THE LEAPFROG GROUP
Giant Leaps for Patient Safety

SUMMARY OF CHANGES TO THE 2023 LEAPFROG HOSPITAL SURVEY AND RESPONSES TO PUBLIC COMMENTS

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Each year, The Leapfrog Group's research team reviews the literature and convenes expert panels to ensure the Leapfrog Hospital Survey aligns with the latest science and the public reporting needs of purchasers and consumers. Once the list of proposed changes is assembled for the next year's Survey, Leapfrog releases that list for public comment. The public comments received are then reviewed by Leapfrog's research team and used to refine the Survey before it is finalized. The Survey is then pilot tested with a diverse group of hospitals across the country. Following the pilot test, Survey content and scoring are finalized for launch on April 1.

Leapfrog received nearly 200 public comments in response to its proposed changes for the 2023 Leapfrog Hospital Survey. Those comments, as well as the results from the pilot test, were incorporated into the final content and scoring algorithms for the Survey. We have summarized the changes in this document and included responses to public comments.

We offer our sincere gratitude to all commenters for the time and thought they gave to the 2023 Leapfrog Hospital Survey. The submitted comments were invaluable to the development of a high-quality Survey that serves our many constituents, including purchasers and payors, as well as hospitals and the public at large.

The 2023 Leapfrog Hospital Survey will open on April 1 and a PDF of the Survey will be available for download here. Leapfrog has scheduled three Town Hall Calls – hospitals and other stakeholders can register here.

DEADLINES AND REPORTING PERIODS FOR 2023

Review the 2023 Leapfrog Hospital Survey deadlines and reporting periods in Appendix I and II.

SUMMARY OF STRUCTURAL CHANGES FOR 2023

Leapfrog is implementing five structural changes to the 2023 Leapfrog Hospital Survey, including the Online Survey Tool.

First, we are combining survey sections related to medication safety into Section 2: Medication Safety. The updated section now includes the following subsections:

- Section 2A: Computerized Physician Order Entry (CPOE)
- Section 2B: EHR Application Information
- Section 2C: Bar Code Medication Administration (BCMA)
- Section 2D: Medication Reconciliation

Because Section 2 is required for submission, hospitals are now required to complete subsections 2C: Bar Code Medication Administration (BCMA) and 2D: Medication Reconciliation to submit the Survey.

Second, with the change to the structure of Section 2, we are making the CPOE Evaluation Tool available immediately upon completion of the Hospital Profile. This allows adult and general hospitals to complete a CPOE Test at their earliest convenience starting on April 1, without having to first complete and affirm Section 2. Although hospitals may complete the CPOE Evaluation Tool early, CPOE Test results will continue to be scored and publicly reported only once the Survey has been submitted.

Third, we are scoring and publicly reporting results for the Nurse Staffing and Skill Level measures (Total Nursing Care Hours per Patient Day, RN Hours per Patient Day, Nursing Skill Mix, and Percentage of RNs who are BSN-Prepared) and adding

these measures to Section 6C: Nursing Workforce. Section 6: Patient Safety Practices now includes the following subsections:

- Section 6A: NQF Safe Practice #1 – Culture of Safety Leadership Structures and Systems
- Section 6B: NQF Safe Practice #2 – Culture Measurement, Feedback, and Intervention
- Section 6C: Nursing Workforce (which includes Total Nursing Care Hours per Patient Day, RN Hours per Patient Day, Nursing Skill Mix, Percentage of RNs who are BSN-Prepared, and NQF Safe Practice #9 – Nursing Workforce)
- Section 6D: Hand Hygiene

Fourth, we are adding Section 7: Managing Serious Errors to the list of sections that are required in order to submit the Survey. The list of sections that are now required to be completed and affirmed before the Survey can be submitted includes:

- Section 1: Basic Hospital Information
- Section 2: Medication Safety (which includes Bar Code Medication Administration (BCMA) and Medication Reconciliation)
- Section 4: Maternity Care
- Section 5: ICU Physician Staffing (IPS)
- Section 6: Patient Safety Practices
- Section 7: Managing Serious Errors

As always, hospitals are urged to submit all sections of the Survey and can indicate within a section if a measure does not apply.

Finally, the CPT Code Workbooks used to report on the volume of outpatient procedures will now be accessible directly from the Survey Dashboard in Section 10: Outpatient Procedures. As in previous years, hospitals are required to complete the American Medical Association's Terms of Use before downloading the CPT Code Workbooks, and in 2023, hospitals will not be able to access Section 10: Outpatient Procedures without doing so. Hospitals are still only required to complete the American Medical Association's Terms of Use once per Survey Cycle (April 1 – November 30).

SUMMARY OF CONTENT AND SCORING CHANGES FOR 2023

HOSPITAL PROFILE

There are no changes to the Hospital Profile.

SECTION 1: BASIC HOSPITAL INFORMATION

SECTION 1A: BASIC HOSPITAL INFORMATION

In recognition of the published evidence and guidelines documenting the importance of environmental hygiene on infection prevention, Leapfrog is exploring the development of a new standard around environmental hygiene and will be consulting with experts in advance of the 2024 Leapfrog Hospital Survey. Environmental hygiene topics under consideration include cleaning and disinfecting surfaces, air-handling, ventilation, and water quality. For the 2023 Leapfrog Hospital Survey, we

are adding an optional, fact-finding question to Section 1A: Basic Hospital Information to assess how hospitals are integrating environmental services and facilities engineering into their quality and safety structures. Based on public comments and feedback received from 2023 Leapfrog Hospital Survey pilot participants, the response options to this question have been updated.

1) How are environmental services (EVS) and facilities engineering integrated into your hospital's quality and safety structures? *Select all that apply.*	☐ EVS leadership participates in and shares relevant data as part of the organization's quality and safety committees ☐ Facilities engineering leadership participates in and shares relevant data as part of the organization's quality and safety committees ☐ EVS and facilities engineering staff are surveyed as part of the hospital's culture of safety survey and leaders conduct debriefings with the EVS and facilities engineering staff around the team's survey results ☐ EVS and facilities engineering staff are included in the hospital's daily patient safety huddles ☐ Other ☐ Not applicable, EVS and facilities engineering are not integrated into the hospital's quality and safety structures

This optional, fact-finding question will not be used in scoring or public reporting in 2023.

SECTION 1B: PERSON-CENTERED CARE: BILLING ETHICS AND HEALTH EQUITY

BILLING ETHICS

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

- Updating question #1, regarding a master itemized bill, to clarify that hospitals must provide instructions on how to obtain a written translation or oral interpretation of the bill in the patient's preferred language.
- Updating question #2, regarding access to billing representatives and timely resolution of billing issues, to give billing representatives 10 days, rather than 5 days, to initiate an investigation into errors on a bill, offer a price adjustment or debt forgiveness based on hospital policy, or offer a payment plan. We are also updating question #2 to require that billing representatives have access to a translation service to help communicate information in the patient's preferred language.
- Leapfrog is also adding two optional fact-finding questions regarding additional aspects of hospital billing practices that will not be used in scoring or public reporting in 2023.

Additionally, we are adding Frequently Asked Questions (FAQs) regarding alternatives to taking legal action against patients and defining a "good faith estimate." The questions and FAQs for Section 1B: Billing Ethics are detailed in Appendix III.

There are no changes to the scoring algorithm.

HEALTH EQUITY

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

SECTION 1C: INFORMED CONSENT

Based on an analysis of responses submitted to the 2022 Leapfrog Hospital Survey and consultation with Leapfrog's Patient and Family Caregiver Expert Panel, Leapfrog will score and publicly report Section 1C: Informed Consent in 2023. We are updating Section 1C as follows:

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

- One (1) question from the Policies and Training domain that focuses on staff training on the hospital's informed consent policies.
- Three (3) questions from the Content of the Informed Consent Forms domain that focus on: detailing expected difficulties with the procedure; naming individuals who will be involved with the procedure, including trainees and assistants; and ensuring consent forms are at a 6th grade reading level.
- Two (2) questions from the Process for Gaining Informed Consent domain that focus on providing medical interpretation in the patient/legal guardian's preferred language, where needed, when discussing informed consent and using the "teach back method" with patients to ensure they understand what is being explained to them.

Based on public comments and feedback received from 2023 Leapfrog Hospital Survey pilot participants, Leapfrog is making several updates to the originally proposed questions. The final questions and scoring algorithm are detailed in Appendix V.

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

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

SECTION 2: MEDICATION SAFETY

As described above, we are combining Section 8: Medication Safety, which includes Section 8A: Bar Code Medication Administration (BCMA) and Section 8B: Medication Reconciliation, with Section 2: Medication Safety. Section 2: Medication Safety now includes the following subsections:

- Section 2A: Computerized Physician Order Entry (CPOE)
- Section 2B: EHR Application Information
- Section 2C: Bar Code Medication Administration (BCMA)
- Section 2D: Medication Reconciliation

Because Section 2 is required for submission, hospitals are required to complete subsections 2C: Bar Code Medication Administration (BCMA) and 2D: Medication Reconciliation to submit the Survey.

SECTION 2A: COMPUTERIZED PHYSICIAN ORDER ENTRY (CPOE)

There are no changes to this subsection.

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

Leapfrog is removing questions regarding Medicare Promoting Interoperability Program scores. As a reminder, the remaining questions in this subsection are not scored or publicly reported.

CPOE EVALUATION TOOL (FOR ADULT AND GENERAL HOSPITALS ONLY)

As described above, Leapfrog is making the CPOE Evaluation Tool available immediately upon completion of the Hospital Profile. This allows adult and general hospitals to complete a CPOE Test at their earliest convenience starting on April 1, without having to first complete and affirm Section 2. CPOE Test results will continue to be scored and publicly reported only once the Survey has been submitted.

Additionally, Leapfrog is making several content updates for the Adult Inpatient Test. First, we are updating the Test Order library as appropriate based on the latest published literature. Second, we are removing the Drug Allergy Order Checking Category due to sustained high performance in this category across all hospitals over multiple years. Finally, we are combining the Drug Dose (Single) and Drug Dose (Daily) Order Checking Categories into a single Order Checking Category renamed Excessive Dose which includes both single and daily dose testing scenarios.

Although the total number of Test Orders is decreasing, there are no changes to the scoring algorithm for the Adult Inpatient Test.

SECTION 2C: BAR CODE MEDICATION ADMINISTRATION (BCMA)

There are no changes to the questions used in scoring or the scoring algorithm for this subsection. However, based on feedback received from hospitals as well as guidance from Leapfrog's Bar Code Medication Administration Expert Panel, Leapfrog is updating the optional, fact-finding questions included in this subsection to focus on BCMA utilization and compliance in the following areas: pre-operative units, post anesthesia care units (PACUs), and emergency departments. Based on questions received during the public comment period, Leapfrog is adding clarifying information to instruct hospitals that have a combined pre-operative and post anesthesia care unit to report their combined data in the pre-operative unit questions. These new questions, which will not be scored or publicly reported in 2023, are detailed in Appendix VI.

SECTION 2D: MEDICATION RECONCILIATION (FOR ADULT AND GENERAL HOSPITALS ONLY)

There are no changes to this subsection.

SECTION 3: ADULT AND PEDIATRIC COMPLEX SURGERY

SECTION 3A: HOSPITAL AND SURGEON VOLUME

Based on feedback from hospitals and under the guidance of the Complex Surgery Expert Panel, Leapfrog is updating the measure specifications that hospitals will use to calculate hospital volume and surgeon volume for the purpose of privileging for three complex surgeries.

