

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA
WEST PALM BEACH DIVISION

CASE NO. 9:25-CV-80526-DMM

GOOD SAMARITAN MEDICAL
CENTER, INC., et al.,

Plaintiffs,

v.

THE LEAPFROG GROUP,

Defendant.

**DECLARATION OF MARY BETH MALONEY IN SUPPORT OF
THE COMMUNITY HOSPITALS' MOTION FOR SUMMARY JUDGMENT**

I, Mary Beth Maloney, declare and state as follows:

1. I am a partner at the law firm of Gibson, Dunn, & Crutcher LLP. I am an attorney and admitted to practice law in the States of New York and California. I have been granted permission by the Court to participate *pro hac vice* in this case. Dkt. 14. I represent the Community Hospitals in this matter and submit this declaration in support of the Community Hospitals' Motion for Summary Judgment (the "Motion") and Rule 56.1 Statement of Material Facts in Support of the Motion (the "Rule 56.1 Statement") filed contemporaneously herewith.

2. I am over the age of eighteen and make this declaration from personal knowledge based on the information and documents referenced in this Declaration.

3. Below I address the various exhibits identified in the Motion and the Rule 56.1 Statement organized by documents produced in this action by the Community Hospitals (Bates stamp beginning with "PBHN"), the Defendant-Leapfrog (Bates stamp beginning with "LEAPFROG"), University of California, Davis (Bates stamp beginning with "UCDAVISTLG"), Patrick Romano (Bates stamp beginning with "ROMANO"), Cura Strategies (Bates stamp beginning with "CURA"), and Florida Alliance for Healthcare Value (Bates stamp beginning with "FHA") (collectively "Produced Documents"), as set forth at, **I. Produced Documents** (Exs.

1-57); and documents collected from public sources, as set forth at, **II. Publicly Accessible Documents** (Exs. 58-79); and documents that were publicly accessible during discovery, but that Leapfrog has since removed from their website, as set forth at, **III. Leapfrog Website Pages, No Longer Publicly Available** (Exs. 80-83); and transcripts of depositions taken in this case, as set forth at, **IV. Deposition Transcripts** (Exs. 84-98); and interrogatory responses served in this case, as set forth at, **V. Interrogatory Responses** (Exs. 99-103).

I. Produced Documents

4. Attached as **Exhibit 1** is a true and correct copy of a *Journal of Patient Safety* article dated April 1, 2013 titled “Safety in Numbers: The Development of Leapfrog’s Composite Patient Safety Score for U.S. Hospitals,” bearing the Bates stamp LEAPFROG3100665.

5. Attached as **Exhibit 2** is a true and correct copy of Leapfrog’s *Business Development Discovery Report* dated February 13, 2018, bearing the Bates stamp LEAPFROG3477483.

6. Attached as **Exhibit 3** is a true and correct copy of a “white paper” authored by Dr. Matthew Austin and Jordan Derk titled *Lives Lost, Lives Saved: An Updated Comparative Analysis of Avoidable Deaths at Hospitals Graded by The Leapfrog Group*, dated May 2019 (the “Lives Lost White Paper”), bearing the Bates stamp LEAPFROG3553123.

7. Attached as **Exhibit 4** is a true and correct copy of Leapfrog’s *2021 Annual Report*, bearing the Bates stamp LEAPFROG02336712.

8. Attached as **Exhibit 5** is a true and correct copy of an excerpt of an Excel spreadsheet showing Leapfrog “Safety Grades” from 2012 to 2023, bearing the Bates stamp LEAPFROG00139502.

9. Attached as **Exhibit 6** is a true and correct copy of Leapfrog’s *Spring 2023 Hospital Safety Grade Scoring Methodology* dated April 10, 2023, bearing the Bates stamp LEAPFROG00030928.

10. Attached as **Exhibit 7** is a true and correct copy of Leapfrog’s *2024 Regional Leader Communications Toolkit*, bearing the Bates stamp LEAPFROG00140378.

11. Attached as **Exhibit 8** is a true and correct copy of a slideshow presentation authored by Alexandra Campione titled *2023 Leapfrog Hospital Safety Grade Accolades Sales Analysis* dated January 2024, bearing the Bates stamp LEAPFROG01168245.

12. Attached as **Exhibit 9** is a true and correct copy of a slideshow presentation titled *Leapfrog Hospital Safety Grade Expert Panel Meeting* dated April 12, 2024, bearing the Bates stamp LEAPFROG00437363.

13. Attached as **Exhibit 10** is a true and correct copy of a Zoom conference video of the April 12, 2024 Leapfrog Hospital Safety Grade Expert Panel Meeting (“Expert Panel Meeting”), bearing the Bates stamp PBHN000017982. This video will be lodged with the Court pursuant to the Community Hospitals’ forthcoming motion to file a video document.

14. Attached as **Exhibit 11** is a true and correct copy of a Zoom conference transcript of the Expert Panel Meeting, bearing the Bates stamp PBHN000018066.

15. Attached as **Exhibit 12** is a true and correct copy of a certified transcript of the Expert Panel Meeting, bearing the Bates stamp PBHN000017983.

16. Attached as **Exhibit 13** is a true and correct copy of an April 22, 2024 email from Matthew Austin to Alexandra Campione, Melissa Danforth, and Preeti Joshi, bearing the Bates stamp LEAPFROG00198293.

17. Attached as **Exhibit 14** is a true and correct copy of an April 25, 2024 email from Ben Choi to Melissa Danforth bearing the Bates stamp LEAPFROG00198278.

18. Attached as **Exhibit 15** is a true and correct copy of a May 3, 2024 email from Patrick Romano to Brenda L. Inman, Robert Jon Kucejko, Penny Jefferson, and Tami L. Gomez bearing the Bates stamp UCDAVISTLG00000635.

19. Attached as **Exhibit 16** is a true and correct copy of a May 14, 2024 email from Patrick Romano to Matthew Austin, bearing the Bates stamp LEAPFROG00198275.

20. Attached as **Exhibit 17** is a true and correct copy of a May 15, 2024 email from Alexandra Campione to Patrick Romano, bearing the Bates stamp LEAPFROG01081490.

21. Attached as **Exhibit 18** is a true and correct copy of a May 21, 2024 email from Leapfrog Help Desk to Alexandra Campione, bearing the Bates stamp LEAPFROG00439030.

22. Attached as **Exhibit 19** is a true and correct copy of a Leapfrog slideshow presentation titled *Strategic Planning Update for the Board of Directors* dated June 2024, bearing the Bates stamp LEAPFROG00237725.

23. Attached as **Exhibit 20** is a true and correct copy of a June 6, 2024 comment from Alana Noble of Mount Sinai Health System to Leapfrog, bearing the Bates stamp LEAPFROG00044934.

24. Attached as **Exhibit 21** is a true and correct copy of a June 7, 2024 comment from Zubin Momin of Piedmont Healthcare to Leapfrog, bearing the Bates stamp LEAPFROG00044966.

25. Attached as **Exhibit 22** is a true and correct copy of a June 10, 2024 comment from Susan Boardman of Providence System to Leapfrog, bearing the Bates stamp LEAPFROG00045043.

26. Attached as **Exhibit 23** is a true and correct copy of a June 18, 2024 email from Paulina Litter to Alexandra Campione, bearing the Bates stamp LEAPFROG00427863.

27. Attached as **Exhibit 24** is a true and correct copy of an internal draft of Leapfrog's *Final Updates to the Leapfrog Hospital Safety Grade Methodology for Fall 2024*, bearing the Bates stamp LEAPFROG00178628.

28. Attached as **Exhibit 25** is a true and correct copy of Leapfrog's *Consolidated Financial Statements* dated June 30, 2024, bearing the Bates stamp LEAPFROG01059783.

29. Attached as **Exhibit 26** is a true and correct copy of a July 15, 2024 email from Leah Binder to Paul Alper, bearing the Bates stamp LEAPFROG00340327.

30. Attached as **Exhibit 27** is a true and correct copy of an August 27, 2024 email from Karen Jupiter to Melissa Danforth, bearing the Bates stamp LEAPFROG00179185.

31. Attached as **Exhibit 28** is a true and correct copy of Leapfrog's Fall 2024 *Hospital Safety Grade Scoring Methodology* dated November 4, 2024, which was downloaded from the following website: <https://www.hospitalsafetygrade.org/media/file/Safety-Grade-Scoring-Methodology-Fall-2024.pdf>, bearing the Bates stamp PBHN000003044.

32. Attached as **Exhibit 29** is a true and correct copy of a *Dwyer & Michaels* article titled "3 Florida Hospitals Receive F Grades for Patient Safety" dated November 26, 2024, which was downloaded from the following website: <https://97x.com/3-florida-hospitals-receive-f-grades-for-patient-safety/>, bearing the Bates stamp PBHN000002245.

33. Attached as **Exhibit 30** is a true and correct copy of a document titled *Leapfrog Long Range Strategic Intent FY2026-2032* dated December 2024, bearing the Bates stamp LEAPFROG00376926.

34. Attached as **Exhibit 31** is a true and correct copy of a *Stet News* article titled "Tenet hospitals at bottom of local safety grades" dated December 9, 2024, which was downloaded from

the following website: <https://stetnews.org/2024/12/09/tenet-hospitals-at-bottom-of-local-safety-grades/>, bearing the Bates stamp PBHN000002571.

35. Attached as **Exhibit 32** is a true and correct copy of a December 10, 2024 email from Sheri Montgomery to Maggie Gill, bearing the Bates stamp PBHN000005138.

36. Attached as **Exhibit 33** is a true and correct copy of a December 10, 2024 email from Sheri Montgomery to Patrick Franklin and Dennis Grady, bearing the Bates stamp PBHN000005169.

37. Attached as **Exhibit 34** is a true and correct copy of a December 11, 2024 email from Patrick Romano to Bruce Hall, Gregory Maynard, Brenda Inman, and Joseph Galante, bearing the Bates stamp ROMANO0000208.

38. Attached as **Exhibit 35** is a true and correct copy of a December 19, 2024 email from Robert Jon Kucejko to Gregory A. Maynard and Brenda L. Inman, bearing the Bates stamp UCDAVISTLG0005346.

39. Attached as **Exhibit 36** is a true and correct copy of Leapfrog's *2025 Regional Leader Communications Toolkit*, bearing the Bates stamp LEAPFROG00401485.

40. Attached as **Exhibit 37** is a true and correct copy of a *MailOnline* article titled "Every acute care hospital in America RANKED: Our interactive map reveals dangers lurking near you..." dated January 6, 2025, which was downloaded from the following website: <https://www.dailymail.co.uk/health/article-14256459/acute-care-hospital-america-ranked-dangerous-interactive-map.html>, bearing the Bates stamp PBHN000002411.

41. Attached as **Exhibit 38** is a true and correct copy of a January 7, 2025 email from Lisa Cook to Amanda Blanchard, bearing the Bates stamp PBHN000009129.

42. Attached as **Exhibit 39** is a true and correct copy of a *Miami Herald* article titled "What are the best and worst South Florida hospitals for patient safety? See the rankings" dated January 16, 2025, which was downloaded from the following website: <https://www.miamiherald.com/news/health-care/article297048999.html>, bearing the Bates stamp PBHN000002309.

43. Attached as **Exhibit 40** is a true and correct copy of a January 28, 2025 email from Andrea Nunes to Ricardo Ramirez, bearing the Bates stamp PBHN000002103.

44. Attached as **Exhibit 41** is a true and correct copy of a March 11, 2025 email from Jill Berger to Leapfrog's Regional Leaders, bearing the Bates stamp LEAPFROG00173403.

45. Attached as **Exhibit 42** is a true and correct copy of the *Final Stats* for Leapfrog's Spring 2025 Hospital Safety Grade dated March 20, 2025, bearing the Bates stamp LEAPFROG00394765.

46. Attached as **Exhibit 43** is a true and correct copy of a Leapfrog Designated Logo License - Letter of Agreement entered into by The Leapfrog Group and Jupiter Medical Center on March 26, 2025, bearing the Bates stamp LEAPFROG01131281.

47. Attached as **Exhibit 44** is a true and correct copy of Leapfrog's Spring 2025 *Hospital Safety Grade Scoring Methodology* dated April 21, 2025, bearing the Bates stamp LEAPFROG00217511.

48. Attached as **Exhibit 45** is a true and correct copy of the 2025 *Leapfrog Hospital Survey* updated May 2, 2025, which was downloaded from the following website: <https://www.leapfroggroup.org/survey-materials/survey-and-cpoe-materials>, bearing the Bates stamp PBHN000002651.

49. Attached as **Exhibit 46** is a true and correct copy of Leapfrog's *Spring 2025 Hospital Safety Grade Media Coverage Report* dated May 8, 2025, bearing the Bates stamp LEAPFROG00241845.

50. Attached as **Exhibit 47** is a true and correct copy of Leapfrog's *Talking Points for Regional Leaders about Leapfrog Lawsuit* dated May 13, 2025, bearing the Bates stamp LEAPFROG01056115.

51. Attached as **Exhibit 48** is a true and correct copy of the *LFG/CURA Meeting Agenda* for a May 22, 2025 meeting, bearing the Bates stamp CURA_000186.

52. Attached as **Exhibit 49** is a true and correct copy of a May 28, 2025 email from Karen van Caulil to Ashley Tait-Dinger, bearing the Bates stamp FHA0002386.

53. Attached as **Exhibit 50** is a true and correct copy of a June 5, 2025 email from Alexandra Campione to Sarah Farinelli, Lauren Bailey, Nathaniel Longmore, and Karen Jupiter, bearing the Bates stamp LEAPFROG00389130.

54. Attached as **Exhibit 51** is a true and correct copy of a July 10, 2025 TikTok video purporting to identify the five worst hospitals in Florida, which was downloaded from the following website: <https://www.tiktok.com/@usamap55/video/7525460573430107405>, bearing the Bates stamp PBHN000002235, and which was last accessed on October 26, 2025. This video

will be lodged with the Court pursuant to the Community Hospitals' forthcoming motion to file a video document.

55. Attached as **Exhibit 52** is a true and correct copy of a July 15, 2025 letter from Humana Military to West Boca Medical Center, bearing the Bates stamp PBHN000008914.

56. Attached as **Exhibit 53** is a true and correct copy of a July 15, 2025 letter from Humana Military to Delray Medical Center, bearing the Bates stamp PBHN000008915.

57. Attached as **Exhibit 54** is a true and correct copy of Leapfrog's "Leapfrog Hospital Safety Grade" webpage, which was downloaded from the following website: <https://www.leapfroggroup.org/data-users/leapfrog-hospital-safety-grade>, bearing the Bates stamp PBHN000004438, and which was last accessed on August 7, 2025.

58. Attached as **Exhibit 55** is a true and correct copy of a letter from "A Concerned Physician in Boca Raton" to the West Boca Medical Center Hospital Ethics Committee, bearing the Bates stamp PBHN000018127.

59. Attached as **Exhibit 56** is a true and correct copy of a screenshot of the "Search Leapfrog's Hospital and Surgery Ratings" webpage on ratings.leapfroggroup.org, bearing the Bates stamp LEAPFROG00155227.

60. Attached as **Exhibit 57** is a true and correct copy of a *Leapfrog Designated Logo License – Letter of Agreement*, bearing the Bates stamp LEAPFROG00077737.

II. Publicly Accessible Documents

61. Attached as **Exhibit 58** is a true and correct copy of Leapfrog's "About the Leapfrog Group" webpage, which was downloaded from the following website: <https://www.hospitalsafetygrade.org/about-our-movement/about-the-leapfrog-group>, and which was last accessed on October 23, 2025.

62. Attached as **Exhibit 59** is a true and correct copy of Leapfrog's "Frequently Asked Questions About The Leapfrog Hospital Safety Grade" webpage, which was downloaded from the following website: <https://www.hospitalsafetygrade.org/yourhospitals-safety-grade/frequently-asked-questions>, and which was last accessed on October 24, 2025.

63. Attached as **Exhibit 60** is a true and correct copy of Leapfrog's "About the Grade" webpage, which was downloaded from the following website: <https://www.hospitalsafetygrade.org/about-the-grade>, and which was last accessed on October 24, 2025.

64. Attached as **Exhibit 61** is a true and correct copy of Leapfrog's "Why the Hospital Safety Grade Works" webpage, which was downloaded from the following website: <https://www.hospitalsafetygrade.org/why-the-hospital-safety-grade-works>, and which was last accessed on October 24, 2025.

65. Attached as **Exhibit 62** is a true and correct copy of Leapfrog's "Welcome to the 2025 Leapfrog Hospital Survey" webpage, which was downloaded from the following website: <https://www.leapfroggroup.org/survey-materials/survey-login-and-materials>, and which was last accessed on October 24, 2025.

66. Attached as **Exhibit 63** is a true and correct copy of Leapfrog's "How to Use the Grade" webpage, which was downloaded from the following website: <https://www.hospitalsafetygrade.org/how-to-use-the-grade>, and which was last accessed on October 25, 2025.

67. Attached as **Exhibit 64** is a true and correct copy of the "Recent Past Grades" tab from Leapfrog's Spring 2025 Hospital Safety Grade for Delray Medical Center in Delray Beach, Florida, which was downloaded from the following website: <https://www.hospitalsafetygrade.org/h/delray-medical-center>, and which was last accessed on October 25, 2025.

68. Attached as **Exhibit 65** is a true and correct copy of the "Recent Past Grades" tab from Leapfrog's Spring 2025 Hospital Safety Grade for Good Samaritan Medical Center in West Palm Beach, Florida, which was downloaded from the following website: <https://www.hospitalsafetygrade.org/h/good-samaritan-medical-center>, and which was last accessed on October 25, 2025.

69. Attached as **Exhibit 66** is a true and correct copy of the "Recent Past Grades" tab from Leapfrog's Spring 2025 Hospital Safety Grade for Palm Beach Gardens Medical Center in Palm Beach Gardens, Florida, which was downloaded from the following website: <https://www.hospitalsafetygrade.org/h/palm-beach-gardens-medical-center>, and which was last accessed on October 25, 2025.

70. Attached as **Exhibit 67** is a true and correct copy of the "Recent Past Grades" tab from Leapfrog's Spring 2025 Hospital Safety Grade for St. Mary's Medical Center in West Palm Beach, Florida, which was downloaded from the following website:

<https://www.hospitalsafetygrade.org/h/st-marys-medical-center-west-palm-beach-fl>, and which was last accessed on October 25, 2025.

71. Attached as **Exhibit 68** is a true and correct copy of the “Recent Past Grades” tab from Leapfrog’s Spring 2025 Hospital Safety Grade for West Boca Medical Center in Boca Raton, Florida, which was downloaded from the following website: <https://www.hospitalsafetygrade.org/h/west-boca-medical-center>, and which was last accessed on October 25, 2025.

72. Attached as **Exhibit 69** is a true and correct copy of the “Practices to Prevent Errors” and “Doctors order medications through a computer” tabs from Leapfrog’s Spring 2025 Hospital Safety Grade for Delray Medical Center in Delray Beach, Florida, which was downloaded from the following website: <https://www.hospitalsafetygrade.org/h/delray-medical-center>, and which was last accessed on October 26, 2025.

73. Attached as **Exhibit 70** is a true and correct copy of the “Practices to Prevent Errors” and “Doctors order medications through a computer” tabs from Leapfrog’s Spring 2025 Hospital Safety Grade for Good Samaritan Medical Center in West Palm Beach, Florida, which was downloaded from the following website: <https://www.hospitalsafetygrade.org/h/good-samaritan-medical-center>, and which was last accessed on October 26, 2025.

74. Attached as **Exhibit 71** is a true and correct copy of the “Practices to Prevent Errors” and “Doctors order medications through a computer” tabs from Leapfrog’s Spring 2025 Hospital Safety Grade for Palm Beach Gardens Medical Center in Palm Beach Gardens, Florida, which was downloaded from the following website: <https://www.hospitalsafetygrade.org/h/palm-beach-gardens-medical-center>, and which was last accessed on October 26, 2025.

75. Attached as **Exhibit 72** is a true and correct copy of the “Practices to Prevent Errors” and “Doctors order medications through a computer” tabs from Leapfrog’s Spring 2025 Hospital Safety Grade for St. Mary’s Medical Center in West Palm Beach Florida, which was downloaded from the following website: <https://www.hospitalsafetygrade.org/h/st-marys-medical-center-west-palm-beach-fl>, and which was last accessed on October 26, 2025.

76. Attached as **Exhibit 73** is a true and correct copy of the “Practices to Prevent Errors” and “Doctors order medications through a computer” tabs from Leapfrog’s Spring 2025 Hospital Safety Grade for West Boca Medical Center in Boca Raton, Florida, which was

downloaded from the following website: <https://www.hospitalsafetygrade.org/h/west-boca-medical-center>, and which was last accessed on October 26, 2025.

77. Attached as **Exhibit 74** is a true and correct copy of the “Practices to Prevent Errors” and “Communication about discharge” tabs from Leapfrog’s Spring 2025 Hospital Safety Grade for Delray Medical Center in Delray Beach, Florida, which was downloaded from the following website: <https://www.hospitalsafetygrade.org/h/delray-medical-center>, and which was last accessed on October 27, 2025.

78. Attached as **Exhibit 75** is a true and correct copy of the TikTok webpage showing a July 10, 2025 video purporting to identify the five worst hospitals in Florida, which was downloaded from the following website: <https://www.tiktok.com/@usamap55/video/7525460573430107405>, and which was last accessed on October 27, 2025.

79. Attached as **Exhibit 76** is a true and correct copy of a portion of the TikTok webpage showing the user profile for @usamap55 and highlighting the view count of the TikTok video in **Exhibit 75**, which was downloaded from the following website: <https://www.tiktok.com/@usamap55>, and which was last accessed on October 27, 2025.

80. Attached as **Exhibit 77** is a true and correct copy of Leapfrog’s 2022 IRS Form 990, which was downloaded from the following website: https://apps.irs.gov/pub/epostcard/cor/522359517_202206_990_2023060921420569.pdf, and which was last accessed on October 24, 2025.

81. Attached as **Exhibit 78** is a true and correct copy of Leapfrog’s 2023 IRS Form 990, which was downloaded from the following website: https://www.causeiq.com/organizations/view_990/522359517/1f7ecb66b6c6e691ed771e60b7a1f4cd, and which was last accessed on October 24, 2025.

82. Attached as **Exhibit 79** is a true and correct copy of Leapfrog’s 2024 IRS Form 990, which was downloaded from the following website: https://www.causeiq.com/organizations/view_990/522359517/a7a6ff6ae157acaba7c09f82da6adc0d, and which was last accessed on October 24, 2025.

III. Produced Leapfrog Website Pages, No Longer Publicly Available

83. Attached as **Exhibit 80** is a true and correct copy of Leapfrog’s *Expert Panel’s Guiding Principles on the Development of the Composite Leapfrog Hospital Safety Grade for U.S.*

Hospitals (“*Guiding Principles*”), as it appeared on Leapfrog’s Safety Grade website on September 23, 2025, when Gibson Dunn downloaded the document, bearing the Bates stamp PBHN000018048.

84. Attached as **Exhibit 81** is a true and correct copy of the same webpage, as it appeared on October 26, 2025, stating that the *Guiding Principles* is “Not Found.” See https://www.hospitalsafetygrade.org/media/file/Expert_Panel_Guiding_Principles_Nov12_updated.pdf.

85. Attached as **Exhibit 82** is a true and correct copy of Leapfrog’s “Lives Lost and Lives Saved” webpage as it appeared on Leapfrog’s Safety Grade website on August 19, 2025, displaying a hyperlink entitled “view the full white paper.” See <https://web.archive.org/web/20250819112415/https://www.hospitalsafetygrade.org/LivesLost> (with underlined hyperlink). That hyperlink opens the Lives Lost White Paper. See **Exhibit 3**, *supra* ¶ 6.

86. Attached as **Exhibit 83** is a true and correct copy of the “Lives Lost and Lives Saved” webpage on Leapfrog’s website, as it appeared on October 26, 2025, showing the Lives Lost White Paper. The hyperlink at “view the full white paper” had been removed (without any underlined hyperlink).¹

IV. Deposition Transcripts

87. Attached as **Exhibit 84** is a true and correct copy of the transcript of the deposition of Dr. Matthew Austin, principal investigator on Leapfrog’s contract with Johns Hopkins University’s Armstrong Institute for Patient Safety and Quality, taken in the above-captioned action on September 25, 2025. The transcript attached hereto incorporates minimal redactions at the request of the witness’s counsel, none of which appear on pages cited by the Community Hospitals in support of their motion or Rule 56.1 statement.

88. Attached as **Exhibit 85** is a true and correct copy of the transcript of the deposition of Lauren Bailey, Leapfrog’s Director of Communications, taken in the above-captioned action on September 10, 2025.

¹ As of filing, a new hyperlink has been embedded in “view the full white paper” that opens an older, 2016 version of the Lives Lost White Paper. See <https://www.hospitalsafetygrade.org/yourhospitals-safety-grade/LivesLost> (with underlined hyperlink).

89. Attached as **Exhibit 86** is a true and correct copy of the transcript of the deposition of Kushagra Banerjee, Leapfrog's Director of Licensing Programs, taken in the above-captioned action on September 16, 2025.

90. Attached as **Exhibit 87** is a true and correct copy of the transcript of the deposition of Leah Binder, Leapfrog's Chief Executive Officer, taken in the above-captioned action on September 22, 2025.

91. Attached as **Exhibit 88** is a true and correct copy of the transcript of the deposition of Alexandra Campione, Leapfrog's Program Manager, taken in the above-captioned action on September 12, 2025.

92. Attached as **Exhibit 89** is a true and correct copy of the transcript of the deposition of Dr. Karen van Caulil, Chief Executive Officer and President of Florida Alliance for Healthcare Value, taken in the above-captioned action on September 25, 2025.

93. Attached as **Exhibit 90** is a true and correct copy of the transcript of the deposition of Erik Cazares, Chief Executive Officer of Palm Beach Gardens Community Hospital, Inc., taken in the above-captioned action on September 24, 2025.

94. Attached as **Exhibit 91** is a true and correct copy of the transcript of the Deposition of Melissa Danforth, Leapfrog's Senior Vice President of Healthcare Ratings, taken in the above-captioned action on September 18, 2025.

95. Attached as **Exhibit 92** is a true and correct copy of the transcript of the Deposition of Jerad Hanlon, Chief Executive Officer of West Boca Medical Center, Inc., taken in the above-captioned action on September 23, 2025.

96. Attached as **Exhibit 93** is a true and correct copy of the transcript of the Deposition of Heather Havericak, Chief Executive Officer of Delray Medical Center, Inc., taken in the above-captioned action on September 19, 2025.

97. Attached as **Exhibit 94** is a true and correct copy of the transcript of the Deposition of Karen Jupiter, Leapfrog's Vice President of Development, taken in the above-captioned action on September 5, 2025.

98. Attached as **Exhibit 95** is a true and correct copy of the transcript of the deposition of Cynthia McCauley, Chief Executive Officer of St. Mary's Medical Center, Inc., taken in the above-captioned action on September 24, 2025.

99. Attached as **Exhibit 96** is a true and correct copy of the transcript of the deposition of Sheri Montgomery, Chief Executive Officer of Good Samaritan Medical Center, Inc., taken in the above-captioned action on September 15, 2025.

100. Attached as **Exhibit 97** is a true and correct copy of the transcript of the deposition of Dr. Patrick Romano, Leapfrog Expert Panelist, taken in the above-captioned action on September 23, 2025.

101. Attached as **Exhibit 98** is a true and correct copy of the transcript of the deposition of Regina West, Director of Quality of Palm Beach Health Network, taken in the above-captioned action on September 25, 2025.

V. Interrogatory Responses

102. Attached as **Exhibit 99** is a true and correct copy of Plaintiff Delray Medical Center, Inc.'s Amended and Supplemented Responses and Objections to Defendant the Leapfrog Group's First Set of Interrogatories to Delray Medical Center, Inc., served on September 8, 2025.

103. Attached as **Exhibit 100** is a true and correct copy of Plaintiff Good Samaritan Medical Center, Inc.'s Amended and Supplemented Responses and Objections to Defendant the Leapfrog Group's First Set of Interrogatories to Good Samaritan Medical Center, Inc., served on September 8, 2025.

104. Attached as **Exhibit 101** is a true and correct copy of Plaintiff Palm Beach Gardens Community Hospital, Inc. d/b/a Palm Beach Gardens Medical Center's Amended and Supplemented Responses and Objections to Defendant the Leapfrog Group's First Set of Interrogatories to Palm Beach Gardens Medical Center, served on September 8, 2025.

105. Attached as **Exhibit 102** is a true and correct copy of Plaintiff St. Mary's Medical Center, Inc.'s Amended and Supplemented Responses and Objections to Defendant the Leapfrog Group's First Set of Interrogatories to St. Mary's Medical Center, Inc., served on September 8, 2025.

106. Attached as **Exhibit 103** is a true and correct copy of Plaintiff West Boca Medical Center, Inc.'s Amended and Supplemented Responses and Objections to Defendant the Leapfrog Group's First Set of Interrogatories to West Boca Medical Center, Inc., served on September 8, 2025.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on October 28, 2025, in New York, New York.



Mary Beth Maloney

Exhibit 1

ORIGINAL ARTICLE

Safety in Numbers: The Development of Leapfrog's Composite Patient Safety Score for U.S. Hospitals

J. Matthew Austin, PhD¹, Guy D'Andrea, MBA², John D. Birkmeyer, MD³, Lucian L. Leape, MD⁴, Arnold Milstein, MD⁵, Peter J. Pronovost, MD, PhD⁶, Patrick S. Romano, MD⁷, Sara J. Singer, MBA, PhD⁸, Timothy J. Vogus, PhD⁹, and Robert M. Wachter, MD¹⁰

Objective: To develop a composite patient safety score that provides patients, health care providers, and health care purchasers with a standardized method to evaluate patient safety in general acute care hospitals in the United States.

Methods: The Leapfrog Group sought guidance from a panel of national patient safety experts to develop the composite score. Candidate patient safety performance measures for inclusion in the score were identified from publicly-reported national sources. Hospital performance on each measure was converted into a 'z-score' and then aggregated using measure-specific weights. A reference mean score was set at three, with scores interpreted in terms of standard deviations above or below the mean, with above reflecting better than average performance.

Results: Twenty-six measures were included in the score. The mean composite score for 2,652 general acute care hospitals in the U.S. was 2.97 (range by hospital, 0.46 to 3.94). Safety scores were slightly lower for hospitals that were publicly owned, rural in location, or that had a larger percentage of patients with Medicaid as their primary insurance.

Conclusions: The Leapfrog patient safety composite provides a standardized method to evaluate patient safety in general acute care hospitals in the United States. While constrained by available data and publicly reported scores on patient safety measures, the composite score reflects the best available evidence regarding a hospital's efforts and outcomes in patient safety. Additional analyses are needed, but the score did not appear to have a strong bias against hospitals with specific characteristics. The composite score will continue to be refined over time as measures of patient safety evolve.

Key words: patient safety, hospital, performance measures, composite, score

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Despite the hundreds of thousands of patients who suffer preventable harm each year in US hospitals,[1] patients, health care providers, and health care purchasers lack a standardized method to evaluate patient safety in US hospitals. This lack of standardized evaluation is especially concerning given recent evidence that many US hospitals have made small incremental improvements in safety or continue to harm patients in large numbers.[2,3,4,5] While the number of publicly-reported patient safety measures has grown over the last decade,[6,7] there is little evidence that patients and providers are using these data to inform their choice of hospital.[8,9] One possible explanation for the lack of use is that safety data have typically been reported on a measure-by measure basis, requiring patients and providers to synthesize many disparate data points in their decision making process.

Composite measures, which combine multiple performance measures using a pre-determined weighting methodology to produce a single score, provide a more general picture of the safety performance of a hospital, making it more understandable and usable for non-medical personnel.[10] However, while composite measures are easier for patients to understand, they can mask a hospital's excellent or poor performance on individual measures. Additionally, the pre-determined weights assigned to each measure may not reflect the preferences of individual patients.[11] Nevertheless, the potential to motivate patient and provider response, and thereby improve patient utility, makes it worthwhile to develop a composite measure of hospital patient safety.

The Leapfrog Group, a national coalition of health care purchasers, sought to address the need for a standardized method for evaluating patient safety in US hospitals by creating a composite safety score. The primary goal was a single, publicly available safety score

for every US hospital, including hospitals that do and do not voluntarily participate in the Leapfrog Hospital Survey. Other national organizations, such as Consumer Reports and US News & World Report, have developed their own composite measures of hospital performance. These organizations, however, have taken quite different approaches to constructing composites. US News relies heavily on reputational surveys and focuses on major academic medical centers and large sized hospitals, whereas Consumer Reports relies heavily on patient experience surveys and readmission rates that favor small to-medium sized community hospitals.[12,13,14] Leapfrog's goal was to balance many different measures of structures, processes, and outcomes that have been linked to patient safety, but which may or may not be related to each other, in order to improve patient and clinician selection of hospitals and to more strongly motivate and better target hospital safety improvement efforts.

The purpose of this paper is to describe the methods used to develop the composite score and to demonstrate its use with recent national data. The Leapfrog Group's Board of Directors has used the composite safety score to assign a letter grade to each hospital. This application of the composite score is beyond the scope of this paper.

METHODS

The Leapfrog Group invited nine national experts to serve on a panel to develop a composite score to evaluate patient safety in US hospitals (see side-bar for the list of panelists.) The work was done in late 2011 and involved defining a conceptual framework for the score, assigning relative weights to each measure, standardizing scores across different measure types, and identifying methods for dealing with missing data.

Defining a Conceptual Framework for the Score

Initially, the panel discussed what the composite score should be designed to measure, and the consensus was patient safety, defined as "freedom from harm." The panel agreed that this focus, which aligns with the Institute of Medicine's improvement aim of 'safe' care, was narrower than hospital quality.

One goal was to develop a composite score suitable for assessing the largest number of general acute care hospitals across the country. Thus, the panel recommended that Leapfrog include publicly-reported measures from national data sources in the score. The panel excluded state-reported and regionally-reported measures because of variations in measure specifications, data collection, and availability that would prevent a consistent comparison across hospitals. Leapfrog staff (JMA, GD) scanned publicly-reported patient safety measures from the Centers for Medicare & Medicaid Services (CMS), The Joint Commission, The Leapfrog

Group, and The Commonwealth Fund to compile a list of candidate measures for the expert panel to review and consider for inclusion in the composite score. Forty-five candidate measures, representing a mix of structural, process, and outcome measures were identified for review.

Members of Safety Score Expert Panel

- John Birkmeyer, MD (University of Michigan)
- Ashish Jha, MD, MPH (Harvard University)
- Lucian Leape, MD (Harvard University)
- Arnold Milstein, MD, MPH (Stanford University)
- Peter Pronovost, MD, PhD (Johns Hopkins University)
- Patrick Romano, MD, MPH (University of California, Davis)
- Sara Singer, MBA, PhD (Harvard University)
- Timothy Vogus, PhD (Vanderbilt University)
- Robert Wachter, MD (University of California, San Francisco)

The panel debated whether the safety score should recognize hospital efforts toward patient safety (process and structural measures), achievements in patient safety (outcome measures), or both. Process and structural measures signal what hospitals have done to improve safety (e.g., adopting specified protocols to reduce infections, implement computerized order entry) and fill gaps where valid outcome data are not yet available. However, outcome measures (e.g., infection rates) reflect whether a hospital has actually achieved safety goals. The panel ultimately recommended that process/structural measures and outcome measures carry equal weights of 50% in the composite score, but recognized that this choice was arbitrary and should be reevaluated periodically as new outcome measures become available to capture the impact of safety-enhancing activities that are currently represented by structure and process measures.

The expert panel reviewed the candidate measures and selected the final set through a process of discussion and repeated voting to maximize consensus. The panel eliminated measures that were not clear safety measures, measures supported by weak research evidence, and process measures with a corresponding outcome measure that better represents patient utility. Table 1 provides the final list of 26 measures included in the composite score.

Weighting the Individual Measures

The expert panel next developed a framework to assign relative weights to each measure using three criteria: strength of evidence, opportunity for improvement, and impact. These criteria track closely with criteria used by the National Quality Forum in its Consensus Development Process for measure endorsement.[15]

These criteria were defined as follows:

- **Strength of Evidence.** Measures with stronger research evidence carry higher weight than measures with weaker evidence. Since the measures selected for the composite score already met high standards of research evidence, any variation in strength of the evidence was assessed using the following scoring method:
 - 1 = Supported by either suggestive clinical or epidemiological studies or theoretical rationale
 - 2 = Supported by experimental, clinical, or epidemiological studies and strong theoretical rationale
- **Opportunity for Improvement.** The panel agreed that measures with greater variation in hospital performance are more valuable for decision-making, because there is greater opportunity for performance improvement. For each measure, the coefficient of variation (standard deviation/mean) was calculated using the measure's national performance data.[16] The coefficient of variation was then converted into an opportunity score by adding 1.0 to the coefficient of variation, capping the maximum score at 3.0 to limit distortions in the final weights that could result from very high coefficients of variation. Thus, the opportunity scores ranged from 1.0 to 3.0, with higher values denoting greater variation and more opportunity for improvement.
- **Impact.** Some measures affect a greater percentage of patients than others. For example, computerized medication orders are applicable to nearly every patient in the hospital, while an intensivist manages only patients in the intensive care unit (ICU). Some measures are associated with clinical events that indicate greater severity of harm (e.g., mortality or serious morbidity). Therefore, impact reflects both the number of patients possibly affected by the event and the severity of harm for individual patients. We defined and scored the dimensions as follows:
 - Number of patients possibly affected by the event:
 - 1 = Rare event (e.g., foreign object retained after surgery)
 - 2 = Some patients in hospital affected (e.g., ICU physician staffing)
 - 3 = All patients in hospital affected (e.g., hand hygiene safe practice)
 - Severity of harm for individual patients:
 - 1 = Limited direct evidence of harm or harm reduction (e.g., culture measurement safe practice)

2 = Clear documentation of harm or harm reduction; adverse events (e.g., foreign object retained after surgery)

3 = Significant mortality reduction (> 1,000 deaths across the US annually, or a 10% reduction in hospital-wide mortality) (e.g., ICU physician staffing)

The values from each dimension were added together and an overall Impact Score given as follows:

1 = Summed value of 2 (Low Impact)

2 = Summed value of 3-4 (Medium Impact)

3 = Summed value of 5-6 (High Impact)

Through an iterative process, the panel reviewed different schemes to assign weights until they reached consensus on a scheme that seemed fair, simple, and intuitively sound. The panel chose a calculation that emphasized the opportunity and the impact of each measure because all selected measures already met a high standard of evidence. Each measure received an overall weight score as follows:

Weight Score = Evidence + (Opportunity × Impact)

The possible weight score for each measure ranged between 2 and 11. By design, this wide scoring range provided substantial differences in weights across measures so that more informative, higher impact measures had a stronger influence on the overall composite score.

In the final stage of the weighting process, each measure's weight score was converted to a percentage weight. To ensure equal overall weights for the process/structural domain and the outcomes domain, we divided the weight score for each measure by the sum of all of the weight scores from measures in that domain and then multiplied by 50%.

Standardizing Scores Across Disparate Measures

One challenge in creating the composite score was combining measures that were expressed in different ways. Some measures were expressed as a point system (the hospital earned x points out of a possible y points), while other measures were expressed as proportions or rates (x occurrences out of a relevant population of y patients).

The panelists agreed that the scores had to be standardized to ensure the measure weights are the primary driver of the composite score and the measure values do not distort the score. Three approaches were considered for standardizing scores: 1) assign points based on a provider's performance relative to the mean or median; 2) assign a score based on the provider's ranking - expressed as simple percentile or categorical value (e.g., quartiles); or 3) divide the difference in the hospital's score from the national mean by the standard deviation.

The panel recommended option three to standardize a hospital's performance on each measure. This option is often called a z-score and is based on the following equation that expresses the hospital's performance as a number of standard deviations from the national mean:

$$\text{Hospital's Z-Score} = \frac{(\text{Hospital's Measure Performance} - \text{Mean Performance for All Hospitals})}{\div \text{Standard Deviation for All Hospitals}}$$

Hospitals that perform close to the national mean earn a z-score near zero. Better hospitals earn a positive z-score, reflecting measure values above the national mean. Worse hospitals earn a negative z-score, reflecting measure values below the national mean.

The z-score allowed us to compare and combine individual scores from different types of data. Besides being simple to understand and explain, a z-score has precedent in health care measurement. It has been used in the Multiple Sclerosis Functional Composite, which is a measure of disability in patients with Multiple Sclerosis (MS).[17] Research has shown that the z-score method produces results comparable to alternative rescaling approaches.[18,19] One potential disadvantage of the z-score, or any rescaling approach, is the exaggeration of clinically meaningless differences when measures have a small standard deviation; this problem was minimized by giving more weight to measures with higher coefficients of variation, as described above.

Dealing with Missing Data

Although the expert panel selected nationally-reported measures, some data were missing for hospitals that did not report to The Leapfrog Group and other data were missing because hospitals did not meet the CMS's minimum sample size requirements to publicly report their results.

The panelists discussed several possible approaches for assessing hospital performance when data were missing, including:

1. Impute the hospital's performance at the national median/mean.
2. Impute the hospital's performance on the missing measures using other available data.
3. Impute a score above or below the median/mean (e.g., -1 standard deviation).
4. Give the hospital zero credit for the measure (e.g., when the hospital chose not to report data to Leapfrog).
5. Exclude the measure and re-calibrate the weights for the affected hospital(s), using only those measures for which data are available.

After conducting sensitivity analyses using each of the above approaches, the panel recommended approach number five to address missing data (excluding the measure for a hospital and re-calibrating the weights for those measures for which performance data were

available) for most measures. In this way, we avoided making questionable assumptions about the performance of hospitals with missing data and we also maintained variation in the final calculated scores by not imputing identical values for all missing observations. Second, with the two exceptions described in the next paragraph, imputation using other variables was deemed inappropriate, as hospital scores on one measure did not predict performance on other measures. Finally, the third and fourth approaches were rejected to avoid creating a structural bias in favor of Leapfrog-reporting hospitals. By scoring hospitals on the available data, the composite scores were based on what was known about the hospital's performance, with no penalties for missing data.

Imputation using alternative data was used for two Leapfrog survey-based measures. Data on Computerized Physician Order Entry (CPOE) and ICU Physician Staffing (IPS) from the American Hospital Association's (AHA) annual survey were used to impute measure scores for hospitals that did not respond to the Leapfrog Hospital Survey. The AHA survey does not collect the same level of detail as the Leapfrog Hospital Survey. Thus, for this first round of scores, hospitals were given a score that was equivalent to what they would have earned had they reported that same limited data to the Leapfrog Hospital Survey. After considerable feedback on the initial imputation approach, the panel conducted additional analyses using data for hospitals that had reported to both data sets and has since revised the imputation method to better reflect an 'expected' value concept. With this change, a hospital's imputed value now reflects an empirically estimated probability of the hospital scoring in each Leapfrog category given their AHA response.

Scores could not be calculated for certain types of hospitals because of the systemic lack of publicly-reported safety data; these include:

- Critical access hospitals (CAH)
- Long-term care facilities
- Mental health facilities
- Federal hospitals (e.g., Veterans Affairs, Indian Health Services)
- Specialty hospitals, including surgical centers and cancer hospitals
- Free-standing pediatric hospitals
- Hospitals located in U.S. territories (e.g., Puerto Rico, Guam)
- Hospitals in Maryland, since they did not report data through CMS's Inpatient Prospective Payment System (IPPS)

In addition, some hospitals had so much missing data that the panel determined it was not possible to reliably calculate a safety score. Hospitals missing more than 9 of 15 process/structural measures or more than 3 of 11 outcome measures were not scored; 605 hospitals were excluded from our analysis for having too little available data. These minimum measure thresholds were chosen to

balance the reliability of the calculated score with the number of hospitals receiving a score.

Final Scoring

A composite safety score for each hospital was calculated by multiplying the weight for each measure by the hospital's z-score on that measure. We added 3 to each hospital's final score to avoid possible confusion with interpreting negative patient safety scores. The final calculation of the safety score was as follows:

$$\text{Safety Score} = 3 + \text{Weight}_{\text{Measure1}} \times \text{Z-Score}_{\text{Measure1}} + \text{Weight}_{\text{Measure2}} \times \text{Z-Score}_{\text{Measure2}} + \text{Weight}_{\text{Measure3}} \times \text{Z-Score}_{\text{Measure3}} + \dots + \text{Weight}_{\text{Measure n}} \times \text{Z-Score}_{\text{Measure n}}$$

In April 2012, Leapfrog applied the final scoring methodology to the most recent available data.ⁱ

Data Analysis

To better understand the associations between calculated composite scores and hospital characteristics, descriptive statistics of the composite safety scores were calculated by characteristic (Table 2). A p-value from a one-way ANOVA was calculated for each characteristic. For each characteristic, the p-value was less than the critical value of 0.05, indicating that the subgroup scores within each characteristic are not all the same.

In addition, we compared the safety of the 605 unscored hospitals to the scored hospitals by calculating the average performance of each group on the structural/process measures and the outcome measures.

RESULTS

Composite safety scores were calculated for 2,652 general acute care hospitals; 605 hospitals were excluded due to excessive missing data. The final composite safety scores for hospitals ranged from 0.46 to 3.94 (Figure 1). For interpretation, the top score of 3.94 represents a hospital that averages almost 1.0 standard deviation above (better than) the national mean across all measures for which data were available. The bottom score of 0.46 represents a hospital that averages almost 2.5 standard deviations below (worse than) the national mean for all measures for which data were available.

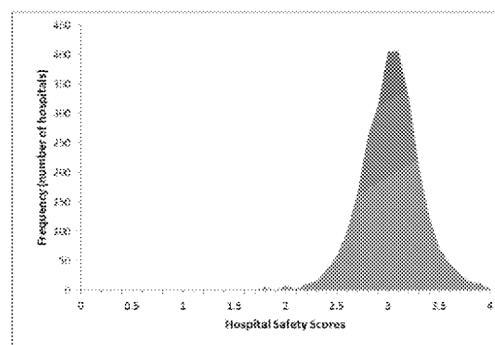


Figure 1. Distribution of Composite Hospital Safety Scores.

Figure 1 illustrates the distribution of composite safety scores for the 2,652 general care acute hospitals. The scores range from 0.46 to 3.94. Scores were calculated by multiplying the weight for each measure by the hospital's z-score on the measure. Three was added to each hospital's final score to avoid possible confusion with interpreting negative patient safety scores.

The range of safety scores for hospitals with a large number of measures that were not reported or were not availableⁱⁱ was similar to those hospitals for which data were available for most measures (0.46-3.82 vs. 1.72-3.93), reflecting poor and excellent performance in both subgroups. However, the scores for hospitals with a large number of missing measures did cluster more toward the middle than those hospitals for which data were available for most measures (standard deviation of scores: 0.29 vs. 0.32). Of the 605 hospitals that were not scored due to excessive missing data, their performance averaged 3% worse on those structural/process measures for which data were available and 11% better on those outcome measures for which data were available (listed in Table 1) than the hospitals that received a score. The unscored hospitals were 1% to 73% better on hospital-acquired conditions than the scored hospitals.

Composite Scores by Hospital Characteristic

Table 2 describes the mean composite safety score by hospital characteristic. Hospitals in the Midwest and Northeast had higher mean composite scores than hospitals in the South and West ($p = 0.001$). Publicly owned hospitals had lower mean composite scores than either for-profit or private non-profit hospitals ($p = 0.000$). Rural hospitals had lower mean composite scores than their urban counterparts ($p = 0.047$). Mean composite

ⁱ The reporting time periods from each data source used to calculate a hospital's score were: 2011 Leapfrog Hospital Survey (Apr 2011 – Mar 2012); CMS Hospital Compare SCIP process measures (Apr 2010 – Mar 2011); CMS Hospital Compare No-Pay Events and AHRQ PSIs (Oct 2008 – Jun 2010); CMS Hospital Compare CLABSI rates (2006-2008); AHA Annual Survey (Jan 2010 – Dec 2010).

ⁱⁱ 'Large number' of missing measures is defined as eight or more missing process/structural measures. Most of the measures in which data were not reported or not available were those reported through voluntary data sources and are almost exclusively in the process/structural domain. Hospitals with eight or more missing process/structural measures are generally hospitals that choose not to report to the Safe Practices section of the Leapfrog Hospital Survey.

scores were lower for hospitals with the largest percentage of patients with Medicaid as the primary payer ($p = 0.000$). The teaching status of the hospital did not appear to be correlated with a hospital's composite score, as the mean composite scores for all teaching statuses were quite similar ($p = 0.043$). Also, the mean composite scores did not vary substantially by the percentage of patients with Medicare as the primary payer ($p = 0.000$).

Table 3 shows the total number of hospitals and the mean composite score for hospitals in each state. Hospitals in Massachusetts had the highest mean score (3.33) and those in Alabama had the lowest mean score (2.78). There was a 0.55 difference in mean scores between Massachusetts and Alabama, representing a spread of about 1.75 standard deviations.

Discussion

The Leapfrog patient safety composite provides a standardized method to evaluate overall patient safety in those US acute care hospitals that have publicly reported data on a sufficient number of individual safety measures. The composite score could be estimated for 2,652 hospitals using a methodology that is transparent, reproducible, and has face validity, as determined by the national expert panel that guided its development.

The reporting of the composite safety score can serve multiple functions. First, it could raise consumer awareness about patient safety in hospitals and prompt patients to engage their providers in discussing variations in safety across hospitals. Second, by serving as a national reference point, it could encourage improvement efforts and assist hospital leaders in identifying and improving drivers of safety and quality.[20] Third, the score could be used by purchasers and payers to set minimum performance thresholds for inclusion in provider networks or recognizing and rewarding performance through value-based purchasing (VBP) initiatives. One example of a payer using a composite measure is CMS, which plans to use the Agency for Healthcare Research and Quality's patient safety indicator (PSI) composite measure (PSI 90) in its 2015 Inpatient Prospective Payment System VBP program.[21]

A strength of the composite patient safety score is the inclusion of measures that reflect both a hospital's efforts toward safety (process and structural measures) and its safety-related results (outcome measures). Another strength of the score was the minimal bias from individual hospital characteristics. Hospitals that were publicly-owned, rural, not part of a larger health system, or had a larger number of patients with Medicaid as their primary insurance did have slightly lower mean composite scores compared to their counterparts; however, many hospitals within these subgroups outperformed hospitals that did not share these characteristics.

There are several limitations to this composite score. The main limitation is the small pool of publicly reported national measures available to assess hospital safety, which resulted in composite scores that only cover a subset of patient safety. The publicly-reported scores are also limited by a relatively small number of valid outcome measures and by flaws in measures derived from administrative rather than clinical data. Some elements of the score come from voluntary hospital surveys. Voluntary reporting may be a limitation to the extent that hospitals differently interpret the survey questions or report inaccurately. This concern is somewhat mitigated by having hospital senior executives affirm the accuracy of their survey responses and having the reporting organizations critically review submitted responses. In addition, our decision to exclude a measure to address missing data may have overstated or understated a hospital's safety performance, depending on how the hospital performed on the measures that remained. Finally, due to the limited reporting of the data underlying each measure (i.e., the numerators and denominators), the weights in the composite score could not be reliability adjusted for the 'signal' of each measure, a practice commonly used in other composite scores.[22,23]

Future research should examine the relationship between hospitals' composite scores and outcomes, specifically risk-adjusted mortality, readmission rates, and infection rates. Although previous studies did not find any relationship between hospitals' mortality rates and their Leapfrog National Quality Forum Safe Practices Scores[24,25] future research should examine whether the Leapfrog composite score, which includes non-mortality outcome measures plus structural and process measures, is a better correlate of patient mortality than previously developed safety composites. It would also be worthwhile comparing hospitals' performance on the Leapfrog patient safety composite score with performance on other safety composite scores.

Those involved in developing the Leapfrog composite score believe it reflects the best patient safety measures and data currently available for a large number of US hospitals. Nonetheless, two challenges we faced in developing a score were the small number of safety measures that are publicly reported at a national level and deficiencies with many of the existing measures. These problems could be addressed with a more formal mechanism to support and encourage the development of robust patient safety measures. The authors hope that this paper will catalyze the entire health care community – patients, providers, purchasers, and policymakers – to work together to develop better and more meaningful patient safety measures and to publicly report those data nationally. As new measures become available, the panel is committed to revisiting the measures and weights that comprise the composite score.

1
2 **Table 1.** List of Measures Included in Composite Safety Score.

Measure	Primary Data Source (Secondary Data Source, if applicable)	Evidence Score ^a	Opportunity Score ^b	Impact Score ^c	Relative Weight (%)
Process and Structural Measures					
Computerized Physician Order Entry (CPOE)	Leapfrog Hospital Survey (AHA Annual Survey)	2	3.00	3	7.7
ICU Physician Staffing (IPS)	Leapfrog Hospital Survey (AHA Annual Survey)	2	2.89	3	7.5
Safe Practice 1: Leadership Structures and Systems	Leapfrog Hospital Survey	1	1.16	2	2.3
Safe Practice 2: Culture Measurement	Leapfrog Hospital Survey	1	1.32	2	2.5
Safe Practice 3: Teamwork Training and Skill Building	Leapfrog Hospital Survey	1	1.36	2	2.6
Safe Practice 4: Identification and Mitigation of Risks and Hazards	Leapfrog Hospital Survey	1	1.22	2	2.4
Safe Practice 9: Nursing Workforce	Leapfrog Hospital Survey	1	1.25	3	3.3
Safe Practice 17: Medication Reconciliation	Leapfrog Hospital Survey	1	1.19	2	2.4
Safe Practice 19: Hand Hygiene	Leapfrog Hospital Survey	2	1.21	2	3.1
Safe Practice 23: Care of the Ventilated Patient	Leapfrog Hospital Survey	1	1.23	2	2.4
SCIP INF 1: Antibiotic within 1 Hour	CMS Hospital Compare	2	1.05	2	2.9
SCIP INF 2: Antibiotic Selection	CMS Hospital Compare	1	1.04	2	2.2
SCIP INF 3: Antibiotic Discontinued After 24 Hours	CMS Hospital Compare	1	1.06	2	2.2
SCIP INF 9: Catheter Removal	CMS Hospital Compare	2	1.12	2	3.0

Measure	Primary Data Source (Secondary Data Source, if applicable)	Evidence Score ^a	Opportunity Score ^b	Impact Score ^c	Relative Weight (%)
SCIP VTE 2: VTE Prophylaxis	CMS Hospital Compare	2	1.09	3	3.7
Outcome Measures					
Foreign Object Retained	CMS Hospital Compare	1	3.00	2	5.6
Air Embolism	CMS Hospital Compare	1	3.00	2	5.6
Pressure Ulcer – Stages 3 and 4	CMS Hospital Compare	1	2.75	3	7.4
Falls and Trauma	CMS Hospital Compare	2	1.82	3	6.0
Central Line Associated Bloodstream Infections (CLABSI)	Leapfrog Hospital Survey (CMS Hospital Compare)	2	2.00	3	6.4
PSI 4: Death Among Surgical Inpatients	CMS Hospital Compare	1	1.17	2	2.7
PSI 6: Iatrogenic Pneumothorax	CMS Hospital Compare	1	1.40	2	3.1
PSI 11: Postoperative Respiratory Failure	CMS Hospital Compare	1	1.37	2	3.0
PSI 12: Postoperative PE/DVT	CMS Hospital Compare	1	1.50	2	3.2
PSI 14: Postoperative Wound Dehiscence	CMS Hospital Compare	1	1.19	2	2.7
PSI 15: Accidental Puncture or Laceration	CMS Hospital Compare	1	1.46	3	4.3

^a A binary score reflecting the strength of evidence of the measure (1 or 2).

^b The coefficient of variation for the measure plus 1.0, capped at a maximum score of 3.0; reflects the variation in performance between hospitals.

^c Measure of the number of patients possibly affected by the safety event and on the severity of harm for individual patients.

Table 2. Descriptive Statistics of the Composite Safety Scores by Hospital Characteristics.

Characteristic	No. Of Hospitals ^a	Mean Score	Median Score	Standard Deviation	P-Value ^b	Table 2 Notes: a Characteristics for 76 hospitals could not be identified from the 2011 AHA annual survey. b One-way ANOVA was used to compare characteristics within each subgroup. c Regions are based on the U.S. Census Bureau's definitions and available at http://www.census.gov/geo/www/us_regdiv.pdf
All hospitals	2,573	2.97	2.98	0.32		
Region of Country ^c					0.001	
Northeast	485	3.00	2.98	0.30		
Midwest	596	3.00	3.01	0.31		
South	987	2.94	2.98	0.31		
West	505	2.97	2.98	0.35		
Size					0.001	
Small (1-99 beds)	496	2.93	2.98	0.36		
Medium (100-399 beds)	1,583	2.99	3.00	0.30		
Large (400+ beds)	493	2.95	2.93	0.32		
Ownership Type					0.000	
For-profit	475	2.97	3.04	0.31		
Private non-profit	1,757	3.00	2.99	0.31		
Public	341	2.83	2.88	0.34		
Teaching Status					0.043	
Major	296	2.97	2.93	0.35		
Minor	683	2.99	2.98	0.31		
Not Teaching	1,594	2.96	2.99	0.31		
Location					0.047	
Rural	64	2.89	2.97	0.38		
Urban	2,509	2.97	2.98	0.31		
Member of Hospital System					0.000	
No	882	2.90	2.94	0.34		
Yes	1,691	3.01	3.01	0.30		
% Medicare Patients					0.000	
Lowest	643	2.93	2.94	0.34		
Quartile 2	643	3.01	3.02	0.30		
Quartile 3	643	2.98	3.00	0.32		
Highest	643	2.96	2.97	0.30		
% Medicaid Patients					0.000	
Lowest	644	3.02	3.03	0.33		
Quartile 2	642	2.96	2.97	0.31		
Quartile 3	643	3.00	3.02	0.31		
Highest	643	2.89	2.89	0.31		

Table 3. Mean Composite Safety Scores by State.

State	Hospital Count	Mean Score	State	Hospital Count	Mean Score	State	Hospital Count	Mean Score
MA	62	3.33	FL	178	3.00	AR	32	2.89
ME	20	3.17	CT	29	2.99	LA	56	2.89
MI	78	3.11	RI	11	2.98	AZ	47	2.89
MN	46	3.07	CO	34	2.97	ND	6	2.88
VT	6	3.07	IA	27	2.97	NM	21	2.88
VA	58	3.06	WI	45	2.96	AK	7	2.88
NJ	73	3.05	IN	67	2.96	WY	4	2.88
IL	113	3.05	PA	130	2.95	OK	42	2.88
DE	5	3.05	KY	49	2.94	KS	37	2.87
TN	69	3.04	UT	21	2.94	OR	32	2.85
MT	10	3.02	ID	12	2.92	WV	24	2.85
SC	39	3.02	GA	78	2.92	HI	12	2.85
CA	264	3.01	NE	17	2.91	NY	150	2.84
OH	101	3.00	NV	19	2.90	SD	10	2.82
NC	70	3.00	MO	68	2.90	DC	7	2.80
WA	41	3.00	TX	221	2.90	AL	54	2.78
NH	12	3.00	MS	38	2.89			

Acknowledgments

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April 1, 2013

Dear Healthcare Leader:

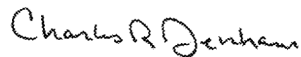
We are delighted to announce that the *Journal of Patient Safety* has graciously given us permission to distribute copies of recently published articles to you in the interest of helping you adopt the National Quality Forum Safe Practices for Better Healthcare – 2009 Update and 2010 Update.

The *Journal of Patient Safety* is dedicated to presenting research advances and field applications in every area of patient safety and we give our highest recommendation for them as a valuable resource toward patient safety from hospital bedside to boardroom. It is in the fulfillment of this mission that they make the gift of these articles to you in your pursuit of your quality journey.

The home page of the *Journal of Patient Safety* can be accessed at the following link: <http://journals.lww.com/journalpatientsafety/pages/default.aspx> and subscription information can be directly accessed online at: <http://journals.lww.com/journalpatientsafety/layouts/1033/oaks.journals/subscriptionseries.aspx>.

We want to acknowledge you and your institution for your current efforts in patient safety. We hope you enjoy this article and find it useful in your future work.

Sincerely,



Charles R. Denham, M.D.
Chairman

Exhibit 2



Business Development Discovery Report

Prepared by:
Stephen Gaus
February 13, 2018

The scope of this document is to report on my assessment of The Leapfrog Group's current state and the opportunity to monetize its IP (Intellectual Property) to sustain current transparency reporting on U.S. Healthcare's Safety & Quality of Care for Acute Care Hospitals. Additional items addressed are from MBO's identified in Leah Binder's offer & assignment letter of 11/2/2017.

Hospital Survey participation:

The participation rate by acute care hospitals continues to grow and currently 66% of representative beds in the US participate in The Leapfrog Group's annual survey.

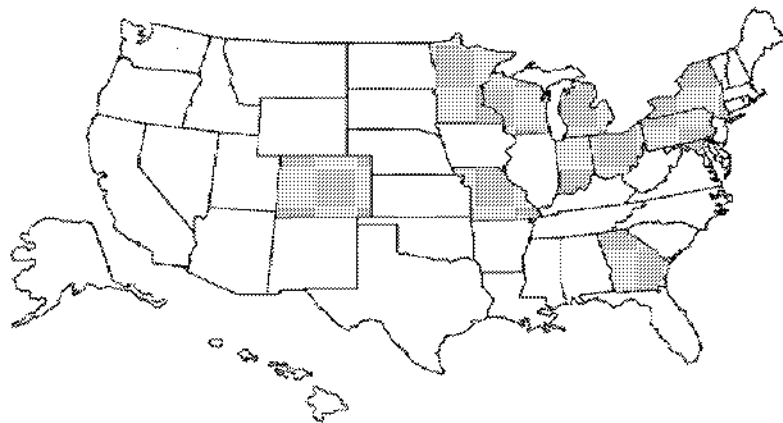
The partnership with Regional Leaders and Coalitions combined with leverage by key Health Insurance Plans has helped to increase the participation to current levels.

To maximize the value of The Leapfrog Group's Data for licensing purposes the level of participation should continue to be increased so it can be perceived as the most complete data set and thus allowing defense of our pricing model and its price points.

Key States to benchmark are:

✓ California	71%
✓ Florida	66%
✓ Illinois	52%
✓ Massachusetts	86%
✓ New Jersey	93%
✓ North Carolina	76%
✓ Tennessee	52%
✓ Texas	62%
✓ Virginia	67%

Key States to Target:



Colorado	44%	Missouri	39%
Georgia	48%	New York	40%
Indiana	21%	Ohio	38%
Maryland	17%	Pennsylvania	47%
Michigan	48%	Wisconsin	6%
Minnesota	4%	Washington DC	38%

The aforementioned states and highlighted map identifies 12 states representing 30% of the US population that all have Hospital Survey participation rates below 50%.

Leapfrog should conduct an exercise to identify the key success factors for more desirable participation inherent in the Top Benchmarking States. We can then prepare a plan & roadmap for the Targeted States to achieve > 50% participation in the hospital survey.

A secondary business development activity could be to produce strategies & tactical plans to improve the participation levels from the ranges of 50-70% to greater than 80%.

Leapfrog should review our current roster of Regional Leaders and/or Coalitions in these "Targeted States" and determine a classification as follows:

M - Meets Expectations & Standards

N - Needs a Regional Leader or Coalition

IR - Needs Improvement or Replacement

Lastly some consideration should be given to potential business development initiatives to gain participation by VA and Military Hospitals in the DHA.

To increase the value of Leapfrog's Data:

Various U.S. industry and enterprises are all leveraging "Big Data" to make better informed decisions. Healthcare may have been a laggard in this adoption curve but we can expect acceleration and we should look to the recent announcement of a new venture by Amazon, JP Morgan & Berkshire Hathaway as a bellwether event. This newly created venture's goal is to impact the cost curve of purchased healthcare by its employees through the use of technology & consumerism.

Healthcare Informatics, Technology and Analytics have entered into a new phase. The next phase will be dominated by leveraging "Big Data" to not only improve clinical diagnostics and care delivery but to also achieve better financial outcomes for the purchasers.

This transition from volumes based model to a value based model is a vitally important initiative for the U.S. The growing cost of Healthcare not only risks American Industry's competitive position in the world economy and it also has implications from a National Security perspective.

There are many key drivers that include the now near full adoption & deployment of E.H.R. systems, increased utilization of Population Health Management Software and recent programs by CMS and Health Insurance Plans to modify reimbursements and to incentivize value in both safety & quality of care.

Leapfrog operates in a cluttered space of Hospital reporting both mandatory and voluntary. The perceived or actual value of the Leapfrog Survey Data can increased be through a number of means and areas.

First Leapfrog can help to increase the perceived value of its survey data by improving on the "messaging" of the science behind the survey, the domains, the elements and its scoring methodologies.

A presentation, collateral marketing brochure and a podcast for inclusion on the Leapfrog Websites should be prepared. The primary intended audience should be potential data licensees who might be looking into the value differentiators and trying to choose the most current data set with the most compete measures that are compiled in an accurate and fair representation or the proverbial "most bang for the buck".

Secondly Leapfrog can continue to sustain its reputation & relevance by making continuous improvements to its survey and process through the means that have been demonstrated through its history. The current modifications planned for 2018 are indicative of this culture of continuous improvement & greater relevancy.

Thirdly Leapfrog can increase both the perceived and actual value of the data by collecting more relevant data that is needed and desired by Purchasers. Including Data from Ambulatory Surgery Centers is a prime example of this expanded data set. Outpatient Surgery is an increasing expenditure for Health Care Purchasers and as such a logical product line extension for Leapfrog to add to the Data License offerings.

Lastly although Healthcare expenditures by Purchasers is financially dominated by care provided in the Acute Care, Ambulatory or Outpatient Surgical Centers there is a growing need and desire for a scoring or rating system for primary care providers. Leapfrog might consider some form of a strategic partnership with an organization that could offer such a tangential or complimentary set of data on providers.

Sales Coverage, Market Segmentation & Increased Market Penetration

Currently Leapfrog identifies 17 unique data license customers covering over 154M lives from our data license contracts.

Of those 17 customers; Leapfrog employs 6 resellers. Currently Leapfrog counts 10 Health Insurance Plan customers of which two have licensed the Value Based Purchasing Program.

The current stream of Data License Contract Revenues total \$1.511M. The breakdown of revenues is: \$818K for Survey Data, \$293K for Safety Grade Data and \$400K for VBP Program. The primary end user customers for our Data License Products are HIPs (Health Insurance Providers).

No direct data license contracts have yet been secured for any TPA's or large employers. It has been estimated that 82% of employers with headcounts greater than 40,000 are self-insured. This is a significant change from 1974 when less than 5% of U.S. employees were covered by an employers' self-insurance. This market represents a significant growth opportunity for Leapfrog's VBP as there are currently 1927 U.S. companies with over 5,000 employees.

Secondary markets for Leapfrog include resellers, transparency vendors, publishers and researchers.

Until November of 2017; The Leapfrog Group had not employed a full time dedicated resource for Business Development or customer acquisition. Prior sales duties were shared by the Director of Communications and the Business Development Coordinator.

The current Leapfrog pricing model although somewhat linear does not offer an affordable entry level price point at the low end of lives for Consultant/Brokers, small Health Plans or Employers with member headcounts under 150,000.

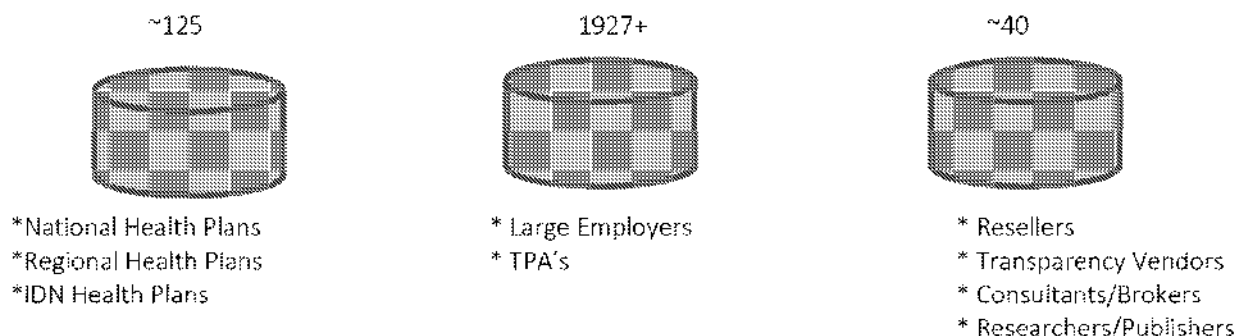
The current Leapfrog Pricing Model utilizes somewhat broad ranges for lives and could achieve a more linear model if a PMPM (per member per month) pricing model was adopted. The PMPM metric is widely adopted and utilized by HIPs & employers. It might aid us in creating optics of more affordability.

The current Leapfrog Resellers model has two potential flaws that limits our revenue growth and inhibits our ability to identify new prospects without creating potential channel conflict.

1. Resellers pay a 2.6 premium over a comparable Health Plan thereby giving them a cross-over or break-even point after three client sales. Thereafter except for annual "lives" census updates no real revenue royalty is realized by Leapfrog for the reseller's success in client license expansions. An annual census update report delays when Leapfrog could realize any modest increase in royalty revenue.
2. Per the DUA & Resellers Agreement there is no requirement for the resellers to provide details on the list of end user clients they have resold and subsequently licensed Leapfrog's Data. This introduces opportunity for potential channel conflict by not knowing who Leapfrog's end user clients are. The DUA language is also deficient in providing Leapfrog practical & affordable surveillance options other than an independent financial audit.

Market Opportunity & Segmentation:

The Data License market can be divided into three logical market segments for sales coverage with estimated numbers:



Currently Leapfrog has existing customers in all three market segments:

Key Decision Makers, Influencers & Points of Contact by Market Segments are:

Health Plans – Chief Medical Officer, Chief Financial Officer, Chief Operating Officer, VP of Network Contracts, VP of Member Services, Director of Quality Care Improvement, Director of Value Purchasing Programs

Large Employers & TPA's - Chief Medical Officer, Chief Financial Officer, VP of Human Resources, VP of Employee Benefits

Resellers & all others – VP of Client Services, VP of Sales, VP of Marketing, VP of Products & Services

Market Coverage Strategy:

Leapfrog should continue to service existing clientele but strive to better understand who resellers sell to and how our data is utilized. Leapfrog should also continue to market directly to HIPs while building a Sales Channel Model that could in time take over this segment to accelerate customer acquisition.

A recommendation to modify our sales coverage would be to modify & expand our channel sales beyond Leapfrog's current resellers. A priority would be to secure a Top Tier National Big Data/Cloud Channel such as IBM Watson. The primary attributes would include:

1. National & Total Market Coverage
2. Existing relationships with HIPs & Large Employers
3. Ability to secure Amazon/JP Morgan/Berkshire
4. Industry & Healthcare Domain knowledge & competency
5. Ability to provide Level 1 support to clients

Leapfrog could leverage this Channel arrangement & utilize IBM Watson to cover the National HIPs and the Fortune 1000 of large employers that are self-insured.

IBM Watson could also be leveraged to market to and cover the HIP segment. Leapfrog would continue to support existing Resellers while modifying agreements to gain better transparency on end user license clients with associated corresponding surveillance activities.

Whenever feasible we would transition to a pricing model that would prove richer to Leapfrog. Leapfrog would also seek to build a network of Broker/Consultants that would license the Leapfrog Data & Value Based Purchasing Program to smaller employers seeking to build more narrow networks for employer plans.

Leapfrog Data License Pricing Considerations:

All of Leapfrog's "lives" pricing for Resellers, Health Plans & Employers should be recalculated to a pmpm model.

The current pricing model has an initial base price point that is too high for small plans or employers when calibrated for pmpm pricing.

The current pricing model is not an ideal set up for Channels. Resellers should be able purchase at a discount off list to allow mark-up to recover sales expense & achieve a gross profit. Transfer price models should be linear and allow Leapfrog revenues to grow with increases in both lives & clients sold by resellers.

The current reseller model does not address potential channel conflict between resellers and Leapfrog direct sales coverage as we have no visibility to resellers' end user clients.

The current pricing model does not account for resellers to sell VBP &/or to charge a per client fee for Leapfrog's onboarding support & Discern consulting services.

To optimize revenue opportunity resellers should report census data and be recalibrated on a quarterly basis for lives & clients and billed in advance for the next quarter's data user licenses.

The current pricing model unduly burdens National VBP Resellers on a per hospital benchmarking & analytics report basis and would total \$1.3M for all 1947 reports.

Partnership & Internal Discounts are very generous at 25% & 40% off. Leapfrog concedes additional revenue contribution if a Regional Leaders' SPIF is paid on VBP Program Sales.

Potential consideration to modify and lower discounts to 10% Partnership, 25% Internal Only & a 15% SPIF on VBP Program Sales.

A recommended modified Pricing Model has been prepared in an accompanying MS Excel file & stored on the Autotask Workplace:

<https://us.awp.autotask.net/1/filelink/cvornq-cckbszi-k37iby42>

Sales Tracking & Infrastructure:

In anticipation of increased sales & marketing activities Leapfrog has licensed an enterprise version of Salesforce.com's CRM and has it deployed and in use now.

Kush Banerjee has loaded all existing customer contact information and is the process of loading all current contract attachments and creating calendar tasks to alert for action prior to the renewal notice period. This action identified a reporting activity for Rally Health to report census data and should lead to an expanded renewal contract with an increase of 293% to \$236,500.

The Salesforce.com CRM tracks all opportunities in the pipeline and all interactions and communications are captured and logged. It serves as the repository for all customer contacts and documents. All emails and proposals are generated from Salesforce.com. Email campaigns can be initiated and driven from Salesforce.com.

All web inquiry leads will be queried against the CRM data base and if not duplicated a new account created and assigned for follow-up.

Leapfrog has recently purchased an instance of PandaDocs to be utilized for our sales proposal platform. This platform will enhance our image and bring our sales branding up and commensurate with The Leapfrog Group's overall Branding. This proposal platform will be integrated with Salesforce.com and will allow us to track prospective clients' reviews, interactions, notations and questions with the proposal to include notifications of "openings", "click throughs" & "forwarded email addresses". These features are key to timely & targeted sales follow-up.

Lastly Leapfrog has identified SEOSamba, a SaaS vendor that will build a micro sales & marketing web-site for us. SEOSamba will collaborate of the web site design & content but yet fully allow us total control, edits, additions and management of the web site. SEO will regularly manage SEO (Search Engine Optimization) to fully ensure maximum exposure to targeted clients without competing with the other Leapfrog websites.

SEOSamba will also help procure a lead list of target executives for the identified market of HIPs. This list will serve as the foundation for our first campaign.

SEOSamba will assist building three campaigns that will employ SMM (Social Media Marketing) to track key target executives and to utilize paid web ad campaigns via LinkedIn, Facebook, Twitter and Google to place Leapfrog content ads on their pages.

SEOSamba will produce & help manage monthly reporting on analytics with free consultative services on how best to manage and optimize our SMM Campaigns.

SEOSamba will also help build a posting schedule and program of related and complimentary postings to maximize our exposure & views driving increased traffic to our Sales & Marketing Micro site.

Additional Opportunity for Monetization of Leapfrog IP & Branding:

The success and significant financial contribution of the Hospital Safety Grade & Top Hospital Accolades Program illustrates the market acceptance and brand influence that Leapfrog carries in the HealthCare Provider space.

Serious consideration should be given to expanding and potentially bundling of the sub categories for Maternity Care and Ambulatory Surgical Centers.

Top Hospitals and A Safety Graded Hospitals might increase their accolade spend with us with the additional opportunities for promotion.

Lower Safety Graded Hospitals may achieve significantly better grades for either Maternity Care or Ambulatory Surgical Centers and thus create new accolades revenue opportunities for Leapfrog.

Exhibit 3

ARMSTRONG INSTITUTE
FOR PATIENT SAFETY AND QUALITY



Lives Lost, Lives Saved: An Updated Comparative Analysis of Avoidable Deaths at Hospitals Graded by The Leapfrog Group

May 2019

by

Matt Austin, Ph.D.
Jordan Derk, M.P.H.

Armstrong Institute for Patient Safety and Quality
Johns Hopkins Medicine

Prepared for The Leapfrog Group, Washington, D.C.

About the Armstrong Institute

Established in 2011, the Armstrong Institute partners with patients, their loved ones, and all interested parties to end preventable harm, to continuously improve patient outcomes and experience, and to eliminate waste in health care delivery, both at Johns Hopkins and around the world. Created with a gift from C. Michael Armstrong, former chairman of the Johns Hopkins Medicine Board of Trustees, the institute develops and tests solutions in safety and quality improvement that can then be shared at the regional, national and global levels. Using a scientific approach to improvement, the organization employs robust measures that can be broadly disseminated and sustained. More information about the Armstrong Institute is available at hopkinsmedicine.org/armstrong_institute/.

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Introduction

In 2012, in an effort to provide patients and health care consumers with information on the safety of their local hospitals, The Leapfrog Group introduced the Hospital Safety Grade, a letter grade rating for hospitals on how safe they are for patients. The Hospital Safety Grade is a composite score of 28 measures of patient safety that are all currently used in national measurement and reporting programs. The Hospital Safety Grade uses performance measures from the Leapfrog Hospital Survey, the Centers for Medicare and Medicaid Services (CMS), and secondary data sources. Hospital Safety Grades are assigned twice a year (in the spring and fall) to more than 2,600 hospitals across the nation. From the calculated scores, hospitals are assigned a letter grade ranging from A to F, with “A” hospitals having the highest scores and “F” hospitals having the lowest scores.

Leapfrog’s membership of employers and other purchasers of health care are interested in helping consumers understand the relative risk of using an “A” hospital versus hospitals that receive lower grades. Leapfrog asked the Armstrong Institute to update its original 2016 analysis of the estimated number of avoidable deaths in hospitals with each letter grade (“A” vs. “B” vs “C” vs “D, F”) and how many lives could be saved if all hospitals in the U.S. that receive a Hospital Safety Grade had a safety record of “A” hospitals.

Methods

Measures Used

Fifteen outcome measures and one structural measure from the Spring 2019 Hospital Safety Grade were used in the analysis. The measures included in the analysis were those for which the literature has clearly identified an attributable mortality to the patient safety event or a closely-related prevention process. Table A (Appendix) reflects the list of measures used in the analysis, the data source for each measure, and the reporting period covered by the measure.

Estimating Incidence of Errors

Using data from those hospitals that received a Spring 2019 Leapfrog Hospital Safety Grade, the mean incidence rate of each patient safety outcome was calculated for “A” hospitals in aggregate, “B” hospitals in aggregate, “C” hospitals in aggregate, and “D” and “F” hospitals together in aggregate. Table 1 reflects the mean incidence rate for each patient safety outcome for hospitals in each letter grade.

Estimating Mortality Risk

The published literature was reviewed to identify the average attributable mortality rate associated with each patient safety outcome when it occurs in the inpatient setting. The attributable mortality rates and the source of those data points are listed in Table 1. As the literature did not typically distinguish differences in mortality between better and worse performing hospitals, the same mortality rate was used for hospitals of all letter grades. The one exception to this is for Patient Safety Indicator 4 (PSI 04): Death among Surgical Inpatients with Serious Treatable Complications. For this measure, a hospital's score on the measure reflects the mortality rate when a serious, treatable complication occurs. As such, for this measure, we could aggregate data across each letter grade to determine a grade-specific mortality rate. The literature did not support any attributable mortality rate for Hospital-Acquired Conditions (HAC): Air Embolism.

While higher adherence to process and structural measures is generally linked to improvements in patient safety and care quality, the literature did not identify quantifiable reductions in mortality rates through improved performance for most of the process and structural measures used in the Hospital Safety Grade. However, one structural measure used in the Hospital Safety Grade, Intensive Care Unit (ICU) Physician Staffing, does have identifiable reductions in mortality risk. It is estimated that full implementation of Leapfrog's ICU Physician Staffing (IPS) standard by all U.S. hospitals could reduce ICU mortality by 30% — from 12% to 8.4%.¹ We assumed a linear relationship between a hospital's adoption of Leapfrog's standard and reductions in mortality rates. Table 2 reflects the estimated excess mortality above 8.4% for each letter grade attributable to lack of full adoption of Leapfrog's IPS standard.

Calculating Mortality Rates per 1,000 Admissions

To estimate the mortality rate for each patient safety outcome in hospitals in each letter grade, we multiplied the mortality rate for each outcome measure by the respective mean incidence rate of that outcome for each Hospital Safety Grade letter grade. As some measures apply only to certain kinds of admissions, such as surgical admissions or ICU admissions, we multiplied the mortality rates by the percentage of all admissions that apply to that measure. From the literature, we identified that 29% of all U.S. hospital admissions involve a procedure in the operating room² and 20% include an ICU admission.³

To estimate the impact of the lack of full adoption of Leapfrog's ICU Physician Staffing standard on patient mortality, we multiplied the incremental mortality rate by the percentage of hospital admissions that are admitted to the ICU.

While the literature we used to estimate the mortality rates for each preventable harm would ideally reflect the mortality that is directly attributable to that preventable harm in isolation, we recognize that some of the estimated mortality risk may be counted across

multiple measures. To account for this limitation, we reduced the mortality associated with the outcome measures by 50%.

Table 1. Mean Incidence Rate of Patient Safety Outcomes for Hospitals in Each Spring 2019 Letter Grade and the Average Attributable Mortality Rate for Each Outcome.

Measure	Mean Incidence Rate of Patient Safety Outcome per 1,000 Hospital Admissions (Based on Spring 2019 grades)				Identified Attributable Mortality Rate
	A	B	C	D & F Combined	
Hospital-Acquired Conditions (HAC): Foreign Object Retained After Surgery	0.00%	0.00%	0.00%	0.01%	2.14% ⁴
Hospital-Acquired Conditions (HAC): Falls and Trauma	0.03%	0.04%	0.05%	0.06%	5.50% ⁵
Hospital-Acquired Conditions (HAC): Air Embolism	0.00%	0.00%	0.00%	0.00%	No identified mortality rate
Central Line-Associated Blood Stream Infection (CLABSI)	0.12%	0.16%	0.18%	0.24%	18.5% ⁵
Catheter-Associated Urinary Tract Infection (CAUTI)	0.14%	0.17%	0.19%	0.23%	2.3% ⁵
Surgical-Site Infections from Colon Surgery (SSI: Colon)	0.01%	0.01%	0.01%	0.01%	2.8% ⁵
Hospital-onset Methicillin-resistant Staphylococcus Aureus (MRSA) Laboratory-identified Blood Infections	0.02%	0.03%	0.04%	0.05%	22.6% ⁶
Hospital-onset Clostridium Difficile (C.diff.) Laboratory-identified Infections	0.32%	0.36%	0.39%	0.38%	23.00% ⁷
Patient Safety Indicator 3: Pressure Ulcer Rate	0.03%	0.04%	0.04%	0.06%	7.23% ⁴
Patient Safety Indicator 4: Death Among Surgical Inpatients with Serious Treatable Complications	0.63%	0.64%	0.65%	0.64%	A: 15.82% B: 16.05% C: 16.37% DF: 17.19% Note: Values are calculated from the actual PSI 04 data
Patient Safety Indicator 6: Iatrogenic Pneumothorax	0.03%	0.03%	0.03%	0.03%	6.99% ⁴
Patient Safety Indicator 11: Postoperative Respiratory Failure	0.76%	0.81%	0.88%	0.94%	21.84% ⁴
Patient Safety Indicator 12: Postoperative Pulmonary Embolism (PE) or Deep Vein Thrombosis (DVT)	0.36%	0.38%	0.40%	0.44%	6.56% ⁴
Patient Safety Indicator 14: Postoperative Wound Dehiscence	0.08%	0.08%	0.09%	0.09%	9.63% ⁴
Patient Safety Indicator 15: Accidental Puncture or Laceration	0.12%	0.13%	0.13%	0.14%	2.16% ⁴

Table 2. Estimated Excess ICU Mortality Attributed to Lack of Full Adoption of Leapfrog's IPS Standard based on Spring 2019 grades.

	Excess ICU Mortality Rate by Spring 2019 Letter Grade				Note
	A	B	C	D & F Combined	
ICU Physician Staffing	1.01%	1.53%	2.34%	2.37%	Values are calculated from actual data; values reflect the incremental mortality above 8.4% due to the lack of hospitals' full adoption of Leapfrog's IPS standard ¹

Hospital Admissions

We used data from the 2017 American Hospital Association's Annual Survey to identify the number of acute care hospital admissions across the United States (34,305,620)⁸ and how those admissions distribute across hospitals in each Hospital Safety Grade letter grade.

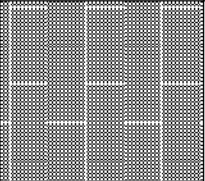
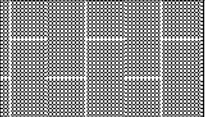
Lives Lost and Lives Saved

We used the distribution of hospital admissions across each Hospital Safety Grade letter grade with the number of lives lost per 1,000 admissions per letter grade to estimate the total number of lives lost for hospitals in each letter grade. We also used these data to calculate the number of lives that would be saved if hospitals with grades lower than "A" operated as safely as "A" hospitals.

Results

Table 3 reflects the key results of the analysis. The number of avoidable deaths per 1,000 admissions ranged from 3.24 lives per 1,000 admissions in "A" hospitals to 6.21 lives per 1,000 admissions in "D" and "F" hospitals. Compared to "A" hospitals, the differences in the estimated relative risk of an avoidable death is 34.9% higher in "B" hospitals, 87.7% higher in "C" hospitals, and 91.8% higher in "D" and "F" hospitals. It is important to recognize, however, that these results reflect average hospital performance in each grade category and individual hospital performance within a letter grade may vary.

Table 3. Rate of Avoidable Deaths per 1,000 Admissions and the Possible Lives Saved with Improved Performance based on Spring 2019 grades.

	A	B	C	D & F Combined
Lives Lost/1,000 Admissions	3.24	4.37	6.08	6.21
Relative Risk of an Avoidable Death Compared to "A" Hospitals		34.9%	87.7%	91.8%
Distribution of Hospital Admissions	33.4%	25.4%	35.7%	5.5%
Lives Saved if All Hospitals Had an "A" Safety Record		9,835	34,775	5,605

Applying the mortality rates for each grade of hospital to the distribution of hospital admissions in 2017, we estimate 161,250 avoidable deaths in U.S. hospitals each year (37,085 in "A" hospitals, 38,038 in "B" hospitals, 74,414 in "C" hospitals, and 11,712 in "D," and "F" hospitals). We estimate 50,215 lives could be saved every year if "B" "C," "D", and "F" hospital had the same safety performance as "A" hospitals.

Conclusions

Efforts to reduce patient safety events have been plentiful, and yet elimination of all preventable harms remains elusive. While hospitals with a Hospital Safety Grade of "A" have better performance than hospitals with lower grades, they still have significant opportunities for improvement. If hospitals with a grade lower than an "A" are able to achieve the safety performance of "A" hospitals, we estimate more than 50,000 patient lives could be saved.

The measures included in this analysis reflect a subset of all potential harms that patients may encounter in U.S. hospitals, and as such, these results likely reflect an underestimation of the avoidable deaths in U.S. hospitals. Also, we have only estimated the deaths from patient safety events and have not captured other morbidities that may be equally important. And while the absolute numbers presented in this analysis are likely an underestimation of the true impact on patients, the relative comparisons presented in this analysis likely hold across all harms, given that the underestimation is likely consistent across all hospitals.

How this study compares to other studies

In comparing the results of this updated analysis to the original 2016 analysis, we found a reduced number of lives lost, from an estimated 206,000 in the original analysis to an estimated 150,000 in this updated analysis. This reduction is primarily attributable to two factors – (1) hospitals have made incremental improvements on those performance measures that are included in the Hospital Safety Grade; and (2) some of the performance measures used in the Hospital Safety Grade have been re-defined and re-baselined since the original analysis.

We have seen an increase in the number of lives that could be saved if every hospital had the performance of an “A” hospital, with an estimated 33,000 lives saved in the original analysis to an estimated 50,000 lives saved in this updated analysis. This increase is reflective of “A” hospitals improving at a faster rate than hospitals in the other grade categories.

Other studies that have estimated the number of lives lost from medical error range from 44,000 to 440,000,^{9,10} with our estimate falling in the middle of that range. We believe our results are an underestimation of the total impact of avoidable death in U.S. hospitals as our results cover a subset of potential harms suffered by patients.

Limitations

This analysis only utilized measures of patient safety harm included in the Spring 2019 Hospital Safety Grade. There are a number of patient safety harms that are not currently measured and publicly reported. Examples include medication errors and diagnostic errors. The estimates of lives lost in this analysis are likely to be conservative.

The mortality rates we used in the analysis were generally the same for all hospitals. One might hypothesize that safer hospitals may actually have lower mortality rates when one of these events occurs. This would exaggerate differences we identified between better and worse performing hospitals.

We cannot quantify the true amount of double-counting of deaths that may occur between the different measures. The literature does not identify the potential impact intensivists have on patient harms in the ICU, so we made a conservative assumption that 50% of the deaths associated with the outcome measures are already captured in the ICU Physician Staffing mortality estimates. The analysis could be refined if one could better understand the impact that the presence of intensivists has on patient harms in the ICU.

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Appendix

Table A. Measures from the Spring 2019 Hospital Safety Grade Used in the Analysis.

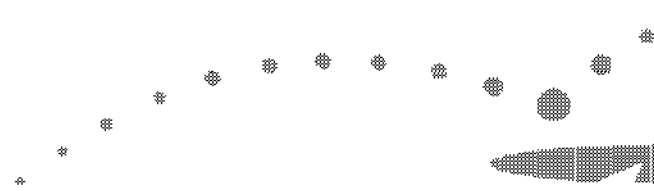
Outcome Measures	Data Source*	Reporting Period
Hospital-Acquired Conditions (HAC): Foreign Object Retained After Surgery	Centers for Medicare and Medicaid Services (CMS)	10/01/2015 - 06/30/2017
Hospital-Acquired Conditions (HAC): Falls and Trauma	Centers for Medicare and Medicaid Services (CMS)	10/01/2015 - 06/30/2017
Hospital-Acquired Conditions (HAC): Air Embolism	Centers for Medicare and Medicaid Services (CMS)	10/01/2015 - 06/30/2017
Central Line-Associated Blood Stream Infection (CLABSI)	2018 Leapfrog Hospital Survey	07/01/2017 - 06/30/2018
	Centers for Medicare and Medicaid Services (CMS)	04/01/2017 - 3/31/2018
Catheter-Associated Urinary Tract Infection (CAUTI)	2018 Leapfrog Hospital Survey	07/01/2017 - 06/30/2018
	Centers for Medicare and Medicaid Services (CMS)	04/01/2017 - 3/31/2018
Surgical-Site Infections from Colon Surgery (SSI: Colon)	2018 Leapfrog Hospital Survey	07/01/2017 - 06/30/2018
	Centers for Medicare and Medicaid Services (CMS)	04/01/2017 - 3/31/2018
Hospital-onset Methicillin-resistant Staphylococcus Aureus (MRSA) Laboratory-identified Blood Infections	2018 Leapfrog Hospital Survey	07/01/2017 - 06/30/2018
	Centers for Medicare and Medicaid Services (CMS)	04/01/2017 - 3/31/2018
Hospital-onset Clostridium Difficile (C.diff.) Laboratory-identified Infections	2018 Leapfrog Hospital Survey	07/01/2017 - 06/30/2018
	Centers for Medicare and Medicaid Services (CMS)	04/01/2017 - 3/31/2018
Patient Safety Indicator 3: Pressure Ulcer Rate	Centers for Medicare and Medicaid Services (CMS)	10/01/2015 - 06/30/2017
Patient Safety Indicator 4: Death Among Surgical Inpatients with Serious Treatable Complications	Centers for Medicare and Medicaid Services (CMS)	10/01/2015 - 06/30/2017
Patient Safety Indicator 6: Iatrogenic Pneumothorax	Centers for Medicare and Medicaid Services (CMS)	10/01/2015 - 06/30/2017
Patient Safety Indicator 11: Postoperative Respiratory Failure	Centers for Medicare and Medicaid Services (CMS)	10/01/2015 - 06/30/2017
Patient Safety Indicator 12: Postoperative Pulmonary Embolism (PE) or Deep Vein Thrombosis (DVT)	Centers for Medicare and Medicaid Services (CMS)	10/01/2015 - 06/30/2017
Patient Safety Indicator 14: Postoperative Wound Dehiscence	Centers for Medicare and Medicaid Services (CMS)	10/01/2015 - 06/30/2017
Patient Safety Indicator 15: Accidental Puncture or Laceration	Centers for Medicare and Medicaid Services (CMS)	10/01/2015 - 06/30/2017
Process/Structural Measure		
ICU Physician Staffing (intensivists managing or co-managing ICU patients)	2018 Leapfrog Hospital Survey	2018
	2017 AHA Annual Survey	2017

*For hospitals located in Maryland, the Hospital-Acquired Conditions and Patient Safety Indicator data were generated by the Maryland Health Care Commission (MHCC)

Exhibit 4

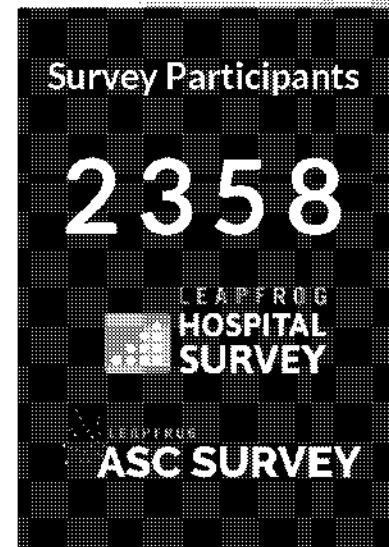
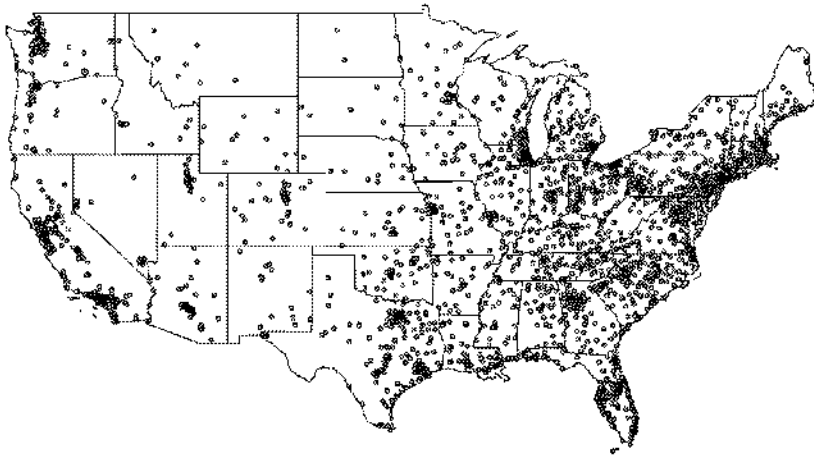


2021 ANNUAL REPORT



THE LEAPFROG GROUP

Giant Leaps for Patient Safety



Thank you!

Because of you, we can deliver on our mission to trigger giant leaps forward in the safety, quality, and affordability of U.S. health care by using transparency to support informed health care decisions and promote high-value care.

2021 – A big year for Leapfrog

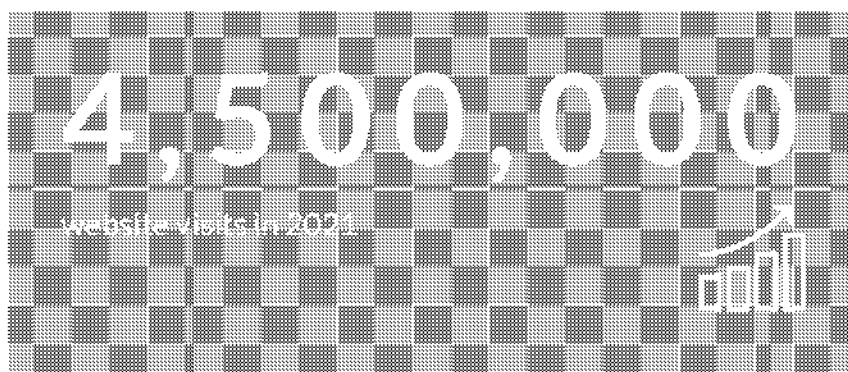
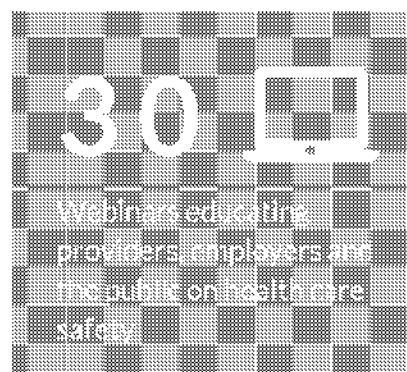
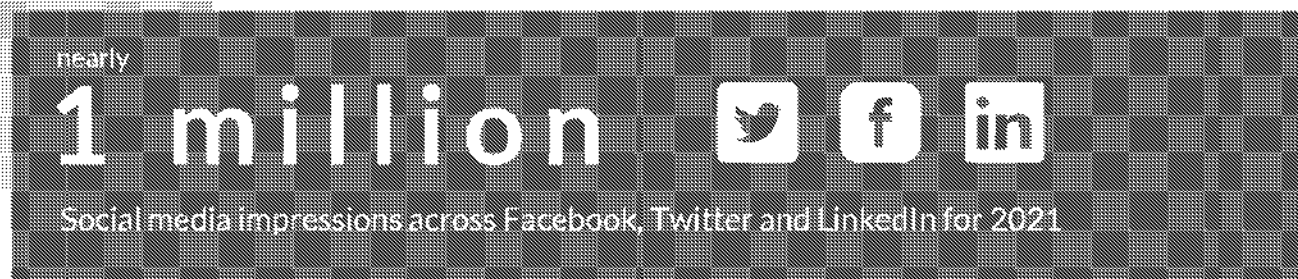
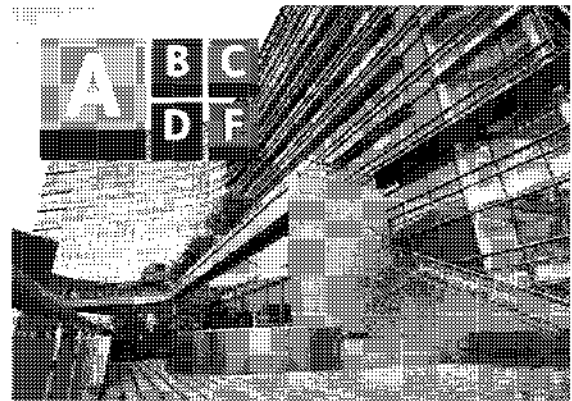
We made incredible strides in 2021 – Leapfrog boldly fought for and stood by patients demanding accountability for safe care. Leapfrog has increased its presence in policy and advocacy efforts in Washington, including the preservation of a critical patient safety measure that keeps hospitals accountable for preventable deaths.

Our donors played a direct role in all these accomplishments. Thanks to your contribution, we have expanded our footprint, influence, and ability to improve health care in this country.

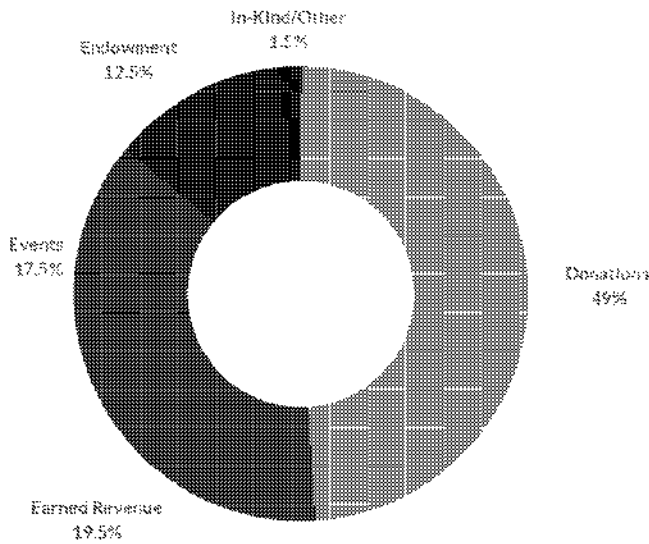
Leapfrog's Impact

What really matters is people. Leapfrog exists to help patients and their families find access to safer health care and, in turn, help save lives. When Carl Flatley was out of town for a bike race last year, he woke up in the middle of the night with severe back pain and knew he needed a hospital. He quickly looked at the Leapfrog Hospital Safety Grades in the area he was in and realized the hospitals closest to him did not perform well. The closest hospital with an "A" grade was 400 miles away, but he made the drive because he wanted to ensure he would get the best, safest care possible. Thanks to the information provided in the Hospital Safety Grade, Carl received the treatment he needed at the hospital and recovered with no complications.

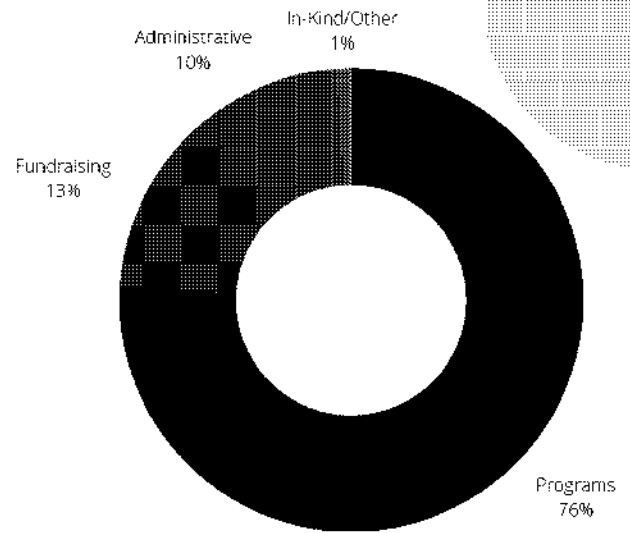
"You have to pick the hospital you go to based on competency – not convenience. Leapfrog provides invaluable data that all patients should use." -Carl Flatley



2021 Income



2021 Expenses



What's Next for 2022

With your continued support, we expect big things in 2022. We look forward to launching our 2022 Leapfrog Surveys and our Leapfrog Hospital Safety Grades, hosting our Green Light Gala in March, launching the Judie Burrows Education Institute, and continuing to expand our influence through public policy and advocacy. Thank you for helping us make giant leaps for patient safety.

7 Policy partnerships with employer groups and other patient safety organizations

2 Letters to Centers for Medicare & Medicaid Services (CMS) on proposed rules, advocating for safer medical care

75 Co-signers stepped CMS from adopting PSI-4, a life-saving mortality measure critical to the Hospital Safety Grade

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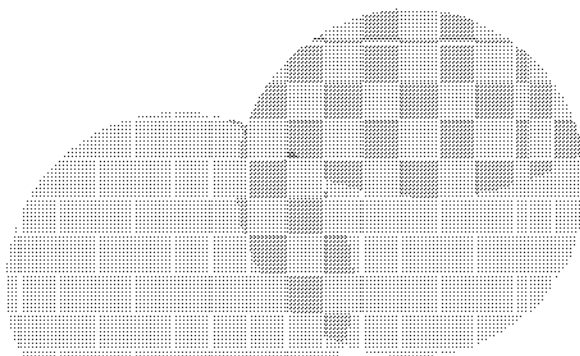
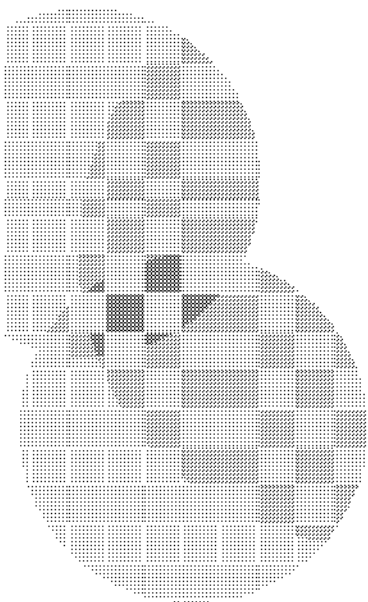
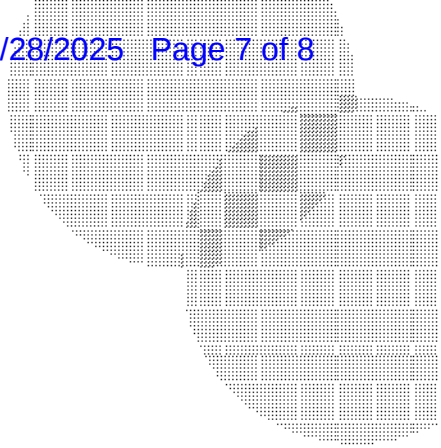
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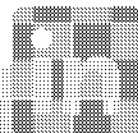
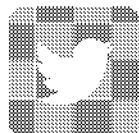


Exhibit 5

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	D	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL	AM	AN
1	FacilityName	2023 Fall- Grade	2023 Spring- Grade	2022 Fall- Grade	2022 Spring- Grade	2021 Fall- Grade	2021 Spring- Grade	2020 Fall- Grade	2020 Spring- Grade	2019 Fall- Grade	2019 Spring- Grade	2018 Fall- Grade	2018 Spring- Grade	2017 Fall- Grade	2017 Spring- Grade	2016 Fall- Grade	2016 Spring- Grade	2015 Fall- Grade	2015 Spring- Grade	2014 Fall- Grade	2014 Spring- Grade	2013 Fall- Grade	2013 Spring- Grade	2012 Fall- Grade	2012 Spring- Grade
682	Palm Beach Gardens Medical Center	C	C	C	C	C	C	C	C	A	A	A	A	A	B	B	C	A	A	A	A	A	A	C	C
717	Delray Medical Center	C	C	C	C	C	C	C	B	A	A	A	B	B	B	B	B	A	A	A	A	A	A	A	C
723	West Boca Medical Center	C	C	C	C	C	B	B	B	C	B	B	B	B	B	A	A	A	A	A	A	A	A	A	A
731	Good Samaritan Medical Center	C	C	C	C	C	C	C	C	B	B	B	B	B	B	C	B	A	A	A	B	C	A	A	B
732	St. Mary's Medical Center	C	C	B	B	C	C	C	C	B	C	B	B	B	B	B	B	A	A	A	A	A	A	B	A

Exhibit 6

LEAPFROG
HOSPITAL
SAFETY GRADE

| Scoring Methodology

| SPRING 2023 SAFETY GRADE

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HOSPITAL
 SAFETY GRADE

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LEAPFROG
HOSPITAL
 SAFETY GRADE

WHAT IS THE HOSPITAL SAFETY GRADE?

Leapfrog Hospital Safety Grades are assigned to nearly 3,000 general acute-care hospitals across the nation twice annually. The Safety Grade uses up to 22 national patient safety measures from the Centers for Medicare & Medicaid Services (CMS) and the Leapfrog Hospital Survey, and information from other supplemental data sources, to produce a single letter grade representing a hospital's overall performance in keeping patients safe from preventable harm and medical errors. The Safety Grade methodology has been peer reviewed and published in the *Journal of Patient Safety*.¹

With the Safety Grade, The Leapfrog Group aims to educate and encourage consumers to consider safety when selecting a hospital for themselves or their families. In addition, we believe the Safety Grade will foster strong market incentives for hospitals to make safety a priority. Safety Grades are publicly reported at www.HospitalSafetyGrade.org.

ELIGIBLE HOSPITALS

Due to the limited availability of public data, Leapfrog is not able to calculate a Safety Grade for every hospital in the U.S., including the following types of hospitals:

- Critical access hospitals (CAH)
- Long-term care and rehabilitation facilities
- Mental health facilities
- Federal hospitals (e.g., Veterans Affairs, Indian Health Services, etc.)
- Some specialty hospitals, such as surgery centers and cancer hospitals
- Free-standing pediatric hospitals
- Hospitals in U.S. territories
- Hospitals that are missing scores for **more than six** (6) process/structural measures, or **more than five** (5) outcome measures, or **missing PSI 90**

¹ The Leapfrog Hospital Safety Grade uses the below-described data and reflects expert opinion as to the relative importance of each category.

LEAPFROG
HOSPITAL
SAFETY GRADE

MEASURES

The Safety Grade utilizes up to 22 national patient safety measures from the Centers for Medicare & Medicaid Services (CMS) and the Leapfrog Hospital Survey, and information from other supplemental data sources.

The measure set is divided into two domains: (1) Process/Structural Measures and (2) Outcome Measures. Each domain represents 50% of the Safety Grade. The following table lists the 22 measures included in the Safety Grade, as well as the data source and reporting period for each measure. In some cases where a hospital's information is not available for a certain measure, Leapfrog uses a secondary data source (as indicated in the table). In cases where a hospital's information is not available from any data source, Leapfrog has outlined a methodology for dealing with the missing data.

PROCESS/STRUCTURAL MEASURES (12)				
Measure Name	Primary Data Source	Reporting Period	Secondary Data Source	Reporting Period
Computerized Physician Order Entry (CPOE)	2022 Leapfrog Hospital Survey	2022	Imputation Model Applied*	N/A
Bar Code Medication Administration (BCMA)	2022 Leapfrog Hospital Survey	2022	Imputation Model Applied*	N/A
ICU Physician Staffing (IPS)	2022 Leapfrog Hospital Survey	2022	Imputation Model Applied*	N/A
Safe Practice 1: Culture of Leadership Structures and Systems	2022 Leapfrog Hospital Survey	2022	N/A	N/A
Safe Practice 2: Culture Measurement, Feedback & Intervention	2022 Leapfrog Hospital Survey	2022	N/A	N/A

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PROCESS/STRUCTURAL MEASURES (12)

Measure Name	Primary Data Source	Reporting Period	Secondary Data Source	Reporting Period
Safe Practice 9: Nursing Workforce	2022 Leapfrog Hospital Survey	2022	N/A	N/A
Hand Hygiene	2022 Leapfrog Hospital Survey	2022	Imputation Model Applied*	N/A
H-COMP-1: Nurse Communication	CMS	04/01/2021 - 03/31/2022	N/A	N/A
H-COMP-2: Doctor Communication	CMS	04/01/2021 - 03/31/2022	N/A	N/A
H-COMP-3: Staff Responsiveness	CMS	04/01/2021 - 03/31/2022	N/A	N/A
H-COMP-5: Communication about Medicines	CMS	04/01/2021 - 03/31/2022	N/A	N/A
H-COMP-6: Discharge Information	CMS	04/01/2021 - 03/31/2022	N/A	N/A

*See [Leapfrog's Imputation Method for CPOE, BCMA, IPS and Hand Hygiene](#) for more information on Leapfrog's imputation methodology for hospital's missing measure scores for CPOE, BCMA, IPS, and/or Hand Hygiene.

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OUTCOME MEASURES (10)

Measure Name	Primary Data Source	Reporting Period	Secondary Data Source	Reporting Period
Foreign Object Retained	CMS	07/01/2019 - 12/31/2019 AND 07/01/2020 - 6/30/2021	N/A	N/A
Air Embolism	CMS	07/01/2019 - 12/31/2019 AND 07/01/2020 - 6/30/2021	N/A	N/A
Falls and Trauma	CMS	07/01/2019 - 12/31/2019 AND 07/01/2020 - 6/30/2021	N/A	N/A
CLABSI	2022 Leapfrog Hospital Survey	07/01/2021 - 06/30/2022	CMS	04/01/2021 - 03/31/2022
CAUTI	2022 Leapfrog Hospital Survey	07/01/2021 - 06/30/2022	CMS	04/01/2021 - 03/31/2022
SSI: Colon	2022 Leapfrog Hospital Survey	07/01/2021 - 06/30/2022	CMS	04/01/2021 - 03/31/2022
MRSA	2022 Leapfrog Hospital Survey	07/01/2021 - 06/30/2022	CMS	04/01/2021 - 03/31/2022
C. Diff.	2022 Leapfrog Hospital Survey	07/01/2021 - 06/30/2022	CMS	04/01/2021 - 03/31/2022
PSI 4: Death rate among surgical inpatients with serious treatable conditions	CMS	07/01/2019 - 12/31/2019 AND 07/01/2020 - 6/30/2021	N/A	N/A

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OUTCOME MEASURES (10)

Measure Name	Primary	Reporting Period	Secondary	Reporting Period
	Data Source		Data Source	
CMS Medicare PSI 90: Patient safety and adverse events composite*	CMS	07/01/2019 - 12/31/2019	N/A	N/A
		AND 07/01/2020 - 6/30/2021		

* CMS calculates PSI 90 using the ten (10) component PSIs. While scores for each of the 10 component PSIs will not be used to calculate fall 2022 Hospital Safety Grades, they will be publicly reported on the Hospital Safety Grade [website](#).

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****COMPONENT PSIs (SCORES NOT USED TO CALCULATE THE HOSPITAL SAFETY GRADE)**

Component PSI	Primary Data Source	Reporting Period	Secondary Data Source	Reporting Period
PSI 3: Pressure ulcer rate	CMS	07/01/2019 - 12/31/2019 AND 07/01/2020 - 6/30/2021	N/A	N/A
PSI 6: Iatrogenic pneumothorax rate	CMS	07/01/2019 - 12/31/2019 AND 07/01/2020 - 6/30/2021	N/A	N/A
PSI 8: In-hospital fall with hip fracture rate	CMS	07/01/2019 - 12/31/2019 AND 07/01/2020 - 6/30/2021	N/A	N/A
PSI 9: Perioperative hemorrhage and hematoma rate	CMS	07/01/2019 - 12/31/2019 AND 07/01/2020 - 6/30/2021	N/A	N/A
PSI 10: Postoperative acute kidney injury rate	CMS	07/01/2019 - 12/31/2019 AND 07/01/2020 - 6/30/2021	N/A	N/A
PSI 11: Postoperative respiratory failure rate	CMS	07/01/2019 - 12/31/2019 AND 07/01/2020 - 6/30/2021	N/A	N/A
PSI 12: Perioperative pulmonary embolism or deep vein thrombosis rate	CMS	07/01/2019 - 12/31/2019 AND 07/01/2020 - 6/30/2021	N/A	N/A
PSI 13: Postoperative sepsis rate	CMS	07/01/2019 - 12/31/2019 AND 07/01/2020 - 6/30/2021	N/A	N/A
PSI 14: Postoperative wound dehiscence rate	CMS	07/01/2019 - 12/31/2019 AND 07/01/2020 - 6/30/2021	N/A	N/A
PSI 15: Unrecognized abdominopelvic accidental puncture/laceration rate	CMS	07/01/2019 - 12/31/2019 AND 07/01/2020 - 6/30/2021	N/A	N/A

Note: CMS calculates PSI 90 using the ten (10) component PSIs listed above. While scores for each of the 10 component PSIs will NOT be used to calculate spring 2023 Hospital Safety Grades, they will be publicly reported on the Hospital Safety Grade [website](#).

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MEASURE & SCORING DESCRIPTIONS

PROCESS/STRUCTURAL MEASURES

For Process/Structural Measures, a higher score is always better because these are measures of compliance with best practices in patient care.

COMPUTERIZED PHYSICIAN ORDER ENTRY (CPOE)

The CPOE measure is collected by The Leapfrog Group on the Leapfrog Hospital Survey. It measures a hospital's progress toward implementing a CPOE system to reduce medication ordering errors. Through participation in the Leapfrog Hospital Survey, hospitals are placed in one of several performance categories: "Achieved the Standard," "Considerable Achievement," "Some Achievement," "Limited Achievement," "Declined to Respond," or "Unable to Calculate Score." For the purposes of calculating the Safety Grade, a numerical score is assigned to each performance category:

Leapfrog Performance Category	Measure Score
Achieved the Standard	100
Considerable Achievement	70
Some Achievement	40
Limited Achievement	15
Declined to Respond	See Using Secondary Data
Unable to Calculate Score	Not Available (See Scoring Terms)

For hospitals that did not submit a 2022 Leapfrog Hospital Survey by November 30, see [Using Secondary Data Sources](#) for more information on Leapfrog's imputation methodology.

BAR CODE MEDICATION ADMINISTRATION (BCMA)

The BCMA measure is collected by The Leapfrog Group on the Leapfrog Hospital Survey. It measures a hospital's progress toward 1) implementation of BCMA throughout the hospital, 2) compliance with patient and medication scans during administration, 3) use of decision support, and 4) structures to monitor and reduce workarounds. Through participation in the Leapfrog Hospital Survey, hospitals are placed in one of several performance categories: "Achieved the Standard," "Considerable Achievement," "Some Achievement," "Limited Achievement," or "Declined to Respond. For the purposes of calculating the Safety Grade, a numerical score is assigned to each performance category:

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Leapfrog Performance Category	Measure Score
Achieved the Standard	100
Considerable Achievement	75
Some Achievement	50
Limited Achievement	25
Declined to Respond	See Using Secondary Data

For hospitals that did not submit a 2022 Leapfrog Hospital Survey by November 30, see [Using Secondary Data Sources](#) for more information on Leapfrog's imputation methodology.

ICU PHYSICIAN STAFFING (IPS)

The IPS measure is collected by The Leapfrog Group on the Leapfrog Hospital Survey. It measures a hospital's use of intensivists in ICUs. Through participation in the Leapfrog Hospital Survey, hospitals are placed in one of several performance categories: "Achieved the Standard," "Considerable Achievement," "Some Achievement," "Limited Achievement," or "Declined to Respond." For the purposes of calculating the Safety Grade, a numerical score is assigned to each performance category:

Leapfrog Performance Category	Measure Score
Achieved the Standard	100
Considerable Achievement	50
Some Achievement	15
Limited Achievement	5
Declined to Respond	See Using Secondary Data
Does Not Apply	Not Available (See Scoring Terms)

For hospitals that did not submit a 2022 Leapfrog Hospital Survey by November 30, see [Using Secondary Data Sources](#) for detailed information on Leapfrog's imputation methodology.

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NQF SAFE PRACTICES

Three (3) NQF Safe Practice measures are collected by The Leapfrog Group on the Leapfrog Hospital Survey. They measure a hospital's progress toward implementing NQF-endorsed processes and protocols to reduce and prevent adverse events. Through participation in the Leapfrog Hospital Survey, hospitals are able to earn up to 100 – 120 points for each Safe Practice. For the purposes of calculating the Safety Grade, individual scores for each Safe Practice are used:

NQF Safe Practice	Possible Measure Score
Safe Practice 1: Culture of Safety Leadership Structures and Systems	0 - 120
Safe Practice 2: Culture Measurement, Feedback and Intervention	0 - 120
Safe Practice 9: Nursing Workforce	0 - 100

There is no secondary data source for the NQF Safe Practices. Therefore, hospitals that did not submit a 2022 Leapfrog Hospital Survey by November 30 will not have these measures included in their Safety Grade and the measure will be reported as "Declined to Report." See [Dealing with Missing Data](#) for more information.

HAND HYGIENE

The Hand Hygiene measure is collected by The Leapfrog Group on the Leapfrog Hospital Survey. It measures processes and protocols that hospitals have in place regarding monitoring hand hygiene practices, fostering a culture of good hand hygiene, offering training and education, and providing equipment.

Publicly reported score from the Leapfrog Hospital Survey	Possible assigned for the purposes of calculating the Hospital Safety Grade
Achieved the Standard	100
Considerable Achievement	70
Some Achievement	40
Limited Achievement	15
Declined to Respond	See Using Secondary Data

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For hospitals that did not submit a 2022 Leapfrog Hospital Survey by November 30, see [Using Secondary Data Sources](#) for detailed information on Leapfrog's imputation methodology.

HOSPITAL CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS (HCAHPS) COMPOSITES

The Hospital HCAHPS survey responses are collected by CMS via the Inpatient Quality Reporting Program. Linear mean scores calculated by CMS incorporate the full range of survey response categories into a single metric for each HCAHPS composite. Five of the six composites are used in the Safety Grade. For the purposes of calculating the Safety Grade, a hospital's linear mean score for each of the five composites is used:

HCAHP Composite	Possible Measure Score
H-COMP-1: Nurse Communication	0 - 100
H-COMP-2: Doctor Communication	0 - 100
H-COMP-3: Staff Responsiveness	0 - 100
H-COMP-5: Communication about Medicines	0 - 100
H-COMP-6: Discharge Information	0 - 100

OUTCOME MEASURES

For Outcome Measures, a lower score is always better because these are measures of harm experienced by patients (e.g., central line-associated blood stream infections).

HOSPITAL-ACQUIRED CONDITIONS

Three hospital-acquired condition measures are calculated by CMS through the [DRA HAC Reporting Program](#): Foreign Object Retained after Surgery, Air Embolism, and Falls and Trauma. Hospital-acquired condition rates are calculated by CMS based on Medicare Fee-for-Service claims and publicly reported as a rate per 1,000 inpatient discharges. For the purposes of calculating the Safety Grade, the rate is used.

HEALTHCARE-ASSOCIATED INFECTIONS

Five healthcare-associated infection measures are collected by The Leapfrog Group on the Leapfrog Hospital Survey: Central line-associated bloodstream infections (CLABSI) in ICUs and select wards, Catheter-associated urinary tract infections (CAUTI) in ICUs and select wards, Surgical site infections from colon surgery (SSI: Colon), Facility-wide inpatient MRSA Blood Laboratory-identified Events, and Facility-wide inpatient C.diff. Laboratory-identified Events. Through participation in the Leapfrog Hospital Survey, hospitals were required to 1) join Leapfrog's NHSN group, 2) provide an accurate NHSN ID in the Profile section of

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the Online Survey Tool, and 3) submit Section 7 Managing Serious Errors by November 30. For the purposes of calculating the Safety Grade, the standardized infection ratio (SIR) is used:

As Reported by Leapfrog	Measure Score	Notes
Standardized Infection Ratio (SIR)	SIR	Measure is included in calculating the Safety Grade
Does Not Apply	Not Available (See Scoring Terms)	Measure is not included in calculating the Safety Grade. No use of Secondary Data.
Unable to Calculate Score	Not Available (See Scoring Terms)	Measure is not included in calculating the Safety Grade. No use of Secondary Data.
Declined to Respond	See Using Secondary Data	Secondary Data source is used.

For hospitals that did not submit a 2022 Leapfrog Hospital Survey by November 30, see [Using Secondary Data Sources](#) for more information on Leapfrog's use of CMS data.

AHRQ PATIENT SAFETY INDICATORS (PSIs)

Two AHRQ Patient Safety Indicators are calculated by CMS through the Inpatient Quality Reporting Program and the [HAC Reduction Program](#): PSI 4 Death Rate among Surgical Inpatients with Serious Treatable Conditions and PSI 90 Patient Safety and Adverse Events Composite. PSI rates are calculated by CMS based on Medicare Fee-for-Service claims and publicly reported as a rate per 1,000 inpatient discharges. For the purposes of calculating the Safety Grade, the smoothed rate is used for both measures.

Note: CMS calculates PSI 90 using the ten (10) component PSIs that are listed in the PSI 90 Components table [above](#). While scores for each of the 10 component PSIs will NOT be used to calculate spring 2023 Hospital Safety Grades, they will be publicly reported on the Hospital Safety Grade [website](#). Additional information about the PSI 90 measure and how it is calculated by CMS can be found [here](#).

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USING SECONDARY DATA SOURCES

Twelve (12) of the 22 measures included in the Safety Grade are derived from the Leapfrog Hospital Survey. The Leapfrog Hospital Survey is voluntary, and as such, hospitals may choose not to submit a Survey. To address this gap in available data, the Safety Grade methodology utilizes secondary data when available. For information on how to complete a free Leapfrog Hospital Survey, visit www.leapfroggroup.org/survey.

IMPUTATION METHOD FOR CPOE, BCMA, IPS, AND HAND HYGIENE

Leapfrog has worked closely with statisticians at Mathematica, Leapfrog's National [Expert Panel](#), and our scientific partners at Johns Hopkins Medicine to develop a new two-step imputation approach for determining scores for CPOE, BCMA, IPS, and Hand Hygiene if they are missing from our [publicly reported Survey Results](#).

STEP 1: USE A HOSPITAL'S MOST RECENT SCORE ON THE MEASURE

CPOE, BCMA, and Hand Hygiene: If the hospital had a score assigned by Leapfrog in the previous four rounds of grades (i.e., fall 2022, spring 2022, fall 2021, spring 2021), the hospital is assigned the most recent score on that measure in the current Hospital Safety Grade (i.e., spring 2023).

IPS: If the hospital had a score assigned by Leapfrog in the previous five rounds of grades (i.e., fall 2022, spring 2022, fall 2021, spring 2021, fall 2020), the hospital is assigned the most recent score on that measure in the current Hospital Safety Grade (i.e., spring 2023).

STEP 2: USE THE MEAN OF THE SCORES ASSIGNED TO OTHER SIMILAR HOSPITALS IN THE U.S. (APPLIES TO CPOE, BCMA, AND HAND HYGIENE ONLY)

The hospital is assigned to a cohort of other similar hospitals using three or four hospital characteristics obtained from the most recent CMS Impact File and the 2022 Leapfrog Hospital Survey: urban/rural status, safety net status, number of beds, and teaching status (urban cohorts only). The CMS Impact File is the data source for urban/rural status, safety net status, and number of beds. The [2022 Leapfrog Hospital Survey Results](#) are the primary data source for teaching status and the CMS impact file is the secondary data source.

The hospital is then assigned the **lower** of two possible mean scores for CPOE, BCMA, and Hand Hygiene based on their cohort's performance:

- **Mean of current and recent scores:** The mean score of the cohort is calculated based on the hospital scores in the current round (i.e., spring 2023) from either Leapfrog's publicly reported Survey Results or Step 1 of the imputation model.

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- **Mean of scores obtained in each hospital's first year of reporting on Leapfrog's CPOE, BCMA, or Hand Hygiene standards via the Leapfrog Hospital Survey:** The mean score of the cohort is calculated based on the score (i.e., performance category from the Leapfrog Hospital Survey) each hospital in the cohort obtained the first year they reported on Leapfrog's CPOE, BCMA, or Hand Hygiene standards, starting with the 2018 Leapfrog Hospital Survey (the year the CPOE and BCMA standards were last significantly updated) or the 2020 Leapfrog Hospital Survey (the year the Hand Hygiene standard was first scored). CPOE Scores from the 2020 Leapfrog Hospital Survey are excluded as the CPOE Evaluation Tool was not included on the Leapfrog Hospital Survey due to COVID-19.

To determine a hospital's cohort and mean score:

1. Download the latest IMPACT Zip file [here](#).
 - a. Open the Microsoft Excel Worksheet in that Zip file named "FY 2023 IPPS Final Rule Impact File"
 - b. Select the "FY 2023 CA" tab
 - c. Filter for the hospital's CMS Certification Number (CCN) under the "Provider Number" column
 - d. Refer to criteria in Table 1: Cohort Criteria
2. View 2022 Leapfrog Hospital Survey Results [here](#).
 - a. Search for the hospital by name or location
 - b. If the hospital submitted a 2022 Leapfrog Hospital Survey, select "More Information" at the bottom of the webpage to view teaching status
 - c. Refer to the criteria in Table 1: Cohort Criteria

Table 1: Cohort Criteria

Characteristic	2022 Leapfrog Hospital Survey Results	Column in CMS Impact File	Criteria
Urban/rural status	N/A	URGEO (Column I)	CMS Impact File: Urban: LURBAN or OURBAN Rural: RURAL
Safety net status	N/A	DSHPCT (Column Y)	CMS Impact File: Safety net: DSHPCT is greater than or equal to 0.4007* *0.4007 is the 80 th percentile of the IMPACT file
Number of Beds	N/A	Beds (Column U)	CMS Impact File

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Characteristic	2022 Leapfrog Hospital Survey Results	Column in CMS Impact File	Criteria
			Fewer than 100 beds 100 or more beds
Teaching status	Teaching Status	Resident to Bed Ratio (Column S)	2022 Leapfrog Hospital Survey Results (primary source): Non-teaching Teaching CMS Impact File (secondary source): Non-teaching: Resident to bed Ratio equals 0 Teaching: Resident to bed ratio is greater than 0

3. Find the cohort's scores for CPOE, BCMA, and Hand Hygiene in Table 2: Cohort Scores

Table 2: Cohort Scores

Cohort #	Urban/Rural Status	Safety Net Status	Number of Beds	Teaching Status	Step 2 CPOE Score (Mean of Cohort)	Step 2 BCMA Score (Mean of Cohort)	Step 2 Hand Hygiene Score (Mean of Cohort)
Cohort 1	Rural	Non-Safety Net	Fewer than 100 beds	N/A	75	79	50
Cohort 2	Rural	Non-Safety Net	100 or more beds	N/A	79	83	53
Cohort 3	Rural	Safety Net	Fewer than 100 beds	N/A	80	79	48
Cohort 4	Rural	Safety Net	100 or more beds	N/A	77	77	56
Cohort 5	Urban	Non-Safety Net	Fewer than 100 beds	Non-Teaching	85	85	57
Cohort 6	Urban	Non-Safety Net	100 or more beds	Non-Teaching	86	84	57
Cohort 7	Urban	Non-Safety Net	Fewer than 100 beds	Teaching	78	85	65
Cohort 8	Urban	Non-Safety Net	100 or more beds	Teaching	88	85	56
Cohort 9	Urban	Safety Net	Fewer than 100 beds	Non-Teaching	84	78	70
Cohort 10	Urban	Safety Net	100 or more beds	Non-Teaching	76	80	62
Cohort 11	Urban	Safety Net	Fewer than 100 beds	Teaching	77	78	43
Cohort 12	Urban	Safety Net	100 or more beds	Teaching	90	80	55

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CMS DATA FOR HAIS

CMS is the **secondary data** source for healthcare-associated infections. For the purposes of calculating the Safety Grade, the standardized infection ratio (SIR) published by CMS is used:

Hospitals That Did Not Submit Section 7: Managing Serious Errors of the 2022 Hospital Survey by November 30, 2022

As Reported by CMS	Measure Score	Notes
Not Available (no locations or low volume)	Not Available (See Scoring Terms)	Measure is not included in calculating the Leapfrog Hospital Safety Grade.
Standard Infection Ratio (SIR)	SIR	Measure is included in calculating the Leapfrog Hospital Safety Grade.

If a hospital does not have available data from the Leapfrog Hospital Survey or CMS (e.g., no locations or low volume), the hospital is reported as Not Available "Not Available." See [Dealing with Missing Data](#) for more information.

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SCORING METHODOLOGY

WEIGHTING INDIVIDUAL MEASURES

Each measure included in the Leapfrog Hospital Safety Grade is assigned a standard weight. The methodology to assign standard weights includes four criteria: (1) Impact, (2) Evidence, (3) Opportunity, and (4) Number of Component Measures. These four criteria are then combined using the equation below, which results in a standard weight for each measure that represents the measure's relative importance within the Hospital Safety Grade.

$$[\text{Evidence} + (\text{Impact} \times \text{Opportunity} \times \text{Number of Component Measures})]$$

EVIDENCE

The Evidence Score for each individual measure is assigned a value of one (1) or two (2) using the following criteria:

- 1 = Supported by either suggestive clinical or epidemiological studies or theoretical rationale
- 2 = Supported by experimental, clinical, or epidemiological studies and strong theoretical rationale

OPPORTUNITY

The Opportunity Score for each individual measure is based on the Coefficient of Variation (Standard Deviation/Mean) of that measure, using the following formula: $[1 + (\text{Standard Deviation}/\text{Mean})]$. The Opportunity Score is on a continuous scale that is capped at three (3). Any measure with an Opportunity Score above three (3) is assigned a three (3).

IMPACT

The Impact Score for each individual measure is comprised of two (2) parts, each of which is assigned a value from one (1) to three (3):

1. Number of patients affected
2. Severity of harm

The *number of patients affected* score is determined by the following:

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- 0 = Extremely rare event (e.g., Air Embolism)
- 1 = Rare event (e.g., Foreign Object Retained After Surgery)
- 2 = Some patients in hospital affected (e.g., ICU Physician Staffing)
- 3 = All patients in hospital affected (e.g., Hand Hygiene)

The *severity of harm* score is determined by the following:

- 1 = No direct evidence of harm or harm reduction (e.g., Patient Experience)
- 2 = Clear documentation of harm or harm reduction; adverse events (e.g., Foreign Object Retained After Surgery)
- 3 = Significant mortality reduction (more than 1,000 deaths or a 10% reduction in hospital wide mortality) (e.g., ICU Physician Staffing)

The values from each part are then added together to arrive at the overall Impact Score using the following criteria:

- 1 = Score of 2 (Low Impact) (e.g., Air Embolism)
- 2 = Score of 3-4 (Medium Impact) (e.g., Patient Experience)
- 3 = Score of 5-6 (High Impact) (e.g., ICU Physician Staffing)

NUMBER OF COMPONENT MEASURES

The number of component measures refers to how many measures are included within the measure. For PSI 90, the number of component measures is 10 (PSI 3, PSI 6, PSI 8, PSI 9, PSI 10, PSI 11, PSI 12, PSI 13, PSI 14, and PSI 15). For all other measures included in the Hospital Safety Grade, the number of component measures within the measure is one (1).

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STANDARD MEASURE WEIGHTS

Measure	Evidence Score	Opportunity Score	Impact Score	Number of Component Measures	Standard Measure Weight
Process/Structural Measure Domain (50%)					
CPOE	2	1.17	3	1	5.7%
BCMA	2	1.14	3	1	5.6%
IPS	2	1.63	3	1	7.1%
SP 1	1	1.07	2	1	3.2%
SP 2	1	1.13	2	1	3.4%
SP 9	1	1.08	3	1	4.4%
Hand Hygiene	2	1.39	2	1	4.9%
H-COMP-1	1	1.03	2	1	3.1%
H-COMP-2	1	1.03	2	1	3.1%
H-COMP-3	1	1.05	2	1	3.2%
H-COMP-5	1	1.05	2	1	3.2%
H-COMP-6	1	1.04	2	1	3.2%
Outcome Measure Domain (50%)					
Foreign Object Retained	1	3.00	2	1	4.3%
Air Embolism	1	3.00	1	1	2.4%
Falls and Trauma	2	2.06	3	1	5.0%
CLABSI	2	1.81	3	1	4.5%
CAUTI	2	1.84	3	1	4.6%
SSI: Colon	2	1.82	2	1	3.4%
MRSA	2	1.74	3	1	4.4%
C. Diff.	2	1.76	3	1	4.5%
PSI 4	1	1.12	2	1	2.0%
PSI 90	1	1.17	2	10	14.9%

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CALCULATING Z-SCORES

Z-Scores are used to standardize data from measures with different performance scales and allow for comparisons (e.g., a linear mean score of 90 on H-COMP-1: Nurse Communication and a CLABSI SIR of 0.870). In addition, Z-Scores can indicate to a hospital whether their measure score is above, below, or equal to the average hospital.

In the Scoring Methodology, a Z-Score is calculated for each available measure score. A Z-Score is calculated using a hospital's actual measure score, the national mean for that measure, and the standard deviation for that measure. The Z-Score for each measure is calculated using the following formulas:

- **For Process/Structural Measures:** $[\text{Hospital Score} - \text{Mean}] / \text{Standard Deviation}$
- **For Outcome Measures:** $[(\text{Mean} - \text{Hospital Score}) / \text{Standard Deviation}]$

The following table includes the national mean and standard deviation for each measure used to calculate a hospital's Z-Score. For display, means and standard deviations are displayed rounded to two or three decimal places. For scoring, these values are not rounded.

Process and Structural Measures	Mean	Standard Deviation
CPOE	91.77	15.26
BMCA	91.22	12.46
IPS	67.47	42.22
SP 1	116.86	7.90
SP 2	115.87	15.08
SP 9	98.13	7.71
Hand Hygiene	71.64	27.77
H-COMP-1	89.81	2.51
H-COMP-2	89.70	2.45
H-COMP-3	81.30	4.18
H-COMP-5	74.21	3.92
H-COMP-6	85.07	3.77

Outcome Measures	Mean	Standard Deviation
Foreign Object Retained	0.015	0.06
Air Embolism	0.001	0.01
Falls and Trauma	0.437	0.46
CLABSI	1.077	0.88
CAUTI	0.862	0.72
SSI: Colon	0.822	0.68
MRSA	1.095	0.81
C. Diff.	0.489	0.37
PSI 4	143.23	17.47
PSI 90	0.98	0.17

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A NOTE ABOUT EXTREME VALUES

For hospitals that have an “extreme” value for a particular measure (i.e., a value that exceeds the 99th percentile) Leapfrog “trims” the reported value to the 99th percentile. For example, a rate of 0.50 per 1,000 patient discharges for Foreign Object Retained after Surgery is “trimmed” to 0.352 (e.g., the 99th percentile). Only “trimmed” rates are displayed on the Leapfrog Hospital Safety Grade [website](#). The table below includes the “trim” values for the spring 2023 Leapfrog Hospital Safety Grade. The PSI 90 measure score represents an observed to expected ratio that has already been risk adjusted at both the component PSI level and at the composite level; therefore, the measure is not “trimmed” by Leapfrog.

Measure	99 th Percentile
Foreign Object Retained	0.352
Air Embolism	0.358
Falls and Trauma	2.229
CLABSI	4.462
CAUTI	3.516
SSI: Colon	3.117
MRSA	3.918
C. Diff.	2.066
PSI 4	186.71

Note: Percentiles are rounded to reflect the precision of the raw data.

DEALING WITH MISSING DATA

Due to a variety of reasons, a hospital may not have a measure score for all 22 measures. If a hospital is missing a measure score for any measure (except PSI 90; hospitals missing PSI 90 are not graded), the standard weight of that measure is redistributed to the other measures in the same measure domain. The new weight for each measure within the domain is calculated by re-apportioning the standard weight assigned to the measure with the missing score to other measures within the same domain.

For example, if a hospital is missing a measure score for ICU Physician Staffing because the hospital does not operate an adult or pediatric medical and/or surgical ICU, the standard weight of 7.1% will be re-apportioned to the remaining 11 measures within the process/structural measure domain.

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To calculate the new weight of each of the remaining 11 measures in the process/structural measure domain, hospitals can use the formula below or use the Leapfrog Hospital Safety Grade Calculator[®], which can be found on the [Safety Grade Review Website](#). Note that each domain contributes to 50% of the overall letter grade.

*[Standard measure weight / (sum of standard weights for the remaining 11 measures in the process/structural measure domain)]*50% = updated measure weight*

For more information about how the measure weight redistribution is calculated and affects the overall score, please see the Leapfrog Hospital Safety Grade Calculator, which can be found on the last page of the [Safety Grade Review Website](#).

CALCULATING WEIGHTED MEASURE SCORES

To calculate a hospital's numerical safety score, multiply the Z-Score of each process/structural measure by the standard weight assigned to that measure to get the weighted process/structural measure score. If a hospital is missing any process/structural measure scores, see [Dealing with Missing Data](#) to determine the updated measure weight. Then, sum all weighted process/structural measure scores. This is the hospital's overall weighted process/structural measures score.

Multiply the Z-Score of each outcome measure by the standard weight assigned to that measure to get the weighted outcome measure score. If a hospital is missing any outcome measure scores, see [Dealing with Missing Data](#) to determine the updated measure weight. Then, sum all weighted outcome measure scores. This is the hospital's overall weighted outcome measures score.

To calculate the overall Safety Grade for a hospital, add the overall weighted process/structural measure score and the overall weighted outcome measures score. Add 3.0 to your score; this is done to normalize scores to a positive distribution. This final numerical score (typically between 1.0 and 4.0) is then assigned to a letter grade. To assist hospitals in calculating their numerical score, a calculator is available on the [Safety Grade Review Website](#). Letter grade cut-points are published during the [Letter Grade Embargo Period](#).

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ADDITIONAL SCORING INFORMATION

TERMS USED IN SCORING AND PUBLIC REPORTING

“Not Available” means that the hospital does not have a score for this measure. This could be because the measure is related to a service the hospital does not provide or because the hospital had too few patients or cases to report data for a condition or procedure. A “Not Available” result does not mean that the hospital withheld information from the public.

In the case of healthcare-associated infections, a SIR is reported as "Not Available" if one of the following applies:

- The number of predicted infections is less than 1.
- The number of observed infections present on admission (community-onset prevalence) was above a pre-determined cut-point.

For more information about NHSN's SIR models, please visit <https://www.cdc.gov/nhsn/pdfs/ps-analysis-resources/nhsn-sir-guide.pdf>.

“Declined to Report” means that a hospital did not voluntarily provide information to the Leapfrog Hospital Survey. Measures scored as “Declined to Report” will not be used in calculating the overall score (see [Dealing with Missing Data](#)).

PUBLIC REPORTING WEBSITE MEASURE CROSSWALK

The table below shows how each measure name is displayed on the [Hospital Safety Grade](#) website.

INFECTIONS

Measure Name	Displayed on Public Reporting Website
MRSA	MRSA Infection
C. Diff.	C. diff Infection
CLABSI	Infection in the blood
CAUTI	Infection in the urinary tract

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SSI: Colon	Surgical Site Infection after colon surgery
PSI 13: Postoperative sepsis rate*	Sepsis infection after Surgery

PROBLEMS WITH SURGERY

Measure Name	Displayed on Public Reporting Website
Foreign Object Retained	Dangerous object left in the patient's body
PSI 14: Postoperative wound dehiscence rate*	Surgical wound splits open
PSI 4: Death rate among surgical inpatients with serious treatable conditions	Death from serious treatable complications
PSI 9: Postoperative hemorrhage and hematoma rate*	Blood leakage
PSI 10: Postoperative acute kidney injury rate*	Kidney injury after surgery
PSI 11: Postoperative respiratory failure rate*	Serious breathing problem
PSI 15: Unrecognized abdominopelvic accidental puncture/laceration rate*	Accidental cuts and tears

SAFETY PROBLEMS

Measure Name	Displayed on Public Reporting Website
CMS Medicare PSI 90: Patient safety and adverse events composite	Harmful events
PSI 3: Pressure ulcer rate*	Dangerous bed sores
Falls and Trauma	Patient falls and injuries

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PSI 8: In-hospital fall with hip fracture rate*	Falls causing a broken hip
PSI 6: Iatrogenic pneumothorax rate*	Collapsed lung
PSI 12: Perioperative pulmonary embolism or deep vein thrombosis rate*	Dangerous blood clot
Air Embolism	Air or gas bubble in the blood

PRACTICES TO PREVENT ERRORS

Measure Name	Displayed on Public Reporting Website
Computerized Physician Order Entry (CPOE)	Doctors order medications through a computer
Bar Code Medication Administration (BCMA)	Safe medication administration
Hand Hygiene	Handwashing
H-COMP-5: Communication about Medicines	Communication about medicines
H-COMP-6: Discharge Information	Communication about discharge
Safe Practice 2: Culture Measurement, Feedback & Intervention	Staff work together to prevent errors

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DOCTORS, NURSES, & HOSPITAL STAFF

Measure Name	Displayed on Public Reporting Website
Safe Practice 1: Culture of Leadership Structures and Systems	Effective leadership to prevent errors
Safe Practice 9: Nursing Workforce	Enough qualified nurses
ICU Physician Staffing (IPS)	Specially trained doctors care for ICU patients
H-COMP-2: Doctor Communication	Communication with doctors
H-COMP-1: Nurse Communication	Communication with nurses
H-COMP-3: Staff Responsiveness	Responsiveness of hospital staff

*Note: CMS calculates PSI 90 using the ten (10) component PSIs listed above. While scores for each of the 10 component PSIs will NOT be used to calculate spring 2023 Hospital Safety Grades, they will be publicly reported on the Hospital Safety Grade website.



SHARED CMS CERTIFICATION NUMBERS

All hospitals that share a CMS Certification Number (CCN) will be assigned the same source data as reported by CMS. Affected measures include the HCAHPS, Hospital-Acquired Conditions, Healthcare-Associated Infections (if secondary data source is used), and Patient Safety Indicators.

UPDATES TO DATA USED IN THE LEAPFROG HOSPITAL SAFETY GRADE

The Leapfrog Hospital Safety Grade relies on publicly available data that hospitals have had the opportunity to review for accuracy. Therefore, Leapfrog does not allow hospitals to make updates to their data following the Data Snapshot Date. In January of each year, Leapfrog publishes the Data Snapshot Dates for each of the two Leapfrog Hospital Safety Grade public releases at <https://www.hospitalsafetygrade.org/for-hospitals/key-dates-and-information>. Leapfrog publishes these dates to give hospitals and other stakeholders advance notice so they can be prepared to submit a Leapfrog Hospital Survey and monitor their performance on CMS measures used in the Safety Grade.

In addition, Leapfrog holds a Courtesy Review Period to give hospitals an additional opportunity to review the data that will be used to calculate their hospital's Safety Grade. The Review Period is an opportunity for hospitals to review the data for accuracy (i.e., identify recording errors, hospital name and address changes, etc.) on a secure website and review changes to the scoring algorithm.

DATA FROM THE LEAPFROG HOSPITAL SURVEY

During the Safety Grade Review Period (February 21 – March 12), Leapfrog will only make corrections to a hospital's data from the 2022 Leapfrog Hospital Survey if a recording error is identified (i.e., we have recorded a different measure score than what is posted on our Survey Results website) or a scoring error is identified (i.e., Leapfrog has calculated an incorrect measure score based on the submitted responses and Leapfrog's published scoring algorithms). Updates to Leapfrog Hospital Survey data that are submitted after the Data Snapshot Date will **not** be included in the current Leapfrog Hospital Safety Grade. Hospitals submitting a Leapfrog Hospital Survey are urged to take advantage of the opportunity to review their Survey Results for accuracy and completeness prior to each of the two published Data Snapshot Dates.

HOW HOSPITALS CAN REVIEW LEAPFROG HOSPITAL SURVEY RESULTS PRIOR TO THE DATA SNAPSHOT DATE

The Leapfrog Hospital Survey is open from April 1 to November 30 of each year. Following the Submission Deadline (June 30), Survey Results are published monthly on a secure 'Hospital Details' page and a public website (ratings.leapfroggroup.org). Hospitals are urged to review their Survey Results immediately. Hospitals that identify any reporting errors are instructed to log back into the Survey to submit a correction. Hospitals can correct and re-submit a previously

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submitted Survey until the Survey closes for the year. Note that corrections submitted after the Data Snapshot Date are not included in the current Leapfrog Hospital Safety Grade. Leapfrog has several automated processes in place to prevent hospitals from making data entry errors in the Online Survey Tool and to enhance the overall accuracy of the Survey Results. Learn more at <http://www.leapfroggroup.org/survey-materials/data-accuracy>.

DATA FROM THE CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

During the Safety Grade Review Period (February 21 – March 12), Leapfrog will only make corrections to a hospital's data from CMS if the correction is issued by CMS and posted on either <https://data.cms.gov/provider-data/> or <https://data.cms.gov/quality-of-care/deficit-reduction-act-hospital-acquired-condition-measures>. If a hospital has identified an error with a measure score published by CMS, and CMS cannot post a correction within the review period, the measure score will not be used in calculating the hospital's Safety Grade, provided that the hospital can document that CMS has agreed to publicly issue a correction or remove the measure score from public reporting. Hospitals participating with CMS are urged to take advantage of the opportunity to participate in the CMS 30-day review periods.

CMS FOOTNOTE 23 POLICY

Leapfrog will notify hospitals that have CMS footnote 23 present for one or more claims-based measure scores (e.g., DRA HAC Rate, PSI 4 rate, or PSI 90 rate) at the start of the Courtesy Review Period. Footnote 23 indicates that "The data are based on claims that the hospital or facility submitted to CMS. The hospital or facility has reported discrepancies in their claims data." Hospital CEOs can request that Leapfrog use the measure score that is accompanied by the footnote. Written requests must be received prior to the close of the Safety Grade Review Period. If written requests are not received by the close of the Review Period, the measure will not be used to calculate the Hospital Safety Grade.

For hospitals that submit a Leapfrog Hospital Survey by the Data Snapshot Date, the CEO, Primary Survey Contact, and Secondary Survey Contact will be notified at the email addresses included in the Hospital's Survey Profile. For hospitals that do not submit a Leapfrog Hospital Survey by the Data Snapshot Date, the CEO will be contacted by certified letter.

HOW HOSPITALS CAN REVIEW CMS DATA PRIOR TO THE DATA SNAPSHOT DATE

CMS administers several hospital-based reporting and payment programs including the Inpatient Quality Reporting Program, HAC Reduction Program, and Value-based Purchasing Program. Several measures collected and calculated by CMS via its various hospital-based programs are used in the Leapfrog Hospital Safety Grade. CMS provides hospitals with a 30-day preview period before publishing measure scores on <https://data.cms.gov/provider-data/> or <https://data.cms.gov/quality-of-care/deficit-reduction-act-hospital-acquired-condition-measures>. More information is available at <https://qualitynet.org>.

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HOW TO PARTICIPATE IN THE LEAPFROG HOSPITAL SURVEY

If a hospital did **not** complete a 2022 Leapfrog Hospital Survey by November 30, Survey Results were not used to calculate the spring 2023 Leapfrog Hospital Safety Grade. Hospitals that would like Survey Results included in the fall 2023 Hospital Safety Grade must submit a 2023 Leapfrog Hospital Survey (including the CPOE Evaluation) by June 30, 2023. Hospitals will be able to review their publicly reported Survey Results in July and respond to any issues identified by Leapfrog's Extensive Monthly Data Verification before the Data Snapshot Date for the fall 2023 Safety Grade of August 31. More information is available at <https://leapfroggroup.org/survey>.

LEAPFROG HELP DESK

If you have any questions regarding the scoring methodology, please contact the Help Desk at <https://leapfroghelpdesk.zendesk.com>.

Exhibit 7



2024 Regional Leader Communications Toolkit: Launching Leapfrog Surveys



Dear Regional Leaders,

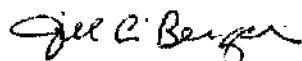
We are excited to launch the 2024 Leapfrog Surveys in our collective effort to make **giant leaps for patient safety**. Hospitals and ambulatory surgery centers (ASCs) continue to face new and evolving challenges. Many of these challenges are receiving heightened media attention, as nursing and other health care worker shortages continue to escalate. This also presents a unique opportunity for our movement to put patient safety on the map and ensure it is a priority for our communities, policymakers, business leaders, and for the hospitals and surgery centers that provide care.

Thanks to the partnership between Leapfrog and Leapfrog Regional Leaders, we received over 2,100 submissions, representing 73% of hospital beds. The ASC Survey is much newer, and though ASC participation lags, it is growing. We hope to turbo-charge that growth this year. Consumers and purchasers deserve to compare safety and quality information on hospital outpatient surgical units along with surgery centers, since they perform most of all procedures done in the country. There has never been a more important time for transparency and Leapfrog's role in keeping health care facilities accountable.

The 2024 Communications Toolkit offers you instructions for launching the Leapfrog Hospital Survey and the Leapfrog ASC Survey in your region, focusing on the critical initial communication you carry out to encourage hospital and ASC participation. It is designed to support you at different stages of the process when it is most useful to you. Additional communication materials included in this toolkit are designed to further help you engage the public, including employers, purchasers, hospitals, and ASCs, such as our comprehensive *Common Objections and Frequently Asked Questions About Leapfrog and Its Ratings* and the *Regional Leaders Best Practices Toolkit*.

As always, we look forward to working alongside you, your members, and your communities to improve transparency and excellence throughout the country.

All the best,



Jill A. Berger
Director, Employer & Payor Engagement
The Leapfrog Group



2024 COMMUNICATIONS TOOLKIT

Table of Contents

I. Step-by-Step: How to Launch the Leapfrog Hospital Survey and Leapfrog ASC Survey in Your Market

II. Key Contact Information and Links

III. Best Practices Used by Regional Leaders

- a. Launching the Leapfrog Surveys in your Communities
- b. Engaging ASCs
- c. Ideas for encouraging non-respondents
- d. Regional Leaders Best Practices Guide

IV. Key Dates

- a. Overview of the Leapfrog Hospital Survey and Leapfrog ASC Survey

VI. Materials to Share with Hospitals and ASCs During Your Survey Rollout

- a. Infographic on why hospitals and ASCs should submit a Leapfrog Survey
- b. Intent to submit form
- c. Copy about Leapfrog Hospital Survey Webinar Series
- d. Copy about Leapfrog System Services
- e. Value Resources for ASCs

VII. Links & Resources

VIII. Template Letters

IX. Common Objections and Frequently Asked Questions about Leapfrog and its Ratings

X. Regional Leader Coverage Areas

I. STEP-BY-STEP: HOW TO LAUNCH THE LEAPFROG HOSPITAL SURVEY & LEAPFROG ASC SURVEY IN YOUR MARKET

Please note: In 2024, Leapfrog will manage the Survey invitation letter to ASCs but will provide Regional Leaders with tools and template materials to supplement outreach in your communities. Regional Leaders are not responsible for sending security code sheets. If a hospital or ASC needs a copy of their security code, they must complete the Security Code Request form available on Leapfrog's website or by contacting the Help Desk.

1. **Get members, hospitals, and ASCs excited about the 2024 Surveys.**
 - Include the Survey launch in your newsletter and member communications along with posting content on your social media channels. Think about highlighting interesting questions/issues on the Survey, such as informed consent or billing ethics. You will find everything you need in this toolkit.
 - Consider any new communication channels that might help you reach the ASC community, like local ASC association publications and events.
 - Think about how you can involve your employers by having them sign on to your letters or attend meetings you have scheduled with some of your facilities.
2. **Personalize template letters* asking HOSPITALS to participate in both the inpatient and outpatient sections of the Survey**
 - Leapfrog provides template letters asking hospitals to participate in the Hospital Survey. You can customize them for your market and add your letterhead.
 - Clearly outline how you plan to use the Hospital Survey data and share it with your members.
 - Ask as many of your employer and purchaser members as possible to sign your letters. This can significantly increase a facility's likelihood of participation.
3. **Work with Leapfrog to invite ASCs to participate in the Leapfrog ASC Survey**
 - Regional Leaders are strongly encouraged to use the mailing list provided by Leapfrog to conduct ongoing outreach to ASCs in your community using provided template letters in the appendix.
 - Leapfrog will send initial letters to ASCs on Regional Leader's letterhead with logos and signatures requesting their participation and providing instructions on obtaining a Security Code.
 - Ask as many of your employer and purchaser members as possible to sign your letters. This can significantly increase a facility's likelihood of participation.
 - If an ASC needs a copy of their security code, they need to complete and submit the Security Code Request form: <http://bit.ly/ASCSecurityCode>.
4. **Send HOSPITAL letters by mail or email no earlier than March 30, but no later than April 30.**
 - Notify Robyn Nabi () if you are unable to send letters this year and require Leapfrog's assistance.
 - Merge the customized hospital letters and the hospital mailing list to generate individual letters and envelopes for each hospital in the region and address the CEO. **Emails can only be sent to the hospital's CEO if the hospital submitted a 2023 Survey.**
 - Notify Robyn Nabi (rnabi@leapfrog-group.org) when you have mailed or emailed the invitations to your hospitals.
 - Keep a list of any returned mail and send any address or CEO updates to Robyn Nabi throughout the year.
 - **Reminder:** If a hospital needs a copy of their security code, they need to complete and submit the Security Code Request form: <http://bit.ly/HospitalSecurityCode>.
5. **Follow up with those who have not responded.**
 - Leapfrog keeps track of Hospital Survey responses by region and will report the status to Regional Leaders in regular readout files sent by email and saved on the Regional Leader section of the Leapfrog website. Interim files will be sent beginning in May, and monthly files will be sent the last week of July through February after the first June 30 Submission Deadline.
 - Follow up with HOSPITALS that have not submitted a Survey as the June 30 Submission Deadline approaches as well as in the fall leading up to the November 30 Late Submission Deadline.

- Leapfrog will provide Regional Leaders with a file of participating facilities by state as well as a template letter so that you can follow up with those that have not participated.

6. Thank Survey participants.

- Using the list of Survey participants and the letter template in this document, send hospitals and ASCs thank you letters and share how you plan to use the data.
 - Remind participating facilities that their results will be publicly reported in July.
- Consider hosting recognition events (including virtual events) to thank hospitals and ASCs who participated and recognize performance.

7. Use results released by Leapfrog.

- Be sure to consult the Regional Leader Best Practices Guide for ideas on using Leapfrog results, including:
 - Encourage your members to use Leapfrog for payment policies, tiering, and public reporting. The measures on the Leapfrog Hospital Survey are selected because they are critical for improving health outcomes and reducing costs for purchasers and consumers.
 - Tailor press announcement templates to highlight Survey performance and why it matters to people in your community.

Reminder: Template letters are available in **Section VII** of this packet

II. KEY CONTACT INFORMATION AND LINKS

Leapfrog Regional Leaders Contact	Jill Berger jberger@leapfrog-group.org
Regional Leader Webpage <i>Regional Leader site with past meeting notes, Survey readout files, and other resources like the Communications Toolkit, FAQ, and Best Practices Guide.</i>	http://www.leapfroggroup.org/login/resources-regional-leaders
Contact for Hospital Rosters	Robyn Nabi RNabi@leapfrog-group.org
Leapfrog Help Desk Email Address Leapfrog Help Desk Website We guarantee a response within 24 hours!	helpdesk@leapfrog-group.org https://leapfroghelpdesk.zendesk.com
Hospital Survey Site	www.leapfroggroup.org/hospital
ASC Survey Site	www.leapfroggroup.org/ASC
Leapfrog Hospital Safety Grade	www.hospitalsafetygrade.org
Leapfrog Website <i>for organizational information</i> <i>consumer site with public Hospital and ASC Survey results</i>	www.leapfroggroup.org www.ratings.leapfroggroup.org

II. BEST PRACTICES USED BY REGIONAL LEADERS

Below are several ideas that have been successful for other Regional Leaders when encouraging participation that you may want to consider trying in your market.

LAUNCHING THE LEAPFROG SURVEYS IN YOUR COMMUNITY

- **Engage employers** with purchasing power to influence hospital decision-making based on Hospital Survey participation. Discuss with employers the differences in quality of care between facilities from which beneficiaries are seeking care—are these the best choices for the care needed? Ask employers to sign the invitation letters with you; public entities (e.g., school systems, city and local governments) can have great purchasing influence on the provider community because of their size and scope.
- **Distribute a press release** to local media about your efforts to encourage hospital transparency through the Leapfrog Hospital Survey and the Leapfrog ASC Survey.
- **Meet with local media** to discuss how you will work with them to share ongoing efforts and results. Discuss one or more items in the survey that might make a good story, such as the new patient consent standard, billing ethics, medication safety, maternity care, or the new Hospital Survey question on C-section rates by race and ethnicity. Encourage them to call attention to the hospitals and ASCs that decline to respond to your request for Survey participation.
- **Reach out to ASCs in your region** inviting them to participate in the ASC Survey. Leapfrog will send the security code and initial invitation to ASCs, but Regional Leaders are urged to send a second letter introducing your organization to facilities and encouraging their participation on behalf of employers in your region. We recognize it is sometimes difficult to identify the right person at an ASC, but as they continue to hear from you over time and the survey results gain more prominence, they will likely become more responsive. We are playing the long game, and persistence is critical.
- **Include an “Intent to Submit” form** with the Hospital Survey invitation or as a follow-up to an invitation and in an ASC-specific mailing. Immediate feedback has been found to improve the likelihood of Survey submission in some markets. If the facility does not plan to submit a 2024 Survey, ask them to indicate on the form why they’ve chosen to decline your call for transparency and public reporting on their quality and safety practices. Including a list of hospitals in your region that respond to the Survey may be helpful. Consider sending this form online using a tool such as Constant Contact or Survey Monkey to make it easier for CEOs to respond in a timely manner.
- **Meet with the CEO and quality improvement staff from health systems** to discuss the importance of the Leapfrog Hospital Survey. Consider including an employer or purchaser. Commitment from system-level executives to participate in the Survey will often result in all facilities within the system being required to submit a Survey. This will also be a good opportunity to illustrate the value many systems find in being able to compare and benchmark their individual facility’s performance on the Survey metrics, including the opportunity to compare their outpatient facility performance to that of ASCs.

BUILDING RELATIONSHIPS WITH ASCS

Engaging with ASCs and increasing participation in the Leapfrog ASC Survey is a priority for Leapfrog in 2024. Below are some ideas to help you identify ASCs and educate them about Leapfrog’s value. We encourage you to select one or two of these strategies and try them out with five ASCs in your region.

- **Meet with local ASC Associations and ASC Administrators in your region** to discuss the value of participating in the Leapfrog ASC Survey, including public reporting benefits, benchmarking, and comparison to hospital outpatient departments.
- **Reach out to the local business bureaus** to help identify ASCs in your area.
- **Get your member employers involved** by asking them to sign participation letters and by joining you on visits to local ASC facilities.
- **Recognize Top ASCs in your area** through events with employer members or media opportunities to demonstrate the value of participating and encourage other ASCs to participate.

IDEAS FOR ENCOURAGING NON-RESPONDENTS TO THE LEAPFROG SURVEYS

The following are actions that your coalition may want to take with non-responding facilities to urge participation in the Leapfrog Hospital Survey and Leapfrog ASC Survey. **It is strongly encouraged that you and/or your members or board pursue these strategies and familiarize yourself with the Common Objections and FAQs resource. Leapfrog staff are always available to provide follow-up and clarifications to hospitals or ASCs as well.**

- **Make phone contact with facility executive leadership.** You can find hospital CEO names and phone numbers on your roster and ASC executive names on the ASC mailing list.
- **Ask your local health plans to follow-up** with their hospital and ASC contacts and urge participation.
- **Contact individual hospital board members** indicating that the hospital has not yet completed the Survey, particularly board members who are part of your organization or who represent large employers.
- **Phone calls to the hospital board chairperson** by your organization's CEO or other senior executives.
- **Share with local media** the names of the first hospitals and ASCs to respond and the names of those that are not responding.

REGIONAL LEADER BEST PRACTICES GUIDE

Additionally, Leapfrog has developed a separate comprehensive **Regional Leader Best Practices Guide**. This guide includes several tactics to use Leapfrog data beyond launching the Surveys, including hosting recognition events for top performing facilities and member employee engagement ideas. The guide compiles examples from Regional Leaders that you may want to consider implementing in your market.

V. KEY DATES FOR THE 2024 SURVEY CYCLE

FOR REGIONAL LEADERS

March 30 – April 30	Mail or email Hospital Invitation Letters <i>Optional: Mail or email request letter to ASCs</i>
June 30	2024 Submission Deadline
June and July	Acknowledge facilities that met the June 30 Submission Deadline
Monthly beginning in June	Review Readout File to identify hospitals that have participated Send reminders to non-participants and thank you letters to participating facilities
September	Send second Survey invitation letter to remind non-participating hospitals of the November 30 Late Submission Deadline
November 30	Late Submission Deadline
December	Acknowledge Leapfrog Top Hospitals and Top ASCs in your community Attend Leapfrog's Annual Meeting and Regional Leader meeting

FOR HOSPITALS & ASCS

April 1	2024 Leapfrog Hospital Survey and Leapfrog ASC Survey open
April & May	<u>Leapfrog Hospital Survey</u> and <u>Leapfrog ASC Survey</u> Town Hall Calls
June 30	2024 Submission Deadline
Monthly beginning in July	Data Review: Facilities have 30 days to submit corrections and/or confirm responses
July 12	Hospital detail page showing results available to hospitals 2024 Survey Results released and posted at https://www.ratings.leapfroggroup.org
August 31	Top Hospital Submission Deadline for hospitals to submit a completed Survey if they would like to be eligible for Top Hospitals Data Snapshot Date for the fall 2024 Leapfrog Hospital Safety Grade
November 30	Late Submission Deadline: No Leapfrog Hospital Survey submissions will be accepted after this date.
December 2024- January 2025	Data review and correction period for previously submitted Surveys

IV. OVERVIEW OF THE 2024 LEAPFROG SURVEYS

To ensure the Leapfrog Hospital Survey and the Leapfrog ASC Survey align with the latest science and the public reporting needs of purchasers and consumers, Leapfrog's research team annually reviews the literature and convenes expert panels. Facilities that voluntarily complete the Leapfrog Surveys demonstrate their commitment to transparency by providing information purchasers and consumers need to choose the best facility for their care.

Leapfrog Hospital Survey

The Leapfrog Hospital Survey uses national performance measures to evaluate individual hospitals on the safety, quality, and efficiency of inpatient and outpatient care. The 2024 Leapfrog Hospital Survey can be found [here](#).

Leapfrog Ambulatory Surgery Center (ASC) Survey

Leapfrog launched the Leapfrog ASC Survey in 2019, expanding our nearly 25-year long experience collecting and publicly reporting safety and quality of hospitals via the Leapfrog Hospital Survey. The Leapfrog ASC Survey uses national performance measures to evaluate individual surgery centers on safety, quality, and efficiency. Below is an overview of the Survey's main sections and key changes for 2024. The 2024 Leapfrog ASC Survey can be found [here](#).

Important Note: The results of the Leapfrog ASC Survey and Leapfrog Hospital Survey are publicly reported by facility at <https://Ratings.LeapfrogGroup.org>

VI. MATERIALS TO SHARE WITH HOSPITALS AND ASCs

EXPLANATION OF MATERIALS

WHAT IT IS	IDEAS ON HOW TO USE THIS
a. Infographic: Why Hospitals and ASCs Should Submit a Survey	Distribute to hospitals and ASCs with Survey invitation letters and email to your employers and purchasers
b. "Intent to Submit" Form	Send along with letters as a way to keep track of which hospitals plan to participate
c. Leapfrog Hospital Survey Webinar Series	Communicate to hospitals as needed
d. Copy about Leapfrog's System Services	Communicate to hospitals and ASCs as needed
e. Value Resources for ASCs	Share with ASCs to help encourage participation

a. INFOGRAPHIC ON WHY HOSPITALS AND ASCS SHOULD SUBMIT A SURVEY

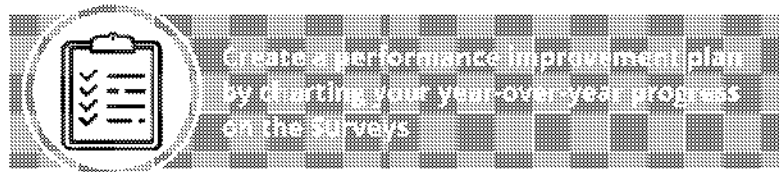
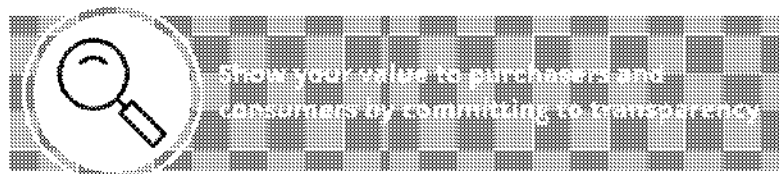
Click here to view the infographic, download, and/or print it for distribution.



Why You Should Participate in the Leapfrog Surveys

Thousands of employers and other purchasers across the country ask hospitals and surgery centers to participate in the Leapfrog Hospital Survey and the Leapfrog ASC Survey. They are the only source of nationally reported ratings by facility on safety and quality issues of importance to purchasers and the public. The measures on the Surveys are predicated on the latest science and reviewed and updated annually by top national expert panels to reflect the current evidence base.

By participating in the Surveys, your facility will be able to:



For more information visit:
www.LeapfrogGroup.org/Hospital
www.LeapfrogGroup.org/ASC

b. "INTENT TO SUBMIT" FORM

Intent to Submit a Leapfrog [Hospital/ASC] Survey for 2024

Please return to [email address].

«CEO»

«Title»

«Hospital_Name»

«Address»

«City», «State» «Zip»

☐

We intend to submit the Leapfrog [Hospital/ASC] Survey for 2024.

Survey Contact Name: _____

Phone Number: _____

E-mail Address: _____

The information will be used to send a reminder about the Survey from [REGIONAL LEADER]

☐

We do not intend to submit the Leapfrog [Hospital/ASC] Survey at this time.

Would you please explain why you do not wish to participate?

[REGIONAL LEADER] represents employers in your market. The Survey is very important to them, and they expressly request your participation. If you would like to discuss your decision via a phone call or web conference, please let us know and we will arrange it for you.

c. COPY ABOUT THE LEAPFROG HOSPITAL SURVEY WEBINAR SERIES

Are you a hospital submitting to Leapfrog for the first time? Get ahead of the game by registering for the Leapfrog Hospital Survey Webinar Series.

The Leapfrog Hospital Survey Webinar Series is held monthly from March to December. Each one-hour webinar includes a presentation as well as a question-and-answer session. The Webinar Series is designed for hospitals that would benefit from a more interactive presentation of Survey materials and information. Though nothing presented in the Webinar Series differs from the information available in the printed materials or through the free electronic Help Desk, many hospital leaders find the interactive format and opportunity for Q&A helpful.

For an annual fee of \$500 per user, hospitals that join the Webinar Series will have access to:

- Topical monthly presentations that focus on Survey and CPOE Evaluation Tool measures and specifications, scoring information, frequently asked questions, technical assistance, and public reporting
- 20-minute open Q & A sessions
- Presentations by Leapfrog's Expert Panel members
- Library of all slide decks and recordings from March-December
- Monthly office hours with the Leapfrog Help Desk

Registration for the 2024 Webinar Series is now open. Please [click here](#) to register.

d. COPY ABOUT HOSPITAL SYSTEM SERVICES

Many large and small health systems across the country engage all hospitals in their system in completing the Leapfrog Hospital Survey. By securing participation from all facilities, health system leaders can easily benchmark performance, identify high and low performers, and demonstrate their value to employers and purchasers in their community, like this high performing health system. Leapfrog offers several tools to assist health systems in their completion of the Leapfrog Hospital Survey and analysis of results. Visit Leapfrog's website to learn more and contact the Help Desk with any questions.

e. ASC VALUE RESOURCES

Why participate in the Leapfrog ASC Survey? Through the Leapfrog ASC Survey, ambulatory surgery centers can benefit from an independent assessment of their quality and safety available to the public. The Survey prominently positions ASCs with employers and purchasers, provides benchmarking opportunities, and galvanizes improvement. The resources below highlight why the Leapfrog ASC Survey will provide value to your surgery center:

- **Discounted National Association for Healthcare Quality Training:** ASCs can get a 25% discount on the HQ Concepts in Healthcare Quality and Safety for Frontline Staffs training. Reach out to the Leapfrog Help Desk for details.
- **Becker's ASC Article:** Reporting to the Leapfrog ASC Survey: 4 competitive advantages
 - This article outlines the benefits of participation as told by ASC leaders and employers

- **AORN Podcast Series: ASCs Today**
 - A digestible podcast series with Association of periOperative Registered Nurses (AORN) President Linda Groah and Leapfrog President and CEO Leah Binder discussing nursing leadership, workforce issues, and safety risks.
- **Leapfrog Case Study: How the Leapfrog ASC Survey Highlights the Importance of Transparency**
 - Leapfrog President and CEO Leah Binder interviews members of Proliance Surgeons' Center for Spine and Joint Replacement Surgery in Washington.
- **Leapfrog Case Study: How the Leapfrog Survey Gives Surgery Centers Credibility Through Accountability**
 - Leapfrog President and CEO Leah Binder interviews Coronado Surgery Center and Owner in Nevada.

VII. LINKS AND RESOURCES

Leapfrog Regional Leader webpage - <http://www.leapfroggroup.org/login/resources-regional-leaders>

- Meeting notes
- Survey readout files
- Communications Toolkit
- Frequently Asked Questions and Common Objections to Leapfrog's Rating Programs
- Regional Leader Best Practices Guide

The Leapfrog Group – www.leapfroggroup.org

- News and events
- Resources for consumers
- Resources for employers, including the Lives & Dollars Lost Calculator
- Information about Leapfrog Value Based Purchasing Program
- Fact Sheets and other Survey resources
- Case studies from hospitals and ASCs that participate in the Leapfrog Surveys
- Information about benchmarking reports for hospitals

Leapfrog Hospital Survey website – www.leapfroggroup.org/hospital

- Hard copy of the Hospital Survey and resources for hospitals completing the Survey
- Log in to the Hospital Survey

Leapfrog ASC Survey website – www.leapfroggroup.org/asc

- Hard copy of Survey and resources for hospitals completing the ASC Survey
- FAQ for ASCs
- Login to ASC Survey

Survey Results – www.ratings.leapfroggroup.org

- Public reporting of Leapfrog Hospital Survey and Leapfrog ASC Survey results
- Search for facilities by name, city/state, zip code, etc.
- Search by procedure and compare hospitals and ASCs side-by-side
- Print Survey results

Leapfrog Hospital Safety Grade – www.hospitalsafetygrade.org

- Public display of Leapfrog Hospital Safety Grade letter grades
- Search for all general acute care hospitals that receive a safety grade
- Compare hospitals on safety
- Resources for consumers

AVIII. CUSTOMIZABLE TEMPLATE LETTERS FOR THE 2024 LEAPFROG SURVEYS

The following are template letters that Regional Leaders can customize and send to hospital and ASC executives. Hospital invitation letters must be sent to each hospital on the roster, including optional relevant enclosures. **As a reminder, Regional Leaders are not responsible for mailing security codes to CEOs in 2024.** Leapfrog is sending invitation letters to ASCs; Regional Leaders are not responsible for this mailing.

The package contains the following templates letter/emails:

- A. For currently submitting hospitals
- B. For hospitals new to the Survey**
- C. For system-level executives on the Hospital and ASC Surveys (*optional to send*)
- D. For ASC Survey to reinforce participation (*strongly encouraged to send*)
- E. Participation reminder (*to be sent in May*)
- F. Thank you for hospital CEOs
- G. Thank you for ASC CEOs
- H. For September: follow-up Survey mailing in high-participation states
- I. For September: follow-up Survey mailing in low-participation states
- J. For currently submitting ASCs
- K. For health plans to send: Hospitals
- L. For health plans to send: ASCs

Suggestions for Using These Letters in Your Market

- **Make it your own.** Although we provide this template messaging, we strongly encourage Regional Leaders to customize these letters to meet your specific market's needs by inserting relevant regional statistics and other information that will appeal to local facilities.
- **Don't forget health system leaders.** You may wish to send a letter to a health system contact in your area. This can be an effective strategy to increase participation in your market. We strongly encourage you to customize the letters per system so they have a clear picture of how reporting to the Surveys can benefit them and understand how you will use their results, as well as to remind them about the ASC Survey and outpatient section of the Hospital Survey.
- **Print on your letterhead.** We suggest printing the letters on your organization's letterhead or perhaps creating a new letterhead if multiple Regional Leaders are collectively requesting hospital participation in a certain area. Have the letter signed by your CEO or Executive Director. Also consider including the Leapfrog Regional Leader logo.
- **Co-signers help.** Consider having multiple purchasers/payors with lives/enrollees in your region co-sign the letter. The more parties you can get to sign on to this letter, the better. Some coalitions also include a second page that lists all their employer members showing they represent their interests in asking for participation.
- **Cite how you will use Leapfrog data.** Describe to your hospitals how you plan to use the data (such as in a consumer guide) and how payors are planning to use or are currently using Leapfrog's Survey data (e.g., value-based purchasing program, high performance network determination, consumer directory). Examples are listed in the template letters below.
- **Reminders help.** Leading up to June 30, it's a good idea to send an email reminder to all facilities that the deadline is approaching and you're looking forward to their participation by the Submission Deadline.
- **Prompt more Survey responses with a fall follow-up.** Many Regional Leaders have found tremendous success in sending a second mailing to non-participating facilities in early fall; this can be an effective strategy to increase participation by facilities that missed the June 30 Submission Deadline but still have time before the November 30 Late Submission Deadline.

A. TEMPLATE LETTER/EMAIL FOR CURRENTLY SUBMITTING HOSPITALS

[Date]
[Prefix] [First] [Last]
Chief Executive Officer
[Facility Name]
[Street Address]
[City, State, ZIP]

Dear [CEO Name]:

On behalf of [REGIONAL LEADER ORGANIZATION] and our [NUMBER] members including [CONSIDER NAMING A FEW BIG NAMES HERE IF YOU DON'T KNOW THIS HOSPITAL WELL], we are writing to request your participation in the 2024 Leapfrog Hospital Survey, which opens on April 1. We, along with our entire community, appreciate your past participation and look forward to your continued dedication to transparency.

More than 2,100 hospitals submitted a Survey in 2023, accounting for 73% of inpatient beds across the country. [INSERT STAT SUCH AS PERCENT INCREASE IN HOSPITALS PARTICIPATING IN 2023 SURVEY, OR PERCENTAGE OF HOSPITALS THAT PARTICIPATE LOCALLY]. Purchasers feel that your continued participation is vital for our region so we can achieve real progress toward a safer, higher-quality, more transparent health care system for all.

By participating in the Leapfrog Hospital Survey, your hospital can:

- 1. Demonstrate your responsiveness to employers in our community who depend on your services**
- 2. Benchmark your performance on quality and safety metrics and create a performance improvement plan**
- 3. Receive public recognition by [REGIONAL LEADER] for your transparency and performance**
- 4. Be eligible for Awards programs such as Leapfrog Top Hospital**
- 5. Ensure your most up-to-date performance is reflected in your Leapfrog Hospital Safety Grade (if applicable)**
- 6. Demonstrate your commitment to quality and safety improvement to our community, including your staff and Board**

Additionally, only hospitals that have submitted a 2024 Leapfrog Hospital Survey will be eligible to apply for the Recognized Leader in Caring for People Living with Diabetes designation. This recognition program started in 2023 through a partnership between Leapfrog and the American Diabetes Association (ADA). The first-ever national recognition program recognizes hospitals providing safe, high-quality care for patients living with diabetes. General acute care and adult specialty hospitals can apply for the designation. The application will open in July 2024. Learn more at www.leapfroggroup.org/recognized-leader-diabetes.

Leapfrog's public reporting website, www.ratings.leapfroggroup.org, allows users to search for and compare hospital and ASC ratings to better understand safety and quality across facilities. Purchasers in [REGION] intend to share these results with their employees and use your performance metrics as part of their value strategy.

You may use the same Security Code you used for previous Surveys. If you need a copy of your Security Code, please complete and submit Leapfrog's Security Code Request form: <http://bit.ly/HospitalSecurityCode>. Though the deadline to complete the Survey is June 30, you can resubmit your Survey at any time throughout the Survey cycle; publicly reported results are updated monthly. For hospitals that do not meet the Submission Deadline, late submissions are accepted through November 30, and until then, incomplete sections are reported as "Declined to Respond."

Visit www.LeapfrogGroup.org/Hospital to begin today. Please contact me at [insert lead tel #] if you have any questions about the reporting process and Leapfrog's activity in our region. The Leapfrog Help Desk is available for any technical or content questions about the Survey and can be accessed at <https://leapfroghelpdesk.zendesk.com>.

Sincerely, [LEAD REGIONAL LEADER]

B. TEMPLATE LETTER FOR HOSPITALS NEW TO THE SURVEY

[Date]

[Prefix] [First] [Last]
 Chief Executive Officer
 [Facility Name]
 [Street Address]
 [City, State, ZIP]

Dear [CEO Name]:

On behalf of [REGIONAL LEADER ORGANIZATION] and our [NUMBER] members including [CONSIDER NAMING A FEW BIG NAMES HERE IF YOU DON'T KNOW THIS HOSPITAL WELL], we are writing to strongly encourage you to participate in the 2024 Leapfrog Hospital Survey which opens on April 1. We, along with our entire community, are looking for your hospital to commit to transparency by reporting on your safety and quality performance. Pandemic setbacks have propelled the issue of patient safety as a national priority. It is more important than ever to participate in Leapfrog's critical patient safety efforts to demonstrate your commitment to quality and safety.

More than 2,100 hospitals submitted a Survey in 2023, accounting for 73% of inpatient beds across the country. [INSERT STAT SUCH AS PERCENT INCREASE IN HOSPITALS PARTICIPATING IN 2023 SURVEY, OR PERCENTAGE OF HOSPITALS THAT PARTICIPATE LOCALLY]. Purchasers feel that your participation is vital for our region so we can achieve real progress toward a safer, higher-quality, more transparent health care system for all.

By participating in the Leapfrog Hospital Survey, your hospital can:

1. **Demonstrate your responsiveness to employers in your community who depend on your services**
2. **Benchmark your performance on quality and safety metrics and create a performance improvement plan**
3. **Receive public recognition by [REGIONAL LEADER] for your transparency and performance**
4. **Be eligible for Awards programs such as Leapfrog Top Hospital**
5. **Ensure your most up-to-date performance is reflected in your Leapfrog Hospital Safety Grade (if applicable)**
6. **Demonstrate your commitment to quality and safety improvement to our community, including your staff and Board**

Additionally, only hospitals that have submitted a 2024 Leapfrog Hospital Survey will be eligible to apply for the Recognized Leader in Caring for People Living with Diabetes designation. This recognition program started in 2023 through a partnership between Leapfrog and the American Diabetes Association (ADA). The first-ever national recognition program recognizes hospitals providing safe, high-quality care for patients living with diabetes. General acute care and adult specialty hospitals can apply for the designation. The application will open in July 2024. Learn more at www.leapfroggroup.org/recognized-leader-diabetes.

Leapfrog's public reporting website, www.ratings.leapfroggroup.org, allows users to search for and compare both hospital and ASC ratings to better understand safety and quality across facilities. Purchasers in [REGION] intend to share these results with their employees and use your performance metrics as part of their value strategy.

To receive the security code needed to complete the Survey, please complete and submit the Security Code Request form: <http://bit.ly/HospitalSecurityCode>. Though the deadline to complete the Survey is June 30, you can resubmit your Survey at any time throughout the Survey cycle; publicly reported results are updated monthly. For hospitals that do not meet the Submission Deadline, late submissions are accepted through November 30, and until then, incomplete sections are reported as "Declined to Respond."

Visit www.LeapfrogGroup.org/Hospital to begin today. Please contact me at [insert lead tel #] if you have any questions about the reporting process and Leapfrog's activity in our region. The Leapfrog Help Desk is available for any technical or content questions about the Survey and can be accessed at <https://leapfroghelpdesk.zendesk.com>.

Sincerely, [LEAD REGIONAL LEADER]

C. TEMPLATE LETTER/EMAIL FOR SYSTEM-LEVEL EXECUTIVES ON THE HOSPITAL AND ASC SURVEYS

[Date]

[Prefix] [First] [Last]
Chief Executive Officer
[ASC Name]
[Street Address]
[City, State, ZIP]

Dear [CEO Name]:

On behalf of [REGIONAL LEADER] and our [NUMBER] members including [CONSIDER NAMING A FEW BIG NAMES HERE IF YOU DON'T KNOW THIS HOSPITAL/ASC/SYSTEM WELL], we are writing to strongly encourage [all facilities within HEALTH SYSTEM NAME] [or: your facility] to participate in the 2024 Leapfrog Surveys, which open on April 1. Inpatient hospitals and hospital outpatient departments are invited to participate in the Leapfrog Hospital Survey and ambulatory surgery centers are invited to participate in the Leapfrog ASC Survey.

More than 2,100 hospitals submitted a Survey in 2023, accounting for 73% of inpatient beds across the country. [INSERT STAT SUCH AS NAMES OF HEALTH SYSTEMS/ASCs THAT PARTICIPATE IN YOUR REGION]. Purchasers feel that your participation is vital so we can show real progress toward a safer, higher-quality, more transparent health care system for all.

By participating in the Leapfrog Surveys, your [system/facility] can:

1. **Demonstrate your responsiveness to employers in our community who depend on your services**
2. **Access customized analytics comparing performance between facilities in your system**
3. **Benchmark your performance on quality and safety metrics and create a performance improvement plan**
4. **Receive public recognition by [REGIONAL LEADER] for your transparency and performance**
5. **Be eligible for Awards programs such as Leapfrog Top Hospital and Top ASC**
6. **Ensure your most current performance is reflected in your Leapfrog Hospital Safety Grades (if applicable)**
7. **Demonstrate your commitment to quality and safety improvement to our community, including your staff and Board**

Additionally, only hospitals that have submitted a 2024 Leapfrog Hospital Survey will be eligible to apply for the Recognized Leader in Caring for People Living with Diabetes designation. This recognition program started in 2023 through a partnership between Leapfrog and the American Diabetes Association (ADA). The first-ever national recognition program recognizes hospitals providing safe, high-quality care for patients living with diabetes. General acute care and adult specialty hospitals can apply for the designation. The application will open in July 2024. Learn more at www.leapfroggroup.org/recognized-leader-diabetes.

Leapfrog's public reporting website, www.ratings.leapfroggroup.org, allows users to search for and compare hospital and ASC ratings to better understand safety and quality across facilities. Purchasers in [REGION] intend to share these results with their employees and use your performance metrics as part of their value strategy.

