit

6) Does your hospital operate any adult or pediatric single acuity Medical Units? <i>A single acuity unit is defined as a unit where at least 90% of the patients receive the same level of care.</i> <i>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 #6, skip question #7 and continue to question #8.</i>	☐ 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 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			

8) Does your hospital operate any adult or pediatric single acuity Surgical Units? <i>A single acuity unit is defined as a unit where at least 90% of the patients receive the same level of care.</i> <i>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 #8, skip question #9 and continue to question #10.</i>	☐ 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 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	(c) Total number of productive hours worked by RN nursing

		contracted nursing staff (RN, LPN/LVN, and UAP) with direct patient care responsibilities:	staff with direct patient care responsibilities:
Quarter 1			
Quarter 2			
Quarter 3			
Quarter 4			

10) Does your hospital operate any adult or pediatric single acuity Med-Surg Units? <i>A single acuity unit is defined as a unit where at least 90% of the patients receive the same level of care.</i> <i>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 #10, skip questions #11-13 and continue to question #14.</i> <i>If “yes, but had fewer than 15 patient days per month for all 3 months of any quarter of the reporting period” to questions #6, #8, and #10, go back to question #2 and respond “Yes, but had fewer than 15 patient days per month for all 3 months of any quarter of the reporting period.”</i>	☐ Yes ☐ No ☐ Yes, but had fewer than 15 patient days per month for all 3 months of any quarter of the reporting period
--	--

11) 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			

For Hospitals that ONLY Operate Adult or Pediatric Mixed Acuity Medical, Surgical, or Med-Surg Units

12) What type(s) of adult or pediatric mixed acuity Medical, Surgical, or Med-Surg Units does your hospital operate?	☐ High Acuity ☐ Moderate Acuity ☐ Blended Acuity
---	---

Select all that apply. A <u>High Acuity Unit</u> 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. A <u>Moderate Acuity Unit</u> 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 <u>Blended Acuity Unit</u> 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.	
---	--

13) 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)

For Hospitals that Operate Adult or Pediatric Single Acuity Medical, Surgical, or Med-Surg Units AND Mixed Acuity Medical, Surgical, or Med-Surg Units

14) What type(s) of adult or pediatric mixed acuity Medical, Surgical, or Med-Surg Units does your hospital operate? Select all that apply. A <u>High Acuity Unit</u> 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. A <u>Moderate Acuity Unit</u> is a mixed acuity unit in which 25-49% of the patients are critical care OR 50-89% of the patients are	☐ High Acuity ☐ Moderate Acuity ☐ Blended Acuity
---	--

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.	
--	--

15) 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

16) Is your hospital currently recognized as an American Nurses Credentialing Center (ANCC) Magnet® organization or a 2020 or 2024 Pathway to Excellence® organization? <i>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 #17, and continue to question #18.</i> <i>Pathway to Excellence® hospitals that have not received either the 2020 or 2024 designation must select “no.”</i>	○ 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
17) 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

18) 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? <i>If “no” to question #18, skip questions #19-20 and continue to the next subsection. The hospital will be scored as “Did Not Measure.”</i>	☐ Yes ☐ No
19) Total number of employed RN nursing staff at the hospital with direct patient care responsibilities:	_____
20) 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):	_____

Additional Question (Optional – Fact-Finding Only)

21) Does your hospital currently engage in virtual nursing?	☐ Yes ☐ No
---	---

Section 5C: Nursing Workforce – Proposed 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.

APPENDIX VIII

Section 6D: Diagnostic Excellence – Proposed Questions for 2026

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 diagnosis; • Sponsored by either the CEO or CMO; • Includes, at a minimum, representatives from nursing, pharmacy, laboratory medicine, radiology, pathology, hospital medicine or inpatient care specialists, emergency medicine, and quality or risk management; • Meets at least quarterly; • Reports to senior leaders quarterly; and • Reports to the Board annually? The multidisciplinary team can be the established patient safety committee if the patient safety committee has a dedicated agenda item at least quarterly to review diagnostic excellence initiatives. If “no” to question #1, skip the remaining questions in Section 6D, and continue to Section 6E.	☐ Yes ☐ No
2) As a standing agenda item of regular meetings, has the multidisciplinary team reviewed any clinical or administrative data, patient experience or patient reported data, or incident reports to identify or track errors in diagnosis?	☐ Yes ☐ No ☐ No, but a different team at the hospital has reviewed data or incident reports to identify or track errors in diagnosis, and presented their findings to the multidisciplinary team
3) In the past 24 months, has the multidisciplinary team encouraged all staff (verbally or in writing), including all clinicians who participate in the diagnostic process, to report errors in diagnosis via the hospital’s incident or event reporting system?	☐ Yes ☐ No ☐ No, but a different team at the hospital has encouraged all staff to report errors in diagnosis
4) In the past 36 months, has your hospital used the Safer Dx Checklist to identify at least one high-priority practice that is not currently at “Full” implementation? If “no” to question #4, skip question #5 and continue to question #6.	☐ Yes, led by our multidisciplinary team ☐ Yes, led by a different entity at the hospital ☐ No
5) What steps has your hospital taken to fully implement the practice? 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 and Staff Engagement