OPEN AORTIC PROCEDURES

Leapfrog is adding one ICD-10 procedure code to Open Aortic Procedures. This procedure code was added by CMS in 2022 and meets our definition of an Open Aortic Procedure: *A procedure where the surgeon exposes the aorta (thoracic or abdominal), clamps it, and sews on the aorta*.

ICD-10 Code	Description
X2RX0N7	Replacement of Thoracic Aorta, Arch using Branched Synthetic Substitute with Intraluminal Device, Open Approach, New Technology Group 7

BARIATRIC SURGERY FOR WEIGHT LOSS

Leapfrog is expanding the list of procedure codes for Bariatric Surgery for Weight Loss to include outpatient procedures captured using Current Procedural Terminology (CPT) codes. The CPT Codes will be available via the Online Survey Tool when the Survey opens on April 1, 2023. Due to the American Medical Association's Terms of Use, hospitals must complete the Terms of Use via the Online Survey Tool to access the CPT Codes. We are also adding this procedure to Leapfrog's Ambulatory Surgery Center (ASC) Survey.

NORWOOD PROCEDURE

Leapfrog is removing questions regarding the Society of Thoracic Surgeons (STS) Congenital Heart Surgery Database (CHSD) Participant Postoperative Length of Stay and Participant Operative Mortality measures but is continuing to ask about hospital participation in the STS CHSD. In 2023, hospitals that perform the Norwood Procedure will be scored using three criteria: total hospital volume, incorporating Leapfrog's minimum annual surgeon volume standards into their process for privileging surgeons, and participation in the STS CHSD. The points assigned to each criterion reflect the Complex Surgery Expert Panel's opinion on its importance to patient outcomes. The scoring algorithm is available in Appendix VII.

SECTION 3B: SURGICAL APPROPRIATENESS

Based on feedback from hospitals and in consultation with the Complex Surgery Expert Panel, Leapfrog is removing questions regarding surgical appropriateness for Open Aortic Procedures as these procedures are performed as a part of life saving efforts.

There are no changes to the public reporting of Section 3B: Surgical Appropriateness for 2023. However, the surgical appropriateness questions have been an important part of the Complex Surgery standards for several years and remain an important area of interest for Leapfrog's purchaser and employer members. As such, Leapfrog plans to incorporate these questions into scoring and public reporting beginning in 2024 for the following complex surgeries: Carotid Endarterectomy, Mitral Valve Repair and Replacement, Bariatric Surgery for Weight Loss, Total Knee Replacement, Total Hip Replacement, Lung Resection for Cancer, Esophageal Resection for Cancer, Pancreatic Resection for Cancer, and Rectal Cancer Surgery.

Additionally, in 2024, Leapfrog plans to add a new question to Section 3B to assess the extent to which a hospital's appropriateness criteria are being utilized by asking hospitals to report on their findings from the retrospective reviews completed in question #3 for the following procedures: Carotid Endarterectomy, Mitral Valve Repair and Replacement, Bariatric Surgery for Weight Loss, Total Knee Replacement, and Total Hip Replacement.

The updated scoring algorithm will be published with the Proposed Changes to the 2024 Leapfrog Hospital Survey.

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

Leapfrog is making two updates to Section 3C: Safe Surgery Checklist for Adult and Pediatric Complex Surgery. First, Leapfrog is increasing the audit requirement from 15 sampled cases to 30 sampled cases for hospitals **only** submitting Section 3 and not also submitting Section 10: Outpatient Procedures. Hospitals that submit **both** Sections 3 and 10 should continue to audit 15 complex surgical cases and 15 outpatient surgical cases.

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

There are no changes to the scoring algorithm for Section 3C: Safe Surgery Checklist for Adult and Pediatric Complex Surgery.

SECTION 4: MATERNITY CARE

Leapfrog is updating the measure specifications from The Joint Commission (TJC) for PC-01 Elective Deliveries (Section 4B) and PC-02 Cesarean Birth (Section 4C) for those hospitals that do not already submit data to TJC and therefore need to retrospectively collect data. Hospitals measuring these quality indicators and reporting results to TJC should continue to use the data reported to TJC when responding to these subsections of the Survey. Hospitals participating in the California Maternal Quality Care Collaborative (CMQCC) Maternal Data Center may continue to use the data provided in their CMQCC reports when responding to subsections 4B: Elective Deliveries, 4C: Cesarean Birth, 4D: Episiotomy, and 4E: 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 subsection 4C: Cesarean Birth.

SECTION 4A: MATERNITY CARE VOLUME AND SERVICES

Leapfrog is renaming Section 4A: Maternity Care Volume to Section 4A: Maternity Care Volume and Services and adding new questions regarding service offerings that will be used for public reporting only. The new questions focus on the availability of midwives and doulas, breastfeeding support, vaginal delivery after cesarean section, and postpartum tubal

ligation. The questions, which are detailed in Appendix VIII, will not be scored, but are required and will be used in public reporting.

SECTION 4B: ELECTIVE DELIVERIES

There are no changes to this subsection.

SECTION 4C: CESAREAN BIRTH

Under the guidance of Leapfrog's Maternity Care Expert Panel, Leapfrog is adding a set of optional fact-finding questions to this subsection to collect cesarean birth rates stratified by racial and ethnic category. Hospitals are asked to provide numerators and denominators for the cesarean birth measure for each of the following racial and ethnic categories: 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). These fact-finding questions, detailed in Appendix IX, are optional and will not be used in scoring or public reporting in 2023.

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

SECTION 4D: EPISIOTOMY

There are no changes to this subsection.

SECTION 4E: PROCESS MEASURES OF QUALITY

There are no changes to this subsection.

SECTION 4F: HIGH-RISK DELIVERIES

There are no changes to this subsection.

NEONATAL INTENSIVE CARE UNIT(S) – NATIONAL PERFORMANCE MEASUREMENT

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

1. Complete a Data Sharing Authorization letter and submit it to VON by the dates listed in Appendix X. (Hospitals that successfully submitted a Data Sharing Authorization letter in previous Leapfrog Hospital Survey Cycles will not be required to submit a new letter in 2023),
2. Select "VON National Performance Measure" in Section 4F: High-Risk Deliveries question #3,
3. Provide an accurate VON Transfer Code in the Hospital Profile (this will be pre-populated if previously provided), and
4. Submit the Leapfrog Hospital Survey by the dates listed in Appendix X.

Hospitals that select "VON National Performance Measure" in question #3 of Section 4F: 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: ICU PHYSICIAN STAFFING (IPS)

Based on feedback from hospitals, Leapfrog is updating the wording of several questions in this section to increase clarity regarding the criteria to respond "yes."

First, question #3, which asks if physicians certified in critical care are managing or co-managing all critical care patients in applicable intensive care units (ICUs), is being separated into two questions.

Second, we are updating questions #11 and #14 to specify the minimum number of hours required for intensivist coverage. The questions are detailed in Appendix XI.

Next, for hospitals that operate more than one type of ICU included in Leapfrog's standard (adult or pediatric general medical and/or surgical ICUs or neuro ICUs) with varying staffing models, Leapfrog is adding a note to remind hospitals that they should respond to questions in this section based on the ICU that has the lowest level of staffing by physicians certified in critical care medicine as described in endnote #25. Additionally, we are updating the phrasing throughout the section to reference the ICU that has the lowest level of staffing by physicians certified in critical care medicine more clearly.

While there are no changes to the scoring algorithm for Section 5: ICU Physician Staffing (IPS), Leapfrog is updating question references in the scoring algorithm to reflect the updated question numbering described above. The scoring algorithm is available in Appendix XI.

SECTION 6: PATIENT SAFETY PRACTICES

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

There are no changes to this subsection.

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

There are no changes to this subsection.

SECTION 6C: NURSING WORKFORCE

As described above, Leapfrog is scoring and publicly reporting results for the Nurse Staffing and Skill Level measures (Total Nursing Care Hours per Patient Day, RN Hours per Patient Day, Nursing Skill Mix, and Percentage of RNs who are BSN-Prepared) and is moving these measures to Section 6C: Nursing Workforce. In preparation for scoring and public reporting, we are also adding a question regarding which method was used to calculate the total number of patient days for each inpatient medical, surgical, and/or med-surg unit.

Leapfrog is also updating the measure specifications for Total Nursing Care Hours per Patient Day, RN Hours per Patient Day, and Nursing Skill Mix to more closely align with how the National Database of Nursing Quality Indicators (NDNQI) defines medical, surgical, and medical/surgical units. Previously hospitals were instructed to exclude units from reporting if

at least 90% of the patients in the unit require telemetry, or the primary reason for admission to the unit is the patient's need for telemetry. That exclusion has been removed for 2023.

Leapfrog has also published benchmarking data for all new nurse staffing and skill mix measures so that hospitals can assess how they compare nationally on these four measures.

Further, given that Leapfrog has asked hospitals to report their progress in implementing the elements of NQF Safe Practice #9 – Nursing Workforce for over 15 years, we are now only asking hospitals to report on five of the seventeen practice elements not directly captured through the Nurse Staffing and Skill Level measures. The five practice elements include:

- 9.2a: held nursing leadership directly accountable for improvements in performance through performance reviews or compensation.
- 9.2b: included nursing leadership as part of the hospital senior administrative leadership team.
- 9.2d: held the board (governance) and senior administrative leadership accountable for the provision of financial resources to ensure adequate nurse staffing levels.
- 9.3d: budgeted financial resources for balancing staffing levels and skill levels to improve performance.
- 9.4a: developed a staffing plan, with input from nurses, to ensure that adequate nursing staff-to-patient ratios are achieved.

Hospitals recognized as an American Nurses Credentialing Center (ANCC) Magnet® hospital or a 2020 Pathway to Excellence® hospital will receive full credit for the five practice elements. However, NQF Safe Practice #9 is not being scored and publicly reported as a stand-alone measure. Instead, the NQF Safe Practice #9 – Nursing Workforce measure will only be used in scoring if the hospital scores in the bottom performance category ("Limited Achievement") on the Nurse Staffing and Skill Mix measures (Total Nursing Care Hours per Patient Day, RN Hours per Patient Day, and Nursing Skill Mix) to bump the hospital's performance category up from "Limited Achievement" to "Some Achievement."

The scoring algorithm is detailed in Appendix XII.

SECTION 6D: HAND HYGIENE

There are no changes to this subsection.

SECTION 6E: NURSE STAFFING AND SKILL LEVEL

As described above, Leapfrog is scoring and publicly reporting results for the Nurse Staffing and Skill Level measures (Total Nursing Care Hours per Patient Day, RN Hours per Patient Day, Nursing Skill Mix, and Percentage of RNs who are BSN-Prepared) and adding these measures to Section 6C: Nursing Workforce.

SECTION 7: MANAGING SERIOUS ERRORS

As described above, we are adding Section 7: Managing Serious Errors to the list of sections required to submit the 2023 Leapfrog Hospital Survey.

SECTION 7A: NEVER EVENTS POLICY STATEMENT

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

SECTION 7B: HEALTHCARE-ASSOCIATED INFECTIONS

There are no changes to this subsection.

The deadlines to join Leapfrog's NHSN Group and associated reporting periods are available in Appendix XIII.