If your facilities participated in the Survey before, their security code has not changed. If a facility needs a copy of its security code, please complete and submit the Security Code Request form: FOR HOSPITALS <http://bit.ly/HospitalSecurityCode>, FOR ASCs <http://bit.ly/ASCSecurityCode>. Though the deadline to complete the Survey is June 30, you can resubmit your Survey at any time throughout the Survey cycle; publicly reported results are updated monthly. For hospitals and ASCs that do not meet the Submission Deadline, late submissions are accepted through November 30. Incomplete sections are reported as "Declined to Respond."

Visit www.LeapfrogGroup.org for more information and please contact me for details on [REGIONAL LEADER's] commitment to employers and purchasers.

Sincerely,

[LEAD REGIONAL LEADER]

D. TEMPLATE LETTER/EMAIL FOR ASC SURVEY PARTICIPATION

[Date]

[Prefix] [First] [Last]
 Chief Executive Officer
 [Facility Name]
 [Street Address]
 [City, State, ZIP]

Dear [CEO/ASC Administrator Name]:

On behalf of the over [NUMBER] employer members of [REGIONAL LEADER], representing [NUMBER] lives and \$(AMOUNT) in annual claims, we are writing to request your ambulatory surgical center's participation in the 2024 Leapfrog Ambulatory Surgery Center (ASC) Survey. As a coalition of employers who invest in the health and well-being of our employees, we feel that your participation in the Leapfrog ASC Survey is vital for our community so we can achieve real progress toward a safer, higher-quality, more transparent health care system for all. The Leapfrog ASC Survey is your opportunity to demonstrate your commitment to transparency.

2024 marks the sixth year of the Leapfrog ASC Survey on patient safety and quality. Since 2000, The Leapfrog Group, an independent national nonprofit, has collected and publicly reported patient safety and quality information about health care facilities. All ASCs in the United States have the opportunity to participate in the annual Leapfrog ASC Survey. Our employer members consult results from the Leapfrog Surveys to inform benefit design, patient referral preferences and direct contracting considerations. Your ASC may be excluded from these evaluations without a Survey response.

By participating in the Leapfrog ASC Survey, your surgery center can:

- 1. Demonstrate your responsiveness to employers in our community who depend on your services**
- 2. Benchmark your performance on quality and safety metrics and create a performance improvement plan**
- 3. Receive public recognition by [REGIONAL LEADER] for your transparency and performance**
- 4. Be eligible for Awards programs such as Leapfrog Top ASC**
- 5. Demonstrate your commitment to quality and safety improvement to our community, including your staff and Board**

Leapfrog's public reporting website, www.ratings.leapfroggroup.org, allows users to search for and compare both hospital and ASC ratings to better understand safety and quality across facilities. Purchasers in [REGION] intend to share these results with their employees and use your performance metrics as part of their value strategy. Like all of Leapfrog's programs, the ASC Survey measures are evidence-based, grounded in the latest science, and developed with guidance from Leapfrog's national Expert Panel and the Armstrong Institute for Patient Safety and Quality at Johns Hopkins Medicine.

You may use the same security code you used for previous Surveys. If you need a copy of your security code, please complete and submit the Security Code Request form: <http://bit.ly/ASCSecurityCode>. Though the deadline to complete the Survey is June 30, you can resubmit your Survey at any time throughout the Survey cycle; publicly reported results are updated monthly. For ASCs that don't meet the Submission Deadline, late submissions are accepted through November 30.

Please visit <http://www.leapfroggroup.org/asc> to learn more. There is never any charge for participation in Leapfrog Surveys.

We strongly recommend your participation in the 2024 Leapfrog ASC Survey. You will derive great value from the process, and our coalition of employers in [REGION] will appreciate your responsiveness and transparency.

Sincerely,

[LEAD REGIONAL LEADER]

E. TEMPLATE EMAIL HOSPITAL PARTICIPATION REMINDER

To: [Hospital Executive]
From: [Regional Leader]
Subject: Leapfrog Hospital Survey reminder

Dear [CEO Name]:

As a follow-up to the formal invitation letter sent to your hospital earlier this spring, I am writing to remind you about the approaching June 30 Submission Deadline for the 2024 Leapfrog Hospital Survey.

By participating in the Leapfrog Hospital Survey, you can see how your hospital performs on quality and safety metrics available from no other source and compare your performance to the other hospitals in our area and nationally. Your hospital can also:

- 1. Demonstrate your responsiveness to employers and other purchasers in our community, who depend on your services and expect transparency and candor**
- 2. Benchmark your performance nationally, regionally, and locally on important quality and safety issues**
- 3. Receive public recognition by [REGIONAL LEADER] for your performance achievements [CONSIDER INSERTING SPECIFIC WAYS YOU & YOUR MEMBERS USE LEAPFROG DATA/RECOGNIZE LOCAL HOSPITALS]**
- 4. Create a performance improvement plan by charting your year-over-year progress on the Survey**
- 5. Demonstrate your commitment to quality and safety improvement to our community, as well as your staff and Board**

Additionally, only hospitals that have submitted a 2024 Leapfrog Hospital Survey will be eligible to apply for the Recognized Leader in Caring for People Living with Diabetes designation. This recognition program started in 2023 through a partnership between Leapfrog and the American Diabetes Association (ADA). The first-ever national recognition program recognizes hospitals providing safe, high-quality care for patients living with diabetes. General acute care and adult specialty hospitals can apply for the designation. The application will open in July 2024. Learn more at www.leapfroggroup.org/recognized-leader-diabetes.

Leapfrog's public reporting website, www.ratings.leapfroggroup.org, allows users to search for and compare both hospital and ASC ratings to better understand safety and quality across facilities. Purchasers in [REGION] intend to share these results with their employees and use your performance metrics as part of their value strategy. Performance for participating facilities is posted and those that do not participate are indicated as "Declined to Respond."

Participation in the Survey and accessing the results is always free. You may use the same security code you used for previous Surveys. If you need a copy of your security code, please complete and submit the Security Code Request form: <http://bit.ly/HospitalSecurityCode>. We look forward to your participation before the June 30 Submission Deadline. You can resubmit your Survey at any time throughout the Survey cycle; publicly reported results are updated monthly. For hospitals that don't meet the Submission Deadline, late submissions are accepted through November 30, and until then, incomplete sections are reported as "Declined to Respond."

Thank you once again for responding to the requests of purchasers in our region and for taking the time to complete the Leapfrog Hospital Survey.

Sincerely,
[LEAD REGIONAL LEADER]

F. TEMPLATE THANK YOU LETTER/EMAIL FOR HOSPITAL CEOS

[Date]

[Prefix] [First] [Last]
Chief Executive Officer
[Facility Name]
[Street Address]
[City, State, ZIP]

Dear [CEO Name]:

I am writing to thank you for participating in the 2024 Leapfrog Hospital Survey. On behalf of our [NUMBER] members including [CONSIDER NAMING A FEW BIG NAMES HERE IF YOU DON'T KNOW THIS HOSPITAL WELL], we commend your commitment to transparency demonstrated through your participation.

[REGIONAL LEADER ORGANIZATION NAME] will share this information with our community to assure recognition for **your performance achievements and improvements**. [CONSIDER INSERTING SPECIFIC WAYS YOU & YOUR MEMBERS USE LEAPFROG DATA/RECOGNIZE LOCAL HOSPITALS]

Additionally, only hospitals that have submitted a 2024 Leapfrog Hospital Survey will be eligible to apply for the Recognized Leader in Caring for People Living with Diabetes designation. This recognition program started in 2023 through a partnership between Leapfrog and the American Diabetes Association (ADA). The first-ever national recognition program recognizes hospitals providing safe, high-quality care for patients living with diabetes. General acute care and adult specialty hospitals can apply for the designation. The application will open in July 2024. Learn more at www.leapfroggroup.org/recognized-leader-diabetes.

As a reminder, Leapfrog Hospital Survey results will be available in July at www.Ratings.LeapfrogGroup.org and are updated monthly. Data collected from the section of the Hospital Survey on outpatient procedures will be publicly reported by facility alongside data from the Leapfrog Ambulatory Surgery Center Survey.

Thank you once again for your investment in improving the health of [REGION] and for taking the time to complete the Leapfrog Hospital Survey. We commend your leadership and look forward to other hospitals in our community following your example.

Sincerely,
[LEAD REGIONAL LEADER]

G. TEMPLATE THANK YOU LETTER/EMAIL FOR ASC ADMINISTRATORS

[Date]

<NAME>

Administrator

<Organization Name>

<Mailing-Street Address>

<Mailing-City>, <Mailing-State> <Mailing-Postal Code>

Dear <NAME>:

I am writing to thank you for participating in the 2024 Leapfrog ASC Survey. On behalf of our [NUMBER] members including [CONSIDER NAMING A FEW BIG NAMES HERE IF YOU DON'T KNOW THIS ASC WELL], we commend your commitment to transparency demonstrated through your participation.

[REGIONAL LEADER ORGANIZATION NAME] will share this information with our community to assure recognition for **your performance achievements and improvements**. [CONSIDER INSERTING SPECIFIC WAYS YOU & YOUR MEMBERS USE LEAPFROG DATA/RECOGNIZE LOCAL ASCs]

As a reminder, Leapfrog ASC Survey results will be available in July at www.Ratings.LeapfrogGroup.org and are updated monthly. Data collected from your facility will be posted alongside results of the Leapfrog Hospital Survey's section on outpatient procedures.

We commend your leadership and look forward to other ASCs in our community following your example. Thank you once again for your investment in improving the health of [REGION].

Sincerely,

[LEAD REGIONAL LEADER]

H. TEMPLATE LETTER/EMAIL FOR SECOND HOSPITAL SURVEY MAILING IN HIGH-PARTICIPATION STATES

[Date]

[Prefix] [First] [Last]
Chief Executive Officer
[Facility Name]
[Street Address]
[City, State, ZIP]

Dear [CEO Name]:

As a follow-up to my initial outreach, I am writing to again ask your hospital to complete the 2024 Leapfrog Hospital Survey.

So far this year, almost [X,XXX] hospitals nationwide have completed the Leapfrog Hospital Survey in response to purchasers' request for increased transparency. In our state, over [X%] of hospitals have completed a 2024 Survey. I strongly urge you to follow the leadership demonstrated by your colleagues and ensure your hospital is not one of the few non-participating hospitals in this region.

By participating in the Leapfrog Hospital Survey, you can see how you perform on quality and safety metrics available from no other source and compare your performance to the other hospitals in our area and nationally. Your hospital can also:

- 1. Demonstrate your responsiveness to employers and other purchasers in our community, who depend on your services and expect transparency and candor**
- 2. Receive public recognition by [REGIONAL LEADER] for your performance achievements [CONSIDER INSERTING SPECIFIC WAYS YOU & YOUR MEMBERS USE LEAPFROG DATA/RECOGNIZE LOCAL HOSPITALS]**
- 3. Create a performance improvement plan by charting your year-over-year progress on the Survey**
- 4. Demonstrate your commitment to quality and safety improvement to our community, as well as your staff and Board**

Additionally, only hospitals that have submitted a 2024 Leapfrog Hospital Survey will be eligible to apply for the Recognized Leader in Caring for People Living with Diabetes designation. This recognition program started in 2023 through a partnership between Leapfrog and the American Diabetes Association (ADA). The first-ever national recognition program recognizes hospitals providing safe, high-quality care for patients living with diabetes. General acute care and adult specialty hospitals can apply for the designation. The application will open in July 2024. Learn more at www.leapfroggroup.org/recognized-leader-diabetes.

Leapfrog's public reporting website, www.ratings.leapfroggroup.org, allows users to search for and compare both hospital and ASC ratings to better understand safety and quality across facilities. Performance for participating facilities is posted and those that do not participate are indicated as "Declined to Respond." Purchasers in [REGION] will be sharing these results with their employees and dependents and use your performance metrics as part of their value strategy.

Participation in the Survey and accessing the results is always free. *If you have participated in the Survey before, your security code has not changed. If you need a copy of your security code, please complete and submit the Security Code Request form: <http://bit.ly/HospitalSecurityCode>.* The Late Submission Deadline for Survey completion is **November 30**. You can resubmit your Survey at any time throughout the Survey cycle; publicly reported results are updated monthly.

Thank you once again for your investment in improving the health of our [REGION] and for taking the time to complete the Leapfrog Hospital Survey.

Sincerely,
[LEAD REGIONAL LEADER]

I. TEMPLATE LETTER/EMAIL FOR SECOND HOSPITAL SURVEY MAILING IN LOW-PARTICIPATION STATES

[Date]

[Prefix] [First] [Last]
Chief Executive Officer
[Facility Name]
[Street Address]
[City, State, ZIP]

Dear [CEO Name]:

As a follow-up to my initial outreach, I am writing to again ask your hospital to complete the 2024 Leapfrog Hospital Survey. So far this year, almost [X,XXX] hospitals nationwide have completed the Leapfrog Hospital Survey in response to purchasers' request for increased transparency. I strongly urge you to follow the leadership demonstrated by your colleagues and heed our call for participation.

By participating in the Leapfrog Hospital Survey, you can see how you perform on quality and safety metrics available from no other source and compare your performance to the other hospitals in our area and nationally. Your hospital can also:

- 1. Demonstrate your responsiveness to employers and other purchasers in our community, who depend on your services and expect transparency and candor**
- 2. Receive public recognition by [REGIONAL LEADER] for your performance achievements [CONSIDER INSERTING SPECIFIC WAYS YOU & YOUR MEMBERS USE LEAPFROG DATA/RECOGNIZE LOCAL HOSPITALS]**
- 3. Create a performance improvement plan by charting your year-over-year progress on the Survey**
- 4. Demonstrate your commitment to quality and safety improvement to our community, as well as your staff, clinicians, and Board**

Additionally, only hospitals that have submitted a 2024 Leapfrog Hospital Survey will be eligible to apply for the Recognized Leader in Caring for People Living with Diabetes designation. This recognition program started in 2023 through a partnership between Leapfrog and the American Diabetes Association (ADA). The first-ever national recognition program recognizes hospitals providing safe, high-quality care for patients living with diabetes. General acute care and adult specialty hospitals can apply for the designation. The application will open in July 2024. Learn more at www.leapfroggroup.org/recognized-leader-diabetes.

Leapfrog's public reporting website, www.ratings.leapfroggroup.org, allows users to search for and compare hospital and ASC ratings to better understand safety and quality across facilities. Performance for participating facilities is posted and those that do not participate are indicated as "Declined to Respond." Purchasers in [REGION] will be sharing these results with their employees and dependents and use your performance metrics as part of their value strategy.

Participation in the Survey and accessing the results is always free. *If you have participated in the Survey before, your security code has not changed. If you need a copy of your security code, please complete and submit the Security Code Request form: <http://bit.ly/HospitalSecurityCode>.* The Late Submission Deadline for Survey completion is **November 30**. You can resubmit your Survey at any time throughout the Survey cycle; publicly reported results are updated monthly.

Thank you once again for your investment in improving the health of our [REGION] and for taking the time to complete the Leapfrog Hospital Survey.

Sincerely,
[LEAD REGIONAL LEADER]

J. TEMPLATE LETTER/EMAIL CURRENTLY SUBMITTING ASCS

[Date]

[Prefix] [First] [Last]
 Chief Executive Officer
 [Facility Name]
 [Street Address]
 [City, State, ZIP]

Dear [CEO/ASC Administrator Name]:

On behalf of the over [NUMBER] employer members of [REGIONAL LEADER], representing [NUMBER] lives and \$(AMOUNT) in annual claims, we are writing to request your ambulatory surgical center's participation in the 2024 Leapfrog Ambulatory Surgery Center (ASC) Survey. We, along with our entire community, appreciate your past participation and look forward to your continued dedication to transparency. As a coalition of employers who invest in the health and well-being of our employees, we feel that your participation in the Leapfrog ASC Survey is vital for our community so we can achieve real progress towards a safer, higher-quality, more transparent health care system for all. Pandemic setbacks and workforce shortages have propelled the issue of patient safety as a national priority. The Leapfrog ASC Survey is your opportunity to demonstrate your commitment to transparency.

2024 marks the sixth year of the Leapfrog ASC Survey on patient safety and quality. Since 2000, The Leapfrog Group, an independent national nonprofit, has collected and publicly reporting patient safety and quality information about health care facilities. All ASCs in the U.S. have the opportunity to participate in the annual Leapfrog ASC Survey. Our employer members consult results from the Leapfrog Surveys to inform benefit design, patient referral preferences and direct contracting considerations. Your ASC may be excluded from these evaluations without a Survey response.

By participating in the Leapfrog ASC Survey, your surgery center can:

- 1. Demonstrate your responsiveness to employers in our community who depend on your services**
- 2. Benchmark your performance on quality and safety metrics and create a performance improvement plan**
- 3. Receive public recognition by [REGIONAL LEADER] for your transparency and performance**
- 4. Be eligible for Awards programs such as Leapfrog Top ASC**
- 5. Demonstrate your commitment to quality and safety improvement to our community, including your staff and Board**

Leapfrog's public reporting website, www.ratings.leapfroggroup.org, allows users to search for and compare both hospital and ASC ratings to better understand safety and quality across facilities. Purchasers in [REGION] intend to share these results with their employees and use your performance metrics as part of their value strategy. Like all of Leapfrog's programs, the ASC Survey measures are evidence-based, grounded in the latest science, and developed with guidance from Leapfrog's national Expert Panel and the Armstrong Institute for Patient Safety and Quality at Johns Hopkins Medicine.

You may use the same security code you used for previous Surveys. If you need a copy of your security code, please complete and submit the Security Code Request form: <http://bit.ly/ASCSecurityCode>. Though the deadline to complete the Survey is June 30, 2024, you can resubmit your Survey at any time throughout the Survey cycle; publicly reported results are updated monthly. For ASCs that don't meet the Submission Deadline, late submissions are accepted through November 30.

Please visit <http://www.leapfroggroup.org/asc> to learn more. There is never any charge for participation in Leapfrog Surveys.

We strongly recommend your participation in the 2024 Leapfrog ASC Survey. You will derive great value from the process, and our coalition of employers in [REGION] will appreciate your responsiveness and transparency.

Sincerely, [LEAD REGIONAL LEADER]

K. TEMPLATE LETTER/EMAIL FOR HEALTH PLANS: HOSPITALS

[Date]

[Chief Executive Officer]

[Hospital Name]

[Mailing Address]

[City], [State] [ZIP Code]

Dear [Chief Executive Officer]:

On behalf of our employer and purchaser clients, we are writing to urge you to participate in the 2024 Leapfrog Hospital Survey. We feel that your participation in the Survey is vital for your community so we can achieve real progress toward a safer, higher-quality, more transparent health care system for all.

More than 2,100 hospitals submitted a Survey in 2023, accounting for 73% of inpatient beds across the country. Our company, along with employers and other purchasers, consumers, and industry leaders, use the Survey Results to make informed choices about hospitals from which to seek care. Without your Survey participation we will not have this critical data on the quality and safety of the care your hospital provides.

For over 20 years, The Leapfrog Group has been collecting and publicly reporting patient safety and quality information about health care facilities. Leapfrog continues to report unique data that matters most to employers, purchasers, payors, and consumers. Furthermore, measures on the Leapfrog Hospital Survey are evidence-based, grounded in the latest science, and developed with guidance from Leapfrog's national Expert Panels and the Johns Hopkins Armstrong Institute for Patient Safety and Quality.

Please visit <http://www.leapfroggroup.org/hospital> to learn more. The deadline for completion is June 30. There is never any charge for participation in Leapfrog Surveys.

We strongly recommend your participation in the 2024 Leapfrog Hospital Survey. Leapfrog is the gold standard in health care transparency, which is why it is important to us that your facility participates. Thank you for your consideration of our request.

Sincerely,

[Your Signature here]

L. TEMPLATE LETTER/EMAIL FOR HEALTH PLANS: ASCS

[Date]

[Chief Executive Officer]

[ASC Name]

[Mailing Address]

[City], [State] [ZIP Code]

Dear [Chief Executive Officer]:

On behalf of our employer and purchaser clients, we are writing to urge you to participate in the 2024 Leapfrog Ambulatory Surgery Center (ASC) Survey. Payors, employers, and purchasers use the Leapfrog ASC Survey to inform patient referral preferences, benefit designs, and direct contracting considerations. Without your Survey participation, we will not have this critical data on your quality and safety performance.

We feel that your participation in the Leapfrog ASC Survey is vital for our community so we can achieve real progress toward a safer, higher-quality, more transparent health care system. This has never been more important than now when health care facilities have become a lifeline for public health and community reassurance.

2024 marks the sixth year of the Leapfrog ASC Survey on patient safety and quality. The Leapfrog Group is a 24-year-old independent national nonprofit collecting and publicly reporting patient safety and quality information about health care facilities. All ASCs in the United States have the opportunity to participate in the annual Leapfrog ASC Survey. Survey results are reported on Leapfrog's public reporting website, <https://ratings.leapfroggroup.org>, where users can search for and compare hospital and ASC ratings to better understand safety and quality across facilities.

Like all of Leapfrog's programs, the ASC Survey measures are evidence-based, grounded in the latest science, and developed with guidance from Leapfrog's national Expert Panel and the Johns Hopkins Armstrong Institute for Patient Safety and Quality.

Please visit <http://www.leapfroggroup.org/asc> to learn more. The deadline for completion is June 30. There is never any charge for participation in Leapfrog Surveys.

We strongly recommend your participation in the 2024 Leapfrog ASC Survey. Leapfrog is the gold standard in health care transparency, which is why it is important to us that your facility participates. Thank you for your consideration of our request.

Sincerely,

[Your Signature here]

Continue to following pages for the Common *Objections and Frequently Asked Questions* and the *Regional Leader Coverage Area* sections.

COMMON OBJECTIONS AND FREQUENTLY ASKED QUESTIONS ABOUT LEAPFROG AND ITS RATINGS

All Leapfrog leaders should be conversant in the issues that arise frequently during the campaign for Survey participation. The common objections and FAQs resource is available for you to familiarize yourself and prepare for conversations with providers and other groups you speak with about Leapfrog.

The Leapfrog Group is a national nonprofit organization that serves as a voice for health care consumers and purchasers, using their collective influence to foster positive change in U.S. health care. The flagship Leapfrog Hospital Survey and Leapfrog Ambulatory Surgery Center (ASC) Survey collect and transparently report hospital and ASC performance, empowering purchasers to find the highest-value care and giving consumers the lifesaving information they need to make informed decisions. The Leapfrog Hospital Safety Grade, Leapfrog's other main initiative, assigns letter grades to hospitals based on their record of patient safety, helping consumers protect themselves and their families from errors, injuries, accidents, and infections.

The following charts detail responses to the common objections and frequently asked questions hospitals and ASCs may have about Leapfrog and its ratings.

COMMON OBJECTIONS TO PARTICIPATING IN LEAPFROG SURVEYS

Objection	Quick Response	Detailed Response
We do not want to participate in the Survey this year because of the new nursing standards. Our hospital, and hospitals nationwide, are facing unprecedented staffing shortages, and the new nursing standards will be impossible to achieve.	While staffing challenges impact hospital operations, it is integral for consumers and purchasers to have insight about nurse staffing by hospital. Years of evidence show a direct relationship between adequate nurse staffing and patient safety outcomes.	Nursing care is a core element to ensuring safe patient care in hospitals, and national data suggests variation among hospitals on the impact of the nurse staffing challenges. With these considerations in mind, Leapfrog is going to continue with its plans to score and publicly report hospitals on the Total Nursing Care Hours per Patient Day, RN Hours per Patient Day, Nursing Skill Mix, and Percentage of RNs who are BSN-Prepared measures on the 2024 Leapfrog Hospital Survey, but as a reminder, hospitals have the option of responding 'did not measure' and will be publicly reported as Limited Achievement. All four of the nurse staffing and skill mix measures from the Leapfrog Hospital Survey have decades of published evidence that support their relationship with patient safety outcomes.
"Leapfrog data is self-reported and therefore unreliable."	Leapfrog goes to extensive lengths to verify the accuracy of data reported through its Surveys, including on-site verification for a sample of facilities.	The integrity of the data we publish and distribute is of utmost importance to Leapfrog. We have many protocols in place to verify the accuracy of our results: • The facility CEO or their designee must complete an Affirmation of Accuracy for each section of the Survey. • The Survey is programmed to detect errors and logic problems and alerts facilities prior to Survey submission. • Each month, Leapfrog conducts an extensive data verification of the responses submitted to the Survey. Quantitative responses are assessed using empirically driven,

		normative data quality standards. Some facilities are randomly selected to submit further documentation for qualitative measures. • A sample of facilities are selected for on-site verification of results. Note: These processes are outlined in more detail on our website.
"Our effort to promote quality is evidenced by many accolades received within the past year, so we don't need to report to Leapfrog."	Performing well on other rankings does not explain why the facility is unwilling to report data purchasers are asking for.	We congratulate hospitals and ASCs on the quality awards they have received. However, performing well on other rankings does not explain why the facility is unwilling to report data purchasers are asking for. Transparency means candor—not just about awards and accomplishments but also about challenges. In short, receiving an award for quality or safety is not a suitable substitute for demonstrating transparency to purchasers by responding to the Leapfrog Hospital Survey or Leapfrog ASC Survey.
"All of the information available through Leapfrog is available elsewhere."	Leapfrog publicly reports data by individual facility that is unavailable from any other source, including CMS, the Joint Commission, and others.	Data collected and reported through the Leapfrog Surveys is often harmonized with other entities to make reporting easier for hospitals and ASCs, but the difference is that Leapfrog makes this data public by facility. For example, hospitals report the same C-section measure to Leapfrog that they report to the Joint Commission, but the Joint Commission doesn't make individual hospital C-section rates available to the public. While some measures on the Leapfrog Hospital Survey align with those collected by CMS, CMS often reports at the system level rather than by individual facility; our results demonstrate that there is real difference between facilities even within the same system.
"We concentrate our data collection resources on CMS."	Employers, purchasers, and patients who are not necessarily Medicare beneficiaries deserve your attention to their needs too. Voluntarily participating in Leapfrog Surveys demonstrates responsiveness to the community and purchasers.	Participation in the Leapfrog Surveys demonstrates a facility's true commitment to transparency because Leapfrog asks hospitals and ASCs to voluntarily report measures they are not required to report otherwise. These measures matter to purchasers and patients.
"We already have a performance improvement and quality standards plan in place and don't need Leapfrog to guide our efforts."	Purchasers and consumers want to see improvement efforts on specific measures that matter most to them, including those reported by Leapfrog.	While acknowledging a facility's many areas of strength, no hospital or ASC is perfect, and Leapfrog is a gold standard for excellence. Measures that are unique to Leapfrog should prompt performance improvement efforts on those metrics. All facilities should welcome the opportunity to build trust from purchasers and consumers by reporting this information, and purchasers are eager to see the improvements hospitals have made.
"Leapfrog is rarely used by the public or insurance companies anymore."	Leapfrog data is used now more than ever before. National health plans, regional health plans, employers, purchasers, and publishers, reaching virtually all Americans,	Leapfrog is more widely used now than ever before. Leapfrog data is used by national and regional health plans in their public reporting and pay-for-performance initiatives. Furthermore, Leapfrog data is included in many of the transparency tools used by employers and purchasers.

"We believe something on the Survey is not risk-adjusted adequately and/or invalid/unscientific."	Leapfrog's Surveys are rigorously evaluated and updated regularly by leading authorities and experts, risk-adjusted when appropriate, and aligned with national reporting enterprises such as the National Quality Forum.	Leapfrog's surveys are rigorous and continuously updated. Leapfrog's Survey team works with faculty at the Armstrong Institute for Patient Safety and Quality at Johns Hopkins Medicine as well as a number of national expert panels to review the evidence and measure specifications for the Surveys each year. All content is released for public comment annually and updated accordingly. Questions and concerns about measures are always welcomed and considered either through the public comment period or any time in the year by contacting Leapfrog.
"We disagree with Leapfrog's hand hygiene standard, and it is burdensome."	Leapfrog's hand hygiene standard is stringent, but its framework pulls from existing evidence from leading health organizations, including WHO, CDC, and The Joint Commission. The pandemic accentuates the importance of implementing higher hand hygiene standards.	Leapfrog's new hand hygiene standard is modeled primarily after the World Health Organization's (WHO) Hand Hygiene Self-Assessment Framework and adapted to specific issues unique to U.S. hospitals and ambulatory surgery centers (ASCs). Leapfrog has also updated the framework based on existing evidence, models from other organizations such as the CDC and The Joint Commission, and expert opinion from our national Hand Hygiene Expert Panel. There are times when Leapfrog's standards are more stringent than what is set by other organizations, and this is one of them. Leapfrog's intent was to set a standard that meets the challenge of the nation's high rate of healthcare-associated infections, which appears to have grown during the pandemic. We recognize that we are holding hospitals and ASCs to a higher standard than what is currently required for hand hygiene and many facilities will not be able to fully adhere to the standard, but our intention is that facilities will work toward meeting the standard in the future.

FREQUENTLY ASKED QUESTIONS

Question	Quick Response	Detailed Response
What is the difference between the Leapfrog Hospital Survey and the Leapfrog Hospital Safety Grade?	The Leapfrog Hospital Survey asks hospitals to voluntarily provide a range of safety and quality data to Leapfrog. The Leapfrog Hospital Safety Grade doesn't ask hospitals for anything but simply assigns a letter grade using all publicly available safety data. The	The Leapfrog Hospital Survey is an annual voluntary survey of safety, quality, and efficiency standards in hospitals. Survey results are publicly reported at https://ratings.leapfroggroup.org . The Leapfrog Hospital Safety Grade is a letter grade rating of A, B, C, D or F assigned to all general hospitals regardless of whether they voluntarily report data to Leapfrog or not. Grades are reported at www.hospitalsafetygrade.org . Data used in the Safety Grade comes primarily from the Leapfrog Hospital Survey and CMS.

	Grade also focuses only on safety, while the Survey has a range of measures.	
Do facilities have to pay to participate in the Surveys?	No, participation in the Surveys is completely free and always has been.	The Leapfrog Hospital Survey and Leapfrog ASC Survey are completely free to participating facilities. Results are also available for free on Leapfrog's websites.
How are Survey results used?	The data collected is publicly reported on Leapfrog's website. Consumers, employers, purchasers, and health plans use Survey results to identify safe, high-quality facilities; develop value-based purchasing strategies; and inform health care needs.	Data collected through the Surveys are publicly reported on Leapfrog's websites and used to educate consumers and purchasers about the quality and safety of facilities in their community so that they can choose the best place for care. Employers and purchasers use Survey results to identify the best facilities for their employees' health care needs and work with health plans to design value-based benefits packages that reward the safest and highest quality performers. Health plans and others include Leapfrog data on plan websites and materials as well as in transparency tools.
How does Leapfrog verify its data? Is Leapfrog data self-reported?	Leapfrog goes to extensive lengths to verify the accuracy of data reported through its Survey, including on-site verification for a sample of hospitals. Any data that are determined to be knowingly false are immediately decertified and removed.	The integrity of the data we publish and distribute is of utmost importance to Leapfrog. We have many protocols in place to verify accuracy of our results: • The facility CEO or their designee must complete an Affirmation of Accuracy for each section of the Survey. • The Survey platform itself scans for potential entry errors and logic problems and alerts facilities prior to Survey submission. • Each month, Leapfrog conducts an extensive data verification of the responses submitted to the Survey. Quantitative responses are assessed using empirically driven, normative data quality standards. Some facilities are randomly selected to submit further documentation for qualitative measures. • A sample of hospitals are selected for on-site verification of results. Note: These processes are outlined in more detail on our website.
What is Leapfrog's initiative to rate outpatient care?	Leapfrog assesses the quality and safety of procedures performed at ambulatory surgery centers (ASCs) and hospital outpatient surgery departments through a stand-alone ASC Survey and additional section on the Hospital Survey.	For five years, Leapfrog has assessed the quality and safety of procedures performed at ambulatory surgery centers (ASCs) and hospital outpatient surgery departments. 60% of employee procedures take place in the outpatient setting. We collect the data through a voluntary Survey of ASCs as well as an outpatient surgery addition to the existing Leapfrog Hospital Survey, which previously covered inpatient care only. Results for both types of facilities are publicly reported at https://ratings.leapfroggroup.org .
Does Leapfrog compare procedures performed at ASCs with those performed in hospitals?	Yes, Leapfrog reports similar information about both settings, allowing patients to better understand the quality and safety by facility. These results can be found on our	Yes. Our goal is to report similar information about both settings. Leapfrog strongly believes that reporting about quality and safety should be patient-centered, and patients seeking a particular procedure do not care about the business entity that houses the operating room; they care about the quality and safety of the procedure. Results for both types of facilities based on similar metrics can be found on our ratings website .

ratings website, and users can compare facilities by procedure and area of care.

Where can I go for help?

The Leapfrog Help Desk can assist hospitals and ASCs with highly technical questions, and can be reached through the [online Leapfrog Help Desk link](#) or by emailing helpdesk@leapfrog-group.org.

Regional leaders with questions should reach out directly to Jill Berger,

Regional Leaders should respond to questions only when they feel comfortable doing so and steer clear of highly technical questions. Please feel free to refer any hospitals or ASCs directly to the Leapfrog Help Desk for questions, especially those questions related to Survey content or technical problems with the Surveys.

Help Desk coverage is 9:00 a.m.–5:00 p.m. ET on business days. The Help Desk is committed to resolving inquiries within two business days, and most inquiries are typically resolved within one day. Have hospitals and ASCs can contact the Help Desk using the [online Leapfrog Help Desk link](#) at the bottom of the home page of the online Survey or by emailing helpdesk@leapfrog-group.org. Regional leaders with questions should reach out directly to Jill Berger,

Why should hospitals and ASCs complete the annual Leapfrog Surveys?

Participating in the Leapfrog Surveys is a free way to demonstrate transparency, accountability, and improvements to purchasers, employers, and consumers. It is a valuable market-driven benchmarking tool for hospital and ASC quality improvement effort.

By participating in the Leapfrog Surveys, your facility can:

- Demonstrate your responsiveness to employers in our community who depend on your services
- Benchmark your performance on quality and safety metrics and create a performance improvement plan
- Receive public recognition by local business groups for your transparency and performance.
- Demonstrate your commitment to quality and safety improvement to your community, including your staff and board

LEAPFROG RATINGS VS OTHER RATINGS: WHAT IS THE DIFFERENCE?

Hospitals and health systems are complicated, and no one ratings program captures everything that matters to everyone. Consumers should consult multiple ratings before deciding where to seek care. They should begin with safety, because without safety little else matters: The best surgeon in the world will not be enough to save the patient if they get an infection or the wrong medication following their procedure. Whether it's stitches in the ER or open heart surgery, safety is the foundation of every patient's hospital experience.

Below is a summary of ratings systems and how they compare to Leapfrog.

Rating	Quick Response	Detailed Response
U.S. News & World Report	These ratings are primarily intended for patients with highly complex conditions; Leapfrog data applies to anyone looking for a	The U.S. News Honor Roll (including condition-specific honor rolls) focuses on identifying the "best medical centers for the most difficult patients," helping consumers determine which hospitals provide the best care for serious or complicated medical conditions and procedures; it

	hospital or ASC. Also, Leapfrog calls out the poor performers as well as the best, while U.S. News focuses on the top performers only.	is not a list intended for the average consumer to use to find a hospital for a routine procedure or condition. For patients with complex conditions, the U.S. News ratings are a helpful addition to the Leapfrog Hospital Safety Grade.
CMS Care Compare (Previously Hospital Compare)	CMS reports most hospitals as “average” on each of the quality and safety measures; Leapfrog shows much more variation between hospitals for each measure.	CMS includes data on safety, mortality, readmissions, patient experience, effectiveness/timeliness of care, and efficient use of medical imaging. On the Care Compare website, 90% of hospitals are shown as “no different than the national average” for each measure—this lack of variation makes it more difficult for consumers trying to identify the best facility for their care. Leapfrog results show more variation and are more timely.
CMS 5-Star Ratings	CMS data on hospitals is aggregated into a consumer-friendly single star rating. The star rating is displayed on Care Compare. It is useful to consumers and shows variation. Leapfrog’s Hospital Safety Grade is a similar composite, but ours only considers safety issues whereas the 5-Star Ratings include a broad array of safety and quality data. Both are useful, but they are different.	CMS offers a 5-star rating aggregating data on safety, mortality, readmissions, patient experience, effectiveness/timeliness of care, and efficient use of medical imaging for each hospital. There is variation among hospitals on number of stars. Safety comprises 22% of the overall star rating, which is why the Hospital Safety Grade—which is 100% safety measures—sometimes differs in its rating of a given hospital.
Healthgrades	Healthgrades publishes several lists of top hospitals for various areas of care. They do not call out poor performers like Leapfrog does. They use different measures than Leapfrog uses, and the methodology is less transparent.	Healthgrades publishes several lists of top 50/100/200 hospitals for various areas of care. It runs its own data analysis for many measures rather than using publicly available data. Unlike Leapfrog, they do not collect data from hospitals. Their Best Hospitals list and Patient Safety Excellence Award use different data than Leapfrog uses. For instance, they do not include infection rates, a significant component of the Safety Grade and the Survey. Only high-performing facilities are recognized.
Lown Institute Hospital Index	Lown Institute publishes hospital ranking lists and grades based on three domains: Equity, Value, and Outcomes. Rankings and grades are publicly reported on a dedicated website.	Lown Institute publishes unique yearly hospital ranking lists, providing hospital grades based on social responsibility. These rankings encompass performance across three domains: Equity, Value, and Outcomes. Featured lists include Avoiding Overuse, Community Benefit, Cost Efficiency, Most Racially Inclusive, and Most Socially Responsible. They apply these criteria and examine a range of 3,000–3,700 hospitals based on 54 metrics. Lown uses hospital characteristic data from a variety of sources, including Fiscal Year 2018 American Hospital Association (AHA) annual survey, Medicare Impact File, and the CMS Hospital Compare database. Users can view hospital grades for each domain publicly reported on a dedicated website as well as on the Lown Institute methodology.

Vendor-created ratings

Vendors like Castlight and CareChex by Quantros draw from claims data, CMS, and sometimes Leapfrog to create tools and insights to sell to employers and other stakeholders. Quality improvement vendors like Vizient give hospitals performance ratings, but their ratings are not available to the public.

We support these efforts and don't see Leapfrog as a competitor. Data from Leapfrog is unavailable from any other source (even claims), so we encourage incorporating Leapfrog into these tools.

Decision-support tools like Castlight are designed for employers to offer to their employees. They consolidate provider metrics with cost information, with many incorporating the Safety Grade and other Leapfrog data, to help employees choose the right facility/provider.

Quantros's CareChex Awards and other vendors use public and proprietary measures of performance to produce their ratings, comparing inpatient quality performance across general acute care hospitals. The awards consider patient complications, readmissions, mortality, AHRQ patient safety indicators, and inpatient quality indicators. Some sell consulting services to hospitals. Quantros is now a part of Healthcare Bluebook.

Vizient and other quality improvement vendors produce rankings designed for hospitals, not employers, purchasers, or consumers. Their Quality and Accountability Ranking identifies their high-performing member organizations in the areas of quality and safety and provides tools to support organizational improvement. None of their insights are made public, and even the hospitals that contract with them cannot see how other individual hospitals performed.

Leapfrog supports the innovative and competitive marketplace aimed at creating the most usable tools to drive improvement. At Leapfrog, we do not see ourselves as competing with these enterprises but giving them data to fuel even better ratings and offering employers and consumers the most relevant information. Data from the Leapfrog Surveys are unique and unavailable from claims or any other source. We encourage these vendors to use Leapfrog's unique data to fuel even better ratings.

Question	Quick Response	Detailed Response
Aren't consumers confused by multiple ratings when choosing a hospital or ASC?	Health care is a complicated enterprise. Consumers should have multiple ways to research, better understand, and compare health care facilities to make informed decisions. But safety should come first: Without safety, the other elements of quality are not as relevant.	Consumers can and should consult a multitude of health care facility ratings to see which is most meaningful for their needs and select a facility using that knowledge. Consumers are accustomed to consulting ratings and reviews for every other industry, from automobiles to appliances to books. By putting meaningful quality and safety metrics into the hands of consumers, we allow them to make informed decisions about their health. Leapfrog believes that safety should come first when it comes to choosing a hospital, and for that, the Leapfrog Hospital Safety Grade is the only tool focused exclusively on safety. But once a patient identifies the safest hospital available to them, they should utilize other ratings specific to the procedure or type of care needed so that they can choose the best facility for their treatment. Leapfrog is not competing with other ratings services but is expanding the pool of data available nationally for decision-making by purchasers and the public.

What makes Leapfrog ratings different than others?

Leapfrog is one of the few organizations collecting data directly from hospitals and ASCs. Leapfrog is designed to measure what matters to consumers and purchasers.

Leapfrog reports by facility, not by system as CMS permits and many ratings organizations do.

Leapfrog shows all ranges of performance, from excellent to poor.

Leapfrog is 100% transparent about its methodology and its ratings.

It is free for consumers to use and free for providers to report their data to the Surveys.

The difference between Leapfrog ratings and other ratings organizations comes down to methodology, focus, and number of performance measures they evaluate and the audiences they serve.

The Leapfrog Surveys use national performance measures to evaluate hospitals' and surgery centers' safety, quality, and efficiency. These measures are of specific interest to health care purchasers and consumers and cover a broad range of hospital processes, outcomes, and structures in key clinical areas such as maternity and intensive care.

The Survey measures are predicated on the latest science and are regularly reviewed with guidance from scientific advisors at the Armstrong Institute for Patient Safety at Johns Hopkins Medicine as well as Leapfrog's volunteer Expert Panels.

Leapfrog scores and publicly reports Survey results, Leapfrog's Survey methodologies are completely transparent, and annual proposed changes are open for public comment.

Comparison Chart:

	Leapfrog Safety Grade	Leapfrog Survey Ratings	U.S. News & World Report	CMS Star Ratings	Healthgrades	Lowest Institute
Patient population						
General	X	X		X	X	X
Rare and complex conditions		X	X		X	
Key focus						
Safety	X	X				
Quality		X	X	X	X	X
Overall facility	X		X	X	X	X
Specialty specific		X	X		X	

Ratings assigned						
Top performers only			X		X	
All: high and low performers	X	X		X		X
Audience						
Consumers	X	X	X	X	X	X
Employers and purchasers	X	X				X
Eligible facilities						
General acute-care hospitals	X	X	X	X	X	X
Specialty hospitals (pediatric, surgical, etc.)		X	X		X	
Ambulatory surgery centers		X		X		
Nursing homes, hospice care, dialysis facilities				X		
Update schedule						
Once per year			X		X	X
Twice per year	X			X		
Multiple times per year		X				

TECHNICAL QUESTIONS ABOUT SUBMITTING THE LEAPFROG HOSPITAL SURVEY

Question	Response
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Where do I get a security code if I haven't received or no longer have a security code?

To get a security code, send the [Security Code Request form](#) to the Leapfrog Help Desk.

We're in your region, why didn't we receive a request to participate in the Survey?

Should the hospital be on your roster? Perhaps it's a new hospital that we don't know about. You should contact the Help Desk with any updated hospital information, including CEO name. Have someone at the hospital send the Security Code Request form to the Leapfrog Help Desk so the hospital CEO can authorize email release of the security code. The form can be found [here](#).

If it's a hospital outside your Leader area or a type of hospital to which the standards are not intended to apply, and you don't need to have them on your list:

- We welcome any hospital to respond to the Survey.
- You needn't handle their request.
- Ask the hospital to request a security code from the home page of the Survey site by following the "Get a Hospital Security Code" link and following the instructions there. The Help Desk will send the code directly to them.

We received the letter, but why is our hospital name and/or CEO name used in the letter incorrect?

Let them know that they can update that information when completing the Survey (in Section 1). Please also update your roster and forward the information to the Help Desk to prevent this from happening again.

If we are multi-campus hospital and have two Medicare numbers but are really one hospital, can we file one Hospital Survey? Or if we are a hospital system and our units share the same Medicare number, can we file one Survey?

If hospitals on multiple campuses share a common CCN, they should report as distinct hospitals. See the Leapfrog policy [here](#).

Where can I go to see a checklist of steps to take to complete the Hospital Survey?

Leapfrog has put together a pre-submission checklist for hospitals that is easy to use. It is available in the hard copy of Survey [here](#).

Why does the consumer site(s) show the wrong information?

The hospital probably needs to update and resubmit its Hospital Survey. No one associated with Leapfrog can alter the data that a hospital submits. It is likely that the hospital made an error during submission. Review the general instruction and timing for public update with the hospital, as indicated above.

Why is my hospital publicly reported as "Declined to Respond" when I completed the Survey?

The hospital may have failed to click the button "Submit Survey." They should log back into the Survey and check their submission status. Or, the publicly reported results haven't been updated yet to

	reflect their participation. Results are updated within the first five business days of each month based on the previous month's submissions.
Where can I ask a clinical or scientific inquiry about a question on the Survey?	Please contact the Help Desk (helpdesk@leapfrog-group.org) for assistance.
My hospital that has an A Safety Grade was cited by my state for quality issues. How can that be?	The Safety Grade reflects a hospital's relative performance to others – meaning that A hospitals have better patient safety outcomes than B, C, and D/F hospitals but it doesn't mean they are perfect. Additionally, if major patient safety issues are occurring now, those worsening patient outcomes will be reflected in the updated data we receive from CMS.

TECHNICAL QUESTIONS ABOUT SUBMITTING THE LEAPFROG ASC SURVEY

Question	Response
How do I access the Survey?	ASCs will need to request a security code to access the Survey if they are new to submitting the ASC Survey, available here . Once the security code is obtained ASCs can log in to the Survey here . If an ASC participated in previous years, their security code will be the same for 2024.
How do I know if my facility is an ASC?	An ASC is a distinct entity that exclusively provides same-day surgical services to patients not requiring hospitalization. Important characteristics of ASCs include the following: • If certified by Medicare, the facility is certified as an ASC (not all ASCs are certified by Medicare) and has been assigned a 10-digit CMS Certification Number (nn-Cnnnnnnn) • Provides surgical services that do not exceed 24 hours • May or may not be affiliated with a hospital • Often are specialty-specific More details can be found here .
What does the Survey cover?	The Leapfrog Group will gather data from ASCs on several important areas of care including basic facility information; ethical billing and health equity; medical, surgical and nursing staff; volume and safety of procedures; patient safety practices; and patient experience. Like all of Leapfrog's programs, the Survey is evidence-based and predicated on the latest science, developed with guidance from Leapfrog's National Expert Panel and the Armstrong Institute for Patient Safety and Quality at Johns Hopkins Medicine.
Will ASCs be reported as "Declined to Respond" if they do not submit the ASC Survey to Leapfrog in 2024?	ASCs that do not submit the 2024 ASC Survey by June 30 will appear in initial location-based search results on Leapfrog's public reporting website, ratings.leapfroggroup.org. However, if users opt to view facilities that declined to respond. Additionally, a direct search by facility name will generate a "Declined to Respond" message if the facility does not participate by June 30. Facilities that miss the June 30 Submission Deadline can still submit a Survey through November 30; results are updated monthly on Leapfrog's website.
Will ASCs get a letter grade?	There are no current plans to give ASCs a letter grade.
Why does the consumer site(s) show the wrong information?	The ASC probably needs to update and resubmit its ASC Survey. No one associated with Leapfrog can alter the data that an ASC submits. It is likely that the ASC made an error during submission.
Can all ASCs participate?	All ASCs in the United States are invited to participate in the Leapfrog ASC Survey, though an ASC must perform at least one of the procedures in the profile section of the ASC Survey in order to participate.
Where can I ask a clinical or scientific inquiry about a question on the Survey?	Please contact the Help Desk (helpdesk@leapfrog-group.org) for assistance.
REGIONAL LEADER COVERAGE AREAS	

Regional Leaders and Designated Coverage		
State/Region	Organization	Coverage (counties)
Alabama	Alabama Employer Health Consortium	All counties
Arkansas	HealthCareTN	Crittenden
California	Purchaser Business Group on Health	All counties
Colorado	Purchaser Business Group on Health	All counties
Delaware	Greater Philadelphia Business Coalition on Health	All counties
District of Columbia	Consumer's Checkbook	The District of Columbia
Florida	Florida Alliance for Healthcare Value	All counties
Georgia	HealthCareTN	East/Mid: Catoosa, Dade, Floyd, Gordon, Murray, Walker, and Whitfield
Georgia	Georgia Watch	Fulton, DeKalb, Cobb, Gwinnett, and Clayton
Illinois	Midwest Business Group on Health	All counties except Bond, Calhoun, Clinton, Jersey, Macoupin, Madison, Monroe, St. Clair
Illinois	St. Louis Area Business Health Coalition	Bond, Calhoun, Clinton, Jersey, Macoupin, Madison, Monroe, St. Clair
Iowa	Health Policy Corporation of Iowa	Benton, Black Hawk, Boone, Bremer, Dallas, Dubuque, Grundy, Gunthrie, Harrison, Jasper, Johnson, Jones, Linn, Madison, Marion, Mills, Polk, Pottawattamie, Scott, Story, Warren, Washington, Woodbury
Indiana	Kentuckiana Health Collaborative	Clark, Floyd, Harrison, and Scott
Kansas	Kansas Business Group on Health	Butler, Cowley, Harper, Harvey, Johnson, Kingman, Reno, Sedgwick, Sumner and Wyandotte
Kentucky	Kentuckiana Health Collaborative	All counties
Louisiana	Louisiana Business Group on Health	All counties
Maine	Healthcare Purchaser Alliance of Maine	All counties
Michigan	The Economic Alliance for Michigan	All counties
Minnesota	Health Action Council	All counties

Mississippi	HealthCareTN	De Soto, Marshall, Tate, Tunica, Union, Lafayette, Lowndes, Benton, Tippah, Alcorn, Tishomingo, Prentiss, Pontotoc, Lee, Itawamba, Clay, Panola, and Monroe
Missouri	St. Louis Area Business Health Coalition	Crawford, Franklin, Jefferson, Lincoln, St. Charles, St. Francis, St. Louis, St. Louis City, Warren, Washington
Montana	Montana Association of Health Care Purchasers	All counties
Nebraska	Health Policy Corporation of Iowa	Douglas
Nevada	Nevada Business Group on Health	Churchill, Douglas, Elko, Eureka, Humboldt, Lander, Lyon, Pershing, Storey, Washoe, White Pine, and Carson City
New Hampshire	New Hampshire Purchasers Group on Health	All counties
New Jersey/New York	New Jersey Health Care Quality Institute	All counties
New Mexico	New Mexico Coalition for Healthcare Value	All counties
North Carolina	North Carolina Business Coalition on Health	All counties
Ohio	Health Action Council	All counties
Oklahoma	The Oklahoma Business Collective on Health	Cherokee, Craig, Muskogee, Nowata, Okmulgee, Payne, Tulsa, Washington, Wagoner, and Rogers
Oregon	Health Action Council	All counties
Pennsylvania: Greater Philadelphia	Greater Philadelphia Business Coalition on Health	Phila, Bucks, Montgomery, Chester, Delaware
Pennsylvania: Lehigh Valley	Lehigh Valley Business Coalition on Health Care	Adams, Bedford, Berks, Bradford, Carbon, Centre, Clinton, Columbia, Cumberland, Dauphin, Franklin, Fulton, Huntingdon, Juniata, Lackawanna, Lancaster, Lebanon, Lehigh, Luzerne, Lycoming, Mifflin, Monroe, Montour, Northampton, Northumberland, Perry, Pike, Potter, Schuylkill, Snyder, Sullivan, Susquehanna, Tioga, Union, Wayne, Wyoming, and York
Pennsylvania: Pittsburgh	Pittsburgh Business Group on Health	Allegheny, Armstrong, Beaver, Blair, Butler, Cambria, Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Fayette, Forest, Greene, Indiana, Jefferson, Lawrence, McKean, Mercer, Somerset, Venango, Warren, Washington, and Westmoreland

South Dakota	Health Policy Corporation of Iowa	Minnehaha
Tennessee	HealthCareTN	All counties
Texas: Dallas/Fort Worth	Dallas Fort Worth Business Group on Health	Collin, Cooke, Dallas, Denton, Ellis, Erath, Grayson, Henderson, Hood, Hunt, Johnson, Kaufman, Navarro, Palo Pinto, Parker, Rockwall, Somervell, Tarrant, Wise
Texas: Houston	Houston Business Coalition on Health	Harris, Fort Bend, Montgomery
Virginia	Virginia Business Coalition on Health	All counties
Washington	Washington Health Alliance	All counties
Wisconsin	The Alliance	All counties

Exhibit 8

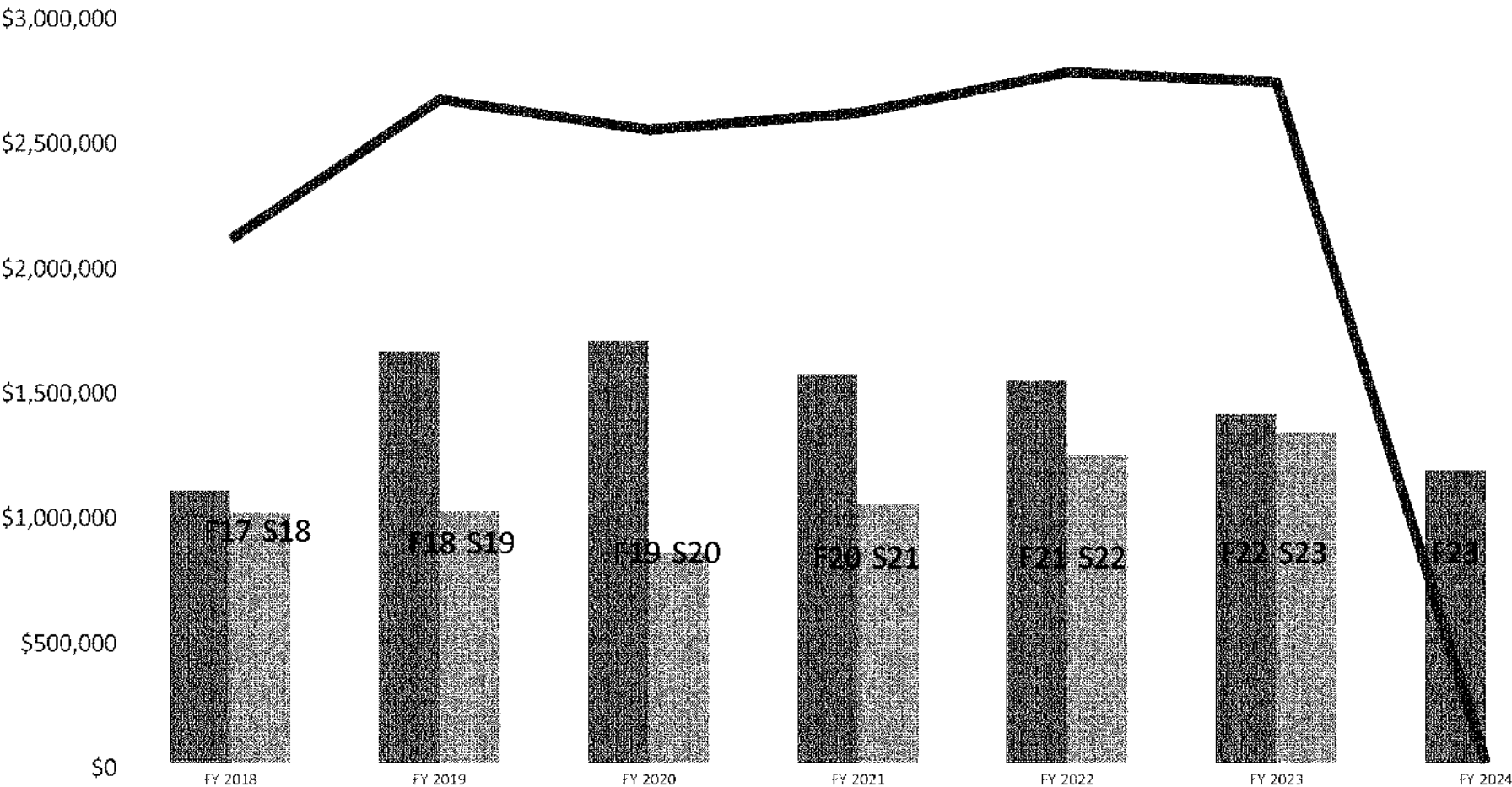
2023 Leapfrog Hospital Safety Grade Accolades Sales Analysis

Alexandra Campione
January 2024

Slide 1 Notes

This analysis looked at the relationship between individual hospitals characteristic and the likelihood of hospitals licensing their "A" grade, as well as our media coverage in metropolitan areas. We wanted to understand what hospital types were licensing and if increased media coverage resulted in more licenses in cities.

Hospital Safety Grade Revenue by Fiscal Year

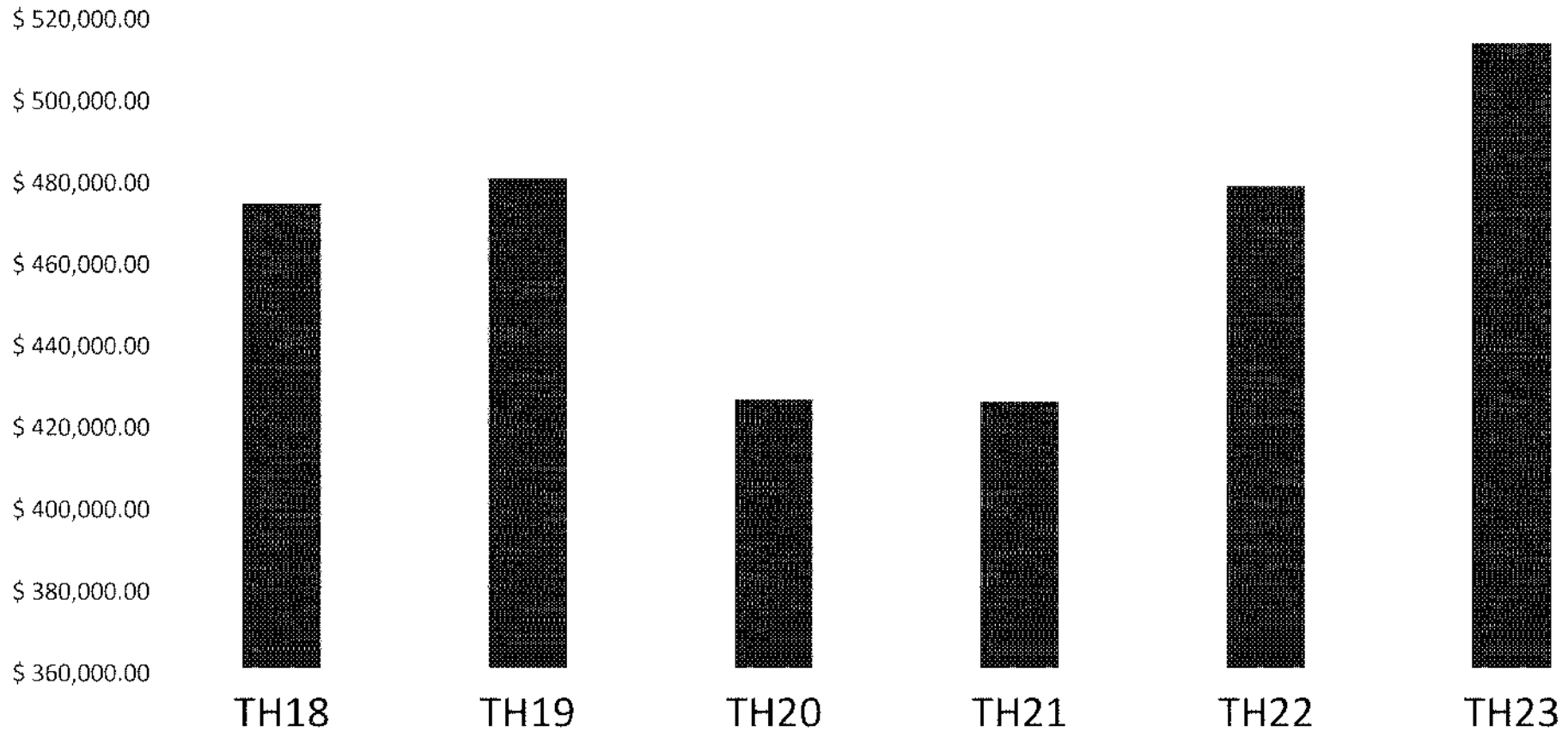


Slide 2 Notes

As an overview

LEAPFROG01168248

Top Hospital Revenue by Fiscal Year



Estimating the Likelihood of Licensing

modeled using fall 2023 licensing data



Survey Participants are
10x more likely to
license



Renewals are
10x more likely to
license



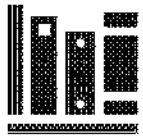
Hospitals that that
have licensed in the
past 2 years are 5x
more likely to license



Hospitals not in a System are
2x more likely to license

Other System Factors

modeled using fall 2023 licensing data



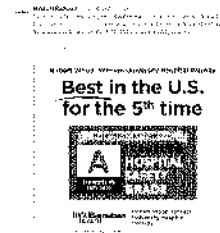
Recent Licensing

Hospitals in a system that recently licensed (past 2 rounds) are 9x more likely to license



System Size

Hospitals in large systems (>10 hospitals) are 1.5x more likely to license



No other 'A's in the System

Hospitals that have only one "A" in their system are 1.5x more likely to license

Survey Participation and Licensing

among hospitals eligible to license in fall 2023 (n= 726)

	Licensed	Did not License	Total	Percent Licensed
Survey Participants*	133	463	596	22%
Non-Survey Participants	3	127	130	2%

*Hospitals that Completed the 2023 Leapfrog Hospital Survey

Slide 6 Notes

The 3 hospitals that didn't do the Survey and licensed anyway were Bakersfield Heart Hospital (HCA), Mission Hospital (Surgery Partners- FKA Symbion Healthcare), and St. Joseph Hospital (Covenant Health)

Survey Participation, System History, and Licensing among hospitals eligible to license in fall 2023 (n= 726)

		Licensed	Did not License	Total	Percent Licensed
Survey Participants	not in a system	14	15	29	48%
	in licensing system*	90	87	177	51%
	in non-licensing system**	43	376	419	10%
Non-Survey Participants	Non-Survey Participants	3	127	130	2%

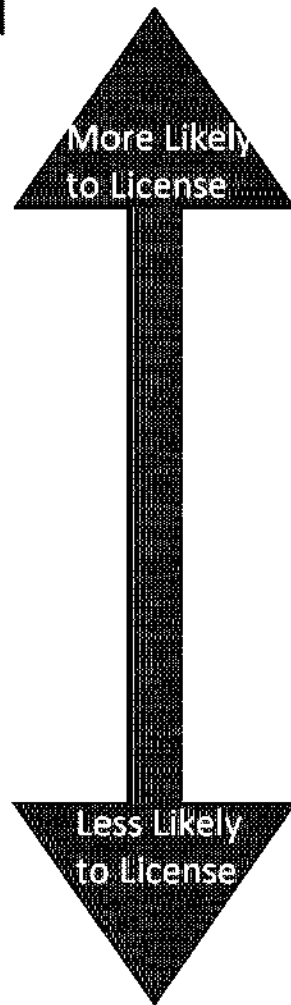
*Licensing System: the system licensed at least once in Spring 2023 or Fall 2022 for one of their hospitals

**Among hospitals in systems with no history of licensing, hospitals that were the only A's in their system were 3 times more likely to license; results were statistically significant ($p < .05$).

Slide 7 Notes

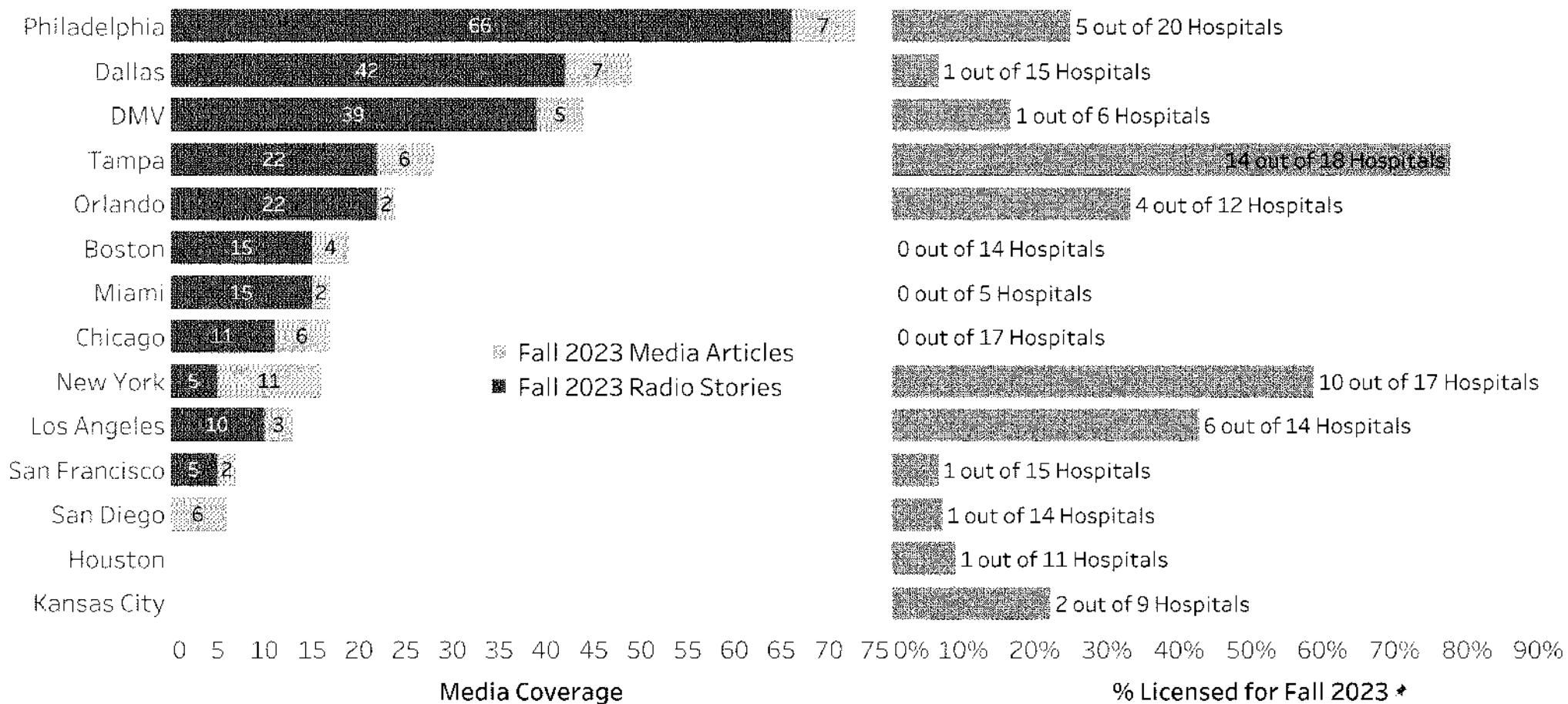
Of the 419 hospitals that were in a system with no history of licensing, 109 were the only A's in their system (26%). Of the 43 that actually licensed, 26 were the only A's in their system (60%).

Hospitals Projected to be Eligible for Spring 2024 Accolades



100	Renewals
20	Survey Participants not in System
78	Survey Participant in Licensing System
410	Survey Participants in Non-Licensing System
115	Did Not Complete 2023 Survey

Fall 2023 Safety Grade Media Coverage and Licensing in 14 Major Metropolitan Markets



Recommendations for Spring 2024

- Update campaigns to target groups with a high probability of licensing:
 - Hospitals that submitted a Survey (596 of 726 “A” hospitals submitted a Survey in fall 2023)
 - A targeted approach of Survey Participants
 - Hospitals not in a system (29 hospitals in fall 2023)
 - Hospitals in systems that have recently licensed (177 hospitals in fall 2023)
 - Hospitals in systems that do not license and are the only “A” (109 hospitals in fall 2023)
- Consider accolade pricing for recruitment only – not marketed, but available if requested
- Review and update campaign messages (support from TechXCO) to include more stats re: consumer shopping, importance to employers, etc.

Exhibit 9

Leapfrog Hospital Safety Grade Expert Panel Meeting

April 12, 2024

THE LEAPFROG GROUP

LEAPFROG00437363

Agenda

- Update on scoring DHA Military Treatment Facilities
- Feedback on re-evaluating imputation model
- Feedback on two possible new outcome measures

Military Treatment Facilities

- Scoring Military Treatment Facilities (MTFs) located in the US

Safety Grade	MTFs (n)	MTFs (%)	Nationally (%)
A	9	43%	29%
B	9	43%	26%
C	3	14%	37%
D	0	0%	7%
F	0	0%	<1%
Total	21		

- We worked directly with DHA to collect PSI and HAC data for all MTFs
 - Patient population included all patients 18 years or older
- MRSA and SSI Colon were previously not tracked for most facilities in NHSN



Measure	MTF Average	National Average	Difference
Computerized Physician Order Entry (CPOE)	70.00	91.81	-21.81
Bar Code Medication Administration (BCMA)	92.86	93.41	-0.56
ICU Physician Staffing (IPS)	64.29	63.27	1.02
Safe Practice 1	111.65	117.59	-5.94
Safe Practice 2	102.38	117.08	-14.70
Total Nursing Hours per Patient Day	97.14	74.68	22.46
Hand Hygiene	75.71	78.64	-2.93
H-COMP-1: Nurse Communication	92.90	89.66	3.24
H-COMP-2: Doctor Communication	93.43	89.52	3.91
H-COMP-3: Staff Responsiveness	87.95	81.13	6.83
H-COMP-5: Communication about Medicines	84.05	74.08	9.97
H-COMP-6: Discharge Information	89.10	84.89	4.20
Foreign Object Retained	0.031	0.014	0.02
Air Embolism	0.000	0.001	0.00
Falls and Trauma	0.410	0.428	-0.02
CLABSI	0.758	0.729	0.03
CAUTI	1.086	0.627	0.46
SSI: Colon	1.470	0.846	0.62
MRSA	1.025	0.794	0.23
C. Diff.	0.53	0.45	0.07
PSI 4	177.12	168.42	8.70
PSI 90	0.90	1.01	-0.11

Re-evaluate Imputation Model

THE LEAPFROG GROUP

LEAPFROG00437366

Problem that We are Working to Solve

- **History**
 - Leapfrog moved to its current imputation approach in 2021, when the American Hospital Association discontinued its survey data license with Leapfrog (AHA Survey had been a long-time secondary data source)
 - Leapfrog was also seeking ways to grade additional hospitals
- **We are currently facing these challenges:**
 - Imputed scores have crept up, making imputation a more favorable choice for lots of hospitals and has de-incentivized true transparency of performance
 - Hospitals are using the Step 1 Imputation (using their individual hospital's historical data) as a reason to not report on the current year's survey

Data Sources and Measure Weights in the Process/Structural Domain

Measure Name	Primary Data Source	Secondary Data Source	Standard Measure Weight
Computerized Physician Order Entry (CPOE)	Leapfrog Hospital Survey	Imputation Model Applied	5.6%
Bar Code Medication Administration (BCMA)	Leapfrog Hospital Survey	Imputation Model Applied	5.4%
ICU Physician Staffing (IPS)	Leapfrog Hospital Survey	Imputation Model Applied	7.2%
Safe Practice 1: Culture of Leadership Structures and Systems	Leapfrog Hospital Survey	N/A	3.2%
Safe Practice 2: Culture Measurement, Feedback & Intervention	Leapfrog Hospital Survey	N/A	3.3%
Total Nursing Care Hours per Patient Day	Leapfrog Hospital Survey	N/A	4.9%
Hand Hygiene	Leapfrog Hospital Survey	Imputation Model Applied	4.7%
H-COMP-1: Nurse Communication	CMS	N/A	3.1%
H-COMP-2: Doctor Communication	CMS	N/A	3.1%
H-COMP-3: Staff Responsiveness	CMS	N/A	3.2%
H-COMP-5: Communication about Medicines	CMS	N/A	3.2%
H-COMP-6: Discharge Information	CMS	N/A	3.1%

Current Imputation Model

CPOE, BCMA, Hand Hygiene, and IPS

- **STEP 1:** Hospital is assigned their most recent score from the past four rounds of Safety Grade
 - For Spring 2024, we used their score for fall 2023, spring 2023, fall 2022, or spring 2022
 - This always corresponds to the three most recent Leapfrog Hospital Surveys (2023, 2022, 2021)
- **STEP 2:** Hospital is assigned the lower of two possible mean scores, based on their cohort's actual performance (Below approach used for CPOE, BCMA, and Hand Hygiene; but not used for IPS)
 - Mean of the cohort's current and recent scores
 - Mean of the cohort's scores from each hospital's first year of reporting on the current standard via the Leapfrog Hospital Survey

Step 2: Cohort Designations

CPOE, BCMA, and Hand Hygiene Only

The hospital is assigned to a cohort of other similar hospitals using three or four hospital characteristics obtained from the most recent CMS Impact File and Leapfrog Hospital Survey:

1. Urban/rural status (CMS Impact File)
2. Safety net status (CMS Impact File)
3. Number of beds (CMS Impact File)
4. Teaching status (only used for urban cohorts; Leapfrog Hospital Survey Results are the primary data source and CMS Impact File is the secondary data source)

Step 2 Imputation for IPS

- The CMS Cost Report is used as a secondary data source for the ICU Physician Staffing (IPS) measure
- ICU designation (i.e., operating a medical ICU, surgical ICU, or pediatric ICU) is determined by Leapfrog based on the number of medical, surgical and/or pediatric ICU beds reported in Worksheet S-3 Part 1 of the hospital's most recent CMS Cost Report. Hospitals that are determined to have one or more medical, surgical, and/or pediatric ICU beds are assigned the same point value (5 points) as those hospitals that achieve the lowest performance category in the Leapfrog Hospital Survey.

Spring 2024 Cohort Means for Step 2 Imputation

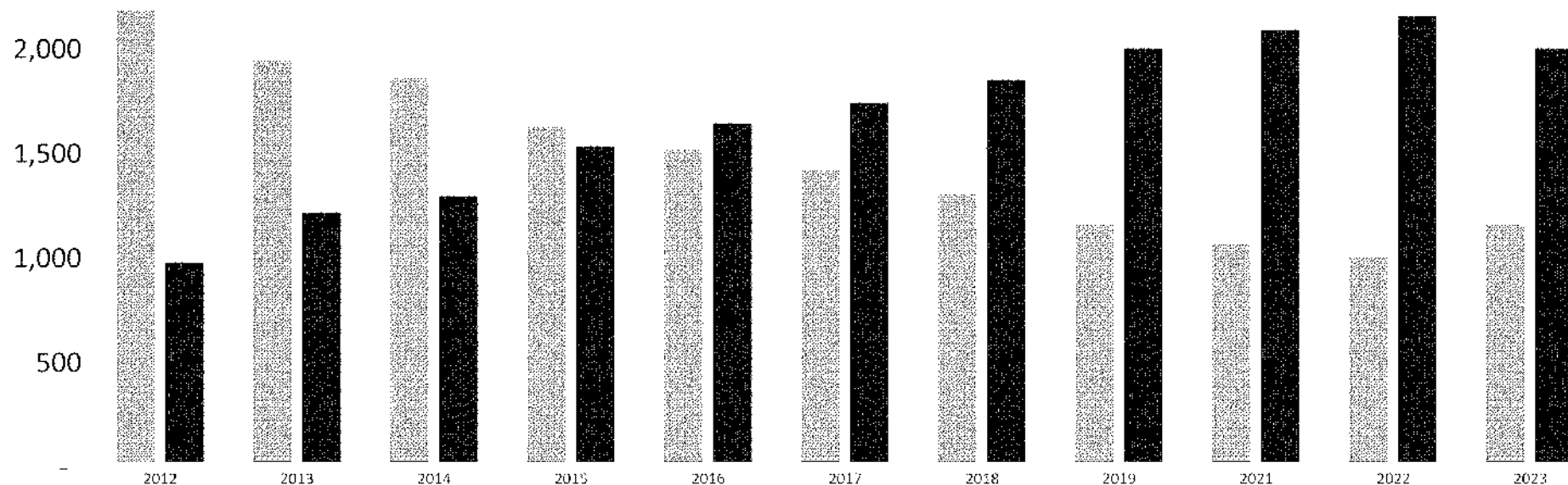
Cohort #	Urban/Rural Status	Safety Net Status	Number of Beds	Teaching Status	Step 2 CPOE Score (Mean of Cohort)	Step 2 BCMA Score (Mean of Cohort)	Step 2 Hand Hygiene Score (Mean of Cohort)
Cohort 1	Rural	Non-Safety Net	Fewer than 100 beds	N/A	75	79	50
Cohort 2	Rural	Non-Safety Net	100 or more beds	N/A	79	82	52
Cohort 3	Rural	Safety Net	Fewer than 100 beds	N/A	85	81	45
Cohort 4	Rural	Safety Net	100 or more beds	N/A	72	80	62
Cohort 5	Urban	Non-Safety Net	Fewer than 100 beds	Non-Teaching	84	85	58
Cohort 6	Urban	Non-Safety Net	100 or more beds	Non-Teaching	86	84	59
Cohort 7	Urban	Non-Safety Net	Fewer than 100 beds	Teaching	79	86	61
Cohort 8	Urban	Non-Safety Net	100 or more beds	Teaching	88	85	56
Cohort 9	Urban	Safety Net	Fewer than 100 beds	Non-Teaching	76	82	63
Cohort 10	Urban	Safety Net	100 or more beds	Non-Teaching	76	81	59
Cohort 11	Urban	Safety Net	Fewer than 100 beds	Teaching	82	81	50
Cohort 12	Urban	Safety Net	100 or more beds	Teaching	89	81	56

Spring 2024 Measure Scores

Leapfrog Performance Category	Corresponding Safety Grade Measure Scores			
	CPOE	BCMA	Hand Hygiene	ICU Physician Staffing (IPS)
Achieved the Standard	100	100	100	100
Considerable Achievement	70	75	70	50
Some Achievement	40	50	40	15
Limited Achievement	15	5	15	5
Average Step 1 Imputed Score	93	92	67	68
Average Step 2 Imputed Score	83	83	55	5

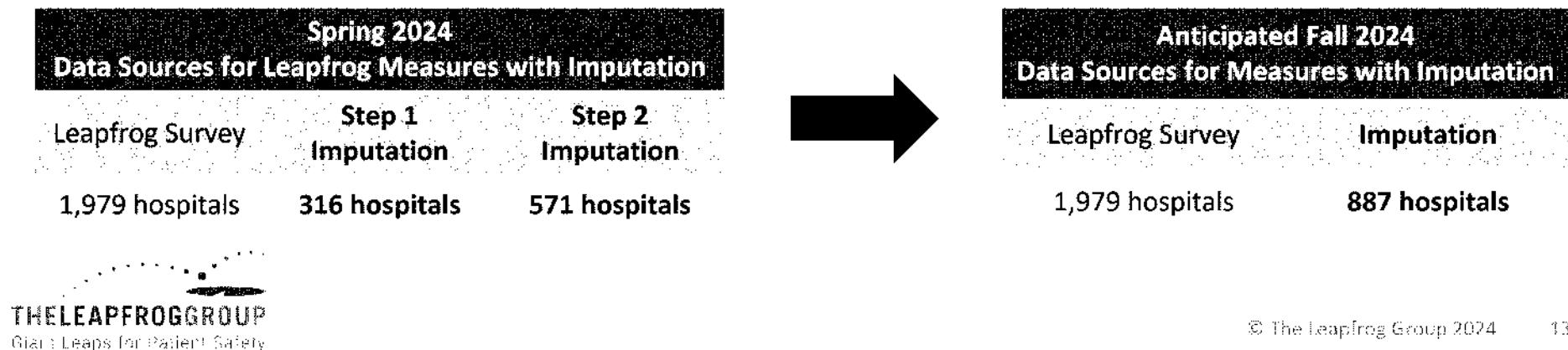
Hospitals Eligible for Imputation

The proportion of hospitals that complete the Leapfrog Survey has increased since 2012 from 31% to 61%. A slight dip in Survey Participation occurred this past year as hospitals opted to use past Survey results in step 1 imputation.



Proposed Future Imputation Methodology

- Retire Step 1 Imputation for all measures
 - Where we allow hospitals to use data from a recent Leapfrog Surveys
- Use Step 2b Imputation for all hospitals for CPOE, BCMA, and Hand Hygiene
 - Assign hospitals that do not complete the most recent Leapfrog Survey to cohorts
 - Calculate the mean of scores obtained in each hospital's first year of reporting on the current standard via the Leapfrog Hospital Survey
 - Hospital is assigned the mean for their cohort
- For IPS, the current Step 2 imputation methodology (CMS Cost Report) would be the only imputation model



New Measures Under Consideration



LEAPFROG00437376

Hospital Harm - Severe Hyperglycemia

- Focuses on severe hypoglycemia as an outcome in the hospital inpatient setting
- Public reporting by CMS will start in 2025
- **Numerator:** Number of inpatient hospital days with a hyperglycemic event (harm)
 - A hyperglycemic event is defined as:
 - 1) A day with at least one blood glucose value >300 mg/dL; OR
 - 2) A day where a blood glucose test was not done, and it was preceded by two consecutive days where at least one glucose value during each of the two days was ≥ 200 mg/dL
- **Denominator:** Total qualifying inpatient hospital days for that encounter for patients 18 years of age or older at admission

<https://ecqi.healthit.gov/sites/default/files/ecqm/measures/CMS871v2.html>

Hospital Harm - Severe Hypoglycemia

- Goal is to assess the occurrence of severe hypoglycemia in hospitalized patients
- Public reporting by CMS will start in 2025
- **Numerator:** Inpatient hospitalizations where a severe hypoglycemic event occurred during the encounter, which is:
 - A glucose result less than 40 mg/dL, AND
 - A hypoglycemic medication administered within 24 hours prior to the start of the severe hypoglycemic event (i.e., the glucose result less than 40 mg/dL), AND
 - No subsequent repeat test for glucose with a result greater than 80 mg/dL within five minutes of the time of the initial glucose test with result less than 40mg/dL
- **Denominator:** Inpatient hospitalizations that end during the measurement period for patients age 18 and older and at least one hypoglycemic medication was administered during the encounter.

<https://ecqm.healthit.gov/sites/default/files/ecqm/measures/CMS816v3.html>

Exhibit 10

Document Produced in Native Format

Exhibit 11

WEBVTT

1

00:00:00.000 --> 00:00:01.280

Matt Austin: So arches.

2

00:00:03.390 --> 00:00:12.660

Arjun Srinivasan, CDC (he/him): I have no financial disclosures. I am a full time employee of the Federal Government and our agent. My division runs the National Health Care Safety Network.

3

00:00:13.440 --> 00:00:15.060

Matt Austin: Great. Thank you, Arjun.

4

00:00:15.150 --> 00:00:17.260

Matt Austin: Sarah, would you like to go next? Please.

5

00:00:18.060 --> 00:00:39.051

Sara Singer: Sure. I'm Sarah Singer. I am a a professor at Stanford, in the medical school and in the business school and organizational behavior. With respect to and I've been on the I I've been on the leapfrog committee. He for it feels like many years. With respect to disclosures.

6

00:00:39.440 --> 00:00:56.070

Sara Singer: I guess financial disclosures. I receive Honoraria for work that I do for both Intermountain Healthcare and Harvard Medical School, and non, financially, I serve on the board for the Harvard Medical Faculty Physicians group.

7

00:00:57.400 --> 00:00:58.740

Matt Austin: Great. Thank you, Sarah.

8

00:00:59.271 --> 00:01:01.279

Matt Austin: Kathy, would you like to go next? Please.

9

00:01:02.400 --> 00:01:07.600

Kathy McDonald: Sure, Kathy McDonald. Hi! Everyone I am. I'm at Johns Hopkins.

10

00:01:07.610 --> 00:01:08.870

Kathy McDonald: colleague of Maths.

11

00:01:09.090 --> 00:01:15.989

Kathy McDonald: and I'm in the School of Nursing and the School of Medicine, and also the Armstrong Institute for safety and quality.

12

00:01:16.340 --> 00:01:18.370

Kathy McDonald: I don't have any

13

00:01:18.450 --> 00:01:19.930

Kathy McDonald: anything that's

14

00:01:21.640 --> 00:01:22.973

Kathy McDonald: nothing financial.

15

00:01:23.640 --> 00:01:24.010

Matt Austin: Thanks.

16

00:01:24.380 --> 00:01:27.300

Matt Austin: Thank you, Kathy. Peter, would you like to go next? Please.

17

00:01:27.850 --> 00:01:30.250

Peter Pronovost: Sure. Hi! I'm Peter pronost I

18

00:01:30.480 --> 00:01:39.050

Peter Pronovost: in the University hospitals, chief clinical transformation and quality officer and a professor in ace schools of medicine, nursing and management.

19

00:01:39.740 --> 00:01:45.209

Peter Pronovost: I think the only disclosure be a Pcori health systems implementation, science. Grant that

20

00:01:45.870 --> 00:01:47.240

Peter Pronovost: on the pi end.

21

00:01:48.300 --> 00:01:49.650

Matt Austin: Great thanks, Peter.

22

00:01:49.800 --> 00:01:51.849

Matt Austin: Tim, would you like to go next, please.

23

00:01:52.650 --> 00:01:53.140

Matt Austin: for.

24

00:01:53.140 --> 00:01:59.982

Tim Vogus: Tim Bogus and the faculty of the Vanderbilt University. Oh, and Graduate School of management. I'm not getting any of that sweet money so

25

00:02:00.920 --> 00:02:01.705

Tim Vogus: disclose.

26

00:02:03.170 --> 00:02:08.803

Matt Austin: Well, I I think you should disclose, Tim, that you are a a former Spartan, and sporting the

27

00:02:09.523 --> 00:02:17.152

Tim Vogus: Yeah. And I, I am the nicest dress person on the call or the opposite of that.

28

00:02:18.810 --> 00:02:21.260

Matt Austin: Alright Doris, would you like to go next? Please.

29

00:02:22.526 --> 00:02:41.680

Doris: Well, the only reason. I'm actually probably the worst dress cause I'm off camera. So I'm wearing a fleece jacket right now. So I'm not well dressed either. My name's Doris, Peter and I work mostly as a subcontractor for Cms through Yale core. Who has was the developer of those 2

30

00:02:41.740 --> 00:02:55.160

Doris: Ecqms. We're gonna maybe talk about the end of this meeting, the Patient Safety Cqms. Not really a disclosure, but just to let you know that I'm somewhat involved in those. And I'm happy to be here, but I have no other things to disclose. Great.

31

00:02:55.160 --> 00:02:57.719

Matt Austin: Thank you, Doris, appreciate that. And, Ernie, please.

32

00:02:58.240 --> 00:03:06.789

arnold milstein: Hi, I'm also off camera, because I'm like several others, a continuous walker. But let's see, so

33

00:03:06.860 --> 00:03:08.800

arnold milstein: relevant to leapfrog.

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00:03:08.860 --> 00:03:11.579

arnold milstein: I'm a Trustee of Intermountain Healthcare.

35

00:03:12.030 --> 00:03:14.309

arnold milstein: I am on the

36

00:03:15.170 --> 00:03:20.139

arnold milstein: the the Board's Quality Committee at at Stanford Hospital.

37

00:03:21.660 --> 00:03:26.980

arnold milstein: What else I am? I'm the Medical Director of the Pacific business group on Health

38

00:03:28.211 --> 00:03:31.930

arnold milstein: and then in terms of financial interests, though none are

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00:03:32.170 --> 00:03:35.000

arnold milstein: are involved with patient safety.

40

00:03:35.040 --> 00:03:37.930

arnold milstein: I have a financial interest in

41

00:03:38.040 --> 00:03:41.790

arnold milstein: in 2 2 startup companies.

42

00:03:42.000 --> 00:03:45.740

arnold milstein: one prealized health, the other in bold health.

43

00:03:47.380 --> 00:03:49.099

Matt Austin: Great. Thank you so much, Arnie.

44

00:03:49.980 --> 00:04:05.380

Matt Austin: So, as I mentioned, we're doing this in the spirit of transparency. If you have any concerns during the meeting, or after a meeting that one of your fellow expert panelists might be operating in a bias manner. We would ask that you reach out to either Missy or myself, and we'd be happy to

45

00:04:05.850 --> 00:04:08.220

Matt Austin: conversation with you about that. So

46

00:04:08.420 --> 00:04:19.579

Matt Austin: thank you so much. Everyone. We're gonna move on to the next agenda item. And I'm actually gonna share my screens with some slides. But I'm actually gonna turn it over to Alex from the leapfrog group

47

00:04:19.760 --> 00:04:25.150

Matt Austin: to talk a little bit about grading the military treatment facilities.

48

00:04:26.500 --> 00:04:36.309

Alexandra Campione: Great. Hi, everyone! My name is Alex. I'm a program analyst here at Lake Frog I work mainly with safety grade. So scoring facilities as well as doing these

49

00:04:37.030 --> 00:04:42.129

Alexandra Campione: analyses and validation like we did for the Mds.

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00:04:43.830 --> 00:04:47.509

Matt Austin: And here I go, just 2 steps behind.

51

00:04:54.660 --> 00:04:56.800

Alexandra Campione: So, as everyone might remember.

52

00:04:57.506 --> 00:05:02.769

Alexandra Campione: We started the validation process of there. Back

53

00:05:03.180 --> 00:05:29.559

Alexandra Campione: think it was about a year ago now. They were interested in receiving safety grades as sort of a way to summarize everything. And we were able to score 21 out of 30 Mts. Located in the Us. We had 9 A's 9 B's and 3 C's, and you can

see this is actually a pretty well performing cohort of hospitals. Compared to the national distribution.

54

00:05:29.941 --> 00:05:57.819

Alexandra Campione: We work with them with Dha directly to collect the psi and hack data because their patient population is restricted to active service members and their families. So, as you can imagine, there's not very much data on those 65 years and older. So there were. There is no Cms data for them. And we had to obtain the data directly from them for patients 18 years or older.

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00:05:58.911 --> 00:06:03.719

Alexandra Campione: Perhaps the biggest accomplishment here was

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00:06:04.180 --> 00:06:33.080

Alexandra Campione: actually cleaning up their hai data so previously. And to dhs surprise, they were not previously tracking Mercen and SSI Colon. At a lot of facilities. So they actually they were not reporting plans in place. For surgical site infections after Colon surgery, or Merca. They were actually tracking it separate, and it was not streamlined. So they had to go back and clean up that

57

00:06:33.080 --> 00:06:44.928

Alexandra Campione: data, and we are able to get to a point where we felt confident in their data. By this January. So that was very exciting. And on the right you can see how they performed

58

00:06:45.240 --> 00:07:12.619

Alexandra Campione: on average, and all of the measures included in the safety grade. You can see that Cpo, and safe practice, too. That's the safety culture of safety survey they were are still lacking in. And they're well aware and working on that this year. As well as the infection measures, and psi. 4. Where they perform really well, is the total nursing care hours per patient day, and their Hcp. Scores.

59

00:07:16.260 --> 00:07:23.089

Matt Austin: So with that, we just wanted to provide an update to you all on that progress, we're happy to

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00:07:23.550 --> 00:07:29.109

Matt Austin: entertain any questions, thoughts, reactions that the the panel might have.

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00:07:32.200 --> 00:07:37.869

Peter Pronovost: Yeah, just more of a curiosity. Their hcup scores are like material better than than others, I

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00:07:38.020 --> 00:07:45.269

Peter Pronovost: I mean, if somewhat surprised in their the infection rates are materially worse. Did they have any insights about? Why, that is.

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00:07:47.070 --> 00:07:59.990

Alexandra Campione: So we have not actually talked to them about their Hcap scores yet. I think the first, especially for SSI Colin and Marsa. It wasn't much of surprise, since it wasn't being tracked previously.

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00:08:00.710 --> 00:08:04.179

Alexandra Campione: but now they're going to be able to track it. So.

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00:08:05.090 --> 00:08:08.609

Peter Pronovost: Yeah. And maybe it's just all driven by their nursing hours per patient day.

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00:08:10.420 --> 00:08:31.829

Missy Danforth (she/her): Yeah. So, Peter, one note I do. Wanna make is that we did get their haps data from Cms. So I'm not sure everyone's aware, but they actually voluntarily report their data into Cms. And so any adjustments done for the other general acute care hospitals like for age are also done to their scores as well.

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00:08:32.059 --> 00:08:37.129

Missy Danforth (she/her): So these are not directly reported from Dha or the Mts. Delete Frog.

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00:08:37.631 --> 00:08:43.040

Missy Danforth (she/her): This is available on the Cms. Care. Compare Provider Catalogs.

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00:08:43.549 --> 00:08:45.720

Missy Danforth (she/her): It's creating.

70

00:08:47.030 --> 00:08:48.630

Matt Austin: Yeah, Patrick, when we spoke.

71

00:08:48.925 --> 00:08:52.759

Missy Danforth (she/her): Pretty obvious data, but we don't have an explanation for the corps.

72

00:08:55.900 --> 00:09:03.510

arnold milstein: Missy. Okay, so am I right that what that means is to the degree that younger people, because they tend to recover more fully.

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00:09:03.730 --> 00:09:12.589

arnold milstein: You know. Might, you know, in retrospect, you know, report a more favorable cap score that's already been adjusted, for that is the younger age population.

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00:09:13.050 --> 00:09:14.550

Missy Danforth (she/her): That's correct. Everybody.

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00:09:14.760 --> 00:09:16.510

Missy Danforth (she/her): Yes, yes, that's correct.

76

00:09:16.850 --> 00:09:17.330

arnold milstein: Thank you.

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00:09:19.870 --> 00:09:38.020

Arjun Srinivasan, CDC (he/him): It's a really interesting point you're raising Peter and I, and I don't know I don't. We don't know it. I don't know enough about this population. I don't know that we've looked at this specifically, and then it it not seems, I know. But you know, I assume that the overwhelming majority of these patients are post trauma patients.

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00:09:38.070 --> 00:09:50.550

Arjun Srinivasan, CDC (he/him): which may have some very different risk factors for some of these Ss. Or some of these hais compared to what we would see in a in a typical hospital population. I don't know. It's hard to know how

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00:09:51.220 --> 00:09:53.990

Arjun Srinivasan, CDC (he/him): how that might be impacting some of this.

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00:09:57.550 --> 00:10:02.419

Matt Austin: Yeah, and talking with Patrick in the last hour, he had a couple of

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00:10:02.510 --> 00:10:06.205

Matt Austin: yeah, he had a sort of a similar question Arjen about, you know.

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00:10:07.160 --> 00:10:14.549

Matt Austin: service members that were injured. Right? Are they being treated in these military facilities here in the Us. Are they being treated abroad?

83

00:10:15.056 --> 00:10:22.099

Matt Austin: That could obviously impact the Hci rates. He also wondered about for the Hcap scores if there was a little bit of a

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00:10:22.830 --> 00:10:34.020

Matt Austin: an effect of that. Your customer is part of an organization that is also providing you the care right? And do you get sort of a just, a higher level of sort of buy in

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00:10:34.367 --> 00:10:38.760

Matt Austin: in that scenario. So there's a little bit of a model issue there.

86

00:10:39.320 --> 00:10:57.486

Arjun Srinivasan, CDC (he/him): Yeah. And some of this is interesting. It's also it. It's based on expectations, right? The the average enlisted person might have a very different expectation of what communication looks like based on what they're how they're used to being communicated with it. So.

87

00:10:58.530 --> 00:10:59.077

Sara Singer: Sure it did.

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00:10:59.260 --> 00:11:08.288

arnold milstein: I? Yeah, I I think it does. I know that. You know, in the commercial sector one of the interesting findings from efforts to connect

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00:11:08.870 --> 00:11:17.240

arnold milstein: connect, you know, working class people such as people in the You know Walmart or Lows employee workforce

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00:11:17.490 --> 00:11:20.800

arnold milstein: is that when they are, you know, hooked up with

91

00:11:20.840 --> 00:11:26.700

arnold milstein: the quality of doctors that you know, that provide care in a so-called center of excellence

92

00:11:26.720 --> 00:11:29.219

arnold milstein: versus, you know, routine community care.

93

00:11:29.310 --> 00:11:35.450

arnold milstein: They are deeply impressed. They've never, you know, been treated that well before.

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00:11:35.480 --> 00:11:44.010

arnold milstein: And and and typically in local communities, particularly in practices that specialize in lower socioeconomic status patients.

95

00:11:44.060 --> 00:11:48.240

arnold milstein: you know, they they, the level of of service that

96

00:11:48.280 --> 00:11:50.470

arnold milstein: the experience, you know, tends to be

97

00:11:50.610 --> 00:11:54.389

arnold milstein: not not great. So they noticed the difference when

98

00:11:54.490 --> 00:11:57.709

arnold milstein: when you know when the people of Lows did.

99

00:11:57.950 --> 00:12:08.620

arnold milstein: People, I'll call particularly, you know, low status. Enlisted people, you know, would would dramatic would notice a dramatic difference in even if the nursing performance were average.

100

00:12:15.910 --> 00:12:30.320

Matt Austin: So I think we have maybe more questions and answers for you all. But did want to share an update on the progress that's been made, and I think hats off to Alex for really digging in with them to to get the data that

101

00:12:31.040 --> 00:12:40.630

Matt Austin: was needed to to do this, and you know, hats off to the Dha. As well for their desire and commitment to wanting to do this too. Right. They've been

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00:12:41.040 --> 00:12:43.960

Matt Austin: active and wanting to have this happen. So.

103

00:12:44.310 --> 00:12:56.909

Sara Singer: Yeah, I would. I would actually comment. I mean, I think I think that's the best part about what I'm seeing here is that it's actually, we've actually put the data forward. And now we have some information. It will.

104

00:12:56.910 --> 00:13:20.110

Sara Singer: W. What will be interesting to see is the next time we're able to do this measurement if relative, if so these relative scores begin to change, especially around the infection rates, because this is the first time they're seeing it if they are able to use it, and probably that into some some action that that moves the needle on some of these things that would be really the win.

105

00:13:24.670 --> 00:13:25.840

Doris: I don't have too much

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00:13:25.980 --> 00:13:30.720

Doris: quick question. You guys already have Va. Hospitals as well as part of leaf frog.

107

00:13:34.250 --> 00:13:37.131

Matt Austin: Was that the Va. Hospitals was that? Go ahead, Miss.

108

00:13:38.170 --> 00:13:50.699

Missy Danforth (she/her): Yeah. So we do not have any of the veterans administration hospitals. But we are going to be using this announcement as a entree to restart this conversations. So that's a great question.

109

00:13:54.880 --> 00:14:05.950

Matt Austin: Yeah, I think that's sort of our biggest gap that remains right is the the Va hospitals. We also aren't able to grade hospitals in any of the Us. Territories.

110

00:14:06.614 --> 00:14:09.290

Matt Austin: You know, Puerto Rico, etc. Because

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00:14:09.650 --> 00:14:13.639

Matt Austin: the the reporting, the the public reporting for those is different. But

112

00:14:15.310 --> 00:14:17.529

Matt Austin: those sort of are the remaining gaps

113

00:14:19.100 --> 00:14:20.610

Matt Austin: in a systematic way.

114

00:14:22.980 --> 00:14:29.220

Matt Austin: Alright. So we'll keep you engaged and posted on that. We just wanted to provide you with that update

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00:14:29.584 --> 00:14:35.940

Matt Austin: what we want to spend up a majority of the time talking about is actually some proposed changes to

116

00:14:35.970 --> 00:14:40.769

Matt Austin: the the model that we'd like to use for imputing scores for hospitals.

117

00:14:41.627 --> 00:14:44.112

Matt Austin: So just to remind everyone

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00:14:44.660 --> 00:15:00.340

Matt Austin: For since really the the kickoff of the Leapfrog Hospital Survey leapfrog was using the American Hospital Association Survey as a primary secondary data source. I can say, a primary secondary. The key secondary data source

119

00:15:00.944 --> 00:15:08.410

Matt Austin: and in 2021 the American Hospital Association made the decision not to renew license for leapfrog

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00:15:09.053 --> 00:15:20.499

Matt Austin: leapfrog was also seeking ways to grade additional hospitals, and so working with some of you, I think, in particular, Patrick Sarah, colleagues at Mathematica.

121

00:15:20.918 --> 00:15:26.361

Matt Austin: We looked at different imputation approaches and came up with a model that seemed

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00:15:26.820 --> 00:15:30.979

Matt Austin: you know, feasible, relevant, and appropriate

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00:15:31.357 --> 00:15:39.990

Matt Austin: but we've run into a couple of challenges that we think we need to maybe make some adjustments, for so one is that the imputed scores have crept up

124

00:15:40.657 --> 00:16:01.930

Matt Austin: over time, which has made imputation a more favorable choice for a fair number of hospitals, and has de incentivized them, actually reporting to the League Frog Hospital Survey. So in some ways we've de incentivized transparency because they've decided that the imputed score is a more favorable path for them.

125

00:16:02.940 --> 00:16:07.407

Matt Austin: What we're also running into is we especially this year. We are

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00:16:07.950 --> 00:16:15.999

Matt Austin: redefining and expandingly from Bcma standard. So in some ways. So let me take half a step back

127

00:16:16.650 --> 00:16:22.289

Matt Austin: our step. One of the imputation model is to look to a hospital's historical data.

128

00:16:22.709 --> 00:16:32.009

Matt Austin: So if a hospital didn't respond to the Leak Frog Hospital Survey this year, we would look back in previous safety grades to see what data were available from those

129

00:16:32.884 --> 00:16:44.510

Matt Austin: and the problem we're going to run into this year is for the Barcode Medication Administration Standard. The frog is going to be expanding the scope of that. So in some ways the standard has changed.

130

00:16:44.983 --> 00:16:52.529

Matt Austin: We also have some concerns about whether there's some drift back or fall back in hospitals meeting the hand hygiene standard

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00:16:53.313 --> 00:16:54.419

Matt Austin: and so

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00:16:54.680 --> 00:17:04.330

Matt Austin: that has sort of put us at a point where we're thinking maybe it's time to refine the imputation model and maybe change up how we're doing things slightly.

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00:17:05.589 --> 00:17:27.030

Matt Austin: The institution model really applies to 4 measures that are part of the safety grade. So those highlighted in green are the 4 measures. It's the use of computerized physician order, entry, Barcode Medication Administration. The use of intensivist in the Icu and Hygiene. We included the standard weights. Just to give you a sense of how much weight are put on those 4 measures.

134

00:17:28.806 --> 00:17:32.373

Matt Austin: So as we've sort of talked about at this point.

135

00:17:33.770 --> 00:17:39.239

Matt Austin: step. One of the imputation model is that the hospitals assigned their most recent

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00:17:39.835 --> 00:17:56.050

Matt Austin: score from the past 4 rounds of the safety grade. So, for example, in the spring, 2024 round, we looked back and saw if I hospital had a score for that measure in fall 2023, spring 2023, fall 22 or spring 22. And if they did, we used that value

137

00:17:56.885 --> 00:18:01.120

Matt Austin: and that actually covers the 3 most recently frog hospital surveys.

138

00:18:01.620 --> 00:18:07.720

Matt Austin: If we didn't have a recent score from those past 4 rounds. Then we moved on to step 2,

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00:18:07.740 --> 00:18:10.820

Matt Austin: which is where we put hospitals into cohorts.

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00:18:11.040 --> 00:18:19.190

Matt Austin: Right? I mean, define cohorts based on number of beds, teaching status, urban rural status, safety net status

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00:18:19.550 --> 00:18:27.630

Matt Austin: and we really looked at 2 calculations and gave them the lower of 2

scores. One was the mean of the cohorts current and recent scores.

142

00:18:27.690 --> 00:18:35.210

Matt Austin: or the mean of the cohort scores from each hospital's first time reporting on the current standard.

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00:18:35.480 --> 00:18:38.080

Matt Austin: And that's really based on the idea that

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00:18:38.100 --> 00:18:41.600

Matt Austin: hospitals, when they first start reporting to the survey.

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00:18:41.650 --> 00:18:46.749

Matt Austin: tend to have lower performance than hospitals that have been reporting for a period of time.

146

00:18:48.280 --> 00:18:50.900

Matt Austin: So that's the current model that we're using

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00:18:53.480 --> 00:19:05.710

Matt Austin: what I'm going to. So it's quickly touched on this. We've defined cohorts based on 4 factors, urban role status, safety net status number of beds and teaching status.

148

00:19:06.280 --> 00:19:19.531

Matt Austin: Where we do have a difference is for Icu physician staffing. We actually use the Cms cost report as the secondary data source, because that actually tells us whether the hospital operates any medical, surgical or

149

00:19:20.030 --> 00:19:22.240

Matt Austin: pediatric icu beds?

150

00:19:22.808 --> 00:19:32.130

Matt Austin: And if so, then we equate that to them, saying they operate icu beds, but have given us no information about their staffing structure.

151

00:19:33.340 --> 00:19:36.010

Matt Austin: So let me jump ahead, because I think

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00:19:36.780 --> 00:19:42.209

Matt Austin: let me go to 2 slides, because I think these 2 are important. So, jumping ahead to

153

00:19:43.390 --> 00:19:48.459

Matt Austin: sort of current trends in hospitals, reporting to the Leapfrog Hospital survey.

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00:19:48.650 --> 00:19:52.839

Matt Austin: so of the hospitals that received a hospital safety grade.

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00:19:53.070 --> 00:20:09.960

Matt Austin: We've seen hospital performance or participation. Excuse me in the leapfrog hospital survey increase from 31% to 61%. And so the bars in green show the upward trend in hospitals participating in the leap Frog Hospital survey.

156

00:20:10.000 --> 00:20:13.660

Matt Austin: We did see a little bit of a drop off in 2023.

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00:20:14.070 --> 00:20:23.370

Matt Austin: The grade bars represent the hospitals that would have scores imputed, and so one would expect those to sort of move in inverse directions.

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00:20:25.960 --> 00:20:31.869

Matt Austin: So what we are going to propose to you all for a refinement to the imputation model

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00:20:32.720 --> 00:20:35.940

Matt Austin: is one is to retire Step One.

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00:20:36.030 --> 00:20:41.180

Matt Austin: which is where we used the recent historical data from hospitals

161

00:20:41.350 --> 00:20:43.160

Matt Austin: to calculate a score.

162

00:20:43.710 --> 00:20:47.019

Matt Austin: So that would be we would do away with step one

163

00:20:47.040 --> 00:21:02.229

Matt Austin: and within step 2, we would specifically focus on hospitals, and how they did on their first year of reporting on the current standard. So we would still group the hospitals into the cohorts. I think we have 12 cohorts

164

00:21:02.370 --> 00:21:08.000

Matt Austin: of hospitals, and we would assign them the score based on the first year reporting.

165

00:21:08.230 --> 00:21:13.529

Matt Austin: and we would continue to use the Cms cost report for the Icu physician staff.

166

00:21:13.830 --> 00:21:19.490

Matt Austin: So the real change here is the elimination or the retirement of step one.

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00:21:22.320 --> 00:21:25.769

Matt Austin: Let me pause there to see if there's any questions first.

168

00:21:26.780 --> 00:21:29.250

Matt Austin: and then let's have a conversation about

169

00:21:30.040 --> 00:21:32.910

Matt Austin: feedback guidance, suggestions.

170

00:21:36.410 --> 00:21:38.499

Peter Pronovost: Matt, I just one

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00:21:38.710 --> 00:21:57.600

Peter Pronovost: comment. It's amazing how quickly markets learn. I was on a call with a bunch of Cmos, and I don't. I doubt they saw this data, but that was the kind of the message. Oh, you do better if you don't, you know, fill out the survey, and it may have been anecdotal for them, but it was. It was clearly discussion amongst the Cmo group.

172

00:22:00.760 --> 00:22:04.589

Matt Austin: So you were saying in terms of the increased participation in the survey, Peter.

173

00:22:04.790 --> 00:22:12.910

Peter Pronovost: No, I think that, in other words, they, with the point that you said about the trends through imputation like the market they were already saying, Don't complete the survey. You do better.

174

00:22:13.413 --> 00:22:14.420

Matt Austin: Okay, yeah.

175

00:22:15.670 --> 00:22:19.270

Matt Austin: that you you would get you would do better by using the imputed score. So.

176

00:22:19.270 --> 00:22:24.929

Peter Pronovost: Correct, and they didn't have any data. It was just like more their hunch or their gut. But it was like

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00:22:25.370 --> 00:22:27.120

Peter Pronovost: a topic of discussion.

178

00:22:29.952 --> 00:22:36.459

Sara Singer: I know you said that. If you rely on the first round of reporting that the scores are

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00:22:36.500 --> 00:22:41.430

Sara Singer: are typically lower. But are they sufficiently lower?

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00:22:42.114 --> 00:22:52.639

Sara Singer: That we think it would create an incentive for them not to go to the hassle of doing the survey? And what about the Cms. Cost report for the Icu staffing. Is it also typically lower.

181

00:22:55.130 --> 00:22:55.860

Matt Austin: So let me.

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00:22:55.860 --> 00:22:56.500

Missy Danforth (she/her): Visiting.

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00:22:57.020 --> 00:22:57.880

Matt Austin: Kevin. Listen.

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00:22:58.700 --> 00:23:01.839

Missy Danforth (she/her): Yes, they're they are significantly lower.

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00:23:02.000 --> 00:23:03.760

Missy Danforth (she/her): and we have seen

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00:23:04.470 --> 00:23:06.939

Missy Danforth (she/her): some of that will debate, because

187

00:23:07.160 --> 00:23:08.629

Missy Danforth (she/her): for the most part, I think

188

00:23:09.350 --> 00:23:12.100

Missy Danforth (she/her): the majority of hospitals do want their current

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00:23:12.650 --> 00:23:18.149

Missy Danforth (she/her): performance reflected, unless it's bad, in which case the imputed scores will be better.

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00:23:18.190 --> 00:23:22.660

Missy Danforth (she/her): But I do think they are sufficiently low enough hopefully to be motivating.

191

00:23:25.390 --> 00:23:30.979

Matt Austin: And when I've brought up brought up on the screen in which I skipped over in the presentation because I wasn't sure

192

00:23:31.230 --> 00:23:34.960

Matt Austin: sort of talk about it is but to Sarah's question, I think.

193

00:23:35.750 --> 00:23:41.810

Matt Austin: does this answer your question, Sarah? In terms of these are the average imputed scores for the 4 measures

194

00:23:41.920 --> 00:23:44.290

Matt Austin: by the step one and step 2.

195

00:23:44.600 --> 00:23:46.529

Sara Singer: The 2 green bars at the bottom.

196

00:23:46.760 --> 00:23:47.790

Matt Austin: Correct.

197

00:23:48.500 --> 00:23:52.539

Matt Austin: And then what we've put up at the top in the white is

198

00:23:52.570 --> 00:24:01.949

Matt Austin: for hospitals that complete the survey. These are their performance categories and the points that they get assigned based on their performance. Category.

199

00:24:01.950 --> 00:24:03.270

Sara Singer: Oh, yeah. Okay.

200

00:24:04.540 --> 00:24:07.430

Matt Austin: So it's to give some context between those that

201

00:24:07.520 --> 00:24:10.700

Matt Austin: report versus those that are getting scores imputed.

202

00:24:11.240 --> 00:24:11.850

Sara Singer: Okay.

203

00:24:15.720 --> 00:24:17.750

Sara Singer: yeah, I mean, it looks like it would

204

00:24:19.090 --> 00:24:20.650

Sara Singer: be motivating.

205

00:24:27.790 --> 00:24:29.439

Matt Austin: So what other

206

00:24:29.880 --> 00:24:35.360

Matt Austin: reactions do folks have to this idea of retiring? Step one

207

00:24:35.900 --> 00:24:37.530

Matt Austin: and simply using

208

00:24:37.680 --> 00:24:43.289

Matt Austin: so basically retiring, we're gonna use your hospitals, historical data.

209

00:24:43.670 --> 00:24:48.590

Matt Austin: And we would basically move solely to a model of putting hospitals into cohorts

210

00:24:49.070 --> 00:24:53.780

Matt Austin: and using the first time reporting scores from that cohort.

211

00:24:57.900 --> 00:25:04.939

Matt Austin: Let me show one more slide just to maybe spur some conversation which is, here are the 12 cohorts

212

00:25:05.160 --> 00:25:08.379

Matt Austin: once again, by the sort of 4 factors.

213

00:25:08.792 --> 00:25:13.140

Matt Austin: And then what the means are for each of those 12 covid.

214

00:25:14.220 --> 00:25:21.270

Sara Singer: Yeah, I mean, I guess you can assume that the Downside is that if there is a high performing organization that doesn't happen to

215

00:25:22.033 --> 00:25:29.696

Sara Singer: you know, want to continue doing the the leapfrog survey. They will be penalized because they'll be lumped together with

216

00:25:30.160 --> 00:25:35.309

Sara Singer: cohort that may not be performing as well as they are. But I think that's the that's

217

00:25:35.730 --> 00:25:39.049

Sara Singer: that's sort of what we're trying to accomplish.

218

00:25:42.710 --> 00:25:50.180

Missy Danforth (she/her): Yeah. And, Sarah, if I can just make one other note, this is Missy is, we do see, slippage and performance on these measures from year to year.

219

00:25:50.440 --> 00:25:56.309

Missy Danforth (she/her): I mean particularly with something like hand hygiene, I think we found like if we talked to them in January, February, or March

220

00:25:56.510 --> 00:25:59.169

Missy Danforth (she/her): versus, you know, busier times of the year.

221

00:25:59.530 --> 00:26:08.479

Missy Danforth (she/her): They may not be doing as well, certainly, as Matt described with Vcma. The standard is changing so much we just can't pull for those old Vcma scores

222

00:26:09.007 --> 00:26:19.729

Missy Danforth (she/her): and with things like nurse staffing and workforce, I'm sorry not our staffing. Cpu, the CPU developers. I know David's not on the call today, but they make content changes to that test every year.

223

00:26:19.920 --> 00:26:23.019

Missy Danforth (she/her): So I also think that it protects us a little bit.

224

00:26:23.160 --> 00:26:25.979

Missy Danforth (she/her): If a hospital's starting to have a down slide.

225

00:26:26.050 --> 00:26:29.610

Missy Danforth (she/her): and we're awarding them those 100 points from previous surveys.

226

00:26:29.630 --> 00:26:33.239

Missy Danforth (she/her): I think at a point it could start to our own trust and great overall.

227

00:26:35.687 --> 00:26:56.249

Sara Singer: I, I'm wondering. So we've taken like, one, option would have been to just eliminate, the most recent score and to use step 2 as it was. If you did that do. I can't remember if the the 2 bars in green do you have a bar? That also shows, if you allow them.

228

00:26:56.360 --> 00:27:03.060

Sara Singer: if you assign them, mean of the cohort. Not just the most recent the the first round of

229

00:27:03.390 --> 00:27:09.039

Sara Singer: of reporting for that cohort is it? Is it also penalizing? But maybe not so drastically so.

230

00:27:09.940 --> 00:27:14.899

Matt Austin: So what I didn't do a great job of explaining Sarah, is the

231

00:27:15.030 --> 00:27:17.760

Matt Austin: current. Methodology is to take

232

00:27:17.770 --> 00:27:22.120

Matt Austin: the lower of 2 scores for step 2,

233

00:27:23.091 --> 00:27:27.610

Matt Austin: which is the recent scores, and the first time reporting.

234

00:27:27.610 --> 00:27:27.990

Sara Singer: I see.

235

00:27:27.990 --> 00:27:35.404

Matt Austin: And so what's in the so what's in the Green Bar would be reflective of that lower which, if that most likely would be the.

236

00:27:35.690 --> 00:27:54.770

Sara Singer: So so the step 2 is, I mean the other advantages. It's it's sort of already socialized with the group. They, you know, th there's some acknowledgement of its validity. So what we're doing now is is taking away the one that hospitals seem to be gaming.

237

00:28:01.590 --> 00:28:04.419

Matt Austin: That would be one. Yes, interpretation of that

238

00:28:07.560 --> 00:28:09.310

Matt Austin: barge in your hands up, do you? Wanna.

239

00:28:09.640 --> 00:28:14.860

Arjun Srinivasan, CDC (he/him): I'm wondering if you all have any experience with hospitals that

240

00:28:15.560 --> 00:28:28.100

Arjun Srinivasan, CDC (he/him): gone back and forth like completed the survey at some not completed at some point it, I mean. They may not be very many, but I'm wondering if you have any anecd data

241

00:28:28.250 --> 00:28:31.170

Arjun Srinivasan, CDC (he/him): on. You know where those hospitals

242

00:28:31.950 --> 00:28:39.560

Arjun Srinivasan, CDC (he/him): where they tend to fall because one of the questions here is like, if the I mean if there is

243

00:28:39.740 --> 00:28:56.300

Arjun Srinivasan, CDC (he/him): not gonna say, a punitive intent. But if there is a kind of motivating intent here to say, Look, we, we think you need to fill out the survey, because without the survey, we really don't have very accurate data. I mean, the bias is that I'm I might look at this and say, Well, if I'm if I'm in the bottom half.

244

00:28:56.510 --> 00:29:00.509

Arjun Srinivasan, CDC (he/him): I'd rather not fill out the survey, because that'll lift me up to the mean

245

00:29:01.082 --> 00:29:04.520

Arjun Srinivasan, CDC (he/him): so would be better for me to just not do it.

246

00:29:04.630 --> 00:29:10.010

Arjun Srinivasan, CDC (he/him): So the question then becomes is like, do you say? Well, you know, if we don't have your data.

247

00:29:10.070 --> 00:29:13.430

Arjun Srinivasan, CDC (he/him): we have to assign you even lower, because

248

00:29:13.670 --> 00:29:27.780

Arjun Srinivasan, CDC (he/him): we're trying to push people to fill out the certain again. I don't know. This is a this is cut mid a little controversial, maybe. But do you say, look, if you don't fill out the survey. I'm sorry, but we have to assign you to the bottom portal because

249

00:29:28.000 --> 00:29:39.529

Arjun Srinivasan, CDC (he/him): we're now making. Maybe we make the assumption that the reason you're not filling out the survey is because you are in the bottom part, and you want that boost and score to get you to the meeting. I don't know.

250

00:29:42.210 --> 00:29:42.720

Missy Danforth (she/her): Urgent.

251

00:29:42.720 --> 00:29:43.050

Matt Austin: There's.

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00:29:43.050 --> 00:29:46.799

Missy Danforth (she/her): Really great question. I think, yeah, I think to date, we've

253

00:29:46.840 --> 00:29:52.870

Missy Danforth (she/her): we've less focused on the penalty portion of it and more focused on really not wanting to potentially

254

00:29:52.960 --> 00:30:01.489

Missy Danforth (she/her): assure patients they're going to a safe place that may have had slippage and if you've been following the news of steward health system.

255

00:30:01.860 --> 00:30:06.330

Missy Danforth (she/her): That would be an example of an area where they have historically done. The survey

256

00:30:06.420 --> 00:30:10.350

Missy Danforth (she/her): didn't do the survey in 2023, for obvious reasons, you know now.

257

00:30:10.720 --> 00:30:14.160

Missy Danforth (she/her): had those scores imputed due to this imputation methodology.

258

00:30:14.410 --> 00:30:18.279

Missy Danforth (she/her): and obviously the backlash in those communities from those patients is.

259

00:30:18.290 --> 00:30:22.909

Missy Danforth (she/her): well, how can this be? Right? So I think that's been the focus less so than

260

00:30:23.200 --> 00:30:27.709

Missy Danforth (she/her): penalty, or, frankly, even motivating people to do the survey. I think it's that

261

00:30:27.730 --> 00:30:31.239

Missy Danforth (she/her): at a minimum. We don't want to report them with the highest score

262

00:30:31.650 --> 00:30:33.660

Missy Danforth (she/her): if we don't have any information.

263

00:30:33.700 --> 00:30:37.939

Missy Danforth (she/her): and if we have empirical information that there is slippage here every year

264

00:30:37.980 --> 00:30:39.070

Missy Danforth (she/her): which we do see.

265

00:30:41.590 --> 00:30:43.680

Peter Pronovost: Missy, though to Arsen's Point.

266

00:30:43.790 --> 00:30:45.950

Peter Pronovost: I wonder, in our model

267

00:30:46.290 --> 00:30:47.834

Peter Pronovost: do we include?

268

00:30:48.610 --> 00:30:55.229

Peter Pronovost: that if they're in the lowest quartile that they stay in that, you know. I mean at least to reduce the gaming. So it does. You know we may not

269

00:30:55.850 --> 00:31:03.869

Peter Pronovost: put everybody in that lowest quarter, but we, if your previous survey you were low. You don't get an elevation, you know, through this invitation.

270

00:31:11.840 --> 00:31:16.050

Matt Austin: Other suggestions, recommendations.

271

00:31:17.990 --> 00:31:20.654

Kathy McDonald: Looking like at the safety net results. I just

272

00:31:21.030 --> 00:31:23.000

Kathy McDonald: have. We thought, through

273

00:31:23.260 --> 00:31:27.680

Kathy McDonald: any of the implications for them I always worry most about.

274

00:31:29.430 --> 00:31:30.509

Kathy McDonald: You know those

275

00:31:32.670 --> 00:31:35.330

Kathy McDonald: those hospitals, and making sure that

276

00:31:35.570 --> 00:31:37.899

Kathy McDonald: they don't end up in with

277

00:31:39.190 --> 00:31:43.770

Kathy McDonald: with a something we haven't thought of an unintended consequence there.

278

00:31:44.160 --> 00:31:46.779

Kathy McDonald: they're already carrying so much burden. So

279

00:31:49.280 --> 00:31:51.830

Kathy McDonald: I haven't thought through this enough to be able to.

280

00:31:53.705 --> 00:31:54.080

Kathy McDonald: Yeah.

281

00:31:54.080 --> 00:31:54.609

Matt Austin: Yeah, I mean, like.

282

00:31:54.610 --> 00:31:56.240

Kathy McDonald: But I wanted to put it out there.

283

00:31:57.190 --> 00:31:59.788

Matt Austin: Yeah, I think where I struggle is.

284

00:32:00.750 --> 00:32:05.123

Matt Austin: what is a true? Wh, where is there a true difference in performance?

285

00:32:06.620 --> 00:32:08.730

Matt Austin: Right? And where is there?

286

00:32:09.218 --> 00:32:13.000

Matt Austin: Some sort of bias in the measurement against them? Right.

287

00:32:13.429 --> 00:32:13.859

Kathy McDonald: Right.

288

00:32:13.860 --> 00:32:17.306

Matt Austin: I think we, I think we wanna minimize the second. And

289

00:32:17.960 --> 00:32:26.080

Matt Austin: right, if there's 2 differences, there's 2 differences. And there, there are structural issues that we need to address there, Kathy, for sure, right? But if

290

00:32:26.550 --> 00:32:29.409

Matt Austin: you know, I think some of the recent research is showing that

291

00:32:29.710 --> 00:32:39.490

Matt Austin: patients of marginalized communities actually do tend to receive care at hospitals that have more patient hearts. Right? And that's just the unfortunate

292

00:32:39.830 --> 00:32:42.649

Matt Austin: reality of our current world and status.

293

00:32:43.820 --> 00:32:46.120

Peter Pronovost: You know the a comment.

294

00:32:46.750 --> 00:32:55.709

Peter Pronovost: yeah, and I'm happy to. We aren't. We won't solve it now. But I think how you message this change is going to be really critical, because I think it could

295

00:32:55.980 --> 00:32:59.369

Peter Pronovost: help, you know, enhance focus on safety or kind of

296

00:32:59.390 --> 00:33:13.200

Peter Pronovost: piss people off and like saying, you're not understanding. We just went through Covid. We don't have staffing. So you know, Missy, your point of all, I mean, like, you know, you know, the persistent. 25% of hospitalized patients are still harmed. The trends are going the wrong way.

297

00:33:13.410 --> 00:33:14.460

Peter Pronovost: and

298

00:33:15.960 --> 00:33:22.640

Peter Pronovost: Consumers have a right to know this. Without this we're miss, we risk misinforming them, and being very, you know, transparent about that risk.

299

00:33:25.000 --> 00:33:26.559

Missy Danforth (she/her): I think that's incredibly.

300

00:33:27.060 --> 00:33:27.270

Matt Austin: Right.

301

00:33:27.270 --> 00:33:28.700

Missy Danforth (she/her): Point, Peter, and well taken.

302

00:33:29.230 --> 00:33:48.000

Peter Pronovost: And I would probably miss it because this is gonna be, I mean the like E, even the discussion. I think it's could be misconstrued like maybe even, you know. Get your Matt, who or who whoever a couple of people, to share this reasoning with the Aj with Premier, with Vizient, you know, with the variety of

303

00:33:48.200 --> 00:33:51.239

Peter Pronovost: groups that might be using this so that you can you

304

00:33:51.490 --> 00:33:53.080

Peter Pronovost: manage that narrative?

305

00:33:55.260 --> 00:33:55.980

Peter Pronovost: Yep.

306

00:33:55.980 --> 00:33:57.230

Missy Danforth (she/her): That's a great idea.

307

00:33:57.600 --> 00:34:05.979

Missy Danforth (she/her): And can I ask just Peter, your opinion? And anyone on the panel is, we have a number of large house systems that have brought this issue to us as well.

308

00:34:06.360 --> 00:34:15.369

Missy Danforth (she/her): which is to say that you know we have a hundred participation in the surgery when we're doing well, and what we're doing not so well cause we want to both that trust in our communities.

309

00:34:15.790 --> 00:34:21.070

Missy Danforth (she/her): We really don't think it's fair that you're allowing hospitals, not reporting to get the highest scores.

310

00:34:21.100 --> 00:34:23.629

Missy Danforth (she/her): because we can't really trust that it's currently true.

311

00:34:23.670 --> 00:34:26.579

Missy Danforth (she/her): To what extent do you think health systems themselves.

312

00:34:26.860 --> 00:34:30.510

Missy Danforth (she/her): who have wanted to be partners at us if we make this change.

313

00:34:31.409 --> 00:34:34.420

Missy Danforth (she/her): could help deliver the message? Or do you think that would backfire.

314

00:34:38.090 --> 00:34:40.162

Peter Pronovost: No, I think

315

00:34:41.340 --> 00:34:46.739

Peter Pronovost: they absolutely could. And, missy, just like in, you know, my hospital colleague, friends.

316

00:34:46.889 --> 00:34:53.591

Peter Pronovost: There's clearly a culture who's committed to reporting and transparency want to do the right thing?

317

00:34:54.520 --> 00:35:06.370

Peter Pronovost: Some of them, though it may be like you can say, is legitimate. Now, a resource thing do they have time to complete the survey and and do without a doubt there are some of those, because hospitals.

318

00:35:06.440 --> 00:35:13.958

Peter Pronovost: quality budgets got crushed with the financial losses with Covid. There's others that who are

319

00:35:14.660 --> 00:35:16.519

Peter Pronovost: not so transparent.

320

00:35:17.190 --> 00:35:22.290

Peter Pronovost: If you highlight those, missy, though I would just make sure that that narrative

321

00:35:22.500 --> 00:35:42.899

Peter Pronovost: that the hospital is telling is consistent with other signals, meaning they make their data transparent, you know, like there's a number of other data points they can choose to be transparent or not, and cause otherwise someone could come back and say, Yeah, but then why aren't they making their? You know, these other data sets that they could make transparent, and they've elected not to.

322

00:35:44.620 --> 00:35:46.440

Missy Danforth (she/her): That's incredibly helpful. Thank you.

323

00:35:51.610 --> 00:35:54.940

Matt Austin: Any other feedback or suggestions on this?

324

00:35:57.450 --> 00:36:02.319

Matt Austin: If not, I think the next step is that leapfrog will

325

00:36:02.940 --> 00:36:08.643

Matt Austin: consider the feedback we've heard from all of you as well as from Patrick earlier today.

326

00:36:09.840 --> 00:36:16.680

Matt Austin: and if the frog decides, it will actually put out for public comment on this proposed change, and

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00:36:16.700 --> 00:36:26.929

Matt Austin: hospitals and other stakeholders would have the opportunity to to comment on this proposal. And Peter, thank you for that suggestion on how the messaging of that could be incredible!

328

00:36:26.930 --> 00:36:33.190

Peter Pronovost: Yeah, I'm happy to review that with you, Matt, or just go think through because it's really it is going to be really important of how people react to this.

329

00:36:33.590 --> 00:36:34.750

Matt Austin: Yeah, okay.

330

00:36:34.780 --> 00:36:35.900

Matt Austin: makes sense.

331

00:36:37.340 --> 00:36:43.550

Matt Austin: Okay? So our final agenda item is to talk about a couple of

332

00:36:44.080 --> 00:36:50.530

Matt Austin: measures that we would like to consider adding to the hospital safety grade.

333

00:36:51.970 --> 00:37:05.380

Matt Austin: so these are 2 new Ec Qms, which are electronic clinical quality measures. Which are measures that are actually derived directly from the Ehr data, as I understand them.

334

00:37:06.107 --> 00:37:13.880

Matt Austin: There's one focused on severe hyperglycemia and another measure focused on severe hypoglycemia.

335

00:37:14.980 --> 00:37:19.989

Matt Austin: Both of these measures are currently being collected by Cms

336

00:37:20.468 --> 00:37:24.739

Matt Austin: and the public reporting of them will start next year in 2025.

337

00:37:25.595 --> 00:37:30.610

Matt Austin: I've included on the slides the numerator and definition, denominator definitions.

338

00:37:31.172 --> 00:37:34.999

Matt Austin: So the for the first one, the severe hyper glycaemia

339

00:37:35.554 --> 00:37:37.156

Matt Austin: is focusing on

340

00:37:38.290 --> 00:37:45.480

Matt Austin: sorry. That was a typo that should say, hyper ergly semia as an outcome in the hospital inpatient setting.

341

00:37:46.029 --> 00:37:50.940

Matt Austin: And this looks at the basically the percentage of inpatient days.

342

00:37:51.443 --> 00:37:56.819

Matt Austin: For patients 18 years and older, for which they had a hyperglycemic event.

343

00:37:57.454 --> 00:38:04.949

Matt Austin: And that event is defined as a day with one blood Google's value greater than 300 milligrams per deciliter.

344

00:38:05.030 --> 00:38:08.010

Matt Austin: or a day where a test was not done.

345

00:38:08.983 --> 00:38:18.689

Matt Austin: But there was a was preceded by 2 consecutive days, where at least one of the glucose values, and one of those 2 days was above or at 200.

346

00:38:18.900 --> 00:38:25.269

Matt Austin: So it would be looking at the percentage of days in which the patient had a hyper glycaemic event.

347

00:38:28.177 --> 00:38:32.590

Matt Austin: So that's one measure for consideration. The other one is severe hypoglycemia

348

00:38:33.440 --> 00:38:41.499

Matt Austin: and this focuses really on for patients that received a hypoglycemic medication

349

00:38:42.633 --> 00:38:45.780

Matt Austin: and whether they had a hypoglycemic event joining.

350

00:38:46.580 --> 00:38:51.430

Matt Austin: There's a definition within the numerator of what is a hypoglycemic event.

351

00:38:52.058 --> 00:38:56.940

Matt Austin: So that's a blood glue close less than 40 milligrams per just a liter

352

00:38:57.305 --> 00:39:03.349

Matt Austin: that they gave them a hypoglycemic medication within 24 h after the start of the event.

353

00:39:03.904 --> 00:39:15.640

Matt Austin: And there was no repeat test for glucose, with a result greater than 90 within 5 min, so that there was sort of a sustained level of hypoglycemia.

354

00:39:18.670 --> 00:39:23.689

Matt Austin: So I will pause there to see here reactions, thoughts.

355

00:39:24.490 --> 00:39:32.220

Matt Austin: Doris, if you have any additional information that you'd like to share, I think, is notable or relevant, would love to hear that as well.

356

00:39:33.640 --> 00:39:42.399

Doris: Sure, I think it's this goes through a period of voluntary reporting. So I'm not sure how much data will be available over what time period. I don't remember all the details of the reporting requirements.

357

00:39:44.400 --> 00:39:46.669

Matt Austin: So your understanding is, the current

358

00:39:46.720 --> 00:39:50.349

Matt Austin: situation is, these would be voluntary measures for hospitals.

359

00:39:52.660 --> 00:40:01.269

Doris: Yeah, I think that they can, if I remember correctly, and I could be totally wrong about this that they could select like from a list of Ecqms.

360

00:40:01.610 --> 00:40:02.520

Matt Austin: Okay.

361

00:40:02.520 --> 00:40:23.539

Doris: So I think it depends on what program they're in because we don't. We started developing these, and then they got taken over by a different developer. So I've not followed their trajectory. But I, if I remember the pro program correctly it would be like you could select from a list. So I don't know how comprehensive reporting will be for your guys. Point of view in terms of you're gonna end up with polls and the data and all that, and invitation back on the table again.

362

00:40:23.680 --> 00:40:26.669

Doris: so, or or some other way of dealing with missing data.

363

00:40:27.310 --> 00:40:34.210

Missy Danforth (she/her): Okay, thank you, Doris. I will clarify that because our understanding in my previous conversations with Michelle

364

00:40:34.930 --> 00:40:39.550

Missy Danforth (she/her): Scriber from Cms is that these new patient safety focus Ecqms.

365

00:40:39.570 --> 00:40:41.240

Missy Danforth (she/her): There's like a kidney

366

00:40:41.350 --> 00:40:46.698

Missy Danforth (she/her): damage, one coming in falls and pressure ulcers will be required, not part of.

367

00:40:47.080 --> 00:40:55.110

Doris: I could be wrong. It's possible they yeah put them in like in the hack program or something, and then they'll be required so I can dig for you if you want to.

368

00:40:58.260 --> 00:41:03.520

arnold milstein: Yeah, this is Arnie. I just like to say that you know one of the you know one of the beauties of this direction

369

00:41:03.790 --> 00:41:15.550

arnold milstein: by, you know. May some courageous officials within Cms. Is it potentially as it expands, you know, begins to, you know, moderate the problem of hospitals, not reporting.

370

00:41:15.650 --> 00:41:19.389

arnold milstein: If Cms is, you know, is requiring these.

371

00:41:19.770 --> 00:41:24.129

arnold milstein: These direct from electronic health record the important measures.

372

00:41:24.300 --> 00:41:26.459

arnold milstein: And and they are.

373

00:41:26.800 --> 00:41:28.120

arnold milstein: they are reported.

374

00:41:28.190 --> 00:41:35.150

arnold milstein: And and the you know they are not optional, and reporting to Cms. And Cms. In turn, you know, shares them

375

00:41:35.240 --> 00:41:38.190

arnold milstein: for public use, such as by leapfrog.

376

00:41:39.670 --> 00:41:43.050

Matt Austin: And Arti, do you feel like the 2? Have face validity

377

00:41:43.380 --> 00:41:44.340

Matt Austin: as

378

00:41:44.760 --> 00:41:47.989

Matt Austin: patient safety harms that should be included?

379

00:41:49.080 --> 00:41:49.770

Matt Austin: Yes.

380

00:41:49.770 --> 00:41:57.359

arnold milstein: I mean, like, like all yeah, I mean, like all cliff edge, you know, definitions, you know, over time

381

00:41:57.870 --> 00:42:01.919

arnold milstein: these measures will will improve. But achieving consensus

382

00:42:02.080 --> 00:42:08.610

arnold milstein: is, you know, is is difficult. And so I think this is a this is a very reasonable start.

383

00:42:09.920 --> 00:42:17.719

Peter Pronovost: Yeah. And Matt, I would just add, from, I think they both have face validity. The harm from hypoglycemia is

384

00:42:17.950 --> 00:42:18.740

Peter Pronovost: app.

385

00:42:19.750 --> 00:42:27.050

Peter Pronovost: Probably a couple of log orders higher than hyperglycemia. So if I had to prioritize

386

00:42:27.621 --> 00:42:39.669

Peter Pronovost: just to not to frighten everybody, there's a couple of health systems who agree to look at how often hypoglycemia occurs. These are my bunch around 800 bit hospitals.

387

00:42:41.400 --> 00:42:46.670

Peter Pronovost: and I think they used 45 as a cutoff. So, but close enough

388

00:42:47.370 --> 00:42:50.130

Peter Pronovost: 50 events per week on average

389

00:42:51.170 --> 00:42:54.809

Peter Pronovost: week. Like, I mean, it is like mind boggling

390

00:42:57.620 --> 00:43:10.800

Peter Pronovost: just again. This, I think it's important for the context that you know. Really the only way health systems manage this because it's quite technical is if they have diabetic educators who guide the physician on how to dose these

391

00:43:10.990 --> 00:43:15.390

Peter Pronovost: drugs and or have staff like when people are Npo

392

00:43:15.973 --> 00:43:20.406

Peter Pronovost: that they adjust their insulin levels, which the you know

393

00:43:23.020 --> 00:43:38.349

Peter Pronovost: haven't done much. But hospitals cut those staff a lot with Covid. And so this problem has gotten significant significantly worse. Or it's a diabetic Np. Who, like, we know, would would work with physicians to to to score, and and you know, and that it's

394

00:43:39.460 --> 00:43:50.160

Peter Pronovost: my mind was blown away. I mean, I could tell you we I don't have any practical way that education is gonna work for this. So we're deploying. I have no financial relations to them. But

395

00:43:50.587 --> 00:44:00.089

Peter Pronovost: a company called Glide Tech. That audit has an AI model that automates the insulin dosing and has built in checks like, if your Npo. It automatically adjusts your

396

00:44:01.119 --> 00:44:06.410

Peter Pronovost: solutions. But my point in that is, if if we do this measure, it would be great to find out

397

00:44:06.510 --> 00:44:10.740

Peter Pronovost: what health systems are doing to perform well on it, cause it's it's it's

398

00:44:11.450 --> 00:44:17.859

Peter Pronovost: putting more staff in is going to be challenge for hospitals. But there are. There's a ton of technology that could help with this.

399

00:44:20.770 --> 00:44:26.579

Matt Austin: That's really helpful context, Peter. Thank you. Especially the the guidance around the hypoglycemia being

400

00:44:26.780 --> 00:44:31.220

Matt Austin: potentially a greater harm to patients on the hyper glycaemia.

401

00:44:31.220 --> 00:44:32.670

Peter Pronovost: The economic piece

402

00:44:32.880 --> 00:44:34.640

Peter Pronovost: in our health system.

403

00:44:35.590 --> 00:44:44.110

Peter Pronovost: One of the the hyper hyper didn't really seem to drive length of stay, or maybe had, like a point 3. These hypoglycemic events.

404

00:44:44.550 --> 00:44:45.890

Peter Pronovost: on average.

405

00:44:46.330 --> 00:44:52.489

Peter Pronovost: added 3 days to our hospital state, you know. Some went to the Icu, but it was a

406

00:44:53.520 --> 00:44:56.200

Peter Pronovost: about a 17 million dollars.

407

00:44:56.660 --> 00:44:59.490

Peter Pronovost: Excess days cost to our health system.

408

00:45:02.680 --> 00:45:07.930

arnold milstein: I certainly I very much agree with Peter's comment that that they

409

00:45:08.030 --> 00:45:12.109

arnold milstein: one would, if if optimally, management, have a lot more

410

00:45:12.360 --> 00:45:21.630

arnold milstein: clinical benefit than the other. But that being said, I think you know Cms. Was courageous to move forward with these 2. And and I think in some ways, you know.

411

00:45:21.730 --> 00:45:24.790

arnold milstein: you know, weak management of of

412

00:45:25.250 --> 00:45:26.870

arnold milstein: of hyperglycemia.

413

00:45:27.050 --> 00:45:34.670

arnold milstein: It it may be an indication of yeah, exactly. So. I think. My, my, I'm

414

00:45:34.740 --> 00:45:38.380

arnold milstein: quite supportive of us, you know, adding both both measures.

415

00:45:38.380 --> 00:45:44.229

Peter Pronovost: Yeah, I I I am, too. I was just given that for the context, because I I was pretty blown away about how common it was.

416

00:45:44.430 --> 00:45:48.279

Sara Singer: Is the management of hyper hyperglycemia. Very different.

417

00:45:50.892 --> 00:45:56.070

Peter Pronovost: No, I mean, you still need to know how to do it, but I think it's it's probably less

418

00:45:56.340 --> 00:45:57.550

Peter Pronovost: complicated.

419

00:45:57.700 --> 00:46:00.530

Peter Pronovost: I would say most of our hyper glycaemia

420

00:46:00.700 --> 00:46:04.019

Peter Pronovost: are people who get steroids, and it bumps it up.

421

00:46:04.220 --> 00:46:06.929

Peter Pronovost: or really common is

422

00:46:07.500 --> 00:46:10.389

Peter Pronovost: they're in the Icu on an insulin drip.

423

00:46:10.510 --> 00:46:19.110

Peter Pronovost: and then they leave the Icu, and that transition isn't managed well, and they rebound really high. Those are very common scenarios.

424

00:46:24.390 --> 00:46:28.550

Matt Austin: Okay, so what I'm hearing from the group is support for

425

00:46:28.770 --> 00:46:32.500

Matt Austin: including these measures. It does sound like that. Maybe we need to

426

00:46:32.530 --> 00:46:34.589

Matt Austin: learn a bit more about the

427

00:46:35.080 --> 00:46:36.949

Matt Austin: whether these measures will be

428

00:46:37.060 --> 00:46:41.710

Matt Austin: reported out in large numbers by hospitals, or if there's going to be sort of a

429

00:46:43.790 --> 00:46:48.429

Matt Austin: smaller number of hospitals, and so maybe that becomes the reason for a delay. But

430

00:46:48.782 --> 00:46:57.009

Matt Austin: we can clarify with Cms with the the current plans are there. And if the plan is to have sort of robust reporting.

431

00:46:57.030 --> 00:47:07.379

Matt Austin: I think the plan would be to to move forward with adding these 2 measures, we would add these to the outcome domain. Is what the the proposal would be.

432

00:47:11.510 --> 00:47:12.480

Matt Austin: I.

433

00:47:12.480 --> 00:47:14.819

Sara Singer: Are there any, as a result that we would roll off.

434

00:47:20.600 --> 00:47:22.320

Matt Austin: Great question.

435

00:47:24.760 --> 00:47:26.749

Matt Austin: I think we could come back

436

00:47:26.880 --> 00:47:30.020

Matt Austin: to you all with a proposal.

437

00:47:30.220 --> 00:47:32.140

Matt Austin: If we think that would be.

438

00:47:32.180 --> 00:47:35.290

Matt Austin: we could come back with an analysis of where things are at.

439

00:47:36.610 --> 00:47:38.549

Matt Austin: We. We had some internal

440

00:47:38.730 --> 00:47:43.299

Matt Austin: conversation about this just the other day, meaning Missy Alex Preeti myself.

441

00:47:44.047 --> 00:47:47.819

Matt Austin: You know we talked about like, you know, air embolism.

442

00:47:47.930 --> 00:47:57.829

Matt Austin: Right? It's most hospitals. The value is 0. But the the challenge is when it's not 0. It tends to be a fairly significant event for that patient.

443

00:47:58.863 --> 00:48:00.150

Matt Austin: You know.

444

00:48:01.130 --> 00:48:05.809

Matt Austin: unattain reform unintended, retain foreign objects.

445

00:48:06.539 --> 00:48:19.719

Matt Austin: You know, still remain non 0. And there's some concern that we're not even capturing all that are actually happening. Right? So we I don't think we are at a point

where we want to retire. Any of the hais

446

00:48:20.586 --> 00:48:22.769

Matt Austin: but we we could definitely

447

00:48:22.810 --> 00:48:25.520

Matt Austin: engage further in that conversation. Sir.

448

00:48:25.970 --> 00:48:44.599

Alexandra Campione: Yeah. And Matt, I'll just add, we have 12 process and structural measures, and only 10 outcome measures. So adding 2 wouldn't necessarily tip the scales too much. We would have to look at what the point distribution is for the other measures, and if we like that but that's also something to consider.

449

00:48:44.600 --> 00:48:50.510

Peter Pronovost: Hey, Matt? Just, you know, on that note cause like these are really rare events. They, you know, and

450

00:48:52.430 --> 00:48:53.720

Peter Pronovost: hang on a second.

451

00:48:54.880 --> 00:48:55.510

Matt Austin: Sure

452

00:49:00.630 --> 00:49:01.510

Matt Austin: India.

453

00:49:03.230 --> 00:49:07.040

Matt Austin: So other thoughts reactions to that while we wait for Peter to come back.

454

00:49:15.380 --> 00:49:19.070

Matt Austin: But, Sarah, we can put something together for you and others. That sort of

455

00:49:19.150 --> 00:49:21.550

Matt Austin: gives us some context around that to my.

456

00:49:21.850 --> 00:49:35.680

Sara Singer: Necessarily suggesting that we do just that. You know, we've talked about continuing to look at it. And so it occurred to me that this might work a time when we should look again. Maybe not retiring, but distribute it. Looking at how we distribute

457

00:49:36.360 --> 00:49:37.300

Sara Singer: weight.

458

00:49:38.450 --> 00:49:46.799

Matt Austin: Yeah, I mean, the implications of adding 2 measures is that the relative weights for the other 10 measures will go down. Yeah.

459

00:49:46.820 --> 00:49:48.979

Peter Pronovost: Matt. What I was going to say

460

00:49:49.980 --> 00:49:50.730

Peter Pronovost: is

461

00:49:50.840 --> 00:49:53.750

Peter Pronovost: a potential or explore collaborating with

462

00:49:54.000 --> 00:49:58.789

Peter Pronovost: Cms. And and you know, as part of that Pcast report for safety.

463

00:49:58.870 --> 00:50:04.109

Peter Pronovost: One of the strong things we were working with Michelle and Cms

464

00:50:04.250 --> 00:50:06.949

Peter Pronovost: is, they have a more robust

465

00:50:08.530 --> 00:50:19.350

Peter Pronovost: through their conditions of participation when they visit hospitals that they use data to guide where they look right now. They, as you know, they don't do that. They just walk around and look at a few charts.

466

00:50:19.410 --> 00:50:26.859

Peter Pronovost: and so the thought would be if it to encourage, as part of that review any of these low risk but serious events.

467

00:50:27.690 --> 00:50:37.090

Peter Pronovost: They? They haven't implemented it, but they felt they didn't need any extension of the cops, but that within that what we

468

00:50:37.940 --> 00:50:45.080

Peter Pronovost: put forward to them is that there would be a meeting with the CEO, the Board Chair, and the Cm. Or the Dmv. Or Joint Commission.

469

00:50:45.100 --> 00:50:57.239

Peter Pronovost: who would look at rates of harm and require an action plan for outliers, because, as you know right now, you could have, like 10 times the rate of Cloud Z. And your joint commission survey wouldn't even look at.

470

00:50:57.750 --> 00:51:06.609

Arjun Srinivasan, CDC (he/him): Yeah. And Pierre, it's it's really, I think it really is Joint commission. And Dnd, who really, because we've had these discussions with joint Commission try to

471

00:51:07.020 --> 00:51:16.789

Arjun Srinivasan, CDC (he/him): get them to do that because it's I mean, it's publicly available data. It's right. It's like going to a website just to take a look, and they've not been.

472

00:51:16.820 --> 00:51:23.520

Arjun Srinivasan, CDC (he/him): There's been some degree of like, well, you know, it's there's a lot of the surveyors they have a lot to do, and

473

00:51:23.620 --> 00:51:26.449

Arjun Srinivasan, CDC (he/him): so that it's not it's not done right.

474

00:51:27.188 --> 00:51:45.669

Arjun Srinivasan, CDC (he/him): And you know I it does seem to be a missed opportunity to say like, well, you could at least ask if their cloud Csir is 1.2. Why don't you ask them? Hey? We smired Csir is 1.2. What are you doing about that right that should be the focus of your infection. Control at least one of your questions

475

00:51:45.670 --> 00:51:59.344

Arjun Srinivasan, CDC (he/him): at the infection control part of the survey, so happy to help with that. We we definitely we'd love to see John Commission. We've had some of these discussions, but I think it's it's not anything that they have moved forward.

476

00:51:59.670 --> 00:52:17.045

Peter Pronovost: You. You know, Arjen, on that, Kevin, and maybe this is something we even do, or even a commentary where I would love to see is get a list of publicly available rate based harms. And say, You know, how could you serve a credit? A hospital? Even you don't look at outliers in these rates. I mean, it's

477

00:52:17.520 --> 00:52:18.370

Peter Pronovost: mind blowing.

478

00:52:18.370 --> 00:52:39.839

Arjun Srinivasan, CDC (he/him): Good time to do it, because I mean, you know, we are collaborating. So we're building a vte measure. We're building a hypoglycemia measure. We're we're thinking we were working on a sepsis measure. So I mean, we are increasingly, no Cms really wants to use Nhs, and more and more especially for fully electronic measurement reporting. So

479

00:52:39.840 --> 00:52:53.113

Arjun Srinivasan, CDC (he/him): there's really really good collaboration in this space. And I think it's only to the good. If we did, I know this is not part of what we're discussing here, but it's only to the good. If if we can get more use of that data that people.

480

00:52:53.390 --> 00:52:54.000

Peter Pronovost: Right.

481

00:52:54.000 --> 00:52:54.719

Arjun Srinivasan, CDC (he/him): Blocked it.

482

00:52:55.410 --> 00:53:06.130

Peter Pronovost: More. It's just like irresponsible personally, that you could accredit a hospital and look at like water stains on their ceiling, but not review rates of harm for publicly available data.

483

00:53:07.160 --> 00:53:07.540

Missy Danforth (she/her): It is.

484

00:53:07.540 --> 00:53:12.529

arnold milstein: I think it's a I think it would be. It'd be an excellent viewpoint or perspective piece.

485

00:53:17.170 --> 00:53:27.569

Peter Pronovost: Alright. I I'm hate taking it, taking it happy to to start some, but, like, you know, just that, even if we just made it. I mean, you have a table of measures that should be reviewed with before a hospital is accredited.

486

00:53:29.550 --> 00:53:45.969

Missy Danforth (she/her): So I think everyone probably saw that Cms just announced. They are calling in the accreditation organization because they have concerns hospitals that have low quality and continue to get accredited. So I think the time is like literally now, and there's gonna be a very small window.

487

00:53:46.510 --> 00:53:49.650

Missy Danforth (she/her): So if we want to regroup offline about that I could.

488

00:53:49.650 --> 00:53:51.060

Peter Pronovost: Yeah. Why don't I do.

489

00:53:51.740 --> 00:53:59.770

Peter Pronovost: Matt? I wonder if you want to take just be point or missy, and get a table of measures that we would like we would put in this list. You can probably do it like in 20 min.

490

00:54:00.480 --> 00:54:01.200

Matt Austin: Yeah.

491

00:54:01.200 --> 00:54:04.289

Peter Pronovost: And I'm happy to start drafting like just a short piece.

492

00:54:04.900 --> 00:54:05.640

Matt Austin: Okay.

493

00:54:06.510 --> 00:54:07.269

Matt Austin: that will work.

494

00:54:07.270 --> 00:54:08.650

arnold milstein: But the contributing.

495

00:54:08.810 --> 00:54:14.240

Peter Pronovost: Perfect. Yeah, love, because I mean, it really is like, it's whatever it's policy failure.

496

00:54:14.960 --> 00:54:15.760

Matt Austin: Yep.

497

00:54:16.800 --> 00:54:23.950

Matt Austin: So, Sarah, we'll we'll put pull something together that could help inform the conversation about whether certain outcome measures need.

498

00:54:24.050 --> 00:54:33.149

Matt Austin: So you're right. I think we do. Wanna keep evolving the safety grade to reflect meaningful, important, timely measures of safety. So.

499

00:54:33.150 --> 00:54:33.590

Sara Singer: Yeah.

500

00:54:33.590 --> 00:54:36.029

Matt Austin: It's always worth so it's worth revisiting.

501

00:54:36.030 --> 00:54:46.959

Sara Singer: Certainly for finding more. And I like the idea that there that these allow for use of Hr data. It's pushing hospitals in that direction, too. So all good. Thank you.

502

00:54:46.960 --> 00:54:50.770

Matt Austin: Okay, yeah. And thank you, Kathy, for the comment in the chat about

503

00:54:51.040 --> 00:54:55.340

Matt Austin: patients sort of seeing these as being important harms as well.

504

00:54:55.370 --> 00:55:01.320

Matt Austin: And we have 1Â min left. So I'm gonna say, a very big thank you to all of you for your ongoing guidance.

505

00:55:01.661 --> 00:55:13.349

Matt Austin: We really treasure and appreciate all of you. We're so so, so, so so lucky to have you on us on this journey with us. So have a great weekend, and we'll be in touch with you all. Take care.

506

00:55:13.990 --> 00:55:15.010

Alexandra Campione: Thanks, emerald.

507

00:55:15.210 --> 00:55:16.310

Tim Vogus: Thanks, bye.

508

00:55:16.630 --> 00:55:17.269

Doris: But I.

Exhibit 12

Page 1

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Good Samaritan Medical Center Inc, at al. v. The
Leapfrog Group
4/12/2024

1 MATT AUSTIN: So, Arjun?

2 ARJUN SRINIVASAN: I have no financial
3 disclosures. I am a full-time employee of the
4 federal government, and our agent, my division,
5 runs the National Healthcare Safety Network.

6 MATT AUSTIN: Great. Thank you, Arjun.
7 Sara, would you like to go next, please?

8 SARA SINGER: Sure. I'm Sara Singer.
9 I'm a professor at Stanford in the medical school
10 and in the business school in organizational
11 behavior. With respect to the -- and I've been
12 on the Leapfrog committee for it feels like many
13 years.

14 With respect to disclosures, I guess
15 financial disclosures, I receive honoraria for
16 work that I do for both Intermountain Healthcare
17 and Harvard Medical School. And non-financially,
18 I serve on the board for the Harvard Medical
19 Faculty Physicians Group.

20 MATT AUSTIN: Great. Thank you, Sara.
21 Kathy, would you like to go next, please?

22 KATHY MCDONALD: Sure. Kathy McDonald.
23 Hi, everyone. I'm at Johns Hopkins, colleague of
24 Matt's, and in the School of Nursing and the
25 School of Medicine and also the Armstrong

Page 3

1 Institute for Safety and Equality. I don't have
2 anything that's -- nothing financial.

3 MATT AUSTIN: Perfect. Thank you,
4 Kathy. Peter, would you like to go next, please?

5 PETER PRONOVOST: Sure. Hi, I'm Peter
6 Pronovost. I am the University Hospitals' Chief
7 Clinical Transformation and Quality Officer and a
8 professor in ACE Schools of Medicine, Nursing,
9 and Management. I think the only disclosure
10 would be a PCORI Health Systems Implementation
11 Science grant that I'm the PI on.

12 MATT AUSTIN: Great. Thanks, Peter.
13 Tim, would you like to go next, please?

14 TIM VOGUS: Sure. Tim Vogus. I'm the
15 faculty of the Vanderbilt University Owen
16 Graduate School of Management. I'm not getting
17 any of that sweet money, so I have nothing to
18 disclose.

19 MATT AUSTIN: Well, I think you should
20 disclose, Tim, that you are a former Spartan and
21 sporting the --

22 TIM VOGUS: Yeah, I'm a sporting the
23 Spartan green, right, and I am the nicest dressed
24 person on the call or the opposite of that.

25 MATT AUSTIN: All right. Doris, would

Page 4

1 you like to go next, please?

2 DORIS PETER: Sure. Well, the only
3 reason -- I'm actually probably the worst dressed
4 because I'm off camera, so I'm wearing a fleece
5 jacket right now, so I'm not well-dressed either.

6 My name is Doris Peter, and I work
7 mostly as a subcontractor for CMS through Yale
8 CORE, who has -- was the developer of those two
9 eQMs that we're going to maybe talk about at the
10 end of this meeting, the patient safety eQMs.
11 Not really a disclosure, but just to let you know
12 that I'm somewhat involved in those, and I'm
13 happy to be here, but I have no other things to
14 disclose.

15 MATT AUSTIN: Great. Thank you, Doris.
16 Appreciate that. And Arnie, please.

17 ARNOLD MILSTEIN: Hi. I'm also off
18 camera because I'm, like several others, a
19 continuous walker. But let's see. So, relevant
20 to Leapfrog, I'm a trustee of Intermountain
21 Healthcare. I am on the board's quality
22 committee at Stanford Hospital.

23 What else? I am the medical director
24 of the Pacific Business Group on Health. And
25 then in terms of financial interests, though none

1 are involved with patient safety, I have a
2 financial interest in two startup companies, one
3 Prealize Health, the other Embold Health.

4 MATT AUSTIN: Great. Thank you so
5 much, Arnie. So, as I mentioned, we're doing
6 this in the spirit of transparency. If you have
7 any concerns during the meeting or after a
8 meeting that one of your fellow expert panelists
9 might be operating in a biased manner, we would
10 ask that you reach out to either Missy or myself,
11 and we'd be happy to have a conversation with you
12 about that.

13 So, thank you so much, everyone. We're
14 going to move on to the next agenda item, and I'm
15 actually going to share my screens with some
16 slides, but I'm actually going to turn it over to
17 Alex from the Leapfrog Group to talk a little bit
18 about grading the military treatment facilities.

19 ALEX CAMPIONE: Great. Hi, everyone.
20 My name is Alex. I'm a program analyst here at
21 Leapfrog. I work mainly with safety grade, so
22 scoring facilities as well as doing these
23 analyses and validation like we did for the MDS.

24 MATT AUSTIN: And here I go, just two
25 steps behind.

1 ALEX CAMPIONE: So, as everyone might
2 remember, we started the validation process of
3 their data back, I think it was about a year ago
4 now. They were interested in receiving safety
5 grades as sort of a way to summarize everything,
6 and we were able to score 21 out of 30 MDS
7 located in the U.S.

8 We had nine As, nine Bs, and three Cs,
9 and you can see this is actually a pretty well-
10 performing cohort of hospitals compared to the
11 national distribution. We worked with them, with
12 DHA directly to collect the PCI and HAC data
13 because their patient population is restricted to
14 active service members and their families.

15 So, as you can imagine, there's not
16 very much data on those 65 years and older. So,
17 there was -- is no CMS data for them, and we had
18 to obtain the data directly from them for
19 patients 18 years or older. Perhaps the biggest
20 accomplishment here was actually cleaning up
21 their HAI data.

22 So, previously, and to DHA's surprise,
23 they were not previously tracking MRSA and SSI
24 colon at a lot of facilities. So, they actually
25 -- there were not reporting plans in place for

1 surgical site infections after colon surgery or
2 MRSA. They were actually tracking it separate,
3 and it was not streamlined.

4 So, they had to go back and clean up
5 that data, and we were able to get to a point
6 where we felt confident in their data by this
7 January. So, that was very exciting. And on the
8 right, you can see how they performed on average
9 in all of the measures included in the safety
10 grade.

11 You can see that CPOE and Safe Practice
12 2, that's the safety -- culture of safety survey,
13 they were -- are still lacking in, and they're
14 well aware and working on that this year, as well
15 as the infection measures and PSI-4.

16 Where they performed really well is the
17 total nursing care hours per patient day and
18 their HCAHPS scores.

19 MATT AUSTIN: So, with that, we just
20 wanted to provide an update to you all on that
21 progress. We're happy to entertain any
22 questions, thoughts, reactions that the panel
23 might have.

24 PETER PRONOVOST: Yeah, just more of a
25 curiosity. Their HCAHPS scores are like material

1 better than others. I mean, I'm somewhat
2 surprised in their infection rates are materially
3 worse. Did they have any insights about why that
4 is?

5 ALEX CAMPIONE: So, we have not
6 actually talked to them about their HCAHPS scores
7 yet. I think the first, especially for SSI colon
8 and MRSA, it wasn't much of a surprise since it
9 wasn't being tracked previously, but now they're
10 going to be able to track it, so.

11 PETER PRONOVOST: Yeah, and maybe it's
12 just all driven by their nursing hours per
13 patient day.

14 MISSY DANFORTH: Yeah, so Peter, one
15 note I do want to make is that we did get their
16 HCAHPS data from CMS. So I'm not sure everyone's
17 aware, but they actually voluntarily report their
18 data into CMS, and so any adjustments done for
19 the other general acute care hospitals, like for
20 age, are also done to their scores as well. So,
21 these are not directly reported from DHA or the
22 MDS to Leapfrog. This is available on the CMS
23 Care Compare provider catalog.

24 MATT AUSTIN: Yeah, Patrick, when we
25 spoke to him --

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1 MISSY DANFORTH: -- data and we don't
2 have an explanation for the performance.

3 ARNOLD MILSTEIN: Missy, so am I right
4 that what that means is to the degree that
5 younger people, because they tend to recover more
6 fully, you know, might, you know, in retrospect,
7 you know, report a more favorable HCAHPS score?
8 That's already been adjusted for, that is the
9 younger age population of the --

10 MISSY DANFORTH: That's correct.

11 ARNOLD MILSTEIN: Okay, thank you.

12 MISSY DANFORTH: Yes, yes. That's
13 correct.

14 ARNOLD MILSTEIN: Thank you.

15 ARJUN SRINIVASAN: Yeah. It's a really
16 interesting point you're raising, Peter, and I
17 don't know, I don't -- we don't know -- I don't
18 know enough about this population. And I don't
19 know that we've looked at this specifically, and
20 it did not seem so. But you know, I assume that
21 the overwhelming majority of these patients are
22 post-trauma patients, which may have some very
23 different risk factors for some of these SSIs or
24 some of these HAIs compared to what we would see
25 in a typical hospital population. I don't know.

1 It's hard to know how that might be impacting
2 some of this.

3 MATT AUSTIN: Yeah, and talking with
4 Patrick in the last hour, he had a couple of --
5 yeah, he had sort of a similar question, Arjun,
6 about, you know, service members that were
7 injured, right? Are they being treated in these
8 military facilities here in the U.S.? Are they
9 being treated abroad? That could obviously
10 impact the HAI rates.

11 He also wondered about, for the HCAHPS
12 scores, if there was a little bit of an effect of
13 that your customer is part of an organization
14 that is also providing you the care, right, and
15 do you get sort of a, just a higher level of sort
16 of buy-in in that scenario? So, there's a little
17 bit of a model issue there.

18 ARJUN SRINIVASAN: Yeah, and some of
19 this is interesting. It's also, it's based on
20 expectations, right? The average enlisted person
21 might have a very different expectation of what
22 communication looks like based on what they're --
23 how they're used to being communicated with. So
24 I don't know if that influences this at all.

25 ALEX CAMPIONE: I'm sure, it does.

1 ARNOLD MILSTEIN: I think -- yeah, I
2 think it does. I know that, you know, in the
3 commercial sector, one of the interesting
4 findings from efforts to connect, you know,
5 working class people, such as people in the
6 Walmart or Lowe's employee workforce, is that
7 when they are hooked up with the quality of
8 doctors that, you know, that provide care in a
9 so-called center of excellence versus, you know,
10 routine community care, they are deeply
11 impressed.

12 They've never, you know, been treated
13 that well before. And typically in local
14 communities, particularly in practices that
15 specialize in lower socioeconomic status
16 patients, you know, they -- the level of service
17 that they experience, you know, tends to be not
18 great. So, they notice the difference when, you
19 know, when people of low -- I'll call it, you
20 know, low status enlisted people, you know, would
21 dramatic -- would notice a dramatic difference in
22 even if the nursing performance were average.

23 MATT AUSTIN: Mm hmm. So, I think we
24 have maybe more questions than answers for you
25 all, but did want to share an update on the

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1 progress that's been made. And I think hats off
2 to Alex for really digging in with them to get
3 the data that was needed to do this and, you
4 know, hats off to the DHA as well for their
5 desire and commitment to wanting to do this too,
6 right. They've been active in wanting to have
7 this happen, so --

8 SARA SINGER: Yeah, I would actually
9 comment. I mean, I think that's the best part
10 about what I'm seeing here is that it's actually,
11 we've actually put the data forward and now we
12 have some information. It will -- what will be
13 interesting to see is the next time we're able to
14 do this measurement, if relative, if some of
15 these relative scores begin to change, especially
16 around the infection rates, because this is the
17 first time they're seeing it, if they are able to
18 use it and parlay that into some action that
19 moves the needle on some of these things, that
20 would be really the win.

21 MATT AUSTIN: (Indiscernible) --

22 SARA SINGER: Quick question. You guys
23 already have VA hospitals as well as part of
24 Leapfrog?

25 MATT AUSTIN: Was that the VA

1 hospitals? Yeah.

2 MISSY DANFORTH: Yeah, so we do not
3 have any of the Veterans Administration
4 hospitals, but we are going to be using this
5 announcement as an entree to restart those
6 conversations. So that's a great question.

7 MATT AUSTIN: Yeah. I think that's
8 sort of our biggest gap that remains, right, is
9 the VA hospitals. We also aren't able to grade
10 hospitals in any of the U.S. territories, you
11 know, Puerto Rico, et cetera, because the
12 reporting -- the public reporting for those is
13 different, but those sort of are the remaining
14 gaps in a systematic way.

15 All right. So, we'll keep you engaged
16 and posted on that. We just wanted to provide
17 you with that update.

18 What we want to spend a majority of the
19 time talking about is actually some proposed
20 changes to the model that we'd like to use for
21 imputing scores for hospitals.

22 So, just to remind everyone, for --
23 since really the kickoff of the Leapfrog hospital
24 survey, Leapfrog was using the American Hospital
25 Association survey as a primary/secondary data

1 source. I shouldn't say a primary, secondary --
2 the key secondary data source. And in 2021, the
3 American Hospital Association made the decision
4 not to renew license for Leapfrog.

5 Leapfrog is also seeking ways to grade
6 additional hospitals. And so working with some
7 of you, I think in particular, Patrick, Sara,
8 colleagues at Mathematica, we looked at different
9 imputation approaches and came up with a model
10 that seemed feasible, relevant, and appropriate.

11 But we've run into a couple of
12 challenges that we think we need to maybe make
13 some adjustments for. So, one is that the
14 imputed scores have crept up over time, which has
15 made imputation a more favorable choice for a
16 fair number of hospitals and has de-incentivized
17 them actually reporting to the Leapfrog hospital
18 survey.

19 So, in some ways we've de-incentivized
20 transparency because they've decided that the
21 imputed score is a more favorable path for them.
22 What we're also running into is we, especially
23 this year, we are redefining and expanding
24 Leapfrog's BCMA standard.

25 So, in some ways -- so let me take half

1 a step back. Our step one of the imputation
2 model is to look to a hospital's historical data.
3 So, if a hospital didn't respond to the Leapfrog
4 hospital survey this year, we would look back in
5 previous safety grades to see what data were
6 available from those.

7 And the problem we're going to run into
8 this year is for the barcode medication
9 administration standard, Leapfrog is going to be
10 expanding the scope of that. So, in some ways
11 the standard has changed. We also have some
12 concerns about whether there's some drift-back or
13 fallback in hospitals meeting the hand hygiene
14 standard. And so that has sort of put us at a
15 point where we're thinking maybe it's time to
16 refine the imputation model and maybe change up
17 how we're doing things slightly.

18 The imputation model really applies to
19 four measures that are part of the safety grade.
20 So, those highlighted in green are the four
21 measures. It's the use of computerized physician
22 order entry, barcode medication administration,
23 the use of intensivists in the ICU and hand
24 hygiene. We included the standard weights just
25 to give you a sense of how much weight are put on

1 those four measures.

2 So, as we've sort of talked about at
3 this point, step one of the imputation model is
4 that the hospitals assigned their most recent
5 score from the past four rounds of the safety
6 grade. So, for example, in the spring 2024
7 round, we looked back and saw if a hospital had a
8 score for that measure in fall 2023, spring 2023,
9 fall '22, or spring '22. And if they did, we
10 used that value. And that actually covers the
11 three most recent Leapfrog hospital surveys.

12 If we didn't have a recent score from
13 those past four rounds, then we moved on to step
14 two, which is where we put hospitals into
15 cohorts, right. And we defined cohorts based on
16 number of beds, teaching status, urban/rural
17 status, safety net status.

18 And we really looked at two
19 calculations and gave them the lower of two
20 scores. One was the mean of the cohorts' current
21 and recent scores, or the mean of the cohort
22 scores from each hospital's first-time reporting
23 on the current standard. And that's really based
24 on the idea that hospitals, when they first start
25 reporting to the survey, tend to have lower

1 performance than hospitals that have been
2 reporting for a period of time.

3 So, that's the current model that we're
4 using. What I'm going to -- so I quickly touched
5 on this. We defined cohorts based on four
6 factors: urban/rural status, safety net status,
7 number of beds, and teaching status. Where we do
8 have a difference is for ICU physician staffing.
9 We actually use the CMS cost report as the
10 secondary data source, because that actually
11 tells us whether the hospital operates any
12 medical, surgical, or pediatric ICU beds. And if
13 so, then we equate that to them saying they
14 operate ICU beds, but have given us no
15 information about their staffing structure.

16 So let me jump ahead, because I think -
17 - let me go to two slides, because I think these
18 two are important.

19 So, jumping ahead to sort of current
20 trends in hospitals reporting to the Leapfrog
21 hospital survey. So, of the hospitals that
22 received a hospital safety grade, we've seen
23 hospital performance -- or participation, excuse
24 me, in the Leapfrog hospital survey increase from
25 31 percent to 61 percent. And so the bars in

1 green show the upward trend in hospitals
2 participating in the Leapfrog hospital survey.
3 We did see a little bit of a drop-off in 2023.

4 The gray bars represent the hospitals
5 that would have scores imputed. And so, one
6 would expect those to sort of move in inverse
7 directions.

8 So, what we are going to propose to you
9 all for a refinement to the imputation model is
10 -- one is to retire step one, which is where we
11 used the recent historical data from hospitals to
12 calculate a score. So that would be -- we would
13 do away with step one. And within step two, we
14 would specifically focus on hospitals and how
15 they did on their first year of reporting on the
16 current standard.

17 So, we would still group the hospitals
18 into the cohorts. I think we have 12 cohorts of
19 hospitals. And we would assign them the score
20 based on the first year of reporting. And we
21 would continue to use the CMS cost report for the
22 ICU physician setting. So, the real change here
23 is the elimination or the retirement of step one.

24 Let me pause there to see if there's
25 any questions first, and then let's have a

1 conversation about feedback, guidance,
2 suggestions.

3 PETER PRONOVOST: Matt, just one
4 comment. It's amazing how quickly markets learn.
5 I was on a call with a bunch of CMOs and I doubt
6 they saw this data, but that was the kind of the
7 message. Oh, you'd do better if you don't fill
8 out the survey. And it may have been anecdotal
9 for them, but it was clearly a discussion amongst
10 the CMO group.

11 MATT AUSTIN: So, you were saying in
12 terms of increased participation in the survey,
13 Peter?

14 PETER PRONOVOST: No, I think that --
15 in other words, they -- the point that you said
16 about the trends through imputation, like the
17 market, they were already saying, don't complete
18 the survey, you can do better.

19 MATT AUSTIN: Oh, okay. Yeah. That
20 you would get -- you would do better by using the
21 imputed scores.

22 PETER PRONOVOST: Correct.

23 MATT AUSTIN: Right --

24 PETER PRONOVOST: And they didn't have
25 any data. It was just like more of their hunch

1 or their gut, but it was like a topic of
2 discussion.

3 SARA SINGER: I know you said that if
4 you rely on the first round of reporting that the
5 scores are typically lower. But are they
6 sufficiently lower that we think it would create
7 an incentive for them not to go to the hassle of
8 doing the survey? And what about the CMS cost
9 report for the ICU staffing? Is it also
10 typically lower?

11 MATT AUSTIN: So, let me --

12 MISSY DANFORTH: (Indiscernible) --

13 MATT AUSTIN: -- go ahead, Missy.

14 MISSY DANFORTH: Yes, they are
15 significantly lower. And we have seen some of
16 that motivate. Because for the most part, I
17 think the majority of hospitals do want their
18 current performance reflected unless it's bad, in
19 which case the imputed scores will be better.
20 But I do think they are sufficiently low enough,
21 hopefully, to be motivating.

22 MATT AUSTIN: And what I've brought up
23 on the screen and which I skipped over in the
24 presentation because I wasn't sure, sort of talk
25 about it is -- but to Sara's question, I think --

1 does this answer your question, Sara, in terms of
2 these are the average imputed scores for the four
3 measures by the step one and step two?

4 SARA SINGER: The two green bars at the
5 bottom?

6 MATT AUSTIN: Correct. And then what
7 we put up at the top in the white is for
8 hospitals that complete the survey. These are
9 their performance categories and the points that
10 they get assigned based on their performance
11 category.

12 SARA SINGER: Oh, yeah. Okay.

13 MATT AUSTIN: So, it's to give some
14 context between those that report versus those
15 that are getting scores imputed.

16 SARA SINGER: Okay. Yeah. I mean, it
17 looks like it would be motivating.

18 MATT AUSTIN: So, what other reactions
19 do folks have to this idea of retiring step one
20 and simply using -- so, basically retiring, we're
21 going to use your hospital's historical data and
22 we would basically move solely to a model of
23 putting hospitals into cohorts and using the
24 first-time reporting scores from that cohort?

25 Let me show one more slide just to

1 maybe spur some conversation, which is here are
2 the 12 cohorts, once again, by the sort of four
3 factors and then what the means are for each of
4 those 12 cohorts.

5 SARA SINGER: Yeah. I mean, I guess
6 you can assume that the downside is that if there
7 is a high performing organization that doesn't
8 happen to want to continue doing the Leapfrog
9 survey, they will be penalized because they'll be
10 lumped together with a cohort that may not be
11 performing as well as they are. But I think
12 that's the -- that's sort of what we're trying to
13 accomplish.

14 MISSY DANFORTH: Yeah. Sara, if I can
15 just make one other note. This is
16 (indiscernible). We do see slippage in
17 performance on these measures from year to year.
18 I mean, particularly with something like hand
19 hygiene, I think we found if we talk to them in
20 January or February or March versus busier times
21 of the year that they may not be doing as well.

22 Certainly as Matt described with BCMA,
23 the standard is changing so much we just can't
24 pull forward those old BCMA scores. And with
25 things like nurse staffing in the workforce --

1 I'm sorry, not nurse staffing, CPOE, the CPOE
2 developers -- I know (indiscernible) is not on
3 the call today. But they make content changes to
4 that test every year. So I also think that it
5 protects us a little bit. If a hospital is
6 starting to have a downslide and we're awarding
7 them those hundred points from previous surveys,
8 I think at a point it could start to erode trust
9 of (indiscernible).

10 SARA SINGER: I'm wondering -- so we've
11 taken -- like one option would have been to just
12 eliminate the most recent score and to use step
13 two as it was. If you did that, I can't remember
14 if the two bars in green -- do you have a bar
15 that also shows if you allow them -- if you
16 assign the mean of the cohort, not just the most
17 recent -- the first round of reporting for that
18 cohort? Is it also penalizing, but maybe not so
19 drastically so?

20 MATT AUSTIN: So what I didn't do a
21 great job of explaining, Sara, is the current
22 methodology is to take the lower of two scores
23 for step two.

24 SARA SINGER: I see.

25 MATT AUSTIN: Which is the recent

1 scores and the first-time reporting.

2 SARA SINGER: I see. Okay.

3 MATT AUSTIN: So what's in the green
4 bar would be reflective of that lower, which --
5 if that -- most likely would be the --

6 SARA SINGER: Yeah. And so the step
7 two is -- I mean, the other advantage is it's
8 sort of already socialized with the group. They
9 -- you know, there's some acknowledgement of its
10 validity. So what we're doing now is taking away
11 the one that hospitals seem to be gaming.

12 MATT AUSTIN: That would be one, yes,
13 interpretation of that. Arjun, your hand is up.
14 Do you want to...

15 ARJUN SRINIVASAN: Yes. I'm wondering
16 if you all have any experience with hospitals
17 that have gone back and forth, like, completed
18 the survey at some point, not completed it at
19 some point. It may not be very many, but I'm
20 wondering if you have any (indiscernible) data
21 on, you know, where those hospitals -- where they
22 tend to fall.

23 Because one of the questions here is if
24 there is -- not going to say a punitive intent,
25 but if there is a kind of motivating intent here

1 to say, look, we think you need to fill out the
2 survey, because without the survey, we really
3 don't have very accurate data. I mean, the bias
4 that I might look at this and say, well, if I'm
5 in the bottom half, I'd rather not fill out the
6 survey. Because that will lift me up to the
7 mean. So would be better for me to just not do
8 it.

9 So the question then becomes just like,
10 do you say, well, if we don't have your data, we
11 have to assign you even lower because we're
12 trying to push people to fill out the -- and
13 again, I don't know, this is maybe a little
14 controversial maybe. But do you say, look, if
15 you don't fill out the survey, I'm sorry, but we
16 have to assign you to the bottom quartile because
17 we're now making -- maybe we make the assumption
18 that the reason you're not filling out the survey
19 is because you are in the bottom part and you
20 want that boost in score to get you to the mean.
21 I don't know.

22 MISSY DANFORTH: Arjun, that's a really
23 great question. I think -- yeah, I think to date
24 we've lost focus on the penalty portion of it and
25 more focused on really not wanting to potentially

1 assure patients they're going to a safe place
2 that may have had some slippage.

3 And if you've been following the news
4 of Steward Health System, that would be an
5 example of an area where they have historically
6 done the survey, didn't do the survey in 2023 for
7 obvious reasons, we know now, had those scores
8 imputed due to this imputation methodology. And
9 obviously, the backlash in those communities from
10 those patients is, well, how can this be. Right?
11 So I think that's been the focus less so than
12 penalty or, frankly, even motivating people to do
13 the survey. I think it's that at a minimum, we
14 don't want to report them with a high score if we
15 don't have any information, and if we have
16 empirical information that there is slippage year
17 over year, which we do see.

18 PETER PRONOVOST: Missy though, to
19 Arjun's point, I wonder in our model, do we
20 include that if they're in the lowest quartile
21 that they stay in that. You know what I mean?
22 At least to reduce the gaming. So we may not put
23 everybody in that lowest quartile, but if your
24 previous survey you were low, you don't get an
25 elevation, you know, through this imputation.

1 MATT AUSTIN: Other suggestions,
2 recommendations?

3 KATHY MCDONALD: I'm looking, like, at
4 the safety net results. I just -- have we
5 thought through any of the implications for them?
6 I always worry most about, you know, those
7 hospitals and making sure that they don't end up
8 in -- with something we haven't thought of, an
9 unintended consequence there. They're already
10 carrying so much burden. So I haven't thought
11 through this enough to be able to --

12 MATT AUSTIN -- (Indiscernible) --

13 KATHY MCDONALD: -- (indiscernible),
14 but I wanted to put it out there.

15 MATT AUSTIN: Yeah. I think where I
16 struggle is what is a true -- well, where is
17 there a true difference in performance, right,
18 and where is there some sort of bias in the
19 measurement against them. Right? And --

20 KATHY MCDONALD: Right.

21 MATT AUSTIN: And I think we want to
22 minimize the second and --

23 KATHY MCDONALD: Yes.

24 MATT AUSTIN: Right? If there's two
25 differences, there's two differences. And there

1 are structural issues that we need to address
2 there, Kathy, for sure.

3 KATHY MCDONALD: Yeah, right.

4 MATT AUSTIN: Right? But, you know, I
5 think some of the recent research is showing that
6 patients of marginalized communities actually do
7 tend to receive care at hospitals that have more
8 patient harms, right? And that's just the
9 unfortunate reality of our current world and
10 status.

11 PETER PRONOVOST: You know, the -- a
12 comment. And I'm happy to -- we won't solve it
13 now. But I think how you message this change is
14 going to be really critical because I think it
15 could help enhance focus on safety or kind of
16 piss people off and like saying you're not
17 understanding, we just went through COVID, we
18 don't have staffing. So, you know, Missy, your
19 point about -- I mean, you know, the persistent
20 25 percent of hospitalized patients are still
21 harmed, the trends are going the wrong way, and
22 consumers have a right to know this without this
23 risk of misinforming them and being very, you
24 know, transparent about that risk.

25 SARA SINGER: I think that's an

1 incredibly important point, Peter, and well-
2 taken.

3 PETER PRONOVOST: And I would probably,
4 Missy -- because this is going to be -- I mean,
5 even though a discussion, I think it could be
6 misconstrued, like maybe even, you know, get you
7 or Matt or whoever, a couple people to share this
8 reasoning with the AHA, with Premier, with
9 Vizient. You know, with a variety of groups that
10 might be using this so that you manage that
11 narrative.

12 MISSY DANFORTH: Yeah. That's a great
13 idea. And can I ask just, Peter, your opinion
14 and anyone on the panel, we have a number of
15 large health systems that have brought this issue
16 to us as well, which is to say that, you know, we
17 have a hundred participation in the
18 (indiscernible) when we're doing well and when
19 we're doing not so well because we want to build
20 that trust in our communities. We really don't
21 think it's fair that you're allowing these
22 hospitals not reporting to get the highest scores
23 because we can't really trust that it's currently
24 true.

25 To what extent do you think health

1 systems themselves, who have wanted to be
2 partners (indiscernible) if we make this change
3 could help deliver the message, or do you think
4 that would backfire?

5 PETER PRONOVOST: You know, I think
6 they absolutely could. And, Missy, just like in,
7 you know, my hospital colleague friends, there's
8 clearly a culture who is committed to reporting
9 and transparency and want to do the right thing.
10 Some of them though it may be like you can say
11 it's a legitimate or not -- a resource thing. Do
12 they have time to complete the survey? And
13 without a doubt, there are some of those.
14 Because hospitals' quality budgets got crushed
15 with the financial losses with COVID. There's
16 others then who are not so transparent.

17 If you highlight those, Missy, though,
18 I would just make sure that that narrative that
19 the hospital is telling is consistent with other
20 signals, meaning they make their STS data
21 transparent. You know, there's a number of other
22 data points they can choose to be transparent or
23 not. And -- because otherwise someone could come
24 back and say, yeah, but then why aren't they
25 making these other data sets that they could make

1 transparent and they have elected not to.

2 MISSY DANFORTH: That's incredibly
3 helpful. Thank you.

4 MATT AUSTIN: Any other feedback or
5 suggestions on this? If not, I think the next
6 step is that Leapfrog will consider the feedback
7 we've heard from all of you as well as from
8 Patrick earlier today. And if Leapfrog decides
9 it will actually put out for public comment on
10 this proposed change and hospitals and other
11 stakeholders would have the opportunity to
12 comment on this proposal.

13 And, Peter, thank you for that
14 suggestion on how the messaging of that could be
15 incredibly important.

16 PETER PRONOVOST: And I'm happy to
17 review that with you, Matt, or just go through
18 it. Because it is going to be really important
19 of how people react to this.

20 MATT AUSTIN: Yeah. Okay, makes sense.
21 Okay. So our final agenda item is to talk about
22 a couple of measures that we would like to
23 consider adding to the hospital safety grade. So
24 these are two new ECQMs, which are Electronic
25 Clinical Quality Measures, which are measures

1 that are actually derived directly from the
2 (indiscernible) data as I understand them.
3 There's one focused on severe hyperglycemia, and
4 another measure focused on severe hypoglycemia.
5 Both of these measures are currently being
6 collected by CMS, and the public reporting of
7 them will start next year in 2025.

8 I've included on the slides the
9 numerator and denominator definitions. So for
10 the first one, the severe hyperglycemia is
11 focusing on -- sorry, that was a typo. That
12 should say hyperglycemia as an outcome in the
13 hospital inpatient setting. And this looks at
14 basically the percentage of inpatient days for
15 patients 18 years and older for which they had a
16 hyperglycemic event. And that event is defined
17 as a day with one blood glucose value greater
18 than 3,000 milligrams per deciliter or a day
19 where a test was not done but there was a -- it
20 was preceded by two consecutive days where at
21 least one of the glucose values on one of those
22 two days was above or at 200. So it would be
23 looking at the percentage of days in which the
24 patient had a hyperglycemic event. So that's one
25 measure for consideration.

1 The other one is severe hypoglycemia.
2 And this focuses really on patients that received
3 a hypoglycemic mediation and whether they had a
4 hypoglycemic event during -- there's a definition
5 within the numerator of what is a hypoglycemic
6 event. So that's a blood glucose less than 40
7 milligrams per deciliter, that they gave them a
8 hypoglycemic medication within 24 hours after the
9 start of the event, and there was no repeat test
10 for glucose with a result greater than 80 within
11 five minutes so that there was sort of a
12 sustained level of hypoglycemia.

13 So I will pause there to see -- hear
14 reactions, thoughts.

15 Doris, if you have any additional
16 information that you would like to share or think
17 is notable or relevant, we would love to hear
18 that as well.

19 DORIS PETER: Sure. I think it's --
20 this goes through a period of voluntary
21 reporting, so I'm not sure how much data will be
22 available over what time period. I don't
23 remember all the details of the reporting
24 requirements.

25 MATT AUSTIN: So your understanding is

1 the current situation is these would be voluntary
2 measures for hospitals?