6) In the past 36 months, has your hospital trained any staff using AHRQ's TeamSTEPPS for Diagnosis Improvement program to improve communication among members of the care team (including nurses, pharmacists, and other allied health professionals), within the context of the diagnostic process or in reducing errors in diagnosis)?	☐ Yes ☐ No
7) 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
8) In the past 24 months, has the multidisciplinary team convened the pathologists and radiologists to develop or implement protocols to ensure timely review and resolution of discrepancies, and timely communication of diagnoses to patients and their families?	☐ Yes ☐ No ☐ No, but radiologists and pathologists independently developed or implemented at least one such protocol, and presented their protocol to the multidisciplinary team

APPENDIX IX

Section 6E: ED Boarding – Proposed 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 – 06/30/202
2) Did your hospital operate a dedicated emergency department (ED) during the reporting period? <i>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.</i>	☐ 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? <i>Select all that apply.</i>	☐ Adult only ☐ Pediatric only ☐ Adult/Pediatric combined

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

4) For adult patients , enter your hospital’s total number of emergency department (ED) visits with an admission to an inpatient non-psychiatric or psychiatric bed (including ED visits where the patient was placed in hospital observation status), the number of those ED visits with a boarding time greater than 4 hours, the total boarding time (hours) spent in the ED for those patients , the median number of hours spent in the ED for those patients, and the 90 th percentile of hours spent in the ED for those patients. <i>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.</i> <i>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).</i>					
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 (hours) spent in the ED for ED visits indicated in column (a)	(d) Median number of <u>hours</u> spent in the ED for ED visits indicated in column (a)	(e) 90 th percentile of <u>hours</u> 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 **pediatric patients** admitted to inpatient non-psychiatric and psychiatric beds (including ED visits where the patient was placed in hospital observation status).

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

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 (hours) spent in the ED for ED visits indicated in column (a)	(d) Median number of <u>hours</u> spent in the ED for ED visits indicated in column (a)	(e) 90 th percentile of <u>hours</u> 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: ED Boarding – Proposed FAQs for 2026

1. How should ED visits be reported for hospitals that admit patients for an elongated psychiatric hold but don’t operate licensed psychiatric beds?

These ED visits should be reported as admitted to a non-psychiatric bed since the hospital does not have any licensed psychiatric beds.



2. How should ED visits be reported for adult patients treated in a pediatric ED or for pediatric patients treated in an adult ED?

ED visits should be reported based on the type of inpatient bed patients are admitted to or placed in, not based on the type of ED where their ED visit occurred. The goal is to measure how long patients wait to be admitted to an inpatient bed or to be placed in hospital observation status. As such, if an ED patient is waiting for an adult inpatient bed (psychiatric or non-psychiatric), include them when reporting on question #4 (adult patients); if an ED patient is waiting for a pediatric inpatient bed (psychiatric or non-psychiatric), include them when reporting on question #5 (pediatric patients).

3. For patients who are medically cleared in the ED before transfer to an inpatient unit, when should the boarding time “start” and “stop”?

The clock should start at the time of the admission order, even if the patient remains under ED observation or is moved to another department while awaiting placement. The final timestamp should reflect the patient’s actual departure to an inpatient bed (or the patient’s final departure from the ED), capturing the total boarding time from the admission decision to inpatient transfer.

4. 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.

APPENDIX X

NHSN Reporting Periods and Deadlines for 2026

NHSN Download Date	NHSN Baseline	HAI Reporting Period	Leapfrog Survey Submission Date	Verify Results
<i>Hospitals must be in the Leapfrog NHSN group before this date</i>	<i>Hospitals should download reports with this baseline on the NHSN Download Date</i>	<i>Hospitals should download reports with this reporting period on the NHSN Download Date</i>	<i>HAI data will not be publicly reported if hospitals have not submitted and provided a valid NHSN ID by this date</i>	<i>Data pulled by Leapfrog will be available to review on the Hospital Details Page or Public Reporting Website by these dates</i>
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 upcoming Care Compare data refresh, then Leapfrog will 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 XI

Section 9F: CMS Measures – Anticipated 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
<i>Leapfrog will download the dataset from the <u>CMS Provider Data Catalog</u> on these dates</i>	<i>These reporting periods are subject to CMS data availability on the download date and may change.</i>	<i>Data pulled by Leapfrog will be available to review on the Hospital Details Page or Public Reporting Website by these dates</i>
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.



****END OF DOCUMENT****