SECTION 8: MEDICATION SAFETY

See Section 2: Medication Safety

SECTION 9: PEDIATRIC CARE

SECTION 9A: PATIENT EXPERIENCE (CAHPS CHILD HOSPITAL SURVEY)

For hospitals administering the CAHPS Child Hospital Survey, Leapfrog is asking an additional question to assess whether the full CAHPS Child Hospital Survey or a truncated version is being administered. Additionally, we are updating the measure specifications to clarify that hospitals administering the truncated version of the CAHPS Child Hospital Survey must retain the demographic questions in their original order and unaltered. This requirement supports Leapfrog's efforts to have hospitals stratify quality measures for the purpose of identifying healthcare disparities.

There are no changes to the scoring algorithm for Section 9A: Patient Experience (CAHPS Child Hospital Survey).

SECTION 9B: PEDIATRIC COMPUTED TOMOGRAPHY (CT) RADIATION DOSE

Based on feedback from hospitals and industry experts, Leapfrog is adding a new unscored question to collect the age of the CT machine being used for pediatric CT scans. We are also adding a question asking for the name of the CT machine's manufacturer. This new information will be used to analyze the relationship between machine age and dose and used to inform thresholds used in Leapfrog's data verification protocols.

There are no changes to the scoring algorithm for Section 9B: Pediatric Computed Tomography (CT) Radiation Dose.

SECTION 10: OUTPATIENT PROCEDURES

SECTION 10A: BASIC OUTPATIENT DEPARTMENT INFORMATION

There are no changes to this subsection.

SECTION 10B: MEDICAL, SURGICAL, AND CLINICAL STAFF

There are no changes to this subsection.

SECTION 10C: VOLUME OF PROCEDURES

There are no changes to this subsection.

SECTION 10D: SAFETY OF PROCEDURES

PATIENT FOLLOW-UP

Leapfrog is removing the CMS outcome measure OP-31 Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery since CMS has made this measure voluntary through the 2023 Hospital Outpatient Reporting (OQR) Final Rule.

Deadlines and reporting periods for OP-32 Rate of Unplanned Hospital Visits After Colonoscopy are available in Appendix XIV.

There are no changes to the scoring algorithm for OP-32 Rate of Unplanned Hospital Visits After Colonoscopy.

PATIENT SELECTION

There are no changes to these questions.

SAFE SURGERY CHECKLIST FOR ADULT AND PEDIATRIC OUTPATIENT PROCEDURES

Leapfrog is making two updates to the Safe Surgery Checklist for Adult and Pediatric Outpatient Procedures question set. First, Leapfrog is increasing the audit requirement from 15 sampled cases to 30 sampled cases for hospitals **only** submitting Section 10 and not also submitting Section 3: Adult and Pediatric Complex Surgery. Hospitals that submit **both** Sections 3 and 10 should continue to audit 15 complex surgical cases and 15 outpatient surgical cases.

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

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

SECTION 10E: MEDICATION SAFETY FOR OUTPATIENT PROCEDURES

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

There are no changes to the scoring algorithm for Section 10E: Mediation Safety for Outpatient Procedures.

SECTION 10F: PATIENT EXPERIENCE (OAS CAHPS)

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

There are no changes to the scoring algorithm for Section 10F: Patient Experience (OAS CAHPS).

More information about the 2023 Leapfrog Hospital Survey is available on our website at http://www.leapfroggroup.org/hospital.

RESPONSES TO PUBLIC COMMENTS

Leapfrog was grateful to receive nearly 200 public comments in response to the proposed changes to the 2023 Leapfrog Hospital Survey. Comments were submitted from health care organizations, as well as health care experts, patient advocates, purchasers, and patients themselves.

Responses to the public comments are organized by Survey section below. If you submitted a comment and do not see a response, or if you have additional questions, please contact the Help Desk at https://leapfroghelpdesk.zendesk.com. Comments are extremely helpful to the development of high-quality surveys, and we thank commenters for their insights.

COMMENTS RELATED TO STRUCTURAL CHANGES

One commenter supported combining the medication safety measures in Section 2 and requiring Section 7 as it makes the submission process clearer and aligns with the sections included in the Leapfrog Hospital Safety Grade.

We appreciate this feedback.

SECTION 1: BASIC HOSPITAL INFORMATION

BASIC HOSPITAL INFORMATION

Some commenters supported the additional fact-finding question on the integration of environmental services (EVS) and facilities engineering into the hospital's quality and safety structures, but expressed that instead of focusing on one approach, such as direct reporting, the approach should be focused on collaborating with safety and quality and integration with the entire care team. In addition, two of these commenters also suggested that instead of focusing on reporting structures, Leapfrog should focus on communication structures such as participation in committees, regular reporting of data, etc.

Thanks to these suggestions, Leapfrog updated the fact-finding question to ask instead if EVS and facilities engineering leadership participate in and share relevant data as part of the organization's quality and safety committees; if EVS and facilities engineering staff are surveyed and debriefed as part of the hospital's Culture of Safety Survey; and if EVS and facilities engineering staff are included in daily patient safety huddles. Review the updated question above.

One commenter noted that Leapfrog should consider regulatory standards that are already established on environment of care standards and building codes when developing a future standard around environmental hygiene. Another commenter cited that many functions of EVS and facilities engineering are already regulated and evaluated by CMS and accreditation agencies.

We appreciate this feedback and will be working with our scientific partners and engaging with experts to review existing standards.

BILLING ETHICS

Some commenters recommended removing the requirement that hospitals provide patients with a billing statement even when there is no balance due.

After consideration of this feedback, Leapfrog has removed this requirement. Hospitals will no longer be required to provide billing statements to patients with no balance due to respond "yes" to question #1 in Section 1B.

Some commenters asked about whether billing representatives who are asked to do each of the three elements described in question #2 in Section 1B: Billing Ethics can be allowed exceptions for cases that are not conclusively resolved due to considerations outside of their control.

Leapfrog has revised question #2 to clarify that billing representatives do not need to conclusively resolve patient inquiries within 10 days; instead, the billing representative only needs to have initiated the resolution. For example, this might mean beginning the investigation into errors, or offering a payment plan or price adjustment. The billing representative is not intended to be held accountable for time delays introduced during an error investigation or in the negotiation over a price adjustment with a patient.

HEALTH EQUITY

One commenter supported the stratification of measures by race, ethnicity, preferred language, sexual orientation, and gender identity.

We appreciate this feedback.

INFORMED CONSENT

Some commenters recommended that Leapfrog wait an additional year to score and publicly report Section 1C: Informed Consent.

While Leapfrog appreciates that some hospitals may need more time to achieve this standard, it is our practice to allow one year of fact-finding on the Survey for any new standard, and if that period is successful, move forward with scoring and public reporting the following year. Based on an analysis of Survey responses submitted in 2022, at least 50% of hospitals responded "yes" to each of the six questions slated for scoring and public reporting in 2023, and over 35% of hospitals would achieve the standard.

Some commenters asked for additional detail about the training program described in question #1 in Section 1C: Informed Consent.

As described in the FAQ in the hard copy of the Survey, the components of the training program should be based on the domains outlined in the AHRQ resource Making Informed Consent an Informed Choice – Training for Health Care Leaders and include training on the definition and principles of informed consent, specifics on the hospital's informed consent policy, and, for patient-facing roles like doctors and nurses, strategies for clear communication, for presenting choices, and for documentation. Administrative staff and interpreters participating in the informed consent process should also be trained on documentation. Examples of trainings include computer-based training, one-on-one precepting, webinars, and staff meeting presentations, as well as other modalities where learning can be assessed after the content is delivered to the trainee.

Training does not need to be exclusive to informed consent and can be included as components or modules in other training; the goal is for each responsible staff person to be trained in their applicable domains. Staff that are not directly

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

Some commenters recommended that Leapfrog reconsider the requirement that re-training be required at least every five years in question #1.

Leapfrog has removed this requirement from question #1 in Section 1C. In future iterations of the Survey, we will revisit whether an interval for re-training is necessary to include in the Survey.

Some commenters recommended that Leapfrog recognize hospitals who have taken an intermediate step towards ensuring all consent forms are written at a 6th grade reading level or lower.

Leapfrog has added a third response option to question #4, which asks if all a hospital's consent forms are written at a 6th grade reading level or lower, to allow hospitals to earn partial credit if they report that "at least one form is written at a 6th grade reading level or lower." The updated question is available for review in Appendix V.

Some commenters noted that there may be specific terms required by the hospital legal department, such as the technical name for the test, treatment, or procedure, that cannot be re-written for a 6th grade reading level.

Leapfrog has added help text to question #4 to clarify that the procedure name and description can be excluded from the reading level assessment. The updated question can be reviewed in Appendix V.

Some commenters noted that qualified medical interpreters may not be able to sign a consent form if they are not present in-person; for example, if a remote or videoconference translation service is used.

Leapfrog has updated question #5 to clarify that medical interpreters can electronically sign the consent form or have another person in the room attest to the fact that a medical interpreter was used. This documentation could be on the consent form or in the patient's electronic health record. The updated question can be reviewed in Appendix V.

Some commenters recommended that Leapfrog rephrase question #11 about whether clinicians specifically address the number of times per year that they conduct the test, treatment, or procedure.

Note that this question is for fact-finding only and responses will not be scored or publicly reported. Our understanding from the Patient and Family Caregiver Expert Panel is that experience with the procedure is a valuable touchstone for patients going through the informed consent process and the number of procedures performed is a specific indicator of that experience. Leapfrog has revised the question to clarify that the number of procedures shared with patients can be an average figure based on prior history and does not need to be an exact count. Leapfrog will continue to review and revise this question in future iterations of the Survey. The updated question can be reviewed in Appendix V.

SECTION 2: MEDICATION SAFETY

CPOE EVALUATION TOOL

One commenter expressed concern that removing the Drug Allergy Order Checking Category from the CPOE Tool would decrease the denominator and impact the overall score.

This change may result in a change to a hospital's overall percentage of test medication orders handled correctly by the CPOE system. However, Leapfrog and the CPOE Evaluation Tool developers are committed to monitoring the length of the CPOE Test and removing orders that provide little value to hospitals or the public. Hospitals have consistently achieved 100 percent in the Drug Allergy Order Checking Category for several years. The removal of this Order Checking Category and

combination of the Single and Daily Drug Dose Order Checking Categories will allow hospitals to focus their improvement efforts on more complex decision-support areas such as Drug Laboratory and Drug Monitoring. Hospitals that score 60% or greater will continue to be scored as Full Demonstration of National Safety Standard for Decision Support on the Test.

BAR CODE MEDICATION ADMINISTRATION (BCMA)

One commenter requested that Leapfrog adjust the compliance target for emergency departments given the need to administer emergent medications in this unit.

The optional fact-finding questions for BCMA will not be scored or publicly reported in 2023. Leapfrog will review the preliminary data with its experts in advance of establishing any new standards and scoring and publicly reporting.

MEDICATION RECONCILIATION

One hospital expressed concern about adding the Medication Reconciliation measure to Section 2 thereby making it a requirement for Survey submission because they felt smaller hospitals may not have the resources to collect data for this measure.

There is ample evidence that shows medication reconciliation has a direct tie to patient safety and that medication reconciliation interventions improve important outcomes such as medication discrepancies and adverse drug events. More information about the importance of medication reconciliation is available in our fact sheet.

Small hospitals with fewer than 30 admissions to medical or med/surg units over the reporting period can indicate this and be scored and publicly reported as “Does Not Apply.”

Hospitals with more than 30 admissions to medical or med/surg units over the reporting period can indicate they did not complete data collection for the measure and be scored and publicly reported as “Limited Achievement.”