3 DORIS PETER: Yeah. I think that they
4 can -- if I remember correctly -- and I could be
5 totally wrong about this -- that they could
6 select from a list of ECQMs.

7 MATT AUSTIN: Okay.

8 DORIS PETER: So I think it depends on
9 what program they are in. Because we don't -- we
10 started developing these and then they got taken
11 over by a different developer. So I have not
12 followed their trajectory. But if I remember the
13 program correctly, it would be like you could
14 select from a list. So I don't know how
15 comprehensive reporting will be for your guys'
16 point of view in terms of you're going to end up
17 with holes in the data and all that and
18 imputation back on the table again or some other
19 way of dealing with missing data.

20 SARA SINGER: Okay. Thank you, Doris.
21 I will clarify that. Because our understanding
22 in my previous conversations with Michelle
23 Scriber from CMS is that these new patient safety
24 focus ECQMs, there's like a kidney damage one
25 coming (indiscernible) --

1 DORIS PETER: Yeah.

2 SARA SINGER: -- for ulcers will be
3 required, not part of (indiscernible). But we'll
4 clarify that. Thank you.

5 DORIS PETER: Yes. Okay. Yeah, I
6 could be wrong. It could be possible they put
7 them in like the HACK program or something and
8 then they'll be required. So I can dig for you
9 if you want to.

10 SARA SINGER: That would be great.
11 Thank you.

12 ARNOLD MILSTEIN: Yeah, this is Arnie.
13 I would just like to say that, you know, one of
14 the beauties of this direction by, you know, some
15 courageous officials within CMS is it potentially
16 as it expands, you know, begins to moderate the
17 problem of hospitals not reporting if CMS is
18 requiring these direct from electronic health
19 record important measures and they are reported
20 and the -- you know, they are not optional in
21 reporting to CMS. And CMS in turn shares them
22 for public use such as by Leapfrog.

23 MATT AUSTIN: And, Arnie, do you feel
24 like the two have face validity as patient safety
25 harms that should be included?

1 ARNOLD MILSTEIN: Yes. Yeah. Like all
2 cliff edge, you know, definitions, you know, over
3 time these measures will improve. But achieving
4 consensus is difficult. And so I think this is a
5 very reasonable start.

6 PETER PRONOVOST: And, Matt, I would
7 just add from -- I think they both have face
8 validity. The harm from hypoglycemia is probably
9 a couple log orders higher than hyperglycemia.
10 So if I had to prioritize -- just to -- not to
11 frighten everybody. But there's a couple of
12 health systems who agree to look at how often
13 hypoglycemia occurs. These are around 800-bed
14 hospitals. And I think they used 45 as a cutoff.
15 So, but close enough. Fifty events per week on
16 average. Week. I mean, it is mind boggling.
17 Just again because I think it's important for the
18 context that you know. Really the only way
19 health systems manage this, because it's quite
20 technical, is if they have diabetic educators who
21 guide the physician on how to dose these drugs
22 and/or have staff. Like when people are NPO,
23 that they adjust their insulin levels. Which,
24 you know, haven't done much, but hospitals cut
25 those staff a lot with COVID.

1 And so this problem has gotten
2 significantly worse. Or isn't a diabetic NP who
3 would work with physicians to score and it's --
4 my mind was blown away. I mean, I could tell you
5 I don't have any practical way that education is
6 going to work for this. So we are deploying -- I
7 have no financial relations to them, but a
8 company called Glytec that has an AI model that
9 automates the insulin dosing and has built-in
10 checks. Like if you're NPO, it automatically
11 adjusts your solution.

12 But my point in that is if we do this
13 measure, it would be great to find out what
14 health systems are doing to perform well on it.
15 Because it's -- putting more staff in it is going
16 to be a challenge for hospitals. But there are -
17 - there's a ton of technology that could help
18 with this.

19 MATT AUSTIN: That's really helpful
20 context, Peter. Thank you. Especially the
21 guidance around the hypoglycemia being
22 potentially a greater harm to patients than the
23 hyperglycemia.

24 PETER PRONOVOST: And just for the
25 economic piece, in our health system one, of the

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1 -- the hyper didn't really seem to drive length
2 of stay or maybe had like a 0.3. These
3 hypoglycemic events on average added three days
4 to our hospital stay. Some went to the ICU. But
5 it was a -- about a \$17 million excess days cost
6 to our health system.

7 ARNOLD MILSTEIN: I very much agree
8 with Peter's comment that one would -- if
9 optimally managed, would have a lot more clinical
10 benefit than the other. But that being said, I
11 think CMS was courageous to move forward with
12 these, too. And I think in some ways, you know,
13 weak management of hyperglycemia, it may be an
14 indication of -- you know, it is likely an --

15 PETER PRONOVOST: (Indiscernible).

16 ARNOLD MILSTEIN: Yeah. Exactly. So I
17 think I'm quite supportive of us adding both
18 measures.

19 PETER PRONOVOST: Yeah, I am too. I
20 was just giving that for the context. Because I
21 was pretty blown away about how common it was.

22 SARA SINGER: Well, is the management
23 of hyperglycemia very different?

24 PETER PRONOVOST: No. I mean, you
25 still need to know how to do it, but I think it's

1 probably less complicated. I would say most of
2 our hyperglycemia are people who get steroids.
3 And it bumps it up. Or really common is they are
4 in the ICU on an insulin drip and then they leave
5 the ICU. And that transition isn't managed well
6 and they rebound really high. Those are very
7 common scenarios.

8 MATT AUSTIN: Okay. So what I'm
9 hearing from the group is support for including
10 these measures. It does sound like maybe we need
11 to learn a bit more about the -- whether these
12 measures will be reported out in large numbers by
13 hospitals or if there's going to be sort of a
14 smaller number of hospitals and so maybe that
15 becomes the reason for a delay. But we can
16 clarify with CMS with what the current plans are
17 there. And if the plan is to have sort of robust
18 reporting, I think the plan would be to move
19 forward with adding these two measures. We would
20 add these to the outcome domain is what the
21 proposal would be.

22 SARA SINGER: Are there any as a result
23 that we would roll off?

24 MATT AUSTIN: Great question. I think
25 we could come back to you all with a proposal if

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1 we think that would be -- we could come back with
2 an analysis of where things are at. We had some
3 internal conversation about this just the other
4 day, meaning Missy, Alex, Preeti, myself. You
5 know, we talked about, you know, air embolism,
6 right? That's to most hospitals the value is
7 zero. The challenge is when it's not zero, it
8 tends to be a fairly significant event for that
9 patient.

10 You know, unintended retained foreign
11 objects, you know, still remain non-zero. And
12 there's some concern that we're not even
13 capturing all that are actually happening.
14 Right? So I don't think we are at a point where
15 we want to retire any of the HAIs, but we could
16 definitely engage further in that conversation,
17 Sara.

18 MISSY DANFORTH: Yeah. And, Matt, I'll
19 just add we have 12 process and structural
20 measures and only ten outcome measure. So adding
21 two wouldn't necessarily tip the scales too much.
22 We would have to look at what the point
23 distribution is for the other measures and if we
24 like that, but that's also something to consider.

25 PETER PRONOVOST: Hey, Matt, just on

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1 that note, because these are really rare events.
2 And -- hang on a second.

3 MATT AUSTIN: Sure. So other thoughts,
4 reactions to that while we wait for Peter to come
5 back?

6 But Sara, we can put something together
7 for you and others that sort of gives us some
8 context around that.

9 SARA SINGER: I wasn't necessarily
10 suggesting that we do, just that, you know, we've
11 talked about continuing to look at it. And so it
12 occurred to me that this might mark a time when
13 we should look again at maybe not retiring, but
14 distributing -- looking how we distribute weight.

15 MATT AUSTIN: Yeah. I mean, the
16 implications of adding two measures is that the
17 relative weights for the other ten measures will
18 go down.

19 SARA SINGER: Goes down. Yeah.

20 MATT AUSTIN: Yeah.

21 PETER PRONOVOST: Matt, what I was
22 going to say is a potential -- or explore
23 collaborating with CMS. And, you know, as part
24 of that PCAST report for safety, one of the
25 strong things we were working with Michelle and

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1 CMS is they have a more robust -- through their
2 conditions of participation when they visit
3 hospitals that they use data to guide where they
4 look. Right now, they -- as you know, they don't
5 do that. They just walk around and look at a few
6 charts. And so the thought would be to encourage
7 as part of that review any of these low-risk but
8 serious events. They haven't implemented it, but
9 they felt they didn't need any extension of the
10 COPs, but that within that what we put forward to
11 them is that there would be a meeting with the
12 CEO, the board chair, and the -- or the DNV or
13 joint commission who would look at rates of harm
14 and require an action plan for outliers. Because
15 as you know, right now you could have like ten
16 times the rate of CLABSI and your joint
17 commission survey wouldn't even look at it.

18 ARJUN SRINIVASAN: Yeah. And, Peter,
19 it's really -- I think it really is joint
20 commission and DNV who really -- because we've
21 had these discussions with joint commission to
22 try to get them to do that. Because, I mean,
23 it's publicly available data. Right? It's like
24 going to a website just to take a look. And
25 they've not been -- I think there's been some

1 degree of like, well, you know, there's a log of
2 surveyors, they have a lot to do. And so it's
3 not done right. And, you know, it does seem to
4 be a missed opportunity to say like, well, you
5 could at least ask. If their CLABSI SIR is 1.2,
6 why don't you ask them, hey, we see your CLABSI
7 SIR is 1.2. What are you doing about that,
8 right? That should be the focus of your
9 infection control or at least one of your
10 questions at the infection control part of the
11 survey.

12 So, happy to help with that. We
13 definitely -- we would love to see joint
14 commission. We've had some of these discussions,
15 but I don't think -- it's not anything that they
16 have moved forward on.

17 PETER PRONOVOST: You know, Arjun, on
18 that coming -- and maybe this is something we
19 could do or even a commentary where I would love
20 to see us get a list of publicly-available rate-
21 based harms and say, you know, how could you
22 accredit a hospital when you don't look at
23 outliers in these rates. I mean, it's mind-
24 blowing.

25 ARJUN SRINIVASAN: It's a good time to

1 do it. Because, I mean, we are collaborating
2 (indiscernible). So we're building a VTE
3 measure, we're building a hypoglycemia measure.
4 We're thinking we're working on a sepsis measure.
5 So, I mean, we are increasingly -- you know, CMS
6 really wants to use NHSN more and more,
7 especially for fully-electronic measurement
8 reporting. So there's some really, really good
9 collaboration in this space. And I think it's
10 only to the good if we -- and I know this is not
11 part of what we're discussing here, but it's only
12 to the good if we can get more use of that data
13 that people are collecting.

14 PETER PRONOVOST: Correct. More it's
15 just like irresponsible personally that you could
16 accredit a hospital and look at like water stains
17 on their ceiling but not review rates of harm for
18 publicly-available data.

19 SARA SINGER: (Indiscernible) --

20 ARNOLD MILSTEIN: I think it would be
21 an excellent viewpoint or perspective piece.

22 PETER PRONOVOST: I may take -- happy
23 to start something. But, you know, even if we
24 just made -- you have a table of measures that
25 should be reviewed before a hospital is

1 accredited.

2 SARA SINGER: So I think everyone
3 probably saw that CMS just announced they are
4 calling in the accreditation organizations
5 because they have concerns about hospitals that
6 have low quality and continue to get accredited.
7 So I think the time is literally now. And
8 there's going to be a very small window. So if
9 we want to regroup offline about that, I can talk
10 to (indiscernible).

11 PETER PRONOVOST: (Indiscernible).
12 Matt, I wonder if you want to take this point, or
13 Missy, and get a table of measures that, like, we
14 would put in this list. You can probably do it
15 like in 20 minutes.

16 MATT AUSTIN: Yeah.

17 PETER PRONOVOST: And I'm happy to
18 start drafting just a short piece.

19 MATT AUSTIN: Okay. That would work.

20 ARNOLD MILSTEIN: I would be glad to
21 contribute.

22 PETER PRONOVOST: Perfect. Yeah.
23 Because it really is -- whatever, it's a policy
24 failure.

25 MATT AUSTIN: Yeah. So, Sara, we'll

1 pull something together that could help inform
2 the conversation about whether certain outcome
3 measures need -- so you're right. I think we do
4 want to keep evolving the safety grade to reflect
5 meaningful, important, timely measures of safety.
6 So it's worth revisiting.

7 SARA SINGER: Yeah, absolutely.
8 Certainly for finding more. And I like the idea
9 that these allow for use of HR data. It's
10 pushing hospitals in that direction, too. So all
11 good. Thank you.

12 MATT AUSTIN: Yeah. So thank you,
13 Kathy, for the comment in the chat about patients
14 sort of seeing these as being important harms as
15 well.

16 And we have one minute left, so I'm
17 going to say a very big thank you to all of you
18 for your ongoing guidance. We really treasure
19 and appreciate all of you. We are so, so, so, so
20 lucky to have you on this journey with us. So
21 have a great weekend and we'll be in touch with
22 you all. Take care.

23 SARA SINGER: Thanks, everyone.

24 ARJUN SRINIVASAN: Thanks. Bye.
25

C E R T I F I C A T I O N

I, Sonya Ledanski Hyde, certify that the foregoing transcript is a true and accurate record of the proceedings.

Sonya M. Ledanski Hyde

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[things - using]

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Exhibit 13

Message

From: Matt Austin [jausti17@jhmi.edu]
Sent: 4/22/2024 12:26:36 PM
To: Alexandra Campione [ACampione@leapfrog-group.org]; Missy Danforth [mdanforth@leapfrog-group.org]; Preeti Joshi [pjoshi23@jh.edu]
Subject: RE: Imputation Changes

External Email - Use Caution

Alex, this looks great.

I'm wondering, do we: (1) want to reflect that we're already using "Drastic Change" for Step 2 for IPS?; and (2) do we want to use a different term for "Drastic Change" like "Large Change"?

Best,
 Matt

From: Alexandra Campione <ACampione@leapfrog-group.org>
Sent: Monday, April 22, 2024 12:17 PM
To: Missy Danforth <mdanforth@leapfrog-group.org>; Matt Austin <jausti17@jhmi.edu>; Preeti Joshi <pjoshi23@jh.edu>
Subject: Imputation Changes

External Email - Use Caution

Hi all,

Please find the table we discussed below. I also included the "underlying issues". Please feel free to edit in a response to this email.

Underlying Issues of the Current Imputation Model

- Hospitals are disincentivized from completing the Survey.
 - They performed well on the Leapfrog Survey last year (or year before) and now can achieve an 'A' grade without devoting resources to completing this year's Survey.
 - Or their imputed scores are better than what they would achieve if they did complete a Leapfrog Survey.
- Concerns
 - For Step 1 Imputation: Performance could have deteriorated since their last Survey.
 - For Step 2 Imputation: Hospitals that choose not to complete the Leapfrog Survey might in fact be poor performers and not perform at the level of Leapfrog hospitals. Therefore, the Step 2 means are not reflective of their standard of care and their assigned scores are inaccurate.

No Change

Small Change

Moderate Change

Drastic Change

Step 1: Recent Survey Participants	Imputation using 4 past rounds (hospitals can complete a Survey <u>once every 3</u> <u>years</u>)	Shorten imputation to 2 past rounds (hospitals can complete a Survey <u>once every 2</u> <u>years</u>)	Shorten imputation to 1 past round (hospitals have until Nov 30 to submit a Survey)	Eliminate 25% imputation
Step 2: Non- Survey Participants	Impute with the mean of first-time scores for their cohort (many are higher than considerable achievement scores)	No change	Assign hospitals to the bottom quartile or several standard deviations below the mean	The same with limited achievement scores

Alexandra Campione, MPH (*she/her/hers*)

Program Analyst, Health Care Ratings

The Leapfrog Group

1775 K St. NW, Suite 400

Washington, DC 20009



LeapfrogGroup.org | HospitalSafetyGrade.org | [Twitter](https://twitter.com/LeapfrogGroup) | [Donate](#)

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Exhibit 14

Message

From: Ben Choi [bchoi@ro3.com]
Sent: 4/25/2024 9:34:08 AM
To: Missy Danforth [mdanforth@leapfrog-group.org]
Subject: FW: [Caution External Sender] Revised FY24 Forecast
Attachments: FY24 Forecast and Historical Financial Analysis[13].xlsx

External Email - Use Caution

FYI

Ben Choi
 bchoi@ro3.com
 917.703.4193 mobile
 Book a meeting: <https://app.onecal.io/b/benchoi/50-minute-meeting>



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From: Leah Binder <lbinder@leapfrog-group.org>
Date: Wednesday, April 24, 2024 at 17:39
To: Ben Choi <bchoi@ro3.com>
Cc: Josh Berlin <jberlin@ro3.com>
Subject: RE: [Caution External Sender] Revised FY24 Forecast

Thanks this is a good summary.

If we move toward cost reduction as the primary strategy it will be much more severe than this, but I'm not going there for now. We can address incremental spending issues, but let's not lose focus on what managers should be thinking about 24/7, which is revenues. It is likely we will need to spend more money not less to harness the revenue opportunities, especially because we are maxed on staff capacity. But truly that's where the \$\$ are if we are ever going to improve this bottom line.

What I want managers focused on are areas where they can generate bookable revenues. That is a different side of the brain than cost-cutting, so let's keep them there. Here's some of my thinking:

- We should look closely at our archival reports on the Safety Grade as an opportunity, and maybe have one of your marketing folks at RO3 help us with that quickly before we launch the grade May 1.
- I have a nuclear strategy for the CPOE reports sales which I will tell you about tomorrow.
- Paul could work on sales of reports on CPOE and/or another report. Maybe we develop a report on technology and patient safety which is a hot topic.
- We should offer a special deal for some form of AM sponsorship if booked before June 30
- We should plan for special discounts/sales pushes around accolade sales to get more in late May and June.
- Expand marketing around the certified coach program.
- There's a lot of attention to us around the Hospital Safety Grade release, how do we harness that more for marketing?

I'd also like detail on the expenses you will capitalize for NetSuite. You probably looked at this as well, but Ralph is working on the project to build a data delivery tool for licensees which will be capitalized, and we should capitalize the internal labor for that as well. We should continue look at opportunities like that to reduce P&L expense.

Thanks, Leah

Leah F. Binder, MA, MGA
President & CEO
The Leapfrog Group
202-292-6713



LeapfrogGroup.org | HospitalSafetyGrade.org | [Twitter](#) | [Donate](#)

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From: Ben Choi <bchoi@ro3.com>
Sent: Wednesday, April 24, 2024 5:00 PM
To: Leah Binder <lbinder@leapfrog-group.org>
Cc: Josh Berlin <jberlin@ro3.com>
Subject: Revised FY24 Forecast

External Email - Use Caution

Hi Leah - As you requested, I wanted to send you over the latest forecast (attached) with the additional levers factored-in: the capitalization of NetSuite costs and recognition of this December's Annual Meeting revenues in FY24. There's some optimistic news, realistic views, and some recommendations.

Optimistic News

- We are forecasting to end this FY at or ahead of budget in all but 3 revenue categories
- Our year-over-year growth is projecting to be 10-11% revenue growth from last year
- Membership continues to be a star with 58% forecasted growth from FY23, 6%+ over budget target set for FY24
- We believe that we can pull-forward at least \$120k in revenue (potentially even more) for Annual Meeting Revenue
- We can capitalize about \$200k of NetSuite implementation costs between software cost and labor/consulting

Realistic Views

- We're forecasting to fall short on topline revenue by ~\$540k. For reasons we've known all year (DHA contract, no media partnership, slow movement on new data products), the deficit we had to make-up was more than \$900k relative to what was budgeted, and it's a very steep hole to climb out of
- Forecasts of expenses that we're either contractually obligated to or will be difficult to avoid have us overspending on expenses by about \$75k in the aggregate across all categories – but specifically stemming from overages in *Marketing & Communications*, *Travel & Meetings*, and *Consulting*. It may be difficult to make major cutbacks on expenses at this point
- Unfortunately, similar to the forecast we originally discussed in January/February, we're forecasting a \$340k net loss for the year as of now

Recommendations

- Push really hard on high-yield revenue opportunities that are already "on the truck" – Membership, Accolades, Annual Meeting Sponsorships to see if we can accelerate pipeline and pull through more topline revenue with bigger ticket items with immediate rev rec

- Pull-back on all discretionary spending and conduct a more granular cost cutting exercise to reduce expenses from now through the end of the FY.
- Based on feedback from the Senior Leadership Team, here are some possible immediate, low-hanging cost cutting measures with a potential impact of between \$15k to \$20k depending on how aggressively we enact
 - Pause staff meals thru end of FY
 - Pause any/all in-person meetings with consultants/constituents through FY except for essentials (e.g., for Board Meeting)
 - Specifically in Marketing/Comms
 - Cut out paid ad spending in Communications account (e.g., Taboola, LinkedIn, Facebook)
 - Pause Krista Hughes videos for remainder of FY24
 - Skip plaques or special article links for HSG this year

I'm more than happy to cancel my scheduled travel to DC next week and the rest of the FY as part of the efforts.

I know this is a lot and would be happy to discuss on our call tomorrow morning.

Thanks,
Ben



Ben Choi
bchoi@ro3.com
Chief Operating & Financial Officer
rule of three, LLC
917.793.4193 mobile
<https://ro3.com/>

Book a meeting: <https://app.meetcal.io/b/benchoi/>



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Exhibit 15

Message

From: Patrick Romano [psromano@ucdavis.edu]
Sent: 5/3/2024 2:50:34 AM
To: Brenda L Inman [bdejarosa@UCDAVIS.EDU]; Robert Jon Kucejko [rjkucejko@ucdavis.edu]; Penny Jefferson [pjefferson@ucdavis.edu]; Tami L Gomez [tgomez@UCDAVIS.EDU]
CC: Leticia M Dickinson [ldickinson@ucdavis.edu]; Karen Davis [kxdavis@ucdavis.edu]; Garth H. Utter [ghutter@ucdavis.edu]; John W Kennedy [jwkennedy@ucdavis.edu]; Gregory A Maynard [gmaynard@UCDAVIS.EDU]
Subject: RE: Theoretical question on PSI 15 - Accidental Puncture or Laceration
Attachments: Safety Grade Expert Panel 240412 REDACTED.pptx

Yes, this is true (about the expected decline).

In fact, Leapfrog staff are exercised about the fact that the response rate decreased in 2023 after many consistent years of increases, see slide 10 attached.

They fear that the imputed scores are "too high" in some cases, not sufficiently incentivizing continued participation. So, they are determined to more aggressively penalize nonparticipants.

They will never remove large hospitals from reporting, so unless we want to continue getting C, and potentially dropping to D, I would advise to start participating again.

At our last expert meeting, I argued for allowing facilities to skip a year, with imputation based on carrying forward results from the prior year, but longer periods of nonparticipation won't fly, as this experience demonstrates.

Patrick S. Romano, MD MPH FAAP FACP

Professor of Medicine and Pediatrics, UC Davis Division of General Medicine

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E-mail: psromano@ucdavis.edu

Website: <https://health.ucdavis.edu/team/pediatrics/122/patrick-romano---internal-medicine---pediatrics-general-sacramento>

From: Brenda L Inman <bdejarosa@UCDAVIS.EDU>

Sent: Thursday, May 2, 2024 6:10 PM

To: Robert Jon Kucejko <rjkucejko@ucdavis.edu>; Penny Jefferson <pjefferson@ucdavis.edu>; Patrick Romano <psromano@ucdavis.edu>; Tami L Gomez <tgomez@UCDAVIS.EDU>

Cc: Leticia M Dickinson <ldickinson@ucdavis.edu>; Karen Davis <kxdavis@ucdavis.edu>; Garth H. Utter

<ghutter@ucdavis.edu>; John W Kennedy <jwkennedy@ucdavis.edu>; Gregory A Maynard <gmaynard@UCDAVIS.EDU>

Subject: Re: Theoretical question on PSI 15 - Accidental Puncture or Laceration

Hi Dr. Romano,

UC Davis no longer participates in Leapfrog. The last data that we submitted was June, 2022. (I was the one who submitted our data). In 2023, Leapfrog reused much of our 2022 data when issuing a safety grade. Leapfrog still has access to our publicly reported data and will continue to issue safety grades to us, but we no longer submit internal data. I spoke with Leapfrog when we discontinued our participation. I was told over time our safety grades would experience an expected decline due to lack of self-reported data. Feel free to reach out to me if you have any other questions.

Thank you!

Brenda

Brenda Inman MSN, RN, CPHQ

Director, Quality and Safety

Clinical Affairs Division, Quality and Safety

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Sacramento, CA 95817

916-734-8928

bdejarosa@ucdavis.edu

UC DAVIS HEALTH

CONFIDENTIAL, PROTECTED BY EVIDENCE CODES 1156 & 1157

From: Robert Jon Kucejko <rjkucejko@ucdavis.edu>

Sent: Thursday, May 2, 2024 5:52 PM

To: Penny Jefferson <pjefferson@ucdavis.edu>; Patrick Romano <psromano@ucdavis.edu>; Tami L Gomez <tgomez@UCDAVIS.EDU>

Cc: Leticia M Dickinson <ldickinson@ucdavis.edu>; Brenda L Inman <bdejarosa@UCDAVIS.EDU>; Karen Davis <kxdavis@ucdavis.edu>; Garth H. Utter <ghutter@ucdavis.edu>; John W Kennedy <jwkennedy@ucdavis.edu>; Gregory A Maynard <gmaynard@UCDAVIS.EDU>

Subject: RE: Theoretical question on PSI 15 - Accidental Puncture or Laceration

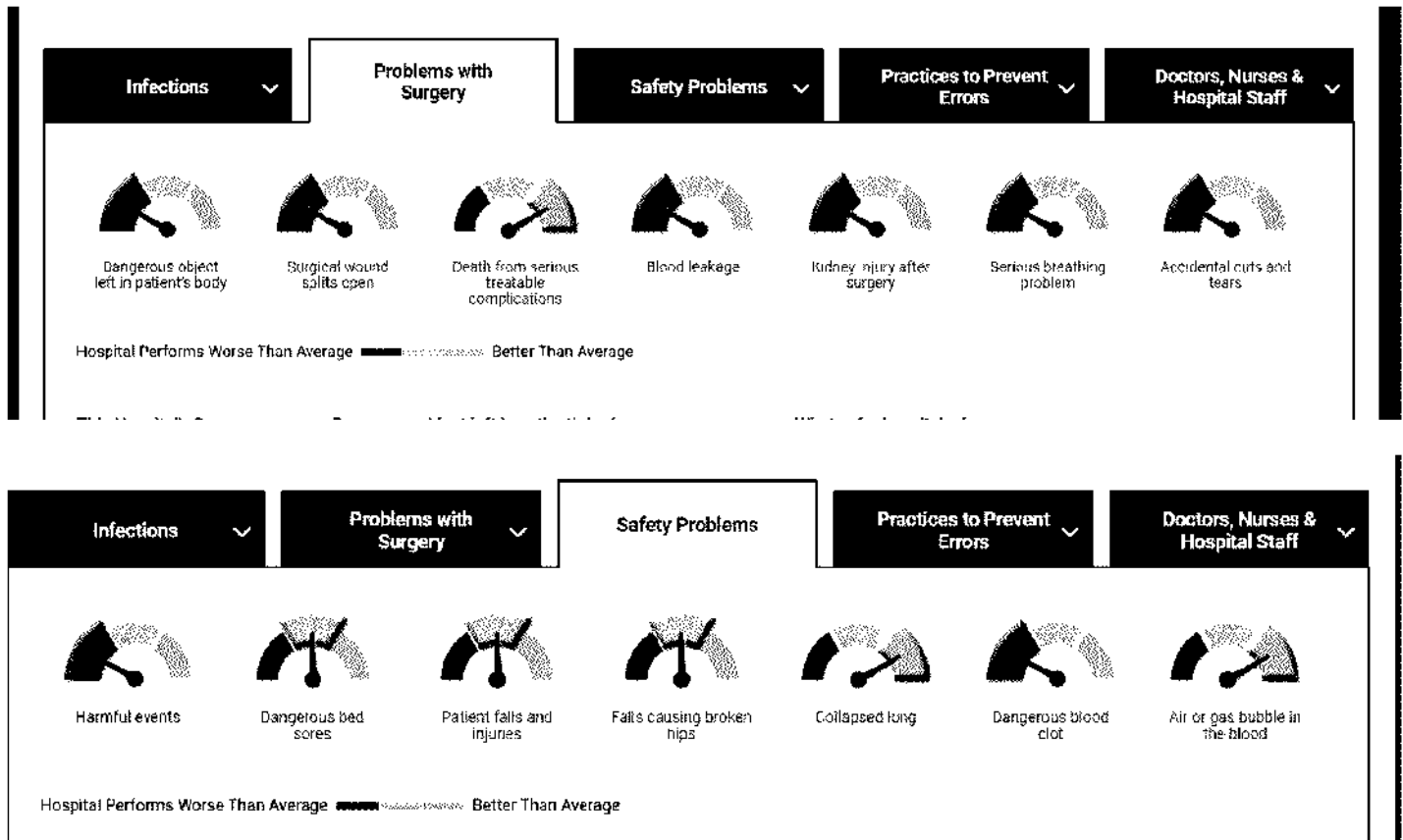
Looks like we did pretty poorly in the safety and infection ratings.

I know they used our PSI 90 data from 7/2020 – 6/2022, so that was before we've made monumental efforts in the last year. The infection data is more recent, and we've also made a big push for identifying MRSA earlier in our pre-op patients, so hopefully we have some efforts already in place to work on this.

But if anyone needed more motivation to respond to safety queries, I think I now have it. 😬

Bobby





From: Penny Jefferson <pjefferson@ucdavis.edu>

Sent: Thursday, May 2, 2024 5:41 PM

To: Patrick Romano <psromano@ucdavis.edu>; Robert Jon Kucejko <rjkucejko@ucdavis.edu>; Tami L Gomez <tgomez@UCDAVIS.EDU>

Cc: Leticia M Dickinson <ldickinson@ucdavis.edu>; Brenda L Inman <bdejarosa@UCDAVIS.EDU>; Karen Davis <kxdavis@ucdavis.edu>; Garth H. Utter <ghutter@ucdavis.edu>; John W Kennedy <jwkennedy@ucdavis.edu>; Gregory A Maynard <gmaynard@UCDAVIS.EDU>

Subject: Re: Theoretical question on PSI 15 - Accidental Puncture or Laceration

adding @Tami L Gomez for inclusion in the discussion.

Penny Jefferson MSN, RN, CCDS, CCDS-O, CCS, CDIP, CRC, CHDA, CRCR, CPHQ

CDI Manager, Coding & Clinical Documentation Integrity Services

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[Please click this link to book time with me](#)



Kindness

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Book time to meet with me

From: Patrick Romano <psromano@ucdavis.edu>
Sent: Thursday, May 2, 2024 5:27 PM
To: Robert Jon Kucejko <rjkucejko@ucdavis.edu>
Cc: Leticia M Dickinson <ldickinson@ucdavis.edu>; Brenda L Inman <bdejarosa@UCDAVIS.EDU>; Karen Davis <kxdavis@ucdavis.edu>; Penny Jefferson <pjefferson@ucdavis.edu>; Garth H. Utter <ghutter@ucdavis.edu>; John W Kennedy <jwkennedy@ucdavis.edu>; Gregory A Maynard <gmaynard@UCDAVIS.EDU>
Subject: RE: Theoretical question on PSI 15 - Accidental Puncture or Laceration

Very sorry to see this story... as you probably know, I serve on Leapfrog's expert panel for hospital safety scoring, <https://www.hospitalafetygrade.org/about-the-grade>

We used to get mostly As with an occasional B, never seen us get a C before 😞

What's driving this decline?

There are certainly opportunities to improve their methods...

From our local paper, <https://www.sacbee.com/news/local/health-and-medicine/article288237040.html>

Eight Sacramento-area hospitals are among the safest in the nation, according to a nonprofit organization that studies patient safety and care. The Leapfrog Group issues Hospital Safety Grade reports twice a year for nearly 3,000 general hospitals in the United States based on rates of preventable errors, accidents, injuries and infections, as well as the systems hospitals use to prevent those. The group's latest report, released Wednesday and searchable as an online database, grades health care facilities across the nation on a scale of A to F — with A being the highest grade and F the lowest. Out of 20 Sacramento-area hospitals, eight received A grades for spring 2024. They included Mercy General Hospital, 4001 J St. in Sacramento, which excelled at having effective leadership and practices to prevent errors, according to the Leapfrog report.

A total of nine hospitals received B grades, including Kaiser Foundation Hospital, 2025 Morse Ave. in Sacramento. That hospital scored high on its work to avoid harmful events such as patient falls and dangerous blood clots, the report found.

Three hospitals received C grades in total. University of California Davis Medical Center, 4301 X St. in Sacramento, scored lower on its efforts to stop infections and problems with surgery, Leapfrog said, but performed well in terms of ordering and administering medications.

How safe are Sacramento-area hospitals? Here are the Leapfrog Group's hospital safety grades for hospitals in Sacramento and the surrounding area:

A grades

Mercy General Hospital, 4001 J St. in Sacramento
Kaiser Foundation Hospital, 6600 Bruceville Road in Sacramento
Methodist Hospital, 7500 Hospital Drive in Sacramento
Mercy San Juan Medical Center, 6501 Coyle Ave in Carmichael
Woodland Memorial Hospital, 1325 Cottonwood St. in Woodland
Kaiser Foundation Hospital, 1600 Eureka Road in Roseville
NorthBay VacaValley Hospital, 1000 Nut Tree Road in Vacaville
NorthBay Medical Center, 1200 B. Gale Wilson Blvd. in Fairfield

B grades

Kaiser Foundation Hospital, 2025 Morse Ave. in Sacramento
Sutter Davis Hospital, 2000 Sutter Place in Davis
Sutter Roseville Medical Center, 1 Medical Plaza Drive in Roseville
Mercy Hospital of Folsom, 1650 Creekside Drive in Folsom
Kaiser Foundation Hospital, 1 Quality Drive in Vacaville
Sutter Auburn Faith Hospital, 11815 Education St. in Auburn
David Grant Medical Center, 101 Bodin Circle in Travis
Adventist Health and Rideout, 726 4th St. in Marysville
Marshall Medical Center, 1100 Marshall Way in Placerville

C grades

Sutter Medical Center, 2825 Capitol Ave. in Sacramento
University of California Davis Medical Center, 4301 X St. in Sacramento
Adventist Health Lodi Medical, 975 Fairmont Ave. in Lodi

How are hospitals graded by Leapfrog Group? The Leapfrog Group grades hospitals on a scale of A to F based on "overall performance in keeping patients safe from preventable harm and medical errors." The group said it came up with its hospital safety grades by looking at up to 30 national performance measures from the Centers for Medicare & Medicaid Services, the Leapfrog Hospital Survey and other supplemental data sources. Leapfrog then worked under the guidance of a panel of patient safety experts to select about two dozen "evidence-based measures" — divided into five key categories — and develop a scoring methodology. Those categories are:

Infections

Problems with surgery

Safety problems

Practices to prevent errors

Doctors, nurses and hospital staff.

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Website: <https://health.ucdavis.edu/team/pediatrics/122/patrick-romano---internal-medicine---pediatrics-general-sacramento>

From: Patrick Romano

Sent: Thursday, May 2, 2024 4:50 PM

To: Robert Jon Kucejko <rjkucejko@ucdavis.edu>

Cc: Leticia M Dickinson <ldickinson@ucdavis.edu>; Brenda L Inman <bdejarosa@UCDAVIS.EDU>; Karen Davis <kxdavis@ucdavis.edu>; Penny Jefferson <pjefferson@ucdavis.edu>; Garth H. Utter <ghutter@ucdavis.edu>; John W Kennedy <jwkennedy@ucdavis.edu>; Gregory A Maynard <gmaynard@UCDAVIS.EDU>

Subject: RE: Theoretical question on PSI 15 - Accidental Puncture or Laceration

LOL Bobby, it's nice to meet you, I just read your story in the Patient Safety Newsletter with great interest 😊

I must share/apportion the blame for PSI 15 with my long-time colleague in your department, Garth Utter. We have written many papers together over the years as we worked with AHRQ to test and improve the measures.

John Kennedy, also cc'd here, is our ICD-10-CM/PCS Certified Coding Specialist and Clinical Documentation Improvement specialist, so he bridges the worlds of clinical documentation, coding, and external measurement.

Also, we often respond to internal case review requests, but we ask that any requests for measure specification changes be routed through official channels, <https://qualityindicators.ahrq.gov/home/contact>, so we can bill AHRQ for our responses, and track refinements over time 😊

I will respond faster and more candidly this way but I may forget what I have said... comments to qisupport@ahrq.hhs.gov get routed to Pantheon Software, which answers the silly questions and the software questions, then the clinical coding questions are referred to Mathematica and from Mathematica to UC Davis.

See below...

Patrick S. Romano, MD MPH FAAP FACP

Professor of Medicine and Pediatrics, UC Davis Division of General Medicine

Co-Editor in Chief, AHRQ *Patient Safety Network* (PSNet and WebM&M)

4150 V Street, PSSB Suite 2400

Sacramento, CA 95817

Telephone: (916) 734-7005 or -7237

E-mail: psromano@ucdavis.edu

Website: <https://health.ucdavis.edu/team/pediatrics/122/patrick-romano---internal-medicine---pediatrics-general-sacramento>

From: Robert Jon Kucejko <rjkucejko@ucdavis.edu>

Sent: Thursday, May 2, 2024 12:57 PM

To: Patrick Romano <psromano@ucdavis.edu>

Cc: Leticia M Dickinson <ldickinson@ucdavis.edu>; Brenda L Inman <bdejarosa@UCDAVIS.EDU>; Karen Davis <kxdavis@ucdavis.edu>; Penny Jefferson <pjefferson@ucdavis.edu>

Subject: Theoretical question on PSI 15 - Accidental Puncture or Laceration

Hi Dr. Romano,

I'm Bobby the PSI MD champion here at UC Davis. We've crossed paths in emails before. I just learned a couple weeks ago, at the National Physician Advisor meeting that the whole PSI process was basically born at UC Davis. Impressive! Thank you for your hard work! I do believe it is one of the best thought out systems for catching actual safety events we have.

One question keeps arising, that I wonder if you have considered. Specifically for PSI 15, it's my understanding that if an accidental puncture or laceration was noted on an initial procedure, but fixed at that same procedure, and no subsequent procedures are coded, then it wouldn't qualify as a PSI. What I've noticed is that we will sometimes trigger a PSI in these cases even if the puncture/laceration is fixed during the initial procedure, but the abdomen is left open with plans for a "second look" laparotomy as is common practice in trauma/acute care surgery.

My concern is that this inadvertently discourages second-look laparotomies, and I wonder if any other "PSI champions" who are non-surgical would discourage the practice. I would never ever suggest this to our trauma team, mostly because second look laparotomies really can only be a good thing, and the literature supports that. It's actually quite hard to convince non-academic surgeons to commit to a second look laparotomy because it requires so many extra resources and time commitment from the surgeons. But, like I said, I cannot imagine when a second look laparotomy would be bad. You get the patient out of the OR quicker during the primary procedure, to restore their own hemostasis and physiology in the ICU, then come back later when they are more stable, and also tissues have had time to demarcate.

Has this ever been considered? I personally don't know how we would code a second-look laparotomy different from a normal laparotomy, or how to code a "negative" second look laparotomy as a way of removing the PSI. Hopefully, I'm not way off base here and not causing a bother. But if you have any thoughts and time to share them, I'd love to hear them!

PSR: No, you're not off base. We have had a series of complaints related to cases where the iatrogenic injury was recognized and repaired in the first operation, when it happened, and then there was a return to the OR for an unrelated reason.

So far, we have addressed in two ways, neither entirely satisfactory:

- *We took the word "unrecognized" out of the title of the indicator, which was previously known as "Unrecognized Abdominopelvic Accidental Puncture or Laceration Rate." In so doing, we remind users that we are no longer assuming that the laceration was UNRECOGNIZED at the time of the initial operation, but we are simply looking for evidence that it was not fully resolved or addressed at that time. In other words, the need for a second invasive procedure (and all the associated morbidity and mortality risk) is now considered "within scope" for the measure, even if the laceration was recognized during the first procedure.*
- *We narrowed the list of subsequent operations that trigger the numerator, creating six different lists based on the specific structure that was injured in the prior operation. This specification change eliminated a lot of false positives due to completely unrelated operations – for example, going back in to complete a tumor resection or to revise a colostomy. However, and Garth can comment further, ex lap remains on the list due to concern that going back into the abdomen is a "big deal," even if the surgeon opts not to repair anything. I am certainly willing to revisit this question and to remove additional procedures from the reoperation list, based on input from you, Garth, and others.*

From the patient perspective, I would hate a "second look laparotomy," and would view it as just as bad as going back into my abdomen to repair a laceration that hadn't been fully repaired during the first operation. As a patient, I do not agree that leaving my abdomen open is completely benign. But I take your point that there may be net benefits to this approach, and would like to discuss further with you and Garth 😊

Thanks again,

Bobby

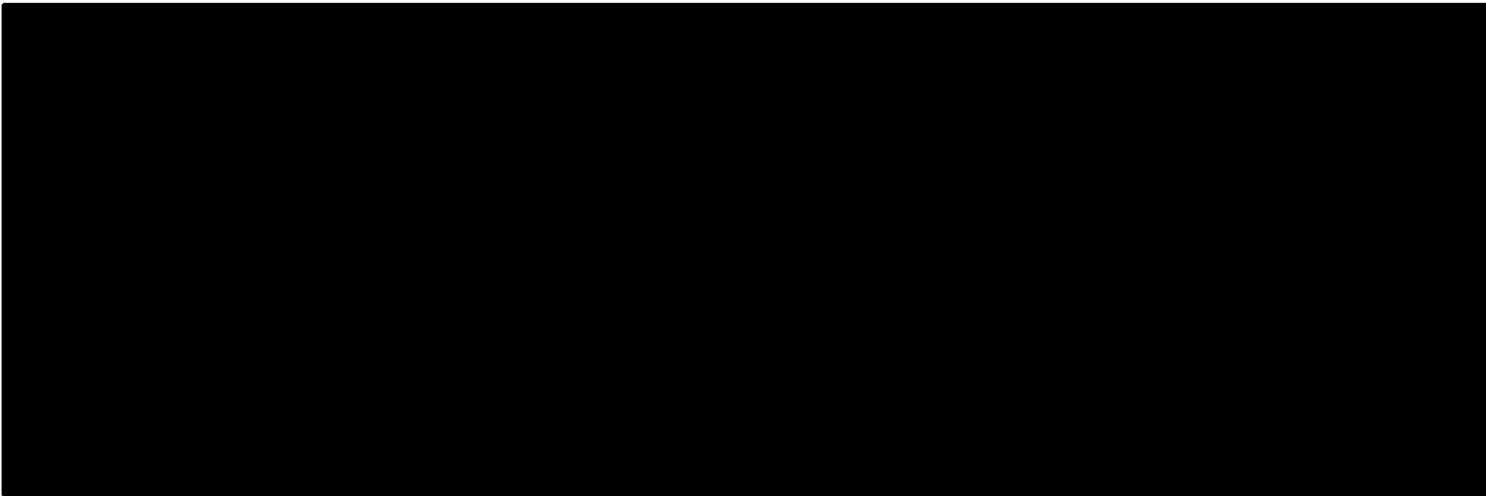
From: Leticia M Dickinson <ldickinson@ucdavis.edu>

Sent: Wednesday, May 1, 2024 2:11 PM

To: Robert Jon Kucejko <rjkucejko@ucdavis.edu>

Cc: Brenda L Inman <bdejarosa@UCDAVIS.EDU>

Subject: PSI 15 - Accidental Puncture or Laceration (Orthopedic Surgery)



Leticia Dickinson, MSN, RNC-OB, C-EFM
Quality Improvement Nurse Analyst
Clinical Affairs Quality & Safety Department
North Addition, 3rd Floor
Microsoft Teams (preferred)
916-734-4291
ldickinson@ucdavis.edu
COVERAGE: Department of Surgery, Orthopedic Surgery

Exhibit 16

Message

From: Patrick Romano [psromano@ucdavis.edu]
Sent: 5/14/2024 10:51:45 PM
To: Matt Austin [jausti17@jhmi.edu]
CC: Missy Danforth [mdanforth@leapfrog-group.org]; Alexandra Campione [ACampione@leapfrog-group.org]
Subject: RE: Leapfrog: Proposed Text for Imputation Change
Attachments: HSG Proposed Imputation Change Fall 2024 PSR.docx

Flag: Follow up

External Email - Use Caution

Thank you for sharing.

I like the simpler and more direct approach here – if the goal is to penalize nonparticipants, you might as well do so in a clear and unmistakable manner, while allowing for hospitals to manage their burden and jump back on the wagon after a year. This approach is certainly much easier to implement and more straightforward than the step 2 imputation that you folks originally proposed, in that the consequences of nonresponse will become readily apparent.

I corrected a couple of typos in Peter's edits and suggested a rephrasing of one sentence.

As I mentioned earlier, your step 2b proposal would have led to lower imputed estimates, but NOT more ACCURATE imputation. I find no reason to believe – and you didn't present any evidence to suggest – that a hospital's unreported data from the current year is better approximated by its cohort mean from the first year of reporting than by its current cohort mean. The underlying hypothesis behind your proposed step 2b approach was that hospitals stop reporting because their true performance deteriorated, relative to their cohort. My hypothesis, by comparison, was that most hospitals stop reporting because it is too burdensome, and because they only find market value in an A grade, which proves impossible to attain or maintain. If my hypothesis is correct, then the current step 2 approach (current cohort mean) would yield more accurate imputations... but it doesn't achieve your strategic objective of penalizing nonparticipants. In other words, I wasn't keen on a backdoor approach to penalizing nonparticipation... if you want to penalize nonparticipants, then don't pretend that you are imputing missing values in a statistically optimal way. Just be honest about your goal.

Patrick S. Romano, MD MPH FAAP FACP

Professor of Medicine and Pediatrics, UC Davis Division of General Medicine

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E-mail: psromano@ucdavis.edu

Website: <https://health.ucdavis.edu/team/pediatrics/122/patrick-romano---internal-medicine---pediatrics-general-sacramento>

From: Matt Austin <jausti17@jhmi.edu>

Sent: Tuesday, May 14, 2024 1:03 PM

To: Patrick Romano <psromano@ucdavis.edu>

Cc: Missy Danforth <mdanforth@leapfrog-group.org>; Alexandra Campione <ACampione@leapfrog-group.org>

Subject: RE: Leapfrog: Proposed Text for Imputation Change

Patrick,

If helpful to your review, Peter offered some suggested edits to clarify the concept of "imputation".

Thanks for any feedback you may have on this communication to hospitals.

Best,
Matt

From: Matt Austin
Sent: Tuesday, May 7, 2024 1:24 PM
To: Patrick Romano <psromano@ucdavis.edu>
Cc: Missy Danforth <mdanforth@leapfrog-group.org>; Alexandra Campione <ACampione@leapfrog-group.org>
Subject: Leapfrog: Proposed Text for Imputation Change

Patrick,

Since our conversation with you a couple of weeks ago about changing the imputation approach used in Leapfrog's Hospital Safety Grade, we met with the broader expert panel to hear their input, and have drafted the attached language to share with hospitals about the proposed changes.

In the attached, I believe you'll see that we have found a path forward that still uses a hospital's unique historical data when available (although for a shortened period of time) and when historical data are not available, creates an incentive for hospitals to share information about their patient safety practices.

We very much value your perspective and expertise, so we'd appreciate hearing any concerns you might have with the proposed.

Best,
Matt

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Exhibit 17

Message

From: Alexandra Campione [/O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=D66D320700BE4B4985D929853FF80E30-ACAMPIONE]
Sent: 5/15/2024 2:06:20 PM
To: Patrick Romano [psromano@ucdavis.edu]
Subject: RE: Leapfrog: Proposed Text for Imputation Change

Patrick,

Thanks for your feedback. I completely agree.

Alex

From: Patrick Romano <psromano@ucdavis.edu>
Sent: Tuesday, May 14, 2024 10:52 PM
To: Matt Austin <jausti17@jhmi.edu>
Cc: Missy Danforth <mdanforth@leapfrog-group.org>; Alexandra Campione <ACampione@leapfrog-group.org>
Subject: RE: Leapfrog: Proposed Text for Imputation Change

External Email - Use Caution

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Patrick S. Romano, MD MPH FAAP FACP
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From: Matt Austin <jausti17@ihmi.edu>
Sent: Tuesday, May 14, 2024 1:03 PM
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Matt

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Sent: Tuesday, May 7, 2024 1:24 PM
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Cc: Missy Danforth <mdanforth@leapfrog-group.org>; Alexandra Campione <ACampione@leapfrog-group.org>
Subject: Leapfrog: Proposed Text for Imputation Change

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We very much value your perspective and expertise, so we'd appreciate hearing any concerns you might have with the proposed.

Best,
Matt

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Exhibit 18

Message

From: Leapfrog Help Desk [support@leapfroghelpdesk.zendesk.com]
Sent: 5/21/2024 3:59:37 PM
To: Alexandra Campione [ACampione@leapfrog-group.org]
Subject: [Leapfrog Help Desk] Re: 103566

External Email - Use Caution

--TYPE YOUR REPLY ABOVE OR IT WILL NOT BE VISIBLE TO AGENT--

This ticket (#103566) has been updated.

To review the status of the ticket and add updates, follow the link below:

<http://leapfroghelpdesk.zendesk.com/agent/tickets/103566>



Missy (Leapfrog Help Desk)

May 21, 2024, 3:11 PM EDT

Private note

we could add a symbol next to gas guages or scores that were imputed instead of just showing in the table rview - that might soften this



Wenthold, Becky

May 21, 2024, 1:17 PM EDT

Wenthold, Becky was not signed in when this comment was submitted. [Learn more](#)

I am disappointed with the 2024 proposed changes. These changes will penalize hospitals that do not submit a Leapfrog Survey. The public will not understand nor dig into the methodology of these grades, and hospitals will be falsely represented with a lower grade, because they chose to not complete a survey. The survey is extremely time intensive and, in a time, when hospitals are barely breaking even financially, they do not have the resources to commit to this survey. Additionally, there is no option to submit a survey for a health system, where process measures apply to several hospitals in that system. A hospital with excellent outcomes, will no longer be able to receive an A grade because limited achievement is assigned to process measures that actually may be in place.

You are an agent. Add a comment by replying to this email or [view ticket in Zendesk Support](#)

Ticket # 103566

Status Open

Requester Wenthold, Becky

CCs --
Followers --
Group 01 Support
Assignee Alex
Priority Normal
Type Question
Channel Web Form

This email is a service from Leapfrog Help Desk. Delivered by [Zendesk](#).

Exhibit 19

Strategic Planning Update for the Board of Directors

June 2024



LEAPFROG00237725

Focusing Our Vision

Current

We envision a future where purchasers will tie health care investment to excellence and educate their employees on choosing the best care. Health plans will support purchasers in their efforts to reward high performance and empower employees. Consumers will fight for the best care for themselves and their families. Providers will be courageous in championing transparency and leading groundbreaking improvements.

Proposed

Stop avoidable death and suffering in health care.

Leapfrog needs a clear and concise vision that extends beyond the world of employers:

- to approach health care as a complete construct
- to include the many facets of care payment and delivery that extend across a complex system.

Introducing New Core Enablers

- **Staff:** Leapfrog must continue to attract top talent, and retain its low turnover with average tenure of > 5 years. We must remain a rewarding place to work with best in class benefits and competitive salaries
- **Board and volunteers:** Leapfrog must continue to attract as volunteers influential leaders, industry influencers, and world-class experts who guide strategy and assure the integrity of our evidence base. The governing board should maintain its independence from industry and continue to aim for 75% purchaser members.
- **Partnerships, carefully structured:** Leapfrog is not a multi-stakeholder organization, but we are proud partners. We must develop good partnerships with people and organizations that make everything happen, including employers, regional leaders, patient and family advocates, providers, industry, policymakers, and the public at large. But we must structure each partnership to maintain Leapfrog's decision-making independent of the health care industry.
- **Diversity:** Leapfrog Board, staff, volunteers, and advisory boards must continually strive for diversity and equal opportunity
- **Financial discipline:** All program growth must be tied to revenue growth. That means leadership must focus on growing revenues as a priority in order to see its intent realized.

Purpose of the Long Range Strategic Intent

- The Proposed Long Range Strategic Intent is the big vision, our true north.
- We will assume things will not always go as planned.
- We will monitor and gauge progress over three years, six years, and beyond.
Management has developed a dashboard of indicators which the committee should monitor each year to determine whether the direction still applies and the strategies are working.
- The Long Range Strategic Planning Committee will review and edit this proposed strategic intent, with the goal of bringing a recommendation to the Board for vote.

CURRENT Long Range Strategic Intent, Through 2026

1

Become the standard for publicly rating health care.

2

Become U.S. purchasers' consensus source of valid data to support informed employee decision-making, achieve greater value, and prevent wasted lives and dollars.

3

Grow our finances so Leapfrog sustains strong policy and market influence, grows impact, and is protected from risk.

Issues with this approach

1. Improving patient safety is not central
2. Our core ongoing actions are minimized in moving us toward our intent (ie collecting, reporting, setting standards for safety)
3. Focus on mobilizing employers, but other stakeholders have been critical to our success as well
4. Unfocused about the settings of health care we want to improve and what we want to improve about them
5. Long term intent only, without intermediary benchmarks. Are we actually getting where we want to be?

PROPOSED Long-Range Strategic Intent, 2024-2030

More, Better, Bigger

1

More Capacity: Leapfrog scales its resources to the capacity needed to make giant leaps for patient safety

2

Better Standards: Leapfrog sets ever-higher standards for patient safety and publicly rates acute care facilities on achievement of those standards

3

Bigger action: Leapfrog motivates stakeholders to accelerate momentum for patient safety and transparency through usage of Leapfrog standards

Summary of the Shift Proposed

- | | |
|---|--|
| <ol style="list-style-type: none">1. Improving patient safety is not central2. Our core ongoing activities are minimized in moving us toward our intent (ie collecting, reporting, setting standards for safety)3. Focus on mobilizing employers, but other stakeholders have been critical to our success as well4. Unfocused about the settings of health care we want to improve and what we want to improve about them5. Long term intent only, without intermediary benchmarks. Are we actually getting where we want to be? | <ul style="list-style-type: none">• <i>Patient safety is central.</i>• <i>Core activities are integrated into the intent.</i>• <i>Accounts for the range of key stakeholders who must be mobilized.</i>• <i>Focuses on acute care settings and patient safety.</i>• <i>3 and 6 year benchmarks</i> |
|---|--|

How We Scale: Our Goals

- Rapidly expand and diversify revenue sources, including grants, development, industry partnerships, data licensure
- Rapidly expand and diversify staff, skills, competencies to support Leapfrog operating and growth objectives
- Accumulate a reserve fund equal to at least six months of expenses
- Expand resources in the Judie Burrows Education Institute to engage and educate stakeholders
- Build infrastructure capability to support additional staff and portfolio development, particularly technology and marketing
- Add advocacy expertise to advance Leapfrog-specific and general priorities in Federal, state, and local policy and regulations

How We Scale: Discussion Points

- A diverse source of revenues is a key pillar of **ensuring Leapfrog's strategic independence**, allowing the organization to pursue our values even if they might be in conflict with an emerging industry priority.
- We need to target a broad audience with the Judie Burrows Education Institute; for example, employers and other Leapfrog data users can use JBI resources to guide their employees on what is available as information guiding their healthcare decision-making.
- New infrastructure and expertise **are critical to build on Leapfrog's existing efforts** in data dissemination, marketing, and advocacy

How Set Standards: Our Goals

- Set high standards that are evidence-based and expertly derived that make health care safer for everyone
- Inform strengthened measure development, while supporting expanded, accessible, and appropriate data sources
- Engage and support increased participation in hospital and ambulatory surgery center survey, as well as evaluate appropriate additional settings of care delivery
- Set high standards that are evidence-based and expertly derived, for the wise use of technology as a tool to improve safety and quality delivery of care
- Set high standards that are evidence-based and expertly derived, focused on reducing inequities in patient safety and quality across acute care facilities
- Consider different approaches to correlating survey with market evolution and data sales/licensures
- Increase the amount of mandated publicly reported measures so that they can be translated into grades for new settings

How We Set Standards: Discussion Points

- Above all, we need a goal that reflects **the overriding imperative to make health care safer for everyone**
- Our standards are both exacting and derived from top experts
- Leapfrog serves an important role in supporting the field of quality measurement development, as experts and as advocates
- An ASC Safety Grade is an important next step that won't be possible without **new mandatory reporting that we have to advocate for**
- Although we aren't ready to expand into other settings yet, we need to prepare the outlines of a strategy so we are ready to seize opportunities that present themselves
- We aren't yet able to set **standards in new areas of technology like AI, but the field is changing fast**

How We Mobilize: Our Goals

- General Public: Communication strategies that make the Hospital Safety Grade and Leapfrog itself household names
- Patients and Family Caregivers: Enable patients and family caregivers to use transparent public information to choose the safest, highest quality care, with an emphasis on areas of care that resonate with consumers (patients can choose, costs vary)
- Patient Activists: identify common priorities and feature leaders in our public outreach
- Regional Leaders: Build a strong infrastructure of regional leaders that engage employers and health care facilities in their markets to maximize provider participation in Leapfrog and to use the data for payment and public reporting

How We Mobilize: Our Goals (continued)

- Purchasers: Enable purchasers and their contractors to tie Leapfrog ratings to payment decisions
- Consultants to purchasers (i.e. brokers): educate brokers on the advantages of using Leapfrog data to inform their approach
- Health Plans: Pressure plans to tie Leapfrog ratings to payment decisions
- Clinicians: Partner with professional associations where our interests align in ameliorating conditions
- HealthTech Vendors/Startups: Partner with vendors of solutions that address Leapfrog's patient safety priorities
- Regulators/Policymaking: Work with Federal and state regulators and policymakers to enact laws and regulations that accelerate Leapfrog's effectiveness

How We Mobilize: Discussion Points

- Leapfrog has many target audiences, but cannot be all things to all people: our plan emphasizes **a specific approach for each individual audience**
- “Consumers” are a broad group that encompasses a light-touch general public, engaged patients and their family caregivers looking for quality information they can use, and patient activists looking to overhaul the system
- **Regional Leaders are Leapfrog’s key force multiplier**
- Many corporate participants in healthcare have individual needs: purchasers and their consultants need education and enablement to use our data, **health plans should be pressured** to adopt our data
- New infrastructure and expertise in marketing and advocacy will enable our multiplicity of communications efforts

Key Environmental Issues



LEAPFROG00237740

Environmental Scan: Price Transparency

- We need evidence to show that transparent hospitals are safer hospitals
- We can leverage that evidence to pressure health plans to publish Safety Grade alongside prices
- Vendors, providers, and patient activists who partner with us need to emphasize there is no good price for poor care
- We can leverage Leapfrog's Lives and Dollars Lost Calculator

Environmental Scan: Artificial Intelligence

- Not enough evidence to make recommendations on AI applications, but we can already sound the alarm on potential for new risks to patient safety
- We can do so by leveraging patient experiences and narratives
- Our approach will differ depending on applications:
 - Generative AI and LLMs are prone to hallucinations and should not replace human touch clinicians
 - Computer vision applications in radiology are promising but trained on biased data
- Electronic Clinical Quality Measures (eCQMs) will continue to proliferate, with new analytic capabilities (e.g. reliable analyses of free-text clinical notes)
- AI applications that reduce the number of administrative tasks that nurses and physicians need to perform can help to relieve workforce shortages
- One notable opportunity: joining the Coalition for Health AI

Environmental Scan: Workforce

- Staffing issues are broad, and go beyond clinicians: nursing assistants, lab technicians, translators, custodial staff, maintenance technicians
- Diversity of staff a concomitant issue
- Workforce shortages have a direct impact on patient safety
 - Patient safety issues exacerbate workforce issues, as safer hospitals will have less turnover
- CMS Patient Safety Structural Measure asks hospitals to attest that they have an action plan for workforce safety that specifically cites violence and psychological safety, among other elements.
- Pilot programs with alternative staff models where RNs can supervise a team of LPNs
- Leapfrog could soon be in a position to set standards

Environmental Scan: Medicare Advantage

- Medicare Advantage threatens Leapfrog: data collection essential to Leapfrog's public reporting function is not consistently available (e.g. patients on Medicare Advantage plans are not counted in the critical PSI-90 measure used in the hospital safety grade).
- However, Medicare Advantage may be an optimal path for financing health care: has already shored up the Medicare trust fund.
- Leapfrog's role is not to opine on whether or not MA is a good thing (or at least not until we have more information about whether quality and value are improved) – but we need to advocate for a federal mandate to report these data back to Medicare, including putting pressure on purchasers to help us advocate for quality reporting.

Environmental Scan: Retail Health

- Leapfrog's role in this area is uncertain: although we could explore new partnerships in this area, these entities are not regulated entities where we would expect to be able to grade or even set standards within the timeframe of the current strategic intent
- However, these do represent an avenue to put pressure on hospitals to report data, as they encounter new competitive threats

Exhibit 20

Planned Updates to the Leapfrog Hospital Safety Grade Methodology for Fall 2024 #104036

6/06/2024 07:12 PM UTC

group_support
hospital_safety_grade
submit_a_public_comment
type: question
priority: normal
Status: Closed

• Alex A

Hi Alana,

Thank you for submitting a comment on our fall 2024 Safety Grade Methodology Changes. We closely considered your comment and provided a response in our final methodology document posted at <https://www.hospitalsafetygrade.org/for-hospitals/key-dates-and-information>.

We greatly appreciate your feedback and participation in our effort to ensure the public has access to useful safety and quality information.

Please let us know if you have any questions.

Best,
Alex

July 1 – November 30:

The 2025 Recognized Leader in Caring for People Living with Diabetes Application is now live. For more information, go to <https://www.leapfroggroup.org/recognized-leader-diabetes/application-materials>.

July 12:

Survey Results will be available on the Hospital and ASC Details pages linked from the Survey Dashboard. Results will be publicly available at <https://ratings.leapfroggroup.org/> on July 25.

August 31:

All Data Verification messages and documentation requests must be resolved before the August 31 deadlines for Hospital Safety Grades and our Top Hospital and Top ASC programs.

October 1:

Submit an abstract to share a case study describing how your hospital or ASC met Leapfrog's standards. Abstracts will be shared at a Poster Session at Leapfrog's Annual Meeting on December 17. Details are available at <https://www.leapfroggroup.org/leapfrog-best-practices-poster-session-partnership-johns-hopkins-armstrong-institute-patient-safety>.

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7/10/2024 06:35 PM UTC

Hi Alana,

Thank you for submitting a comment on our Safety Grade Methodology Changes. We will be closely reviewing all comments before publishing the final changes to the imputation methodology.

The final changes will have responses to public comments and will be published prior to June 30, 2024.

Best,
Alex

May 21 - June 7:

Review proposed changes to the fall 2024 Hospital Safety Grade at <https://www.hospitalsafetygrade.org/for-hospitals/key-dates-and-information>. Comments may be submitted to the Leapfrog Help Desk through June 7.

Friday, June 21 at 10 PM ET through Saturday, June 22:

The CPOE Evaluation Tool will be offline for platform updates from 10 PM ET on Friday, June 21 until Saturday, June 22. During this time, the Sample Test and Adult Inpatient Test will be unavailable.

June 30:

The Hospital and ASC Surveys are open and have a Submission Deadline of June 30. Hospital Survey information is available at www.leapfroggroup.org/hospital. ASC Survey information is available at www.leapfroggroup.org/asc.

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6/07/2024 03:16 PM UTC

- Katie S. KS

public comment

6/06/2024 07:13 PM UTC Internal note

- Alana Noble AN

We strongly disagree with the proposed Fall 2024 Step 2 Imputation. If Leapfrog is going to implement this change, they need to offer hospitals an option to opt out of being graded rather than penalize a hospital for not submitting the resource-intensive survey. The survey is very resource intensive outside of existing regulatory, quality operations and quality improvement efforts. Hospitals who do not have the resources to do the survey annually should not be so adversely punished especially in the post-Covid era where resources are increasingly hard to come by and retain.

6/06/2024 07:12 PM UTC

Exhibit 21

Imputation Model Updates #104051

6/07/2024 01:56 PM UTC

group_support
hospital_safety_grade
submit_a_public_comment

type: question

priority: normal

Status: Closed

• Alex A

Hi Zubin,

Thank you for submitting a comment on our fall 2024 Safety Grade Methodology Changes. We closely considered your comment and provided a response in our final methodology document posted at <https://www.hospitalsafetygrade.org/for-hospitals/key-dates-and-information>.

We greatly appreciate your feedback and participation in our effort to ensure the public has access to useful safety and quality information.

Please let us know if you have any questions.

Best,
Alex

July 1 – November 30:

The 2025 Recognized Leader in Caring for People Living with Diabetes Application is now live. For more information, go to <https://www.leapfroggroup.org/recognized-leader-diabetes/application-materials>.

July 12:

Survey Results will be available on the Hospital and ASC Details pages linked from the Survey Dashboard. Results will be publicly available at <https://ratings.leapfroggroup.org/> on July 25.

August 31:

All Data Verification messages and documentation requests must be resolved before the August 31 deadlines for Hospital Safety Grades and our Top Hospital and Top ASC programs.

October 1:

Submit an abstract to share a case study describing how your hospital or ASC met Leapfrog's standards. Abstracts will be shared at a Poster Session at Leapfrog's Annual Meeting on December 17. Details are available at <https://www.leapfroggroup.org/leapfrog-best-practices-poster-session-partnership-johns-hopkins-armstrong-institute-patient-safety>.

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7/10/2024 06:35 PM UTC

Hi Zubin,

Thank you for submitting a comment on our Safety Grade Methodology Changes. We will be closely reviewing all comments before publishing the final changes to the Imputation methodology.

The final changes will have responses to public comments and will be published prior to June 30, 2024.

Best,
Alex

May 21 - June 7:

Review proposed changes to the fall 2024 Hospital Safety Grade at <https://www.hospitalsafetygrade.org/for-hospitals/key-dates-and-information>. Comments may be submitted to the Leapfrog Help Desk through June 7.

Friday, June 21 at 10 PM ET through Saturday, June 22:

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June 30:

The Hospital and ASC Surveys are open and have a Submission Deadline of June 30. Hospital Survey information is available at www.leapfroggroup.org/hospital. ASC Survey information is available at www.leapfroggroup.org/asc.

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6/07/2024 03:16 PM UTC

- Katie S. KS

public comment

6/07/2024 02:17 PM UTC Internal note

- Zubin Momin ZM

Leapfrog should consider moving towards one CPOE test for large hospital systems that utilize the same EMR. It is a large administrative burden to get all tests scheduled and completed in a short amount of time from April 1st to June 30th. The time commitment to complete the test for each hospital is extensive and requires numerous hours of high-salaried FTEs. The frequency requirement should also be re-evaluated as it is unlikely hospitals are changing their EMR significantly each year or every other year.

Imputation Step 1 Model:

Is Leapfrog willing to re-evaluate the decision on the point assignment for the BCMA measure? 25 points out of the 100 points seems very low for hospitals that chose to not submit a survey to save on the time and resource commitment required to complete a survey this year if they have just submitted one last year. The impact of adding a few units to the BCMA measure is unlikely to drop performance from 100 to 25 for hospitals. Even if compliance was low, pre-op and PACU areas do not typically administer a volume of medications that would yield a drop from 100 to 25 points. Leapfrog should consider using N/A or a higher point assignment for this measure. The current proposal is causing hospitals to allocate unplanned hours and resources to complete the annual survey to avoid a negative impact to their Safety Grades.

Leapfrog should also consider announcing changes to imputation models at least one year in advance. The last-minute notice of changes that negatively impact hospitals that do not submit requires rapid shifting of priorities for the FTEs heavily involved in survey submission. The completion of the survey requires a great deal of coordination between various departments across the hospital including Informatics, Physicians, Pharmacy, Women's Services, Quality & Safety, and Nursing. The brief time period does not allow us to have all required sections completed without the addition of unplanned supplementary resources.

Imputation Step 2 Model:

We feel like this model is unnecessarily punitive. We often skip survey submission because the responses provided for IPS, Hand Hygiene, BMCA, and CPOE are largely unchanged in the 2-year period that was allotted before negatively impacting grades. The FTE resource commitment to complete the survey is already significant. There is no value added by completing a survey every year or every other year when practices in our hospitals have not changed.

Exhibit 22

Proposed Fall 2024 Imputation Method #104088

6/08/2024 04:15 AM UTC

group_support
hospital_safety_grade
submit_a_public_comment
type: question
priority: high
Status: Closed

• Alex A

Hi Susan,

Thank you for submitting a comment on our fall 2024 Safety Grade Methodology Changes. We closely considered your comment and provided a response in our final methodology document posted at <https://www.hospital-safety-grade.org/for-hospitals/key-dates-and-information>.

We greatly appreciate your feedback and participation in our effort to ensure the public has access to useful safety and quality information.

Please let us know if you have any questions.

Best,
Alex

July 1 – November 30:

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July 12:

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Submit an abstract to share a case study describing how your hospital or ASC met Leapfrog's standards. Abstracts will be shared at a Poster Session at Leapfrog's Annual Meeting on December 17. Details are available at <https://www.leapfroggroup.org/leapfrog-best-practices-poster-session-partnership-johns-hopkins-armstrong-institute-patient-safety>.

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7/10/2024 06:34 PM UTC

Hi Susan,

Thank you for submitting a comment on our Safety Grade Methodology Changes. We will be closely reviewing all comments before publishing the final changes to the imputation methodology.

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Best,
Alex

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June 30:

The Hospital and ASC Surveys are open and have a Submission Deadline of June 30. Hospital Survey information is available at www.leapfroggroup.org/hospital. ASC Survey information is available at www.leapfroggroup.org/asc.

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6/10/2024 03:08 PM UTC

- Heather H

Public comment

6/10/2024 12:20 PM UTC Internal note

- Boardman, Susan BS

The proposed changes to the Imputation Method would result in an inaccurate portrayal of the actual status of the patient safety structures and processes in place for the Leapfrog grade measures CPOE, BCMA, IPS, and Hand Hygiene at hospitals that choose not to expend the resources to submit a 2024 Leapfrog Hospital Survey and had not submitted a 2023 Leapfrog Hospital Survey. Under "Step 2" of the proposed new Imputation method, the points assigned for these measures would be the same that earned for "Limited Achievement" if the 2024 Survey were submitted. This is not a like to like comparison between hospitals. Rather, if 2023 or 2024 were not submitted, more accurate options include: 1) Not assigning a Grade for hospitals that did not submit either a 2023 or a 2024 survey, or at least allowing these hospitals to opt out of the Fall 2024 Leapfrog Hospital Safety Grade; 2) Publishing to versions of the Fall 2024 Leapfrog Hospital Safety Grade, one for hospitals completing the 2023 or 2024 Survey, and one just based on CMS measures, not including the survey based measures so there is no penalty for not submitting a survey. For the proposed new Imputation Method, if a hospital has completed a survey in the past where the measure section has not substantially changed, allowing the hospital to attest that there has not been changes to reduce the number of Medication Alerts for the CPOE measure, to save the resources required for retaking the CPOE evaluation test. And for the BCMA, IPS and Hand Hygiene measures, allow hospitals to just submit any of these sections if there have been changes on the Leapfrog questions, or if the hospital cannot attest that there have not been changes to their previous responses.

Exhibit 23

Message

From: Paulina Litter [PLitter@leapfrog-group.org]
Sent: 6/18/2024 12:55:38 PM
To: Alexandra Campione [ACampione@leapfrog-group.org]
Subject: RE: New imputation denotation

I think that works really well!

Paulina Litter (she/her/hers)
Senior Specialist, Operations and Special Projects
(202) 868-4775
1775 K St. NW, Suite 400
Washington, DC 20006



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From: Alexandra Campione <ACampione@leapfrog-group.org>
Sent: Tuesday, June 18, 2024 12:30 PM
To: Paulina Litter <PLitter@leapfrog-group.org>
Subject: RE: New imputation denotation

Actually, it should be “assigned”, not “calculated”. See below.
This hospital declined to report data for this measure, so a score was assigned using an imputation model approved by patient safety experts.

From: Alexandra Campione
Sent: Tuesday, June 18, 2024 12:29 PM
To: Paulina Litter <PLitter@leapfrog-group.org>
Subject: RE: New imputation denotation

Okay, great. It’s working for me too. Thanks for doing this, but we can’t say “external data sources” because we’re arbitrarily assigning them the points associated with the bottom scoring category (“limited achievement”) or old data from the previous Survey (internal data source).

Leah wanted us to make it sound like the expert panel approved it and the assigning of these points was legitimate. What about this: This hospital declined to report data for this measure, so a score was calculated using an imputation model approved by patient safety experts.

I think linking to the methodology would be neat, but I don’t think Leah or Missy cared to do so. We could ask.

From: Paulina Litter <PLitter@leapfrog-group.org>
Sent: Tuesday, June 18, 2024 11:42 AM
To: Alexandra Campione <ACampione@leapfrog-group.org>
Subject: RE: New imputation denotation

Yeah, I just did it and got the stage version so everything is working as it should on my end.

A few thoughts on the language:

- This hospital declined to report data for this measure, so a score was calculated with external data sources using an imputation model.
- This hospital declined to report data directly to Leapfrog for this measure, so a score was calculated using external data sources based on an imputation model.
- This hospital declined to report data for this measure, so a score was calculated using an imputation model. For more information, see the [Spring 2024 Safety Grade Scoring Methodology](#).
- This hospital declined to report data for this measure, so a score was calculated with external data sources using an imputation model. For more information, see the [Spring 2024 Safety Grade Scoring Methodology](#).
- This hospital declined to report data directly to Leapfrog to this measure, so a score was calculated using external data sources based on an imputation model. For more information, see the [Spring 2024 Safety Grade Scoring Methodology](#).

Let me know what you think of the above options.

Paulina Litter (*she/her/hers*)
Senior Specialist, Operations and Special Projects
(202) 868-4775
1775 K St. NW, Suite 400
Washington, DC 20006



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From: Alexandra Campione <ACampione@leapfrog-group.org>
Sent: Tuesday, June 18, 2024 11:29 AM
To: Paulina Litter <PLitter@leapfrog-group.org>
Subject: Re: New imputation denotation

Yes, but are you able to see the change on his link? I followed all the instructions and I'm going to try again later today. I've just been out and am catching up on stuff.

That was the language Missy wanted but Leah wants something else that makes it sound like the data we imputed wasn't random, so lmk if you have any ideas.

I will respond to him later today once I'm sure it doesn't display on stage for me, and I come up with new phrasing. Otherwise, his mockup looks right.

Alexandra Campione, MPH (she/her/hers)
Program Analyst, Health Care Ratings
The Leapfrog Group
1775 K St. NW, Suite 400
Washington, DC 20009



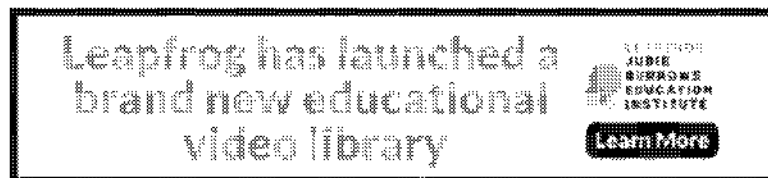
leapfroggroup.org | [HospitalSafetyGrade.org](https://hospital.safetygrade.org) | [Twitter](https://twitter.com/leapfrog) | [Donate](#)

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From: Paulina Litter <PLitter@leapfrog-group.org>
Sent: Tuesday, June 18, 2024 11:26:09 AM
To: Alexandra Campione <ACampione@leapfrog-group.org>
Subject: FW: New imputation denotation

Does this work for you? My only callout is the language seems a bit off to me as a layperson to know what imputed means. Maybe we can change it to say "so a score was calculated using imputation for the measure" would that work?

Paulina Litter (she/her/hers)
Senior Specialist, Operations and Special Projects
(202) 868-4775
1775 K St. NW, Suite 400
Washington, DC 20006



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From: Devon Weller <dweller@atlasworks.com>
Sent: Friday, June 14, 2024 12:01 PM
To: Alexandra Campione <ACampione@leapfrog-group.org>
Cc: Paulina Litter <PLitter@leapfrog-group.org>; jeff <jeff@ravencreative.com>
Subject: Re: New imputation denotation

External Email - Use Caution

Great. That makes it easier since we will not have to re-import any new data.

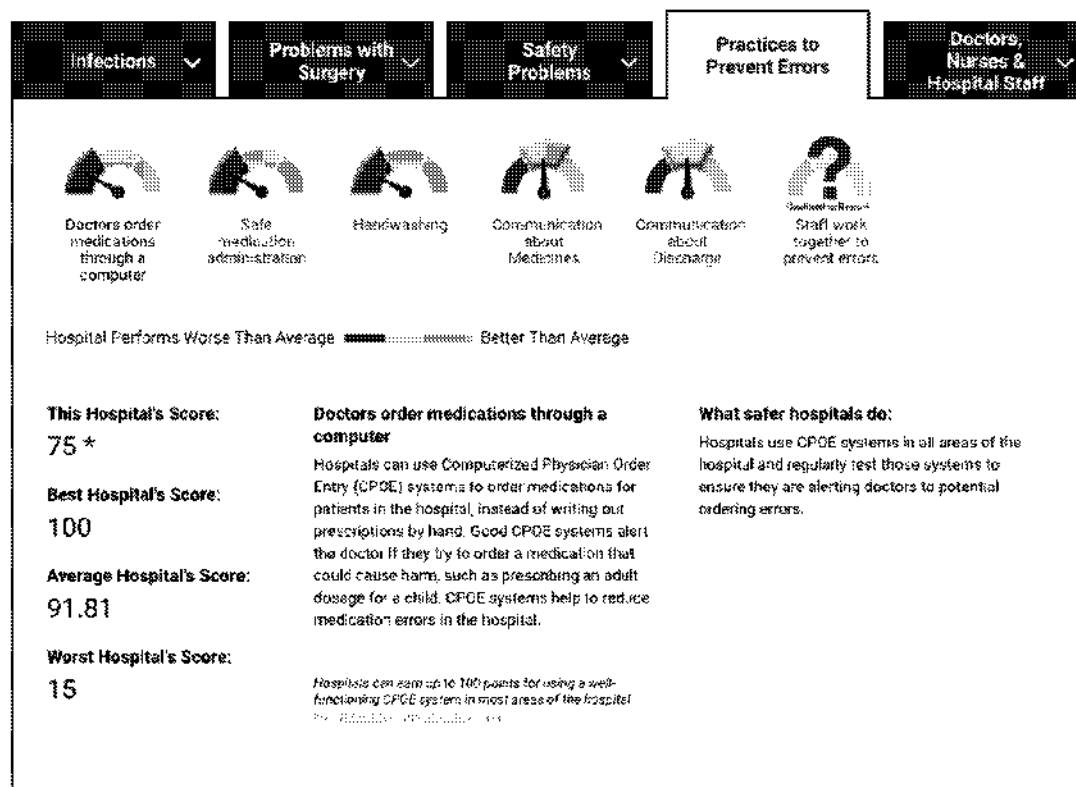
I implemented this in a staged version of the database.

To preview the staged version, please do the following:

1. Open a new **Incognito window** in Chrome.
2. Visit this URL in the new **Incognito window**:

<https://www.hospitalsafetygrade.org/?dbver=20240601STAGE>

3. Then do a search for a hospital (e.g. Mizell Memorial Hospital) and visit the hospital details page.



Notes and Definitions

1. **Declined to Report:** The hospital was asked to provide this information to the public, but did not.
2. **Not Available:** "Not Available" means that the hospital does not have data for this measure. This could be because the measure is related to a service the hospital does not provide. For example, a hospital that does not have an ICU would not be able to report data about it. It could also be because the hospital had too few patients or cases to report data for a particular condition or procedure. A "Not Available" count does not mean that the hospital withheld information from the public.
3. **The hospital declined to report data for this measure, so a score was imputed for the measure.**

1. Die gewöhnliche Differentialgleichung zweiter Ordnung $y'' + p(x)y' + q(x)y = r(x)$ ist für $x \in I$ zu lösen, wobei I ein Intervall in $\mathbb{R}$ ist, $p, q, r: I \rightarrow \mathbb{R}$ stetige Funktionen sind und $y: I \rightarrow \mathbb{R}$ die gesuchte Funktion ist. Die Randwerte $y(a) = \alpha$ und $y(b) = \beta$ sind vorgegeben. Die Randwerte $y(a) = \alpha$ und $y(b) = \beta$ sind vorgegeben. Die Randwerte $y(a) = \alpha$ und $y(b) = \beta$ sind vorgegeben.

If you accidentally enable the staged preview not in an Incognito window, you will need to clear cookies for the site to return to normal. You will know if you are seeing the staged version if you see something like this in the top right of the page:



Please review this when you get a chance. If all looks good, I will copy this change to the live database to make this live.

- Devon

On Tue, Jun 4, 2024 at 2:11 PM Alexandra Campione <ACampione@leapfrog-group.org> wrote:

Hi Devon,

I am so silly. We don't need extra columns!

The asterisks should appear anytime the measure's data source= "Imputation Model Applied".

This would only apply to the following columns:

- CPOE (Data Source) and CPOE (Hospital Score)
- BCMA (Data Source) and BCMA (Hospital Score)
- ICU Physician Staffing (Data Source) and ICU Physician Staffing (Hospital Score)
- Hand Hygiene (Data Source) and Hand Hygiene (Hospital Score)

Example: if *CPOE (Data Source)*= "Imputation Model Applied", then *This Hospital's Score*= *CPOE (Hospital Score)* & "**".

Please let me know if you have any questions. Attached is an example file to visualize.

Best,
Alex

From: Paulina Litter <PLitter@leapfrog-group.org>

Sent: Thursday, May 30, 2024 11:05 AM

To: devon@atlasworks.com

Cc: Alexandra Campione <ACampione@leapfrog-group.org>

Subject: FW: New imputation denotation

Hi Devon,

Here is the information for the safety grade update. Thank you for all of your help!

Paulina Litter (*she/her/hers*)

Senior Specialist, Operations and Special Projects

(202) 868-4775

1775 K St. NW, Suite 400

Washington, DC 20005

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We would like to add a third item to the “Notes and Definitions” at the bottom and an optional asterisk to 4 measures’ scores (CPOE, BCMA, IPS, and Hand Hygiene). The data file would denote whether the asterisk should be present either with 4 additional columns or include the asterisk in the original data columns. The latter would be similar to the data review website, but I am guessing it wouldn’t work since the numeric values are used to determine the gas gauge direction.

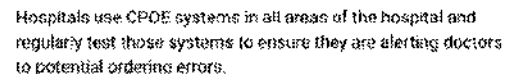
[illegible]

Exhibit 24



Final Updates to the Leapfrog Hospital Safety Grade Methodology for Fall 2024

On May 21, 2024, Leapfrog published planned updates to the Hospital Safety Grade methodology and held a public comment period through June 7, 2024. We thank commenters for their insightful feedback and suggestions that helped us finalize the methodology.

This document includes responses to the comments received and summarizes the final updates that will be made to the scoring methodology. Additionally, Table 2 on pages 5-6 includes a summary of data sources and anticipated reporting periods for the fall 2024 Hospital Safety Grades.

Summary of Changes

Starting in fall 2024, Leapfrog will update the Imputation Methodology for CPOE, BCMA, IPS, and Hand Hygiene measures for hospitals that do not submit a 2024 Leapfrog Hospital Survey by August 31, 2024. The changes come under the guidance of Leapfrog's national expert panel, the research team at Johns Hopkins Medicine, and in response to stakeholder feedback.

More information can be found on the Hospital Safety Grade website at <https://www.hospitalsafetygrade.org/for-hospitals/key-dates-and-information>.

RESPONSES TO PUBLIC COMMENTS

Four commenters supported the change to the imputation methodology.

We appreciate the feedback and agree that participating hospitals committed to transparency should be acknowledged for the resources and time they devote to completing the Leapfrog Hospital Survey. Hospitals that choose not to complete the Survey should not inadvertently benefit from hospitals that continuously strive to make improvements and maintain Leapfrog standards.

Two commentors expressed concerns about Step 2 Imputation misrepresenting the current procedures or infrastructure of the hospital to the public.

We recognize that hospitals eligible for Step 2 Imputation may score higher if they complete a Leapfrog Hospital Survey. However, we cannot ensure this is the case if we do not have the data, and our analyses have shown that performance among hospitals that intermittently complete the annual Survey is lower than those hospitals that completed the most recent Survey. The expert panel recognized that hospitals with a drop in performance may be incentivized to not report via the Leapfrog Hospital Survey and scores calculated using participating hospitals would misrepresent their true performance. We encourage hospitals to complete the Leapfrog Hospital Survey so they can receive credit for implementing processes that protect patients and save lives.

We do acknowledge the commenter's point that the public may misinterpret the assigned measure scores. In response, we will add a new denotation to the Hospital Safety Grade website (<https://www.hospitalsafetygrade.org/>) for scores that have been imputed.

Two commentors requested that the proposed changes be delayed until spring 2025 to allow hospitals time to complete the Leapfrog Hospital Survey.

While we do strongly encourage hospitals to submit their Survey by the Submission Deadline of June 30, 2024, hospitals that wish to have 2024 Leapfrog Hospital Survey data used in their fall 2024 Safety Grade will have until August 31 to submit or resubmit their Survey. Hospitals that completed a 2023 Leapfrog Hospital Survey will be eligible for Step 1 Imputation. Hospitals eligible for Step 2 Imputation have opted not to complete 2 consecutive years of the Leapfrog Hospital Survey and will be scored accordingly.

Four commenters opposed penalizing hospitals that choose not to devote resources to completing a voluntary Survey each year and be allowed to opt out of the Hospital Safety Grade.

The Leapfrog Hospital Survey is designed to help hospitals benchmark their progress in quality and safety. To ensure that these standards are consistently met, hospitals must continuously measure. While our Survey, is not required or linked to federal funding, we think it is just as important. Patients, employers, and purchasers benefit from having access to current and accurate information.

Our expert panel recognized that awareness and participation in the Leapfrog Hospital Survey has grown exponentially in recent years. As such, the choice of hospitals to not complete the Leapfrog Hospital Survey is one that could not be ignored as patient safety must remain a priority. A key element of the Hospital Safety Grade is that all eligible hospitals are compared to hospitals nationwide. The choice to not participate should not excuse a hospital from being graded, nor should they be given a score that unfairly awards them points.

FINAL UPDATE TO IMPUTATION METHOD FOR CPOE, BCMA, IPS, AND HAND HYGIENE

BACKGROUND

The Leapfrog Group and other national organizations have ongoing concerns with the trajectory of patient safety in US hospitals. Leapfrog wants to ensure that the public has timely, transparent, and trustworthy information about a hospital's patient safety performance. Leapfrog's longstanding commitment is to use the best and most recent data publicly available to calculate Hospital Safety Grades.

To ensure the Hospital Safety Grade methodology continues to support these goals, Leapfrog's blue-ribbon Expert Panel and researchers at Johns Hopkins Medicine annually review the scoring methodology. The panel advised that Leapfrog modify the current imputation method, which is used to fill in missing data among hospitals that did not complete the most recent Leapfrog Survey.

Leapfrog is proposing the following changes to its imputation approaches effective with the fall 2024 Hospital Safety Grade.

CHANGES TO IMPUTATION METHOD FOR CPOE, BCMA, IPS, AND HAND HYGIENE

Leapfrog is proposing the following changes effective with the fall 2024 Hospital Safety Grade.

1) New Step 1 Imputation (Does not apply to BCMA)

If the hospital had a score assigned by Leapfrog in the previous two rounds of grades (i.e., spring 2024, fall 2023), the hospital is assigned the most recent score on that measure in the current Hospital Safety Grade (i.e., fall 2024). This is a reduction from the previous methodology, which imputed scores from up to four previous rounds of grades. This will help ensure any historical data used in calculating the Safety Grade is reflective of hospital protocols within the past 2 years (e.g., the reporting periods for CPOE IPS, and Hand Hygiene on the 2023 Leapfrog Hospital Survey was 2023).

Note that Step 1 imputation will be temporarily paused for the BCMA measure. In 2024, Leapfrog expanded the BCMA Standard to include pre-operative and post-anesthesia care units in addition to med-surg units, critical care units, and labor and delivery units. Due to these changes, scores from the 2023 Leapfrog Hospital Survey are not an accurate representation of performance on the current measure and thus not suitable for Step 1 imputation.

2) New Step 2 Imputation

For hospitals that do not have historical data from the last two rounds of the Safety Grade (Step 2 imputation then applies), instead of imputing a score based on the cohort mean, hospitals will be assigned a point value that is equivalent to receiving "Limited Achievement" for that measure on the Leapfrog Hospital Survey (Table 1). This category assignment would reflect Leapfrog's lack of current information about a hospital's status in implementing these important patient safety structures.

Step 2 imputation for the IPS measure will only apply to hospitals that operate an adult or pediatric medical and/or surgical ICU or neuro ICU. A hospital's ICU designation will be determined using the most recently available CMS Cost Report. Hospitals that report operating one or more medical, surgical and/or pediatric ICU beds in Worksheet S-3 Part 1 will be eligible for Step 2 Imputation.

Table 1. Step 2 Imputation Point Assignments Beginning Fall 2024

	Leapfrog Hospital Survey Performance Category	Corresponding Safety Grade Measure Score
CPOE	Limited Achievement 	15
BCMA	Limited Achievement 	25
IPS	Limited Achievement 	5
Hand Hygiene	Limited Achievement 	15

Table 2. Planned Fall 2024 Leapfrog Safety Grade Measures, Data Sources, And Anticipated Reporting Periods

PROCESS/STRUCTURAL MEASURES (12)				
Measure Name	Primary Data Source	Reporting Period	Secondary Data Source	Reporting Period
Computerized Physician Order Entry (CPOE)	2024 Leapfrog Hospital Survey	2024	Imputation Model Applied	N/A
Bar Code Medication Administration (BCMA)	2024 Leapfrog Hospital Survey	2024	Imputation Model Applied	N/A
ICU Physician Staffing (IPS)	2024 Leapfrog Hospital Survey	2024	Imputation Model Applied	N/A
Safe Practice 1: Culture of Leadership Structures and Systems	2024 Leapfrog Hospital Survey	2024	N/A	N/A
Safe Practice 2: Culture Measurement, Feedback & Intervention	2024 Leapfrog Hospital Survey	2024	N/A	N/A
Total Nursing Care Hours per Patient Day	2024 Leapfrog Hospital Survey	2024	N/A	N/A
Hand Hygiene	2024 Leapfrog Hospital Survey	2024	Imputation Model Applied	N/A
H-COMP-1: Nurse Communication	CMS	10/01/2022 - 09/30/2023	N/A	N/A
H-COMP-2: Doctor Communication	CMS	10/01/2022 - 09/30/2023	N/A	N/A
H-COMP-3: Staff Responsiveness	CMS	10/01/2022 - 09/30/2023	N/A	N/A
H-COMP-5: Communication about Medicines	CMS	10/01/2022 - 09/30/2023	N/A	N/A
H-COMP-6: Discharge Information	CMS	10/01/2022 - 09/30/2023	N/A	N/A

OUTCOME MEASURES (10)				
Measure Name	Primary Data Source	Reporting Period	Secondary Data Source	Reporting Period
Foreign Object Retained	CMS	07/01/2021 - 06/30/2023	N/A	N/A
Air Embolism	CMS	07/01/2021 - 06/30/2023	N/A	N/A
Falls and Trauma	CMS	07/01/2021 - 06/30/2023	N/A	N/A
CLABSI	2024 Leapfrog Hospital Survey	01/01/2023 - 12/31/2023	CMS	10/01/2022 - 09/30/2023
CAUTI	2024 Leapfrog Hospital Survey	01/01/2023 - 12/31/2023	CMS	10/01/2022 - 09/30/2023
SSI: Colon	2024 Leapfrog Hospital Survey	01/01/2023 - 12/31/2023	CMS	10/01/2022 - 09/30/2023
MRSA	2024 Leapfrog Hospital Survey	01/01/2023 - 12/31/2023	CMS	10/01/2022 - 09/30/2023
C. Diff.	2024 Leapfrog Hospital Survey	01/01/2023 - 12/31/2023	CMS	10/01/2022 - 09/30/2023
PSI 4: Death rate among surgical inpatients with serious treatable conditions	CMS	07/01/2020 - 06/30/2022	N/A	N/A
CMS Medicare PSI 90: Patient safety and adverse events composite*	CMS	07/01/2020 - 06/30/2022	N/A	N/A

*Note: CMS calculates PSI 90 using the ten (10) component PSIs listed above. While scores for each of the 10 component PSIs will NOT be used to calculate fall 2024 Hospital Safety Grades, they will be publicly reported on the Hospital Safety Grade [website](#).

Exhibit 25

THE LEAPFROG GROUP AND AFFILIATE

CONSOLIDATED FINANCIAL STATEMENTS

JUNE 30, 2024

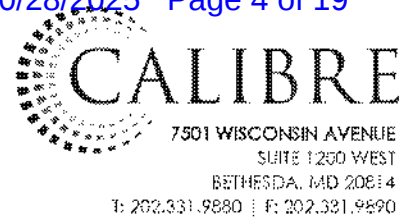
THE LEAPFROG GROUP AND AFFILIATE

CONSOLIDATED FINANCIAL STATEMENTS

YEARS ENDED JUNE 30, 2024 AND 2023

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INDEPENDENT AUDITOR'S REPORT

Board of Directors
The Leapfrog Group and Affiliate

Opinion

We have audited the accompanying consolidated financial statements of The Leapfrog Group and Affiliate (Leapfrog), which comprise the consolidated statements of financial position as of June 30, 2024 and 2023, and the related consolidated statements of activities, functional expenses, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of The Leapfrog Group and Affiliate as of June 30, 2024 and 2023, and the changes in its net assets and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Consolidated Financial Statements section of our report. We are required to be independent of Leapfrog and to meet our other ethical responsibilities in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of the consolidated financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the consolidated financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about Leapfrog's ability to continue as a going concern within one year after the date that the consolidated financial statements are available to be issued.

Auditor's Responsibilities for the Audit of the Consolidated Financial Statements

Our objectives are to obtain reasonable assurance about whether the consolidated financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with generally accepted auditing standards will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements, including omissions, are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the consolidated financial statements.

In performing an audit in accordance with generally accepted auditing standards, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the consolidated financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the consolidated financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of Leapfrog's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the consolidated financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about Leapfrog's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control related matters that we identified during the audit.

Calibre CPA Group, PLLC

Bethesda, MD
March 28, 2025

THE LEAPFROG GROUP AND AFFILIATE

CONSOLIDATED STATEMENTS OF FINANCIAL POSITION

JUNE 30, 2024 AND 2023

	2024	2023
Assets		
Current assets		
Cash and cash equivalents	\$ 1,781,870	\$ 2,999,926
Accounts and grants receivable	699,980	620,715
Prepaid expenses	308,181	156,242
Total current assets	<u>2,790,031</u>	<u>3,776,883</u>
Property and equipment		
Equipment	122,243	109,804
Furniture	161,307	161,307
Leasehold improvements	447,431	447,431
Website and survey development costs	1,237,149	671,410
	<u>1,968,130</u>	<u>1,389,952</u>
Less: accumulated depreciation and amortization	<u>(945,093)</u>	<u>(755,110)</u>
Net property and equipment	<u>1,023,037</u>	<u>634,842</u>
Non-current assets		
Deposits	39,253	39,253
Finance right-of-use asset	5,855	5,205
Operating right-of-use asset	2,713,451	3,096,580
Total non-current assets	<u>2,758,559</u>	<u>3,141,038</u>
Total assets	<u>\$ 6,571,627</u>	<u>\$ 7,552,763</u>
Liabilities and Net Assets		
Current liabilities		
Accounts payable and accrued liabilities	\$ 503,717	\$ 281,372
Accrued salaries and related benefits	197,736	193,696
Refundable advance	177,878	816,023
Deferred income	881,398	1,059,737
Operating lease, current portion	418,496	390,288
Finance lease obligation	2,196	2,196
Total current liabilities	<u>2,181,421</u>	<u>2,743,312</u>
Long-term liabilities		
Operating lease, net of current portion	2,639,112	3,057,608
Finance lease obligation	1,216	3,074
Total long-term liabilities	<u>2,640,328</u>	<u>3,060,682</u>
Total liabilities	<u>4,821,749</u>	<u>5,803,994</u>
Net assets		
Without donor restrictions	1,610,866	1,748,769
With donor restrictions	139,012	-
Total net assets	<u>1,749,878</u>	<u>1,748,769</u>
Total liabilities and net assets	<u>\$ 6,571,627</u>	<u>\$ 7,552,763</u>

See accompanying notes to consolidated financial statements.

THE LEAPFROG GROUP AND AFFILIATE
CONSOLIDATED STATEMENTS OF ACTIVITIES
YEARS ENDED JUNE 30, 2024 AND 2023

	2024			2023		
	Without Donor Restrictions	With Donor Restrictions	Total	Without Donor Restrictions	With Donor Restrictions	Total
Revenue and support						
Accolade licensing revenue	\$ 3,288,926	\$ -	\$ 3,288,926	\$ 3,208,489	\$ -	\$ 3,208,489
Data licensure	2,174,816	-	2,174,816	2,154,096	-	2,154,096
Membership	1,141,413	-	1,141,413	828,250	-	828,250
Contributions and honoraria	439,391	139,012	578,403	317,634	-	317,634
Grants	25,000	751,520	776,520	175,002	516,902	691,904
Data products and reports	314,499	-	314,499	141,135	-	141,135
Media partnership	11,775	-	11,775	165,345	-	165,345
Investment income	44,330	-	44,330	49,623	-	49,623
Miscellaneous income	26,637	-	26,637	-	-	-
Net assets released from donor restrictions	751,520	(751,520)	-	903,291	(903,291)	-
Total revenue and support	8,218,307	139,012	8,357,319	7,942,865	(386,389)	7,556,476
Expenses						
Program services						
Ratings	3,663,443	-	3,663,443	3,649,756	-	3,649,756
Communications	2,064,535	-	2,064,535	1,690,291	-	1,690,291
Supporting services						
Membership	1,439,172	-	1,439,172	1,298,824	-	1,298,824
General and administrative	838,069	-	838,069	919,324	-	919,324
Fundraising	350,991	-	350,991	417,472	-	417,472
Total expenses	8,356,210	-	8,356,210	7,975,667	-	7,975,667
Change in net assets	(137,903)	139,012	1,109	(32,802)	(386,389)	(419,191)
Net assets						
Beginning of year	1,748,769	-	1,748,769	1,781,571	386,389	2,167,960
End of year	\$ 1,610,866	\$ 139,012	\$ 1,749,878	\$ 1,748,769	\$ -	\$ 1,748,769

See accompanying notes to consolidated financial statements.

THE LEAPFROG GROUP AND AFFILIATE

CONSOLIDATED STATEMENT OF FUNCTIONAL EXPENSES

YEAR ENDED JUNE 30, 2024

	Program Services			Supporting Services				
	Ratings	Communications	Subtotal	Membership	General and Administrative	Fundraising	Subtotal	Total Expenses
Salaries and staff development	\$ 1,770,836	\$ 699,839	\$ 2,470,675	\$ 819,352	\$ 525,025	\$ 277,048	\$ 1,621,425	\$ 4,092,100
Consulting	868,357	495,441	1,363,798	798	-	-	798	1,364,596
Communications and marketing	25,148	591,163	616,311	11,487	-	6,512	17,999	634,310
Technology	461,508	56,964	518,472	18,131	5,583	16,124	39,838	558,310
Meetings and travel	77,513	64,461	141,974	417,824	15,913	950	434,687	576,661
Operations	371,545	123,615	495,160	131,162	278,097	36,481	445,740	940,900
Depreciation	<u>88,536</u>	<u>33,052</u>	<u>121,588</u>	<u>40,418</u>	<u>13,451</u>	<u>13,876</u>	<u>67,745</u>	<u>189,333</u>
Total expenses	<u>\$ 3,663,443</u>	<u>\$ 2,064,535</u>	<u>\$ 5,727,978</u>	<u>\$ 1,439,172</u>	<u>\$ 838,069</u>	<u>\$ 350,991</u>	<u>\$ 2,628,232</u>	<u>\$ 8,356,210</u>

See accompanying notes to consolidated financial statements.

THE LEAPFROG GROUP AND AFFILIATE

CONSOLIDATED STATEMENT OF FUNCTIONAL EXPENSES

YEAR ENDED JUNE 30, 2023

	Program Services			Supporting Services				
	Ratings	Communications	Subtotal	Membership	General and Administrative	Fundraising	Subtotal	Total Expenses
Salaries and staff development	\$ 1,804,131	\$ 668,969	\$ 2,473,100	\$ 759,663	\$ 643,323	\$ 313,082	\$ 1,716,068	\$ 4,189,168
Consulting	732,825	358,944	1,091,769	14,580	-	1,807	16,387	1,108,156
Communications and marketing	42,981	486,480	529,461	1,959	-	25,080	27,039	556,500
Technology	549,556	23,410	572,966	15,765	7,322	18,650	41,737	614,703
Meetings and travel	78,920	40,232	119,152	372,641	24,013	948	397,602	516,754
Operations	367,038	85,256	452,294	102,409	230,546	44,716	377,671	829,965
Depreciation	74,305	27,000	101,305	31,807	14,120	13,189	59,116	160,421
Total expenses	<u>\$ 3,649,756</u>	<u>\$ 1,690,291</u>	<u>\$ 5,340,047</u>	<u>\$ 1,298,824</u>	<u>\$ 919,324</u>	<u>\$ 417,472</u>	<u>\$ 2,635,620</u>	<u>\$ 7,975,667</u>

See accompanying notes to consolidated financial statements.

THE LEAPFROG GROUP AND AFFILIATE
CONSOLIDATED STATEMENTS OF CASH FLOWS
YEARS ENDED JUNE 30, 2024 AND 2023

	<u>2024</u>	<u>2023</u>
Cash flows from operating activities		
Change in net assets	\$ 1,109	\$ (419,191)
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Depreciation	189,983	160,421
Amortization of finance right-of-use asset	(650)	-
Amortization of operating right-of-use asset	(7,159)	2,802
Changes in net assets and liabilities		
Accounts receivable	(79,265)	6,607
Prepaid expenses	(151,939)	(15,532)
Accounts payable and accrued liabilities	222,345	899
Accrued salaries and related benefits	4,040	6,852
Refundable advances	(638,145)	(516,902)
Deferred income	(178,339)	3,718
Net cash used in operating activities	<u>(638,020)</u>	<u>(770,326)</u>
Cash flows from investing activities		
Purchases of property and equipment	<u>(578,178)</u>	<u>(88,244)</u>
Net cash used in investing activities	<u>(578,178)</u>	<u>(88,244)</u>
Cash flows from financing activities		
Payments on finance lease obligation	<u>(1,858)</u>	<u>(2,113)</u>
Net cash used in financing activities	<u>(1,858)</u>	<u>(2,113)</u>
Net change in cash and cash equivalents	<u>(1,218,056)</u>	<u>(860,683)</u>
Cash and cash equivalents		
Beginning of year	<u>2,999,926</u>	<u>3,860,609</u>
End of year	<u>\$ 1,781,870</u>	<u>\$ 2,999,926</u>
Supplemental disclosure of cash flow information		
Cash paid during the year for interest	<u>\$ 397</u>	<u>\$ 237</u>

See accompanying notes to consolidated financial statements.

THE LEAPFROG GROUP AND AFFILIATE

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

YEARS ENDED JUNE 30, 2024 AND 2023

NOTE 1. NATURE OF ACTIVITIES AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Nature of activities - The Leapfrog Group (Leapfrog) is a non-profit organization incorporated in the District of Columbia in 2001. Leapfrog works to identify problems and propose solutions to improve hospital systems for patients and health care providers.

The Leapfrog Due Diligence Cooperative, LLC, was established in 2011. Its purpose is to collect, evaluate, and summarize information about companies providing healthcare-related services to employers.

A summary of Leapfrog's significant accounting policies follows:

Principles of consolidation - The consolidated financial statements include the assets, liabilities and activities and changes in net assets of The Leapfrog Group and The Leapfrog Due Diligence Cooperative, LLC (collectively, Leapfrog). All intercompany accounts and transactions have been eliminated.

Basis of presentation - The consolidated financial statement presentation follows the recommendations under the *Not-for-Profit Entities* Topic of the Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC). Under the ASC, Leapfrog is required to report information regarding its financial position and activities according to two classes of net assets: net assets without donor restrictions and net assets with donor restrictions, as applicable.

Net assets without donor restrictions - These net assets are available to finance the general operations of Leapfrog. The only limits on the use of net assets without donor restrictions are the broad limits resulting from the nature of Leapfrog, the environment in which it operates, and the purposes specified in its organizing documents.

Net assets with donor restrictions - These net assets result from contributions and other inflows of assets, the use of which by Leapfrog is limited by donor-imposed time or purpose restrictions that may be either temporary or perpetual.

Cash and cash equivalents - For consolidated financial statement purposes, Leapfrog considers certain highly liquid securities purchase with an original maturity of three months or less to be cash equivalents.

NOTE 1. NATURE OF ACTIVITIES AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Bank deposit accounts are insured by the Federal Deposit Insurance Corporation (FDIC) up to a limit of \$250,000. At times during the year, Leapfrog maintains cash balances in excess of the FDIC insurance limits. Management believes the risk in these situations to be minimal.

Receivables - Accounts receivable approximate fair value, and are primarily uncollateralized obligations comprised of amounts due from data licensure revenue, accolade licensing revenue, and conference revenue. At each financial position date, Leapfrog recognizes an expected allowance for credit losses. The allowance estimate is derived from a review of Leapfrog's historical losses based on the aging of receivables. This estimate is adjusted for management's assessment of current conditions, reasonable and supportable forecasts regarding future events, and any other factors deemed relevant by Leapfrog. Leapfrog writes off receivables when there is information that indicates the debtor is facing significant financial difficulty and there is no possibility of recovery. If any recoveries are made from any accounts previously written off, they will be recognized in income or an offset to credit loss expense in the year of recovery, in accordance with the entity's accounting policy election. The total amount of write-offs was immaterial to the consolidated financial statements as a whole for the year ending December 31, 2024.

Pledges receivable - Pledges receivable is due in less than one year and are recorded at their net realizable value, which approximates fair value. Conditional promises to give are not included as support until the conditions are substantially met. Management considers all amounts to be fully collectible. Accordingly, an allowance of doubtful accounts has not been established.

Property and equipment - Property and equipment with a cost exceeding \$1,000 is recorded at original cost and is depreciated over its estimated useful lives of three to eight years using the straight-line method from the date it is placed in service. Leasehold improvements are amortized over the shorter of the lease term or the expected useful life.

Valuation of long-lived assets - Leapfrog reviews equipment and certain identifiable intangible assets for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset may not be recoverable. Recoverability of the long-lived asset is measured by a comparison of the carrying amount of the asset to future undiscounted net cash flows expected to be generated by the asset. If such assets are considered to be impaired, the impairment to be recognized is measured by the amount by which the carrying amount of the assets exceeds the estimated fair value of the assets. Assets to be disposed of are reported at the lower of the carrying amount or fair value, less costs to sell. There were no long-lived assets considered impaired during the years ended June 30, 2024 and 2023.

NOTE 1. NATURE OF ACTIVITIES AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Refundable advances - Assets received in a conditional contribution are accounted for as refundable advances until the conditions have been substantially met or explicitly waived by the donor. Revenue is recognized on the date the condition is met. At June 30, 2024 and 2023, refundable advances include grant received as detailed in Note 7.

Support and revenue - Leapfrog performs an analysis of the individual grants and contributions to determine if the revenue streams follow the contribution rules or if they should be recorded as an exchange transaction depending upon whether the transactions are deemed reciprocal or nonreciprocal under Accounting Standards Updates (ASU) 2018-08, *Not-for-Profit Entities* (Topic 958).

Contribution revenue is recognized upon notification of the award and satisfaction of all conditions, if applicable. Conditional promises to give are not recognized until the conditions on which they depend are substantially met. Unconditional contributions that have donor restrictions are recognized as "without donor restrictions" only to the extent of actual expenses incurred in compliance with the donor-imposed restrictions and satisfaction of time restrictions; such funds in excess of expenses incurred are shown as net assets with donor restriction in the accompanying consolidated financial statements.

Membership and program revenue classified as exchange transactions are recorded as revenue at a point in time when the performance obligations are met. Leapfrog has elected to opt out of all (or certain) disclosures not required for nonpublic entities. Transaction price is based on cost. Funding received in advance of satisfying performance obligations are recorded as deferred revenue.

Membership dues (IFL dues) include general member benefits that are a series of distinct obligations. The revenue is recognized ratably over the membership period. There are several benefits received that are individual distinct obligations; however, they are immaterial in nature to the contract and thus are included with the general member benefits.

Accolade licensing revenue: Leapfrog licenses logos that signify hospitals' achievements in two of their programs: The Leapfrog Top Hospital logo and the Hospital Safety Grade of "A". The cost of the license is non-refundable. Hospitals may use the dated logo as long as they wish. Revenue is recognized when the performance obligation is met which is the date upon issuance of the logo.

Data licensure: Leapfrog sells data from its two hospital ratings programs, the Leapfrog Hospital Survey and Leapfrog Hospital Safety Grade, to organizations such as health plans that incorporate the Leapfrog data in their own platforms and products. These data users sign year-long license agreements, which can be terminated by either party with adequate notice as specified in the data use agreement.

NOTE 1. NATURE OF ACTIVITIES AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Contract revenue is recognized when the performance obligation is met which is monthly over the contract period. Amounts collected and not earned are included in deferred income and amounts earned but not received are in accounts receivable. Leapfrog also licenses a value-based purchasing program that helps health plans identify the highest performing hospitals in their network and offer corresponding recognition. As part of the licensure contract, Leapfrog offers ongoing support in the form of calls, webinars, and in-person meetings, guidance in structuring rewards, as well as bi-annual hospital analytics reports. Health plans subscribing to the program sign a year-long license agreement, which can be cancelled with adequate notice as specified in the data use agreement. Revenue is recognized when performance obligations are met which is monthly over the period of the contract.

Data products: Leapfrog sells customized analytics reports to hospitals, health plans, researchers and others, using data from one or more of its programs. These are one-time reports and the fees are non-refundable. Revenue is recognized when performance obligation is met which is upon the issuance of the report. Leapfrog also operates a user's group that meets monthly to discuss topics of interest to hospitals; hospital representatives pay an annual fee to join this group. Revenue is recognized upon registration and the fees are non-refundable.

Media partnership: Leapfrog receives media partnership revenue and revenue is recognized when performance obligations are met which is when received.

Income taxes - Leapfrog is generally exempt from federal income taxes under the provisions of Section 501(c)(3) of the Internal Revenue Code (IRC). Additionally, no provision for income taxes has been made in the accompanying consolidated financial statements. Leapfrog is not a private foundation. The Leapfrog Due Diligence Cooperative, LLC is a limited liability company treated as a partnership for income tax purposes with all income tax liabilities and/or benefits, if any, being passed through to its member. As such, no recognition of taxes has been recognized in the accompanying consolidated financial statements.

Management evaluated Leapfrog's tax positions and concluded that Leapfrog has taken no uncertain tax positions that require adjustment to the consolidated financial statements to comply with the provisions of this guidance. Generally, Leapfrog is no longer subject to income tax examinations by the U.S. federal, state or local tax authorities for years before 2021.

Use of estimates - The preparation of consolidated financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosures of contingent assets and liabilities at the date of the consolidated financial statements, and the reported amounts of revenue and expenses during the reporting period. Actual results could differ from those estimates.

NOTE 1. NATURE OF ACTIVITIES AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Functional allocation of expenses - The costs of providing various programs and other activities have been summarized on a functional basis in the consolidated statements of activities and functional expenses. Direct costs associated with specific programs are recorded as program expenses. Certain costs have been allocated among the programs and supporting services. Fringe benefits are allocated based on salaries and programmatic time codes charges in timesheets. Other select expenses are allocated based on management's assessment of employee work. Management and general expenses include those expenses that are not directly identifiable with any other specific function but that provide for the overall support and direction of Leapfrog.

New accounting pronouncement adopted - During the year ended June 30, 2024, Leapfrog adopted the provisions of Accounting Standards Update (ASU) 2016-13, *Financial Instruments – Credit Losses* (Topic 326). This ASU replaced the incurred loss methodology with an expected loss methodology that is referred to as the current expected credit loss (CECL) methodology. The ASU requires nonprofit entities to immediately recognize the estimated expected credit losses over the life of a financial instrument, including trade receivables. The estimate of expected credit losses considers not only historical information, but also current and future economic conditions and events.

Leapfrog adopted the ASU effective July 1, 2023. The impact of the adoption was not considered material to the consolidated financial statements and primarily resulted in additional disclosures.

NOTE 2. LEASE COMMITMENTS

Leapfrog leased office space in Washington, D.C., under an agreement that commenced on May 1, 2012, and expired April 30, 2020. Base rent was \$132,096 per year, plus a proportionate share of expenses, increasing by a factor of 2.5% per year, except for the sixth lease year when rent increase by \$2 per square foot of the fifth-year rate.

Leapfrog entered into a new 130-month lease agreement for office space in Washington, D.C. that commenced on August 1, 2020. The lease provides for ten months of abated rent beginning on lease commencement date. Base rent is \$31,665 per month, plus a proportionate share of expenses, increasing by a factor of 2.5% per year.

The right-of-use asset and the operating lease liability are being amortized over the life of the lease agreement. As of June 30, 2024, the unamortized right-of-use asset was \$2,713,451 and the unamortized operating lease liability was \$2,654,917. The lease cost, including imputed interest and amortization of the right-of-use asset plus the straight-line rent expense for the year ended June 30, 2024, was \$401,112. Rent expense for the year ended June 30, 2023 was \$401,112, also included in operating expenses.

NOTE 2. LEASE COMMITMENTS (CONTINUED)

In March 2023, Leapfrog entered into a finance lease obligation for a copier, which expires in 2026. A finance lease right-of-use asset and related finance lease liability is reported in the consolidated financial statements.

Future minimum lease payments under Leapfrog's operating and finance leases as of June 30, 2024, are as follows:

<u>Year</u>	<u>Operating</u>	<u>Finance</u>
2025	\$ 418,496	\$ 2,196
2026	428,986	1,455
2027	439,742	-
2028	450,762	-
2029	462,048	-
Thereafter	918,478	-
Undiscounted future cash flows	3,118,512	3,651
Less: effects of discounting	(60,904)	(239)
Lease liability recognized	<u>\$ 3,057,608</u>	<u>\$ 3,412</u>

Supplemental qualitative information related to both the operating and finance leases are as follows:

WEIGHTED AVERAGE DISCLOSURES

Weighted average lease term (years) - operating leases	6.92
Weighted average lease term (years) - finance leases	1.67
Weighted average discount rate - operating leases	0.55%
Weighted average discount rate - finance leases	7.82%

NOTE 3. NET ASSETS WITH DONOR RESTRICTIONS

During the year ended June 30, 2023, \$516,902 was recognized as net assets with donor restrictions and \$903,291 of these restricted net assets were released from donor restrictions by incurring expenses which satisfied the restricted purposes specified by the donors resulting in a remaining balance of \$-0- in net assets with donor restrictions at June 30, 2023. During the year ended June 30, 2024, \$890,532 grant was recognized as net assets with donor restrictions and \$751,520 of the restricted net assets were released from donor restrictions, resulting in a remaining balance of \$139,012 in net assets with donor restrictions at June 30, 2024. The grant was purpose restricted and recognized when expenses were incurred.

NOTE 4. LIQUIDITY AND AVAILABILITY

Financial assets available for use for general expenditures within one year of the consolidated statements of financial position date comprise the following:

	2024	2023
Cash and cash equivalents	\$ 1,781,870	\$ 2,999,926
Accounts receivable	699,980	620,715
Total financial assets available	2,481,850	3,620,641
Less: donor restricted funds		
Net assets with donor restrictions	(139,012)	-
Total financial assets available to meet cash needs for general expenditures within one year	<u>\$ 2,342,838</u>	<u>\$ 3,620,641</u>

Leapfrog has a policy to structure its financial assets to be available and liquid as its obligations become due. As of June 30, 2024 and 2023, Leapfrog had financial assets equal to approximately seven and five months of operating expenses, respectively.

NOTE 5. CONTRACT ASSETS AND LIABILITIES

The timing of billings, cash collections, and revenue recognition result in contract assets and contract liabilities associated with revenue from exchange transactions. Contract assets consist entirely of trade accounts receivable, which are recognized only to the extent it is probable that Leapfrog will collect substantially all of the consideration to which it is entitled in exchange for the goods or services that will be or have been transferred. Contract liabilities consist entirely of deferred revenue that results when Leapfrog receives advance payments from customers before revenue is recognized.

Balances in these accounts as of the beginning and end of the years ended June 30, 2024 and 2023 are as follows:

	2024	June 30, 2023	2022
Accounts receivable			
Licensing	\$ 648,640	\$ 601,403	\$ 557,561
Data sales	48,890	14,362	12,460
	<u>\$ 697,530</u>	<u>\$ 615,765</u>	<u>\$ 570,021</u>
Deferred revenue			
Deferred Data Sales, LVBP, System Services	\$ 869,210	\$ 1,008,312	\$ 1,056,019
Other	12,188	51,425	-
	<u>\$ 881,398</u>	<u>\$ 1,059,737</u>	<u>\$ 1,056,019</u>

NOTE 6. HUMAN RESOURCES MANAGEMENT

Leapfrog has contracted with Human Resources, Inc., a professional employer and administrative services organization. All the responsibilities of employee-related administration are handled by Human Resources, Inc., including payroll reporting, health care plans, deferred compensation plans, and worker's compensation insurance. Leapfrog reimburses Human Resources, Inc. for the cost of these benefits, plus a monthly management fee. The total human resource management fees for the years ended June 30, 2024 and 2023 were \$60,850 and \$54,040, respectively.

NOTE 7. REFUNDABLE ADVANCES

In April 2022, Leapfrog received a grant from the Gordon and Betty Moore Foundation. The purpose of the grant was to support a national reporting system that recognizes hospital and health system performance in standards of diagnostic excellence. The Grant was in the amount of \$1,332,925 and was received in full in April 2022. An additional grant of \$113,375 has been received from the grantor during the year ended June 30, 2024.

The funds under the Grant are considered to be a conditional contribution under ASC 958-605 as they include a right of return and specific outcome requirements. As of June 30, 2024, the funds have not been fully used, and revenue was recognized as the specific outcome requirements have are met. Revenue recognized during the year ended June 30, 2024, was \$751,520. The remaining amount of \$177,878 is recognized on the consolidated statements of financial position as a refundable advance.

NOTE 8. RETIREMENT PLANS

Leapfrog provides retirement benefits to employees through a defined contribution plan covering all full-time employees with one year of service. Eligible employees may elect to contribute, subject to certain limitations, a portion of their salary on a tax-deferred basis.

Leapfrog contributes an additional 10% of the eligible employees' gross pay to the Plan. Employees are immediately vested. The employer contributions to the defined contribution plan for the years ended June 30, 2024 and 2023 totaled \$269,596 and \$251,007, respectively.

NOTE 9. SUBSEQUENT EVENTS

Subsequent events have been evaluated through March 28, 2025, which is the date the consolidated financial statements were available to be issued. This review and evaluation revealed no material event or transaction which would require an adjustment to or disclosure in the accompanying consolidated financial statements.

Exhibit 26

Message

From: Leah Binder [/O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=464D5CA22AE54CB5851B932186D83A1F-LBINDER]
Sent: 7/15/2024 11:34:16 AM
To: Paul Alper [palper@leapfrog-group.org]
CC: Karen Jupiter [kjupiter@leapfrog-group.org]
Subject: RE: FINAL SLIDES FOR AHE TALK - DUE TO BE SUBMITTED TOMORROW FOR ANY FINAL COMMENT/SUGGESTIONS
LEAH! THANKS!
Attachments: LFG About Us Slides 2024.pptx

Hi Paul, Looking great.
I have a few suggestions:

- Typo on slide 9 (the word “decision” should be plural)
- I think before Slide 10 you should say something about the employer origins of Leapfrog. The employer and the business coalitions set the standards through Leapfrog and aim to drive a market for safety. That is a major part of the reason hospitals participate and pay attention to Leapfrog and our Surveys. Attached are template slides I use but adapt as you wish.
- Slide 12: I’m not sure the page views stat is universally compelling, there are lots of websites that get a lot more traffic (ie probably many hospital associations) and touting the number could backfire as a message. Another stat you might use here instead: over 65% of hospitals now report using Leapfrog standards for executive compensation reviews. If you want to show the prominence of the grade, you could use a slide showing media clips or a photo of a hospital touting their A.
- Slide 24: just an idea, you could do the math that if 54,000 opportunities arise on a 25 bed unit (slide 22) that means 37,800 (70%) are encounters with patients are below the standard of good hygiene—in just one 25 bed unit.
- Slide 16: The statistic on A vs F hospitals meeting the hand hygiene standard won’t pass our test of validity. First, hand hygiene is a standard in the grade so A hospitals will by definition be more likely to achieve it. However it would be ok to site them for 40% complianc,except not only in comparison to F hospitals. There are only a small handful of F hospitals each round (20ish) so it’s likely not statistically significant to compare all the As against them. So please leave this stat out, the presentation is strong enough without it.
- We did change the methodology for Fall 2024 so that hospitals that don’t report to the Leapfrog Survey this year or last year will be imputed with the lowest score on hand hygiene. I’m sure the survey team has a slide on that. But please be sure you thoroughly understand this change and the talking points around it if you do decide to use it—it’s a very big deal to hospitals (and a major incentive to report to the Survey) and you could easily get a question on it.

Great job with this! Leah

Leah F. Binder, MA, MGA
President & CEO
The Leapfrog Group
202-292-6713



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From: Paul Alper <palper@leapfrog-group.org>

Sent: Monday, July 15, 2024 10:07 AM

To: Leah Binder <lbinder@leapfrog-group.org>

Cc: Karen Jupiter <kjupiter@leapfrog-group.org>

Subject: FINAL SLIDES FOR AHE TALK - DUE TO BE SUBMITTED TOMORROW FOR ANY FINAL COMMENT/SUGGESTIONS

LEAH! THANKS!

They have been reviewed and approved by AHE education committee

Paul

Paul Alper, BA, LCC

Senior Advisor

The Leapfrog Group

Mobile +1 843-870-4801

Member APIC, The Association for Professionals in Infection Control and Epidemiology

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Exhibit 27

Message

From: Karen Jupiter [kjupiter@leapfrog-group.org]
Sent: 8/27/2024 10:58:25 AM
To: Missy Danforth [mdanforth@leapfrog-group.org]
Subject: RE: CEO Report

Yep! Got it.

From: Missy Danforth <mdanforth@leapfrog-group.org>
Sent: Monday, August 26, 2024 12:03 PM
To: Karen Jupiter <kjupiter@leapfrog-group.org>
Subject: RE: CEO Report

Katie should have sent you submission article. JL sent AARP. Fall SG update below:

Fall 2024 Safety Grade Update

Starting with the fall 2024 Hospital Safety Grade, Leapfrog will only impute missing measure scores from the previous two rounds of grades (i.e., spring 2024, fall 2023) instead of the previous four rounds of grades. Additionally, instead of assigning hospitals the mean score of similar hospitals if they don't have a recent score available for imputation, Leapfrog will now assign a point value associated with "Limited Achievement" on that measure. The update dramatically lowers imputed scores for certain measures for hospitals that decline to report to the Leapfrog Hospital Survey. This follows a strong recommendation from the Expert Panel. This has appeared to impact hospital reporting to the Survey as we are seeing record participation this year. Additionally, these changes strengthen the Grade overall by ensuring hospitals are not receiving undue credit for performance they have not achieved.

Missy Danforth (she/her/hers)
Senior Vice President, Health Care Ratings
(202) 292-6713
1775 K St. NW, Suite 400
Washington, DC 20006



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From: Karen Jupiter <kjupiter@leapfrog-group.org>
Sent: Wednesday, August 21, 2024 2:16 PM
To: Ben Choi <bchoi@leapfrog-group.org>; Andrea Clay <aclay@leapfrog-group.org>; Missy Danforth <mdanforth@leapfrog-group.org>; Kush Banerjee <kBanerjee@leapfrog-group.org>; Ralph Johnson <RJohnson@leapfrog-group.org>
Subject: CEO Report

In preparation for the Exec Cte meeting, please send me the following information, by COB on 8/29, for inclusion in the CEO Report. Feel free to add anything I missed.

Ben:
NetSuite Implementation
2023 FY End Numbers

Missy:
Submissions to date
Fall HSG

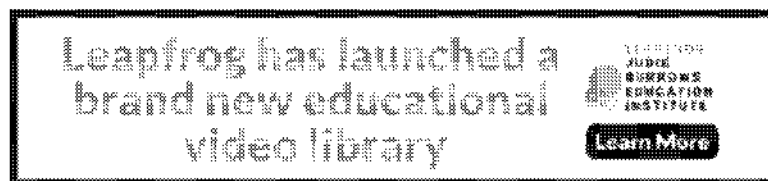
Karen (FYD):
Annual Meeting Updates
IPPS Media Coverage
Hand hygiene Report
JBEI – Videos and Toolkits

Andrea:
PAC Updates and Workgroups

Kush:
Licensing and Data Sales Updates

Ralph:
Data Visualization

Karen Jupiter
Vice President for Development
The Leapfrog Group
202-719-9784



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Exhibit 28

LEAPFROG
HOSPITAL
SAFETY GRADE

| Scoring Methodology

FALL 2024 SAFETY GRADE

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11/4/2024

HOSPITAL

SAFETY GRADE

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HOSPITAL

SAFETY GRADE

WHAT IS THE HOSPITAL SAFETY GRADE?

Leapfrog Hospital Safety Grades are assigned to nearly 3,000 general acute-care hospitals across the nation twice annually. The Safety Grade uses up to 22 national patient safety measures from the Centers for Medicare & Medicaid Services (CMS) and the Leapfrog Hospital Survey, and information from other supplemental data sources, to produce a single letter grade representing a hospital's overall performance in keeping patients safe from preventable harm and medical errors. The Safety Grade methodology has been peer reviewed and published in the *Journal of Patient Safety*.¹

With the Safety Grade, The Leapfrog Group aims to educate and encourage consumers to consider safety when selecting a hospital for themselves or their families. In addition, we believe the Safety Grade will foster strong market incentives for hospitals to make safety a priority. Safety Grades are publicly reported at www.HospitalSafetyGrade.org.

ELIGIBLE HOSPITALS

Due to the limited availability of public data, Leapfrog is not able to calculate a Safety Grade for every hospital in the U.S., including the following types of hospitals:

- Critical access hospitals (CAH)
- Rural emergency hospitals (REH)
- Long-term care and rehabilitation facilities
- Mental health facilities
- Federal hospitals (e.g., Veterans Affairs, Indian Health Services, etc.)
- Some specialty hospitals, such as surgery centers and cancer hospitals
- Free-standing pediatric hospitals
- Hospitals in U.S. territories
- Hospitals that are missing scores for **more than six (6)** process/structural measures, or **more than five (5)** outcome measures, or **missing PSI 90**

¹ The Leapfrog Hospital Safety Grade uses the below-described data and reflects expert opinion as to the relative importance of each category.

HOSPITAL

SAFETY GRADE

MEASURES

The Safety Grade utilizes up to 22 national patient safety measures from the Centers for Medicare & Medicaid Services (CMS) and the Leapfrog Hospital Survey, and information from other supplemental data sources.

The measure set is divided into two domains: (1) Process/Structural Measures and (2) Outcome Measures. Each domain represents 50% of the Safety Grade. The following table lists the 22 measures included in the Safety Grade, as well as the data source and reporting period for each measure. In some cases where a hospital's information is not available for a certain measure, Leapfrog uses a secondary data source (as indicated in the table). In cases where a hospital's information is not available from any data source, Leapfrog has outlined a methodology for dealing with the missing data.

PROCESS/STRUCTURAL MEASURES (12)

Measure Name	Primary Data Source	Reporting Period	Secondary Data Source	Reporting Period
Computerized Physician Order Entry (CPOE)	2024 Leapfrog Hospital Survey	2024	Imputation Model Applied*	N/A
Bar Code Medication Administration (BCMA)	2024 Leapfrog Hospital Survey	2024	Imputation Model Applied*	N/A
ICU Physician Staffing (IPS)	2024 Leapfrog Hospital Survey	2024	Imputation Model Applied*	N/A
Safe Practice 1: Culture of Leadership Structures and Systems	2024 Leapfrog Hospital Survey	2024	N/A	N/A
Safe Practice 2: Culture Measurement, Feedback & Intervention	2024 Leapfrog Hospital Survey	2024	N/A	N/A

HOSPITAL

SAFETY GRADE

PROCESS/STRUCTURAL MEASURES (12)

Measure Name	Primary Data Source	Reporting Period	Secondary Data Source	Reporting Period
Total Nursing Care Hours per Patient Day	2024 Leapfrog Hospital Survey	01/01/2023 - 12/31/2023	N/A	N/A
Hand Hygiene	2024 Leapfrog Hospital Survey	2024	Imputation Model Applied*	N/A
H-COMP-1: Nurse Communication	CMS	10/01/2022 - 09/30/2023	N/A	N/A
H-COMP-2: Doctor Communication	CMS	10/01/2022 - 09/30/2023	N/A	N/A
H-COMP-3: Staff Responsiveness	CMS	10/01/2022 - 09/30/2023	N/A	N/A
H-COMP-5: Communication about Medicines	CMS	10/01/2022 - 09/30/2023	N/A	N/A
H-COMP-6: Discharge Information	CMS	10/01/2022 - 09/30/2023	N/A	N/A

*See Leapfrog's Imputation Method for CPOE, BCMA, IPS and Hand Hygiene for more information on the imputation methodology used for hospitals that did not submit a Leapfrog Hospital Survey by the Data Snapshot Date (August 31, 2024).

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SAFETY GRADE

OUTCOME MEASURES (10)

Measure Name	Primary Data Source	Reporting Period	Secondary Data Source	Reporting Period
Foreign Object Retained	CMS	07/01/2021 - 06/30/2023	N/A	N/A
Air Embolism	CMS	07/01/2021 - 06/30/2023	N/A	N/A
Falls and Trauma	CMS	07/01/2021 - 06/30/2023	N/A	N/A
CLABSI	2024 Leapfrog Hospital Survey	01/01/2023 - 12/31/2023	CMS	10/01/2022 - 09/30/2023
CAUTI	2024 Leapfrog Hospital Survey	01/01/2023 - 12/31/2023	CMS	10/01/2022 - 09/30/2023
SSI: Colon	2024 Leapfrog Hospital Survey	01/01/2023 - 12/31/2023	CMS	10/01/2022 - 09/30/2023
MRSA	2024 Leapfrog Hospital Survey	01/01/2023 - 12/31/2023	CMS	10/01/2022 - 09/30/2023
C. Diff.	2024 Leapfrog Hospital Survey	01/01/2023 - 12/31/2023	CMS	10/01/2022 - 09/30/2023
PSI 4: Death rate among surgical inpatients with serious treatable complications	CMS	07/01/2020 - 06/30/2022	N/A	N/A
CMS Medicare PSI 90: Patient safety and adverse events composite*	CMS	07/01/2020 - 06/30/2022	N/A	N/A

* CMS calculates PSI 90 using the ten (10) component PSIs. While scores for each of the 10 component PSIs are not used to calculate fall 2024 Hospital Safety Grades, they will be publicly reported on the Hospital Safety Grade [website](#).

HOSPITAL

SAFETY GRADE

****COMPONENT PSIs (SCORES NOT USED TO CALCULATE THE HOSPITAL SAFETY GRADE)**

Component PSI	Primary Data Source	Reporting Period	Secondary Data Source	Reporting Period
PSI 3: Pressure ulcer rate	CMS	07/01/2020 - 06/30/2022	N/A	N/A
PSI 6: Iatrogenic pneumothorax rate	CMS	07/01/2020 - 06/30/2022	N/A	N/A
PSI 8: In-hospital fall with hip fracture rate	CMS	07/01/2020 - 06/30/2022	N/A	N/A
PSI 9: Postoperative hemorrhage or hematoma rate	CMS	07/01/2020 - 06/30/2022	N/A	N/A
PSI 10: Postoperative acute kidney injury requiring dialysis rate	CMS	07/01/2020 - 06/30/2022	N/A	N/A
PSI 11: Postoperative respiratory failure rate	CMS	07/01/2020 - 06/30/2022	N/A	N/A
PSI 12: Perioperative pulmonary embolism or deep vein thrombosis rate	CMS	07/01/2020 - 06/30/2022	N/A	N/A
PSI 13: Postoperative sepsis rate	CMS	07/01/2020 - 06/30/2022	N/A	N/A
PSI 14: Postoperative wound dehiscence rate	CMS	07/01/2020 - 06/30/2022	N/A	N/A
PSI 15: Abdominopelvic accidental puncture or laceration rate	CMS	07/01/2020 - 06/30/2022	N/A	N/A

Note: CMS calculates PSI 90 using the ten (10) component PSIs listed above. While scores for each of the 10 component PSIs are not used to calculate fall 2024 Hospital Safety Grades, they will be publicly reported on the Hospital Safety Grade [website](#).

HOSPITAL

SAFETY GRADE

MEASURE & SCORING DESCRIPTIONS

PROCESS/STRUCTURAL MEASURES

For Process/Structural Measures, a higher score is always better because these are measures of compliance with best practices in patient care.

COMPUTERIZED PHYSICIAN ORDER ENTRY (CPOE)

The CPOE measure is collected by The Leapfrog Group on the Leapfrog Hospital Survey. It measures a hospital's progress toward implementing a CPOE system to reduce medication ordering errors. Through participation in the Leapfrog Hospital Survey, hospitals are placed in one of several performance categories: "Achieved the Standard," "Considerable Achievement," "Some Achievement," "Limited Achievement," or "Unable to Calculate Score." For the purposes of calculating the Safety Grade, a numerical score is assigned to each performance category:

Leapfrog Performance Category	Measure Score
Achieved the Standard	100
Considerable Achievement	70
Some Achievement	40
Limited Achievement	15
Unable to Calculate Score	Not Available (See Scoring Terms)

For hospitals that did not submit a 2024 Leapfrog Hospital Survey by August 31, see [Using Secondary Data Sources](#) for more information on Leapfrog's imputation methodology.

HOSPITAL SAFETY GRADE

BAR CODE MEDICATION ADMINISTRATION (BCMA)

The BCMA measure is collected by The Leapfrog Group on the Leapfrog Hospital Survey. It measures a hospital's progress toward 1) implementation of BCMA throughout the hospital, 2) compliance with patient and medication scans during administration, 3) use of decision support, and 4) structures to monitor and reduce workarounds. Through participation in the Leapfrog Hospital Survey, hospitals are placed in one of several performance categories: "Achieved the Standard," "Considerable Achievement," "Some Achievement," "Limited Achievement," or "Does Not Apply." For the purposes of calculating the Safety Grade, a numerical score is assigned to each performance category:

Leapfrog Performance Category	Measure Score
Achieved the Standard	100
Considerable Achievement	75
Some Achievement	50
Limited Achievement	25
Does Not Apply	Not Available (See Scoring Terms)

For hospitals that did not submit a 2024 Leapfrog Hospital Survey by August 31, see [Using Secondary Data Sources](#) for more information on Leapfrog's imputation methodology.

ICU PHYSICIAN STAFFING (IPS)

The IPS measure is collected by The Leapfrog Group on the Leapfrog Hospital Survey. It measures a hospital's use of intensivists in ICUs. Through participation in the Leapfrog Hospital Survey, hospitals are placed in one of several performance categories: "Achieved the Standard," "Considerable Achievement," "Some Achievement," "Limited Achievement," or "Does Not Apply." For the purposes of calculating the Safety Grade, a numerical score is assigned to each performance category:

Leapfrog Performance Category	Measure Score
Achieved the Standard	100
Considerable Achievement	50
Some Achievement	15
Limited Achievement	5
Does Not Apply	Not Available (See Scoring Terms)

For hospitals that did not submit a 2024 Leapfrog Hospital Survey by August 31, see [Using Secondary Data Sources](#) for detailed information on Leapfrog's imputation methodology.

HOSPITAL SAFETY GRADE

NATIONAL QUALITY FORUM (NQF) SAFE PRACTICES

Two (2) NQF Safe Practice measures are collected by The Leapfrog Group on the Leapfrog Hospital Survey. They measure a hospital's progress toward implementing endorsed processes and protocols to reduce and prevent adverse events. Through participation in the Leapfrog Hospital Survey, hospitals can earn up to 120 points for each Safe Practice. For the purposes of calculating the Safety Grade, individual scores for each Safe Practice are used:

NQF Safe Practice	Possible Measure Score
Safe Practice 1: Culture of Safety Leadership Structures and Systems	0 - 120
Safe Practice 2: Culture Measurement, Feedback and Intervention	0 - 120

There is no secondary data source for the NQF Safe Practices. Therefore, hospitals that did not submit a 2024 Leapfrog Hospital Survey by August 31 will not have these measures included in their Safety Grade and the measure will be reported as "Declined to Report." See [Dealing with Missing Data](#) for more information.

TOTAL NURSING CARE HOURS PER PATIENT DAY

The Total Nursing Care Hours per Patient Day measure is collected by The Leapfrog Group on the Leapfrog Hospital Survey. It measures the hospital's total number of productive hours worked by employee or contract nursing staff (i.e., RNs, LPNs, and UAPs) with direct patient care responsibilities per patient day across three unit types: medical, surgical, and med/surg. Through participation in the Leapfrog Hospital Survey, hospitals are placed in one of several performance categories: "Achieved the Standard," "Considerable Achievement," "Some Achievement," "Limited Achievement," or "Does Not Apply." For the purposes of calculating the Safety Grade, a numerical score is assigned to each performance category:

Leapfrog Performance Category	Measure Score
Achieved the Standard	100
Considerable Achievement	70
Some Achievement	40
Limited Achievement	15
Does Not Apply	Not Available (See Scoring Terms)

There is no secondary data source for the Total Nursing Care Hours per Patient Day measure. Therefore, hospitals that did not submit a 2024 Leapfrog Hospital Survey by August 31 will not have this measure included in their Safety Grade and the measure will be reported as "Declined to Report." See [Dealing with Missing Data](#) for more information.

HOSPITAL SAFETY GRADE

HAND HYGIENE

The Hand Hygiene measure is collected by The Leapfrog Group on the Leapfrog Hospital Survey. It measures processes and protocols that hospitals have in place regarding monitoring hand hygiene practices, fostering a culture of good hand hygiene, offering training and education, and providing equipment. Through participation in the Leapfrog Hospital Survey, hospitals are placed in one of several performance categories: "Achieved the Standard," "Considerable Achievement," "Some Achievement," "Limited Achievement." For the purposes of calculating the Safety Grade, a numerical score is assigned to each performance category:

Leapfrog Performance Category	Measure Score
Achieved the Standard	100
Considerable Achievement	70
Some Achievement	40
Limited Achievement	15

For hospitals that did not submit a 2024 Leapfrog Hospital Survey by August 31, see [Using Secondary Data Sources](#) for detailed information on Leapfrog's imputation methodology.

HOSPITAL CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS (HCAHPS) COMPOSITES

The Hospital HCAHPS survey responses are collected by CMS via the Inpatient Quality Reporting Program. Linear mean scores calculated by CMS incorporate the full range of survey response categories into a single metric for each HCAHPS composite. Five of the six composites are used in the Safety Grade. For the purposes of calculating the Safety Grade, a hospital's linear mean score for each of the five composites is used:

HCAHP Composite	Possible Measure Score
H-COMP-1: Nurse Communication	0 - 100
H-COMP-2: Doctor Communication	0 - 100
H-COMP-3: Staff Responsiveness	0 - 100
H-COMP-5: Communication about Medicines	0 - 100
H-COMP-6: Discharge Information	0 - 100

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OUTCOME MEASURES

For Outcome Measures, a lower score is always better because these are measures of harm experienced by patients (e.g., central line-associated blood stream infections).

HOSPITAL-ACQUIRED CONDITIONS

Three hospital-acquired condition measures are calculated by CMS through the [DRA HAC Reporting Program](#): Foreign Object Retained after Surgery, Air Embolism, and Falls and Trauma. Hospital-acquired condition rates are calculated by CMS based on Part A Medicare Fee-for-service (FFS) claims and publicly reported as a rate per 1,000 Part A Medicare FFS discharges. No age restrictions are applied. For the purposes of calculating the Safety Grade, the rate is used. More information is available in the [DRA HAC methodology](#).

HEALTHCARE-ASSOCIATED INFECTIONS

Five healthcare-associated infection measures are collected by The Leapfrog Group on the Leapfrog Hospital Survey: Central line-associated bloodstream infections (CLABSI) in ICUs and select wards, Catheter-associated urinary tract infections (CAUTI) in ICUs and select wards, Surgical site infections from colon surgery (SSI: Colon), Facility-wide inpatient MRSA Blood Laboratory-identified Events, and Facility-wide inpatient C.diff. Laboratory-identified Events. Through participation in the Leapfrog Hospital Survey, hospitals were required to 1) join Leapfrog's NHSN group, 2) provide an accurate NHSN ID in the Profile section of the Online Survey Tool, and 3) submit a Survey by August 31. For the purposes of calculating the Safety Grade, the [standardized infection ratio \(SIR\)](#) is used:

As Reported by Leapfrog	Measure Score	Notes
Standardized Infection Ratio (SIR)	SIR	Measure is included in calculating the Safety Grade
Does Not Apply	Not Available (See Scoring Terms)	Measure is not included in calculating the Safety Grade. No use of Secondary Data.
Unable to Calculate Score	Not Available (See Scoring Terms)	Measure is not included in calculating the Safety Grade. No use of Secondary Data.
Declined to Respond	See Using Secondary Data	Secondary Data source is used.

For hospitals that did not join Leapfrog's NHSN group, provide an accurate NHSN ID, or submit a 2024 Leapfrog Hospital Survey by August 31, see [Using Secondary Data Sources](#) for more information on Leapfrog's use of CMS data.

HOSPITAL SAFETY GRADE

AHRQ PATIENT SAFETY INDICATORS (PSI)

Two AHRQ Patient Safety Indicators are calculated by CMS through the Inpatient Quality Reporting Program and the [HAC Reduction Program](#): PSI 4 Death Rate among Surgical Inpatients with Serious Treatable Conditions and PSI 90 Patient Safety and Adverse Events Composite. PSI rates are calculated by CMS based on Medicare Fee-for-Service claims and publicly reported as a rate per 1,000 inpatient discharges. CMS only includes claims from patients 18 years or older. For the purpose of calculating the Safety Grade, the smoothed rate is used for both measures. More information on calculating PSIs is available on the [Patient Safety Indicators \(PSI\) 2024 Resources website](#).

Note: CMS calculates PSI 90 using the ten (10) component PSIs that are listed in the PSI 90 Components table [above](#). While scores for each of the 10 component PSIs are NOT used to calculate fall 2024 Hospital Safety Grades, they will be publicly reported on the Hospital Safety Grade [website](#). Additional information about the PSI 90 measure and how it is calculated by CMS can be found [here](#).

HOSPITAL SAFETY GRADE

USING SECONDARY DATA SOURCES

Twelve (12) of the 22 measures included in the Safety Grade are derived from the Leapfrog Hospital Survey. The Leapfrog Hospital Survey is voluntary, and as such, hospitals may choose not to submit a Survey. To address this gap in available data, the Safety Grade methodology utilizes secondary data when available. For information on how to complete a free Leapfrog Hospital Survey, visit www.leapfroggroup.org/survey.

IMPUTATION METHOD FOR CPOE, BCMA, IPS, AND HAND HYGIENE

Leapfrog has worked closely with statisticians at Mathematica, Leapfrog's National Expert Panel, and our scientific partners at Johns Hopkins Armstrong Institute for Patient Safety and Quality to develop a new two-step imputation approach for determining scores for CPOE, BCMA, IPS, and Hand Hygiene if they are missing from our publicly reported Survey Results.

STEP 1: USE A HOSPITAL'S MOST RECENT SCORE ON THE MEASURE (APPLIES TO CPOE, IPS, AND HAND HYGIENE ONLY)

If the hospital had a score assigned by Leapfrog in the previous two rounds of grades (i.e., spring 2024, fall 2023), excluding imputed scores, the hospital is assigned the most recent score on that measure in the current Hospital Safety Grade (i.e., fall 2024).

STEP 2: USE IMPUTATION POINT ASSIGNMENT (APPLIES TO CPOE, BCMA, IPS AND HAND HYGIENE)

If the hospital does not have historical data from the last two rounds (i.e., spring 2024, fall 2023) of the Safety Grade, the hospital is assigned a point value that is equivalent to receiving "Limited Achievement" for this measure on the Leapfrog Hospital Survey:

Measure	Leapfrog Hospital Survey Performance Category	Corresponding Safety Grade Measure Score
CPOE	Limited Achievement	15
BCMA	Limited Achievement	25
IPS	Limited Achievement	5
Hand Hygiene	Limited Achievement	15

Note about IPS: Only hospitals that operate an adult or pediatric medical and/or surgical ICU or neuro ICU are eligible for Step 2 Imputation of the IPS measure. A hospital's ICU designation (i.e., operating a medical ICU, surgical ICU, or pediatric ICU) is determined from the number of medical, surgical and/or pediatric ICU beds reported in Worksheet S-3 Part 1 of the hospital's most recent CMS Cost Report. If your hospital does not operate an ICU, but shares a CMS Certification Number with a hospital that does, please contact the Help Desk immediately if an IPS score was imputed.

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CMS DATA FOR HAIS

CMS is the **secondary data** source for healthcare-associated infections. For the purposes of calculating the Safety Grade, the standardized infection ratio (SIR) published by CMS is used:

Hospitals That Did Not Join Leapfrog's NHSN Group and Submit Section 7: Managing Serious Errors of the 2024 Leapfrog Hospital Survey by August 31

As Reported by CMS	Measure Score	Notes
Not Available (no locations or low volume)	Not Available (See Scoring Terms)	Measure is not included in calculating the Leapfrog Hospital Safety Grade.
Standard Infection Ratio (SIR)	SIR	Measure is included in calculating the Leapfrog Hospital Safety Grade.

If a hospital does not have available data from the Leapfrog Hospital Survey or CMS (e.g., no locations or low volume), the hospital is reported as "Not Available." See [Dealing with Missing Data](#) for more information.

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SAFETY GRADE

SCORING METHODOLOGY

WEIGHTING INDIVIDUAL MEASURES

Each measure included in the Leapfrog Hospital Safety Grade is assigned a standard weight. The methodology to assign standard weights includes four criteria: (1) Impact, (2) Evidence, (3) Opportunity, and (4) Number of Component Measures. These four criteria are then combined using the equation below, which results in a standard weight for each measure that represents the measure's relative importance within the Hospital Safety Grade.

$$[\text{Evidence} + (\text{Impact} \times \text{Opportunity} \times \text{Number of Component Measures})]$$

EVIDENCE

The Evidence Score for each individual measure is assigned a value of one (1) or two (2) using the following criteria:

- 1 = Supported by either suggestive clinical or epidemiological studies or theoretical rationale
- 2 = Supported by experimental, clinical, or epidemiological studies and strong theoretical rationale

OPPORTUNITY

The Opportunity Score for each individual measure is based on the Coefficient of Variation (Standard Deviation/Mean) of that measure, using the following formula: $[1 + (\text{Standard Deviation}/\text{Mean})]$. The Opportunity Score is on a continuous scale that is capped at three (3). Any measure with an Opportunity Score above three (3) is assigned a three (3).

IMPACT

The Impact Score for each individual measure is comprised of two (2) parts, each of which is assigned a value from one (1) to three (3):

1. Number of patients affected
2. Severity of harm

The *number of patients affected* score is determined by the following:

- 0 = Extremely rare event (e.g., Air Embolism)
- 1 = Rare event (e.g., Foreign Object Retained After Surgery)

HOSPITAL SAFETY GRADE

- 2 = Some patients in hospital affected (e.g., ICU Physician Staffing)
- 3 = All patients in hospital affected (e.g., Hand Hygiene)

The *severity of harm* score is determined by the following:

- 1 = No direct evidence of harm or harm reduction (e.g., Patient Experience)
- 2 = Clear documentation of harm or harm reduction; adverse events (e.g., Foreign Object Retained After Surgery)
- 3 = Significant mortality reduction (more than 1,000 deaths or a 10% reduction in hospital wide mortality) (e.g., ICU Physician Staffing)

The values from each part are then added together to arrive at the overall Impact Score using the following criteria:

- 1 = Score of 2 (Low Impact) (e.g., Air Embolism)
- 2 = Score of 3-4 (Medium Impact) (e.g., Patient Experience)
- 3 = Score of 5-6 (High Impact) (e.g., ICU Physician Staffing)

NUMBER OF COMPONENT MEASURES

The number of component measures refers to how many measures are included within the measure. For PSI 90, the number of component measures is 10 (PSI 3, PSI 6, PSI 8, PSI 9, PSI 10, PSI 11, PSI 12, PSI 13, PSI 14, and PSI 15). For all other measures included in the Hospital Safety Grade, the number of component measures within the measure is one (1).

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STANDARD MEASURE WEIGHTS

Measure	Evidence Score	Opportunity Score	Impact Score	Number of Component Measures	Standard Measure Weight
Process/Structural Measure Domain (50%)					
CPOE	2	1.44	3	1	6.2%
BCMA	2	1.39	3	1	6.0%
IPS	2	1.68	3	1	6.9%
SP 1	1	1.06	2	1	3.0%
SP 2	1	1.13	2	1	3.2%
Total Nursing Care Hours per Patient Day	2	1.42	2	1	4.7%
Hand Hygiene	2	1.51	2	1	4.9%
H-COMP-1	1	1.03	2	1	3.0%
H-COMP-2	1	1.03	2	1	3.0%
H-COMP-3	1	1.05	2	1	3.0%
H-COMP-5	1	1.06	2	1	3.0%
H-COMP-6	1	1.04	2	1	3.0%
Outcome Measure Domain (50%)					
Foreign Object Retained	1	3.00	2	1	4.2%
Air Embolism	1	3.00	1	1	2.4%
Falls and Trauma	2	2.05	3	1	4.9%
CLABSI	2	1.82	3	1	4.5%
CAUTI	2	1.88	3	1	4.6%
SSI: Colon	2	1.85	2	1	3.4%
MRSA	2	1.79	3	1	4.5%
C. Diff.	2	1.79	3	1	4.5%
PSI 4	1	1.13	2	1	2.0%
PSI 90	1	1.19	2	10	15.0%

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SAFETY GRADE

CALCULATING Z-SCORES

Z-Scores are used to standardize data from measures with different performance scales and allow for comparisons (e.g., a linear mean score of 90 on H-COMP-1: Nurse Communication and a CLABSI SIR of 0.870). In addition, Z-Scores can indicate to a hospital whether their measure score is above, below, or equal to the average hospital.

In the Scoring Methodology, a Z-Score is calculated for each available measure score. A Z-Score is calculated using a hospital's actual measure score, the national mean for that measure, and the standard deviation for that measure. The Z-Score for each measure is calculated using the following formulas:

- **For Process/Structural Measures:** $(\text{Hospital Score} - \text{Mean}) / \text{Standard Deviation}$
- **For Outcome Measures:** $[(\text{Mean} - \text{Hospital Score}) / \text{Standard Deviation}]$

The following table includes the national mean and standard deviation for each measure used to calculate a hospital's Z-Score. For display, means and standard deviations are displayed rounded to two or three decimal places. For scoring, these values are not rounded.

Process and Structural Measures	Mean	Standard Deviation
CPOE	79.04	34.62
BMCA	80.51	31.02
IPS	64.45	43.96
SP 1	117.40	6.66
SP 2	116.60	15.20
Total Nursing Care Hours per Patient Day	76.10	31.78
Hand Hygiene	72.43	36.61
H-COMP-1	90.04	2.56
H-COMP-2	89.80	2.48
H-COMP-3	81.48	4.41
H-COMP-5	74.33	4.16
H-COMP-6	85.14	3.78

Outcome Measures	Mean	Standard Deviation
Foreign Object Retained	0.014	0.050
Air Embolism	0.002	0.055
Falls and Trauma	0.385	0.404
CLABSI	0.687	0.566
CAUTI	0.577	0.505
SSI: Colon	0.852	0.722
MRSA	0.746	0.588
C. Diff.	0.418	0.330
PSI 4	168.34	21.85
PSI 90	1.01	0.19

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A NOTE ABOUT EXTREME VALUES

For hospitals that have an “extreme” value for a particular measure (i.e., a value that exceeds the 99th percentile) Leapfrog “trims” the reported value to the 99th percentile. For example, a rate of 0.500 per 1,000 patient discharges for Foreign Object Retained after Surgery is “trimmed” to 0.327 (e.g., the 99th percentile). Only “trimmed” rates are displayed on the Leapfrog Hospital Safety Grade [website](#). The table below includes the “trim” values for the fall 2024 Leapfrog Hospital Safety Grade. The PSI 90 measure score represents an observed to expected ratio that has already been risk adjusted at both the component PSI level and at the composite level; therefore, the measure is not “trimmed” by Leapfrog.

Measure	99 th Percentile
Foreign Object Retained	0.327
Air Embolism	2.890
Falls and Trauma	1.942
CLABSI	2.534
CAUTI	2.550
SSI: Colon	3.534
MRSA	2.696
C. Diff.	1.699
PSI 4	222.68

Note: Percentiles are rounded to reflect the precision of the raw data.

HOSPITAL SAFETY GRADE

DEALING WITH MISSING DATA

Due to a variety of reasons, a hospital may not have a measure score for all 22 measures. If a hospital is missing a measure score for any measure (except PSI 90; hospitals missing PSI 90 are not graded), the standard weight of that measure is redistributed to the other measures in the same measure domain. The new weight for each measure within the domain is calculated by re-apportioning the standard weight assigned to the measure with the missing score to other measures within the same domain. For example, if a hospital is missing a measure score for ICU Physician Staffing because the hospital does not operate an adult or pediatric medical and/or surgical ICU, the standard weight of 6.9% will be re-apportioned to the remaining 11 measures within the process/structural measure domain.

To calculate the new weight of each of the remaining 11 measures in the process/structural measure domain, hospitals can use the formula below or use the Leapfrog Hospital Safety Grade Calculator[®], which can be found on the [Safety Grade Review Website](#). Note that each domain contributes to 50% of the overall letter grade.

[Standard measure weight / (sum of standard weights for the remaining 11 measures in the process/structural measure domain)]*50% = updated measure weight

For more information about how the measure weight redistribution is calculated and affects the overall score, please see the Leapfrog Hospital Safety Grade Calculator, which can be found on the last page of the [Safety Grade Review Website](#).

CALCULATING WEIGHTED MEASURE SCORES

To calculate a hospital's numerical safety score, multiply the Z-Score of each process/structural measure by the standard weight assigned to that measure to get the weighted process/structural measure score. If a hospital is missing any process/structural measure scores, see [Dealing with Missing Data](#) to determine the updated measure weight. Then, sum all weighted process/structural measure scores. This is the hospital's overall weighted process/structural measures score.

Multiply the Z-Score of each outcome measure by the standard weight assigned to that measure to get the weighted outcome measure score. If a hospital is missing any outcome measure scores, see [Dealing with Missing Data](#) to determine the updated measure weight. Then, sum all weighted outcome measure scores. This is the hospital's overall weighted outcome measures score.

To calculate the overall Safety Grade for a hospital, add the overall weighted process/structural measures score and the overall weighted outcome measures score. Add 3.0 to your score; this is done to normalize scores to a positive distribution. This final numerical score (typically between 1.0 and 4.0) is then assigned to a letter grade. To assist hospitals in calculating their numerical score, a calculator is available on the [Safety Grade Review Website](#). Letter grade cut-points are published during the [Letter Grade Embargo Period](#).

HOSPITAL SAFETY GRADE

ADDITIONAL SCORING INFORMATION

TERMS USED IN SCORING AND PUBLIC REPORTING

“Not Available” means that the hospital does not have a score for this measure. This could be because the measure is related to a service the hospital does not provide or because the hospital had too few patients or cases to report data for a condition or procedure. A “Not Available” result does not mean that the hospital withheld information from the public.

In the case of healthcare-associated infections, a SIR is reported as “Not Available” if one of the following applies:

- The number of predicted infections is less than 1.
- The number of observed infections present on admission (community-onset prevalence) was above a pre-determined cut-point.

For more information about NHSN's SIR models, please visit <https://www.cdc.gov/nhsn/pdfs/ps-analysis-resources/nhsn-sir-guide.pdf>.

“Declined to Report” means that a hospital did not voluntarily provide information to the Leapfrog Hospital Survey. Measures scored as “Declined to Report” will not be used in calculating the overall score (see [Dealing with Missing Data](#)).

SHARED CMS CERTIFICATION NUMBERS

All hospitals that share a CMS Certification Number (CCN) will be assigned the same source data as reported by CMS. Affected measures include the HCAHPS, Hospital-Acquired Conditions, Healthcare-Associated Infections (if secondary data source is used), and Patient Safety Indicators.

HOSPITAL SAFETY GRADE

UPDATES TO DATA USED IN THE LEAPFROG HOSPITAL SAFETY GRADE

The Leapfrog Hospital Safety Grade relies on publicly available data that hospitals have had the opportunity to review for accuracy. Therefore, Leapfrog does not allow hospitals to make updates to their data following the Data Snapshot Date. In January of each year, Leapfrog publishes the Data Snapshot Dates for each of the two Leapfrog Hospital Safety Grade public releases at <https://www.hospitalsafetygrade.org/for-hospitals/key-dates-and-information>. Leapfrog publishes these dates to give hospitals and other stakeholders advance notice so they can be prepared to submit a Leapfrog Hospital Survey and monitor their performance on CMS measures used in the Safety Grade.

In addition, Leapfrog holds a Courtesy Review Period to give hospitals an additional opportunity to review the data that will be used to calculate their hospital's Safety Grade. The Review Period is an opportunity for hospitals to review the data for accuracy (i.e., identify recording errors, hospital name and address changes, etc.) on a secure website and review changes to the scoring algorithm.

DATA FROM THE LEAPFROG HOSPITAL SURVEY

During the Safety Grade Review Period (September 25 – October 15), Leapfrog will only make corrections to a hospital's data from the 2024 Leapfrog Hospital Survey if a recording error is identified (i.e., we have recorded a different measure score than what is posted on our Survey Results website) or a scoring error is identified (i.e., Leapfrog has calculated an incorrect measure score based on the submitted responses and Leapfrog's published scoring algorithms). Updates to Leapfrog Hospital Survey data that are submitted after the Data Snapshot Date will **not** be included in the current Leapfrog Hospital Safety Grade. Hospitals submitting a Leapfrog Hospital Survey are urged to take advantage of the opportunity to review their Survey Results for accuracy and completeness prior to each of the two published Data Snapshot Dates.

HOW HOSPITALS CAN REVIEW LEAPFROG HOSPITAL SURVEY RESULTS PRIOR TO THE DATA SNAPSHOT DATE

The Leapfrog Hospital Survey is open from April 1 to November 30 of each year. Following the Submission Deadline (June 30), Survey Results are published monthly on a secure 'Hospital Details' page and a public website (ratings.leapfroggroup.org). Hospitals are urged to review their Survey Results immediately. Hospitals that identify any reporting errors are instructed to log back into the Survey to submit a correction. Hospitals can correct and re-submit a previously submitted Survey until the Survey closes for the year. Note that corrections submitted after the Data Snapshot Date (August 31 for the fall Safety Grade and January 31 for the spring Safety Grade) are not included in the current Leapfrog Hospital Safety Grade. Leapfrog has several automated processes in place to prevent hospitals from making data entry errors in the Online Survey Tool and to enhance the overall accuracy of the Survey Results. Learn more at

<https://www.leapfroggroup.org/for-hospitals/key-dates-and-information>.

HOSPITAL SAFETY GRADE

DATA FROM THE CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

During the Safety Grade Review Period (September 25 – October 15), Leapfrog will only make corrections to a hospital's data from CMS if the correction is issued by CMS and posted to the Data.CMS.Gov website. If a hospital has identified an error with a measure score published by CMS, and CMS cannot post a correction within the review period, the measure score will not be used in calculating the hospital's Safety Grade, provided that the hospital can document that CMS has agreed to publicly issue a correction or remove the measure score from public reporting. Hospitals participating with CMS are urged to take advantage of the opportunity to participate in the CMS 30-day review periods.

CMS FOOTNOTE 23 POLICY

Leapfrog will notify hospitals that have CMS footnote 23 present for one or more claims-based measure scores (e.g., DRA HAC Rate, PSI 4 rate, or PSI 90 rate) at the start of the Courtesy Review Period. Footnote 23 indicates that "The data are based on claims that the hospital or facility submitted to CMS. The hospital or facility has reported discrepancies in their claims data." Hospital CEOs can request that Leapfrog use the measure score that is accompanied by the footnote. Written requests must be received prior to the close of the Safety Grade Review Period. If written requests are not received by the close of the Review Period, the measure will not be used to calculate the Hospital Safety Grade.

For hospitals that submit a Leapfrog Hospital Survey by the Data Snapshot Date, the CEO, Primary Survey Contact, and Secondary Survey Contact will be notified at the email addresses included in the Hospital's Survey Profile. For hospitals that do not submit a Leapfrog Hospital Survey by the Data Snapshot Date, the CEO will be contacted by certified letter.

HOW HOSPITALS CAN REVIEW CMS DATA PRIOR TO THE DATA SNAPSHOT DATE

CMS administers several hospital-based reporting and payment programs including the Inpatient Quality Reporting Program, HAC Reduction Program, and Value-based Purchasing Program. Several measures collected and calculated by CMS via its various hospital-based programs are used in the Leapfrog Hospital Safety Grade. CMS provides hospitals with a 30-day preview period before publishing measure scores on the Data.Medicare.Gov website and the Data.CMS.Gov website. More information is available at <https://qualitynet.org>.

HOSPITAL SAFETY GRADE

HOW TO PARTICIPATE IN THE LEAPFROG HOSPITAL SURVEY

If a hospital did **not** complete a 2024 Leapfrog Hospital Survey by August 31, Survey Results were not used to calculate the fall 2024 Leapfrog Hospital Safety Grade. Hospitals that would like Survey Results included in the spring 2025 Hospital Safety Grade must submit a 2024 Leapfrog Hospital Survey (including the CPOE Evaluation) by November 30, 2024. Hospitals will be able to review their publicly reported Survey Results in December and respond to any issues identified by Leapfrog's Extensive Monthly Data Verification before the Data Snapshot Date for the spring 2025 Safety Grade of January 31. More information is available at <https://leapfroggroup.org/survey>.

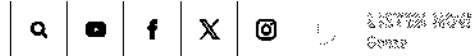
LEAPFROG HELP DESK

If you have any questions regarding the scoring methodology, please contact the Help Desk at <https://leapfroghelpdesk.zendesk.com>.

Exhibit 29



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3 FLORIDA HOSPITALS RECEIVE 'F' GRADES FOR PATIENT SAFETY

(Dwyer & Michaels) - Leapfrog Hospital Safety Grades 'F' 7/

(Alamy.com image)

SHARE ON FACEBOOK

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Three hospitals in Florida have recently earned concerning "F" grades for patient safety, according to the latest Leapfrog Hospital Safety Grades.



Getty Images

Recent evaluations by the Leapfrog Group gave alarming "F" grades to three Florida hospitals, citing concerns in infection control, staff communication, and error prevention. These findings highlight serious issues with patient safety and care quality, helping patients make more informed healthcare decisions.

DWYER & MICHAELS



RECALL: CELSIUS Energy Drinks Were Filled With High Noon Vodka Seltzer



Steamwheelers Host Eastern Conference Championship at Vibrant Arena



Americana History, Treasures, And A Car Show At The Rust Belt



Dwyer & Michaels Morning Show: Show Notes Monday 08/04/25

MIX THE JUS



Dwyer And Michaels



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What it Means if You
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Delray Medical Center - Delray Beach, FL



Delray Medical Center - Google Maps - 5352 Linton Boulevard Delray Beach, FL

Delray Medical Center performs below average in preventing and managing blood infections, surgical site infections after colon surgery, and sepsis following surgery. Patients at the facility are at higher risk for these serious infections, which can lead to prolonged recovery, complications, organ failure, and even death if not promptly treated. The hospital also struggles with blood leakage during surgery, which can result in clot formation or ongoing internal bleeding, leading to severe organ damage or death. Additionally, the center faces challenges with preventing dangerous blood clots, which can travel to the lungs and cause chest pain, unconsciousness, or death. These issues highlight the need for significant improvements in infection control, patient care, and safety protocols.

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MHSA Infection



C. diff Infection



Infection in the blood



Infection in the
urinary tract



Surgical site
infection after colon
surgery



Sepsis infection
after surgery

Hospital Performs:

Worse Than Average Better Than Average

Infection Safety Ratings - Leapfrog - Delray Medical Center

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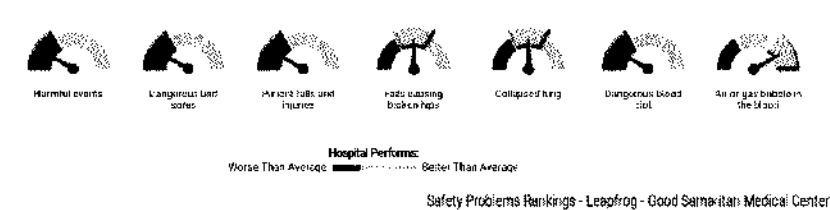
Delray Medical Center received the lowest scores in key areas of error prevention and staff performance. It struggles with electronic medication orders, safe medication administration, and handwashing protocols. Communication about medications, discharge instructions, and **coordination among staff is poor**. The hospital lacks specialized ICU doctors and has issues with staff responsiveness.

Good Samaritan Medical Center - West Palm Beach, FL



Good Samaritan Medical Center - Google Maps - 1309 N. Flagler Drive West Palm Beach, FL

Good Samaritan Medical Center has been found to perform worse than average in several key areas, including infection control and patient safety. The hospital struggles with preventing infections in the blood, urinary tract, and surgical site infections after colon surgery, putting patients at greater risk for complications, prolonged recovery, and **potentially life-threatening conditions**. In addition, issues such as dangerous blood clots, surgical wounds splitting open, blood leakage, and serious breathing problems further contribute to poor patient outcomes. The hospital also faces challenges with harmful events, such as patient falls and injuries.



Good Samaritan Medical Center scored poorly in error prevention and staff performance. It struggles with ensuring doctors use electronic medication orders, administer medications safely, and follow handwashing protocols. Communication with patients about medications and discharge instructions is lacking, as is coordination among doctors, nurses, and staff. The hospital also faces challenges with specialized ICU care and staff responsiveness, **all affecting care quality**.

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Palm Beach Gardens Medical Center - Palm Beach Gardens, FL

Palm Beach Gardens Medical Center - Google Maps - 3360 Burns Road Palm Beach Gardens, FL

Palm Beach Gardens Medical Center has been found to perform worse than average in several key areas, including infection control, patient safety, and preventing harmful events. **Patients are at higher risk for serious infections**, such as those in the blood, urinary tract, and surgical sites after colon surgery, which can lead to complications, prolonged recovery, and even death if not properly managed. The hospital also struggles with preventing dangerous blood clots, surgical wound splits, blood leakage, and breathing problems, all of which contribute to poor patient outcomes.

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Practice To Prevent Errors Ratings - Leapfrog - Palm Beach Gardens Medical Center

Palm Beach Gardens Medical Center performs poorly in communication and error prevention, with low scores in nearly all related areas. **Coordination among doctors, nurses, and staff is lacking**, causing issues with medication orders, discharge instructions, and patient safety. The hospital also struggles with electronic medication orders, safe medication administration, and handwashing protocols. The absence of specialized ICU doctors and unresponsive staff worsen these issues.

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A Wake-Up Call for Patient Safety

The Leapfrog Group's evaluations highlight the critical need for robust safety protocols in hospitals. All three facilities must urgently address these deficiencies to safeguard the health and well-being of their patients.

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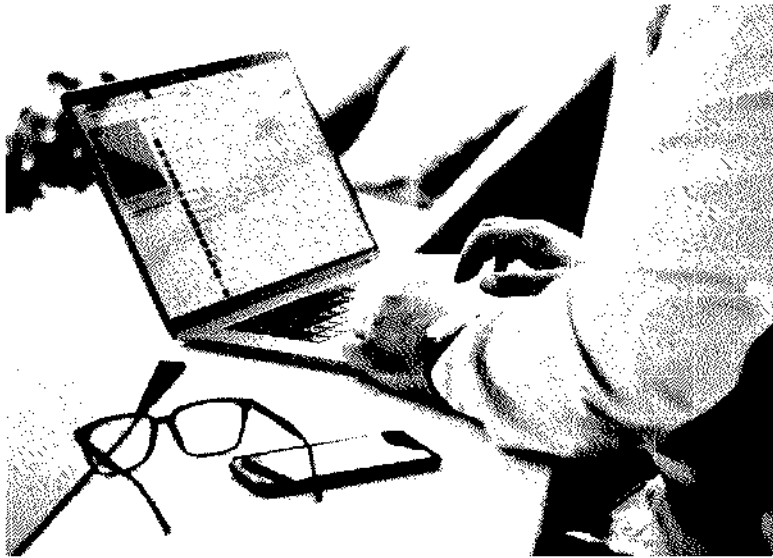


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LOOK: THE BIGGEST SCAMS TODAY AND HOW YOU CAN PROTECT YOURSELF FROM THEM

Using data from the **BBB Scam Tracker Annual Risk Report**, Stacker identified the most common and costly types of scams in 2022.



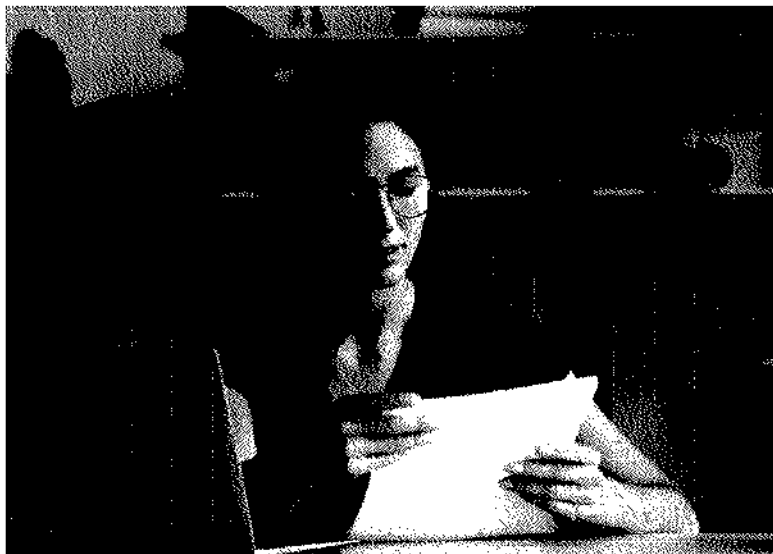
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#27. Charity (tie)

- BBB risk index: 0.6
- Share of total scams reported: 0.5%
- Share of scams that reported a monetary loss: 20.0%
- Median reported loss: \$100

Charity scams come from an organization claiming to be taking donations to help a specific cause. You donate the money only to find out the charity or cause never really existed or that the charity grossly misrepresented how much of the money was actually going to the cause. These scams can be hard to identify as many scammers go to great lengths to create social media accounts for the charity or cause and even impersonate victims.

In October 2017, a couple created a GoFundMe page for a homeless veteran and concocted a heartwarming, but false story that resulted in more than 14,000 people donating more than \$400,000. To keep yourself safe, be sure to vet charities before donating using something like the BBB Wise Giving Alliance.



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#27. Tax collection (tie)

- BBB risk index: 0.6
- Share of total scams reported: 0.2%
- Share of scams that reported a monetary loss: 19.1%
- Median reported loss: \$236

Tax scams are one of the oldest scams to date and show no signs of slowing down. A fake IRS agent may contact you claiming that you owe taxes to be paid immediately by prepaid debit card or wire transfer with threats of arrest and hefty fines or contacting you with claims that they are sending out refunds but need your personal information to do so.

In one scenario, for which the IRS has already sent several warnings, a scammer will use your Social Security number to file a tax return in your name and then claim the refund. The biggest red flag in this scam is being pressured to act quickly. In actuality, the IRS will give you the chance to ask questions and appeal what you owe while never demanding payment over the phone or requiring that you use a non-refundable form of payment. To avoid this scam, make sure to pay your taxes in full each year and file your return as early as possible.



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#26. Yellow Pages/directories

- BBB risk index: 0.8
- Share of total scams reported: 0.1%
- Share of scams that reported a monetary loss: 29.4%
- Median reported loss: \$550

The Yellow Pages and other similar directories have decreased in popularity since the rise of the internet, but scammers are still benefiting from them. Scammers contact a company claiming to represent a directory and request basic information—address, phone number, email, etc.—before prompting the employee to confirm the listing. Later, the scammed company will receive an invoice for a few hundred dollars, and if they call to complain, the scammer will reply that the employee verbally confirmed placement in their directory and agreed to the cost.

These scams are always done over the phone making them hard to identify. But, easy ways to protect yourself and your company include educating staff and training them to ask suspicious callers questions, researching the company the caller claims to represent, asking specifically about the terms and conditions, and having a clear process in place for inspecting invoices.



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#24. COVID-19 (tie)

- BBB risk index: 2.7
- Share of total scams reported: 0.8%
- Share of scams that reported a monetary loss: 14.8%
- Median reported loss: \$400

There are two types of COVID-19-related scams. The first is when folks obtain financial and insurance information from individuals in exchange for (what should be free) tests and vaccinations. The other involves scammers capitalizing on the increase in online shopping, stealing money or banking information from individuals through peer-to-peer payment apps, like Venmo or CashApp, under the guise of accepted virtual payment options.

To protect yourself from these scams, never give personal information to unvetted agencies or over the phone, e-mail, or text. Additionally, never use P2P payment options when buying from an unknown vendor, stick to vetted checkout processes instead.



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#24. Health care (including Medicaid and Medicare) (tie)

- BBB risk index: 2.7
- Share of total scams reported: 1.4%
- Share of scams that reported a monetary loss: 12.9%
- Median reported loss: \$250

Health care scams come in many forms, but all involve someone either wanting your personal information for identity theft—under the guise of updating your insurance—or attempting to use your insurance to submit fraudulent medical charges. Most versions also include robocalls, texts, or emails from someone claiming to be a government official wanting your information.

Never share your personal information with someone who contacts you without your request. You should instead call a trusted number from your healthcare provider to verify the legitimacy of the request.

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#23. Moving

- BBB risk index: 3.7
- Share of total scams reported: 0.9%
- Share of scams that reported a monetary loss: 76.0%
- Median reported loss: \$90

Moving can be an incredibly stressful experience, and finding out you've been scammed can make it infinitely worse. The most popular scam includes getting a quote from a moving company and sending a deposit, only to have the movers never show up. Another scam includes companies quoting you a rate based on item weight and then, on moving day, informing you your belongings are much heavier than projected and that the price per additional pound will be double the original quote. Moving companies can also scam you by never delivering your items, meaning either your stuff is gone forever or you have to pay a hefty "ransom fee" to return your items.

The best ways to avoid these scams are heavily researching to ensure the company's legitimacy, keeping an inventory of your belongings, getting everything in writing, and never sending a full payment in advance of the move.



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#21. Family/friend emergency (tie)

- BBB risk index: 4.5
- Share of total scams reported: 0.4%
- Share of scams that reported a monetary loss: 26.1%
- Median reported loss: \$800

Family/friend emergency scams prey on your love for your nearest and dearest and your willingness to do whatever it takes to ensure their safety and happiness. Scammers will contact you, claiming to be someone you know in a dire situation and need money. Scammers will also scour social media accounts learning minute details—like nicknames and travel plans—to legitimize their stories.

Resist the urge to act immediately and call your friend or family member directly. If you can't reach them, speak to others who may know of their whereabouts. Double checking these stories is the only surefire way to avoid this scam.



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#21. Utility (tie)

- BBB risk index: 4.5
- Share of total scams reported: 1.2%
- Share of scams that reported a monetary loss: 12.3%
- Median reported loss: \$500

Utility scams are seasonal, often happening in the summer and winter when people depend on air conditioning or heat. Scammers pose as water, electric, or gas company representatives and contact you, threatening service deactivation if a certain fee or bill is not paid immediately.

As noted by the BBB, the biggest red flag for this scam is when a company requests you pay with a prepaid debit card or wire transfer. A legitimate utility company will always accept a check or credit card payment. Never allow a utility worker into your home unless you have a pre-scheduled appointment, and always call customer service to verify any requested payments.



Canva

#20. Foreign money exchange

- BBB risk index: 5.1
- Share of total scams reported: 0.1%
- Share of scams that reported a monetary loss: 27.8%
- Median reported loss: \$3,724

Foreign money exchange is a scam being phased out as most millennials are aware of it and on guard against it. The most popular version begins with a fake Nigerian prince or a wealthy businessman who will spin a sad story, over email, about how they have had to flee Nigeria but have left their money and valuables behind. The scammer pleads for your help to retrieve their belongings and money, and in return, promises to award you a few of their millions. What follows are the additional fees, bribes, taxes, and legal costs after the initial bank transfer you agreed to—all of which you will be asked to pay upfront.

The easiest ways to avoid this scam are by never sending money to a person you only know via email, being wary of strangers offering you large sums of money, and always being suspicious of transactions that involve additional and hidden fees.



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#19. Credit card

- BBB risk index: 5.6
- Share of total scams reported: 1.8%
- Share of scams that reported a monetary loss: 38.0%
- Median reported loss: \$139

Credit card scams are very similar to identity theft scams and often share the same end goal: to make unauthorized transactions or steal your identity. Scammers will contact you, claiming to be your bank or credit card company, and ask you to verify your account information. Occasionally, the scam will be done over an email requesting you click a link to confirm your information, but instead, the link downloads malware to your device.

To entice you to give your information, these scammers often offer a better interest rate, inform you that they need to send you a new card as your old one has been compromised, or tell you that they need to verify a charge.

In order to avoid this, consider how your bank or credit card company usually contacts you and check directly with your bank or credit card company using a trusted customer service number to verify the request or offer.

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#18. Debt collection

- BBB risk index: 6.1
- Share of total scams reported: 3.0%
- Share of scams that reported a monetary loss: 7.8%
- Median reported loss: \$450

Scammers running **debt-collection scams** are particularly scary because of how persistent they can be. Scammers will call claiming to work for a debt collection agency or a government office and need to collect a debt you owe immediately. They may threaten you with consequences if you refuse—wage garnishment, arrest, court appearances, etc. If that fails, they will continue contacting you until you give in.

Stay on top of your debts and track what you owe and to whom. In the United States and Canada, debt collectors must notify you of your debt in writing—a "validation notice." They are not legitimate if a company can't or won't provide this.



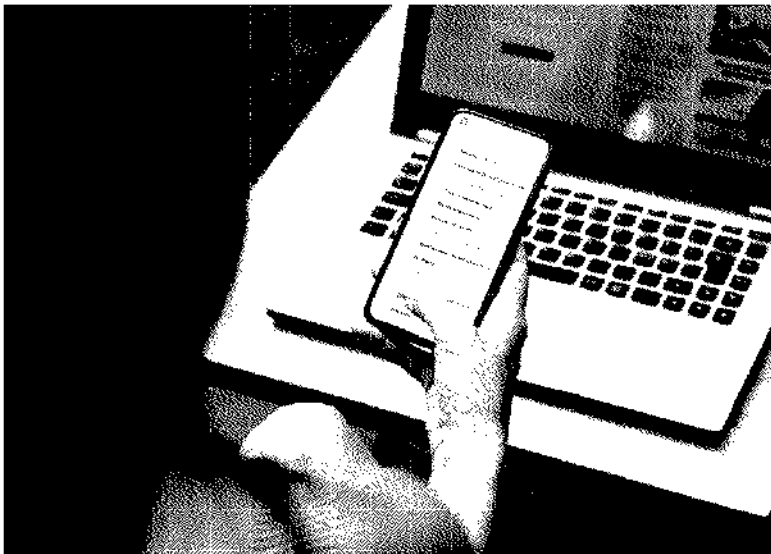
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#17. Identity theft

- BBB risk index: 6.2
- Share of total scams reported: 1.9%
- Share of scams that reported a monetary loss: 19.8%
- Median reported loss: \$283

In 2017 alone, 16.7 million individuals were impacted by identity theft, and more than \$16.8 billion dollars were stolen. With the right information, scammers can steal and use your identity to open a line of credit in your name, take money out of your bank accounts, or obtain services that they never pay for—to name a few.

Identity theft can be hard to uncover, as scammers often go to great lengths to keep you unaware such as ensuring all bills and statements are sent to an alternative address. Make sure to regularly check your accounts for unexplained withdrawals and check your credit score often to ensure no unauthorized accounts have been opened in your name. You should also carefully guard your personal information—keeping all personal documents in a secure location and never giving out information to unsolicited callers.



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#16. Sweepstakes, lottery, and prizes

- BBB risk index: 7.2
- Share of total scams reported: 4.5%
- Share of scams that reported a monetary loss: 13.3%
- Median reported loss: \$200

If you haven't entered a contest, sweepstakes, or lottery, you are not eligible to win its prize. An email or phone call alerting you that you have won that prize and can collect it at any time after paying taxes and fees via a prepaid debit card or wire transfer is most definitely a scam. The same goes for a foreign lottery letter telling you you've won the jackpot. In the United States and Canada, citizens can't enter foreign lotteries by phone or mail—meaning you would have had to visit the country to enter.

Keeping track of any contests, sweepstakes, or lotteries you do enter is the best way to avoid falling prey to this scam. Remember that a legitimate sweepstakes company will never ask you to pay upfront fees to claim a prize.



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#15. Counterfeit product

- BBB risk index: 12.3
- Share of total scams reported: 3.5%

- Share of scams that reported a monetary loss: 66.7%
- Median reported loss: \$90

For a consumer who's been lusting over a \$1,300 handbag for months, finding the same bag on a different retailer's website for only \$700 may seem like a dream come true. The reality is often far from dreamy as this handbag hopeful probably just fell prey to a counterfeit product scam.

Counterfeit goods mimic designer goods right down to the trademarked logo but are made with inferior materials and workmanship and are sold online—sometimes through reputable sites, in flea markets, by street vendors, and in traditional retail stores for majorly reduced prices. Avoid sketchy retailers, choose to stick to the source or authorized sellers, and be wary of too-good-to-be-true prices.



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#14. Romance

- BBB risk index: 12.5
- Share of total scams reported: 0.6%
- Share of scams that reported a monetary loss: 36.6%
- Median reported loss: \$900

Romance scams have increased as online dating and social media apps make it easy to have an entire relationship with someone you've never met. The scams essentially all work the same way: Someone will make a fake online profile on a dating or social media site to connect with you, and after chatting and exchanging pictures, will offer some excuse as to why they cannot meet in person—they're in the military, visiting family, working overseas, etc.

Once they sense an emotional connection, the scammer will make their move asking you for money perhaps to come and visit or for an emergency. After you've sent the money, they vanish from your life altogether, leaving behind the fake profile to strike again from a new one. Keep an eye out for red flags like the relationship moving more quickly than normal, excessive talk about trust, a refusal to meet you in person, too many "hard luck" stories, and language that doesn't seem to match up with their claims.

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#13. Rental

- BBB risk index: 13.4
- Share of total scams reported: 0.9%
- Share of scams that reported a monetary loss: 49.5%
- Median reported loss: \$504

Especially for those in major cities where the rental market is tough, finding a new place to live can be difficult. In an effort to make the exhausting process easier, many skimp on their research and rush into agreements to have the taxing process over with. Scammers prey on these situations, luring you in with online ads of beautiful listings at low prices before telling you that time is short, others are interested, and immediate action is required to secure the listing.

After paying a hefty security deposit, the first and last month's rent, and an agent's fee, you discover the property is unavailable and maybe never even existed. ApartmentList reported that 43.1% of renters have encountered a fraudulent listing, and 5.2 million renters have lost money because of rental scams. Be wary of rentals that seem too good to be true and insist on seeing the listing in person before sending any money.



Corbis

#12. Credit repair/debt relief

- BBB risk index: 14
- Share of total scams reported: 1.2%
- Share of scams that reported a monetary loss: 32.7%
- Median reported loss: \$600

Scammers will contact you promising a specific credit score or a reduction or total elimination of your debt as long as you pay an upfront fee. You pay the fee, and nothing changes except that you are now out money that you could have put towards the debt you owe. Never believe in guarantees and always avoid advance fees. In the United States, credit repair and debt relief companies can only collect money after performing the promised services.



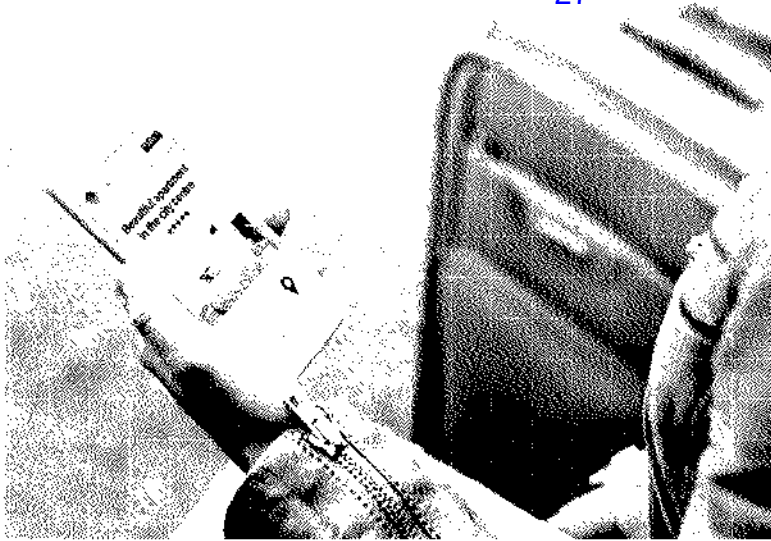
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#11. Phishing

- BBB risk index: 17.6
- Share of total scams reported: 11.9%
- Share of scams that reported a monetary loss: 9.30%
- Median reported loss: \$270

Phishing scams can be the hardest to identify as they come in such a wide variety of forms. The most common are emails either claiming you have won a prize and need to claim it or owe something and threatening consequences if unpaid. Sometimes these emails include a PDF, either linked or as an attachment, which downloads malware to your computer and steals your personal information.

Keep yourself safe by never opening anything from an unrecognized email address and being wary of emails that contain only the most general information—your name is excluded from the email, or the last four digits are absent from the credit card on which they are claiming payment is due.



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#10. Travel and vacation

- BBB risk index: 20.3
- Share of total scams reported: 0.9%
- Share of scams that reported a monetary loss: 56.5%
- Median reported loss: \$700

One of the most common travel and vacation scams is similar to a rental scam. A con artist will post a listing for a vacation rental that either doesn't exist or doesn't look as pictured, pressure you into acting quickly, and then ask you to submit a deposit before vanishing into the night with your money (and the beach house of your dreams).

Another common version preys on those looking to sell their timeshares. A real estate broker or agent, who claims to specialize in timeshare resales, will call claiming to have dozens of potential buyers, and offer to expedite the selling process if only you'll pay a small upfront fee. Talk to the owner of the vacation home you're looking to rent, check public records and online reviews to make sure the location matches the description, and never pay any kind of upfront fees via prepaid debit cards or wire transfers.



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#9. Tech support

- BBB risk index: 22
- Share of total scams reported: 3.1%

- Share of scams that reported a monetary loss: 24.3%
- Median reported loss: \$500

For many of us, there would be nothing worse than losing all of the data on our computers or having them rendered useless by viruses. Those running **tech support scams** know this and have invented clever ways to steal your money by preying on this fear. Posing as tech support staff from well-known computer companies—Dell, Norton, or Microsoft—scammers will call informing you that your computer is infected, or a pop-up will appear alerting you that something is wrong and giving you a number to call.

When you call, the scammer will offer to fix the problem if you pay a fee. They may even ask for remote access to fix the problem and then install malware to steal your personal information. Never grant access to your computer, know that legitimate tech companies would not call out of the blue, and shut down your computer when a suspicious pop-up appears.

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#8. Government grant

- BBB risk index: 24.8
- Share of total scams reported: 2.2%
- Share of scams that reported a monetary loss: 19.5%
- Median reported loss: \$1,000

The government is not in the business of offering free money to random people "just because." Getting a government grant is a long, involved process and is only initiated when you take the first step. Anyone reaching out to you telling you otherwise—perhaps with claims that you have been awarded a grant you won't have to repay as long as you pay a few small upfront fees—may be trying to pull a **government grant scam** over on you.

There are hundreds of fake "look alike" agencies out there, so always double check any grant agency contacting you against the **only official list** of all U.S. federal grant-making agencies.



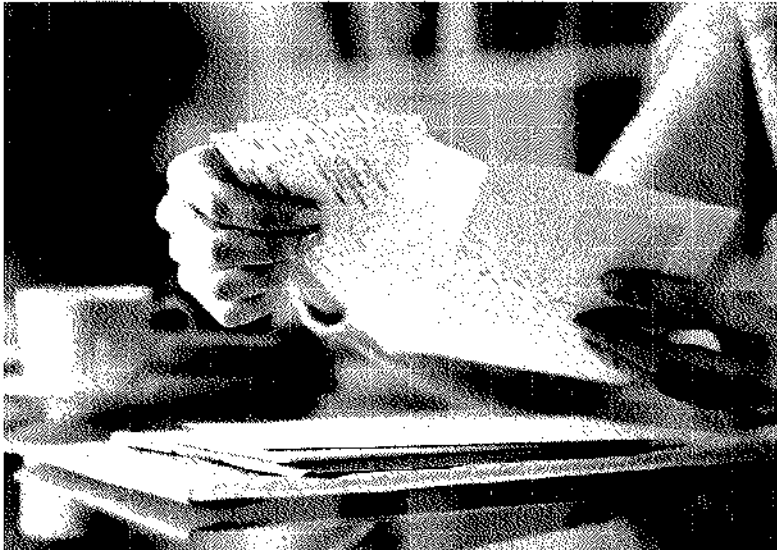
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#7. Advance fee loan

- BBB risk index: 25.9
- Share of total scams reported: 1.8%
- Share of scams that reported a monetary loss: 40.6%
- Median reported loss: \$609

Many scams prey on financially unstable people, and advance fee loan scams are no exception. In this scam, a loan broker will promise you a substantial loan, regardless of your credit history or score, after you pay an upfront fee or "insurance." Of course, as soon as you do, the loan broker and all the money you promised are gone.

While various fees are associated with loans, they are always communicated clearly and taken from the money you are being loaned. Real lenders will never guarantee a loan before checking your credit history and will never accept strange fee payment forms like gift cards, prepaid debit cards, or wire transfers.



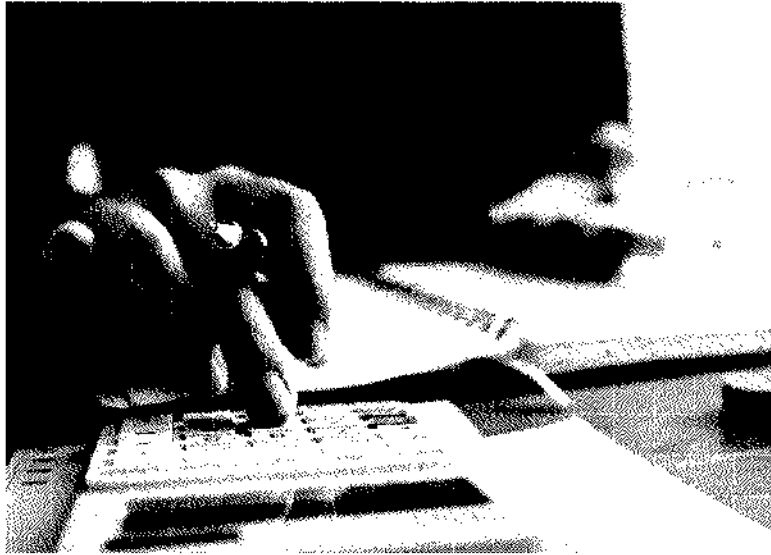
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#6. Fake check/money order

- BBB risk index: 27.1
- Share of total scams reported: 2.1%
- Share of scams that reported a monetary loss: 14.8%
- Median reported loss: \$1,475

Fake check and money order scams can be hard to peg down as con artists use various stories and situations to steal your money. Often you will receive a check worth far more than what was expected. A scammer will then ask you to deposit the check and wire back the difference saving them the trouble of canceling that check and sending over another. Forged checks often take weeks to be uncovered, and by the time the check bounces, the extra money you thought you had, plus the difference you wired back to the scammer, will be gone.

Always be aware of overpayments, especially gross overpayments. If you receive a much larger check than you were expecting, send it back; otherwise, you may be on the hook for funds used against the amount.



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#5. Investment

- BBB risk index: 29.9
- Share of total scams reported: 0.8%
- Share of scams that reported a monetary loss: 56.9%
- Median reported loss: \$1,100

Con artists put a lot of effort into their scams to make them convincing; investment scams are the best example. In the most basic version of this scam, you'll be convinced to invest in a project, company, or loan, but when you try to withdraw your money, find what you invested in never really existed. Another common investment scam is a Ponzi scheme; think Bernie Madoff's Bernard L. Madoff Investment Securities.

Educate yourself about investments and industry regulations before getting involved with a project, and keep your eyes peeled for too-good-to-be-true buzzwords.



Dusan Petkovic // Shutterstock

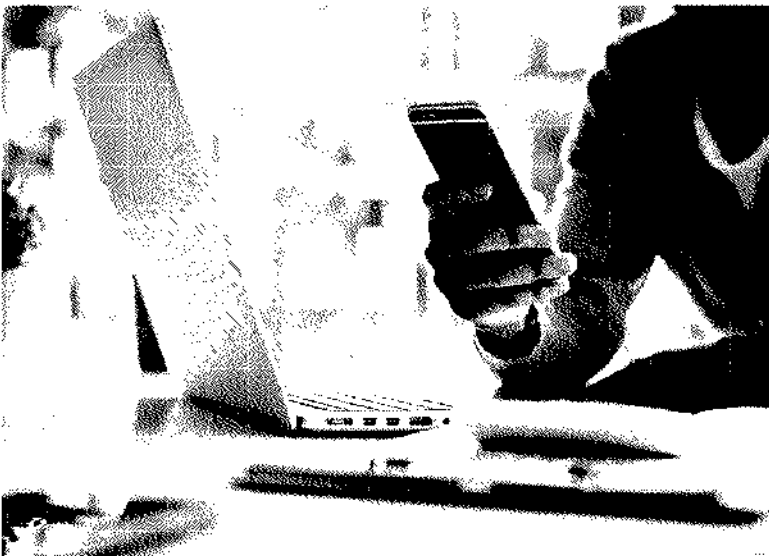
#4. Home improvement

- BBB risk index: 45.2
- Share of total scams reported: 1.4%
- Share of scams that reported a monetary loss: 59.1%
- Median reported loss: \$955

One of the few in-person scams on this list is the **home improvement scam**, which starts with a knock on your door and a contractor offering services at a below-average price, often claiming they're finishing another project in the neighborhood and can squeeze you in if you act now. They will then either ask for a deposit and walk away with it, find dozens of "additional issues" after they've begun work that you'll need to pay for, or coax you into signing away your insurance payment.

Always check a contractor's references and reviews before allowing them to start work, be wary of huge upfront costs and high-pressure deals, insist on having a written contract before work begins, and ask to see a contractor's business license, permits, and other official documents validating their legitimacy.

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#3. Employment

- BBB risk index: 63
- Share of total scams reported: 7.8%

- Share of scams that reported a monetary loss: 15.1%
- Median reported loss: \$900

Employment scams happen when con artists pose as legitimate companies recruiting or hiring. After receiving your application, they'll hire you almost immediately, usually without a proper interview, and request your banking information to set you up for a direct deposit or charge you for training.

Keep in mind that some jobs—those without special training, licensing, or educational requirements like secret shoppers and customer service reps—are more susceptible to this scam than others. Be aware of any out-of-the-ordinary hiring procedures, like being offered a job without an interview.



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#2. Cryptocurrency

- BBB risk index: 90.6
- Share of total scams reported: 1.9%
- Share of scams that reported a monetary loss: 66.2%
- Median reported loss: \$1,200

The average person doesn't have a solid understanding of what, exactly, cryptocurrency is or how it works, which makes it easy for scammers to prey on them. According to the FTC, cryptocurrency scams run the gamut from folks impersonating romantic interests and established businesses who demand payment in cryptocurrency to so-called investment managers promising to grow your wealth at an unbelievable rate.

Keep an eye out for investment managers or businesses who reach out to you unprompted, returns that seem too good to be true, and investment opportunities that don't include details or explanations.



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#1. Online purchase

- BBB risk index: 167.4
- Share of total scams reported: 37.4%
- Share of scams that reported a monetary loss: 74.9%
- Median reported loss: \$101

Online purchase scams often happen on direct seller-to-buyer sites like eBay and Craigslist. If you're the seller in this scam, you might agree to sell your item outside the site's routine checkout process and opt to receive payment by cashier's check or money order only to have the buyer run a fake check/money order scam.

If you're the buyer, you'll purchase an item or service only to never receive what was ordered and paid for. To keep yourself secure, only use websites and online marketplaces that offer protection to buyers and sellers, and never agree to exchanges outside the usual checkout process.

Filed Under: Florida, Hospital Ratings, ICU Care, Infection Control, Leapfrog Group, Patient Safety, West Palm Beach

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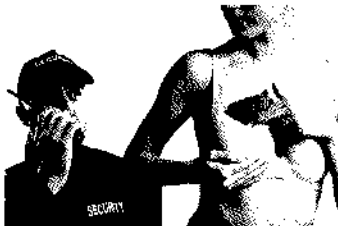
RECALL: CELSIUS Energy Drinks Were Filled With High Noon Vodka Seltzer



Watch Out Florida—Thousands of Tarantulas Are on the Move Across The State



Another Golf Course Fight, But This One Ends In An Arrest



Florida Woman Caught Trying to Sneak Turtles Through Airport Security—In Her Bra



Teen Arrested After Bomb Joke Delays Spirit Airlines Flight in Florida



Oh No Florida, This Daily Habit Has Been Linked To Dementia



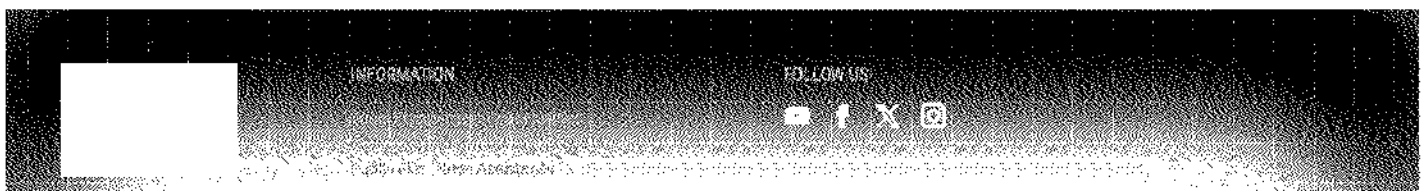
Florida Man Arrested After Allegedly Stealing Sex Toys and Ice Cream from Walmart



What Biting Your Nails Secretly Reveals About People In Florida: It's Not Anxiety



Are People In Florida Drinking Cockroach Milk? Here's What It Is:



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Exhibit 30

GIANT LEAPS FOR PATIENT SAFETY

STOP AVOIDABLE DEATH AND SUFFERING IN HEALTH CARE

OBJECTIVES AND 1-YEAR, 3-YEAR, AND 6-YEAR BENCHMARK INDICATORS

OBJECTIVE 1-

Scale resources to the capacity needed to make giant leaps for patient safety and stop avoidable death and suffering

OBJECTIVE 2 -

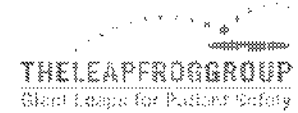
Drive ever-higher standards for patient safety and publicly rate acute care facilities on achievement of those standards

OBJECTIVE 3 -

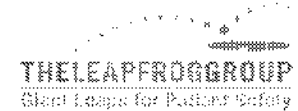
Build communities that achieve the mission

OBJECTIVE 1- *Scale resources to the capacity needed to make giant leaps for patient safety and stop avoidable death and suffering*

Goal	Benchmark Indicators
<i>Expand revenue from existing sources, including funding through development, industry partnerships, data licensure – with less dependence on accolade revenue</i>	Sept 2025: \$9 million revenue 2028: \$12 million 2031: \$18 million Sept 2025: 8 net new partners, \$1,307,000 revenue target 75% retention rate overall 2028: 11 net new partners, \$1,800,000 revenue target 80 retention rate overall 2031: 14 net new partners, \$2,300,000 revenue target 85% retention rate over Sept 2025: \$2.3 million dollars data licensing revenue 2028: 20% increase from 2025 2031: 20% increase from 2028
<i>Expand and diversify staff, skills, and competencies to support operating and growth objectives</i>	Sept 2025: No net loss for annual meeting 2028: \$300,000 profit from annual meeting 2031: \$500,000 profit from annual meeting Sept 2025: 20% of Board and staff are representative of gender, race, ethnicity, age, and other underrepresented groups 2028: 25% 2031: 30% Sept 2025: Increase staff retention and average length of tenure by 5% 2028: Increase by 15% 2031: Increase by 20%
<i>Expand the reserve fund equal to at least six months of expenses</i>	Sept 2025: 20% of annual revenues (e.g. 20% of \$9 million end FY25 = \$1.8 million) in net assets 2028: 25%

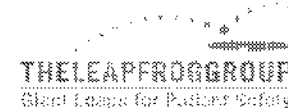
LEAPFROG LONG RANGE STRATEGIC INTENT FY2026-2032 – Board Approved December 2024

Goal	Benchmark Indicators
	2031: 30%
	Sept 2025: Establish a separate cash reserve fund with board-approved policies for use and investment: reserve funds @ \$200,000 2028: Reserve funds @ \$1 million 2031: Reserve funds @ \$2 million
<i>Expand the Judie Burrows Education Institute to educate stakeholders</i>	Sept 2025: Increase participation in educational programs 2028: Compared to 2025, increase by 20% 2031: Compared to 2028, increase by 20%
<i>Increase investment in policy advocacy to advance Leapfrog-specific and general priorities in Federal, state, and local policy and regulations</i>	Sept 2025: \$50K direct/indirect resource dedication 2028: 1 FTE dedicated 2031: 2 FTEs / department

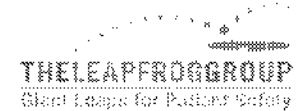
LEAPFROG LONG RANGE STRATEGIC INTENT FY2026-2032 – Board Approved December 2024**OBJECTIVE 2 - Drive ever-higher standards for patient safety and publicly rate acute care facilities on achievement of those standards**

Goal	Proposed Metric
<i>Continue setting high standards, which are evidence-based and expertly derived, to make health care safer for everyone</i>	Sept 2025: % of hospitals and ASCs showing improvement over the past 3 years in a selection of Leapfrog measures including outcomes and structural measures (i.e., infection rates, C-sections, Nurse Staffing and Skill Mix, Informed Consent, Health equity, etc.) 2028: 10% improvement over above 2031: 10% improvement over above
<i>Foster the wise use of technology in a dynamically changing environment</i>	Sept 2025: Partner with experts to identify measures and develop evidence-based standards for best practices for patient safety that account for and make use of the rapid advancement of technology and AI 2028: At least 1 measure added to Hospital Survey 2031: At least 1 measure publicly reporting; 10% of hospitals achieving the standard
<i>Reduce health care inequities by evangelizing standards impacting all communities</i>	Sept 2025: release report highlighting inequities to set 3/6 year targets 2028: XX 2031: XX
<i>Support innovative measure development leveraging new data sources</i>	Sept 2025: Implement two new ED Boarding measures on Hospital Survey 2028: Publicly report two ED measures, explore additional measures of ED safety and quality 2031: Add additional measures of ED safety and quality to the Hospital Survey and/or advance publicly reported measures into the Safety Grade and VBP Program
<i>Increase participation in Leapfrog's Hospital and ASC Surveys</i>	HOSPITALS #s and % of beds— Sept 2025: 2433, 78% of inpatient beds 2028: 85% of inpatient beds 2031: 90% of inpatient beds ASC Sept 2025: 150 ASCs submitting, 2.4% of ASCs registered with CMS 2028: 20% of ASCs 2031: 50%
<i>Advocate for increased mandated reporting and public reporting, so that Leapfrog can grade more acute care settings, while considering condition-specific reporting when appropriate</i>	

OBJECTIVE 3 - Build communities that achieve the mission

LEAPFROG LONG RANGE STRATEGIC INTENT FY2026-2032 – Board Approved December 2024

Goal	Proposed Metric
<i>The General Public: Create communication strategies that make the Hospital Safety Grade and Leapfrog itself household names</i>	Sept 2025: X# annual Website Visits (all Leapfrog owned sites)(LeapfrogGroup.org, HospitalSafetyGrade.org, & Ratings.LeapfrogGroup.org) 2028: Compared to 2025, increase by 30%. 2031: Compared to 2025, increase by 100%.
<i>Patients and Family Caregivers: Enable patients and family caregivers to use transparent public information to choose the safest, highest quality care, with an emphasis on areas of care that resonate with consumers (patients can choose, costs vary)</i>	Sept 2025: Participation in educational programs at X# 2028: Participation in educational programs at Y# 2031: Participation in educational programs at Z#
Patient Activists: Identify common priorities and feature leaders in our public outreach	
Regional Leaders: Build a strong network of regional leaders that engage employers and health care facilities in their markets to maximize participation in Leapfrog's ratings program and to use the data for payment and public reporting	Sept 2025: Coverage by regional leaders of X% of states 2028: improvement% of states 2031: improvement% of states
Purchasers/Employers: Enable purchasers and their contractors to tie Leapfrog ratings to payment decisions	Sept 2025: Engage purchasers and influencers around using Leapfrog data (i.e., tie ratings to payment decisions for their employee population, leveraging The Hopper) 2028: 5 purchasers use Leapfrog data in decision-making/reporting 2031: 50 purchasers use Leapfrog data in decision-making/reporting
Purchasers' Consultants: Educate brokers on the advantages of using Leapfrog data to inform their approach	Sept 2025: Using The Hopper, begin expanding relationships with consultants 2028: At least 1 broker/consultant using Leapfrog data with purchaser clients 2031: At least 3 broker/consultants using Leapfrog data with purchaser clients
Health Plans: Pressure plans to tie Leapfrog ratings to payment decisions	Sept 2025: 1 of health plans engaged with Leapfrog as partners and/or data users 2028: 4 of health plans engaged with Leapfrog as partners and/or data users 2031: 7 of health plans engaged with Leapfrog as partners and/or data users
Clinicians: Partner with professional associations where our interests align	

LEAPFROG LONG RANGE STRATEGIC INTENT FY2026-2032 – Board Approved December 2024

Goal	Proposed Metric
<u>Vendors/Startups:</u> Partner with and increase donations from vendors of startup solutions that address Leapfrog's patient safety priorities, no matter the care delivery setting (e.g., on-site clinics)	
<u>Regulators/ Policymakers:</u> Work with Federal and state regulators and policymakers to enact laws and regulations that accelerate Leapfrog's effectiveness (e.g., more mandated reporting and public reporting)	
<u>Education:</u> Support efforts to incorporate patient safety in clinical education and certs (physicians, nurses, pharmacists, etc.)	
<u>Media/Opinion Leaders:</u> Raise awareness on critical patient safety and quality issues	Sept 2025: Social Media Engagement Metric, i.e. number of followers, all platforms 2028: Compared to 2025, increase by 30%. 2031: Compared to 2025, increase by 100%.

Exhibit 31

The decline of local journalism has real-life consequences.

HIGHER TAXES



stet news
PALM BEACH COUNTY



LOCAL NEWS COUNTY CITIES THE JUICE 561INSIDER THE MORGUE ABOUT

NEWSLETTER

Tenet hospitals at bottom of local safety grades

December 9, 2024 · by Jane Musgrave



Jupiter Medical Center is the lone local A grade in annual rankings by The Leapfrog Group.



St. Mary's Medical Center is one of five Tenet Healthcare hospitals in Palm Beach County to score a safety rating of D or F in a recent survey. (Photo: Joel Engelhardt/Stet)

Editor's note: *This story has been updated to include comments Tenet provided Stet on Dec. 12, more than two weeks after it was first contacted and two days after the story was published.*

Five of Palm Beach County's largest medical centers — all owned by Tenet Healthcare — received F and D grades from a national nonprofit that rates hospitals across the country for patient safety.

Good Samaritan, Palm Beach Gardens and Delray medical centers received F grades in the fall biannual rating released Nov. 15 by The Leapfrog Group, which uses federal medical reports to rank roughly 3,000 hospitals nationwide.

Two other Tenet hospitals, St. Mary's and West Boca medical centers, received D grades from the group that assesses injuries, infections, and medical and medication errors to spur hospitals to take steps to reduce preventable inpatient deaths.

Jupiter Medical Center was the only hospital in the county to get an A grade. It is the third consecutive time and the fifth since 2020 that the nonprofit hospital was awarded a top score.

Other hospitals rounding out the list:

- JFK Hospital and JFK Hospital North, owned by HCA, received C grades, as did Boca Raton Regional and Bethesda West, which are owned by Baptist Health. Wellington Regional Hospital, owned by Universal Health Services, also got a C.
- Bethesda Hospital East, also owned by Baptist Health, and Palms West, another HCA hospital, received B grades.
- The group doesn't rate government-run hospitals, like the Riviera Beach VA Medical Center and Lakeside Medical Center in Belle Glade, or children's hospitals.

Why it's important? Preventable medical errors, accidents, injuries and infections in hospitals kill roughly 200,000 people a year, making it the third leading cause of death in the country, said Alex Campione, program analyst for Leapfrog.

"It is critical to monitor safety before choosing a hospital," he said.

A 2019 analysis by Johns Hopkins Armstrong Institute for Patient Safety and Quality for Leapfrog found that D and F hospitals carry nearly twice the risk of

death as A hospitals.

“Over 50,000 lives could be saved if all hospitals performed at the level of A graded hospitals,” researchers said.



St. Mary's Medical Center on 45th Street in West Palm Beach. (Photo: Joel Engelhardt/Stet)

What is Tenet saying? In a statement, the Dallas-based hospital giant insisted the grades “aren’t accurate or reflective of our hospitals’ safety environment.”

Andrew Lofholm, a spokesperson for Tenet’s five county hospitals, which operate as the Palm Beach Health Network, said the grades were particularly unfair because the company didn’t participate in a survey Leapfrog distributes as part of the review process.

The surveys, however, “are just one piece of the puzzle,” Campione said. The grades are based on information from the Centers for Medicare and Medicaid Services, he said. “These facilities are also performing poorly in data that is collected and publicly reported,” he said.

The voluntary surveys allow hospitals to offer Leapfrog additional information about efforts to reduce inpatient falls, infections and surgical errors and to detail policies, such as hand-washing and staffing levels, designed to protect patients.

The Tenet health network has completed the surveys in the past and its hospitals got mostly C grades. Lofholm said it didn't participate in Leapfrog's recent survey "given it is not a regulatory or credentialing agency."

"The Palm Beach Health Network's top priority is providing high quality patient care," Lofholm said in the statement. "We take our responsibility to provide the safest possible environment for our patients very seriously, and we are continually implementing improvement initiatives."

The Tenet health network's hospitals were among 20 percent nationwide and the only ones in the county that didn't complete the survey.

What are others saying? Not surprisingly, Jupiter Medical Center, lauded the results.

"This national designation affirms to our community that the care provided by Jupiter Medical Center is the safest possible in Palm Beach County and the Treasure Coast," Dr. Amit Rastogi, hospital president and CEO, said in a statement.

Pamela Rada, a spokesperson for Wellington Regional, said the hospital was "disappointed" by its C grade, which it has gotten consistently since 2021 after receiving B and A grades, respectively, in the fall and spring of 2020.

But, she added, the score doesn't "accurately reflect the high quality of healthcare provided to our patients."

- "The scores are based on historical data, some of which date back a few years," Rada said in a statement. "We have action plans in place that utilize real-time data for continuous quality improvement efforts. These plans include implementing best practices and committee recommendations, along with ongoing employee and medical staff education."

Louis Lochte, a spokesperson for HCA, said its three hospitals in the county take patient safety seriously.

"We recognize the importance of measuring quality and safety in patient care and are working hard to improve in certain areas," he said in an email. "Our physicians, nurses and colleagues are dedicated to providing exceptional care for our patients."

[Click here](#) to read the report.

1/2/2025 10:28:25 AM

stet news

PALM BEACH COUNTY

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Exhibit 32

Message

From: Montgomery, Sheri [Sheri.Montgomery@tenethealth.com]
Sent: 12/10/2024 5:43:58 PM
To: Gill, Maggie [maggie.gill@tenethealth.com]
Subject: Fwd: Your request

Did you see this article. This is terrible. I've been getting a lot of heat. Dr Goodman had to take a patient to Jupiter they refused to come to us. Wanted us to make a clarifying statement.

Get [Outlook for iOS](#)

From: Judy Goodman <judygoodmanpa@aol.com>
Sent: Tuesday, December 10, 2024 9:46 AM
To: Montgomery, Sheri <Sheri.Montgomery@tenethealth.com>
Subject: Your request

Dear Sheri,

Unfortunately I came down with Covid last night (my grandchildren are visiting and the baby must have passed it) so I'm out for awhile.

I hope you can wait later in the season for my input on potential younger board members. My Palm Beach Health Committee is sponsoring an event for younger women in February and I'd like to look over that group for prospects. But if you need it now, these are good choices:

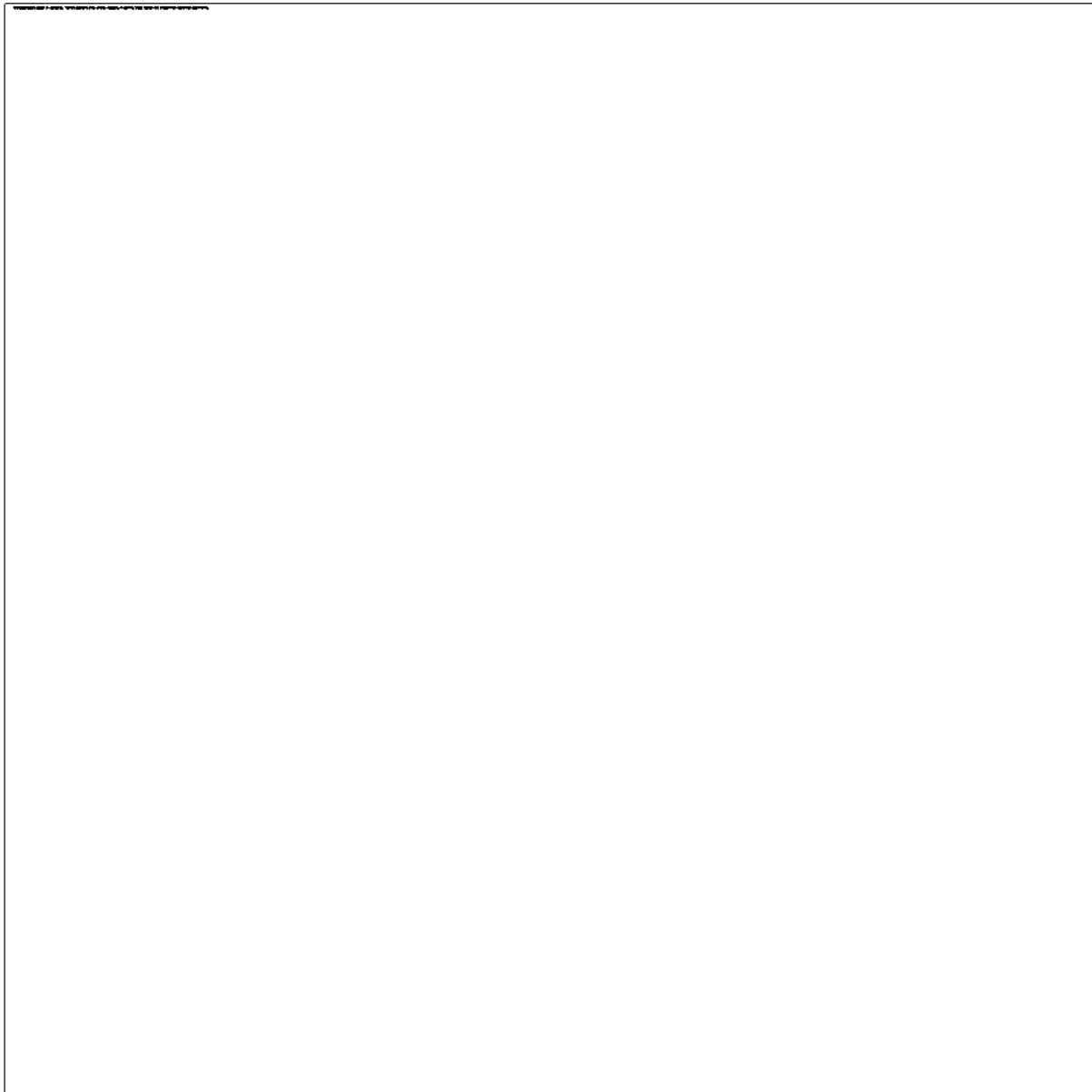
Cara Coniglio McClure, (Gail's daughter, but may be St. Mary-focused);
Ted Cooney may be a good choice; he sits on Town Council although his Dad, Dr. John F. Cooney, may be more St. Mary's focused now.

Christina Matthews McFarland is Flagler Matthews grand-daughter; a lovely girl who manages philanthropy and service nicely.

However, it's hard to recruit right now when this story appeared this morning:

This story appeared in the emailed STET blog I get claiming Tenet did not reply to their questions. I wish the communications team would respond in a way that leadership could copy.

 **Tenet gets an F**



St. Mary's Medical Center is one of five Tenet Healthcare hospitals in Palm Beach County to score a safety rating of D or F in a recent survey. (Photo: Joel Engelhardt/Stet)

Five of Palm Beach County's largest medical centers — all owned by Tenet Healthcare — received F and D grades from a national nonprofit that rates hospitals across the country for patient safety.

Good Samaritan, Palm Beach Gardens and Delray medical centers received F grades in the fall biannual rating released Nov. 15 by The Leapfrog Group, which uses federal medical reports to rank roughly 3,000 hospitals nationwide.

Two other Tenet hospitals, St. Mary's and West Boca medical centers, received D grades from the group that assesses injuries, infections, and medical and medication errors to spur hospitals to take steps to reduce preventable inpatient deaths.

Independently owned Jupiter Medical Center was the only hospital in the county to get an A grade.

Why it's important? Preventable medical errors, accidents, injuries and infections in hospitals kill roughly 200,000 people a year, making it the third leading cause of death in the country, said Alex Campione, program analyst for Leapfrog.

What he said: "It is critical to monitor safety before choosing a hospital."

Other hospitals rounding out the list:

- B grades: Baptist Health's Bethesda Hospital East and HCA's Palms West.
- C grades: HCA's JFK and JFK North, Baptist Health's Boca Raton Regional and Bethesda West and Universal Health Services' Wellington Regional.

Of note: Universal Health is building a 300-bed hospital at Interstate 95 and Donald Ross Road in Palm Beach Gardens.

Click here to see what hospital officials had to say about the rankings.

Spoiler alert: Tenet did not reply to Stet's questions.

— Jane Musgrave

Judith B. Goodman, Esq. (Ret).

Phone: (561) 346-7836

Fax: (561) 835-9481

Email: JudyGoodmanPA@aol.com

Exhibit 33

Message

From: Montgomery, Sheri [/O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=556D2C5F48EB4C77B931C5DF74C97399-MONTGOMERY,]
Sent: 12/10/2024 10:36:13 PM
To: Patrick Franklin [frankln@ulpbc.org]; Dennis Grady [dgrady@palmbeaches.org]
Subject: RE: How scary is THIS?

Hi Patrick, the leapfrog survey is a voluntary survey from a private organization that 20% of hospitals do not participate or submit a response, however they still publish a grade with incomplete information. I am happy to discuss in more detail if you want to call me on my cell. 561-866-2753.

Sheri Montgomery
Chief Executive Officer
Good Samaritan Medical Center
1309 North Flagler Drive
West Palm Beach, FL 33401
Office: 561-650-6201
sheri.montgomery@tenethealth.com

Exec. Asst.: Laura Feak
Office 561-650-6201
Laura.Feak@tenethealth.com



Stronger Together. For You.

#PBHNProud

From: Patrick Franklin <frankln@ulpbc.org>
Sent: Tuesday, December 10, 2024 4:44 PM
To: Dennis Grady <dgrady@palmbeaches.org>; Montgomery, Sheri <Sheri.Montgomery@tenethealth.com>
Subject: RE: How scary is THIS?

Sheri
Is this a legitimate article?

Patrick Franklin | President and CEO | Frankln@ulpbc.org | www.ulpbc.org



Yash Patel | Executive Assistant: | YPatel@ulpbc.org | T: 561.833.1461 x3014 | F: 561.833.6050
1700 North Australian Ave, West Palm Beach, FL 33407

**Urban League of
Palm Beach County, Inc.**

*Empowering Communities.
Changing Lives.*



From: Dennis Grady <dgrady@palmbeaches.org>
Sent: Tuesday, December 10, 2024 4:14 PM
To: Sheri Montgomery <Sheri.Montgomery@tenethealth.com>; Patrick Franklin <frankln@ulpbc.org>
Subject: Fwd: How scary is THIS?

Sent from my iPad

Begin forwarded message:

From: Evelyn T Hopkins <Evelyn.Hopkins@floridacrystals.com>
Date: December 10, 2024 at 2:38:15 PM EST
To: Dennis Grady <dgrady@palmbeaches.org>, "Frost Jack (Home)" <jfrost1996@aol.com>
Subject: RE: How scary is THIS?

It's scary and unacceptable. I don't recall data reported to us that supports this. Are you sharing with Patrick and Sheri?

From: Dennis Grady <dgrady@palmbeaches.org>
Sent: Tuesday, December 10, 2024 2:29 PM
To: Frost Jack (Home) <jfrost1996@aol.com>; Evelyn T Hopkins <evelyn.hopkins@floridacrystals.com>
Subject: Fwd: How scary is THIS?

CAUTION: This email originated from outside of the organization. Do not click links or open attachments unless you recognize the sender and know the content is safe.

Sent from my iPad

Begin forwarded message:

From: "Harvey E. Oyer, III" <HOyer@shutts.com>
Date: December 10, 2024 at 2:24:30 PM EST
To: Dennis Grady <dgrady@palmbeaches.org>
Subject: FW: How scary is THIS?

This isn't good.

Tenet hospitals at bottom of local safety grades

December 9, 2024

by Jane Musgrave

1.

•

Good Samaritan, Palm Beach Gardens and Delray medical centers received F grades in the fall biannual rating released Nov. 15 by The

Leapfrog Group, which uses federal medical reports to rank roughly 3,000 hospitals nationwide.

Two other Tenet hospitals, St. Mary's and West Boca medical centers, received D grades from the group that assesses injuries, infections, and medical and medication errors to spur hospitals to take steps to reduce preventable inpatient deaths.

Jupiter Medical Center was the only hospital in the county to get an A grade. It is the third consecutive time and the fifth since 2020 that the nonprofit hospital was awarded a top score.

Other hospitals rounding out the list:

- 1. JFK Hospital and JFK Hospital North, owned by HCA, received C grades, as did Boca Raton Regional and Bethesda West, which are owned by Baptist Health. Wellington Regional Hospital, owned by Universal Health Services, also got a C.**
- 2. Bethesda Hospital East, also owned by Baptist Health, and Palms West, another HCA hospital, received B grades.**
- 3. The group doesn't rate government-run hospitals, like the Riviera Beach VA Medical Center and Lakeside Medical Center in Belle Glade, or children's hospitals.**

Why it's important? Preventable medical errors, accidents, injuries and infections in hospitals kill roughly 200,000 people a year, making it the third leading cause of death in the country, said Alex Campione, program analyst for Leapfrog.

"It is critical to monitor safety before choosing a hospital," he said.

A 2019 analysis by Johns Hopkins Armstrong Institute for Patient Safety and Quality for Leapfrog found that D and F hospitals carry nearly twice the risk of death as A hospitals.

"Over 50,000 lives could be saved if all hospitals performed at the level of A graded hospitals," researchers said.



St. Mary's Medical Center on 45th Street in West Palm Beach. (Photo: Joel Engelhardt/Stet)

What is Tenet saying? The Dallas-based hospital giant didn't respond to emails requesting comment.

The three Tenet medical centers in the county, which operate as the Palm Beach Network, are among about 20 percent of hospitals nationwide that didn't respond to a survey Leapfrog distributed to assess patient safety. The networks have responded to the surveys in the past when its hospitals got mostly C grades.

The surveys, however, "are just one piece of the puzzle," Campione said. The grades are based on information from the Centers for Medicare and Medicaid Services, he said. "These facilities are also performing poorly in data that is collected and publicly reported," he said.

The voluntary surveys allow hospitals to offer Leapfrog additional information about efforts to reduce inpatient falls, infections and surgical errors and to detail policies, such as hand-washing and staffing levels, designed to protect patients.

What are others saying? Not surprisingly, Jupiter Medical Center, lauded the results.

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But, she added, the score doesn’t “accurately reflect the high quality of healthcare provided to our patients.”

1. “The scores are based on historical data, some of which date back a few years,” Rada said in a statement. “We have action plans in place that utilize real-time data for continuous quality improvement efforts. These plans include implementing best practices and committee recommendations, along with ongoing employee and medical staff education.”

Louis Lochte, a spokesperson for HCA, said its three hospitals in the county take patient safety seriously.

“We recognize the importance of measuring quality and safety in patient care and are working hard to improve in certain areas,” he said in an email. “Our physicians, nurses and colleagues are dedicated to providing exceptional care for our patients.

--

**Brian Chegus, Principal Planner
iPlan & Design
823 N. Olive Avenue
West Palm Beach, FL 33401**

561.797.4217

Exhibit 34

Wood, Courtney L.

From: Patrick S Romano <psromano@health.ucdavis.edu>
Sent: Tuesday, August 26, 2025 1:01 AM
To: Blair, Kimberly E.; Wood, Courtney L.
Subject: FW: Leapfrog confidential attorney-client privilege - internal communications #3

Follow Up Flag: Follow up
Flag Status: Flagged

EXTERNAL EMAIL This email originated from outside the organization.

Patrick S. Romano, MD MPH
Professor of Internal Medicine and Pediatrics
UC Davis Division of General Internal Medicine and Bioethics
4150 V Street, PSSB Suite 2400
Sacramento, CA 95817
Telephone: (916) 734-7237 or -7005
Email: psromano@health.ucdavis.edu (please note new email domain)
Web: <https://health.ucdavis.edu/chpr/research/healthcare-quality-and-safety/>
LinkedIn: <https://www.linkedin.com/in/patrick-romano-aa1b2622/>

From: Patrick S Romano
Sent: Wednesday, December 11, 2024 2:47 PM
To: Bruce Hall <blhall@ucdavis.edu>; Gregory A Maynard <gmaynard@UCDAVIS.EDU>; Brenda L Inman <bdelarosa@UCDAVIS.EDU>; Joseph M Galante <jmgalante@ucdavis.edu>
Subject: RE: Leapfrog Announcements for Hospitals - December 2024

LOL, thank you Bruce, I appreciate your clinical leadership as well...

Re Leapfrog, methinks you folks are too critical... their decision to increase the penalty for nonparticipation was a simple business decision, just like our decision not to participate. It's just business, folks!
Their business model, as you know, depends on producing data that add value for health plans and employers... and the data are not valuable if participation is low.

Patrick S. Romano, MD MPH FAAP FACP
Professor of Medicine and Pediatrics, UC Davis Division of General Medicine
Co-Editor in Chief, AHRQ *Patient Safety Network* (PSNet and WebM&M)
4150 V Street, PSSB Suite 2400
Sacramento, CA 95817
Telephone: (916) 734-7005 or -7237
E-mail: psromano@ucdavis.edu
Website: <https://health.ucdavis.edu/team/pediatrics/122/patrick-romano---internal-medicine---pediatrics-general-sacramento>

From: Bruce Hall <blhall@ucdavis.edu>
Sent: Wednesday, December 11, 2024 2:33 PM
To: Patrick S Romano <psromano@ucdavis.edu>; Gregory A Maynard <gmaynard@UCDAVIS.EDU>; Brenda L Inman

<bdelarosa@UCDAVIS.EDU>; Joseph M Galante <jmgalante@ucdavis.edu>

Subject: Re: Leapfrog Announcements for Hospitals - December 2024

Thank you Patrick- this is very helpful information. I'm copying in CMO Galante as well.

Let me again express my appreciation for all that you have accomplished in your career advancing the cause of measuring quality and safety for our profession. You have been an important thought leader for a long time.

With respect to Leapfrog specifically, I think it is irresponsible and reckless of them to deliver incomplete assessments to the public. Despite that personal sense, I am asking Greg and Brenda to assemble more information on what the resource burden would be if we chose to participate (we had planned to do this for Jan 2025 anyway).

Thank you- I hope you have a wonderful holiday!- Bruce

From: Patrick S Romano <psromano@ucdavis.edu>

Date: Wednesday, December 11, 2024 at 10:45 AM

To: Bruce Hall <blhall@ucdavis.edu>, Gregory A Maynard <gmaynard@UCDAVIS.EDU>, Brenda L Inman <bdelarosa@UCDAVIS.EDU>

Subject: RE: Leapfrog Announcements for Hospitals - December 2024

Well, friends, we can now see the consequences of our nonparticipation... a D grade, in the same league with Oroville and Manteca, which is embarrassing for an organization that claims to be high-quality...

<https://www.sacbee.com/news/local/health-and-medicine/article295787714.html>

Although our HAI rates were high (hospital score 1.338 versus average 0.746), and our PSI rates were a bit above average (1.36 versus 1.01), the real killer for us was nonparticipation (15/100 points on safety practices, 0/120 on staffing).

<https://www.hospitalsafetygrade.org/h/university-of-california-davis-medical-center>

<https://www.hospitalsafetygrade.org/table-details/university-of-california-davis-medical-center>

According to Google AI,

◆ AI Overview

Yes, the University of California Davis Medical Center (UC Davis Medical Center) received a D grade for hospital safety from the Leapfrog Group: ⚡

Reason

UC Davis Medical Center received a D grade for issues with staph infection control, sepsis infection prevention after surgery, and patient falls and injuries. ⚡

How the Leapfrog Group rates hospitals

The Leapfrog Group uses a numerical score based on up to 27 measures of patient safety, including rates of infections, injuries, and preventable errors. The numerical score is then converted into a letter grade, with A being the best and F being the worst. ⚡

What the grades mean

The numerical score cut-points for the letter grades are:

- **A:** 3.159 or higher ⚡
- **B:** 2.972 or higher ⚡
- **C:** 2.506 or higher ⚡
- **D:** 2.040 or higher ⚡
- **F:** Less than 2.040 ⚡

The Leapfrog Group is an independent, not-for-profit organization founded by private health care experts and employers. ⚡

Always happy to meet with anyone to discuss Leapfrog's approach (since I serve on their Expert Panel, <https://www.hospitalsafetygrade.org/about-the-grade>) or to facilitate UCDH participation 😊

Patrick S. Romano, MD MPH FAAP FACP

Professor of Medicine and Pediatrics, UC Davis Division of General Medicine

Co-Editor in Chief, AHRQ *Patient Safety Network* (PSNet and WebM&M)

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Sacramento, CA 95817

Telephone: (916) 734-7005 or -7237

E-mail: psromano@ucdavis.edu

Website: <https://health.ucdavis.edu/team/pediatrics/122/patrick-romano---internal-medicine---pediatrics-general-sacramento>

From: Bruce Hall <blhall@ucdavis.edu>

Sent: Wednesday, May 15, 2024 3:20 PM

To: Gregory A Maynard <gmaynard@UCDAVIS.EDU>; Patrick Romano <psromano@ucdavis.edu>; Brenda L Inman <bdelarosa@UCDAVIS.EDU>

Subject: Re: Leapfrog Announcements for Hospitals - May 2024

Thanks Patrick,

I agree with Greg and wouldn't change course on this today. Can we ask ourselves this question again in January 2025?

Bruce

From: Gregory A Maynard <gmaynard@UCDAVIS.EDU>

Date: Wednesday, May 15, 2024 at 1:42 PM

To: Patrick Romano <psromano@ucdavis.edu>, Brenda L Inman <bdelarosa@UCDAVIS.EDU>

Cc: Bruce Hall <blhall@ucdavis.edu>

Subject: RE: Leapfrog Announcements for Hospitals - May 2024

Patrick,

I have brought this up with Dr. Hall. We are both ambivalent about the value of Leapfrog. And I think that ambivalence tilts even more negative when our lack of participation guarantees a lower grade which they still publish, effectively blackmailing centers to participate.

I coped Dr. Hall. Given our competing priorities and staff shortages, I am not sure we should take this on given short timeline for this year's submission, but Dr. Hall, please weigh in, we can follow your guidance.

GM

From: Patrick Romano <psromano@ucdavis.edu>

Sent: Wednesday, May 15, 2024 9:27 AM

To: Brenda L Inman <bdelarosa@UCDAVIS.EDU>; Gregory A Maynard <gmaynard@UCDAVIS.EDU>

Subject: Fwd: Leapfrog Announcements for Hospitals - May 2024

Your opportunity to reconsider... they are changing their imputation approach so hospitals can get away with responding in alternate years, but if you skip more than one year, you will never get above a C... might even drop to D.

Patrick S. Romano, MD MPH
Co-Editor in Chief, AHRQ Patient Safety Network (PSNet and WebM&M)
Professor of Internal Medicine and Pediatrics
UC Davis Division of General Medicine
4150 V Street, PSSB Suite 2400
Sacramento, CA 95817
Telephone (916) 734-7005 or -7237
Psromano@ucdavis.edu

From: The Leapfrog Group <helpdesk@leapfrog-group.org>

Sent: Wednesday, May 15, 2024 8:24 AM

To: Patrick Romano <psromano@ucdavis.edu>

Subject: Leapfrog Announcements for Hospitals - May 2024

Informational Updates for Hospitals

[View this email in your browser](#)



2024 Hospital Survey is Open

GET STARTED ON THE 2024 HOSPITAL SURVEY

The 2024 Leapfrog Hospital Survey opened on April 1. Download a hard copy of the Survey and scoring algorithms, request a 1:1 orientation call, and review deadlines on our website at www.leapfroggroup.org/hospital.

CHANGE SUMMARY ISSUED MAY 14

Section 9C Volume of Procedures: Added four CPT Codes to the Outpatient Procedure CPT Code workbook for Adult General Surgery - Lumpectomy or Quadrantectomy of Breast Procedures. Hospitals are not required to make updates to data already collected and/or reported but have the option to include these additional CPT Codes in their volume if they wish. As a reminder, these data are not used in scoring, but volume of procedures are publicly reported.

You can download an updated copy of the Outpatient Procedure CPT Code workbook from the [Survey Dashboard](#). Instructions for downloading the workbook are available on page 297 of the [Survey](#).

Educational Opportunities

MONTHLY SUPPORT AND GUIDANCE FOR HOSPITAL SURVEY PARTICIPATION

The 2024 Leapfrog Hospital Survey Webinar Series, which is held monthly from March to December, is designed for hospitals that would benefit from more regular support and an interactive presentation of Survey materials and information.

Hospitals that join the Webinar Series will have access to:

- **Monthly office hours with Leapfrog's subject matter experts:** 30-minute sessions to get real-time technical assistance, answers to your questions and help staying on top of upcoming deadlines. Staffed by Leapfrog's subject matter experts.
- **Monthly webinars:** Timely and focused presentations on Survey measures and specifications, scoring information, frequently asked questions and public reporting. Each webinar focuses on a specific topic (e.g., nurse staffing and workforce, barcode medication administration, preparing for data verification, etc.) and concludes with a 20-minute open Q&A session.
- **Archive library:** Slides and recordings from each webinar are archived in an online portal that participants can access from March to January.

[Review the 2024 Webinar Series schedule and register now.](#)

In addition to the Webinar Series, Leapfrog offers **free** technical and content-related support to all participating facilities via our electronic [Help Desk](#), which is staffed by dedicated subject matter experts.

Important Dates

JUNE 30 SUBMISSION DEADLINE

The 2024 Leapfrog Hospital Survey Submission Deadline is June 30. Hospitals submitting by June 30 will be able to preview their results on their Hospital Details Page starting July 12 and will have results publicly reported on July 25. Hospitals will also receive a free Competitive Benchmarking Summary Report.

[Review key deadlines.](#)

HELP DESK HOLIDAY SCHEDULE

The Leapfrog Help Desk is staffed from 9:00 a.m. to 5:00 p.m. ET on all regular business days. The Help Desk is not staffed on federal holidays. Please take note of the following upcoming closures.

Staff Training

May 22 - closed

Memorial Day

May 24 - closing at 2 pm ET

May 27 - closed

Juneteenth

June 19 - closed

Independence Day

July 4 - closed

Other Announcements

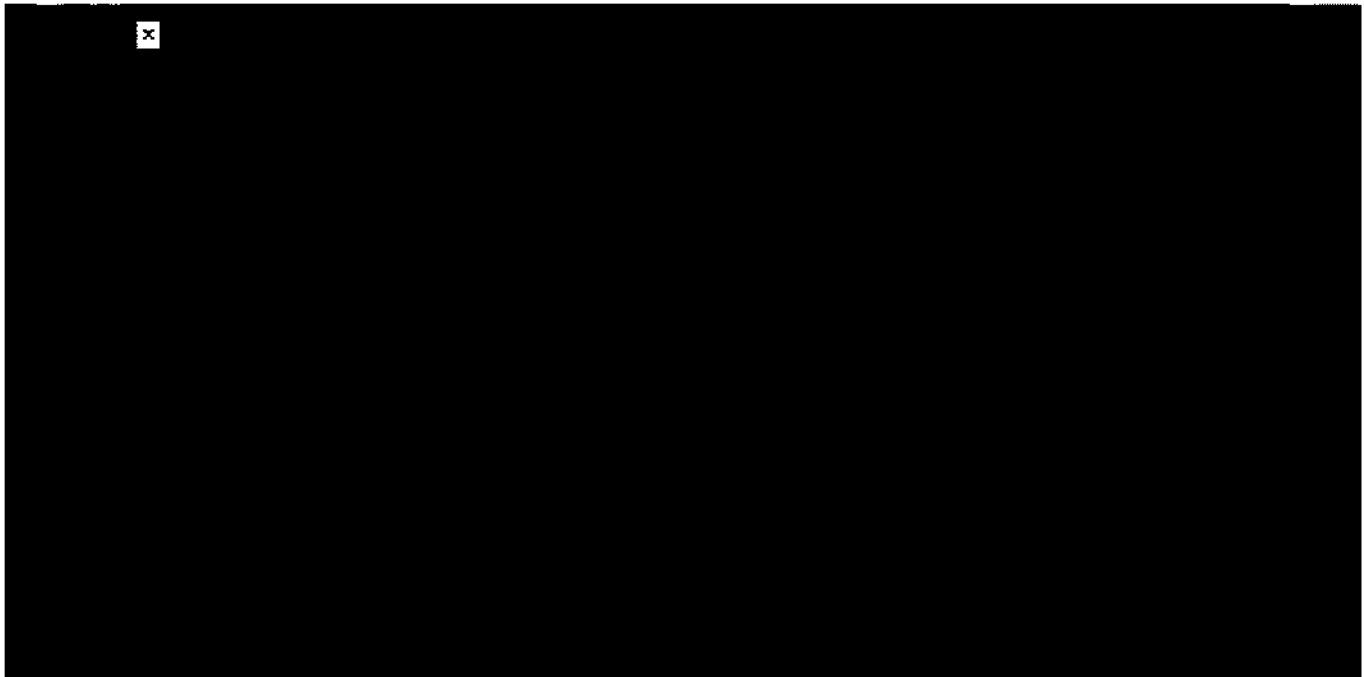
RECOGNIZED LEADER APPLICATION OPENS JULY 1

Look out for the next round of applications for the Recognized Leader in Caring for People Living with Diabetes program! The application to be a 2025 Recognized Leader opens July 1, 2024, to all hospitals who have submitted a 2024 Leapfrog Hospital Survey. Details on updates to the program will be available in late June. Applications will be open until November 30, 2024, with Recognized Leaders announced in Spring 2025.

A joint effort from The Leapfrog Group and the American Diabetes Association, this first-ever national inpatient diabetes recognition program honors hospitals providing safe and high-quality health care for people living with diabetes, taking steps such as:

- Making it a policy to work with patients to safely self-manage their diabetes medications
- Implementing blood glucose testing and hypoglycemia protocols as well as additional testing and monitoring before and during inpatient surgeries
- Supporting patients with education they need to manage their care, and connecting them with health care providers after they leave the hospital

[Find more information here.](#)



LEARN FROM OTHER LEAPFROG REPORTING HOSPITALS

Earlier this month Leapfrog held a webinar with the Michigan Health Improvement Alliance (MiHIA). MiHIA partnered with The Leapfrog Group and used Leapfrog data to identify hospitals

with sustained highest performance in CLABSI, CAUTI, and Falls/Trauma. Leaders at MiHIA and participants in their consortium shared four best practices based on the shared learnings from a collaboration formed between these high performing hospitals and a team of regional safety and quality experts.

[View the recording here.](#)

[Download a Summary of the Findings here.](#)

SURVEY SUPPORT FOR HEALTH SYSTEMS

Are you responsible for coordinating the Leapfrog Hospital Survey submission for all the hospitals in your health system? Want to make it easier to track submission status, review responses and scored results, and track performance from year to year?

Subscribe to Health System Support and receive all your hospital's 16-digit security codes, Survey responses, and scored Survey Results in an Excel file three times a year: following the June 30 deadline, following August 31 (the deadline for Top Hospital and the Snapshot Date for the fall 2024 Hospital Safety Grade), and following the January 31 year-end deadline.

Subscribers also receive a free registration for Leapfrog's [monthly webinar series.](#)

[Find more information here.](#)

STRENGTHEN YOUR ORGANIZATION'S CRP WITH THE PACT COLLABORATIVE

Communication and Resolution Programs (CRPs) are gaining support and traction on the national stage. Ensure your organization is ready for the changing health care landscape by joining the [PACT Collaborative](#), a groundbreaking learning community supporting the implementation of highly reliable CRPs founded by Ariadne Labs, the Collaborative for Accountability & Improvement, and the Institute for Healthcare Improvement.

[Learn more here.](#)



COME SEE US AT APIC 2024!

The Leapfrog Group will be at booth 638 at the Association for Professionals in Infection Control and Epidemiology (APIC) conference June 5-8. The conference brings together health care professionals, researchers, educators, and industry leaders to connect, collaborate, and shape the future of infection prevention.

[Visit us at APIC.](#)



Panelists from two large healthcare systems will discuss how their organizations have aligned employee experience to patient safety culture. They'll discuss internal research demonstrating a link between the two and the steps each organization took to demonstrate this link in a practical way for front-line leaders. They'll also share how they've used new tools and technology to measure, understand, and drive a culture of safety.

This webinar is a program of the Partners Advisory Committee and is sponsored by Microsoft. While The Leapfrog Group does not endorse the products, services, and/or technology showcased on this webinar, we encourage you to explore these offerings that support Leapfrog's work.

Register Now



Exploring the benefits of standardization of chemicals, surveillance for transmittible infections, staff education, and infection prevention basis that apply to all areas to reduce the risk of infections. Reviewing the methods of cleaning and disinfection throughout healthcare, to include acute care, ambulatory surgical centers, long-term acute care, skill nursing, rehab, and senior facilities. Discussing the role of surveillance and changes in regulatory requirements for prevention of healthcare and community-based infection and the importance of communication between staff and care sites. Explore common themes of patient safety and staff engagement to drive better satisfaction results.

This webinar is a program of the Partners Advisory Committee and is sponsored by Steriliz, LLC. While The Leapfrog Group does not endorse the products, services, and/or technology showcased on this webinar, we encourage you to explore these offerings that support Leapfrog's work.

Register Now

STAY CONNECTED WITH THE LEAPFROG GROUP



[SUBSCRIBE FOR UPDATES](#)



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Suite 400
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federal privacy laws. If you received this e-mail in error, be aware that any unauthorized use, disclosure, copying, or distribution is strictly prohibited. If you received this e-mail in error, please contact the sender immediately and destroy/delete all copies of this message.

Exhibit 35

Message

From: Robert Jon Kucejko [rjkucejko@ucdavis.edu]
Sent: 12/19/2024 12:09:47 AM
To: Gregory A Maynard [gmaynard@UCDAVIS.EDU]; Brenda L Inman [bdelarosa@UCDAVIS.EDU]
Subject: RE: Responding to patient questions about rankings

Yeah I mean I agree with all that. It truly is marketing blackmail. Can't we sue leapfrog?

You don't have to answer that.....

B

From: Gregory A Maynard <gmaynard@UCDAVIS.EDU>
Sent: Wednesday, December 18, 2024 4:03 PM
To: Robert Jon Kucejko <rjkucejko@ucdavis.edu>; Brenda L Inman <bdelarosa@UCDAVIS.EDU>
Subject: RE: Responding to patient questions about rankings

Conversations are ongoing about this, and we are reaching out to other UCs to see if we want to take a common approach.

The problem: Participating in Leapfrog surveys is time consuming but does not give us value in terms of insight or driving improvement. The benefit is strictly limited to avoid taking the blackmail-like reputational hits.

I think leadership will cave and we'll start participating again (without any additional resource to do the survey work).

GM

From: Robert Jon Kucejko <rjkucejko@ucdavis.edu>
Sent: Wednesday, December 18, 2024 3:59 PM
To: Brenda L Inman <bdelarosa@UCDAVIS.EDU>; Gregory A Maynard <gmaynard@UCDAVIS.EDU>
Subject: FW: Responding to patient questions about rankings

Interesting commentary on our LeapFrog standing coming from my outpatient clinic director.

We discussed this all back in April when I first learned all of these things after Dr. Romano suggested we re-invest in it.

This is probably a marketing issue more so than an actual safety issue, but its interesting how we can see the direct effects. Given our current capacity crunch, I don't think the patients lost due to these rankings are significant, but if we ever expect to shift our payor mix more toward an academic hospital and less toward a county hospital, I think we need to be mindful of this.



Happy holidays!

Bobby

From: Mohit Gulati <mogulati@ucdavis.edu>
Sent: Wednesday, December 18, 2024 3:54 PM
To: Surgery Clinics <surgeryclinics@groups.ucdavis.edu>
Subject: FW: Responding to patient questions about rankings

Hello Surgery Clinic Staff and Providers(BCC'd),

Just incase patients reach out or mention a bad quality report that came from a company called Leapfrog, I wanted to make sure you have the information below.

The recent release from Leapfrog results indicated a low-quality score for UCDH. As a result, unfortunately, we have seen some patients canceling appointments and/or procedures.

Ultimately - UC Davis Medical Center has not participated in the Leapfrog survey for many years. UC Davis Health did not provide Leapfrog with any data, thus resulting in the low ranking for that survey.

From: HS-Ambulatory Care Leadership <HS-AmbulatoryCareLeadership@ucdavis.edu>
Sent: Wednesday, December 18, 2024 11:00 AM
Subject: Responding to patient questions about rankings

Good morning, Ambulatory managers,

At UC Davis Health, we are committed to delivering exceptional care and maintaining the highest standards of patient safety, quality, and outcomes. Recognitions and rankings are an important reflection of our efforts, and we appreciate the value they bring to our community and patients.

The recent release of Leapfrog results indicated a low score for UCDH. As a result, we have seen some patients canceling appointments and/or procedures. To help address patient inquiries regarding the survey, we have included information below about our participation in different hospital rankings and surveys, including the Leapfrog report, in case you should get any questions from patients. Please share and review with your teams.

“I was wondering about the hospital’s rankings and participation in surveys like the recent Leapfrog report.”

- UC Davis Medical Center is consistently recognized as one of the best hospitals in America.
- Influential organizations and publications, such as *U.S. News & World Report*, have ranked us #1 in the Sacramento region.
- There are numerous third-party organizations that compile hospital rankings, including Leapfrog.
- However, due to resource constraints, we are unable to dedicate staff time to participate in and provide data for all available surveys.
- As a result, UC Davis Medical Center has not participated in the Leapfrog survey for many years. UC Davis Health did not provide Leapfrog with any data, thus resulting in the low ranking for that particular survey.
- More information about awards and honors UC Davis Health has received is available on our [website](#).

If you have any additional questions or need further information, please don't hesitate to ask.

Dave

David Del Pizzo, MHA, RVT

Associate Chief Operating Officer (Interim)
Executive Director | Ancillary Services
Ambulatory Operations | UC Davis Health

10850 White Rock Rd, Suite 2105
Rancho Cordova, CA 95670
Phone: 916.734.8203
djdelpizzo@ucdavis.edu



Exhibit 36



2025 Regional Leader Communications Toolkit: Launching Leapfrog Surveys



We are excited to launch the 2025 Leapfrog Surveys in our collective effort to make **giant leaps for patient safety**. Hospitals and ambulatory surgery centers (ASCs) continue to face new and evolving challenges

Thanks to the partnership between Leapfrog and Leapfrog Regional Leaders, we received over 2,400 submissions, representing 80% of hospital beds. The ASC Survey participation lags, but we hope to change that this year by making the case to ASCs and purchasers alike that there is real value in reporting quality data. Consumers and purchasers deserve to compare safety and quality information on hospital outpatient surgical units along with surgery centers, since they perform most of all procedures done in the country. There has never been a more important time for transparency and Leapfrog's role in keeping health care facilities accountable.

The 2025 Communications Toolkit offers you instructions for launching the Leapfrog Hospital Survey and the Leapfrog ASC Survey in your region, focusing on the critical initial communication you carry out to encourage hospital and ASC participation. It is designed to support you at different stages of the process when it is most useful to you. Additional communication materials included in this toolkit are designed to further help you engage the public, including employers, purchasers, hospitals, and ASCs, such as our comprehensive [Common Objections and Frequently Asked Questions About Leapfrog and Its Ratings](#) and the [Regional Leaders Best Practices Toolkit](#). We have outlined the materials in an easy to access manner so you can find what you need.



2025 COMMUNICATIONS TOOLKIT

Table of Contents

I. Step-by-Step: How to Launch the Leapfrog Hospital Survey and Leapfrog ASC Survey in Your Market

II. Key Contact Information and Links

IV. Key Dates

- a. Overview of the Leapfrog Hospital Survey and Leapfrog ASC Survey

VII. Links & Resources

VIII. Template Letters

X. Regional Leader Coverage Areas

VI. Materials to Share with Hospitals and ASCs During Your Survey Rollout

- b. Infographic on why hospitals and ASCs should submit a Leapfrog Survey
- c. Intent to submit form
- d. Copy about Leapfrog Hospital Survey Webinar Series
- e. Copy about Leapfrog System Services
- f. Value Resources for ASCs

III. Best Practices Used by Regional Leaders

- g. Launching the Leapfrog Surveys in your Communities
- h. Engaging ASCs
- i. Ideas for encouraging non-respondents

IX. Common Objections and Frequently Asked Questions about Leapfrog and its Ratings

I. STEP-BY-STEP: HOW TO LAUNCH THE LEAPFROG HOSPITAL SURVEY & LEAPFROG ASC SURVEY IN YOUR MARKET

Please note: In 2025, Leapfrog will manage the Survey invitation letter to ASCs but will provide Regional Leaders with tools and template materials to supplement outreach in your communities.

Regional Leaders are not responsible for sending security code sheets. If a hospital or ASC needs a copy of their security code, they must complete the Security Code Request form available on Leapfrog's website or by contacting the Help Desk.

1. **March 1 – April 30 Get members, hospitals, and ASCs excited about the 2025 Surveys.**

- Include the Survey launch in your newsletter and member communications along with posting content on your social media channels. Think about highlighting interesting questions/issues on the Survey, such as informed consent or billing ethics. You will find everything you need here.
- Consider any new communication channels that might help you reach the ASC community, like local ASC association publications and events.
- Think about how you can involve your employers by having them sign on to your letters or attend meetings you have scheduled with some of your facilities.

2. **Personalize template letters* asking HOSPITALS to participate in both the inpatient and outpatient sections of the Survey. March 1 – April 30**

- Leapfrog provides template letters asking hospitals to participate in the Hospital Survey. You can customize them for your market and add your letterhead.
- Clearly outline how you plan to use the Hospital Survey data and share it with your members.
- Ask as many of your employer and purchaser members as possible to sign your letters. This can significantly increase a facility's likelihood of participation.

3. **Work with Leapfrog to invite ASCs to participate in the Leapfrog ASC Survey. March 1 – April 30**

- Regional Leaders are strongly encouraged to use the mailing list provided by Leapfrog to conduct ongoing outreach to ASCs in your community using provided template letters in the appendix.
- Leapfrog will send initial letters to ASCs on Regional Leader's letterhead with logos and signatures requesting their participation and providing instructions on obtaining a Security Code.
- Ask as many of your employer and purchaser members as possible to sign your letters. This can significantly increase a facility's likelihood of participation.
- If an ASC needs a copy of their security code, they need to complete and submit the Security Code Request form: <http://bit.ly/ASCSecurityCode>.

4. **Send HOSPITAL letters by mail or email no earlier than March 30, but no later than April 30.**

- Notify Robyn Nabi () if you are unable to send letters this year and require Leapfrog's assistance.
- Merge the customized hospital letters and the hospital mailing list to generate individual letters and envelopes for each hospital in the region and address the CEO. **Emails can only be sent to the hospital's CEO if the hospital submitted a 2024 Survey.**
- Notify Robyn Nabi (rnabi@leapfrog-group.org) when you have mailed or emailed the invitations to your hospitals.

- Keep a list of any returned mail and send any address or CEO updates to Robyn Nabi throughout the year.
- **Reminder:** If a hospital needs a copy of their security code, they need to complete and submit the Security Code Request form: <http://bit.ly/HospitalSecurityCode>.

5. Follow up with those who have not responded. May through the end of the year

- Leapfrog keeps track of Hospital Survey responses by region and will report the status to Regional Leaders in regular readout files sent by email and saved on the [Regional Leader section of the Leapfrog website](#). Interim files will be sent beginning in May, and monthly files will be sent the last week of July through February after the first June 30 Submission Deadline.
- Follow up with HOSPITALS that have not submitted a Survey as the June 30 Submission Deadline approaches as well as in the fall leading up to the November 30 Late Submission Deadline.
 - Leapfrog will provide Regional Leaders with a file of participating facilities by state as well as a template letter so that you can follow up with those that have not participated.

6. Thank Survey participants. July, through the end of the year.

- Using the list of Survey participants and the letter template in this document, send hospitals and ASCs thank you letters and share how you plan to use the data.
 - Remind participating facilities that their results will be publicly reported in July.
- Consider hosting recognition events (including virtual events) to thank hospitals and ASCs who participated and recognize performance.

7. Use results released by Leapfrog.

- Be sure to consult the Regional Leader Best Practices Guide for ideas on using Leapfrog results, including:
 - Encourage your members to use Leapfrog for payment policies, tiering, and public reporting. The measures on the Leapfrog Hospital Survey are selected because they are critical for improving health outcomes and reducing costs for purchasers and consumers.
 - Tailor press announcement templates to highlight Survey performance and why it matters to people in your community.

Reminder: [Template letters are available in Section VII of this packet](#)

II. KEY CONTACT INFORMATION AND LINKS

Leapfrog Regional Leaders Contact

Jill Berger
jberger@leapfrog-group.org

Regional Leader Webpage <i>Regional Leader site with past meeting notes, Survey readout files, and other resources like the Communications Toolkit, FAQ, and Best Practices Guide.</i>	http://www.leapfroggroup.org/login/resources-regional-leaders
Contact for Hospital Rosters	Robyn Nabi RNabi@leapfrog-group.org
Leapfrog Help Desk Email Address	helpdesk@leapfrog-group.org
Leapfrog Help Desk Website	https://leapfroghelpdesk.zendesk.com
We guarantee a response within 24 hours!	
Hospital Survey Site	www.leapfroggroup.org/hospital
ASC Survey Site	www.leapfroggroup.org/ASC
Leapfrog Hospital Safety Grade	www.hospitalsafetygrade.org
Leapfrog Website <i>for organizational information</i>	www.leapfroggroup.org
<i>consumer site with public Hospital and ASC Survey results</i>	www.ratings.leapfroggroup.org

III. BEST PRACTICES USED BY REGIONAL LEADERS

Below are several ideas that have been successful for other Regional Leaders when encouraging participation that you may want to consider trying in your market.

LAUNCHING THE LEAPFROG SURVEYS IN YOUR COMMUNITY

- **Engage employers** with purchasing power to influence hospital decision-making based on Hospital Survey participation. Discuss with employers the differences in quality of care between facilities from which beneficiaries are seeking care—are these the best choices for the care needed? Ask employers to sign the invitation letters with you; public entities (e.g., school systems, city and local governments) can have great purchasing influence on the provider community because of their size and scope.
- **Distribute a press release** to local media about your efforts to encourage hospital transparency through the Leapfrog Hospital Survey and the Leapfrog ASC Survey.
- **Meet with local media** to discuss how you will work with them to share ongoing efforts and results. Discuss one or more items in the survey that might make a good story, such as the new patient consent standard, billing ethics, medication safety, maternity care, or the new Hospital Survey question on C-section rates by race and ethnicity. Encourage them to call attention to the hospitals and ASCs that decline to respond to your request for Survey participation.
- **Reach out to ASCs in your region** inviting them to participate in the ASC Survey. Leapfrog will send the security code and initial invitation to ASCs, but Regional Leaders are urged to send a second letter introducing your organization to facilities and encouraging their participation on behalf of employers in your region. We recognize it is sometimes difficult to identify the right person at an ASC, but as they continue to hear from you over time and the survey results gain more prominence, they will likely become more responsive. We are playing the long game, and persistence is critical.
- **Include an “Intent to Submit” form** with the Hospital Survey invitation or as a follow-up to an invitation and in an ASC-specific mailing. Immediate feedback has been found to improve the likelihood of Survey submission in some markets. If the facility does not plan to submit a 2025 Survey, ask them to indicate on the form why they’ve chosen to decline your call for transparency and public reporting on their quality and safety practices. Including a list of hospitals in your region that respond to the Survey may be helpful. Consider sending this form online using a tool such as Constant Contact or Survey Monkey to make it easier for CEOs to respond in a timely manner.
- **Meet with the CEO and quality improvement staff from health systems** to discuss the importance of the Leapfrog Hospital Survey. Consider including an employer or purchaser. Commitment from system-level executives to participate in the Survey will often result in all facilities within the system being required to submit a Survey. This will also be a good opportunity to illustrate the value many systems find in being able to compare and benchmark their individual facility’s performance on the Survey metrics, including the opportunity to compare their outpatient facility performance to that of ASCs.

BUILDING RELATIONSHIPS WITH ASCS

Engaging with ASCs and increasing participation in the Leapfrog ASC Survey is a priority for Leapfrog in 2025. Below are some ideas to help you identify ASCs and educate them about Leapfrog’s value. We encourage you to select one or two of these strategies and try them out with five ASCs in your region.

- **Meet with local ASC Associations and ASC Administrators in your region** to discuss the value of participating in the Leapfrog ASC Survey, including public reporting benefits, benchmarking, and comparison to hospital outpatient departments.
- **Reach out to the local business bureaus** to help identify ASCs in your area.
- **Get your member employers involved** by asking them to sign participation letters and by joining you on visits to local ASC facilities.

- **Recognize Top ASCs in your area** through events with employer members or media opportunities to demonstrate the value of participating and encourage other ASCs to participate.

IDEAS FOR ENCOURAGING NON-RESPONDENTS TO THE LEAPFROG SURVEYS

The following are actions that your coalition may want to take with non-responding facilities to urge participation in the Leapfrog Hospital Survey and Leapfrog ASC Survey. **It is strongly encouraged that you and/or your members or board pursue these strategies and familiarize yourself with the Common Objections and FAQs resource. Leapfrog staff are always available to provide follow-up and clarifications to hospitals or ASCs as well.**

- **Make phone contact with facility executive leadership.** You can find hospital CEO names and phone numbers on your roster and ASC executive names on the ASC mailing list.
- **Ask your local health plans to follow-up** with their hospital and ASC contacts and urge participation.
- **Contact individual hospital board members** indicating that the hospital has not yet completed the Survey, particularly board members who are part of your organization or who represent large employers.
- **Phone calls to the hospital board chairperson** by your organization’s CEO or other senior executives.
- **Share with local media** the names of the first hospitals and ASCs to respond and the names of those that are not responding.

REGIONAL LEADER BEST PRACTICES GUIDE

Additionally, Leapfrog has developed a separate comprehensive **Regional Leader Best Practices Guide**. This guide includes several tactics to use Leapfrog data beyond launching the Surveys, including hosting recognition events for top performing facilities and member employee engagement ideas. The guide compiles examples from Regional Leaders that you may want to consider implementing in your market. You can find the guide here - Regional Leader section of the Leapfrog website.

IV. KEY DATES FOR THE 2025 SURVEY CYCLE

FOR REGIONAL LEADERS

March 30 – April 30	Mail or email Hospital Invitation Letters <i>Optional: Mail or email request letter to ASCs</i>
June 30	2025 Submission Deadline
June and July	Acknowledge facilities that met the June 30 Submission Deadline

Monthly beginning in June	Review the Readout File to identify hospitals that have participated Send reminders to non-participants and thank you letters to participating facilities
September	Send a second Survey invitation letter to remind non-participating hospitals of the November 30 Late Submission Deadline
November 30	Late Submission Deadline
December	Acknowledge Leapfrog Top Hospitals and Top ASCs in your community Attend Leapfrog's Annual Meeting and Regional Leader meeting

FOR HOSPITALS & ASCS

April 1	2025 Leapfrog Hospital Survey and Leapfrog ASC Survey open
April & May	<u>Leapfrog Hospital Survey</u> and <u>Leapfrog ASC Survey</u> Town Hall Calls
June 30	2025 Submission Deadline
Monthly beginning in July	Data Review: Facilities have 30 days to submit corrections and/or confirm responses
July 12	Hospital detail page showing results available to hospitals 2025 Survey Results released and posted at https://www.ratings.leapfroggroup.org
August 31	Top Hospital Submission Deadline for hospitals to submit a completed Survey if they would like to be eligible for Top Hospitals Data Snapshot Date for the fall 2025 Leapfrog Hospital Safety Grade
November 30	Late Submission Deadline: No Leapfrog Hospital Survey submissions will be accepted after this date.
December 2025- January 2026	Data review and correction period for previously submitted Surveys

IV. OVERVIEW OF THE 2025 LEAPFROG SURVEYS

To ensure the Leapfrog Hospital Survey and the Leapfrog ASC Survey align with the latest science and the public reporting needs of purchasers and consumers, Leapfrog's research team annually reviews the literature and convenes expert panels. Facilities that

voluntarily complete the Leapfrog Surveys demonstrate their commitment to transparency by providing information purchasers and consumers need to choose the best facility for their care.

Leapfrog Hospital Survey

The Leapfrog Hospital Survey uses national performance measures to evaluate individual hospitals on the safety, quality, and efficiency of inpatient and outpatient care. The 2025Leapfrog Hospital Survey can be found [here](#).

Leapfrog Ambulatory Surgery Center (ASC) Survey

Leapfrog launched the Leapfrog ASC Survey in 2019, expanding our nearly 25-year long experience collecting and publicly reporting safety and quality of hospitals via the Leapfrog Hospital Survey. The Leapfrog ASC Survey uses national performance measures to evaluate individual surgery centers on safety, quality, and efficiency. Below is an overview of the Survey’s main sections and key changes for 2025. The 2025 Leapfrog ASC Survey can be found [here](#).

Important Note: The results of the Leapfrog ASC Survey and Leapfrog Hospital Survey are publicly reported by facility at <https://Ratings.LeapfrogGroup.org>

VI. MATERIALS TO SHARE WITH HOSPITALS AND ASCS

EXPLANATION OF MATERIALS

WHAT IT IS	IDEAS ON HOW TO USE THIS
a. <u>Infographic: Why Hospitals and ASCs Should Submit a Survey</u>	Distribute to hospitals and ASCs with Survey invitation letters and email to your employers and purchasers
b. <u>“Intent to Submit” Form</u>	Send along with letters to keep track of which hospitals plan to participate
c. <u>Leapfrog Hospital Survey Webinar Series</u>	Communicate to hospitals as needed

d. Copy about Leapfrog's System Services

Communicate to hospitals and ASCs as needed

e. Value Resources for ASCs

Share with ASCs to help encourage participation

a. INFOGRAPHIC ON WHY HOSPITALS AND ASCS SHOULD SUBMIT A SURVEY

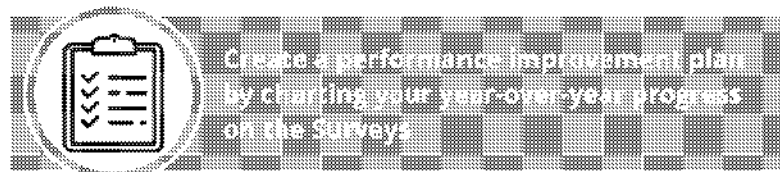
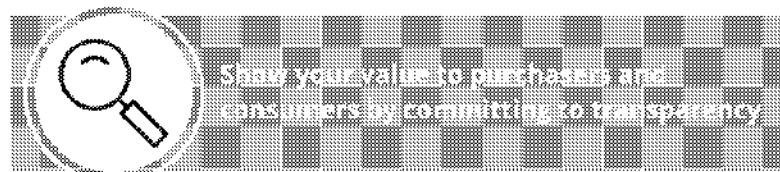
[Click here](#) to view the infographic, download, and/or print it for distribution.



Why You Should Participate in the Leapfrog Surveys

Thousands of employers and other purchasers across the country ask hospitals and surgery centers to participate in the Leapfrog Hospital Survey and the Leapfrog ASC Survey. They are the only source of nationally reported ratings by facility on safety and quality issues of importance to purchasers and the public. The measures on the Surveys are predicated on the latest science and reviewed and updated annually by top national expert panels to reflect the current evidence base.

By participating in the Surveys, your facility will be able to:



For more information visit:
www.LeapfrogGroup.org/Hospital
www.LeapfrogGroup.org/ASC

b. "INTENT TO SUBMIT" FORM

Intent to Submit a Leapfrog [Hospital/ASC] Survey for 2025

Please return to [email address].

«CEO»

«Title»

«Hospital_Name»

«Address»

«City», «State» «Zip»

☐

We intend to submit the Leapfrog [Hospital/ASC] Survey for 2025.

Survey Contact Name: _____

Phone Number: _____

E-mail Address: _____

The information will be used to send a reminder about the Survey from [REGIONAL LEADER]

☐

We do not intend to submit the Leapfrog [Hospital/ASC] Survey at this time.

Would you please explain why you do not wish to participate?

[REGIONAL LEADER] represents employers in your market. The Survey is very important to them, and they expressly request your participation. If you would like to discuss your decision via a phone call or web conference, please let us know and we will arrange it for you.

c. Do you have a hospital submitting for the first time? COPY ABOUT THE LEAPFROG HOSPITAL SURVEY WEBINAR SERIES

Are you a hospital submitting to Leapfrog for the first time? Get ahead of the game by registering for the Leapfrog Hospital Survey Webinar Series.

The Leapfrog Hospital Survey Webinar Series is held monthly from March to December. Each one-hour webinar includes a presentation as well as a question-and-answer session. The Webinar Series is designed for hospitals that would benefit from a more interactive presentation of Survey materials and information. Though nothing presented in the Webinar Series differs from the information available in the printed materials or through the free electronic Help Desk, many hospital leaders find the interactive format and opportunity for Q&A helpful.

For an annual fee of \$500 per user, hospitals that join the Webinar Series will have access to:

- Topical monthly presentations that focus on Survey and CPOE Evaluation Tool measures and specifications, scoring information, frequently asked questions, technical assistance, and public reporting
- 20-minute open Q & A sessions
- Presentations by Leapfrog's Expert Panel members
- Library of all slide decks and recordings from March-December
- Monthly office hours with the Leapfrog Help Desk

Registration for the 2025 Webinar Series is now open. Please [click here](#) to register.

d. COPY ABOUT HOSPITAL SYSTEM SERVICES

Many large and small health systems across the country engage all hospitals in their system in completing the Leapfrog Hospital Survey. By securing participation from all facilities, health system leaders can easily benchmark performance, identify high and low performers, and demonstrate their value to employers and purchasers in their community, like this [high performing health system](#). Leapfrog offers several tools to assist health systems in their completion of the Leapfrog Hospital Survey and analysis of results. Visit [Leapfrog's website](#) to learn more and contact the [Help Desk](#) with any questions.

e. ASC VALUE RESOURCES

Why participate in the Leapfrog ASC Survey? Through the Leapfrog ASC Survey, ambulatory surgery centers can benefit from an independent assessment of their quality and safety available to the public. The Survey prominently positions ASCs with employers and purchasers, provides benchmarking opportunities, and galvanizes improvement. Although there are many benchmarking opportunities available, Leapfrog's is the only one that will directly compare your ASC to hospital outpatient departments – at no cost to you.

The resources below highlight why the Leapfrog ASC Survey will provide value to your surgery center:

- **Discounted National Association for Healthcare Quality Training:** ASCs can get a 25% discount on the HQ Concepts in Healthcare Quality and Safety for Frontline Staffs training. Reach out to the Leapfrog Help Desk for details.
- **Becker's ASC Article:** Reporting to the Leapfrog ASC Survey: 4 competitive advantages
 - This article outlines the benefits of participation as told by ASC leaders and employers
- **AORN Podcast Series:** ASCs Today
 - A digestible podcast series with Association of periOperative Registered Nurses (AORN) President Linda Groah and Leapfrog President and CEO Leah Binder discussing nursing leadership, workforce issues, and safety risks. Part 1, Part 2, Part 3.
- **Leapfrog Case Study:** How the Leapfrog ASC Survey Highlights the Importance of Transparency
 - Leapfrog President and CEO Leah Binder interviews members of Proliance Surgeons' Center for Spine and Joint Replacement Surgery in Washington.
- **Leapfrog Case Study:** How the Leapfrog Survey Gives Surgery Centers Credibility Through Accountability
 - Leapfrog President and CEO Leah Binder interviews Coronado Surgery Center and Owner in Nevada.

VII. LINKS AND RESOURCES

Leapfrog Regional Leader webpage - <http://www.leapfroggroup.org/login/resources-regional-leaders>

Meeting notes

Survey readout files

Communications Toolkit

Frequently Asked Questions and Common Objections to Leapfrog's Rating Programs

Regional Leader Best Practices Guide

The Leapfrog Group – www.leapfroggroup.org

News and events

Resources for consumers

Resources for employers, including the Lives & Dollars Lost Calculator

Information about Leapfrog Value Based Purchasing Program

Fact Sheets and other Survey resources

Case studies from hospitals and ASCs that participate in the Leapfrog Surveys

Information about benchmarking reports for hospitals

Leapfrog Hospital Survey website – www.leapfroggroup.org/hospital

Hard copy of the Hospital Survey and resources for hospitals completing the Survey

Log in to the Hospital Survey

Leapfrog ASC Survey website – www.leapfroggroup.org/asc

Hard copy of Survey and resources for hospitals completing the ASC Survey

FAQ for ASCs

Login to ASC Survey

Survey Results – www.ratings.leapfroggroup.org

Public reporting of Leapfrog Hospital Survey and Leapfrog ASC Survey results

Search for facilities by name, city/state, zip code, etc.

Search by procedure and compare hospitals and ASCs side-by-side

Print Survey results

Leapfrog Hospital Safety Grade – www.hospitalsafetygrade.org

Public display of Leapfrog Hospital Safety Grade letter grades

Search for all general acute care hospitals that receive a safety grade

Compare hospitals on safety

Resources for consumers

VIII. CUSTOMIZABLE TEMPLATE LETTERS FOR THE 2025 LEAPFROG SURVEYS

The following are template letters that Regional Leaders can customize and send to hospital and ASC executives. Hospital invitation letters must be sent to each hospital on the roster, including optional relevant enclosures. **As a reminder, Regional Leaders are not responsible for mailing security codes to CEOs in 2025.** Leapfrog is sending invitation letters to ASCs; Regional Leaders are not responsible for this mailing.

The following letters are required for Regional Leaders to send:

- A. For currently submitting hospitals
- B. For hospitals new to the Survey

The following letters are optional, but highly encouraged for Regional Leaders to send:

- C. For system-level executives on the Hospital and ASC Surveys (optional to send)
- D. For ASC Survey to reinforce participation (*strongly encouraged to send*)
- E. Participation reminder (*to be sent in May*)
- F. Thank you for hospital CEOs
- G. Thank you for ASC CEOs
- H. For September: follow-up Survey mailing in high-participation states
- I. For September: follow-up Survey mailing in low-participation states
- J. For currently submitting ASCs
- K. For health plans to send: Hospitals
- L. For health plans to send: ASCs

The following letters can be used to congratulate Leapfrog Top Hospitals, Leapfrog Top ASCs and hospitals that earn an “A” on the Leapfrog Hospital Safety Grade:

- M. Congratulate Leapfrog Top Hospitals
- N. Congratulate Leapfrog Top ASCs
- O. Congratulate “A” Graded Hospitals

Suggestions for using these letters in your market:

- **Make it your own.** Although we provide this template messaging, we strongly encourage Regional Leaders to customize these letters to meet your specific market’s needs by inserting relevant regional statistics and other information that will appeal to local facilities.
- **Don’t forget health system leaders.** You may wish to send a letter to a health system contact in your area. This can be an effective strategy to increase participation in your market. We strongly encourage you to customize the letters per system so they have a clear picture of how reporting to the Surveys can benefit them and understand how you will use their results, as well as to remind them about the ASC Survey and outpatient section of the Hospital Survey.
- **Print on your letterhead.** We suggest printing the letters on your organization’s letterhead or perhaps creating a new letterhead if multiple Regional Leaders are collectively requesting hospital participation in a certain area. Have the letter signed by your CEO or Executive Director. Also consider including the Leapfrog Regional Leader logo.
- **Co-signers help.** Consider having multiple purchasers/payors with lives/enrollees in your region co-sign the letter. The more parties you can get to sign on to this letter, the better. Some coalitions also include a second page that lists all their employer members showing they represent their interests in asking for participation.
- **Cite how you will use Leapfrog data.** Describe to your hospitals how you plan to use the data (such as in a consumer guide) and how payors are planning to use or are currently using Leapfrog’s Survey data (e.g., value-based purchasing program, high performance network determination, consumer directory). Examples are listed in the template letters below.
- **Reminders help.** Leading up to June 30, it’s a good idea to send an email reminder to all facilities that the deadline is approaching and you’re looking forward to their participation by the submission deadline.
- **Prompt more Survey responses with a fall follow-up.** Many Regional Leaders have found tremendous success in sending a second mailing to non-participating facilities in early fall; this can be an effective strategy to increase participation by facilities that missed the June 30 submission deadline but still have time before the November 30 late submission deadline.

TEMPLATE LETTER/EMAIL FOR CURRENTLY SUBMITTING HOSPITALS

[Date]
[Prefix] [First] [Last]
Chief Executive Officer
[Facility Name]
[Street Address]
[City, State, ZIP]
Dear [CEO Name]:

On behalf of [REGIONAL LEADER ORGANIZATION] and our [NUMBER] members including [CONSIDER NAMING A FEW BIG NAMES HERE IF YOU DON'T KNOW THIS HOSPITAL WELL], we are writing to request your participation in the 2025 Leapfrog Hospital Survey, which opens on April 1. We, along with our entire community, appreciate your past participation and look forward to your continued dedication to transparency.

In 2024, more than 2,400 hospitals participated, representing 80% of inpatient beds nationwide. [INSERT STAT SUCH AS PERCENT INCREASE IN HOSPITALS PARTICIPATING IN 2024 SURVEY, OR PERCENTAGE OF HOSPITALS THAT PARTICIPATE LOCALLY].

This year marks **Leapfrog's 25th Anniversary** and the **25th year of the Leapfrog Hospital Survey**—a vital tool for health care transparency. Your participation is essential. For 25 years, hospitals have helped drive safer, higher-quality care through Leapfrog. Let's make this milestone year our strongest yet—thank you for your commitment!

By participating in the Leapfrog Hospital Survey, your hospital can:

1. **Demonstrate your responsiveness to employers in our community who depend on your services**
2. **Benchmark your performance on quality and safety metrics and create a performance improvement plan**
3. **Receive public recognition by [REGIONAL LEADER] for your transparency and performance**
4. **Be eligible for awards programs such as Leapfrog Top Hospital**
5. **Ensure your most up-to-date performance is reflected in your Leapfrog Hospital Safety Grade (if applicable)**
6. **Demonstrate your commitment to quality and safety improvement to our community, including your staff and board**

Leapfrog's public reporting website, ratings.leapfroggroup.org, allows users to search for and compare hospital and ASC ratings to better understand safety and quality across facilities. Purchasers in [REGION] intend to share these results with their employees and use your performance metrics as part of their value strategy.

You may use the same security code you used for previous Surveys. If you need a copy of your security code, please complete and submit Leapfrog's Security Code Request form: <http://bit.ly/HospitalSecurityCode>. Though the deadline to complete the Survey is June 30, you can resubmit your Survey at any time throughout the Survey cycle; publicly reported results are updated monthly. For hospitals that do not meet the deadline, late submissions are accepted through November 30, and until then, incomplete sections are reported as "Declined to Respond."

Visit www.LeapfrogGroup.org/Hospital to begin today. Leapfrog hosts Town Hall Calls to provide background information about the content of the Survey. Register and learn more at <https://www.leapfroggroup.org/survey-materials/town-hall-calls>. Please contact me at [insert lead tel #] if you have any questions about the reporting process and Leapfrog's activity in our region. The Leapfrog Help Desk is available for any technical or content questions about the Survey and can be accessed at <https://leapfroghelpdesk.zendesk.com>.

Sincerely,

[LEAD REGIONAL LEADER]

TEMPLATE LETTER FOR HOSPITALS NEW TO THE SURVEY

[Date]
[Prefix] [First] [Last]

Chief Executive Officer
[Facility Name]
[Street Address]
[City, State, ZIP]

Dear [CEO Name]:

On behalf of [REGIONAL LEADER ORGANIZATION] and our [NUMBER] members including [CONSIDER NAMING A FEW BIG NAMES HERE IF YOU DON'T KNOW THIS HOSPITAL WELL], we are writing to strongly encourage you to participate in the 2025 Leapfrog Hospital Survey which opens on April 1. We, along with our entire community, are looking for your hospital to commit to transparency by reporting on your safety and quality performance. Pandemic setbacks have propelled the issue of patient safety as a national priority. It is more important than ever to participate in Leapfrog's critical patient safety efforts to demonstrate your commitment to quality and safety.

In 2024, more than 2,400 hospitals participated, representing 80% of inpatient beds nationwide. [INSERT STAT SUCH AS PERCENT INCREASE IN HOSPITALS PARTICIPATING IN 2024 SURVEY, OR PERCENTAGE OF HOSPITALS THAT PARTICIPATE LOCALLY].

This year marks **Leapfrog's 25th Anniversary** and the **25th year of the Leapfrog Hospital Survey**—a vital tool for health care transparency. Your participation is essential. For 25 years, hospitals have helped drive safer, higher-quality care through Leapfrog. Purchasers feel that your participation is more vital than ever for our region so we can achieve real progress toward a safer, higher-quality, more transparent health care system for all.

By participating in the Leapfrog Hospital Survey, your hospital can:

1. **Demonstrate your responsiveness to employers in your community who depend on your services**
2. **Benchmark your performance on quality and safety metrics and create a performance improvement plan**
3. **Receive public recognition by [REGIONAL LEADER] for your transparency and performance**
4. **Be eligible for awards programs such as Leapfrog Top Hospital**
5. **Ensure your most up-to-date performance is reflected in your Leapfrog Hospital Safety Grade (if applicable)**
6. **Demonstrate your commitment to quality and safety improvement to our community, including your staff and board**

Leapfrog's public reporting website, www.ratings.leapfroggroup.org, allows users to search for and compare both hospital and ASC ratings to better understand safety and quality across facilities. Purchasers in [REGION] intend to share these results with their employees and use your performance metrics as part of their value strategy.

To receive the security code needed to complete the Survey, please complete and submit the Security Code Request form: <http://bit.ly/HospitalSecurityCode>. Though the deadline to complete the Survey is June 30, you can resubmit your Survey at any time throughout the Survey cycle; publicly reported results are updated monthly. For hospitals that do not meet the submission deadline, late submissions are accepted through November 30, and until then, incomplete sections are reported as "Declined to Respond."

Visit www.LeapfrogGroup.org/Hospital to begin today. Leapfrog hosts Town Hall Calls to provide background information about the content of the Survey. Register and learn more at <https://www.leapfroggroup.org/survey-materials/town-hall-calls>. Please contact me at [insert lead tel #] if you have any questions about the reporting process and Leapfrog's activity in our region. The Leapfrog Help Desk is available for any technical or content questions about the Survey and can be accessed at <https://leapfroghelpdesk.zendesk.com>.

Sincerely, [LEAD REGIONAL LEADER]

TEMPLATE LETTER/EMAIL FOR SYSTEM-LEVEL EXECUTIVES ON THE HOSPITAL AND ASC SURVEYS

[Date]

[Prefix] [First] [Last]
Chief Executive Officer
[ASC Name]
[Street Address]

[City, State, ZIP]

Dear [CEO Name]:

On behalf of [REGIONAL LEADER] and our [NUMBER] members including [CONSIDER NAMING A FEW BIG NAMES HERE IF YOU DON'T KNOW THIS HOSPITAL/ASC/SYSTEM WELL], we are writing to strongly encourage [all facilities within HEALTH SYSTEM NAME] [or: your facility] to participate in the 2025 Leapfrog Surveys, which open on April 1. Inpatient hospitals and hospital outpatient departments are invited to participate in the Leapfrog Hospital Survey and ambulatory surgery centers are invited to participate in the Leapfrog ASC Survey.

More than 2,400 hospitals submitted a Survey in 2024, accounting for 80% of inpatient beds across the country. [INSERT STAT SUCH AS NAMES OF HEALTH SYSTEMS/ASCs THAT PARTICIPATE IN YOUR REGION].

This year marks **Leapfrog's 25th Anniversary** and the **25th year of the Leapfrog Hospital Survey**—a vital tool for health care transparency. Your participation is essential. For 25 years, hospitals have helped drive safer, higher-quality care through Leapfrog. Purchasers feel that your participation is more vital than ever for our region so we can achieve real progress toward a safer, higher-quality, more transparent health care system for all.

By participating in the Leapfrog Surveys, your [system/facility] can:

1. **Demonstrate your responsiveness to employers in our community who depend on your services**
2. **Access customized analytics comparing performance between facilities in your system**
3. **Benchmark your performance on quality and safety metrics and create a performance improvement plan**
4. **Receive public recognition by [REGIONAL LEADER] for your transparency and performance**
5. **Be eligible for awards programs such as Leapfrog Top Hospital and Top ASC**
6. **Ensure your most current performance is reflected in your Leapfrog Hospital Safety Grades (if applicable)**
7. **Demonstrate your commitment to quality and safety improvement to our community, including your staff and board**

Leapfrog's public reporting website, www.ratings.leapfroggroup.org, allows users to search for and compare hospital and ASC ratings to better understand safety and quality across facilities. Purchasers in [REGION] intend to share these results with their employees and use your performance metrics as part of their value strategy.

If your facilities participated in the Survey before, their security code has not changed. If a facility needs a copy of its security code, please complete and submit the Security Code Request form: FOR HOSPITALS <http://bit.ly/HospitalSecurityCode>, FOR ASCs <http://bit.ly/ASCSecurityCode>. Though the deadline to complete the Survey is June 30, you can resubmit your Survey at any time throughout the Survey cycle; publicly reported results are updated monthly. For hospitals and ASCs that do not meet the deadline, late submissions are accepted through November 30. Incomplete sections are reported as "Declined to Respond."

Visit www.LeapfrogGroup.org for more information and please contact me for details on [REGIONAL LEADER's] commitment to employers and purchasers.

Sincerely,

[LEAD REGIONAL LEADER]

TEMPLATE LETTER/EMAIL FOR ASC SURVEY PARTICIPATION

[Date]

[Prefix] [First] [Last]

Chief Executive Officer

[Facility Name]

[Street Address]

[City, State, ZIP]

Dear [CEO/ASC Administrator Name]:

On behalf of the over [NUMBER] employer members of [REGIONAL LEADER], representing [NUMBER] lives and \$[AMOUNT] in annual claims, we are writing to request your ambulatory surgical center's participation in the 2025 Leapfrog Ambulatory Surgery Center (ASC) Survey. As a coalition of employers who invest in the health and well-being of our employees, we feel that your participation in the Leapfrog ASC Survey is vital for our community so we can achieve real progress toward a safer, higher-quality, more transparent health care system for all.

2025 marks the seventh year of the Leapfrog ASC Survey. This year also marks the 25th anniversary of The Leapfrog Group, an independent national nonprofit dedicated to collecting and publicly reporting patient safety and quality data from health care facilities. All ASCs in the United States are invited to participate in the annual Leapfrog ASC Survey, free of charge. Our employer members use results from the Leapfrog Surveys to inform benefit design, patient referral preferences and direct contracting considerations. Your ASC can be included in these evaluations by participating in the Leapfrog ASC Survey.

By participating in the Leapfrog ASC Survey, your surgery center can also:

1. **Demonstrate your responsiveness to employers in our community who depend on your services**
2. **Benchmark your performance on quality and safety metrics**
3. **Receive public recognition by [REGIONAL LEADER] for your transparency and performance**
4. **Be eligible for awards programs such as Leapfrog Top ASC**
5. **Demonstrate your commitment to quality and safety improvement to our community, including your staff and board**

Leapfrog's public reporting website, www.ratings.leapfroggroup.org, allows users to search for and compare both hospital and ASC ratings to better understand safety and quality across facilities. Purchasers in [REGION] intend to share these results with their employees and use your performance in their strategy to direct their employees to the safest, most cost-effective options. Like all of Leapfrog's programs, the ASC Survey measures are evidence-based, grounded in the latest science and developed with guidance from Leapfrog's national expert panel and the Armstrong Institute for Patient Safety and Quality at Johns Hopkins Medicine.

The ASC Survey is **narrowly tailored** to the targeted care that surgery centers deliver – with half as many measures as the Hospital Survey. To submit an ASC Survey, you are only responsible for providing data applicable to your practice – sections of the Survey having to do with surgeries you don't perform can be skipped and will not penalize your publicly reported results.

To access your personalized Survey profile, please complete and submit the Security Code Request form: <http://bit.ly/ASCSecurityCode>. Though the deadline to complete the Survey is June 30, you can resubmit your Survey at any time throughout the Survey cycle to reflect the latest data; publicly reported results are updated monthly. For ASCs that don't meet the submission deadline, late submissions are accepted through November 30.

Please visit <http://www.leapfroggroup.org/asc> to learn more, and contact Leapfrog's Help Desk for an individual orientation to the Survey. There is never any charge for participation in Leapfrog Surveys.

We strongly recommend that you participate in the 2025 Leapfrog ASC Survey. You will derive great value from the process, and our coalition of employers in [REGION] will appreciate your responsiveness and transparency.

Sincerely, [LEAD REGIONAL LEADER]

E. TEMPLATE EMAIL HOSPITAL PARTICIPATION REMINDER

To: [Hospital Executive]
From: [Regional Leader]
Subject: Leapfrog Hospital Survey reminder

Dear [CEO Name]:

As a follow-up to the formal invitation letter sent to your hospital earlier this spring, I am writing to remind you about the approaching June 30 submission deadline for the 2025 Leapfrog Hospital Survey.

This year marks **Leapfrog's 25th Anniversary** and the **25th year of the Leapfrog Hospital Survey**—a vital tool for health care transparency. Your participation is essential. For 25 years, hospitals have helped drive safer, higher-quality care through Leapfrog. Purchasers feel that your participation is more vital than ever for our region so we can achieve real progress toward a safer, higher-quality, more transparent health care system for all.

By participating in the Leapfrog Hospital Survey, you can see how your hospital performs on quality and safety metrics available from no other source and compare your performance to the other hospitals in our area and nationally. Your hospital can also:

- 1. Demonstrate your responsiveness to employers and other purchasers in our community, who depend on your services and expect transparency and candor**
- 2. Benchmark your performance nationally, regionally and locally on important quality and safety issues**
- 3. Receive public recognition by [REGIONAL LEADER] for your performance achievements [CONSIDER INSERTING SPECIFIC WAYS YOU & YOUR MEMBERS USE LEAPFROG DATA/RECOGNIZE LOCAL HOSPITALS]**
- 4. Create a performance improvement plan by charting your year-over-year progress on the Survey**
- 5. Demonstrate your commitment to quality and safety improvement to our community, as well as your staff and board**

Leapfrog's public reporting website, www.ratings.leapfroggroup.org, allows users to search for and compare both hospital and ASC ratings to better understand safety and quality across facilities. Purchasers in [REGION] intend to share these results with their employees and use your performance metrics as part of their value strategy. Performance for participating facilities is posted and those that do not participate are indicated as "Declined to Respond."

Participation in the Survey and accessing the results is always free. You may use the same security code you used for previous Surveys. If you need a copy of your security code, please complete and submit the Security Code Request form: <http://bit.ly/HospitalSecurityCode>. We look forward to your participation before the June 30 submission deadline. You can resubmit your Survey at any time throughout the Survey cycle; publicly reported results are updated monthly. For hospitals that don't meet the deadline, late submissions are accepted through November 30, and until then, incomplete sections are reported as "Declined to Respond."

Thank you once again for responding to the requests of purchasers in our region and for taking the time to complete the Leapfrog Hospital Survey.

Sincerely,
[LEAD REGIONAL LEADER]

F. TEMPLATE THANK YOU LETTER/EMAIL FOR HOSPITAL CEOS

[Date]

[Prefix] [First] [Last]
Chief Executive Officer
[Facility Name]
[Street Address]
[City, State, ZIP]

Dear [CEO Name]:

I am writing to thank you for participating in the 2025 Leapfrog Hospital Survey. On behalf of our [NUMBER] members including [CONSIDER NAMING A FEW BIG NAMES HERE IF YOU DON'T KNOW THIS HOSPITAL WELL], we commend your commitment to transparency demonstrated through your participation.

[REGIONAL LEADER ORGANIZATION NAME] will share this information with our community to assure recognition for **your performance achievements and improvements**. [CONSIDER INSERTING SPECIFIC WAYS YOU & YOUR MEMBERS USE LEAPFROG DATA/RECOGNIZE LOCAL HOSPITALS]

This year marks **Leapfrog's 25th Anniversary** and the **25th year of the Leapfrog Hospital Survey**—a vital tool for health care transparency. Your participation is essential. Thank you for being part of this movement to drive safer, higher-quality care through Leapfrog participation.

As a reminder, Leapfrog Hospital Survey results will be available in July at www.Ratings.LeapfrogGroup.org and are updated monthly. Data collected from the section of the Hospital Survey on outpatient procedures will be publicly reported by facility alongside data from the Leapfrog Ambulatory Surgery Center Survey.

Thank you once again for your investment in improving the health of [REGION] and for taking the time to complete the Leapfrog Hospital Survey. We commend your leadership and look forward to other hospitals in our community following your example.

Sincerely,
[LEAD REGIONAL LEADER]

G. TEMPLATE THANK YOU LETTER/EMAIL FOR ASC ADMINISTRATORS

[Date]

<NAME>
Administrator

<Organization Name>
<Mailing-Street Address>
<Mailing-City>, <Mailing-State> <Mailing-Postal Code>

Dear <NAME>:

I am writing to thank you for participating in the 2024 Leapfrog ASC Survey. On behalf of our [NUMBER] members including [CONSIDER NAMING A FEW BIG NAMES HERE IF YOU DON'T KNOW THIS ASC WELL], we commend your commitment to transparency demonstrated through your participation.

This year marks **Leapfrog's 25th Anniversary** and the seventh year of the Leapfrog ASC Survey. Thank you for being part of this movement to drive safer, higher-quality care through Leapfrog participation.

[REGIONAL LEADER ORGANIZATION NAME] will share this information with our community to assure recognition for **your performance achievements and improvements**. [CONSIDER INSERTING SPECIFIC WAYS YOU & YOUR MEMBERS USE LEAPFROG DATA/RECOGNIZE LOCAL ASCs]

As a reminder, Leapfrog ASC Survey results will be available in July at www.Ratings.LeapfrogGroup.org and are updated monthly. Data collected from your facility will be posted alongside results of the Leapfrog Hospital Survey's section on outpatient procedures, so that you can compare your performance to that of other groups offering similar services in your area.

Look out for your free benchmarking report, which will be sent in January 2026. This report offers a comparison of your performance against ASCs nationwide, as well as hospital outpatient departments. Your benchmarking performance is **not** publicly reported; but you are certainly free to share that information internally to identify areas of excellence to build on, and opportunities for improvement.

We commend your leadership and look forward to other ASCs in our community following your example. Thank you once again for your investment in improving the health of [REGION].

Sincerely,

[LEAD REGIONAL LEADER]

H. TEMPLATE LETTER/EMAIL FOR SECOND HOSPITAL SURVEY MAILING IN HIGH-PARTICIPATION STATES

[Date]

[Prefix] [First] [Last]
Chief Executive Officer
[Facility Name]
[Street Address]
[City, State, ZIP]

Dear [CEO Name]:

As a follow-up to my initial outreach, I am writing to again ask your hospital to complete the 2025 Leapfrog Hospital Survey. This year marks **Leapfrog's 25th Anniversary** and the **25th year of the Leapfrog Hospital Survey**—a vital tool for health care transparency. Your participation is essential.

So far this year, almost [X,XXX] hospitals nationwide have completed the Leapfrog Hospital Survey in response to purchasers' request for increased transparency. In our state, over [X%] of hospitals have completed a 2025 Survey. I strongly urge you to follow the leadership demonstrated by your colleagues and ensure your hospital is not one of the few non-participating hospitals in this region.

By participating in the Leapfrog Hospital Survey, you can see how you perform on quality and safety metrics available from no other source and compare your performance to the other hospitals in our area and nationally. Your hospital can also:

1. **Demonstrate your responsiveness to employers and other purchasers in our community, who depend on your services and expect transparency and candor**
2. **Receive public recognition by [REGIONAL LEADER] for your performance achievements [CONSIDER INSERTING SPECIFIC WAYS YOU & YOUR MEMBERS USE LEAPFROG DATA/RECOGNIZE LOCAL HOSPITALS]**
3. **Create a performance improvement plan by charting your year-over-year progress on the Survey**
4. **Demonstrate your commitment to quality and safety improvement to our community, as well as your staff and board**

Leapfrog's public reporting website, www.ratings.leapfroggroup.org, allows users to search for and compare both hospital and ASC ratings to better understand safety and quality across facilities. Performance for participating facilities is posted and those that do not participate are indicated as "Declined to Respond." Purchasers in [REGION] will be sharing these results with their employees and dependents and use your performance metrics as part of their value strategy.

Participation in the Survey and accessing the results is always free. *If you have participated in the Survey before, your security code has not changed. If you need a copy of your security code, please complete and submit the Security Code Request form: <http://bit.ly/HospitalSecurityCode>.* The late submission deadline for Survey completion is **November 30**. You can resubmit your Survey at any time throughout the Survey cycle; publicly reported results are updated monthly.

Thank you once again for your investment in improving the health of our [REGION] and for taking the time to complete the Leapfrog Hospital Survey.

Sincerely,
[LEAD REGIONAL LEADER]

I. TEMPLATE LETTER/EMAIL FOR SECOND HOSPITAL SURVEY MAILING IN LOW-PARTICIPATION STATES

[Date]

[Prefix] [First] [Last]
Chief Executive Officer
[Facility Name]
[Street Address]
[City, State, ZIP]

Dear [CEO Name]:

As a follow-up to my initial outreach, I am writing to again ask your hospital to complete the 2025 Leapfrog Hospital Survey. This year marks **Leapfrog's 25th Anniversary** and the **25th year of the Leapfrog Hospital Survey**—a vital tool for health care transparency. Your participation is essential.

So far this year, almost [X,XXX] hospitals nationwide have completed the Leapfrog Hospital Survey in response to purchasers' request for increased transparency. I strongly urge you to follow the leadership demonstrated by your colleagues and heed our call for participation.

By participating in the Leapfrog Hospital Survey, you can see how you perform on quality and safety metrics available from no other source and compare your performance to the other hospitals in our area and nationally. Your hospital can also:

1. **Demonstrate your responsiveness to employers and other purchasers in our community, who depend on your services and expect transparency and candor**
2. **Receive public recognition by [REGIONAL LEADER] for your performance achievements [CONSIDER INSERTING SPECIFIC WAYS YOU & YOUR MEMBERS USE LEAPFROG DATA/RECOGNIZE LOCAL HOSPITALS]**
3. **Create a performance improvement plan by charting your year-over-year progress on the Survey**
4. **Demonstrate your commitment to quality and safety improvement to our community, as well as your staff, clinicians and board**

Leapfrog's public reporting website, www.ratings.leapfroggroup.org, allows users to search for and compare hospital and ASC ratings to better understand safety and quality across facilities. Performance for participating facilities is posted and those that do not participate are indicated as "Declined to Respond." Purchasers in [REGION] will be sharing these results with their employees and dependents and use your performance metrics as part of their value strategy.

Participation in the Survey and accessing the results is always free. *If you have participated in the Survey before, your security code has not changed. If you need a copy of your security code, please complete and submit the Security Code Request form: <http://bit.ly/HospitalSecurityCode>.* The late submission deadline for Survey completion is **November 30**. You can resubmit your Survey at any time throughout the Survey cycle; publicly reported results are updated monthly.

Thank you once again for your investment in improving the health of our [REGION] and for taking the time to complete the Leapfrog Hospital Survey.

Sincerely,
[LEAD REGIONAL LEADER]

J. TEMPLATE LETTER/EMAIL CURRENTLY SUBMITTING ASCS

[Date]

[Prefix] [First] [Last]
Chief Executive Officer
[Facility Name]
[Street Address]
[City, State, ZIP]

Dear [CEO/ASC Administrator Name]:

On behalf of the over [NUMBER] employer members of [REGIONAL LEADER], representing [NUMBER] lives and \$(AMOUNT) in annual claims, we are writing to request your ambulatory surgical center's participation in the 2025 Leapfrog Ambulatory Surgery Center (ASC) Survey. We, along with our entire community, appreciate your past participation and look forward to your continued dedication to transparency. As a coalition of employers who invest in the health and well-being of our employees, we feel that your participation

in the Leapfrog ASC Survey is vital for our community so we can achieve real progress towards a safer, higher-quality, more transparent health care system for all. The Leapfrog ASC Survey is your opportunity to demonstrate your commitment to transparency.

2025 marks the seventh year of the Leapfrog ASC Survey on patient safety and quality. This year also marks the 25th anniversary of The Leapfrog Group, an independent national nonprofit dedicated to collecting and publicly reporting patient safety and quality data from health care facilities. All ASCs in the United States are invited to participate in the annual Leapfrog ASC Survey, free of charge. Our employer members use results from the Leapfrog Surveys to inform benefit design, patient referral preferences and direct contracting considerations. Your ASC can be included in these evaluations by participating in the Leapfrog ASC Survey.

By participating in the Leapfrog ASC Survey, your surgery center can:

1. **Demonstrate your responsiveness to employers in our community who depend on your services**
2. **Benchmark your performance on quality and safety metrics**
3. **Receive public recognition by [REGIONAL LEADER] for your transparency and performance**
4. **Be eligible for awards programs such as Leapfrog Top ASC**
5. **Demonstrate your commitment to quality and safety improvement to our community, including your staff and board**

Leapfrog's public reporting website, www.ratings.leapfroggroup.org, allows users to search for and compare both hospital and ASC ratings to better understand safety and quality across facilities. Purchasers in [REGION] intend to share these results with their employees and use your performance metrics as part of their value strategy. Like all of Leapfrog's programs, the ASC Survey measures are evidence-based, grounded in the latest science and developed with guidance from Leapfrog's national expert panel and the Armstrong Institute for Patient Safety and Quality at Johns Hopkins Medicine.

The ASC Survey is **narrowly tailored** to the targeted care that surgery centers deliver – with half as many measures as the Hospital Survey. To submit an ASC Survey, you are only responsible for providing data applicable to your practice – sections of the Survey having to do with surgeries you don't perform can be skipped and will not penalize your publicly reported results.

You may use the same security code you used for previous Surveys. If you need a copy of your security code, please complete and submit the Security Code Request form: <http://bit.ly/ASCSecurityCode>. Though the deadline to complete the Survey is June 30 you can resubmit your Survey at any time throughout the Survey cycle; publicly reported results are updated monthly. For ASCs that don't meet the submission deadline, late submissions are accepted through November 30.

Please visit <http://www.leapfroggroup.org/asc> to learn more, and contact Leapfrog's Help Desk for an individual orientation to the Survey. There is never any charge for participation in Leapfrog Surveys.

We strongly recommend your participation in the 2025 Leapfrog ASC Survey. You will derive great value from the process, and our coalition of employers in [REGION] will appreciate your responsiveness and transparency.

Sincerely, [LEAD REGIONAL LEADER]

K. TEMPLATE LETTER/EMAIL FOR HEALTH PLANS: HOSPITALS

[Date]

[Chief Executive Officer]

[Hospital Name]

[Mailing Address]

[City], [State] [ZIP Code]

Dear [Chief Executive Officer]:

On behalf of our employer and purchaser clients, we are writing to urge you to participate in the 2025 Leapfrog Hospital Survey. We feel that your participation in the Survey is vital for your community so we can achieve real progress toward a safer, higher-quality, more transparent health care system for all.

More than 2,400 hospitals submitted a Survey in 2024, accounting for 80% of inpatient beds across the country. Our company, along with employers and other purchasers, consumers and industry leaders, use the Survey Results to make informed choices about hospitals from which to seek care. Without your Survey participation we will not have this critical data on the quality and safety of the care your hospital provides.

For 25 years, The Leapfrog Group has been collecting and publicly reporting patient safety and quality information about health care facilities. Leapfrog continues to report unique data that matters most to employers, purchasers, payors and consumers. Furthermore, measures on the Leapfrog Hospital Survey are evidence-based, grounded in the latest science and developed with guidance from Leapfrog's national expert panels and the Johns Hopkins Armstrong Institute for Patient Safety and Quality.

Please visit <http://www.leapfroggroup.org/hospital> to learn more. The deadline for completion is June 30. There is never any charge for participation in Leapfrog Surveys.

We strongly recommend your participation in the 2025 Leapfrog Hospital Survey. Leapfrog is the gold standard in health care transparency, which is why it is important to us that your facility participates. Thank you for your consideration of our request.

Sincerely,

[Your Signature here]

L. TEMPLATE LETTER/EMAIL FOR HEALTH PLANS: ASCS

[Date]

[Chief Executive Officer]

[ASC Name]

[Mailing Address]

[City], [State] [ZIP Code]

Dear [Chief Executive Officer]:

On behalf of our employer and purchaser clients, we are writing to urge you to participate in the 2025 Leapfrog Ambulatory Surgery Center (ASC) Survey. Payors, employers and purchasers use the Leapfrog ASC Survey to inform patient referral preferences, benefit designs and direct contracting considerations. Without your Survey participation, we will not have this critical data on your quality and safety performance.

We feel that your participation in the Leapfrog ASC Survey is vital for our community so we can achieve real progress toward a safer, higher-quality, more transparent health care system. This has never been more important than now when surgery centers are growing exponentially as a share of the health care market.

2025 marks the seventh year of the Leapfrog ASC Survey on patient safety and quality. The Leapfrog Group is a 25-year-old independent national nonprofit collecting and publicly reporting patient safety and quality information about health care facilities. All ASCs in the United States have the opportunity to participate in the annual Leapfrog ASC Survey. Survey results are reported on Leapfrog's public reporting website, <https://ratings.leapfroggroup.org>, where users can search for and compare hospital and ASC ratings to better understand safety and quality across facilities.

Like all of Leapfrog's programs, the ASC Survey measures are evidence-based, grounded in the latest science and developed with guidance from Leapfrog's national expert panel and the Johns Hopkins Armstrong Institute for Patient Safety and Quality.

The ASC Survey is **narrowly tailored** to the targeted care that surgery centers deliver – with half as many measures as the Hospital Survey. To submit an ASC Survey, you are only responsible for providing data applicable to your practice – sections of the Survey having to do with surgeries you don't perform can be skipped, and will not penalize your publicly reported results.

Please visit <http://www.leapfroggroup.org/asc> to learn more. The deadline for completion is June 30. There is never any charge for participation in Leapfrog Surveys.

We strongly recommend your participation in the 2025 Leapfrog ASC Survey. Leapfrog is the gold standard in health care transparency, which is why it is important to us that your facility participates. Thank you for your consideration of our request.

Sincerely,

[Your Signature here]

M. TEMPLATE LETTER/EMAIL TO CONGRATULATE A TOP HOSPITAL CEO

[Date]

[Prefix] [First] [Last]

Chief Executive Officer

[Facility Name]

[Street Address]

[City, State, ZIP]

Dear [CEO Name]:

Congratulations on [Facility Name] earning a **2025 Leapfrog Top Hospital**, a recognition that places your hospital among an elite group of healthcare institutions nationwide. On behalf of our [NUMBER] members including [CONSIDER NAMING A FEW BIG NAMES HERE IF YOU DON'T KNOW THIS HOSPITAL WELL], we commend your commitment to patient safety.

[REGIONAL LEADER ORGANIZATION NAME] will share this information with our community to ensure recognition of **your performance achievements. [CONSIDER INSERTING SPECIFIC WAYS YOU & YOUR MEMBERS USE LEAPFROG DATA/RECOGNIZE LOCAL HOSPITALS]**

This recognition is a testament to your unwavering commitment to patient safety and dedication to providing the highest care possible. We hope you will share this achievement publicly so your community is reassured that you put your patients first. This recognition reflects well on your institutional culture and tells prospective employees, patients, and clinicians that your hospital is a leader in keeping patients safe.

On behalf of [REGIONAL LEADER ORGANIZATION NAME], our Board of Directors, and our employer and purchaser members committed to giant leaps forward for patient safety, we applaud you and thank you sincerely for your commitment to the well-being of your patients.

Sincerely,

[LEAD REGIONAL LEADER]

N. TEMPLATE LETTER/EMAIL TO CONGRATULATE SAFETY GRADE A HOSPITAL CEO

[Date]

[Prefix] [First] [Last]
Chief Executive Officer
[Facility Name]
[Street Address]
[City, State, ZIP]

Dear [CEO Name]:

Congratulations on [Facility Name] earning an "A" for the fall 2024 Leapfrog Hospital Safety Grade. On behalf of our [NUMBER] members including [CONSIDER NAMING A FEW BIG NAMES HERE IF YOU DON'T KNOW THIS HOSPITAL WELL], we commend your commitment to patient safety.

[REGIONAL LEADER ORGANIZATION NAME] will share this information with our community to ensure recognition of **your performance achievements**. **[CONSIDER INSERTING SPECIFIC WAYS YOU & YOUR MEMBERS USE LEAPFROG DATA/RECOGNIZE LOCAL HOSPITALS]**

This recognition is a testament to your unwavering commitment to patient safety and dedication to providing the highest care possible. We hope you will share this achievement publicly so your community is reassured that you put your patients first. Your "A" grade reflects well on your institutional culture and tells prospective employees, patients, and clinicians that your hospital is a leader in keeping patients safe.

On behalf of [REGIONAL LEADER ORGANIZATION NAME], our Board of Directors, and our employer and purchaser members committed to giant leaps forward for patient safety, we applaud you and thank you sincerely for your commitment to the well-being of your patients.

Sincerely,
[LEAD REGIONAL LEADER]

O. TEMPLATE LETTER/EMAIL TO CONGRATULATE A TOP ASC CEO

[Date]

[Prefix] [First] [Last]
Chief Executive Officer
[Facility Name]
[Street Address]
[City, State, ZIP]

Dear [Chief Executive Officer Name]:

Congratulations on [Facility Name] earning a **2025 Leapfrog Top Ambulatory Surgery Center (ASC) a recognition** that places your ASC among an elite group of healthcare institutions nationwide. On behalf of our [NUMBER] members including [CONSIDER NAMING A FEW BIG NAMES HERE IF YOU DON'T KNOW THIS HOSPITAL WELL], we commend your commitment to patient safety.

[REGIONAL LEADER ORGANIZATION NAME] will share this information with our community to ensure recognition of **your performance achievements. [CONSIDER INSERTING SPECIFIC WAYS YOU & YOUR MEMBERS USE LEAPFROG DATA/RECOGNIZE LOCAL HOSPITALS]**

This recognition is a testament to your unwavering commitment to patient safety and dedication to providing the highest care possible. We hope you will share this achievement publicly so your community is reassured that you put your patients first. This recognition reflects well on your institutional culture and tells prospective employees, patients, and clinicians that your hospital is a leader in keeping patients safe.

On behalf of [REGIONAL LEADER ORGANIZATION NAME], our Board of Directors, and our employer and purchaser members committed to giant leaps forward for patient safety, we applaud you and thank you sincerely for your commitment to the well-being of your patients.

Sincerely,
[LEAD REGIONAL LEADER]

COMMON OBJECTIONS AND FREQUENTLY ASKED QUESTIONS ABOUT LEAPFROG AND ITS RATINGS

All Leapfrog leaders should be conversant in the issues that arise frequently during the campaign for Survey participation. The common objections and FAQs resource is available for you to familiarize yourself and prepare for conversations with providers and other groups you speak with about Leapfrog.

The Leapfrog Group is a national nonprofit organization that serves as a voice for health care consumers and purchasers, using their collective influence to foster positive change in U.S. health care. The flagship Leapfrog Hospital Survey and Leapfrog Ambulatory Surgery Center (ASC) Survey collect and transparently report hospital and ASC performance, empowering purchasers to find the highest-value care and giving consumers the lifesaving information they need to make informed decisions. The Leapfrog Hospital Safety Grade, Leapfrog's other main initiative, assigns letter grades to hospitals based on their record of patient safety, helping consumers protect themselves and their families from errors, injuries, accidents, and infections.

The following charts detail responses to the common objections and frequently asked questions hospitals and ASCs may have about Leapfrog and its ratings.

COMMON OBJECTIONS TO PARTICIPATING IN LEAPFROG SURVEYS

Objection	Response
"We do not want to participate in the Survey this year because of the nursing standards. Our hospital, and hospitals nationwide, are facing unprecedented staffing shortages, and the new nursing standards will be impossible to achieve."	Nursing care is a core element to ensure safe patient care in hospitals, and national data suggests variation among hospitals on the impact of the nurse staffing challenges. With these considerations in mind, Leapfrog will continue to score and publicly report hospital performance on the Total Nursing Care Hours per Patient Day, RN Hours per Patient Day, Nursing Skill Mix, and Percentage of RNs who are BSN-Prepared measures on the 2025 Leapfrog Hospital Survey, but as a reminder, hospitals have the option of responding 'did not measure' and will be publicly reported as "Limited Achievement." All four of the nurse staffing and skill mix measures from the Leapfrog Hospital Survey have decades of published evidence that support their relationship with patient safety outcomes.
"Leapfrog data is self-reported and therefore unreliable."	The integrity of the data we publish and distribute is of utmost importance to Leapfrog. We have many protocols in place to verify the accuracy of our results: • The facility CEO or their designee must complete an Affirmation of Accuracy for each section of the Survey. • The Survey is programmed to detect errors and logic problems and alerts facilities prior to Survey submission. • Each month, Leapfrog conducts an extensive data verification of the responses submitted to the Survey. Quantitative responses are assessed using empirically driven, normative data quality standards. Some facilities are randomly selected to submit further documentation for qualitative measures. • A sample of facilities are selected for on-site verification of results. Note: These processes are outlined in more detail on our website.
"Our effort to promote quality is evidenced by many accolades received within the past year, so we don't need to report to Leapfrog."	We congratulate hospitals and ASCs on the quality awards they have received. However, performing well on other rankings does not explain why the facility is unwilling to report data purchasers are asking for. Transparency means candor—not just about awards and accomplishments but also about challenges. In short, receiving an award for quality or safety is not a suitable substitute for demonstrating transparency to purchasers by responding to the Leapfrog Hospital Survey or Leapfrog ASC Survey.

"All of the information available through Leapfrog is available elsewhere."	Data collected and reported through the Leapfrog Surveys is often harmonized with other entities to make reporting easier for hospitals and ASCs, but the difference is that Leapfrog makes this data public by facility. For example, hospitals report the same C-section measure to Leapfrog that they report to the Joint Commission, but the Joint Commission doesn't make individual hospital C-section rates available to the public. While some measures on the Leapfrog Hospital Survey align with those collected by CMS, CMS often reports at the system level rather than by individual facility; our results demonstrate that there is real difference between facilities even within the same system.
"We concentrate our data collection resources on CMS."	Participation in the Leapfrog Surveys demonstrates a facility's true commitment to transparency because Leapfrog asks hospitals and ASCs to voluntarily report on measures they are not required to report otherwise. These measures matter to purchasers and patients. Voluntarily participating in Leapfrog Surveys demonstrates responsiveness to the community and purchasers.
"We already have a performance improvement and quality standards plan in place and don't need Leapfrog to guide our efforts."	While acknowledging a facility's many areas of strength, no hospital or ASC is perfect, and Leapfrog is a gold standard for excellence. Measures that are unique to Leapfrog should prompt performance improvement efforts on those metrics. All facilities should welcome the opportunity to build trust
"Leapfrog is rarely used by the public or insurance companies anymore."	purchasers and consumers by reporting this information, and purchasers are eager to see the improvements hospitals have made. Leapfrog is more widely used now than ever before. Leapfrog data is used by national and regional health plans in their public reporting and pay-for-performance initiatives. Furthermore, Leapfrog data is included in many of the transparency tools used by employers and purchasers reaching virtually all Americans.
"We believe something on the Survey is not risk-adjusted adequately and/or invalid/unscientific."	Leapfrog's surveys are rigorously evaluated and continuously updated. Leapfrog's Survey team works with faculty at the Armstrong Institute for Patient Safety and Quality at Johns Hopkins Medicine as well as a number of national expert panels to review the evidence and measure specifications for the Surveys each year. Measures are risk-adjusted when appropriate, but many involve things that all hospitals should be doing regardless of the population served. All content is released for public comment annually and updated accordingly. Questions and concerns about measures are always welcomed and considered either through the public comment period or any time in the year by contacting Leapfrog's Help Desk: https://leapfroghelpdesk.zendesk.com/ .
"We disagree with Leapfrog's hand hygiene standard, and it is burdensome."	Leapfrog's hand hygiene standard is modeled primarily after the World Health Organization's (WHO) Hand Hygiene Self-Assessment Framework and adapted to specific issues unique to U.S. hospitals and ambulatory surgery centers (ASCs). Leapfrog has also updated the framework based on existing evidence, models from other organizations such as the CDC and The Joint Commission, and expert opinion from our national Hand Hygiene Expert Panel. There are times when Leapfrog's standards are more stringent than what is set by other organizations, and this is one of them. Leapfrog's intent was to set a standard that meets the challenge of the nation's high rate of healthcare-associated infections. We recognize that we are holding hospitals and ASCs to a higher standard than what is currently required for hand hygiene and many facilities will not be able to fully adhere to the standard, but our intention is that facilities will work toward meeting the standard in the future.

FREQUENTLY ASKED QUESTIONS ON THE LEAPFROG SURVEY

Question	Response

What is the difference between the Leapfrog Hospital Survey and the Leapfrog Hospital Safety Grade?	The Leapfrog Hospital Survey is an annual voluntary survey of safety, quality, and efficiency standards in hospitals. Survey results are publicly reported at https://ratings.leapfroggroup.org. The Leapfrog Hospital Safety Grade is a letter grade rating of A, B, C, D or F assigned to all general hospitals regardless of whether they voluntarily report data to Leapfrog or not. Grades are reported at www.hospitalsafetygrade.org. Data used in the Safety Grade comes primarily from the Leapfrog Hospital Survey and CMS. The Grade also focuses only on safety, while the Survey has a range of measures. More information on the differences between these two programs is available at https://www.hospitalsafetygrade.org/for-hospitals/HospitalFAQ.
Do facilities have to pay to participate in the Surveys? How are Survey results used?	The Leapfrog Hospital Survey and Leapfrog ASC Survey are completely free to participating facilities. Results are also available for free on Leapfrog's websites. Data collected through the Surveys are publicly reported on Leapfrog's websites and used to educate consumers and purchasers about the quality and safety of facilities in their community so that they can choose the best place for care. Employers and purchasers use Survey results to identify the best facilities for their employees' health care needs and work with health plans to design value-based benefits packages that reward the safest and highest quality performers. Health plans and others include Leapfrog data on plan websites and materials as well as in transparency tools.
What is Leapfrog's initiative to rate outpatient care?	For five years, Leapfrog has assessed the quality and safety of procedures performed at ambulatory surgery centers (ASCs) and hospital outpatient procedure departments. 60% of employee procedures take place in the outpatient setting. Leapfrog collects the data through a voluntary Survey of ASCs as well as an outpatient procedure addition to the existing Leapfrog Hospital Survey, which previously covered inpatient care only. Results for both types of facilities are publicly reported at https://ratings.leapfroggroup.org, allowing comparison between both
Does Leapfrog compare procedures performed at ASCs with those performed in hospitals?	Yes. Our goal is to report similar information about both settings. Leapfrog strongly believes that reporting about quality and safety should be patient-centered, and patients seeking a particular procedure do not care about the business entity that houses the operating room; they care about the quality and safety of the procedure. Results for both types of facilities based on similar metrics can be found on Leapfrog's ratings website: https://ratings.leapfroggroup.org.
Where can I go for help?	The Leapfrog Help Desk can assist hospitals and ASCs with highly technical questions, and can be reached through the online Leapfrog Help Desk link or by emailing helpdesk@leapfrog-group.org. Help Desk coverage is 9:00 a.m.–5:00 p.m. ET on business days. The Help Desk is committed to resolving inquiries within two business days, and most inquiries are typically resolved within one day. Regional leaders with questions should reach out directly to Jill Berger. Regional Leaders should respond to questions only when they feel comfortable doing so and steer clear of highly technical questions. Please feel free to refer any hospitals or ASCs directly to the Leapfrog Help Desk for questions, especially those questions related to Survey content or technical problems with the Surveys.

Why should hospitals and ASCs complete the annual Leapfrog Surveys?

By participating in the Leapfrog Surveys, which is free, your facility can:

- Demonstrate your responsiveness to employers in our community who depend on your services
- Benchmark your performance on quality and safety metrics and create a performance improvement plan
- Receive public recognition by local business groups for your transparency and performance.
- Demonstrate your commitment to quality and safety improvement to your community, including your staff and board

LEAPFROG RATINGS VS OTHER RATINGS: WHAT IS THE DIFFERENCE?

Hospitals and health systems are complicated, and no one ratings program captures everything that matters to everyone. Consumers should consult multiple ratings before deciding where to seek care. They should begin with safety, because without safety little else matters: The best surgeon in the world will not be enough to save the patient if they get an infection or the wrong medication following their procedure. Whether it's stitches in the ER or open heart surgery, safety is the foundation of every patient's hospital experience.

Below is a summary of ratings systems and how they compare to Leapfrog.

Rating	Detailed Response
U.S. News & World Report	The U.S. News Honor Roll (including condition-specific honor rolls) focuses on identifying the "best medical centers for the most difficult patients," helping consumers determine which hospitals provide the best care for serious or complicated medical conditions and procedures; it is not a list intended for the average consumer to use to find a hospital for a routine procedure or condition. For patients with complex conditions, the U.S. News ratings are a helpful addition to the Leapfrog Hospital Safety Grade.
CMS Care Compare (Previously Hospital Compare)	CMS includes data on safety, mortality, readmissions, patient experience, effectiveness/timeliness of care, and efficient use of medical imaging. On the Care Compare website, 90% of hospitals are shown as "no different than the national average" for each measure—this lack of variation makes it more difficult for consumers trying to identify the best facility for their care. Leapfrog results show more variation and are more timely.
CMS 5-Star Ratings	CMS offers a 5-star rating aggregating data on safety, mortality, readmissions, patient experience, effectiveness/timeliness of care, and efficient use of medical imaging for each hospital. There is variation among hospitals on number of stars. Safety comprises 22% of the overall star rating, which is why the Hospital Safety Grade—which is 100% safety measures—sometimes differs in its rating of a given hospital.
Healthgrades	Healthgrades publishes several lists of top 50/100/200 hospitals for various areas of care. It runs its own data analysis for many measures rather than using publicly available data. Unlike Leapfrog, they do not collect data from hospitals. Their Best Hospitals list and Patient Safety Excellence Award use different data than Leapfrog uses. For instance, they do not include infection rates, a significant component of the Safety Grade and the Survey. Only high-performing facilities are recognized. They do not call out poor performers like Leapfrog does.
Lown Institute Hospital Index	Lown Institute publishes unique yearly hospital ranking lists, providing hospital grades based on social responsibility. These rankings encompass performance across three domains: Equity, Value,

Vendor-created ratings

and Outcomes. Featured lists include Avoiding Overuse, Community Benefit, Cost Efficiency, Most Racially Inclusive, and Most Socially Responsible. They apply these criteria and examine a range of 3,000–3,700 hospitals based on 54 metrics. Lown uses hospital characteristic data from a variety of sources, including Fiscal Year 2018 American Hospital Association (AHA) annual survey, Medicare Impact File, and the CMS Care Compare database. Users can view hospital grades for each domain publicly reported on a dedicated website as well as view the Lown Institute methodology.

Vendors like Castlight and CareChex by Quantros draw from claims data, CMS, and sometimes Leapfrog to create tools and insights to sell to employers and other stakeholders. Decision-support tools like Castlight are designed for employers to offer to their employees. They consolidate provider metrics with cost information, with many incorporating the Safety Grade and other Leapfrog data, to help employees choose the right facility/provider.

Quantros's CareChex Awards and other vendors use public and proprietary measures of performance to produce their ratings, comparing inpatient quality performance across general acute care hospitals. The awards consider patient complications, readmissions, mortality, AHRQ patient safety indicators, and inpatient quality indicators. Some sell consulting services to hospitals. Quantros is now a part of Healthcare Bluebook.

Vizient and other quality improvement vendors produce rankings designed for hospitals, not employers, purchasers, or consumers. Their Quality and Accountability Ranking identifies their high-performing member organizations in the areas of quality and safety and provides tools to support organizational improvement. None of their insights are made public, and even the hospitals that contract with them cannot see how other individual hospitals performed.

Leapfrog supports the innovative and competitive marketplace aimed at creating the most usable tools to drive improvement. At Leapfrog, we do not see ourselves as competing with these enterprises but giving them data to fuel even better ratings and offering employers and consumers the most relevant information. Data from the Leapfrog Surveys are unique and unavailable from claims or any other source. We encourage these vendors to use Leapfrog's unique data to fuel even better ratings.

Below is a collection of common questions.

Question	Desired Response
Aren't consumers confused by multiple ratings when choosing a hospital or ASC?	Health care is complicated. Consumers can and should consult a multitude of health care facility ratings to see which is most meaningful for their needs and select a facility using that knowledge. Consumers are accustomed to consulting ratings and reviews for every other industry, from automobiles to appliances to books. By putting meaningful quality and safety metrics into the hands of consumers, we allow them to make informed decisions about their health. Leapfrog believes that safety should come first when it comes to choosing a hospital,

What makes Leapfrog ratings different than others?

and for that, the Leapfrog Hospital Safety Grade is the only tool focused exclusively on safety. But once a patient identifies the safest hospital available to them, they should utilize other ratings specific to the procedure or type of care needed so that they can choose the best facility for their treatment. Leapfrog is not competing with other ratings services but is expanding the pool of data available nationally for decision-making by purchasers and the public.

Leapfrog is designed to measure what matters most to consumers and purchasers. The difference between Leapfrog ratings and other ratings organizations comes down to methodology, focus, and number of performance measures they evaluate and the audiences they serve.

The Leapfrog Surveys use national performance measures to evaluate hospitals' and surgery centers' safety, quality, and efficiency. These measures are of specific interest to health care purchasers and consumers and cover a broad range of hospital processes, outcomes, and structures in key clinical areas such as maternity and intensive care.

The Survey measures are predicated on the latest science and are regularly reviewed with guidance from scientific advisors at the Armstrong Institute for Patient Safety at Johns Hopkins Medicine as well as Leapfrog's volunteer Expert Panels.

Leapfrog scores and publicly reports Survey Results, Leapfrog's Survey methodologies are completely transparent, and annual proposed changes are open for public comment.

Comparison Chart:

	Leapfrog Safety Grade	Leapfrog Survey Ratings	U.S. News & World Report	CMS Star Ratings	Healthgrades	Lown Institute
Patient population						
General	X	X		X	X	X
Rare and complex conditions		X	X		X	
Key focus						
Safety	X	X				
Quality		X	X	X	X	X
Overall facility	X	X	X	X	X	X
Specialty specific		X	X		X	
Ratings assigned						
Top performers only			X		X	
All: high and low performers	X	X		X		X

Audience						
Consumers	X	X	X	X	X	X
Employers and purchasers	X	X				X
Eligible facilities						
General acute-care hospitals	X	X	X	X	X	X
Specialty hospitals (pediatric, surgical, etc.)		X	X		X	
Ambulatory surgery centers		X		X		
Nursing homes, hospice care, dialysis facilities				X		
Update schedule						
Once per year			X		X	X
Twice per year	X			X		
Multiple times per year		X				

TECHNICAL QUESTIONS ABOUT SUBMITTING THE LEAPFROG HOSPITAL SURVEY

Question	Response
Where do I get a security code if I haven't received or no longer have a security code?	To get a security code, send the Security Code Request form to the Leapfrog Help Desk.
We're in your region, why didn't we receive a request to participate in the Survey?	If it's a new hospital say, "you should <u>contact the Help Desk</u> with any updated hospital information, including CEO name. Have the hospital send the Security Code Request form to the Leapfrog Help Desk so the hospital CEO can authorize email release of the security code. The form can be found here." If it's a hospital outside your Leader area or a type of hospital to which the standards are not intended to apply, and you don't need to have them on your list: • We welcome any hospital to respond to the Survey. • You needn't handle their request. • Ask the hospital to request a security code from the home page of the Survey site by following the "Get a Hospital Security Code" link and following the instructions there. The Help Desk will send the code directly to them.

We received the letter, but why is our hospital name and/or CEO name used in the letter incorrect?

Hospitals can update contact information when completing the Survey (in Survey Profile).

(RLS should update their roster and forward the information to Robyn Nabi (rnabi@leapfrog-group.org) to prevent this from happening again.)

If we are multi-campus hospital and have two Medicare numbers but are really one hospital, can we file one Hospital Survey? Or if we are a hospital system and our units share the same Medicare number, can we file one Survey?

If hospitals on multiple campuses share a common CCN, they should report as distinct hospitals. See the Leapfrog policy [here](#).

Where can I go to see a checklist of steps to take to complete the Hospital Survey?

Leapfrog has put together a pre-submission checklist for hospitals that is easy to use. It is available in the hard copy of Survey [here](#).

Why does the consumer site(s) show the wrong information?

You probably need to update and resubmit your Hospital Survey. No one associated with Leapfrog can alter the data that a hospital submits. It is likely that the hospital made an error during submission. Review the general instruction and timing for public update with the hospital, as indicated above.

Why is my hospital publicly reported as "Declined to Respond" when I completed the Survey?

You may have failed to click the button "Submit Survey. You should log back into the Survey and check your submission status. Or the publicly reported results haven't been updated yet to reflect their participation. Results are updated within the first five business days of each month based on the previous month's submissions.

Where can I ask a clinical or scientific inquiry about a question on the Survey?

Please contact the Help Desk (<https://leapfroghelpdesk.zendesk.com/>) for assistance.

My hospital that has an A Safety Grade was cited by my state for quality issues. How can that be?

The Safety Grade reflects a hospital's relative performance to others – meaning that A hospitals have better patient safety outcomes than B, C, and D/F hospitals but it doesn't mean they are perfect. Additionally, if major patient safety issues are occurring now, those worsening patient outcomes will be reflected in the updated data we receive from CMS.

TECHNICAL QUESTIONS ABOUT SUBMITTING THE LEAPFROG ASC SURVEY

Question	Response
How do I access the Survey?	ASCs will need to request a security code to access the Survey if they are new to submitting the ASC Survey, using the ASC Security Code Request Form available here . If an ASC participated in previous years, their security code will be the same for 2025.
How do I know if my facility is an ASC?	An ASC is a distinct entity that exclusively provides same-day surgical services to patients not requiring hospitalization. Important characteristics of ASCs include the following: • If certified by Medicare, the facility is certified as an ASC (not all ASCs are certified by Medicare) and has been assigned a 10-digit CMS Certification Number (nn-Cnnnnnnn) • Provides surgical services that do not exceed 24 hours • May or may not be affiliated with a hospital • Often are specialty-specific More details can be found here .
What does the Survey cover?	The Leapfrog ASC Survey includes measures of several important areas of care including basic facility information; ethical billing and health equity; medical, surgical and nursing staff; volume and safety of procedures; patient safety practices; and patient experience. Like all of Leapfrog's programs, the Survey is evidence-based and predicated on the latest science, developed with guidance from Leapfrog's National Expert Panel and the Armstrong Institute for Patient Safety and Quality at Johns Hopkins Medicine.
Will ASCs be reported as "Declined to Respond" if they do not submit the ASC Survey to Leapfrog in 2025?	ASCs that do not submit the 2025 ASC Survey by June 30 will appear in initial location-based search results on Leapfrog's public reporting website, ratings.leapfroggroup.org if users opt to view facilities that declined to respond. Additionally, a direct search by facility name will generate a "Declined to Respond" message if the facility does not participate by June 30. Facilities that miss the June 30 Submission Deadline can still submit a Survey through November 30; results are updated monthly on Leapfrog's website.
Will ASCs get a letter grade? What is Leapfrog's initiative to rate outpatient care?	There are no current plans to give ASCs a letter grade. For five years, Leapfrog has assessed the quality and safety of procedures performed at ambulatory surgery centers (ASCs) and hospital outpatient procedure departments. 60% of employee procedures take place in the outpatient setting. Leapfrog collects the data through a voluntary Survey of ASCs as well as an outpatient procedure in addition to the existing Leapfrog Hospital Survey, which previously covered inpatient care only. Results for both types of facilities are publicly reported at https://ratings.leapfroggroup.org , allowing comparison between both.
Can all ASCs participate?	All ASCs in the United States are invited to participate in the Leapfrog ASC Survey, though an ASC must perform at least one of the procedures in the profile section of the ASC Survey in order to participate.

Where can I ask a clinical or scientific inquiry about a question on the Survey? Please contact the Help Desk (<https://leapfroghelpdesk.zendesk.com/>) for assistance.

TECHNICAL QUESTIONS ABOUT THE LEAPFROG HOSPITAL SAFETY GRADE

Question	Response
What is The Leapfrog Hospital Safety Grade?	The Leapfrog Hospital Safety Grade is an "A," "B," "C," "D," or "F" assigned to general hospitals in the U.S., the only such rating program focused exclusively on how safe they are for their patients. The grade uses over 30 measures including rates of preventable errors, injuries and infections, and whether hospitals have systems in place to prevent them. Grades are updated twice annually, in the fall and spring, and are freely available to the public at www.hospitalsafetygrade.org . The Hospital Safety Grade uses a public, peer-reviewed methodology, calculated by top patient safety experts under the guidance of a National Expert Panel, and is 100% transparent and free to the public.
What is the difference between the Leapfrog Hospital Survey and the Leapfrog Hospital Safety Grade?	The Leapfrog Hospital Survey is an annual voluntary survey in which Leapfrog asks hospitals to report quality and safety data and then publicly reports that information by hospital. The Leapfrog Hospital Safety Grade is a letter grade Leapfrog bi-annually assigns to general hospitals in the United States, whether they voluntarily report data to Leapfrog or not. If a hospital does not report to the Leapfrog Hospital Survey, other sources of data are used to calculate a Grade. The majority of data used to calculate the Safety Grade comes from the Centers for Medicare and Medicaid Services (CMS).
Where can I see more FAQs?	Frequently Asked Questions About The Leapfrog Hospital Safety Grade

Regional Leaders and Designated Coverage		
State/Region	Organization	Coverage (counties)
Alabama	Alabama Employer Health Consortium	All counties
Arkansas	Employers Healthcare Alliance	All counties (except Crittenden)
Arkansas	HealthCareTN	Crittenden
California	Purchaser Business Group on Health	All counties
Colorado	Purchaser Business Group on Health	All counties
Delaware	Greater Philadelphia Business Coalition on Health	All counties
District of Columbia	Consumer's Checkbook	The District of Columbia
Florida	Florida Alliance for Healthcare Value	All counties
Georgia	HealthCareTN	East/Mid: Catoosa, Dade, Floyd, Gordon, Murray, Walker, and Whitfield
Georgia	Georgia Watch	Fulton, DeKalb, Cobb, Gwinnett, and Clayton
Illinois	Midwest Business Group on Health	All counties except Bond, Calhoun, Clinton, Jersey, Macoupin, Madison, Monroe, St. Clair
Illinois	St. Louis Area Business Health Coalition	Bond, Calhoun, Clinton, Jersey, Macoupin, Madison, Monroe, St. Clair
Iowa	Health Policy Corporation of Iowa	Benton, Black Hawk, Boone, Bremer, Dallas, Dubuque, Grundy, Gunthrie, Harrison, Jasper, Johnson, Jones, Linn, Madison, Marion, Mills, Polk, Pottawattamie, Scott, Story, Warren, Washington, Woodbury
Indiana	Kentuckiana Health Collaborative	Clark, Floyd, Harrison, and Scott
Kansas	Employers Healthcare Alliance	All counties
Kentucky	Kentuckiana Health Collaborative	All counties
Louisiana	Louisiana Business Group on Health	All counties
Maine	Healthcare Purchaser Alliance of Maine	All counties
Michigan	The Economic Alliance for Michigan	All counties

Minnesota	Health Action Council	All counties
Mississippi	HealthCareTN	De Soto, Marshall, Tate, Tunica, Union, Lafayette, Lowndes, Benton, Tippah, Alcorn, Tishomingo, Prentiss, Pontotoc, Lee, Itawamba, Clay, Panola, and Monroe
Missouri	St. Louis Area Business Health Coalition	All counties
Montana	Montana Association of Health Care Purchasers	All counties
Nebraska	Health Policy Corporation of Iowa	Douglas
Nevada	Nevada Business Group on Health	Churchill, Douglas, Elko, Eureka, Humboldt, Lander, Lyon, Pershing, Storey, Washoe, White Pine, and Carson City
New Hampshire	Institute for Health Policy & Practice	All counties
New Jersey/New York	New Jersey Health Care Quality Institute	All counties
New Mexico	New Mexico Coalition for Healthcare Value	All counties
North Carolina	North Carolina Business Coalition on Health	All counties
Ohio	Health Action Council	All counties
Oklahoma	The Oklahoma Business Collective on Health	Cherokee, Craig, Muskogee, Nowata, Okmulgee, Payne, Tulsa, Washington, Wagoner, and Rogers
Oregon	Health Action Council	All counties
Pennsylvania: Greater Philadelphia	Greater Philadelphia Business Coalition on Health	Phila, Bucks, Montgomery, Chester, Delaware
Pennsylvania: Lehigh Valley	Lehigh Valley Business Coalition on Health Care	Adams, Bedford, Berks, Bradford, Carbon, Centre, Clinton, Columbia, Cumberland, Dauphin, Franklin, Fulton, Huntingdon, Juniata, Lackawanna, Lancaster, Lebanon, Lehigh, Luzerne, Lycoming, Mifflin, Monroe, Montour, Northampton, Northumberland, Perry, Pike, Potter, Schuylkill, Snyder, Sullivan, Susquehanna, Tioga, Union, Wayne, Wyoming, and York
Pennsylvania: Pittsburgh	Pittsburgh Business Group on Health	Allegheny, Armstrong, Beaver, Blair, Butler, Cambria, Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Fayette, Forest, Greene, Indiana, Jefferson, Lawrence, McKean, Mercer, Somerset, Venango, Warren, Washington, and Westmoreland

South Dakota	Health Policy Corporation of Iowa	Minnehaha
Tennessee	HealthCareTN	All counties
Texas: Dallas/Fort Worth	Dallas Fort Worth Business Group on Health	Collin, Cooke, Dallas, Denton, Ellis, Erath, Grayson, Henderson, Hood, Hunt, Johnson, Kaufman, Navarro, Palo Pinto, Parker, Rockwall, Somervell, Tarrant, Wise
Texas: Houston	Houston Business Coalition on Health	Harris, Fort Bend, Montgomery
Virginia	Virginia Business Coalition on Health	All counties
Washington	Washington Health Alliance	All counties
Wisconsin	The Alliance	All counties

Exhibit 37

Every acute care hospital in America RANKED: Our interactive map reveals dangers lurking near you...

MailOnline

January 6, 2025 Monday 8:01 PM GMT

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MailOnline

Section: HEALTH; Version:1

Length: 1582 words

Byline: Sadie Whitelocks For Dailymail.com

Body

• READ MORE: Face mask mandates return as doctors warn of 'quad-demic'

If you have a health emergency, the last thing you want to have to worry about is whether the hospital you are being treated in is unsafe.

Yet this is very real concern. More than 200,000 people die every year from preventable hospital errors, injuries, accidents, and infections - the equivalent of around 550 per day - according to multiple studies.

Now, thanks to exclusive new data provided to DailyMail.com, you can find out this vital information in advance by entering your zip code into our interactive map.

Analysts at Leapfrog Hospital Safety graded more than 3,000 general acute care hospitals across the nation from A to F.

The ratings are based on factors such as the number of medical errors, accidents and hospital-acquired infections reported by each center over the past 12 months.

Director of healthcare ratings at Leapfrog, Katie Stewart, told DailyMail.com: 'Hospitals with an 'F' grade rank in the bottom 1 percent nationally for patient safety.

'Patients treated in hospitals with a 'D' or 'F' grade are twice as likely to die from preventable errors compared to those in hospitals with an 'A' Grade.'

And there are some worrying trends when grades are compared state by state...

USE OUR TOOL BELOW, CREATED IN COLLABORATION WITH LEAPFROG HEALTH, TO FIND YOUR LOCAL HOSPITAL:

What the data shows

To produce the Leapfrog Hospital Safety Grade report, the experts looked at 22 measures of patient safety - including the amount of infections, patient-doctor communication, surgery errors and cleanliness - and rated each one accordingly.

Every acute care hospital in America RANKED: Our interactive map reveals dangers lurking near you...

In some cases, when a hospital's information was not available for a certain measure, Leapfrog contacted the organizations for more information or analyzed external reports.

Due to the limited availability of public data Leapfrog - which releases safety reports twice a year - was not able to calculate a safety grade for every hospital in the US.

Institutions with restricted public data include long-term care and rehabilitation facilities, mental health facilities and some specialty hospitals, such as surgery centers and cancer hospitals.

The worst rankings

A total of 14 out the 3,000 hospitals ranked were graded 'F' in the report.

The research showed that Florida has some of the worst-rated hospitals in the country, with three awarded the dreaded 'F' ratings.

These were Delray Medical Center, the Good Samaritan Medical Center, and Palm Beach Gardens Medical Center, which together treat more than 450,000 patients each year.

Palm Beach Gardens Medical Center has been involved in several medical care scandals, including its doctors allegedly falsifying medical records and being sued over misdiagnoses.

Michigan was the only other state with multiple hospitals slapped with 'F' ratings.

These included MC Detroit Receiving Hospital and DMC Sinai-Grace Hospital, which treat a combined number of 200,000 patients annually.

In Michigan, DMC Detroit Receiving Hospital is currently embroiled in a multi-million dollar lawsuit over claims of negligence, which allegedly led to two patients being raped, and another committing suicide inside a room.

Former staff members have said that severe understaffing had allowed the hospital turn into a crime scene.

One of the most shocking cases alleged in the lawsuit involved a male patient who raped a female psychiatric patient receiving in-patient care while restrained in bed.

Elsewhere, scandal-hit SSM Health DePaul Hospital in Missouri was also given an F rating.

Last year more than 30 patients alleged sexual abuse, including some as young as five years old.

Other US hospitals to receive F rankings included the Regional West Medical Center in Nebraska, Berkeley Medical Center in West Virginia, Rivers Health in West Virginia, HSHS St. Mary's Hospital in Illinois, Hutchinson Regional Medical Center in Kansas, Pacifica Hospital of the Valley in California and Howard University Hospital in Washington DC.

Daily Mail has approached the hospitals that received poor scores for comment.

The best hospitals

The state with the highest percentage of A grade hospitals was Utah, with just over 60 percent of its care facilities getting top marks.

Some of the state's top ranking hospitals included Lone Peak, Lakeview, Intermountain Spanish Fork and Holy Cross.

These health centers scored highly in many areas, with an effective leadership said to be one of the main factors in lowering the number of harmful events and increasing all-round efficiency.

Every acute care hospital in America RANKED: Our interactive map reveals dangers lurking near you...

In at second place, Virginia saw 58 percent of its hospitals get A grades. It was followed by Connecticut (50 percent), North Carolina (46.7 percent), and New Jersey (46.3 percent).

California ranked in the top 10 for the first time since fall 2014, coming in at sixth place in the state rankings with 44.9 percent of its hospitals getting A grades.

Rounding out the top ten were Rhode Island (44.4 percent), Idaho (42.9 percent), and Pennsylvania (41.2 percent), while Colorado and South Carolina tied at tenth place with 40.4 percent scores.

Iowa, North and South Dakota and Vermont did not have any hospitals with an A grades.

Making improvements

The analysts said the latest grades showed hospitals are 'making progress in patient safety across several performance measures including notable improvements in healthcare associated infections, hand hygiene and medication safety'.

But they added that there are still far too many disparities and 'we haven't yet achieved consistent improvements across all areas of safety'.

Leapfrog representative, Ms Stewart, said the data showed that 'many hospitals with poor grades show a strong commitment to improvement and often enhance patient safety quickly'.

'We have seen hospitals go from an 'F' Grade all the way to an 'A' through an unrelenting focus on putting patients first,' she added.

More than 20 hospitals that received C ratings in Leapfrog's spring 2024 report saw these bumped up to A grades come fall.

However, more than 50,000 lives could be saved every year if F, D, C, and B grades could improve their patient safety record to that achieved by A grade hospitals.

A 2024 report led by researchers from Michigan State University highlighted that 400,000 hospitalized patients experienced some preventable harm each year.

Medical errors can also have a high cost, with some experts estimating that adverse events cost the healthcare system \$20 billion each year.

Others approximate healthcare costs of \$35.7 billion to \$45 billion annually for hospital-acquired infections alone.

Commenting further on the findings, Leapfrog Group's CEO, Leah Binder, said: 'Preventable deaths and harm in hospitals have been a major policy concern for decades.

'So, it is good news that Leapfrog's latest safety grades reveal that hospitals across the country are making notable gains in patient safety, saving countless lives.

'Next, we need hospitals to accelerate this progress - because no one should have to die from a preventable error in a hospital.'

The most common blunders

More than 200,000 people die every year from preventable hospital errors, injuries, accidents, and infections, the equivalent of around 550 per day.

In the Leapfrog report, medication errors were shown to be the most common type of blunder.

Research suggested the average hospitalized patient is subject to at least one medication error per day, and an estimated 40 percent of errors occur in handoffs during the admission, transfer and discharge of patients.

Every acute care hospital in America RANKED: Our interactive map reveals dangers lurking near you...

Company spokesperson Ms Stewart said: 'We are still not where we need to be as a country, and too many lives are lost to preventable errors.'

She encouraged patients to consult the grades when seeking care, as 'all hospitals are not the same' when it comes to standards.

An adverse events report from the Joint Commission - a US-based not-for-profit organization that analyzes hospital and healthcare data from across the world - recently revealed a range of blunders from hospitals across the US.

It has been releasing data about these events since at least 2013.

The report from 2023 (the most recent available) found there were 110 patients who had foreign objects left in their body - an 11 percent increase from 2022.

Of the objects mistakenly left behind, 35 percent were sponges, 10 percent were guide wires and eight percent were fragments of medical instruments.

The remaining 47 percent was a miscellaneous mixture of other tools - with one case reporting surgical scissors left in the body.

After foreign objects, there were 106 cases of assault, rape, sexual assault or homicides involving hospitalized patients in America in 2023, according to the report.

Half of these were patient-on-patient, 28 percent involved staff-on-patient and 13 percent involved a patient acting on a staff member.

Finally, there were 81 cases where patients had treatment delayed unnecessarily and 71 cases where patients committed suicide while at the hospital.

The Joint Commission's hospital patient safety goals for 2025 include improving patient identification to ensure they get the correct medicine and treatment, encouraging more staff to adhere to hand cleaning guidelines and taking greater care in surgery to avoid potentially fatal mistakes.

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Industry: HOSPITALS (94%); HEALTH CARE (89%); ACADEMIC MEDICAL CENTERS (79%); HEALTH CARE ASSOCIATED INFECTIONS (79%); HEALTH CARE INFORMATION (79%); MEDICAL MALPRACTICE (78%);

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MEDICAL RECORDS (74%); CANCER HOSPITALS (72%); PHYSICIANS & SURGEONS (72%); LONG TERM HEALTH CARE (68%)

Geographic: DETROIT, MI, USA (79%); FLORIDA, USA (79%); MICHIGAN, USA (79%); UNITED STATES (92%)

Load-Date: March 16, 2025

End of Document

Exhibit 38

Message

From: Cook, Lisa1 [/O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=D379204ED57B4064AB70172BB99CEB8D-COOK, LISA1]
Sent: 1/7/2025 10:10:05 PM
To: Blanchard, Amanda [Amanda.Blanchard@tenethealth.com]
Subject: RE: Palm Beach Gardens Living Magazine

.....

From: Blanchard, Amanda <Amanda.Blanchard@tenethealth.com>
Sent: Tuesday, January 7, 2025 2:24 PM
To: Cook, Lisa1 <lisad.cook@tenethealth.com>
Subject: FW: Palm Beach Gardens Living Magazine

From: Cazares, Erik <ERIK.CAZARES@TENETHEALTH.COM>
Sent: Tuesday, January 7, 2025 12:37 PM
To: Blanchard, Amanda <Amanda.Blanchard@tenethealth.com>
Subject: FW: Palm Beach Gardens Living Magazine

FYI

From: Mitrione, Michael <MMitrione@gunster.com>
Sent: Tuesday, January 7, 2025 11:08 AM
To: Cazares, Erik <ERIK.CAZARES@TENETHEALTH.COM>
Subject: RE: Palm Beach Gardens Living Magazine

Good morning!

I don't mean to be a pest about marketing, and I know you don't control it, but I am passing on relevant information. This morning, on the Channel 5 news, Jupiter Medical ran a misleading ad which said that it is "the only A-rated hospital in Palm Beach County." It did not say according to Leapfrog or any other limiting language – a flat out broad statement. PBGMC needs to fight fire with fire if it wants to improve its image in the community.

Mike

From: Mitrione, Michael
Sent: Monday, January 6, 2025 3:53 PM
To: Cazares, Erik <ERIK.CAZARES@TENETHEALTH.COM>
Subject: Palm Beach Gardens Living Magazine

Hi Erik,

Happy New Year!

Attached is a page from the Palm Beach Gardens Living magazine which I received in the mail today. I believe this magazine is mailed to every home in PBG. It's a shame that Jupiter Medical Center, and not PBGMC, is

getting to tell its story to all PBG residents. I suspect that this is paid advertising, but I suggest that you forward this to our marketing group and ask them to look into doing something like this in the next issue of this magazine. We should try to take back control of the messaging in our own backyard.

Thanks, and I look forward to seeing you on Wednesday morning!

Mike



Michael V. Mitrione | Attorney
M&A, Securities, Banking and General Corporate Practice Groups
Former Chair of Corporate Practice Group
Honored in Best Lawyers in America every year since 1991

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Exhibit 39

HEALTH CARE

What are the best and worst South Florida hospitals for patient safety? See the rankings

By Michelle Marchante

Updated January 16, 2025 11:00 AM



 **Miami Herald**

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Florida hospitals rank high for patient safety in Leapfrog Group's reports. How do South Florida hospitals fare? *McClatchy File*



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00:00

1.0x

09:26

How safe is your hospital?

A national watchdog has analyzed hospital data for more than 20 years, giving A to F grades to hospitals nationwide twice a year for patient safety.

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1:04

03:00

Florida hospitals are doing a good job with patient safety, with the state just behind California for the highest number of hospitals recognized by the Leapfrog Group as a “Top Hospital.” But some South Florida hospitals have some work to do.

More than half the hospitals in the Miami-Fort Lauderdale-West Palm Beach metro area received a “C” or lower in preventing medical errors, accidents and infections in the fall 2024 patient safety report card.

The good news is that one of the region’s “A” hospitals, Larkin Community Hospital in South Miami, did well enough in patient safety to earn a “Top Hospital” recognition in December.

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"In "A" hospitals, leadership is involved in regular safety huddles and works to create a culture where staff at all levels feel comfortable speaking up when an error or near-miss occurs," Missy Danforth, senior vice president of healthcare ratings at The Leapfrog Group, told the Miami Herald in an email.

Leapfrog's next report will be released in May.

The nonprofit Leapfrog uses more than 20 factors, including rates of preventable errors, injuries and infections to help patients pick the best hospital near them for care. Some of the collected data is voluntarily reported by hospitals to Leapfrog, and other data is collected from other sources such as from the federal Centers for Medicare and Medicaid Services.

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Here's what to know about the grades and rankings:

South Florida's Leapfrog patient safety grades

Eleven hospitals in Miami-Dade, Broward and Palm Beach counties scored an "A" in the report, slightly better than in the previous report released in May. Nine hospitals got a B, 25 got a C, and three got a D. This time around, three hospitals in Palm Beach County received "F" grades.

"Florida ranks number 13 among all states for percentage of "A" graded hospitals, with 37% of hospitals in the state achieving the "A" Grade. In South Florida specifically, we see a mix of Grades. There are "A" graded hospitals and as low as "F" graded hospitals," Danforth said.

"Patients in "D" or "F" hospitals are twice as likely to die from preventable errors compared to those in "A" hospitals. Many hospitals with poor grades improve over time, showing strong commitment to keeping patients safe from preventable harm," she said. "Patients and families should communicate with doctors and hospital leaders about the importance of prioritizing patient safety."

The rankings don't include specialty hospitals, including children's hospitals such as Nicklaus near South Miami or Joe DiMaggio in Hollywood. It also doesn't include surgical centers, critical access hospitals and veteran hospitals, including the Miami VA. Leapfrog said a hospital could be excluded from the report for various reasons. They include not being required to publicly report their safety record to the federal government, being too small or lacking the necessary data.

Here's a look at how South Florida hospitals did:

How did Miami-Dade and Broward's public hospitals score?

- Jackson Memorial Hospital in Miami, Jackson North, Jackson West in Doral and Jackson South, all part of Miami-Dade's public hospital system, kept their "C" grades.

Jackson Health System, in an emailed statement to the Miami Herald, said patient safety is its highest priority.

"Over the last year, we have focused on implementing best practices in quality and safety at all of our facilities, and have seen gradual improvement. These grades reflect one-step forward as we make Jackson one of safest, highest quality healthcare systems in Miami-Dade County," Jackson Health said in its statement. "We pay close attention to these safety scores and use them as a tool to evaluate ways in which we can further improve and implement lasting change throughout our organization."

- Broward Health North in Deerfield Beach kept its "A" grade. Broward Health Coral Springs kept its "B" grade. Fort Lauderdale's Broward Health Medical Center and Broward Health Imperial Point kept their "C" grades.

Broward Health, in an emailed statement to the Miami Herald, said its proud of Broward Health North retaining its "A" and being the "only hospital in its primary service area" to earn an "A" in Leapfrog's most recent report.

"The system remains dedicated to the continuous improvement of patient safety and care quality," Broward Health said in a statement. "These Leapfrog scores also provide valuable insights for growth and reinforce our commitment to ensuring the highest levels of safety, quality and satisfaction for all patients."

- Memorial Hospital Miramar kept its A. Memorial Regional Hospital in Hollywood, Memorial Regional Hospital South in Hollywood, Memorial Hospital Pembroke Pines and Memorial Hospital West in Pembroke Pines kept their “C” grades.

Best and worst South Florida hospitals for patient safety?

Here are the hospitals that scored an “A” grade:

- Baptist Health Homestead Hospital, 975 Baptist Way, Homestead, kept its “A” grade.
- Baptist Health South Miami Hospital, 6200 SW 73rd St., kept its “A” grade.
- Baptist Health West Kendall Baptist Hospital, 9555 SW 162nd Ave., kept its “A” grade.

Other Baptist Health South Florida hospitals scored B’s and C’s.

“Our mission is to provide high-quality and compassionate care in a welcoming and safe environment. We appreciate programs like Leapfrog and their efforts to help customers make decisions while holding healthcare systems to high standards,” Baptist Health said in a statement. “We recognize that there are always opportunities for improvement, and remain committed to providing the best possible care for our patients.”

- Broward Health North, 201 E Sample Rd. in Deerfield Beach, kept its “A” grade.
- HCA Florida Aventura Hospital, 20900 Biscayne Blvd., boosted its score from a “B” to an “A.”
- HCA Florida Kendall Hospital, 11750 SW 40th St., kept its “A” grade.
- HCA Florida Westside Hospital, 8201 W Broward Blvd. in Plantation, kept its “A” grade.

HCA Florida’s other hospitals in the region and elsewhere in the state received scores ranging from A-C’s. One HCA Florida hospital in Citrus County received a “D.”

“Our hospitals regularly measure and report hundreds of quality and patient safety data points, directly related to patient outcomes, across multiple patient populations,” HCA Florida Healthcare told the Miami Herald in a statement. “We recognize the importance of measuring quality and safety in patient care and are

working hard to improve in certain areas. Our physicians, nurses, and colleagues are dedicated to providing exceptional care for our patients.”

- Jupiter Medical Center, 1210 S. Old Dixie Hwy., kept its “A” grade.
- Larkin Community Hospital, 7031 SW 62nd Ave. in South Miami, kept its “A” grade. The teaching hospital was also awarded a “Top Hospital” award by Leapfrog in December for being one of the state’s top-performing hospitals in patient safety and care.

READ MORE: These Miami-area hospitals and surgery centers are the best in the state, rankings say

- Memorial Hospital Miramar, 1901 SW 172nd Ave., kept its “A” grade.
- Hialeah Hospital, 651 E 25th St., boosted its score from a “B” to an “A.”

Here are the hospitals that scored a “D” or worse:

- Delray Medical Center, 5352 Linton Blvd. in Delray Beach, saw its score lower from a “D” to an “F.”
- Good Samaritan Medical Center, 1309 N. Flagler Dr. in West Palm Beach, saw its score worsen from a “C” to an “F.”
- Mount Sinai Medical Center, 4300 Alton Rd. in Miami Beach, kept its “D” grade.
- Palm Beach Gardens Medical Center, 3360 Burns Rd., saw its score worsen from a “C” to an F.”
- St. Mary’s Medical Center, 901 45th St. in West Palm Beach, saw its score lower from a “C” to a “D.”
- West Boca Medical Center, 21644 State Rd. 7, kept its “D” grade.

Check your South Florida’s hospital patient safety grade

How did your South Florida hospital do in patient safety? Take a look at the chart below:

How safe is your South Florida hospital?

Leapfrog Group gives A-F grades to hospitals nationwide twice a year for patient safety. Here's how South Florida hospitals ranked in the nonprofit's Fall 2024 report. A is best, F is worst.

Page 1 of 11 >

Hospital Name	City	County	Fall 2024 Score	Spring 2024 Score
Baptist Health Homestead Hospital	Homestead	Miami-Dade County	A	A
Baptist Health Baptist Hospital of Miami	Miami	Miami-Dade County	C	C
Baptist Health Bethesda Hospital East	Boynton Beach	Palm Beach County	B	C
Baptist Health Bethesda Hospital West	Boynton Beach	Palm Beach County	C	C
Baptist Health Boca Raton Regional Hospital	Boca Raton	Palm Beach County	C	C

The rankings don't include specialty hospitals, including children's hospitals, surgical centers, critical access hospitals and veteran hospitals. LeapFrog said this could be because the hospitals aren't required to publicly report their safety record to the federal government, the hospitals are too small or they lack the necessary data.

Source: Leapfrog Group • Table: Michelle Marchante

Visit hospitalsafetygrade.org/ to learn more about your hospital's grade and to see how other Florida hospitals scored.

What the Leapfrog patient safety hospital report shows

- LeapFrog said it grades nearly 3,000 hospitals in the country twice a year “on the very basics of medical care, such as hand-washing, entering prescriptions through a computer, and the availability of highly trained nurses.” While you can look at a hospital's overall grade, you can also get a more detailed look at how your hospital ranked in categories including infections; problems with surgery; safety problems; practices to prevent errors; and how well doctors, nurses and hospital staff respond and communicate.
- LeapFrog recommends people consider how well a hospital scores in hand-washing, reducing blood infections and patient falls when picking a place to seek care. Of course, if you have an emergency, go to your nearest hospital for care.

This story was originally published January 16, 2025 at 5:00 AM.

Do you want to see more? Check out these articles!

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3. [More than 10,000 Black Miamians were surveyed about their needs. Here's what they said](#)
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Michelle Marchante *Miami Herald*     305-376-2708

Michelle Marchante covers the pulse of healthcare in South Florida and also the City of Coral Gables. Before that, she covered the COVID-19 pandemic, hurricanes, crime, education, entertainment and other topics in South Florida for the Herald as a breaking news reporter. An investigative series about the abrupt closure of a Miami heart transplant program led Michelle and her colleagues to be recognized as finalists in two 2024 Florida Sunshine State Award categories. She also won second place in the 73rd annual Green Eyeshade Awards for her consumer-focused healthcare stories and was part of the team of reporters who won a 2022 Pulitzer Prize for the Miami Herald's breaking news coverage of the Surfside building collapse. Michelle graduated with honors from Florida International University and was a 2025 National Press Foundation Covering Workplace Mental Health fellow and a 2020-2021 Poynter-Koch Media & Journalism fellow. Support my work with a digital subscription



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Exhibit 40

Message

From: Nunes, Andrea [/O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=74E5480103274FD1B0332021509C584A-NUNES, ANDR]
Sent: 1/28/2025 11:34:10 PM
To: Ramirez, Ricardo [Ricardo.Ramirez@tenethealth.com]
Subject: Leapfrog WBMC Score

Dr. Ocampo just sent me a text with a screen shot of the West Boca Medical Center D Grade. I am sharing her concern in the statements below.

Her friend subsequently bypassed us for Boca Regional.

She asked me if it was true. I said, yes, we really received a D. I explained we do not participate in the surveys and do not have the benefit of adding additional information. Leapfrog selects Patient Experience, HAIs, HACs and PSI.

She states her friend is a physician, does not care about google ratings but does care about leapfrog.

I do believe we could increase to a C, maybe a B if we resurveyed by June. I think we would need to work on the CPOE and Bar Coding.

Patient Experience brings us down significantly. (I did not tell her this opinion.)

Thanks,
Andrea

Andrea Nunes, RN, BSN, MHM, CPHQ, CPHRM
Director Clinical Quality Improvement
21644 State Road 7
Boca Raton, Florida 33428
Fax: 561.883.7268
Telephone: 561.488.8287
Email: andrea.nunes@tenethealth.com



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Notice: The information in this communication is confidential and is directed only to the intended recipient. Please do not forward this communication without my permission. If you have received this communication in error, please notify me immediately and delete/destroy this communication.

Exhibit 41

Message

From: Jill Berger [jberger@leapfrog-group.org]
Sent: 3/11/2025 9:25:11 AM
To: Regional Leaders [RegionalLeaders@leapfrog-group.org]
CC: LFStaff [LFStaff@leapfrog-group.org]
Subject: Regional Leader Agenda and Patient Safety Awareness Week 2025 Social Content
Attachments: 2025 Patient Safety Awareness Week Social Media.docx; PSAW25 (2).zip; March Regional Leader Agenda .docx

Dear Regional Leaders -

This week is Patient Safety Awareness Week. I have attached a few social media posts and graphics for you to use with your community. Please feel free to share!

I've also attached the agenda for our Regional Leader meeting tomorrow. You'll notice that the 2025 Communication Toolkit is online and has a new look. I look forward to sharing it tomorrow. We will also have a presentation from Trinette Small, one of our 2024 Bruce Bradley Fellows, on her project - Maternity Care Insights.

Please let me know if you have any questions.