Additionally, hospitals that completed data collection for the measure on a smaller sample size than required by Leapfrog (fewer than 30 patients over the reporting period) can indicate this and be scored and publicly reported as “Some Achievement.”

SECTION 3: ADULT AND PEDIATRIC COMPLEX SURGERY

SURGICAL APPROPRIATENESS

One commenter stated that they do not agree with Leapfrog’s decision to remove open aortic procedures from Section 3B as some of these procedures are performed electively.

The decision to remove open aortic procedures from Section 3B was made based on recommendations from our Complex Surgery National Expert Panel who are practicing surgeons in the field. The Expert Panel specified that the open aortic procedures included in the Leapfrog Hospital Survey (reference list of procedures in the hard copy of 2022 Survey measure specifications, pages 84-92) are almost always performed as part of life saving efforts.

One commenter expressed concern with adding an auditing requirement to Section 3B for 2024, noting that it does not align with current patient safety concerns and/or priorities.

For the past five years, hospitals have been asked about whether they perform retrospective audits of surgical cases to evaluate the extent to which their appropriateness criteria are met or not met by each surgeon. The only change proposed for 2024 is that hospitals responding "yes" to this question will be asked to report on the findings of the audits they have reported performing for the following applicable procedures:

- Carotid endarterectomy,
- Mitral valve repair and replacement,
- Bariatric surgery for weight loss,
- Total knee replacement, and
- Total hip replacement.

Surgical appropriateness and overuse of surgical interventions remains a high priority for Leapfrog's constituents and an important balancing measure to Leapfrog's hospital and surgeon volume standards. More information about the importance of surgical appropriateness is available in our fact sheet.

SECTION 4: MATERNITY CARE

MATERNITY CARE VOLUME AND SERVICES

A few commenters supported the addition of the new questions on maternity care services offered at the hospital regarding doulas, midwives, breastfeeding support, and other services. This included patients that felt this information would have been helpful when looking for a place for delivery.

We appreciate this feedback.

One commenter asked for clarification on the timeframe for offering tubal ligation.

Leapfrog updated the question to ask if tubal ligation is offered during the labor and delivery admission. Review the updated question in Appendix VIII.

Several commenters suggested that Leapfrog add additional questions regarding maternity care services, including questions regarding policies for doulas and midwives not employed by the hospital and policies on accepting baby formula donations, further emphasizing the gap in information available to birthing people and their families.

Leapfrog appreciates these recommendations and continues to review the addition of the new services questions for future Surveys. However, the current 2023 Survey questions allow Leapfrog to focus on identifying any potential data collection or reporting issues that may arise. Additional questions about services will be considered in further iterations of the Survey.

CESAREAN BIRTH

Some hospitals supported the addition of new fact-finding questions that ask hospitals to stratify their cesarean birth data by racial and ethnic category, but a few asked how the data will be used and eventually scored and publicly reported.

Leapfrog will share aggregate national data from 2023 Leapfrog Hospital Surveys with our national Maternity Care Expert Panel in advance of making any decisions regarding future Surveys.

A couple commenters asked how data should be reported for hospitals with small denominators and recommended that Leapfrog not allow hospitals to sample when reporting on these questions.

For the 2023 Survey, Leapfrog will ask hospitals to report on all cases when responding to the new fact-finding questions that ask hospitals to stratify their cesarean birth data by racial and ethnic category. Leapfrog will only allow numerator reporting for those racial and ethnic categories where the denominator is 10 or more. We will continue to evaluate these parameters with our national Maternity Care Expert Panel in advance of making any decisions regarding future Surveys.

SECTION 5: ICU PHYSICIAN STAFFING (IPS)

One commenter supported Leapfrog's question updates in Section 5 to enhance clarity.

We appreciate this feedback.

SECTION 6: PATIENT SAFETY PRACTICES

NURSING WORKFORCE

Several commenters asked that Leapfrog delay scoring and publicly reporting the Total Nursing Care Hours per Patient Day, RN Hours per Patient Day, Nursing Skill Mix, and Percentage of RNs who are BSN-Prepared measures to a future cycle of the Leapfrog Hospital Survey given the current challenges of attracting nurses to work in hospitals and a limited pipeline of nursing graduates to fill open positions.

Leapfrog recognizes that the current nurse staffing challenges can impact hospital operations. However, that impact is itself why consumers and purchasers need insight about nurse staffing at each hospital. Nursing care is a core element to ensuring safe patient care in hospitals, and national data suggests variation among hospitals on the impact of the nurse staffing challenges. As a result, Leapfrog is continuing with its plans to score and publicly report hospitals on the Total Nursing Care Hours per Patient Day, RN Hours per Patient Day, Nursing Skill Mix, and Percentage of RNs who are BSN-Prepared measures on the 2023 Leapfrog Hospital Survey.

Several commenters expressed concern about the "Percentage of RNs who are BSN-Prepared" measure, suggesting the measure does not reflect the current environment of the nursing profession, there is a lack of evidence to support moving in this direction, and the data on this measure may be tracked differently from organization to organization.

All four nurse staffing and skill mix measures are supported by decades of published evidence demonstrating a relationship with patient safety outcomes. The strength of the evidence is why the IOM's Future of Nursing report includes the goal that

80% of RNs in the United States be educated to a Bachelor of Science in Nursing level or higher. Regarding standardization of the tracking of this data, Leapfrog has provided hospitals with detailed specifications for reporting on this measure for the past two years, which are aligned with those used by NDNQI, a national nursing database.

Leapfrog will be working with its national Nursing Workforce Expert Panel to identify if a sampling methodology could be appropriately used for this measure.

Several commenters expressed concern that there is a lack of studies that support a correlation between mandated staffing ratios and better patient outcomes.

Leapfrog takes no position on whether policymakers should mandate specific patient-to-nurse staffing ratios for hospitals. Leapfrog's role is to promote transparency, publicly reporting for consumers and purchasers the variation in nurse staffing that exists among different hospitals. That allows consumers to decide for themselves.

There is evidence that nurse staffing levels correlate with patient outcomes.

One commenter expressed concern that NDNQI has not yet developed reports to accurately obtain the data needed to report on the Total Nursing Care Hours per Patient Day, RN Hours per Patient Day, and Nursing Skill Mix measures through the Leapfrog Hospital Survey.

Hospitals that report to NDNQI will be able to respond to questions #4 - 10 in Section 6C: Nursing Workforce using data that is available upon request for system product users. Hospitals should email NDNQISupport@PressGaney.com or call 855-304-9788 to connect with one of NDNQI's team members and specify that they are requesting support for extracting data from the data summary report or system data export for the purposes of reporting on Total Nursing Care Hours per Patient Day, RN Hours per Patient Day, and Nursing Skill Mix in the 2023 Leapfrog Hospital Survey.

Several commenters expressed concern that comparing hospitals to only hospitals within the same cohort, and not to a national benchmark, could be unfair to hospitals depending on the number of hospitals in each cohort.

Leapfrog will categorize hospitals into one of five cohorts – 1) large teaching, 2) small teaching, 3) non-teaching, 4) pediatric, and 5) critical access hospitals. Hospitals will be compared to other hospitals within those cohorts. The cohorts were established based on published literature and data submitted to prior Leapfrog surveys, which suggested that each cohort is of an adequate size.

One commenter noted that there was an exclusionary statement in the Survey related to telemetry that does not align with NDNQI.

Leapfrog has further updated the measure specifications for medical, surgical, and medical/surgical units to align with NDNQI unit definitions. Units where at least 90% of the patients in the unit require telemetry, or where the primary reason for admission to the unit is the patient's need for telemetry, are no longer excluded. According to NDNQI's unit definitions, hospitals should evaluate the actual acuity of the patients to determine the appropriate unit designation. Telemetry is not a true evaluation of the patient's acuity; a unit that has all telemetry may still have a general population level of patients that would meet NDNQI's definition of a medical, surgical, or med-surg unit.

Several commenters asked if hospitals with Magnet status would receive full credit for being magnet designated.

Hospitals recognized as an American Nurses Credentialing Center (ANCC) Magnet® hospital or a 2020 Pathway to Excellence® hospital will receive full credit for the five practice elements in Safe Practice #9. However, NQF Safe Practice #9 will no longer be scored and publicly reported as a stand-alone measure. Instead, the NQF Safe Practice #9 – Nursing Workforce measure will only be used if the hospital scores in the bottom performance category ("Limited Achievement") on the Nurse Staffing and Skill Level measures (Total Nursing Care Hours per Patient Day, RN Hours Per Patient Day, and Nursing Skill Mix) to bump the hospital's performance category up from "Limited Achievement" to "Some Achievement."

SECTION 7: MANAGING SERIOUS ERRORS

No comments were submitted.

SECTION 8: MEDICATION SAFETY

See Section 2: Medication Safety on pages 20-21.

SECTION 9: PEDIATRIC CARE

PEDIATRIC COMPUTED TOMOGRAPHY (CT) RADIATION DOSE

Several commenters supported Leapfrog's addition of the new question regarding CT machine age.

We appreciate this feedback.

Some commenters questioned how to respond to the new question concerning CT machine age if they utilize multiple CT machines at the hospital.

Leapfrog has clarified in the question that hospitals should report the age of the oldest machine they are using for pediatric head and abdomen/pelvis CT scans. Additionally, experts at the American College of Radiology have advised that hospitals can most easily find age on the manufacturer's gantry label, which will also be specified in the Survey.

A few commenters expressed concerns about Leapfrog correlating machine age with doses and felt that this information may not be valuable. They also felt that that there are additional factors that should be looked at (other than machine age) when evaluating the relationship between machine type and low doses.

These questions were created in conjunction with experts at the American College of Radiology (ACR). The purpose of these questions is to evaluate the relationship between the responses to all the fact-finding questions, including the new question on the age of a machine, and the reported CT doses to monitor trends in hospital's reporting of very low CT doses.

SECTION 10: OUTPATIENT PROCEDURES

No comments were submitted.

APPENDIX I: 2023 LEAPFROG HOSPITAL SURVEY DEADLINES

Date	Deadline
March	Summary of Changes to the 2023 Leapfrog Hospital Survey and Responses to Public Comments will be published at www.leapfroggroup.org/hospital.
April 1	**2023 LEAPFROG HOSPITAL SURVEY LAUNCH**
June 22	**FIRST NHSN GROUP DEADLINE:** Hospitals that join Leapfrog's NHSN Group by June 22, provide a valid NHSN ID in the Profile, and submit the Leapfrog Hospital Survey by June 30, will have data available prior to public reporting on their Hospital Details Page starting on July 12. Results will be publicly reported on July 25. Please see Appendix XIII for instructions and other 2023 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 on July 12. Results will be publicly reported 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. Hospitals that would like to receive a free Summary Report for competitive benchmarking 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/October.
July 12	**HOSPITAL DETAILS PAGE AVAILABLE:** The first set of Leapfrog Hospital Survey Results, which reflect Surveys submitted by June 30, will be privately available for hospitals to view on July 12 via the Hospital Details Page link on the Survey Dashboard. In addition, Leapfrog will send out its first round of monthly data verification emails and documentation requests.
July 25	**HOSPITAL SURVEY RESULTS PUBLICLY AVAILABLE:** The first set of Leapfrog Hospital Survey Results, which reflect Surveys submitted by June 30 are published. Hospitals that do not submit a Survey by June 30 will be publicly reported as "Declined to Respond" until a Survey has been submitted. After July, results are updated on the fifth business day of the month to reflect Surveys (re)submitted by the end of the previous month.
August 31	**TOP HOSPITAL DEADLINE:** Submission deadline for hospitals to be eligible to receive a Leapfrog Top Hospital Award. Hospitals are encouraged to submit their Survey by June 30 in order to resolve any data entry or reporting errors identified by Leapfrog through its monthly data verification and documentation requests. **DATA SNAPSHOT DATE FOR THE FALL 2023 HOSPITAL SAFETY GRADE:** Adult and general hospitals that would like Leapfrog Hospital Survey Results included in the fall 2023 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:**

Date	Deadline
	The 2023 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 2024 Leapfrog Hospital Safety Grade must submit a Survey and CPOE Evaluation Tool by November 30. Hospitals that submitted a Survey by August 31 are strongly urged to review their Last Submitted Survey to ensure it is accurate and complete. Find more information about the Leapfrog Hospital Safety Grade here.
January 31, 2024	**CORRECTIONS DEADLINE:** Hospitals that need to make corrections to previously submitted 2023 Leapfrog Hospital Surveys must make necessary updates and re-submit the entire Survey by January 31, 2024. Hospitals will not be able to make changes or 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 2024 HOSPITAL SAFETY GRADE:** Adult and general hospitals that would like Leapfrog Hospital Survey Results included in the spring 2024 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.