Best,

Jill

Jill A. Berger (she/her)
Senior Advisor, Employer & Payor Engagement
The Leapfrog Group
1775 K Street, NW, Suite 400
Washington, DC 20006
(202) 292-6713

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Exhibit 42

FINAL STATS – DO NOT DISTRIBUTE**Spring2025 Hospital Safety Grade****Survey Participation Among Graded Hospitals**

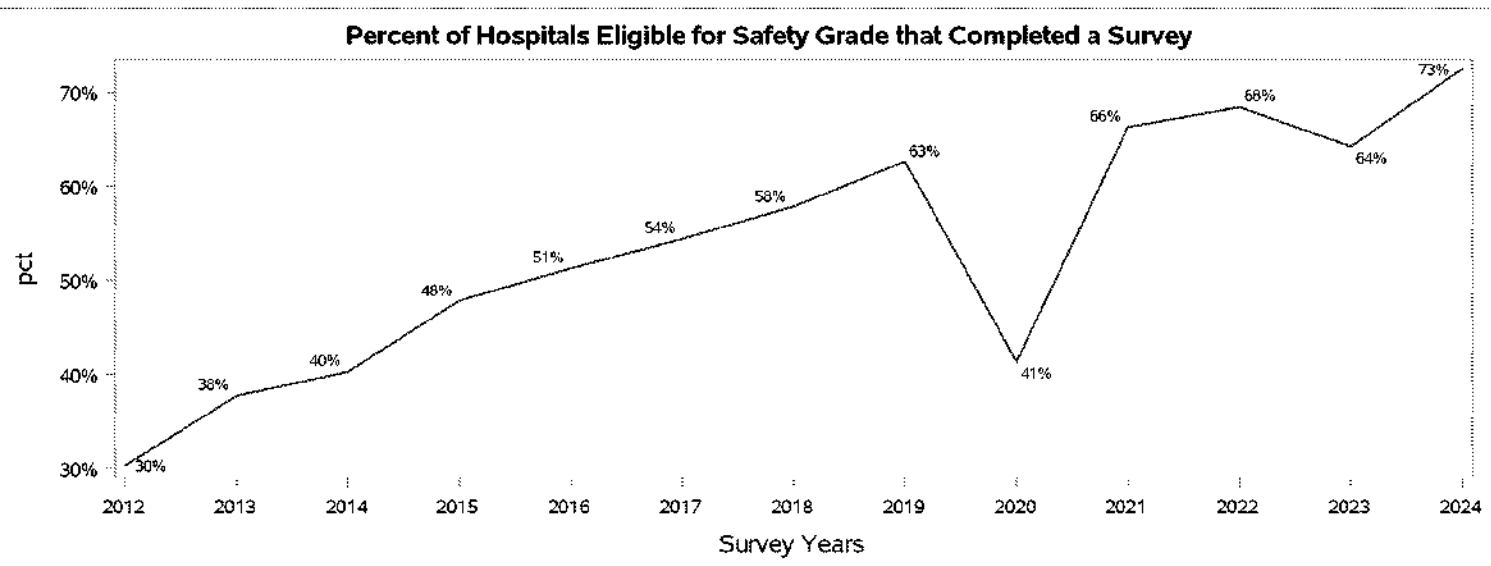
Survey	Fall_2023	Spring_2024	Fall_2024	Spring_2025
Completed Survey	68%	69%	79%	79%
Did not complete Survey	32%	31%	21%	21%

Survey	Fall_2023	Spring_2024	Fall_2024	Spring_2025
Completed Survey	1921	1962	2245	2237
Did not complete Survey	913	885	590	592
Total Graded	2834	2847	2835	2829

Spring2025 Safety Grades

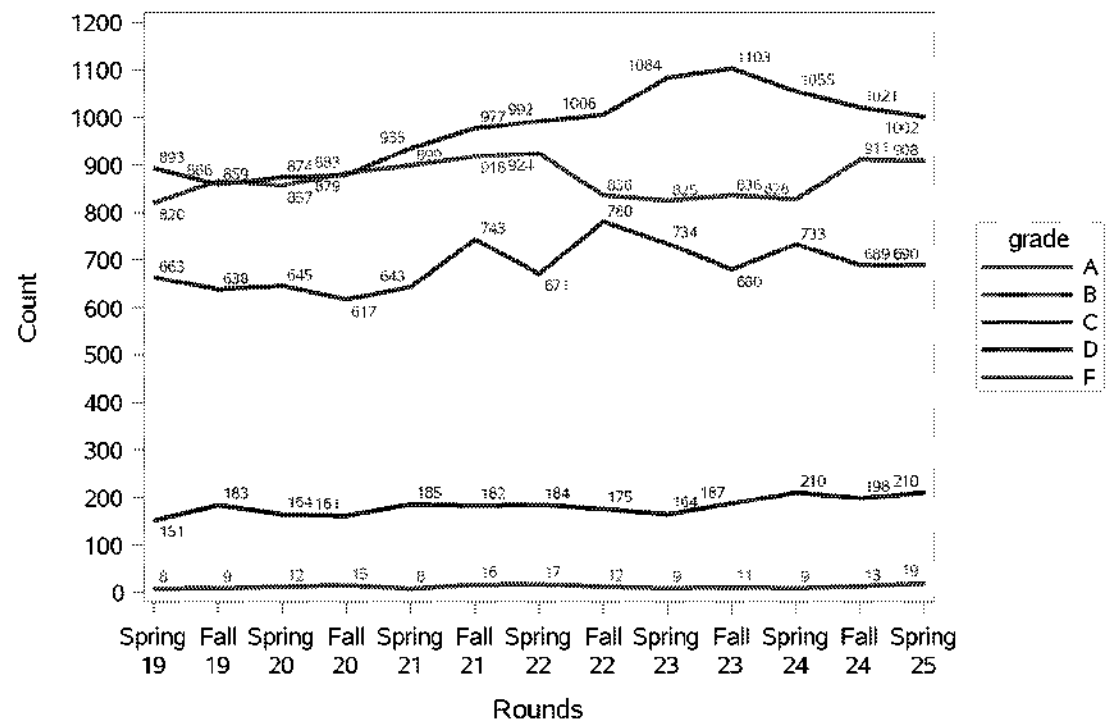
	Count	%
A	908	32.09%
B	690	24.39%
C	1002	35.41%
D	210	7.42%
F	19	0.67%
TOTAL	2829	100.00%

316 hospitals eligible for Safety Grades were missing too much data to be scored



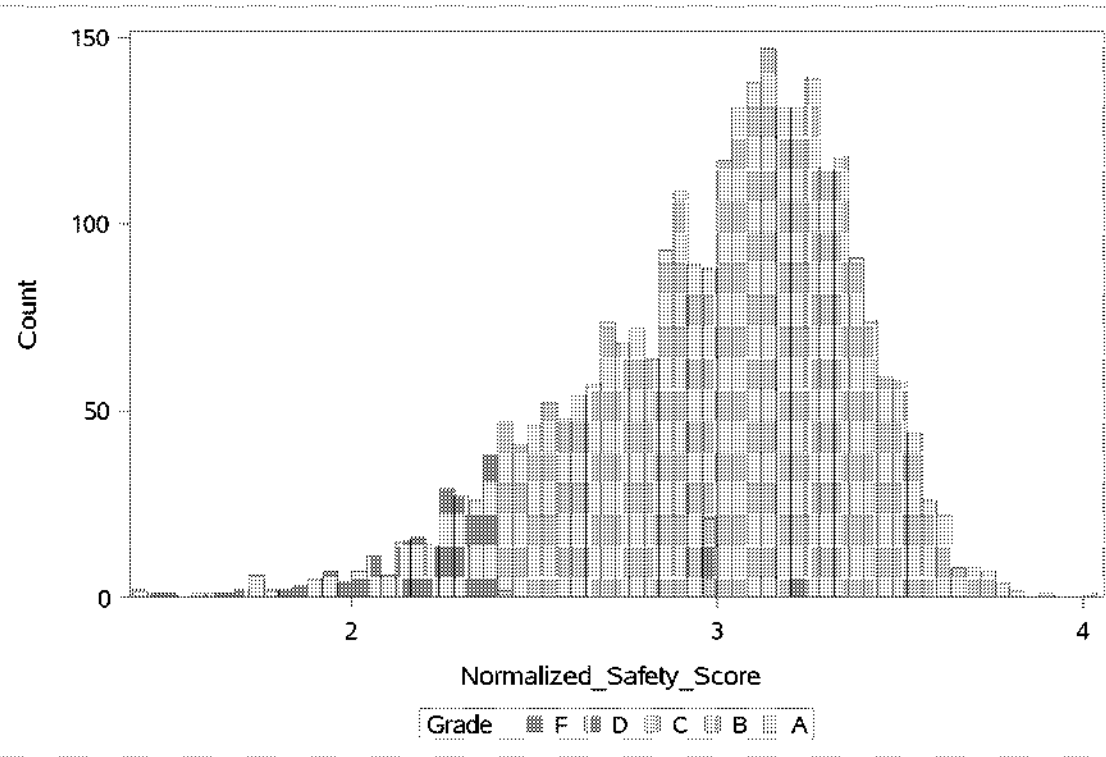
Grade Counts Over Time

grade	Spring 19	Fall 19	Spring 20	Fall 20	Spring 21	Fall 21	Spring 22	Fall 22	Spring 23	Fall 23	Spring 24	Fall 24	Spring 25
A	820	866	857	883	899	918	924	836	825	836	828	911	908
B	663	638	645	617	643	743	671	780	734	680	733	689	690
C	893	859	874	879	935	977	992	1006	1084	1103	1055	1021	1002
D	151	183	164	161	185	182	184	175	164	187	210	198	210
F	8	9	12	15	8	16	17	12	9	11	9	13	19



Distribution of Grades Over Time

grade	Spring 19	Fall 19	Spring 20	Fall 20	Spring 21	Fall 21	Spring 22	Fall 22	Spring 23	Fall 23	Spring 24	Fall 24	Spring 25
A	32.35	33.89	33.58	34.56	33.67	32.37	33.14	29.76	29.30	29.68	29.21	32.17	32.10
B	26.15	24.97	25.27	24.15	24.08	26.20	24.07	27.77	26.07	24.14	25.86	24.33	24.39
C	35.23	33.62	34.25	34.40	35.02	34.45	35.58	35.81	38.49	39.16	37.21	36.05	35.42
D	5.96	7.16	6.43	6.30	6.93	6.42	6.60	6.23	5.82	6.64	7.41	6.99	7.42
F	0.32	0.35	0.47	0.59	0.30	0.56	0.61	0.43	0.32	0.39	0.32	0.46	0.67



Spring 2025

Last Round	This Round				
	A	B	C	D	F
A	740	147	5	0	0
B	144	385	155	0	0
C	17	157	764	72	0
D	0	1	53	131	11
F	0	0	0	5	8
NG	7	0	15	2	0

Changed 2 or more grades	%	No change in grade	%	Total Scored
33	1.17	2028	71.69	2829

Fall 2024

Last Round	This Round				
	A	B	C	D	F
A	645	140	25	0	0
B	199	345	174	4	0
C	58	193	700	86	3
D	0	3	96	97	8
F	0	0	1	6	2
NG	9	8	12	5	0

Changed 2 or more grades	%	No change in grade	%	Total Scored
107	3.78	1789	63.17	2832

Spring 2024

Last Round	This Round				
	A	B	C	D	F
A	625	187	10	0	0
B	154	347	176	0	0
C	33	182	784	83	0
D	0	1	64	119	3
F	0	0	1	4	5
NG	16	16	14	4	0

Changed 2 or more grades	%	No change in grade	%	Total Scored
52	1.83	1880	66.31	2835

Fall 2023

Last Round	This Round				
	A	B	C	D	F
A	628	159	29	0	0
B	164	343	220	1	0
C	38	171	786	79	2
D	0	0	54	100	7
F	0	0	1	5	3
NG	6	7	7	2	0

Changed 2 or more grades	%	No change in grade	%	Total Scored
76	2.7	1860	66.03	2817

Military Treatment Facility (MTF) Performance

	Scored Status		
	Scored	Unscored - Missing data	Unscored - Removed
MTF	22	23	.
Non-MTF	2807	293	1
TOTAL	2829	316	1

grade	Spring 24	Fall 24	Spring 25
A	9	15	16
B	9	5	4
C	3	.	2

Spring2025 First Time Graded Survey Participation

	Count	%
No	2	22.22%
Yes	7	77.77%
TOTAL	9	100.00%

Fall2024 First Time Graded Survey Participation

	Count	%
No	2	18.18%
Yes	9	81.81%
TOTAL	11	100.00%

**Statistically Significant Changes in Mean
Fall24 vs Spr25
Imputed Values were excluded for CPOE, BCMA, IPS, and Hand Hygiene**

Process Measures	Fall24	Spr25	Change_in_Mean	Pvalue	Change
CPOE	96.021	96.395	+ 0.6418	< 0.05	Significantly Better
BCMA	96.54	96.916	+ 0.5482	< 0.05	Significantly Better
IPS	79.737	79.23	+ 0.2724	< 0.05	Significantly Better
HandHygiene	87.96	89.464	+ 2.1859	< 0.05	Significantly Better
SP1	117.407	117.487	+ 0.3373	< 0.05	Significantly Better
SP2	116.656	116.853	+ 0.5847	< 0.05	Significantly Better
NW	76.166	77.068	+ 1.1657	< 0.05	Significantly Better
HCAHPS1_Nurse	90.022	90.191	+ 0.1514	< 0.05	Significantly Better
HCAHPS2_Doctor	89.785	89.91	+ 0.1066	< 0.05	Significantly Better
HCAHPS3_Staff	81.438	81.626	+ 0.1478	< 0.05	Significantly Better
HCAHPS5_Medicine	74.304	74.424	+ 0.0875	< 0.05	Significantly Better
HCAHPS6_Discharge	85.131	85.252	+ 0.1066	< 0.05	Significantly Better

Outcome Measures	Fall24	Spr25	Change_in_Mean	Pvalue	Change
ForeignObject	0.014	0.014	0	< 0.05	
AirEmbolism	0.002	0.002	0	< 0.05	
FallsTrauma	0.386	0.384	-0.0002	< 0.05	Significantly Better
CLABSI	0.685	0.651	-0.0364	< 0.05	Significantly Better
CAUTI	0.578	0.54	-0.0342	< 0.05	Significantly Better
SSIcolon	0.854	0.831	-0.0276	< 0.05	Significantly Better
MRSA	0.744	0.719	-0.0213	0.0614	
CDiff	0.414	0.401	-0.0144	< 0.05	Significantly Better
PSI_4	168.247	177.452			No new data
PSI_90	1.007	1.002			No new data

Changes in Survey Performance

12:19 Thursday, March 20, 2025 8

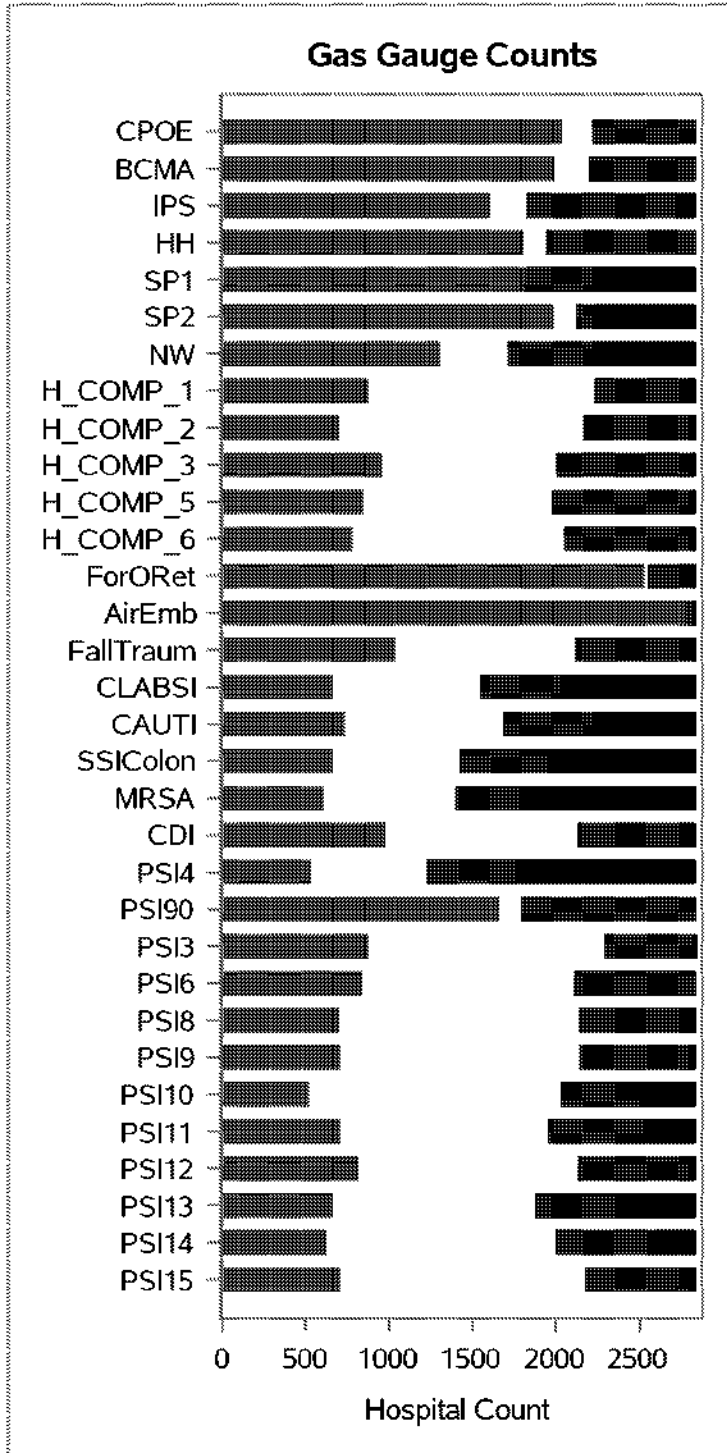
Survey Year	CPOE	Count of Hospitals Achieving the Standard	Total # of Hospitals	%	Statistically Significant Change
2018	Achieved the Standard	1302	1986	65.6%	Yes
2019	Achieved the Standard	1553	2107	73.7%	Yes
2020	Achieved the Standard	1120	1411	79.4%	Yes
2021	Achieved the Standard	2000	2256	88.7%	Yes
2022	Achieved the Standard	1941	2304	84.2%	Yes
2023	Achieved the Standard	1780	2149	82.8%	No
2024	Achieved the Standard	2112	2397	88.1%	Yes

Survey Year	BCMA	Count of Hospitals Achieving the Standard	Total # of Hospitals	%	Statistically Significant Change
2018	Achieved the Standard	907	1918	47.3%	Yes
2019	Achieved the Standard	1558	2122	73.4%	Yes
2020	Achieved the Standard	922	1410	65.4%	Yes
2021	Achieved the Standard	1603	2223	72.1%	Yes
2022	Achieved the Standard	1755	2276	77.1%	Yes
2023	Achieved the Standard	1862	2149	86.6%	Yes
2024	Achieved the Standard	2084	2397	86.9%	No

Changes in Survey Performance

Survey Year	HH	Count of Hospitals Achieving the Standard	Total # of Hospitals	%	Statistically Significant Change
2021	Achieved the Standard	860	2256	38.1%	Yes
2022	Achieved the Standard	1328	2304	57.6%	Yes
2023	Achieved the Standard	1592	2149	74.1%	Yes
2024	Achieved the Standard	1857	2397	77.5%	No

Survey Year	IPS	Count of Hospitals Achieving the Standard	Total # of Hospitals	%	Statistically Significant Change
2018	Achieved the Standard	1111	1850	60.1%	Yes
2019	Achieved the Standard	1234	1956	63.1%	Yes
2020	Achieved the Standard	833	1321	63.1%	Yes
2021	Achieved the Standard	1387	2092	66.3%	Yes
2022	Achieved the Standard	1477	2143	68.9%	Yes
2023	Achieved the Standard	1430	2002	71.4%	Yes
2024	Achieved the Standard	1622	2237	72.5%	Yes



measure	Min	Mean	Max	cutpointLowValue	cutpointHighValue
cpoe	15.00	80.232	100.000	63.159	97.304
bcma	25.00	81.866	100.000	66.641	97.092
ips	5.00	65.151	100.000	43.284	87.018
sp1	9.23	117.487	120.000	114.093	120.000
sp2	0.00	116.853	120.000	109.861	120.000
NW	15.00	77.068	100.000	61.264	92.871
HH	15.00	74.397	100.000	56.326	92.469
H_COMP_1	73.00	90.191	97.000	88.934	91.447
H_COMP_2	73.00	89.910	97.000	88.670	91.151
H_COMP_3	55.00	81.626	95.000	79.447	83.805
H_COMP_5	55.00	74.424	93.000	72.360	76.487
H_COMP_6	67.00	85.252	97.000	83.399	87.104
ForORet	0.00	0.014	0.327	0.000	0.039
AirEmb	0.00	0.002	2.890	0.000	0.030
FallTraum	0.00	0.384	1.926	0.183	0.586
CLABSI	0.00	0.651	2.782	0.375	0.927
CAUTI	0.00	0.540	2.512	0.293	0.787
SSIColon	0.00	0.831	3.094	0.487	1.176
mrsa	0.00	0.719	2.850	0.424	1.015
cdi	0.00	0.401	1.607	0.238	0.564
PSI4	84.66	177.452	235.510	165.441	189.462
PSI90	0.53	1.002	3.100	0.991	1.013
PSI3	0.05	0.637	7.500	0.364	0.911
PSI6	0.10	0.251	0.650	0.223	0.278
PSI8	0.15	0.290	0.560	0.268	0.313
PSI9	1.01	2.420	5.530	2.165	2.674
PSI10	0.74	1.690	4.600	1.513	1.867
PSI11	1.94	10.531	57.800	8.669	12.393

Gas Gauge Counts

12:19 Thursday, March 20, 2025 11

measure	Min	Mean	Max	cutpointLowValue	cutpointHighValue
PSI12	1.56	3.897	8.150	3.476	4.317
PSI13	1.95	5.626	12.560	5.040	6.212
PSI14	1.13	1.867	4.000	1.728	2.006
PSI15	0.28	0.887	2.410	0.779	0.995

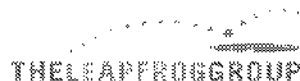
State Rankings

12:19 Thursday, March 20, 2025 12

Spr25 Rank	Fall24 Rank	State	Total # of As	Total # of Hospitals	% As	Fall24 Total # of As	Fall24 % As
1	1	UT	17	28	60.7%	17	60.7%
2	7	RI	5	9	55.6%	4	44.4%
3	5	NJ	36	66	54.5%	31	46.3%
4	3	CT	14	28	50.0%	14	50.0%
5	10	SC	24	51	47.1%	21	40.4%
5	2	VA	33	70	47.1%	41	57.7%
7	10	CO	21	46	45.7%	19	40.4%
8	26	DE	3	7	42.9%	2	28.6%
9	6	CA	122	285	42.8%	128	44.9%
10	9	PA	56	132	42.4%	54	41.2%
11	37	DC	2	5	40.0%	1	20.0%
12	4	NC	35	92	38.0%	43	46.7%
13	12	TN	27	73	37.0%	28	38.4%
14	13	FL	70	191	36.6%	71	37.0%
15	15	TX	81	224	36.2%	79	35.1%
16	21	NV	7	20	35.0%	6	30.0%
17	14	LA	20	58	34.5%	22	36.7%
18	19	ME	5	15	33.3%	5	31.3%
18	16	MT	3	9	33.3%	3	33.3%
20	23	IL	35	109	32.1%	32	29.1%
21	30	MD	13	41	31.7%	11	26.8%
21	18	OK	13	41	31.7%	13	32.5%
23	20	NH	4	13	30.8%	4	30.8%
24	29	MI	24	81	29.6%	22	27.2%
25	26	AK	2	7	28.6%	2	28.6%
25	8	ID	4	14	28.6%	6	42.9%
27	28	AZ	14	50	28.0%	14	28.0%

Spr25 Rank	Fall24 Rank	State	Total # of As	Total # of Hospitals	% As	Fall24 Total # of As	Fall24 % As
28	23	MA	15	55	27.3%	16	29.1%
29	17	WA	13	48	27.1%	16	32.7%
30	25	WI	17	67	25.4%	19	28.8%
31	34	NY	36	143	25.2%	32	22.1%
32	33	IN	18	72	25.0%	18	25.0%
33	32	OH	28	113	24.8%	29	25.2%
34	40	MS	9	37	24.3%	6	16.2%
35	35	GA	19	79	24.1%	17	21.5%
36	31	KS	7	30	23.3%	8	25.8%
36	22	KY	14	60	23.3%	18	29.5%
38	41	OR	7	33	21.2%	5	15.2%
39	37	AR	6	30	20.0%	6	20.0%
40	36	MO	10	59	16.9%	12	20.3%
41	44	HI	2	12	16.7%	1	8.3%
42	37	NE	3	20	15.0%	4	20.0%
43	45	AL	6	57	10.5%	4	6.7%
44	48	SD	1	10	10.0%	0	0.0%
45	42	MN	4	44	9.1%	5	11.4%
46	46	NM	1	18	5.6%	1	5.6%
47	47	WV	1	22	4.5%	1	4.5%
48	48	IA	0	30	0.0%	0	0.0%
48	48	ND	0	7	0.0%	0	0.0%
48	48	VT	0	6	0.0%	0	0.0%
48	43	WY	0	9	0.0%	1	11.1%

Exhibit 43



LEAPFROG DESIGNATED LOGO LICENSE — LETTER OF AGREEMENT

The Leapfrog Group and Jupiter Medical Center as of 3/26/2025 with 242
Name of Hospital (Licensee) **Effective Date** **# of Staffed Beds**

agree that Leapfrog grants Licensee a limited, non-transferable, and non-exclusive license to use one or more of the following Leapfrog logos, including their respective program logos (collectively, the "Designated Leapfrog Logos"), as indicated below, in accordance with the terms of this Letter of Agreement for both commercial and non-commercial promotion:

- ☒ **Spring 2025 Hospital Safety Grade (e.g. "A" or "B" Logo)**
☐ **Leapfrog 2024 Top Hospital**
☐ **2025 Recognized Leader in Caring for People with Diabetes**

Licensee acknowledges that this Agreement applies only to the Designated Leapfrog Logos selected above and all terms and conditions outlined herein govern their use.

Fee Table: Licensee agrees to pay The Leapfrog Group (please indicate tier of staffed beds on the table below):

Hospital Size	Indicate Tier with an "X"	Safety Grade Price	Top Hospital Price	Recognized Leader in Diabetes Care Price	Price with \$1,000 Embargo Discount**
<50 staffed beds		\$6,700	\$6,700	\$6,700	\$5,700
50 – 99 staffed beds		\$7,900	\$7,900	\$7,900	\$6,900
100 – 149 staffed beds		\$9,900	\$9,900	\$9,900	\$8,900
150 – 199 staffed beds		\$10,900	\$10,900	\$10,900	\$9,900
200 – 249 staffed beds	X	\$12,900	\$12,900	\$12,900	\$11,900
250 – 299 staffed beds		\$17,900	\$17,900	\$17,900	\$16,900
300 – 399 staffed beds		\$19,900	\$19,900	\$19,900	\$18,900
400 – 499 staffed beds		\$26,900	\$26,900	\$26,900	\$25,900
500+ staffed beds		\$29,900	\$29,900	\$29,900	\$28,900

Total Price: 11,900.00

* Combined purchase of two or more logo licenses will receive a 20% discount.

**Embargo Discount applied when signed license received by 4/30/2025 and cannot be combined with any other discounts.

This license allows the Licensee to use the Designated Leapfrog Logos in accordance with this Agreement and the Terms of Use attached as Exhibit A and the Leapfrog Group Style Guide for Hospitals. The Agreement becomes effective upon execution. An invoice will be issued within 72 hours of Leapfrog's receipt of the executed Agreement, and payment is due upon receipt.

Leapfrog releases updated Safety Grades twice per year, in Fall and Spring, and the Top Hospital designation once per year in the fall. Recognized Leader in Diabetes Care is designated once annually. This Agreement allows Licensee to use the Leapfrog Hospital Safety Grade "A" or "B" Logo and Leapfrog Hospital Safety Grade Program Logo for the current Spring 2025 ratings cycle plus the subsequent, Fall 2025 ratings cycle if Licensee is deemed eligible to use the respective logo by Leapfrog. The Designated Leapfrog Logos for the year or cycle this license is purchased may be promoted in perpetuity. Congratulations on earning the prestigious accolades.

Accepted and Agreed To:

Hospital Name: Jupiter Medical Center

Address: 1210 S. Old Dixie Hwy. Jupiter, FL 33458

Name: Sue Goulding

Title: Marketing Manager

Email: sgoulding@jupitermed.com

Phone: 561-263-3861

Signature: Sue Goulding

Effective Date: Mar 26, 2025

Designated User (contact will be authorized to access and download the Designated Logos provided through this LOA)

Name: Sue Goulding

Email: sgoulding@jupitermed.com

Billing Contact:

Name: Sue Goulding

Department: Marketing

Email: sgoulding@jupitermed.com

Phone: 561-263-3861

Additional Instructions: please send an invoice

Please scan the completed Letter of Agreement and email to Licensing@Leapfrog-Group.Org.

EXHIBIT A

Terms of Use of the Leapfrog Designated Logos

A. Licensee shall have the following rights and obligations:

1. Licensee may announce and display the Designated Leapfrog Logos on its website, hospital signage, through broadcast and radio advertisements, in paid print and online advertisements and through marketing materials (collectively, "Commercial Use"). Licensee may not change the form or display any of the Designated Leapfrog Logos.
2. If part of a multicampus organization or part of a multihospital system, Licensee must make clear that the Designated Leapfrog Logos apply only to specific campuses or to specific hospitals and not to the entire organization or system.
3. Licensee should give credit to The Leapfrog Group and link to Leapfrog's respective program webpage where possible and appropriate, for example:
 - i. Leapfrog Hospital Safety Grade website (www.hospitalsafetygrade.org)
 - ii. Leapfrog Top Hospital: (www.leapfroggroup.org/TopHospitals)
 - iii. Leapfrog and ADA's Recognized Leader in Caring for People Living with Diabetes <https://www.leapfroggroup.org/diabetes>
4. Licensee may NOT publish or refer to the Leapfrog Hospital Safety Grade underlying numerical values or display numerical values relating to the ratings programs (e.g. Hospital Safety Grade's numerical scores) via web, print, or any other media.
5. When using or displaying the Leapfrog Designated Logos, Licensee must display the most recent, officially licensed Leapfrog Designated Logos during the term of the License. The date-stamped logo (e.g., Spring 20XX or Fall 20XX) corresponding to the applicable Leapfrog Program cycle must be included wherever the designation appears. No alterations, modifications, or removal of date stamps from the logo are permitted.
6. Licensee may not republish the Designated Logos of any facilities other than its own purchased through this Agreement. The Designated Leapfrog Logos may only be used by the specific facility or facilities that have individually purchased a license. Logos may not be transferred, sublicensed, or displayed by any other hospital within a multi-hospital system or by parent organizations that have not obtained an active license for each facility using the logos.
7. Licensees using the Leapfrog Hospital Safety Grade must display the Official Licensure Logo (Leapfrog Hospital Safety Grade "A" or "B" Logo) as displayed below in any printed or web materials. Licensees may choose to display the Leapfrog Hospital Safety Grade Program Logo and/or The Leapfrog Group Logo.

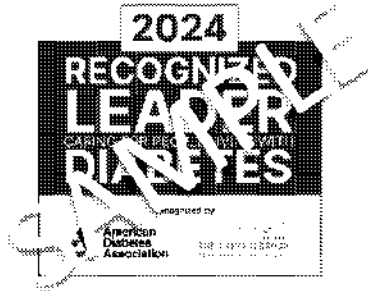


LEAPFROG
**HOSPITAL
SAFETY GRADE**

- i. The Leapfrog Hospital Safety Grade measures patient safety. Licensee must not state or imply that the Leapfrog Hospital Safety Grade measures or describes any other quality, e.g., patient satisfaction, quality of care provided, overall performance, etc.
 - ii. Licensee must not state or imply that it is safer than hospitals receiving lower letter grades on the Leapfrog Hospital Safety Grade unless the statement is qualified to indicate the concept "as measured by the Leapfrog Hospital Safety Grade." Preferred language would be, "X Hospital has received a higher Leapfrog Hospital Safety Grade than other hospitals in our community." Licensee must not state or imply that it is safer than other hospitals receiving the same letter grade on the Leapfrog Hospital Safety Grade. Licensee may not publicly display or otherwise reveal relative rankings among hospitals receiving the same letter grade in any use.
8. Licensees using the Top Hospital Designation must display the Official Licensure Logo (Top Hospital Logo) as displayed below in any printed or web materials. Licensee may additionally choose to display The Leapfrog Group Logo.



9. Licensees using the Leapfrog and American Diabetes Association Recognized Leader in Caring for People With Diabetes Designation Logo as displayed below in any printed or web materials. Licensee may additionally choose to display The Leapfrog Group Logo.



10. Licensees with a current, active license that is purchased within one year of the Effective Date, may also display The Leapfrog Group Logo as displayed below in any printed or web materials.



13. Nothing in this Agreement shall give Licensee any right, title or interest in or to the Designated Leapfrog Logos. Licensee acknowledges and agrees that Leapfrog is the exclusive owner of all rights, title and interest in and to the Designated Leapfrog Logos. Licensee shall not act in any manner that would or might conflict with or compromise Leapfrog's ownership of the Designated Leapfrog Logos, or similarly affect the value or goodwill pertaining to the Designated Leapfrog Logos, such as by applying to register any identical or similar trademark anywhere in the world.
14. The Designated Leapfrog Logos and all Intellectual Property Rights (defined below) therein are owned by Leapfrog. Licensee shall not reproduce, republish, distribute, modify, reverse engineer or otherwise exploit the Designated Leapfrog Logos in whole or in part, in any manner not expressly permitted by this Agreement and must not remove or modify any copyright or trademark notice, or other notice of ownership.

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15. Licensee agrees to indemnify and hold each of Leapfrog and any agent appointed by Leapfrog to pursue and enforce its rights and to undertake and fulfill its obligations under this Agreement ("Agent") and their respective affiliates and all of their respective past, present, and future directors, officers, employees, successors and agents and all of their respective successors and assigns, both individually and in their official capacities harmless from and against any and all liabilities, damages, demands, claims, causes of action, fines or penalties (including, without limitation, court costs and reasonable attorneys' fees) arising out of or related to the failure of Licensee to fulfill any of Licensee's obligations under this Agreement or Licensee's use of or access to the Designated Leapfrog Logos.

16. NEITHER LEAPFROG NOR ITS AGENT WILL HAVE ANY RESPONSIBILITY AND WILL BEAR NO LIABILITY WHATSOEVER WITH REGARD TO REPLACING, UPLOADING, VALIDATING, OR CORRECTING ANY LEAPFROG HOSPITAL SAFETY GRADE OR TOP HOSPITAL DESIGNATION ONCE RELEASED. LICENSEE ACKNOWLEDGES AND AGREES THAT, SINCE THE LEAPFROG HOSPITAL SAFETY GRADES AND TOP HOSPITAL DESIGNATIONS ARE BASED ON INFORMATION PROVIDED BY THIRD PARTIES, IT IS REASONABLE THAT THE LEAPFROG HOSPITAL SAFETY GRADE AND TOP HOSPITAL DESIGNATIONS, AND ANY SERVICES PROVIDED UNDER THIS AGREEMENT BE, AND THEY ARE "AS IS", "AS AVAILABLE" AND "WITH ALL FAULTS". LEAPFROG AND ITS AGENT DISCLAIM ANY AND ALL WARRANTIES, EXPRESS OR IMPLIED, INCLUDING ANY WARRANTY OF TITLE, NON-INFRINGEMENT, FITNESS FOR A PARTICULAR PURPOSE, MERCHANTABILITY, OR ARISING OUT OF ANY COURSE OF DEALING.
17. TO THE FULL EXTENT PERMITTED BY LAW, NEITHER LEAPFROG NOR AGENT IS LIABLE FOR ANY INDIRECT, PUNITIVE, SPECIAL, INCIDENTAL, CONSEQUENTIAL, OR EXEMPLARY DAMAGES OR ANY DAMAGES FOR LOSS OF BUSINESS, REVENUE, OR PROFIT OR ANY OTHER DAMAGES OF ANY KIND OR NATURE ARISING OUT OF OR IN CONNECTION WITH LICENSEE'S USE OF DESIGNATED LEAPFROG LOGOS, EVEN IF LEAPFROG HAS PREVIOUSLY BEEN ADVISED OF, OR REASONABLY COULD HAVE FORESEEN, THE POSSIBILITY OF SUCH DAMAGES, HOWEVER THEY ARISE, WHETHER IN CONTRACT, TORT, WARRANTY, OR ANY OTHER LEGAL THEORY.
18. This Agreement, the rights, and obligations hereunder, and any claims or disputes relating thereto, will be governed by and construed in accordance with the laws of the District of Columbia without regard to the principles of conflicts of laws. Any claim, suit, or action arising under or relating to this Agreement must be brought and maintained exclusively in courts located within the District of Columbia.
19. Licensee may not assign, sublicense, delegate or otherwise transfer this Agreement or any right granted hereunder.
20. This Agreement constitutes the entire agreement between Licensee and Leapfrog relating to this subject matter.
21. This Agreement shall terminate automatically and immediately upon a breach by the Licensee, as determined in Leapfrog's sole and absolute discretion. Upon termination of the License, Licensee must immediately cease use of the Top Hospital Designation and the Hospital Safety Grade and all Designated Leapfrog Logos.
22. If payment is not received by Leapfrog within forty-five (45) days after the due date, or any Licensee violates, or is perceived by Leapfrog to have violated, the terms of this Agreement, as determined within Leapfrog's sole discretion, Leapfrog reserves its rights to: (1) impose interest on its outstanding invoices at a rate of six (6) percent annually; (2) immediately suspend this Agreement, and any rights Licensee has or may have hereunder; and, (3) categorize Licensee as ineligible for licensure under future iterations of this Agreement. Additionally, Leapfrog reserves the right to indefinitely refuse and withhold future licensure to any Licensee or potential Licensee, in its sole discretion, based upon said Licensee being in arrears on payments due to Leapfrog under this Agreement.
23. These Terms of Use shall survive the termination of this Agreement.

Spring 2025 Accolade Letter of Agreement & Exhibit A

Final Audit Report

2025-03-26

Created:	2025-03-26
By:	Lindsay Belville (lbelville@leapfrog-group.org)
Status:	Filled
Transaction ID:	CBJCHBCAABAAKxNNIZRBGkUiLin9g6vyPHR6JORzhO4h

"Spring 2025 Accolade Letter of Agreement & Exhibit A" History

-  Web Form created by Lindsay Belville (lbelville@leapfrog-group.org)
2025-03-20 - 9:11:45 PM GMT
-  Web Form filled in by Sue Goulding (sgoulding@jupitermed.com)
2025-03-26 - 11:39:09 AM GMT- IP address: 198.72.44.8
-  Email verification link emailed to Sue Goulding (sgoulding@jupitermed.com)
2025-03-26 - 11:39:11 AM GMT
-  Email viewed by Sue Goulding (sgoulding@jupitermed.com)
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-  Agreement completed.
2025-03-26 - 11:39:38 AM GMT

Exhibit 44

LEAPFROG
HOSPITAL
SAFETY GRADE

Scoring Methodology

SPRING 2025 SAFETY GRADE

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4/21/2025

LEAPFROG00217511

HOSPITAL

SAFETY GRADE

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HOSPITAL

SAFETY GRADE

WHAT IS THE HOSPITAL SAFETY GRADE?

Leapfrog Hospital Safety Grades are assigned to nearly 3,000 general acute-care hospitals across the nation twice annually. The Safety Grade uses up to 22 national patient safety measures from the Centers for Medicare & Medicaid Services (CMS) and the Leapfrog Hospital Survey, and information from other supplemental data sources, to produce a single letter grade representing a hospital's overall performance in keeping patients safe from preventable harm and medical errors. The Safety Grade methodology has been peer reviewed and published in the Journal of Patient Safety.¹

With the Safety Grade, The Leapfrog Group aims to educate and encourage consumers to consider safety when selecting a hospital for themselves or their families. In addition, we believe the Safety Grade will foster strong market incentives for hospitals to make safety a priority. Safety Grades are publicly reported at www.HospitalSafetyGrade.org.

ELIGIBLE HOSPITALS

Due to the limited availability of public data, Leapfrog is not able to calculate a Safety Grade for every hospital in the U.S., including the following types of hospitals:

- Critical access hospitals (CAH)
- Rural emergency hospitals (REH)
- Long-term care and rehabilitation facilities
- Mental health facilities
- Federal hospitals (e.g., Veterans Affairs, Indian Health Services, etc.)
- Some specialty hospitals, such as surgery centers and cancer hospitals
- Free-standing pediatric hospitals
- Hospitals in U.S. territories
- Hospitals that are missing scores for **more than six (6)** process/structural measures, or **more than five (5)** outcome measures, or **missing PSI 90**

¹ The Leapfrog Hospital Safety Grade uses the below-described data and reflects expert opinion as to the relative importance of each category.

HOSPITAL

SAFETY GRADE

MEASURES

The Safety Grade utilizes up to 22 national patient safety measures from the Centers for Medicare & Medicaid Services (CMS) and the Leapfrog Hospital Survey, and information from other supplemental data sources.

The measure set is divided into two domains: (1) Process/Structural Measures and (2) Outcome Measures. Each domain represents 50% of the Safety Grade. The following table lists the 22 measures included in the Safety Grade, as well as the data source and reporting period for each measure. In some cases where a hospital's information is not available for a certain measure, Leapfrog uses a secondary data source (as indicated in the table). In cases where a hospital's information is not available from any data source, Leapfrog has outlined a methodology for dealing with the missing data.

PROCESS/STRUCTURAL MEASURES (12)				
Measure Name	Primary Data Source	Reporting Period	Secondary Data Source	Reporting Period
Computerized Physician Order Entry (CPOE)	2024 Leapfrog Hospital Survey	2024	Imputation Model Applied*	N/A
Bar Code Medication Administration (BCMA)	2024 Leapfrog Hospital Survey	2024	Imputation Model Applied*	N/A
ICU Physician Staffing (IPS)	2024 Leapfrog Hospital Survey	2024	Imputation Model Applied*	N/A
Safe Practice 1: Culture of Leadership Structures and Systems	2024 Leapfrog Hospital Survey	2024	N/A	N/A
Safe Practice 2: Culture Measurement, Feedback & Intervention	2024 Leapfrog Hospital Survey	2024	N/A	N/A

LEAPFROG
HOSPITAL
 SAFETY GRADE

PROCESS/STRUCTURAL MEASURES (12)

Measure Name	Primary Data Source	Reporting Period	Secondary Data Source	Reporting Period
Total Nursing Care Hours per Patient Day	2024 Leapfrog Hospital Survey	01/01/2023 - 12/31/2023 or 07/01/2023 - 06/30/2024	N/A	N/A
Hand Hygiene	2024 Leapfrog Hospital Survey	2024	Imputation Model Applied*	N/A
H-COMP-1: Nurse Communication	CMS	01/01/2023 - 12/31/2023	N/A	N/A
H-COMP-2: Doctor Communication	CMS	01/01/2023 - 12/31/2023	N/A	N/A
H-COMP-3: Staff Responsiveness	CMS	01/01/2023 - 12/31/2023	N/A	N/A
H-COMP-5: Communication about Medicines	CMS	01/01/2023 - 12/31/2023	N/A	N/A
H-COMP-6: Discharge Information	CMS	01/01/2023 - 12/31/2023	N/A	N/A

*See Leapfrog's Imputation Method for CPOE, BCMA, IPS and Hand Hygiene for more information on the imputation methodology used for hospitals that did not submit a Leapfrog Hospital Survey by November 30, 2024.

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 SAFETY GR_{AD}DE

OUTCOME MEASURES (10)

Measure Name	Primary Data Source	Reporting Period	Secondary Data Source	Reporting Period
Foreign Object Retained	CMS	07/01/2021 - 06/30/2023	N/A	N/A
Air Embolism	CMS	07/01/2021 - 06/30/2023	N/A	N/A
Falls and Trauma	CMS	07/01/2021 - 06/30/2023	N/A	N/A
CLABSI	2024 Leapfrog Hospital Survey	07/01/2023 - 06/30/2024	CMS	01/01/2023 - 12/31/2023
CAUTI	2024 Leapfrog Hospital Survey	07/01/2023 - 06/30/2024	CMS	01/01/2023 - 12/31/2023
SSI: Colon	2024 Leapfrog Hospital Survey	07/01/2023 - 06/30/2024	CMS	01/01/2023 - 12/31/2023
MRSA	2024 Leapfrog Hospital Survey	07/01/2023 - 06/30/2024	CMS	01/01/2023 - 12/31/2023
C. Diff.	2024 Leapfrog Hospital Survey	07/01/2023 - 06/30/2024	CMS	01/01/2023 - 12/31/2023

LEAPFROG
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 SAFETY GRADE

OUTCOME MEASURES (10)

PSI 4: Death rate among surgical
 inpatients with serious
 treatable complications

CMS

07/01/2021 - 06/30/2023

N/A

N/A

Measure Name	Primary Data Source	Reporting Period	Secondary Data Source	Reporting Period
CMS Medicare PSI 90: Patient safety and adverse events composite*	CMS	07/01/2021 - 06/30/2023	N/A	N/A

* CMS calculates PSI 90 using the ten (10) component PSIs. While scores for each of the 10 component PSIs are not used to calculate spring 2025 Hospital Safety Grades, they will be publicly reported on the Hospital Safety Grade [website](#).

***COMPONENT PSIs (SCORES NOT USED TO CALCULATE THE HOSPITAL SAFETY GRADE)

Component PSI	Primary Data Source	Reporting Period	Secondary Data Source	Reporting Period
PSI 3: Pressure ulcer rate	CMS	07/01/2021 - 06/30/2023	N/A	N/A
PSI 6: Iatrogenic pneumothorax rate	CMS	07/01/2021 - 06/30/2023	N/A	N/A
PSI 8: In-hospital fall with hip fracture rate	CMS	07/01/2021 - 06/30/2023	N/A	N/A
PSI 9: Postoperative hemorrhage or hematoma rate	CMS	07/01/2021 - 06/30/2023	N/A	N/A
PSI 10: Postoperative acute kidney injury requiring dialysis rate	CMS	07/01/2021 - 06/30/2023	N/A	N/A
PSI 11: Postoperative respiratory failure rate	CMS	07/01/2021 - 06/30/2023	N/A	N/A
PSI 12: Perioperative pulmonary embolism or deep vein thrombosis rate	CMS	07/01/2021 - 06/30/2023	N/A	N/A
PSI 13: Postoperative sepsis rate	CMS	07/01/2021 - 06/30/2023	N/A	N/A
PSI 14: Postoperative wound dehiscence rate	CMS	07/01/2021 - 06/30/2023	N/A	N/A
PSI 15: Abdominopelvic accidental puncture or laceration rate	CMS	07/01/2021 - 06/30/2023	N/A	N/A

Note: CMS calculates PSI 90 using the ten (10) component PSIs listed above. While scores for each of the 10 component PSIs are not used to calculate spring 2025 Hospital Safety Grades, they will be publicly reported on the Hospital Safety Grade [website](#).

MEASURE & SCORING DESCRIPTIONS**PROCESS/STRUCTURAL MEASURES**

For Process/Structural Measures, a higher score is always better because these are measures of compliance with best practices in patient care.

COMPUTERIZED PHYSICIAN ORDER ENTRY (CPOE)

The CPOE measure is collected by The Leapfrog Group on the Leapfrog Hospital Survey. It measures a hospital's progress toward implementing a CPOE system to reduce medication ordering errors. Through participation in the Leapfrog Hospital Survey, hospitals are placed in one of several performance categories: "Achieved the Standard," "Considerable Achievement," "Some Achievement," "Limited Achievement," or "Unable to Calculate Score." For the purposes of calculating the Safety Grade, a numerical score is assigned to each performance category:

Leapfrog Performance Category	Measure Score
Achieved the Standard	100
Considerable Achievement	70
Some Achievement	40
Limited Achievement	15
Unable to Calculate Score	Not Available (See Scoring Terms)

For hospitals that did not submit a 2024 Leapfrog Hospital Survey by November 30, see [Using Secondary Data Sources](#) for more information on Leapfrog's imputation methodology.

BAR CODE MEDICATION ADMINISTRATION (BCMA)

The BCMA measure is collected by The Leapfrog Group on the Leapfrog Hospital Survey. It measures a hospital's progress toward 1) implementation of BCMA throughout the hospital, 2) compliance with patient and medication scans during administration, 3) use of decision support, and 4) structures to monitor and reduce workarounds. Through participation in the Leapfrog Hospital Survey, hospitals are placed in one of several performance categories: "Achieved the Standard," "Considerable Achievement," "Some Achievement," "Limited Achievement," or "Does Not Apply." For the purposes of calculating the Safety Grade, a numerical score is assigned to each performance category:

Leapfrog Performance Category	Measure Score
Achieved the Standard	100
Considerable Achievement	75
Some Achievement	50
Limited Achievement	25
Does Not Apply	Not Available (See Scoring Terms)

For hospitals that did not submit a 2024 Leapfrog Hospital Survey by November 30, see [Using Secondary Data Sources](#) for more information on Leapfrog's imputation methodology.

ICU PHYSICIAN STAFFING (IPS)

The IPS measure is collected by The Leapfrog Group on the Leapfrog Hospital Survey. It measures a hospital's use of intensivists in ICUs. Through participation in the Leapfrog Hospital Survey, hospitals are placed in one of several performance categories: "Achieved the Standard," "Considerable Achievement," "Some Achievement," "Limited Achievement," or "Does Not Apply." For the purposes of calculating the Safety Grade, a numerical score is assigned to each performance category:

Leapfrog Performance Category	Measure Score
Achieved the Standard	100
Considerable Achievement	50
Some Achievement	15
Limited Achievement	5
Does Not Apply	Not Available (See Scoring Terms)

For hospitals that did not submit a 2024 Leapfrog Hospital Survey by November 30, see [Using Secondary Data Sources](#) for detailed information on Leapfrog's imputation methodology.

NATIONAL QUALITY FORUM (NQF) SAFE PRACTICES

Two (2) NQF Safe Practice measures are collected by The Leapfrog Group on the Leapfrog Hospital Survey. They measure a hospital's progress toward implementing endorsed processes and protocols to reduce and prevent adverse events. Through participation in the Leapfrog Hospital Survey, hospitals can earn up to 120 points for each Safe Practice. For the purposes of calculating the Safety Grade, individual scores for each Safe Practice are used:

NQF Safe Practice	Possible Measure Score
Safe Practice 1: Culture of Safety Leadership Structures and Systems	0 - 120
Safe Practice 2: Culture Measurement, Feedback and Intervention	0 - 120

There is no secondary data source for the NQF Safe Practices. Therefore, hospitals that did not submit a 2024 Leapfrog Hospital Survey by November 30 will not have these measures included in their Safety Grade and the measure will be reported as "Declined to Report." See [Dealing with Missing Data](#) for more information.

TOTAL NURSING CARE HOURS PER PATIENT DAY

The Total Nursing Care Hours per Patient Day measure is collected by The Leapfrog Group on the Leapfrog Hospital Survey. It measures the hospital's total number of productive hours worked by employee or contract nursing staff (i.e., RNs, LPNs, and UAPs) with direct patient care responsibilities per patient day across three unit types: medical, surgical, and med/surg. Through participation in the Leapfrog Hospital Survey, hospitals are placed in one of several performance categories: "Achieved the Standard," "Considerable Achievement," "Some Achievement," "Limited Achievement," or "Does Not Apply." For the purposes of calculating the Safety Grade, a numerical score is assigned to each performance category:

Leapfrog Performance Category	Measure Score
Achieved the Standard	100
Considerable Achievement	70
Some Achievement	40
Limited Achievement	15
Does Not Apply	Not Available (See Scoring Terms)

There is no secondary data source for the Total Nursing Care Hours per Patient Day measure. Therefore, hospitals that did not submit a 2024 Leapfrog Hospital Survey by November 30 will not have these measures included in their Safety Grade and the measure will be reported as "Declined to Report." See [Dealing with Missing Data](#) for more information.

HAND HYGIENE

The Hand Hygiene measure is collected by The Leapfrog Group on the Leapfrog Hospital Survey. It measures processes and protocols that hospitals have in place regarding monitoring hand hygiene practices, fostering a culture of good hand hygiene, offering training and education, and providing equipment. Through participation in the Leapfrog Hospital Survey, hospitals are placed in one of several performance categories: "Achieved the Standard," "Considerable Achievement," "Some Achievement," "Limited Achievement." For the purposes of calculating the Safety Grade, a numerical score is assigned to each performance category:

Leapfrog Performance Category	Measure Score
Achieved the Standard	100
Considerable Achievement	70
Some Achievement	40
Limited Achievement	15

For hospitals that did not submit a 2024 Leapfrog Hospital Survey by November 30, see [Using Secondary Data Sources](#) for detailed information on Leapfrog's imputation methodology.

HOSPITAL CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS (HCAHPS) COMPOSITES

The Hospital HCAHPS survey responses are collected by CMS via the Inpatient Quality Reporting Program. Linear mean scores [calculated by CMS](#) incorporate the full range of survey response categories into a single metric for each HCAHPS composite. Five of the six composites are used in the Safety Grade. For the purposes of calculating the Safety Grade, a hospital's linear mean score for each of the five composites is used:

HCAHP Composite	Possible Measure Score
H-COMP-1: Nurse Communication	0 - 100
H-COMP-2: Doctor Communication	0 - 100
H-COMP-3: Staff Responsiveness	0 - 100
H-COMP-5: Communication about Medicines	0 - 100
H-COMP-6: Discharge Information	0 - 100

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OUTCOME MEASURES

For Outcome Measures, a lower score is always better because these are measures of harm experienced by patients (e.g., central line-associated blood stream infections).

HOSPITAL-ACQUIRED CONDITIONS

Three hospital-acquired condition measures are calculated by CMS through the [DRA HAC Reporting Program](#): Foreign Object Retained after Surgery, Air Embolism, and Falls and Trauma. Hospital-acquired condition rates are calculated by CMS based on Part A Medicare Fee-for-service (FFS) claims and publicly reported as a rate per 1,000 Part A Medicare FFS discharges. No age restrictions are applied. For the purposes of calculating the Safety Grade, the rate is used. More information is available in the [DRA HAC methodology](#).

HEALTHCARE-ASSOCIATED INFECTIONS

Five healthcare-associated infection measures are collected by The Leapfrog Group on the Leapfrog Hospital Survey: Central line-associated bloodstream infections (CLABSI) in ICUs and select wards, Catheter-associated urinary tract infections (CAUTI) in ICUs and select wards, Surgical site infections from colon surgery (SSI: Colon), Facility-wide inpatient MRSA Blood Laboratory-identified Events, and Facility-wide inpatient C.diff. Laboratory-identified Events. Through participation in the Leapfrog Hospital Survey, hospitals were required to 1) join Leapfrog's NHSN group, 2) provide an accurate NHSN ID in the Profile section of the Online Survey Tool, and 3) submit a Survey by November 30. For the purposes of calculating the Safety Grade, the [standardized infection ratio \(SIR\)](#) is used:

As Reported by Leapfrog	Measure Score	Notes
Standardized Infection Ratio (SIR)	SIR	Measure is included in calculating the Safety Grade
Does Not Apply	Not Available (See Scoring Terms)	Measure is not included in calculating the Safety Grade. No use of Secondary Data.
Unable to Calculate Score	Not Available (See Scoring Terms)	Measure is not included in calculating the Safety Grade. No use of Secondary Data.
Declined to Respond	See Using Secondary Data	Secondary Data source is used.

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For hospitals that did not join Leapfrog's NHSN group, provide an accurate NHSN ID, or submit a 2024 Leapfrog Hospital Survey by November 30, see [Using Secondary Data Sources](#) for more information on Leapfrog's use of CMS data.

AHRQ PATIENT SAFETY INDICATORS (PSI)

Two AHRQ Patient Safety Indicators are calculated by CMS through the Inpatient Quality Reporting Program and the [HAC Reduction Program](#): PSI 4 Death Rate among Surgical Inpatients with Serious Treatable Conditions and PSI 90 Patient Safety and Adverse Events Composite. PSI rates are calculated by CMS based on Medicare Fee-for-Service claims and publicly reported as a rate per 1,000 inpatient discharges. CMS only includes claims from patients 18 years or older. For the purpose of calculating the Safety Grade, the smoothed rate is used for both measures. More information on calculating PSIs is available on the [Patient Safety Indicators \(PSI\) 2024 Resources website](#).

Note: CMS calculates PSI 90 using the ten (10) component PSIs that are listed in the PSI 90 Components table [above](#). While scores for each of the 10 component PSIs are NOT used to calculate spring 2025 Hospital Safety Grades, they will be publicly reported on the Hospital Safety Grade [website](#). Additional information about the PSI 90 measure and how it is calculated by CMS can be found [here](#).

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USING SECONDARY DATA SOURCES

Twelve (12) of the 22 measures included in the Safety Grade are derived from the Leapfrog Hospital Survey. The Leapfrog Hospital Survey is voluntary, and as such, hospitals may choose not to submit a Survey. To address this gap in available data, the Safety Grade methodology utilizes secondary data when available. For information on how to complete a free Leapfrog Hospital Survey, visit www.leapfroggroup.org/survey.

IMPUTATION METHOD FOR CPOE, BCMA, IPS, AND HAND HYGIENE

Leapfrog has worked closely with statisticians at Mathematica, Leapfrog's National [Expert Panel](#), and our scientific partners at Johns Hopkins Medicine to develop a new two-step imputation approach for determining scores for CPOE, BCMA, IPS, and Hand Hygiene if they are missing from our [publicly reported](#) Survey Results.

STEP 1: USE A HOSPITAL'S MOST RECENT SCORE ON THE MEASURE (APPLIES TO CPOE, IPS, AND HAND HYGIENE ONLY)

If the hospital had a score assigned by Leapfrog in the previous two rounds of grades (i.e., fall 2024, spring 2024), excluding imputed scores, the hospital is assigned the most recent score on that measure in the current Hospital Safety Grade (i.e., spring 2025).

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STEP 2: USE IMPUTATION POINT ASSIGNMENT (APPLIES TO CPOE, BCMA, IPS AND HAND HYGIENE)

If the hospital does not have historical data from the last two rounds (i.e., fall 2024, spring 2024) of the Safety Grade, the hospital is assigned a point value that is equivalent to receiving “Limited Achievement” for this measure on the Leapfrog Hospital Survey.

Note about IPS: Only hospitals that operate an adult or pediatric medical and/or surgical ICU or neuro ICU are eligible for Step 2 Imputation of the IPS measure. A hospital’s ICU designation (i.e., operating a medical ICU, surgical ICU, or pediatric ICU) is determined from the number of medical, surgical and/or pediatric ICU beds reported in Worksheet S-3 Part 1 of the hospital’s most recent CMS Cost Report. If your hospital does not operate an ICU, but shares a CMS Certification Number with a hospital that does, please contact the Help Desk immediately if an IPS score was imputed.

Step 2 Imputation Point Assignments

Measure	Leapfrog Hospital Survey Performance Category	Corresponding Safety Grade Measure Score
CPOE	Limited Achievement	15
BCMA	Limited Achievement	25
IPS	Limited Achievement	5
Hand Hygiene	Limited Achievement	15

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CMS DATA FOR HAIS

CMS is the **secondary data** source for healthcare-associated infections. For the purposes of calculating the Safety Grade, the standardized infection ratio (SIR) published by CMS is used:

Hospitals That Did Not Join Leapfrog's NHSN Group and Submit Section 7: Managing Serious Errors of the 2024 Leapfrog Hospital Survey by November 30

As Reported by CMS	Measure Score	Notes
Not Available (no locations or low volume)	Not Available (See Scoring Terms)	Measure is not included in calculating the Leapfrog Hospital Safety Grade.
Standard Infection Ratio (SIR)	SIR	Measure is included in calculating the Leapfrog Hospital Safety Grade.

If a hospital does not have available data from the Leapfrog Hospital Survey or CMS (e.g., no locations or low volume), the hospital is reported as Not Available "Not Available." See [Dealing with Missing Data](#) for more information.

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SCORING METHODOLOGY

WEIGHTING INDIVIDUAL MEASURES

Each measure included in the Leapfrog Hospital Safety Grade is assigned a standard weight. The methodology to assign standard weights includes four criteria: (1) Impact, (2) Evidence, (3) Opportunity, and (4) Number of Component Measures. These four criteria are then combined using the equation below, which results in a standard weight for each measure that represents the measure's relative importance within the Hospital Safety Grade.

$$[\text{Evidence} + (\text{Impact} \times \text{Opportunity} \times \text{Number of Component Measures})]$$

EVIDENCE

The Evidence Score for each individual measure is assigned a value of one (1) or two (2) using the following criteria:

- 1 = Supported by either suggestive clinical or epidemiological studies or theoretical rationale
- 2 = Supported by experimental, clinical, or epidemiological studies and strong theoretical rationale

OPPORTUNITY

The Opportunity Score for each individual measure is based on the Coefficient of Variation (Standard Deviation/Mean) of that measure, using the following formula: $[1 + (\text{Standard Deviation}/\text{Mean})]$. The Opportunity Score is on a continuous scale that is capped at three (3). Any measure with an Opportunity Score above three (3) is assigned a three (3).

IMPACT

The Impact Score for each individual measure is comprised of two (2) parts, each of which is assigned a value from one (1) to three (3):

1. Number of patients affected

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2. Severity of harm

The *number of patients affected* score is determined by the following:

- 0 = Extremely rare event (e.g., Air Embolism)
- 1 = Rare event (e.g., Foreign Object Retained After Surgery)
- 2 = Some patients in hospital affected (e.g., ICU Physician Staffing)
- 3 = All patients in hospital affected (e.g., Hand Hygiene)

The *severity of harm* score is determined by the following:

- 1 = No direct evidence of harm or harm reduction (e.g., Patient Experience)
- 2 = Clear documentation of harm or harm reduction; adverse events (e.g., Foreign Object Retained After Surgery)
- 3 = Significant mortality reduction (more than 1,000 deaths or a 10% reduction in hospital wide mortality) (e.g., ICU Physician Staffing)

The values from each part are then added together to arrive at the overall Impact Score using the following criteria:

- 1 = Score of 2 (Low Impact) (e.g., Air Embolism)
- 2 = Score of 3-4 (Medium Impact) (e.g., Patient Experience)
- 3 = Score of 5-6 (High Impact) (e.g., ICU Physician Staffing)

NUMBER OF COMPONENT MEASURES

The number of component measures refers to how many measures are included within the measure. For PSI 90, the number of component measures is 10 (PSI 3, PSI 6, PSI 8, PSI 9, PSI 10, PSI 11, PSI 12, PSI 13, PSI 14, and PSI 15). For all other measures included in the Hospital Safety Grade, the number of component measures within the measure is one (1).

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STANDARD MEASURE WEIGHTS

Measure	Evidence Score	Opportunity Score	Impact Score	Number of Component Measures	Standard Measure Weight
Process/Structural Measure Domain (50%)					
CPOE	2	1.43	3	1	6.2%
BCMA	2	1.37	3	1	6.0%
IPS	2	1.67	3	1	6.9%
SP 1	1	1.06	2	1	3.1%
SP 2	1	1.12	2	1	3.2%
Total Nursing Care Hours per Patient Day	2	1.41	2	1	4.7%
Hand Hygiene	2	1.49	2	1	4.9%
H-COMP-1	1	1.03	2	1	3.0%
H-COMP-2	1	1.03	2	1	3.0%
H-COMP-3	1	1.05	2	1	3.0%
H-COMP-5	1	1.06	2	1	3.1%
H-COMP-6	1	1.04	2	1	3.0%
Outcome Measure Domain (50%)					
Foreign Object Retained	1	3.00	2	1	4.2%
Air Embolism	1	3.00	1	1	2.4%
Falls and Trauma	2	2.05	3	1	4.9%
CLABSI	2	1.85	3	1	4.5%
CAUTI	2	1.91	3	1	4.7%
SSI: Colon	2	1.83	2	1	3.4%
MRSA	2	1.82	3	1	4.5%
C. Diff.	2	1.81	3	1	4.5%
PSI 4	1	1.14	2	1	2.0%
PSI 90	1	1.20	2	10	15.0%



CALCULATING Z-SCORES

Z-Scores are used to standardize data from measures with different performance scales and allow for comparisons (e.g., a linear mean score of 90 on H-COMP-1: Nurse Communication and a CLABSI SIR of 0.870). In addition, Z-Scores can indicate to a hospital whether their measure score is above, below, or equal to the average hospital.

In the Scoring Methodology, a Z-Score is calculated for each available measure score. A Z-Score is calculated using a hospital's actual measure score, the national mean for that measure, and the standard deviation for that measure. The Z-Score for each measure is calculated using the following formulas:

- **For Process/Structural Measures:** $[\text{Hospital Score} - \text{Mean}] / \text{Standard Deviation}$
- **For Outcome Measures:** $[(\text{Mean} - \text{Hospital Score}) / \text{Standard Deviation}]$

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The following table includes the national mean and standard deviation for each measure used to calculate a hospital's Z-Score. For display, means and standard deviations are displayed rounded to two or three decimal places. For scoring, these values are not rounded.

Process and Structural Measures	Mean	Standard Deviation
CPOE	80.23	34.14
BMCA	81.87	30.45
IPS	65.15	43.73
SP 1	117.49	6.79
SP 2	116.85	13.98
Total Nursing Care Hours per Patient Day	77.07	31.61
Hand Hygiene	74.40	36.14
H-COMP-1	90.19	2.51
H-COMP-2	89.91	2.48
H-COMP-3	81.63	4.36
H-COMP-5	74.42	4.13
H-COMP-6	85.25	3.70

Outcome Measures	Mean	Standard Deviation
Foreign Object Retained	0.014	0.050
Air Embolism	0.002	0.055
Falls and Trauma	0.384	0.402
CLABSI	0.651	0.552
CAUTI	0.540	0.494
SSI: Colon	0.831	0.689
MRSA	0.719	0.591
C. Diff.	0.401	0.326
PSI 4	177.452	24.020
PSI 90	1.002	0.196

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A NOTE ABOUT EXTREME VALUES

For hospitals that have an “extreme” value for a particular measure (i.e., a value that exceeds the 99th percentile) Leapfrog “trims” the reported value to the 99th percentile. For example, a rate of 0.500 per 1,000 patient discharges for Foreign Object Retained after Surgery is “trimmed” to 0.327 (e.g., the 99th percentile). Only “trimmed” rates are displayed on the Leapfrog Hospital Safety Grade [website](#). The table below includes the “trimmed” values for the spring 2025 Leapfrog Hospital Safety Grade. The PSI 90 measure score represents an observed to expected ratio that has already been risk adjusted at both the component PSI level and at the composite level; therefore, the measure is not “trimmed” by Leapfrog.

Measure	99 th Percentile
Foreign Object Retained	0.327
Air Embolism	2.89
Falls and Trauma	1.926
CLABSI	2.782
CAUTI	2.512
SSI: Colon	3.094
MRSA	2.85
C. Diff.	1.607
PSI 4	235.51

Note: Percentiles are rounded to reflect the precision of the raw data.

DEALING WITH MISSING DATA

Due to a variety of reasons, a hospital may not have a measure score for all 22 measures. If a hospital is missing a measure score for any measure (except PSI 90; hospitals missing PSI 90 are not graded), the standard weight of that measure is redistributed to the other measures in the same measure domain. The new weight for each measure within the domain is calculated by re-apportioning the standard weight assigned to the measure with the missing score to other measures within the same domain.

For example, if a hospital is missing a measure score for ICU Physician Staffing because the hospital does not operate an adult or pediatric medical and/or surgical ICU, the standard weight of 6.9% will be re-apportioned to the remaining 11 measures within the process/structural measure domain.

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To calculate the new weight of each of the remaining 11 measures in the process/structural measure domain, hospitals can use the formula below or use the Leapfrog Hospital Safety Grade Calculator[®], which can be found on the [Safety Grade Review Website](#). Note that each domain contributes to 50% of the overall letter grade.

*[Standard measure weight / (sum of standard weights for the remaining 11 measures in the process/structural measure domain)]*50% = updated measure weight*

For more information about how the measure weight redistribution is calculated and affects the overall score, please see the Leapfrog Hospital Safety Grade Calculator, which can be found on the last page of the [Safety Grade Review Website](#).

CALCULATING WEIGHTED MEASURE SCORES

To calculate a hospital's numerical safety score, multiply the Z-Score of each process/structural measure by the standard weight assigned to that measure to get the weighted process/structural measure score. If a hospital is missing any process/structural measure scores, see [Dealing with Missing Data](#) to determine the updated measure weight. Then, sum all weighted process/structural measure scores. This is the hospital's overall weighted process/structural measures score.

Multiply the Z-Score of each outcome measure by the standard weight assigned to that measure to get the weighted outcome measure score. If a hospital is missing any outcome measure scores, see [Dealing with Missing Data](#) to determine the updated measure weight. Then, sum all weighted outcome measure scores. This is the hospital's overall weighted outcome measures score.

To calculate the overall Safety Grade for a hospital, add the overall weighted process/structural measure score and the overall weighted outcome measures score. Add 3.0 to your score; this is done to normalize scores to a positive distribution. This final numerical score (typically between 1.0 and 4.0) is then assigned to a letter grade. To assist hospitals in calculating their numerical score, a calculator is available on the [Safety Grade Review Website](#). Letter grade cut-points are published during the [Letter Grade Embargo Period](#).

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ADDITIONAL SCORING INFORMATION

TERMS USED IN SCORING AND PUBLIC REPORTING

“Not Available” means that the hospital does not have a score for this measure. This could be because the measure is related to a service the hospital does not provide or because the hospital had too few patients or cases to report data for a condition or procedure. A “Not Available” result does not mean that the hospital withheld information from the public.

In the case of healthcare-associated infections, a SIR is reported as “Not Available” if one of the following applies:

- The number of predicted infections is less than 1.
- The number of observed infections present on admission (community-onset prevalence) was above a pre-determined cut-point.

For more information about NHSN's SIR models, please visit <https://www.cdc.gov/nhsn/pdfs/ps-analysis-resources/nhsn-sir-guide.pdf>.

“Declined to Report” means that a hospital did not voluntarily provide information to the Leapfrog Hospital Survey. Measures scored as “Declined to Report” will not be used in calculating the overall score (see [Dealing with Missing Data](#)).

SHARED CMS CERTIFICATION NUMBERS

All hospitals that share a CMS Certification Number (CCN) will be assigned the same source data as reported by CMS. Affected measures include the HCAHPS, Hospital-Acquired Conditions, Healthcare-Associated Infections (if secondary data source is used), and Patient Safety Indicators.

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UPDATES TO DATA USED IN THE LEAPFROG HOSPITAL SAFETY GRADE

The Leapfrog Hospital Safety Grade relies on publicly available data that hospitals have had the opportunity to review for accuracy. Therefore, Leapfrog does not allow hospitals to make updates to their data following the Data Snapshot Date. In January of each year, Leapfrog publishes the Data Snapshot Dates for each of the two Leapfrog Hospital Safety Grade public releases at <https://www.hospitalsafetygrade.org/for-hospitals/key-dates-and-information>. Leapfrog publishes these dates to give hospitals and other stakeholders advance notice so they can be prepared to submit a Leapfrog Hospital Survey and monitor their performance on CMS measures used in the Safety Grade.

In addition, Leapfrog holds a Courtesy Review Period to give hospitals an additional opportunity to review the data that will be used to calculate their hospital's Safety Grade. The Review Period is an opportunity for hospitals to review the data for accuracy (i.e., identify recording errors, hospital name and address changes, etc.) on a secure website and review changes to the scoring algorithm.

DATA FROM THE LEAPFROG HOSPITAL SURVEY

During the Safety Grade Review Period (February 24 – March 14), Leapfrog will only make corrections to a hospital's data from the 2024 Leapfrog Hospital Survey if a recording error is identified (i.e., we have recorded a different measure score than what is posted on our Survey Results website) or a scoring error is identified (i.e., Leapfrog has calculated an incorrect measure score based on the submitted responses and Leapfrog's published scoring algorithms). Updates to Leapfrog Hospital Survey data that are submitted after the Data Snapshot Date will **not** be included in the current Leapfrog Hospital Safety Grade. Hospitals submitting a Leapfrog Hospital Survey are urged to take advantage of the opportunity to review their Survey Results for accuracy and completeness prior to each of the two published Data Snapshot Dates.

HOW HOSPITALS CAN REVIEW LEAPFROG HOSPITAL SURVEY RESULTS PRIOR TO THE DATA SNAPSHOT DATE

The Leapfrog Hospital Survey is open from April 1 to November 30 of each year. Following the Submission Deadline (June 30), Survey Results are published monthly on a secure 'Hospital Details' page and a public website (ratings.leapfroggroup.org). Hospitals are urged to review their Survey Results immediately. Hospitals that identify any reporting errors are instructed to log back into the Survey to submit a correction. Hospitals can correct and re-submit a previously submitted Survey until the Survey closes for the year. Note that corrections submitted after the Data Snapshot Date are not included in the current Leapfrog Hospital Safety Grade. Leapfrog has several automated processes in place to prevent hospitals from making data entry errors in the Online Survey Tool and to enhance the overall accuracy of the Survey Results. Learn more at <http://www.leapfroggroup.org/survey-materials/data-accuracy>.

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DATA FROM THE CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

During the Safety Grade Review Period (February 24 – March 14), Leapfrog will only make corrections to a hospital's data from CMS if the correction is issued by CMS and posted to the Data.CMS.Gov website. If a hospital has identified an error with a measure score published by CMS, and CMS cannot post a correction within the review period, the measure score will not be used in calculating the hospital's Safety Grade, provided that the hospital can document that CMS has agreed to publicly issue a correction or remove the measure score from public reporting. Hospitals participating with CMS are urged to take advantage of the opportunity to participate in the CMS 30-day review periods.

CMS FOOTNOTE 23 POLICY

Leapfrog will notify hospitals that have CMS footnote 23 present for one or more claims-based measure scores (e.g., DRA HAC Rate, PSI 4 rate, or PSI 90 rate) at the start of the Courtesy Review Period. Footnote 23 indicates that "The data are based on claims that the hospital or facility submitted to CMS. The hospital or facility has reported discrepancies in their claims data." Hospital CEOs can request that Leapfrog use the measure score that is accompanied by the footnote. Written requests must be received prior to the close of the Safety Grade Review Period. If written requests are not received by the close of the Review Period, the measure will not be used to calculate the Hospital Safety Grade.

For hospitals that submit a Leapfrog Hospital Survey by the Data Snapshot Date, the CEO, Primary Survey Contact, and Secondary Survey Contact will be notified at the email addresses included in the Hospital's Survey Profile. For hospitals that do not submit a Leapfrog Hospital Survey by the Data Snapshot Date, the CEO will be contacted by certified letter.

HOW HOSPITALS CAN REVIEW CMS DATA PRIOR TO THE DATA SNAPSHOT DATE

CMS administers several hospital-based reporting and payment programs including the Inpatient Quality Reporting Program, HAC Reduction Program, and Value-based Purchasing Program. Several measures collected and calculated by CMS via its various hospital-based programs are used in the Leapfrog Hospital Safety Grade. CMS provides hospitals with a 30-day preview period before publishing measure scores on the Data.Medicare.Gov website and the Data.CMS.Gov website. More information is available at <https://qualitynet.org>.

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HOW TO PARTICIPATE IN THE LEAPFROG HOSPITAL SURVEY

If a hospital did **not** complete a 2024 Leapfrog Hospital Survey by November 30, Survey Results were not used to calculate the spring 2025 Leapfrog Hospital Safety Grade. Hospitals that would like Survey Results included in the fall 2025 Hospital Safety Grade must submit a 2025 Leapfrog Hospital Survey (including the CPOE Evaluation) by June 30, 2025. Hospitals will be able to review their publicly reported Survey Results in July and respond to any issues identified by Leapfrog's Extensive Monthly Data Verification before the Data Snapshot Date for the fall 2025 Safety Grade of August 31. More information is available at <https://leapfroggroup.org/survey>.

LEAPFROG'S HELP DESK

If you have any questions regarding the scoring methodology, please contact the Help Desk at <https://leapfroghelpdesk.zendesk.com>.

Exhibit 45

Leapfrog Hospital Survey Hard Copy

**QUESTIONS & REPORTING PERIODS
ENDNOTES
MEASURE SPECIFICATIONS
FAQS**



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Welcome to the 2025 Leapfrog Hospital Survey

<https://leapfroggroup.org/hospital>

Dear Hospital Leaders,

This year marks Leapfrog's 25th anniversary, and I want to thank you, our annual Survey participants, for being a critical part of our successful journey.

As we reflect on the progress made over the past quarter-century, it is clear that the work we have done together has reshaped health care for the better. Your transparency and willingness to be held to the highest standards of excellence have elevated American health care, empowering patients and families while challenging all of us to do better.

Of course, the journey ahead is still long, and we have much more work to do to achieve the uniform level of excellence that all Americans need and deserve from health care. But it is worth taking a few moments to reflect on the impact we've made together to date driving giant leaps for patient safety.

Over this milestone year, you will hear more from Leapfrog on our analysis of the progress our country has made in patient safety and quality of care. There are many bright spots. We are grateful to you and your colleagues for your leadership, hard work and bold transparency that makes it possible. You are saving lives.

We look forward to the journey forward with you.

With gratitude,



Leah Binder
President & CEO
The Leapfrog Group



Important Notes About the 2025 Survey

1. The Leapfrog Hospital Survey webpages are located at <https://leapfroggroup.org/hospital>. Please bookmark this URL.
2. Note the word “hospital” used throughout this Survey refers to an individual hospital. If your hospital is part of a multi-hospital health care system or a multi-campus hospital, you will need to complete the Survey for each individual hospital. Please refer to [Leapfrog’s Multi-Campus Hospital Reporting Policy](#).
3. To submit a Survey via the Online Hospital Survey Tool, hospitals are required to complete and affirm the following six sections: Section 1: Patient Rights and Ethics, Section 2: Medication Safety, Section 4: Maternity Care, Section 5: Physician and Nurse Staffing, Section 6: Patient Safety Practices, and Section 7: Managing Serious Errors. However, hospitals are urged to submit all sections of the Survey and can indicate within a section if a measure does not apply. Hospitals that would like to be eligible for [Top Hospital](#) must submit all sections of the Survey.
4. Adult and general hospitals that indicate they have a Computerized Physician Order Entry (CPOE) system in at least one inpatient unit are asked to demonstrate, via a test, that the inpatient CPOE system can alert prescribers to at least 60% of frequent serious medication errors known to cause harm to patients. Hospitals will have access to the CPOE Evaluation Tool immediately after completing the Hospital Profile in the Online Hospital Survey Tool. Hospitals cannot submit the Survey, including results from the Adult Inpatient CPOE Test until all the following Survey sections have been completed and affirmed: Section 1: Patient Rights and Ethics, Section 2: Medication Safety, Section 4: Maternity Care, Section 5: Physician and Nurse Staffing, Section 6: Patient Safety Practices, and Section 7: Managing Serious Errors. Hospitals are urged to ensure that the Adult Inpatient CPOE Test is submitted along with the Survey (i.e., in the same month) to meet the deadlines for the Leapfrog Hospital Survey and Leapfrog’s other programs such as Top Hospital and the Leapfrog Hospital Safety Grade.
5. Adult and pediatric hospitals reporting on Section 7B: Healthcare-Associated Infections are required to join Leapfrog’s NHSN Group. Information about teaching status will also be pulled directly from NHSN. More information, including important deadlines, is available on the [Join NHSN Group webpage](#).
6. Leapfrog Hospital Survey Results will be available on the Hospital Details Page beginning July 12 and publicly reported on the [public reporting website](#) on July 25 for hospitals that submit a Survey by the June 30 Submission Deadline. After July, the Hospital Details Page and public reporting website will be refreshed monthly within the first seven (7) business days of each month to reflect Surveys submitted or resubmitted between July 1 and November 30 and previously submitted Surveys that were corrected between December 1 and January 31. Survey Results are frozen from February to July 25.
7. All questions regarding the Leapfrog Hospital Survey should be submitted to the Help Desk at <https://leapfroghelpdesk.zendesk.com>. Questions submitted to the Help Desk will receive a response within 1-2 business days (see [Help Desk Holiday Schedule](#) for planned closures).
8. For hospitals that would like Leapfrog Hospital Survey Results included in their **Leapfrog Hospital Safety Grade**, please visit the “For Hospitals” section of the Hospital Safety Grade [website](#) for important information on Data Snapshot Dates. A Leapfrog Hospital Survey must be submitted by the Data Snapshot Date for Survey data to be used in the Hospital Safety Grade.
9. Leapfrog is committed to verifying the accuracy of Leapfrog Hospital Survey Results. Please review the information on the [Data Accuracy webpage](#).
10. The [Submission Deadline](#) for the 2025 Leapfrog Hospital Survey is **June 30, 2025**, and the Late Submission and Performance Update Deadline is **November 30, 2025**. Hospitals that do not submit a Survey or CPOE Evaluation Tool (adult and general hospitals only) before 11:59 pm Eastern Time on

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General Information

November 30, 2025, will have to wait until the launch of the 2026 Leapfrog Hospital Survey on April 1, 2026 to submit a Survey.

Overview of the 2025 Leapfrog Hospital Survey

The Leapfrog Hospital Survey is divided into nine sections and the Hospital Profile. A description of each section is listed below. For a more detailed overview of the 2025 Leapfrog Hospital Survey, including a crosswalk of nationally endorsed measures and a description of how measures are publicly reported, visit the [Survey Overview webpage](#).

Section Number	Section Title	Brief Description
	<u>Hospital Profile</u>	The Hospital Profile includes questions about demographic and contact information. The Profile can be accessed and updated anytime throughout the year after logging into the Online Hospital Survey Tool . The Hospital Profile must be completed and submitted before you can access Sections 1-9 and the CPOE Evaluation Tool on the Survey Dashboard.
1	<u>Patient Rights and Ethics</u>	Section 1 includes questions about your hospital's billing ethics, health care equity, and informed consent processes. This section also includes questions on your hospital bed size, admissions, ICUs, and teaching status.
2	<u>Medication Safety</u>	Section 2 includes questions about your hospital's use of CPOE and BCMA, and (for adult and general hospitals) questions about your hospital's medication reconciliation process. The EHR application subsection (2B) is only applicable to adult and general hospitals and will not be scored or publicly reported. In 2025, three questions about Artificial Intelligence (AI) applications were added to subsection 2B – these questions are optional and will not be scored or publicly reported.
3	<u>Adult and Pediatric Complex Surgery</u>	Section 3 includes questions about your hospital's volume and process for privileging surgeons for eleven high-risk procedures, outcomes for mitral valve repair and replacement, and participation in The Society of Thoracic Surgeon's Congenital Heart Surgery Database for hospitals that perform the Norwood procedure. This section also includes questions about the implementation of a safe surgery checklist.
4	<u>Maternity Care</u>	Section 4 includes questions about maternity care volume and services, cesarean birth, episiotomy, newborn bilirubin screening, and DVT prophylaxis for women undergoing cesarean delivery. The section also includes questions about high-risk deliveries, including volume and outcomes. The subsection on cesarean birth (4C) includes questions about cesarean births stratified by race/ethnicity that will not be scored or publicly reported, however, responses will be used for confidential reporting on the Hospital Details Page in 2025.
5	<u>Physician and Nurse Staffing</u>	Section 5 includes questions about the management of critical care patients and the staffing structure of your hospital's adult and pediatric general medical, surgical, medical/surgical, and neuro ICUs, and questions about your hospital's nursing staffing and skill mix (previously included in Section 6).
6	<u>Patient Safety Practices</u>	Section 6 includes questions about your hospital's adherence to two National Quality Forum-endorsed Safe Practices, and questions about your hospital's hand hygiene practices. It also includes a subsection on diagnostic excellence (6D) and a new subsection on Hospital Boarding in the Emergency Department (ED) (6E) – both subsections are optional and will not be scored or publicly reported.

Section Number	Section Title	Brief Description
7	<u>Managing Serious Errors</u>	Section 7 includes questions about your hospital's response to Never Events. In addition, Leapfrog collects information via its NHSN Group about five healthcare-associated infections (CLABSI, CAUTI, MRSA, C. diff., and SSI: Colon). Hospitals reporting on Section 7B: Healthcare-Associated Infections are required to join Leapfrog's NHSN Group. Important information and deadlines are available on the Join NHSN Group webpage .
8	<u>Pediatric Care</u>	Section 8 includes questions about patient experience (CAHPS Child Hospital Survey) and Computed Tomography (CT) radiation dose for pediatric patients.
9	<u>Outpatient Procedures</u>	Section 9 includes questions about the volume and safety of same-day procedures performed in hospital outpatient departments, as well as the experience of patients who had a same-day surgery performed.

Section 1: Patient Rights and Ethics, Section 2: Medication Safety, Section 4: Maternity Care, Section 5: Physician and Nurse Staffing, Section 6: Patient Safety Practices, and Section 7: Managing Serious Errors are required to submit a Survey via the Online Hospital Survey Tool. Hospitals are strongly urged to submit all sections of the Leapfrog Hospital Survey and can indicate within a section if a measure does not apply.

The hard copy of the Survey and the Online Hospital Survey Tool are organized in the same format for all nine sections:

- **General information** about The Leapfrog Group's standard (included in the hard copy only).
- **Reporting periods** to provide hospitals with specific periods of time for each set of questions.
- **Survey questions** which may include references to endnotes or FAQs. The Survey questions and endnotes match the Online Hospital Survey Tool exactly.
- **Affirmation of accuracy** by your hospital's CEO/Chief Administrative Officer or by an individual that has been designated by the hospital CEO. These statements affirm the accuracy of your hospital's responses and must be completed in the Online Hospital Survey Tool to submit a Survey.
- **Reference information** which includes "What's New" and "Change Summaries," important measure specifications, answers to frequently asked questions, and other notes that must be carefully reviewed before responding to any of the Survey questions (included in the hard copy only).

In addition to the Survey questions, adult and general hospitals that indicate they have a CPOE system in at least one inpatient unit are asked to demonstrate, via a test, that the inpatient CPOE system can alert physicians to at least 60% of frequent serious medication errors known to cause harm to patients. Adult and general hospitals can access the CPOE Evaluation Tool immediately after completing the Hospital Profile in the Online Hospital Survey Tool. Carefully review the information on the [Prepare for a CPOE Tool webpage](#).

Any changes made to the measure specifications after April 1 will be reflected in the hard copy of the Survey in the Reference Information sections under the "Change Summary" header (see [Table of Contents](#)). In addition, the updates to the specifications will be highlighted in yellow. If the changes are substantial, we will email the Primary Survey Contact your hospital provided in the Hospital Profile of the Online Hospital Survey Tool. If the notification is sent before your hospital submits a 2025 Leapfrog Hospital Survey, the email will go to the Primary Survey Contact provided in the previous year's Survey.

The Leapfrog Group and its participating members are committed to presenting information that is as current as possible, therefore we allow hospitals to update and resubmit their Survey until the **November 30 Late Submission and Performance Update Deadline**. Please carefully review the reporting periods in each section before updating your Survey. Leapfrog Hospital Survey Results are updated monthly beginning in July on Leapfrog's [public reporting website](#). Hospitals are required to update the

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information in their Survey within 30 days of any change in status. We reserve the right to decertify information that is not current. More information on updating your Survey is available on the [Updating Your Hospital Survey webpage](#).

Pre-Submission Checklist

Before you complete and submit the Survey via the Online Hospital Survey Tool, there are several steps you should complete:

- ☐ **Visit the Hospital Survey webpages at <https://leapfroggroup.org/hospital>.**
- ☐ **Make sure you have a 16-digit security code.** If you don't, download a [Security Code Request](#) form. If your hospital is part of a multi-hospital healthcare system, you will need a separate security code for each individual hospital within the system. Please refer to [Leapfrog's Multi-Campus Hospital Reporting Policy](#).
- ☐ **Download a hard copy of the Survey** (PDF or Word document) on the [Survey and CPOE Materials](#) webpage. Read through the entire document to ensure that you understand what information is required.
- ☐ **Review the reference information** in each section of the Survey document and **download other supporting materials**. These documents and tools contain information that you will need to accurately respond to the Survey questions.
- ☐ **Join Leapfrog's NHSN Group.** Hospitals reporting on Section 7B: Healthcare-Associated Infections are required to join Leapfrog's NHSN Group. More information, including important deadlines, is available on the [Join NHSN Group](#) webpage.
- ☐ **Accept the American Medical Association's Terms of Use and Download the CPT Code Workbook.** Hospitals reporting on Section 3 Adult and Pediatric Complex Procedures (that perform bariatric surgery for weight loss, total hip replacement surgery, or total knee replacement surgery) and Section 9 Outpatient Procedures (that perform outpatient procedures) must accept the American Medical Association's Terms of Use and download the CPT Code Workbook via the button on the [Survey Dashboard](#) in Section 9.
- ☐ **Identify individuals from your hospital to help you** gather the data you will need to complete the various sections of the Survey.
- ☐ **Complete a hard copy of the Survey before you log in to the Online Survey Tool.** This will expedite the data entry into the Online Survey Tool and help to avoid the Tool "timing out" after 20 minutes of idle time (a security precaution). Once all the information has been collected and recorded in the hard copy of the Survey, the CEO or the CEO's designee can typically complete the online data entry in less than an hour. Please note, responses must be entered into the Online Survey Tool to be submitted.
- ☐ **Download and review a copy of the Online Survey Tool Guide** on the [Get Started](#) webpage and includes important instructions on how to navigate the Online Hospital Survey Tool, including instructions on how to verify your hospital has successfully submitted the Survey.
- ☐ **Check Survey deadlines.** Carefully review [Survey deadlines](#) before you begin. Ensure that you have enough time to collect the data, complete a hard copy of the Survey, and complete and submit the Survey via the Online Hospital Survey Tool. In addition, for adult and general hospitals that have implemented CPOE in at least one inpatient unit, make sure you have enough time to take a [CPOE Evaluation Tool](#).
- ☐ **Download and review the 2025 Leapfrog Hospital Survey [Scoring Algorithms](#).**
- ☐ **Review Leapfrog's policies and procedures regarding data accuracy.** Detailed information can be found on the [Data Accuracy](#) webpage.

Leapfrog Hospital Survey Binder: Hospitals should utilize the Leapfrog Hospital Survey Binder to assist in organizing the documentation used to complete the Survey. Download a copy of the binder on the [Survey and CPOE Materials](#) webpage.

Instructions for Submitting a Leapfrog Hospital Survey

Important Notes:

Note 1: Please carefully review these instructions and the [Online Survey Tool Guide](#) before you begin.

Note 2: Each section of the Survey must be completed before it can be affirmed in the Online Hospital Survey Tool. Only sections that are affirmed can be submitted. Hospitals are responsible for ensuring that each submitted section is accurate.

1. Log into the [Online Hospital Survey Tool](#) using your 16-digit security code.
2. The first time you log into the 2025 Leapfrog Hospital Survey, you will need to complete and submit the Hospital Profile. The Hospital Profile includes demographic and contact information. The Hospital Profile should be updated throughout the year if any information changes and can be accessed at any time. **Failure to maintain current contact information could result in important, time-sensitive information being missed or sent to the wrong person.**
3. Once the Hospital Profile has been submitted, you will be taken to the Hospital Survey Dashboard.
4. You can navigate into sections of the Online Hospital Survey Tool using the linked section names on the Hospital Survey Dashboard. You can also access the CPOE Evaluation Tool immediately after completing the Hospital Profile using the Take CPOE Tool button on the Hospital Survey Dashboard. More information about navigating within the Online Hospital Survey Tool is available in the [Online Survey Tool Guide](#).
5. Within sections, you can enter responses to questions and/or update responses to previously submitted sections. The Online Hospital Survey Tool will automatically save your responses as you enter them. There is no “save” button.
6. Once you have completed each section, you will need to return to the Hospital Survey Dashboard to affirm each section of the Survey. Please remember that if you are making updates, all updated sections must be re-affirmed. Please note that affirmed sections are not yet submitted, please review Step 7 below to ensure successful submission.
7. Before you can submit the Survey (select the “*submit affirmed sections*” button on the Hospital Survey Dashboard), you will need to “*check for data review warnings*.” When you select the “*check for data review warnings*” button, the sections of your Survey that have been affirmed will be scanned for potential reporting errors. If any errors are identified, a data review warning message will be generated and will appear on the Hospital Survey Dashboard.
8. If any [data review warnings](#) are generated, you will still be able to submit your Survey. However, you will need to address the potential reporting errors identified during the scan or risk having the related sections of your Survey decertified (publicly reported as “Declined to Respond”). Please note this may not be a comprehensive list – you may still receive additional data verification messages via email.
9. Once you have checked for data review warnings, you can select the “*submit affirmed sections*” button to submit the Survey. Please review the Section Status column on the Hospital Survey Dashboard to verify which sections have been submitted.
10. Use the “*Print Last Submitted Survey*” button on the Hospital Survey Dashboard to print a copy of your Last Submitted Survey and review it for accuracy and completeness. Remember, sections that are not affirmed will not be submitted.
11. Review the 2025 Leapfrog Hospital Survey [Scoring Algorithms](#) to see how your Survey responses will be scored and publicly reported by Leapfrog.
12. Review your Survey Results on the [Hospital Details Page](#) or [public reporting website](#). Hospitals that submit by June 30 can preview their Survey Results on the Hospital Details Page beginning on July 12, before Leapfrog [publicly reports](#) Survey Results beginning on July 25. After July, the

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Hospital Details Page and public reporting website will be refreshed monthly within the first seven (7) business days of each month following your (re)submission.

13. Adult and general hospitals submitting a CPOE Evaluation Tool should carefully review the instructions, scoring information, and FAQs available on the [Survey and CPOE Materials webpage](#) (see CPOE Tool Instructions under Other Supporting Materials).
14. Leapfrog is committed to verifying the accuracy of Leapfrog Hospital Survey Results. Please review our data accuracy protocols on the [Data Accuracy webpage](#).
15. Responses can be updated or corrected, and the Survey can be resubmitted at any point during the Survey Cycle (April 1 – November 30). Please remember that if you are making updates, all updated sections must be re-affirmed. More information on updating your Survey is available on the [Updating Your Hospital Survey webpage](#).

Reporting Policy Following Cybersecurity Events and Natural Disasters

Hospitals that experience a cybersecurity event or natural disaster that impacts data availability during one or more Survey reporting periods can complete and [submit a request form](#) in order to participate in the 2025 Leapfrog Hospital Survey. If approved, hospitals will report on the impacted measures using the data available and exclude data from the month(s) impacted by the cybersecurity event or natural disaster. Results will still be calculated if minimum reporting requirements are met and will be displayed on the [Survey Results website](#) with the following footnote: "Results are based on limited data due to a reported cybersecurity event or natural disaster." This revised policy closely aligns with the Extraordinary Circumstances Exception policy from the Centers for Medicare and Medicaid Services (CMS) but will only be applied to cybersecurity events and natural disasters.

For the purposes of the Safety Grade, a letter grade will still be calculated based on the data available, but any underlying measures impacted by the event will have results reported along with the following footnote: "Results are based on limited data due to a reported cybersecurity event or natural disaster." Hospitals will still be eligible for Leapfrog Top Hospital pending committee review and subject to meeting all criteria.

Verifying Submission

Use the following steps to verify that your submission was completed and that the appropriate sections were submitted:

- **Check the Hospital Survey Dashboard:** Refer to the "Section Status" column on the Hospital Survey Dashboard. All submitted sections will be marked as "Submitted."
- **Check your email:** You will receive a Survey submission confirmation email within five minutes of submitting a Survey. Please Note: This email will not specify which sections were submitted – you will need to use the other steps to determine which sections were submitted.
- **Print Last Submitted Survey:** The Survey submission date will be listed at the top of the page under the heading "Submitted Survey." Be sure to check the submission date, review each section for accuracy and completeness, and check that each affirmation is complete (Sections 1-9).
- **Review the Hospital Details Page:** Your Survey Results will be available beginning July 12 via the Hospital Details Page link on the Hospital Survey Dashboard. Carefully review your results, including data from VON for high-risk deliveries, and your NHSN information for applicable healthcare-associated infections.
- **Check your publicly reported results:** Always check your Leapfrog Hospital Survey Results on the public reporting [website](#). Results are posted on July 25 and are updated within the first 7 (seven) business days of the month following your submission starting in August.

Updating or Correcting a Previously Submitted Leapfrog Hospital Survey

2025 Leapfrog Hospital Survey – Hard Copy

General Information

Hospitals can update or correct previously submitted Survey responses at any point during the Survey Cycle (April 1 to November 30). Please review the [Survey Deadlines webpage](#). Most updates or corrections are made:

- At the request of Leapfrog:
 - Following Leapfrog's [Extensive Monthly Data Verification](#), the Primary Survey Contact, Secondary Survey Contact, and System Survey Contact will receive an email from the Help Desk detailing potential reporting errors.
- Following [On-Site Data Verification](#):
 - Hospitals selected for On-Site Data Verification will receive a report which will indicate any responses that need to be updated or corrected.
- At the discretion of the hospital:
 - To correct a data entry or reporting error.
 - To reflect a change in status or performance on a measure (e.g., closed a unit, stopped performing a procedure, implemented a new policy, etc.).
 - To provide more current responses based on the reporting periods outlined in the hard copy of the Survey.

Following any updates, hospitals should always use the steps for verifying submission provided [above](#).

Updating a Survey after Receiving a Help Desk Email

Leapfrog conducts [Extensive Monthly Data Verification](#) of responses submitted to the Leapfrog Hospital Survey starting with Surveys submitted by the June 30 Submission Deadline and monthly thereafter until the Online Survey Tool is taken offline on January 31. Following the Extensive Monthly Data Verification, the **Primary Survey Contact, Secondary Survey Contact, and System Contact** are notified by email of any Survey responses that need to be reviewed and/or updated by the hospital.

If you receive a Data Verification email, you are required to document that your original responses were correct or update/correct your previously submitted Leapfrog Hospital Survey by the end of the same month using the **original** reporting period that was used for that section of the Survey in the original submission. For example, if a hospital submitted a Survey for the first time on August 20, then received a Data Verification email at the beginning of September, they would update their responses based on the reporting period used in the August 20 submission.

Hospitals that receive a [Category A](#) Data Verification message at the beginning of the month for any measure will have until the end of that same month to contact the [Help Desk](#) to either (1) document that the original response was correct or (2) correct the data entry or reporting error, or they will be publicly reported as "Pending Leapfrog Verification" for that measure. This term is used to indicate that the hospital has self-reported Survey responses that are under further review by Leapfrog.

If any Category A Data Verification messages are not resolved by January 31 (when the Online Hospital Survey Tool is taken offline), the entire Survey will be decertified, and the hospital will be publicly reported as "Declined to Respond" for the entire Leapfrog Hospital Survey.

Updating a Survey following On-Site Data Verification

Hospitals that are selected for On-Site Data Verification will receive a findings report. If the findings report details any responses that need to be updated or corrected, please contact the [Help Desk](#).

Making General Updates (for hospitals that have not received a Help Desk email)

Leapfrog offers hospitals multiple reporting periods so that they can report the most current data. Except for Section 4E: High-Risk Deliveries (VON data only), Section 7B: Healthcare-Associated Infections, and Section 9D: Patient Follow-up (OP-32), updating a Survey is optional. However, we do recommend that if your performance or if a structure has changed significantly, you update your Survey within 30 days. In addition, hospitals should update their Surveys if they become aware of any reporting errors or data inaccuracies in their previous submission.

Hospitals may update one or more sections of the Survey without updating the entire Survey. In addition, hospitals are not required to retake the CPOE Evaluation Tool if making updates to Section 2A: CPOE questions #3 and #4.

General updates and corrections can be made at any point during the Survey Cycle (April 1 – November 30). The months of December and January are reserved for correcting data entry (i.e., correcting data entry errors) or reporting errors (i.e., in response to Leapfrog's Extensive Monthly Data Verification) to previously submitted sections of the Survey. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. **Updates made to reflect a change in performance after November 30 will not be scored or publicly reported. New sections of the Survey submitted after November 30 will not be scored or publicly reported.**

Hospitals that are submitting general updates should:

- Use the stated reporting period at the top of each section selected based on the date of your resubmission.
- For Section 4: Maternity Care and Section 6A-6B: NQF Safe Practice #1 and #2, update responses to ALL questions within the section they wish to update using the same reporting period. For example, if a hospital submitted a Survey for the first time in June and then wanted to update the responses for the Cesarean Birth questions in subsection 4B in November, they would update the entire Section 4: Maternity Care based on the updated reporting period for November.

For information on Leapfrog's automatic updates to the VON data in Section 4E: High-Risk Deliveries, the NHSN data in Section 7B: Healthcare-Associated Infections, or the CMS data in Section 9D: Patient Follow-up, please review the Section 4E: High-Risk Deliveries Measure Specifications, the Join NHSN Group webpage, and the Section 9D: Patient Follow-up Measure Specifications.

Quick Tip: Remember to re-affirm any section of the Survey that has been updated, check for data review warnings, and then resubmit the entire Survey. Always print a copy of your Last Submitted Survey and review it for accuracy and completeness. Check your updated Survey Results within the first 7 (seven) business days of the month following your resubmission on the public reporting website and the Hospital Details Page.

Deadlines

Deadlines for the 2025 Leapfrog Hospital Survey

The 2025 Leapfrog Hospital Survey, including the CPOE Evaluation Tool (if applicable), opens on April 1 and has a Submission Deadline of **June 30, 2025**. The Late Submission and Performance Update Deadline is **November 30, 2025**. Surveys and Adult Inpatient CPOE Tests must be submitted before 11:59 pm Eastern Time on **November 30**. The CPOE Evaluation Tool will not be available after **November 30**. The View CPOE Evaluation Tool results link on the Survey Dashboard can only be accessed between April 1 and November 30, so test results must be printed by November 30.

Corrections to Surveys submitted by **November 30** must be submitted by the **January 31, 2026** Corrections Deadline. The Online Hospital Survey Tool will not be available after **January 31, 2026**. Find detailed information about the 2025 Leapfrog Hospital Survey Deadlines, including deadlines for receiving free Competitive Benchmarking Summary Reports and consideration for Top Hospital Awards on the [Deadlines webpage](#).

Deadlines for Vermont Oxford Network Data

Hospitals participating in the Vermont Oxford Network (VON) may opt to report on the VON National Performance Measure in Section 4E: High-Risk Deliveries. Instructions, deadlines, and reporting periods can be reviewed in the [VON National Performance Measure Specifications](#).

Deadlines to Join Leapfrog's NHSN Group

Hospitals reporting on Section 7B: Healthcare-Associated Infections are required to join Leapfrog's NHSN Group. Please visit our [webpage](#) for instructions on how to join the group as well as information about important deadlines.

Deadlines Related to the Hospital Safety Grade

Hospitals that would like Leapfrog Hospital Survey Results used in their Leapfrog Hospital Safety Grade must submit a Survey and an Adult Inpatient CPOE Test by the [Data Snapshot Dates](#). The Leapfrog Hospital Survey and the Hospital Safety Grade are distinct programs administered by The Leapfrog Group. Though some measures from the Leapfrog Hospital Survey are used in the Hospital Safety Grade, the grade also utilizes publicly available data from other data sources. Find answers to Frequently Asked Questions in the "For Hospitals" section of the Hospital Safety Grade [website](#).

Technical Assistance

Leapfrog's Help Desk

Connect with Leapfrog's in-house subject matter experts via our dedicated Help Desk to get timely support for:

- Survey content and scoring questions,
- Data verification messages and requests for documentation, and
- Technical issues related to the Online Survey Tool, CPOE Evaluation Tool, or the Hospital and Surgery Center Ratings [website](#).

You can also schedule a 1:1 Hospital Survey Orientation and submit feedback on any of Leapfrog's ratings programs, including [Top Hospitals](#) and [Top ASCs](#), the [Hospital Safety Grade](#), the [Recognized Leader in Caring for People with Diabetes Program](#) and [Leapfrog's Value-Based Purchasing Program](#).

To quickly get you to the right in-house expert for the right level of support, submit your inquiry in writing through the Zendesk ticketing portal at <https://leapfroghelpdesk.zendesk.com>. You'll receive a reply within 1-2 business days, if not sooner. Tickets submitted during a CPOE Test receive a reply within 10 minutes during normal business hours. More information on submitting and managing Help Desk tickets can be found in the [Help Desk Guide](#).

The Help Desk is staffed Monday through Friday from 9:00 a.m. to 5:00 p.m. ET, except on federal holidays. Please review the Help Desk Holiday Schedule for closures and allow ample time for staff to respond to time sensitive requests before any program deadlines.

You can manage your open tickets through email and/or create an account with Zendesk to manage open and archived tickets.

To ensure that you receive our emails, please work with your IT department to add the following to your safe sender list:

- @leapfrog-group.org
- @leapfroghelpdesk.zendesk.com
- @em8434.leapfrog-group.org
- IP address: 159.183.167.150

Leapfrog Hospital Survey Webinar Series

The Leapfrog Hospital Survey Webinar Series is designed for Survey coordinators, hospital leaders, and others who would benefit from a more interactive presentation of Survey materials and information.

The Webinar Series is held monthly from March to December and includes monthly office hours in addition to monthly webinars. The one-hour webinars focus on specific topics related to the Survey, including new measures. Throughout each webinar, participants can ask questions live or via the Zoom Q&A function.

The monthly 30-minute office hours are designed to give participants another regular, interactive touch point with Leapfrog's Help Desk, so Survey coordinators always have the information they need, when they need it.

Join now and start benefiting from:

- **Monthly office hours with the Leapfrog Help Desk:** 30 minutes to get real-time technical assistance, answers to your questions, and help staying on top of upcoming deadlines. Staffed by Leapfrog's expert Help Desk.
- **Monthly webinars:** Timely and focused presentations on Survey and CPOE Evaluation Tool measures and specifications, scoring information, frequently asked questions, technical assistance, and public reporting. Each webinar concludes with a 20-minute open Q & A session.

- **Archive Library:** Slides and recordings from each webinar are archived in an online portal that participants can access from March to January.

The annual registration fee is \$500 per individual.

For a schedule of events and to register, please visit the Leapfrog [Hospital Survey Webinar Series webpage](#).

Support for Health Systems

Are you responsible for coordinating Leapfrog Hospital Survey submissions for more than one hospital? Leapfrog's Health System Support subscription for multi-hospital health systems is designed to help Survey coordinators and health system leaders become in-house experts on the Leapfrog Hospital Survey and the Hospital Safety Grade and make it easy to monitor, compare, and analyze your hospitals' Leapfrog Hospital Survey Results, Hospital Safety Grades, and Competitive Benchmarking scores. The subscription gives you timely data for all your hospitals in a series of easy-to-use Excel workbooks, so you can quickly perform analysis, benchmark performance, build performance dashboards, and identify areas for improvement.

The support package includes the following:

- Hospital Webinar Series (one registration per health system)
- Leapfrog Hospital Survey Responses and Results
- Leapfrog Hospital Safety Grades
- Competitive Benchmarking Scores

More information is available on the [Support for Health Systems webpage](#). Please contact the [Help Desk](#) for more information.

Reporting Periods

Important Note: Reporting periods should be selected based on the date of Survey or section submission. However, hospitals do not need to use the same reporting period throughout the Survey.

	Survey Submitted <u>Prior to</u> September 1	Survey (Re)Submitted <u>on or</u> <u>After</u> September 1
Survey Section/ Measure	Reporting Period	Reporting Period
1A Basic Hospital Information	12 months ending 12/31/2024	12 months ending 06/30/2025
1B Billing Ethics	N/A	N/A
1C Health Care Equity	N/A	N/A
1D Informed Consent	N/A	N/A
2A Computerized Physician Order Entry (CPOE)	Latest 3 months prior to Survey submission	Latest 3 months prior to Survey submission
2B EHR Application Information	N/A	N/A
2C Bar Code Medication Administration (BCMA)	Latest 3 months prior to Survey submission	Latest 3 months prior to Survey submission
2D Medication Reconciliation	Latest 6 months prior to Survey submission	Latest 6 months prior to Survey submission
3A Hospital and Surgeon Volume	Volume: 12 months or 24-month annual average ending 12/31/2024	Volume: 12 months or 24-month annual average ending 06/30/2025
	STS MVR Composite Score: Latest 36-month report	STS MVR Composite Score: Latest 36-month report
3B Safe Surgery Checklist for Adult and Pediatric Complex Surgery	Latest 12 months prior to Survey submission	Latest 12 months prior to Survey submission
4A Maternity Care Volume and Services	Volume: 12 months ending 12/31/2024	Volume: 12 months ending 06/30/2025
	Services: N/A	Services: N/A
4B Cesarean Birth	12 months ending 12/31/2024	12 months ending 06/30/2025
	Cesarean Birth Stratified by Race/Ethnicity: 24 months ending 12/31/2024	Cesarean Birth Stratified by Race/Ethnicity: 24 months ending 06/30/2025
4C Episiotomy	12 months ending 12/31/2024	12 months ending 06/30/2025
4D Process Measures of Quality	12 months ending 12/31/2024	12 months ending 06/30/2025

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General Information

	Survey Submitted <u>Prior</u> to September 1	Survey (Re)Submitted <u>on or</u> <u>After</u> September 1
Survey Section/ Measure	Reporting Period	Reporting Period
4E High-Risk Deliveries*	Volume: 12 months ending 12/31/2024	Volume: 12 months ending 06/30/2025
	VON: 2023 report	VON: 2024 report
5A Adult ICU Physician Staffing	Latest 3 months prior to Survey submission	Latest 3 months prior to Survey submission
5B Pediatric ICU Physician Staffing	Latest 3 months prior to Survey submission	Latest 3 months prior to Survey submission
5C Nursing Workforce	Nurse Staffing and Skill Mix: 12 months ending 12/31/2024	Nurse Staffing and Skill Mix: 12 months ending 06/30/2025
	NQF Safe Practice #9: Latest 12 months prior to Survey submission	NQF Safe Practice #9: Latest 12 months prior to Survey submission
	Percentage of RNs who are BSN-Prepared: N/A	Percentage of RNs who are BSN-Prepared: N/A
6A NQF Safe Practice #1 – Culture of Safety Leadership Structures and Systems	Latest 12 months prior to Survey submission	Latest 12 months prior to Survey submission
6B NQF Safe Practice #2 – Culture Measurement, Feedback, and Intervention	Latest 12 or 24 months prior to Survey submission (see individual safe practice for specific reporting period)	Latest 12 or 24 months prior to Survey submission (see individual safe practice for specific reporting period)
6C Hand Hygiene	N/A	N/A
6D Diagnostic Excellence	CEO Commitment to Diagnostic Excellence, Patient Engagement, Risk Assessment and Mitigation, Convening a Multidisciplinary Team Focused on Diagnostic Excellence, Training and Education: N/A	CEO Commitment to Diagnostic Excellence, Patient Engagement, Risk Assessment and Mitigation, Convening a Multidisciplinary Team Focused on Diagnostic Excellence, Training and Education: N/A
	Closing the Loop on Cancer Diagnosis: 12 months ending 12/31/2024	Closing the Loop on Cancer Diagnosis: 12 months ending 06/30/2025
6E Hospital Boarding in the Emergency Department (ED)	12 months ending 12/31/2024	12 months ending 06/30/2025
7A Never Events	N/A	N/A
7B Healthcare-Associated Infections**	June and August Data Downloads: 01/01/2024 – 12/31/2024	October and December Data Downloads: 07/01/2024 – 06/30/2025

	Survey Submitted <u>Prior to</u> September 1	Survey (Re)Submitted <u>on or</u> <u>After</u> September 1
Survey Section/ Measure	Reporting Period	Reporting Period
8A Patient Experience (CAHPS Child Hospital Survey)	Latest 12 months prior to Survey submission	Latest 12 months prior to Survey submission
8B Pediatric Computed Tomography (CT) Radiation Dose	12 months ending 12/31/2024	12 months ending 06/30/2025
9A Basic Outpatient Department Information	12 months ending 12/31/2024	12 months ending 06/30/2025
9B Medical, Surgical, and Clinical Staff	Latest 3 months prior to Survey submission	Latest 3 months prior to Survey submission
9C Volume of Procedures	12 months ending 12/31/2024	
9D Safety of Procedures***	Patient Follow-up: Latest 24 months prior to Survey submission	Patient Follow-up: Latest 24 months prior to Survey submission
	Safe Surgery Checklist: Latest 12 months prior to Survey submission	Safe Surgery Checklist: Latest 12 months prior to Survey submission
9E Medication Safety for Outpatient Procedures	12 months ending 12/31/2024	12 months ending 06/30/2025
9F Patient Experience (OAS CAHPS)	Latest 12 months prior to Survey submission	Latest 12 months prior to Survey submission

*Leapfrog will update VON data 3 times per Survey Cycle for all hospitals that have provided an accurate VON Transfer Code in the Hospital Profile, submitted a [Data Sharing Authorization](#) letter to VON, selected "VON National Performance Measure" in Section 4E, and submitted the 2025 Leapfrog Hospital Survey.

**Adult and pediatric hospitals reporting on Section 7B: Healthcare-Associated Infections are required to join Leapfrog's NHSN Group. More information, including important deadlines, is available on the [Join NHSN Group webpage](#). Leapfrog will update data 4 times for all members of our NHSN group that have provided an accurate NHSN ID in the Hospital Profile and submitted the 2025 Leapfrog Hospital Survey.

***Adult and pediatric hospitals reporting on Section 9D: Patient Follow-up are required to provide an accurate CMS Certification Number (CCN) in the Hospital Profile. Leapfrog will update data 3 times per Survey Cycle for all hospitals that have provided an accurate CCN in the Hospital Profile and submitted Section 9: Outpatient Procedures.

Included Units by Survey Section

Note: Only include units that were open for the entire reporting period and that remain currently open.

Survey Section/ Measure	Units
1A Basic Hospital Information	• <u>Acute-Care Units</u>¹ (adult and/or pediatric) • <u>General Medical, Surgical, Medical/Surgical and Neuro ICUs</u>¹⁴ (adult and/or pediatric) • <u>Specialty ICUs</u> (adult and/or pediatric) • <u>Neonatal ICUs</u>¹⁷
1B Billing Ethics	N/A
1C Health Care Equity	N/A
1D Informed Consent	N/A
2A Computerized Physician Order Entry (CPOE)	N/A
2B EHR Application Information	N/A
2C Bar Code Medication Administration (BCMA)	• <u>General Medical, Surgical, Medical/Surgical, and Neuro ICUs</u>¹⁴ (adult and/or pediatric) • <u>Neonatal ICUs</u>¹⁷ • <u>Specialty ICUs</u> (adult and/or pediatric) • <u>Medical, Surgical, and Medical/Surgical Units (including telemetry units)</u>¹⁹ (adult and/or pediatric) • <u>Step-down/Progressive Units</u>²⁰ (adult and/or pediatric) • <u>Labor and Delivery Units</u>²¹ • <u>Pre-operative and Post-anesthesia Care Units</u>²² (adult and/or pediatric)
2D Medication Reconciliation	• <u>Medical and Medical/Surgical Units (including telemetry units)</u> (adult only) • <u>Step-down/Progressive Units</u>²⁰ (adult only)
3A Hospital and Surgeon Volume	N/A
3B Safe Surgery Checklist for Adult and Pediatric Complex Surgery	N/A
4A Maternity Care Volume and Services	N/A
4B Cesarean Birth	N/A
4C Episiotomy	N/A
4D Process Measures of Quality	N/A
4E High-Risk Deliveries	• <u>Neonatal ICUs</u>¹⁷

Survey Section/ Measure	Units
5A Adult ICU Physician Staffing	<u>General Medical, Surgical, Medical/Surgical, and Neuro ICUs¹⁴</u> (adult)
5B Pediatric ICU Physician Staffing	<u>General Medical, Surgical, Medical/Surgical, and Neuro ICUs¹⁴</u> (pediatric)
5C Nursing Workforce	Nurse Staffing and Skill Level: - Single Acuity Medical Units (adult and/or pediatric) - Single Acuity Surgical Units (adult and/or pediatric) - Single Acuity Med-Surg Combined Units (adult and/or pediatric) - Mixed Acuity Medical, Surgical and Med-Surg Units (adult and/or pediatric) Percentage of RNs who are BSN-Prepared: - N/A For more information, refer to the Section 5C: Nursing Workforce Measure Specifications.
6A NQF Safe Practice #1 – Culture of Safety Leadership Structures and Systems	N/A
6B NQF Safe Practice #2 – Culture Measurement, Feedback, and Intervention	N/A
6C Hand Hygiene	<u>Medical, Surgical, and Medical/Surgical Units (including telemetry units)¹⁹</u> (adult and/or pediatric) <u>Step-down/Progressive Units²⁰</u> (adult and/or pediatric) <u>Obstetrical Units (Labor and Delivery Units²¹, nursery, etc., excluding procedural areas)</u> <u>General Medical, Surgical, Medical/Surgical, and Neuro ICUs¹⁴</u> (adult and/or pediatric) <u>Neonatal ICUs¹⁷</u> - Specialty ICUs (adult and/or pediatric) <u>Pre-operative and Post-anesthesia Care Units²²</u> (adult and/or pediatric) - Observation units (adult and/or pediatric) <u>Dedicated Emergency Departments⁴⁷</u> (adult and/or pediatric)
6D Diagnostic Excellence	N/A
6E Hospital Boarding in the Emergency Department (ED)	<u>Dedicated Emergency Departments⁴⁷</u> (adult and/or pediatric)
7A Never Events	N/A
7B Healthcare-Associated Infections	N/A

Survey Section/ Measure	Units
8A Patient Experience (CAHPS Child Hospital Survey)	N/A
8B Pediatric Computed Tomography (CT) Radiation Dose	N/A
9A Basic Outpatient Department Information	N/A
9B Medical, Surgical, and Clinical Staff	N/A
9C Volume of Procedures	N/A
9D Safety of Procedures***	N/A
9E Medication Safety for Outpatient Procedures	N/A
9F Patient Experience (OAS CAHPS)	N/A

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HOSPITAL PROFILE

Hospitals must complete and submit a Hospital Profile via the Online Hospital Survey Tool before accessing the Hospital Survey Dashboard for the first time. The Profile is available year-round and should be updated as needed.

Hospital Profile

The Hospital Profile includes questions about demographic and contact information. The Profile can be accessed and updated anytime throughout the year after logging into the Online Hospital Survey Tool.

The Hospital Profile must be completed and submitted before you can access Sections 1-9 and the CPOE Evaluation Tool on the Survey Dashboard.

Hospital Profile

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Important Notes:

Note 1: Leapfrog uses an administration system that links contacts shared by hospitals (i.e., CEOs, Survey Contacts, System Contacts, and Public Relations Contacts). Only one phone number and email address will be maintained for each contact, meaning that if this shared contact's information is updated in one hospital's Profile, it will be updated for all hospitals associated with the contact.

Note 2: Following [Leapfrog's Extensive Monthly Data Verification](#), the Primary Survey Contact, Secondary Survey Contact, and System Survey Contact will receive an email from the Help Desk detailing potential reporting errors.

Hospital Information

Organization Name This is the name that will appear on Leapfrog's public reporting website.	CMS Certification Number (CCN)² If the CCN displayed in the Online Hospital Survey Tool is not correct, contact the Leapfrog Help Desk immediately.
	Does your hospital share this CCN with another facility? ☐ Yes ☐ No
	NHSN ID³
	Vermont Oxford Network (VON) Transfer Code⁴
	Federal Tax Identification Number (TIN)⁵
	National Provider Identifier (NPI)⁶ If the NPI displayed in the Online Hospital Survey Tool is not correct, contact the Leapfrog Help Desk immediately.
	Does your hospital share this NPI with another facility? ☐ Yes ☐ No

Demographic Information

Physical Address (used for public reporting)	Mailing Address (used to send important communications)
Street Address	Street Address or P.O. Box
City	City
State⁷	Country
Zip Code	State

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Hospital Profile

Zip Code Suffix	Zip Code
Main Phone Number	Zip Code Suffix
Hospital Website Address⁸ (so consumers can learn more about your hospital's efforts in the area of patient safety and quality improvement)	

Contact Information

Chief Executive Officer (CEO)	Chairperson of the Board
Prefix (e.g., Mr., Ms., Mrs., Dr., etc.)	First Name
First Name	Last Name
Last Name	
Title (e.g. CEO, President, etc.)	
E-mail Address (required for emailing of security codes and Top Hospital notification)	

Primary Survey Contact	Secondary Survey Contact
First Name	First Name
Last Name	Last Name
Title	Title
Phone Number	Phone Number
Phone Number Extension	Phone Number Extension
E-mail Address	E-mail Address

Hospital Public Relations Contact (required so that Leapfrog may provide information on Leapfrog accolades, such as Top Hospital notification, and announcements)
First Name
Last Name
Phone Number

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Hospital Profile

Phone Number Extension
E-mail Address

Opt-Out Opt-out of having information in the "Contact Information" subsection shared with third parties.	☐ Opt-out
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Healthcare System Information
Name of Healthcare System or Integrated Delivery Network⁹ If the name displayed in the Online Hospital Survey Tool is not correct, contact the Leapfrog Help Desk immediately.
System Contact First Name Provide a System Contact for the IDN displayed. If no System Contact for the IDN displayed, enter a Contact for a larger parent system or re-enter your Primary or Secondary Survey Contact information.
System Contact Last Name
System Contact E-mail Address

System Public Relations Contact First Name (required so that Leapfrog may provide information on Leapfrog accolades, such as Top Hospital notification, and announcements)
System Public Relations Contact Last Name
System Public Relations Contact Phone Number
System Public Relations Contact Phone Number Extension
System Public Relations Contact E-mail Address

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SECTION 1: PATIENT RIGHTS AND ETHICS

This section includes questions and reference information for Section 1: Patient Rights and Ethics. Please carefully review the questions, endnotes, and reference information (e.g., measure specifications, notes, and frequently asked questions) before you begin. Failure to review the reference information could result in inaccurate responses.

Section 1: Patient Rights and Ethics

Billing Ethics Bibliography and Fact Sheet:

<https://ratings.leapfroggroup.org/measure/hospital/2025/billing-ethics>

Health Care Equity Bibliography and Fact Sheet:

<https://ratings.leapfroggroup.org/measure/hospital/2025/health-care-equity>

Informed Consent Bibliography and Fact Sheet:

<https://ratings.leapfroggroup.org/measure/hospital/2025/informed-consent>

Section 1 includes questions about your hospital's billing ethics, health care equity, and informed consent processes. This section also includes questions on your hospital bed size, admissions, ICUs, and teaching status.

Each hospital achieving the standard for Billing Ethics:

- 1) Provides every patient with a billing statement within 30 days after final claims adjudication that includes all 10 required elements listed in question #1, **and**
- 2) Gives patients instructions for contacting a billing representative with access to an interpretation service to communicate in the patient's preferred language and has the authority to do all three required elements in question #2 within ten business days, **and**
- 3) Does NOT take legal action against patients for late or insufficient payment.

Each hospital achieving the standard for Health Care Equity:

- 1) Collects patient self-identified race, ethnicity, and preferred written and/or spoken language data, **and**
- 2) Trains staff responsible for collecting self-identified demographic data from patients, **and**
- 3) Uses the patient self-identified demographic data to stratify at least one quality measure, **and**
- 4) If disparities were identified, has an updated or revised policy or procedure to address the disparity or has developed a written action plan, **and**
- 5) Shares information about efforts to identify and reduce health care disparities on its public website, **and**
- 6) Reports out and discusses efforts to identify and address health care disparities with the board.

Each hospital achieving the standard for Informed Consent:

- 1) Has a training program on informed consent that tailors different training topics to different staff roles and has made the training required for newly hired staff and existing staff who were not trained, **and**
- 2) Ensures that as part of the process for obtaining informed consent, clinicians explain expected difficulties, recovery time, pain management, and restrictions after a procedure, and give the patient an opportunity to ask questions, **and**
- 3) Ensures every applicable consent form used by the hospital includes the name of the clinician performing the procedure, whether the clinician is expected to be absent, and whether any assistants or trainees will be involved, **and**
- 4) Ensures every applicable consent form is written at a 6th-grade reading level or lower, **and**
- 5) Prior to conducting the informed consent discussion, identifies the patient/legal guardian's preferred language and provides a medical interpreter, and has a place in the consent form that indicates whether an interpreter was used, **and**
- 6) Requires clinicians at the hospital to use the "teach back method" with patients/legal guardians.

Download the 2025 Leapfrog Hospital Survey Scoring Algorithm on the [Scoring and Results webpage](#).

1A: Basic Hospital Information

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review Leapfrog's Multi-Campus Reporting Policy.

Important Note: Only include units that were open for the entire reporting period and that remain currently open.

Specifications: See Basic Hospital Information Measure Specifications in the Reference Information beginning on page 50.

Reporting Period: 12 months

- Surveys submitted prior to September 1:
 - 01/01/2024 – 12/31/2024
- Surveys (re)submitted on or after September 1:
 - 07/01/2024 – 06/30/2025

Note: As a reminder, the Corrections Period (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

General Information

1) Reporting period used:	☐ 01/01/2024 – 12/31/2024 ☐ 07/01/2024 – 06/30/2025
2) Total number of <u>licensed acute-care</u> ¹⁰ beds.	_____
3) Total number of <u>staffed acute-care</u> ¹¹ beds.	_____
4) Total number of <u>adult acute-care admissions</u> ¹² to your hospital during the reporting period.	_____
5) Total number of <u>pediatric acute-care admissions</u> ¹³ to your hospital during the reporting period.	_____
6) Does your hospital operate any adult and/or pediatric <u>general medical, surgical, medical/surgical, or neuro ICUs</u> ¹⁴ ? <i>If "yes" to question #6, skip question #11 below.</i> <i>If "no" to question #6, skip questions #7-10 and continue to question #11.</i>	☐ Yes ☐ No
7) Total number of <u>licensed</u> ¹⁵ adult and pediatric general medical, surgical, medical/surgical, and neuro ICU beds.	_____
8) Total number of <u>staffed</u> ¹⁶ adult and pediatric general medical, surgical, medical/surgical, and neuro ICU beds.	_____
9) Total number of adult <u>general medical, surgical, medical/surgical, and neuro ICU</u> ¹⁴ admissions during the reporting period.	_____
10) Total number of pediatric <u>general medical, surgical, medical/surgical, and neuro ICU</u> ¹⁴ admissions during the reporting period.	_____
11) If your hospital does not operate dedicated adult or pediatric general medical, surgical, medical/surgical, or neuro ICUs, does your hospital admit adult and/or pediatric general medical, surgical, medical/surgical or neuro ICU patients to mixed acuity units?	☐ Yes ☐ No

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Section 1: Patient Rights and Ethics

12) Does your hospital operate any of the following specialty ICUs: medical cardiac, respiratory, surgical cardiothoracic, burn, trauma, pediatric cardiothoracic, oncology, or any level neonatal ICU? <i>If "no" to question #12, skip question #13 and continue to question #14.</i>	☐ Yes ☐ No
13) Total number of admissions to any level neonatal ICU ¹⁷ during the reporting period.	_____
14) Is your hospital a Major or Graduate teaching hospital (based on NHSN's definitions) for physicians and/or physicians-in-training or nursing students?	<i>No response required here. Determined automatically based on NHSN 2024 Patient Safety Component – Annual Hospital Survey.</i>

Reporting Period: Answer questions #15-18 based on the practices currently in place at the time you submit this section of the Survey.

Note: As a reminder, the Corrections Period (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

General Hospital Policies

15) To help ensure that patients are cared for by well-trained physicians and other providers (e.g., certified registered nurse anesthetists, certified midwives, or certified nurse-midwives, etc.), do your medical staff by-laws or hospital-wide policies require all physicians and providers who have privileges to provide care at your hospital to be board certified or board eligible?	☐ Yes ☐ No
16) Does your hospital include performance on the Leapfrog Hospital Survey, Leapfrog Hospital Safety Grade, or Leapfrog Top Hospital in performance reviews and/or compensation incentives for senior administrative leadership?	☐ Yes ☐ No
17) Does your hospital have a policy and protocol that empowers patients, or their family caregivers, to activate a rapid response team (RRT) to evaluate the patient for possible escalation of care, that includes all the following elements: • A process to notify patients and family caregivers, verbally or in writing, about how to activate the rapid response team; • A process to ensure clinicians are trained to recognize when a patient or family caregiver is asking for an evaluation by a rapid response team; and • A process to ensure clinicians are trained on how to conduct the evaluation if they are part of the rapid response team?	☐ Yes ☐ No
18) Does your hospital have a protocol to follow-up on patient-reported concerns about their care that includes all the following elements: • All patients and family caregivers are <u>notified</u> of at least one method to report concerns with their care, • All patients and family caregivers who report a concern are <u>contacted</u> by a hospital representative within 30 days of making the report, and • All concerns reported by patients and family caregivers are <u>logged</u> in an incident reporting system?	☐ Yes ☐ No

1B: Billing Ethics

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Important Note: Hyperlinks throughout this subsection refer to the [Billing Ethics FAQs](#) beginning on page 50, not to endnotes. These hyperlinks are not included in the Online Survey Tool.

Reporting Period: Answer questions #1-3 based on the practices currently in place at the time you submit this section of the Survey.

Note: As a reminder, the [Corrections Period](#) (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

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

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iii. offer a payment plan?	
3) Does your hospital take <u>legal action</u> against patients for late payment or insufficient payment of a medical bill? <i>This question does not include patients with whom your hospital has entered into a written agreement specifying a <u>good faith estimate</u> for a medical service.</i> <i>Only Military Treatment Facilities should respond “no, but required by federal law to transfer delinquent payments to the Department of Treasury for action.”</i>	○ Yes ○ No ○ No, but required by federal law to transfer delinquent payments to the Department of Treasury for action

Additional Questions (Optional – Fact Finding Only)

4) Does your hospital screen ALL patients to determine if they are eligible for your hospital's financial assistance program, regardless of whether they apply for financial assistance? <i>If “no, we only screen uninsured patients for financial assistance eligibility” or “no, we only screen patients who have applied for financial assistance,” skip question #5 and continue to question #6.</i> <i>If “no, our hospital does not have a financial assistance program,” skip questions #5-7 and continue to the next subsection.</i>	○ Yes, using a presumptive eligibility tool licensed from a third-party ○ Yes, using our hospital's own approach to assessing financial assistance eligibility ○ No, we only screen uninsured patients for financial assistance eligibility ○ No, we only screen patients who have applied for financial assistance ○ No, our hospital does not have a financial assistance program
5) Does your hospital notify ALL patients who were determined to be eligible for your hospital's financial assistance program that they have qualified for the program within 30 days of the determination?	○ Yes ○ No
6) Does your hospital's financial assistance program apply to ALL clinician fees, in addition to facility fees, for clinicians with privileges at your hospital?	○ Yes ○ No ○ No, but we include a list of covered providers and services in our financial assistance application
7) Does your hospital's financial assistance application include notification that some services, including physician services, may be billed separately?	○ Yes ○ No

1C: Health Care Equity

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Important Notes:

Note 1: Question #5 will not be used in scoring for hospitals that do not identify disparities or if there is inadequate data to determine if disparities exist in question #4. Additionally, question #7 is optional and will not be used in scoring or publicly reported. All other questions will be used in scoring and public reporting.

Note 2: Hyperlinks throughout this subsection refer to the [Health Care Equity FAQs](#) beginning on page 52, not to endnotes. These hyperlinks are not included in the Online Survey Tool.

Reporting Period: Answer questions #1-8 based on the practices currently in place at the time you submit this section of the Survey.

Note: As a reminder, the [Corrections Period](#) (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

1) Which of the following patient self-identified demographic data does your hospital collect <u>directly from its patients (or patient's legal guardian)</u> prior to or while registering a patient for a hospital visit? <i>Select all that apply.</i> <i>If "none of the above," skip the remaining questions in Section 1C and continue to the next subsection. The hospital will be scored as "Limited Achievement."</i>	☐ Race ☐ Ethnicity ☐ Spoken language preferred for health care (patient or legal guardian) ☐ Written language preferred for health care (patient or legal guardian) ☐ Sexual orientation ☐ Gender identity ☐ <u>Ability status</u> ☐ None of the above
2) Does your hospital train staff responsible for collecting the self-identified demographic data either in-person or over the phone from patients (or patient's legal guardian) in question #1 at both: - the time of onboarding, and - annually thereafter?	☐ Yes ☐ No
3) Does your hospital use the patient self-identified demographic data it collects directly from patients (or patient's legal guardian) in question #1 to stratify <u>any</u> quality measure(s) with the aim of identifying <u>health care disparities</u>? <i>If "no" to question #3, skip questions #4-5 and continue to question #6.</i>	☐ Yes ☐ No
4) By stratifying the quality measure(s) from question #3, has your hospital identified any health care disparities among its patients? <i>If "no, disparities were not identified" or "inadequate data available to determine if disparities exist" to question #4, skip question #5 and continue to question #6.</i>	☐ Yes, disparities were identified ☐ No, disparities were not identified ☐ Inadequate data available to determine if disparities exist

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5) In the past 12 months, has your hospital used the data and information obtained through question #4 to update or revise its policies or procedures? OR In the past 12 months, has your hospital developed a written action plan that describes how it will address at least one of the health care disparities identified through question #4?	☐ Yes ☐ No
6) Does your hospital share information on its efforts to identify and reduce health care disparities and the impact of those efforts on its public website based on <i>race, ethnicity, spoken language preferred for health care (patient or legal guardian), written language preferred for health care (patient or legal guardian), sexual orientation, gender identity, or ability status</i>? <i>If "no" to question #6, skip question #7 and continue to question #8.</i>	☐ Yes ☐ No
7) <u>Webpage</u>⁸ URL where efforts to identify and reduce health care disparities and the impact of those efforts (based on the self-identified demographic data collected directly from patients or patient's legal guardian) are displayed: <i>The http:// prefix needs to be included.</i> <i>This question is optional and response will not be scored or publicly reported in 2025.</i>	_____
8) Does your hospital report out and discuss efforts related to identifying and addressing disparities with the Board at least annually?	☐ Yes ☐ No

1D: Informed Consent

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Important Notes:

Note 1: Question #2, while required, will not be scored or publicly reported.

Note 2: In this subsection, questions regarding the informed consent process and consent forms **ONLY** apply to those procedures where general anesthesia, regional anesthesia, or monitored anesthesia care is used. The questions do **NOT** apply to anesthesia care; they only apply to the consent process and consent forms for applicable procedures.

Note 3: Hyperlinks throughout this subsection refer to the [Informed Consent FAQs](#) beginning on page 54, not to endnotes. These hyperlinks are not included in the Online Survey Tool.

Reporting Period: Answer questions #1-7 based on the practices currently in place at the time you submit this section of the Survey.

Note: As a reminder, the [Corrections Period](#) (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

Policies and Training

1) Does your hospital train employed staff on informed consent and tailor different training topics to <u>different staff roles</u> , including hospital leaders, MD/NP/PA, nurses and other clinical staff, administrative staff, and interpreters, and has your hospital made the training: - a required component of onboarding for the appropriate newly hired staff, and - required for the appropriate existing staff who were not previously trained?	☐ Yes ☐ No
2) At least once a year, does your hospital solicit feedback from patients/legal guardians about your hospital's informed consent process to understand how it can be improved over time? <i>This question is required but response will not be scored or publicly reported in 2025.</i>	☐ Yes ☐ No

Content of Informed Consent Forms

3) As part of your hospital's process for obtaining informed consent, does: - the clinician explain expected difficulties, recovery time, pain management, and restrictions after a procedure that may be experienced by the patient either in the hospital or post-discharge, if applicable; - the patient have the opportunity to ask questions; and - the consent form document that these two elements of the process have taken place?	☐ Yes ☐ No
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4) Do ALL applicable consent forms used by your hospital include: - the name(s) of the clinician(s) performing the procedure; - whether the clinician is expected to be absent from portions of the procedure (e.g., opening, closing), if applicable; and - whether any assistants or trainees will be involved in the procedure, if applicable?	☐ Yes ☐ No
5) Are ALL applicable consent forms used by your hospital written at a 6th-grade reading level or lower? <i>The procedure name and description, and any words accompanied by a plain language definition can be excluded from the <u>reading level assessment</u>.</i>	☐ Yes, all applicable forms are written at a 6th-grade reading level or lower ☐ No, but at least one form is written at a 6th-grade reading level or lower ☐ No forms are written at a 6th-grade reading level or lower ☐ No, all applicable forms are written at a 9th-grade reading level or lower

Process for Gaining Informed Consent

6) Prior to the informed consent discussion, does your hospital: - ask what the patient/legal guardian's preferred language for medical decision-making is; - where needed, provide the patient/legal guardian access to a <u>qualified medical interpreter</u>, NOT a family caregiver; - use a consent form or notation in the medical record to document whether a qualified medical interpreter was used to conduct the informed consent process; and - have the medical interpreter sign the consent form (either in-person, electronically, or by documenting the use of an interpreter in the medical record)?	☐ Yes ☐ No
7) As part of the informed consent discussion, do clinicians at your hospital use the "teach back method" with patients/legal guardians where patients/legal guardians are asked to describe in their own words what they understand will be performed, why it will be performed, and what are the primary risks?	☐ Yes ☐ No

Affirmation of Accuracy

As the hospital CEO or as an employee of the hospital to whom the hospital CEO has delegated responsibility, I have reviewed this information pertaining to the Patient Rights and Ethics Section at our hospital, and I hereby certify that this information is true, accurate, and reflects the current, normal operating circumstances at our hospital. I am authorized to make this certification on behalf of our hospital.

The hospital and I understand that The Leapfrog Group, its members, the public and entities and persons who contract or have other business dealings with The Leapfrog Group are relying on the truth and accuracy of this information. The hospital and I also understand that The Leapfrog Group will make this information and/or analyses of this information public through the Survey Results public reporting website, The Leapfrog Group's Hospital Safety Grade, and/or other Leapfrog Group products and services. This information and/or analyses and all intellectual property rights therein shall be and remain the sole and exclusive property of The Leapfrog Group in which The Leapfrog Group retains exclusive ownership. This information does not infringe upon any third-party intellectual property rights or any other third-party rights whatsoever and is free and clear of all encumbrances and liens of any kind. The hospital and I acknowledge that The Leapfrog Group may use this information in a commercial manner for profit. The hospital shall be liable for and shall hold harmless and indemnify The Leapfrog Group from any and all damages, demands, costs, or causes of action resulting from any inaccuracies in the information or any misrepresentations in this Affirmation of Accuracy. The Leapfrog Group and its members and entities and persons who contract or have other business dealings with The Leapfrog Group reserve the right to omit or disclaim information that is not current, accurate or truthful.

Affirmed by _____, the hospital's _____,
(first name and last name) (title)
on _____.
(date)

Section 1: Patient Rights and Ethics Reference Information***What's New in the 2025 Survey*****Section 1A: Basic Hospital Information**

In response to comments collected during the public comment period and through the national pilot, Leapfrog is making additional updates to Section 1A: Basic Hospital Information to ask hospitals that do not operate dedicated general medical, surgical, medical/surgical, or neuro ICUs if they admit adult and/or pediatric general medical, surgical, medical/surgical, or neuro ICU patients to mixed acuity units. The purpose of this new question is to identify hospitals without a dedicated ICU that are eligible to report on ICU Physician Staffing in Sections 5A: Adult ICU Physician Staffing and 5B: Pediatric ICU Physician Staffing. Leapfrog is also asking hospitals to report on adult and pediatric admissions to their general medical, surgical, medical/surgical, and neuro ICUs separately to help identify what types of ICUs hospitals are eligible to report on.

Additionally, Leapfrog is updating the unit description endnotes in Section 1A: Basic Hospital Information to add further clarification and alignment with reporting in other sections of the Survey. The endnotes defining licensed acute-care beds and licensed ICU beds are also being updated to instruct hospitals to report the number of staffed beds if beds are currently staffed higher than licensed. The endnote for acute-care beds will also instruct hospitals to include telemetry, as well as step-down/progressive beds, and exclude observation and swing beds. The endnote for licensed ICU beds will instruct hospitals to exclude beds used for step-down/progressive care.

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

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

Section 1B: Billing Ethics

In response to feedback from hospitals participating in the Survey, Leapfrog is making the following updates to Section 1B: Billing Ethics:

- Question #1, regarding the itemized billing statement, will continue to ask that the itemized billing statement be provided either by mail or electronically (via email or the patient portal), however, Leapfrog is no longer adding patient preference in 2025.

Additionally, Leapfrog is retaining the optional, fact-finding questions regarding presumptive screening of patients for financial assistance and patient notification when financial assistance has been applied, for a second year with plans to incorporate into the national Billing Ethics Standard in 2026, but is making the following updates:

- Question #4, regarding the presumptive screening of patients for financial assistance, is being updated to clarify that ALL patients should be included in the screening process. We are also adding a response option for hospitals that only screen uninsured patients.

Two additional fact-finding questions will also be added regarding whether all clinicians are included in the hospital's financial assistance program as well as a notification that some services may be billed separately. We are also adding a FAQ with further information

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

Section 1C: Health Care Equity

Leapfrog will continue to score and publicly report the Health Care Equity standard and will be making the following updates to Section 1C: Health Care Equity:

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

Leapfrog will add a new optional question asking hospitals to provide a link to where they publicly share their efforts to identify and reduce health care disparities. Only hospitals that answer “yes” to question #6 will be asked to provide the URL. This question, and the provided URL, will be used as part of Leapfrog's Data Verification Protocols. The URL will not be scored or publicly reported.

There are no changes to the scoring algorithm for Section 1C: Health Care Equity

Section 1D: Informed Consent

Based on the fact that health care facilities in Georgia and Texas have a statutory protection facilitated by using consent forms at a ninth-grade reading level, Leapfrog will maintain the current scoring algorithm giving hospitals the ability to earn “Considerable Achievement” by having all consent forms written at a ninth-grade reading level, when additional criteria in the section are met. However, since 54% of Americans between the ages of 16 and 74 read below the equivalent of a sixth-grade level, hospitals will continue to be required to have all applicable consent forms written at a sixth-grade reading level or lower to “Achieve the Standard.” In response to questions and feedback from hospitals participating in the Survey, Leapfrog is updating question #1 to clarify that the question about training only concerns individuals employed by the hospital.

We are also updating FAQ#22 to indicate that only administrative staff with a patient-facing role need to be trained on informed consent.

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

Change Summary Since Release

None. If substantive changes are made to this section of the Survey after release on April 1, 2025, they will be documented in this Change Summary section.

Section 1A: Basic Hospital Information Measure Specifications

Important Note: Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Teaching Status is obtained directly from CDC's National Healthcare Safety Network (NHSN) using a hospital's response to the following questions within the "Hospital Facility" section of the 2024 Patient Safety Component – Annual Hospital Survey:

Is your hospital a teaching hospital for physicians and/or physicians-in-training or nursing students? [Yes, No]

If Yes, what type: [Major, Graduate, Undergraduate]

NHSN Home		View Annual Survey	
Alerts			
Dashboard	▶	Mandatory fields marked with *	
Reporting Plan	▶	Facility ID: * The Leapfrog Group Test (ID 93395)	
Patient	▶	Survey Type: * FACSRSV-PS - Hospital Survey Data	
Event	▶	Survey Year: * 2024	
Procedure	▶	In the previous calendar year, indicate: Facility was not operational in this survey year	
Summary Data	▶	Facility Characteristics (completed by Infection Preventionist)	
COVID-19	▶	Facility ownership: * GOV - Government	
Import/Export		Hospital Facility:	
Surveys	▶	Number of Patient Days: *	
Analysis	▶	Number of Admissions: *	
Users	▶	Is your hospital a teaching hospital for physicians and/or physicians-in-training or nursing students? * N - No	
Facility	▶	If Yes, what type: MAJOR GRADUATE UNDERGRADUATE	

For the purposes of the 2025 Leapfrog Hospital Survey and Leapfrog's Top Hospital program, Leapfrog will consider the following types a "teaching hospital." Major and Graduate. NHSN's definitions for types of teaching hospitals may be reviewed [here](#). This designation will also be used for the purposes of assigning hospitals to a teaching or non-teaching hospital cohort for the purposes of scoring the Total Nursing Care Hours per Patient Day, RN Hours per Patient Day, and Nursing Skill Mix measures in [Section 5C: Nursing Workforce](#).

In order for Leapfrog to obtain teaching status from NHSN, hospitals must complete the following steps:

- 1) Join Leapfrog's NHSN Group and review/accept Leapfrog's Data Rights Template by the published [deadlines](#)*,
- 2) Enter a valid NHSN ID in the Profile of their 2025 Leapfrog Hospital Survey, and
- 3) Submit a 2025 Leapfrog Hospital Survey by the published [deadlines](#).

*Hospitals are not required to "re-join" Leapfrog's NHSN Group if they joined and conferred rights in previous Leapfrog Hospital Survey Cycles. However, all hospitals in Leapfrog's NHSN Group must review their Rights Acceptance Report at least annually by the published [join-by deadlines](#).

Instructions for joining or verifying that you are in Leapfrog's NHSN Group are available [here](#) (See "NHSN Guidance: Join the Group, Data Rights Template, and Downloading Reports"). These instructions also include information for verifying the teaching status response to the 2024 Patient Safety Component – Annual Hospital Survey.

Section 1: Patient Rights and Ethics Frequently Asked Questions (FAQs)

Basic Hospital Information FAQs

1. How does Leapfrog define board certified and board eligible?

For physicians:

- **Board certified** means that the physician has been awarded certification from the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA).
- **Board eligible** indicates that the physician has completed their initial training/fellowship but has not yet passed an existing board-certifying exam in a specialty. Leapfrog adheres to the ABMS and AOA Board Eligibility Policy for all specialties, which may be reviewed here: <https://www.abms.org/board-certification/board-certification-requirements/board-eligibility/> and <https://certification.osteopathic.org/about/>, respectively. These eligibility periods provide the physician with an adequate window to take their boards and re-take if necessary.

For CRNAs, **board certified** means that the RN has been awarded certification from The National Board of Certification and Recertification for Nurse Anesthetists (NBCRNA).

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

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

3. What are some examples of a protocol to follow-up on patient-reported concerns? What kinds of concerns are we supposed to be capturing?

Leapfrog's goal is to capture how hospitals are encouraging the submission of, and following up on, issues or complaints from patients that are specific to the care they received at the hospital.

Examples of opportunities to report would include any of the following:

- Notifying patients on admission about their right to report concerns as part of their [rights and responsibilities](#);
- A patient experience department that can be contacted by telephone, e-mail, and in-person;
- A reporting system available to patients through the patient portal e.g. a specific function or message in the application that prompts patients to report concerns, including through messaging the provider directly;
- A patient survey administered to patients soliciting concerns with their care; or
- The free text fields of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey.

Billing Ethics FAQs

4. Can we consider information provided to patients at admission, or as part of the "conditions of admission" packet of material, as information that meets one or more of the elements of the billing statement in question #1?

No. Only information provided directly to the patient by mail or electronically (via email or the patient portal) can be considered.

5. To meet the criteria for item “i” in question #1, does our hospital have to translate the billing statement and/or master itemized bill to every language spoken by our patients?

Hospitals must provide instructions, in the patient's preferred language, on how to obtain a written translation or oral interpretation of the bill if the language constitutes 5% (and at least 50 patients) or 1,000 patients (whichever is less) of the population eligible to be served or likely to receive care at the hospital.

6. As a SafetyNet hospital, our funding comes from taxpayers, grants, and government funding. A large portion of our patients are deemed indigent and do not receive a bill for any services. Only a small portion with insurance will receive a bill. Therefore, we do not send a bill to every patient. Can we respond “yes” to question #1?

Yes. Hospitals do not need to provide billing statements to patients with no balance due in order to respond “yes” to question #1. However, for those patients who are receiving a bill, all the criteria listed in the question must be included to respond “yes.”

7. What does Leapfrog mean by “legal action” in question #3?

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

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

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

8. What are alternatives to legal action against patients?

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

9. What is a “good faith estimate” as referred to in question #3?

A good faith estimate includes an itemized list of expected charges for the primary item or service the patient will receive and any other items or services provided as part of the same scheduled episode of care. The final bill must be no more than \$400 over the amount of the good faith estimate. The Centers for Medicare and Medicaid Services have published an example template for providing good faith estimates: <https://www.cms.gov/files/document/good-faith-estimate-example.pdf>.

10. How and when should hospitals initiate the screening process for their financial assistance program?

Hospitals should initiate the eligibility screening process on all patients at the time of registration. Hospitals can do so by using presumptive eligibility software used to determine Medicaid eligibility to help determine if patients are eligible for the hospital's own financial assistance programs (e.g., Waystar, FinThrive, RevCo, etc.). Hospitals can use tools such as Experian or paper applications to assess a patient's ability to pay.

11. What does Leapfrog mean when asking if the hospital's financial assistance program includes ALL clinicians with privileges at the hospital?

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

Health Care Equity FAQs**12. Our hospital is just starting to explore the collection and use of demographic data. What are some resources or tools we can use to collect demographic data?**

Hospitals can refer to [the Toronto Measuring Health Equity website](https://www.toronto.ca/health-equity) which includes training videos, manuals, and presentations on how to collect demographic data from patients, including the modeling of interactions between health care staff and patients. Additionally, CMS also has some free tools available on their website at: <https://www.cms.gov/priorities/health-equity/minority-health/research-data/research-data/tools>.

13. What types of demographic data should hospitals be collecting?

At minimum, hospitals should collect ethnicity and race data from patients. While the Office of Management and Budget (OMB) has revised their Standards for maintaining, collecting, and presenting federal data on race and ethnicity, hospitals may not have implemented those updates. However, the following minimum categories should be used: American Indian or Alaska Native, Asian, Black or African American, Hispanic or Latino, Native Hawaiian or Pacific Islander, and White.

Regarding patient self-identified gender identity and sexual orientation, the Centers for Disease Control and Prevention has issued helpful guidance for providers and facilities, including guidance on the type of questions to ask patients. More information is available at <https://www.cdc.gov/hivnexus/hcp/sexual-history/index.html>.

14. To select any of the patient self-identified demographic data in question #1, does a hospital need to collect the data in a particular way?

Hospitals should be regularly collecting the information via registration or a nurse admission assessment directly from the patient or, for pediatric and other patients who cannot communicate the information themselves, the patient's legal guardian. Patients or their legal guardians should have the opportunity to provide the information either verbally (in-person or over the phone) or via a paper form or online patient portal. Information should NOT be collected through observation or other documents (e.g., state-issued ID). This information should be collected from inpatients and outpatients.

15. Does Leapfrog have an example of how to collect patient self-reported "sexual orientation" in question #1?

The CDC has helpful information available on their website at <https://www.cdc.gov/hivnexus/hcp/sexual-history/index.html>. This webpage includes guidance for discussing sexual health, sexual orientation, and gender identity. Additionally, they provide some helpful tips on what questions to ask to collect the data.

16. What does Leapfrog mean by "ability status"?

As described by the [CDC](https://www.cdc.gov/disability-and-health/about/), a disability is any condition of the body or mind (impairment) that makes it more difficult for the person with the condition to do certain activities (activity limitation) and interact with the world around them (participation restrictions). More information is available on the CDC website at https://www.cdc.gov/disability-and-health/about/?CDC_AAref_Val=https://www.cdc.gov/ncbddd/disabilityandhealth/disability.html.

Examples of questions and ways to determine one's ability status can be found here:

- https://www.cdc.gov/dhds/datasets/?CDC_AAref_Val=https://www.cdc.gov/ncbddd/disabilityandhealth/datasets.html

- <https://torontohealthequity.ca/wp-content/uploads/2018/03/Measuring-Health-Equity-Participant-Manual-2018.pdf>
- [Short Set of question on Disability: Data Collection - Washington Group](#)
- [Video 2 - Collecting Disability Data](#)

17. How does Leapfrog define “health care disparities?”

Leapfrog defines health care disparities as differences in the quality of health care that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention. More information is available at <https://www.ihl.org/insights/words-matter-making-sense-health-equity-terminology>.

18. In question #4, what does Leapfrog mean by “inadequate data available to determine if disparities exist”?

Hospitals may find that they cannot determine if a health care disparity exists due to small sample sizes (e.g., fewer than 25 patients able to be measured).

19. Can we report on health system level data in question #4 if we do not have adequate data to determine if disparities exist?

Yes, individual hospitals that do not have enough data to identify disparities among their patients based on the demographic data selected in question #1 can respond “yes” to question #4 if they are aggregating their data for the purposes of analysis with other facilities that are part of their system.

20. In question #6, is Leapfrog asking whether our hospital is publicly reporting the measures we stratify from question #3 on our website?

No. We are trying to assess the extent to which hospitals are sharing any information on their efforts to identify and reduce health care disparities based on the self-identified demographic data collected directly from the patient or legal guardian present and the impact of those efforts. This may take the form of sharing quantitative or qualitative data. It may also include a description of the types of demographic data collected and the analyses performed, which in some cases demonstrated no apparent health care disparities. Please note that the information on your webpage should be easily accessible. If your hospital is part of a health system, you must provide a link to the system webpage from your hospital's individual website. Below are examples that meet the criteria for question #6.

- Henry Ford Health: <https://www.henryford.com/about/diversity/why-we-ask>
- NewYork-Presbyterian: <https://www.nyp.org/daliocenter/data-and-infrastructure>

Informed Consent FAQs

21. In cases where hospitals do not have information about informed consent processes that take place at a clinician’s (e.g., surgeon’s) office, or if informed consent processes are conducted by clinicians that are not employed by the hospital, or in other cases where the hospital does not have visibility into the informed consent process, how should hospitals respond to questions in this section?

Hospitals that do not have input over the consent form or visibility into the informed consent process for procedures performed at a hospital, should select “No” for the questions in this section.

If the hospital does have input over the consent form and visibility into the informed consent process for procedures performed at the hospital, such as through the privileging process to allow clinicians to practice at their facility, but the consent forms and the consent process are being completed at the clinician(s)'s office, the hospital can work with those offices to implement the requirements outlined in the questions and, via an annual audit, verify that the forms and process meet the criteria to respond “Yes” to the questions in this section. All documentation should be maintained throughout the Survey Cycle.

22. Are there any examples of patients for whom the informed consent questions would not apply?

When responding to the questions in this subsection, you can exclude patients who are unable to communicate and for whom no legal guardian or medical proxy has been identified at least one week prior to the procedure being performed.

23. Should we consider the term “legal guardian” to be equivalent to the term “legal surrogate decision-maker”?

Yes, for the purposes of the Leapfrog Hospital Survey, these terms are equivalent.

24. What roles and staff levels need to be included in the training program on informed consent included in question #1? What types of training can we use?

As described on page 98 of the AHRQ's Making Informed Consent an Informed Choice – Training for Health Care Leaders, the appropriate roles for training include all the following: hospital leaders, physicians/independent nurse practitioners/independent physician assistants, nurses or other clinical staff, administrative staff in a patient-facing role, and interpreters. The training may be tailored to only include relevant materials based on the staff role. The goal is for each responsible staff person to be trained in their applicable domains. For example:

- For hospital leaders, training on the definition and principles of informed consent and specifics on the hospital's informed consent policy is appropriate.
- Clinical staff such as physicians and nurses should also be trained in strategies for clear communication, for presenting choices, and for documentation, if they are responsible for directly conducting the informed consent process.
- For administrative staff in a patient-facing role and interpreters, participating in the informed consent process should also be trained in reviewing and completing documentation.

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

Training does not need to be exclusive to informed consent and can be included as a component or module in other trainings. Examples of trainings include computer-based training, one-on-one precepting, webinars, and staff meeting presentations, as well as other modalities where learning can be assessed after the content is delivered to the trainee.

25. Regarding the process for soliciting patient feedback in question #2, what parameters should this process follow? Is there a specific patient feedback form that should be used?

Any method of soliciting feedback from patients who have gone through your informed consent process would be acceptable. One example would be surveying patients after discharge; another example would be asking the hospital's Patient and Family Caregiver Advisory Council (PFAC), if the PFAC includes at least one person who has experience with consenting to a procedure at the hospital in the past 24 months, either for themselves or on behalf of a patient as a caregiver. Asking about the specific verbiage used in the consent form, as well as more general questions about the consent process itself, would both be acceptable areas of inquiry. It is Leapfrog's goal to encourage hospitals to ensure their process is working well for patients by being as flexible as possible in allowing for differing methods.

For an example of a survey of patient's experience with the informed consent process, see: Hallock JL, Rios R, Handa VL. Patient satisfaction and informed consent for surgery. *Am J Obstet Gynecol*. 2017 Aug;217(2):181.e1-181.e7. doi: 10.1016/j.ajog.2017.03.020. Epub 2017 Mar 28. PMID: 28363439.

26. Should each consent form be customized to include patient- and procedure-specific details to explain expected difficulties and recovery time (question #3)?

No. Instead, the consent form must document that the conversation between the patient and the clinician took place, and that the patient had the opportunity to ask questions. For example, such language might read: “I confirm that the choices for my treatment were explained to me. I understand the risks I may face and the benefits that may happen. I also know about the issues I might face from having the procedure. I understand how long I will take to recover, how I can manage my pain, and any rules to follow while I am in the hospital and after I leave. I also understand why the procedure is being done.”

27. Does the consent form need to specifically name the assistants and trainees who will be involved in the procedure, the same way the consent form needs to name the clinician performing the procedure?

No. The consent form only needs to indicate that assistants or trainees may be involved, if this applies to the specific procedure the patient is signing the consent form for.

28. Why has Leapfrog selected a 6th-grade reading level target for consent forms, and what are some strategies we can use to meet this?

Just over half of U.S. adults have a reading level that permits them to understand and synthesize information from a complex text. According to a [Gallup analysis](#), 54% of Americans between the ages of 16 and 74 read below the equivalent of a sixth-grade level. A more recent survey by the [Organization for Economic Development and Cooperation \(OECD\)](#) indicates that literacy in the U.S. has gradually declined since that Gallup analysis, suggesting a still-greater proportion of the population reads below a sixth-grade level today.

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

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

29. How should the reading level of the consent form be assessed?

There are software tools available to assess reading level. For example, consent forms can be edited in Microsoft Word 365, where a readability tool can be used to make this assessment by: (1) on the "File" tab, click the "Options" button; (2) on the "Proofing" tab, under "When correcting spelling and grammar in Word," select the "Show readability statistics" check box. Exit the window. Then, under the Review tab in your Word document, click the "Editor" button in the far left corner of the ribbon, then click "Insights – Document Stats" on the "Editor" sidebar: Word displays a message box showing you the Flesch-Kincaid readability grade-level: any value less than or equal to 6.9 is considered a "sixth-grade" reading level. Reading level can also be assessed using online tools, such as those provided at [Readable.com](#), provided those tools use either the Flesch-Kincaid or SMOG readability standard to evaluate the readability of written language.

30. What information on the consent form can be excluded from the reading level assessment?

The procedure name and description can be excluded from the reading level assessment. In addition, information intended to be read by the provider or administrative staff ONLY, such as instructions for signing and returning the consent form, and information that is written in by an individual provider to give that patient information specific to their condition, can also be excluded. Finally, any words where a sixth-grade reading level definition is included with the term can be excluded from the reading level assessment. For example, in the sentence "anesthesia (putting you to sleep)," only "putting you to sleep" needs to be considered in the reading level assessment.

31. What is a qualified medical interpreter?

In the [U.S. Department of Health and Human Services 2023 Language Access Plan](#), a qualified medical interpreter is defined as "A bilingual/multilingual person who has the appropriate training and experience or demonstrated ability to fully understand, analyze, and process and then faithfully render a spoken, written, or signed message in one language into a second language and who abides by a code of professional practice and ethics." Leapfrog adheres to this definition for the purposes of reporting on the Hospital Survey.

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SECTION 2: MEDICATION SAFETY

This section includes questions and reference information for Section 2: Medication Safety. Please carefully review the questions, endnotes, and reference information (e.g., measure specifications, notes, and frequently asked questions) before you begin. Failure to review the reference information could result in inaccurate responses.

Section 2: Medication Safety**Computerized Physician Order Entry (CPOE) Fact Sheet and Bibliography:**<https://ratings.leapfroggroup.org/measure/hospital/2025/safe-medication-ordering>**Bar Code Medication Administration (BCMA) Fact Sheet and Bibliography:**<https://ratings.leapfroggroup.org/measure/hospital/2025/safe-medication-administration>**Medication Reconciliation Fact Sheet:**<https://ratings.leapfroggroup.org/measure/hospital/2025/medication-reconciliation>

In Section 2, pediatric hospitals should only respond to questions in Sections 2A and 2C. Sections 2B and 2D do not apply to pediatric hospitals. Additionally, pediatric hospitals are not required to complete the CPOE Evaluation Tool.

Section 2 includes questions about your hospital's use of CPOE and BCMA, and (for adult and general hospitals) questions about your hospital's medication reconciliation process. The EHR application subsection (2B) is only applicable to adult and general hospitals and will not be scored or publicly reported. In 2025, three questions about Artificial Intelligence (AI) applications were added to subsection 2B – these questions are optional and will not be scored or publicly reported.

Each hospital achieving the standard for Computerized Physician Order Entry (CPOE):

1. Assures that prescribers enter at least 85% of inpatient medication orders via a computer system that includes decision support software to reduce prescribing errors, **and**
2. For adult and general hospitals, demonstrates, via a test, that its inpatient CPOE system can alert physicians to at least 60% of frequent serious medication errors known to cause harm to patients.

Each hospital achieving the standard for Bar Code Medication Administration:

1. Has implemented the use of BCMA at the bedside in 100% of applicable units; **and**
2. Has achieved at least 95% compliance with scanning patients and medications during administration in applicable units where BCMA is implemented; **and**
3. Has a BCMA system that includes all the following types of decision support: wrong patient, wrong medication, wrong dose, wrong time, and second nurse check needed; **and**
4. Has at least six of the following structures in place to monitor and reduce workarounds: has a formal committee that meets routinely to review data reports on BCMA system use, has back-up equipment for hardware failures, has a help desk that provides timely responses to urgent BCMA issues in real-time, conducting real-time observations of users using the BCMA system, and engages nursing leadership at the unit level on BCMA use. Additionally, information from these structures is used to implement quality improvement projects or monitor previous quality improvement projects focusing on the hospital's BCMA system. Results from the quality improvement projects are evaluated and demonstrate that these projects have resulted in higher adherence to standard medication administration processes. Finally, resolution of system deficiencies and/or problems that may have contributed to the workaround are communicated back to the end user.

Each hospital achieving the standard for Medication Reconciliation:

1. Uses a nationally endorsed protocol to collect data on the accuracy of its medication reconciliation process for at least 30 sampled patients and reported the data collected to Leapfrog, **and**
2. Has a rate of unintentional medication discrepancies that is lower than the 50th percentile (where lower performance is better).

Download the 2025 Leapfrog Hospital Survey Scoring Algorithm on the [Scoring and Results webpage](#).

2A: Computerized Physician Order Entry (CPOE)

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review Leapfrog's [Multi-Campus Reporting Policy](#).

Important Notes:

Note 1: "Prescribers" used throughout this subsection refers to all licensed clinicians who are authorized by the state in which the hospital is located to order medications for patients. This includes residents and interns who are authorized to order medications under their own authority.

Note 2: Adult and general hospitals must complete an Adult Inpatient Test at least once per Survey Cycle (April to November). Hospitals are encouraged to ensure that the Adult Inpatient CPOE Test is submitted along with the Survey to meet the deadlines for Leapfrog's Programs such as Top Hospital, Leapfrog Hospital Safety Grade, etc.

Note 3: Hospitals will have access to the CPOE Evaluation Tool immediately after completing the Hospital Profile in the Online Hospital Survey Tool.

Specifications: See [Computerized Physician Order Entry \(CPOE\) Measure Specifications](#) in the Reference Information beginning on page 72.

Reporting Period: 3 months

Answer questions #1-5 for the latest 3-month period prior to the submission of this section of the Survey.

Note: As a reminder, the [Corrections Period](#) (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

1) What is the latest 3-month reporting period for which your hospital is submitting responses to this section? 3-month reporting period ending:	_____ Format: Month/Year
2) Does your hospital have a functioning CPOE system in one or more <u>inpatient</u> units of the hospital that: - includes decision support software to reduce prescribing errors; and - is <u>linked</u>¹⁸ to pharmacy, laboratory, and admitting-discharge-transfer (ADT) information in your hospital? <i>If "no" to question #2, skip the remaining questions in Section 2A and Section 2B, and continue to Section 2C. The hospital will be scored as "Limited Achievement."</i>	☐ Yes ☐ No
3) Total number of inpatient medication orders , including orders made in units that do NOT have a functioning CPOE system.	_____
4) Total number of inpatient medication orders in question #3 that licensed prescribers entered via a CPOE system that meets the criteria outlined in question #2.	_____

*If "yes" to question #2 and you are an **adult or general hospital**, use the **Take CPOE Tool** button on the Survey Dashboard to access the **CPOE Evaluation Tool**. Question #5 does not apply to pediatric hospitals.*

5) Hospital's score when it tested its CPOE system using the Leapfrog CPOE Evaluation Tool:

Adult Inpatient Test must be completed between April 1 and November 30, 2025.

No response required here. Determined automatically based on separately completing a test using the Leapfrog CPOE Evaluation Tool.

2B: EHR Application Information

This section is not applicable to pediatric hospitals.

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review Leapfrog's Multi-Campus Reporting Policy.

Important Note: This subsection will not be scored or publicly reported. The information collected in this subsection is used by the CPOE Evaluation Tool developers for research and CPOE Evaluation Tool improvements.

Reporting Period: Answer questions #1-6 based on the EHR application currently in place at the time you submit this section of the Survey.

Note: As a reminder, the Corrections Period (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

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

Additional Questions (Optional – Fact Finding Only)

7) Does your hospital currently use any Artificial Intelligence (AI) applications as part of your medication ordering decision support system? <i>If “no” to question #7, skip the remaining questions in Section 2B, and continue to Section 2C.</i>	☐ Yes ☐ No
8) Which Artificial Intelligence (AI) vendor source is your hospital currently using as part of your medication ordering decision support system? <i>Select all that apply.</i> <i>If “Other AI Vendor” or “Other Homegrown AI Application” is selected, continue to question #9. Otherwise, skip question #9 and continue to the next subsection.</i>	EHR Vendors ☐ Epic ☐ Cerner ☐ Allscripts (Altera) ☐ Meditech ☐ Quadramed ☐ CPSI Medication Safety Vendors ☐ First Databank ☐ Medi-Span ☐ Multum ☐ Lexicomp ☐ Elsevier Other ☐ Other AI Vendor ☐ Other Homegrown AI Application
9) What are the names of the Other AI Vendors or Other Homegrown AI Applications that your hospital is currently using as part of your medication ordering decision support system? <i>If entering multiple Other AI Vendors or Other Homegrown AI Applications, separate each by a comma.</i>	_____

2C: Bar Code Medication Administration (BCMA)

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review Leapfrog's Multi-Campus Reporting Policy.

Important Note: Only include units that were open for the entire reporting period and that remain currently open.

Specifications: See Bar Code Medication Administration (BCMA) Measure Specifications in the Reference Information beginning on page 73.

Reporting Period: 3 months

Answer questions #1-21 for the latest 3-month period prior to the submission of this section of the Survey.

Note: As a reminder, the Corrections Period (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

1) What is the latest 3-month reporting period for which your hospital is submitting responses to questions #2-21? 3-month reporting period ending:	_____ <i>Format: Month/Year</i>
2) Does your hospital use a Bar Code Medication Administration (BCMA) system that is linked to the electronic medication administration record (eMAR) when administering medications at the bedside in at least one of the following adult and/or pediatric units: • <u>General Medical, Surgical, Medical/Surgical, Neuro¹⁴, Neonatal¹⁷, or Specialty ICUs;</u> • <u>Medical, Surgical, or Medical/Surgical Units (including telemetry units)¹⁹;</u> • <u>Step-down/Progressive Units²⁰;</u> • <u>Labor and Delivery Unit²¹; or</u> • <u>Pre-operative and Post-anesthesia Care Units²²?</u> <i>If "no" to question #2, skip questions #3-21 and continue to the next subsection. The hospital will be scored as "Limited Achievement."</i>	☐ Yes ☐ No
3) Does your hospital operate adult and/or pediatric <u>General Medical, Surgical, Medical/Surgical, Neuro¹⁴, Neonatal¹⁷, or Specialty ICUs?</u> <i>If "no" to question #3, skip questions #4-5 and continue to question #6.</i>	☐ Yes ☐ No
4) If "yes," how many of this type of unit are open and staffed in the hospital?	_____
5) How many of the units in question #4 utilized the BCMA/eMAR system when administering medications at the bedside?	_____
6) Does your hospital operate adult and/or pediatric <u>Medical, Surgical, or Medical/Surgical Units (including telemetry units)¹⁹?</u> <i>If "no" to question #6, skip questions #7-8 and continue to question #9.</i>	☐ Yes ☐ No
7) If "yes," how many of this type of unit were open and staffed in the hospital?	_____

8) How many of the units in question #7 utilized the BCMA/eMAR system when administering medications at the bedside?	_____
9) Does your hospital operate adult and/or pediatric <u>Step-down/Progressive Units</u> ²⁰ ? <i>If "no" to question #9, skip questions #10-11 and continue to question #12.</i>	☐ Yes ☐ No
10) If "yes," how many of this type of unit were open and staffed in the hospital?	_____
11) How many of the units in question #10 utilized the BCMA/eMAR system when administering medications at the bedside?	_____
12) Does your hospital operate a <u>Labor and Delivery Unit</u> ²¹ ? <i>If "no" to question #12, skip questions #13-14 and continue to question #15.</i>	☐ Yes ☐ No
13) If "yes," how many of this type of unit were open and staffed in the hospital?	_____
14) How many of the units in question #13 utilized the BCMA/eMAR system when administering medications at the bedside?	_____
15) Does your hospital operate adult and/or pediatric <u>Pre-operative and Post-anesthesia Care Units</u> ²² ? <i>If "no" to question #15, skip questions #16-17 and continue to question #18.</i>	☐ Yes ☐ No
16) If "yes," how many of this type of unit are open and staffed in the hospital?	_____
17) How many of the units in question #16 utilized the BCMA/eMAR system when administering medications at the bedside?	_____

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

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

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

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

21) Which of the following mechanisms does your hospital use to reduce and understand potential BCMA system “workarounds?”		
a)	Has a formal committee that meets routinely to review data reports on BCMA system use	☐ Yes ☐ No
b)	Has back-up equipment (e.g., extra scanners, portable computers, batteries, and mice) for BCMA hardware failures	☐ Yes ☐ No
c)	Has a Help Desk that provides timely responses to urgent BCMA issues in real-time	☐ Yes ☐ No
d)	Conducts real-time observations of users at the unit level using the BCMA system	☐ Yes ☐ No
e)	Engages nursing leadership at the unit level on BCMA use	☐ Yes ☐ No
f)	In the past 12 months used the data and information obtained through items a-e to implement quality improvement projects that have focused on improving the hospital's BCMA performance OR In the past 12 months used the data and information obtained through items a-e to monitor a previously implemented quality improvement project focused on improving the hospital's BCMA performance <i>Cannot respond “yes” to this question, unless “yes” to either 21a, 21d or 21e.</i>	☐ Yes ☐ No
g)	In the past 12 months evaluated the results of the quality improvement projects (from f) and demonstrated that these projects have resulted in higher adherence to your hospital's standard medication administration process OR In the past 12 months evaluated the results of the quality improvement projects (from f) and demonstrated continued adherence to your hospital's standard medication administration process <i>Cannot respond “yes” to this question, unless “yes” to 21f.</i>	☐ Yes ☐ No
h)	Communicated back to end users the resolution of any system deficiencies and/or problems that may have contributed to workarounds <i>Cannot respond “yes” to this question, unless “yes” to either 21a, 21d or 21e.</i>	☐ Yes ☐ No

2D: Medication Reconciliation

This section is not applicable to pediatric hospitals.

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review Leapfrog's Multi-Campus Reporting Policy.

Specifications: See **Medication Reconciliation Measure Specifications** in the Reference Information beginning on page 76.

Reporting Period: 6 months

Answer questions #1-8 for the latest 6-month period prior to the submission of this section of the Survey.

Note: As a reminder, the Corrections Period (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

Sufficient Sample: See **Medication Reconciliation Measure Specifications** for instructions on identifying a sufficient sample for question #3.

1) What is the latest 6-month reporting period for which your hospital is submitting responses to this section? 6-month reporting period ending:	<u> </u> Format: Month/Year
2) During the 6-month reporting period, did your hospital conduct a random sample of adult patients and have a pharmacist or <u>certified pharmacy technician</u>²³ complete the following steps for each patient included in the sample: • <u>Interview Patient and Obtain the Gold Standard Medication History</u> (pharmacist or <u>certified pharmacy technician</u>²³); • <u>Complete a Medication Reconciliation Worksheet for each sampled patient</u> (pharmacist or <u>certified pharmacy technician</u>²³); • <u>Compare Gold Standard Medication History to Admission Orders</u> (pharmacist only); and • <u>Compare Gold Standard Medication History to Discharge Orders</u> (pharmacist only)? <i>If "no" to question #2, skip the remaining questions in Section 2D and go to the Affirmation of Accuracy. The hospital will be scored as "Did Not Measure."</i> <i>If "no, had fewer than 30 admissions to medical or med/surg units" to question #2, skip the remaining questions in Section 2D and go to the Affirmation of Accuracy. The hospital will be scored as "Does Not Apply."</i>	○ Yes ○ No ○ No, had fewer than 30 admissions to medical or med/surg units

For questions #3-8, if the sample is less than 30 patients from the 6-month period, the hospital will be scored as "Some Achievement" and the rate of unintentional discrepancies will not be publicly reported.

3) Number of adult patients that your hospital <u>sampled</u> ²⁴ .	<u> </u> Max value 500
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4) Number of patients from question #3 who had zero (0) Gold Standard Medications. <i>If more than 10 out of 30 patients (or one-third) included in the sample had zero (0) Gold Standard Medications, the hospital will be scored as "Unable to Calculate Score."</i>	_____
5) Total number of medications obtained by the pharmacist or <u>certified pharmacy technician</u> ²³ from the <u>Gold Standard Medication History</u> ²⁵ for the adult patients included in the sample.	_____
6) Total number of <u>unintentional discrepancies in admission and discharge among the gold standard medications</u> ²⁶ in question #5 identified by the pharmacist.	_____
7) Total number of <u>unintentionally ordered additional medications</u> ²⁷ for the adult patients included in the sample on admission and/or discharge identified by the pharmacist.	_____
8) Total number of <u>discrepancies due to unintentionally ordered additional medications</u> ²⁸ in question #7 identified by the pharmacist.	_____

Affirmation of Accuracy

As the hospital CEO or as an employee of the hospital to whom the hospital CEO has delegated responsibility, I have reviewed this information pertaining to the Medication Safety Section at our hospital, and I hereby certify that this information is true, accurate, and reflects the current, normal operating circumstances at our hospital. I am authorized to make this certification on behalf of our hospital.

The hospital and I understand that The Leapfrog Group, its members, the public and entities and persons who contract or have other business dealings with The Leapfrog Group are relying on the truth and accuracy of this information. The hospital and I also understand that The Leapfrog Group will make this information and/or analyses of this information public through the Survey Results public reporting website, The Leapfrog Group's Hospital Safety Grade, and/or other Leapfrog Group products and services. This information and/or analyses and all intellectual property rights therein shall be and remain the sole and exclusive property of The Leapfrog Group in which The Leapfrog Group retains exclusive ownership. This information does not infringe upon any third-party intellectual property rights or any other third-party rights whatsoever and is free and clear of all encumbrances and liens of any kind. The hospital and I acknowledge that The Leapfrog Group may use this information in a commercial manner for profit. The hospital shall be liable for and shall hold harmless and indemnify The Leapfrog Group from any and all damages, demands, costs, or causes of action resulting from any inaccuracies in the information or any misrepresentations in this Affirmation of Accuracy. The Leapfrog Group and its members and entities and persons who contract or have other business dealings with The Leapfrog Group reserve the right to omit or disclaim information that is not current, accurate or truthful.

Affirmed by _____, the hospital's _____,
(first name and last name) (title)
on _____.
(date)

Section 2: Medication Safety Reference Information

What's New in the 2025 Survey

CPOE Evaluation Tool

The CPOE Evaluation Tool developers will update the test medication scenarios to reflect changes to clinical guidelines and to address medications that hospitals frequently reported as not being in their medication formulary. Due to unforeseen operational challenges, the Test Patients PDF will not include the date of birth for each patient. Hospitals will need to calculate the date of birth based on the age provided. To make this easier for hospitals, Leapfrog will include a Date of Birth Calculator on the [Survey and CPOE Materials webpage](#) starting on April 1.

Additionally, patient allergies will not be removed, as the CPOE test is designed to simulate a real-life environment where allergy information is typically included in patient profiles.

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

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

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

Section 2A: Computerized Physician Order Entry (CPOE)

In response to comments collected during the public comment period and in consultation with Leapfrog's CPOE Expert Panel, Leapfrog is updating the measure specifications for question #3 to include medications ordered via a secure texting platform in the denominator only. Medications ordered via a secure texting platform should be excluded from question #4, the numerator, since these orders are not entered through the CPOE system.

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

Section 2B: EHR Application Information

Leapfrog is adding optional fact-finding questions about Artificial Intelligence (AI) vendors. The responses will be used to research AI vendor influence on a hospital's CPOE Test score. Additionally, we are adding an FAQ to define Artificial Intelligence.

These optional, fact-finding questions are not used in scoring or public reporting. Section 2B: EHR Application Information is not scored or publicly reported.

Section 2C: Bar Code Medication Administration (BCMA)

Leapfrog will continue to ask hospitals about their utilization of BCMA in the following adult and/or pediatric units: medical, surgical, and medical/surgical units; intensive care units (including neonatal); labor and delivery units; and pre-operative and post-anesthesia care units, but, we are updating the unit

definitions to further align with other sections of the Survey, including specifying the inclusion of both single and mixed acuity units when reporting on medical, surgical, and medical/surgical units. Previously, step-down/progressive units were included when reporting on medical, surgical, and medical/surgical units. For 2025, Leapfrog is adding new questions to assess the utilization of step-down/progressive units separately. Hospitals without a dedicated stepdown/progressive unit will continue to report on any medical, surgical, and medical/surgical units and include any medications administered to step-down/progressive patients in these units. This has been clarified in the corresponding endnote for medical, surgical, and medical/surgical units. Telemetry units will continue to be reported with medical, surgical, and medical/surgical units. These questions have been refined for more clarity based on comments collected during the public comment period and national pilot.

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

Leapfrog is making two updates to assist hospitals reporting on their mechanisms used to reduce and understand potential BCMA system “workarounds.” First, Leapfrog is updating one of the questions to ask about “back-up equipment (e.g., extra scanners, portable computers, batteries, and mice)” for BCMA hardware failures, instead of “back-up systems.” Second, we are adding a FAQ reminding hospitals that they should still implement or monitor a quality improvement program even if they are at 95% compliance to ensure that they can continue to improve and maintain high compliance.

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

Section 2D: Medication Reconciliation

There are no changes to this subsection.

Change Summary Since Release

None. If substantive changes are made to this section of the Survey after release on April 1, 2025, they will be documented in this Change Summary section.

Section 2: Medication Safety Measure Specifications

Computerized Physician Order Entry (CPOE) Measure Specifications

Important Notes:

Note 1: Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Note 2: "Licensed prescriber" refers to all licensed clinicians who are authorized by the state in which the hospital is located to order medications for patients. This includes residents and interns who are authorized to order medications under their own authority.

Source: The Leapfrog Group

Reporting Period: The latest 3-month period prior to the submission of this section of the Survey.

Medications: For the purposes of this measure, a **medication** is a substance that is taken into, or placed onto, the body of a person for one or more of the following reasons:

- as a placebo
- to prevent a disease (e.g., flu vaccine)
- to make a diagnosis (e.g., contrast dye)
- to test for the possibility of an adverse effect
- to modify a physiological, biochemical, or anatomical function or abnormality (e.g., heparin/heparin flushes, statins, antihypertensives, etc.)
- to replace a missing factor (e.g., blood product)
- to ameliorate a symptom (e.g., aspirin)
- to treat a disease or condition (including topicals, nasal sprays, eye drops, compounds, inhalants, injectables, patches, etc.)
- to induce anesthesia
- to stabilize or hydrate during medical treatment or procedures (e.g., IV fluids, normal saline, lactated ringers, etc.)
- to provide nutrition (e.g., enteral nutrition products, parenteral nutrition products, breast milk [breast milk applies to BCMA measure only])
- as a supplement (e.g., iron for a patient with iron deficiency anemia or calcium/vitamin D for a patient with osteoporosis)

For the purposes of this measure, the following are **not** considered medications:

- Pre-filled saline flushes and pre-filled heparin flushes (i.e., saline and heparin flushes that come from the manufacturer already filled and are not filled by the hospital's pharmacy)
- Chlorhexidine and alcohol preparation pads
- Intra-op irrigation solutions

Question #3 (denominator): Total number of inpatient medication orders, including medication orders made in inpatients units that do NOT have a functioning CPOE system.

Include:

- Medications ordered for **any patient with an inpatient status**, including those with an inpatient status who may be in an outpatient unit during an overflow situation.
- Medications ordered for any neonatal ICU patient.
- Medications ordered by **any individual**, including nurses and pharmacists.
- Medications ordered electronically, via a secure texting platform, verbally or via paper.
- Medications ordered verbally during a rapid response (prevention of serious injury, cardiac arrest, and respiratory arrest).

Exclude:

- Medications ordered for any newborn in a nursery or mother's room.

- New medication orders that have been modified from the original order but maintain the intent of the original order (e.g., “new” medication orders generated when a dose, route, frequency, or brand are changed).
- Medications ordered verbally during a “code blue” (i.e., medications ordered verbally when a patient requires resuscitation or needs immediate medical attention, most often as the result of a respiratory arrest or cardiac arrest).
- Medications ordered in an operating room or procedural area.

Question #4 (numerator): Total number of inpatient medication orders in question #3 that licensed prescribers entered via a CPOE system that meets the criteria outlined in question #2.

Include:

- Medication orders entered into the CPOE system by a licensed prescriber
- In addition, the following types of medication orders entered in to a CPOE system by a non-licensed prescriber, such as a nurse or pharmacist, can also be included:
 - Per protocol medication orders (i.e., medication orders with detailed guidance on how to administer, dose or adjust a medication) approved by a medical committee where the implementation of the protocol was authorized by a licensed prescriber and orders were initiated in the CPOE system.
 - Standing medication orders (i.e., orders which can be initiated based on medical staff approval of a screening criteria and indication for all patients that meet the screening criteria) approved by a medical committee that were initiated in the CPOE system.
 - Medication orders entered into the CPOE system that required either verbal read back of alerts to the licensed prescriber or a co-signature by a licensed prescriber prior to administration to ensure that the licensed prescriber was made aware of all advice/information generated by the CPOE system.

Exclude:

- Medications ordered verbally, via a secure texting platform, or via paper.
- Medication orders entered into the CPOE system by a non-licensed prescriber, such as a nurse or pharmacist, that were **NOT** per protocol medication orders or standing medication orders.
- Medication orders entered into the CPOE system by a non-licensed prescriber, such as a nurse or pharmacist, that **DID NOT** require either verbal read back of alerts or a co-signature of a licensed prescriber prior to administration.

See FAQs for additional information about responding to the questions in this section.

Bar Code Medication Administration (BCMA) Measure Specifications

Important Note: Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Source: The Leapfrog Group
Reporting Period: The latest 3-month period prior to the submission of this section of the Survey.
Included Adult and/or Pediatric Units: • General Medical, Surgical, Medical/Surgical, Neuro¹⁴, Neonatal¹⁷, or Specialty ICUs • Medical, Surgical, or Medical/Surgical Units (including telemetry units)¹⁹, • Step-down/Progressive Units²⁰ • Labor and Delivery Unit²¹ • Pre-operative and Post-anesthesia Care Units²²
Excluded Units: • Emergency departments • Operating rooms • Procedural and diagnostic areas, such as radiology units, endoscopy units, etc. ○ Note: Pre-operative and post-anesthesia care areas in these units must be included • Units that were not open for the entire reporting period or that are not currently open
Important Note: Hospitals should count units as they do internally (i.e., if units are considered separate units despite sharing a space, report the units as two; if they are considered a single combined unit, report the unit as one.
Medications: For the purposes of this measure, a medication is a substance that is taken into, or placed onto, the body of a person for one or more of the following reasons: • as a placebo • to prevent a disease (e.g., flu vaccine) • to make a diagnosis (e.g., contrast dye) • to test for the possibility of an adverse effect • to modify a physiological, biochemical or anatomical function or abnormality (e.g., heparin/heparin flushes, statins, antihypertensives, etc.) • to replace a missing factor (e.g., blood product) • to ameliorate a symptom (e.g., aspirin) • to treat a disease or condition (including topicals, nasal sprays, eye drops, compounds, inhalants, injectables, patches, etc.) • to induce anesthesia • to stabilize or hydrate during medical treatment or procedures (e.g., IV fluids, normal saline, lactated ringers, etc.) • to provide nutrition (e.g., enteral nutrition products, parenteral nutrition products, breast milk [breast milk applies to BCMA measure only]) • as a supplement (e.g., iron for a patient with iron deficiency anemia or calcium/vitamin D for a patient with osteoporosis)
For the purposes of this measure, the following are not considered medications: • Pre-filled saline flushes and pre-filled heparin flushes (i.e., saline and heparin flushes that come from the manufacturer already filled and are not filled by the hospital's pharmacy) • Chlorhexidine and alcohol preparation pads • Intra-op irrigation solutions
Question #18 (denominator): Total number of scannable medication administrations during the reporting period in those units that utilize BCMA as indicated in questions #5, #8, #11, #14 and #17.
Include all scannable medication administrations (regardless of patient's admission status and administering provider) in adult and/or pediatric general medical, surgical, medical/surgical, neuro, neonatal, and specialty ICUs; medical, surgical, and medical/surgical units (including telemetry units);

step-down/progressive units; labor and delivery units; and pre-operative and post-anesthesia care units that utilize a BCMA system that is linked to the electronic medication administration record (eMAR).

Include medication administrations during a procedure if the hospital combines their procedural areas with their pre-operative or post-anesthesia care units and is **unable** to distinguish between these medication administrations.

Exclude:

- Medication administrations in units that are not specified in question #5, #8, #11, #14 or #17
- Medication administrations in units that do not utilize a BCMA system that is linked to the eMAR
- Medication administrations in units that have not been open or staffed for the entire 3-month reporting period or in units that are not open currently
- Medication administrations during a procedure if the hospital combines their procedural areas with their pre-operative or post-anesthesia care units and is able to distinguish between these medication administrations
- Administrations of medications that are not "scannable," i.e., medications that do not have a bar code and could not be scanned if BCMA were in use

Question #19 (numerator): Total number of medication administrations from question #18 that had both the patient and the medication scanned during administration with a BCMA system that is linked to the electronic medication administration record (eMAR).

Include medication administrations where both the patient and medication were scanned during administration with a BCMA system that is linked to the eMAR.

Exclude medication administrations where neither patient nor medication were scanned during administration or only the patient or only the medication were scanned with a BCMA system that is linked to the eMAR.

See [FAQs](#) for additional information about responding to the questions in this section.

Medication Reconciliation Measure Specifications**Important Notes:**

Note 1: This section does not apply to pediatric hospitals.

Note 2: Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Note 3: A hospital pharmacist or certified pharmacy technician²³ plays two important roles in data collection for this measure. First, the pharmacist or certified pharmacy technician is responsible for obtaining the Gold Standard Medication History from each sampled patient. Second, the pharmacist is responsible for identifying the unintentional discrepancies by comparing the Gold Standard Medication History to admission orders and discharge orders.

Source: Brigham and Women's Hospital (NQF #2456)

Reporting Period: The latest 6-month period prior to submission of this section of the Survey.

Materials for Data Collection:

To complete the data collection for this subsection and respond to questions #3-8 hospitals should download four important tools:

- The **Medication Reconciliation Workbook** (Excel) includes 3 tabs: Instructions, Sampling, and Data Entry. This can be used to identify patients to sample and collect data from, as well as calculate the responses to enter into the Online Hospital Survey Tool from the completed Worksheets.
- The **Medication Reconciliation Worksheet** (Word) can be used by the pharmacist to identify the number of unintentional discrepancies at admission and/or discharge for each sampled patient (question #6). The Medication Reconciliation Worksheet can also be used to track additional medications that were ordered unintentionally at admission and/or discharge (questions #7-8).
- The **MARQUIS 2 Best Possible Medication History: Quick Tips** tri-fold (PDF) includes important information on how the pharmacist or certified pharmacy technician²³ should obtain the Gold Standard Medication History
- **Identifying Discrepancies Flow Chart** (PDF) includes important information on how the pharmacist should identify discrepancies between the Gold Standard Medication History and admission and discharge orders.

All of these tools are available on the [Survey and CPOE Materials webpage](#) and should be used when reporting on this measure.

The intent of this measure is to calculate your hospital's rate of unintentional medication discrepancies per medication. Hospitals may perform data collection on a regular basis or just once for the purposes of reporting on this measure to Leapfrog.

1. Hospitals that collect these data on a regular basis and did so using the previous year's measure specifications can use those data when reporting on this section of the Survey. For example, if your hospital samples regularly on a quarterly basis and collected data January through March using the previous year's specifications, you can report those data on the current year's Survey. We do ask that you download and use the most recent measure specifications and materials when they are made available on April 1 each year.
2. Hospitals that do not sample patients on a regular basis (i.e., quarterly) should sample in real-time beginning April 1 and can collect data at any time during the Survey Cycle (April 1 – November 30). Sampling can be spread out over the entire 6-month reporting period (e.g., five patients per month), or within a shorter time period within those 6 months (e.g., 30 patients in a two-week period).

Follow the steps below to complete data collection for this measure:**Step 1: Identify Patients to Include in the Sample (Survey Coordinator)**

- a. To be scored on the rate of unintentional medication discrepancies, hospitals are required to sample at least 30 patients from a 6-month reporting period. Hospitals that sample fewer than 30 patients during the reporting period will be scored and publicly reported as “Some Achievement.”
- b. All hospitals should exclude patients under 18 years old, patients who were discharged or expired before the Gold Standard Medication History could be obtained, and patients that do not have discharge orders written during the reporting period.
- c. Hospitals should sample patients from medical, medical/surgical, and step-down/progressive units (adult only) to reduce the number of sampled patients with zero (0) Gold Standard Medications. However, hospitals may expand their sampling to patients in additional units of the hospitals.
- d. Hospitals should sample patients from different days of the week, including patients admitted on the weekend.
- e. On the day of data collection, obtain a list of patients that were admitted the day before to medical and/or medical/surgical units, in the order that they were admitted.
- f. Follow the instructions in the Medication Reconciliation Workbook to randomly sample admitted patients.
- g. Send the list of sampled patients to the pharmacist, pharmacy resident, or pharmacy technician so they can schedule an in-person, video, or phone interview with each patient to obtain their Gold Standard Medication History.