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APPENDIX II: 2023 LEAPFROG HOSPITAL SURVEY REPORTING PERIODS

	Survey Submitted Prior to September 1	Survey (Re)Submitted on or After September 1
Survey Section	**Reporting Period**	**Reporting Period**
1A Basic Hospital Information	12 months ending 12/31/2022	12 months ending 06/30/2023
1B Person-Centered Care: Billing Ethics and Health Equity	N/A	N/A
1C Informed Consent	N/A	N/A
2A Medication Safety - 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 12/31/2022	Volume: 12 months or 24 months ending 06/30/2023
	STS MVRR Composite Score: Latest 36-month report	STS MVRR Composite Score: Latest 36-month report
3B Surgical Appropriateness	Latest 12 months prior to Survey submission	Latest 12 months prior to Survey submission
3C Safe Surgery Checklist for Adult and Pediatric Complex Surgery	Latest 6 months prior to Survey submission	Latest 6 months prior to Survey submission
4A Maternity Care Volume and Services	12 months ending 12/31/2022	12 months ending 06/30/2023
4B Elective Deliveries	12 months ending 12/31/2022	12 months ending 06/30/2023
4C Cesarean Birth	12 months ending 12/31/2022	12 months ending 06/30/2023
4D Episiotomy	12 months ending 12/31/2022	12 months ending 06/30/2023
4E Process Measures of Quality	12 months ending 12/31/2022	12 months ending 06/30/2023
4F High-Risk Deliveries	Volume: 12 months ending 12/31/2022	Volume: 12 months ending 06/30/2023
	VON: 2021 report	VON: 2022 report
5 ICU Physician Staffing	Latest 3 months prior to Survey submission	Latest 3 months prior to Survey submission
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)

	Survey Submitted Prior to September 1	Survey (Re)Submitted on or After September 1
Survey Section	**Reporting Period**	**Reporting Period**
6C Nursing Workforce	NQF Safe Practice #9: Latest 12 months prior to Survey submission	NQF Safe Practice #9: Latest 12 months prior to Survey submission
	Nursing Staffing and Skill Level: 12 months ending 12/31/2022	Nursing Staffing and Skill Level: 12 months ending 06/30/2023
6D Hand Hygiene	N/A	N/A
7A Never Events Policy	N/A	N/A
7B Healthcare-Associated Infections	June and August Data Downloads: 01/01/2022 – 12/31/2022	October and December Data Downloads: 07/01/2022 – 06/30/2023
8A 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 12/31/2022	12 months ending 06/30/2023
9A Basic Outpatient Department Information	12 months ending 12/31/2022	12 months ending 06/30/2023
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 12/31/2022	12 months ending 06/30/2023
9D Safety of Procedures	Patient Follow-up: Latest 24 months prior to Survey submission	Patient Follow-up: Latest 24 months prior to Survey submission
	Patient Selection: N/A	Patient Selection: N/A
	Safe Surgery Checklist: Latest 6 months prior to Survey submission	Safe Surgery Checklist: Latest 6 months prior to Survey submission
9E Medication Safety for Outpatient Procedures	12 months ending 12/31/2022	12 months ending 06/30/2023
9F Patient Experience (OAS CAHPS)	Latest 12 months prior to Survey submission	Latest 12 months prior to Survey submission

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APPENDIX III: BILLING ETHICS QUESTIONS AND FAQS FOR 2023

Section 1B: Billing Ethics – Questions for 2023

1) Within 30 days of the final claims adjudication (or within 30 days from date of service for patients without insurance), does your hospital provide every patient, either by mail or electronically, with a billing statement and/or master itemized bill for facility services that includes ALL the following? a. Name and address of the facility where billed services occurred b. Date(s) of service c. An individual line item for each service or bundle of services performed d. Description of services billed that accompanies each line item or bundle of services performed e. Amount of any principal, interest, or fees (e.g., late or processing fees), if applicable f. Amount of any adjustments to the bill (e.g., health plan payment or discounts), if applicable g. Amount of any payments already received (from the patient or any other party), if applicable h. Instructions on how to apply for financial assistance i. Instructions in the patient's preferred language on how to obtain a written translation or oral interpretation of the bill j. Notification that physician services will be billed separately, if applicable *If any one of the elements above are only provided upon request, select "Only upon request." If any one of the elements above are not ever provided, select "No."*	*Yes* *No* *Only upon request*
2) Does your hospital give patients instructions for contacting a billing representative with: • access to an interpretation service to communicate in the patient's preferred language, **and** • the authority to do all the following within 10 business days of being contacted by the patient or patient representative? a. Initiate an investigation into errors on a bill b. Offer a price adjustment or debt forgiveness based on hospital policy c. Offer a payment plan *If "no" to question #2, skip question #4 and continue to question #5.*	*Yes* *No*

3) Does your hospital take legal action against patients for late payment or insufficient payment of a medical bill? *This question does not include patients with whom your hospital has entered into a written agreement specifying a good faith estimate for a medical service.*	*Yes* *No*

Additional Question (Optional – Fact Finding Only)

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

Section 1B: Billing Ethics – FAQs for 2023

1) To meet the criteria for item "i" in question #1, does our hospital have to translate the billing statement and/or master itemized bill to every language spoken by our patients?
Hospitals must provide instructions, in the patient's primary language, on how to obtain a written translation or oral interpretation of the bill if the language constitutes 5% (and at least 50 patients) or 1,000 patients (whichever is less) of the population eligible to be served or likely to receive care at the hospital.

2) What is a "good faith estimate" as referred to in question #3?
A good faith estimate includes an itemized list of expected charges for the primary item or service the patient will receive, and any other items or services provided as part of the same scheduled episode of care. The final bill must be no more than $400 over the amount of the good faith estimate. The Centers for Medicare and Medicaid Services have published an example template for providing good faith estimates: https://www.cms.gov/files/document/good-faith-estimate-example.pdf.

3) What does Leapfrog mean by "legal action" in question #3?
Legal action can include, but is not limited to, a lawsuit, wage garnishment, filing to take a patient's money out of their tax return, seizing or placing a lien on a patient's personal property, and selling or transferring a patient's debt to a debt collection agency that will take legal action against the patient. If the debt collection agency is prevented from taking legal action against patients by their contract with the hospital, selling or transferring a patient's debt to that debt collection agency would not be considered legal action.

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

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

4) What are alternatives to legal action against patients?

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

5) What procedure should we follow to conduct the quantified analysis of response times for billing representatives as described in question #4?

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

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

APPENDIX IV: HEALTH EQUITY QUESTIONS FOR 2023 (NOT SCORED OR PUBLICLY REPORTED)

1) Which of the following **patient self-identified** demographic data does your hospital collect **directly from its patients (or patient's legal guardian)** prior to or while registering a patient for a hospital visit? *Select all that apply.* *If "none of the above," skip the remaining questions.*	☐ Race ☐ Ethnicity ☐ Spoken language preferred for healthcare (patient or legal guardian) ☐ Written language preferred for healthcare (patient or legal guardian) ☐ Sexual orientation ☐ Gender identity ☐ None of the above
2) Which of the following methods does your hospital use to collect the demographic data in question #1 directly from patients (or patient's legal guardian)? *Select all that apply.*	☐ Online Patient Portal ☐ Paper Registration Forms ☐ Over the Phone ☐ At Registration (in-person)
3) Does your hospital train staff responsible for registering patients either in-person or over the phone on how to collect self-identified demographic data in question #1 from its patients (or patient's legal guardian) at both: • the time of onboarding; and • annually thereafter?	*Yes* *No*
4) Does your hospital routinely take any of the following steps to ensure the accuracy of the patient self-identified demographic data collected directly from its patients (or patient's legal guardian) in question #1? *Select all that apply.*	☐ Ensure appropriate data collection fields are available in EHR ☐ Use analytic tools to assess completion rates of data collection fields in EHR ☐ Compare data collected from patient experience surveys with EHR data ☐ Compare data collected through patient portals with EHR data ☐ Compare data collected with community data provided by state or county or Community Health Needs Assessment (CHNA) ☐ Compare data collected to census data for the hospital's service area ☐ Other ☐ None of the above

5) Does your hospital use the patient self-identified demographic data it collects directly from patients (or patient's legal guardian) in question #1 to stratify <u>any</u> quality measure(s) with the aim of identifying health care disparities? *If "no," skip questions #6-10 and continue to question #11.*	*Yes* *No*
6) Which type(s) of quality measure(s) does your hospital stratify? *Select all that apply.*	☐ Clinical process measures ☐ Clinical outcome measures ☐ CAHPS measures (i.e., Adult HCAHPS, OAS CAHPS, CAHPS Child Hospital Survey, etc.) ☐ Other patient experience measures ☐ Other
7) What types of patient self-identified demographic data selected in question #1 did your hospital use to stratify the quality measures selected in question #6? *Select all that apply.* *Hospitals can only select items that were also selected in question #1.*	☐ Race ☐ Ethnicity ☐ Spoken language preferred for healthcare (patient or legal guardian) ☐ Written language preferred for healthcare (patient or legal guardian) ☐ Sexual orientation ☐ Gender identity
8) Prior to using the patient self-identified demographic data selected in question #7 to stratify quality measures, did your hospital do any of the following to ensure the quality of the data? *Select all that apply.*	☐ Periodically (e.g., monthly for first six months, and quarterly thereafter) review data set to identify critical issues with data quality ☐ Set targets for missing data (e.g., 10%) to use as a benchmark for performance ☐ Monitor "other" response rates to identify issues with existing data collection categories or methods ☐ Include the data collection team (i.e., registration team) when addressing data quality issues ☐ None of the above

9) By stratifying the measure(s) selected in question #6, has your hospital identified any disparities among its patients based on the demographic data selected in question #7? *If "no, disparities were not identified" or "inadequate data available to determine if disparities exist," skip question #10 and continue to question #11.*	*Yes, disparities were identified* *No, disparities were not identified* *Inadequate data available to determine if disparities exist*
10) In the past 12 months, has your hospital used the data and information obtained through question #7 to update or revise its policies or procedures? OR In the past 12 months, has your hospital developed a written action plan that describes how it will address at least one of the health care disparities identified through question #7?	*Yes* *No*
11) Does your hospital share information on its efforts to identify and reduce health care disparities based on *race, ethnicity, spoken language preferred for healthcare (patient or legal guardian), written language preferred for healthcare (patient or legal guardian), sexual orientation, gender identity* and the impact of those efforts on its public website?	*Yes* *No*
12) Does your hospital report out and discuss efforts related to identifying and addressing disparities with the Board at least annually?	*Yes* *No*
13) Does your hospital make unconscious and implicit bias training available to all hospital staff?	*Yes* *No*

APPENDIX V: INFORMED CONSENT QUESTIONS AND SCORING ALGORITHM FOR 2023

Section 1C: Informed Consent – Questions for 2023

Policies and Training

1) Does your hospital have a training program on informed consent that tailors different training topics to different staff roles, including hospital leaders, MD/NP/PA, nurses and other clinical staff, administrative staff, and interpreters, and has your hospital made the training: • a required component of onboarding for the appropriate newly hired staff, AND • required for the appropriate existing staff who were not previously trained?	*Yes* *No*

Content of Informed Consent Forms

2) As part of your hospital's process for obtaining informed consent, does: • the clinician explain expected difficulties, recovery time, pain management, and restrictions after a test, treatment, or procedure, in the facility and post-discharge, if applicable, • the patient have the opportunity to ask questions, AND • the consent form document that this element of the process has taken place?	*Yes* *No*
3) Do ALL your hospital's consent forms include: • the name(s) of the clinician(s) performing the test, treatment, or procedure, • whether the clinician is expected to be absent from portions of the test, treatment, or procedure (e.g., opening, closing), AND • if any assistants or trainees will be involved in the test, treatment, or procedure?	*Yes* *No*
4) Are ALL your hospital's consent forms written at a 6th grade reading level or lower? *The procedure name and description can be excluded from the reading level assessment.*	*Yes, all forms are written at a 6th grade reading level or lower* *At least one form is written at a 6th grade reading level or lower* *No forms are written at a 6th grade reading level or lower*

Process for Gaining Informed Consent

5) Prior to the informed consent discussion, does your hospital: • ask what the patient/legal guardian's preferred language for medical decision-making is, • where needed, provide the patient/legal guardian access to a qualified medical interpreter,	*Yes* *No*

• use a consent form or notation in the medical record that captures whether a qualified medical interpreter was used to conduct the informed consent process, AND • have the medical interpreter sign the consent form (either in-person, electronically, or noted in the medical record)? *If anyone other than a qualified medical interpreter is ever used to translate (e.g., caregiver or family member), select "No."*	
6) As part of the informed consent discussion, do clinicians at your hospital use the "teach back method" with patients/legal guardians, where patients/legal guardians are asked to describe, in their own words, what they understand will be performed, why it will be performed, and what are the primary risks?	*Yes* *No*

Additional Questions (Optional – Fact Finding Only)

7) Does your hospital's written policy on informed consent reference a list, or a defined set of guidelines, so the appropriate staff know which tests, treatments, and procedures require patient/legal guardian consent, with any exceptions noted?	*Yes* *No*
8) As part of your hospital's process for obtaining informed consent, does: • the clinician explain all of the patient's testing or treatment choices (including the choice of declining to go through with the test, treatment, or procedure), including the severity and probability of the risks and benefits of each choice, if applicable, • the patient have the opportunity to ask questions, AND • the consent form document that this element of the process has taken place?	*Yes* *No*
9) As part of your hospital's process for obtaining informed consent, does: • the clinician explain the clinical rationale (i.e., condition-specific justification) for why the test, treatment, or procedure is being performed, • the patient have the opportunity to ask questions, AND • the consent form document that this element of the process has taken place?	*Yes* *No*
10) Which clinician is responsible for conducting the informed consent process at your hospital?	*The clinician primarily responsible for performing the procedure* *Another clinician on the procedure team* *Another clinician not involved with performing the procedure* *Other*
11) As part of the informed consent discussion, do clinicians at your hospital tell patients/legal guardians how many times a year, on average, they perform the test, treatment, or procedure?	*Yes* *No*

12) For tests, treatments, and procedures that are scheduled a week (i.e., seven calendar days) or more in advance, is the consent form shared with the patient at least three calendar days before the patient's test, treatment, or procedure?	*Yes* *No*
13) For tests, treatments, and procedures that are scheduled a week (i.e., seven calendar days) or more in advance, do clinicians practicing at your hospital discuss the consent form with the patient/legal guardian at least one calendar day before the patient's procedure, and is the patient/legal guardian provided with an opportunity to ask questions?	*Yes* *No*
14) At least once a year, does your hospital solicit feedback from patients/legal guardians about your hospital's informed consent process to understand how it can be improved over time?	*Yes* *No*
15) At least once a year, does your hospital complete an audit of the informed consent process to evaluate its efficacy and provide feedback to staff on opportunities for improvement?	*Yes* *No*

Section 1C: Informed Consent –Scoring Algorithm for 2023

Informed Consent Score (Performance Category)	**Meaning that…**
Achieved the Standard (4 bars)	The hospital responded "yes, **all** forms are written at a 6th grade reading level or lower" to question #4 and then "yes" to the remaining **five** questions in Policies and Training (question #1), Content of Informed Consent Forms (questions #2-3), and Process for Gaining Informed Consent (questions #5-6).
Considerable Achievement (3 bars)	The hospital responded "yes, **all** forms are written at a 6th grade reading level or lower" **and** then "yes" to at least **four** additional questions in Policies and Training (question #1), Content of Informed Consent Forms (questions #2-3), and Process for Gaining Informed Consent (questions #5-6). **OR** The hospital responded that "at least **one** form is written at a 6th grade reading level or lower" and then "yes" to the **five** remaining questions in Policies and Training (question #1), Content of Informed Consent Forms (questions #2-3), and Process for Gaining Informed Consent (questions #5-6).
Some Achievement (2 bars)	The hospital responded "yes, **all** forms are written at a 6th grade reading level or lower" **OR** "at least **one** form is written at a 6th grade reading level or lower" and then "yes" to at least **three** additional questions in Policies and Training (question #1), Content of Informed Consent Forms (questions #2-3), and Process for Gaining Informed Consent (questions #5-6). **OR**

	The hospital responded "No forms are written at a 6th grade reading level or lower" but responded "yes" to **at least four** questions in Policies and Training (question #1), Content of Informed Consent Forms (questions #2-4), and Process for Gaining Informed Consent (questions #5-6).
Limited Achievement (1 bar)	The hospital responded to all the questions in this section, but it does not yet meet the criteria for Some Achievement.

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APPENDIX VI: BAR CODE MEDICATION ADMINISTRATION OPTIONAL FACT-FINDING QUESTIONS FOR 2023

1) Does your hospital operate pre-operative units? *If your hospital has a combined pre-operative and post anesthesia care unit (PACU), select "yes" to question #1 and report the data for the combined unit in questions #2-5.* *If "no" to question #1, skip questions #2-5 and continue to question #6.*	*Yes* *No*
2) If "yes," how many of this type of unit are open and staffed in the hospital?	_____
3) How many of the units in question #2 utilized the BCMA/eMAR system when administering medications at the bedside?	_____
4) The number of scannable medication administrations during the reporting period in those **pre-operative units** that utilize BCMA as indicated in question #3 above:	_____
5) The number of medication administrations from question #4 that had both the patient and the medication scanned during administration with a BCMA system that is linked to the electronic medication administration record (eMAR):	_____
6) Does your hospital operate post anesthesia care units (PACUs)? *If your hospital has a combined pre-operative and post anesthesia care unit (PACU), select "no" to question #6 and instead report on questions #1-5.* *If "no" to question #6, skip questions #7-10 and continue to question #11.*	*Yes* *No*
7) If "yes," how many of this type of unit were open and staffed in the hospital?	_____
8) How many of the units in question #7 utilized the BCMA/eMAR system when administering medications at the bedside?	_____
9) The number of scannable medication administrations during the reporting period in those **PACUs** that utilize BCMA as indicated in question #8 above:	_____
10) The number of medication administrations from question #9 that had both the patient and the medication scanned during administration with a BCMA system that is linked to the eMAR:	_____
11) Does your hospital operate an emergency department? *If "no" to question #11, skip questions #12-15 and continue to the next subsection.*	*Yes* *No*
12) If "yes," how many of this type of unit were open and staffed in the hospital?	_____
13) How many of the units in question #12 utilized the BCMA/eMAR system when administering medications at the bedside?	_____
14) The number of scannable medication administrations during the reporting period in those **emergency departments** that utilize BCMA as indicated in question #13 above:	_____
15) The number of medication administrations from question #14 that had both the patient and the medication scanned during administration with a BCMA system that is linked to the eMAR:	_____

APPENDIX VII: NORWOOD PROCEDURE SCORING ALGORITHM FOR 2023

First, hospitals will be assigned points based on whether they meet each of the three (3) criteria:

Norwood Procedure Criteria	Leapfrog's Standard	Points Assigned
The hospital met the minimum hospital volume standard	Hospital has experience with 8 cases per year	• 50 points, if met • 0 points, if not met
The hospital's process for privileging surgeons includes meeting or exceeding the minimum annual surgeon volume standard	Hospital's privileging process requires a surgeon to have experience with at least 5 cases per year	• 25 points, if met • 0 points, if not met
The hospital participates in the Society of Thoracic Surgeons (STS) Congenital Heart Surgery Database (CHSD)	Hospital participates in STS CHSD	• 50 points, if participates • 0 points, if does not participate

Then points on each criterion are totaled together to assign an overall Performance Category for public reporting:

Norwood Procedure Score (Performance Category)	**Total Points**
Achieved the Standard (4 bars)	100 or more points
Considerable Achievement (3 bars)	75 points
Some Achievement (2 bars)	50 points
Limited Achievement (1 bar)	25 or fewer points
Does Not Apply	The hospital does not perform the procedure.

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APPENDIX VIII: MATERNITY CARE SERVICES QUESTIONS FOR 2023 (PUBLICLY REPORTED)

1) Does your hospital have certified nurse-midwives and/or certified midwives deliver newborns?	*Yes* *No*
2) Does your hospital use doulas for labor and delivery? *Select all that apply.*	☐ *Yes, the hospital employs or contracts with doulas* ☐ *Yes, the hospital allows patients to bring their own doulas* ☐ *No*
3) Does your hospital offer breastfeeding/lactation consultants? *Select all that apply.*	☐ *Yes, in the hospital* ☐ *Yes, in the outpatient setting* ☐ *Yes, at home after discharge* ☐ *No*
4) Is your hospital designated as a Baby-Friendly hospital based on the World Health Organization/UNICEF Baby-Friendly Hospital Initiative (i.e., they adhere to the Ten Steps to Successful Breastfeeding)?	*Yes* *No*
5) Does your hospital routinely offer vaginal birth after cesarean section (VBAC)?	*Yes* *No*
6) Does your hospital offer postpartum tubal ligation during the labor and delivery admission?	*Yes* *No*

APPENDIX IX: CESAREAN BIRTH OPTIONAL FACT-FINDING QUESTIONS FOR 2023

1) Did your hospitals stratify NTSV cesarean births by the racial and ethnic categories below for the reporting period and do you choose to report those data to this Survey? *If "no" to question #1, skip question #2 and continue to the next subsection.*		*Yes* *No*
2) Enter your hospital's responses below by racial and ethnic category: *If the number of cases for a racial/ethnic category is less than 10 (in column a), skip column b and then move to the next category. If zero, enter "0" in column a.*		
Racial and Ethnic Category	a) Total number of nulliparous mothers (or sufficient sample of them) that delivered a live term singleton newborn in the vertex presentation with >= 37 weeks of gestation completed, with ***Excluded populations*** removed (denominator)	b) Total number of mothers indicated in question #2a that had their newborn delivered via cesarean section (numerator)
Non-Hispanic White	_____	_____
Non-Hispanic Black	_____	_____
Non-Hispanic American Indian or Alaska Native	_____	_____
Non-Hispanic Asian or Pacific Islander	_____	_____
Hispanic	_____	_____
Non-Hispanic Other (including two or more races)	_____	_____
Unknown	_____	_____