Step 2: Interview Patients and Obtain the Gold Standard Medication History (Pharmacist or Certified Pharmacy Technician²³)

- a. A trained pharmacist, pharmacy resident, or certified pharmacy technician²³ must interview the patients from Step 1 and obtain the Gold Standard Medication History within 24 hours after admission, typically the morning after admission. Note that this is in addition to, and separate from, any pre-admission medication list that was created as part of normal care.
- b. The pharmacist, pharmacy resident, or certified pharmacy technician²³ can customize the following script to explain to the patient the reason for the interview: “Hi, I’m *(pharmacist’s name)*, a pharmacist at *(name of hospital)*. I know *(care team member who may have collected a pre-admission medication list or PAML)* already asked you about the medications you were taking before you were admitted to the hospital. I’m here to ask you about these medications again. Our hospital has asked me to collect this information again so I can use it to measure how well we are doing in gathering medication histories. What we learn will help us improve our processes of care in the future and make sure we manage patients’ medications safely when they come into and after they leave the hospital.”
- c. The Gold Standard Medication History is the list of medications that the patient was taking prior to admission. Best practices for collecting the Gold Standard Medication History can be found in the “Other Supporting Materials” for Section 2 on the Survey and CPOE Materials webpage.
 - i. Pharmacists, pharmacy residents, and certified pharmacy technicians²³ should try to use two sources of information (see MARQUIS 2 Best Possible Medication History: Quick Tips and Medication Reconciliation Implementation Toolkit for examples) and explore any discrepancies (e.g., errors related to dose, route, timing, etc.) before finalizing the Gold Standard Medication History. Once the pharmacist, pharmacy resident, or certified pharmacy technician²³ has completed the patient interview, they can utilize support from non-certified pharmacy technicians, medical assistants, or nurses to investigate second or third information sources (e.g., EHR list, pharmacy list, primary or specialty provider information, etc.). However, the pharmacist, pharmacy resident, or certified pharmacy technician²³ must be the one to obtain and finalize the Gold Standard Medication History.
 - ii. Medications that a patient is completely non-adherent to, meaning the patient has not taken the medication for at least 30 days, should be excluded from the Gold Standard Medication History.
 - iii. If a patient has been taking a medication differently to how it was prescribed, then the Gold Standard Medication History should list the medication as the patient was taking it.
 - iv. Exclude PRN medications unless they are clinically relevant. This includes topical locations and creams, saline nasal spray and artificial tear eye drops, herbals and supplements, and

vitamins. Two examples of clinically relevant medications that should not be excluded from the gold standard pre-admission medication list would be iron for a patient with iron-deficiency anemia or calcium/vitamin D for a patient with osteoporosis.

- v. Include PRN medications that are clinically relevant. This includes inhalers, nitroglycerin, analgesics (opioid and non-opioid), muscle relaxants, and sedatives, including medications where sedation is a common side effect (e.g., sedation occurs in more than 10% of individuals). This also includes topical medications with systemic actions (e.g., lidocaine, triamcinolone, sulfadiazine, etc.).
- vi. Clinically relevant is defined as any PRN medication that treats a medical condition on the patient's problem list and/or condition they are being treated for during the visit (i.e., reason for the hospital stay).

Step 3: Complete a Medication Reconciliation Worksheet for each sampled patient (Pharmacist or Certified Pharmacy Technician²³)

- a. Once the Gold Standard Medication History is complete, print out the Medication Reconciliation Worksheet for each sampled patient.
- b. Page 1 needs to be printed out for each sampled patient. Page 2 needs to be printed for each Gold Standard Medication the patient was taking.
- c. Complete the "Gold Standard Medication" column highlighted in yellow for each Gold Standard Medication on the list:

Gold Standard Medication	
Name:	
Dose/Route/ Frequency:	
Drug Class:	
☐ PRN ☐ OTC	
Pt Adherence:	
☐ Completely non-adherent* ☐ Sporadically non-adherent^	☐ Systematically non-adherent** ☐ Adherent
Comments:	
All Sources Used:	
☐ Patient ☐ Pill Bottles ☐ Outpatient EMR ☐ Transfer Records ☐ Pharmacy(s) ☐ Other:	☐ Patient's family/Caregiver ☐ Patient's Own Med List ☐ Outpatient Provider(s) ☐ Past DC Summary ☐ Pharmacy Database

- d. If possible, wait until after the patient has been discharged to complete the next steps.

Step 4: Compare Gold Standard Medication History to Admission Orders (Pharmacist Only)

- a. After the patient has been discharged, obtain the admission and discharge orders for the patient (instructions for comparing the discharge orders are in Step 5 below). Admission orders include all orders written from the time of admission until 8:00 a.m. the following morning or up until 12 hours after the time of admission, whichever comes first.
- b. Compare the admission orders to each Gold Standard Medication on the Medication Reconciliation Worksheet. Note any differences.
 - i. Review the records for the patient to determine if the differences were intentional or unintentional. Use the Identifying Discrepancies Flow Charts to help with this step.

- ii. If the discrepancy was unintentional, then check the box next to “Yes” highlighted in orange. Otherwise, check “No.”

Admission Comparison
Note Differences: (select all that apply) ☐ Dose ☐ Route ☐ Frequency ☐ Substitution ☐ Duplication ☐ Formulation ☐ Duration ☐ Other: ☐ Omission
Reason: ☐ Unintentional (History or Reconciliation Error) ☐ Intentional (Clinical Reason)
Were there any <u>unintentional</u> discrepancies between the gold standard and the admission order? ☐ Yes ☐ No <i>If “yes,” count as 1</i>

- c. Review the admission orders for any medications that were not listed in the Gold Standard Medication History. If any of the additional medications were ordered **unintentionally**, list it on the first page of the Medication Reconciliation Worksheet in the blue-highlighted column. You may need to contact the Provider to determine if the medication was ordered unintentionally or not.

Additional Medications that were Ordered Unintentionally:

Additional Medication:	Unintentionally Ordered on:	Comments:
<u>Name:</u>	☐ Admission (count as 1)	
<u>Dose/Route/Frequency:</u>	☐ Discharge (count as 1)	
	☐ Both (count as 2)	
<u>Name:</u>	☐ Admission (count as 1)	
<u>Dose/Route/Frequency:</u>	☐ Discharge (count as 1)	
	☐ Both (count as 2)	
<u>Name:</u>	☐ Admission (count as 1)	
<u>Dose/Route/Frequency:</u>	☐ Discharge (count as 1)	
	☐ Both (count as 2)	

- d. If the pharmacist identifies an unintentional discrepancy in the admission orders prior to discharge and alerts the physician so that the unintentional discrepancy can be corrected prior to discharge, this should be recorded on the Medication Reconciliation Worksheet as an unintentional discrepancy in the Admission Comparison and Discharge Comparison columns of the worksheet.

Step 5: Compare Gold Standard Medication History to Discharge Orders (Pharmacist Only)

- Obtain the discharge orders for the patient.
- Perform the comparison between the Gold Standard Medications and the discharge orders using the same steps as the admission comparison. Remember to use the Identifying Discrepancies Flow Charts to help with this step.
- Review the discharge orders for any medications that were not listed in the Gold Standard Medication History. If any of the additional medications were ordered **unintentionally**, list them on the first page of the Medication Reconciliation Worksheet in the blue-highlighted column.

- i. If an unintentionally ordered additional medication was only ordered on admission, then check the “Admission” box in the pink-highlighted column.
- ii. If an unintentionally ordered additional medication was only ordered on discharge, then check the “Discharge” box in the pink-highlighted column.
- iii. If the unintentionally ordered additional medication was ordered on both admission and discharge, then check the “Both” box in the pink-highlighted column.

Step 6: Sum the number of medications and discrepancies (Survey Coordinator)

- a. The top of the first page of the Medication Reconciliation Worksheet contains four spaces for you to list the data for the patient.

Total # Unintentional Additional Medications: _____

(Enter into column F in the Med Rec Excel Workbook)

Total # of admission and discharge discrepancies due to Unintentional Additional Meds: _____

(Number of medications that were ordered unintentionally at admission (count as 1), discharge (count as 1), or both admission and discharge (count as 2). Enter into column H in the Med Rec Excel Workbook.

Total Number of Gold Standard Meds: _____

(Enter into column B in the Med Rec Excel Workbook)

Total # of admission and discharge discrepancies in Gold Standard Meds: _____

(For each Gold Standard Med, count the number of ‘yes’ responses to the error question. Minimum number of discrepancies per med is zero. Maximum number of discrepancies per med is 2. Enter into column D in the Med Rec Excel Workbook)

- i. Find the number of unintentionally ordered additional medications from the blue highlighted column on the same page. Enter in the first space, also highlighted in blue.
- ii. Find the number of **discrepancies** due to unintentionally ordered additional medications from the pink highlighted column on the same page.
 1. If a medication was only ordered on admission or only ordered on discharge, then this counts as one discrepancy.
 2. If a medication was ordered on **both** admission and discharge, then this counts as two discrepancies.
 3. Sum the number of discrepancies across all unintentionally ordered additional medications and enter this number in the pink-highlighted space.
- iii. Find the number of Gold Standard Medications and enter this number in the yellow-highlighted space.
- iv. Find the number of discrepancies in the admission and discharge orders for the Gold Standard Medications
 1. Review the Medication Reconciliation Worksheet for each Gold Standard Medication.
 2. Sum the number of times the orange highlighted “Yes” box is checked, indicating an unintentional discrepancy in admission or discharge orders.
 3. Enter this sum into the orange-highlighted space on the first page of the Medication Reconciliation Worksheet.

Step 7: Contact providers if necessary (Pharmacist Only)

If you found any serious discrepancies that could cause the patient harm, you will need to contact the providers. The provider may need to reach out to the patient, PCP, or pharmacies to have the issue corrected.

Step 8: Enter data into Excel Workbook and Online Hospital Survey Tool (Survey Coordinator)

- a. Collect all the Medication Reconciliation Worksheets from the pharmacists. Open the Data Entry Tab of the Medication Reconciliation Excel Workbook.
 - i. Enter the numbers from the top of each Medication Reconciliation Worksheet into the corresponding columns of the Excel Workbook, for the sampled patient, one patient per row.

- ii. As you enter the data, Row 6 (in red) will automatically sum the values entered for each patient. Once you have entered the data for all sampled patients, you will have the final values to enter into the Online Hospital Survey Tool.
- iii. On the right, your hospital's rate of unintentional medication discrepancies per medication will automatically be calculated based on the data entered.

Step 9: Use your hospital's results in quality improvement (Survey Coordinator and Pharmacist)

The developer of this measure has two toolkits available for hospitals that wish to implement a medication reconciliation program:

- [Medication Reconciliation Implementation Toolkit](#) (free)
- [The MARQUIS Collaborative](#) (fee to participate)

See [FAQs](#) for additional information about responding to the questions in this section.

Section 2: Medication Safety Frequently Asked Questions (FAQs)**Computerized Physician Order Entry (CPOE) FAQs**

Information specific to the CPOE Evaluation Tool, including instructions and FAQs, is available on the [Survey and CPOE Materials webpage](#) and the [Prepare for CPOE Tool webpage](#).

1. **What 3-month reporting period should be used when reporting on this section?**
When responding to the questions in Section 2A, hospitals should use the most recent three months prior to submitting the Survey for which they have complete data. For example, if submitting Section 2A in the month of June, the most recent 3-month reporting period for which you have complete data may be February, March, and April or March, April, and May. Hospitals cannot submit data collected for less than three full months.
2. **My hospital transitioned to a new CPOE system, and we have not been on the new system for a full 3 months. How should we respond to the questions in Section 2A-2B?**
When responding to questions #3 and #4 in Section 2A, hospitals can combine inpatient medication data from their old CPOE system with their new CPOE system to have three full months of data. However, hospitals should respond to the questions in Section 2B based on the new CPOE system and take the CPOE Evaluation Tool using the new CPOE system. When taking the CPOE Evaluation Tool, hospitals should select a licensed prescriber that is fully trained on the new system. All hospitals are urged to take a Sample Test before starting the Adult Inpatient Test.
3. **Should we include medications ordered verbally or via paper during system downtime when responding to question #3 (denominator)?**
Yes. Count medication orders entered during system downtime when responding to question #3. Exclude these orders when responding to question #4.
4. **We can't exclude medication orders that originated from an operating room or procedural area from the CPOE report that we are using to respond to questions #3 (denominator) and #4 (numerator). Can we include these medication orders?**
Yes, if you are unable to exclude medication orders for inpatients that were ordered from an operating room or procedural area, you can count these orders when responding to questions #3 and #4.
5. **What are examples of per protocol orders?**
Examples of per protocol orders include vancomycin dosing per protocol and heparin drip per protocol. Per protocol orders refer to orders that the medical staff has approved the use of, based on evidence-based guidance, in advance of its use. Per protocol orders are often identified by the Pharmacy and Therapeutics (P&T) committee and then recommended to the Medical Executive Committee (MEC) for approval. Once approved, per protocol orders are initiated by a licensed prescriber, but then acted on by pharmacy, nursing, radiology, respiratory therapy, etc. Count per protocol orders when responding to questions #3 (denominator) and #4 (numerator).
6. **What are examples of standing orders?**
Examples of standing orders include influenza vaccine, pneumonia vaccine, hepatitis B vaccine, or erythromycin eye ointment. Standing orders are usually rare, limited use situations. Count standing orders when responding to questions #3 (denominator) and #4 (numerator).
7. **My hospital requires readback for all phone orders, but there is no way to document that the readback occurred. How can we include these orders when responding to question #4 (numerator)?**
If your hospital cannot document that verbal readback on phone orders occurred, you should develop a written policy that outlines training and implementation of this practice and perform a

random audit at least annually to ensure the policy is being followed. Maintain documentation of the audit that demonstrates compliance with the policy as Leapfrog performs monthly documentation requests starting with June 30 submissions and continuing until the Survey closes on January 31.

8. When should we take the CPOE Evaluation Tool?

The CPOE Evaluation Tool is a core element of Leapfrog's CPOE Standard. Hospitals are urged to ensure that the Adult Inpatient CPOE Test is submitted along with the Survey (i.e., in the same month) in order to meet the deadlines for the Leapfrog Hospital Survey and Leapfrog's other programs such as Top Hospital and the Leapfrog Hospital Safety Grade.

Hospitals that submit the Survey, but do not submit an Adult Inpatient Test via the CPOE Evaluation Tool, are scored and publicly reported as "Limited Achievement" on the CPOE measure.

Within a Survey Cycle (April 1 – November 30), a hospital cannot retake a CPOE Evaluation Tool until at least 120 days have passed since their last test.

9. Should hospitals take the CPOE Test more than once per Survey Cycle?

Not necessarily. Hospitals have the option of re-taking a test after 120 days, but if there were no changes made to your CPOE system after the first test there is likely no reason to retake the test. Hospitals that switch vendors, perform major upgrades, or make significant changes to their decision support settings and/or formulary (e.g., expanding from a limited formulary to a large formulary) should re-take the test to ensure the results reflect their current system.

10. If we update our responses to questions #3 and #4, do we need to re-take the CPOE Test?

No. Hospitals don't need to retake the CPOE Evaluation Tool after submitting updates to Section 2 via the Online Survey Tool. Retaking a test is only recommended for hospitals that switched vendors, performed major upgrades, or made significant changes to their decision support settings and/or formulary.

EHR Application Information FAQs

11. What is the definition of Artificial Intelligence?

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

Bar Code Medication Administration (BCMA) FAQs

General Questions

12. Why does the Bar Code Medication Administration system have to be connected to an electronic medication administration record (eMAR)?

An eMAR serves as the communication interface that automatically documents the administration of medication into certified Electronic Health Record (EHR) technology. By linking BCMA with the eMAR, information on medication administration is captured in a much timelier manner than a manual documentation process can accomplish.

Units

13. Should a unit that has only been open for part of the 3-month reporting period be included?

No. Only include those units that are currently open and have been opened and staffed for the entire 3-month reporting period. For example, if you open a new unit that has only been open and

staffed for 1-month out of the 3-month reporting period, you will not include that unit when responding to the questions in this section.

14. How should a hospital report if they had BCMA implemented in some units but not all during the reporting period?

To answer “yes” to question #2, your hospital must have a Bar Code Medication Administration (BCMA) system that is linked to the electronic medication administration record (eMAR) when administering medications at the bedside in *at least one* of the following adult and/or pediatric units: general medical, surgical, medical/surgical, neuro, neonatal, or specialty ICU; medical, surgical, or medical/surgical unit (including telemetry units); step-down/progressive unit; labor and delivery unit; or pre-operative unit and/or post-anesthesia care unit. You should only report on units that are currently open and have been in operation for the entire 3-month reporting period selected in question #1. For example, if you have 3 surgical units and are only using BCMA in 1 of the 3 units, you will respond 3 in question #7 and 1 in question #8. You should only include medication administrations that were ordered and scannable in the open and staffed units in which a BCMA system was implemented (as indicated in questions #5, #8, #11, and #14, and #17) when reporting on compliance in questions #18-19.

15. How should hospitals report if they have a combined pre-operative and post-anesthesia care unit (PACU)?

As noted in endnote #22, hospitals must include combined pre-operative and post-anesthesia care units when reporting on questions #15-17. Therefore, hospitals should respond “yes” to question #15 and then report on how many of these units are open and staffed in question #16 and how many of the units utilize the BCMA/eMAR system in question #17. Medication administrations that occurred in these combined pre-operative and post-anesthesia care units must be included when reporting on compliance in question #18-19 provided these units utilize a BCMA system that is linked to the eMAR.

16. Should we include pre-operative and post-anesthesia care units that are located in our surgery centers or free-standing hospital outpatient departments that share our hospital’s license or CMS Certification Number (CCN) when reporting on questions #15-17?

No, for the purposes of reporting on Section 2C: BCMA, only include pre-operative and post-anesthesia care units (adult and/or pediatric) that are located in or co-located³¹ with your hospital.

17. Certain procedural units in our hospital (e.g., endoscopy, interventional radiology, cath lab, etc.) encompass the pre-op area, procedural area, and post-anesthesia care area – meaning the same area is used for all three aspects of care. As such, our data includes medications administered pre-operatively, post-operatively, and administered during the procedures. Should we include or exclude these procedural units?

Please include these units when responding to questions #15-17 regarding pre-op/PACUs. If you can separate out the medications that are being administered pre- and post- from those that are administered during a procedure, exclude medications administered during a procedure when reporting on compliance in questions #18-19. Otherwise, you can count these medication administrations when responding to questions #18-19.

Compliance

18. What is considered a “scannable” medication?

Any medication (see measure specifications) that has a bar code and could be scanned if BCMA were in use would be considered “scannable.” In question #18, hospitals should only include ordered and “scannable” medications from the units where they indicated a BCMA system was implemented.

19. Should we only include inpatient medication administrations when reporting on compliance in questions #18-19?

No, hospitals must include all scannable medication administrations (regardless of the patient's admission status) from the units in questions #5, #8, #11, #14 and #17 that were utilizing a BCMA system linked to the eMAR during the reporting period. This would include scannable medications administered to inpatients, outpatients, observation status patients, etc.

20. Should we exclude medications that were administered in units that are not currently implementing BCMA?

Yes. Question #18 is asking about medication administrations ordered and scannable in those units that are open and staffed and that have implemented a BCMA system. You should include all scannable medications ordered and administered to patients in the open and staffed units (from questions #5, #8, #11, #14 and #17) in which a BCMA system was implemented. Question #18 is used as the denominator to calculate the rate of compliance and should include administrations whether the medication and/or patient was scanned during the administration. Question #19 is used as the numerator and is where you would report the number of medication administrations from these units where the patient and medication were scanned during the administration. We would not expect these two responses to be the same.

21. Should we exclude medications that are given during emergencies when responding to questions #18-19?

No. If the medications are considered "scannable" e.g., any medication that has a bar code and could be scanned if BCMA were in use, they should be included in question #18 (the denominator) but would not be counted in question #19 (the numerator) if the patient and medication were not scanned during administration, even if due to an emergency. Leapfrog's target rate for compliance is 95% to allow for emergency cases such as these.

22. Should we exclude medications that are given during a system downtime when responding to questions #18-19?

No. Medications administered during a system downtime should be included in question #18 (the denominator) but would not be counted in questions #19 (the numerator) if the patient and medication were not scanned during administration because the hospital's BCMA system was down.

23. Our vendor report provides medication and patient scanning rates separately. How can we report on our compliance if our reports do not provide the number of administrations that had both the medication and patient scanned?

If your vendor's report only provides the percentage of patients scanned and the percentage of medications scanned separately but does not provide the rate of administrations where both the patient and medication were scanned, please report the lower of the two rates (supply the denominator in question #18 and numerator in question #19), as that would be the maximum possible rate of having both scanned.

Moving forward, we do ask that your hospital work with your vendor to report out the rate of administrations where both the patient and medication are scanned. It is only when both are scanned that safe medication administration can be ensured.

24. Is manual scanning (e.g., in lieu of scanning the patient's wristband, typing in the patient's number) something we can count in our BCMA scans?

No. The problem is that the user may type in the wrong patient number, negating the safety benefits. The best practice is to scan the wristband that is on the wrist of the patient.

25. Our process is to scan the patient once and then scan each medication. Question #19 seems to want each medication and patient scanned with each medication. Can you clarify?

Hospitals should report on the number of administrations where both the patient and the medication were scanned during the administration. During administrations where multiple

medications are administered sequentially, the patient should be scanned first, but does not need to be rescanned before each medication is administered.

- 26. In our hospital some medications are ordered and scheduled, but not administered. Should medications that are ordered and scheduled, but not administered be included when responding to questions #18-19?**

No, medications that are not administered should not be included in questions #18-19.

Decision Support

- 27. If an alert is part of the eMAR, but not the Bar Code Medication Administration system, should we respond “yes” to the decision support elements in question #20a - e?**

If the provider and pharmacist are notified or alerted (e.g., second nurse check), but the nurse or provider administering the medication does not receive an alert at the point of administration, then your hospital should answer “no” to these questions about decision support.

- 28. My hospital’s EHR workflow for medication administration is designed in such a way that our system will never generate a “wrong patient” alert. How should we answer the question in the Survey about whether we have that type of decision support?**

If your hospital’s EHR workflow is designed so that the nurse scans the patient first, and then the medications, such that the nurse would never receive a “wrong patient” alert, for purposes of the Survey, your hospital should indicate that it has ‘wrong patient’ decision support. The goal of including a “wrong patient” alert is to acknowledge that as a safe practice and to drive organizations to validate the “right patient” in the medication administration process. The workflow described helps ensure that a ‘wrong patient’ is not encountered.

- 29. Is the “second nurse check needed” decision support element required for all medications or just certain medication classes in order to answer “yes” to question #17e?**

No. An alert for “second nurse check needed” is only required for certain medications and it is up to each hospital to decide which medication classes require this alert during administration.

Workarounds

- 30. Must a hospital establish a separate committee to meet solely to review data reports on BCMA system use?**

While establishing a committee that has the sole purpose of reviewing data reports on BCMA system use is encouraged, it is not required. At a minimum, a pre-existing standing committee that meets on a regular basis could be given the responsibility of reviewing these reports. The committee chosen to review the reports must include individuals whose roles reflect each part of the BCMA process (e.g., pharmacists, nurses, IT personnel, etc.).

- 31. What are some examples of “back-up equipment” for hardware failures?**

Examples of “back-up equipment” include extra BCMA scanners, portable computers, batteries, and mice that are easily accessible to nurses experiencing equipment malfunctions. Quickly replacing malfunctioning equipment is essential to prevent workarounds.

- 32. What are some examples of “engaging nursing leadership at the unit level on BCMA use?”**

Engaging nursing leadership on BCMA use should be an active, ongoing process. An engaged leader would actively use BCMA data to coach staff towards safe or desired behaviors. Examples of activities in which nursing leadership could be engaged include, but are not limited to:

- Education sessions in units
- Review of policies regarding use and non-use of BCMA
- Investigating problems with BCMA specific to the unit
- Providing a forum for users to report BCMA problems and reasons for workarounds
- Providing suggestions for improvements to both technology and process

33. How often should hospitals conduct real-time observations and what do 'best practices' look like?

At a minimum, the observations should be conducted on each unit at least biannually (2x/year) and should be 30 minutes or 30 medication administrations in length, whichever is shorter. If a central team does observations, they should ensure each type of unit is observed within that 6-month period. More frequent observations are appropriate for hospitals that have recently introduced BCMA and/or when safety reports indicate a problem, where observations can be helpful in understanding the root cause of an incident or near miss.

The observations should be direct nurse-BCMA observations, watching how the nurse uses the BCMA system as part of the bedside medication administration process. The observer should note if nurses are using any workarounds to compensate for system issues. In addition to observing the nurse-BCMA interaction, the observer should also have conversations with the nurses, as their comments are often a good source for understanding the causes of workarounds. The observations collected from the different units should be aggregated together to understand trends across the hospital and where the hospital should place a priority for addressing BCMA system issues.

34. If our hospital meets the 95% compliance target, do we still need to implement or monitor a quality improvement project for question #21f?

Yes, the hospital should still implement or monitor a quality improvement project to ensure that they can continue to improve and maintain high compliance and the project should focus on those units included in the standard. For example, perhaps through reviewing compliance you have recognized that one or more units is lower performing, so you develop a project (training, observing, etc.) to improve. Another example is improving the timeliness of Help Desk responses for equipment failures etc.

35. What are some appropriate mechanisms for communicating back to end users for question #21h?

Appropriate mechanisms for communicating back to end users would include staff meetings, safety briefings or unit huddles, or sharing in a Nursing Informatics eNewsletter, through a Medication Safety Team, or Quality Committee newsletter/flyer.

Medication Reconciliation FAQs**Sampling****36. Are we required to use Leapfrog's random sampling methodology?**

No. You may use a different sampling methodology from the methodology provided in the Medication Reconciliation Workbook. However, you should be sure to sample from different days of the week, including weekends.

37. If the first few patients included in the sample have zero gold standard medications, should we sample more than 30 patients?

Yes, hospitals can sample more than 30 patients to ensure their rate of unintentional discrepancies per medication is scored and publicly reported. While 30 is the minimum sample size, hospitals are welcome to sample more than this.

Gold Standard Medication History**38. A pharmacist, pharmacy resident, or certified pharmacy technician creates the pre-admission Medical List as part of normal care. Can this be used as the Gold Standard Medication List?**

No, a different trained pharmacist, pharmacy resident, or certified pharmacy technician²³ should collect the Gold Standard Medication List when collecting data for this measure.

39. Does the same pharmacist, pharmacy resident, or certified pharmacy technician who obtains the Gold Standard Medication List also need to perform the review to identify unintentional medication discrepancies?

No, different pharmacists or pharmacy residents can play different roles in the data collection process. Only pharmacists and pharmacy residents can compare the Gold Standard Medication List to admission and discharge orders to identify unintentional medication discrepancies.

40. We have two differing records of what dose the patient was taking prior to admission, one from the patient and one from the outpatient pharmacy. What do we record as the correct dose for the Gold Standard Medication?

In cases where the medication history obtained from interviewing the patient does not match other written records, the pharmacist will need to go back to the patient with the pharmacy records in hand and figure out the source of the discrepancy (e.g., the patient systematically takes it differently than prescribed vs. the patient was just mistaken about the strength of the pill, etc.). If the discrepancy can't be resolved, then another source will be needed (e.g., caregiver, PCP).

Admission and Discharge Orders**41. Are there any types of admission orders that can or should be excluded?**

Yes, (a) Medication orders that are clearly related to the chief complaint (e.g., levofloxacin for pneumonia when pneumonia is the admitting diagnosis), (b) Medication orders that are clearly documented (e.g., Lovenox for DVT prophylaxis), and (c) Standard PRN orders at your hospital (e.g., Tylenol PM if that is in the standard order set at your hospital).

42. Should admission orders that are discontinued prior to discharge be included?

Yes. Some of these orders may end up being counted in question #7 (additional medications that were unintentionally ordered).

Identifying Discrepancies**43. If a dose and a route discrepancy are found for the same medication, does it count as one or two in the number of unintentional discrepancies?**

The number of unintentional discrepancies is a count of medication orders where an unintentional discrepancy occurred. A medication order may have several errors associated with it (e.g., dose, route, timing, etc.). You should not count the number of errors associated with the same medication order. However, discrepancies in admission orders and discharge orders are counted separately. For example, if a medication on the Gold Standard Medication List is ordered for a patient on admission with the incorrect dose, this counts as one discrepancy. If this medication is ordered on discharge with the same incorrect dose, this would count as a second discrepancy. But a medication with a dose and frequency discrepancy in admission orders counts as one discrepancy.

44. Do all the additional medications that were ordered unintentionally in question #7 count as unintentional discrepancies in #8?

Yes. If a medication is unintentionally ordered at admission, then this counts as one discrepancy. If the same medication is unintentionally ordered at discharge, then this counts as a second discrepancy. If an unintentionally ordered medication in question #7 was ordered on both admission and discharge, then this would count as **two** discrepancies in question #8 (but counts as one medication in question #7).

45. If there is no documentation of systematic or sporadic nonadherence, why does the pharmacist have to count unintentional discrepancies on admission and discharge?

Systematically non-adherent means the patient consistently takes the medication differently than prescribed. Lack of appropriate documentation of systematic non-adherence can lead to an adverse drug event. For example, if a patient is prescribed hydralazine 25mg three times a day, but always takes 25mg two times a day this must be documented in the clinical record so the care team can decide how to order the medication on admission and discharge (i.e., recorded on the Med Rec Worksheet as an intentional discrepancy). If the systematic non-adherence is not

documented and the care team is unaware of how the patient has been taking the medication, they could order and administer it as prescribed and cause, in this example, hypotension in the patient.

Sporadically non-adherent means that the patient takes the medication as prescribed but, on average, misses two or more doses per week. Lack of appropriate documentation of sporadic non-adherence can lead to an adverse drug event. For example, if a patient is prescribed four antihypertensives, but misses two or more doses per week, this must be documented in the clinical record so the care team can decide how to order the medication on admission and discharge (i.e., recorded on the Med Rec Worksheet as an intentional discrepancy). If the sporadic non-adherence is not documented and the care team is unaware of how the patient has been taking the medication, they could order and administer it as prescribed and cause, in this example, hypotension in the patient.

46. A patient had two medications that were not on our hospital's formulary. They were not substituted. Do these two medications count as errors of omission?

Yes. If a Gold Standard Medication was not ordered or appropriately substituted on admission and discharge, it would count as two unintentional medication discrepancies for each medication that was omitted.

Scoring

47. What questions are used to calculate the numerator and denominator that results in the rate of unintentional medication discrepancies per medication?

The rate of unintentional medication discrepancies per medication is calculated using the following formula:

$$\frac{(\text{Question \#6} + \text{Question \#8})}{(\text{Question \#5} + \text{Question \#7})} = \text{Rate of unintentional medication discrepancies per medication}$$

This rate is calculated for you in the Med Rec Workbook provided on the [Survey Materials webpage](#). This information is also available in the [Scoring Algorithms](#).

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SECTION 3: ADULT AND PEDIATRIC COMPLEX SURGERY

This section includes questions and reference information for Section 3: Adult and Pediatric Complex Surgery. Please carefully review the questions, endnotes, and reference information (e.g., measure specifications, notes, and frequently asked questions) before you begin. Failure to review the reference information could result in inaccurate responses.

Section 3: Adult and Pediatric Complex Surgery

Adult and Pediatric Complex Surgery Fact Sheet and Bibliography:

<https://ratings.leapfroggroup.org/measure/hospital/2025/complex-adult-and-pediatric-surgery>

Section 3 is applicable to all hospitals. Hospitals that do not perform the high-risk procedures included in Section 3A should select “None of the above” in question #2 and move on to the Affirmation of Accuracy. Your hospital’s results will be displayed as “Does Not Apply” on Leapfrog’s public reporting website. Pediatric hospitals should only report on the Norwood procedure, if applicable.

Section 3 includes questions about your hospital’s volume and process for privileging surgeons for eleven high-risk procedures, outcomes for mitral valve repair and replacement, and participation in The Society of Thoracic Surgeons’ Congenital Heart Surgery Database for hospitals that perform the Norwood procedure. This section also includes questions about the implementation of a safe surgery checklist.

Each hospital achieving the standard for each of the nine applicable high-risk procedures:

1. Meets the minimum hospital volume standard for the procedure, **and**
2. Has a process for privileging surgeons that includes the surgeon meeting or exceeding the minimum annual surgeon volume standard for the procedure.

Each hospital achieving the standard for mitral valve repair and replacement procedures:

1. Meets the minimum hospital volume standard for the procedure, **and**
2. Has a process for privileging surgeons that includes meeting or exceeding the minimum annual surgeon volume standard for the procedure, **and**
3. Participates in the Society of Thoracic Surgeons (STS) Adult Cardiac Surgery Database (ACSD), **and**
4. Has an STS Mitral Valve Repair/Replacement Composite Score of 3 Stars.

Each hospital achieving the standard for Norwood procedures:

1. Meets the minimum hospital volume standard for the procedure, **and**
2. Has a process for privileging surgeons that includes meeting or exceeding the minimum annual surgeon volume standard for the procedure, **and**
3. Participates in the Society of Thoracic Surgeons (STS) Congenital Heart Surgery Database (CHSD).

Each hospital achieving the standard for the safe surgery checklist:

1. Uses a safe surgery checklist on **all** patients undergoing an applicable procedure (reported on in Section 3A, if applicable) that includes **all** safe surgery checklist elements; **and**
2. Verbalizes **all** safe surgery checklist elements in the presence of the appropriate personnel; **and**
3. Completes an audit on a sufficient sample of patients to document adherence to the checklist; **and**
4. Has documented adherence to the checklist for at least 90% of the patients included in the audit.

Download the 2025 Leapfrog Hospital Survey Scoring Algorithm on the Scoring and Results webpage.

3A: Hospital and Surgeon Volume

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Important Notes:

Note 1: This subsection is applicable to all hospitals. Hospitals that do not perform the procedures included in this subsection should select "None of the above" in question #2 and move on to the Affirmation of Accuracy. Your hospital's results will be displayed as "Does Not Apply" on Leapfrog's public reporting website.

Note 2: Pediatric hospitals should only respond to questions regarding the Norwood procedure, if applicable. If the Norwood procedure is not applicable, select "None of the above" in question #2 and move on to the Affirmation of Accuracy. Your hospital's results will be displayed as "Does Not Apply" on Leapfrog's public reporting website.

Specifications: See [Hospital and Surgeon Volume Measure Specifications](#) in the Reference Information beginning on page 101.

Reporting Period: 12 months or optionally 24 months (annual average)

- Surveys submitted prior to September 1:
 - 01/01/2024 – 12/31/2024 (12-month count) or 01/01/2023 – 12/31/2024 (24-month annual average)
- Surveys (re)submitted on or after September 1:
 - 07/01/2024 – 06/30/2025 (12-month count) or 07/01/2023 – 06/30/2025 (24-month annual average)

Note: As a reminder, the [Corrections Period](#) (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

1) 12-month or 24-month reporting period used:	○ 01/01/2024 – 12/31/2024 (12-month count) ○ 01/01/2023 – 12/31/2024 (24-month annual average) ○ 07/01/2024 – 06/30/2025 (12-month count) ○ 07/01/2023 – 06/30/2025 (24-month annual average)
2) Check all procedures that your hospital performs as defined in the Adult and Pediatric Complex Surgery Reference Information. <i>Select all that apply.</i> <i>Do not check the box for a procedure if your hospital ONLY performs the procedure on an emergency basis or when a patient is too unstable for safe transfer.</i> <i>If "none of the above," skip the remaining questions in Section 3 and go to the Affirmation of Accuracy. The hospital will be scored as "Does Not Apply."</i>	☐ Carotid endarterectomy ☐ Mitral valve repair and replacement ☐ Open aortic procedures ☐ Lung resection for cancer ☐ Esophageal resection for cancer ☐ Pancreatic resection for cancer ☐ Rectal cancer surgery ☐ Bariatric surgery for weight loss ☐ Total knee replacement ☐ Total hip replacement ☐ Norwood procedure ☐ None of the above

Respond to questions #3-11 based on the procedures selected in question #2.

3) Total **hospital** volume for each selected procedure during the reporting period:

Volume should represent a 12-month count or 24-month annual average consistent with the reporting period selected in question #1.

<i>Procedure</i>	<i>Hospital Volume Standard</i>	<i>Total Hospital Volume (12-month count or 24-month annual average)</i>
Carotid endarterectomy	20	
Mitral valve repair and replacement	40	
Open aortic procedures	10	
Lung resection for cancer	40	
Esophageal resection for cancer	20	
Pancreatic resection for cancer	20	
Rectal cancer surgery	16	
Bariatric surgery for weight loss	50	
Total knee replacement	50	
Total hip replacement	50	
Norwood procedure	8	

4) Does the total hospital volume for total knee replacement, total hip replacement, and/or bariatric surgery for weight loss reported on in question #3 above include procedures performed on an inpatient basis, outpatient basis, or both?

Total knee replacement	☐ Inpatient ☐ Outpatient ☐ Both (inpatient and outpatient)
Total hip replacement	☐ Inpatient ☐ Outpatient ☐ Both (inpatient and outpatient)
Bariatric surgery for weight loss	☐ Inpatient ☐ Outpatient ☐ Both (inpatient and outpatient)

5) Does your hospital's privileging process include the surgeon meeting or exceeding the minimum annual surgeon volume standard listed below?

<i>Procedure</i>	<i>Annual Surgeon Volume Standard</i>	
Carotid endarterectomy	10	☐ Yes ☐ No
Mitral valve repair and replacement	20	☐ Yes ☐ No
Open aortic procedures	7	☐ Yes ☐ No
Lung resection for cancer	15	☐ Yes ☐ No
Esophageal resection for cancer	7	☐ Yes ☐ No
Pancreatic resection for cancer	10	☐ Yes ☐ No

Rectal cancer surgery	6	☐ Yes ☐ No
Bariatric surgery for weight loss	20	☐ Yes ☐ No
Total knee replacement	25	☐ Yes ☐ No
Total hip replacement	25	☐ Yes ☐ No
Norwood procedure	5	☐ Yes ☐ No

If your hospital performs mitral valve repair and replacement (selected the checkbox in question #2), continue to question #6. Otherwise, skip questions #6-9 and continue to question #10.

Reporting Period: Base your responses on the latest **36-month** report received from the Society of Thoracic Surgeons (STS) Adult Cardiac Surgery Database (ACSD) for the **Mitral Valve Repair/Replacement Composite Score**.

Note: As a reminder, the Corrections Period (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

6) Does your hospital participate in the <u>Society of Thoracic Surgeons (STS) Adult Cardiac Surgery Database (ACSD)</u> and submit data for all applicable procedures during the most recent 36-month period for which performance reports are available? <i>If "no" to question #6, skip questions #7-9 and continue to question #10.</i>	☐ Yes ☐ No
7) What is the most recent 36-month reporting period for which STS performance reports are available? Reporting period ending:	_____ <i>Format: Month/Year</i>
8) Does your hospital have a Mitral Valve Repair/Replacement Composite Score publicly reported on the STS website and do you choose to report data from the most recent performance report to this Survey? <i>If "no" or "yes, but did not meet the STS Data Completeness Requirement" during the reporting period, skip question #9 and continue to question #10.</i>	☐ Yes ☐ No ☐ Yes, but did not meet the STS Data Completeness Requirement during the reporting period
9) What is your hospital's Mitral Valve Repair/Replacement Composite Score?	☐ 1 star – lower-than-expected performance ☐ 2 stars – as-expected performance ☐ 3 stars – higher-than-expected performance

If your hospital performs the Norwood procedure (selected the checkbox in question #2), continue to question #10. Otherwise, skip questions #10-11 and continue to the next subsection.

10) Does your hospital participate in the <u>Society of Thoracic Surgeons (STS) Congenital Heart Surgery Database (CHSD)</u> and did your hospital submit data for the Norwood procedure during the most recent 48-month period for which performance reports are available? <i>If “no” to question #10, skip question #11 and continue to the next subsection.</i>	☐ Yes ☐ No
11) What is the most recent 48-month reporting period for which STS performance reports are available? Reporting period ending:	<i>Format: Month/Year</i>

3B: Safe Surgery Checklist for Adult and Pediatric Complex Surgery

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Important Notes:

Note 1: The elements required for each stage of the safe surgery checklist are adapted from the [WHO Surgical Safety Checklist](#) and the [AHRQ Endoscopy Checklist](#).

Note 2: Question #7 will not be used in scoring or public reporting.

Note 3: Hyperlinks throughout this subsection refer to the [Safe Surgery Checklist for Adult and Pediatric Complex Surgery FAQs](#) beginning on page 143, not to endnotes. These hyperlinks are not included in the Online Survey Tool.

Specifications: See [Safe Surgery Checklist for Adult and Pediatric Complex Surgery Measure Specifications](#) in the Reference Information beginning on page 141.

Reporting Period: 12 months

Answer questions #1-9 for the latest 12-month period prior to submission of this section of the Survey.

Note: As a reminder, the [Corrections Period](#) (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

Sufficient Sample: See [Safe Surgery Checklist for Adult and Pediatric Complex Surgery Measure Specifications](#) for instructions on identifying a sufficient sample for questions #6-9.

1) What is the latest 12-month reporting period for which your hospital is submitting responses to questions #2-9? 12-month reporting period ending:	<i>Format: Month/Year</i>
2) Does your hospital utilize a safe surgery checklist on <u>every</u> patient <u>every</u> time one of the applicable procedures in Section 3A is performed? <i>If "no" to question #2, skip the remaining questions in Section 3B and go to the Affirmation of Accuracy. The hospital will be scored as "Limited Achievement."</i>	☐ Yes ☐ No
3) Before the induction of anesthesia , is a safe surgery checklist that includes <u>all</u> the following elements <u>read aloud</u> in the presence of the <u>anesthesia professional and nursing personnel</u> : • Patient ID; • Confirmation of procedure; • Patient consent; • Site marked, if applicable; • Anesthesia/medication check; • Allergies assessed; • Difficult airway/aspiration risk; • Risk of blood loss (only applicable if risk of blood loss is >500ml for adults or >7ml/kg for children); and • Availability of devices (applicable to endoscopy procedures only)?	☐ Yes ☐ No

4) Before the skin incision and/or before the procedure begins, is a safe surgery checklist that includes <u>all</u> the following elements <u>read aloud</u> in the presence of the <u>whole surgical team</u>: • <u>Clinical team introduction</u>; • Confirmation of patient name, procedure, and, if applicable, surgical/incision site; • Antibiotic prophylaxis, if applicable; • Anticipated Critical Events (i.e., non-routine steps, length of procedure, blood loss, patient-specific concerns, sterility); • Equipment check/concerns; and • Essential imaging available, if applicable?	○ Yes ○ No
5) Before the patient leaves the operating room and/or procedure room, is a safe surgery checklist that includes <u>all</u> the following elements <u>read aloud</u> in the presence of the <u>whole surgical team</u>: • Confirmation of procedure performed; • Instrument/supply counts; • Specimen labeling, if applicable; • Equipment concerns; and • Patient recovery/management concerns?	○ Yes ○ No

If “no” to question #3, #4, or #5, skip the remaining questions in Section 3B and go to the Affirmation of Accuracy. The hospital will be scored as “Limited Achievement.”

Hospitals performing the audit in Section 3B question #6 and the audit in Section 9D question #6 should audit 15 cases who underwent a procedure included in Section 3A and 15 cases who underwent a procedure included in Section 9C. Hospitals only performing the audit in Section 3B question #6 and not in Section 9D question #6 should audit 30 cases who underwent a procedure included in Section 3A.

6) Did your hospital perform an audit (either in-person or via the medical record or other EHR data) on a sufficient sample of patients who underwent a procedure included in Section 3A and measure adherence to the safe surgery checklist? <i>Free-standing pediatric hospitals that perform the Norwood Procedure and hospitals that reported a combined total hospital volume of less than the sufficient sample for all the procedures in Section 3A can sample any patients that had a procedure performed under general anesthesia.</i> <i>If “no” to question #6, skip the remaining questions in Section 3B and go to the Affirmation of Accuracy. The hospital will be scored as “Limited Achievement.”</i> <i>If “no, performed fewer than 30 total inpatient procedures under general anesthesia” to question #6, skip the remaining questions in Section 3B and go to the Affirmation of Accuracy. The hospital will be scored as “Unable to Calculate Score.”</i>	○ Yes ○ No ○ No, performed fewer than 30 total inpatient procedures under general anesthesia
7) How many cases were included in the audit from question #6?	_____ <i>Max value 100</i>

8) Which method was used to perform the audit on a sufficient sample in question #6?	○ In-person observational audit ○ Retrospective audit of medical records or EHR data ○ Both
9) Based on your hospital's audit (either in-person or via the medical record or other EHR data) on a sufficient sample of patients who underwent a procedure included in Section 3A, what was your hospital's documented rate of adherence to the safe surgery checklist (i.e., what percentage of the sampled cases had all elements in questions #3, #4, and #5 completed)?	○ 90%-100% ○ 75%-89% ○ 50%-74% ○ Less than 50%

Affirmation of Accuracy

As the hospital CEO or as an employee of the hospital to whom the hospital CEO has delegated responsibility, I have reviewed this information pertaining to the Adult and Pediatric Complex Surgery Section at our hospital, and I hereby certify that this information is true, accurate, and reflects the current, normal operating circumstances at our hospital. I am authorized to make this certification on behalf of our hospital.

The hospital and I understand that The Leapfrog Group, its members, the public and entities and persons who contract or have other business dealings with The Leapfrog Group are relying on the truth and accuracy of this information. The hospital and I also understand that The Leapfrog Group will make this information and/or analyses of this information public through the Survey Results public reporting website, The Leapfrog Group's Hospital Safety Grade, and/or other Leapfrog Group products and services. This information and/or analyses and all intellectual property rights therein shall be and remain the sole and exclusive property of The Leapfrog Group in which The Leapfrog Group retains exclusive ownership. This information does not infringe upon any third-party intellectual property rights or any other third-party rights whatsoever and is free and clear of all encumbrances and liens of any kind. The hospital and I acknowledge that The Leapfrog Group may use this information in a commercial manner for profit. The hospital shall be liable for and shall hold harmless and indemnify The Leapfrog Group from any and all damages, demands, costs, or causes of action resulting from any inaccuracies in the information or any misrepresentations in this Affirmation of Accuracy. The Leapfrog Group and its members and entities and persons who contract or have other business dealings with The Leapfrog Group reserve the right to omit or disclaim information that is not current, accurate or truthful.

Affirmed by _____, the hospital's _____,
(first name and last name) (title)
on _____.
(date)

Section 3: Adult and Pediatric Complex Surgery Reference Information

What's New in the 2025 Survey

Section 3A: Hospital and Surgeon Volume

For mitral valve repair and replacement, Leapfrog is updating the questions and measure specifications to clarify that hospitals can only report on their Mitral Valve Repair/Replacement Composite Score if the score is publicly reported on the STS website at <https://publicreporting.sts.org/search/acsd>. For Bariatric Surgery for Weight Loss, Leapfrog is making two updates:

- First, we are removing three procedure codes from the list of CPT codes used to count same-day bariatric procedures as they do not meet the criteria for inclusion in our volume standards since they are used for the placement of gastric banding rather than bypass of the stomach.
- Second, we are adding several ICD-10-CM procedure codes that bring greater alignment with the Centers for Medicare and Medicaid's payment policies for bariatric surgery. These additional codes expand on the current procedure code list, with a continued focus on the bypass of the stomach but reflect additional tissue types and approach types. The additions can be reviewed in the Section 3A: Hospital and Surgeon Volume Measure Specifications.

Section 3B: Safe Surgery Checklist for Adult and Pediatric Complex Surgery

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

Change Summary Since Release

May 1, 2025 – Added four ICD-10 Morbid Obesity Diagnosis Codes for Bariatric Surgery for Weight Loss for Adult and Pediatric Complex Surgery. Hospitals are not required to make updates to data already collected and/or reported but have the option to include the additional codes if they wish.

The additional codes were added to the Complex Surgery ICD 10 Codes Workbook (available on the Survey Materials [webpage](#)) and CPT Code workbook (available on the [Survey Dashboard](#)). Please review the updated codes on page 131 of the Survey.

Section 3: Adult and Pediatric Complex Surgery Measure Specifications

Hospital and Surgeon Volume Measure Specifications

Important Notes:

Note 1: Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Note 2: For each of the eleven high-risk procedures included in Section 3A: Hospital and Surgeon Volume, Leapfrog has provided a set of ICD-10 procedure codes, and in some cases an additional set of CPT codes (for Total Hip Replacement, Total Knee Replacement, and Bariatric Surgery for Weight Loss) or ICD-10 diagnosis codes, for counting **patient discharges**. Please carefully review the measure specifications for each individual procedure to ensure you have the complete list of codes needed. ICD-10 codes are provided below and are also available in an Excel document on the [Survey Materials webpage](#). See Note 3 below for instructions on downloading CPT codes.

Note 3: CPT Codes are provided in downloadable Excel files on the Survey Dashboard. To access the files, click the CPT Code Workbook button next to Section 9. You will be required to complete the American Medical Association's Terms of Use before downloading the Excel file and using the individual CPT codes to query your EHR or billing system. You are only required to complete the Terms of Use once per Survey Cycle (April 1 – November 30).

The CPT Code Workbooks (Excel files) are labeled for Section 3A: Total Hip Replacement, Total Knee Replacement, and Bariatric Surgery for Weight Loss and Section 9C: Volume of Procedures. Please note, if you are part of a hospital system, each hospital will need to complete the Terms of Use. This is a requirement of the American Medical Association.

Source: The Leapfrog Group, American Medical Association

Reporting Period: 12 months or *optionally* 24 months (annual average)

- Surveys submitted prior to September 1:
 - 01/01/2024 – 12/31/2024 (12-month count) or 01/01/2023 – 12/31/2024 (24-month annual average)
- Surveys (re)submitted on or after September 1:
 - 07/01/2024 – 06/30/2025 (12-month count) or 07/01/2023 – 06/30/2025 (24-month annual average)

Question #2: Check all procedures that your hospital performs as defined in the Adult and Pediatric Complex Surgery Reference Information (listed below):

- Carotid endarterectomy
- Mitral valve repair and replacement
- Open aortic procedures
- Lung resection for cancer
- Esophageal resection for cancer
- Pancreatic resection for cancer
- Rectal cancer surgery
- Bariatric surgery for weight loss
- Total knee replacement
- Total hip replacement
- Norwood procedure

Free-standing pediatric hospitals should only report on the Norwood procedure, if applicable.

Do not check the box for the procedure if:

- Your hospital does not perform the procedure or **ONLY** performs the procedure on an emergency basis or when a patient is too unstable for safe transfer.

- Your hospital has started to perform the procedure in the last 18 months. Leapfrog gives hospitals an 18-month grace period before having to report on hospital volume and process for privileging surgeons for new service lines.

Do check the box for the procedure if:

- Your hospital would perform the procedure but had zero cases during the reporting period. Select the procedure and indicate a hospital volume of zero in question #3. Please note that hospitals can elect to report on a 24-month annual average.
- Your hospital has reached the end of the 18-month grace period for a new service line. You will now have to report on both hospital volume and your process for privileging surgeons for this procedure.

Question #3: Total **hospital volume** for each selected procedure (from question #2) during the reporting period:

- Carotid endarterectomy (Hospital Volume Standard: 20)
- Mitral valve repair and replacement (Hospital Volume Standard: 40)
- Open aortic procedures (Hospital Volume Standard: 10)
- Lung resection for cancer (Hospital Volume Standard: 40)
- Esophageal resection for cancer (Hospital Volume Standard: 20)
- Pancreatic resection for cancer (Hospital Volume Standard: 20)
- Rectal cancer surgery (Hospital Volume Standard: 16)
- Bariatric surgery for weight loss (Hospital Volume Standard: 50)
- Total knee replacement (Hospital Volume Standard: 50)
- Total hip replacement (Hospital Volume Standard: 50)
- Norwood procedure (Hospital Volume Standard: 8)

When calculating total **hospital volume** count the number of **patients** discharged from your hospital within the reporting period with any one or more of the ICD-10 codes or CPT codes (for Total Hip Replacement, Total Knee Replacement, and Bariatric Surgery for Weight Loss) specified for each procedure, subject to the inclusion criteria below:

- Only the ICD-10 procedure, CPT, and diagnosis codes provided by Leapfrog should be used to report on the questions in Section 3A: Hospital and Surgeon Volume. ICD-10 codes are provided below and are also available in an Excel document on the [Survey Materials webpage](#). See Note 3 above for instructions on downloading CPT codes.
- For procedures that include TWO sets of codes (one set of procedure codes and one set of diagnosis codes), both sets of codes must be used for counting patient discharges (e.g., at least one procedure code AND one diagnosis code must be present).
- Except for bariatric surgery for weight loss (where the ICD-10 diagnosis code must be the primary diagnosis) and total knee replacement and total hip replacement (where the procedure code must be the primary procedure), ICD-10 codes for the other procedures can appear in ANY procedure field and ANY diagnosis field.
- Age restrictions apply – For the Norwood procedure only include discharges for pediatric patients (ages 17 years and younger). For the remaining ten procedures, only include discharges for adult patients (ages 18 years and older).

Question #4: Does the total hospital volume for total knee replacement, total hip replacement, and/or bariatric surgery for weight loss reported on in question #3 above include procedures performed on an inpatient basis, outpatient basis, or both?

- If your hospital only performs total knee replacement, total hip replacement, and/or bariatric surgery for weight loss on an inpatient basis, select inpatient.
- If your hospital only performs total knee replacement, total hip replacement, and/or bariatric surgery for weight loss on an outpatient basis, select outpatient.
- If your hospital performs total knee replacement, total hip replacement, and/or bariatric surgery for weight loss on both an inpatient and outpatient basis, select both (inpatient and outpatient).

Question #5: Does your hospital's privileging process include the surgeon meeting or exceeding the minimum annual surgeon volume standard listed below?

- Carotid endarterectomy: 10
- Mitral valve repair and replacement: 20
- Open aortic procedures: 7
- Lung resection for cancer: 15
- Esophageal resection for cancer: 7
- Pancreatic resection for cancer: 10
- Rectal cancer surgery: 6
- Bariatric surgery for weight loss: 20
- Total knee replacement: 25
- Total hip replacement: 25
- Norwood procedure: 5

When determining whether surgeons have met or exceeded Leapfrog's minimum annual surgeon volume standards for the purposes of privileging, only refer to the ICD-10 procedure codes and CPT codes (for Total Hip Replacement, Total Knee Replacement, and Bariatric Surgery for Weight Loss) – **diagnosis** codes can be ignored.

Source: The Society of Thoracic Surgeons (STS)

Reporting Period: Latest **36-month** report from Society of Thoracic Surgeons (STS) Adult Cardiac Surgery Database (ACSD) for the **Mitral Valve Repair/Replacement Composite Score**.

Question #6: Does your hospital participate in the Society of Thoracic Surgeons (STS) Adult Cardiac Surgery Database (ACSD), submit data for all applicable procedures during the most recent 36-month period for which performance reports are available?

Select "yes" if your hospital participates in the Society of Thoracic Surgeons (STS) Adult Cardiac Surgery Database (ACSD) and has submitted data for all applicable procedures during the most recent 36-month period.

Question #7: What is the most recent 36-month reporting period for which STS performance reports are available? Reporting period ending:

Select the most recent 36-month reporting period for which STS performance reports are available. The reporting period is displayed when reviewing your "MVRR Composite Quality Ratings" at <https://publicreporting.sts.org/search/acsd>. See screenshot provided for question #9 below.

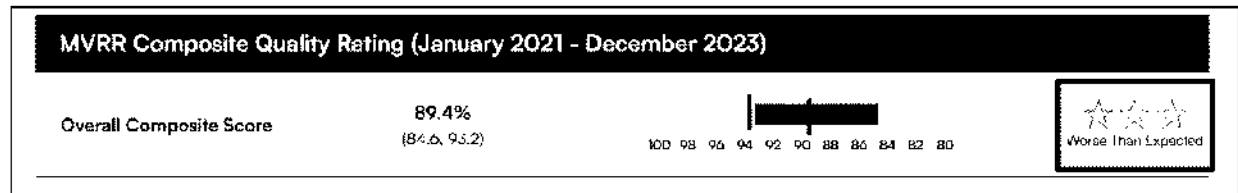
Question #8: Does your hospital have a Mitral Valve Repair/Replacement Composite Score publicly reported on the STS website and do you choose to report data from the most recent performance report to this Survey?

Select "yes" if your hospital elects to share the MVRR data from your most recent performance report with Leapfrog.

Question #9: What is your hospital's Mitral Valve Repair/Replacement Composite Score?

Report your Mitral Valve Repair/Replacement Overall Composite Score from the STS Public Reporting website: <https://publicreporting.sts.org/search/acsd>.

Click on "Search All Groups." Then search for your hospital name/surgery group name in the "Participant Surgery Group Name" field and click your hospital name/surgery group name. On the next page find your "MVRR Composite Quality Rating" and your "Overall Composite Score." Report the number of stars displayed for "Overall Composite Score" represented in the screenshot below.



Source: The Society of Thoracic Surgeons (STS)

Question #10: Does your hospital participate in the Society of Thoracic Surgeons (STS) Congenital Heart Surgery Database (CHSD) and did your hospital submit data for the Norwood procedure during the most recent 48-month period for which performance reports are available?

Select "yes" if your hospital participates in the Society of Thoracic Surgeons (STS) Congenital Heart Surgery Database (CHSD) and has submitted data for the Norwood procedure during the most recent 48-month period.

Question #11: What is the most recent 48-month reporting period for which STS performance reports are available? Reporting period ending:

Select the most recent 48-month reporting period for which STS performance reports are available. The reporting period should appear at the top of your STS performance report.

See [FAQs](#) for additional information about responding to the questions in this section.

Carotid Endarterectomy Measure Specifications

For carotid endarterectomy, there are two sets of ICD-10 codes for counting patient discharges. The first set of codes is to identify patients who have had the procedure. The second set of codes is to identify patients with a specific diagnosis.

Count the number of patients, ages 18 years and older, discharged with the following ICD-10 codes in any procedure field AND any of the following ICD-10 codes in any diagnosis field.

ICD-10 Carotid Endarterectomy Procedure Codes

ICD-10 Procedure Code	Code Description
03CH0ZZ	Extirpation of Matter from Right Common Carotid Artery, Open Approach
03CJ0ZZ	Extirpation of Matter from Left Common Carotid Artery, Open Approach
03CK0ZZ	Extirpation of Matter from Right Internal Carotid Artery, Open Approach
03CL0ZZ	Extirpation of Matter from Left Internal Carotid Artery, Open Approach
03CM0ZZ	Extirpation of Matter from Right External Carotid Artery, Open Approach
03CN0ZZ	Extirpation of Matter from Left External Carotid Artery, Open Approach

ICD-10 Occlusion and Stenosis and Cerebral Infarction Diagnosis Codes

ICD-10 Diagnosis Code	Code Description
I63.031	Cerebral infarction due to thrombosis of right carotid artery
I63.032	Cerebral infarction due to thrombosis of left carotid artery
I63.033	Cerebral infarction due to thrombosis of bilateral carotid arteries
I63.039	Cerebral infarction due to thrombosis of unspecified carotid artery
I63.131	Cerebral infarction due to embolism of right carotid artery
I63.132	Cerebral infarction due to embolism of left carotid artery
I63.133	Cerebral infarction due to embolism of bilateral carotid arteries
I63.139	Cerebral infarction due to embolism of unspecified carotid artery
I63.231	Cerebral infarction due to unspecified occlusion or stenosis of right carotid arteries
I63.232	Cerebral infarction due to unspecified occlusion or stenosis of left carotid arteries
I63.233	Cerebral infarction due to unspecified occlusion or stenosis of bilateral carotid arteries
I63.239	Cerebral infarction due to unspecified occlusion or stenosis of unspecified carotid arteries
I65.21	Occlusion and stenosis of right carotid artery
I65.22	Occlusion and stenosis of left carotid artery
I65.23	Occlusion and stenosis of bilateral carotid arteries
I65.29	Occlusion and stenosis of unspecified carotid artery
I65.8	Occlusion and stenosis of other precerebral arteries
I65.9	Occlusion and stenosis of unspecified precerebral artery

Mitral Valve Repair and Replacement Measure Specifications

For mitral valve repair and replacement, there is only one set of ICD-10 codes for counting patient discharges. The set of codes is to identify patients who have had the procedure.

Count the number of patients, ages 18 years and older, discharged with the following ICD-10 codes in any procedure field.

ICD-10 Mitral Valve Repair and Replacement Procedure Codes

ICD-10 Procedure Code	Code Description
027G04Z	Dilation of Mitral Valve with Drug-eluting Intraluminal Device, Open Approach
027G0DZ	Dilation of Mitral Valve with Intraluminal Device, Open Approach
027G0ZZ	Dilation of Mitral Valve, Open Approach
02CG0ZZ	Extirpation of Matter from Mitral Valve, Open Approach
02NG0ZZ	Release Mitral Valve, Open Approach
02QG0ZE	Repair Mitral Valve created from Left Atrioventricular Valve, Open Approach
02QG0ZZ	Repair Mitral Valve, Open Approach
02RG07Z	Replacement of Mitral Valve with Autologous Tissue Substitute, Open Approach
02RG08Z	Replacement of Mitral Valve with Zooplasic Tissue, Open Approach
02RG0JZ	Replacement of Mitral Valve with Synthetic Substitute, Open Approach
02RG0KZ	Replacement of Mitral Valve with Nonautologous Tissue Substitute, Open Approach
02UG07E	Supplement Mitral Valve created from Left Atrioventricular Valve with Autologous Tissue Substitute, Open Approach
02UG07Z	Supplement Mitral Valve with Autologous Tissue Substitute, Open Approach
02UG08E	Supplement Mitral Valve created from Left Atrioventricular Valve with Zooplasic Tissue, Open Approach
02UG08Z	Supplement Mitral Valve with Zooplasic Tissue, Open Approach
02UG0JE	Supplement Mitral Valve created from Left Atrioventricular Valve with Synthetic Substitute, Open Approach
02UG0JZ	Supplement Mitral Valve with Synthetic Substitute, Open Approach
02UG0KE	Supplement Mitral Valve created from Left Atrioventricular Valve with Nonautologous Tissue Substitute, Open Approach
02UG0KZ	Supplement Mitral Valve with Nonautologous Tissue Substitute, Open Approach
02VG0ZZ	Restriction of Mitral Valve, Open Approach

Open Aortic Procedures Measure Specifications

For open aortic procedures, there is only one set of ICD-10 codes for counting patient discharges. The set of codes is to identify patients who have had the procedure.

Count the number of patients, ages 18 years and older, discharged with the following ICD-10 codes in any procedure field.

ICD-10 Open Aortic Procedure Codes

ICD-10 Procedure Code	Code Description
0410090	Bypass Abdominal Aorta to Abdominal Aorta with Autologous Venous Tissue, Open Approach
0410091	Bypass Abdominal Aorta to Celiac Artery with Autologous Venous Tissue, Open Approach
0410092	Bypass Abdominal Aorta to Mesenteric Artery with Autologous Venous Tissue, Open Approach
0410093	Bypass Abdominal Aorta to Right Renal Artery with Autologous Venous Tissue, Open Approach
0410094	Bypass Abdominal Aorta to Left Renal Artery with Autologous Venous Tissue, Open Approach
0410095	Bypass Abdominal Aorta to Bilateral Renal Artery with Autologous Venous Tissue, Open Approach
0410096	Bypass Abdominal Aorta to Right Common Iliac Artery with Autologous Venous Tissue, Open Approach
0410097	Bypass Abdominal Aorta to Left Common Iliac Artery with Autologous Venous Tissue, Open Approach
0410098	Bypass Abdominal Aorta to Bilateral Common Iliac Arteries with Autologous Venous Tissue, Open Approach
0410099	Bypass Abdominal Aorta to Right Internal Iliac Artery with Autologous Venous Tissue, Open Approach
021K0ZW	Bypass Right Ventricle to Aorta, Open Approach
021L0ZW	Bypass Left Ventricle to Aorta, Open Approach
021W08A	Bypass Thoracic Aorta, Descending to Innominate Artery with Zooplastic Tissue, Open Approach
021W08B	Bypass Thoracic Aorta, Descending to Subclavian with Zooplastic Tissue, Open Approach
021W08D	Bypass Thoracic Aorta, Descending to Carotid with Zooplastic Tissue, Open Approach
021W08F	Bypass Thoracic Aorta, Descending to Abdominal Artery with Zooplastic Tissue, Open Approach
021W08G	Bypass Thoracic Aorta, Descending to Axillary Artery with Zooplastic Tissue, Open Approach
021W08H	Bypass Thoracic Aorta, Descending to Brachial Artery with Zooplastic Tissue, Open Approach
021W08P	Bypass Thoracic Aorta, Descending to Pulmonary Trunk with Zooplastic Tissue, Open Approach
021W08Q	Bypass Thoracic Aorta, Descending to Right Pulmonary Artery with Zooplastic Tissue, Open Approach
021W08R	Bypass Thoracic Aorta, Descending to Left Pulmonary Artery with Zooplastic Tissue, Open Approach
021W08V	Bypass Thoracic Aorta, Descending to Lower Extremity Artery with Zooplastic Tissue, Open Approach

ICD-10 Procedure Code	Code Description
021W09B	Bypass Thoracic Aorta, Descending to Subclavian with Autologous Venous Tissue, Open Approach
021W09A	Bypass Thoracic Aorta, Descending to Innominate Artery with Autologous Venous Tissue, Open Approach
021W09D	Bypass Thoracic Aorta, Descending to Carotid with Autologous Venous Tissue, Open Approach
021W09F	Bypass Thoracic Aorta, Descending to Abdominal Artery with Autologous Venous Tissue, Open Approach
021W09G	Bypass Thoracic Aorta, Descending to Axillary Artery with Autologous Venous Tissue, Open Approach
021W09H	Bypass Thoracic Aorta, Descending to Brachial Artery with Autologous Venous Tissue, Open Approach
021W09P	Bypass Thoracic Aorta, Descending to Pulmonary Trunk with Autologous Venous Tissue, Open Approach
021W09Q	Bypass Thoracic Aorta, Descending to Right Pulmonary Artery with Autologous Venous Tissue, Open Approach
021W09R	Bypass Thoracic Aorta, Descending to Left Pulmonary Artery with Autologous Venous Tissue, Open Approach
021W09V	Bypass Thoracic Aorta, Descending to Lower Extremity Artery with Autologous Venous Tissue, Open Approach
021W0AA	Bypass Thoracic Aorta, Descending to Innominate Artery with Autologous Arterial Tissue, Open Approach
021W0AB	Bypass Thoracic Aorta, Descending to Subclavian with Autologous Arterial Tissue, Open Approach
021W0AD	Bypass Thoracic Aorta, Descending to Carotid with Autologous Arterial Tissue, Open Approach
021W0AF	Bypass Thoracic Aorta, Descending to Abdominal Artery with Autologous Arterial Tissue, Open Approach
021W0AG	Bypass Thoracic Aorta, Descending to Axillary Artery with Autologous Arterial Tissue, Open Approach
021W0AH	Bypass Thoracic Aorta, Descending to Brachial Artery with Autologous Arterial Tissue, Open Approach
021W0AP	Bypass Thoracic Aorta, Descending to Pulmonary Trunk with Autologous Arterial Tissue, Open Approach
021W0AQ	Bypass Thoracic Aorta, Descending to Right Pulmonary Artery with Autologous Arterial Tissue, Open Approach
021W0AR	Bypass Thoracic Aorta, Descending to Left Pulmonary Artery with Autologous Arterial Tissue, Open Approach
021W0AV	Bypass Thoracic Aorta, Descending to Lower Extremity Artery with Autologous Arterial Tissue, Open Approach
021W0JA	Bypass Thoracic Aorta, Descending to Innominate Artery with Synthetic Substitute, Open Approach
021W0JB	Bypass Thoracic Aorta, Descending to Subclavian with Synthetic Substitute, Open Approach
021W0JD	Bypass Thoracic Aorta, Descending to Carotid with Synthetic Substitute, Open Approach
021W0JF	Bypass Thoracic Aorta, Descending to Abdominal Artery with Synthetic Substitute, Open Approach
021W0JG	Bypass Thoracic Aorta, Descending to Axillary Artery with Synthetic Substitute, Open Approach
021W0JH	Bypass Thoracic Aorta, Descending to Brachial Artery with Synthetic Substitute, Open Approach
021W0JP	Bypass Thoracic Aorta, Descending to Pulmonary Trunk with Synthetic Substitute, Open Approach

ICD-10 Procedure Code	Code Description
021W0JQ	Bypass Thoracic Aorta, Descending to Right Pulmonary Artery with Synthetic Substitute, Open Approach
021W0JR	Bypass Thoracic Aorta, Descending to Left Pulmonary Artery with Synthetic Substitute, Open Approach
021W0JV	Bypass Thoracic Aorta, Descending to Lower Extremity Artery with Synthetic Substitute, Open Approach
021W0KA	Bypass Thoracic Aorta, Descending to Innominate Artery with Nonautologous Tissue Substitute, Open Approach
021W0KB	Bypass Thoracic Aorta, Descending to Subclavian with Nonautologous Tissue Substitute, Open Approach
021W0KD	Bypass Thoracic Aorta, Descending to Carotid with Nonautologous Tissue Substitute, Open Approach
021W0KF	Bypass Thoracic Aorta, Descending to Abdominal Artery with Nonautologous Tissue Substitute, Open Approach
021W0KG	Bypass Thoracic Aorta, Descending to Axillary Artery with Nonautologous Tissue Substitute, Open Approach
021W0KH	Bypass Thoracic Aorta, Descending to Brachial Artery with Nonautologous Tissue Substitute, Open Approach
021W0KP	Bypass Thoracic Aorta, Descending to Pulmonary Trunk with Nonautologous Tissue Substitute, Open Approach
021W0KQ	Bypass Thoracic Aorta, Descending to Right Pulmonary Artery with Nonautologous Tissue Substitute, Open Approach
021W0KR	Bypass Thoracic Aorta, Descending to Left Pulmonary Artery with Nonautologous Tissue Substitute, Open Approach
021W0KV	Bypass Thoracic Aorta, Descending to Lower Extremity Artery with Nonautologous Tissue Substitute, Open Approach
021W0ZA	Bypass Thoracic Aorta, Descending to Innominate Artery, Open Approach
021W0ZB	Bypass Thoracic Aorta, Descending to Subclavian, Open Approach
021W0ZD	Bypass Thoracic Aorta, Descending to Carotid, Open Approach
021W0ZP	Bypass Thoracic Aorta, Descending to Pulmonary Trunk, Open Approach
021W0ZQ	Bypass Thoracic Aorta, Descending to Right Pulmonary Artery, Open Approach
021W0ZR	Bypass Thoracic Aorta, Descending to Left Pulmonary Artery, Open Approach
021X08A	Bypass Thoracic Aorta, Ascending/Arch to Innominate Artery with Zooplastic Tissue, Open Approach
021X08B	Bypass Thoracic Aorta, Ascending/Arch to Subclavian with Zooplastic Tissue, Open Approach
021X08D	Bypass Thoracic Aorta, Ascending/Arch to Carotid with Zooplastic Tissue, Open Approach
021X08P	Bypass Thoracic Aorta, Ascending/Arch to Pulmonary Trunk with Zooplastic Tissue, Open Approach
021X08Q	Bypass Thoracic Aorta, Ascending/Arch to Right Pulmonary Artery with Zooplastic Tissue, Open Approach
021X08R	Bypass Thoracic Aorta, Ascending/Arch to Left Pulmonary Artery with Zooplastic Tissue, Open Approach
021X09A	Bypass Thoracic Aorta, Ascending/Arch to Innominate Artery with Autologous Venous Tissue, Open Approach
021X09B	Bypass Thoracic Aorta, Ascending/Arch to Subclavian with Autologous Venous Tissue, Open Approach
021X09D	Bypass Thoracic Aorta, Ascending/Arch to Carotid with Autologous Venous Tissue, Open Approach

ICD-10 Procedure Code	Code Description
021X09P	Bypass Thoracic Aorta, Ascending/Arch to Pulmonary Trunk with Autologous Venous Tissue, Open Approach
021X09Q	Bypass Thoracic Aorta, Ascending/Arch to Right Pulmonary Artery with Autologous Venous Tissue, Open Approach
021X09R	Bypass Thoracic Aorta, Ascending/Arch to Left Pulmonary Artery with Autologous Venous Tissue, Open Approach
021X0AA	Bypass Thoracic Aorta, Ascending/Arch to Innominate Artery with Autologous Arterial Tissue, Open Approach
021X0AB	Bypass Thoracic Aorta, Ascending/Arch to Subclavian with Autologous Arterial Tissue, Open Approach
021X0AD	Bypass Thoracic Aorta, Ascending/Arch to Carotid with Autologous Arterial Tissue, Open Approach
021X0AP	Bypass Thoracic Aorta, Ascending/Arch to Pulmonary Trunk with Autologous Arterial Tissue, Open Approach
021X0AQ	Bypass Thoracic Aorta, Ascending/Arch to Right Pulmonary Artery with Autologous Arterial Tissue, Open Approach
021X0AR	Bypass Thoracic Aorta, Ascending/Arch to Left Pulmonary Artery with Autologous Arterial Tissue, Open Approach
021X0JA	Bypass Thoracic Aorta, Ascending/Arch to Innominate Artery with Synthetic Substitute, Open Approach
021X0JB	Bypass Thoracic Aorta, Ascending/Arch to Subclavian with Synthetic Substitute, Open Approach
021X0JD	Bypass Thoracic Aorta, Ascending/Arch to Carotid with Synthetic Substitute, Open Approach
021X0JP	Bypass Thoracic Aorta, Ascending/Arch to Pulmonary Trunk with Synthetic Substitute, Open Approach
021X0JQ	Bypass Thoracic Aorta, Ascending/Arch to Right Pulmonary Artery with Synthetic Substitute, Open Approach
021X0JR	Bypass Thoracic Aorta, Ascending/Arch to Left Pulmonary Artery with Synthetic Substitute, Open Approach
021X0KA	Bypass Thoracic Aorta, Ascending/Arch to Innominate Artery with Nonautologous Tissue Substitute, Open Approach
021X0KB	Bypass Thoracic Aorta, Ascending/Arch to Subclavian with Nonautologous Tissue Substitute, Open Approach
021X0KD	Bypass Thoracic Aorta, Ascending/Arch to Carotid with Nonautologous Tissue Substitute, Open Approach
021X0KP	Bypass Thoracic Aorta, Ascending/Arch to Pulmonary Trunk with Nonautologous Tissue Substitute, Open Approach
021X0KQ	Bypass Thoracic Aorta, Ascending/Arch to Right Pulmonary Artery with Nonautologous Tissue Substitute, Open Approach
021X0KR	Bypass Thoracic Aorta, Ascending/Arch to Left Pulmonary Artery with Nonautologous Tissue Substitute, Open Approach
021X0ZA	Bypass Thoracic Aorta, Ascending/Arch to Innominate Artery, Open Approach
021X0ZB	Bypass Thoracic Aorta, Ascending/Arch to Subclavian, Open Approach
021X0ZD	Bypass Thoracic Aorta, Ascending/Arch to Carotid, Open Approach
021X0ZP	Bypass Thoracic Aorta, Ascending/Arch to Pulmonary Trunk, Open Approach
021X0ZQ	Bypass Thoracic Aorta, Ascending/Arch to Right Pulmonary Artery, Open Approach
021X0ZR	Bypass Thoracic Aorta, Ascending/Arch to Left Pulmonary Artery, Open Approach
02BW0ZX	Excision of Thoracic Aorta, Descending, Open Approach, Diagnostic
02BW0ZZ	Excision of Thoracic Aorta, Descending, Open Approach

ICD-10 Procedure Code	Code Description
02BX0ZX	Excision of Thoracic Aorta, Ascending/Arch, Open Approach, Diagnostic
02BX0ZZ	Excision of Thoracic Aorta, Ascending/Arch, Open Approach
02QW0ZZ	Repair Thoracic Aorta, Descending, Open Approach
02QX0ZZ	Repair Thoracic Aorta, Ascending/Arch, Open Approach
02RW07Z	Replacement of Thoracic Aorta, Descending with Autologous Tissue Substitute, Open Approach
02RW08Z	Replacement of Thoracic Aorta, Descending with Zooplastic Tissue, Open Approach
02RW0JZ	Replacement of Thoracic Aorta, Descending with Synthetic Substitute, Open Approach
02RW0KZ	Replacement of Thoracic Aorta, Descending with Nonautologous Tissue Substitute, Open Approach
02RX07Z	Replacement of Thoracic Aorta, Ascending/Arch with Autologous Tissue Substitute, Open Approach
02RX08Z	Replacement of Thoracic Aorta, Ascending/Arch with Zooplastic Tissue, Open Approach
02RX0JZ	Replacement of Thoracic Aorta, Ascending/Arch with Synthetic Substitute, Open Approach
02RX0KZ	Replacement of Thoracic Aorta, Ascending/Arch with Nonautologous Tissue Substitute, Open Approach
02SW0ZZ	Reposition Thoracic Aorta, Descending, Open Approach
02SX0ZZ	Reposition Thoracic Aorta, Ascending/Arch, Open Approach
02UW07Z	Supplement Thoracic Aorta, Descending with Autologous Tissue Substitute, Open Approach
02UW08Z	Supplement Thoracic Aorta, Descending with Zooplastic Tissue, Open Approach
02UW0JZ	Supplement Thoracic Aorta, Descending with Synthetic Substitute, Open Approach
02UW0KZ	Supplement Thoracic Aorta, Descending with Nonautologous Tissue Substitute, Open Approach
02UX08Z	Supplement Thoracic Aorta, Ascending/Arch with Zooplastic Tissue, Open Approach
041009B	Bypass Abdominal Aorta to Left Internal Iliac Artery with Autologous Venous Tissue, Open Approach
041009C	Bypass Abdominal Aorta to Bilateral Internal Iliac Arteries with Autologous Venous Tissue, Open Approach
041009D	Bypass Abdominal Aorta to Right External Iliac Artery with Autologous Venous Tissue, Open Approach
041009F	Bypass Abdominal Aorta to Left External Iliac Artery with Autologous Venous Tissue, Open Approach
041009G	Bypass Abdominal Aorta to Bilateral External Iliac Arteries with Autologous Venous Tissue, Open Approach
041009H	Bypass Abdominal Aorta to Right Femoral Artery with Autologous Venous Tissue, Open Approach
041009J	Bypass Abdominal Aorta to Left Femoral Artery with Autologous Venous Tissue, Open Approach
041009K	Bypass Abdominal Aorta to Bilateral Femoral Arteries with Autologous Venous Tissue, Open Approach
041009Q	Bypass Abdominal Aorta to Lower Extremity Artery with Autologous Venous Tissue, Open Approach
041009R	Bypass Abdominal Aorta to Lower Artery with Autologous Venous Tissue, Open Approach
04100A0	Bypass Abdominal Aorta to Abdominal Aorta with Autologous Arterial Tissue, Open Approach

ICD-10 Procedure Code	Code Description
04100A1	Bypass Abdominal Aorta to Celiac Artery with Autologous Arterial Tissue, Open Approach
04100A2	Bypass Abdominal Aorta to Mesenteric Artery with Autologous Arterial Tissue, Open Approach
04100A3	Bypass Abdominal Aorta to Right Renal Artery with Autologous Arterial Tissue, Open Approach
04100A4	Bypass Abdominal Aorta to Left Renal Artery with Autologous Arterial Tissue, Open Approach
04100A5	Bypass Abdominal Aorta to Bilateral Renal Artery with Autologous Arterial Tissue, Open Approach
04100A6	Bypass Abdominal Aorta to Right Common Iliac Artery with Autologous Arterial Tissue, Open Approach
04100A7	Bypass Abdominal Aorta to Left Common Iliac Artery with Autologous Arterial Tissue, Open Approach
04100A8	Bypass Abdominal Aorta to Bilateral Common Iliac Arteries with Autologous Arterial Tissue, Open Approach
04100A9	Bypass Abdominal Aorta to Right Internal Iliac Artery with Autologous Arterial Tissue, Open Approach
04100AB	Bypass Abdominal Aorta to Left Internal Iliac Artery with Autologous Arterial Tissue, Open Approach
04100AC	Bypass Abdominal Aorta to Bilateral Internal Iliac Arteries with Autologous Arterial Tissue, Open Approach
04100AD	Bypass Abdominal Aorta to Right External Iliac Artery with Autologous Arterial Tissue, Open Approach
04100AF	Bypass Abdominal Aorta to Left External Iliac Artery with Autologous Arterial Tissue, Open Approach
04100AG	Bypass Abdominal Aorta to Bilateral External Iliac Arteries with Autologous Arterial Tissue, Open Approach
04100AH	Bypass Abdominal Aorta to Right Femoral Artery with Autologous Arterial Tissue, Open Approach
04100AJ	Bypass Abdominal Aorta to Left Femoral Artery with Autologous Arterial Tissue, Open Approach
04100AK	Bypass Abdominal Aorta to Bilateral Femoral Arteries with Autologous Arterial Tissue, Open Approach
04100AQ	Bypass Abdominal Aorta to Lower Extremity Artery with Autologous Arterial Tissue, Open Approach
04100AR	Bypass Abdominal Aorta to Lower Artery with Autologous Arterial Tissue, Open Approach
04100J0	Bypass Abdominal Aorta to Abdominal Aorta with Synthetic Substitute, Open Approach
04100J1	Bypass Abdominal Aorta to Celiac Artery with Synthetic Substitute, Open Approach
04100J2	Bypass Abdominal Aorta to Mesenteric Artery with Synthetic Substitute, Open Approach
04100J3	Bypass Abdominal Aorta to Right Renal Artery with Synthetic Substitute, Open Approach
04100J4	Bypass Abdominal Aorta to Left Renal Artery with Synthetic Substitute, Open Approach
04100J5	Bypass Abdominal Aorta to Bilateral Renal Artery with Synthetic Substitute, Open Approach
04100J6	Bypass Abdominal Aorta to Right Common Iliac Artery with Synthetic Substitute, Open Approach
04100J7	Bypass Abdominal Aorta to Left Common Iliac Artery with Synthetic Substitute, Open Approach
04100J8	Bypass Abdominal Aorta to Bilateral Common Iliac Arteries with Synthetic Substitute, Open Approach

ICD-10 Procedure Code	Code Description
04100J9	Bypass Abdominal Aorta to Right Internal Iliac Artery with Synthetic Substitute, Open Approach
04100JB	Bypass Abdominal Aorta to Left Internal Iliac Artery with Synthetic Substitute, Open Approach
04100JC	Bypass Abdominal Aorta to Bilateral Internal Iliac Arteries with Synthetic Substitute, Open Approach
04100JD	Bypass Abdominal Aorta to Right External Iliac Artery with Synthetic Substitute, Open Approach
04100JF	Bypass Abdominal Aorta to Left External Iliac Artery with Synthetic Substitute, Open Approach
04100JG	Bypass Abdominal Aorta to Bilateral External Iliac Arteries with Synthetic Substitute, Open Approach
04100JH	Bypass Abdominal Aorta to Right Femoral Artery with Synthetic Substitute, Open Approach
04100JJ	Bypass Abdominal Aorta to Left Femoral Artery with Synthetic Substitute, Open Approach
04100JK	Bypass Abdominal Aorta to Bilateral Femoral Arteries with Synthetic Substitute, Open Approach
04100JQ	Bypass Abdominal Aorta to Lower Extremity Artery with Synthetic Substitute, Open Approach
04100JR	Bypass Abdominal Aorta to Lower Artery with Synthetic Substitute, Open Approach
04100K0	Bypass Abdominal Aorta to Abdominal Aorta with Nonautologous Tissue Substitute, Open Approach
04100K1	Bypass Abdominal Aorta to Celiac Artery with Nonautologous Tissue Substitute, Open Approach
04100K2	Bypass Abdominal Aorta to Mesenteric Artery with Nonautologous Tissue Substitute, Open Approach
04100K3	Bypass Abdominal Aorta to Right Renal Artery with Nonautologous Tissue Substitute, Open Approach
04100K4	Bypass Abdominal Aorta to Left Renal Artery with Nonautologous Tissue Substitute, Open Approach
04100K5	Bypass Abdominal Aorta to Bilateral Renal Artery with Nonautologous Tissue Substitute, Open Approach
04100K6	Bypass Abdominal Aorta to Right Common Iliac Artery with Nonautologous Tissue Substitute, Open Approach
04100K7	Bypass Abdominal Aorta to Left Common Iliac Artery with Nonautologous Tissue Substitute, Open Approach
04100K8	Bypass Abdominal Aorta to Bilateral Common Iliac Arteries with Nonautologous Tissue Substitute, Open Approach
04100K9	Bypass Abdominal Aorta to Right Internal Iliac Artery with Nonautologous Tissue Substitute, Open Approach
04100KB	Bypass Abdominal Aorta to Left Internal Iliac Artery with Nonautologous Tissue Substitute, Open Approach
04100KC	Bypass Abdominal Aorta to Bilateral Internal Iliac Arteries with Nonautologous Tissue Substitute, Open Approach
04100KD	Bypass Abdominal Aorta to Right External Iliac Artery with Nonautologous Tissue Substitute, Open Approach
04100KF	Bypass Abdominal Aorta to Left External Iliac Artery with Nonautologous Tissue Substitute, Open Approach
04100KG	Bypass Abdominal Aorta to Bilateral External Iliac Arteries with Nonautologous Tissue Substitute, Open Approach
04100KH	Bypass Abdominal Aorta to Right Femoral Artery with Nonautologous Tissue Substitute, Open Approach

ICD-10 Procedure Code	Code Description
04100KJ	Bypass Abdominal Aorta to Left Femoral Artery with Nonautologous Tissue Substitute, Open Approach
04100KK	Bypass Abdominal Aorta to Bilateral Femoral Arteries with Nonautologous Tissue Substitute, Open Approach
04100KQ	Bypass Abdominal Aorta to Lower Extremity Artery with Nonautologous Tissue Substitute, Open Approach
04100KR	Bypass Abdominal Aorta to Lower Artery with Nonautologous Tissue Substitute, Open Approach
04100Z0	Bypass Abdominal Aorta to Abdominal Aorta, Open Approach
04100Z1	Bypass Abdominal Aorta to Celiac Artery, Open Approach
04100Z2	Bypass Abdominal Aorta to Mesenteric Artery, Open Approach
04100Z3	Bypass Abdominal Aorta to Right Renal Artery, Open Approach
04100Z4	Bypass Abdominal Aorta to Left Renal Artery, Open Approach
04100Z5	Bypass Abdominal Aorta to Bilateral Renal Artery, Open Approach
04100Z6	Bypass Abdominal Aorta to Right Common Iliac Artery, Open Approach
04100Z7	Bypass Abdominal Aorta to Left Common Iliac Artery, Open Approach
04100Z8	Bypass Abdominal Aorta to Bilateral Common Iliac Arteries, Open Approach
04100Z9	Bypass Abdominal Aorta to Right Internal Iliac Artery, Open Approach
04100ZB	Bypass Abdominal Aorta to Left Internal Iliac Artery, Open Approach
04100ZC	Bypass Abdominal Aorta to Bilateral Internal Iliac Arteries, Open Approach
04100ZD	Bypass Abdominal Aorta to Right External Iliac Artery, Open Approach
04100ZF	Bypass Abdominal Aorta to Left External Iliac Artery, Open Approach
04100ZG	Bypass Abdominal Aorta to Bilateral External Iliac Arteries, Open Approach
04100ZH	Bypass Abdominal Aorta to Right Femoral Artery, Open Approach
04100ZJ	Bypass Abdominal Aorta to Left Femoral Artery, Open Approach
04100ZK	Bypass Abdominal Aorta to Bilateral Femoral Arteries, Open Approach
04100ZQ	Bypass Abdominal Aorta to Lower Extremity Artery, Open Approach
04100ZR	Bypass Abdominal Aorta to Lower Artery, Open Approach
041C090	Bypass Right Common Iliac Artery to Abdominal Aorta with Autologous Venous Tissue, Open Approach
041C0A0	Bypass Right Common Iliac Artery to Abdominal Aorta with Autologous Arterial Tissue, Open Approach
041C0J0	Bypass Right Common Iliac Artery to Abdominal Aorta with Synthetic Substitute, Open Approach
041C0K0	Bypass Right Common Iliac Artery to Abdominal Aorta with Nonautologous Tissue Substitute, Open Approach
041C0Z0	Bypass Right Common Iliac Artery to Abdominal Aorta, Open Approach
041D090	Bypass Left Common Iliac Artery to Abdominal Aorta with Autologous Venous Tissue, Open Approach
041D0A0	Bypass Left Common Iliac Artery to Abdominal Aorta with Autologous Arterial Tissue, Open Approach
041D0J0	Bypass Left Common Iliac Artery to Abdominal Aorta with Synthetic Substitute, Open Approach
041D0K0	Bypass Left Common Iliac Artery to Abdominal Aorta with Nonautologous Tissue Substitute, Open Approach
041D0Z0	Bypass Left Common Iliac Artery to Abdominal Aorta, Open Approach

ICD-10 Procedure Code	Code Description
04B00ZX	Excision of Abdominal Aorta, Open Approach, Diagnostic
04B00ZZ	Excision of Abdominal Aorta, Open Approach
04Q00ZZ	Repair Abdominal Aorta, Open Approach
04R007Z	Replacement of Abdominal Aorta with Autologous Tissue Substitute, Open Approach
04R00JZ	Replacement of Abdominal Aorta with Synthetic Substitute, Open Approach
04R00KZ	Replacement of Abdominal Aorta with Nonautologous Tissue Substitute, Open Approach
04S00ZZ	Reposition Abdominal Aorta, Open Approach
04U007Z	Supplement Abdominal Aorta with Autologous Tissue Substitute, Open Approach
04U00JZ	Supplement Abdominal Aorta with Synthetic Substitute, Open Approach
04U00KZ	Supplement Abdominal Aorta with Nonautologous Tissue Substitute, Open Approach
X2RX0N7	Replacement of Thoracic Aorta, Arch using Branched Synthetic Substitute with Intraluminal Device, Open Approach, New Technology Group 7

Lung Resection for Cancer Measure Specifications

For lung resection for cancer, there are two sets of ICD-10 codes for counting patient discharges. The first set of codes is to identify patients who have had the procedure. The second set of codes is to identify patients with a specific diagnosis.

Count the number of patients, ages 18 years and older, discharged with the following ICD-10 codes in any procedure field AND any of the following ICD-10 codes in any diagnosis field.

ICD-10 Lung Resection for Cancer Procedure Codes

ICD-10 Procedure Code	Code Description
0BBC0ZZ	Excision of Right Upper Lung Lobe, Open Approach
0BBC3ZZ	Excision of Right Upper Lung Lobe, Percutaneous Approach
0BBC4ZZ	Excision of Right Upper Lung Lobe, Percutaneous Endoscopic Approach
0BBD0ZZ	Excision of Right Middle Lung Lobe, Open Approach
0BBD3ZZ	Excision of Right Middle Lung Lobe, Percutaneous Approach
0BBD4ZZ	Excision of Right Middle Lung Lobe, Percutaneous Endoscopic Approach
0BBF0ZZ	Excision of Right Lower Lung Lobe, Open Approach
0BBF3ZZ	Excision of Right Lower Lung Lobe, Percutaneous Approach
0BBF4ZZ	Excision of Right Lower Lung Lobe, Percutaneous Endoscopic Approach
0BBG0ZZ	Excision of Left Upper Lung Lobe, Open Approach
0BBG3ZZ	Excision of Left Upper Lung Lobe, Percutaneous Approach
0BBG4ZZ	Excision of Left Upper Lung Lobe, Percutaneous Endoscopic Approach
0BBH0ZZ	Excision of Lung Lingula, Open Approach
0BBH3ZZ	Excision of Lung Lingula, Percutaneous Approach
0BBH4ZZ	Excision of Lung Lingula, Percutaneous Endoscopic Approach
0BBJ0ZZ	Excision of Left Lower Lung Lobe, Open Approach
0BBJ3ZZ	Excision of Left Lower Lung Lobe, Percutaneous Approach
0BBJ4ZZ	Excision of Left Lower Lung Lobe, Percutaneous Endoscopic Approach
0BBK0ZZ	Excision of Right Lung, Open Approach
0BBK3ZZ	Excision of Right Lung, Percutaneous Approach
0BBK4ZZ	Excision of Right Lung, Percutaneous Endoscopic Approach
0BBL0ZZ	Excision of Left Lung, Open Approach
0BBL3ZZ	Excision of Left Lung, Percutaneous Approach
0BBL4ZZ	Excision of Left Lung, Percutaneous Endoscopic Approach
0BBL7ZZ	Excision of Left Lung, Via Natural or Artificial Opening
0BTC0ZZ	Resection of Right Upper Lung Lobe, Open Approach
0BTC4ZZ	Resection of Right Upper Lung Lobe, Percutaneous Endoscopic Approach
0BTD0ZZ	Resection of Right Middle Lung Lobe, Open Approach
0BTD4ZZ	Resection of Right Middle Lung Lobe, Percutaneous Endoscopic Approach
0BTF0ZZ	Resection of Right Lower Lung Lobe, Open Approach
0BTF4ZZ	Resection of Right Lower Lung Lobe, Percutaneous Endoscopic Approach
0BTG0ZZ	Resection of Left Upper Lung Lobe, Open Approach
0BTG4ZZ	Resection of Left Upper Lung Lobe, Percutaneous Endoscopic Approach

ICD-10 Procedure Code	Code Description
0BTH0ZZ	Resection of Lung Lingula, Open Approach
0BTH4ZZ	Resection of Lung Lingula, Percutaneous Endoscopic Approach
0BTJ0ZZ	Resection of Left Lower Lung Lobe, Open Approach
0BTJ4ZZ	Resection of Left Lower Lung Lobe, Percutaneous Endoscopic Approach
0BTK0ZZ	Resection of Right Lung, Open Approach
0BTK4ZZ	Resection of Right Lung, Percutaneous Endoscopic Approach
0BTL0ZZ	Resection of Left Lung, Open Approach
0BTL4ZZ	Resection of Left Lung, Percutaneous Endoscopic Approach

ICD-10 Malignant Tumor and Cancer in Situ Diagnosis Codes

ICD-10 Diagnosis Code	Code Description
C7A.090	Malignant carcinoid tumor of the bronchus and lung
C7A.1	Malignant poorly differentiated neuroendocrine tumors
C7A.8	Other malignant neuroendocrine tumors
C34.00	Malignant neoplasm of main bronchus
C34.01	Malignant neoplasm of right main bronchus
C34.02	Malignant neoplasm of left main bronchus
C34.10	Malignant neoplasm of upper lobe, unspecified bronchus or lung
C34.11	Malignant neoplasm of upper lobe, right bronchus or lung
C34.12	Malignant neoplasm of upper lobe, left bronchus or lung
C34.2	Malignant neoplasm of middle lobe, bronchus or lung
C34.30	Malignant neoplasm of lower lobe, unspecified bronchus or lung
C34.31	Malignant neoplasm of lower lobe, right bronchus or lung
C34.32	Malignant neoplasm of lower lobe, left bronchus or lung
C34.80	Malignant neoplasm of overlapping sites of unspecified bronchus and lung
C34.81	Malignant neoplasm of overlapping sites of right bronchus and lung
C34.82	Malignant neoplasm of overlapping sites of left bronchus and lung
C34.90	Malignant neoplasm of unspecified part of unspecified bronchus or lung
C34.91	Malignant neoplasm of unspecified part of right bronchus or lung
C34.92	Malignant neoplasm of unspecified part of left bronchus or lung
D02.20	Carcinoma in situ of unspecified bronchus and lung
D02.21	Carcinoma in situ of right bronchus and lung
D02.22	Carcinoma in situ of left bronchus and lung

Esophageal Resection for Cancer Measure Specifications

For esophageal resection for cancer, there are two sets of ICD-10 codes for counting patient discharges. The first set of codes is to identify patients who have had the procedure. The second set of codes is to identify patients with a specific diagnosis.

Count the number of patients, ages 18 years and older, discharged with the following ICD-10 codes in any procedure field AND any of the following ICD-10 codes in any diagnosis field.

ICD-10 Esophageal Resection for Cancer Procedure Codes

ICD-10 Procedure Code	Code Description
0D11074	Bypass Upper Esophagus to Cutaneous with Autologous Tissue Substitute, Open Approach
0D11076	Bypass Upper Esophagus to Stomach with Autologous Tissue Substitute, Open Approach
0D11079	Bypass Upper Esophagus to Duodenum with Autologous Tissue Substitute, Open Approach
0D1107A	Bypass Upper Esophagus to Jejunum with Autologous Tissue Substitute, Open Approach
0D1107B	Bypass Upper Esophagus to Ileum with Autologous Tissue Substitute, Open Approach
0D110J4	Bypass Upper Esophagus to Cutaneous with Synthetic Substitute, Open Approach
0D110J6	Bypass Upper Esophagus to Stomach with Synthetic Substitute, Open Approach
0D110J9	Bypass Upper Esophagus to Duodenum with Synthetic Substitute, Open Approach
0D110JA	Bypass Upper Esophagus to Jejunum with Synthetic Substitute, Open Approach
0D110JB	Bypass Upper Esophagus to Ileum with Synthetic Substitute, Open Approach
0D110K4	Bypass Upper Esophagus to Cutaneous with Nonautologous Tissue Substitute, Open Approach
0D110K6	Bypass Upper Esophagus to Stomach with Nonautologous Tissue Substitute, Open Approach
0D110K9	Bypass Upper Esophagus to Duodenum with Nonautologous Tissue Substitute, Open Approach
0D110KA	Bypass Upper Esophagus to Jejunum with Nonautologous Tissue Substitute, Open Approach
0D110KB	Bypass Upper Esophagus to Ileum with Nonautologous Tissue Substitute, Open Approach
0D110Z4	Bypass Upper Esophagus to Cutaneous, Open Approach
0D110Z6	Bypass Upper Esophagus to Stomach, Open Approach
0D110Z9	Bypass Upper Esophagus to Duodenum, Open Approach
0D110ZA	Bypass Upper Esophagus to Jejunum, Open Approach
0D110ZB	Bypass Upper Esophagus to Ileum, Open Approach
0D113J4	Bypass Upper Esophagus to Cutaneous with Synthetic Substitute, Percutaneous Approach
0D11474	Bypass Upper Esophagus to Cutaneous with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0D11476	Bypass Upper Esophagus to Stomach with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0D11479	Bypass Upper Esophagus to Duodenum with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0D1147A	Bypass Upper Esophagus to Jejunum with Autologous Tissue Substitute, Percutaneous Endoscopic Approach

ICD-10 Procedure Code	Code Description
0D1147B	Bypass Upper Esophagus to Ileum with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0D114J4	Bypass Upper Esophagus to Cutaneous with Synthetic Substitute, Percutaneous Endoscopic Approach
0D114J6	Bypass Upper Esophagus to Stomach with Synthetic Substitute, Percutaneous Endoscopic Approach
0D114J9	Bypass Upper Esophagus to Duodenum with Synthetic Substitute, Percutaneous Endoscopic Approach
0D114JA	Bypass Upper Esophagus to Jejunum with Synthetic Substitute, Percutaneous Endoscopic Approach
0D114JB	Bypass Upper Esophagus to Ileum with Synthetic Substitute, Percutaneous Endoscopic Approach
0D114K4	Bypass Upper Esophagus to Cutaneous with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0D114K6	Bypass Upper Esophagus to Stomach with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0D114K9	Bypass Upper Esophagus to Duodenum with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0D114KA	Bypass Upper Esophagus to Jejunum with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0D114KB	Bypass Upper Esophagus to Ileum with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0D114Z4	Bypass Upper Esophagus to Cutaneous, Percutaneous Endoscopic Approach
0D114Z6	Bypass Upper Esophagus to Stomach, Percutaneous Endoscopic Approach
0D114Z9	Bypass Upper Esophagus to Duodenum, Percutaneous Endoscopic Approach
0D114ZA	Bypass Upper Esophagus to Jejunum, Percutaneous Endoscopic Approach
0D114ZB	Bypass Upper Esophagus to Ileum, Percutaneous Endoscopic Approach
0D11874	Bypass Upper Esophagus to Cutaneous with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D11876	Bypass Upper Esophagus to Stomach with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D11879	Bypass Upper Esophagus to Duodenum with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D1187A	Bypass Upper Esophagus to Jejunum with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D1187B	Bypass Upper Esophagus to Ileum with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D118J4	Bypass Upper Esophagus to Cutaneous with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic
0D118J6	Bypass Upper Esophagus to Stomach with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic
0D118J9	Bypass Upper Esophagus to Duodenum with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic
0D118JA	Bypass Upper Esophagus to Jejunum with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic
0D118JB	Bypass Upper Esophagus to Ileum with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic
0D118K4	Bypass Upper Esophagus to Cutaneous with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D118K6	Bypass Upper Esophagus to Stomach with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic

ICD-10 Procedure Code	Code Description
0D118K9	Bypass Upper Esophagus to Duodenum with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D118KA	Bypass Upper Esophagus to Jejunum with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D118KB	Bypass Upper Esophagus to Ileum with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D118Z4	Bypass Upper Esophagus to Cutaneous, Via Natural or Artificial Opening Endoscopic
0D118Z6	Bypass Upper Esophagus to Stomach, Via Natural or Artificial Opening Endoscopic
0D118Z9	Bypass Upper Esophagus to Duodenum, Via Natural or Artificial Opening Endoscopic
0D118ZA	Bypass Upper Esophagus to Jejunum, Via Natural or Artificial Opening Endoscopic
0D118ZB	Bypass Upper Esophagus to Ileum, Via Natural or Artificial Opening Endoscopic
0D12074	Bypass Middle Esophagus to Cutaneous with Autologous Tissue Substitute, Open Approach
0D12076	Bypass Middle Esophagus to Stomach with Autologous Tissue Substitute, Open Approach
0D12079	Bypass Middle Esophagus to Duodenum with Autologous Tissue Substitute, Open Approach
0D1207A	Bypass Middle Esophagus to Jejunum with Autologous Tissue Substitute, Open Approach
0D1207B	Bypass Middle Esophagus to Ileum with Autologous Tissue Substitute, Open Approach
0D120J4	Bypass Middle Esophagus to Cutaneous with Synthetic Substitute, Open Approach
0D120J6	Bypass Middle Esophagus to Stomach with Synthetic Substitute, Open Approach
0D120J9	Bypass Middle Esophagus to Duodenum with Synthetic Substitute, Open Approach
0D120JA	Bypass Middle Esophagus to Jejunum with Synthetic Substitute, Open Approach
0D120JB	Bypass Middle Esophagus to Ileum with Synthetic Substitute, Open Approach
0D120K4	Bypass Middle Esophagus to Cutaneous with Nonautologous Tissue Substitute, Open Approach
0D120K6	Bypass Middle Esophagus to Stomach with Nonautologous Tissue Substitute, Open Approach
0D120K9	Bypass Middle Esophagus to Duodenum with Nonautologous Tissue Substitute, Open Approach
0D120KA	Bypass Middle Esophagus to Jejunum with Nonautologous Tissue Substitute, Open Approach
0D120KB	Bypass Middle Esophagus to Ileum with Nonautologous Tissue Substitute, Open Approach
0D120Z4	Bypass Middle Esophagus to Cutaneous, Open Approach
0D120Z6	Bypass Middle Esophagus to Stomach, Open Approach
0D120Z9	Bypass Middle Esophagus to Duodenum, Open Approach
0D120ZA	Bypass Middle Esophagus to Jejunum, Open Approach
0D120ZB	Bypass Middle Esophagus to Ileum, Open Approach
0D123J4	Bypass Middle Esophagus to Cutaneous with Synthetic Substitute, Percutaneous Approach
0D12474	Bypass Middle Esophagus to Cutaneous with Autologous Tissue Substitute, Percutaneous Endoscopic Approach

ICD-10 Procedure Code	Code Description
0D12476	Bypass Middle Esophagus to Stomach with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0D12479	Bypass Middle Esophagus to Duodenum with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0D1247A	Bypass Middle Esophagus to Jejunum with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0D1247B	Bypass Middle Esophagus to Ileum with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0D124J4	Bypass Middle Esophagus to Cutaneous with Synthetic Substitute, Percutaneous Endoscopic Approach
0D124J6	Bypass Middle Esophagus to Stomach with Synthetic Substitute, Percutaneous Endoscopic Approach
0D124J9	Bypass Middle Esophagus to Duodenum with Synthetic Substitute, Percutaneous Endoscopic Approach
0D124JA	Bypass Middle Esophagus to Jejunum with Synthetic Substitute, Percutaneous Endoscopic Approach
0D124JB	Bypass Middle Esophagus to Ileum with Synthetic Substitute, Percutaneous Endoscopic Approach
0D124K4	Bypass Middle Esophagus to Cutaneous with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0D124K6	Bypass Middle Esophagus to Stomach with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0D124K9	Bypass Middle Esophagus to Duodenum with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0D124KA	Bypass Middle Esophagus to Jejunum with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0D124KB	Bypass Middle Esophagus to Ileum with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0D124Z4	Bypass Middle Esophagus to Cutaneous, Percutaneous Endoscopic Approach
0D124Z6	Bypass Middle Esophagus to Stomach, Percutaneous Endoscopic Approach
0D124Z9	Bypass Middle Esophagus to Duodenum, Percutaneous Endoscopic Approach
0D124ZA	Bypass Middle Esophagus to Jejunum, Percutaneous Endoscopic Approach
0D124ZB	Bypass Middle Esophagus to Ileum, Percutaneous Endoscopic Approach
0D12874	Bypass Middle Esophagus to Cutaneous with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D12876	Bypass Middle Esophagus to Stomach with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D12879	Bypass Middle Esophagus to Duodenum with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D1287A	Bypass Middle Esophagus to Jejunum with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D1287B	Bypass Middle Esophagus to Ileum with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D128J4	Bypass Middle Esophagus to Cutaneous with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic
0D128J6	Bypass Middle Esophagus to Stomach with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic
0D128J9	Bypass Middle Esophagus to Duodenum with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic
0D128JA	Bypass Middle Esophagus to Jejunum with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic

ICD-10 Procedure Code	Code Description
0D128JB	Bypass Middle Esophagus to Ileum with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic
0D128K4	Bypass Middle Esophagus to Cutaneous with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D128K6	Bypass Middle Esophagus to Stomach with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D128K9	Bypass Middle Esophagus to Duodenum with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D128KA	Bypass Middle Esophagus to Jejunum with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D128KB	Bypass Middle Esophagus to Ileum with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D128Z4	Bypass Middle Esophagus to Cutaneous, Via Natural or Artificial Opening Endoscopic
0D128Z6	Bypass Middle Esophagus to Stomach, Via Natural or Artificial Opening Endoscopic
0D128Z9	Bypass Middle Esophagus to Duodenum, Via Natural or Artificial Opening Endoscopic
0D128ZA	Bypass Middle Esophagus to Jejunum, Via Natural or Artificial Opening Endoscopic
0D128ZB	Bypass Middle Esophagus to Ileum, Via Natural or Artificial Opening Endoscopic
0D13074	Bypass Lower Esophagus to Cutaneous with Autologous Tissue Substitute, Open Approach
0D13076	Bypass Lower Esophagus to Stomach with Autologous Tissue Substitute, Open Approach
0D13079	Bypass Lower Esophagus to Duodenum with Autologous Tissue Substitute, Open Approach
0D1307A	Bypass Lower Esophagus to Jejunum with Autologous Tissue Substitute, Open Approach
0D1307B	Bypass Lower Esophagus to Ileum with Autologous Tissue Substitute, Open Approach
0D130J4	Bypass Lower Esophagus to Cutaneous with Synthetic Substitute, Open Approach
0D130J6	Bypass Lower Esophagus to Stomach with Synthetic Substitute, Open Approach
0D130J9	Bypass Lower Esophagus to Duodenum with Synthetic Substitute, Open Approach
0D130JA	Bypass Lower Esophagus to Jejunum with Synthetic Substitute, Open Approach
0D130JB	Bypass Lower Esophagus to Ileum with Synthetic Substitute, Open Approach
0D130K4	Bypass Lower Esophagus to Cutaneous with Nonautologous Tissue Substitute, Open Approach
0D130K6	Bypass Lower Esophagus to Stomach with Nonautologous Tissue Substitute, Open Approach
0D130K9	Bypass Lower Esophagus to Duodenum with Nonautologous Tissue Substitute, Open Approach
0D130KA	Bypass Lower Esophagus to Jejunum with Nonautologous Tissue Substitute, Open Approach
0D130KB	Bypass Lower Esophagus to Ileum with Nonautologous Tissue Substitute, Open Approach
0D130Z4	Bypass Lower Esophagus to Cutaneous, Open Approach
0D130Z6	Bypass Lower Esophagus to Stomach, Open Approach
0D130Z9	Bypass Lower Esophagus to Duodenum, Open Approach
0D130ZA	Bypass Lower Esophagus to Jejunum, Open Approach
0D130ZB	Bypass Lower Esophagus to Ileum, Open Approach

ICD-10 Procedure Code	Code Description
0D133J4	Bypass Lower Esophagus to Cutaneous with Synthetic Substitute, Percutaneous Approach
0D13474	Bypass Lower Esophagus to Cutaneous with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0D13476	Bypass Lower Esophagus to Stomach with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0D13479	Bypass Lower Esophagus to Duodenum with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0D1347A	Bypass Lower Esophagus to Jejunum with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0D1347B	Bypass Lower Esophagus to Ileum with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0D134J4	Bypass Lower Esophagus to Cutaneous with Synthetic Substitute, Percutaneous Endoscopic Approach
0D134J6	Bypass Lower Esophagus to Stomach with Synthetic Substitute, Percutaneous Endoscopic Approach
0D134J9	Bypass Lower Esophagus to Duodenum with Synthetic Substitute, Percutaneous Endoscopic Approach
0D134JA	Bypass Lower Esophagus to Jejunum with Synthetic Substitute, Percutaneous Endoscopic Approach
0D134JB	Bypass Lower Esophagus to Ileum with Synthetic Substitute, Percutaneous Endoscopic Approach
0D134K4	Bypass Lower Esophagus to Cutaneous with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0D134K6	Bypass Lower Esophagus to Stomach with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0D134K9	Bypass Lower Esophagus to Duodenum with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0D134KA	Bypass Lower Esophagus to Jejunum with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0D134KB	Bypass Lower Esophagus to Ileum with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0D134Z4	Bypass Lower Esophagus to Cutaneous, Percutaneous Endoscopic Approach
0D134Z6	Bypass Lower Esophagus to Stomach, Percutaneous Endoscopic Approach
0D134Z9	Bypass Lower Esophagus to Duodenum, Percutaneous Endoscopic Approach
0D134ZA	Bypass Lower Esophagus to Jejunum, Percutaneous Endoscopic Approach
0D134ZB	Bypass Lower Esophagus to Ileum, Percutaneous Endoscopic Approach
0D13874	Bypass Lower Esophagus to Cutaneous with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D13876	Bypass Lower Esophagus to Stomach with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D13879	Bypass Lower Esophagus to Duodenum with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D1387A	Bypass Lower Esophagus to Jejunum with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D1387B	Bypass Lower Esophagus to Ileum with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D138J4	Bypass Lower Esophagus to Cutaneous with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic
0D138J6	Bypass Lower Esophagus to Stomach with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic

ICD-10 Procedure Code	Code Description
0D138J9	Bypass Lower Esophagus to Duodenum with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic
0D138JA	Bypass Lower Esophagus to Jejunum with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic
0D138JB	Bypass Lower Esophagus to Ileum with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic
0D138K4	Bypass Lower Esophagus to Cutaneous with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D138K6	Bypass Lower Esophagus to Stomach with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D138K9	Bypass Lower Esophagus to Duodenum with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D138KA	Bypass Lower Esophagus to Jejunum with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D138KB	Bypass Lower Esophagus to Ileum with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D138Z4	Bypass Lower Esophagus to Cutaneous, Via Natural or Artificial Opening Endoscopic
0D138Z6	Bypass Lower Esophagus to Stomach, Via Natural or Artificial Opening Endoscopic
0D138Z9	Bypass Lower Esophagus to Duodenum, Via Natural or Artificial Opening Endoscopic
0D138ZA	Bypass Lower Esophagus to Jejunum, Via Natural or Artificial Opening Endoscopic
0D138ZB	Bypass Lower Esophagus to Ileum, Via Natural or Artificial Opening Endoscopic
0D15074	Bypass Esophagus to Cutaneous with Autologous Tissue Substitute, Open Approach
0D15076	Bypass Esophagus to Stomach with Autologous Tissue Substitute, Open Approach
0D15079	Bypass Esophagus to Duodenum with Autologous Tissue Substitute, Open Approach
0D1507A	Bypass Esophagus to Jejunum with Autologous Tissue Substitute, Open Approach
0D1507B	Bypass Esophagus to Ileum with Autologous Tissue Substitute, Open Approach
0D150J4	Bypass Esophagus to Cutaneous with Synthetic Substitute, Open Approach
0D150J6	Bypass Esophagus to Stomach with Synthetic Substitute, Open Approach
0D150J9	Bypass Esophagus to Duodenum with Synthetic Substitute, Open Approach
0D150JA	Bypass Esophagus to Jejunum with Synthetic Substitute, Open Approach
0D150JB	Bypass Esophagus to Ileum with Synthetic Substitute, Open Approach
0D150K4	Bypass Esophagus to Cutaneous with Nonautologous Tissue Substitute, Open Approach
0D150K6	Bypass Esophagus to Stomach with Nonautologous Tissue Substitute, Open Approach
0D150K9	Bypass Esophagus to Duodenum with Nonautologous Tissue Substitute, Open Approach
0D150KA	Bypass Esophagus to Jejunum with Nonautologous Tissue Substitute, Open Approach
0D150KB	Bypass Esophagus to Ileum with Nonautologous Tissue Substitute, Open Approach
0D150Z4	Bypass Esophagus to Cutaneous, Open Approach
0D150Z6	Bypass Esophagus to Stomach, Open Approach
0D150Z9	Bypass Esophagus to Duodenum, Open Approach

ICD-10 Procedure Code	Code Description
0D150ZA	Bypass Esophagus to Jejunum, Open Approach
0D150ZB	Bypass Esophagus to Ileum, Open Approach
0D153J4	Bypass Esophagus to Cutaneous with Synthetic Substitute, Percutaneous Approach
0D15474	Bypass Esophagus to Cutaneous with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0D15476	Bypass Esophagus to Stomach with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0D15479	Bypass Esophagus to Duodenum with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0D1547A	Bypass Esophagus to Jejunum with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0D1547B	Bypass Esophagus to Ileum with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0D154J4	Bypass Esophagus to Cutaneous with Synthetic Substitute, Percutaneous Endoscopic Approach
0D154J6	Bypass Esophagus to Stomach with Synthetic Substitute, Percutaneous Endoscopic Approach
0D154J9	Bypass Esophagus to Duodenum with Synthetic Substitute, Percutaneous Endoscopic Approach
0D154JA	Bypass Esophagus to Jejunum with Synthetic Substitute, Percutaneous Endoscopic Approach
0D154JB	Bypass Esophagus to Ileum with Synthetic Substitute, Percutaneous Endoscopic Approach
0D154K4	Bypass Esophagus to Cutaneous with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0D154K6	Bypass Esophagus to Stomach with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0D154K9	Bypass Esophagus to Duodenum with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0D154KA	Bypass Esophagus to Jejunum with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0D154KB	Bypass Esophagus to Ileum with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0D154Z4	Bypass Esophagus to Cutaneous, Percutaneous Endoscopic Approach
0D154Z6	Bypass Esophagus to Stomach, Percutaneous Endoscopic Approach
0D154Z9	Bypass Esophagus to Duodenum, Percutaneous Endoscopic Approach
0D154ZA	Bypass Esophagus to Jejunum, Percutaneous Endoscopic Approach
0D154ZB	Bypass Esophagus to Ileum, Percutaneous Endoscopic Approach
0D15874	Bypass Esophagus to Cutaneous with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D15876	Bypass Esophagus to Stomach with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D15879	Bypass Esophagus to Duodenum with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D1587A	Bypass Esophagus to Jejunum with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D1587B	Bypass Esophagus to Ileum with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D158J4	Bypass Esophagus to Cutaneous with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic

ICD-10 Procedure Code	Code Description
0D158J6	Bypass Esophagus to Stomach with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic
0D158J9	Bypass Esophagus to Duodenum with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic
0D158JA	Bypass Esophagus to Jejunum with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic
0D158JB	Bypass Esophagus to Ileum with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic
0D158K4	Bypass Esophagus to Cutaneous with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D158K6	Bypass Esophagus to Stomach with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D158K9	Bypass Esophagus to Duodenum with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D158KA	Bypass Esophagus to Jejunum with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D158KB	Bypass Esophagus to Ileum with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D158Z4	Bypass Esophagus to Cutaneous, Via Natural or Artificial Opening Endoscopic
0D158Z6	Bypass Esophagus to Stomach, Via Natural or Artificial Opening Endoscopic
0D158Z9	Bypass Esophagus to Duodenum, Via Natural or Artificial Opening Endoscopic
0D158ZA	Bypass Esophagus to Jejunum, Via Natural or Artificial Opening Endoscopic
0D158ZB	Bypass Esophagus to Ileum, Via Natural or Artificial Opening Endoscopic
0DB10ZZ	Excision of Upper Esophagus, Open Approach
0DB13ZZ	Excision of Upper Esophagus, Percutaneous Approach
0DB14ZZ	Excision of Upper Esophagus, Percutaneous Endoscopic Approach
0DB17ZZ	Excision of Upper Esophagus, Via Natural or Artificial Opening
0DB18ZZ	Excision of Upper Esophagus, Via Natural or Artificial Opening Endoscopic
0DB20ZZ	Excision of Middle Esophagus, Open Approach
0DB23ZZ	Excision of Middle Esophagus, Percutaneous Approach
0DB24ZZ	Excision of Middle Esophagus, Percutaneous Endoscopic Approach
0DB27ZZ	Excision of Middle Esophagus, Via Natural or Artificial Opening
0DB28ZZ	Excision of Middle Esophagus, Via Natural or Artificial Opening Endoscopic
0DB30ZZ	Excision of Lower Esophagus, Open Approach
0DB33ZZ	Excision of Lower Esophagus, Percutaneous Approach
0DB34ZZ	Excision of Lower Esophagus, Percutaneous Endoscopic Approach
0DB37ZZ	Excision of Lower Esophagus, Via Natural or Artificial Opening
0DB38ZZ	Excision of Lower Esophagus, Via Natural or Artificial Opening Endoscopic
0DB50ZZ	Excision of Esophagus, Open Approach
0DB53ZZ	Excision of Esophagus, Percutaneous Approach
0DB54ZZ	Excision of Esophagus, Percutaneous Endoscopic Approach
0DB57ZZ	Excision of Esophagus, Via Natural or Artificial Opening
0DB58ZZ	Excision of Esophagus, Via Natural or Artificial Opening Endoscopic
0DT10ZZ	Resection of Upper Esophagus, Open Approach
0DT14ZZ	Resection of Upper Esophagus, Percutaneous Endoscopic Approach

ICD-10 Procedure Code	Code Description
0DT17ZZ	Resection of Upper Esophagus, Via Natural or Artificial Opening
0DT18ZZ	Resection of Upper Esophagus, Via Natural or Artificial Opening Endoscopic
0DT20ZZ	Resection of Middle Esophagus, Open Approach
0DT24ZZ	Resection of Middle Esophagus, Percutaneous Endoscopic Approach
0DT27ZZ	Resection of Middle Esophagus, Via Natural or Artificial Opening
0DT28ZZ	Resection of Middle Esophagus, Via Natural or Artificial Opening Endoscopic
0DT30ZZ	Resection of Lower Esophagus, Open Approach
0DT34ZZ	Resection of Lower Esophagus, Percutaneous Endoscopic Approach
0DT37ZZ	Resection of Lower Esophagus, Via Natural or Artificial Opening
0DT38ZZ	Resection of Lower Esophagus, Via Natural or Artificial Opening Endoscopic
0DT44ZZ	Resection of Esophagogastric Junction, Percutaneous Endoscopic Approach
0DT50ZZ	Resection of Esophagus, Open Approach
0DT54ZZ	Resection of Esophagus, Percutaneous Endoscopic Approach
0DT57ZZ	Resection of Esophagus, Via Natural or Artificial Opening
0DT58ZZ	Resection of Esophagus, Via Natural or Artificial Opening Endoscopic
0DT60ZZ	Resection of Stomach, Open Approach
0DT64ZZ	Resection of Stomach, Percutaneous Endoscopic Approach
0DT67ZZ	Resection of Stomach, Via Natural or Artificial Opening
0DT68ZZ	Resection of Stomach, Via Natural or Artificial Opening Endoscopic
0DX60Z5	Transfer Stomach to Esophagus, Open Approach
0DX64Z5	Transfer Stomach to Esophagus, Percutaneous Endoscopic Approach
0DX80Z5	Transfer Small Intestine to Esophagus, Open Approach
0DX84Z5	Transfer Small Intestine to Esophagus, Percutaneous Endoscopic Approach
0DXE0Z5	Transfer Large Intestine to Esophagus, Open Approach
0DXE4Z5	Transfer Large Intestine to Esophagus, Percutaneous End

ICD-10 Malignant Tumor and Carcinoma in Situ Diagnosis Codes

ICD-10 Diagnosis Code	Code Description
C15.3	Malignant neoplasm of upper third of esophagus
C15.4	Malignant neoplasm of middle third of esophagus
C15.5	Malignant neoplasm of lower third of esophagus
C15.8	Malignant neoplasm of overlapping sites of esophagus
C15.9	Malignant neoplasm of esophagus, unspecified
C16.0	Malignancy of the cardio-esophageal junction
D00.1	Carcinoma in situ of esophagus

Pancreatic Resection for Cancer Measure Specifications

For pancreatic resection for cancer, there are two sets of ICD-10 codes for counting patient discharges. The first set of codes is to identify patients who have had the procedure. The second set of codes is to identify patients with a specific diagnosis.

Count the number of patients, ages 18 years and older, discharged with the following ICD-10 codes in any procedure field AND any of the following ICD-10 codes in any diagnosis field.

ICD-10 Pancreatic Resection for Cancer Procedure Codes

ICD-10 Procedure Code	Code Description
0DB90ZZ	Excision of Duodenum, Open Approach
0DB93ZZ	Excision of Duodenum, Percutaneous Approach
0DB94ZZ	Excision of Duodenum, Percutaneous Endoscopic Approach
0DB97ZZ	Excision of Duodenum, Via Natural or Artificial Opening
0DB98ZZ	Excision of Duodenum, Via Natural or Artificial Opening Endoscopic
0DT90ZZ	Resection of Duodenum, Open Approach
0DT94ZZ	Resection of Duodenum, Percutaneous Endoscopic Approach
0DT97ZZ	Resection of Duodenum, Via Natural or Artificial Opening
0DT98ZZ	Resection of Duodenum, Via Natural or Artificial Opening Endoscopic
0FBG0ZZ	Excision of Pancreas, Open Approach
0FBG3ZZ	Excision of Pancreas, Percutaneous Approach
0FBG4ZZ	Excision of Pancreas, Percutaneous Endoscopic Approach
0FBG8ZZ	Excision of Pancreas, Via Natural or Artificial Opening Endoscopic
0FTG0ZZ	Resection of Pancreas, Open Approach
0FTG4ZZ	Resection of Pancreas, Percutaneous Endoscopic Approach

ICD-10 Malignant Tumor Diagnosis Codes

ICD-10 Diagnosis Code	Code Description
C7A.1	Malignant poorly differentiated neuroendocrine tumors
C7A.8	Other malignant neuroendocrine tumors
C17.0	Malignant neoplasm of duodenum
C24.0	Malignant neoplasm of extrahepatic bile duct
C24.1	Malignant neoplasm of ampulla of Vater
C24.8	Malignant neoplasm of overlapping sites of biliary tract
C24.9	Malignant neoplasm of biliary tract, unspecified
C25.0	Malignant neoplasm of head of pancreas
C25.1	Malignant neoplasm of body of pancreas
C25.2	Malignant neoplasm of tail of pancreas
C25.3	Malignant neoplasm of pancreatic duct
C25.4	Malignant neoplasm of endocrine pancreas
C25.7	Malignant neoplasm of other parts of pancreas
C25.8	Malignant neoplasm of overlapping sites of pancreas
C25.9	Malignant neoplasm of pancreas, unspecified

Rectal Cancer Surgery Measure Specifications

For rectal cancer surgery, there are two sets of ICD-10 codes for counting patient discharges. The first set of codes is to identify patients who have had the procedure. The second set of codes is to identify patients with a specific diagnosis.

Count the number of patients, ages 18 years and older, discharged with the following ICD-10 codes in any procedure field AND any of the following ICD-10 codes in any diagnosis field.

ICD-10 Rectal Cancer Surgery Procedure Codes

ICD-10 Procedure Code	Code Description
0DBP0ZZ	Excision of Rectum, Open Approach
0DBP3ZZ	Excision of Rectum, Percutaneous Approach
0DBP4ZZ	Excision of Rectum, Percutaneous Endoscopic Approach
0DBP7ZZ	Excision of Rectum, Via Natural or Artificial Opening
0DBP8ZZ	Excision of rectum, via natural or artificial opening endoscopic
0DTP0ZZ	Resection of Rectum, Open Approach
0DTP4ZZ	Resection of Rectum, Percutaneous Endoscopic Approach
0DTP7ZZ	Resection of Rectum, Via Natural or Artificial Opening
0DTP8ZZ	Resection of Rectum, Via Natural or Artificial Opening Endoscopic

ICD-10 Malignant Tumor and Carcinoma in Situ Diagnosis Codes

ICD-10 Diagnosis Code	Code Description
C19	Malignant neoplasm of rectosigmoid junction
C20	Malignant neoplasm of rectum
C21.0	Malignant neoplasm of anus, unspecified
C21.1	Malignant neoplasm of anal canal
C21.2	Malignant neoplasm of cloacogenic zone
C21.8	Malignant neoplasm of overlapping sites of rectum, anus and anal canal
C78.5	Secondary malignant neoplasm of large intestine and rectum
D01.1	Carcinoma in situ of rectosigmoid junction
D01.2	Carcinoma in situ of rectum
D01.3	Carcinoma in situ of anus and anal canal

Bariatric Surgery for Weight Loss Measure Specifications

For bariatric surgery for weight loss, there are three sets of codes. One set of ICD-10 codes for counting inpatient discharges and one set of CPT codes for counting outpatient discharges. The first two sets of codes are to identify patients who have had the procedure. The third set of codes (ICD-10 diagnosis codes) is to identify patients with a specific diagnosis.

To determine the number of patients, ages 18 years and older, discharged for this procedure, hospitals have two options:

1. Count the number of patients, ages 18 years and older, discharged with the following ICD-10 codes or the CPT Codes in any procedure field AND any of the following ICD-10 codes in the **primary** diagnosis field. This method does not require chart review.
2. Count the number of patients, ages 18 years and older, discharged with the following ICD-10 codes or the CPT Codes in any procedure field AND any of the following ICD-10 codes in any diagnosis field. In addition, the procedure must have been done **explicitly for weight loss purposes** (i.e., presence of one of the diagnosis codes is necessary, but not sufficient for inclusion). This method requires chart review to ensure the procedure was performed explicitly for weight loss purposes.

ICD-10 Bariatric Surgery Procedure Codes

ICD-10 Procedure Code	Code Description
0D16079	Bypass Stomach to Duodenum with Autologous Tissue Substitute, Open Approach
0D1607A	Bypass Stomach to Jejunum with Autologous Tissue Substitute, Open Approach
0D1607B	Bypass Stomach to Ileum with Autologous Tissue Substitute, Open Approach
0D160J9	Bypass Stomach to Duodenum with Synthetic Substitute, Open Approach
0D160JA	Bypass Stomach to Jejunum with Synthetic Substitute, Open Approach
0D160JB	Bypass Stomach to Ileum with Synthetic Substitute, Open Approach
0D160K9	Bypass Stomach to Duodenum with Nonautologous Tissue Substitute, Open Approach
0D160KA	Bypass Stomach to Jejunum with Nonautologous Tissue Substitute, Open Approach
0D160KB	Bypass Stomach to Ileum with Nonautologous Tissue Substitute, Open Approach
0D160Z9	Bypass Stomach to Duodenum, Open Approach
0D160ZA	Bypass Stomach to Jejunum, Open Approach
0D160ZB	Bypass Stomach to Ileum, Open Approach
0D16479	Bypass Stomach to Duodenum with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0D1647A	Bypass Stomach to Jejunum with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0D1647B	Bypass Stomach to Ileum with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0D164J9	Bypass Stomach to Duodenum with Synthetic Substitute, Percutaneous Endoscopic Approach
0D164JA	Bypass Stomach to Jejunum with Synthetic Substitute, Percutaneous Endoscopic Approach
0D164JB	Bypass Stomach to Ileum with Synthetic Substitute, Percutaneous Endoscopic Approach
0D164K9	Bypass Stomach to Duodenum with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0D164KA	Bypass Stomach to Jejunum with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach

0D164KB	Bypass Stomach to Ileum with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
0D164Z9	Bypass Stomach to Duodenum, Percutaneous Endoscopic Approach
0D164ZA	Bypass Stomach to Jejunum, Percutaneous Endoscopic Approach
0D164ZB	Bypass Stomach to Ileum, Percutaneous Endoscopic Approach
0D16879	Bypass Stomach to Duodenum with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D1687A	Bypass Stomach to Jejunum with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D1687B	Bypass Stomach to Ileum with Autologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D168J9	Bypass Stomach to Duodenum with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic
0D168JA	Bypass Stomach to Jejunum with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic
0D168JB	Bypass Stomach to Ileum with Synthetic Substitute, Via Natural or Artificial Opening Endoscopic
0D168K9	Bypass Stomach to Duodenum with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D168KA	Bypass Stomach to Jejunum with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D168KB	Bypass Stomach to Ileum with Nonautologous Tissue Substitute, Via Natural or Artificial Opening Endoscopic
0D168Z9	Bypass Stomach to Duodenum, Via Natural or Artificial Opening Endoscopic
0D168ZA	Bypass Stomach to Jejunum, Via Natural or Artificial Opening Endoscopic
0D168ZB	Bypass Stomach to Ileum, Via Natural or Artificial Opening Endoscopic
0DB60Z3	Excision of Stomach, Open Approach, Vertical
0DB60ZZ	Excision of Stomach, Open Approach
0DB63Z3	Excision of Stomach, Percutaneous Approach, Vertical
0DB63ZZ	Excision of Stomach, Percutaneous Approach
0DB64Z3	Excision of Stomach, Percutaneous Endoscopic Approach, Vertical
0DB64ZZ	Excision of Stomach, Percutaneous Endoscopic Approach

ICD-10 Morbid Obesity Diagnosis Codes

ICD-10 Diagnosis Code	Code Description
E66.01	Morbid (severe) obesity due to excess calories
E66.09	Other obesity due to excess calories
E66.1	Drug induced obesity
E66.2	Morbid (severe) obesity with alveolar hypoventilation
E66.3	Overweight
E66.8	Other obesity
E66.811	Obesity, class 1
E66.812	Obesity, class 2
E66.813	Obesity, class 3
E66.89	Other obesity not elsewhere classified
E66.9	Obesity, unspecified

ICD-10 Diagnosis Code	Code Description
Z68.35	Body mass index (BMI) 35.0-35.9, adult
Z68.36	Body mass index (BMI) 36.0-36.9, adult
Z68.37	Body mass index (BMI) 37.0-37.9, adult
Z68.38	Body mass index (BMI) 38.0-38.9, adult
Z68.39	Body mass index (BMI) 39.0-39.9, adult
Z68.41	Body mass index (BMI) 40.0-44.9, adult
Z68.42	Body mass index (BMI) 45.0-49.9, adult
Z68.43	Body mass index (BMI) 50.0-59.9, adult
Z68.44	Body mass index (BMI) 60.0-69.9, adult
Z68.45	Body mass index (BMI) 70 or greater, adult

CPT Bariatric Surgery for Weight Loss Procedure Codes

Leapfrog has provided a set of CPT codes for counting **patients** discharged from your hospital who have undergone the procedure during the reporting period on an outpatient basis.

CPT Codes are provided in downloadable Excel files on the Survey Dashboard. To access the files, click the CPT Code Workbook button next to Section 9. You will be required to complete the American Medical Association's Terms of Use before downloading the Excel file and using the individual CPT codes to query your EHR or billing system. You are only required to complete the Terms of Use once per Survey Cycle (April 1 – November 30).

The CPT Code Workbooks (Excel files) are labeled for Section 3A: Total Hip Replacement, Total Knee Replacement, and Bariatric Surgery for Weight Loss and Section 9C: Volume of Procedures. Please note, if you are part of a hospital system, each hospital will need to complete the Terms of Use. This is a requirement of the American Medical Association.

Using the CPT codes found for Bariatric Surgery for Weight Loss in the "Instructions" sheet, count the total number of adult (18 years of age or older) patients discharged for the procedures with the CPT codes listed AND any of the above ICD-10 diagnosis codes in the **primary** diagnosis field. The CPT codes can be in any procedure field.

Total Knee Replacement Measure Specifications

For total knee replacement, there are two sets of codes. One set of ICD-10 codes for counting inpatient discharges and one CPT code for counting outpatient discharges. The two sets of codes are to identify patients who have had the procedure.

To determine the number of patients, ages 18 years and older, discharged for this procedure, hospitals have two options:

- Count the number of patients, ages 18 years and older, discharged with any of the following ICD-10 codes in the **primary** procedure field or the CPT Code in any procedure field. This method does not require chart review. Hospitals should report on total knee replacement procedures performed in the outpatient locations included in Section 9: Outpatient Procedures.
- Count the number of patients, ages 18 years and older, discharged with any of the following ICD-10 codes or CPT Code in any procedure field. **For inpatient cases using ICD-10 codes, exclude any patients where the procedure was done as a revision** (i.e., the presence of one of the procedure codes is necessary, but not sufficient for inclusion). This method requires chart review of inpatient cases to ensure that revisions are not included. Chart review is not required for outpatient cases using the specified CPT Code. Hospitals should report on total knee replacement procedures performed in the outpatient locations included in Section 9: Outpatient Procedures.

ICD-10 Total Knee Replacement Procedure Codes

ICD10 Procedure Code	Code Description
0SRC0J9	Replacement of Right Knee Joint with Synthetic Substitute, Cemented, Open Approach
0SRC0JA	Replacement of Right Knee Joint with Synthetic Substitute, Uncemented, Open Approach
0SRC0JZ	Replacement of Right Knee Joint with Synthetic Substitute, Open Approach
0SRD0J9	Replacement of Left Knee Joint with Synthetic Substitute, Cemented, Open Approach
0SRD0JA	Replacement of Left Knee Joint with Synthetic Substitute, Uncemented, Open Approach
0SRD0JZ	Replacement of Left Knee Joint with Synthetic Substitute, Open Approach
0SRC069	Replacement of Right Knee Joint with Oxidized Zirconium on Polyethylene Synthetic Substitute, Cemented, Open Approach
0SRC06A	Replacement of Right Knee Joint with Oxidized Zirconium on Polyethylene Synthetic Substitute, Uncemented, Open Approach
0SRC06Z	Replacement of Right Knee Joint with Oxidized Zirconium on Polyethylene Synthetic Substitute, Open Approach
0SRD069	Replacement of Left Knee Joint with Oxidized Zirconium on Polyethylene Synthetic Substitute, Cemented, Open Approach
0SRD06A	Replacement of Left Knee Joint with Oxidized Zirconium on Polyethylene Synthetic Substitute, Uncemented, Open Approach
0SRD06Z	Replacement of Left Knee Joint with Oxidized Zirconium on Polyethylene Synthetic Substitute, Open Approach

CPT Total Knee Replacement Procedure Code

Leapfrog has provided a CPT code for counting **patients** discharged from your hospital who have undergone the procedure during the reporting period on an outpatient basis.

CPT Codes are provided in downloadable Excel files on the Survey Dashboard. To access the files, click the CPT Code Workbook button next to Section 9. You will be required to complete the American Medical Association's Terms of Use before downloading the Excel file and using the individual CPT codes to query your EHR or billing system. You are only required to complete the Terms of Use once per Survey Cycle (April 1 – November 30).

The CPT Code Workbooks (Excel files) are labeled for Section 3A: Total Hip Replacement, Total Knee Replacement, and Bariatric Surgery for Weight Loss and Section 9C: Volume of Procedures. Please note, if you are part of a hospital system, each hospital will need to complete the Terms of Use. This is a requirement of the American Medical Association.

Using the CPT code found for Total Knee Replacement in the "Instructions" sheet, count the total number of adult (18 years of age or older) patients discharged for the procedure with the CPT code listed. The CPT code can be in any procedure field.

Total Hip Replacement Measure Specifications

For total hip replacement, there are two sets of codes. One set of ICD-10 codes for counting inpatient discharges and one CPT code for counting outpatient discharges. The two sets of codes are to identify patients who have had the procedure.

To determine the number of patients, ages 18 years and older, discharged for this procedure, hospitals have two options:

- Count the number of patients, ages 18 years and older, discharged with any of the following ICD-10 codes in the **primary** procedure field or the CPT code in any procedure field. This method does not require chart review. Hospitals should report on total hip replacement procedures performed in the outpatient locations included in Section 9: Outpatient Procedures.
- Count the number of patients, ages 18 years and older, discharged with any of the following ICD-10 codes or the CPT code in any procedure field. **For inpatient cases using ICD-10 codes, exclude any patients where the procedure was done as a revision** (i.e., the presence of one of the procedure codes is necessary, but not sufficient for inclusion). This method requires chart review of inpatient cases to ensure that revisions are not included. Chart review is not required for outpatient cases using the specified CPT Code. Hospitals should report on total hip replacement procedures performed in the outpatient locations included in Section 9: Outpatient Procedures.

ICD-10 Total Hip Replacement Procedure Codes

ICD10 Procedure Code	Code Description
0SR9019	Replacement of Right Hip Joint with Metal Synthetic Substitute, Cemented, Open Approach
0SR901A	Replacement of Right Hip Joint with Metal Synthetic Substitute, Uncemented, Open Approach
0SR901Z	Replacement of Right Hip Joint with Metal Synthetic Substitute, Open Approach
0SR9029	Replacement of Right Hip Joint with Metal on Polyethylene Synthetic Substitute, Cemented, Open Approach
0SR902A	Replacement of Right Hip Joint with Metal on Polyethylene Synthetic Substitute, Uncemented, Open Approach
0SR902Z	Replacement of Right Hip Joint with Metal on Polyethylene Synthetic Substitute, Open Approach
0SR9039	Replacement of Right Hip Joint with Ceramic Synthetic Substitute, Cemented, Open Approach
0SR903A	Replacement of Right Hip Joint with Ceramic Synthetic Substitute, Uncemented, Open Approach
0SR903Z	Replacement of Right Hip Joint with Ceramic Synthetic Substitute, Open Approach
0SR9049	Replacement of Right Hip Joint with Ceramic on Polyethylene Synthetic Substitute, Cemented, Open Approach
0SR904A	Replacement of Right Hip Joint with Ceramic on Polyethylene Synthetic Substitute, Uncemented, Open Approach
0SR904Z	Replacement of Right Hip Joint with Ceramic on Polyethylene Synthetic Substitute, Open Approach
0SR90J9	Replacement of Right Hip Joint with Synthetic Substitute, Cemented, Open Approach
0SR90JA	Replacement of Right Hip Joint with Synthetic Substitute, Uncemented, Open Approach
0SR90JZ	Replacement of Right Hip Joint with Synthetic Substitute, Open Approach
0SRA009	Replacement of Right Hip Joint, Acetabular Surface with Polyethylene Synthetic Substitute, Cemented, Open Approach
0SRA00A	Replacement of Right Hip Joint, Acetabular Surface with Polyethylene Synthetic Substitute, Uncemented, Open Approach

0SRA00Z	Replacement of Right Hip Joint, Acetabular Surface with Polyethylene Synthetic Substitute, Open Approach
0SRA019	Replacement of Right Hip Joint, Acetabular Surface with Metal Synthetic Substitute, Cemented, Open Approach
0SRA01A	Replacement of Right Hip Joint, Acetabular Surface with Metal Synthetic Substitute, Uncemented, Open Approach
0SRA01Z	Replacement of Right Hip Joint, Acetabular Surface with Metal Synthetic Substitute, Open Approach
0SRA039	Replacement of Right Hip Joint, Acetabular Surface with Ceramic Synthetic Substitute, Cemented, Open Approach
0SRA03A	Replacement of Right Hip Joint, Acetabular Surface with Ceramic Synthetic Substitute, Uncemented, Open Approach
0SRA03Z	Replacement of Right Hip Joint, Acetabular Surface with Ceramic Synthetic Substitute, Open Approach
0SRA0J9	Replacement of Right Hip Joint, Acetabular Surface with Synthetic Substitute, Cemented, Open Approach
0SRA0JA	Replacement of Right Hip Joint, Acetabular Surface with Synthetic Substitute, Uncemented, Open Approach
0SRA0JZ	Replacement of Right Hip Joint, Acetabular Surface with Synthetic Substitute, Open Approach
0SRB019	Replacement of Left Hip Joint with Metal Synthetic Substitute, Cemented, Open Approach
0SRB01A	Replacement of Left Hip Joint with Metal Synthetic Substitute, Uncemented, Open Approach
0SRB01Z	Replacement of Left Hip Joint with Metal Synthetic Substitute, Open Approach
0SRB029	Replacement of Left Hip Joint with Metal on Polyethylene Synthetic Substitute, Cemented, Open Approach
0SRB02A	Replacement of Left Hip Joint with Metal on Polyethylene Synthetic Substitute, Uncemented, Open Approach
0SRB02Z	Replacement of Left Hip Joint with Metal on Polyethylene Synthetic Substitute, Open Approach
0SRB039	Replacement of Left Hip Joint with Ceramic Synthetic Substitute, Cemented, Open Approach
0SRB03A	Replacement of Left Hip Joint with Ceramic Synthetic Substitute, Uncemented, Open Approach
0SRB03Z	Replacement of Left Hip Joint with Ceramic Synthetic Substitute, Open Approach
0SRB049	Replacement of Left Hip Joint with Ceramic on Polyethylene Synthetic Substitute, Cemented, Open Approach
0SRB04A	Replacement of Left Hip Joint with Ceramic on Polyethylene Synthetic Substitute, Uncemented, Open Approach
0SRB04Z	Replacement of Left Hip Joint with Ceramic on Polyethylene Synthetic Substitute, Open Approach
0SRB0J9	Replacement of Left Hip Joint with Synthetic Substitute, Cemented, Open Approach
0SRB0JA	Replacement of Left Hip Joint with Synthetic Substitute, Uncemented, Open Approach
0SRB0JZ	Replacement of Left Hip Joint with Synthetic Substitute, Open Approach
0SRE009	Replacement of Left Hip Joint, Acetabular Surface with Polyethylene Synthetic Substitute, Cemented, Open Approach
0SRE00A	Replacement of Left Hip Joint, Acetabular Surface with Polyethylene Synthetic Substitute, Uncemented, Open Approach
0SRE00Z	Replacement of Left Hip Joint, Acetabular Surface with Polyethylene Synthetic Substitute, Open Approach
0SRE019	Replacement of Left Hip Joint, Acetabular Surface with Metal Synthetic Substitute, Cemented, Open Approach

0SRE01A	Replacement of Left Hip Joint, Acetabular Surface with Metal Synthetic Substitute, Uncemented, Open Approach
0SRE01Z	Replacement of Left Hip Joint, Acetabular Surface with Metal Synthetic Substitute, Open Approach
0SRE039	Replacement of Left Hip Joint, Acetabular Surface with Ceramic Synthetic Substitute, Cemented, Open Approach
0SRE03A	Replacement of Left Hip Joint, Acetabular Surface with Ceramic Synthetic Substitute, Uncemented, Open Approach
0SRE03Z	Replacement of Left Hip Joint, Acetabular Surface with Ceramic Synthetic Substitute, Open Approach
0SRE0J9	Replacement of Left Hip Joint, Acetabular Surface with Synthetic Substitute, Cemented, Open Approach
0SRE0JA	Replacement of Left Hip Joint, Acetabular Surface with Synthetic Substitute, Uncemented, Open Approach
0SRE0JZ	Replacement of Left Hip Joint, Acetabular Surface with Synthetic Substitute, Open Approach
0SR9069	Replacement of Right Hip Joint with Oxidized Zirconium on Polyethylene Synthetic Substitute, Cemented, Open Approach
0SR906A	Replacement of Right Hip Joint with Oxidized Zirconium on Polyethylene Synthetic Substitute, Uncemented, Open Approach
0SR906Z	Replacement of Right Hip Joint with Oxidized Zirconium on Polyethylene Synthetic Substitute, Open Approach
0SRB069	Replacement of Left Hip Joint with Oxidized Zirconium on Polyethylene Synthetic Substitute, Cemented, Open Approach
0SRB06A	Replacement of Left Hip Joint with Oxidized Zirconium on Polyethylene Synthetic Substitute, Uncemented, Open Approach
0SRB06Z	Replacement of Left Hip Joint with Oxidized Zirconium on Polyethylene Synthetic Substitute, Open Approach

CPT Total Hip Replacement Procedure Code

Leapfrog has provided a CPT code for counting **patients** discharged from your hospital who have undergone the procedure during the reporting period on an outpatient basis.

CPT Codes are provided in downloadable Excel files on the Survey Dashboard. To access the files, click the CPT Code Workbook button next to Section 9. You will be required to complete the American Medical Association's Terms of Use before downloading the Excel file and using the individual CPT codes to query your EHR or billing system. You are only required to complete the Terms of Use once per Survey Cycle (April 1 – November 30).

The CPT Code Workbooks (Excel files) are labeled for Section 3A: Total Hip Replacement, Total Knee Replacement, and Bariatric Surgery for Weight Loss and Section 9C: Volume of Procedures. Please note, if you are part of a hospital system, each hospital will need to complete the Terms of Use. This is a requirement of the American Medical Association.

Using the CPT code found for Total Hip Replacement in the "Instructions" sheet, count the total number of adult (18 years of age or older) patients discharged for the procedure with the CPT code listed. The CPT code can be in any procedure field.

Norwood Procedure Measure Specifications

For Norwood procedure, there are two sets of ICD-10 procedure codes for counting patient discharges. For a patient to be counted, they must have at least one ICD-10 procedure code from each list.

The first set of codes is to identify patients who have had an arch repair. The second set of codes is to identify patients who have had a shunt.

Count the number of patients, ages 17 years and younger, discharged with at least one of the following ICD-10 procedure codes from each list in any procedure field (i.e., each patient discharge will need to have at least one ICD-10 procedure code from the arch repair set AND at least one ICD-10 procedure code from the shunt set). Both procedures would need to be done as part of the same operative session.

ICD-10 Arch Repair Procedure Codes

ICD-10 Procedure Code	Code Description
02UX07Z	Supplement Thoracic Aorta, Ascending/Arch with Autologous Tissue Substitute, Open Approach
02UX0JZ	Supplement Thoracic Aorta, Ascending/Arch with Synthetic Substitute, Open Approach
02UX0KZ	Supplement Thoracic Aorta, Ascending/Arch with Nonautologous Tissue Substitute, Open Approach

ICD-10 Shunt Procedure Codes

ICD-10 Procedure Code	Code Description
021K08P	Bypass Right Ventricle to Pulmonary Trunk with Zooplastic Tissue Substitute, Open Approach
021K08Q	Bypass Right Ventricle to Right Pulmonary Artery with Zooplastic Tissue Substitute, Open Approach
021K08R	Bypass Right Ventricle to Left Pulmonary Artery with Zooplastic Tissue Substitute, Open Approach
021K09P	Bypass Right Ventricle to Pulmonary Trunk with Autologous Venous Tissue, Open Approach
021K09Q	Bypass Right Ventricle to Right Pulmonary Artery with Autologous Venous Tissue, Open Approach
021K09R	Bypass Right Ventricle to Right Pulmonary Artery with Autologous Venous Tissue, Open Approach
021K0AP	Bypass Right Ventricle to Pulmonary Trunk with Autologous Arterial Tissue, Open Approach
021K0AQ	Bypass Right Ventricle to Right Pulmonary Artery with Autologous Arterial Tissue, Open Approach
021K0AR	Bypass Right Ventricle to Right Pulmonary Artery with Autologous Arterial Tissue, Open Approach
021K0JP	Bypass Right Ventricle to Pulmonary Trunk with Synthetic Substitute, Open Approach
021K0JQ	Bypass Right Ventricle to Right Pulmonary Artery with Synthetic Substitute, Open Approach
021K0JR	Bypass Right Ventricle to Left Pulmonary Artery with Synthetic Substitute, Open Approach
021K0KP	Bypass Right Ventricle to Pulmonary Trunk with Nonautologous Tissue Substitute, Open Approach
021K0KQ	Bypass Right Ventricle to Right Pulmonary Artery with Nonautologous Tissue Substitute, Open Approach

ICD-10 Procedure Code	Code Description
021K0KR	Bypass Right Ventricle to Right Pulmonary Artery with Nonautologous Tissue Substitute, Open Approach
021Q08A	Bypass Right Pulmonary Artery from Innominate Artery with Zooplastic Tissue, Open Approach
021Q08B	Bypass Right Pulmonary Artery from Subclavian with Zooplastic Tissue, Open Approach
021Q08D	Bypass Right Pulmonary Artery from Carotid with Zooplastic Tissue, Open Approach
021Q09A	Bypass Right Pulmonary Artery from Innominate Artery with Autologous Venous Tissue, Open Approach
021Q09B	Bypass Right Pulmonary Artery from Subclavian with Autologous Venous Tissue, Open Approach
021Q09D	Bypass Right Pulmonary Artery from Carotid with Autologous Venous Tissue, Open Approach
021Q0AA	Bypass Right Pulmonary Artery from Innominate Artery with Autologous Arterial Tissue, Open Approach
021Q0AB	Bypass Right Pulmonary Artery from Subclavian with Autologous Arterial Tissue, Open Approach
021Q0AD	Bypass Right Pulmonary Artery from Carotid with Autologous Arterial Tissue, Open Approach
021Q0JA	Bypass Right Pulmonary Artery from Innominate with Synthetic Substitute, Open Approach
021Q0JB	Bypass Right Pulmonary Artery from Subclavian with Synthetic Substitute, Open Approach
021Q0JD	Bypass Right Pulmonary Artery from Carotid with Synthetic Substitute, Open Approach
021Q0KA	Bypass Right Pulmonary Artery from Innominate Artery with Nonautologous Tissue Substitute, Open Approach
021Q0KB	Bypass Right Pulmonary Artery from Subclavian with Nonautologous Tissue Substitute, Open Approach
021Q0KD	Bypass Right Pulmonary Artery from Carotid with Nonautologous Tissue Substitute, Open Approach
021V0ZP	Bypass Superior Vena Cava to Pulmonary Trunk, Open Approach
021V0ZQ	Bypass Superior Vena Cava to Right Pulmonary Artery, Open Approach
021V0ZR	Bypass Superior Vena Cava to Left Pulmonary Artery, Open Approach

Safe Surgery Checklist for Adult and Pediatric Complex Surgery Measure Specifications

Important Note: Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Source: The Leapfrog Group, WHO Surgical Safety Checklist and Implementation Manual , AHRQ Endoscopy Checklist
Reporting Period: 12 months Latest 12-month period prior to submission of this section of the Survey
Safe Surgery Checklist Workbook (Excel) To complete the data collection and respond to questions #6-9, hospitals should download the Safe Surgery Checklist Workbook (Excel). This workbook includes five tabs: Instructions, Section 3B (Complex Surgery), Section 3B – Data Entry, Section 9D (Outpatient Procedures), Section 9D – Data Entry. The Section 3B tabs can be used to complete the safe surgery checklist audits for this subsection and to calculate the response for question #9. The workbook is available on the Survey Materials Webpage.
Sampling: Hospitals that perform procedures in both Section 3A and Section 9C, and submit both Section 3 and 9, can randomly sample 15 patients (who had one of the procedures included in Section 3A) and measure and report adherence to the safe surgery checklist based on that sample. Hospitals that ONLY perform the procedures in Section 3A, or that ONLY submit Section 3, must randomly sample 30 patients (who had one of the procedures included in Section 3A) and measure and report adherence to the safe surgery checklist based on that sample. When sampling from a larger population of cases, hospitals that perform multiple procedures (e.g., bariatric surgery for weight loss, total hip replacement, total knee replacement, etc.) included in Section 3A and hospitals that perform procedures for both adult and pediatric patients (e.g., the Norwood Procedures) should obtain a representative sample (i.e., include patients who underwent different procedures and include both adult and pediatric patients, if applicable). <i>Free-standing pediatric hospitals that perform the Norwood Procedure and hospitals that reported a combined total hospital volume of less than the sufficient sample for all the procedures in Section 3A can sample any patients that had a procedure performed under general anesthesia.</i>
Question #6: Did your hospital perform an audit (either in-person or via the medical record or other EHR data) on a sufficient sample of patients who underwent a procedure included in Section 3A and measure adherence to the safe surgery checklist? To respond “yes” to question #6, hospitals must measure and document whether all the elements in questions #3, #4, and #5 were verbalized in the presence of the appropriate personnel for each sampled case. Hospitals that completed the audit should respond “yes” to this question regardless of whether the adherence to the checklist was 100%. Hospitals will report on adherence to the checklist in question #9.
Question #7: How many cases were included in the audit from question #6? Hospitals that perform procedures in both Section 3A and Section 9C, and submit both Section 3 and 9, can randomly sample 15 patients (who had one of the procedures included in Section 3A) and measure and report adherence to the safe surgery checklist based on that sample. Hospitals that ONLY perform the procedures in Section 3A, or that ONLY submit Section 3, must randomly sample 30 patients (who had one of the procedures included in Section 3A) and measure and report adherence to the safe surgery checklist based on that sample.

Question #8: What method was used to perform the audit on a sufficient sample in question #6?

Hospitals can only perform a retrospective audit by reviewing medical records or EHR data if adherence to the safe surgery checklist is clearly documented in the medical record or EHR and the documentation clearly demonstrates that each element was verbalized in the presence of the appropriate personnel. If hospitals cannot clearly determine whether (a) the checklist element was verbalized and (b) that the appropriate personnel were present via a retrospective audit, an in-person observational audit must be completed.

Hospitals performing in-person observational audits must do so in the latest 12 months prior to Survey submission.

Hospitals performing retrospective audits must audit cases from the latest 12 months prior to Survey submission but can also review any case from Section 3A that was performed in the latest calendar year prior to Survey submission.

Question #9: Based on your hospital's audit (either in-person or via the medical record or other EHR data) on a sufficient sample of patients who underwent a procedure included in Section 3A, what was your hospital's documented rate of adherence to the safe surgery checklist (i.e., what percentage of the sampled cases had all elements in questions #3, #4, and #5 completed)?

Based on the audit completed for question #6, determine the total number of patient audits where all elements of the safe surgery checklist (included in questions #3, #4, and #5) were read aloud in the presence of the appropriate personnel 1) before the induction of anesthesia, 2) before the skin incision and/or the procedure began, and 3) before the patient left the operating and/or procedure room.

Included cases:

- The patient audit shows that all elements of the safe surgery checklist, at all three time points, were read aloud in the presence of the appropriate personnel.

Excluded cases:

- The patient audit does not demonstrate that all elements of the safe surgery checklist were read aloud in the presence of the appropriate personnel (i.e., one or more elements of the checklist were not read aloud or the appropriate personnel were not present during the checklist).
- The patient audit does not demonstrate that the safe surgery checklist was read aloud in the presence of the appropriate personnel at all three time points (i.e., before anesthesia, before the skin incision, and before the patient leaves).

Important Note: If a Safe Surgery Checklist element includes the qualifier "if applicable," hospitals should determine if that element of the checklist was applicable to the patient and procedure being performed. If the element was determined to be "not applicable" to the patient and procedure, it does not count against the total adherence. For example, if your hospital performed a bariatric surgery for weight loss, the availability of a device on-site would not be applicable. Therefore, when completing the Safe Surgery Checklist Workbook for this patient, indicate N/A for that element (device on-site) and your hospital would be able to count that case as adherent.

See [FAQs](#) for additional information about responding to the questions in this section.

Section 3: Adult and Pediatric Complex Surgery Frequently Asked Questions (FAQs)

General Questions

1. Does this section apply to critical access hospitals?

Yes. In general, critical access hospitals do not perform many of the procedures that are included in this section, but if the critical access hospital does perform the procedure, the standards still apply.

2. Should we select a procedure from the list in Section 3A question #2 if we only perform that procedure on an outpatient basis?

Hospitals that only perform total hip replacements, total knee replacements, and/or bariatric surgery for weight loss on an outpatient basis should select and report on those procedures in Section 3A.

Otherwise, hospitals should not select and report on the remaining eight procedures if the procedures are always scheduled with the intention of the patient being released on the same day.

If some of the procedures are scheduled with the intention of the patient being admitted and staying in the hospital overnight, the hospital should report on performing the procedure in question #2 and then **ONLY** report on the total number of patients discharged following an inpatient stay.

3. My hospital has a tumor center that only performs total hip replacements and total knee replacements as they come up during a tumor removal surgery, should we select these procedures from the list in Section 3A question #2?

If your hospital has a tumor center where orthopedic tumor surgeries are performed and the **ONLY** total hip replacement and/or total knee replacement procedures ever done at that hospital are for the treatment of the tumor, you should not select and report on total hip replacements or total knee replacements in Section 3A.

Hospital Volume FAQs

4. How should hospitals calculate volume using a 24-month annual average?

To report on a 24-month annual average, calculate the total volume over the past 24 months, and then divide by 2 (i.e., the volume of year one plus the volume of year 2 divided by two equals the 24-month annual average).

5. Can we count patients who have had one of the procedures listed in Section 3A in combination with another procedure not listed in Section 3A?

Yes, hospitals should count all patients that meet the criteria specified in the Hospital and Surgeon Volume Measure Specifications. For example, if a patient has a CABG and a mitral valve repair done at the same time, the hospital should count the patient when calculating total volume for mitral valve repair and replacement.

6. When counting patients, should we only include those patients who had the procedure performed on a scheduled basis?

No. Once a hospital selects a procedure from the list in question #2, they should use the measure specifications for each procedure to count all patients that meet the criteria. This includes patients who had the procedure performed urgently.

7. If a hospital elects to begin a new service line of procedures, how should the hospital report its volume and surgeon volumes while establishing the new line?

Leapfrog gives hospitals an 18-month grace period before having to report on hospital and surgeon volume for a new procedure. From the day that the hospital performs the procedure for the first time, the hospital and its surgeons will have 18 months to reach the annual volume standard. During this period, the hospital does not have to report its procedure volumes for the hospital or its surgeons. However, once the hospital reaches the end of the 18-month grace period, it must report its hospital and surgeon procedure volume.

8. How should we deal with a temporary drop in volume due to losing a surgeon's service?

To accommodate fluctuations in hospital volumes, hospitals have the option of reporting on their average case volumes over a 24-month period.

9. Can we count minimally invasive and/or robotic Mitral Valve Repair and Replacement procedures towards our hospital's volume?

Yes, the ICD-10 codes Leapfrog has provided for this procedure will capture minimally invasive and/or robotic MVRR procedures in the hospital's count as these are the codes used for those cases.

10. Our hospital has a free-standing outpatient surgery center that shares our license and/or CMS Certification Number (CCN). Many of our same day total hip replacements, total knee replacements, and bariatric surgery for weight loss procedures are performed there. Can we include these procedures in our total hospital volume when responding to question #3 in Section 3A?

Yes, hospitals may count patient discharges with the appropriate CPT procedure code during the reporting period from hospital outpatient departments that share your hospital's license and/or CMS Certification Number (CCN), including, but not limited to free-standing surgery centers and hospital outpatient departments.

Surgeon Volume FAQs**11. Does the specific procedure and minimum annual surgeon volume standard listed need to be included in our process for privileging surgeons?**

Yes. Hospitals must ensure that the specific procedure (as defined using the ICD-10 and CPT procedure codes) and minimum annual surgeon volume standard are included in your process for privileging surgeons. Diagnosis codes can be ignored.

12. Does our privileging process for surgeons have to include the annual surgeon volume standard for initial privileging only or ongoing/renewal of privileging as well?

Both. Leapfrog's minimum annual surgeon volume standards should be fully integrated into your hospital's process for privileging surgeons, including both initial and ongoing privileging. There are two exceptions:

- a. Surgeons who have just finished training: see [FAQ #14](#) below.
- b. Surgeons who were not active for the entire reporting period: see [FAQ #15](#) below.

13. When counting annual surgeon volume for the purposes of privileging, should we consider procedures performed by the surgeon at other hospitals?

Yes. When determining whether a surgeon has met or has exceeded Leapfrog's minimum annual surgeon volume standard, we expect that hospitals will consider total experience in the privileging process – this would include procedures performed within the reporting period at different facilities. It is our understanding that through the [OPPE process](#), hospitals have access to total surgeon volume, including the number of procedures performed at other hospitals.

14. For determining surgeon volume for the purposes of privileging, how should we count procedures that involve surgeons who have just finished training and are building up their experience?

Surgeons who have just finished their training should receive a 24-month grace period to build up their experience. After that point, the surgeon's volume should be tracked and included in privileging decisions. The procedures performed by this surgeon during the reporting period should still be counted towards the hospital's volume total, as the broader staff still had the experience with the procedure.

15. If a surgeon was not "active" during the entire reporting period (e.g., just hired, sabbatical, illness, etc.), should they be included when responding to question #5?

If a surgeon was absent for an extended time during the reporting period, the procedures performed by this surgeon during the reporting period should still be counted towards the hospital's procedure total (question #3). However, the surgeon would not need to be considered when responding to question #5 regarding whether your hospital's process for privileging includes the surgeon having to meet Leapfrog's minimum annual surgeon volume standards until they have been active again for an entire reporting period (likely the next year).

16. When counting surgeon volume for the purposes of privileging, if a procedure is completed by two surgeons (i.e., an assistant or co-surgeon) would they both be able to count the case?

If a surgeon assists another surgeon or is a co-surgeon during a procedure, the procedure should NOT count for both surgeons' procedure totals. The case should be applied to a single surgeon.

17. When determining which surgeons should be required to meet Leapfrog's minimum annual surgeon volume standards for the process of privileging, should surgeons who only ever perform a procedure in emergency circumstances and never perform the procedure on a scheduled basis be included?

For the purposes of reporting on question #5 in Section 3A, hospitals can exclude surgeons who will only ever perform a procedure in emergency circumstances if they never perform the procedure on a scheduled basis.

However, for the purposes of reporting on question #3 in Section 3A, hospitals should count all patients discharged with the relevant procedure or diagnosis for those procedures indicated in question #2 in Section 3A. See FAQ #6.

Safe Surgery Checklist for Adult and Pediatric Complex Surgery FAQs**18. What 12-month reporting period should be used when reporting on this section?**

When responding to the questions in Section 3B, hospitals should enter the month in which they complete their observational in-person or retrospective EHR review audits. If your hospital does not perform an audit, enter the month in which you are completing the Survey.

19. Does the safe surgery checklist referenced in Section 3B apply to all procedures, including endoscopies?

Yes, it applies to all procedures in Section 3A. If your hospital does not utilize a safe surgery checklist for all procedures in Section 3A, including endoscopies, respond "no" to question #2.

20. Can different elements of the "Before the induction of anesthesia" checklist (question #3) be performed in different places?

Yes, hospitals may perform some elements of the pre-anesthesia checklist outside of the operating room. Hospitals may read aloud the following elements in a pre-procedure (preop) area: Patient ID, Confirmation of procedure, Patient consent, Site marked, if applicable, and Allergies assessed.

Hospitals should not remove conversation prompts as it is harmful to the purpose of the checklist and should continue debriefing and requiring participation of the surgical team members in key

moments.

21. Do we need to perform a “clinical team introduction” if the team already knows each other and/or will be in the operating room together all day?

Yes. Even if a clinical team knows each other they must perform an introduction stating their name and role at the first procedure of the day. They do not need to reintroduce themselves for the remaining procedures but should confirm everyone was introduced beforehand. However, if any team members change between operations, introductions must be performed again.

22. Do the Safe Surgery Checklist components included in questions #3, #4, and #5 need to be in one document that would align with the WHO example or can they be in different documents (i.e., pre-anesthesia notes, surgeon H&P, and pre-surgical checklists, etc.)?

It is possible to have separate checklists for each phase of the surgical procedure (i.e., before the induction of anesthesia, before the skin incision and/or before the procedure begins, and before the patient leaves the operating or procedure room). However, each individual component included in questions #3, #4, and #5 should be listed on the checklist(s) and hospitals should document whether the components were read aloud at the appropriate time with the appropriate members of the surgical team present.

23. How is “whole surgical team” defined?

“Whole surgical team” is comprised of the surgeons, anesthesia professionals, nurses, technicians, and other operating room personnel involved in surgery. This is based off the World Alliance for Patient Safety Implementation Manual Surgical Safety Checklist (First Edition).

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SECTION 4: MATERNITY CARE

This section includes questions and reference information for Section 4: Maternity Care. Please carefully review the questions, endnotes, and reference information (e.g., measure specifications, notes, and frequently asked questions) before you begin. Failure to review the reference information could result in inaccurate responses.

Section 4: Maternity Care

Maternity Care Fact Sheet and Bibliography:

<https://ratings.leapfroggroup.org/measure/hospital/2025/maternity-care>

Hospitals that did not deliver newborns during the reporting period or did not have an open labor and delivery unit during the entire reporting period should select “no” in question #2 and move on to the Affirmation of Accuracy. Your hospital’s results will be displayed as “Does Not Apply” on Leapfrog’s public reporting website.

Section 4 includes questions about maternity care volume and services, cesarean birth, episiotomy, newborn bilirubin screening, and DVT prophylaxis for women undergoing cesarean delivery. The section also includes questions about high-risk deliveries, including volume and outcomes. The subsection on cesarean birth (4C) includes questions about cesarean births stratified by race/ethnicity that will not be scored or publicly reported, however, responses will be used for confidential reporting on the [Hospital Details Page](#) in 2025.

Each hospital achieving the standard for Cesarean Birth:

Meets or is better than the 23.6% target for performance on the nationally endorsed outcome measure.

Each hospital achieving the standard for Episiotomy:

Meets or is better than the 5.0% target for performance on the nationally endorsed outcome measure.

Each hospital achieving the standard for Newborn Bilirubin Screening Prior to Discharge:

Meets or exceeds the 90% target for the process measure of care.

Each hospital achieving the standard for Appropriate DVT Prophylaxis in Women Undergoing Cesarean Delivery:

Meets or exceeds the 90% target for the process measure of care.

Each hospital achieving the standard for High-Risk Deliveries:

Achieves favorable hospital volume characteristics for high-risk deliveries by admitting 50 or more very low birth weight newborns/year to its neonatal ICU,

OR

Achieves favorable outcomes for high-risk deliveries as measured by the Vermont Oxford Network.

Download the 2025 Leapfrog Hospital Survey Scoring Algorithm on the [Scoring and Results webpage](#).

4A: Maternity Care Volume and Services

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Important Notes:

Note 1: This section is only applicable to hospitals that deliver newborn babies. Hospitals that do not deliver newborn babies should select "no" in question #2 in 4A and move on to the Affirmation of Accuracy. Your hospital's results will be displayed as "Does Not Apply" on Leapfrog's public reporting website.

Note 2: Hospitals must use the same 12-month reporting period for all subsections in Section 4: Maternity Care, except for Section 4A questions #4-9 and Section 4B questions #6-8.

Note 3: Maternity Care Services (questions #4-9) will not be scored but will be used in public reporting.

Specifications: See [Maternity Care Volume and Services Measure Specifications](#) in the Reference Information beginning on page 163.

Reporting Period: 12 months

- Surveys submitted prior to September 1:
 - 01/01/2024 – 12/31/2024
- Surveys (re)submitted on or after September 1:
 - 07/01/2024 – 06/30/2025

Note: As a reminder, the [Corrections Period](#) (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

Maternity Care Volume

1) 12-month reporting period used:	☐ 01/01/2024 – 12/31/2024 ☐ 07/01/2024 – 06/30/2025
2) Did the hospital deliver newborn babies during the reporting period? <i>If "no" or "yes, but unit is now closed or wasn't open for the entire reporting period," skip the remaining questions in Section 4, including all subsections, and go to the Affirmation of Accuracy. The hospital will be scored as "Does Not Apply."</i>	☐ Yes ☐ No ☐ Yes, but unit is now closed or wasn't open for the entire reporting period
3) Total number of live births (i.e., liveborn infants) at this hospital location for the reporting period. <i>If fewer than 10 cases, skip the remaining questions in Section 4, including all subsections, and go to the Affirmation of Accuracy. The hospital will be scored as "Unable to Calculate Score" or "Does Not Apply."</i>	_____

Maternity Care Services

Reporting Period: Answer questions #4-9 based on the practices currently in place at the time you submit this section of the Survey.

Note: As a reminder, the Corrections Period (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

4) Does your hospital have certified nurse-midwives and/or certified midwives deliver newborns?	☐ Yes ☐ No
5) Does your hospital use doulas for labor and delivery? <i>Select all that apply.</i>	☐ Yes, the hospital employs or contracts with doulas ☐ Yes, the hospital allows patients to bring their own doulas ☐ No
6) Does your hospital offer breastfeeding/lactation consultants? <i>Select all that apply.</i>	☐ Yes, in the hospital ☐ Yes, in the outpatient setting ☐ Yes, at home after discharge ☐ No
7) Does your hospital offer patients the opportunity to attempt vaginal birth after cesarean section (VBAC)?	☐ Yes ☐ No
8) Does your hospital offer postpartum tubal ligation during the labor and delivery admission?	☐ Yes ☐ No
9) Has your hospital adopted a policy that prevents nonmedically indicated early elective deliveries (before 39 completed weeks gestation) that includes all the following: • Written standards for when an early elective delivery is, and is not, appropriate based on ACOG and national guidelines (i.e., The Joint Commission), • Written protocols for the medical director, or other designated physician, to review and approve an early elective delivery when medically indicated based on ACOG and national guidelines, and • Written protocols for staff to follow when scheduling an early elective delivery if approved by the medical director or other designated physician?	☐ Yes ☐ No

4B: Cesarean Birth

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Important Notes:

Note 1: Hospitals must use the same 12-month reporting period for all subsections in Section 4: Maternity Care, except for Section 4B questions #6-8.

Note 2: Cesarean Birth Stratified by Race/Ethnicity (questions #6-8) will not be scored or publicly reported but will be used for confidential reporting on the Hospital Details Page.

Specifications: See [Cesarean Birth Measure Specifications](#) in the Reference Information beginning on page 164.

Reporting Period: 12 months

Answer questions #1-5 based on all cases (or a sufficient sample of them for questions #2-3)

- Surveys submitted prior to September 1:
 - 01/01/2024 – 12/31/2024
- Surveys (re)submitted on or after September 1:
 - 07/01/2024 – 06/30/2025

Note: As a reminder, the [Corrections Period](#) (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

Sufficient Sample: See [Cesarean Birth Measure Specifications](#) for instructions for identifying a sufficient sample for questions #2 and #3.

1) 12-month reporting period used:	☐ 01/01/2024 – 12/31/2024 ☐ 07/01/2024 – 06/30/2025
2) Total number of nulliparous mothers (or sufficient sample of them) that delivered a live term singleton newborn in the vertex presentation with ≥ 37 weeks of gestation completed, with Excluded Populations removed: <i>If fewer than 10 cases met the criteria for the denominator, skip questions #3-8 and continue to the next subsection. The hospital will be scored as "Unable to Calculate Score."</i>	_____
3) Total number of mothers indicated in question #2 that had their newborn delivered via cesarean section:	_____
4) Do the responses in questions #2 and #3 above represent a sample of cases?	☐ Yes ☐ No
5) If "yes" to question #4, did your hospital sample using The Joint Commission's sampling algorithm or Leapfrog's sampling instructions, as provided in the Maternity Care Reference Information?	☐ The Joint Commission ☐ The Leapfrog Group

Cesarean Birth Stratified by Race/Ethnicity**Reporting Period: 24 months**

Answer questions #6-8 based on all cases

- Surveys submitted prior to September 1:
 - 01/01/2023 – 12/31/2024
- Surveys (re)submitted on or after September 1:
 - 07/01/2023 – 06/30/2025

Note: As a reminder, the Corrections Period (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

6) 24-month reporting period used:		☐ 01/01/2023 – 12/31/2024 ☐ 07/01/2023 – 06/30/2025
7) Did your hospital stratify NTSV cesarean births by race/ethnicity for the reporting period using the measure specifications provided and do you choose to report those data to this Survey? <i>If "no" to question #7, skip question #8 and continue to the next subsection.</i>		☐ Yes ☐ No
8) Enter your hospital's responses below by race/ethnicity: <i>If the number of cases for a race/ethnicity is less than 10 (in column a), skip column b and then move to the next category. If zero, enter "0" in column a.</i>		
Race/ethnicity	a) Total number of nulliparous mothers that delivered a live term singleton newborn in the vertex presentation with ≥ 37 weeks of gestation completed, with Excluded Populations removed (denominator)	b) Total number of mothers indicated in question #8a that had their newborn delivered via cesarean section (numerator)
Non-Hispanic White	_____	_____
Non-Hispanic Black	_____	_____
Non-Hispanic American Indian or Alaska Native	_____	_____
Non-Hispanic Asian or Pacific Islander	_____	_____
Hispanic	_____	_____
Non-Hispanic Other (including two or more races)	_____	_____
Unknown	_____	_____

4C: Episiotomy

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review Leapfrog's Multi-Campus Reporting Policy.

Important Note: Hospitals must use the same 12-month reporting period for all subsections in Section 4: Maternity Care, except for Section 4B questions #6-8.

Specifications: See **Episiotomy Measure Specifications** in the Reference Information beginning on page 172.

Reporting Period: 12 months

Answer questions #1-3 based on all cases.

- Surveys submitted prior to September 1:
 - 01/01/2024 – 12/31/2024
- Surveys (re)submitted on or after September 1:
 - 07/01/2024 – 06/30/2025

Note: As a reminder, the Corrections Period (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

1) 12-month reporting period used:	◦ 01/01/2024 – 12/31/2024 ◦ 07/01/2024 – 06/30/2025
2) Total number of vaginal deliveries, with Excluded Populations removed: <i>If fewer than 10 cases met the criteria for the denominator, skip question #3 and continue to the next subsection. The hospital will be scored as "Unable to Calculate Score."</i>	_____
3) Total number of mothers indicated in question #2 that had an episiotomy procedure performed:	_____

4D: Process Measures of Quality

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Important Note: Hospitals must use the same 12-month reporting period for all subsections in Section 4: Maternity Care, except for Section 4B questions #6-8.

Specifications: See [Process Measures of Quality Measure Specifications](#) in the Reference Information beginning on page 173.

Reporting Period: 12 months

Answer questions #1-9 based on all cases (or a sufficient sample of them).

- Surveys submitted prior to September 1:
 - 01/01/2024 – 12/31/2024
- Surveys (re)submitted on or after September 1:
 - 07/01/2024 – 06/30/2025

Note: As a reminder, the Corrections Period (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

Sufficient Sample: See [Process Measures of Quality Measure Specifications](#) for instructions for identifying a sufficient sample for questions #3-4 and #7-8.

1) 12-month reporting period used:	☐ 01/01/2024 – 12/31/2024 ☐ 07/01/2024 – 06/30/2025
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Newborn Bilirubin Screening Prior to Discharge

2) Did your hospital perform a medical record audit on all cases (or a sufficient sample of them) and measure adherence to the newborn bilirubin screening prior to discharge clinical guideline? <i>If “no” to question #2, skip questions #3-5 and continue to question #6. The hospital will be scored as “Did Not Measure.”</i> <i>If “yes, but fewer than 10 cases met the inclusion criteria for the denominator,” skip questions #3-5 and continue to question #6. The hospital will be scored as “Unable to Calculate Score.”</i>	☐ Yes ☐ No ☐ Yes, but fewer than 10 cases met the inclusion criteria for the denominator
3) Number of cases measured against the guideline, either all cases or a sufficient sample of them (denominator):	_____
4) Number of cases in question #3 that adhere to the clinical process guideline (numerator):	_____
5) Do the responses in questions #3 and #4 represent a sample of cases?	☐ Yes ☐ No

Appropriate DVT Prophylaxis in Women Undergoing Cesarean Delivery

6) Did your hospital perform a medical record audit on all cases (or a sufficient sample of them) and measure adherence to the appropriate DVT prophylaxis in women undergoing cesarean delivery clinical guideline? <i>If “no” to question #6, skip questions #7-9 and continue to the next subsection. The hospital will be scored as “Did Not Measure.”</i> <i>If “yes, but fewer than 10 cases met the inclusion criteria for the denominator,” skip questions #7-9 and continue to the next subsection. The hospital will be scored as “Unable to Calculate Score.”</i>	○ Yes ○ No ○ Yes, but fewer than 10 cases met the inclusion criteria for the denominator
7) Number of cases measured against the guideline, either all cases or a sufficient sample of them (denominator):	_____
8) Number of cases in question #7 that adhere to the clinical process guideline (numerator):	_____
9) Do the responses in questions #7 and #8 represent a sample of cases?	○ Yes ○ No

4E: High-Risk Deliveries

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Important Note: Only include units that were open for the entire reporting period and that remain currently open.

1) Does your hospital <u>electively</u> admit high-risk deliveries³⁰? <i>If "no" to question #1, skip the remaining questions in Section 4E, and go to the Affirmation of Accuracy. The hospital will be scored as "Does Not Apply."</i>	☐ Yes ☐ No
2) Does your hospital operate a neonatal ICU (NICU), or is it <u>co-located</u>³¹ with a hospital that operates a NICU, that admits or accepts transfers of <u>very low birth weight babies</u>³²? <i>If "no" to question #2, skip the remaining questions in Section 4E, and go to the Affirmation of Accuracy. The hospital will be scored as "Limited Achievement."</i> <i>If the NICU is co-located in another hospital and your hospital immediately transfers all complicated newborns there, answer question #3 and either questions #4-5 or #6-10 based on information pertaining to the co-located hospital's NICU.</i>	☐ Yes ☐ No
3) Hospitals that participate in the Vermont Oxford Network (VON) and have a recent 12-month report available may elect to report their hospital's Volume (questions #4-5) OR the <u>VON's Death or Morbidity Measure</u>³³ (questions #6-10). Hospitals that do not participate in the Vermont Oxford Network should report their hospital's Volume (questions #4-5). Please indicate which measure the hospital will report on: <i>If you elect to report on Volume, answer questions #4-5 and skip questions #6-10.</i> <i>If you elect to report on the VON National Performance Measure, skip questions #4-5. Please ensure that you have entered an accurate VON Transfer Code in the Hospital Profile and submitted the Data Share Authorization letter to VON. Otherwise, you will be scored as "Declined to Respond."</i>	☐ Volume ☐ VON National Performance Measure

Neonatal Intensive Care Unit(s) – Volume

Important Note: Hospitals must use the same 12-month reporting period for all subsections in Section 4: Maternity Care, except for Section 4B questions #6-8.

Specifications: See **Neonatal Intensive Care Unit(s) – Volume Measure Specifications** in the Reference Information beginning on page 173.

Reporting Period: 12 months

- Surveys submitted prior to September 1:
 - 01/01/2024 – 12/31/2024
- Surveys (re)submitted on or after September 1:
 - 07/01/2024 – 06/30/2025

Note: As a reminder, the Corrections Period (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

4) 12-month reporting period used:	○ 01/01/2024 – 12/31/2024 ○ 07/01/2024 – 06/30/2025
5) For the reporting period, how many very low birth weight babies were admitted to your hospital's neonatal intensive care unit(s)?	_____

Neonatal Intensive Care Unit(s) – National Performance Measurement

Important Note: Hospitals participating in the Vermont Oxford Network (VON) may opt to report on the VON National Performance Measure. In order for Leapfrog to obtain the data from VON, the VON data must be finalized, and hospitals must complete the following steps:

1. Provide an accurate VON Transfer Code in the Hospital Profile,
2. Complete a Data Sharing Authorization letter and submit it to VON by **June 16**. Hospitals that submitted their Data Sharing Authorization letter to VON in previous Leapfrog Hospital Survey Cycles do not have to re-submit a new letter in 2025.
3. Select "VON National Performance Measure" in question #3, and
4. Submit the 2025 Leapfrog Hospital Survey by the June 30 Submission Deadline.

Hospitals that select "VON National Performance Measure" in question #3, but do not adhere to the other steps will be scored and publicly reported as "Declined to Respond" for the High-Risk Deliveries measure.

Specifications: See **Neonatal Intensive Care Unit(s) – National Performance Measurement Measure Specifications** in the Reference Information beginning on page 173.

Reporting Period: 12 months

Responses are based on the latest 12-month report received from the Vermont Oxford Network (VON) for the **Death or Morbidity Measure**.

- 2023 VON data
- 2024 VON data (usually available after August 31)

Leapfrog will update the VON data three times per Survey Cycle for all hospitals that have completed the steps noted above. See deadlines and reporting periods in the **Neonatal Intensive Care Unit(s) - National Performance Measurement Measure Specifications**.

6) Most recent 12-month reporting period for which VON performance results are available:	<i>No response required here. Determined automatically based on VON data.</i>
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Section 4: Maternity Care

7) Hospital's volume based on VON report:	No response required here. Determined automatically based on VON data.
8) Hospital's standardized mortality ratio (SMR) 95% lower bound based on VON report:	No response required here. Determined automatically based on VON data.
9) Hospital's observed to expected ratio of morbidity or mortality (SMR shrunken) based on VON report:	No response required here. Determined automatically based on VON data.
10) Hospital's SMR 95% upper bound based on VON report:	No response required here. Determined automatically based on VON data.

Affirmation of Accuracy

As the hospital CEO or as an employee of the hospital to whom the hospital CEO has delegated responsibility, I have reviewed this information pertaining to the Maternity Care Section at our hospital, and I hereby certify that this information is true, accurate, and reflects the current, normal operating circumstances at our hospital. I am authorized to make this certification on behalf of our hospital.

The hospital and I understand that The Leapfrog Group, its members, the public and entities and persons who contract or have other business dealings with The Leapfrog Group are relying on the truth and accuracy of this information. The hospital and I also understand that The Leapfrog Group will make this information and/or analyses of this information public through the Survey Results public reporting website, The Leapfrog Group's Hospital Safety Grade, and/or other Leapfrog Group products and services. This information and/or analyses and all intellectual property rights therein shall be and remain the sole and exclusive property of The Leapfrog Group in which The Leapfrog Group retains exclusive ownership. This information does not infringe upon any third-party intellectual property rights or any other third-party rights whatsoever and is free and clear of all encumbrances and liens of any kind. The hospital and I acknowledge that The Leapfrog Group may use this information in a commercial manner for profit. The hospital shall be liable for and shall hold harmless and indemnify The Leapfrog Group from any and all damages, demands, costs, or causes of action resulting from any inaccuracies in the information or any misrepresentations in this Affirmation of Accuracy. The Leapfrog Group and its members and entities and persons who contract or have other business dealings with The Leapfrog Group reserve the right to omit or disclaim information that is not current, accurate or truthful.

Affirmed by _____, the hospital's _____,
(first name and last name) (title)
on _____.
(date)

Section 4: Maternity Care Reference Information

What's New in the 2025 Survey

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

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

Section 4A: Maternity Care Volume and Services

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

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

Section 4B: Cesarean Birth

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

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

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

Section 4C: Episiotomy

There are no changes to this subsection.

Section 4D: Process Measures of Quality

In response to feedback and consultation with our Maternity Care Expert Panel, Leapfrog is updating the measure specifications for Appropriate DVT Prophylaxis in Women Undergoing Cesarean Delivery to add further clarification regarding the timing of the prophylaxis. The numerator will continue to include women undergoing cesarean delivery that received either pneumatic compression devices prior to surgery or fractionated or unfractionated heparin or heparinoid. Beginning in 2026, Leapfrog plans to remove the inclusion of patients receiving heparin or heparinoid, unless they also received a pneumatic compression device prior to surgery. As a reminder, the target for this measure is 90%.

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

Section 4E: High-Risk Deliveries

Neonatal Intensive Care Unit(s) – National Performance Measurement

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

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

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

Change Summary Since Release

None. If substantive changes are made to this section of the Survey after release on April 1, 2025, they will be documented in this Change Summary section.

Section 4: Maternity Care Measure Specifications

Maternity Care Volume Measure Specifications

Important Note: Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Reporting Period: 12 months

- Surveys submitted prior to September 1:
 - 01/01/2024 – 12/31/2024
- Surveys (re)submitted on or after September 1:
 - 07/01/2024 – 06/30/2025

Question #3: The number of live births (i.e., infants) at this hospital location (inborn cases only), reported to your state during the reporting period.

Alternatively, the below list of Z codes can be used to identify live births, with the caution that these codes are coded for the newborn, not the mother; likely to be found in your hospital's birth CIS/medical record system; but often not in claims data since normal newborn care may be included in the mother's claim without baby's diagnosis coding.

Z38.00 – Z38.01: Single liveborn infant, born in hospital

Z38.30 – Z38.31: Twin liveborn infant, born in hospital

Z38.61 – Z38.69: Other multiple liveborn infant, born in hospital

Note: This data point is simply used to qualify a hospital for further reporting of the normal delivery measures.

Cesarean Birth Measure Specifications**Important Notes:**

Note 1: Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Note 2: Leapfrog uses the specifications created by The Joint Commission (TJC) for the Cesarean Births measure. As such, Leapfrog will update its instructions annually, and more frequently if appropriate, to maintain alignment with TJC. Hospitals can access the TJC's measure specifications directly using the links in the table below.

Note 3: Cesarean Births (questions #2-3) can be reported based on all eligible cases OR a sufficient sample of cases as outlined in the denominator specifications for the 12-month reporting period. Cesarean Births Stratified by Race/Ethnicity (questions #7-8) must be reported based on all eligible cases for the 24-month reporting period.

Source: Joint Commission PC-02

- (version [2024B](#)): Discharges between 01/01/2024 – 12/31/2024
- version [2025A](#): Discharges between 01/01/2025 – 06/30/2025

Reporting Period: 12 months

- Surveys submitted prior to September 1:
 - 01/01/2024 – 12/31/2024
- Surveys (re)submitted on or after September 1:
 - 07/01/2024 – 06/30/2025

Note: The discharge date must be used to determine whether a case falls within the reporting period specified.

If you measured this quality indicator, reported the results to The Joint Commission (TJC), and continue to submit these data to The Joint Commission, **use those data when responding to this subsection of the Survey**. Leapfrog will accept data collected for either the chart-abstracted measure (PC-02) or the electronic clinical quality measure (ePC-02).

Hospitals participating in the California Maternal Quality Care Collaborative (CMQCC) Maternal Data Center may use the data provided in CMQCC reports when responding to this subsection of the Survey. Download instructions for using the CMQCC reports on the [Survey and CPOE Materials webpage](#).

Hospitals participating in the Michigan Obstetrics Initiative (OBI) may use the data provided in OBI reports when responding to this subsection of the Survey.

Otherwise, use TJC's PC-02 Cesarean Birth measure specifications to retrospectively collect and report data for this measure. The PC-02 measure specifications are outlined below based on discharge date. To access the measure specifications directly on The Joint Commission's website, see the specification manuals linked below:

- version [2024B](#): Discharges between 01/01/2024 – 12/31/2024
- version [2025A](#): Discharges between 01/01/2025 – 06/30/2025

eCQM specifications can be found [here](#).

Sampling Cases: Hospitals that report the Perinatal Care Measure Set to TJC may use the sampling methodology used by the TJC to report on questions #2-3.

Otherwise, hospitals opting to identify a sufficient sample of mothers for this measure, in lieu of full case reporting, should follow the instructions below. Hospitals may refer to the TJC Measure Algorithm flow chart at the bottom of each set of specifications linked above, for an example of how to identify cases.

Sampling instructions for 01/01/2024 – 12/31/2024 discharges:

- Review your hospital's first delivery as of **April 15, 2024**.

- Evaluate this case against the inclusion criteria; retain the case for the sample if it meets the inclusion criteria.
- Evaluate this case against the exclusion criteria; retain the case for the sample if it does not meet any of the listed exclusions.
- Move to the next delivery and evaluate for inclusion/exclusion applicability.
- Continue through cases in sequential order until **a sample of at least 30 cases** is reached, or all cases discharged during the reporting period are reviewed, whichever comes first.

When sampling for the 01/01/2024 – 12/31/2024 reporting period, use one set of measure specifications:

- version 2024B: Discharges between 01/01/2024 – 12/31/2024 (sample cases as of April 15, 2024)

Sampling instructions for 07/01/2024 – 06/30/2025 discharges:

Sampling requires hospitals to use two different sets of measure specifications and therefore sampling has two steps, both of which need to be completed

Step #1:

- Review your hospital's first delivery as of **July 15, 2024**.
- Evaluate this case against the inclusion criteria; retain the case for the sample if it meets the inclusion criteria.
- Evaluate this case against the exclusion criteria; retain the case for the sample if it does not meet any of the listed exclusions.
- Move to the next delivery and evaluate for inclusion/exclusion applicability.
- Continue through cases in sequential order until **a sample of at least 15 cases** is reached, or all cases discharged during the first 6-month reporting period of 07/01/2024 – 12/31/2024 are reviewed, whichever comes first.

Step #2:

- After sampling the first 15 cases, review your hospital's first delivery as of **January 15, 2025**.
- Evaluate this case against the inclusion criteria; retain the case for the sample if it meets the inclusion criteria.
- Evaluate this case against the exclusion criteria; retain the case for the sample if it does not meet any of the listed exclusions.
- Move to the next delivery and evaluate for inclusion/exclusion applicability.
- Continue through cases in sequential order until **a sample of at least 15 cases** is reached, or all cases discharged during the second 6-month reporting period of 01/01/2025 – 06/30/2025 are reviewed, whichever comes first.

When sampling for the 07/01/2024 – 06/30/2025 reporting period, use the measure specifications based on the correct discharge date, which are outlined below:

- version 2024B: Discharges between 07/01/2024 – 12/31/2024 (sample cases as of July 15, 2024)
- version 2025A: Discharges between 01/01/2025 – 06/30/2025 (sample cases of January 15, 2025)

Discharges between 01/01/2024 – 12/31/2024 (version <u>2024B</u>)	Question #2 (denominator): Nulliparous patients delivered of a live term singleton newborn in vertex presentation with Excluded populations removed. <i>Note: The denominator should include both nulliparous mothers with a live term singleton newborn in vertex presentation that had their newborn delivered via cesarean section and nulliparous mothers that delivered vaginally.</i> Included Populations: • ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes for delivery as defined in Appendix A, Table 11.01.1 Delivery. • Nulliparous patients with ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes for outcome of delivery as
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	defined in Appendix A, Table <u>11.08 Outcome of Delivery</u> and with a delivery of a newborn with 37 weeks or more of gestation completed. • <u>ICD-10-CM Principal Diagnosis Code or ICD-10 CM Other Diagnosis Codes</u> for term gestational age as defined in Appendix A, Table <u>11.10 Term Gestational Age</u> Excluded Populations: • <u>ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes</u> for multiple gestations, abnormal presentations, and conditions justifying cesarean delivery as defined in Appendix A, Table <u>11.09 Multiple Gestations, Abnormal Presentations, and Conditions Justifying Cesarean Delivery</u> • Less than 8 years of age • Greater than or equal to 65 years of age • <u>Gestational Age</u> < 37 weeks or Unable to Determine (UTD) Data Elements: Visit https://manual.jointcommission.org/releases/TJC2024B/MIF0167.html. <i>If fewer than 10 cases during the reporting period, skip the next question.</i> Question #3 (numerator): Patients in the denominator with cesarean births. Included Populations: <u>ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes</u> for cesarean birth as defined in Appendix A, Table <u>11.06 Cesarean Birth</u> Excluded Populations: None Data Elements: Visit https://manual.jointcommission.org/releases/TJC2024B/MIF0167.html.
Discharges between 01/01/2025 – 06/30/2025 (version <u>2025A</u>)	Question #2 (denominator): Nulliparous patients delivered of a live term singleton newborn in vertex presentation with Excluded populations removed. <i>Note: The denominator should include both nulliparous mothers with a live term singleton newborn in vertex presentation that had their newborn delivered via cesarean section and nulliparous mothers that delivered vaginally.</i> Included Populations: • <u>ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes</u> for delivery as defined in Appendix A, Table <u>11.01.1 Delivery</u>. • Nulliparous patients with <u>ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes</u> for outcome of delivery as defined in Appendix A, Table <u>11.08 Outcome of Delivery</u> and with a delivery of a newborn with 37 weeks or more of gestation completed. Excluded Populations: • <u>ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes</u> for multiple gestations, abnormal presentations, and conditions justifying cesarean delivery as defined in Appendix A, Table <u>11.09 Multiple Gestations, Abnormal Presentations, and Conditions Justifying Cesarean Delivery</u> • Less than 8 years of age

	- Greater than or equal to 65 years of age <u>Gestational Age</u> < 37 weeks or Unable to Determine (UTD) Data Elements: Visit https://manual.jointcommission.org/releases/TJC2025A/MIF0167.html. If fewer than 10 cases during the reporting period, skip the next question. Question #3 (numerator): Patients in the denominator with cesarean births. Included Populations: ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes for cesarean birth as defined in Appendix A, Table <u>11.06 Cesarean Birth</u> Excluded Populations: None Data Elements: Visit https://manual.jointcommission.org/releases/TJC2025A/MIF0167.html.
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Cesarean Birth Stratified by Race/Ethnicity

Source: Joint Commission PC-02 - version <u>2024B</u>: Discharges between 01/01/2023 – 12/31/2024 - version <u>2025A</u>: Discharges between 01/01/2025 – 06/30/2025	
Reporting Period: 24 months - Surveys submitted prior to September 1: 01/01/2023 – 12/31/2024 - Surveys (re)submitted on or after September 1: 07/01/2023 – 06/30/2025 Note: The discharge date must be used to determine whether a case falls within the reporting period specified. When reporting on Cesarean Birth Stratified by Race/Ethnicity, hospitals must report using a 24-month reporting period as specified in question #6. Hospitals participating in the California Maternal Quality Care Collaborative (CMQCC) Maternal Data Center may use the data provided in CMQCC reports when responding to question #8. Download instructions for using the CMQCC reports on the <u>Survey and CPOE Materials webpage</u>. Hospitals reporting to the U.S. News & World Report Maternity Services Survey may use the data provided to U.S. News & World Report and the crosswalk provided below when responding to question #8. Otherwise, hospitals should use TJC's PC-02 Cesarean Birth measure specifications to retrospectively review all cases and then stratify those cases by race/ethnicity. The PC-02 measure specifications are outlined below based on the discharge date. To access the measure specifications directly on The Joint Commission's website, see the specification manuals linked below: - version <u>2024B</u>: Discharges between 01/01/2023 – 12/31/2024 - version <u>2025A</u>: Discharges between 01/01/2025 – 06/30/2025	
Discharges between 01/01/2023 – 12/31/2024 (version <u>2024B</u>)	Question #8a (denominator): Total number of nulliparous patients delivered of a live term singleton newborn in vertex presentation with Excluded populations removed by the following races/ethnicities: - Non-Hispanic White - Non-Hispanic Black - Non-Hispanic American Indian or Alaska Native - Non-Hispanic Asian or Pacific Islander - Hispanic - Non-Hispanic Other (including two or more races)

- Unknown

Each patient should only be counted once and included in the appropriate race/ethnicity category based on known race/ethnicity information. If race or ethnicity is unknown, include the case in the “Unknown” category. Hispanic patients should be included in the “Hispanic” category regardless of race. If a race/ethnicity category is not used by your hospital, include the case in the “Unknown” category, i.e., if patients with more than one race are listed as “multiracial” regardless of their ethnicity, include these cases in the “Unknown” category. Hospitals that do not collect all races for patients that identify with multiple races are not able to report.

Hospitals reporting to U.S. News can use the below crosswalk when reporting to Leapfrog. Hospitals using CMQCC can use the below crosswalk or information provided directly in their Leapfrog CMQCC report:

CMQCC Race/Ethnicity	U.S. News Race/Ethnicity	Leapfrog Race/Ethnicity
Hispanic-US Born	Hispanic or Latino	Hispanic
Hispanic Non-US Born		
White	White	Non-Hispanic White
	Middle Eastern or North African	
Black	Black or African American	Non-Hispanic Black
Asian	Asian	Non-Hispanic Asian or Pacific Islander
Pacific Islander	Native Hawaiian or Pacific Islander	
Native American (American Indian or Alaska Native)	American Indian or Alaska Native	Non-Hispanic American Indian or Alaska Native
Other	N/A	Non-Hispanic Other (including two or more races)
Multiracial	Multiracial and/or Multiethnic	
Unknown	Unknown	Unknown

Note: The denominator should include both nulliparous mothers with a live term singleton newborn in vertex presentation that had their newborn delivered via cesarean section and nulliparous mothers that delivered vaginally.

Included Populations:

- ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes for delivery as defined in Appendix A, Table 11.01.1 Delivery.
- Nulliparous patients with ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes for outcome of delivery as defined in Appendix A, Table 11.08 Outcome of Delivery and with a delivery of a newborn with 37 weeks or more of gestation completed.
- ICD-10-CM Principal Diagnosis Code or ICD-10 CM Other Diagnosis Codes for term gestational age as defined in Appendix A, Table 11.10 Term Gestational Age

Excluded Populations:

	• <u>ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes</u> for multiple gestations, abnormal presentations, and conditions justifying cesarean delivery as defined in Appendix A, Table <u>11.09 Multiple Gestations, Abnormal Presentations, and Conditions Justifying Cesarean Delivery</u> • Less than 8 years of age • Greater than or equal to 65 years of age • <u>Gestational Age</u> < 37 weeks or Unable to Determine (UTD) Data Elements: Visit https://manual.jointcommission.org/releases/TJC2024B/MIF0167.html. If fewer than 10 cases during the reporting period for any race/ethnicity, skip the next question. Question #8b (numerator): Patients in the denominator with cesarean births by the following races/ethnicities: • Non-Hispanic White • Non-Hispanic Black • Non-Hispanic American Indian or Alaska Native • Non-Hispanic Asian or Pacific Islander • Hispanic • Non-Hispanic Other (including two or more races) • Unknown Included Populations: <u>ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes</u> for cesarean birth as defined in Appendix A, Table <u>11.06 Cesarean Birth</u> Excluded Populations: None Data Elements: Visit https://manual.jointcommission.org/releases/TJC2024B/MIF0167.html.
Discharges between 01/01/2025 – 06/30/2025 (version 2025A)	Question #8a (denominator): Total number of nulliparous patients delivered of a live term singleton newborn in vertex presentation with Excluded populations removed by the following races/ethnicities: • Non-Hispanic White • Non-Hispanic Black • Non-Hispanic American Indian or Alaska Native • Non-Hispanic Asian or Pacific Islander • Hispanic • Non-Hispanic Other (including two or more races) • Unknown Each patient should only be counted once and included in the appropriate race/ethnicity category based on known race/ethnicity information. If race or ethnicity is unknown, include the case in the “Unknown” category. Hispanic patients should be included in the “Hispanic” category regardless of race. If a race/ethnicity category is not used by your hospital, include the case in the “Unknown” category, i.e., if patients with more than one race are listed as “multiracial” regardless of their ethnicity, include these cases in the “Unknown” category. Hospitals that do not collect all races for patients that identify with multiple races are not able to report. Hospitals reporting to U.S. News can use the below crosswalk when reporting to Leapfrog. Hospitals using CMQCC can use the below crosswalk or information provided directly in their Leapfrog CMQCC report:

CMQCC Race/Ethnicity	U.S. News Race/Ethnicity	Leapfrog Race/Ethnicity
Hispanic-US Born	Hispanic or Latino	Hispanic
Hispanic Non-US Born		
White	White	Non-Hispanic White
	Middle Eastern or North African	
Black	Black or African American	Non-Hispanic Black
Asian	Asian	Non-Hispanic Asian or Pacific Islander
Pacific Islander	Native Hawaiian or Pacific Islander	
Native American (American Indian or Alaska Native)	American Indian or Alaska Native	Non-Hispanic American Indian or Alaska Native
Other	N/A	Non-Hispanic Other (including two or more races)
Multiracial	Multiracial and/or Multiethnic	
Unknown	Unknown	Unknown

Note: The denominator should include both nulliparous mothers with a live term singleton newborn in vertex presentation that had their newborn delivered via cesarean section and nulliparous mothers that delivered vaginally.

Included Populations:

- ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes for delivery as defined in Appendix A, Table 11.01.1 Delivery.
- Nulliparous patients with ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes for outcome of delivery as defined in Appendix A, Table 11.08 Outcome of Delivery and with a delivery of a newborn with 37 weeks or more of gestation completed.

Excluded Populations:

- ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes for multiple gestations abnormal presentations and conditions justifying cesarean delivery as defined in Appendix A, Table 11.09 Multiple Gestations, Abnormal Presentations, and Conditions Justifying Cesarean Delivery
- Less than 8 years of age
- Greater than or equal to 65 years of age
- Gestational Age < 37 weeks or Unable to Determine (UTD)

Data Elements: Visit

<https://manual.jointcommission.org/releases/TJC2025A/MIF0167.html>.

If fewer than 10 cases during the reporting period, skip the next question.

	Question #8b (numerator): Patients in the denominator with cesarean births by the following races/ethnicities: • Non-Hispanic White • Non-Hispanic Black • Non-Hispanic American Indian or Alaska Native • Non-Hispanic Asian or Pacific Islander • Hispanic • Non-Hispanic Other (including two or more races) • Unknown Included Populations: <i>ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes</i> for cesarean birth as defined in Appendix A, Table <u>11.06 Cesarean Birth</u> Excluded Populations: None Data Elements: Visit https://manual.jointcommission.org/releases/TJC2025A/MIF0167.html
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Episiotomy Measure Specifications

Important Note: Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Source: National Quality Forum #0470

Reporting Period: 12 months

- Surveys submitted prior to September 1:
 - 01/01/2024 – 12/31/2024
- Surveys (re)submitted on or after September 1:
 - 07/01/2024 – 06/30/2025

Note: The discharge date must be used to determine whether a case falls within the reporting period specified.

Hospitals participating in the California Maternal Quality Care Collaborative (CMQCC) Maternal Data Center may use the data provided in CMQCC reports when responding to this subsection of the Survey. Download instructions for using the CMQCC reports on the [Survey and CPOE Materials webpage](#).

Question #2 (denominator): Total number of vaginal deliveries during the reporting period, with Excluded Populations removed.

For the purposes of this measure, use the following MS-DRGs to identify a vaginal delivery:

- 768: Vaginal delivery with O.R. procedure except sterilization and/or D&C
- 796: Vaginal delivery with sterilization/D&C with MCC
- 797: Vaginal delivery with sterilization/D&C with CC
- 798: Vaginal delivery with sterilization/D&C without CC/MCC
- 805: Vaginal delivery without sterilization/D&C with MCC
- 806: Vaginal delivery without sterilization/D&C with CC
- 807: Vaginal delivery without sterilization/D&C without CC/MCC

The following APR-DRGs should also be used to identify a vaginal delivery if your hospital uses APR-DRG coding:

- 541: Vaginal delivery with sterilization and/or D&C
- 542: Vaginal delivery with complicating procedures excluding sterilization and/or D&C
- 560: Vaginal delivery

The following Tricare DRGs should also be used to identify a vaginal delivery if your hospitals uses Tricare DRG coding:

- 762 Vaginal delivery with sterilization or D&C with MCC
- 763 Vaginal delivery with sterilization or D&C with CC
- 764 Vaginal delivery with sterilization or D&C without CC/MCC
- 768 Vaginal delivery with O.R. procedure except sterilization and/or D&C
- 805 Vaginal delivery without sterilization or D&C with MCC
- 806 Vaginal delivery without sterilization or D&C with CC
- 807 Vaginal delivery without sterilization or D&C without CC/MCC

Excluded Populations:

Exclude any cases with the following ICD-10-CM diagnostic code in any field:

- O66.0: Obstructed labor due to shoulder dystocia

Question #3 (numerator): Total number of mothers included in question #2 (the denominator) that had an episiotomy procedure performed.

For the purposes of this measure, the following ICD-10-PCS procedure codes should be used for identifying an episiotomy:

- 0W8NXZZ: Division of female perineum, external approach

Process Measures of Quality Measure Specifications**Important Notes:**

Note 1: Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Note 2: For Maternity Care Process Measures, hospitals with a sufficient sample size (as defined below), can randomly sample for the denominator of each indicator, and measure and report adherence based on that sample. Most likely, the numerator criteria for these two measures will require medical chart review if these specific data are not already extracted or coded consistently for other purposes.

Newborn Bilirubin Screening Prior to Discharge

Source: Providence Health

Reporting Period: 12 months

- Surveys submitted prior to September 1:
 - 01/01/2024 – 12/31/2024
- Surveys (re)submitted on or after September 1:
 - 07/01/2024 – 06/30/2025

Note: The discharge date must be used to determine whether a case falls within the reporting period specified.

Hospitals participating in the California Maternal Quality Care Collaborative (CMQCC) Maternal Data Center may use the data provided in CMQCC reports when responding to this subsection of the Survey. Download instructions for using the CMQCC reports on the [Survey and CPOE Materials webpage](#).

Sampling: If you have fewer than 30 cases that meet the criteria for inclusion in the denominator of the process measure during the time period of the medical record audit, include ALL of these cases in measuring adherence to the process guidelines. You need NOT use more than 12 months of historical data to increase the eligible cases beyond 30; just measure and report on ALL eligible cases that you have in that reporting period.

If you have more than 30 cases that meet the criteria for inclusion in the denominator of the process measure during the time period of the medical record audit, you may randomly sample at least 30 of them for the denominator of each guideline, and measure and report adherence based on that sample.

Question #3 (denominator): Eligible cases include all normal newborns born at or beyond 35 completed weeks gestation that were delivered in the hospital during the reporting period (all inborns) with **Excluded Populations** removed.

Excluded Populations:

- admitted to a neonatal ICU, either at your hospital or another hospital; or
- with parental refusal to test; or
- prenatal documentation of severe congenital anomalies in the newborn and documentation that the newborn will receive comfort care measures only; or
- newborn died prior to discharge

Question #4 (numerator): Number of eligible cases included in the denominator who have a serum or transcutaneous bilirubin screen prior to discharge to identify risk of hyperbilirubinemia.

Appropriate DVT Prophylaxis in Women Undergoing Cesarean Delivery**Source:** National Quality Forum #0473**Reporting Period: 12 months**

- Surveys submitted prior to September 1:
 - 01/01/2024 – 12/31/2024
- Surveys (re)submitted on or after September 1:
 - 07/01/2024 – 06/30/2025

Note: The discharge date must be used to determine whether a case falls within the reporting period specified.

Hospitals participating in the California Maternal Quality Care Collaborative (CMQCC) Maternal Data Center may use the data provided in CMQCC reports when responding to this subsection of the Survey. Download instructions for using the CMQCC reports on the [Survey and CPOE Materials webpage](#).

Sampling: If you have fewer than 30 cases that meet the criteria for inclusion in the denominator of the process measure during the time period of the medical record audit, include ALL of these cases in measuring adherence to the process guidelines. You need NOT use more than 12 months of historical data to increase the eligible cases beyond 30; just measure and report on ALL eligible cases that you have in that reporting period.

If you have more than 30 cases that meet the criteria for inclusion in the denominator of the process measure during the time period of the medical record audit, you may randomly sample at least 30 of them for the denominator of each guideline, and measure and report adherence based on that sample.

Question #7 (denominator): Eligible cases include all women undergoing cesarean delivery during the reporting period.

Include cases with one of the following MS-DRG codes:

- 783: Cesarean section with sterilization with MCC
- 784: Cesarean section with sterilization with CC
- 785: Cesarean section with sterilization without CC/MCC
- 786: Cesarean section without sterilization with MCC
- 787: Cesarean section without sterilization with CC
- 788: Cesarean section without sterilization without CC/MCC

The following APR-DRGs should also be used to identify a cesarean delivery if your hospital uses APR-DRG coding:

- 539: Cesarean section with sterilization
- 540: Cesarean section without sterilization

The following Tricare DRGs should also be used to identify a cesarean delivery if your hospitals uses Tricare DRG coding:

- 771 Cesarean section without sterilization with MCC
- 772 Cesarean section without sterilization with CC
- 773 Cesarean section without sterilization without CC/MCC
- 783 Cesarean section with sterilization with MCC
- 784 Cesarean section with sterilization with CC
- 785 Cesarean section with sterilization without CC/MCC

Excluded Populations: None.

Question #8 (numerator) Number of eligible cases included in the denominator who received either

- fractionated or unfractionated heparin or heparinoid, or
- pneumatic compression devices prior to surgery.

Note: Use of a pneumatic compression device may be documented in the OR log but must be placed pre-operatively to qualify for inclusion in the numerator.

For a list of approved pneumatic compression devices, see the devices listed under "Intermittent Pneumatic Compression Device (IPC)" in [Table 2.1 VTE Prophylaxis Inclusion Table](#).

High-Risk Deliveries Measure Specifications**Important Notes:**

Note 1: Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Note 2: Hospitals should report on the selection from Section 4E question #3 (**either** Volume OR the National Performance Measure (VON)).

Neonatal Intensive Care Unit(s) – Volume

Hospitals opting to report on Volume should only use ICD-10-CM codes as indicated in the specifications below. When calculating hospital volume, count the number of patients with any one or more of the specified diagnosis codes for high-risk deliveries, subject to the other inclusion/exclusion criteria below. The diagnosis codes may be in any field. The count can include inborn as well as transfer cases.

Source: The Leapfrog Group

Reporting Period: 12 months

- Surveys submitted prior to September 1:
 - 01/01/2024 – 12/31/2024
- Surveys (re)submitted on or after September 1:
 - 07/01/2024 – 06/30/2025

Note: The discharge date must be used to determine whether a case falls within the reporting period specified.

Question #5 (Instructions for Volume Reporting)**Included Populations:**

Number of newborns admitted to the neonatal ICU with the following ICD-10-CM codes:

ICD-10-CM Code	Description
P05.02	Newborn light for gestational age, 500-749 grams
P05.03	Newborn light for gestational age, 750-999 grams
P05.04	Newborn light for gestational age, 1000-1249 grams
P05.05	Newborn light for gestational age, 1250-1499 grams
P05.12	Newborn small for gestational age, 500-749 grams
P05.13	Newborn small for gestational age, 750-999 grams
P05.14	Newborn small for gestational age, 1000-1249 grams
P05.15	Newborn small for gestational age, 1250-1499 grams
P05.2	Newborn affected by fetal malnutrition not light or small for gestational age
P05.9	Newborn affected by slow intrauterine growth, unspecified
P07.02	Extremely low birth weight newborn, 500-749 grams
P07.03	Extremely low birth weight newborn, 750-999 grams
P07.14	Other low birth weight newborn, 1000-1249 grams
P07.15	Other low birth weight newborn, 1250-1499 grams

Excluded Populations: Newborns admitted to the neonatal ICU weighing 1500 grams or more.

Neonatal Intensive Care Unit(s) – National Performance Measurement

Hospitals participating in the Vermont Oxford Network (VON) may opt to report on the VON National Performance Measure. In order for Leapfrog to obtain the data from VON, the VON data must be finalized, and hospitals must complete the following steps:

1. Provide an accurate VON Transfer Code in the Hospital Profile,
2. Complete a Data Sharing Authorization letter and submit it to VON by **June 16** (Hospitals that submitted their Data Sharing Authorization letter to VON in previous Leapfrog Hospital Survey Cycles do not have to re-submit a new letter in 2025),
3. Select "VON National Performance Measure" in question #3, and
4. Submit the 2025 Leapfrog Hospital Survey by the June 30 Submission Deadline.

Hospitals that select "VON National Performance Measure" in question #3, but do not adhere to the other steps will be scored and publicly reported as "Declined to Respond" for the High-Risk Deliveries measure.

Data will be available for review on the Leapfrog Hospital Survey Hospital Details Page beginning on July 12. The VON data Leapfrog obtains can be found in the Vermont Oxford Network's Nightingale Internet Reporting System. Leapfrog has provided instructions for using the VON Nightingale online tool on the Survey and CPOE Materials webpage. These instructions can be used to verify the data that Leapfrog is obtaining from VON, which includes:

Variable	From the Vermont Oxford Network (SMR Report from Nightingale online tool)
Volume	From the latest 12-month standardized mortality or morbidity ratio (SMR) report for Death or Morbidity, the hospital's "N" for the volume of cases for the reporting period.
SMR 95% (lower bound)	From the same report, the hospital's "SMR 95% (lower)" for Death or Morbidity. This represents the lower value of your hospital's 95% confidence interval.
SMR (shrunk)	From the same report, the hospital's "SMR (shrunk)" for Death or Morbidity. This is the weighted average of the hospital value and the population (Vermont Oxford Network) mean value.
SMR 95% (upper bound)	From the same report, the hospital's "SMR 95% (upper)" for Death or Morbidity. This represents the upper value of your hospital's 95% confidence interval.

Deadlines and Reporting Periods

Leapfrog will update the VON data three times per Survey Cycle for all hospitals that have completed the steps noted above according to the deadlines and reporting periods listed in the following table:

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

* Hospitals that successfully submitted a Data Sharing Authorization letter in previous years are not required to submit another letter in 2025.

**Anticipated release of 2024 VON data.

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

See [FAQs](#) for additional information about responding to the questions in this section.

Section 4: Maternity Care Frequently Asked Questions (FAQs)

- 1. Under normal circumstances our hospital does not perform newborn deliveries. However, during the reporting period we had a few emergency situations and/or transfers. Should we indicate delivering newborns during the reporting period?**

If your hospital does not electively perform newborn deliveries (i.e., no labor/delivery unit, only admit in an emergency situation), you would respond “no” to question #2 in Section 4A, as hospitals are instructed to report inborns only.

- 2. Should newborns that are delivered outside of the hospital that are brought to labor and delivery be included in the total number of live births in Section 4A?**

When calculating the total number of live births in Section 4A question #3, refer to the measure specifications for Maternity Care Volume. Only inborns should be included in the total volume.

- 3. Should hospitals use delivery date or discharge date when including births/cases for the measures reported in Section 4: Maternity Care?**

The discharge date should be used to determine whether a case falls within the reporting period specified.

- 4. What would qualify as offering breastfeeding/lactation consultants “at home after discharge” for the purposes of question #6 in Section 4A?**

“At home after discharge” includes lactation services provided in the home either in-person or via telehealth with video capabilities. A phone call would not be sufficient.

- 5. Can our hospital answer “yes” to question #8 in Section 4A if we offer pre-planned postpartum tubal ligation during the labor and delivery admission?**

Yes, the tubal ligation can be pre-planned and would qualify if you offer this during the labor and delivery admission.

- 6. In Section 4D, what tools should hospitals use for managing patients that receive a serum or transcutaneous bilirubin screen to assess the risk of hyperbilirubinemia prior to discharge?**

One example a hospital can use is the Bhutani Nomogram. For an example, please see: *American Academy of Pediatrics Clinical Practice Guidelines: Management of Hyperbilirubinemia in the Newborn Infant 35 or More Weeks of Gestation*.

<http://pediatrics.aappublications.org/content/114/1/297.full>

Tip: To view any Figure in the reference, click on it to open, then again to enlarge.

Other tools may also be used if the serum or transcutaneous screen is conducted prior to discharge and risk is managed appropriately.

- 7. In Section 4D, what codes or diagnoses should be used to identify severe congenital anomalies for exclusions for newborn bilirubin screening prior to discharge?**

Leapfrog’s Maternity Care Expert Panel has opted to not overcomplicate the measure by providing ICD-codes for identifying congenital anomalies in the newborn. Instead, we would suggest that you focus on identifying the following exclusions: documentation that the newborn will receive comfort care measures only, which would accompany the prenatal documentation of severe congenital anomalies in the newborn.

If you have concerns about the level of effort required to identify these exclusions, please note that Leapfrog allows hospitals to report on a sample of 30 cases for those facilities that opt to report on a sample instead of full case reporting. You can find those instructions in the [Maternity Care Process Measure Specifications](#).

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SECTION 5: PHYSICIAN AND NURSE STAFFING

This section includes questions and reference information for Section 5: Physician and Nurse Staffing. Please carefully review the questions, endnotes, and reference information (e.g., measure specifications, notes, and frequently asked questions) before you begin. Failure to review the reference information could result in inaccurate responses.

Section 5: Physician and Nurse Staffing**Adult and Pediatric ICU Physician Staffing Fact Sheet and Bibliography:**

<https://ratings.leapfroggroup.org/measure/hospital/2025/specially-trained-doctors-care-critical-care-patients>

Nursing Workforce Fact Sheet and Bibliography:

<https://ratings.leapfroggroup.org/measure/hospital/2025/nursing-workforce>

Hospitals that do not admit adult critical care patients or operate an adult general medical, surgical, medical/surgical, or neuro ICU should select “No” in question #2 in Section 5A: Adult ICU Physician Staffing and move on to Section 5B: Pediatric ICU Physician Staffing. Hospitals that do not admit pediatric critical care patients or operate a pediatric general medical, surgical, medical/surgical, or neuro ICU should select “No” in question #2 in Section 5B: Pediatric ICU Physician Staffing and move on to Section 5C: Nursing Workforce.

Hospitals that regularly admit adult and/or pediatric critical care patients to a mixed acuity unit, should select “Yes” in question #2 in Section 5A: Adult ICU Physician Staffing and/or Section 5B: Pediatric ICU Physician Staffing and respond to all applicable questions. The standard applies to all adult and pediatric general medical, surgical, medical/surgical, and neuro critical care patients (medical and surgical), including those patients in mixed acuity units.

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

Section 5 includes questions about the management of critical care patients and the staffing structure of your hospital's adult and pediatric general medical, surgical, medical/surgical, and neuro ICUs, and questions about your hospital's nursing staffing and skill mix (previously included in Section 6).

Each hospital achieving the standard for Adult and/or Pediatric ICU Physician Staffing assures that:

All critical care patients³⁴ in its General Medical, Surgical, Medical/Surgical, and Neuro ICUs¹⁴ are managed or co-managed³⁵ by physicians certified in critical care medicine³⁶ who:

- Are ordinarily present in the ICU³⁷ during daytime hours for at least 8 hours per day, 7 days per week, and during this time provide clinical care exclusively³⁷ in the ICU
OR
- Are present via telemedicine³⁸, in combination with on-site intensivist coverage, for a total of 24 hours per day, 7 days per week; meet all of Leapfrog's ICU requirements for intensivist presence in the ICU via telemedicine; and supported by an on-site intensivist who establishes and revises the daily care plan for each ICU patient, **and**
- At other times*
 - Return more than 95% of ICU calls within 5 minutes, based on a quantified analysis³⁹ of notification device response time; and
 - Can rely on a physician, physician assistant, nurse practitioner⁴², or an ECSS-certified nurse effector⁴⁰ who is in the hospital and able to reach ICU patients within 5 minutes in more than 95% of cases, based on a quantified hospital analysis of response time of the effector reaching the patient.

*Not applicable for hospitals with 24/7 intensivist coverage.

Each hospital achieving the standard for Total Nursing Care Hours per Patient Day:

Has a ratio of total nursing care hours per patient day that is greater than or equal to the 50th percentile (where higher is better) for that hospital's cohort (small teaching, large teaching, non-teaching, mixed acuity, pediatric, or critical access hospital).

Each hospital achieving the standard for RN Hours per Patient Day:

Has a ratio of RN hours per patient day that is greater than or equal to the 50th percentile (where higher is better) for that hospital's cohort (small teaching, large teaching, non-teaching, mixed acuity, pediatric, or critical access hospital).

Each hospital achieving the standard for Nursing Skill Mix:

Has a percentage of total productive nursing hours worked by RN nursing staff that is higher than or equal to the 50th percentile (where higher is better) for the hospital's cohort (small teaching, large teaching, non-teaching, mixed acuity, pediatric, or critical access hospitals).

Each hospital achieving the standard for Percentage of RNs who are BSN-Prepared:

Has a percentage of RNs who are BSN-prepared that is greater than or equal to 80%.

Download the 2025 Leapfrog Hospital Survey Scoring Algorithm on the [Scoring and Results](#) webpage.

5A: Adult ICU Physician Staffing

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review Leapfrog's [Multi-Campus Reporting Policy](#).

Important Notes:

Note 1: Each of the endnotes referenced in the questions below must be reviewed before responding to each question.

Note 2: Some intensivist "presence" may be accomplished via tele-intensivists per Leapfrog's specifications ([More Information](#)³⁸). However, at this time hospitals cannot achieve the standard through the sole use of tele-intensivists.

Note 3: On an interim basis, other categories of physicians may be considered by Leapfrog to be "certified in Critical Care Medicine" ([More Information](#)³⁶).

Note 4: The standard applies to all adult general medical, surgical, medical/surgical, and neuro critical care patients (medical and surgical), including those patients in mixed acuity units.

Reporting Period: 3 months

Answer questions #1-15 based on the staffing structure currently in place at the time that you submit this section of the Survey. The staffing structure should have been in place for at least the past 3 months and reflect the ordinary staffing structure for each applicable ICU.

Note: As a reminder, the [Corrections Period](#) (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

1) What is the latest 3-month reporting period for which your hospital is submitting responses to this section? 3 months ending:	<u> </u> Format: Month/Year
2) Does your hospital operate any adult <u>General Medical, Surgical, Medical/Surgical, or Neuro ICUs</u>¹⁴? <i>If your hospital has more than one applicable adult ICU, respond to all questions in this section based on the adult ICU that has the lowest level of staffing by physicians certified in critical care medicine (More Information¹⁴).</i> <i>If your hospital does not operate an applicable adult ICU but regularly admits adult critical care patients to mixed acuity units, select "yes" and respond to the remaining questions in Section 5A.</i> <i>If "no" to question #2, skip the remaining questions in Section 5A and continue to the next subsection. The hospital will be scored as "Does Not Apply."</i>	☐ Yes ☐ No
3) Is the ICU staffed with physicians who are <u>certified in critical care medicine</u>³⁶ and present on-site or via telemedicine? <i>If "no, the ICU is not staffed with any physicians certified in critical care medicine" to question #3, skip the remaining</i>	☐ Yes, the ICU is staffed with physicians certified in critical care medicine ☐ Yes, the ICU is staffed with physicians certified in critical care medicine

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Section 5: Physician and Nurse Staffing

questions in Section 5A and continue to the next subsection. This hospital will be scored as "Limited Achievement."	based on Leapfrog's expanded definition ○ No, the ICU is not staffed with any physicians certified in critical care medicine
4) Do the physicians who are <u>certified in critical care medicine</u>³⁶ (whether present on-site or via telemedicine) manage or co-manage <u>all critical care patients</u>³⁴ in the ICU? If "no" to question #4, skip questions #5-11 and continue to question #12.	○ Yes, all patients are managed or co-managed by a physician certified in critical care medicine when the physician is present (on-site or via telemedicine) ○ No, not all patients are managed or co-managed by a physician certified in critical care medicine when the physician is present (on-site or via telemedicine)

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

5) Are <u>all critical care patients</u>³⁴ in the ICU <u>managed or co-managed</u>³⁵ by one or more physicians <u>certified in critical care medicine</u>³⁶ who meet all the following criteria: • <u>ordinarily present</u>³⁷ on-site in the ICU during daytime hours; • for at least 8 hours per day, 7 days per week; and • providing clinical care <u>exclusively</u>³⁷ in the ICU during these hours? If "yes" to question #5, skip question #6 and continue to question #7.	○ Yes ○ No
6) Are <u>all critical care patients</u>³⁴ in the ICU <u>managed or co-managed</u>³⁵ by one or more physicians <u>certified in critical care medicine</u>³⁶ who meet all the following criteria: • present via telemedicine, in combination with on-site intensivist coverage, for a total of 24 hours per day, 7 days per week; • meet all of Leapfrog's ICU requirements for intensivist presence in the ICU via telemedicine (<u>More Information</u>³⁸); and • supported by an on-site intensivist who establishes and revises the daily care plan for each ICU patient?	○ Yes ○ No

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

7) When the physicians (from question #3) are not present in the ICU on-site or via telemedicine, do they return more than 95% of calls/pages/texts from these units within five minutes, based on a <u>quantified analysis</u>³⁹ of notification device response time? (<u>More information on the use of telemedicine to cover calls</u>⁴¹)	○ Yes ○ No ○ Not applicable; intensivists are present on-site 24/7
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Section 5: Physician and Nurse Staffing

8) When the physicians (from question #3) are not present on-site in the ICU or not able to physically reach an ICU patient within 5 minutes, can they rely on a <u>physician, physician assistant, nurse practitioner⁴², or FCCS-certified nurse or intern “effector”⁴⁰</u> who is in the hospital and able to reach these ICU patients within five minutes in more than 95% of the cases, based on a <u>quantified analysis³⁹</u> of response time of the effector reaching the patient?	○ Yes ○ No ○ Not applicable; intensivists are present on-site 24/7
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If “no” to either question #7 or #8 in this section, continue to questions #9-15. If “yes” or “not applicable; intensivists are present on-site 24/7” to questions #7 and #8, skip the remaining questions in Section 5A and continue to the next subsection.

9) Are <u>all critical care patients³⁴</u> in the ICU <u>managed or co-managed³⁵</u> by one or more physicians <u>certified in critical care medicine³⁶</u> who meet all the following criteria: • <u>ordinarily present³⁷</u> on-site in the ICU during daytime hours; • for at least 8 hours per day, 4 days per week or 4 hours per day, 7 days per week; and • providing clinical care <u>exclusively³⁷</u> in the ICU during these hours?	○ Yes ○ No
10) Are <u>all critical care patients³⁴</u> in the ICU <u>managed or co-managed³⁵</u> by one or more physicians <u>certified in critical care medicine³⁶</u> who meet all the following criteria: • present via telemedicine for 24 hours per day, 7 days per week; • meet all of Leapfrog’s modified ICU requirements for intensivist presence in the ICU via telemedicine (<u>More Information⁴³</u>); and • supported in the establishment and revision of daily care planning for each ICU patient by an on-site intensivist, hospitalist, anesthesiologist, or physician trained in emergency medicine?	○ Yes ○ No
11) Are <u>all critical care patients³⁴</u> in the ICU <u>managed or co-managed³⁵</u> by one or more physicians <u>certified in critical care medicine³⁶</u> who are: • on-site at least 4 days per week to establish or revise daily care plans for each critical care patient in the ICU?	○ Yes ○ No

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

12) If not <u>all critical care patients³⁴</u> are <u>managed or co-managed³⁵</u> by physicians <u>certified in critical care medicine³⁶</u> , either on-site or via <u>telemedicine³⁶</u> , are some critical care patients managed or co-managed by these physicians who are: • <u>ordinarily present³⁷</u> on-site in the ICU during daytime hours; • for at least 8 hours per day, 4 days per week or 4 hours per day, 7 days per week; and • providing clinical care <u>exclusively³⁷</u> in the ICU during these hours?	○ Yes ○ No
13) Does an on-site clinical pharmacist do all the following: • at least 5 days per week, makes daily on-site rounds on <u>all critical care patients³⁴</u> in the ICU; and • on the other 2 days per week, returns more than 95% of calls/pages/texts from the unit within 5 minutes, based on a <u>quantified analysis³⁹</u> of notification device response time; OR • makes daily on-site rounds on <u>all critical care patients³⁴</u> in the ICU 7 days per week?	○ Yes ○ No ○ Clinical pharmacist rounds 7 days per week

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14) Does a physician <u>certified in critical care medicine</u> ³⁶ lead daily interprofessional rounds on-site on <u>all critical care patients</u> ³⁴ in the ICU 7 days per week?	☐ Yes ☐ No
15) Are physicians <u>certified in critical care medicine</u> ³⁶ responsible for all ICU admission and discharge decisions when they are: • present on-site for at least 8 hours per day, 4 days per week or 4 hours per day, 7 days per week?	☐ Yes ☐ No

5B: Pediatric ICU Physician Staffing

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review Leapfrog's Multi-Campus Reporting Policy.

Important Notes:

Note 1: Each of the endnotes referenced in the questions below must be reviewed before responding to each question.

Note 2: Some intensivist "presence" may be accomplished via tele-intensivists per Leapfrog's specifications (More Information³⁸). However, at this time hospitals cannot achieve the standard through the sole use of tele-intensivists.

Note 3: On an interim basis, other categories of physicians may be considered by Leapfrog to be "certified in Critical Care Medicine" (More Information³⁶).

Note 4: The standard applies to all pediatric general medical, surgical, medical/surgical, and neuro critical care pediatric patients (medical and surgical), including those pediatric patients in mixed acuity units.

Reporting Period: 3 months

Answer questions #1-15 based on the staffing structure currently in place at the time that you submit this section of the Survey. The staffing structure should have been in place for at least the past 3 months and reflect the ordinary staffing structure for each applicable ICU.

Note: As a reminder, the Corrections Period (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

1) What is the latest 3-month reporting period for which your hospital is submitting responses to this section? 3 months ending:	_____ <i>Format: Month/Year</i>
2) Does your hospital operate any pediatric <u>General Medical, Surgical, Medical/Surgical, or Neuro ICUs</u>¹⁴? <i>If your hospital has more than one applicable pediatric ICU, respond to all questions in this section based on the pediatric ICU that has the lowest level of staffing by physicians certified in critical care medicine (<u>More Information</u>¹⁴).</i> <i>If your hospital does not operate an applicable pediatric ICU but regularly admits critical care pediatric patients to mixed acuity units, select "yes" and respond to the remaining questions in Section 5B.</i> <i>If "no" to question #2, skip the remaining questions in Section 5B and continue to the next subsection. The hospital will be scored as "Does Not Apply."</i>	☐ Yes ☐ No

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3) Is the ICU staffed with physicians who are <u>certified in critical care medicine</u>³⁶ and present on-site or via telemedicine? <i>If “no, the ICU is not staffed with any physicians certified in critical care medicine” to question #3, skip the remaining questions in Section 5B and continue to the next subsection. This hospital will be scored as “Limited Achievement.”</i>	○ Yes, the ICU is staffed with physicians certified in critical care medicine ○ Yes, the ICU is staffed with physicians certified in critical care medicine based on Leapfrog’s expanded definition ○ No, the ICU is not staffed with any physicians certified in critical care medicine
4) Do the physicians who are <u>certified in critical care medicine</u>³⁶ (whether present on-site or via telemedicine) manage or co-manage <u>all critical care patients</u>³⁴ in the ICU? <i>If “no” to question #4, skip questions #5-11 and continue to question #12.</i>	○ Yes, all patients are managed or co-managed by a physician certified in critical care medicine when the physician is present (on-site or via telemedicine) ○ No, not all patients are managed or co-managed by a physician certified in critical care medicine when the physician is present (on-site or via telemedicine)

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

5) Are all critical care patients³⁴ in the ICU managed or co-managed³⁵ by one or more physicians <u>certified in critical care medicine</u>³⁶ who meet all the following criteria: • <u>ordinarily present</u>³⁷ on-site in the ICU during daytime hours; • for at least 8 hours per day, 7 days per week; and • providing clinical care <u>exclusively</u>³⁷ in the ICU during these hours? <i>If “yes” to question #5, skip question #6 and continue to question #7.</i>	○ Yes ○ No
6) Are <u>all critical care patients</u>³⁴ in the ICU managed or co-managed³⁵ by one or more physicians <u>certified in critical care medicine</u>³⁶ who meet all the following criteria: • present via telemedicine, in combination with on-site intensivist coverage, for a total of 24 hours per day, 7 days per week; • meet all of Leapfrog’s ICU requirements for intensivist presence in the ICU via telemedicine (<u>More Information</u>³⁸); and • supported by an on-site intensivist who establishes and revises the daily care plan for each ICU patient?	○ Yes ○ No

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

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7) When the physicians (from question #3) are not present in the ICU on-site or via telemedicine, do they return more than 95% of calls/pages/texts from these units within five minutes, based on a <u>quantified analysis</u> ³⁹ of notification device response time? (<u>More information on the use of telemedicine to cover calls</u> ⁴¹)	☐ Yes ☐ No ☐ Not applicable; intensivists are present on-site 24/7
8) When the physicians (from question #3) are not present on-site in the ICU or not able to physically reach an ICU patient within 5 minutes, can they rely on a <u>physician, physician assistant, nurse practitioner</u> ⁴² , or <u>FCCS-certified nurse or intern “effector”</u> ⁴⁰ who is in the hospital and able to reach these ICU patients within five minutes in more than 95% of the cases, based on a <u>quantified analysis</u> ³⁹ of response time of the effector reaching the patient?	☐ Yes ☐ No ☐ Not applicable; intensivists are present on-site 24/7

If “no” to either question #7 or #8 in this section, continue to questions #9-15. If “yes” or “not applicable; intensivists are present on-site 24/7” to questions #7 and #8, skip the remaining questions in Section 5B and continue to the next subsection.

9) Are <u>all critical care patients</u> ³⁴ in the ICU <u>managed or co-managed</u> ³⁵ by one or more physicians <u>certified in critical care medicine</u> ³⁶ who meet all the following criteria: - ordinarily present³⁷ on-site in the ICU during daytime hours; - for at least 8 hours per day, 4 days per week or 4 hours per day, 7 days per week; and - providing clinical care <u>exclusively</u>³⁷ in the ICU during these hours?	☐ Yes ☐ No
10) Are <u>all critical care patients</u> ³⁴ in the ICU <u>managed or co-managed</u> ³⁵ by one or more physicians <u>certified in critical care medicine</u> ³⁶ who meet all the following criteria: - present via telemedicine for 24 hours per day, 7 days per week; - meet all of Leapfrog's modified ICU requirements for intensivist presence in the ICU via telemedicine (<u>More Information</u>⁴³); and - supported in the establishment and revision of daily care planning for each ICU patient by an on-site intensivist, hospitalist, anesthesiologist, or physician trained in emergency medicine?	☐ Yes ☐ No
11) Are <u>all critical care patients</u> ³⁴ in the ICU <u>managed or co-managed</u> ³⁵ by one or more physicians <u>certified in critical care medicine</u> ³⁶ who are: on-site at least 4 days per week to establish or revise daily care plans for each critical care patient in the ICU?	☐ Yes ☐ No

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

12) If not <u>all critical care patients</u> ³⁴ are <u>managed or co-managed</u> ³⁵ by physicians <u>certified in critical care medicine</u> ³⁶ , either on-site or via <u>telemedicine</u> ³⁸ , are some critical care patients managed or co-managed by these physicians who are: - ordinarily present³⁷ on-site in the ICU during daytime hours; - for at least 8 hours per day, 4 days per week or 4 hours per day, 7 days per week; and - providing clinical care <u>exclusively</u>³⁷ in the ICU during these hours?	☐ Yes ☐ No
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Section 5: Physician and Nurse Staffing

13) Does an on-site clinical pharmacist do all the following: • at least 5 days per week, makes daily on-site rounds on <u>all critical care patients</u>³⁴ in the ICU; and • on the other 2 days per week, returns more than 95% of calls/pages/texts from the unit within 5 minutes, based on a <u>quantified analysis</u>³⁹ of notification device response time; OR • makes daily on-site rounds on <u>all critical care patients</u>³⁴ in the ICU 7 days per week?	☐ Yes ☐ No ☐ Clinical pharmacist rounds 7 days per week
14) Does a physician <u>certified in critical care medicine</u>³⁶ lead daily interprofessional rounds on-site on <u>all critical care patients</u>³⁴ in the ICU 7 days per week?	☐ Yes ☐ No
15) Are physicians <u>certified in critical care medicine</u>³⁶ responsible for all ICU admission and discharge decisions when they are: • present on-site for at least 8 hours per day, 4 days per week or 4 hours per day, 7 days per week?	☐ Yes ☐ No

5C: Nursing Workforce

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Total Nursing Care Hours per Patient Day, RN Hours per Patient Day, and Nursing Skill Mix**Important Notes:**

Note 1: Hospitals should respond to questions #1-5 and #6-11 if they operate at least one adult or pediatric **single** acuity Medical, Surgical, or Med-Surg unit, defined as a unit where at least 90% of patients in the unit receive the same level of care. If responding to questions #6-11, skip questions #12-14.

Note 2: Hospitals should respond to questions #1-5 and #12-14 if they:

- **do not** operate any adult or pediatric **single** acuity Medical, Surgical, or Med-Surg Units, **but**
- operate at least one adult or pediatric **mixed** acuity Medical, Surgical, or Med-Surg Unit, defined as a unit where more than 10% of the patients in the unit receive varying levels of care (e.g., general medical care and progressive care or intensive care).

Note 3: Single or mixed acuity Medical, Surgical, or Med-Surg Units that had fewer than 15 patient days per month for all 3 months of any quarter of the reporting period should be excluded in questions #6-11 or #12-14.

Note 4: Single or mixed acuity Medical, Surgical, or Med-Surg Units that transitioned to an excluded unit type during the reporting period should be excluded in questions #6-11 or #12-14. For example, if a single acuity Medical Unit transitioned to an ICU during the reporting period, the unit should be excluded when responding to questions #6-11.

Specifications: See [Nursing Workforce Measure Specifications](#) in the Reference Information beginning on page 200.

Reporting Period: 12 months

- Survey submitted prior to September 1:
 - 01/01/2024 – 12/31/2024
- Surveys submitted on or after September 1:
 - 07/01/2024 – 06/30/2025

Note: As a reminder, the [Corrections Period](#) (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

1) 12-month reporting period used:	○ 01/01/2024 – 12/31/2024 ○ 07/01/2024 – 06/30/2025
2) Does your hospital operate at least one adult or pediatric single acuity Medical, Surgical, or Med-Surg Unit? <i>A single acuity unit is defined as a unit where at least 90% of the patients receive the same level of care.</i> <i>If "yes" to question #2, skip question #3 and continue to question #4.</i>	○ Yes ○ No

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Section 5: Physician and Nurse Staffing

3) If your hospital does not operate at least one adult or pediatric single acuity Medical, Surgical, or Med-Surg Unit, does your hospital operate at least one adult or pediatric mixed acuity Medical, Surgical or Med-Surg Unit? <i>A mixed acuity unit is defined as a unit where more than 10% of patients receive varying levels of care.</i> <i>If “no” to question #3, skip questions #4-16 and continue to question #17. The hospital will be scored as “Does Not Apply.”</i>	☐ Yes ☐ No
4) Did your hospital calculate total number of patient days, total number of productive hours worked by employed and contracted nursing staff with direct patient care responsibilities (RN, LPN/LVN, and UAP), and total number of productive hours worked by RN nursing staff with direct patient care responsibilities for the reporting period, and do you choose to report those data to this Survey? <i>If “no” to question #4, skip questions #5-16 and continue to question #17. The hospital will be scored as “Did Not Measure.”</i>	☐ Yes ☐ No
5) Which method did your hospital use to calculate the total number of patient days for each single acuity Medical, Surgical, Med-Surg or mixed acuity Medical, Surgical or Med-Surg Unit?	☐ Midnight census (including observation patients) ☐ Midnight census and patient days from actual hours for short stay patients ☐ Patient days from actual hours ☐ Patient days from multiple census reports

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

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

6) Does your hospital operate any adult or pediatric single acuity <u>Medical Units</u>? <i>A single acuity unit is defined as a unit where at least 90% of the patients receive the same level of care.</i> <i>If “no” or “yes, but had fewer than 15 patient days per month for all 3 months of any quarter of the reporting period” to question #6, skip question #7 and continue to question #8.</i>	☐ Yes ☐ No ☐ Yes, but had fewer than 15 patient days per month for all 3 months of any quarter of the reporting period
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7) Enter your hospital's responses for each quarter for all adult and pediatric single acuity <u>Medical Units</u> for the reporting period selected in question #1:			
	(a) Total number of patient days:	(b) Total number of productive hours worked by employed and contracted nursing staff (RN, LPN/LVN, and UAP) with direct patient care responsibilities:	(c) Total number of productive hours worked by RN nursing staff with direct patient care responsibilities:
Quarter 1			
Quarter 2			

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Section 5: Physician and Nurse Staffing

Quarter 3			
Quarter 4			

8) Does your hospital operate any adult or pediatric single acuity <u>Surgical Units</u>? <i>A single acuity unit is defined as a unit where at least 90% of the patients receive the same level of care.</i> <i>If “no” or “yes, but had fewer than 15 patient days per month for all 3 months of any quarter of the reporting period” to question #8, skip question #9 and continue to question #10.</i>	○ Yes ○ No ○ Yes, but had fewer than 15 patient days per month for all 3 months of any quarter of the reporting period
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9) Enter your hospital's responses for each quarter for all adult and pediatric single acuity <u>Surgical Units</u> for the reporting period selected in question #1:			
	(a) Total number of patient days:	(b) Total number of productive hours worked by employed and contracted nursing staff (RN, LPN/LVN, and UAP) with direct patient care responsibilities:	(c) Total number of productive hours worked by RN nursing staff with direct patient care responsibilities:
Quarter 1			
Quarter 2			
Quarter 3			
Quarter 4			

10) Does your hospital operate any adult or pediatric single acuity <u>Med-Surg Units</u>? <i>A single acuity unit is defined as a unit where at least 90% of the patients receive the same level of care.</i> <i>If “no” or “yes, but had fewer than 15 patient days per month for all 3 months of any quarter of the reporting period” to question #10, skip questions #11-14 and continue to question #15.</i> <i>If “yes, but had fewer than 15 patient days per month for all 3 months of any quarter of the reporting period” to questions #6, #8, and #10, skip questions #11-16 and continue to question #17. The hospital will be scored as “Unable to Calculate Score.”</i>	○ Yes ○ No ○ Yes, but had fewer than 15 patient days per month for all 3 months of any quarter of the reporting period
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11) Enter your hospital's responses for each quarter for all adult and pediatric single acuity <u>Med-Surg Units</u> for the reporting period selected in question #1:			
	(a) Total number of patient days:	(b) Total number of productive hours worked by employed and contracted nursing staff (RN, LPN/LVN, and UAP) with direct patient care responsibilities:	(c) Total number of productive hours worked by RN nursing staff with direct patient care responsibilities:
Quarter 1			
Quarter 2			
Quarter 3			

Quarter 4			
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For Hospitals that Only Operate Adult or Pediatric Mixed Acuity Medical, Surgical, or Med-Surg Units

12) Was your adult and/or pediatric mixed acuity Medical, Surgical, or Med-Surg Unit(s) open for the entire reporting period? <i>A mixed acuity unit is defined as a unit where more than 10% of patients receive varying levels of care.</i> <i>If "no" to question #12, skip questions #13-16 and continue to question #17. The hospital will be scored as "Does Not Apply."</i> <i>If "yes, but had fewer than 15 patient days per month for all 3 months of any quarter of the reporting period" to question #12, skip questions #13-16 and continue to question #17. The hospital will be scored as "Unable to Calculate Score."</i>	☐ Yes ☐ No ☐ Yes, but had fewer than 15 patient days per month for all 3 months of any quarter of the reporting period
13) What type(s) of adult or pediatric mixed acuity Medical, Surgical, or Med-Surg Units does your hospital operate? <i>Select all that apply.</i> <i>A <u>High Acuity Unit</u> is a mixed acuity unit in which 50-89% of the patients are critical care and the remaining 11-49% can be any other acuity level.</i> <i>A <u>Moderate Acuity Unit</u> is a mixed acuity unit in which 25-49% of the patients are critical care OR 50-89% of the patients are step down care. The remaining percentage can be any other acuity level.</i> <i>A <u>Blended Acuity Unit</u> is a mixed acuity acute care unit in which less than 90% of the patients receive a single acuity level of care, less than 50% receive step down care, and less than 25% receive critical care.</i>	☐ High Acuity ☐ Moderate Acuity ☐ Blended Acuity

14) Enter your hospital's responses for each quarter for all adult and pediatric mixed acuity Medical, Surgical, and Med-Surg Units for the reporting period selected in question #1:			
	(a) Total number of patient days:	(b) Total number of productive hours worked by employed and contracted nursing staff (RN, LPN/LVN, and UAP) with direct patient care responsibilities:	(c) Total number of productive hours worked by RN nursing staff with direct patient care responsibilities:
Quarter 1			
Quarter 2			
Quarter 3			
Quarter 4			

NQF Safe Practice #9 – Nursing Workforce

Important Note: Hyperlinks in question #16 refer to the Patient Safety Practices FAQs beginning on page 214, not to endnotes. These hyperlinks are not included in the Online Survey Tool.

Specifications: See **NQF Safe Practice Measure Specifications** in the Reference Information beginning on page 238.

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

Percentage of RNs who are BSN-Prepared

Specifications: See **Nursing Workforce Measure Specifications** in the Reference Information beginning on page 236.

Reporting Period: 12 months

Answer questions #17-19 based on the most recent day within the last 12-months for which you have complete data.

Note: As a reminder, the Corrections Period (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

17) Did your hospital calculate the Percentage of RNs who are BSN-Prepared measure for the reporting period, and do you choose to report those data to this Survey? <i>If "no" to question #17, skip questions #18-19 and continue to the next subsection. The hospital will be scored as "Did Not Measure."</i>	☐ Yes ☐ No
18) Total number of employed RN nursing staff at the hospital with direct patient care responsibilities:	_____
19) Total number of employed RN nursing staff at the hospital with direct patient care responsibilities who have a BSN degree or higher (e.g., MSN, DNP, PhD):	_____

Affirmation of Accuracy:

As the hospital CEO or as an employee of the hospital to whom the hospital CEO has delegated responsibility, I have reviewed this information pertaining to the Physician and Nurse Staffing Section at our hospital, and I hereby certify that this information is true, accurate, and reflects the current, normal operating circumstances at our hospital. I am authorized to make this certification on behalf of our hospital.

The hospital and I understand that The Leapfrog Group, its members, the public and entities and persons who contract or have other business dealings with The Leapfrog Group are relying on the truth and accuracy of this information. The hospital and I also understand that The Leapfrog Group will make this information and/or analyses of this information public through the Survey Results public reporting website, The Leapfrog Group's Hospital Safety Grade, and/or other Leapfrog Group products and services. This information and/or analyses and all intellectual property rights therein shall be and remain the sole and exclusive property of The Leapfrog Group in which The Leapfrog Group retains exclusive ownership. This information does not infringe upon any third-party intellectual property rights or any other third-party rights whatsoever and is free and clear of all encumbrances and liens of any kind. The hospital and I acknowledge that The Leapfrog Group may use this information in a commercial manner for profit. The hospital shall be liable for and shall hold harmless and indemnify The Leapfrog Group from any and all damages, demands, costs, or causes of action resulting from any inaccuracies in the information or any misrepresentations in this Affirmation of Accuracy. The Leapfrog Group and its members and entities and persons who contract or have other business dealings with The Leapfrog Group reserve the right to omit or disclaim information that is not current, accurate or truthful.

Affirmed by _____, the hospital's _____,
(first name and last name) (title)
on _____.
(date)

Section 5: Physician and Nurse Staffing Reference Information***What's New in the 2025 Survey***

Leapfrog renamed Section 5: ICU Physician Staffing to Section 5: Physician and Nurse Staffing and moved Section 6C: Nursing Workforce to Section 5C: Nursing Workforce.

Section 5A: Adult ICU Physician Staffing and Section 5B: Pediatric ICU Physician Staffing

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

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

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

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

Section 5C: Nursing Workforce

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

Leapfrog is updating question #3 to clarify that hospitals should only respond to the questions about mixed acuity units if the hospital does not operate any of the applicable single acuity units. Further clarification on single acuity medical, surgical, and med-surg units to include or exclude, as well as additional clarification on the definition of acuity (i.e., level of care), will be added. Critical Access Units, defined as units where more than 10% of beds are for skilled nursing (swing beds), will be added as an exclusion for both single acuity and mixed acuity units.

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

Leapfrog is also updating the measure specifications for total productive hours worked by employed and contracted nursing staff with direct patient care responsibilities to clarify that sitter hours can only be

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included if the sitter is authorized to physically touch the patient when providing direct patient care (i.e., does not need to call another staff member if physical intervention of any type is required).

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

For NQF Safe Practice #9 on the 2025 Leapfrog Hospital Survey, Leapfrog will continue to accept 2020 American Nurses Credentialing Center (ANCC) Pathway to Excellence® criteria and will add 2024 ANCC Pathway to Excellence® criteria. There are no changes to the scoring algorithm for Section 5C: Nursing Workforce.

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

Change Summary Since Release

None. If substantive changes are made to this section of the Survey after release on April 1, 2025, they will be documented in this Change Summary section.

Nursing Workforce Measure Specifications

Important Note: Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Total Nursing Care Hours per Patient Day, RN Hours per Patient Day, and Nursing Skill Mix Measure Specifications

Source: American Nurses Association (ANA) (National Quality Forum #0204 and #0205)

Reporting Period: 12 months

- Survey submitted prior to September 1:
 - 01/01/2024 – 12/31/2024
- Surveys submitted on or after September 1:
 - 07/01/2024 – 06/30/2025

Hospitals that report this data to NDNQI® (National Database of Nursing Quality Indicators®):
Data for this measure can be obtained directly from NDNQI. See details below.

Hospitals that submit nursing care hours and patient days to NDNQI will be able to respond to questions #5 - 14 in Section 5C. Active NDNQI clients should email NDNQISupport@PressGaney.com or call 855-304-9788 to connect with one of NDNQI's team members and specify that they are requesting support for the purposes of Leapfrog Hospital Survey reporting on Total Nursing Care Hours per Patient Day, RN Hours per Patient Day, and Nursing Skill Mix. For 2025, additional support for these calculations for active NDNQI clients with eligible data will be provided at no additional cost.

For NDNQI units to include, please reach out directly to ndnqisupport@pressganey.com.

Hospitals that do not report this data to NDNQI:
Data for this measure can be obtained using the measure specifications below.

Question #2: Does your hospital operate at least one adult or pediatric single acuity Medical, Surgical, or Med-Surg Unit?

Leapfrog has aligned with the National Database of Nursing Quality Indicators' (NDNQI) unit definitions below.

Single Acuity Medical Unit (adult and pediatric):

A single acuity general care unit in which at least 90% of the patients are admitted to medical services, such as internal medicine, oncology, or cardiology. Medical specialty units such as Cardiac Medical, GI Medical, Infectious Disease Medical, Neurology Medical, Hematology/Oncology Medical, Renal Medical, and Respiratory Medical, are also included.

Single Acuity Surgical Unit (adult and pediatric):

A single acuity general care unit in which at least 90% of the patients are admitted to surgical services, such as general surgery, neurosurgery, or orthopedics. Surgical specialty units such as Bariatric Surgery, Cardio-thoracic Surgery, Gynecologic Surgery, Neurosurgery, Orthopedic Surgery, Plastic Surgery, Transplant Surgery, and Trauma Surgery, are also included.

Single Acuity Med-Surg Combined Unit (adult and pediatric):

A single acuity general care unit that cares for patients admitted for medical, surgical, or family practice services and does not meet the 90% criteria for Medical or Surgical unit type. Specialty med-surg units such as Cardiac Med-Surg, Neuro/Neurosurgery Med-Surg, and Hematology/Oncology Med-Surg, are also included.

Excluded units:

- Labor and Delivery
- Neonatal

- Critical Access Unit: a unit where more than 10% of beds are for skilled nursing (swing beds)
- Rehabilitation
- Psychiatric
- Perioperative
- Critical Care
- Step Down/Progressive
- Hospice
- Mixed Acuity Units: a unit where more than 10% of the patients in the unit receive varying levels of care (e.g., general medical care and progressive care or intensive care)
- Units with fewer than 15 patient days per month for all 3 months of any quarter of the reporting period
- Units that transitioned to an excluded unit type during the reporting period (e.g., a single acuity Medical Unit transitioned to a critical care unit during the reporting period)

Question #3: If your hospital does not operate at least one adult or pediatric single acuity Medical, Surgical, or Med-Surg Unit, does your hospital operate at least one adult or pediatric mixed acuity Medical, Surgical, or Med-Surg Unit?

Leapfrog has aligned with the National Database of Nursing Quality Indicators' (NDNQI) unit definitions below.

Mixed Acuity Medical, Surgical and Med-Surg Units (adult and pediatric):

A unit where more than 10% of patients receive varying levels of care.

Types of mixed acuity units include the following:

High Acuity Medical, Surgical and Med-Surg Units:

A mixed acuity unit in which 50-89% of the patients are critical care and the remaining 11-49% can be any other acuity level.

Moderate Acuity Medical, Surgical and Med-Surg Units:

A mixed acuity unit in which 25-49% of the patients are critical care OR 50-89% of the patients are step down care. The remaining percent can be any other acuity level.

Blended Acuity Medical, Surgical and Med-Surg Units:

A mixed acuity acute care unit in which less than 90% of the patients receive a single acuity level of care, less than 50% receive step down care, and less than 25% receive critical care.

Excluded units:

- Cardiac
- Neurology
- Hematology/Oncology
- Critical Access (a unit where more than 10% of beds are for skilled nursing (swing beds))
- Units with fewer than 15 patient days per month for all 3 months of any quarter of the reporting period
- Units that transitioned to an excluded unit type during the reporting period (e.g., a mixed acuity Medical Unit transitioned to a critical care unit during the reporting period)

Question #5: Which method did your hospital use to calculate the total number of patient days for each single acuity Medical, Surgical, Med-Surg or mixed acuity Medical, Surgical or Med-Surg Unit?

- **Midnight Census (including observation patients):** The sum of the daily midnight census counts (the number of *all* patients on the unit at midnight each day) during the reporting period. Short stay patients (who are in and out of the unit before the census count is taken) should be included; otherwise, this method cannot be used.
- **Midnight Census and Patient Days from Actual Hours for Short Stay Patients:** A combination of Midnight Census and Patient Days from Actual Hours collected during the reporting period.

- **Patient Days from Actual Hours:** The sum of the actual hours for all patients during the reporting period divided by 24; typically obtained from an accounting system that tracks the actual time spent in the hospital by each patient.
- **Patient Days from Multiple Census Reports:** The sum of the daily average censuses collected during the reporting period; typically collected multiple times per day (e.g., every 4 hours or each shift).

Note: Patient days should be calculated to include all patients in adult and pediatric single acuity Medical, Surgical, Med-Surg or mixed acuity Medical, Surgical or Med-Surg Units. This includes patients that do not have inpatient status (i.e., observation patients).

Hospitals that operate adult or pediatric **single acuity** Medical, Surgical, or Med-Surg Units should use the measure specifications directly below to respond to questions #6-11.

Hospitals that operate adult or pediatric **mixed acuity** Medical, Surgical, or Med-Surg Units should use the measure specifications for **mixed acuity** units to respond to questions #12-14.

Single Acuity Adult or Pediatric Medical, Surgical, or Med-Surg Units (questions #6-11)

Question #6: Does your hospital operate any adult or pediatric single acuity Medical Units?

Single Acuity Medical Unit (adult and pediatric):

A single acuity general care unit in which at least 90% of the patients are admitted to medical services, such as internal medicine, oncology, or cardiology. Medical specialty units such as Cardiac Medical, GI Medical, Infectious Disease Medical, Neurology Medical, Hematology/Oncology Medical, Renal Medical, and Respiratory Medical, are also included.

Excluded units:

- Labor and Delivery
- Neonatal
- Critical Access (a unit where more than 10% of beds are for skilled nursing (swing beds))
- Rehabilitation
- Psychiatric
- Perioperative
- Critical Care
- Step Down/Progressive
- Hospice
- Mixed Acuity Units: a unit where more than 10% of the patients in the unit are receive varying levels of care (e.g., general medical care and progressive care or intensive care)
- Units with fewer than 15 patient days per month for all 3 months of any quarter of the reporting period
- Units that transitioned to an excluded unit type during the reporting period (e.g., a single acuity Medical Unit transitioned to a critical care unit during the reporting period)

Question #7: Single Acuity Medical Units

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

Question #7(a): Total number of patient days across all adult and pediatric single acuity **Medical Units** during each quarter of the reporting period based on your hospital's method for counting patient days.

Patient days should be calculated to include all patients in adult and pediatric single acuity Medical Units. This includes patients that do not have inpatient status (i.e., observation patients).

Question #7(b): Total number of productive hours worked by employed and contracted **nursing staff (RN, LPN/LVN, and UAP)** with direct patient care responsibilities in all adult and pediatric single acuity **Medical Units** during each quarter of the reporting period.

Productive Hours

Include the following hours worked by employed and contracted RNs, LPN/LVNs, and UAPs:

- Actual direct patient care hours worked by nursing staff
- Overtime spent performing direct patient care
- Orientation hours for new hires that are considered part of the unit's staffing matrix, whose work hours are charged to the unit's cost center, and who would be replaced if they called out sick
- Sitter hours authorized for both physical touch and direct patient care intervention

Exclude the following hours worked by employed and contracted RN, LPN/LVN, and UAP:

- Budgeted or scheduled hours
- Vacation time, sick time, education leave, or committee time
- Orientation hours for new hires that are not considered part of the unit's staffing matrix, whose work hours are not charged to the unit's cost center, and would not be replaced if they call out sick
- Hours from when the unit was staffed but there were no patients in the unit
 - If these nursing hours cannot be removed, then the unit should not be included.
- Virtual or remote hours
- Sitter hours without authorization for both physical touch and direct patient care intervention

Employed and Contracted Nursing Staff

Include the following RN, LPN/LVN, and UAP nursing staff:

- Staff employed by the hospital
- Temporary staff who are not employed by the hospital (i.e., contracted/agency staff)
- Float staff who are assigned to a unit other than their unit of employment on an as-needed basis if they are assigned direct patient care responsibilities
- Staff who are counted in the unit's staffing matrix, are replaced if they call out sick, and whose work hours are charged to the unit's cost center

Exclude the following RN, LPN/LVN, and UAP nursing staff:

- Nursing staff whose primary responsibility is administrative in nature (at least 50% of their time is administrative)
- Specialty teams, patient educators, or case managers who are not assigned to a specific unit
- Unit secretaries or clerks, monitor technicians, and others with no direct patient care responsibilities
- Advanced Practice Registered Nurses (APRNs), including certified nurse-midwife (CNM), clinical nurse specialist (CNS), certified nurse practitioner (CNP), and certified registered nurse anesthetist (CRNA)

A UAP is any unlicensed person, regardless of title, who performs tasks delegated by a nurse. This includes certified nursing aides/assistants (CNAs), patient care assistants (PCAs), patient care technicians (PCTs), state-tested nursing assistants (STNA), nursing assistants-registered (NA/Rs) or certified medication aides/assistants (MA-Cs).

Direct Patient Care Responsibilities

Direct Patient Care Responsibilities are defined as patient centered nursing activities by hospital unit-based staff in the presence of the patient and activities that occur away from the patient that are patient related:

- Medication administration
- Nursing treatments
- Nursing rounds
- Admission, transfer, discharge activities
- Patient teaching
- Patient communication

- Coordination of patient care
- Documentation time
- Treatment planning
- Patient screening (e.g., fall risk) and assessment

Questions #7(c): Total number of productive hours worked by **RN nursing staff** with direct patient care responsibilities in all adult and pediatric single acuity **Medical Units** in each quarter.

Include the total number of productive work hours worked by employed and contracted **RN nursing staff ONLY** from question 7B.

Question #8: Does your hospital operate any adult or pediatric single acuity Surgical Units?

Single Acuity Surgical Unit (adult and pediatric):

A single acuity general care unit in which at least 90% of the patients are admitted to surgical services, such as general surgery, neurosurgery, or orthopedics. Surgical specialty units such as Bariatric Surgery, Cardio-thoracic Surgery, Gynecologic Surgery, Neurosurgery, Orthopedic Surgery, Plastic Surgery, Transplant Surgery, and Trauma Surgery, are also included.

Excluded units:

- Labor and Delivery
- Neonatal
- Critical Access (a unit where more than 10% of beds are for skilled nursing (swing beds))
- Rehabilitation
- Psychiatric
- Perioperative
- Critical Care
- Step Down/Progressive
- Hospice
- Mixed Acuity Units: a unit where more than 10% of the patients in the unit are receive varying levels of care (e.g., general medical care and progressive care or intensive care)
- Units with fewer than 15 patient days per month for all 3 months of any quarter of the reporting period
- Units that transitioned to an excluded unit type during the reporting period (e.g., a single acuity Medical Unit transitioned to a critical care unit during the reporting period)

Question #9: Single Acuity Surgical Units

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

Question #9(a): Total number of patient days across all adult and pediatric single acuity **Surgical Units** during each quarter of the reporting period based on your hospital's method for counting patient days.

Patient days should be calculated to include all patients in adult and pediatric single acuity Surgical Units. This includes patients that do not have inpatient status (i.e., observation patients).

Question #9(b): Total number of productive hours worked by employed and contracted **nursing staff (RN, LPN/LVN, and UAP)** with direct patient care responsibilities in all single acuity adult and pediatric **Surgical Units** in each quarter.

Productive Hours

Include the following hours worked by employee and contract RNs, LPN/LVNs, and UAPs:

- Actual direct patient care hours worked by nursing staff
- Overtime spent performing direct patient care
- Orientation hours for new hires that are considered part of the unit's staffing matrix, whose work hours are charged to the unit's cost center, and who would be replaced if they called out sick
- Sitter hours authorized for both physical touch and direct patient care intervention

Exclude the following hours worked by employed and contracted RN, LPN/LVN, and UAP:

- Budgeted or scheduled hours
- Vacation time, sick time, education leave, or committee time
- Orientation hours for new hires that are not considered part of the unit's staffing matrix, whose work hours are not charged to the unit's cost center, and would not be replaced if they call out sick
- Hours from when the unit was staffed but there were no patients in the unit
 - If these nursing hours cannot be removed, then the unit should not be included.
- Virtual or remote hours
- Sitter hours without authorization for both physical touch and direct patient care intervention

Employed and Contracted Nursing Staff

Include the following RN, LPN/LVN, and UAP nursing staff:

- Staff employed by the hospital
- Temporary staff who are not employed by the hospital (i.e., contracted/agency staff)
- Float staff who are assigned to a unit other than their unit of employment on an as-needed basis if they are assigned direct patient care responsibilities
- Staff who are counted in the unit's staffing matrix, are replaced if they call out sick, and whose work hours are charged to the unit's cost center

Exclude the following RN, LPN/LVN, and UAP nursing staff:

- Nursing staff whose primary responsibility is administrative in nature (at least 50% of their time is administrative)
- Specialty teams, patient educators, or case managers who are not assigned to a specific unit
- Unit secretaries or clerks, monitor technicians, and others with no direct patient care responsibilities
- Advanced Practice Registered Nurses (APRNs), including certified nurse-midwife (CNM), clinical nurse specialist (CNS), certified nurse practitioner (CNP), and certified registered nurse anesthetist (CRNA)

A UAP is any unlicensed person, regardless of title, who performs tasks delegated by a nurse. This includes certified nursing aides/assistants (CNAs), patient care assistants (PCAs), patient care technicians (PCTs), state-tested nursing assistants (STNA), nursing assistants-registered (NA/Rs) or certified medication aides/assistants (MA-Cs).

Direct Patient Care Responsibilities

Direct Patient Care Responsibilities are defined as patient centered nursing activities by hospital unit-based staff in the presence of the patient and activities that occur away from the patient that are patient related:

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

Questions #9(c): Total number of productive hours worked by **RN nursing staff** with direct patient care responsibilities in all adult and pediatric single acuity **Surgical Units** in each quarter.

Include the total number of productive work hours worked by employed and contracted **RN nursing staff ONLY** from question 9b.

Question #10: Does your hospital operate any adult or pediatric single acuity Med-Surg Units?

Single Acuity Med-Surg Combined Unit (adult and pediatric):

A single acuity general care unit that cares for patients admitted for medical, surgical, or family practice services and does not meet the 90% criteria for Medical or Surgical unit type. Specialty med-surg units such as Cardiac Med-Surg, Neuro/Neurosurgery Med-Surg, and Hematology/Oncology Med-Surg, are also included.

Excluded units:

- Labor and Delivery
- Neonatal
- Critical Access (a unit where more than 10% of beds are for skilled nursing (swing beds))
- Rehabilitation
- Psychiatric
- Perioperative
- Critical Care
- Step Down/Progressive
- Hospice
- Mixed Acuity Units: a unit where more than 10% of the patients in the unit are receive varying levels of care (e.g., general medical care and progressive care or intensive care)
- Units with fewer than 15 patient days per month for all 3 months of any quarter of the reporting period
- Units that transitioned to an excluded unit type during the reporting period (e.g., a single acuity Medical Unit transitioned to a critical care unit during the reporting period)

Question #11: Single Acuity Med-Surg Units

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

Question #11(a): Total number of patient days across all adult and pediatric single acuity **Med-Surg Units** for each quarter included in the reporting period based on your hospital's method for counting patient days.

Patient days should be calculated to include all patients in adult and pediatric single acuity Med-Surg Units. This includes patients that do not have inpatient status (i.e., observation patients).

Question #11(b): Total number of productive hours worked by employed and contracted **nursing staff (RN, LPN/LVN, and UAP)** with direct patient care responsibilities in all single acuity adult and pediatric **Med-Surg Units** in each quarter.

Productive Hours

Include the following hours worked by employed and contracted RNs, LPN/LVNs, and UAPs:

- Actual direct patient care hours worked by nursing staff
- Overtime spent performing direct patient care
- Orientation hours for new hires that are considered part of the unit's staffing matrix, whose work hours are charged to the unit's cost center, and who would be replaced if they called out sick
- Sitter hours authorized for both physical touch and direct patient care intervention

Exclude the following hours worked by employed and contracted RN, LPN/LVN, and UAP:

- Budgeted or scheduled hours
- Vacation time, sick time, education leave, or committee time
- Orientation hours for new hires that are not considered part of the unit's staffing matrix, whose work hours are not charged to the unit's cost center, and would not be replaced if they call out sick
- Hours from when the unit was staffed but there were no patients in the unit
 - If these nursing hours cannot be removed, then the unit should not be included.
- Virtual or remote hours
- Sitter hours without authorization for both physical touch and direct patient care intervention

Employed and Contracted Nursing Staff

Include the following RN, LPN/LVN, and UAP nursing staff:

- Staff employed by the hospital
- Temporary staff who are not employed by the hospital (i.e., contracted/agency staff)
- Float staff who are assigned to a unit other than their unit of employment on an as-needed basis if they are assigned direct patient care responsibilities
- Staff who are counted in the unit's staffing matrix, are replaced if they call out sick, and whose work hours are charged to the unit's cost center

Exclude the following RN, LPN/LVN, and UAP nursing staff:

- Nursing staff whose primary responsibility is administrative in nature (at least 50% of their time is administrative)
- Specialty teams, patient educators, or case managers who are not assigned to a specific unit
- Unit secretaries or clerks, monitor technicians, and others with no direct patient care responsibilities
- Advanced Practice Registered Nurses (APRNs), including certified nurse-midwife (CNM), clinical nurse specialist (CNS), certified nurse practitioner (CNP), and certified registered nurse anesthetist (CRNA)

A UAP is any unlicensed person, regardless of title, who performs tasks delegated by a nurse. This includes certified nursing aides/assistants (CNAs), patient care assistants (PCAs), patient care technicians (PCTs), state-tested nursing assistants (STNA), nursing assistants-registered (NA/Rs) or certified medication aides/assistants (MA-Cs).

Direct Patient Care Responsibilities

Direct Patient Care Responsibilities are defined as patient centered nursing activities by hospital unit-based staff in the presence of the patient and activities that occur away from the patient that are patient related:

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

Questions #11(c): Total number of productive hours worked by **RN nursing staff** with direct patient care responsibilities in all adult and pediatric single acuity **Med-Surg Units** in each quarter.

Include the total number of productive work hours worked by RN nursing staff ONLY from question 11b.

Mixed Acuity Adult or Pediatric Medical, Surgical, or Med-Surg Units (questions #12-14)

Question #12: Was your adult and/or pediatric mixed acuity Medical, Surgical, or Med-Surg Unit(s) open for the entire reporting period?

Leapfrog has aligned with the National Database of Nursing Quality Indicators' (NDNQI) unit definitions below.

Excluded units:

- Cardiac

- Neurology
- Hematology/Oncology
- Critical Access (a unit where more than 10% of beds are for skilled nursing (swing beds))
- Units with fewer than 15 patient days per month for all 3 months of any quarter of the reporting period
- Units that transitioned to an excluded unit type during the reporting period (e.g., a mixed acuity Medical Unit transitioned to a critical care unit during the reporting period)

Question #13: What type(s) of adult and/or pediatric mixed acuity Medical, Surgical or Med-Surg Units does your hospital operate?

Leapfrog has aligned with the National Database of Nursing Quality Indicators' (NDNQI) unit definitions below.

High Acuity Medical, Surgical and Med-Surg Units:

A mixed acuity unit in which 50-89% of the patients are critical care and the remaining 11-49% can be any other acuity level.

Moderate Acuity Medical, Surgical and Med-Surg Units:

A mixed acuity unit in which 25-49% of the patients are critical care OR 50-89% of the patients are step down care. The remaining percent can be any other acuity level.

Blended Acuity Medical, Surgical and Med-Surg Units:

A mixed acuity acute care unit in which less than 90% of the patients receive a single acuity level of care, less than 50% receive step down care, and less than 25% receive critical care.

Question #14: Mixed Acuity Medical, Surgical and Med-Surg Units

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

Question #14(a): Total number of patient days across all adult and pediatric **mixed acuity Medical, Surgical and Med-Surg Units** for each quarter included in the reporting period based on your hospital's method for counting patient days.

Patient days should be calculated to include all patients in all adult and pediatric mixed acuity Medical, Surgical or Med-Surg Units. This includes patients that do not have inpatient status (i.e., observation patients).

Question #14(b): Total number of productive hours worked by employed and contracted **nursing staff (RN, LPN/LVN, and UAP)** with direct patient care responsibilities in all adult and pediatric **mixed acuity Medical, Surgical, and Med-Surg Units** in each quarter.

Productive Hours

Include the following hours worked by employed and contracted RNs, LPN/LVNs, and UAPs:

- Actual direct patient care hours worked by nursing staff
- Overtime spent performing direct patient care
- Orientation hours for new hires that are considered part of the unit's staffing matrix, whose work hours are charged to the unit's cost center, and who would be replaced if they called out sick
- Sitter hours authorized for both physical touch and direct patient care intervention

Exclude the following hours worked by employed and contracted RN, LPN/LVN, and UAP:

- Budgeted or scheduled hours
- Vacation time, sick time, education leave, or committee time
- Orientation hours for new hires that are not considered part of the unit's staffing matrix, whose work hours are not charged to the unit's cost center, and would not be replaced if they call out sick
- Hours from when the unit was staffed but there were no patients in the unit
 - If these nursing hours cannot be removed, then the unit should not be included.
- Virtual or remote hours
- Sitter hours without authorization for both physical touch and direct patient care intervention

Employed and Contracted Nursing Staff

Include the following RN, LPN/LVN, and UAP nursing staff:

- Staff employed by the hospital
- Temporary staff who are not employed by the hospital (i.e., contracted/agency staff)
- Float staff who are assigned to a unit other than their unit of employment on an as-needed basis if they are assigned direct patient care responsibilities
- Staff who are counted in the unit's staffing matrix, are replaced if they call out sick, and whose work hours are charged to the unit's cost center

Exclude the following RN, LPN/LVN, and UAP nursing staff:

- Nursing staff whose primary responsibility is administrative in nature (at least 50% of their time is administrative)
- Specialty teams, patient educators, or case managers who are not assigned to a specific unit
- Unit secretaries or clerks, monitor technicians, and others with no direct patient care responsibilities
- Advanced Practice Registered Nurses (APRNs), including certified nurse-midwife (CNM), clinical nurse specialist (CNS), certified nurse practitioner (CNP), and certified registered nurse anesthetist (CRNA)

A UAP is any unlicensed person, regardless of title, who performs tasks delegated by a nurse. This includes certified nursing aides/assistants (CNAs), patient care assistants (PCAs), patient care technicians (PCTs), state-tested nursing assistants (STNA), nursing assistants-registered (NA/Rs) or certified medication aides/assistants (MA-Cs).

Direct Patient Care Responsibilities

Direct Patient Care Responsibilities are defined as patient centered nursing activities by hospital unit-based staff in the presence of the patient and activities that occur away from the patient that are patient related:

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

Question #14(c): Total number of productive hours worked by **RN nursing staff** with direct patient care responsibilities in all adult and pediatric **mixed acuity Medical, Surgical, and Med-Surg Units** in each quarter.

Include the total number of productive work hours worked by employed and contracted RN nursing staff **ONLY** from question 14b.

See [FAQs](#) for additional information about responding to the questions in this section.

Percentage of RNs who are BSN-Prepared Specifications

Source: The Leapfrog Group
Reporting Period: Answer questions #17-19 based on the most recent day within the last 12-months for which you have complete data.
Question #18 (denominator): Total number of employed RN nursing staff at the hospital with direct patient care responsibilities. <u>Included RN Nursing Staff:</u> • Staff employed by the hospital in most all hospital units, including observation, <u>co-located</u>³¹ outpatient units, and emergency departments who: ○ Are counted in the unit's staffing matrix, and ○ Are replaced if they call in sick, and ○ Whose work hours are charged to the unit's cost center • Float staff who are assigned to a unit other than their unit of employment on an as-needed basis if they are assigned direct patient care responsibilities <u>Excluded RN Nursing staff:</u> • Staff that are not employed by the hospital (i.e., contracted/agency staff) • Staff that are exclusively assigned to skilled nursing units or mixed acuity neonatal units • Staff that are part of specialty teams or are patient educators or case managers who are not assigned to a specific unit • Unit secretaries or clerks or others with no direct patient care responsibilities • Staff that are primarily responsible for administrative tasks (at least 50% of their time is administrative) • Advanced Practice Registered Nurses (APRNs), including certified nurse-midwife (CNM), clinical nurse specialist (CNS), certified nurse practitioner (CNP), and certified registered nurse anesthetist (CRNA) <u>Direct Patient Care Responsibilities</u> are defined as patient centered nursing activities by hospital unit-based staff in the presence of the patient and activities that occur away from the patient that are patient related: • Medication administration • Nursing treatments • Nursing rounds • Admission, transfer, discharge activities • Patient teaching • Patient communication • Coordination of patient care • Documentation time • Treatment planning • Patient screening (e.g., fall risk) and assessment Question #19 (numerator): Total number of employed RN nursing staff at the hospital with direct patient care responsibilities who have a BSN degree or higher (e.g., MSN, DNP, and PhD). Note: Hospitals can use any method to identify RN nursing staff who have a BSN degree or higher, including: • NDNQI Annual RN Survey • Data collected by the nurse managers at the hospital • Information from HR or credentialing office, or • Staff survey via SurveyMonkey or other free data collection tool.

See [FAQs](#) for additional information about responding to the questions in this section.

Section 5: Physician and Nurse Staffing Frequently Asked Questions (FAQs)

Adult and Pediatric ICU Physician Staffing FAQs

ICU General Questions

1. What is the reporting period for the ICU measure?

Hospitals should report on Section 5A and 5B based on their staffing structure at the time they submit this section of the Survey. The staffing structure must have been in place for at least the past 3 months and should reflect the ordinary staffing structure for the ICU.

2. How should hospitals report if they have more than one type of qualifying ICU?

If your hospital has more than one applicable ICU (i.e., multiple adult ICUs or multiple pediatric ICUs), respond to all questions in each section based on the ICU that has the lowest level of staffing by physicians certified in critical care medicine. Review endnote 34 for more information.

3. Does Leapfrog's ICU standard apply to mixed acuity units? A multi-organizational service unit (MOSU) unit?

The standard applies to all adult and pediatric general medical, surgical, medical/surgical, and neuro critical care patients (medical and surgical), including those patients in mixed acuity units and other non-critical care units.

4. Are cardiac critical care patients in a general medical, surgical, and medical/surgical ICU required to be co-managed by an intensivist?

Cardiac critical care patients in a general medical, surgical, or medical/surgical ICU that are in beds dedicated to cardiac critical care patients and being cared for by dedicated cardiac physicians (e.g., cardiologist or cardiac surgeon) and nursing staff are not included in Leapfrog's ICU Physician Staffing standard and do not need to be managed/co-managed by the intensivist. However, cardiac critical care patients in a general medical, surgical, or medical/surgical ICU bed being cared for by general medical or surgical critical care physicians and nursing staff are included in the standard and do need to be managed/co-managed by the intensivist. Additional clarification is available here.

5. Does Leapfrog's ICU Physician Staffing standard include cardiac critical care patients?

For the purposes of reporting on Section 5A and 5B, cardiac critical care patients in general medical, surgical, or medical/surgical ICU beds being cared for by general medical and/or surgical critical care physicians and nursing staff are included in the standard and need to be managed/co-managed by the intensivist. Cardiac critical care patients in a general medical, surgical, or medical/surgical ICU that are in beds dedicated to cardiac critical care patients and being cared for by dedicated cardiac physicians (e.g., cardiologist or cardiac surgeon) and nursing staff are not included in Leapfrog's ICU Physician Staffing standard and do not need to be managed/co-managed by the intensivist.

ICU Certification

6. Is there any empirical basis for specifying a minimum annual number of days of ICU experience for each board-eligible physician providing ICU care?

No. Accordingly, if it is added to the Leapfrog standard in the future, it will be based on newly published research and expert advice.

7. Do all intensivists serving as tele-intensivists need to meet Leapfrog's definition of "certified in critical care medicine"?

Yes. All intensivists who serve as tele-intensivists do need to meet Leapfrog's definition of "certified in critical care medicine."

8. Is a physician who is awaiting the results of the certification test considered “certified in critical care medicine”?

A physician is considered certified in critical care medicine as long as the board that originally certified the physician in critical care medicine deems that physician certified. Intensivists that are close to having their certification lapse should check with the board that certified them to see how exactly that board defines a lapsed certification.

9. Are physicians board certified in critical care medicine from the American Osteopathic Association (AOA) considered “certified in critical care medicine” for Leapfrog’s ICU Physician Staffing Standard?

Yes. Physicians with a board certification in critical care from American Osteopathic Association (AOA) are considered “certified in critical care medicine.”

10. How should intensivists trained in critical medicine in a foreign country be treated for purposes of meeting the ICU Physician Staffing (IPS) Standard?

Foreign trained physicians who were certified in critical care medicine in the country in which they trained would be considered certified for the purposes of the ICU Physician Staffing (IPS) standard.

ICU Telemedicine

11. Can you clarify what you mean by combined presence of tele-intensivists and on-site intensivists, as needed, for 24 hours per day/7 days per week in question #6 for Sections 5A and 5B?

Hospitals can achieve Leapfrog’s IPS Standard by having daily on-site intensivist coverage combined with a telemedicine service that meets all ten of the Leapfrog requirements. For example, an on-site intensivist takes two hours in the morning to establish and revise the daily care plan for each ICU patient, then a tele-intensivist picks up management or co-management of the ICU patients and is continually monitoring all critical care patients for the remaining 22 hours, for a combined total of 24 hours per day/7 days per week.

Hospitals should minimize the number of hand-offs between the on-site intensivist and the tele-intensivist during a 24-hour period and maximize the continuous time that one type of intensivist is caring for critical care patients. **Leapfrog does not recommend more than 4 hand-offs per 24 hours.**

12. Our hospital uses a telemedicine service to provide coverage in our ICU for 16 hours/7 days per week coverage when the on-site intensivist is not present at the hospital. Can our hospital still fully meet Leapfrog’s standard?

Hospitals that use telemedicine to cover “call” for the on-site intensivist are able to fully meet Leapfrog’s standard if: (1) the telemedicine service meets all ten of the Leapfrog requirements; and (2) the hospital has an “effector” (physician/PA/NP/FCCS-certified nurse or intern) on-site during that time period to carry out the tele-intensivist’s orders and can reach the ICU patient within 5 minutes, 95% of the time.

ICU Response Time

13. Does Leapfrog specify standards for second tier calls (e.g., the initial call to a physician is not answered within 5 minutes)?

No. We do not intend to reach this level of detail in our specifications, absent a compelling case that the gain would offset its added complexity.

14. Are there definitions for what constitutes high and low urgency calls/pages/texts?

No, and hospitals don’t have to focus only on high urgency calls/pages/texts, but some notification device systems can make this differentiation, and, in these instances, low urgency calls/pages/texts can be excluded from the analysis of response times.

- 15. If my hospital has few instances where there is no intensivist coverage, how should we conduct the response time audit? Can we perform mock pages to satisfy the intent?**
Unannounced mock pages would meet the intent. For the audit to be reliable, 20 unannounced mock pages over 90 days should be evaluated.
- 16. When an intensivist is not on-site in the ICU, can hospitals use a non-FCCS-certified CRNA as the “effector?”**
No. To serve as the “effector,” CRNAs require FCCS-certification.
- 17. When an intensivist is not on-site in the ICU, can hospitals use FCCS-certified interns as the “effector?”**
Yes. An FCCS-certified intern can serve as the “effector.”

ICU Rounding

- 18. How does Leapfrog define “makes on-site daily rounds” for clinical pharmacists in question #13 within Sections 5A and 5B?**
A clinical pharmacist would need to make on-site daily rounds (5 or 7 days per week) on **all** critical care patients (not some or most critical care patients) in **all** applicable ICUs (adult or pediatric general medical, surgical, medical/surgical, and neuro ICUs).
- Please note that if your clinical pharmacist is rounding 5 days per week, then, during the other 2 days per week, a clinical pharmacist still needs to respond to calls/texts/pages within 5 minutes, as determined by a response time audit.
- 19. Are pharmacy residents considered clinical pharmacists in question #13 within Sections 5A and 5B?**
To be considered a clinical pharmacist, Leapfrog only requires that the pharmacist have a Doctor of Pharmacy (PharmD) degree. Therefore, a PharmD graduate completing a residency would meet Leapfrog’s criterion to be considered a clinical pharmacist.
- 20. What roles should be included in interprofessional rounds in question #14 within Sections 5A and 5B?**
For rounds to be considered interprofessional, the team should include 3 or more persons. Typical personnel that would be part of the rounding team include physician, nurse, pharmacist, physical and/or occupational therapist, and nutritionist.

Total Nursing Care Hours per Patient Day, RN Hours per Patient Day, and Nursing Skill Mix FAQs

- 21. Why has Leapfrog aligned their unit type definitions with NDNQI?**
Though NDNQI participation is not required to report on the Total Nursing Care Hours per Patient Day, RN Hours per Patient Day, or Nursing Skill Mix measures, a number of hospitals participate in NDNQI and have data available to report to the Leapfrog Hospital Survey.
- 22. How is patient acuity defined?**
Patient acuity is the level of care that patients are receiving. The three levels of care are:
- critical care (highest level of acuity)
 - step down (lower level of acuity that patients in a critical care unit yet a higher level of acuity than is provided on a general care unit)
 - general care

Single acuity medical, surgical and med-surg units are units where at least 90% of the patients receive general care. Mixed acuity medical, surgical and med-surg units are units where less than 90% of the patients receive a single acuity level of care (more than 10% of patient receive varying levels of care).

NQF Safe Practice #9 – Nursing Workforce FAQs**23. How do I know if my hospital is eligible to report it has a current Pathways to Excellence designation?**

Hospitals that applied for Pathway to Excellence designation beginning in January 2021 and onward were certified using the 2020 or 2024 Pathways to Excellence® criteria and are eligible to report that they have a current designation.

Hospitals can check the Designation Year or Redesignation Year on the [American Nurses Credentialing Center website](#). If the year is 2021 or later, the hospital meets the Pathways to Excellence® criteria.

24. 15e: If the state has set minimum nurse to patient staffing ratios, do hospitals in that state automatically meet the intent of this element?

No. Minimum ratios do not necessarily address the “adequacy” issue, as the make-up of your hospital’s patient population may require more intensive staffing than is prescribed by the state’s minimum.

25. 15e: What are the minimum requirements to qualify as a “staffing plan?”

“A staffing plan” refers to nursing policies and procedures or a specific process used by the organization to pre-determine appropriate staffing patterns based on usual patient mix and nursing qualifications. A hospital must demonstrate full achievement of its targets.

Organizations must integrate several data sets into a staffing system that predefines and quantifies appropriate staffing targets. These data sets include:

- Historical Data (e.g., patient volumes, acuity levels, and staff volumes of direct caregivers)
- Comparative Data (e.g., comparisons between similar units internally and comparative external data from hospitals of like size and geographic location)
- Clinical Outcomes
- Skill Mix of Staff (e.g., licensing levels and educational training, years of experience, and volume of new graduates on a unit)
- Physical environment (e.g., distance staff have to travel to access support equipment, visibility of patients, locations of nursing stations to patient rooms, etc.)
- Type of patient care needs
- Support services available

Daily monitoring should take place to determine variances between predetermined staffing patterns and actual staffing patterns. If necessary, corrective action should be taken. Regular monitoring should take place to determine the accuracy of targets established and determine adjustments as needed.

Percentage of RNs who are BSN-Prepared FAQs**26. Should RNs with direct patient care responsibilities exclusively assigned to outpatient units or hospital clinics be included when reporting on the Percentage of RNs who are BSN-Prepared measure?**

Yes. The total number of RN nursing staff employed at the hospital should include nurses with direct care responsibilities in most hospital units, including observation, co-located³¹ outpatient units, and emergency departments. Only employed RNs exclusively assigned to Skilled Nursing units or Mixed Acuity Neonatal units should be excluded when reporting on the measure.

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SECTION 6: PATIENT SAFETY PRACTICES

This section includes questions and reference information for Section 6: Patient Safety Practices. Please carefully review the questions, endnotes, and reference information (e.g., measure specifications, notes, and frequently asked questions) before you begin. Failure to review the reference information could result in inaccurate responses.

Section 6: Patient Safety Practices

NQF Safe Practices Fact Sheets:

<https://ratings.leapfroggroup.org/measure/hospital/2025/effective-leadership-prevent-errors>

Hand Hygiene Fact Sheet and Bibliography:

<https://ratings.leapfroggroup.org/measure/hospital/2025/handwashing>

Diagnostic Excellence Bibliography:

<https://ratings.leapfroggroup.org/measure/hospital/2025/whats-new-2025>

Hospital Boarding in the Emergency Department (ED) Bibliography:

<https://ratings.leapfroggroup.org/measure/hospital/2025/whats-new-2025>

Section 6 includes questions about your hospital's adherence to two National Quality Forum-endorsed Safe Practices, and questions about your hospital's hand hygiene practices. It also includes a subsection on diagnostic excellence (6D) and a new subsection on Hospital Boarding in the Emergency Department (ED) (6E) – both subsections are optional and will not be scored or publicly reported.

Each hospital achieving the standard for NQF Safe Practice #1 – Culture of Safety Leadership Structures and Systems and NQF Safe Practice #2 – Culture Measurement, Feedback, and Intervention:

Has earned 100% of points (adopted all elements) for the NQF Safe Practice.

Each hospital achieving the standard for Hand Hygiene:

Has met all elements for the Monitoring domain including collecting compliance data on at least 200 hand hygiene opportunities* each month in each patient care unit. Has also met all elements for the Feedback domain, as well as **2 of the 3** remaining domains for hand hygiene:

- Training and Education Domain
- Infrastructure Domain
- Culture Domain

OR

Has met all elements for the Monitoring domain including collecting compliance data on at least 100 hand hygiene opportunities* each month in each patient care unit, as well as **all 4** remaining domains for hand hygiene:

- Feedback Domain
- Training and Education Domain
- Infrastructure Domain
- Culture Domain

**or at least the number of hand hygiene opportunities outlined based on the unit type in [Tables 1-3](#) or [Tables 4-6](#).*

Download the 2025 Leapfrog Hospital Survey Scoring Algorithm on the [Scoring and Results](#) webpage.

6A: NQF Safe Practice #1 – Culture of Safety Leadership Structures and Systems

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review Leapfrog's Multi-Campus Reporting Policy.

Important Notes:

Note 1: Page numbers throughout this subsection refer to the NQF Safe Practices for Better Healthcare – 2010 Update report, not this document.

Note 2: Hyperlinks throughout this subsection refer to the Patient Safety Practices FAQs beginning on page 251, not to endnotes. These hyperlinks are not included in the Online Survey Tool.

Specifications: See NQF Safe Practice Measure Specifications in the Reference Information beginning on page 238.

Awareness

1.1) Within the last 12 months, in regard to raising the awareness of key stakeholders to our organization's efforts to improve patient safety, the following actions related to the identification and mitigation of risks and hazards have been taken:		
a. <u>board</u> (governance) minutes reflect <u>regular communication</u> regarding all three of the following:		
i. <u>risks and hazards</u> (as defined by <u>NQF Safe Practice #4 – Identification and Mitigation of Risks and Hazards</u>);	☐ Yes	☐ No
ii. <u>culture measurement</u> (as defined by <u>NQF Safe Practice #2 – Culture Measurement, Feedback, and Intervention</u>); and		
iii. <u>progress towards resolution of safety and quality problems</u> . (p.75)		
b. <u>patients and/or families of patients</u> are active participants in the hospital-wide safety and quality <u>committee</u> that meets on a regularly scheduled basis (e.g., biannually or quarterly). (p.75)	☐ Yes	☐ No
c. <u>steps have been taken to report</u> ongoing efforts to improve safety and quality in the organization and the results of these efforts to the community. (p.75)	☐ Yes	☐ No
d. <u>all staff and independent practitioners</u> were made aware of ongoing efforts to reduce risks and hazards and to improve patient safety and quality in the organization. (p.75)	☐ Yes	☐ No

Accountability

1.2) Within the last 12 months, in regard to holding the <u>board, senior administrative leadership, midlevel management, nursing leadership, physician leadership, and frontline caregivers</u> directly accountable for results related to the identification and mitigation of risks and hazards, the organization has done the following:		
a. <u>an integrated patient safety program</u> has been in place for the entire reporting period, providing oversight and alignment of safe practice activities. (p.76)	☐ Yes	☐ No
b. a <u>Patient Safety Officer (PSO)</u> has been appointed and <u>communicates regularly</u> with the <u>board</u> (governance) and <u>senior administrative leadership</u> ; the PSO is the primary point of contact of the integrated patient safety program. (p.76)	☐ Yes	☐ No
c. <u>performance has been documented in performance reviews and/or compensation incentives</u> for all levels of hospital management and hospital-employed caregivers noted above. (p.76)	☐ Yes	☐ No
d. <u>the interdisciplinary patient safety team communicated regularly with senior administrative leadership</u> regarding both of the following and documented these communications in meeting minutes (pp. 76-77):	☐ Yes	☐ No
i. <u>progress in meeting safety goals</u> , and		
ii. <u>provided team training to caregivers</u> .		

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e. the hospital <u>reported</u> adverse events to external mandatory or voluntary programs. (p.77)	☐ Yes ☐ No
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Ability

1.3) Within the last 12 months, in regard to implementation of the patient safety program, the <u>board</u> (governance) and <u>senior administrative leadership</u> have provided resources to cover the implementation, as evidenced by:	
a. dedicated patient safety program <u>budgets</u> to support the program, staffing, and technology investment. (p.77)	☐ Yes ☐ No

Action

1.4) Within the last 12 months, structures and systems have been in place to ensure that <u>senior administrative leadership</u> is taking direct action, as evidenced by:	
a. CEO and <u>senior administrative leadership</u> are personally <u>engaged</u> in reinforcing patient safety improvements, e.g., “walk-arounds,” and reporting to the <u>board</u> (governance). Calendars reflect allocated time. (p.78)	☐ Yes ☐ No
b. CEO has actively <u>engaged</u> leaders from <u>service lines, midlevel management, nursing leadership, and physician leadership</u> in patient safety improvement actions. (p.79)	☐ Yes ☐ No
c. hospital has established a <u>structure</u> for input into the patient safety program by licensed independent practitioners and the organized medical staff and physician leadership. Input documented in meeting minutes or materials. (p.79)	☐ Yes ☐ No

6B: NQF Safe Practice #2 – Culture Measurement, Feedback, and Intervention

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Important Notes:

Note 1: Page numbers throughout this subsection refer to the [NQF Safe Practices for Better Healthcare – 2010 Update](#) report, not this document.

Note 2: Hyperlinks throughout this subsection refer to the [Patient Safety Practices FAQs](#) beginning on page 249, not to endnotes. These hyperlinks are not included in the Online Survey Tool.

Note 3: Throughout this subsection, the culture of safety survey referenced in each practice element refers to one administered in the last 24 months as indicated in 2.1a. This means that the same culture of safety survey should be used when responding to each practice element.

Specifications: See [NQF Safe Practice Measure Specifications](#) in the Reference Information beginning on page 238.

Awareness

2.1) Within the last 24 months, in regard to culture measurement, our organization has done the following:	
a. conducted a culture of safety survey of our employees using a nationally recognized tool that has demonstrated validity, consistency, and reliability. The units surveyed account for at least 50% of the aggregated care delivered to patients within the hospital and include the high patient safety risk units or departments. (p.88)	☐ Yes ☐ No
<i>If "no" to question 2.1a, skip the remaining questions in Section 6B and continue to the next subsection. The hospital will be scored as "Limited Achievement."</i>	
b. portrayed the results of the culture of safety survey in a report, which reflects both hospital-wide and individual unit level results, as applicable. (p.88)	☐ Yes ☐ No
c. benchmarked results of the culture of safety survey against external organizations, such as "like" hospitals or other hospitals within the same health system.	☐ Yes ☐ No
d. compared results of the culture of safety surveys across roles and staff levels .	☐ Yes ☐ No
e. service line, midlevel managers, or senior administrative leaders used the results of the culture of safety survey to debrief at the relevant unit level, using semi-structured approaches for the debriefings and presenting results in aggregate form to ensure the anonymity of survey respondents.	☐ Yes ☐ No

Accountability

2.2) Within the last 24 months, in regard to accountability for improvements in culture measurement, our organization has done the following:	
a. shared the results of the culture of safety survey with the board (governance) and senior administrative leadership in a formal report and discussion. (p.88)	☐ Yes ☐ No
b. included in performance evaluation criteria for senior administrative leadership both the response rates to the culture of safety survey and the use of the culture of safety survey results in the improvement efforts.	☐ Yes ☐ No

Ability

2.3) Within the last 12 months, in regard to culture measurement, the organization has done the following (or has had the following in place):

a. conducted staff <u>education program(s)</u> on methods to improve the culture of safety, tailored to the organization's culture of safety survey results.	☐ Yes ☐ No
b. included the costs of culture measurement/follow-up activities in the patient safety program <u>budget</u> .	☐ Yes ☐ No

Action

2.4) Within the last 12 months, in regard to accountability for improvements in culture measurement, our organization has done the following:

a. developed or implemented explicit, hospital-wide organizational policies and procedures for regular culture measurement. (p.88)	☐ Yes ☐ No
b. <u>disseminated</u> the results of the culture of safety survey widely across the institution, and <u>senior administrative leadership</u> held follow-up meetings with the sampled units to discuss the unit's results and concerns. (p.88)	☐ Yes ☐ No
c. identified performance improvement interventions based on the culture of safety survey results, which were shared with <u>senior administrative leadership</u> and subsequently measured and monitored. (p.88)	☐ Yes ☐ No

6C: Hand Hygiene

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Important Notes:

Note 1: Hyperlinks not followed by a superscript throughout this subsection refer to the [Patient Safety Practices FAQs](#) beginning on page 251. These hyperlinks are not included in the Online Survey Tool.

Note 2: The framework and questions in this subsection are modeled after the World Health Organization's [Hand Hygiene Self-Assessment Framework](#).

Note 3: Hospital responses should reflect patient care units only, including all adult and pediatric medical, surgical, and medical/surgical units (including telemetry units), step-down/progressive units, obstetrical units, intensive care units (including neonatal units), pre-operative and post-anesthesia care units, observation units, and dedicated emergency department units.

Note 4: Only include units that were open for the entire reporting period (i.e., most recent month or past three months based on responses selected in monitoring questions #8-10) and that remain currently open.

Specifications: See [Hand Hygiene Measure Specifications](#) in the Reference Information beginning on page 237.

Reporting Period: Answer questions #1-21 based on the practices currently in place at the time you submit this section of the Survey.

Note: For monitoring, this means that the monthly sample size (or quarterly sample size if answering question #10) would need to be met at least once in each patient care unit the month (or quarter) preceding the time of the submission of the Survey and there must be a process in place to meet the monthly (or quarterly) sample size thereafter in each patient care unit every month/quarter.

Note: As a reminder, the [Corrections Period](#) (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

Training and Education

1) Do individuals who touch patients or who touch items that will be used by patients⁴⁴ in your patient care units receive hand hygiene training from a <u>professional with appropriate training and skills</u>⁴⁵ at both: - the time of onboarding, and - annually thereafter? <i>If "no" to question #1, skip questions #2-3 and continue to question #4.</i>	☐ Yes ☐ No
2) In order to pass the initial hand hygiene training, do <u>individuals who touch patients or who touch items that will be used by patients</u>⁴⁴ in your patient care units need to <u>physically demonstrate</u> proper hand hygiene with soap and water and alcohol-based hand sanitizer?	☐ Yes ☐ No

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3) Are all six of the following topics included in your hospital's initial and annual hand hygiene training: • Evidence linking hand hygiene and infection prevention; • When <u>individuals who touch patients or who touch items that will be used by patients⁴⁴</u> should perform hand hygiene (e.g., <u>WHO's 5 Moments for Hand Hygiene</u>, <u>CDC's Guideline for Hand Hygiene</u>); • How <u>individuals who touch patients or who touch items that will be used by patients⁴⁴</u> should clean their hands with alcohol-based hand sanitizer and soap and water as to ensure they cover all surfaces of hands and fingers, including thumbs and fingernails; • When gloves should be used in addition to hand washing (e.g., caring for <i>C. diff.</i> patients) and how hand hygiene should be performed when gloves are used; • The minimum time that should be spent performing hand hygiene with soap and water and alcohol-based hand sanitizer; and • How hand hygiene compliance is monitored?	☐ Yes ☐ No
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Infrastructure

4) Does your hospital conduct quarterly audits on a sample of dispensers in your patient care units to ensure all the following: • Paper towels, soap dispensers, and alcohol-based hand sanitizer dispensers are refilled when they are empty or near empty, and • Batteries in automated paper towel dispensers, soap dispensers, and alcohol-based hand sanitizer dispensers (if automated dispensers are used in the patient care units) are replaced?	☐ Yes ☐ No
5) Do all rooms and bed spaces in your patient care units have: • an alcohol-based hand sanitizer dispenser located at the entrance to the room or bed space, and • alcohol-based hand sanitizer dispenser(s) located inside the room or bed space that are equally accessible to the location of all patients in the room or bed space?	☐ Yes ☐ No

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6) Does your hospital conduct audits of the volume of alcohol-based hand sanitizer that is delivered with each activation of a wall-mounted dispenser (manual and automated) on a sample of dispensers in your patient care units at all the following times: • upon installation, • whenever the brand of product or system changes, and • whenever adjustments are made to the dispensers? OR Has your hospital conducted an audit of the volume of alcohol-based hand sanitizer that is delivered with each activation of a wall-mounted dispenser (manual and automated) on a sample of your hospital's <u>existing</u> dispensers if there have been no changes to any dispensers? <i>If "no" or "does not apply, wall-mounted dispensers are not used," skip question #7 and continue to question #8.</i>	○ Yes ○ No ○ Does not apply, wall-mounted dispensers are not used
7) Do all the audited dispensers deliver, with one activation, 1.0 mL of alcohol-based hand sanitizer OR a volume of alcohol-based hand sanitizer that covers the hands completely and requires 15 or more seconds for hands to dry (on average)?	○ Yes ○ No

Monitoring

8) Does your hospital collect hand hygiene compliance data on at least 200 hand hygiene opportunities, or at least the number of hand hygiene opportunities outlined based on the unit type in Tables 1-3, each month in each patient care unit? <i>If "yes" to question #8, skip questions #9-10 and continue to question #11.</i>	○ Yes, using an electronic compliance monitoring system throughout all patient care units ○ Yes, using an electronic compliance monitoring system throughout some patient care units and only direct observation in all other patient care units ○ Yes, using only direct observation throughout all patient care units ○ No
9) Does your hospital collect hand hygiene compliance data on at least 100 hand hygiene opportunities, or at least the number of hand hygiene opportunities outlined based on the unit type in Tables 4-6, each month in each patient care unit? <i>If "yes" to question #9, skip question #10 and continue to question #11.</i>	○ Yes, using an electronic compliance monitoring system throughout all patient care units ○ Yes, using an electronic compliance monitoring system throughout some patient care units and only direct observation in all other patient care units ○ Yes, using only direct observation throughout all patient care units ○ No

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10) Does your hospital collect hand hygiene compliance data on at least 100 hand hygiene opportunities each quarter in each patient care unit? <i>If “no” to question #10, skip questions #11-19 and continue to question #20.</i>	○ Yes, using an electronic compliance monitoring system throughout all patient care units ○ Yes, using an electronic compliance monitoring system throughout some patient care units and only direct observation in all other patient care units ○ Yes, using only direct observation throughout all patient care units ○ No
11) Does your hospital use hand hygiene coaches or compliance observers to provide <u>individuals who touch patients or who touch items that will be used by patients</u>⁴⁴ in your patient care units with feedback on both when they are and are not compliant with performing hand hygiene?	○ Yes ○ No

Direct Monitoring – Electronic Compliance Monitoring System

If “yes, using an electronic compliance monitoring system throughout all patient care units” or “yes, using an electronic compliance monitoring system throughout some patient care units and only direct observation in all other patient care units” to question #8, question #9, or question #10, answer questions #12-13 based on the units that use an electronic compliance monitoring system.

12) In those patient care units where an electronic compliance monitoring system is used, does the monitoring system used meet both of the following criteria: • The system can identify both opportunities for hand hygiene and that hand hygiene was performed, and • The hospital itself has validated the accuracy of the data collected by the electronic compliance monitoring system?	○ Yes ○ No
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13) In those patient care units where an electronic compliance monitoring system is used, are direct observations also conducted for coaching and intervention purposes that meet all the following criteria: • Observers immediately intervene prior to any harm occurring to provide non-compliant individuals with immediate feedback; • Observations identify both opportunities for hand hygiene and compliance with those opportunities; • Observations determine who practiced hand hygiene, verify when they practiced it, and whether their technique was correct; • Observations within a unit are conducted weekly or monthly across all shifts and on all days of the week proportional to the number of <u>individuals who touch patients or who touch items that will be used by patients</u>⁴⁴ on duty for that shift; and • Observations capture a representative sample of the different roles of <u>individuals who touch patients or who touch items that will be used by patients</u>⁴⁴ (e.g., nurses, physicians, techs, environmental services workers)?	☐ Yes ☐ No
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Direct Monitoring – Direct Observation

If “yes, using an electronic compliance monitoring system throughout some patient care units and only direct observation in all other patient care units” or “yes, using only direct observation” to question #8, question #9, or question #10 answer questions #14-15 based on the units that do NOT use an electronic compliance monitoring system.

14) In those patient care units where an electronic compliance monitoring system is NOT used, do the direct observations meet all the following criteria: • Observations identify both opportunities for hand hygiene and compliance with those opportunities; • Observations determine who practiced hand hygiene, verify when they practiced it, and whether their technique was correct; • Observations within a unit are conducted weekly or monthly across all shifts and on all days of the week proportional to the number of <u>individuals who touch patients or who touch items that will be used by patients</u>⁴⁴ on duty for that shift; and • Observations are conducted to capture a representative sample of the different roles of <u>individuals who touch patients or who touch items that will be used by patients</u>⁴⁴ (e.g., nurses, physicians, techs, environmental services workers)?	☐ Yes ☐ No
15) Does your hospital have a system in place for both the initial and recurrent training and validation of hand hygiene compliance observers?	☐ Yes ☐ No

Feedback

16) Are unit-level hand hygiene compliance data fed back to <u>individuals who touch patients or who touch items that will be used by patients⁴⁴</u> at least monthly for improvement work?	☐ Yes ☐ No
17) Are unit-level hand hygiene compliance data used for creating unit-level action plans?	☐ Yes ☐ No
18) Is regular (at least every 6 months) feedback of hand hygiene compliance data, with demonstration of trends over time, given to: • <u>senior administrative leadership, physician leadership, and nursing leadership,</u> • the <u>board</u> (governance), and • the <u>medical executive committee</u>? <i>If “no” to question #18, skip question #19 and continue to question #20.</i>	☐ Yes ☐ No
19) If “yes” to question #18, is <u>senior administrative leadership, physician leadership, and nursing leadership</u> held directly accountable for hand hygiene performance through <u>performance reviews or compensation</u> ?	☐ Yes ☐ No

Culture

20) Are patients and visitors <u>invited to remind individuals who touch patients or who touch items that will be used by patients⁴⁴</u> to perform hand hygiene?	☐ Yes ☐ No
21) Have all the following individuals (or their equivalents) demonstrated a commitment to support hand hygiene improvement in the last year (e.g., a written or verbal commitment delivered to those <u>individuals who touch patients or who touch items that will be used by patients⁴⁴</u>): • Chief Executive Officer, • Chief Medical Officer, and • Chief Nursing Officer?	☐ Yes ☐ No

6D: Diagnostic Excellence (Optional – Fact-Finding Only)

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review Leapfrog's Multi-Campus Reporting Policy.

Important Notes:

Note 1: This subsection will not be scored or publicly reported.

Note 2: A diagnostic error is an event where one or both of the following occurred, with harm or high potential of harm to the patient:

- Delayed, wrong, or missed diagnosis: At least one missed opportunity to pursue or identify an accurate and timely diagnosis based on the information that existed at the time.
- Diagnosis not communicated to the patient: An accurate diagnosis was available but was not effectively communicated to the patient or family caregiver.

All references to “errors in diagnoses” refer to both types of events.

Note 3: Diagnosis excellence means making and communicating a correct and timely diagnosis using appropriate resources while maximizing patient experience and managing uncertainty.

Reporting Period: Answer questions #1-16 based on the practices currently in place at the time you submit this section of the Survey.

Note: As a reminder, the Corrections Period (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

CEO Commitment to Diagnostic Excellence

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

Patient Engagement

3) Has your hospital chartered a Patient and Family Advisory Council (PFAC) that meets at least quarterly? <i>If “no” to question #3, skip question #4 and continue to question #5.</i>	☐ Yes ☐ No
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4) In the past 36 months, has your hospital's PFAC: - received education regarding errors in diagnosis in the hospital or the <u>diagnostic process</u>⁴⁶, - had input into any initiatives aimed at reducing errors in diagnosis in the hospital, or - led any initiatives aimed at reducing errors in diagnosis in the hospital?	☐ Yes ☐ No
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Risk Assessment and Mitigation

5) In the past 36 months, has your hospital used the <u>Safer Dx Checklist</u> to identify at least one high-priority practice that is not currently at "Full" implementation? <i>If "no" to question #5, skip question #6 and continue to question #7.</i>	☐ Yes, led by our multidisciplinary team ☐ Yes, led by a different entity at the hospital (please specify): _____ ☐ No
6) What steps has your hospital taken to fully implement the practice? <i>Select all that apply.</i>	☐ Allocated budget ☐ Appointed an individual or team responsible for implementation ☐ Set a date for full implementation ☐ None of the above

Convening a Multidisciplinary Team Focused on Diagnostic Excellence

7) In the past 36 months, has your hospital convened a multidisciplinary team that meets all the following requirements: - Solely focused on reducing harm to patients from errors in diagnosis; - Sponsored by either the CEO or CMO; - Includes, at a minimum, representatives from nursing, pharmacy, laboratory medicine, radiology, pathology, hospital medicine or inpatient care specialists, emergency medicine, and quality or risk management; - Meets at least quarterly; - Reports to senior leaders quarterly; and - Reports to the Board annually? <i>The multidisciplinary team should be a distinct entity at your hospital, not the established patient safety committee.</i> <i>If "no" to question #7, skip question #8 and continue to question #9.</i>	☐ Yes ☐ No
8) In the past 24 months, has the multidisciplinary team helped to educate staff on their work on reducing errors in diagnosis?	☐ Yes ☐ No
9) As a standing agenda item of regular meetings, has the multidisciplinary team reviewed any clinical or administrative data, patient experience or patient reported data, or incident reports to identify or track errors in diagnosis? <i>If "no" to question #9, skip question #10 and continue to question #11.</i>	☐ Yes ☐ No ☐ No, but a different team at the hospital has reviewed data or incident reports to identify or track errors in diagnosis

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10) In the past 24 months, if an error in diagnosis was identified through the review of any of the data sources used in question #9, did the multidisciplinary team conduct any analyses or case reviews within four weeks of the error being identified and ensure the findings were communicated to the individuals involved in the patient's care and hospital leadership?	☐ Yes ☐ No ☐ No, but a different team at the hospital has conducted at least one root cause analysis or case review of a diagnostic error
11) In the past 24 months, has the multidisciplinary team encouraged all staff (verbally or in writing), including all clinicians who participate in the diagnostic process, to report errors in diagnosis via the hospital's incident or event reporting system?	☐ Yes ☐ No ☐ No, but a different team at the hospital has encouraged all staff to report errors in diagnosis
12) In the past 24 months, has the multidisciplinary team convened emergency medicine staff to identify commonly misdiagnosed conditions (e.g., stroke, heart attack, VTE) in the emergency department? <i>If "no" to question #12, skip question #13 and continue to question #14.</i>	☐ Yes ☐ No ☐ No, but the emergency medicine staff independently meet to identify commonly misdiagnosed conditions
13) In the past 24 months, has the multidisciplinary team worked with the emergency medicine staff to develop or implement any initiatives aimed at improving accurate and timely diagnosis of these commonly misdiagnosed conditions?	☐ Yes ☐ No ☐ No, but the emergency medicine staff have independently implemented at least one such initiative
14) In the past 24 months, has the multidisciplinary team convened radiologists and pathologists to discuss diagnosis related issues, including potential discrepancies, and analyze cases where there is a discrepancy between radiology and pathology findings? <i>If "no" to question #14, skip question #15 and continue to question #16.</i>	☐ Yes ☐ No ☐ No, but radiologists and pathologists independently meet to discuss diagnosis-related issues
15) In the past 24 months, has the multidisciplinary team worked with the pathologists and radiologists to develop or implement protocols to ensure timely review and resolution of discrepancies, and timely communication of diagnoses to patients and their families?	☐ Yes ☐ No ☐ No, but radiologists and pathologists independently developed or implemented at least one such protocol

Training and Education

16) In the past 36 months, has your hospital trained any staff using <u>AHRQ's TeamSTEPPS for Diagnosis Improvement</u> program to improve communication among members of the care team (including nurses, pharmacists, and other allied health professionals), within the context of the diagnostic process or in reducing errors in diagnosis)?	☐ Yes ☐ No
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Closing the Loop on Cancer Diagnosis**Reporting Period: 12 months**

- Survey submitted prior to September 1:
 - 01/01/2024 – 12/31/2024
- Surveys submitted on or after September 1:
 - 07/01/2024 – 06/30/2025

Note: As a reminder, the Corrections Period (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

Sufficient Sample: See Closing the Loop on Cancer Diagnosis Measure Specifications for instructions on identifying a sufficient sample for questions #19-22.

17) 12-month reporting period used:	☐ 01/01/2024 – 12/31/2024 ☐ 07/01/2024 – 06/30/2025
18) Do pathologists at your hospital routinely document the date in which they communicate <u>pathology reports</u> indicating a diagnosis of colon, lung, or breast cancer to a patient or a patient's ordering physician? <i>If "no" or "our hospital does not operate an on-site pathology service" to question #18, skip the remaining questions in Section 6D and continue to the next subsection.</i>	☐ Yes ☐ No ☐ Our hospital does not operate an on-site pathology service
19) Did your hospital perform an audit on a sufficient sample of patients to calculate the proportion of colon, lung, or breast cancer diagnoses in which the patient or patient's ordering physician was notified within five business days of the report being signed by the pathologist, and do you choose to report those data to this Survey? <i>If "no" or "yes, but fewer than 30 cases met the inclusion criteria for the denominator," skip the remaining questions in Section 6D and continue to the next subsection.</i>	☐ Yes ☐ No ☐ Yes, but fewer than 30 cases met the inclusion criteria for the denominator
20) How many cases were included in the audit from question #19 with a diagnosis of colon, lung, or breast cancer:	_____
21) Total number of patients from question #20 with documented communication between the pathologist and the patient or patient's ordering physician within five business days of the report being signed by the pathologist: <i>Documented communication includes:</i> • A documented phone call between the pathologist and patient or patient's ordering physician of the diagnosis, and • A timestamp, read receipt, or email response indicating that the patient or patient's ordering physician read an electronic communication of the diagnosis.	_____
22) Total number of patients from question #20 who were notified, either by phone or electronically, that the pathology report with their diagnosis was uploaded to the patient portal and ready for review: <i>Hospitals that do not upload pathology reports to the patient portal or notify patients when reports are uploaded, should enter "0."</i>	_____

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

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review Leapfrog's Multi-Campus Reporting Policy.

Important Notes:

Note 1: This subsection will not be scored or publicly reported.

Note 2: Only include units that were open for the entire reporting period and that remain currently open.

Note 3: When reporting on questions #4 and/or #5, include Emergency Department (ED) visits with an admission to an inpatient non-psychiatric or psychiatric bed, including ED visits with an admission to hospital observation status.

Specifications: See Hospital Boarding in the Emergency Department (ED) Measure Specifications in the Reference Information beginning on page 162.

Reporting Period: 12 months

- Surveys submitted prior to September 1:
 - 01/01/2024 – 12/31/2024
- Surveys (re)submitted on or after September 1:
 - 07/01/2024 – 06/30/2025

Note: As a reminder, the Corrections Period (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

1) 12-month reporting period used:	☐ 01/01/2024 – 12/31/2024 ☐ 07/01/2024 – 06/30/2025
2) Did your hospital operate a <u>dedicated emergency department (ED)</u> ⁴⁷ during the reporting period? <i>If “no” or “yes, but ED is now closed or wasn’t open for the entire reporting period,” skip questions #3-5 and go to the Affirmation of Accuracy.</i>	☐ Yes ☐ No ☐ Yes, but ED is now closed or wasn’t open for the entire reporting period
3) What type(s) of <u>dedicated emergency department(s)</u> ⁴⁷ did your hospital operate? <i>Select all that apply.</i>	☐ Adult only ☐ Pediatric only ☐ Adult/Pediatric combined

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

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

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

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

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

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

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

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

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

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

Admitted to an inpatient psychiatric bed				
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Affirmation of Accuracy

As the hospital CEO or as an employee of the hospital to whom the hospital CEO has delegated responsibility, I have reviewed this information pertaining to the Patient Safety Practices Section at our hospital, and I hereby certify that this information is true, accurate, and reflects the current, normal operating circumstances at our hospital. I am authorized to make this certification on behalf of our hospital.

The hospital and I understand that The Leapfrog Group, its members, the public and entities and persons who contract or have other business dealings with The Leapfrog Group are relying on the truth and accuracy of this information. The hospital and I also understand that The Leapfrog Group will make this information and/or analyses of this information public through the Survey Results public reporting website, The Leapfrog Group's Hospital Safety Grade, and/or other Leapfrog Group products and services. This information and/or analyses and all intellectual property rights therein shall be and remain the sole and exclusive property of The Leapfrog Group in which The Leapfrog Group retains exclusive ownership. This information does not infringe upon any third-party intellectual property rights or any other third-party rights whatsoever and is free and clear of all encumbrances and liens of any kind. The hospital and I acknowledge that The Leapfrog Group may use this information in a commercial manner for profit. The hospital shall be liable for and shall hold harmless and indemnify The Leapfrog Group from any and all damages, demands, costs, or causes of action resulting from any inaccuracies in the information or any misrepresentations in this Affirmation of Accuracy. The Leapfrog Group and its members and entities and persons who contract or have other business dealings with The Leapfrog Group reserve the right to omit or disclaim information that is not current, accurate or truthful.

Affirmed by _____, the hospital's _____,
(first name and last name) (title)
on _____.
(date)

Section 6: Patient Safety Practices Reference Information***What's New in the 2025 Survey*****Section 6A: NQF Safe Practice #1 – Culture of Safety Leadership Structures and Systems**

Leapfrog is updating the FAQ for Safe Practice 1.1b to clarify the requirement of having patients and/or families of patients as active participants in the hospital-wide safety and quality committee for hospitals that utilize a systemwide safety and quality committee instead of a local committee.

Additionally, the definition of Board has been updated to clarify that a system-wide board that governs hospitals in the system would meet the criteria.

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

Section 6B: NQF Safe Practice #2 – Culture Measurement, Feedback, and Intervention

There are no changes to this subsection.

Section 6C: Hand Hygiene

Leapfrog is adding further clarification in the measure specifications regarding the units included when reporting on Section 6C: Hand Hygiene, including reminding hospitals to exclude units that are not currently open and/or were not open consistently throughout the entire reporting period (i.e., most recent month or past three months based on responses selected in monitoring questions #8-10). The units are being updated to add further clarification and alignment with reporting in other sections of the Survey, including specifying the inclusion of both single acuity and mixed acuity units when reporting on medical, surgical, and medical/surgical units. In addition, hospitals will need to include any pre-operative and post-anesthesia care units that are located in or co-located with their hospital (previously hospitals were asked to only include those used for inpatient procedures and those used for outpatient procedures listed in Section 9: Outpatient Procedures), as well as those located in free-standing hospital outpatient departments that perform the outpatient procedures listed in Section 9: Outpatient Procedures and that share the hospital's license or CMS Certification Number.

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

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

Section 6D: Diagnostic Excellence

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

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

- Question #1, regarding the CEO's commitment to diagnostic excellence, will be updated to specify that the commitment must specifically focus on errors in diagnosis, and to indicate that the commitment must have been made by the hospital's current CEO or CMO.
- Questions #3 and #4, regarding patient engagement, will be updated to specify a timeframe for Patient and Family Advisory Council (PFAC) meetings and clarify that PFAC activities should focus on diagnosis in the hospital.

- Question #5 and #6, regarding risk assessment and mitigation, will be updated to specify that hospitals should use the Safer Dx Checklist to identify at least one practice not currently fully implemented and to clarify the specific steps the hospital is taking to close those gaps.
- Questions #7-15, regarding convening a multidisciplinary team focused on diagnostic excellence, will be updated to confirm that the multidisciplinary team should be a distinct entity at the hospital, not the established patient safety committee, as well as specifying specific timeframes for activities. A new FAQ will clarify that multidisciplinary teams should be hospital-specific, not system-level.
- Question #16, regarding training and education, will be updated to specify that the AHRQ's TeamSTEPPS for Diagnosis Improvement program is the training hospitals should be using to improve communication among members of the care team within the context of the diagnostic process.
- Questions #17-22, regarding closing the loop on cancer diagnosis, will include new FAQs to clarify which reports should be included, and how patients should be tabulated.

Section 6E: Hospital Boarding in the Emergency Department (ED)

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

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

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

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

- The percentage of ED patients that are admitted to the hospital that had a boarding time in the ED of more than 4 hours (where lower percentages are desirable)
- The median length of stay in the ED for patients admitted to the hospital (where lower values are desirable)
- The 90th percentile length of stay in the ED for patients admitted to the hospital (where lower values are desirable)

Based on responses received during the public comment period and further input from our Emergency Department Boarding Expert Panel, Leapfrog is making the following updates to the originally proposed questions:

- To better recognize the underlying systems issues that are key drivers of admitted inpatients boarding in the ED, Leapfrog will rename the subsection "Hospital Boarding in the Emergency Department (ED)" instead of "ED Boarding."
- Leapfrog will include patients admitted to observation status, as well as those admitted to the hospital's inpatient setting.
- Leapfrog will ask hospitals to report the median ED length of stay instead of the average ED length of stay for patients with an ED visit that are admitted to the hospital given that the average can be skewed by outliers.

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- Leapfrog will also ask hospitals to report the 90th percentile ED length of stay for patients with an ED visit that are admitted to the inpatient setting to better understand a “bad” day in the ED.
- To address differences in boarding times among certain populations, such as behavioral health patients and pediatric patients, hospitals will be asked to stratify their data in two different ways: (1) separating adult patients from pediatric patients; and (2) separating patients admitted to an inpatient psychiatric bed from those admitted to an inpatient non-psychiatric bed. Leapfrog will monitor the use of admission to an inpatient psychiatric bed as the stratification decision moving forward, to understand if there are more accurate and/or more feasible approaches to capturing patients with a behavioral health diagnosis.

The questions will not be scored or publicly reported in 2025.

Change Summary Since Release

April 18, 2025 – Updated the measure specifications used to report on Hospital Boarding in the Emergency Department (ED) to exclude ED patients transferred from the ED to another hospital from questions 4a and 5a.

Section 6: Patient Safety Practices Measure Specifications

NQF Safe Practice Measure Specifications

Instructions for Reporting on NQF Safe Practices:

1. **Prepare:**
 - a. Download and review a copy of the National Quality Forum's *Safe Practices for Better Healthcare – 2010 Update* report for reporting on subsections 6A and 6B available at <http://leapfroggroup.org/survey-materials/survey-and-cpoe-materials>.
 - b. Print and review a hard copy of (1) the Survey questions, (2) the practice-specific FAQs, and (3) the scoring algorithm.
2. **Identify Individuals to Assist:** Decide who should participate on your team to assist in collection of the documentation for assessment.
3. **Plan:** The team should be briefed and assigned duties to help capture the key information necessary for submission of this section.
4. **Collect and Maintain:** Key documentation must be collected to support answering the questions in this section of the Survey. Please refer to the Survey Binder for examples of acceptable documentation. Documentation should be maintained to ensure that your hospital can respond to Leapfrog's request for documentation should you be selected for our Monthly Documentation Requirements. Reviews are performed every month during the Survey Cycle (April 1 to November 30) and throughout the Corrections Period. In addition, the documentation can be helpful if your hospital is planning to update and resubmit this section of the Survey prior to November 30.
5. **Assess:** When all the supporting documents are assembled, it is recommended that hospitals review their final responses to Section 6 with the CEO and/or responsible leadership. Hospitals should update their answers online as they adopt additional practices throughout the Survey Cycle (April 1 to November 30). As a reminder, the Corrections Period (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.
6. **Submit:** Section 6 must be completed and affirmed before it can be submitted with the Survey.

Hand Hygiene Measure Specifications

Important Note: Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Source: The framework and questions in this subsection are modeled after the World Health Organization's [Hand Hygiene Self-Assessment Framework](#).

Reporting Period: Answer questions #1-21 based on the practices currently in place at the time you submit this section of the Survey.

Note: For monitoring, this means that the monthly sample size (or quarterly sample size if answering question #10) would need to be met at least once in each patient care unit the month (or quarter) preceding the time of the submission of the Survey and there must be a process in place to meet the monthly (or quarterly) sample size thereafter in each patient care unit every month/quarter.

If the monitoring sample size is not met at any point after submission, the Survey must be updated and re-submitted. More information about updating a Survey can be found at <https://www.leapfroggroup.org/survey-materials/updating-your-hospital-survey>.

As a reminder, Leapfrog randomly requests documentation on a monthly basis and key documentation must be collected and maintained to support responses to all questions. Hospitals are urged to regularly review their documentation, including reports supporting their monitoring of hand hygiene, and maintain copies throughout the Survey Cycle. Please refer to the [Survey Binder](#) for examples.

Patient Care Units: Include only the following patient care units when reporting on the questions in this subsection:

- Medical, Surgical, and Medical/Surgical Units (including telemetry units)¹⁹ (adult and/or pediatric)
- Step-down/progressive Units²⁰ (adult and/or pediatric)
- Obstetrical Units (Labor and Delivery Units²¹, nursery, etc., excluding procedural areas)
- General Medical, Surgical, Medical/Surgical, and Neuro ICUs¹⁴ (adult and/or pediatric)
- Neonatal ICUs¹⁷
- Specialty ICUs (adult and/or pediatric)
- Pre-operative and Post-anesthesia Care Units²² (adult and/or pediatric)
- Observation Units (adult and/or pediatric)
- Dedicated Emergency Departments⁴⁷ (adult and/or pediatric)

Other units that are not denoted above would be excluded for the purposes of reporting on Section 6D Hand Hygiene. The following units would be excluded:

- Behavioral Health Units
- Psychiatric Units
- Palliative Care and Hospice Units
- Rehabilitation Units
- Operating Rooms
- Procedural and Diagnostic Areas, such as Radiology, Endoscopy, Dialysis, and Radiation Units
- Admission Units that don't hold patients overnight
- Primary Care Clinics
- Units that are not currently open and/or were not open consistently throughout the entire reporting period (i.e., most recent month or past three months based on responses selected in monitoring questions #8-10)

Infrastructure

Question #4: Does your hospital have a process in place to ensure that **all** the following are done, as necessary, and quarterly audits are conducted on a sample of dispensers in your patient care units to ensure that the process is followed?

- Refill paper towels, soap dispensers, and alcohol-based hand sanitizer dispensers when they are empty or near empty
- Replace batteries in automated paper towel dispensers, soap dispensers, and alcohol-based hand sanitizer dispensers (if automated dispensers are used in the patient care units)

In order to respond “yes” to question #4, a process must be in place to ensure that paper towel, soap, and alcohol-based hand sanitizer dispensers are refilled when they are empty or near empty and batteries are replaced in automated paper towel, soap, and alcohol-based hand sanitizer dispensers (if automated dispensers are used in patient care units).

In addition, a quarterly audit must be conducted on a sample of paper towel, soap, and alcohol-based hand sanitizer dispensers to include checking that dispensers are refilled and that batteries in automated dispensers are replaced. The quarterly audit should be a supplement to a system that checks these supplies on a routine basis (e.g., environmental services check with their regular cleaning).

Sampling Instructions: The sample must be based on a random or systematic sampling procedure, where the sampling plan assures wide sampling (i.e., the same places would not always be monitored) and includes at least 5% of the dispensers in 20% of the patient care units.

Question #6: Does your hospital conduct audits of the volume of alcohol-based hand sanitizer that is delivered with each activation of a wall-mounted dispenser (manual and automated) on a sample of dispensers in your patient care units at **all** the following times:

- upon installation;
- whenever the brand of product or system changes; and
- whenever adjustments are made to the dispensers;

OR

Has your hospital conducted an audit of the volume of alcohol-based hand sanitizer that is delivered with each activation of a wall-mounted dispenser (manual and automated) on a sample of your hospital's existing dispensers if there have been no changes to any dispensers?

In order to respond “yes” to question #6, a volume audit on a sample of wall-mounted alcohol-based hand sanitizer dispensers (manual and automated) in your patient care units must be conducted **at least** once (upon installation, whenever the brand of product or system changes, and whenever adjustments are made to the dispensers) using one of the below methods. Prior volume audits are acceptable if they were conducted using the instructions in Leapfrog's 2019-2024 Surveys, documentation has been maintained, and no changes have been made to the dispensers since the audit.

Sampling Instructions: The sample must be based on a random or systematic sampling procedure, where the sampling plan assures wide sampling (i.e., the same places would not always be monitored) and includes at least 5% of the dispensers.

Method #1 - Auditing Liquid Volume: To audit the **liquid volume** of alcohol-based hand sanitizer that is delivered with each activation of a wall-mounted dispenser (manual and automated), use the following process:

1. Select a sample of dispensers based on a random or systematic sampling procedure.
2. Take a small, graduated plastic medicine cup and have the dispenser deliver 10 doses of alcohol-based hand sanitizer.
3. Divide the total volume dispensed by 10 to get an average of the amount dispensed.

NOTE: Hospitals using foam alcohol-based hand sanitizer will need to follow the steps above, but will instead need to weigh the sample, divide the results by 10 to obtain the average output of the sample, and then convert the weight in grams to milliliters by dividing the weight by the density (which can be provided by your vendor for your specific product).

Method #2 – Auditing Average Hand Rubbing Time: To audit the **average hand rubbing time** of alcohol-based hand sanitizer that is delivered with each activation of a wall-mounted dispenser (manual and automated), use the following process:

1. Select a sample of dispensers based on a random or systematic sampling procedure.
2. Identify multiple individuals (at least 10) with varying hand sizes (by quick observation).
3. For each sampled dispenser, have each of the individuals identified in step #1 dispense a volume of alcohol-based hand sanitizer.
4. For each individual, have a separate individual time the amount of hand rubbing time required for hands to dry completely.
5. Repeat this process for each individual and calculate an **average** time based on the ten observations conducted.
6. Repeat this process for each sampled dispenser.

Question #7: Do all the audited dispensers deliver, with one activation, 1.0 mL of alcohol-based hand sanitizer OR a volume of alcohol-based hand sanitizer that covers the hands completely and requires 15 or more seconds for hands to dry (on average)?

In order to respond “yes” to question #7, the **average** liquid volume for **each** sampled dispenser needs to be at least 1.0 mL (if using method #1) or the **average** hand rubbing time for **each** sampled dispenser needs to be at least 15 seconds (if using method #2).

Monitoring

Hand hygiene opportunities: Hand hygiene opportunities are the number of times that an individual who touches patients or who touches items used by patients should have cleaned their hands given the hand hygiene framework your hospital has adopted (e.g., WHO’s “5 moments,” Ontario’s 4 moments, CDC’s guidelines, etc.). In terms of determining opportunities to monitor, this would depend on the guidelines the hospital chooses to follow.

For example, many facilities choose to audit before and after patient contact or room entry and exit because this is operationally the simplest method. Auditing opportunities before and after dirty tasks is operationally difficult. There is some evidence that measuring adherence on room entry and exit may be an acceptable stand-in for other opportunities within the patient encounter.

Electronic compliance monitoring system: Electronic compliance monitoring systems would include door minder or activity monitoring systems, systems that include the wearing of electronic badges, and camera-based systems that are used to monitor hand hygiene compliance.

Question #8: Does your hospital collect hand hygiene compliance data on at least **200 hand hygiene opportunities**, or at least the number of hand hygiene opportunities outlined based on the unit type in Tables 1-3, **each month in each patient care unit**?

In order to respond “yes” to question #8, your hospital must monitor at least **200 hand hygiene opportunities**, or at least the number of hand hygiene opportunities outlined based on the unit type in Tables 1-3, **each month in each patient care unit** using either:

- An electronic compliance monitoring system throughout all patient care units
- An electronic compliance monitoring system throughout some patient care units and only direct observation in all other patient care units
- Only direct observation throughout all patient care units

Refer to the following tables to determine how many hand hygiene opportunities must be monitored in each patient care unit monthly for question #8. **Historical data** (e.g., past 3 months, 6 months, 12 months, etc.) on the monthly occupancy rates or procedure/patient volumes should be used.

Units/areas can be combined for the purposes of determining if you have met the monthly or quarterly monitoring sample size if they share a common group of staff (i.e., staff are scheduled to work in the broader area and float between units or staff may be scheduled to work either unit on any given day). Hand hygiene opportunities would still need to be monitored throughout both units/areas.

Table 1: Units where the monthly occupancy rate can be calculated

If your unit’s average daily census is...	Your patient care unit needs to collect hand hygiene compliance data for at least
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	this number of <u>hand hygiene opportunities</u> per month for question #8...
13 patients or higher	200
10-12 patients	150
7-9 patients	100
5-6 patients	75
3-4 patients	45
1-2 patients	15

Table 2: Units where the monthly occupancy rate cannot be calculated (e.g., PACU, labor and delivery, outpatient units)

If your unit's average number of procedures/patient volume in a month is...	Your patient care unit needs to collect hand hygiene compliance data for at least this number of <u>hand hygiene opportunities</u> per month for question #8...
400 procedures/patients or greater	200
320-399 procedures/patients	150
240-319 procedures/patients	100
160-239 procedures/patients	75
120-159 procedures/patients	50
60-119 procedures/patients	30
30-59 procedures/patients	15
<30 procedures/patients	5

Table 3: Emergency department units

If your emergency department's average number of visits in a month is...	Your patient care unit needs to collect hand hygiene compliance data for at least this number of <u>hand hygiene opportunities</u> per month for question #8...
2000 visits or greater	200
1500-1999 visits	150
1000-1499 visits	100
750-999 visits	75
500-749 visits	50
250-499 visits	25
150-249 visits	15
<150 visits	5

Question #9: Does your hospital collect hand hygiene compliance data on at least **100 hand hygiene opportunities**, or at least the number of hand hygiene opportunities outlined based on the unit type in Tables 4-6, **each month in each patient care unit**?

In order to respond "yes" to question #9, your hospital must monitor at least **100 hand hygiene opportunities**, or at least the number of hand hygiene opportunities outlined based on the unit type in Tables 4-6, **each month in each patient care unit** using either:

- An electronic compliance monitoring system throughout all patient care units
- An electronic compliance monitoring system throughout some patient care units and only direct observation in all other patient care units
- Only direct observation throughout all patient care units

Refer to the following tables to determine how many hand hygiene opportunities must be monitored in each patient care unit monthly for question #9. **Historical data** (e.g., past 3 months, 6 months, 12 months, etc.) on the monthly occupancy rates or procedure/patient volumes should be used.

Units/areas can be combined for the purposes of determining if you have met the monthly or quarterly monitoring sample size if they share a common group of staff (i.e., staff are scheduled to work in the

broader area and float between units or staff may be scheduled to work either unit on any given day). Hand hygiene opportunities would still need to be monitored throughout both units/areas.

Table 4: Units where the monthly occupancy rate can be calculated

If your unit's average daily census is...	Your patient care unit needs to collect hand hygiene compliance data for at least this number of <u>hand hygiene opportunities per month</u> for question #9...
13 patients or higher	100
10-12 patients	75
7-9 patients	50
5-6 patients	37
3-4 patients	22
1-2 patients	7

Table 5: Units where the monthly occupancy rate cannot be calculated (e.g., PACU, labor and delivery, outpatient units)

If your unit's average number of procedures/patient volume in a month is...	Your patient care unit needs to collect hand hygiene compliance data for at least this number of <u>hand hygiene opportunities per month</u> for question #9...
400 procedures/patients or greater	100
320-399 procedures/patients	75
240-319 procedures/patients	50
160-239 procedures/patients	37
120-159 procedures/patients	25
60-119 procedures/patients	15
30-59 procedures/patients	7
<30 procedures/patients	2

Table 6: Emergency department units

If your emergency department's average number of visits in a month is...	Your patient care unit needs to collect hand hygiene compliance data for at least this number of <u>hand hygiene opportunities per month</u> for question #9...
2000 visits or greater	100
1500-1999 visits	75
1000-1499 visits	50
750-999 visits	37
500-749 visits	25
250-499 visits	15
150-249 visits	7
<150 visits	2

Question #10: Does your hospital collect hand hygiene compliance data on at least 100 hand hygiene opportunities each quarter in each patient care unit?

In order to respond "yes" to question #10, your hospital must monitor at least **100 hand hygiene opportunities each quarter in each patient care unit** using either:

- An electronic compliance monitoring system throughout all patient care units
- An electronic compliance monitoring system throughout some patient care units and only direct observation in all other patient care units
- Only direct observation throughout all patient care units

There are no alternate sample sizes for the quarterly requirement. Hospitals trying to meet the quarterly requirement in question #10 will need to monitor 100 hand hygiene opportunities a quarter.

Units/areas can be combined for the purposes of determining if you have met the monthly or quarterly monitoring sample size if they share a common group of staff (i.e., staff are scheduled to work in the broader area and float between units or staff may be scheduled to work either unit on any given day). Hand hygiene opportunities would still need to be monitored throughout both units/areas.

Question #12: In those patient care units where an electronic compliance monitoring system is used, does the monitoring system used meet both of the following criteria?

- The system can identify both opportunities for hand hygiene and that hand hygiene was performed
- The hospital itself has validated the accuracy of the data collected by the electronic compliance monitoring system

In order to respond "yes" to question #12, the electronic monitoring system in use must identify both opportunities and that hand hygiene was performed, which could include both group monitoring systems and badge-based systems.

For example, an electronic monitoring system that records when an individual (not identified) enters and exits a room and also records if a dispenser was used within the same time frame, would qualify as the entry and exit is used as a proxy for a hand hygiene opportunity (before and after touching a patient) and the dispenser use is used as a proxy for a hand hygiene event. This data can be adjusted to take visitors into account and used to estimate hand hygiene compliance. Another example would be a badge-based system where individuals or their roles can be identified.

In addition, validation of the accuracy of the data collected by the electronic compliance monitoring system must be performed by hospital personnel or independent third-party personnel, in addition to any validation conducted by the manufacturer. It needs to include both a "planned path" phase where the researcher(s) make timed observations of room entries and exits and use of dispensers and compare their results to data recorded by the electronic compliance monitoring system. Followed by a "behavioral path" phase where observers record the same variables when individuals who touch patients or who touch items that will be used by patients are performing their usual duties, as this tends to be more chaotic and variable. A general validation protocol that can be used for both group monitoring systems and badge-based systems has been described in a fair amount of detail in the 2016 article by Limper H et al. Similar methods for conducting validation studies of badge-based system have been described by Pineles LL, et al. in 2014, and by Doll ME et al. in 2019. The 2023 article from Parker et al. regarding sample sizes for the validation can also be referenced.

Question #13: In those patient care units where an electronic compliance monitoring system is used, are direct observations also conducted for coaching and intervention purposes that meet all the following criteria?

- Observers immediately intervene prior to any harm occurring to provide non-compliant individuals with immediate feedback
- Observations identify both opportunities for hand hygiene and compliance with those opportunities
- Observations determine who practiced hand hygiene, verify when they practiced it, and whether their technique was correct
- Observations within a unit are conducted weekly or monthly across all shifts and on all days of the week proportional to the number of individuals who touch patients or who touch items that will be used by patients⁴⁴ on duty for that shift
- Observations capture a representative sample of the different roles of individuals who touch patients or who touch items that will be used by patients⁴⁴ (e.g., nurses, physicians, techs, environmental services workers)

In order to respond "yes" to question #13, direct observations must be conducted for coaching and intervention purposes and meet the following sample sizes at a minimum:

In units with either low hand hygiene compliance* and/or units with high infection rates:**

- On a monthly basis, hospitals will need to perform 20 direct observations.

- If after collecting those observations, more than 50% of the observations were NOT compliant and/or did NOT demonstrate proper technique, the hospital will need to perform an additional 20 observations the following month (40 total observations per unit with low hand hygiene compliance or high infection rates).
- The hospital must continue to collect 40 observations per month until the number of observations that are NOT compliant and/or did not demonstrate proper technique is reduced to less than 50%.

Compliance and infection rates must be assessed at least quarterly and additional observations need to be collected on a monthly basis for the entire quarter if warranted based on the above rules. If a standardized infection ratio cannot be calculated for the quarter, units with 2 or more observed infections should do the additional collection of direct observations.

**Low hand hygiene compliance is defined as two or more standard deviations below the hospital's overall mean hand hygiene compliance rate.*

***High infection rates are defined as two or more standard deviations above the hospital's standardized infection ratio for any of the following healthcare-associated infection measures: CLABSI, CAUTI, MRSA, and C.diff.*

In all other units:

- On a quarterly basis, hospitals using ECM need to perform 10% of the observations noted in Tables 1-3 in ALL patient care units included in Leapfrog's Hand Hygiene Standard (e.g., if the unit would require 200 direct observations without ECM, then with the use of ECM, they need to collect 20 direct observations).
- Units in which direct observation data is being collected monthly (i.e., units with low hand hygiene compliance and/or high infection rates) do not require the additional quarterly data collection.

All direct observations conducted must meet the following criteria:

- Observers immediately intervene prior to any harm occurring to provide non-compliant individuals with immediate feedback
- Observations identify both opportunities for hand hygiene and compliance with those opportunities
- Observations determine who practiced hand hygiene, verify when they practiced it, and whether their technique was correct
- Observations within a unit are conducted weekly or monthly across all shifts and on all days of the week proportional to the number of individuals who touch patients or who touch items that will be used by patients⁴⁴ on duty for that shift
Observations capture a representative sample of the different roles of individuals who touch patients or who touch items that will be used by patients⁴⁴ (e.g., nurses, physicians, techs, environmental services workers)

Observers must record at least the following:

- The date as well as the start and end time of the observation session (or the date and shift being observed)
- The unit where the observation session is being conducted
- The role of the individual being observed (e.g., nurse, physician, etc.)
- The indication (or moment) for performing hand hygiene (e.g., before/after touching a patient, before/after a procedure, before/after touching patient surroundings, etc.)
- Whether hand hygiene was performed or not performed based on the indication noted and if the technique was correct

Question #14: In those patient care units where an electronic compliance monitoring system is NOT used, do the direct observations meet all the following criteria?

- Observations identify both opportunities for hand hygiene and compliance with those opportunities
- Observations determine who practiced hand hygiene, verify when they practiced it, and whether their technique was correct
- Observations within a unit are conducted weekly or monthly across all shifts and on all days of the week proportional to the number of individuals who touch patients or who touch items that will be used by patients⁴⁴ on duty for that shift
- Observations capture a representative sample of the different roles of individuals who touch patients or who touch items that will be used by patients⁴⁴ (e.g., nurses, physicians, techs, environmental services workers)

In order to respond “yes” to question #14, direct observations must be conducted in patient care units that do not use an electronic compliance monitoring system and must meet the following criteria:

- Observations identify both opportunities for hand hygiene and compliance with those opportunities
- Observations determine who practiced hand hygiene, verify when they practiced it, and whether their technique was correct
- Observations within a unit are conducted weekly or monthly across all shifts and on all days of the week proportional to the number of individuals who touch patients or who touch items that will be used by patients⁴⁴ on duty for that shift
- Observations capture a representative sample of the different roles of individuals who touch patients or who touch items that will be used by patients⁴⁴ (e.g., nurses, physicians, techs, environmental services workers)

Observers must record at least the following:

- The date as well as the start and end time of the observation session (or the date and shift being observed)
- The unit where the observation session is being conducted
- The role of the individual being observed (e.g., nurse, physician, etc.)
- The indication (or moment) for performing hand hygiene (e.g., before/after touching a patient, before/after a procedure, before/after touching patient surroundings, etc.)
- Whether hand hygiene was performed or not performed based on the indication noted and if the technique was correct

Question #15: Does your hospital have a system in place for both the initial and recurrent training and validation of hand hygiene compliance observers?

In order to respond “yes” to question #15, your hospital must regularly monitor the quality and accuracy of observations that are collected by each observer through initial and recurrent validation (at least once a year) of hand hygiene compliance observers. This would include having an individual trained in infection control simultaneously collecting data with the hand hygiene compliance observers and comparing results. Alternatively, videos which include an interactive assessment and completion of an observation form, such as the WHO Hand Hygiene Training Film and Slides Accompanying the Training Films, Videos from Hand Hygiene Australia, or internally developed videos with assessment, would also be sufficient for validating hand hygiene compliance observers. Hospitals must expand the testing scenarios that are included in the videos (i.e., the videos should be expanded to include: various types of individuals who touch patients or who touch items that will be used by patients, a larger number of scenarios where individuals are adherent and non-adherent, the inclusion of all moments observed, etc.).

See [FAQs](#) for additional information about responding to the questions in this section.

Closing the Loop on Cancer Diagnosis Measure Specifications

Important Note: Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Source: The Leapfrog Group
Reporting Period: 12 months - Surveys submitted prior to September 1: 01/01/2024 – 12/31/2024 - Surveys submitted on or after September 1: 07/01/2024 – 06/30/2025
Sufficient Sample: Hospitals must randomly sample at least 30 patients 18 years and older who were diagnosed with at least one of colon, lung, or breast cancer, and measure the number of those patients where there is evidence of documented communication (in the medical record or otherwise) between the pathologist and the patient or patient's ordering physician, and the number of those patients who were notified that the pathology report with their diagnosis was uploaded to the patient portal.
Question #20 (denominator): How many cases were included in the audit from question #19 with a diagnosis of colon, lung, or breast cancer?
Question #21 (numerator): Total number of patients from question #20 with documented communication between the pathologist and the patient or patient's ordering physician within five business days of the report being signed by the pathologist: Documented communication includes: A documented phone call between the pathologist and patient or patient's ordering physician of the diagnosis, and a timestamp, read receipt, or email response indicating that the patient or patient's ordering physician read an electronic communication of the diagnosis.
Question #22 (numerator): Total number of patients from question #20 who were notified, either by phone or electronically, that the pathology report with their diagnosis was uploaded to the patient portal and ready for review: Hospitals that do not upload pathology reports to the patient portal or notify patients when reports are uploaded, should enter "0."

Hospital Boarding in the Emergency Department (ED) Boarding Measure Specifications

Important Note: Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Source: The Leapfrog Group

Reporting Period: 12 months

- Survey submitted prior to September 1:
 - 01/01/2024 – 12/31/2024
- Surveys submitted on or after September 1:
 - 07/01/2024 – 06/30/2025

Hospital Boarding in the ED Workbook (Excel):

To complete the data collection and respond to questions #4-5, hospitals should download the Hospital Boarding in the Emergency Department Workbook (Excel). This workbook includes five tabs: Instructions, Adult Inpatient Non-Psychiatric, Adult Psychiatric, Pediatric Inpatient Non-Psychiatric, Pediatric Psychiatric. The four tabs can be used to calculate the responses to questions #4b. number of adult patients boarding >4 hours, c. median length of stay (LOS), and d. 90th percentile LOS and questions #5b. number of pediatric patients boarding >4 hours, c. median length of stay (LOS), and d. 90th percentile LOS.

The workbook is available on the [Survey Materials Webpage](#).

Included Units:

- Dedicated Emergency Department⁴⁷ (adult, pediatric, and adult/pediatric)

Question #4, column a: Total number of adult ED visits with an inpatient admission or where the patient was placed in hospital observation status.

Enter the total number of emergency department (ED) visits during the reporting period for each of the following admission types:

Adult (18 years of age or older) patients admitted to an inpatient **non-psychiatric bed**
Adult (18 years of age or older) patients admitted to an inpatient **psychiatric bed**

Include:

- Patients with an ED visit that were admitted to the hospital's inpatient setting or placed in hospital observation status.

Exclude:

- Patients with an ED visit that were placed in ED observation status.
- Patients transferred to another hospital.

Note: A patient can have multiple ED visits with a hospital admission and/or placed in hospital observation status during the performance period so each patient ED visit with an inpatient admission or placement into hospital observation status is included in the denominator (question #4a).

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

Question #4, column b: Number of ED visits indicated in column (a) with a boarding time greater than 4 hours.

Enter the total number of emergency department (ED) visits indicated in column (a) with a boarding time greater than 4 hours for each of the following admission types:

Adult (18 years of age or older) patients admitted to an inpatient **non-psychiatric bed**
Adult (18 years of age or older) patients admitted to an inpatient **psychiatric bed**

Include:

- Patients with an ED visit that were admitted to the hospital's inpatient setting or placed in hospital observation status with an ED boarding time that was longer than 4 hours.

Boarding time is defined as the difference between the "time from the admission order" to "patient departure from the ED."

Question #4, column c: Median number of hours spent in the ED for ED visits indicated in column (a).

Enter the median number of hours spent in the ED for ED visits indicated in column (a) for each of the following admission types:

Adult (18 years of age or older) patients admitted to an inpatient **non-psychiatric bed**

Adult (18 years of age or older) patients admitted to an inpatient **psychiatric bed**

Include:

- Hours spent in the ED for patients with an ED visit that were admitted to the hospital's inpatient setting or placed in hospital observation status.

Hours spent in the ED is defined as the difference between the "patient arrival time at the ED" to "patient departure from the ED."

Question #4, column d: 90th percentile of hours spent in the ED for ED visits indicated in column (a).

Enter the 90th percentile of hours spent in the ED for ED visits indicated in column (a) for each of the following admission types:

Adult (18 years of age or older) patients admitted to an inpatient **non-psychiatric bed**

Adult (18 years of age or older) patients admitted to an inpatient **psychiatric bed**

Include:

- Hours spent in the ED for patients with an ED visit that were admitted to the hospital's inpatient setting or placed in hospital observation status.

Hours spent in the ED is defined as the difference between the "patient arrival time at the ED" to "patient departure from the ED."

Question #5, column a: Total number of pediatric ED visits with an inpatient admission or where the patient was placed in hospital observation status.

Enter the total number of emergency department (ED) visits during the reporting period for each of the following admission types:

Pediatric (17 years of age or younger) patients admitted to an inpatient **non-psychiatric bed**

Pediatric (17 years of age or younger) patients admitted to an inpatient **psychiatric bed**

Include:

- Patients with an ED visit that were admitted to the hospital's inpatient setting or placed in hospital observation status.

Exclude:

- Patients with an ED visit that were placed in ED observation status.
- Patients transferred to another hospital.

Note: A patient can have multiple ED visits with a hospital admission and/or placed in hospital observation status during the performance period so each patient ED visit with an inpatient admission or placement into hospital observation status is included in the denominator (question #4a).

If the number of visits for a pediatric admission type is less than 10 (in column a), skip columns b, c, and d.

Question #5, column b: Number of **ED visits** indicated in column (a) with a boarding time greater than 4 hours.

Enter the total number of emergency department (**ED**) **visits** indicated in column (a) with a boarding time greater than 4 hours for each of the following admission types:

Pediatric (17 years of age or younger) patients admitted to an inpatient **non-psychiatric bed**

Pediatric (17 years of age or younger) patients admitted to an inpatient **psychiatric bed**

Include:

- Patients with an ED visit that were admitted to the hospital's inpatient setting or placed in hospital observation status with an ED boarding time that was longer than 4 hours.

Boarding time is defined as the difference between the "time from the admission order" to "patient departure from the ED."

Question #5, column c: Median number of **hours** spent in the ED for ED visits indicated in column (a).

Enter the median number of hours spent in the ED for ED visits indicated in column (a) for each of the following admission types:

Pediatric (17 years of age or younger) patients admitted to an inpatient **non-psychiatric bed**

Pediatric (17 years of age or younger) patients admitted to an inpatient **psychiatric bed**

Include:

- Hours spent in the ED for patients with an ED visit that were admitted to the hospital's inpatient setting or placed in hospital observation status.

Hours spent in the ED is defined as the difference between the "patient arrival time at the ED" to "patient departure from the ED."

Question #5, column d: 90th percentile of **hours** spent in the ED for ED visits indicated in column (a).

Enter the 90th percentile of hours spent in the ED for ED visits indicated in column (a) for each of the following admission types:

Pediatric (17 years of age or younger) patients admitted to an inpatient **non-psychiatric bed**

Pediatric (17 years of age or younger) patients admitted to an inpatient **psychiatric bed**

Include:

- Hours spent in the ED for patients with an ED visit that were admitted to the hospital's inpatient setting or placed in hospital observation status.

Hours spent in the ED is defined as the difference between the "patient arrival time at the ED" to "patient departure from the ED."

Patient Safety Practices Frequently Asked Questions (FAQs)**General Questions****1. For the purposes of reporting on Section 6 of the Leapfrog Hospital Survey:**

- a. **Frontline caregivers** include, but are not necessarily limited to employed physicians, mid-levels (NPs, PAs), nurses, environmental services staff, allied health professionals, and occupational and physical therapists.
- b. **Service line management** refers to those who manage all functions within a specific service line (e.g., oncology, cardiac, women's, orthopedics). These individuals may be managing a departmental sub-function within a broader department (e.g., cardiac care within the Department of Medicine).
- c. **Midlevel management** includes the intermediate management of an organization that is subordinate to the executive management and responsible for at least two lower levels of staff below them. An example would include a Director of Nursing, who might oversee Nursing Managers, who oversee the nurses who care directly for patients.
- d. **Physician leadership** refers to physicians who serve in a leadership role in the organization. Titles may include positions such as Chief Medical Officer, Vice President for Medical Affairs, Medical Director, and/or Department Chair.
- e. **Nursing leadership** refers to nurses who serve in a leadership role (e.g., Chief Nursing Officer, Vice President/Assistant Vice President of Nursing, Vice President/Assistant Vice President for Clinical Operations, etc.).
- f. **Senior administrative leadership** refers to administrators who are responsible for hospital-wide departments or services (e.g., Chief Executive Officer, Chief Administrative Officer, Chief Nursing Officer, Chief Medical Officer, etc.).
- g. **Patient Safety Officer** refers to the patient safety leader (who may or may not have the title "Patient Safety Officer") who has responsibility for multiple and integrated areas of patient safety. The organization may appoint an officer who may have other assigned duties or may specifically employ a Patient Safety Officer designated with this responsibility. Multiple executives who are responsible for individual areas (i.e., risk, quality, infection prevention, etc.), but do not assess the integrated safety issues, would not qualify.
- h. **Board (governance)** refers to the individual hospital's board of directors, or the board that governs the hospital and can pass policies that impact the hospital, or a system-wide board that governs hospitals in the system, or a committee of the board (such as a board-appointed, hospital-wide Patient Safety and Quality Committee, which includes board members).
- i. **Medical executive committee** refers to a primary governance committee for medical staff. The medical executive committee makes leadership decisions related to medical staff policies, procedures, and rules, with an emphasis on quality control and quality improvement. They also adopt and implement these policies and procedures and are responsible for medical staff appointment and reappointment.

2. Why is it necessary to continue to review a safe practice once it has been implemented?

All too often in the hectic pace of providing patient care in a hospital, with frequent staff turnover and lots of part-time employees, it is difficult to get a change in practice well-established. Annual review with monitoring and tracking of the safe practices will ensure that they are embedded in the operations of the hospital and not lost in the transition of new staff coming in or part-time employees coming and going.

3. **The phrase “performance reviews or compensation” is used throughout Section 6 within many Accountable elements. Do performance reviews and compensation plans need to have specific language about the Safe Practice or can a set of patient safety goals related to the specific Safe Practice be attached?**

A performance review or compensation plan should include specific language about a Safe Practice. A list of Safe Practices and related goals may be incorporated into the performance review and/or compensation plan or formalized programs whereby a measure of success of those activities or programs is tied to individual performance reviews or compensation incentive plans of executives.

Every employee should have a patient safety component included in their annual review. Another option is to include in the employee's competency review (Ongoing Professional Practice Evaluation, Focused Professional Practice Evaluation).

4. **There are several references to hospital budgets throughout Section 6 within many Ability elements. How can hospitals meet the intent of these elements?**

The intent of these elements is to verify that actions specific to the Safe Practices have been included in hospital budgets. To meet the intent of these elements, hospitals should ensure that these actions can be identified within a department budget or hospital budget. If the budget includes categories that address the Safe Practice but do not specifically name the Safe Practice, then the intent of the element is met.

Further, if a hospital has not allocated budget dollars for activities tied to a Safe Practice but can document expenses specific to the Safe Practice during the reporting period, the intent of the element is met. Plans to allocate specific budget dollars for a Safe Practice should be incorporated into the next upcoming budget year as an ongoing process.

Hospitals may also document training or education expenditures specific to the Safe Practice or expenditures on educational materials that are specific to the Safe Practice.

Hospitals that have invested in in-house staff educators and who include in their job descriptions the coordination and delivery of training and education to appropriate hospital staff on specific Safe Practices meet the intent of this element. For example, if the position description for an in-house educator, such as the Quality Director, includes the coordination and delivery of in-service training and educational sessions related to improving the culture of safety based on the organization's culture of safety survey results, then the intent of this practice is met. Specific time allocations are not required as long as there is documentation of staff participation through dated meeting minutes or attendance records. Training can be in-person or virtual/ computer-based.

5. **How should staff education be measured?**

Educational meetings should clearly address the subject matter pertinent to adverse events and performance improvement targeted by the specific Safe Practice. Hospitals should track meeting dates, frequency of training sessions provided, attendance records or completion records, and the percentage of the total staff who received the information. Training can be in-person or virtual/ computer-based.

6. **There are several references to developing or implementing Performance Improvement Programs throughout Section 6 within many Action elements. How can hospitals meet the intent of these elements?**

At a minimum, performance improvement programs should include all the following five criteria:

- **Education** regarding the pertinent adverse event frequency, severity, and/or impact of best practices. These expenses should be budgeted and tracked to meet the budget elements of the Safe Practices.
- **Skill building** in use of performance improvement tools. These expenses should be budgeted and tracked to meet the budget elements of the Safe Practices.

- **Measurement** of process measures or outcomes measures. The “Outcome, Process, Structure, and Patient-Centered Measures” section at the end of each Safe Practice in the NQF Safe Practices for Better Healthcare 2010 Update suggests performance measures that can be used to support measuring and monitoring quality improvement efforts.
- **Process improvement** and interventions.
- **Reporting** of performance outcomes.

A “campaign” such as an awareness campaign would not meet the intent of these elements.

NQF Safe Practice #1 – Leadership Structures and Systems FAQs

7. **1.1a, 1.2b, and 1.2d: Several elements within NQF Safe Practice #1 mention that “regular communication” is required. How does Leapfrog define “regular communication”?**
Regular communication means more than once a year. Some hospitals may discuss these items quarterly or even monthly. Hospitals can document that these communications took place through dated meeting minutes. We would urge hospitals to improve the detail of their board and other meeting minutes to ensure they are able to clearly document that the issues were discussed.

The discussion of these items can be a general note in the minutes, without specific details. However, hospitals should maintain copies of dated presentations and reports related to these agenda items in order to document adherence to these elements. Meetings can be in-person or virtual.

8. **1.1a: If NQF Safe Practice #4 – Identification and Mitigation of Risks and Hazards has been removed from the Leapfrog Hospital Survey, are hospital boards still expected to communicate regularly regarding risks and hazards?**

Though we are not asking hospitals to report on this Safe Practice, it remains important to communicate the actions you are taking to identify and mitigate risks and hazards to patients to your board.

9. **1.1b: What is meant by “patients and/or families of patients are active participants in the hospital-wide safety and quality committee?”**

To meet the intent of this element, hospitals must have patients and/or families of patients participate on the hospital-wide safety and quality committee. The safety and quality committee should have influence over hospital-wide quality and safety issues, not just a particular department or service line. Hospitals with a system-wide safety and quality committee must have one patient representative per campus on the system-wide safety and quality committee.

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

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

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

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

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

10. 1.1c: What are some examples of how a hospital can report to the community ongoing efforts and results of these efforts to improve safety and quality?

Hospitals can utilize several communication vehicles to reach the broader community, including webpages that are prominent from the organization's homepage, electronic newsletters, mailings or annual reports, or an ad in the local paper. The communication must include **both** efforts the hospital is taking to improve safety and quality and the results of those efforts. As the sole focus of the NQF Safe Practices for Better Health Care report is reducing or preventing adverse events (refer to NQF list of adverse events at https://www.qualityforum.org/topics/sres/serious_reportable_events.aspx), patient safety and quality efforts **reported to the community** must have this focus as well. In other words, efforts the hospital is taking to improve safety and quality should be related to reducing or preventing these adverse events and the results of those efforts would be the measurable outcomes.

Meetings where a few community members are present would not meet the intent of this practice as the intent is to reach a larger audience.

Each hospital within the same health care system would need to report the results to the community for each hospital in the system because the results of efforts to improve safety and quality would be different at each hospital.

11. 1.2a, 1.3a, 1.4c: What are the minimum requirements to qualify as a “patient safety program?”

As part of accreditation through The Joint Commission, hospitals are required to meet standard LD.03.09.01, which identifies the elements that must be included in an integrated patient safety program (see pages 57 – 62 in the Organization Culture and System Performance Expectations chapter of *The Joint Commission E-dition*). Hospitals that are not accredited by The Joint Commission can use these elements as a guide as well.

12. 1.2d: What is the role of an interdisciplinary patient safety committee?

An interdisciplinary patient safety committee is an internal hospital committee that oversees the activities defined in the NQF Safe Practice #1 Practice Element Specifications and develops action plans to create solutions and changes in performance.

13. 1.2d: What is an example of team training that is appropriate for caregivers?

Hospitals can utilize TeamSTEPPS, a comprehensive, evidence-based training program for health care professionals. At a minimum, the elements of basic teamwork training should be met as described on page 96 of the Safe Practices for Better Healthcare– 2010 Update, which is available for download here: <http://www.leapfroggroup.org/survey-materials/survey-and-cpoe-materials>.

Team training to caregivers would need to be provided and then reported to senior administrative leadership by the interdisciplinary patient safety team to meet the intent of Safe Practice 1.2d.

14. 1.2e: How can hospitals that have not had any adverse events during the reporting period earn credit for this element?

First, we urge your hospital to reassess its conclusion that no adverse events occurred; that would be highly unusual. Following the reassessment, if no adverse events were identified and the hospital can document that it has policies in place to report such events when they do occur (to a mandatory or voluntary program), the hospital would meet the intent of this element. Please see Section 7A: Never Events for a list of adverse events and components of a Never Events Policy.

15. 1.4a: What are some examples of how the CEO and senior administrative leadership can be personally engaged in reinforcing patient safety improvements?

Executive walk-arounds are an example of how the CEO and senior administrative leadership can be personally engaged in reinforcing patient safety improvements. The executive walk-arounds provide staff with visibility and access to senior management. They also provide the CEO and senior administrative leadership with the opportunity to address issues and concerns in various departments in real-time, rather than in monthly meetings. Monthly meetings with staff in a centralized location do not meet the intent of this Safe Practice.

Progress on the implementation of walk-arounds can be measured by tracking the number of walk-arounds performed per unit or clinical area for designated time periods as shown in the calendars of the CEO and senior administrative leadership. Some progressive hospitals have tied incentives to regular executive walk-arounds and to reliable exchange of information on clinical unit performance. Some hospitals have established a feedback loop between the CEO and senior administrative leadership and staff to measure the implementation of performance improvement ideas that were generated during executive walk-arounds.

16. 1.4b: What are some examples of how the CEO can actively engage leaders from service lines, midlevel management, clinical leadership, and physician leadership in patient safety improvement actions?

Hospitals can refer to the American College of Healthcare Executives professional policy statement, which includes examples of how leaders should be engaged in patient safety and quality.

17. 1.4c: What are some examples of how hospitals can engage the medical staff as direct contributors to the patient safety program?

Examples may include:

- Senior leadership requests time on Medical Staff Department standing agendas to provide patient safety updates and elicit direct feedback on specific areas as well as “what keeps the medical staff up at night.”
- Medical staff are invited and encouraged to be active participants in clinical unit meetings where patient safety is addressed.
- The board appoints a community-based active medical staff member to represent the organization on a regional patient safety initiative.

18. 1.4c: In a hospital where all medical staff is employed, how do we answer this question?

The intent of this element is to ensure that physicians and medical staff have the opportunity to provide input on the hospital's patient safety plan because often they do not have a significant position in the hierarchical structure of an organization but carry a great deal of influence over how the organization is run. Thus, they are informal leaders who can be change agents and “accelerators or barriers for improvement.” If the organization's board and senior administrative leadership seek and document input from physicians and medical staff regarding patient safety programs, the intent of this element has been met.

NQF Safe Practice #2 – Culture Measurement, Feedback, and Intervention FAQs

19. Why are two different reporting periods used in NQF Safe Practice #2?

Within the *Awareness and Accountability* elements, a 24-month reporting period is used because these elements are related to conducting the culture of safety survey, which is typically conducted every other year. Within the *Ability and Action* elements, a 12-month reporting period is used because these practices are related to follow-up activities that would be completed after the results from the culture of safety survey are available.

20. 2.1a: What are the requirements to qualify as a “culture of safety survey?”

Several surveys are readily available that specifically address culture, safety climate, and teamwork. These surveys incorporate all the additional specifications as outlined in NQF Safe Practice #2 (see 2010 NQF Safe Practice Report).

Hospitals that do not use a nationally recognized culture of safety tool must ensure that their culture of safety survey meets Leapfrog's guidelines for what constitutes a valid, consistent, and reliable survey tool. These guidelines were developed in consultation with Leapfrog's Culture of Safety Expert Panel. The guidelines can be found on the [Survey and CPOE Materials webpage](#) under supporting materials for Section 6.

A general employee satisfaction survey that has a small component of the survey addressing organizational culture does not qualify.

21. 2.1a Can an employee engagement survey and nationally recognized culture of safety tool be conducted at the same time?

Yes, if the culture of safety tool is unaltered and administered in its entirety.

22. 2.1a: What does “50% of the aggregated care delivered to patients within the hospital” mean?

As described on page 88 of the NQF Safe Practices for Better Healthcare Report, “a census of units or service areas that in aggregate deliver care to more than 50 percent of the patients receiving care should be surveyed, service lines or units where there is a high patient safety risk should be measured, and there should be a valid sample to allow for unit-level analysis and facilitate improvement.”

23. 2.1b: For reporting individual unit level results, what is the minimum number of responses a hospital should have?

Most major vendors use a threshold of 5 or more responses and a 40% response rate. For larger units, a lower response rate may be acceptable. If a unit does not meet these thresholds, your hospital could aggregate the results of “like” units together (e.g., medical/surgical units, ICUs, ORs). Hospitals should not combine results across “unlike” units.

24. 2.1c: What is meant by “like” hospitals? Can hospitals benchmark against those within the same network or system? How would a pediatric hospital benchmark against other pediatric hospitals?

Hospitals should benchmark their results against hospitals with similar demographics, such as hospital type, number of beds, number of admissions, urban/rural designation, etc. Hospitals in systems or healthcare networks should benchmark throughout the health system, but not within the same region.

Pediatric hospitals utilizing the AHRQ Hospital Survey on Patient Safety Culture can benchmark their results using the [AHRQ's User Comparative Database Report](#) (refer to instructions starting on page 29).

25. 2.1d: What is meant by roles and staff levels?

Roles are job types (e.g., surgeons, nurses, hospitalists, physician assistants, or clinical and non-clinical, etc.). Staff levels are defined within the organization's hierarchy (e.g., senior administrators, directors, managers, etc.).

26. 2.2b: Does performance evaluation criteria for senior administrative leadership need to include the actual targeted response rate to the culture of safety survey?

Yes. The organization's targeted response rate to the culture of safety survey should be included in performance evaluation criteria for senior administrative leadership. Criteria for using the survey results in improvement efforts should also be included to meet the intent of this element.

27. 2.3a: Which employees should be included in the staff education program? Employees in all units or just those in low-performing units?

Staff education needs to include education for all levels of staff, from senior administrative and clinical leadership to frontline caregivers. In addition, because all units have opportunities for improvement, the staff education should include all units but can focus on deficiencies of a specific unit or department.

28. 2.1e and 2.4b: What is the difference between 2.1e and 2.4b? Both seem to focus on sharing and discussing the Culture of Safety Survey results.

While both elements focus on sharing and discussing Culture of Safety Survey results, these elements focus on different audiences and activities, and the result is that different kinds of feedback are collected. Safe Practice 2.1e requires local leaders (e.g., unit/department manager) to engage their unit/departments in a discussion about the survey results, while Safe Practice 2.4b requires senior administrative leadership to engage each sampled unit in a discussion about the survey results and their concerns.

Hand Hygiene FAQs**Training and Education****29. Are online training modules acceptable for the purposes of question #1 and question #3?**

Online training modules are acceptable for the purposes of answering question #1 and question #3 if they meet all requirements outlined in the question.

For question #1, the online training must be done at the frequency specified and would need to be delivered and/or developed by a professional with appropriate training and skills. For question #3, the online training must meet all six topics outlined in the question.

Physical demonstration (question #2) **cannot** be done using an online training module.

30. Can a hospital answer “yes” to the training and education questions #1-3 if the training and education for medical/nursing/pharmacy students is done by the medical/nursing/pharmacy school?

Yes, you can answer “yes” to questions #1-3 if your hospital, alone, or in combination with other hospitals, has developed a standard orientation/on-boarding curriculum for students that meets all requirements outlined in the training and education questions. Your hospital will need to have continued and ongoing input into the curriculum, but the administration of the training and education for students, including physical demonstration of proper hand hygiene technique, could be conducted by the school.

31. What are examples of what can count as “physically demonstrating” proper hand hygiene during the initial hand hygiene training?

Before new individuals to your hospital have contact with patients and the patient care space, they will need to demonstrate proper hand hygiene with soap and water and alcohol-based hand sanitizer. This demonstration could be done as part of other onboarding activities, during occupational health activities as part of the TB test, during department orientations, in small

groups, etc. A group “teach-back” would be acceptable, but with no more than 10 students per one trainer/monitor. An online or in-person “simulation” would not be sufficient for this purpose. Computer-based assessments of an individual’s hand hygiene technique are acceptable if the assessment tracks an individual’s hand motions, is done without providing instructions to the individual during the assessment, and feedback is given to them at the end.

Hospitals that are starting to implement this component should add physical demonstration to their **initial** training for any **new individuals who touch patients or who touch items that will be used by patients at their hospital**. Leapfrog is not asking hospitals to retroactively train individuals.

Infrastructure

32. Is having an electronic system and dashboards that display low product and low battery reports which are used to ensure that the refilling and replacing of dispensers is completed in a timely manner sufficient for meeting the quarterly audit requirements in question #4?

Yes, if you have ongoing and reliable electronic ways of understanding when product or batteries are low, that would suffice for the audit. The goal is to make sure that supplies are available in soap, alcohol-based hand sanitizer, and paper towel dispensers.

33. What does Leapfrog mean by “equally accessible to the location of all patients in the room or bed space” for the purposes of question #5?

Equally means the same distance from any patient’s bed, which can be measured in steps. Leapfrog is not looking for an exact distance, but rather the goal is to ensure that hand hygiene can be easily performed regardless of the location of the patient being cared for in the room or bed space.

Monitoring

34. Why did Leapfrog select 200 hand hygiene opportunities for monthly monitoring in question #8?

200 hand hygiene opportunities were chosen as the sample size based on a study by Yin et. al which showed that 180-195 opportunities would need to be monitored to accurately observe a 10% change in hand hygiene compliance (Yin et al.). The additional sample sizes outlined in the measure specifications are for smaller patient care units where monitoring 200 opportunities may not be feasible.

References:

Steed C, Kelly JW, Blackhurst D, Boeker S, Diller T, Alper P, Larson E. Hospital hand hygiene opportunities: where and when (HOW2)? The HOW2 Benchmark Study. American Journal of Infection control. 2011 Feb 1;39(1):19-26.

Jun Yin MS, Heather Schacht Reisinger PhD, Mark Vander Weg PhD, Marin L. Schweizer PhD, Andrew Jesson, Daniel J. Morgan MD MS, Graeme Forrest MD, Margaret Graham, Lisa Pineles MA and Eli N. Perencevich MD MS. Establishing evidence-based criteria for directly observed hand hygiene compliance monitoring programs: a prospective, multicenter cohort study. Infection Control and Hospital Epidemiology Vol. 35, No. 9 2014 Sep, pp. 1163-8.