APPENDIX X: VON REPORTING PERIODS AND DEADLINES FOR 2023

Complete and submit Data Sharing Authorization to VON by*	Data downloaded from VON will be scored and publicly reported for hospitals that have submitted Section 4 by	VON Reporting Period	Available on Hospital Details Page and Public Reporting Website on
June 15, 2023	June 30, 2023	2021	July 12, 2023 Hospital Details Page July 25, 2023 Public Reporting Website
August 15, 2023	August 31, 2023	2022**	September 8, 2023***
November 15, 2023	November 30, 2023	2022	December 7, 2023***

* Hospitals that successfully submitted a Data Sharing Authorization letter in previous years will not be required to submit another letter in 2023.
**Anticipated release of 2022 VON data.
*** Available on Hospital Details Page on the same date as public release of Survey Results

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APPENDIX XI: ICU PHYSICIAN STAFFING QUESTIONS AND SCORING ALGORITHM FOR 2023

Section 5: ICU Physician Staffing (IPS) – Questions for 2023

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

There are currently two different options to achieve Leapfrog's ICU Physician Standard: on-site intensivist coverage for 8 hours a day/7 days per week or 24/7 tele-intensivist coverage with some daily on-site intensivist coverage. Questions #5 and #6 are meant to differentiate between these two options; however, they are both worth the same credit. Hospitals that have 24/7 ***on-site*** *intensivist coverage, and who meet all the criteria listed, should respond "yes" to question #5.*

5) Are all critical care patients in the ICU managed or co-managed by one or more physicians certified in critical care medicine who meet **all** of the following criteria: • ordinarily present **on-site** in the ICU during daytime hours • for at least **8 hours per day, 7 days per week** • providing clinical care exclusively in the ICU during these hours *If "yes" to question #5, skip question #6 and continue to question #7.*	*Yes* *No*
6) Are all critical care patients in the ICU managed or co-managed by one or more physicians certified in critical care medicine who meet **all** of the following criteria: • present via telemedicine, in combination with on-site intensivist coverage, for a total of **24 hours per day, 7 days per week** • meet all of Leapfrog's ICU requirements for intensivist presence in the ICU via telemedicine • supported by an on-site intensivist who establishes and revises the daily care plan for each ICU patient	*Yes* *No*

If "no" to question #5 and question #6, skip questions #7-8 and continue to question #9.

7) When the physicians (from question #3) are not present in the ICU on-site or via telemedicine, do they return more than 95% of calls/pages/texts from these units within five minutes, based on a quantified analysis of notification device response time?	*Yes* *No* *Not applicable; intensivists are present on-site 24/7*
8) When the physicians (from question #3) are not present on-site in the ICU or not able to physically reach an ICU patient within 5 minutes, can they rely on a physician, physician assistant, nurse practitioner, or FCCS-certified nurse or intern "effector" who is in the hospital and able to reach these ICU patients within five minutes in more than 95% of the cases, based on a quantified analysis of response time of the effector reaching the patient?	*Yes* *No* *Not applicable; intensivists are present on-site 24/7*

If "no" to either question #7 or #8 in this section, please answer questions #9-15. If "yes" or "not applicable; intensivists are present on-site 24/7" to questions #7 and #8, skip the remaining questions in Section 5 and go to the Affirmation of Accuracy.

9) Are all critical care patients in the ICU managed or co-managed by one or more physicians certified in critical care medicine who meet **all** of the following criteria: • ordinarily present on-site in the ICU during daytime hours • for at least **8 hours per day, 4 days per week or 4 hours per day, 7 days per week** • providing clinical care exclusively in the ICU during these hours	*Yes* *No*

10) Are all critical care patients in the ICU managed or co-managed by one or more physicians certified in critical care medicine who meet **all** of the following criteria: • present via telemedicine for **24 hours per day, 7 days per week** • meet all of Leapfrog's modified ICU requirements for intensivist presence in the ICU via telemedicine • supported in the establishment and revision of daily care planning for each ICU patient by an on-site intensivist, hospitalist, anesthesiologist, or physician trained in emergency medicine	*Yes* *No*
11) Are all critical care patients in the ICU managed or co-managed by one or more physicians certified in critical care medicine who are: • on-site at least **4 days per week** to establish or revise daily care plans for each critical care patient in the ICU	*Yes* *No*

If "yes" to question #9, #10, or #11, skip question #12 and continue to question #13.

12) If not all critical care patients are managed or co-managed by physicians certified in critical care medicine, either on-site or via telemedicine, are **some patients** managed or co-managed by these physicians who are: • ordinarily present on-site in the ICU during daytime hours • for at least **8 hours per day, 4 days per week or 4 hours per day, 7 days per week** • providing clinical care exclusively in the ICU during these hours	*Yes* *No*
13) Does an on-site clinical pharmacist do **all** of the following: • at least 5 days per week, makes daily on-site rounds on all critical care patients in the ICU • on the other 2 days per week, returns more than 95% of calls/pages/texts from the unit within 5 minutes, based on a quantified analysis of notification device response time **OR** makes daily on-site rounds on all critical care patients in the ICU 7 days per week	*Yes* *No* *Clinical pharmacist rounds 7 days per week*
14) Does a physician certified in critical care medicine lead daily interprofessional rounds on-site on all critical care patients in the ICU 7 days per week?	*Yes* *No*
15) Are physicians certified in critical care medicine responsible for all ICU admission and discharge decisions when they are: • present on-site for at least **8 hours per day, 4 days per week or 4 hours per day, 7 days per week**	*Yes* *No*

Section 5: ICU Physician Staffing (IPS) – Scoring Algorithm for 2023

IPS Score (Performance Category)	Meaning that…

Achieved the Standard (4 bars)	The hospital responded "Yes" or "Not applicable, intensivists are present 24/7" to **all** the following questions:
	
	• Question #3:
	The ICU is staffed with physicians either present on-site or via telemedicine who are either certified in critical care medicine or meet Leapfrog's expanded definition for certification in critical care
	• Question #4:
	All critical care patients are being managed or co-managed by physicians certified in critical care medicine (when present on-site or via telemedicine)
	
	• Question #5 **or** #6:
	One or more intensivist(s) is/are
	  ○ Ordinarily present on-site in the ICU during daytime hours for at least 8 hours per day, 7 days per week, providing clinical care exclusively in the ICU during these hours
	  ○ Present via telemedicine, in combination with on-site intensivist coverage, for a total of 24 hours per day, 7 days per week; meet all of Leapfrog's ICU requirements for intensivist presence in the ICU via telemedicine; and supported by an on-site intensivist who establishes and revises the daily care plan for each ICU patient
	• Question #7:
	When physicians (from question #3) are not present (on-site or via telemedicine) in the ICU, one of them returns more than 95% of calls/pages/texts from these units within five minutes
	• Question #8:
	When physicians (from question #3) are not present (on-site or via telemedicine) in the ICU or not able to physically reach an ICU patient within 5 minutes, another physician, physician assistant, nurse practitioner or FCCS-certified nurse "effector" is on-site at the hospital and able to reach ICU patients within five minutes in more than 95% of the cases
	
	Note: When telemedicine is employed as a substitute for on-site intensivist coverage, it must meet all ten requirements detailed in endnote #29 (in the hard copy of the Survey), which includes some on-site intensivist time to manage the ICU patients' admissions, discharges, and care planning.

IPS Score (Performance Category)	Meaning that…

Considerable Achievement (3 bars)	The hospital responded "Yes" or "Clinical pharmacist rounds 7 days per week" to **all** the following questions:
	• Question #3: The ICU is staffed with physicians either present on-site or via telemedicine who are either certified in critical care medicine or meet Leapfrog's expanded definition for certification in critical care
	• Question #4: All critical care patients are being managed or co-managed by physicians certified in critical care medicine (when present on-site or via telemedicine)
	• Question #9 **or** #13:
	  ○ One or more intensivist(s) is/are ordinarily present in the ICU during daytime hours for at least 8 hours per day, 4 days per week or 4 hours per day, 7 days per week; providing clinical care exclusively in the ICU during these hours
	  ○ On-site clinical pharmacist makes daily rounds on all critical care patients in the ICU at least 5 days/week, and on the other 2 days/week, a clinical pharmacist returns more than 95% of calls/pages/texts from these units within five minutes; or on-site clinical pharmacist rounds 7 days per week
	• Question #14 **or** #15:
	  ○ An intensivist leads daily, interprofessional rounds on-site on all critical care patients in the ICU 7 days per week
	  ○ When intensivists are on-site in the ICU, they make all admission and discharge decisions at least 8 hours per day, 4 days per week OR 4 hours per day, 7 days a week

Considerable Achievement (alternative) (3 bars)	The hospital responded "Yes" to **all** the following questions: • Question #3: The ICU is staffed with physicians either present on-site or via telemedicine who are either certified in critical care medicine or meet Leapfrog's expanded definition for certification in critical care • Question #4: All critical care patients are being managed or co-managed by physicians certified in critical care medicine (when present on-site or via telemedicine) • Question #10: One or more intensivist(s) is/are present via telemedicine 24 hours per day, 7 days per week, meet all of Leapfrog's modified ICU requirements, with on-site care planning done by an intensivist, hospitalist, anesthesiologist, or a physician trained in emergency medicine

IPS Score (Performance Category)	Meaning that…
	Note: When telemedicine is employed as a substitute for on-site intensivist coverage, it must meet all nine requirements detailed in endnote #34 (in the hard copy of the Survey).

Some Achievement (2 bars)	The hospital responded "Yes" to **all** the following questions:
	• Question #3: The ICU is staffed with physicians either present on-site or via telemedicine who are either certified in critical care medicine or meet Leapfrog's expanded definition for certification in critical care
	• Question #4: All critical care patients are being managed or co-managed by physicians certified in critical care medicine (when present on-site or via telemedicine)
	• Question #11: One or more intensivist(s) is/are present on-site at least 4 days per week to establish or revise daily care plans for all critical care patients in the ICU
	• Question #14 **or** #15:
	  ○ An intensivist leads daily, interprofessional rounds on-site on all critical care patients in the ICU 7 days per week
	  ○ When intensivists are on-site in the ICU, they make all admission and discharge decisions at least 8 hours per day, 4 days per week OR 4 hours per day, 7 days a week
	Or the hospital responded "Yes" to **all** the following questions:
	• Question #12: If not all, at least some critical care patients are managed or co-managed by physicians who are certified in critical care medicine (i.e., "intensivists"), either on-site or via telemedicine at least 8 hours per day, 4 days per week OR 4 hours per day, 7 days per week
	• Question #14 **or** #15:
	  ○ An intensivist leads daily, interprofessional rounds on-site on all critical care patients in the ICU 7 days per week
	  ○ When intensivists are on-site in the ICU they make all admission and discharge decisions at least 8 hours per day, 4 days per week OR 4 hours per day, 7 days a week
	Note: When telemedicine is employed as a substitute for on-site intensivist coverage, it must meet all nine requirements detailed in endnote #34 (in the hard copy of the Survey).

IPS Score (Performance Category)	Meaning that…
Limited Achievement (1 bar)	The hospital responded to all the questions in this section, but it does not yet meet the criteria for ***Some Achievement***.
Does Not Apply	The hospital does not operate an adult or pediatric general medical or surgical intensive care unit or a neuro intensive care unit.

THE LEAPFROG GROUP
Giant Leaps for Patient Safety

APPENDIX XII: NURSE STAFFING AND SKILL LEVEL SCORING ALGORITHMS FOR 2023

A hospital's performance on the **Total Nursing Care Hours per Patient Day** measure is calculated by adding together the "Total number of productive hours worked by employee or contract nursing staff with direct patient care responsibilities" across all three unit types (medical, surgical, and med/surg) and all four quarters, and then dividing by the sum of the "Total number of patient days" across all three unit types (medical, surgical, and med/surg) and all four quarters.

To calculate the 50th, 25th, and 10th percentiles used in scoring, Leapfrog places hospitals into one of five cohorts based on teaching designation reported on in the 2022 Patient Safety Component – Annual Hospital Survey in NHSN and number of staffed beds reported in Section 1A: Basic Hospital Information of the 2023 Leapfrog Hospital Survey:

- small teaching (< 500 staffed beds)
- large teaching (> 499 staffed beds)
- non-teaching (includes hospitals that do not join Leapfrog's NHSN Group)
- pediatric
- critical access hospitals

Hospitals are only compared to hospitals within the same cohort.

Total Nursing Care Hours per Patient Day Score (Performance Category)	**Meaning that…**
Achieved the Standard (4 bars)	The hospital's total nursing care hours per patient day is **greater than or equal to the 50th percentile** (where higher is better) for that hospital's cohort (small teaching, large teaching, non-teaching, pediatric, or critical access hospital).
Considerable Achievement (3 bars)	The hospital's total nursing care hours per patient day is **less than the 50th percentile but greater than or equal to the 25th percentile** (where higher is better) for that's hospital cohort (small teaching, large teaching, non-teaching, pediatric, or critical access hospital).
Some Achievement (2 bars)	The hospital's total nursing care hours per patient day is **less than the 25th percentile but greater than or equal to the 10th percentile** (where higher is better) for that's hospital cohort (small teaching, large teaching, non-teaching, pediatric, or critical access hospital). **OR** The hospital's responses did not pass Leapfrog's Extensive Monthly Data Verification Process.
Some Achievement (alternative) (2 bars)	The hospital's total nursing care hours per patient day is **less than the 10th percentile** (where higher is better) for that's hospital cohort (small teaching, large teaching, non-teaching, pediatric, or critical access hospital). **AND** The hospital achieved Leapfrog's standard for National Quality Forum (NQF) Safe Practice #9 – Nursing Workforce.
Limited Achievement (1 bar)	The hospital's total nursing care hours per patient day is **less than the 10th percentile** (where higher is better) for that's hospital cohort (small teaching, large teaching, non-teaching, pediatric, or critical access hospital). **OR** The hospital did not measure.

Does Not Apply	The hospital does not have any Medical, Surgical, or Med-Surg Units.

A hospital's performance on the **RN Hours per Patient Day** measure is calculated by adding together the "Total number of productive hours worked by RN nursing staff with direct patient care responsibilities" across all three unit types (medical, surgical, and med/surg) and all four quarters and dividing by the sum of the "Total number of patient days" across all three unit types (medical, surgical, and med/surg) and all four quarters.

To calculate the 50th, 25th, and 10th percentiles used in scoring, Leapfrog places hospitals into one of five cohorts based on teaching designation reported on in the 2022 Patient Safety Component – Annual Hospital Survey in NHSN and number of staffed beds reported in Section 1A: Basic Hospital Information of the 2023 Leapfrog Hospital Survey:

- small teaching (< 500 staffed beds)
- large teaching (> 499 staffed beds)
- non-teaching (includes hospitals that do not join Leapfrog's NHSN Group)
- pediatric
- critical access hospitals

Hospitals are only compared to hospitals within the same cohort.

RN Hours per Patient Day Score (Performance Category)	Meaning that…
Achieved the Standard (4 bars)	The hospital's RN hours per patient day is **greater than or equal to the 50th percentile** (where higher is better) for that hospital's cohort (small teaching, large teaching, non-teaching, pediatric, or critical access hospital).
Considerable Achievement (3 bars)	The hospital's RN hours per patient day is **less than the 50th percentile but greater than or equal to the 25th percentile** (where higher is better) for that's hospital cohort (small teaching, large teaching, non-teaching, pediatric, or critical access hospital).
Some Achievement (2 bars)	The hospital's RN hours per patient day is **less than the 25th percentile but greater than or equal to the 10th percentile** (where higher is better) for that's hospital cohort (small teaching, large teaching, non-teaching, pediatric, or critical access hospital). **OR** The hospital's responses did not pass Leapfrog's Extensive Monthly Data Verification Process.
Some Achievement (alternative) (2 bars)	The hospital's RN hours per patient day is **less than the 10th percentile** (where higher is better) for that's hospital cohort (small teaching, large teaching, non-teaching, pediatric, or critical access hospital). **AND** The hospital achieved Leapfrog's standard for National Quality Forum (NQF) Safe Practice #9 – Nursing Workforce.
Limited Achievement (1 bar)	The hospital's RN hours per patient day is **less than the 10th percentile** (where higher is better) for that's hospital cohort (small teaching, large teaching, non-teaching, pediatric, or critical access hospital). **OR**

	The hospital did not measure.
Does Not Apply	The hospital does not have any Medical, Surgical, or Med-Surg Units.

A hospital's performance on the **Nursing Skill Mix** measure is calculated by adding together the "Total number of productive hours worked by RN nursing staff with direct patient care responsibilities" across all three unit types (medical, surgical, and med/surg) and all four quarters and dividing by the sum of the "Total number of productive hours worked by employee or contract nursing staff with direct patient care responsibilities" across all three unit types (medical, surgical, and med/surg) and all four quarters.

The result is the percentage of total productive nursing hours worked by RN (employee and contract) nursing staff with direct patient care responsibilities in all medical, surgical, or med-surgical units.

To calculate the 10th, 25th, and 50th percentiles used in scoring, Leapfrog places hospitals into one of five cohorts based on teaching designation reported on in the 2022 Patient Safety Component – Annual Hospital Survey in NHSN and number of staffed beds reported in Section 1A: Basic Hospital Information of the 2023 Leapfrog Hospital Survey:

- small teaching (< 500 staffed beds)
- large teaching (> 499 staffed beds)
- non-teaching (includes hospitals that do not join Leapfrog's NHSN)
- pediatric
- critical access hospitals

Hospitals are only compared to hospitals within the same cohort.

Nursing Skill Mix Score (Performance Category)	Meaning that…
Achieved the Standard (4 bars)	The hospital's percentage of total productive nursing hours worked by RN nursing staff is **higher than or equal to the 50th percentile** (where a higher is better) for that hospital's cohort (small teaching, large teaching, non-teaching, pediatric, or critical access hospital).
Considerable Achievement (3 bars)	The hospital's percentage of total productive nursing hours worked by RN nursing staff is **lower than the 50th percentile but higher than or equal to the 25th percentile** (where higher is better) for that hospital's cohort (small teaching, large teaching, non-teaching, pediatric, or critical access hospital).
Some Achievement (2 bars)	The hospital's percentage of total productive nursing hours worked by RN nursing staff is **lower than the 25th percentile but higher than or equal to the 10th percentile** (where higher is better) for that hospital's cohort (small teaching, large teaching, non-teaching, pediatric, or critical access hospital) **OR** The hospital's responses did not pass Leapfrog's Extensive Monthly Data Verification Process.
Some Achievement (alternative) (2 bars)	The hospital's percentage of total productive nursing hours worked by RN nursing staff is **lower than the 10th percentile** (where higher is

	better) for that hospital's cohort (small teaching, large teaching, non-teaching, pediatric, or critical access hospital) **AND** The hospital achieved Leapfrog's standard for National Quality Forum (NQF) Safe Practice #9 – Nursing Workforce.
Limited Achievement (1 bar)	The hospital's percentage of total productive nursing hours worked by RN nursing staff is **lower than the 10th percentile** (where higher is better) for that hospital's cohort (small teaching, large teaching, non-teaching, pediatric, or critical access hospital) **OR** The hospital did not measure.
Does Not Apply	The hospital does not have any Medical, Surgical, or Med-Surg Units.

A hospital's performance on the **Percentage of RNs who are BSN-prepared** measure will be based on the percentage of RNs who are BSN-prepared.

Percentage of RNs who are BSN-prepared Score (Performance Category)	Percentage of BSN-prepared RNs
Achieved the Standard (4 bars)	>= 80%
Considerable Achievement (3 bars)	> 50% and <= 79%
Some Achievement (2 bars)	> 20% and <= 49%
Limited Achievement (1 bar)	< = 20% or the hospital did not measure

A hospital's performance on the **NQF Safe Practice #9 – Nursing Workforce** measure is only used if the hospital scores in the bottom performance category (Limited Achievement) on the Total Nursing Care Hours per Patient Day measure, RN Hours Per Patient Day measure, or Nursing Skill Mix measure. See above for more information.

NQF Safe Practice #9 Score (Performance Category)	Meaning that…
Achieved the Standard	The hospital responded "yes" to all five elements, the hospital is currently recognized as an American Nurses Credentialing Center (ANCC) Magnet® organization, or the hospital is currently recognized as a 2020 Pathway to Excellence® organization.

APPENDIX XIII: NHSN REPORTING PERIODS AND DEADLINES FOR 2023

Join Leapfrog's NSHN Group by	Leapfrog will download data from NHSN for all current group members on	Data downloaded from NHSN will be scored and publicly reported for hospitals that have submitted Section 7 by	HAI Reporting Period	Available on Hospital Details Page and Public Reporting Website on
June 22, 2023	June 23, 2023	June 30, 2023	01/01/2022 – 12/31/2022	July 12, 2023 Details Page July 25, 2023 Public Reporting Website
August 23, 2023	August 24, 2023	August 31, 2023	01/01/2022 – 12/31/2022	September 8, 2023*
October 23, 2023	October 24, 2023	October 31, 2023	07/01/2022 – 06/30/2023	November 7, 2023*
December 20, 2023	December 21, 2023**	November 30, 2023	07/01/2022 – 06/30/2023	January 8, 2024*

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

* Available on Hospital Details Page on the same date as the public release of Survey Results
** The Leapfrog Hospital Survey closes on November 30, 2023. The last NHSN data download is on December 21, 2023 to incorporate any facilities and corrections from facilities that joined by the last join date of December 20, 2023.

APPENDIX XIV: PATIENT FOLLOW-UP REPORTING PERIODS AND DEADLINES FOR 2023

Data downloaded from CMS* will be scored and publicly reported for Hospitals that have submitted Section 10 by	CMS Reporting Period	Available on Hospital Details Page and Public Reporting Website on
June 30, 2023	Most recent 24 months	July 12, 2023 Details Page July 25, 2023 Public Reporting Website
August 31, 2023	Most recent 24 months	September 8, 2023**
November 30, 2023	Most recent 24 months	December 7, 2023**

* Data will be downloaded from the CMS provider catalog at https://data.cms.gov/provider-data/dataset/632h-zaca.
** Available on Hospital Details Page on the same date as public release of Survey Results

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