35. My hospital uses an electronic compliance monitoring system, but it does not meet all the criteria outlined in questions #12-13. Can I report on the hand hygiene compliance data we collect via direct observation instead?

Yes. If your hospital also uses direct observation to collect hand hygiene compliance data (not just for coaching/intervention) throughout **all** patient care units (including those with the electronic compliance monitoring system), you can select “yes, using only direct observation” in either question #8, question #9, or question #10 and report on your adherence to the direct observation criteria only. Otherwise, you will need to respond “no” to question #12.

36. Is Leapfrog encouraging hospitals to implement electronic compliance monitoring? These systems can be costly, and the technology still needs to advance.

The questions in the hand hygiene standard ask about a variety of strategies that can be used to monitor and improve hand hygiene. Leapfrog is encouraging hospitals to take a multimodal approach. Regarding monitoring, while hospitals can achieve the Leapfrog standard with direct observation alone, Leapfrog is communicating a strong preference for use of electronic monitoring (implemented according to evidence-based principles). In addition to literature suggesting electronic monitoring works better to pinpoint compliance issues, the difference in the sheer number of hand hygiene opportunities covered by the two monitoring strategies represent powerful evidence in favor of electronic monitoring. Electronic monitoring allows facilities to monitor virtually every patient encounter, while direct observation monitors a selection. Based on the evidence, our standard calls for monitoring 200 hand hygiene opportunities per unit per month, which is a small subset of overall hand hygiene opportunities. Even beyond capturing more encounters aligned with the evidence, electronic monitoring alleviates the ethical quandary of an observer watching patient harm without intervening.

As with Computerized Physician Order Entry (CPOE) systems and Bar Code Medication Administration (BCMA) systems, we anticipate that electronic compliance monitoring technology will improve over time and become an important component of a comprehensive hand hygiene program. Electronic monitoring is a routine component of public safety in other industries where compliance is critical, so health care can and should achieve those standards for its patients.

All items included in Section 6D are based on the evidence review and recommendations from Leapfrog's national Hand Hygiene Expert Panel and others. We have included in the Hand Hygiene bibliography several peer-reviewed studies that have examined the benefits of using electronic monitoring systems over direct observation. The bibliography is available at <https://ratings.leapfroggroup.org/measure/hospital/2025/handwashing>.

37. How does reporting the number of hand hygiene opportunities monitored in questions #8-10 impact our hospital's scoring?

Hospitals can earn "Achieved the Standard" by either answering "yes" to question #8 and monitoring 200 hand hygiene opportunities (or at least the number of hand hygiene opportunities outlined based on the unit type in Tables 1-3 of the Hand Hygiene Measure Specifications) each month in each patient care unit and also meeting all other elements of the Monitoring and Feedback domains, as well as meeting all elements in 2 of the 3 remaining domains OR by answering "yes" to question #9 and monitoring at least 100 hand hygiene opportunities (or at least the number of hand hygiene opportunities outlined based on the unit type in Tables 4-6 of the Hand Hygiene Measure Specifications) each month in each patient care unit and also meeting all other elements of the Monitoring domain and all elements in the remaining four domains. Facilities that answer "yes" to question #10 and only monitor 100 hand hygiene opportunities a quarter are only eligible to earn a maximum performance category of "Considerable Achievement" based on their adherence to the elements in the other domains. Hospitals should review the Hand Hygiene scoring algorithm in the 2025 Leapfrog Hospital Survey Scoring Algorithms document for more details.

38. Are online training modules acceptable for the purposes of training hand hygiene compliance observers in question #15?

Online training can be used for the initial and recurrent training of hand hygiene compliance observers. Please refer to the Hand Hygiene Measure Specifications for more information on the requirements for the validation of hand hygiene compliance observers.

Feedback**39. For the purposes of responding to question #19, what are some examples of how hospital leadership can be held accountable through performance reviews or compensation?**

A performance review or compensation plan should include specific language about hand hygiene performance. A list of hand hygiene practices and related goals may be incorporated into

the performance review and/or compensation plan or formalized programs whereby a measure of success of those activities or programs is tied to individual performance reviews or compensation incentive plans of executives. Examples include meeting targets for hand hygiene compliance rates, having bonuses tied to structural changes like the implementation of electronic compliance monitoring systems, etc. Language pertaining solely to infection control practices and performance would NOT be sufficient.

Culture

40. What are some examples of how patients and visitors can be invited to remind individuals who touch patients or who touch items that will be used by patients to perform hand hygiene?

Patients and visitors can be invited to remind individuals who touch patients or who touch items that will be used by patients to perform hand hygiene with posters placed in patient care units, bedside placards, buttons worn by the staff, etc.

41. What are some examples of demonstrating a commitment to hand hygiene improvement as referenced in question #21?

Some examples of how individuals can demonstrate a commitment to support hand hygiene improvement are written or verbal commitments given during town hall meetings, videos, e-mails from the CEO, public comments to staff, etc. This needs to be a verbal or written commitment that is delivered to those individuals who touch patients or who touch items that will be used by patients.

Diagnostic Excellence FAQs

42. What are examples of a CEO or CMO commitment to reducing errors in diagnosis?

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

43. What are examples of a PFAC having input in or leading initiatives aimed at reducing errors in diagnosis?

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

44. Can our hospital system convene a multidisciplinary team at the system level, instead of individual hospitals assembling teams at their respective facilities?

Multidisciplinary teams convened to solely focus on reducing diagnostic errors should be specific to individual hospitals in order to closely oversee case analyses, review data specific to individual sites, and be responsive to the individual hospital's leadership.

45. What pathology reports should be included in our response to question #19? Are inpatient and outpatient reports included?

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

46. What ICD-10 codes should we use to identify diagnoses of colon, lung, or breast cancer?

Leapfrog has not identified a specific set of ICD-10 codes to use to select these cases.

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SECTION 7: MANAGING SERIOUS ERRORS

This section includes questions and reference information for Section 7: Managing Serious Errors. Please carefully review the questions, endnotes, and reference information (e.g., measure specifications, notes, and frequently asked questions) before you begin. Failure to review the reference information could result in inaccurate responses.

Section 7: Managing Serious Errors

Never Events Fact Sheet: <https://ratings.leapfroggroup.org/measure/hospital/2025/responding-never-events>

Section 7 includes questions about your hospital's response to Never Events. In addition, Leapfrog collects information via its NHSN Group about five healthcare-associated infections (CLABSI, CAUTI, MRSA, *C. diff.*, and SSI: Colon). Hospitals reporting on Section 7B: Healthcare-Associated Infections are required to join Leapfrog's NHSN Group. Important information and deadlines are available on the [Join NHSN Group webpage](#).

Each hospital achieving the standard for Never Events:

Has a policy that includes the nine principles of Leapfrog's Never Events policy and will implement this policy if a "never event" occurs within their hospital.

Each hospital achieving the standards for Healthcare-Associated Infections:

1. Has a CLABSI standardized infection ratio of less than or equal to 0.413 for ICU and select ward inpatients.
2. Has a CAUTI standardized infection ratio of less than or equal to 0.427 for ICU and select ward inpatients.
3. Has a MRSA standardized infection ratio of less than or equal to 0.496 for facility-wide inpatients.
4. Has a *C. diff.* standardized infection ratio of less than or equal to 0.621 for facility-wide inpatients.
5. Has an SSI: Colon standardized infection ratio of less than or equal to 0.349 for inpatients following eligible colon procedures.

Download the 2025 Leapfrog Hospital Survey Scoring Algorithm on the [Scoring and Results webpage](#).

7A: Never Events

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Important Note: To earn credit for these questions, hospitals must have a policy in place that addresses the National Quality Forum's list of Serious Reportable Events. All references to "never event" or "serious reportable event" are specific to the National Quality Forum list available at https://www.qualityforum.org/topics/sres/serious_reportable_events.aspx.

Reporting Period:

Answer questions #1-9 based on the principles currently included in your hospital's never events policy at the time you submit this section of the Survey.

Note: As a reminder, the Corrections Period (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

Below are the nine elements which make up The Leapfrog Group's Policy Statement regarding never events.⁴⁸ Indicate which of the following principles are included in your hospital's current never events policy.

1) We <u>apologize to the patient</u> ⁴⁹ and/or family affected by the <u>never event</u> ⁴⁸ .	☐ Yes ☐ No
2) We report the event to at least one of the following <u>external agencies</u> ⁵⁰ within 15 business days of becoming aware that the <u>never event</u> ⁴⁸ has occurred: • Joint Commission, as part of its Sentinel Events policy; • DNV GL Healthcare; • State reporting program for medical errors; or • Patient Safety Organization (as defined in The Patient Safety and Quality Improvement Act of 2005).	☐ Yes ☐ No
3) We perform a <u>root cause analysis</u> ⁵¹ , which at a minimum, includes the elements required by the chosen external reporting agency. <i>If "no," skip questions #6-7. The hospital will be scored as "Limited Achievement."</i>	☐ Yes ☐ No
4) We waive all costs directly related to the <u>never event</u> ⁴⁸ . <i>In order to respond "yes" to this question, all costs directly related to the never event must be waived to both the patient and the payor.</i>	☐ Yes ☐ No
5) We make a copy of this policy available to patients, patients' family members, and payers upon request.	☐ Yes ☐ No
6) We interview patients and/or families, who are willing and able, to gather evidence for the <u>root cause analysis</u> ⁵¹ .	☐ Yes ☐ No
7) We inform the patient and/or the patient's family of the action(s) that our hospital will take to prevent future recurrences of similar events based on the findings from the <u>root cause analysis</u> ⁵¹ .	☐ Yes ☐ No
8) We have a protocol in place to provide support for caregivers involved in <u>never events</u> ^{48,49} and make that protocol known to all caregivers and affiliated clinicians.	☐ Yes ☐ No
9) We perform an annual review to ensure compliance with each element of Leapfrog's Never Events Policy for each <u>never event</u> ⁴⁸ that occurred. <i>If "no" to any questions #1-8, skip this question and continue to the next subsection.</i>	☐ Yes ☐ No

7B: Healthcare-Associated Infections

Hospitals that share a CMS Certification Number must have a unique NHSN ID as required by NHSN. Please carefully review Leapfrog's Multi-Campus Reporting Policy on the [Join NHSN Group webpage](#).

Specifications: See [Healthcare-Associated Infections Measure Specifications](#) in the Reference Information beginning on page 269.

Reporting Period: 12 months

- June and August Data Downloads: 01/01/2024 – 12/31/2024
- October and December Data Downloads: 07/01/2024 – 06/30/2025

Leapfrog will update data four times per Survey Cycle for all members of our NHSN group that have provided an accurate NHSN ID in the Hospital Profile and submitted the 2025 Leapfrog Hospital Survey.

Visit the [Join NHSN Group webpage](#) for important information on deadlines for joining Leapfrog's NHSN Group.

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

1) Has your hospital joined Leapfrog's NHSN Group and entered a valid NHSN ID in the Profile so that the standardized infection ratios (SIRs) for each of the following applicable infection measures can be downloaded directly from the CDC's National Healthcare Safety Network (NHSN) for scoring and public reporting: • CLABSI in ICUs and select wards; • CAUTI in ICUs and select wards; • Facility-wide inpatient MRSA Blood Laboratory-identified Events; • Facility-wide inpatient C. diff. Laboratory-identified Events; and • SSI: Colon?	○ Yes, the hospital has joined Leapfrog's NHSN Group, accepted Leapfrog's Rights Acceptance Report/Data Rights Template, and entered a valid NHSN ID in the Profile ○ No, the hospital has not joined Leapfrog's NHSN Group, accepted Leapfrog's Rights Acceptance Report/Data Rights Template, or entered a valid NHSN ID in the Profile and acknowledges that the hospital will be publicly reported as "Declined to Respond" for all five infection measures
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*Hospitals are not required to "re-join" Leapfrog's NHSN Group if they joined and conferred rights in previous Leapfrog Hospital Survey Cycles. However, all hospitals in Leapfrog's NHSN Group must review their Rights Acceptance Report annually (by the published [join-by deadlines](#)) to ensure that Leapfrog has access to the data from all of the locations that were active during the reporting period, even if those locations are no longer active, to ensure that Leapfrog obtains the appropriate SIR. Instructions for joining or verifying that you are in Leapfrog's NHSN Group are available in the "NHSN Guidance: Join the Group, Review/Accept Data Rights Template, and Download Reports" document on our [Join NHSN Group webpage](#).

Hospitals that join Leapfrog's NHSN group, but do not provide an accurate NHSN ID in the Hospital Profile or do not submit the 2025 Leapfrog Hospital Survey, will be scored and publicly reported as "Declined to Respond" for each of the five infection measures. Hospitals that have a predicted value <1 for an infection measure, or hospitals whose number of observed MRSA or CDI infections present on admission are above a pre-determined cut-point, will be scored as "Unable to Calculate" for that measure. Hospitals for whom a measure does not apply during the reporting period (e.g., zero device days or procedure days, no applicable locations) will be scored as "Does Not Apply" for that measure. Hospitals that are PPS-Exempt Cancer hospitals, as classified by CMS, will be scored as "Does Not Apply" for CLABSI and CAUTI only.

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Section 7: Managing Serious Errors

For all other deadlines, please refer to the “Deadlines and Reporting Periods” table provided in the Healthcare-Associated Infections Measure Specifications, as well as online.

Affirmation of Accuracy

As the hospital CEO or as an employee of the hospital to whom the hospital CEO has delegated responsibility, I have reviewed this information pertaining to the Managing Serious Errors Section at our hospital, and I hereby certify that this information is true, accurate, and reflects the current, normal operating circumstances at our hospital. I am authorized to make this certification on behalf of our hospital.

The hospital and I understand that The Leapfrog Group, its members, the public and entities and persons who contract or have other business dealing with The Leapfrog Group are relying on the truth and accuracy of this information. The hospital and I also understand that The Leapfrog Group will make this information and/or analyses of this information public through the Survey Results public reporting website, The Leapfrog Group's Hospital Safety Grade, and/or other Leapfrog Group products and services. This information and/or analyses and all intellectual property rights therein shall be and remain the sole and exclusive property of The Leapfrog Group in which The Leapfrog Group retains exclusive ownership. This information does not infringe upon any third-party intellectual property rights or any other third-party rights whatsoever and is free and clear of all encumbrances and liens of any kind. The hospital and I acknowledge that The Leapfrog Group may use this information in a commercial manner for profit. The hospital shall be liable for and shall hold harmless and indemnify The Leapfrog Group from any and all damages, demands, costs, or causes of action resulting from any inaccuracies in the information or any misrepresentations in this Affirmation of Accuracy. The Leapfrog Group and its members and entities and persons who contract or have other business dealing with The Leapfrog Group reserve the right to omit or disclaim information that is not current, accurate or truthful.

Affirmed by _____, the hospital's _____,
(first name and last name) (title)
on _____.
(date)

Section 7: Managing Serious Errors Reference Information

What's New in the 2025 Survey

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

Change Summary Since Release

None. If substantive changes are made to this section of the Survey after release on April 1, 2025, they will be documented in this Change Summary section.

Section 7B: Healthcare-Associated Infections Measure Specifications

Important Note: Hospitals that share a CMS Certification Number must have a unique NHSN ID as required by NHSN. Please carefully review Leapfrog's Multi-Campus Reporting Policy on the [Join NHSN Group webpage](#).

Checklist for Joining Leapfrog's NHSN Group and Ensuring the Data are Accurate:

- ☐ **Join or verify that you are in Leapfrog's NHSN Group by the join-by dates**
 - Instructions for joining or verifying that you are in Leapfrog's NHSN Group are available [here](#) in the "NHSN Guidance: Join the Group, Review/Accept Data Rights Template, and Download Reports" document.
 - Join-by dates are listed in the "Deadlines and Reporting Periods" table below.
- ☐ **Review and accept Leapfrog's Data Rights Template within NHSN**
 - **All hospitals** are required to review and accept the Data Rights Template at least annually before **June 19, 2025**, NHSN join-by date and whenever updates are made to their location mapping in NHSN.
 - Include any locations that were active during the reporting period even if they are currently inactive to ensure that Leapfrog obtains the appropriate SIR.
 - Confirm that you have given Leapfrog access to data from your 2024 NHSN Patient Safety Component - Annual Hospital Survey. Surveillance data from the 2024 NHSN Annual Hospital Survey is used by NHSN to risk adjust SIRs; SIRs cannot be calculated by NHSN or downloaded by Leapfrog if you restrict access to this data.
 - Failure to review and update (as needed) your Data Rights Template may result in Leapfrog pulling incorrect data for your hospital.
 - Instructions for reviewing and accepting the Data Rights Template are available [here](#) in the "NHSN Guidance: Join the Group, Review/Accept Data Rights Template, and Download Reports" document.
- ☐ **Generate datasets and download reports within NHSN on the same day as Leapfrog**
 - All hospitals are required to (a) generate datasets within NHSN, (b) download CMS IPPS reports, and (c) download a copy of your 2024 Patient Safety Component - Annual Hospital Survey from NHSN on the **same day** that Leapfrog will be downloading the data from NHSN for all current group members.
 - Instructions for generating datasets and downloading these reports from NHSN are available [here](#) in the "NHSN Guidance: Join the Group, Review/Accept Data Rights Template, and Download Reports" document.
 - NHSN data download dates are listed in the "Deadlines and Reporting Periods" table below (please note that there are four NHSN data download dates per Survey Cycle).
 - By generating datasets and downloading reports within NHSN on the same day as Leapfrog, hospitals can confirm that their data matches the data Leapfrog has obtained.
 - If hospitals do not generate datasets and download reports on the same day as Leapfrog, the Help Desk will not review any discrepancies.
- ☐ **Review SIRs**
 - For verification purposes, hospitals are required to download reports from NHSN on the **same day**, as described above.
 - Once Leapfrog has published the healthcare-associated infection Survey Results on the [Hospital Details Page](#), hospitals are urged to compare the Survey Results to their NHSN reports that were pulled on the **same day** as Leapfrog.
 - Dates on which the Survey Results will be available on the Hospital Details page are listed in the "Deadlines and Reporting Periods" table below.

❑ Report discrepancies

If, while comparing your NHSN reports to your Leapfrog Hospital Survey Results, you find a discrepancy, you must contact Leapfrog's [Help Desk](#) immediately. If you do not contact Leapfrog by the **end of the month** in which scored results are [available](#) on your Hospital Details Page (i.e., July, September, November, and January, respectively), the issue will not be investigated by the Help Desk.

Deadlines and Reporting Periods

Join Leapfrog's NHSN Group by	Leapfrog will download data from NHSN for all current group members	Data downloaded from NHSN will be scored and publicly reported for hospitals that have submitted Section 7 by	HAI Reporting Period	Available on Hospital Details Page and Public Reporting Website
June 19, 2025	June 20, 2025	June 30, 2025	01/01/2024 – 12/31/2024	July 12, 2025 Hospital Details Page July 25, 2025 Public Reporting Website
August 21, 2025	August 22, 2025	August 31, 2025	01/01/2024 – 12/31/2024	September 10, 2025*
October 22, 2025	October 23, 2025	October 31, 2025	07/01/2024 – 06/30/2025	November 12, 2025*
December 17, 2025**	December 18, 2025**	November 30, 2025	07/01/2024 – 06/30/2025	January 12, 2026*

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

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

Section 7A: Never Events Frequently Asked Questions (FAQs)**1. When reporting Never Events, what “state reporting program for medical errors” applies in my state?**

Congress has passed legislation requiring all states to develop a reporting program for medical errors. At this time, many states have already enacted or adopted some requirement that hospitals report serious medical errors or similar adverse events to a state agency. Others are still implementing legislation or regulations that define that requirement. States that have developed programs may also define reportable events differently.

2. What if there is no “state reporting program for medical errors” in my state? Do we still have to report Never Events to meet Leapfrog principles for this policy? To whom?

Hospitals in states that do not have a state reporting program or requirement in effect can meet the reporting requirement of Leapfrog's principles for implementation of a Never Events policy by reporting all Never Events voluntarily to The Joint Commission, DNV GL Healthcare, or a Patient Safety Organization.

If there is no state-required reporting program in effect, no available Patient Safety Organization to which your hospital can report, and your hospital is not Joint Commission or DNV GL Healthcare accredited, the Leapfrog requirement for reporting to an external agency is amended. Hospitals must report the Never Event to their governance board and must still perform a root-cause analysis internally of each Never Event to meet Leapfrog's principle for full implementation of its Never Events policy.

3. The reportable adverse events defined by our state's reporting program don't include all 25 Never Events endorsed by the National Quality Forum (NQF) and adopted in the Leapfrog policy. Will reporting only the state-required reportable events to the state agency suffice for meeting Leapfrog's requirement for reporting Never Events to an external agency? Does our hospital have to report other Never Events, as defined by NQF/Leapfrog, to that state agency even though not required by our state's reporting program?

Hospitals should report all their state-required reportable events to the state agency. All other Never Events, as defined by NQF's list of Serious Reportable Events, which cannot be reported to the state agency, should be reported to another external agency (e.g., accreditor, Patient Safety Organization), if possible. If reporting those events to another external agency is not possible, the final option is to report those events to the hospital's governance board.

4. Won't Leapfrog's request to have hospitals apologize to the patient put the hospital at risk for liability?

Not necessarily. Research indicates that malpractice suits are often the result of a failure on the hospital's part to communicate openly with the patient and apologize for its error. Patients feel the most anger when they perceive that no one is willing to take responsibility for the adverse event that has occurred. A sincere apology from the responsible hospital staff can help to heal the breach of trust between doctor/hospital and patient. (When Things Go Wrong: Responding to Adverse Events. Boston, 2006. Mass Coalition for the Prevention of Medical Errors)

5. How does Leapfrog define “waive cost?”

At its core, Leapfrog's approach to never events is about improving patient care. While the policy asks hospitals to refrain from billing either the patient or a third-party payer, such as a health plan or employer company, for any costs directly related to a serious reportable adverse event, Leapfrog understands that, due to the wide array of circumstances surrounding never events, specific details of what constitutes “waiving cost” should be handled on a case-by-case basis by the parties involved. For an example, please see “Lessons learned from implementing a principled approach to resolution following patient harm” by Smith et. al.

6. Does Leapfrog recommend any resources for hospitals looking to adhere to Leapfrog's Never Events principles?

Yes, the Agency for Healthcare Research and Quality (AHRQ) has developed and tested the Communication and Optimal Resolution (CANDOR) Toolkit, which outlines a process for hospitals and practitioners to respond to unexpected events in a timely, thorough, and just way. The National Patient Safety Foundation (NPSF) has issued a report titled RCA²: Improving Root Cause Analyses and Actions to Prevent Harm, which examines best practices and provides guidelines to help standardize and improve Root Cause Analysis. In addition, hospitals can download tips and tools for interviewing patients and families for the Root Cause Analysis on the Survey and CPOE Materials webpage.

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SECTION 8: PEDIATRIC CARE

This section includes questions and reference information for Section 8: Pediatric Care. Please carefully review the questions, endnotes, and reference information (e.g., measure specifications, notes, and frequently asked questions) before you begin. Failure to review the reference information could result in inaccurate responses.

Section 8: Pediatric Care

Pediatric Care Fact Sheet: <https://ratings.leapfroggroup.org/measure/hospital/2025/pediatric-care>

Hospitals that do not care for (or perform CT scans on) patients 17 years of age or younger should respond “no” to question #2 in 8A and 8B and move on to the Affirmation of Accuracy. Your hospital’s results will be displayed as “Does Not Apply” on Leapfrog’s public reporting website.

Section 8 includes questions about patient experience (CAHPS Child Hospital Survey) and Computed Tomography (CT) radiation dose for pediatric patients.

Each hospital achieving the standard for Patient Experience (CAHPS Child Hospital Survey):

Performed in the top quartile for at least 4 of the 5 CAHPS Child Hospital Survey domains (a subset of the 18 total domains), listed below:

- Communication with Parent – Communication about your child’s medicines
- Communication with Parent – Keeping you informed about your child’s care
- Communication with Child – How well nurses communicate with your child
- Communication with Child – How well doctors communicate with your child
- Attention to Safety and Comfort – Preventing mistakes and helping you report concerns

Each hospital achieving the standard for Pediatric Computed Tomography (CT) Dose:

Received 75% or more of the possible points based on comparing CT radiation doses across two anatomic areas (head and abdomen/pelvis) and five age strata to national benchmarks.

Download the 2025 Leapfrog Hospital Survey Scoring Algorithm on the [Scoring and Results webpage](#).

8A: Patient Experience (CAHPS Child Hospital Survey)

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Important Notes:

Note 1: This subsection is only applicable to hospitals that care for patients 17 years of age or younger. Hospitals that do not care for patients 17 years of age or younger should respond "no" to question #2 in 8A and move on to 8B. Your hospital's results will be displayed as "Does Not Apply" on Leapfrog's public reporting website.

Note 2: To help ensure that the [Top Box Scores](#)⁵² represent an appropriate sample of patients, hospitals must have at least 100 pediatric acute-care admissions to inpatient units other than a neonatal ICU (NICU). Otherwise, they should respond "Yes, but fewer than 100 pediatric admissions were for non-NICU patients" to question #2 and skip the remaining questions in Section 8A. The hospital will be scored as "Does Not Apply." For example, if your hospital had 600 pediatric acute-care admissions, and 550 of those admissions were to a neonatal ICU, you should respond "Yes, but fewer than 100 pediatric admissions were for non-NICU patients" to question #2 as your hospital only has 50 admissions to inpatient units other than a neonatal ICU.

Specifications: See [Patient Experience \(CAHPS Child Hospital Survey\) Measure Specifications](#) in the Reference Information beginning on page 282.

Reporting Period: 12 months

Answer questions #1-12 for the latest 12-month period prior to the submission of this section of the Survey.

Note: As a reminder, the [Corrections Period](#) (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

1) What is the latest 12-month reporting period for which your hospital is submitting responses to this section? 12-month reporting period ending:	<i>Format: Month/Year</i>
2) Did your hospital have at least 500 pediatric acute-care admissions during the 12-month period referenced in Section 1, question #5? <i>Refer to your responses to questions #5 and #13 in Section 1A: Basic Hospital Information.</i> <i>If "no" or "yes, but fewer than 100 pediatric admissions were for non-NICU patients," skip questions #3-12 and continue to the next subsection. The hospital will be scored as "Does Not Apply."</i>	☐ Yes ☐ Yes, but fewer than 100 pediatric admissions were for non-NICU patients ☐ No
3) Has your hospital administered, or started to administer the CAHPS Child Hospital Survey during the reporting period? <i>If "no" to question #3, skip questions #4-12 and continue to the next subsection. The hospital will be scored as "Did Not Measure."</i>	☐ Yes ☐ No
4) Did your hospital administer the full CAHPS Child Hospital Survey or a truncated version? <i>If administering a truncated version, hospitals must follow the specifications for truncating the survey provided in the Patient Experience (CAHPS Child Hospital Survey) Measure Specifications.</i>	☐ Full version ☐ Truncated version

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Section 8: Pediatric Care

5) How many surveys were returned during the reporting period? <i>If less than 100, skip questions #6-12 and continue to the next subsection. The hospital will be scored as "Unable to Calculate Score."</i>	_____
6) Which of the following modes were used to administer the survey? <i>Select all that apply.</i>	☐ Mail ☐ Phone ☐ Email ☐ Tablet
7) Which of the following times were surveys administered during the reporting period? <i>Select all that apply.</i>	☐ Day of discharge ☐ After discharge

In questions #8-12, report your hospital's Top Box Score⁵² (rounded to the nearest whole number) from each of the five publicly reported patient experience measures from your 12-month vendor report that matches the reporting period that you selected in question #1.

8) Communication with Parent – Communication about your child's medicines	_____
9) Communication with Parent – Keeping you informed about your child's care	_____
10) Communication with Child – How well nurses communicate with your child	_____
11) Communication with Child – How well doctors communicate with your child	_____
12) Attention to Safety and Comfort – Preventing mistakes and helping you report concerns	_____

8B: Pediatric Computed Tomography (CT) Radiation Dose

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Important Notes:

Note 1: All pediatric patient (ages 17 years and younger) scans performed at your hospital should be included when reporting on this measure, including cases that were never admitted to an inpatient ward.

Note 2: This section is only applicable to hospitals that perform CT scans on patients 17 years of age or younger. Hospitals that do not perform CT scans on patients 17 years of age or younger should respond "no" to question #2 in 8B and move on to the Affirmation of Accuracy. Your hospital's results will be displayed as "Does Not Apply" on Leapfrog's public reporting website.

Specifications: See [Pediatric Computed Tomography \(CT\) Radiation Dose Measure Specifications](#) in the Reference Information beginning on page 283.

Reporting Period: 12 months

Answer questions #1-7 based on all cases (or a sufficient sample of them)

- Surveys submitted prior to September 1:
 - 01/01/2024 – 12/31/2024
- Surveys (re)submitted on or after September 1:
 - 07/01/2024 – 06/30/2025

Note: As a reminder, the [Corrections Period](#) (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

Sufficient Sample: See [Pediatric Computed Tomography \(CT\) Radiation Dose Measure Specifications](#) for instructions on identifying a sufficient sample for questions #2-7.

1) 12-month reporting period used:	☐ 01/01/2024 – 12/31/2024 ☐ 07/01/2024 – 06/30/2025
2) Does your hospital perform CT scans on pediatric patients? <i>If "no" to question #2, skip the remaining questions in Section 8B, and go to the Affirmation of Accuracy. The hospital will be scored as "Does Not Apply."</i>	☐ Yes ☐ No
3) Did your hospital calculate its distribution of CT radiation doses for pediatric patients over the reporting period, and do you choose to report those data to this Survey? <i>If "no" to question #3, skip the remaining questions in Section 8B, and go to the Affirmation of Accuracy. The hospital will be scored as "Did Not Measure."</i>	☐ Yes ☐ No
4) Which of the following is your hospital using to report the CT radiation dose length product (DLP)? <i>If "manual data collection" is not selected, skip question #5 and continue to question #6.</i>	☐ Manual Data Collection ☐ Dose Monitoring Software ☐ ACR National Radiology Data Registry Report

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Section 8: Pediatric Care

- 5) If using manual data collection, do the responses in questions #6 and #7 represent a sample?

If your hospital reviewed all cases for age strata with fewer than 30 encounters and sampled for those age strata with greater than 30 encounters, select "yes."

- ☐ Yes
☐ No

- 6) Enter your hospital's 25th, 50th, and 75th percentiles (rounded to the nearest whole number) for CT radiation dose length product (DLP) in **head** scans for pediatric patients for each age stratum standardized to 16cm phantoms.

If the number of encounters for an age stratum is less than 10 (in column a), skip columns b, c, and d and then move to the next age stratum. If zero, enter "0" in column a. The hospital will be scored as "Unable to Calculate Score" if all age strata have less than 10 encounters.

Age Stratum	HEAD			
	(a) Number of encounters	(b) 25 th Percentile	(c) 50 th Percentile	(d) 75 th Percentile
< 1 year				
1 - 4				
5 - 9				
10 - 14				
15 - 17				

- 7) Enter your hospital's 25th, 50th, and 75th percentiles (rounded to the nearest whole number) for CT radiation dose length product (DLP) in **abdomen/pelvis** scans for pediatric patients for each age stratum standardized to 32cm phantoms.

If the number of encounters for an age stratum is less than 10 (in column a), skip columns b, c, and d and then move to the next age stratum. If zero, enter "0" in column a. The hospital will be scored as "Unable to Calculate Score" if all age strata have less than 10 encounters.

Age Stratum	ABDOMEN/PELVIS			
	(a) Number of encounters	(b) 25 th Percentile	(c) 50 th Percentile	(d) 75 th Percentile
< 1 year				
1 - 4				
5 - 9				
10 - 14				
15 - 17				

Affirmation of Accuracy

As the hospital CEO or as an employee of the hospital to whom the hospital CEO has delegated responsibility, I have reviewed this information pertaining to the Pediatric Care Section at our hospital, and I hereby certify that this information is true, accurate, and reflects the current, normal operating circumstances at our hospital. I am authorized to make this certification on behalf of our hospital.

The hospital and I understand that The Leapfrog Group, its members, the public and entities and persons who contract or have other business dealings with The Leapfrog Group are relying on the truth and accuracy of this information. The hospital and I also understand that The Leapfrog Group will make this information and/or analyses of this information public through the Survey Results public reporting website, The Leapfrog Group's Hospital Safety Grade, and/or other Leapfrog Group products and services. This information and/or analyses and all intellectual property rights therein shall be and remain the sole and exclusive property of The Leapfrog Group in which The Leapfrog Group retains exclusive ownership. This information does not infringe upon any third-party intellectual property rights or any other third-party rights whatsoever and is free and clear of all encumbrances and liens of any kind. The hospital and I acknowledge that The Leapfrog Group may use this information in a commercial manner for profit. The hospital shall be liable for and shall hold harmless and indemnify The Leapfrog Group from any and all damages, demands, costs, or causes of action resulting from any inaccuracies in the information or any misrepresentations in this Affirmation of Accuracy. The Leapfrog Group and its members and entities and persons who contract or have other business dealings with The Leapfrog Group reserve the right to omit or disclaim information that is not current, accurate or truthful.

Affirmed by _____, the hospital's _____,
(first name and last name) (title)
on _____.
(date)

Section 8: Pediatric Care Reference Information

What's New in the 2025 Survey

There are no changes to Section 8A: Patient Experience (CAHPS Child Hospital Survey) or Section 8B: Pediatric CT Radiation Dose.

Change Summary Since Release

None. If substantive changes are made to this section of the Survey after release on April 1, 2025, they will be documented in this Change Summary section.

Section 8: Pediatric Care Measure Specifications**Patient Experience (CAHPS Child Hospital Survey) Measure Specifications**

Important Note: Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review Leapfrog's Multi-Campus Reporting Policy.

Source: Agency for Healthcare Quality and Research (AHRQ) (NQF #2548)

Reporting Period: The latest 12-month period prior to the submission of this section of the Survey. Hospitals can elect to use either survey return date or discharge date to pull reports for this measure.

This section of the Leapfrog Hospital Survey asks hospitals who care for pediatric patients about their results from the CAHPS Child Hospital Survey. The first several questions are designed to learn more about the current administration of the survey. The last five questions collect the "Top Box" ⁵² score for each of the following five domains:

- Communication with Parent – Communication about your child's medicines
- Communication with Parent – Keeping you informed about your child's care
- Communication with Child – How well nurses communicate with your child
- Communication with Child – How well doctors communicate with your child
- Attention to Safety and Comfort – Preventing mistakes and helping you report concerns

Hospitals using Press Ganey, NRC, or PRC to administer the CAHPS Child Hospital Survey can use the AHRQ CAHPS Crosswalk below to ensure they are reporting on the correct domains. The Crosswalk is designed to help translate the standard vendor report to the AHRQ Domains used in questions #8-12 of the Leapfrog Hospital Survey.

Hospitals that opt to truncate the CAHPS Child Hospital Survey after question 40, which is the last question required to report on the five domains listed above, must ensure that all questions prior to and including question 40 remain in order and unaltered. In addition, hospitals opting to truncate the survey must retain questions 50-54 and 56-57 (in order and unaltered) which ask for the child and survey participant's demographic information. Note: Hospitals that collect information captured in questions 51-52 administratively are not required to retained them.

For more information regarding which questions from the CAHPS Child Hospital Survey correspond to the five domains listed above, visit <https://www.ahrq.gov/cahps/surveys-guidance/hp/about/child-survey-measures.html>.

CAHPS Child Hospital Survey Domain Crosswalk

AHRQ Domain Name	Press Ganey Domain Name	NRC Domain Name	PRC Domain Name
Communication with Parent – Communication about your child's medicines	Communication Child's Med	Communication About Meds	Communication About Medicines
Communication with Parent – Keeping you informed about your child's care	Informed Child's Care	Keeping You Informed About Your Child's Care	Keeping Parent Informed
Communication with Child – How well nurses communicate with your child	Nurses Communicate Child	Nurse Communication With Child	Nurses – Child
Communication with Child – How well doctors communicate with your child	Doctors Communicate Child	Doctor Communication With Child	Doctors – Child
Attention to Safety and Comfort – Preventing mistakes and helping you report concerns	Prevent Mistakes Rpt Conc	Preventing Mistakes and Helping You Report Concerns	Preventing Mistakes

See FAQs for additional information about responding to the questions in this section.

Pediatric Computed Tomography (CT) Radiation Dose Measure Specifications**Important Notes:**

Note 1: Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Note 2: For purposes of this measure, an "encounter" consists of a full examination and any CT scans performed within one hour of each other involving the designated anatomic area (i.e., head or abdomen/pelvis). For example, two CT scans conducted 30-minutes apart on the same patient's head are considered one "encounter." CT scans of the same anatomic area performed with and without contrast are considered one "encounter." Scans of two different anatomic areas performed within one hour would not be considered the same "encounter." Scans of the same anatomic area performed greater than 60 minutes apart would also not be considered the same "encounter."

Note 3: This measure includes two sets of instructions in the table below: one for hospitals using dose monitoring software and one for hospitals that are not using dose monitoring software. Please be sure to use the correct set of instructions.

Note 4: Hospitals performing manual data collection must use the CT Dose Workbook provided on the [Survey and CPOE Materials webpage](#) to standardize their CT radiation dose length product (DLP) for head scans to 16cm phantoms and abdomen/pelvis scans to 32cm phantoms.

Source: University of California, San Francisco (NQF #2820)

Reporting Period: 12 months

- Surveys submitted prior to September 1:
 - 01/01/2024 – 12/31/2024
- Surveys (re)submitted on or after September 1:
 - 07/01/2024 – 06/30/2025

Hospitals participating in the ACR National Radiology Data Registry:

Data for this measure can be obtained directly from a special Leapfrog report. See details below.

Hospitals that report to the American College of Radiology (ACR) and receive reports through the National Radiology Data Registry (NRDR) will be able to respond to questions #6-7 in Section 8B using a specialized report that will be made available with the quarterly Dose Index Registry Executive Summary reports. This separate "Leapfrog" report will be available for download through the NRDR portal and will contain data according to the age ranges and measure specifications of the Leapfrog Hospital Survey. **Enter values from the "Leapfrog" tab using the "Table: Pediatric Exams for Leapfrog Survey" and the appropriate percentiles in the Head and Abdomen Pelvis columns rounded to the nearest whole number directly into the Online Hospital Survey Tool.** While this report should be from the most recent 12 months, it does not need to include the full 12 months.

Hospitals using dose monitoring software:

Data for this measure can be obtained using dose monitoring software. See instructions below.

Question #6, column a: Total Number of Encounters

Using your dose monitoring software, obtain the total number of encounters in **head scans** for each age stratum (<1, 1-4, 5-9, 10-14, 15-17). Enter these values into the Survey.

Inclusions:

CT HEAD BRN WO IVCON
 CT HEAD WO IVCON
 CT PEDS HEAD WO IVCON
 CT HEAD
 CT PEDS HEAD BRN WO IVCON
 CT BRN WO IVCON
 CT HEAD BRN
 CT HEAD BRN W IVCON
 CT HEAD W IVCON

CT HEAD WO & W IVCON
 CT HEAD BRN WO & W IVCON
 CT BRN WO & W IVCON
 CT BRN W IVCON

Exclusions:

- Encounters involving facial bones or sinuses
- Encounters where the indication is for a biopsy, including prop studies and stereotactic studies and procedures
- Encounters that cross multiple anatomic areas should be excluded. For example, encounters involving both the head and neck are excluded from the “head” anatomic region.
- Encounters where the documented age is missing or listed as the date of admission (i.e., an accurate birthday could not be obtained and therefore the admission date was used), as is the case for some trauma patients

Sampling Cases: Hospitals using dose monitoring software must report on all encounters in the 12-month reporting period.

Hospitals using Radimetrics Dose Monitoring Software:

- If your hospital is using unique study instance UIDs for every scan performed, review your data to ensure that any scans performed on the same patient and same anatomic area within a one-hour timeframe are being combined into one encounter. The DLPs for all scans within the one-hour timeframe should be combined and that combined value used to calculate the percentiles reported to Leapfrog.
- If your hospital is NOT using unique study instance UIDs and is combining DLPs for all scans performed on the same patient and same anatomic area within one hour into one study instance UID, no review is required as this adheres to the definition of encounter. However, these hospitals should review any repeat or delayed scans to ensure repeat or delayed scans performed greater than 60 minutes apart are not being combined into the same study instance UID.

Question #6, columns b, c, and d: 25th, 50th, and 75th Percentiles

Based on the encounters identified for each age stratum (column a), use your dose monitoring software to calculate the 25th percentile (column b), the 50th percentile (column c), and the 75th percentile (column d) for CT radiation dose length product (DLP) in **head scans standardized to 16cm phantoms**. Enter these values into the Survey rounded to the nearest whole number.

If the number of encounters for an age stratum (i.e., <1 or 1-4, etc.) is less than 10 (column a), skip columns b, c, and d. If the number of encounters for an age stratum is zero, enter “0” in column a, and skip columns b, c, and d. You cannot leave any rows in column a blank.

Phantom Dose Specifications:

For head scans, use a 16 cm phantom dose value. The orange box in the screenshot below the table is an example of a Dose Report which shows the phantom dose value used. The phantom dose value is used to estimate the radiation dose to the patient.

Scout Doses (Topograms) should not be included when calculating the 25th, 50th, or 75th percentiles.

Question #7 column a: Total Number of Encounters

Using your dose monitoring software, obtain the total number of encounters in **abdomen/pelvis** for each age stratum (<1, 1-4, 5-9, 10-14, 15-17). Enter these values into the Survey.

Inclusions:

CT ABD PELVIS W IVCON
 CT ABD/PEL W IVCON
 CT PEDS ABD PELVIS
 CT ABD PELVIS WO IVCON
 CT ABD/PEL WO IVCON
 CT ABD/PEL

CT PEDS ABD/PEL WO IVCON
 CT ABD PELVIS WO & W IVCON
 CT ABD/PEL WO & W IVCON
 CT ABD PELVIS
 CT ABD PELVIS WO IVCON

Exclusions:

- Encounters where the indication is for a biopsy, including prop studies and stereotactic studies and procedures
- Encounters that cross multiple anatomic areas should be excluded. For example, encounters involving both the chest and abdomen/pelvis are excluded from the "abdomen/pelvis" anatomic region.
- Encounters where the documented age is missing or listed as the date of admission (i.e., an accurate birthday could not be obtained and therefore the admission date was used), as is the case for some trauma patients

Sampling Cases: Hospitals using dose monitoring software must report on all encounters in the 12-month reporting period.

Question #7, columns b, c, and d: 25th, 50th, and 75th Percentiles

Based on the encounters identified for each age stratum (column a), use your dose monitoring software to calculate the 25th percentile (column b), the 50th percentile (column c), and the 75th percentile (column d) for CT radiation dose length product (DLP) in **abdomen/pelvis scans standardized to 32cm phantoms**. Enter these values into the Survey rounded to the nearest whole number.

If the number of encounters for an age stratum (i.e., <1 or 1-4, etc.) is less than 10 (column a), skip columns b, c, and d. If the number of encounters for an age stratum is zero, enter "0" in column a, and skip columns b, c, and d. You cannot leave any rows in column a blank.

Phantom Dose Specifications:

For abdomen/pelvis scans, use a 32cm phantom dose value. The orange box in the screenshot below the table is an example of a Dose Report which shows the phantom dose value used. The phantom dose value is used to estimate the radiation dose to the patient.

Scout Doses (Topograms) should not be included when calculating the 25th, 50th, or 75th percentiles.

Hospitals not using dose monitoring software:

Data for this measure can be obtained from Dose Reports that come directly from the CT Machine and are sent along with the images to the Picture Archiving and Communications (PACS) used to review the images. See instructions below.

CT Dose Excel Workbook

To assist hospitals who do not use dose monitoring software in calculating the responses to questions #6 and #7, Leapfrog has developed a CT Dose Workbook to assist hospitals in standardizing their CT dose data based on these specifications. The workbook includes 12 tabs: Instructions, Summary, and 10 Data Entry tabs for each anatomic area/age stratum combination. The tabs for head scans are red and the tabs for abdomen/pelvis scans are blue. Once you enter your hospital's CT radiation dose length product (DLP) data into the appropriate tab, the workbook will automatically calculate your responses to questions #6 and #7 in the Summary tab, and those values should be entered in the Survey.

The CT Dose Workbook is available on the Survey and CPOE Materials [webpage](#) and should be used when reporting on this measure.

Question #6, column a: Total Number of Encounters

To determine the total number of encounters in **head scans** for each age stratum (<1, 1-4, 5-9, 10-14, 15-17), you will need to obtain dose reports. See sampling instructions below.

Inclusions:

CT HEAD BRN WO IVCON
 CT HEAD WO IVCON
 CT PEDS HEAD WO IVCON
 CT HEAD
 CT PEDS HEAD BRN WO IVCON
 CT BRN WO IVCON
 CT HEAD BRN
 CT HEAD BRN W IVCON
 CT HEAD W IVCON
 CT HEAD WO & W IVCON
 CT HEAD BRN WO & W IVCON
 CT BRN WO & W IVCON
 CT BRN W IVCON

Exclusions:

- Encounters involving facial bones or sinuses
- Encounters where the indication is for a biopsy, including prop studies and stereotactic studies and procedures
- Encounters that cross multiple anatomic areas should be excluded. For example, encounters involving both the head and neck are excluded from the "head" anatomic region.
- Encounters where the documented age is missing or listed as the date of admission (i.e., an accurate birthday could not be obtained and therefore the admission date was used), as is the case for some trauma patients

Sampling Cases:

Hospitals that are using information stored in the CT Machine have the option of reporting on all encounters or a sample of encounters. Hospitals opting to identify a sample of encounters for this measure should follow these instructions:

- Review your hospital's scans starting on January 15, 2024 (or July 15, 2024 if (re)submitting a Survey on or after September 1, 2025).
- Work sequentially until **a sample of at least 30 encounters per anatomic area and age strata combination** (i.e., head <1; head 1-4, etc.) is reached, or all cases in the reporting period are reviewed, whichever comes first.

Question #6, columns b, c, and d: 25th, 50th, and 75th Percentiles

Using your dose reports, enter the phantom dose and **Total DLP (mGY-cm)** for each encounter into each of the 5 "Head" tabs of the CT Dose Workbook. Be sure to review the instructions tab carefully before you begin entering data. The worksheet will automatically standardize your dose data to a 16cm phantom, if necessary. The worksheet will then automatically calculate the total number of encounters, as well as the 25th, 50th, and 75th percentiles for each anatomic area and age stratum.

See the example CT Dose Report from a CT scanner at the end of this table:

- The orange box in the screenshot is an example of a Dose Report which shows the phantom dose value used. The phantom dose value is used to estimate the radiation dose to the patient.
- The red box highlights the Total DLP. Note that your CT scanner may have a differently formatted Dose Report.

Scout Doses (Topograms) should not be included when entering the Total DLP for each encounter into the CT Dose Workbook.

Question #7 column a: Total Number of Encounters

To determine the total number of encounters in **abdomen/pelvis scans** for each age stratum (<1, 1-4, 5-9, 10-14, 15-17), you will need to obtain dose reports. See sampling instructions below.

Inclusions:

CT ABD PELVIS W IVCON
 CT ABD/PEL W IVCON
 CT PEDS ABD PELVIS
 CT ABD PELVIS WO IVCON
 CT ABD/PEL WO IVCON
 CT ABD/PEL
 CT PEDS ABD/PEL WO IVCON
 CT ABD PELVIS WO & W IVCON
 CT ABD/PEL WO & W IVCON
 CT ABD PELVIS
 CT ABD PELVIS WO IVCON

Exclusions:

- Encounters where the indication is for a biopsy, including prop studies and stereotactic studies and procedures
- Encounters that cross multiple anatomic areas should be excluded. For example, encounters involving both the chest and abdomen/pelvis are excluded from the "abdomen/pelvis" anatomic region.
- Encounters where the documented age is missing or listed as the date of admission (i.e., an accurate birthday could not be obtained and therefore the admission date was used), as is the case for some trauma patients

Question #7 columns b, c, and d: 25th, 50th, and 75th Percentiles

Using your dose reports, enter the phantom dose and **Total DLP (mGY-cm)** for each encounter into each of the 5 "Abdomen Pelvis" tabs of the **CT Dose Workbook**. Be sure to review the instructions tab carefully before you begin entering data. The worksheet will automatically standardize your dose data to a 32cm phantom, if necessary. The worksheet will then automatically calculate the total number of encounters, as well as the 25th, 50th, and 75th percentiles for each anatomic area and age stratum.

See the example CT Dose Report from a CT scanner at the end of this table:

- The orange box in the screenshot is an example of a Dose Report which shows the phantom dose value used. The phantom dose value is used to estimate the radiation dose to the patient.
- The red box highlights the Total DLP. Note that your CT scanner may have a differently formatted Dose Report.

Patient Name:		Exam no.: 91432			
Accession Number:		Sep 01, 2016			
Patient ID:		LightSpeed 4Vx1			
Exam Description: CT ABD/PEL W & W IVCON					
Dose Report					
Series	Type	Scan Range (mm)	CT DIAP (mGy)	DLP (mGy-cm)	Phantom CTDI
1	Scout	-	-	-	
2	Scout	-	-	-	
200	Axial	522.250-522.250	4.72	2.06	Body: 32
4	Helical	5348.250-513.750	21.77	989.67	Body: 32
5	Helical	5019.600-528.600	10.90	166.88	Body: 32
Total Exam DLP:				1280.61	
1.1					

Scout Doses (Topograms) should not be included when entering the Total DLP for each encounter into the CT Dose Workbook.

See [FAQs](#) for additional information about responding to the questions in this section.

Section 8: Pediatric Care Frequently Asked Questions (FAQs)**Patient Experience (CAHPS Child Hospital Survey) FAQs**

- 1. Why does Leapfrog refer to two different reporting periods in Section 8A question #2: one reporting period which refers to the number of pediatric admissions during the 12 months from Section 1 and one reporting period which refers to the results of our CAHPS Child Hospital Survey?**

These two reporting periods are different because hospitals that have not historically had 500 pediatric admissions annually may not have begun to administer the CAHPS Survey to their patients and therefore it would not be appropriate to ask these facilities to report on their current results in Section 8A.

- 2. Do I need to include neonatal ICU (NICU) discharges when administering the CAHPS Child Hospital Survey and reporting those results to Leapfrog?**

The Child CAHPS Hospital Survey was designed to be administered to pediatric discharges including NICU discharges. Additional details on fielding the CAHPS Child Hospital Survey can be found [here](#).

In 2025, hospitals that have been administering the CAHPS survey without including NICU discharges in their sample can report those results to Leapfrog, provided they meet the minimum sample size and timing requirements in the Leapfrog Hospital Survey. However, we are urging those hospitals to begin including NICU discharges-- per the manual guidelines-- immediately, as CAHPS is designed to include those patients. Hospitals that are just starting to administer the survey in 2025 should include NICU discharges in their sample per the sampling framework detailed in the manual.

- 3. Can we use other lower cost modes for administering the CAHPS Child Hospital Survey? Survey administration is costly, and our hospital has low response rates.**

Some hospitals have asked about the use of alternative, lower cost modes of survey administration, such as administering paper surveys at discharge that can then be batched and mailed to a vendor to calculate results. This approach is potentially an opportunity both to lower the cost of administration and to increase response rates.

[Leapfrog's Pediatric Expert Panel](#) has noted that while administering the CAHPS Child Hospital Survey using paper forms at discharge is not on the list of AHRQ-approved modes, hospitals that are trying to find ways to administer the survey and increase response rate should be able to submit results to the 2025 Leapfrog Hospital Survey. That said, the Pediatric Expert Panel has expressed a desire for these different modes to be tested, and so we cannot guarantee that you will be able to submit these results for future Leapfrog Hospital Surveys.

- 4. Is Interactive Voice Response (IVR) or texting a link to an online survey an acceptable mode for administering the CAHPS Child Hospital Survey?**

Hospitals that administer the CAHPS Child Hospital Survey via IVR should select "phone" in question #6. Hospitals that administer the CAHPS Child Hospital Survey by texting a link to an online survey to the patient should select "email."

Pediatric Computed Tomography (CT) Radiation Dose FAQs

- 5. Is this measure only applicable to pediatric inpatients, or should all pediatric scans be included?**

All pediatric patient (ages 17 years and younger) scans should be included when reporting on this measure, including cases that were never admitted to an inpatient ward.

6. Should multiple phase scans be included in the reporting?

Yes, the intent of this measure is to capture the entire dose a patient receives, even if this radiation is received over multiple phase scans.

7. Should any CT encounters involving anatomic areas not listed in the Survey questions (i.e., head or abdomen/pelvis) be included in the reporting?

No. When reporting CT encounters in the Survey, only encounters involving the head or abdomen/pelvis should be included. Encounters involving any other anatomic area should not be reported. For example, encounters involving both the head and neck are excluded from the "head" anatomic region.

8. Are the CT doses adjusted for any factors other than age, such as height and weight?

No, CT doses are only stratified by age and anatomic region. The pediatric CT radiation dose measure is an NQF-endorsed measure, developed so that all hospitals in the country who do pediatric CT scans can report. Its known limitation is that it does not consider patient size (e.g., height and weight) but instead uses age as a proxy for size. Part of the reason is that unless hospitals use dose monitoring software, which not all hospitals currently do due to cost, they would not have this information readily available to them. However, to align with the American College of Radiology (ACR), head scans are standardized to 16cm phantoms and abdomen/pelvis scans are standardized to 32cm phantoms.

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SECTION 9: OUTPATIENT PROCEDURES

This section includes questions and reference information for Section 9: Outpatient Procedures. Please carefully review the questions, endnotes, and reference information (e.g., measure specifications, notes, and frequently asked questions) before you begin. Failure to review the reference information could result in inaccurate responses.

Section 9: Outpatient Procedures

Outpatient Procedures Fact Sheet and Bibliography:

<https://ratings.leapfroggroup.org/measure/hospital/2025/care-elective-outpatient-surgery-patients>

Section 9 includes questions about the volume and safety of same-day procedures performed in hospital outpatient departments, as well as the experience of patients who had a same-day surgery performed.

Hospitals will not be able to access Section 9 until the American Medical Association's Terms of Use are completed via the CPT Code Workbook button on the Survey Dashboard, and the appropriate CPT Code Workbook is downloaded.

Each hospital achieving the standards for Certified Clinicians Present While Patients Are Recovering:

1. Has an ACLS certified clinician, plus a second clinician, present at all times and immediately available in the building while adult patients are present in the hospital outpatient department.
2. Has a PALS certified clinician, plus a second clinician, present at all times and immediately available in the building while pediatric patients are present in the hospital outpatient department.

Each hospital achieving the standard for Patient Follow-up:

Provided an accurate CCN in the Hospital Profile, reported volume for adult lower gastrointestinal endoscopy procedures in Section 9C, and is in the top quartile of performance for OP-32, Rate of Unplanned Hospital Visits After an Outpatient Colonoscopy, based on responses to the 2022 Leapfrog ASC Survey and Section 9 of the 2022 Leapfrog Hospital Survey submitted by June 30, 2022.

Each hospital achieving the standard for the Safe Surgery Checklist:

1. Uses a safe surgery checklist on **all** patients undergoing an applicable procedure (reported on in Section 9C, if applicable) that includes **all** safe surgery checklist elements; **and**
2. Verbalizes **all** safe surgery checklist elements in the presence of the appropriate personnel; **and**
3. Completes an audit on a sufficient sample of patients to document adherence to the checklist; **and**
4. Has documented adherence to the checklist for at least 90% of the patients included in the audit.

Each hospital achieving the standard for Medication Safety for Outpatient Procedures:

Has met the 90% target for documenting all three components: home medications, visit medications, and allergies/adverse reaction(s) in the clinical record.

Each hospital achieving the standard for Patient Experience (OAS CAHPS):

Performed in the top quartile based on responses to the 2020 Leapfrog ASC and Hospital Surveys submitted by August 31, 2020, for the four OAS CAHPS domains, listed below:

- a) Facilities and Staff
- b) Communication About Your Procedure
- c) Patients' Rating of the Facility
- d) Patients Recommending the Facility

Download the 2025 Leapfrog Hospital Survey Scoring Algorithm on the [Scoring and Results webpage](#).

9A: Basic Outpatient Department Information

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Important Notes:

Note 1: In order to access this section in the Online Survey Tool, hospitals must complete the American Medical Association's Terms of Use via the CPT Code Workbook button next to Section 9 on the Survey Dashboard and download the appropriate CPT Code Workbook. Instructions for downloading the CPT Code Workbook are available in the [Volume of Procedures Measure Specifications](#). Each hospital must complete these steps even if they are part of a hospital system.

Note 2: This subsection will not be scored but will be used in public reporting.

Note 3: The term "hospital outpatient department" is used to refer to all hospital outpatient departments or areas of the hospital, including areas that are used for **both** inpatient and outpatient procedures, that perform the outpatient procedures listed in Section 9C and that share your hospital's license or CMS Certification Number (CCN). This would include, but is not limited to surgery centers, free-standing hospital outpatient departments, as well as outpatient departments that are located in your hospital or are co-located³¹ with your hospital. Hospitals should only include hospital outpatient departments or areas of the hospital that perform the procedures listed in Section 9C in an operating room⁵³ or procedure room⁵⁴.

Reporting Period: 12 months

- Surveys submitted prior to September 1:
 - 01/01/2024 – 12/31/2024
- Surveys (re)submitted on or after September 1:
 - 07/01/2024 – 06/30/2025

Note: As a reminder, the [Corrections Period](#) (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

1. 12-month reporting period used:	☐ 01/01/2024 – 12/31/2024 ☐ 07/01/2024 – 06/30/2025
2. Does your hospital perform any of the procedures listed in Section 9C on an outpatient basis: • in the hospital or at a hospital outpatient department <u>co-located</u>³¹ with the hospital - and/or • at a surgery center or free-standing hospital outpatient department that shares your hospital's license or CMS Certification Number?	☐ Yes ☐ No

If "no" to question #2, skip the remaining questions in Section 9, including all subsections, and go to the Affirmation of Accuracy.

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Section 9: Outpatient Procedures

3. Total number of <u>operating rooms</u> ⁵³ used to perform the outpatient procedures listed in Section 9C:	_____
4. Total number of <u>endoscopic procedure rooms</u> ⁵⁴ used to perform the outpatient procedures listed in Section 9C:	_____

9B: Medical, Surgical, and Clinical Staff

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Important Notes:

Note 1: The term “hospital outpatient department” is used to refer to all hospital outpatient departments or areas of the hospital, including areas that are used for **both** inpatient and outpatient procedures, that perform the outpatient procedures listed in Section 9C and that share your hospital's license or CMS Certification Number (CCN). This would include, but is not limited to surgery centers, free-standing hospital outpatient departments, as well as outpatient departments that are located in your hospital or are co-located³¹ with your hospital. Hospitals should only include hospital outpatient departments or areas of the hospital that perform the procedures listed in Section 9C in an operating room⁵³ or procedure room⁵⁴.

Note 2: Hyperlinks throughout these questions refer to the [Medical, Surgical, and Clinical Staff FAQs](#) beginning on page 318, as well as to endnotes. FAQ hyperlinks are not included in the Online Survey Tool.

Reporting Period: 3 months

Answer questions #1-2 based on the staffing structure currently in place at the time that you submit this section of the Survey. The staffing structure should have been in place for at least the past 3 months and reflect the ordinary staffing structure for each applicable hospital outpatient department.

Note: As a reminder, the [Corrections Period](#) (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

1. Is there an Advanced Cardiovascular Life Support (ACLS) trained [clinician](#)⁵⁵, as well as a second [clinician](#)⁵⁵ (regardless of ACLS training), present at all times and immediately available in the building while an adult patient (13 years and older) is present in the hospital outpatient department?

Hospitals with more than one hospital outpatient department, including a surgery center or free-standing hospital outpatient department, should respond based on the least intensively staffed location.

Hospitals should report on all hospital outpatient departments or areas of the hospital that perform the outpatient procedures listed in Section 9C and that share the hospital's license or CCN.

Hospitals that did not perform any applicable procedures on patients 13 years and older during the reporting period should select “not applicable; pediatric patients only.” The hospital will be scored as “Does Not Apply.”

- Yes
- No
- Not applicable; pediatric patients only

2. Is there a Pediatric Advanced Life Support (PALS) trained <u>clinician</u>⁵⁵, as well as a second <u>clinician</u>⁵⁵ (regardless of PALS training), present at all times and immediately available in the building while a pediatric patient (infant through 12 years) is present in the hospital outpatient department? <i>Hospitals with more than one hospital outpatient department, including a surgery center or free-standing hospital outpatient department, should respond based on the least intensively staffed location.</i> <i>Hospitals should report on all hospital outpatient departments or areas of the hospital that perform the outpatient procedures listed in Section 9C and that share the hospital's license or CCN.</i> <i>Hospitals that do not care for pediatric patients should select "not applicable; adult patients only" and hospitals that only performed applicable pediatric procedures on pediatric patients 13 years and older during the reporting period should select "not applicable; pediatric patients are all aged 13-17," regardless of the presence of clinicians trained in PALS. The hospital will be scored as "Does Not Apply."</i>	○ Yes ○ No ○ Not applicable; adult patients only ○ Not applicable; pediatric patients are all aged 13-17
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9C: Volume of Procedures

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Important Notes:

Note 1: CPT Codes are provided in downloadable Excel files on the Survey Dashboard. To access the files, click the CPT Code Workbook button next to Section 9. You will be required to complete the American Medical Association's Terms of Use before downloading the Excel file and using the individual CPT codes to query your EHR or billing system. You are only required to complete the Terms of Use once per Survey Cycle (April 1 – November 30).

The CPT Code Workbooks (Excel files) are labeled for Section 3A: Total Hip Replacement, Total Knee Replacement, and Bariatric Surgery for Weight Loss and Section 9C: Volume of Procedures. Please note, if you are part of a hospital system, each hospital will need to complete the Terms of Use. This is a requirement of the American Medical Association.

Note 2: This subsection will not be scored but will be used in public reporting to inform purchasers and consumers about the hospital's experience with the procedure. Additionally, this information will be used to facilitate the search functionality on Leapfrog's public reporting website (i.e., allowing users to search for hospitals that perform the procedure they need on an outpatient basis).

Note 3: The term "hospital outpatient department" is used to refer to all hospital outpatient departments or areas of the hospital, including areas that are used for **both** inpatient and outpatient procedures, that perform the outpatient procedures listed in Section 9C and that share your hospital's license or CMS Certification Number (CCN). This would include, but is not limited to surgery centers, free-standing hospital outpatient departments, as well as outpatient departments that are located in your hospital or are co-located³¹ with your hospital. Hospitals should only include hospital outpatient departments or areas of the hospital that perform the procedures listed in Section 9C in an operating room⁵³ or procedure room⁵⁴.

Note 4: Hospitals should only report on procedures they electively perform. If your hospital does not perform the procedure on an outpatient basis or ONLY does so when a procedure is urgent, you should answer "no" and not report on those procedures.

Specifications: See [Volume of Procedures Measure Specifications](#) in the Reference Information beginning on page 321.

Reporting Period: 12 months

- 01/01/2024 – 12/31/2024

Note: As a reminder, the Corrections Period (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

1) 12-month reporting period used:

*No response required here.
Reporting period
automatically 01/01/2024 –
12/31/2024.*

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Section 9: Outpatient Procedures

2) During the reporting period, were one or more of the following ophthalmology procedures performed at your hospital outpatient department(s) on <u>adult</u> and/or <u>pediatric</u> patients: • Anterior segment eye procedures, • Posterior segment eye procedures, or • Ocular adnexa and other eye procedures? <i>If “no” or “yes, but no longer performs these procedures,” skip questions #11-13 below.</i>	☐ Yes ☐ Yes, but no longer performs these procedures ☐ No
3) During the reporting period, were one or more of the following orthopedic procedures performed at your hospital outpatient department(s) on <u>adult</u> and/or <u>pediatric</u> patients: • Finger, hand, wrist, forearm, and elbow procedures; • Shoulder procedures; • Spine procedures; • Hip procedures; • Knee procedures; • Toe, foot, ankle, and leg procedures; or • General orthopedic procedures? <i>If “no” or “yes, but no longer performs these procedures,” skip questions #14-16 below.</i>	☐ Yes ☐ Yes, but no longer performs these procedures ☐ No
4) During the reporting period, were one or more of the following otolaryngology procedures performed at your hospital outpatient department(s) on <u>adult</u> and/or <u>pediatric</u> patients: • Ear procedures; • Mouth procedures; • Nasal/sinus procedures; or • Pharynx/adenoid/tonsil procedures? <i>If “no” or “yes, but no longer performs these procedures,” skip questions #17-19 below.</i>	☐ Yes ☐ Yes, but no longer performs these procedures ☐ No
5) During the reporting period, were one or more of the following gastroenterology procedures performed at your hospital outpatient department(s) on <u>adult</u> patients: • Upper GI endoscopy, or • Lower GI endoscopy? <i>If “no” or “yes, but no longer performs these procedures,” skip questions #20-22 below.</i>	☐ Yes ☐ Yes, but no longer performs these procedures ☐ No

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Section 9: Outpatient Procedures

6) During the reporting period, were one or more of the following general surgery procedures performed at your hospital outpatient department(s) on <u>adult</u> patients: • Cholecystectomy and common duct exploration; • Hemorrhoid procedures; • Inguinal and femoral hernia repair; • Other hernia repair; • Laparoscopy; • Lumpectomy or quadrantectomy of breast; or • Mastectomy? <i>If "no" or "yes, but no longer performs these procedures," skip questions #23-25 below.</i>	☐ Yes ☐ Yes, but no longer performs these procedures ☐ No
7) During the reporting period, were one or more of the following urology procedures performed at your hospital outpatient department(s) on <u>adult</u> patients: • Circumcision; • Cystourethroscopy; • Male genital procedures; • Urethra procedures; or • Vaginal repair procedures? <i>If "no" or "yes, but no longer performs these procedures," skip questions #26-28 below.</i>	☐ Yes ☐ Yes, but no longer performs these procedures ☐ No
8) During the reporting period, was the following neurological surgery procedure performed at your hospital outpatient department(s) on <u>adult</u> patients: • Spinal fusion procedures? <i>If "no" or "yes, but no longer performs this procedure," skip questions #29-31 below.</i>	☐ Yes ☐ Yes, but no longer performs this procedure ☐ No
9) During the reporting period, were one or more of the following obstetrics and gynecology procedures performed at your hospital outpatient department(s) on <u>adult</u> patients: • Cervix procedures, • Hysteroscopy, or • Uterus and adnexa laparoscopies? <i>If "no" or "yes, but no longer performs these procedures," skip questions #32-34 below.</i>	☐ Yes ☐ Yes, but no longer performs these procedures ☐ No
10) During the reporting period, were one or more of the following plastic and reconstructive surgery procedures performed at your hospital outpatient department(s) on <u>adult</u> patients: • Breast repair or reconstruction, or • Skin graft/reconstruction procedures? <i>If "no" or "yes, but no longer performs these procedures," skip questions #35-37 below.</i>	☐ Yes ☐ Yes, but no longer performs these procedures ☐ No

Ophthalmology

11) Total adult and/or pediatric volume for each of the following applicable procedures performed at your hospital outpatient department(s) during the reporting period.

*You cannot leave any blank. If you did not perform one or more of the procedures listed below enter 0 (zero). If you had zero volume for **all** procedures, go back to question #2 and update your response from "yes" to "no."*

	(a) Adult Volume	(b) Pediatric Volume
Anterior segment eye procedures	_____	_____
Posterior segment eye procedures	_____	_____
Ocular adnexa and other eye procedures	_____	_____

12) Where were these **ophthalmology** procedures performed?

Select all that apply.

If only "hospital" is selected, skip question #13 and continue to question #14.

- ☐ Hospital
☐ Surgery center or free-standing hospital outpatient department

13) Please provide the name and city location of each surgery center or free-standing hospital outpatient department performing **ophthalmology** procedures:

	Name	City
Surgery Center/Free-Standing Hospital Outpatient Department 1		
Surgery Center/Free-Standing Hospital Outpatient Department 2		
Surgery Center/Free-Standing Hospital Outpatient Department 3		
Surgery Center/Free-Standing Hospital Outpatient Department 4		
Surgery Center/Free-Standing Hospital Outpatient Department 5		

Orthopedic

14) Total adult and/or pediatric volume for each of the following applicable procedures performed at your hospital outpatient department(s) during the reporting period.

*You cannot leave any blank. If you did not perform one or more of the procedures listed below enter 0 (zero). If you had zero volume for **all** procedures, go back to question #3 and update your response from "yes" to "no."*

	(a) Adult Volume	(b) Pediatric Volume
Finger, hand, wrist, forearm, and elbow procedures	_____	_____
Shoulder procedures	_____	_____
Spine procedures	_____	_____
Hip procedures	_____	_____
Knee procedures	_____	_____
Toe, foot, ankle, and leg procedures	_____	_____
General orthopedic procedures	_____	_____

15) Where were these **orthopedic** procedures performed?

Select all that apply.

If only "hospital" is selected, skip question #16 and continue to question #17.

- ☐ Hospital
- ☐ Surgery center or free-standing hospital outpatient department

16) Please provide the name and city location of each surgery center or free-standing hospital outpatient department performing **orthopedic** procedures:

	Name	City
Surgery Center/Free-Standing Hospital Outpatient Department 1		
Surgery Center/Free-Standing Hospital Outpatient Department 2		
Surgery Center/Free-Standing Hospital Outpatient Department 3		
Surgery Center/Free-Standing Hospital Outpatient Department 4		
Surgery Center/Free-Standing Hospital Outpatient Department 5		

Otolaryngology

17) Total adult and/or pediatric volume for each of the following applicable procedures performed at your hospital outpatient department(s) during the reporting period.

*You cannot leave any blank. If you did not perform one or more of the procedures listed below enter 0 (zero). If you had zero volume for **all** procedures, go back to question #4 and update your response from "yes" to "no."*

	(a) Adult Volume	(b) Pediatric Volume
Ear procedures	_____	_____
Mouth procedures	_____	_____
Nasal/sinus procedures	_____	_____
Pharynx/adenoid/tonsil procedures	_____	_____

18) Where were these **otolaryngology** procedures performed?

Select all that apply.

If only "hospital" is selected, skip question #19 and continue to question #20.

- ☐ Hospital
- ☐ Surgery center or free-standing hospital outpatient department

19) Please provide the name and city location of each surgery center or free-standing hospital outpatient department performing **otolaryngology** procedures:

	Name	City
Surgery Center/Free-Standing Hospital Outpatient Department 1		
Surgery Center/Free-Standing Hospital Outpatient Department 2		
Surgery Center/Free-Standing Hospital Outpatient Department 3		
Surgery Center/Free-Standing Hospital Outpatient Department 4		
Surgery Center/Free-Standing Hospital Outpatient Department 5		

Gastroenterology

20) Total adult volume for each of the following applicable procedures performed at your hospital outpatient department(s) during the reporting period.

You cannot leave any blank. If you did not perform one or more of the procedures listed below enter 0 (zero). If you had zero volume for all procedures, go back to question #5 and update your response from "yes" to "no."

	Adult Volume
Upper GI endoscopies	_____
Lower GI endoscopies	_____

21) Where were these **gastroenterology** procedures performed?

Select all that apply.

If only "hospital" is selected, skip question #22 and continue to question #23.

- ☐ Hospital
- ☐ Surgery center or free-standing hospital outpatient department

22) Please provide the name and city location of each surgery center or free-standing hospital outpatient department performing **gastroenterology** procedures:

	Name	City
Surgery Center/Free-Standing Hospital Outpatient Department 1		
Surgery Center/Free-Standing Hospital Outpatient Department 2		
Surgery Center/Free-Standing Hospital Outpatient Department 3		
Surgery Center/Free-Standing Hospital Outpatient Department 4		
Surgery Center/Free-Standing Hospital Outpatient Department 5		

General Surgery

23) Total adult volume for each of the following applicable procedures performed at your hospital outpatient department(s) during the reporting period.

*You cannot leave any blank. If you did not perform one or more of the procedures listed below enter 0 (zero). If you had zero volume for **all** procedures, go back to question #6 and update your response from "yes" to "no."*

	Adult Volume
Cholecystectomies and common duct explorations	_____
Hemorrhoid procedures	_____
Inguinal and femoral hernia repairs	_____
Other hernia repairs	_____
Laparoscopies	_____
Lumpectomies or quadrantectomy of breast procedures	_____
Mastectomies	_____

24) Where were these **general surgery** procedures performed?

Select all that apply.

If only "hospital" is selected, skip question #25 and continue to question #26.

- ☐ Hospital
☐ Surgery center or free-standing hospital outpatient department

25) Please provide the name and city location of each surgery center or free-standing hospital outpatient department performing **general surgery** procedures:

	Name	City
Surgery Center/Free-Standing Hospital Outpatient Department 1		
Surgery Center/Free-Standing Hospital Outpatient Department 2		
Surgery Center/Free-Standing Hospital Outpatient Department 3		
Surgery Center/Free-Standing Hospital Outpatient Department 4		
Surgery Center/Free-Standing Hospital Outpatient Department 5		

Urology

26) Total adult volume for each of the following applicable procedures performed at your hospital outpatient department(s) during the reporting period.

*You cannot leave any blank. If you did not perform one or more of the procedures listed below enter 0 (zero). If you had zero volume for **all** procedures, go back to question #7 and update your response from "yes" to "no."*

	<i>Adult Volume</i>
Circumcisions	_____
Cystourethroscopies	_____
Male genital procedures	_____
Urethra procedures	_____
Vaginal repair procedures	_____

27) Where were these **urology** procedures performed?

Select all that apply.

If only "hospital" is selected, skip question #28 and continue to question #29.

- ☐ Hospital
☐ Surgery center or free-standing hospital outpatient department

28) Please provide the name and city location of each surgery center or free-standing hospital outpatient department performing **urology** procedures:

	<i>Name</i>	<i>City</i>
Surgery Center/Free-Standing Hospital Outpatient Department 1		
Surgery Center/Free-Standing Hospital Outpatient Department 2		
Surgery Center/Free-Standing Hospital Outpatient Department 3		
Surgery Center/Free-Standing Hospital Outpatient Department 4		
Surgery Center/Free-Standing Hospital Outpatient Department 5		

Neurological Surgery

29) Total adult volume for the following procedure performed at your hospital outpatient department(s) during the reporting period.

You cannot leave any blank. If you did not perform the procedure listed below, go back to question #8 and update your response from “yes” to “no.”

	Adult Volume
Spinal fusion procedures	_____

30) Where were these **neurological surgery** procedures performed?

Select all that apply.

If only “hospital” is selected, skip question #31 and continue to question #32.

- ☐ Hospital
☐ Surgery center or free-standing hospital outpatient department

31) Please provide the name and city location of each surgery center or free-standing hospital outpatient department performing **neurological surgery** procedures:

	Name	City
Surgery Center/Free-Standing Hospital Outpatient Department 1		
Surgery Center/Free-Standing Hospital Outpatient Department 2		
Surgery Center/Free-Standing Hospital Outpatient Department 3		
Surgery Center/Free-Standing Hospital Outpatient Department 4		
Surgery Center/Free-Standing Hospital Outpatient Department 5		

Obstetrics and Gynecology

32) Total adult volume for each of the following applicable procedures performed at your hospital outpatient department(s) during the reporting period.

*You cannot leave any blank. If you did not perform one or more of the procedures listed below enter 0 (zero). If you had zero volume for **all** procedures, go back to question #9 and update your response from "yes" to "no."*

	<i>Adult Volume</i>
Cervix procedures	_____
Hysteroscopies	_____
Uterus and adnexa laparoscopies	_____

33) Where were these **obstetrics and gynecology** procedures performed?

Select all that apply.

If only "hospital" is selected, skip question #34 and continue to question #35.

- ☐ Hospital
☐ Surgery center or free-standing hospital outpatient department

34) Please provide the name and city location of each surgery center or free-standing hospital outpatient department performing **obstetrics and gynecology** procedures:

	<i>Name</i>	<i>City</i>
Surgery Center/Free-Standing Hospital Outpatient Department 1		
Surgery Center/Free-Standing Hospital Outpatient Department 2		
Surgery Center/Free-Standing Hospital Outpatient Department 3		
Surgery Center/Free-Standing Hospital Outpatient Department 4		
Surgery Center/Free-Standing Hospital Outpatient Department 5		

Plastic and Reconstructive Surgery

35) Total adult volume for each of the following applicable procedures performed at your hospital outpatient department(s) during the reporting period.

*You cannot leave any blank. If you did not perform one or more of the procedures listed below enter 0 (zero). If you had zero volume for **all** procedures, go back to question #10 and update your response from "yes" to "no."*

	Adult Volume
Breast repair or reconstructive procedures	_____
Skin graft/reconstruction procedures	_____

36) Where were these **plastic and reconstructive surgery** procedures performed?

Select all that apply.

If only "hospital" is selected, skip question #37 and continue to the next subsection.

- ☐ Hospital
☐ Surgery center or free-standing hospital outpatient department

37) Please provide the name and city location of each surgery center or free-standing hospital outpatient department performing **plastic and reconstructive surgery** procedures:

	Name	City
Surgery Center/Free-Standing Hospital Outpatient Department 1		
Surgery Center/Free-Standing Hospital Outpatient Department 2		
Surgery Center/Free-Standing Hospital Outpatient Department 3		
Surgery Center/Free-Standing Hospital Outpatient Department 4		
Surgery Center/Free-Standing Hospital Outpatient Department 5		

9D: Safety of Procedures

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review Leapfrog's Multi-Campus Reporting Policy.

Important Note: The term “hospital outpatient department” is used to refer to all hospital outpatient departments or areas of the hospital, including areas that are used for **both** inpatient and outpatient procedures, that perform the outpatient procedures listed in Section 9C and that share your hospital's license or CMS Certification Number (CCN). This would include, but is not limited to surgery centers, free-standing hospital outpatient departments, as well as outpatient departments that are located in your hospital or are co-located³¹ with your hospital. Hospitals should only include hospital outpatient departments or areas of the hospital that perform the procedures listed in Section 9C in an operating room⁵³ or procedure room⁵⁴.

Patient Follow-up

This section is not applicable to pediatric hospitals.

Specifications: See the Patient Follow-up Measure Specifications in the Reference Information beginning on page 327.

Reporting Period: 24 months

Most recent 24-month reporting period published by CMS.

Leapfrog will update data three times per Survey Cycle for hospitals that have provided an accurate CCN in the Hospital Profile and submitted Section 9 of the Leapfrog Hospital Survey.

Leapfrog obtains data for one CMS Hospital Quality Star Rating Program measure directly from CMS' website:

- OP-32: Rate of Unplanned Hospital Visits After an Outpatient Colonoscopy

In order for Leapfrog to obtain the data for this measure, hospitals must provide a valid CMS Certification Number (CCN) in the Hospital Profile and submit Section 9 of the Leapfrog Hospital Survey.

Hospitals that do not perform adult colonoscopy procedures will be scored and publicly reported as “Does Not Apply.” Hospitals that do not provide an accurate CCN in the Hospital Profile or do not report data to CMS will be scored and publicly reported as “Unable to Calculate Score.” Hospitals that do not respond to questions in Section 9 or do not submit a Leapfrog Hospital Survey will be scored and publicly reported as “Declined to Respond.”

Please refer to the Deadlines and Reporting Periods table in the Patient Follow-up Measure Specifications.

Safe Surgery Checklist for Adult and Pediatric Outpatient Procedures**Important Notes:**

Note 1: The elements required for each stage of the safe surgery checklist in questions #5-12 are adapted from the WHO Surgical Safety Checklist and the AHRQ Endoscopy Checklist.

Note 2: Question #7 will not be used in scoring or public reporting. Hospitals that do not perform outpatient procedures on adult or pediatric patients will be scored and publicly reported as “Does Not Apply.”

Note 3: Hyperlinks throughout these questions refer to the Safe Surgery Checklist for Adult and Pediatric Outpatient Procedures FAQs beginning on page 328, not to endnotes. These hyperlinks are not included in the Online Survey Tool.

Specifications: See the Safe Surgery Checklist for Adult and Pediatric Outpatient Procedures Measure Specifications in the Safety of Procedures Reference Information beginning on page 326.

Reporting Period: 12 months

Answer questions #1-9 for the latest 12-month period prior to submission of this section of the Survey.

Note: As a reminder, the Corrections Period (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

Sufficient Sample: See Safe Surgery Checklist for Adult and Pediatric Outpatient Procedures Measure Specifications for instructions on identifying a sufficient sample for questions #6-9.

1) What is the latest 12-month reporting period for which your hospital is submitting responses to questions #2-9? 12-month reporting period ending:	<u> </u> Format: Month/Year
2) Does your hospital utilize a safe surgery checklist on <u>every</u> patient, <u>every</u> time one of the applicable procedures in Section 9C is performed? <i>Hospitals with more than one hospital outpatient department, including a surgery center or free-standing hospital outpatient department, should respond based on the location with the fewest processes in place.</i> <i>If “no” to question #2, skip the remaining questions in Section 9D and continue to the next subsection. The hospital will be scored as “Limited Achievement.”</i>	☐ Yes ☐ No
3) Before the induction of anesthesia , is a safe surgery checklist that includes <u>all</u> the following elements <u>read aloud</u> in the presence of the <u>anesthesia professional and nursing personnel</u> : • Patient ID; • Confirmation of procedure; • Patient consent; • Site marked, if applicable; • Anesthesia/medication check; • Allergies assessed; • Difficult airway/aspiration risk; • Risk of blood loss (only applicable if risk of blood loss is >500ml for adults or >7ml/kg for children); and	☐ Yes ☐ No

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• Availability of devices (applicable to endoscopy procedures only)?	
4) Before the skin incision and/or before the procedure begins, is a safe surgery checklist that includes <u>all</u> the following elements <u>read aloud</u> in the presence of the <u>whole surgical team</u>: • <u>Clinical team introduction</u>; • Confirmation of patient name, procedure, and, if applicable, surgical/incision site; • Antibiotic prophylaxis, if applicable; • Anticipated Critical Events (i.e., non-routine steps, length of procedure, blood loss, patient-specific concerns, sterility); • Equipment check/concerns; and • Essential imaging available, if applicable?	○ Yes ○ No
5) Before the patient leaves the operating room and/or procedure room, is a safe surgery checklist that includes <u>all</u> the following elements <u>read aloud</u> in the presence of the <u>whole surgical team</u>: • Confirmation of procedure performed; • Instrument/supply counts, if applicable; • Specimen labeling, if applicable; • Equipment concerns; and • Patient recovery/management concerns?	○ Yes ○ No

If “no” to question #3, #4, or #5, skip the remaining questions in Section 9D and continue to the next subsection. The hospital will be scored as “Limited Achievement.”

Hospitals performing the audit in Section 3B question #6 and the audit in Section 9D question #6 should audit 15 cases who underwent a procedure included in Section 3A and 15 cases who underwent a procedure included in Section 9C. Hospitals only performing the audit in Section 9D question #6 and not in Section 3B question #6 should audit 30 cases who underwent a procedure included in Section 9C.

6) Did your hospital perform an audit (either in-person or via the medical record or other EHR data) on a sufficient sample of patients who underwent a procedure included in Section 9C and measure adherence to the safe surgery checklist? <i>Hospitals with more than one hospital outpatient department, including a surgery center or free-standing hospital outpatient department, should select at least one case from each location.</i> <i>If “no” to question #6, skip the remaining questions in Section 9D and continue to the next subsection. The hospital will be scored as “Limited Achievement.”</i>	○ Yes ○ No
7) How many cases were included in the audit from question #6?	_____ <i>Max value is 100</i>
8) Which method was used to perform the audit on a sufficient sample in question #6?	○ In-person observational audit ○ Retrospective audit of medical records or EHR data ○ Both

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- | | |
|---|--|
| <p>9) Based on your hospital's audit (either in-person or via the medical record or other EHR data) on a sufficient sample of patients who underwent a procedure included in Section 9C, what was your hospital's documented rate of adherence to the safe surgery checklist (i.e., what percentage of the sampled cases had all elements in questions #3, #4, and #5 completed)?</p> | <ul style="list-style-type: none">○ 90%-100%○ 75%-89%○ 50%-74%○ Less than 50% |
|---|--|

9E: Medication Safety for Outpatient Procedures

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review Leapfrog's Multi-Campus Reporting Policy.

Important Note: The term “hospital outpatient department” is used to refer to all hospital outpatient departments or areas of the hospital, including areas that are used for **both** inpatient and outpatient procedures, that perform the outpatient procedures listed in Section 9C and that share your hospital's license or CMS Certification Number (CCN). This would include, but is not limited to surgery centers, free-standing hospital outpatient departments, as well as outpatient departments that are located in your hospital or are co-located³¹ with your hospital. Hospitals should only include hospital outpatient departments or areas of the hospital that perform the procedures listed in Section 9C in an operating room⁵³ or procedure room⁵⁴.

Specifications: See **Medication Safety for Outpatient Procedures Measure Specifications** in the Reference Information beginning on page 330.

Reporting Period: 12 months

Answer questions #2-7 based on all cases (or a sufficient sample of them),

- Surveys submitted prior to September 1:
 - 01/01/2024 – 12/31/2024
- Surveys (re)submitted on or after September 1:
 - 07/01/2024 – 06/30/2025

Note: As a reminder, the Corrections Period (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

Sufficient Sample: See **Medication Safety for Outpatient Procedures Measure Specifications** for instructions on identifying a sufficient sample for questions #2-7.

1) 12-month reporting period used:	☐ 01/01/2024 – 12/31/2024 ☐ 07/01/2024 – 06/30/2025
2) Did your hospital perform an audit of clinical records for all patients undergoing those procedures included in Section 9C (or a <u>sufficient sample</u> of them) who were discharged from a hospital outpatient department for the reporting period selected and measure adherence to medication documentation guidelines regarding home medications, medications administered during the visit or prescribed at discharge, and medication allergies? <i>If “no” to question #2, skip questions #3-7 and continue to the next subsection. The hospital will be scored as “Did Not Measure.”</i> <i>If “yes, but there were fewer than 30 outpatients discharged for the reporting period,” skip questions #3-7 and continue to the next subsection. The hospital will be scored as “Unable to Calculate Score.”</i>	☐ Yes ☐ No ☐ Yes, but there were fewer than 30 outpatients discharged for the reporting period
3) Number of cases measured (either all cases or a <u>sufficient sample</u> of them):	_____
4) Number of cases in question #3 with a list of all home medication(s) , including dose, route, and frequency, documented in the clinical record:	_____

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5) Number of cases in question #3 with a list of <u>all medication(s) administered during the visit and new medications prescribed at discharge</u> , including the strength, dose, route, date, and time of administration, documented in the clinical record:	_____
6) Number of cases in question #3 with a list of <u>all medication allergies and adverse reaction(s)</u> documented in the clinical record:	_____
7) Do the responses in questions #3-6 represent a sample of cases?	☐ Yes ☐ No

9F: Patient Experience (OAS CAHPS)

This section is not applicable to pediatric hospitals.

Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Important Note: The term “hospital outpatient department” is used to refer to all hospital outpatient departments or areas of the hospital, including areas that are used for **both** inpatient and outpatient procedures, that perform the outpatient procedures listed in Section 9C and that share your hospital's license or CMS Certification Number (CCN). This would include, but is not limited to surgery centers, free-standing hospital outpatient departments, as well as outpatient departments that are located in your hospital or are co-located³¹ with your hospital. Hospitals should only include hospital outpatient departments or areas of the hospital that perform the procedures listed in Section 9C in an operating room⁵³ or procedure room⁵⁴.

Specifications: See [Patient Experience \(OAS CAHPS\) Measure Specifications](#) in the Reference Information beginning on page 337.

Reporting Period: 12 months

Answer questions #1-10 for the latest 12-month period prior to the submission of this section of the Survey.

Note: As a reminder, the Corrections Period (December 1-January 31) is reserved for corrections to previously submitted Surveys only. Any updates made to reflect a change in performance must be made prior to the November 30 Late Submission and Performance Update Deadline. Updates made to reflect a change in performance after November 30 will not be scored or publicly reported.

1) What is the latest 12-month reporting period for which your hospital is submitting responses to this section? 12-month reporting period ending:	_____ Format: Month/Year
2) Did your hospital have at least 300 <u>eligible discharges</u> ⁵⁶ during the 12-month period referenced above? <i>If “no” to question #2, skip the remaining questions in Section 9F and go to the Affirmation of Accuracy. The hospital will be scored as “Does Not Apply.”</i>	☐ Yes ☐ No
3) Has your hospital administered, or started to administer, the entire OAS CAHPS Survey during the reporting period? <i>Hospitals not currently administering the OAS CAHPS Survey should select “no,” skip the remaining questions in Section 9F, and go to the Affirmation of Accuracy. The hospital will be scored as “Did Not Measure.”</i>	☐ Yes ☐ No
4) Total number of months in which your hospital administered the OAS CAHPS Survey during the reporting period.	_____
5) Total number of returned surveys during the reporting period. <i>If less than 100, skip the remaining questions in Section 9F and go to the Affirmation of Accuracy. The hospital will be scored as “Unable to Calculate Score.”</i>	_____

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6) Do the responses to the questions in this subsection include discharges from more than one location (e.g., hospital and surgery center or free-standing hospital outpatient department, hospital and multiple free-standing hospital outpatient departments, etc.)?	☐ Yes ☐ No
--	---

In questions #7-10, report your hospital's Top Box Score⁵² (rounded to the nearest whole number) from each of the following patient experience **domains** from your vendor report that matches the reporting period that you selected in question #1.

7) Facilities and Staff	_____ Format: Whole numbers only
8) Communication About Your Procedure	_____ Format: Whole numbers only
9) Patients' Rating of the Facility	_____ Format: Whole numbers only
10) Patients Recommending the Facility	_____ Format: Whole numbers only

Affirmation of Accuracy

As the hospital CEO or as an employee of the hospital to whom the hospital CEO has delegated responsibility, I have reviewed this information pertaining to the Outpatient Procedures Section at our hospital, and I hereby certify that this information is true, accurate, and reflects the current, normal operating circumstances at our hospital. I am authorized to make this certification on behalf of our hospital.

The hospital and I understand that The Leapfrog Group, its members, the public and entities and persons who contract or have other business dealings with The Leapfrog Group are relying on the truth and accuracy of this information. The hospital and I also understand that The Leapfrog Group will make this information and/or analyses of this information public through the Survey Results public reporting website, The Leapfrog Group's Hospital Safety Grade, and/or other Leapfrog Group products and services. This information and/or analyses and all intellectual property rights therein shall be and remain the sole and exclusive property of The Leapfrog Group in which The Leapfrog Group retains exclusive ownership. This information does not infringe upon any third-party intellectual property rights or any other third-party rights whatsoever and is free and clear of all encumbrances and liens of any kind. The hospital and I acknowledge that The Leapfrog Group may use this information in a commercial manner for profit. The hospital shall be liable for and shall hold harmless and indemnify The Leapfrog Group from any and all damages, demands, costs, or causes of action resulting from any inaccuracies in the information or any misrepresentations in this Affirmation of Accuracy. The Leapfrog Group and its members and entities and persons who contract or have other business dealings with The Leapfrog Group reserve the right to omit or disclaim information that is not current, accurate or truthful.

Affirmed by _____, the hospital's _____,
(first name and last name) (title)
on _____.
(date)

Section 9: Outpatient Procedures Reference Information

What's New in the 2025 Survey

Section 9A: Basic Outpatient Department Information

There are no changes to this subsection.

Section 9B: Medical, Surgical, and Clinical Staff

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

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

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

Section 9C: Volume of Procedures

Leapfrog is adding back five anterior segment eye procedure CPT codes and four lumpectomy or quadrantectomy of breast CPT codes for adult patients that were previously removed in 2024, due to feedback that the procedures continue to be performed in both ambulatory surgery centers and hospital outpatient departments. In addition, Leapfrog is adding three new CPT codes for spinal fusion for adult patients, two new CPT codes for nasal/sinus procedures for both adult and pediatric patients, and one new CPT code for cystourethroscopy for adult patients.

Section 9D: Safety of Procedures

Patient Follow-up

There are no changes to these questions.

Safe Surgery Checklist for Adult and Pediatric Outpatient Procedures

There are no changes to these questions.

Section 9E: Medication Safety for Outpatient Procedures

There are no changes to these questions.

Section 9F: Patient Experience (OAS CAHPS)

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

Change Summary Since Release

None. If substantive changes are made to this section of the Survey after release on April 1, 2025, they will be documented in this Change Summary section.

Basic Outpatient Department Information Frequently Asked Questions (FAQs)

- 1. Our hospital shares a CMS Certification Number (CCN) with other hospitals, and we have many hospital outpatient department locations (e.g., surgery centers, endoscopy centers, free-standing hospital outpatient departments, etc.) all under the same CCN. How should we report on Section 9: Outpatient Procedures?**

As per Leapfrog's Multi-Campus Reporting Policy, all hospital campuses will need to complete their own Leapfrog Hospital Survey unless they are co-located.

For Section 9: Outpatient Procedures, each hospital campus will need to indicate in Section 9A if they are performing the outpatient procedures listed in Section 9C at their hospital and/or at a surgery center or free-standing hospital outpatient department that shares their hospital's CMS Certification Number (CCN). You should only include those hospital outpatient departments that your hospital refers patients to. The remainder of the questions in Section 9 will need to be answered based on:

- all hospital outpatient departments in your hospital, including any areas such as inpatient units, where outpatient procedures are performed (as reported in Section 9A question #2); and,
- all surgery centers and free-standing hospital outpatient departments that share your hospital's CCN (as reported in Section 9A question #3)

In Section 9C, you will be able to provide total volume across all hospital outpatient department locations (as reported in Section 9A questions #2 and #3) and information for the different outpatient locations where the specific outpatient procedures are performed. All other questions should be answered based on all outpatient locations. If you have different adherence across locations, you should answer based on the least adherent location.

If all hospital campuses are referring patients to the same surgery centers and free-standing hospital outpatient departments, you would include the information and volume for these locations when responding to Section 9 on all their Leapfrog Hospital Surveys.

- 2. How should our hospital report on the number of operating rooms and endoscopic procedure rooms in questions #4-5 if our operating/procedure rooms are used for both inpatient and outpatients? How should we report if we have multiple hospital outpatient departments?**

Hospitals should report on the total number of adult and pediatric operating rooms or procedure rooms if these rooms are used for both inpatient and outpatient procedures. Otherwise, hospitals should only report on the number of operating/procedure rooms that are used for outpatient procedures. If your hospital has multiple hospital outpatient departments, report the total number of adult and pediatric outpatient operating rooms or procedure rooms across all locations. You should only be reporting on operating rooms and procedure rooms that are used to perform the outpatient procedures listed in Section 9C Volume of Procedures.

Medical, Surgical, and Clinical Staff Frequently Asked Questions (FAQs)

1. How does Leapfrog define “immediately available” and “in the building” as it pertains to ACLS and/or PALS trained clinicians?

“Immediately available” is defined as being physically present in the building and not engaged in an activity or procedure that cannot be interrupted if hands-on intervention is needed for a patient.

Leapfrog defines “in the building” as within the hospital outpatient department or surgery center or in an area co-located with the hospital outpatient department or surgery center. Leapfrog defines co-located as a location within “immediate physical proximity,” meaning the two locations are physically connected, either by a tunnel, an enclosed bridge, or the locations abut each other so that hallways readily connect.

2. If a hospital did not perform any outpatient pediatric procedures during the reporting period selected in Section 9C, should they still report on PALS-trained clinicians in Section 9B question #2?

No. If your hospital did not report any pediatric discharges for the procedures listed in Section 9C during the reporting period, then you should select “Not applicable; adult patients only” in question #2.

3. Is the PEARS certification the equivalent of PALS certification for the purposes of responding to question #2?

No. PEARS is not the equivalent of or substitution for PALS certification. The PEARS curriculum is focused on recognition of and steps to mitigate pediatric respiratory emergencies, whereas the PALS curriculum informs clinicians how to manage these emergencies, with emphasis on leadership of the care team, and how to perform key air management techniques. Additionally, the PALS curriculum instructs providers on multiple ways to obtain IV access to improve circulatory issues.

4. How should hospitals report on ACLS/PALS certification if they have more than one hospital outpatient department performing the procedures listed in Section 9C Volume of Procedures?

Hospitals with more than one hospital outpatient department are instructed to respond to questions #1-2 based on the location with the least intensive staffing. For example, if one hospital outpatient department has an ACLS trained clinician, as well as a second clinician present at all times and immediately available in the building when adult patients are in the hospital outpatient department, but another hospital outpatient department does not, you should answer “no” to question #1.

5. If a free-standing pediatric hospital has clinicians trained in PALS but a small percentage of the patient population is over 13, should these clinicians also have ACLS training, or would the PALS training be sufficient?

If your hospital outpatient departments are performing procedures on adult and pediatric patients, there should be at least one clinician with ACLS training when adult patients (13 years and older) are recovering and one clinician with PALS training when pediatric patients (infant to 12 years) are recovering. This could mean that some clinicians maintain both certifications or some maintain ACLS, and others maintain PALS.

Volume of Procedures Measure Specifications**Important Notes:**

Note 1: Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Note 2: CPT Codes are provided in downloadable Excel files on the Survey Dashboard. To access the files, click the CPT Code Workbook button next to Section 9. You will be required to complete the American Medical Association's Terms of Use before downloading the Excel file and using the individual CPT codes to query your EHR or billing system. You are only required to complete the Terms of Use once per Survey Cycle (April 1 – November 30).

The CPT Code Workbooks (Excel files) are labeled for Section 3A: Total Hip Replacement, Total Knee Replacement, and Bariatric Surgery for Weight Loss and Section 9C: Volume of Procedures. Please note, if you are part of a hospital system, each hospital will need to complete the Terms of Use. This is a requirement of the American Medical Association.

Note 3: When counting patients for the purposes of identifying total volume in Section 9C, you should only include scheduled outpatient (i.e., admitted and discharged on the same day) procedures performed at your hospital outpatient departments within the reporting period. Include scheduled outpatient procedures with a planned observation or extended recovery stay. Exclude scheduled outpatient procedures with a planned inpatient admission. Exclude emergent/urgent cases, such as procedures for patients that come through the emergency department. To count patient discharges, use the Volume of Procedures Measure Specifications below and the CPT codes available in the Library on the Survey Dashboard.

Source: The Leapfrog Group, American Medical Association, The Health Care Cost Institute

Reporting Period: 12 months

- 01/01/2024 – 12/31/2024

Questions #2-10: Respond "yes" or "no" based on whether your hospital outpatient department(s) performed any of the procedures during the reporting period on adult and/or pediatric patients. The procedures fall within nine specialty areas:

Adult Procedures

1. Ophthalmology procedures: anterior segment eye procedures; posterior segment eye procedures; and ocular adnexa and other eye procedures
2. Orthopedic procedures: finger, hand, wrist, forearm, and elbow procedures; shoulder procedures; spine procedures; hip procedures; knee procedures; toe, foot, ankle, and leg procedures; and general orthopedic procedures
3. Otolaryngology procedures: ear procedures; mouth procedures; and nasal/sinus procedures
4. Gastroenterology procedures: upper GI endoscopy; and lower GI endoscopy
5. General surgery procedures: cholecystectomy and common duct exploration; hemorrhoid procedures; inguinal and femoral hernia repairs; other hernia repairs; laparoscopy; lumpectomy or quadrantectomy of breast; and mastectomy
6. Urology procedures: circumcisions; cystourethroscopy; male genital procedures; urethra procedures; and vaginal repair procedures
7. Neurological surgery procedures: spinal fusion procedures
8. Obstetrics and gynecology procedures: cervix procedures; hysteroscopy; and uterus and adnexa laparoscopies
9. Plastic and reconstructive surgery procedures: breast repair or reconstructive procedures; and skin graft/reconstruction procedures

Pediatric Procedures

1. Ophthalmology procedures: ocular adnexa and other eye procedures
2. Orthopedic procedures: finger, hand, wrist, forearm, and elbow procedures; shoulder procedures; knee procedures; toe, foot, ankle, and leg procedures; and general orthopedic procedures

3. Otolaryngology procedures: ear procedures; mouth procedures; nasal/sinus procedures; pharynx/adenoid/tonsil procedures

Respond “yes” if:

- One or more of your hospital outpatient departments performed the procedure on an outpatient basis for the entire reporting period (12 months) and continues to do so
- One or more of your hospital outpatient departments performed the procedure on an outpatient basis during part of the reporting period (less than 12 months) and continues to perform the procedure

Respond “yes, but no longer perform these procedures” if your hospital outpatient departments performed the procedure for all or some of the reporting period, but NO longer performs the procedure

Respond “no” if your hospital outpatient departments do not perform the procedure.

Questions #11-37: Based on your responses to questions #2-10, report on the total (a) adult and/or (b) pediatric volume for each procedure (from questions #2-10) during the reporting period:

Adult Procedures

1. Ophthalmology procedures: anterior segment eye procedures; posterior segment eye procedures; and ocular adnexa and other eye procedures
2. Orthopedic procedures: finger, hand, wrist, forearm, and elbow procedures; shoulder procedures; spine procedures; hip procedures; knee procedures; toe, foot, ankle, and leg procedures; and general orthopedic procedures
3. Otolaryngology procedures: ear procedures; mouth procedures; and nasal/sinus procedures
4. Gastroenterology procedures: upper GI endoscopy; and lower GI endoscopy
5. General surgery procedures: cholecystectomy and common duct exploration; hemorrhoid procedures; inguinal and femoral hernia repairs; other hernia repairs; laparoscopy; lumpectomy or quadrantectomy of breast; and mastectomy
6. Urology procedures: circumcisions; cystourethroscopy; male genital procedures; urethra procedures; and vaginal repair procedures
7. Neurological surgery procedures: spinal fusion procedures
8. Obstetrics and gynecology procedures: cervix procedures; hysteroscopy; and uterus and adnexa laparoscopies
9. Plastic and reconstructive surgery procedures: breast repair or reconstructive procedures; and skin graft/reconstruction procedures

Pediatric Procedures

1. Ophthalmology procedures: ocular adnexa and other eye procedures
2. Orthopedic procedures: finger, hand, wrist, forearm, and elbow procedures; shoulder procedures; knee procedures; toe, foot, ankle, and leg procedures; and general orthopedic procedures
3. Otolaryngology procedures: ear procedures; mouth procedures; nasal/sinus procedures; pharynx/adenoid/tonsil procedures

When calculating total **hospital outpatient department volume for (a) adult and/or (b) pediatric patients** count the number of **patients** discharged from your hospital outpatient department(s) within the reporting period with any one or more of the codes specified for each procedure, subject to the criteria below:

- Only include scheduled outpatient (i.e., admitted and discharged on the same day) procedures performed at your hospital outpatient departments within the reporting period. Include scheduled outpatient procedures with a planned observation or extended recovery stay.
- Exclude scheduled outpatient procedures with a planned inpatient admission. Exclude emergent/urgent cases, such as procedures for patients that come through the emergency department.
- Only the procedure codes provided by Leapfrog should be used to report on the questions in Section 9C.

- If a patient had more than one of the listed procedures performed on the same visit (i.e., repair of dislocating knee cap (CPT: 27422) and repair of superior labrum anterior/posterior (SLAP) lesion (CPT: 29807)), include the patient in the total volume for both procedures.

Ophthalmology Measure Specifications

For ophthalmology procedures, use the CPT codes available via the [Survey Dashboard](#) to count **patients** discharged from your hospital outpatient departments who have undergone any of the 3 procedures during the reporting period.

One procedure applies to **both adult and pediatric patients**:

- Ocular adnexa and other eye procedures

Two procedures apply to **adult patients only**:

- Anterior segment eye procedures
- Posterior segment eye procedures

Using the "Ophthalmology_adult" sheet, count the total number of adult (18 years of age or older) patients discharged for each procedure with any of the CPT codes listed. The CPT code can be in any procedure field.

Using the "Ophthalmology_ped" sheet, count the total number of pediatric (17 years of age and younger) patients discharged for each procedure with any of the CPT codes listed. The CPT code can be in any procedure field.

Orthopedic Measure Specifications

For orthopedic procedures, use the CPT codes available via the [Survey Dashboard](#) to count **patients** discharged from your hospital outpatient departments who have undergone any of the 7 procedures during the reporting period.

Five procedures apply to **both adult and pediatric patients**:

- Finger, hand, wrist, forearm, and elbow procedures
- Shoulder procedures
- Knee procedures
- Toe, foot, ankle, and leg procedures
- General orthopedic procedures

Two procedures apply to **adult patients only**:

- Spine procedures
- Hip procedures

Using the "Orthopedic_adult" sheet, count the total number of adult (18 years of age or older) patients discharged for each procedure with any of the CPT codes listed. The CPT code can be in any procedure field.

Using the "Orthopedic_ped" sheet, count the total number of pediatric (17 years of age and younger) patients discharged for each procedure with any of the CPT codes listed. The CPT code can be in any procedure field.

Otolaryngology Measure Specifications

For otolaryngology procedures, use the CPT codes available via the [Survey Dashboard](#) to count **patients** discharged from your hospital outpatient departments who have undergone any of the 4 procedures during the reporting period.

Three procedures apply to **both adult and pediatric patients**:

- Ear procedures

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- Mouth procedures
- Nasal/sinus procedures

One procedure applies to **pediatric patients only**:

- Pharynx/adenoid/tonsil procedures

Using the “Otolaryngology_adult” sheet, count the total number of adult (18 years of age or older) patients discharged for each procedure with any of the CPT codes listed. The CPT code can be in any procedure field.

Using the “Otolaryngology_ped” sheet, count the total number of pediatric (17 years of age and younger) patients discharged for each procedure with any of the CPT codes listed. The CPT code can be in any procedure field.

Gastroenterology Measure Specifications

For gastroenterology procedures, use the CPT codes available via the [Survey Dashboard](#) to count **patients** discharged from your hospital outpatient departments who have undergone either of the 2 procedures during the reporting period.

Both procedures apply to **adult patients only**:

- Upper GI endoscopy
- Lower GI endoscopy

Using the “Gastroenterology_adult” sheet, count the total number of adult (18 years of age or older) patients discharged for each procedure with any of the CPT codes listed. The CPT code can be in any procedure field.

General Surgery Measure Specifications

For general surgery procedures, use the CPT codes available via the [Survey Dashboard](#) to count **patients** discharged from your hospital outpatient departments who have undergone any of the 7 procedures during the reporting period.

All seven procedures apply to **adult patients only**:

- Cholecystectomy and common duct exploration
- Hemorrhoid procedure
- Laparoscopy
- Lumpectomy or quadrantectomy of breast
- Mastectomy
- Inguinal and femoral hernia repair
- Other hernia repair

Using the “General surgery_adult” sheet, count the total number of adult (18 years of age or older) patients discharged for each procedure with any of the CPT codes listed. The CPT code can be in any procedure field.

Urology Measure Specifications

For urology procedures, use the CPT codes available via the [Survey Dashboard](#) to count **patients** discharged from your hospital outpatient departments who have undergone any of the 5 procedures during the reporting period.

All five procedures apply to **adult patients only**:

- Circumcision
- Cystourethroscopy

- Male genital procedures
- Urethra procedures
- Vaginal repair procedures

Using the "Urology_adult" sheet, count the total number of adult (18 years of age or older) patients discharged for each procedure with any of the CPT codes listed. The CPT code can be in any procedure field.

Neurological Surgery Measure Specifications

For neurological surgery procedures, use the CPT codes available via the [Survey Dashboard](#) to count **patients** discharged from your hospital outpatient departments who have undergone the procedure during the reporting period.

One procedure applies to **adult patients only**:

- Spinal fusion procedures

Using the "Neurological surgery_adult" sheet, count the total number of adult (18 years of age or older) patients discharged with any of the CPT codes listed. The CPT code can be in any procedure field.

Obstetrics and Gynecology Measure Specifications

For obstetrics and gynecology procedures, use the CPT codes available via the [Survey Dashboard](#) to count **patients** discharged from your hospital outpatient departments who have undergone any of the 3 procedures during the reporting period.

Three procedures apply to **adult patients only**:

- Cervix procedures
- Hysteroscopy
- Uterus and adnexa laparoscopies

Using the "Obstetrics and gynecology_adult" sheet, count the total number of adult (18 years of age or older) patients discharged for each procedure with any of the CPT codes listed. The CPT code can be in any procedure field.

Plastic and Reconstructive Surgery Measure Specifications

For plastic and reconstructive surgery procedures, use the CPT codes available via the [Survey Dashboard](#) to count **patients** discharged from your hospital outpatient departments who have undergone either of the 2 procedures during the reporting period.

Two procedures apply to **adult patients only**:

- Breast repair or reconstruction
- Skin graft/reconstruction procedures

Using the "Plastic_reconstruct surg_adult" sheet, count the total number of adult (18 years of age or older) patients discharged for each procedure with any of the CPT codes listed. The CPT code can be in any procedure field.

See [FAQs](#) for additional information about responding to questions in this section.

Volume of Procedures Frequently Asked Questions (FAQs)

1. How did Leapfrog select these 9 specialties and the procedures in this section of the Survey?

Leapfrog worked with the Health Care Cost Institute (HCCI) to identify the most commonly billed surgical procedures in ambulatory surgery centers and hospital outpatient departments for commercially insured adult and pediatric patients. Leapfrog's technical experts then assessed the list of procedures based on their frequency and type of anesthesia used during the procedure. Those selected for the Survey represent the highest volume procedures nationally requiring moderate to general anesthesia (including nerve blocks).

Please reach out to the [Leapfrog Help Desk](#) if you believe additional CPT Codes should be added to the Survey; Leapfrog will take these suggestions to our technical experts.

2. Should we count patients discharged with a G code for colonoscopy?

No. A "G" (HCPCS II) code is used to differentiate between colonoscopies performed for screening purposes rather than for a diagnostic or therapeutic procedure. The Survey only includes major diagnostic and therapeutic procedures.

Safety of Procedures Measure Specifications***Patient Follow-up***

Leapfrog obtains data for one CMS Hospital Outpatient measures directly from CMS' [website](#):

- OP-32: Rate of Unplanned Hospital Visits After an Outpatient Colonoscopy

In order for Leapfrog to obtain the data for this measure, hospitals must provide a valid CMS Certification Number (CCN) in the Hospital Profile and submit Section 9 of the Leapfrog Hospital Survey.

Deadlines and Reporting Periods

Data downloaded from CMS will be scored and publicly reported for Hospitals that have submitted Section 9 by	CMS Reporting Period	Available on Hospital Details Page and Public Reporting Website on
June 30, 2025	Most recent 24-month reporting period	July 12, 2025 Details Page July 25, 2025 Public Reporting Website
August 31, 2025	Most recent 24-month reporting period	September 10, 2025
November 30, 2025	Most recent 24-month reporting period	December 9, 2025

Review your CMS data for OP-32

- Once Leapfrog has published your hospital's Survey Results on the [Hospital Details Page](#), hospitals are urged to compare the CMS data Leapfrog has obtained with the data published on CMS' [website](#).
- Dates on which the Survey Results will be available on the Hospital Details page are listed in the "Deadlines and Reporting Periods" table above.

If you find a discrepancy while comparing your hospital's data published on the CMS [website](#) to the data published on the Hospital Details page, contact [Leapfrog's Help Desk](#) immediately.

Safe Surgery Checklist for Adult and Pediatric Outpatient Procedures

Important Note: Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Source: The Leapfrog Group, WHO Surgical Safety Checklist and Implementation Manual, AHRQ Endoscopy Checklist
Reporting Period: 12 months Latest 12-month period prior to submission of this section of the Survey
Safe Surgery Checklist Workbook (Excel) To complete the data collection and respond to questions #6-9, hospitals should download the Safe Surgery Checklist Workbook (Excel). This workbook includes five tabs: Instructions, Section 3B (Complex Surgery), Section 3B – Data Entry, Section 9D (Outpatient Procedures), and Section 9D – Data Entry. The Section 9D tabs can be used to complete the safe surgery checklist audits for this subsection and to calculate the response for question #9. The workbook is available on the Survey Materials Webpage.
Sampling: For hospitals with one hospital outpatient department that performs the procedures listed in Section 9C and Section 3A and submit both Section 9 and 3: Hospitals can randomly sample 15 patients (who had one of the procedures included in Section 9C) and measure and report adherence to the safe surgery checklist based on that sample. When sampling from a larger population of cases, hospitals that perform procedures across multiple surgical specialties (e.g., general surgery, orthopedics, urology, etc.) included in Section 9C and facilities that perform procedures for both adult and pediatric patients should obtain a representative sample (i.e., include patients who underwent procedures in different surgical specialties and include both adult and pediatric patients, if applicable). For hospitals with multiple hospital outpatient departments that perform the procedures listed in Section 9C and Section 3A and submit both Section 9 and 3: Hospitals can randomly sample 15 patients (who had one of the procedures included in Section 9C) and measure and report adherence to the safe surgery checklist based on that sample. However, hospital must sample across the various locations where the procedures are being performed, including freestanding hospital outpatient departments or surgery centers, in addition to ensuring that the sample includes patients who underwent procedures in different surgical specialties and both adult and pediatric patients, if applicable. For hospitals with one or multiple hospital outpatient departments that ONLY perform the procedures in Section 9C or that ONLY submit Section 9: Hospitals must randomly sample 30 patients who had one of the procedures included in Section 9C and report adherence to the safe surgery checklist on that sample. Hospitals that perform the procedures listed in Section 9C and 3A should follow the guidance above.
Question #6: Did your hospital perform an audit (either in-person or via the medical record or other EHR data) on a sufficient sample of patients who underwent a procedure included in Section 9C and measure adherence to the safe surgery checklist? To respond “yes” to question #6, hospitals must measure and document whether all the elements in questions #3, #4, and #5 were verbalized in the presence of the appropriate personnel for each sampled case. Hospitals that completed the audit should respond “yes” to this question regardless of whether the adherence to the checklist was 100%. Hospitals will report on adherence to the checklist in question #9.

Question #7: How many cases were included in the audit from question #6?

Hospitals that perform procedures in both Section 3A and Section 9C, and submit both Section 3 and 9, can randomly sample 15 patients (who had one of the procedures included in Section 9C) and measure and report adherence to the safe surgery checklist based on that sample.

Hospitals that **ONLY** perform the procedures in Section 3AC, or that **ONLY** submit Section 9, must randomly sample 30 patients (who had one of the procedures included in Section 9C) and measure and report adherence to the safe surgery checklist based on that sample.

Question #8: What method was used to perform the audit on a sufficient sample in question #6?

Hospitals can only perform a retrospective audit by reviewing medical records or EHR data if adherence to the safe surgery checklist is clearly documented in the medical record or EHR and the documentation clearly demonstrates that each element was verbalized in the presence of the appropriate personnel. If hospitals cannot clearly determine whether (a) the checklist element was verbalized and (b) that the appropriate personnel were present via a retrospective audit, an in-person observational audit must be completed.

Hospitals performing in-person observational audits must do so in the latest 12 months prior to Survey submission.

Hospitals performing retrospective audits must audit cases from the latest 12 months prior to Survey submission but can also review any case from Section 9C that was performed in the latest calendar year prior to Survey submission.

Question #9: Based on your hospital's audit (either in-person or via the medical record or other EHR data) on a sufficient sample of patients who underwent a procedure included in Section 9C, what was your hospital's documented rate of adherence to the safe surgery checklist (e.g., what percentage of the sampled cases had all elements in questions #3, #4, and #5 completed)?

Based on the audit completed for question #6, determine the total number of patient audits where **all** elements of the safe surgery checklist (included in questions #3, #4, and #5) were read aloud in the presence of the appropriate personnel 1) before the induction of anesthesia, 2) before the skin incision and/or the procedure began, and 3) before the patient left the operating and/or procedure room.

Included cases:

- The patient audit shows that **all** elements of the safe surgery checklist, at **all** three time points, were read aloud in the presence of the appropriate personnel.

Excluded cases:

- The patient audit does **not** demonstrate that all elements of the safe surgery checklist were read aloud in the presence of the appropriate personnel (i.e., one or more elements of the checklist were not read aloud, or the appropriate personnel were not present during the checklist).
- The patient audit does **not** demonstrate that the safe surgery checklist was read aloud in the presence of the appropriate personnel at all three time points (i.e., before anesthesia, before skin incision, and before the patient leaves).

Important Note: If a Safe Surgery Checklist element includes the qualifier "if applicable," hospitals should determine if that element of the checklist was applicable to the patient and procedure being performed. If the element was determined to be "not applicable" to the patient and procedure, it does not count against the total adherence. For example, if your hospital performed a hernia repair, the availability of a device on-site would not be applicable. Therefore, when completing the Safe Surgery Checklist Workbook for this patient, indicate N/A for that element (device on-site) and your hospital would be able to count that case as adherent.

Safety of Procedures Frequently Asked Questions (FAQs)***General Questions***

- 1. How should hospitals report on the processes in Section 9D Safety of Procedures if they have more than one hospital outpatient department performing the procedures listed in Section 9C Volume of Procedures?**

Hospitals with more than one hospital outpatient department are instructed to respond to Section 9D based on the location with the fewest processes in place. For example, if one hospital outpatient department uses a safe surgery checklist on all patients, but another hospital outpatient department does not, you should answer “no” to question #6.

Patient Follow-up FAQs

- 2. Do hospitals need to do anything for Leapfrog to obtain data for the CMS measures?**

Leapfrog will automatically use your hospital's data that are reported to CMS for OP-32 if you provide an accurate CCN in the Hospital Profile and submit Section 9 of the 2025 Leapfrog Hospital Survey. For OP-32, if your hospital does not perform adult lower GI endoscopy procedures, you will be scored as “Does Not Apply.” More information is available in the Leapfrog Hospital Survey Scoring Algorithms.

Safe Surgery Checklist for Adult and Pediatric Outpatient Procedures FAQs

- 3. What 12-month reporting period should be used when reporting on this section?**

When responding to the questions in Section 9D, hospitals should enter the month in which they complete their observational in-person or retrospective EHR review audits. If your hospital does not perform an audit, enter the month in which you are completing the Survey.

- 4. Does the safe surgery checklist referenced in Section 9D questions #1-9 apply to all procedures, including colonoscopies, endoscopies, etc.?**

Yes, it applies to all procedures in Section 9C questions #2-10. If your hospital outpatient department(s) do not utilize a safe surgery checklist for colonoscopy and/or endoscopy, respond “No” to question #2.

- 5. Can different elements of the “Before the induction of anesthesia” checklist (question #3) be performed in different places?**

Yes, hospitals may perform some elements of the pre-anesthesia checklist outside of the operating room. Hospitals may read aloud the following elements in a pre-procedure (preop) area: Patient ID, Confirmation of procedure, Patient consent, Site marked, if applicable, and Allergies assessed.

Hospitals should not remove conversation prompts as it is harmful to the purpose of the checklist and should continue debriefing and requiring participation of the surgical team members in key moments.

- 6. Do we need to perform a “clinical team introduction” if the team already knows each other and/or will be in the operating room together all day?**

Yes. Even if a clinical team knows each other they must perform an introduction stating their name and role at the first procedure of the day. They do not need to reintroduce themselves for the remaining procedures but should confirm everyone was introduced beforehand. However, if any team members change between operations, introductions must be performed again.

- 7. Do the Safe Surgery Checklist components included in questions #3, #4, and #5 need to be in one document that would align with the WHO example or can they be in different documents (i.e., pre-anesthesia notes, surgeon H&P, and pre-surgical checklists, etc.)?**

It is possible to have separate checklists for each phase of the surgical procedure (i.e., before the induction of anesthesia, before the skin incision and/or before the procedure begins, and before the patient leaves the operating or procedure room). However, each individual component included in questions #3, #4, and #5 should be listed on the checklist(s) and hospitals should document whether the components were read aloud at the appropriate time with the appropriate members of the surgical team present.

- 8. How is “whole surgical team” defined?**

“Whole surgical team” is comprised of the surgeons, anesthesia professionals, nurses, technicians, and other operating room personnel involved in surgery. This is based off the World Alliance for Patient Safety Implementation Manual Surgical Safety Checklist (First Edition).

Medication Safety for Outpatient Procedures Measure Specifications

Important Note: Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#).

Source: The Leapfrog Group

Reporting Period: 12 months

- Surveys submitted prior to September 1:
 - 01/01/2024 – 12/31/2024
- Surveys (re)submitted on or after September 1:
 - 07/01/2024 – 06/30/2025

Medication Safety Documentation Workbook (Excel)

To complete the data collection for this subsection and respond to questions #3-7, hospitals should download the Medication Safety Documentation Workbook (Excel). This workbook includes seven tabs: Instructions, 2024 Sampling, 2025 Sampling, Home Meds, Visit Meds, Allergies, and Data Entry and can be used to identify patients to sample in order to complete the three clinical record audits, as well as calculate the responses to enter into the Online Hospital Survey Tool for each of the audits.

This workbook is available on the [Survey Materials webpage](#) and should be used when completing this subsection.

Sampling:***For hospitals with one hospital outpatient department that performs the procedures listed in Section 9C:***

If you have more than 30 cases that meet the criteria for inclusion in the denominator of the process measures during the time period of the clinical record audit, you may randomly sample 30 of them for the denominator of each documentation guideline, and measure and report adherence based on that sample. When sampling from a larger population of cases, this is the minimum number of cases needed to make a statistically reliable statement of percent adherence to the process guidelines.

For hospitals with multiple hospital outpatient departments that perform the procedures listed in Section 9C:

If you have more than 30 cases total (across all hospital outpatient departments) that meet the criteria for inclusion in the denominator of the process measure during the time period of the clinical record audit, you may randomly sample a minimum of 10 cases from the hospital (including any co-located hospital outpatient departments or inpatient areas performing outpatient procedures) and each free-standing hospital outpatient department or surgery center. Hospitals will need to report on a total minimum sample size of at least 30, and measure and report adherence based on that sample. When sampling from a larger population of cases, this is the minimum number of cases needed to make a statistically reliable statement of percent adherence to the process guidelines.

For example, if you are reporting on your hospital (including multiple areas where outpatient procedures are performed), as well as another hospital outpatient department that is free-standing, you could sample 15 cases from each for a total sample size of 30. If you are reporting on seven locations, you could sample 10 cases from each for a total sample size of 70.

Note: Hospitals that share a CMS Certification Number (CCN) with other hospitals may use the same sample for reporting on a shared hospital outpatient department location (e.g., surgery center, endoscopy center, free-standing hospital outpatient department, etc.). For example, Hospital A and Hospital B share a CCN and both refer patients to the same gastroenterology center. Hospital A samples 15 cases from their hospital and 15 cases from the gastroenterology center. Hospital B can use the sample of 15 cases from the gastroenterology center in addition to sampling from their hospital when reporting on their own Leapfrog Hospital Survey.

Medications: For the purposes of this measure, a **medication** is a substance that is taken into, or placed onto, the body of a person for one or more of the following reasons:

- as a placebo
- to prevent a disease (e.g., flu vaccine)
- to make a diagnosis (e.g., contrast dye)
- to test for the possibility of an adverse effect
- to modify a physiological, biochemical or anatomical function or abnormality (e.g., heparin/heparin flushes, statins, antihypertensives, etc.)
- to replace a missing factor (e.g., blood product)
- to ameliorate a symptom (e.g., aspirin)
- to treat a disease or condition (including topicals, nasal sprays, eye drops, compounds, inhalants, injectables, patches, etc.)
- to induce anesthesia
- to stabilize or hydrate during medical treatment or procedures (e.g., IV fluids, normal saline, lactated ringers, etc.)
- to provide nutrition (e.g., enteral nutrition products, parenteral nutrition products, breast milk [breast milk applies to BCMA measure only])
- as a supplement (e.g., iron for a patient with iron deficiency anemia or calcium/vitamin D for a patient with osteoporosis)

For the purposes of this measure, the following are **not** considered medications:

- Pre-filled saline flushes and pre-filled heparin flushes (i.e., saline and heparin flushes that come from the manufacturer already filled and are not filled by the hospital's pharmacy)
- Chlorhexidine and alcohol preparation pads
- Intra-op irrigation solutions

Question #3 (denominator): Number of cases measured (either all cases or a sufficient sample of them).

Your hospital should perform a clinical record audit of either all adult and/or pediatric patients undergoing those procedures included in Section 9C discharged during the reporting period or a sufficient sample of those patients discharged during the reporting period as described above.

This audit of clinical records can be done retrospectively (anytime during the Survey Cycle of April 1 – November 30).

The total number of clinical records included in your audit is reported in question #3.

Excluded cases: Patients discharged from the hospital outpatient departments without having one of the procedures included in Section 9C performed during the reporting period.

Question #4 (numerator): Number of cases in question #3 with a list of **all home medication(s)**, including dose, route, and frequency, documented in the clinical record.

Determine the total number of clinical records included in the audit (in question #3), where a list of all home medication(s), including dose, route, and frequency, was documented in the clinical record either on the day of the procedure or after a pre-screening phone call (i.e., 1-2 days in advance of the procedure). Records that include documentation that the patient had no home medications should be included.

"Home medications" are defined as medications that the patient was taking prior to admission.

The following home medications may be excluded from the clinical record unless they are clinically relevant* (e.g., herbal supplement that is known to interact with anesthesia):

- as needed (PRN) medications
- topical lotions/creams
- saline nasal spray and artificial tear eye drops
- herbals and supplements and vitamins

- medications prescribed for the purpose of operative prep prior to colonoscopy

Home medications that must be included in the clinical record include clinically relevant* PRN medications such as inhalers, nitroglycerin, analgesics (opioid and non-opioid), muscle relaxants, and sedatives.

**Clinically relevant is defined as any PRN medication that treats a medical condition on the patient's problem list and/or condition they are being treated for during the visit (i.e., reason for the hospital stay).*

Included cases:

- The clinical record includes documentation that the patient has no home medications.

Excluded cases:

- The clinical record is missing a list of all home medication(s).
- The clinical record is missing dose, route, or frequency for a home medication

Question #5 (numerator): Number of cases in question #3 with a list of **all medication(s) administered during the visit and new medications prescribed at discharge**, including the strength, dose, route, date, and time of administration, documented in the clinical record.

Determine the total number of clinical records included in the audit (question #3), where a list of all medication(s) administered during the visit and new medications prescribed at discharge, including the strength, dose, route, date, and time of administration, was documented in the clinical record on the day of the procedure.

Local, regional, and general anesthesia medications must only have **total dose, date, and time of administration** documented in the clinical record to be considered complete.

IV solutions must have **strength, dose, route, date, and time of administration** documented in the clinical record to be considered complete. However, if the IV solution only comes in one concentration/strength (such as the LR Injection), the strength can be entered as N/A and the start time and volume of the bag can be documented for dose in order to be considered complete.

New medications prescribed at discharge, but not administered at the hospital must only have **strength, dose, route, and date the medication was prescribed** documented in the clinical record to be considered complete.

Excluded cases:

- The clinical record is missing a medication that was administered or prescribed during the visit or at discharge.
- The clinical record is missing strength, dose, route, date, or time of administration for a medication administered or prescribed during the visit or at discharge except as described above for anesthesia medications, IV solutions, and prescribed medications.
- The clinical record is missing dose for lidocaine jelly.

Question #6 (numerator): Number of cases in question #3 with a list of **all medication allergies and adverse reaction(s)** documented in the clinical record.

Determine the total number of clinical records included in the audit (question #3), where a list of all medication allergies and adverse reaction(s) was documented in the clinical record. Hospitals should only assess medication allergies (i.e., hospitals do not need to assess food or environmental allergies).

Included cases:

- The clinical record includes documentation that the patient reported no known allergies.

Excluded cases:

- The clinical record does **not** include either a list of allergies and adverse reaction(s) nor documentation of no known allergies.

- The clinical record does include a list of allergies but does not include documentation of the adverse reaction(s) for each allergy.

Important Note: In addressing allergies and adverse reaction statuses noted as “unknown” in the clinical record, hospitals should assess if:

- “unknown” is used to indicate that the patient (or patient’s family) was asked for the adverse reaction status, but they indicated it was not known, in which situation the case should be included in the numerator (question #6); or
- “unknown” is used in the clinical record to indicate that the information is not available because it was not requested or documented by the clinician, in which situation the case should be excluded from the numerator (question #6)

See [FAQs](#) for additional information about responding to questions in this section.

Medication Safety for Outpatient Procedures Frequently Asked Questions (FAQs)

1. How often do home medications need to be updated in the clinical record for Section 9E question #4?

Home medications must be recorded in a pre-screening phone call 1-2 days in advance of the procedure or updated on the day of the clinical procedure (for all procedures included in Section 9C of the 2024 Leapfrog Hospital Survey).

Patients who are returning for a second or follow-up procedure within 12 months of the initial procedure are not required to have an updated home medication list in their clinical record in order for the record to be counted in the numerator of the home medication audit (i.e., included in the count in question #4). However, in cases of frequent repeated clinical visits, the home medications list should be updated at least once every 12 months.

2. For medications that only ever have a single route of administration (e.g., orally only), does route have to be documented in the clinical record for questions #4 and #5?

No. If there is a medication that can only ever be given via a single route, route does not have to be documented to count the case when responding to questions #4 and #5.

3. We do medication reconciliation on patients for certain outpatient procedures. Will the medication reconciliation on the procedure day suffice for the "medication audits" requirement in question #4? Or does it have to be a retrospective audit after the procedure day?

Leapfrog specifies that, unless all medical records are audited, the clinical record audit should be conducted on a random sample of discharged patients. If your hospital does not perform medication reconciliation before all patients are discharged to ensure that the correct dose, route, and frequency are documented in the clinical record for all home medications this would not meet the requirements of Section 9E.

Instead, your hospital should randomly sample from all clinical records of discharged outpatients (adults and children) who had the procedures included in Section 9C during the reporting period, not just those records that had medication reconciliation conducted during the same day visit. This audit may occur on the same day as the patient visit or following patient discharge.

Patient Experience (OAS CAHPS) Measure Specifications

Important Note: Hospitals that share a CMS Certification Number are required to report by facility. Please carefully review [Leapfrog's Multi-Campus Reporting Policy](#)

Source: Developed by Centers for Medicare and Medicaid Services (CMS) using Agency for Healthcare Quality and Research (AHRQ) guidelines. More information available at <https://oascahps.org/General-Information/About-OAS-CAHPS-Survey>.

Reporting Period: The latest 12-month period prior to the submission of this section of the Survey. Hospitals can elect to use either survey return date or discharge date to pull reports for this measure.

This section of the Survey asks hospitals about their results from the OAS CAHPS Survey. The first several questions are designed to learn more about the current administration of the survey. The last four questions collect the Top Box Score⁵² for each of the following four domains:

- Facilities and Staff
- Communication About Your Procedure
- Patient's Rating of the Facility
- Patients Recommending the Facility

Hospitals using Press Ganey, NRC, or PRC to administer the OAS CAHPS Survey can use the CMS OAS CAHPS crosswalk below to ensure they are reporting on the correct domains. The crosswalk is designed to help translate the standard vendor report to the CMS domains used in questions #7-10.

CMS OAS CAHPS Crosswalk

CMS Domain Name	Press Ganey Domain Name	NRC Domain Name	PRC Domain Name
Facilities and Staff	Facility/Personal Treatment	About Facilities and Staff	Facility and Staff
Communication About Your Procedure	Communication	Communications About Your Procedure	Communication
Patient's Rating of the Facility	Facility Rating 0-10	Overall Rating of Facility	Overall Facility Rating
Patients Recommending the Facility	Recommend the Facility	Would Recommend Facility	Would Recommend

Question #2: Did your hospital have at least 300 eligible discharges⁵⁶ during the 12-month reporting period?

This section of the Survey is designed for hospitals that discharged at least 300 eligible patients during the reporting period. Hospitals that discharged fewer than 300 eligible patients should respond "no," skip the rest of the questions, and move on to the Affirmation of Accuracy.

Eligible discharges include discharges for adult patients (ages 18 years and older) who had both medically and non-medically necessary outpatient surgeries and/or procedures. A detailed description of patient sampling criteria, including a list of OAS CAHPS-eligible surgeries and procedures, is available in the Protocols and Guidelines Manual, version 9.0 at <https://oascahps.org/Survey-Materials>.

Question #3: Has your hospital administered, or started to administer, the entire OAS CAHPS Survey, during the reporting period?

The OAS CAHPS survey includes questions about patients' experiences with their preparation for the surgery or procedure, check-in processes, cleanliness of the facility, communications with the facility staff, discharge from the facility, and preparation for recovering at home. The survey also includes questions about whether patients received information about what to do if they had possible side effects during their recovery. OAS CAHPS is designed to be national in scope and requires standardized administration protocols.

If your hospital shares a CMS Certification Number (CCN) with another hospital that administers the OAS CAHPS survey, only include results from hospital outpatient departments used to report on Section 9: Outpatient Procedures.

Question #4: Total number of months in which your hospital administered the OAS CAHPS Survey during the reporting period.

It is recommended that hospitals (or their survey vendor) sample over a 12-month period and ensure an even distribution of patients is sampled over the 12-month period. However, Leapfrog will accept OAS CAHPS results from hospitals that have administered the survey over a period of time less than 12 months if they have at least 100 returned surveys.

Question #5: Total number of returned surveys during the reporting period.

It is recommended that hospitals (or their survey vendor) administer the survey to a large enough sample in order to achieve 300 returned surveys in a 12-month reporting period. However, Leapfrog will accept OAS CAHPS results from hospitals that have at least 100 returned surveys. All returned surveys from eligible patient discharges, regardless of completeness and date of return, should be included.

Question #6: Do the responses to the questions in this subsection include discharges from more than one location (e.g., hospital and surgery center or free-standing hospital outpatient department, hospital and multiple free-standing hospital outpatient departments, etc.)?

Indicate "yes" if your OAS CAHPS results include eligible patient discharges from multiple locations (e.g., hospital and surgery center or free-standing hospital outpatient department, hospital and multiple free-standing hospital outpatient departments, etc.). Otherwise indicate "no."

Questions #7-10: In questions #7-10, report your hospital's Top Box Score⁵² (rounded to the nearest whole number) from each of the following patient experience domains from your 12-month vendor report that matches the reporting period selected in question #1. Hospitals should not use domain scores that are publicly reported on the CMS Hospital Compare [website](#) as these scores have been risk adjusted. Hospitals should report results from all hospital outpatient departments.

These four questions capture the Top Box Score for each of the four domains of patient experience: facilities and staff, communication about your procedure, patients' rating of the facility, and patients recommending the facility.

The following questions from the OAS CAHPS Survey are included in each domain:

Facilities and Staff

Q3: Did the check-in process run smoothly?

Q4: Was the facility clean?

Q5: Were the clerks and receptionists at the facility as helpful as you thought they should be?

Q6: Did the clerks and receptionists at the facility treat you with courtesy and respect?

Q7: Did the doctors and nurses treat you with courtesy and respect?

Q8: Did the doctors and nurses make sure you were as comfortable as possible?

Communication About Your Procedure

Q1: Before your procedure, did your doctor or anyone from the facility give you all the information you needed about your procedure?

Q2: Before your procedure, did your doctor or anyone from the facility give you easy to understand instructions about getting ready for your procedure?

Q9: Did the doctors and nurses explain your procedure in a way that was easy to understand?

Q10: Anesthesia is something that would make you feel sleepy or go to sleep during your procedure. Were you given anesthesia?

Q11: (If 'Yes' to Q10) Did your doctor or anyone from the facility explain the process of giving anesthesia in a way that was easy to understand?

Q12: (If 'Yes' to Q10) Did your doctor or anyone from the facility explain the possible side effects of the anesthesia in a way that was easy to understand?

Patients' Rating of the Facility

Q23: Using any number from 0 to 10, where 0 is the worst facility possible and 10 is the best facility possible, what number would you use to rate this facility?

Patients Recommending the Facility

Q24: Would you recommend this facility to your friends and family?

Please note that question numbers are taken from the OAS CAHPS Survey, which you can download at <https://oascahps.org/Survey-Materials>.

See [FAQs](#) for additional information about responding to questions in this section.

Patient Experience (OAS CAHPS) Frequently Asked Questions (FAQs)

- 1) We share a CMS Certification Number (CCN) with another hospital that participates in the OAS CAHPS Survey. How can we report on results from the OAS CAHPS Survey that are specific to our outpatient department?**

While OAS CAHPS results are reported to CMS using a single CMS Certification Number, hospitals with more than one location (i.e., components, strata) must specify to their vendor where eligible surgeries occurred, so the vendor can properly sample patients. Vendors have the ability to provide OAS CAHPS results for a particular set of locations upon request. Hospitals should report results to Leapfrog from only those components included in their Section 9 responses.

- 2) Isn't 300 returned surveys the minimum sample size recommended by CMS?**

Yes, however, Leapfrog has received feedback that many hospitals and ambulatory surgery centers have only recently started to administer the survey. In order to ensure as many hospitals and ambulatory surgery centers as possible are able to report on this subsection, we have reduced the minimum sample size for reporting results to the Leapfrog Hospital and ASC Surveys to 100 returned surveys. This will help ensure that hospitals and ASCs that have made the investment to administer the Survey are able to earn credit for doing so. Additionally, this minimum sample size aligns with Section 8A of the Leapfrog Hospital Survey, which asks about the CAHPS Child Hospital Survey, and with the CMS requirement for the CAHPS Child Hospital Survey.

If possible, however, it is recommended that hospitals (or their survey vendor) administer the survey to a large enough sample in order to achieve 300 returned surveys in a 12-month reporting period.

- 3) We administer our own patient experience survey to collect specific information about our patient's experience. Can we report the results from our hospital's patient experience survey?**

No, hospitals can only report the results of the official OAS CAHPS Survey on Section 9F of the Leapfrog Hospital Survey.

However, according to the OAS CAHPS Protocols and Guidelines Manual, survey vendors and ASCs/HOPDs may choose to add up to 15 supplemental questions after the 'core' OAS CAHPS Survey questions that are personalized to the hospital/vendor. More information on these supplemental questions, including restrictions and required approval, may be reviewed on pages 20-22 of the CMS OAS CAHPS Survey Protocols and Guidelines Manual, which is available for download here: <https://oascahps.org/Survey-Materials>. Please note, the responses to these supplemental questions will not be reported on the Leapfrog Hospital Survey.

Endnotes

¹ **Acute-Care Units**

Include units used for short-term, acute-care medical, surgical, medical/surgical (including telemetry), as well as obstetrical, intensive, and step-down/progressive care.

Exclude units used for short and long-term psychiatric care, rehabilitation, observation, or sub-acute care (e.g., skilled nursing facility, hospice extended care, sub-acute eating disorder treatment, extended care facility, or residential substance abuse treatment), and swing bed units.

² **CMS Certification Number (CCN)**

A CMS Certification Number (CCN) is issued by the Centers for Medicare and Medicaid Services (CMS) to financial reporting entities, which may be individual hospitals or a group of hospitals, for the purpose of reimbursement. While Leapfrog does ask each campus of a multi-hospital system to submit an individual Survey, hospitals within the system may be assigned the same CMS Certification Number and therefore should have the same CCN reported in this field. CCNs are six digits; with the first two digits representing the state in which the hospital is located. Hospitals that do not receive Medicare reimbursement may not have a CMS Certification Number and should not have a CCN reported in this field. Leapfrog pre-populates this field in the Online Hospital Survey Tool. If the hospital's CCN is different from the one shown online, please contact the [Help Desk](#).

³ **National Health Safety Network (NHSN) ID**

A NHSN ID is issued by the Centers for Disease Control and Prevention and is used as a unique identifier for facilities participating in NHSN surveillance activities. Each hospital within a system, even if they share a CCN, must report separately to NHSN and should have their own NHSN ID if they are located separately. Please see the NHSN instructions available at <http://www.leapfroggroup.org/survey-materials/join-nhsn>. NHSN IDs are five digits. Leapfrog pre-populates this field in the Online Hospital Survey Tool for hospitals that provided a valid NHSN ID, joined our NHSN Group, and submitted the 2024 Leapfrog Hospital Survey. If the hospital NHSN ID is different from the one shown online, please update accordingly.

In order to be scored and publicly reported for any of the five applicable infection measures and to have the hospital's teaching status represented, hospitals must: (1) provide an accurate NHSN ID in the Profile, (2) join Leapfrog's NHSN Group by the appropriate [deadline](#), and (3) submit the 2025 Leapfrog Hospital Survey by the appropriate [deadline](#).

⁴ **Vermont Oxford Network (VON) Transfer Code**

A Vermont Oxford Network (VON) Transfer Code is issued by the Vermont Oxford Network and is used as a unique identifier for hospitals reporting data through the VON Nightingale Internet Reporting System. Each hospital has their own VON Transfer Code, which can be found at <https://public.vtoxford.org/transfer-codes/>. VON Transfer Codes are four, five, or seven digits. Leapfrog pre-populates this field in the Online Hospital Survey Tool Profile for hospitals that provided a valid VON Transfer Code in 2024. If the hospital's VON Transfer Code is different from the one shown online, please update accordingly.

⁵ **Federal Tax Identification Number (TIN)**

Enter the TIN that your hospital uses for billing purposes. *The number is a nine-digit number (e.g., 098765432) and must conform precisely to this format – be sure to enter any leading 0.* If your hospital has more than one TIN, use the one that would most typically be used for UB-04 claims filed with commercial health insurance plans for inpatient hospital stays.

⁶ National Provider Identifier (NPI)

The NPI is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number of covered health care providers. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or medical specialty. Leapfrog pre-populates this field in the Online Hospital Survey Tool. If the hospital's NPI is different from the one shown online, please contact the [Help Desk](#).

⁷ State

Your hospital is assigned to a state based on the CMS Certification Number assigned (or identifier specially issued by the Leapfrog Help Desk) to your hospital. If your hospital is incorrectly assigned to a state, contact the [Help Desk](#) to resolve the discrepancy.

⁸ Tips for Entering Web Addresses

This address becomes the link attached to your hospital's name in the public release of Survey Results. Enter it exactly as you wish it to be and test it.

- Do not exit out of the Online Hospital Survey Tool to go to the Web page of interest while you are entering data into the Survey or some of your Survey entries may be lost.
- Instead, minimize (but don't close) the Survey window and any other windows that are open, then open your internet browser in a separate window. Find the Web page whose address you wish to enter and Copy/Paste the entire address into the Survey entry. **The http:// prefix needs to be included.**
- If entering the Web page address manually, be careful to type it correctly, without embedded spaces. Forward (/) or backward (\) slashes may be used. Don't forget the "www." if that is part of the address. **The http:// prefix needs to be included.**
- Make sure to use .org, rather than .com, if that's the domain for your hospital's website.
- Although many hospitals elect to enter the address for the home page of their hospital website, consider pointing it to a page specific to patient safety, the Leapfrog safety practices, or other quality improvement activities that you want to communicate to your community.

⁹ Healthcare System or Integrated Delivery Network

Healthcare Systems or Integrated Delivery Networks (IDN) are central organizations that own, lease, or sponsor two or more hospitals with the goal of providing coordinated patient care. Pediatric, specialty, and rehabilitation hospitals are included as hospitals in this definition. IDNs may belong to a larger parent system. Leapfrog pre-populates this field in the Online Hospital Survey Tool and only uses the field internally (e.g., it will not be shared publicly). If the IDN displayed in the Online Survey Tool is incorrect, please contact the [Help Desk](#).

¹⁰ Licensed Acute-Care Beds

If your state does not license bed types or if acute-care beds are currently staffed higher than the number of licensed beds, enter the number of staffed beds from question #3. If the number of licensed beds has changed in the last year, indicate the average or other number most representative of your operating bed capacity over the last year.

Include short-term, acute-care medical, surgical, medical/surgical (including telemetry), obstetrical, and intensive care beds, as well as step-down/progressive care beds as licensed by your state.

Exclude beds licensed or used for short and long-term psychiatric care, rehabilitation, observation, or sub-acute care (e.g., skilled nursing facility, hospice extended care, sub-acute eating disorder treatment, extended care facility, or residential substance abuse treatment) and swing beds.

¹¹ Staffed Acute-Care Beds

Include licensed beds regularly in operation, whether currently occupied by a patient or not. If the number has changed over the last year, indicate the average or other number most representative of your operating bed capacity over the last year.

¹² Total Adult Acute-Care Admissions

Include adult (aged 18 years and older) acute-care medical, surgical, and medical/surgical (including telemetry), obstetrical, and intensive care admissions. Include transfers from other hospitals. Include admissions directly to an ICU, even if counted in question #9. Include admissions to step-down/progressive units.

Exclude short and long-term psychiatric care, rehabilitation, observation, or sub-acute care (e.g., skilled nursing facility, hospice extended care, sub-acute eating disorder treatment, extended care facility, or residential substance abuse treatment) admissions and admissions to swing units.

¹³ Total Pediatric Acute-Care Admissions

Include pediatric (ages 17 years and younger) acute-care medical, surgical, medical/surgical (including telemetry), and intensive care admissions. Include transfers from other hospitals. Include admissions directly to an ICU or neonatal ICU (NICU), even if counted in question #10 or #13. Include admissions to step-down/progressive units.

Exclude newborn admissions to the nursery and pediatric patients admitted for maternity care, short and long-term psychiatric care, rehabilitation, observation, or sub-acute care (e.g., skilled nursing facility, hospice extended care, sub-acute eating disorder treatment, extended care facility, or residential substance abuse treatment) and admissions to swing units. Exclude admissions for patients that were transferred to another facility.

¹⁴ General Medical, Surgical, Medical/Surgical, and Neuro ICUs

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

For the purposes of reporting on adult and pediatric ICU admissions in Section 1A: Basic Hospital Information questions #9 and #10, include admissions to general medical, surgical, medical/surgical, and neuro ICUs (medical and surgical), whether directly admitted to the unit or transferred to the unit from another area of your hospital (e.g., post-operatively). Include transfers from other hospitals as admissions to your hospital. Include the number of admissions that include an ICU stay, not the number of patient trips to the ICU.

¹⁵ Licensed ICU Beds

If your state separately designates ICU beds, indicate the number of licensed beds in adult and pediatric general medical, surgical, medical/surgical, and neuro ICUs (medical and surgical). If your state does not license ICU beds or if the number of staffed ICU beds is currently higher than the number of licensed ICU beds, enter the number of staffed ICU beds from question #8. See endnote #14 for more information.

Exclude beds “dedicated exclusively” to patients with specialized conditions (e.g., cardiac, burn, trauma, neonatal). “Dedicated exclusively” means that general medical, surgical, medical/surgical, or neuro intensive care patients are not also cared for in these specialized units (except in rare overflow situations). Exclude beds used for step-down/progressive care.

¹⁶ Staffed ICU Beds

Indicate the number of ICU beds from question #7 that are regularly in operation, whether currently occupied by a patient or not. If the number has changed over the last year, indicate the average or other number most representative of your operating ICU capacity over the last year. See endnote #14 for more information.

¹⁷ Neonatal ICUs

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

http://www.cdc.gov/nhsn/PDFs/pscManual/15LocationsDescriptions_current.pdf.

For the purposes of reporting on NICU admissions in Section 1A: Basic Hospital Information question #13, include admissions to any level NICU, even if counted in question #5. Include transfers from other hospitals as admissions to your hospital. Exclude admissions for patients that were transferred to another facility.

¹⁸ CPOE Linked to Pharmacy, Laboratory, ADT Information

The ability of a CPOE system to catch the majority of common, serious prescribing errors depends on proper identification of patients (ADT information), current and recent pharmacy orders and drug dispensing history, and access and integration of key laboratory results for the patient. CPOE systems that are not linked to those other systems or do not reflect that current information accurately about the patient are not likely to catch serious prescribing errors.

¹⁹ Medical, Surgical, and Medical/Surgical Units

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

For the purposes of reporting on Sections 2C: BCMA and 6C: Hand Hygiene, include both single and mixed acuity medical, surgical, medical/surgical, and telemetry units, as well as step-down/progressive beds in a dedicated medical, surgical, or medical/surgical unit.

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

²⁰ Step-down/Progressive Units

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

²¹ Labor and Delivery Units

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

22 Pre-Operative or Post-Anesthesia Care Units

For reporting on Section 2C: BCMA include all pre-operative and post-anesthesia care units (PACUs) located in or co-located with your hospital. For reporting on Section 6C: Hand Hygiene, include all pre-operative and post-anesthesia care units (PACUs) located in or co-located with your hospital, as well as those located in free-standing hospital outpatient departments that perform the outpatient procedures listed in Section 9: Outpatient Procedures and that share your hospital's license or CMS Certification Number. This includes combined pre-operative and post-anesthesia care units as well. If the hospital distinguishes between post-anesthesia phases within its PACU(s) (i.e., Phase I, Phase II, and Phase III recovery), all phases must be included when reporting.

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

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

23 Certified Pharmacy Technician

A certified pharmacy technician would include a pharmacy technician that has earned either the ASHP Medication History-Taking Certificate or the Pharmacy Technicians Certification Board's (PTCB) Medication History Certificate.

24 Sampling for Medication Reconciliation

The sample must contain at least 30 patients from a 6-month reporting period. Sampling is limited to medical, medical/surgical units and step-down/progressive units (adult only). Patients that were discharged or expired before the Gold Standard Medication History could be obtained must be excluded from the sample. Patients that do not have discharge orders written during the reporting period must also be excluded from the sample. A sampling worksheet is available in the Medication Reconciliation Workbook for those who would like assistance in obtaining a random sample of patients.

25 Gold Standard Medication History

The Gold Standard Medication History is the list of medications that the patient was taking prior to admission. Within 24 hours after admission, a trained pharmacist, pharmacy resident, or certified pharmacy technician must interview each patient selected for the 6-month sample and obtain the Gold Standard Medication History. Note that this is in addition to, and separate from, any pre-admission medication list that was created as part of normal care. Best practices for collecting the Gold Standard Medication History can be found in the "Other Supporting Materials" for Section 2 on our website.

26 Discrepancies in Gold Standard Medications

For each Gold Standard Medication, there may be up to two unintentional discrepancies: a discrepancy in admission orders and a discrepancy in discharge orders. For example, if a medication on the Gold Standard Medication History is ordered for a patient on admission with the incorrect dose, this counts as one discrepancy. If this medication is ordered on discharge for the same incorrect dose, this counts as a second discrepancy. The number of unintentional discrepancies is a count of medication orders where an unintentional discrepancy occurred. You should not count the number of errors associated with the same medication order (e.g., a discrepancy in the dose and frequency in the same medication in admission orders counts as one discrepancy).

27 Unintentionally Ordered Additional Medications

Count medications where a patient was not taking (and was not supposed to be taking) a certain medication, but the medical team incorrectly thought the patient was taking the medication and therefore ordered it on admission and/or discharge. Count each medication once, regardless of whether it was ordered on admission, discharge, or both.

28 Discrepancies Due to Unintentionally Ordered Additional Medications

For each unintentionally ordered additional medication, there may be up to two discrepancies: unintentionally ordered at admission, unintentionally ordered at discharge, or both. For example, if a medication is unintentionally ordered at admission, then this counts as one discrepancy. If the same medication is also ordered at discharge, then this counts as a second discrepancy.

29 Data Completeness Requirement for the STS Mitral Valve Repair/Replacement (MVRR) Composite Score

Participants are excluded from the analysis if they have fewer than 36 isolated MVRR procedures in the patient population. Please find more information in the NQF-endorsed measure specifications, available at <https://www.sts.org/quality-safety/performance-measures/descriptions#MVRRComposite>.

30 High-Risk Deliveries Electively Admitted

Includes deliveries with:

- expected birth weight <1500 grams; or
- gestational age at least 22 weeks but <32 weeks.

Not all women at risk for delivery of babies with these conditions are known beforehand to be at risk. Therefore, deliveries in which these high-risk conditions were unknown prior to admission are not considered electively admitted high-risk deliveries.

If your hospital admits deliveries where these conditions are known prior to admission, then your hospital electively admits high-risk deliveries and you must answer "yes" to question #1; otherwise, answer "no."

31 Co-located

A location within "immediate physical proximity" of the hospital would be considered a co-located location or unit, e.g., a co-located neonatal ICU (NICU) or co-located hospital outpatient location. "Immediate physical proximity" means the two locations must be physically connected, either by a tunnel, an enclosed bridge, or the locations abut each other so that the hallways readily connect.

32 Very low birth weight babies

Complicated newborns are those infants with a birth weight <1500 grams. If your hospital has a neonatal ICU (or is co-located with a hospital that has a neonatal ICU) that admits or accepts transfers of neonates with these conditions, you must answer "yes" to question #2.

33 VON's Death or Morbidity Measure

This measure is collected and calculated by the Vermont Oxford Network and includes patients who have died or are known to have one or more of the following: severe intraventricular hemorrhage (SIVH); chronic lung disease (CLD); necrotizing enterocolitis (NEC); pneumothorax; any late infection (bacterial, fungal, or coagulase negative staph); or cystic periventricular leukomalacia (PVL).

34 All Critical Care Patients

"All critical care patients" means all general medical, surgical, medical/surgical, and neuro ICU patients including critical care patients in mixed acuity units.

³⁵ Managed or Co-Managed

The intensivist, when present (whether on-site or via telemedicine), is authorized to diagnose, treat, and write orders for a patient in the ICU on the intensivist's own authority. Examples of co-management include, but are not limited to, communication on patient status between the intensivist and hospitalist on a daily basis, intensivists co-develop care plans for all ICU patients, etc. Mandatory consults or daily rounds by an intensivist are not sufficient to meet the managed/co-managed requirement. However, an ICU need not be closed to meet this requirement.

³⁶ Certified in Critical Care Medicine

A physician who is "certified in Critical Care Medicine" is a board-certified physician who is additionally certified in the subspecialty of Critical Care Medicine. Certification in Critical Care Medicine is awarded by the American Boards of Internal Medicine, Surgery, Anesthesiology, Pediatrics, and Emergency Medicine, as well as the American Osteopathic Board (AOS).

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

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

Expanded Definition of Certified in Critical Care Medicine

On an interim basis, three other categories of physicians are considered by Leapfrog to be equivalent to a physician "certified in Critical Care Medicine" for the purpose of meeting the standard:

- Physicians who completed training prior to availability of subspecialty certification in critical care in their specialty (1987 for Internal Medicine, Surgery, Anesthesiology, Pediatrics and 2013 for Emergency Medicine), who are board-certified in their specialty, and who have provided at least six weeks of full-time ICU care annually. (The weeks need not be consecutive weeks.)
- Physicians who have finished their fellowship in Critical Care Medicine, but have not yet passed an existing board-certifying exam, are considered to be equivalent to a physician "Certified in Critical Care Medicine" for up to three years after completion of the fellowship. This provides the physician an adequate window to take her/his boards and re-take if necessary.
- Physicians who are board-certified in their primary specialty and have completed a critical care fellowship at an ACGME-accredited program, but are ineligible to sit for a board-certifying exam in Critical Care in either their primary specialty or subspecialty because their training occurred under two separate certifying boards, are considered to be equivalent to a physician "Certified in

Critical Care Medicine” if they are board-certified in their primary specialty and have provided at least six weeks of full-time ICU care annually. (The weeks need not be consecutive weeks.)

Physicians who have let their board certification lapse are not considered to be “Certified in Critical Care Medicine.”

³⁷ **Ordinarily and Exclusively Present in the ICU**

“Ordinarily present in the ICU” refers to direct on-site presence in the ICU of an intensivist during the 4-hour or 8-hour period. While it need not be the same intensivist for the entire 4-hour or 8-hour period, it is expected that the ICU(s) are primarily staffed by dedicated ICU intensivists who are ordinarily and exclusively present in the ICU(s). “Presence” does *not* mean staffed part-time by multiple physicians who are not ordinarily and exclusively dedicated to the ICU, *nor* does it mean the cumulative time that one or more intensivists spend in the unit visiting, rounding, consulting, or responding to pages.

The standard allows for normally expected intensivist activities outside of the ICU related to their responsibilities in the ICU (e.g., evaluating patients proposed for ICU admission), as long as intensivists are ordinarily present in the ICU and return immediately when paged. An intensivist present in one ICU immediately adjacent to another can be considered present in both units as long as they can respond to demands in both units as if they would if both units were one larger unit. For the purposes of this Survey, “adjacent” units are those units that can be reached within 5 minutes. While tele-intensivists can be used to meet the presence requirement, some on-site intensivist presence is still necessary to meet the Leapfrog specifications.

“Exclusively” means that when the physician is in the ICU, they have no concurrent clinical responsibilities to non-ICU patients.

³⁸ **Intensivist Presence via Telemedicine**

To meet the Leapfrog ICU requirement for intensivist presence in the ICU via telemedicine, a hospital must be able to document that it fulfills all the following 10 key features based on a modification of the approach reported in Critical Care Medicine (Rosenfeld, B. et al. “Intensive care unit telemedicine: Alternate paradigm for providing continuous intensivist care,” *Critical Care Medicine*, Vol. 28, No. 1, pp. 3925-3931).

1. A physician certified in critical care medicine (see endnote #36) who is physically present in the ICU (“on-site intensivist”) performs a comprehensive review of each ICU patient each day and establishes and/or revises the care plan. The on-site intensivist must be available by phone to answer any questions from the tele-intensivist related to the established or revised care plan.

The tele-intensivist, who must also be a physician certified in critical care medicine (see endnote #36), has immediate access to information regarding the on-site intensivist’s care plan at the time the management responsibility is transferred to the tele-intensivist by the on-site intensivist.

When care is transferred back to the on-site intensivist, the tele-intensivist must communicate any changes to the care plan to the on-site intensivist. Hospitals relying on electronic hand-offs must ensure that physician sign-in and sign-out of reports is being recorded. In addition, these reports should be monitored as one way to audit compliance with the hand-off process described above.

2. When an intensivist is not on-site in the ICU managing or co-managing all ICU patients, a tele-intensivist is continuously monitoring and able to manage all ICU patients for the remaining 24 hours per day, 7 days per week. “Continuously monitoring” means the tele-intensivist has no other concurrent responsibilities, is immediately available to communicate with ICU staff, and is continuously in the physical presence of the tele-ICU’s patient monitoring and communications equipment. “Manage” means authorized to diagnose, treat, and write orders for a patient in the ICU

on the intensivist's own authority.

3. The tele-intensivist's care is proactive, with routine visualization and physiological review of all patients at a frequency appropriate to their severity of illness.
4. The tele-intensivist has immediate access to key patient data, including:
 - a) physiologic bedside monitor data (in real-time);
 - b) laboratory orders and results;
 - c) medications ordered and administered; and,
 - d) notes, radiographs, ECGs, etc. on demand.
5. Bedside cameras are physically available in each ICU. If cameras are not mounted in each patient room within the unit, then at least one dedicated bedside camera must be available for every five beds in the ICU, plus a dedicated back-up camera in each ICU. If ICUs are located on different floors of the hospital, each ICU on each floor must have its own set of dedicated cameras if they are not mounted in every room. "Dedicated" means that the cameras are on the unit for the sole purpose of patient care. Personal devices (e.g., personal phones, tablets, etc.) would not meet this requirement.
6. The tele-intensivist must be able to turn on each bedside camera to visualize patients, with sufficient clarity to assess breathing pattern and communicate with on-site personnel at the bedside in real time.
7. Within five minutes of a request for assistance being initiated by hospital staff, the tele-intensivist's patient workload ordinarily permits the tele-intensivist to complete a comprehensive visual and physiological assessment of any patient.
8. Data links between the ICU and the tele-intensivist are reliable (>98% up-time) and secure (HIPAA compliant).
9. Written standards for remote care are established and include, at a minimum:
 - a) tele-intensivists are certified by a national medical specialty board in critical care medicine;
 - b) tele-intensivists are licensed to practice in the legal jurisdiction in which the ICU is located;
 - c) tele-intensivists are credentialed in each hospital to which he/she provides remote care (can be special telemedicine credentialing);
 - d) activities of the tele-intensivist are reviewed within the hospital's quality assurance committee structure;
 - e) there are explicit written policies regarding roles and responsibilities of both the on-site intensivist and the tele-intensivist;
 - f) ICU staff are educated regarding the function, roles, and responsibilities of the tele-intensivist; and
 - g) there is an established written process to ensure effective communication between the ICU staff and the tele-intensivist.
10. The tele-intensivist documents patient care activities and this documentation is incorporated into the patient record.

³⁹ **Quantified Analysis of Response Times**

Hospitals can monitor the response times of intensivists, "effectors," and clinical pharmacists in multiple ways, as long as the data collection process is non-biased and scientific.

As an example, hospitals can have the ICU staff maintain an exception log in the ICU(s) on six randomly sampled days per year. On those days, ICU nurses could record:

- For question #7, the number of calls/pages/texts made to the intensivist when they were not present in the unit (whether on-site or via telemedicine) and the number of times the intensivist's response time exceeded 5 minutes
- For question #8, the number of calls/pages/texts made to a physician, physician assistant, nurse practitioner, or FCCS-certified nurse or intern "effector" and the number of times these individuals did not reach the patient at the bedside within 5 minutes
- For question #13, the number of calls/pages/texts made to the clinical pharmacist on days when they were not rounding on-site in the unit and the number of times the clinical pharmacist's response time exceeded 5 minutes

Hospitals can then estimate whether they meet the 95% timely response standards by dividing the total number of log exceptions by the total number of calls/pages/texts per day.

Hospitals may exclude low-urgency calls/pages/texts, if the notification device system can designate low-urgency calls/pages/texts, or if the hospital has an alternative scientific method for documenting high-urgency calls/pages/texts that are not returned within 5 minutes.

The six randomly selected days can be conducted over the course of a year prior to submission of Section 5 of the Survey. If resubmitting responses to Section 5, six new randomly selected days must be sampled in the three-month reporting period prior to resubmission.

Hospitals that use telemedicine to cover 'call' for the on-site intensivist should review endnote #41. Hospitals that have an effector that is dedicated 24/7 to the ICU (as defined as being within a 5 min walk to the ICU) should review endnote #42.

⁴⁰ **FCCS-Certified Nurse or Intern "Effector"**

FCCS certificates are awarded to nurses and doctors upon their successful completion of a brief course developed by the Society for Critical Care Medicine to improve/confirm critical care knowledge and skills. For more information visit <https://www.sccm.org/Education-Center/Educational-Programming/Fundamentals/Fundamental-Critical-Care-Support>.

At present, this is the only such course recommended by The Leapfrog Group's expert advisory panel. Intensivists and any other physicians who are certified in critical care medicine (or eligible based on residency training or fellowship) need not also be FCCS certified.

Physicians, physician assistants, and nurse practitioners also are not required to be FCCS certified, but they must meet the criteria specified in endnote #42 to serve as the responder/"effector."

⁴¹ **Use of Tele-intensivists to Cover Calls**

Hospitals that use telemedicine to cover 'call' for the on-site intensivist are able to answer "yes" to question #7 if: (1) the telemedicine service meets all ten of the requirements outlined in endnote #38; and (2) the hospital has an 'effector' (physician/PA/NP/FCCS certified nurse or intern) on-site during that time period to carry out the tele-intensivist's orders and can reach the ICU patient within 5 minutes, 95% of the time.

⁴² **Physician/PA/NP serving as the Responder/"Effector"**

Physicians/PAs/NPs (includes Clinical nurse Specialists, Nurse Anesthetists, or NPs) serving as the responder in the ICU must meet the following criteria:

1. Be a graduate with a training license from an ACGME accredited training program or have an active state license to practice as a physician, nurse practitioner, or physician assistant in the state in which the patient is located.
2. Have privileges to provide medical services in the unit (i.e., ICU) and for patients of the age range approved in advance by the hospital's governing body (e.g., medical staff committee, chief

medical officer, chief nursing officer, etc.), as specified by the institutions internal policies (bylaws).

3. Carry out the intensivist's orders and instructions, under the intensivist's guidance, when they are serving in a responder role.

If the effector is dedicated 24/7 to the ICU (as defined as being within a 5 min walk to the ICU), then hospitals can indicate "yes" to meeting the response time requirement (5 min response; 95% of the time) in question #8, in lieu of conducting a response time audit.

⁴³ Modified Intensivist Presence via Telemedicine

To earn reduced credit on the Leapfrog ICU standard for intensivist presence in the ICU via telemonitoring, a hospital must affirm that its telemonitoring intensivist presence fulfills the following nine key features based on a modification of the approach reported in Critical Care Medicine (Rosenfeld, B. et al. "Intensive care unit telemedicine: Alternate paradigm for providing continuous intensivist care," *Critical Care Medicine*, Vol. 28, No. 1, pp. 3925-3931). Note that, as with other Leapfrog specifications, these features must be met under ordinary circumstances.

1. When an intensivist is not on-site in the ICU managing or co-managing all ICU patients, a tele-intensivist is continuously monitoring and able to manage all ICU patients for the remaining 24 hours per day, 7 days per week. "Continuously monitoring" means the tele-intensivist has no other concurrent responsibilities, is immediately available to communicate with ICU staff, and is continuously in the physical presence of the tele-ICU's patient monitoring and communications equipment. "Manage" means authorized to diagnose, treat, and write orders for a patient in the ICU on the intensivist's own authority.
2. The tele-intensivist's care is proactive, with routine visualization and physiological review of all patients at a frequency appropriate to their severity of illness.
3. The tele-intensivist has immediate access to key patient data, including:
 - a) physiologic bedside monitor data (in real-time);
 - b) laboratory orders and results;
 - c) medications ordered and administered; and,
 - d) notes, radiographs, ECGs, etc. on demand.
4. Bedside cameras are physically available in each ICU. If cameras are not mounted in each patient room within the unit, then at least one dedicated bedside camera must be available for every five beds in the ICU, plus a dedicated back-up camera in each ICU. If ICUs are located on different floors of the hospital, each ICU on each floor must have its own set of dedicated cameras if they are not mounted in every room. "Dedicated" means that the cameras are on the unit for the sole purpose of patient care. Personal devices (e.g., personal phones, tablets, etc.) would not meet this requirement.
5. The tele-intensivist must be able to turn on each bedside camera to visualize patients, with sufficient clarity to assess breathing pattern and communicate with on-site personnel at the bedside in real time.
6. Within five minutes of a request for assistance being initiated by hospital staff, the tele-intensivist's patient workload ordinarily permits the tele-intensivist to complete a comprehensive visual and physiological assessment of any patient.
7. Data links between the ICU and the tele-intensivist are reliable (>98% up-time) and secure (HIPAA compliant).
8. Written standards for remote care are established and include, at a minimum:

- a) tele-intensivists are certified by a national medical specialty board in critical care medicine;
 - b) tele-intensivists are licensed to practice in the legal jurisdiction in which the ICU is located;
 - c) tele-intensivists are credentialed in each hospital to which he/she provides remote care (can be special telemedicine credentialing);
 - d) activities of the tele-intensivist are reviewed within the hospital's quality assurance committee structure;
 - e) there are explicit written policies regarding roles and responsibilities of both the on-site intensivist and the tele-intensivist;
 - f) ICU staff are educated regarding the function, roles, and responsibilities of the tele-intensivist; and
 - g) there is an established written process to ensure effective communication between the ICU staff and the tele-intensivist.
9. The tele-intensivist documents patient care activities and this documentation is incorporated into the patient record.

⁴⁴ Individuals who touch patients or who touch items that will be used by patients

This would include individuals who are formally engaged by the hospital to help support the patient care process. This would include both direct and indirect care providers that are likely to have contact with patients in a patient care unit, enter a patient care unit, touch items that will be used by patients in a patient care unit, or interact with patient fluids (e.g., blood, specimens) in a patient care unit, such as doctors, mid-levels, nurses, pharmacists, environmental services staff, phlebotomists, laboratory techs, etc. This would also include students and volunteers. These individuals must be trained to identify and perform proper hand hygiene for the specific indications/moments (see WHO's 5 Moments for Hand Hygiene, CDC's Guideline for Hand Hygiene) that are relevant to their work.

Administrative workers that only perform office duties and do not touch patients or touch items that will be used by patients in a patient care unit would not be included in this definition. Patients and their visitors would also not be included in this definition. While patients and their loved ones are important parts of the patient care process, they are not formally engaged by the hospital for this work. Vendors would also not be included.

⁴⁵ Professional with Appropriate Training and Skills

This would include staff formally trained in Infection Control or Infectious Diseases, whose tasks include dedicated time for staff training. In some settings, this could also be medical or nursing staff involved in clinical work, with dedicated time to acquire thorough knowledge of the evidence for and correct practice of hand hygiene.

At a minimum, the trainer must have an understanding of the information and concepts presented in the WHO Guidelines on Hand Hygiene in Health Care and the Hand Hygiene Technical Reference Manual.

⁴⁶ Diagnostic Process

A process that starts with the patient's first engagement with the health care system and ends with clinicians either communicating a timely and correct diagnosis or learning from a diagnostic error or near miss that contributed to the patient's clinical outcomes. In that timeframe, clinicians and others involved in caring for the patient gather information, integrate and interpret that information, formulate a diagnosis, communicate the diagnosis to the patient, and develop a plan of care based on the diagnosis (adapted from the National Academy of Medicine's Improving Diagnosis in Health Care, 2015).

⁴⁷ Dedicated Emergency Department

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

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

For the purposes of reporting on the Survey, only include emergency departments that are located in your hospital. Exclude free-standing emergency departments.

⁴⁸ Never Event

In 2011, the National Quality Forum released a list of 29 events that they termed “serious reportable events,” extremely rare medical errors that should never happen to a patient. Often termed “never events,” these include errors such as surgery performed on the wrong body part or on the wrong patient, leaving a foreign object inside a patient after surgery, or discharging an infant to the wrong person. This is an update of NQF’s original 2002 and 2006 reports. Please see NQF’s “Never Events” list at https://www.qualityforum.org/topics/sres/serious_reportable_events.aspx. Hospitals may not earn credit for this question if they have only implemented a policy that includes the Center for Medicare and Medicaid (CMS) Never Events.

⁴⁹ Apology to the Patient

While Leapfrog recognizes that on very rare occasions “never events” can occur that are not the fault of care systems or clinical care staff, given the high level of trust patients place in health care providers, Leapfrog feels it is appropriate for caregivers to apologize when a patient within their care setting suffers a serious event.

As the National Quality Forum identified in their 2002, 2006, and 2011 Serious Reportable Events Report, given the serious nature of these events, it is reasonable for hospitals to initially assume that the adverse event was due to the referenced course of care. And while further investigation and/or root cause analysis of the unplanned event may be needed to confirm or refute the presumed relationship, delaying an apology to the patient is not treating the patient with compassion and sympathy.

⁵⁰ Reporting Never Events to External Agencies

If your hospital is not accredited by The Joint Commission or DNV GL Healthcare, is located in a state without a state-wide reporting program for medical errors, AND there is no available Patient Safety Organization to which your hospital can report medical errors, the hospital should report the event to the Board of Trustees. Full implementation of the Never Events policy still requires the hospital to conduct a root cause analysis of the event.

⁵¹ Root Cause Analysis

The National Patient Safety Foundation published a set of best practices and guidelines in its report “RCA² Improving Root Cause Analysis and Action to Prevent Harm.” The report can be found at <http://www.npsf.org/resources/Pages/Tools/RCA2-Improving-Root-Cause-Analyses-and-Actions-to-Prevent-Harm.aspx>.

⁵² Top Box Score

The percent of survey respondents who chose the most positive score for a given item. Looking at the **top box** is an approach to understand the number of responses with a strong sentiment.

For the CAHPS Child Hospital Survey “Global Rating – Recommend hospital” domain, responses of 9 and 10 are included in the top box score. For the “Global Rating – Recommend hospital” domain,

responses of “Definitely yes” are included in the top box score. For all other domains included in Section 8A, the top box score is the percent of survey respondents choosing “Always.”

For the OAS CAHPS Survey “Patients’ Rating of the Facility” domain, responses of 9 or 10 are included in the top box score. For the “Patients Recommending the Facility” domain, responses of “Definitely yes” are included in the top box score. For all other domains included in Section 9F, the top box score is the percent of survey respondents choosing “Yes, definitely.”

⁵³ Operating Rooms

If your state designates and licenses operating rooms, enter the number of operating rooms licensed by your state that are used to perform the outpatient procedures listed in Section 9C. If your state does not designate and license operating rooms, enter the number of operating rooms used to perform the outpatient procedures listed in Section 9C that meet the following definition from the 2018 FGI Guidelines: a room that meets the requirements of a restricted area, is designated and equipped for performing surgical or other invasive procedures, and has the environmental controls for an OR as indicated in ASHRAE 170. An aseptic field is required for all procedures performed in an OR.

More information about the 2018 FGI Guidelines can be found at https://www.fgiguideelines.org/wp-content/uploads/2017/08/SLS17_FGI_ExamProcedureOperatingImaging_170721.pdf.

Hospitals must include the total number of operating rooms that are used to perform the outpatient procedures listed in Section 9C, including operating rooms that are used for both inpatient and outpatient procedures.

⁵⁴ Endoscopic Procedure Rooms

If your state designates and licenses procedure rooms, enter the number of procedure rooms licensed by your state that are used for endoscopies listed in Section 9C. If your state does not designate and license procedure rooms, enter the number of procedure rooms that are used for endoscopies listed in Section 9C that meet the following definition from the 2018 FGI Guidelines: a room designated for the performance of patient care that requires high-level disinfection or sterile instruments and some environmental controls but is not required to be performed with the environmental controls of an operating room.

More information about the 2018 FGI Guidelines can be found at https://www.fgiguideelines.org/wp-content/uploads/2017/08/SLS17_FGI_ExamProcedureOperatingImaging_170721.pdf.

Hospitals must include the total number of procedure rooms that are used to perform the endoscopies listed in Section 9C, including procedure rooms that are used for both inpatient and outpatient procedures.

⁵⁵ Clinician

A clinician refers to a physician, physician assistant (PA), nurse practitioner (NP), certified registered nurse anesthetist (CRNA), nurse (RN or MSN), or respiratory therapist.

⁵⁶ Eligible Discharges

Discharged adult patients (ages 18 years and older) who had both medically and non-medically necessary outpatient surgeries and/or procedures are eligible to complete the OAS CAHPS Survey. A detailed description of patient sampling criteria, including a list of OAS CAHPS-eligible surgeries and procedures is available in the Protocols and Guidelines Manual, version 9.0 at <https://oascahps.org/Survey-Materials>.

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Exhibit 46



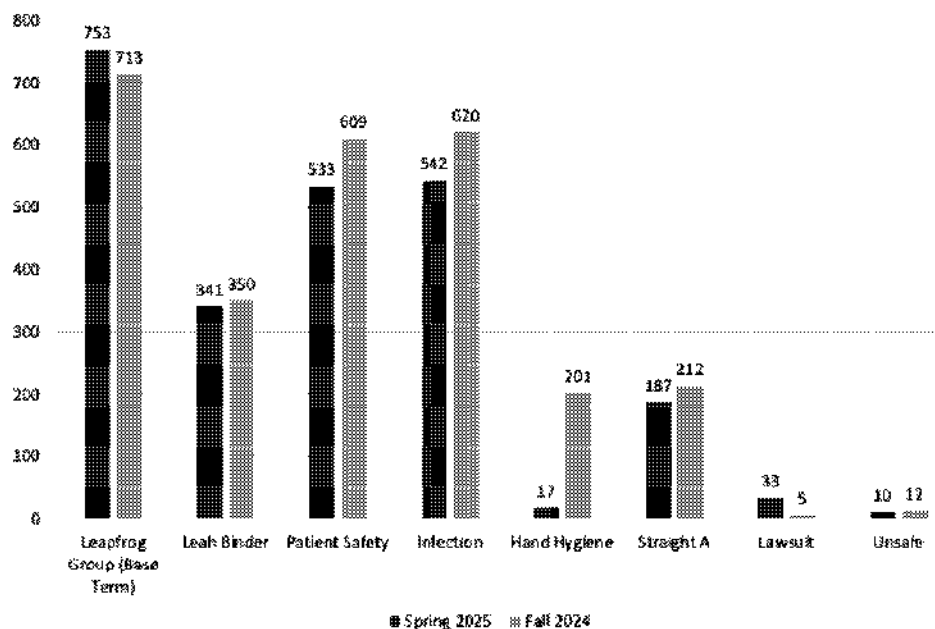
Spring 2025 Hospital Safety Grade
Media Coverage Report
May 1 – May 8, 2025

Executive Media Summary: Spring 2025 Hospital Safety Grade Media Coverage

- **774 online articles** from 486 different publications with a reach of ~ 59 million (722 online articles in fall 2024, a 7.2% increase)
- **127 unique print placements** across several media markets (160 print placements in fall 2024)
- **251 broadcast placements**, including 151 television placements across 37 stations and 100 radio placements across 56 stations (239 broadcast placements in spring 2024, a 5% increase)
- **427 press release pickups** with a total potential audience of 88.5 million (444 pickups in fall 2024, a 4% decrease)
- **78 hospital-issued publications** across several health systems (85 publications in fall 2024)

Coverage Spread Highlights

Key Terms/Message Pull Through

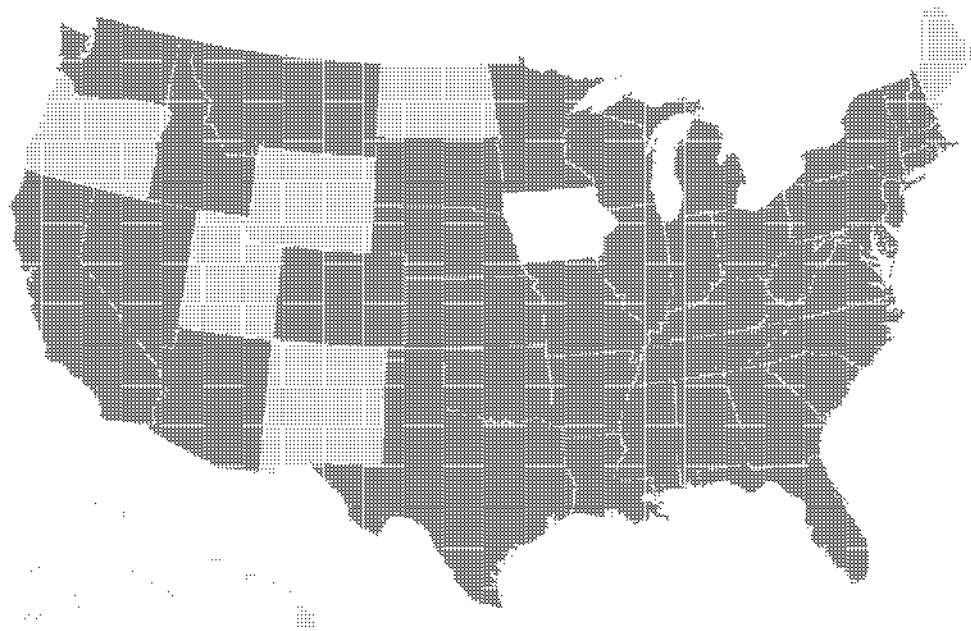


Message Pull Through Insights: Key message pull through correlates with Leapfrog’s national press release language (see declines this cycle in infection and hand hygiene mentions). Interestingly, “straight A” mentions were slightly higher in the fall 2024 cycle, likely due to

hospitals touting their straight A's and regional outlets picking up the stories (note, there were slightly fewer hospital press releases this cycle than last).

Leapfrog Group Coverage Across America

Coverage



Reach Insights (Reporting Period May 1 – 8):

- This cycle, we have coverage in 3 fewer states than fall 2024. However, we secured coverage in states that have not historically covered the Safety Grades and did not cover them last cycle (South Dakota, West Virginia, Vermont, Delaware).
- States with the highest concentration of coverage include New York (62), Florida (46), New Jersey (43), Illinois (41), Michigan (38). As we've seen in previous cycles, there is no correlation between high performing states and quantity of coverage. Surprisingly, we have yet to see coverage in Utah this cycle—despite their high ranking, the state isn't historically a large coverage driver (5 articles last cycle). Reporter interest in covering the Safety Grades may be a bit diluted by their repeated high ranking (fourth consecutive cycle as #1). The highest percentage of "Straight A" hospital angle doesn't seem to have moved the needle on coverage.



Spring 2025 Hospital Safety Grade
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- The Northeast (NY, NJ, PA), Midwest (IL, MI) and South (SC, NC, VA, FL, TX) continue to be major coverage drivers. The west continues to be the toughest area to break into in the absence of major media markets in some of those states.

Placements

Featured Placements

- **Patient Safety & Quality Healthcare**, Latest Leapfrog Safety Grades Highlight Top Performing Hospitals
- **WTOP**, DC, Md. and Virginia hospitals land on national honor roll with drop in accidents
- **Modern Healthcare**, Leapfrog hospital grades improve with help from AI, tech
- **Chief Healthcare Executive**,
 - Hospitals making strides in Leapfrog Group's Spring 2025 Safety Grades
 - To improve patient safety, hospital leaders must make it a top priority
 - These 11 hospitals have earned an 'A' in every Leapfrog Group report card
- **Chicago Tribune**, Illinois ranks 20th in the nation for hospital safety, with more hospitals getting As and Ds
- **Chicago Tribune**, Daywatch: How Illinois ranks for hospital safety
- **Tampa Bay Times**, St. Petersburg's Bayfront hospital earns first ever A grade for safety
- **Crain's New York Business**, One quarter of NY hospitals receive As for patient safety: Leapfrog Group
- **Crain's Grand Rapids Business**, Trio of Corewell hospitals in West Michigan earn top grades in latest safety report
- **New Jersey Herald – USA Today**, NJ hospital safety grades are in. See how yours did
- **Newsday**, Thirteen Long Island hospitals receive A grades for patient safety
- **Crain's Chicago Business**, What's the secret to Chicago's straight-A performers for hospital safety?
- **MLive**, 3 Michigan hospitals earn failing patient safety grades for spring 2025
- **CBS News Chicago**, 3 Chicago area hospitals highlighted in Leapfrog Group semiannual safety grades

Featured Regional Coverage

- **Michigan Public NPR**, Michigan hospitals improve in patient safety report — but three DMC hospitals get "F"
- **Kansas City Star**, These are the Kansas City area's most unsafe hospitals. See the ratings
- **The Charlotte Observer**, These are the safest hospitals in NC, report says. See if yours made the list
- **Pittsburgh Business Times**, Twelve Pittsburgh hospitals earn top safety grade in Leapfrog Group's spring rankings
- **Sarasota Herald-Tribune**, Four Sarasota area hospitals maintain A grades in latest Leapfrog Group rankings



Spring 2025 Hospital Safety Grade
Media Coverage Report
May 1 – May 8, 2025

- **The Dominion Post**, Mon Medical Center earns A in Leapfrog Hospital Safety Grade
- **Patch**, Holy Redeemer Hospital Just Got Ranked On Safety. Where Do They Stand?
- **The Richmond Observer**, Moore Regional Hospital-Richmond earns an 'A' Hospital Safety Grade from The Leapfrog Group
- **Spectrum News 1**, 5 Kettering Health centers receives 'A' grades from national watchdog
- **Orange Observer**, Orlando Health — Horizon West Hospital earns 'A' grade for patient safety | West Orange Times & Observer
- **Central Penn Business Journal**, WellSpan hospitals earn top safety 'A' Leapfrog rating
- **Lehigh Valley Business Journal**, Lehigh Valley hospitals earn top safety grades
- **Rock Hill Herald**, Which Columbia-area hospitals got top marks in new safety grades? See the rankings
- **Patch**, 7 Minnesota Hospitals Got A 'D' For Patient Safety—Is Yours On The List?
- **Rapid City Journal**, Rapid City Hospital earns highest safety grade in state
- **News 12 Long Island**, 12 LI hospitals receive 'A' grade for safety in newly released guide
- **Greenburgh Daily Voice**, Hospitals Receive 'A' Grade For Patient Safety In Hudson Valley, New Report Says
- **The Southern Maryland Chronicle**, Southern MD Hospitals Earn Mixed Safety Scores

Featured Trade Coverage

- **MedPage Today** (mention), One in eight hospitals sustained an A safety grade for more than 2 years opens in a new tab or window, according to the Leapfrog Group's latest report
- **Tech Target**, Leapfrog: Hospitals give sustained effort in patient safety
- **Healthcare Facilities Today**, The Leapfrog Group Releases Spring 2025 Hospital Safety Grades
- **HCN Healthcare News**, Johnson Memorial Hospital Earns 'A' Safety Grade from the Leapfrog Group
- **Becker's Hospital Review**, Where are Leapfrog's 11 straight-A hospitals?
- **Becker's Hospital Review**, Where are Leapfrogs 19 'F' hospitals?
- **Contagion Live**, The Leapfrog Group Releases its Spring 2025 Hospital Safety Grades
- **Healthcare Innovation**, The Leapfrog Group Spotlights 'Straight A' Hospitals

Featured Broadcast Coverage

- **FOX 44 News** (Fort Cavazos, TX), Darnall Army Medical Center gets 'A' safety grade for third time
- **WKFR-FM** (Kalamazoo, MI), Indiana's 18 Safest Hospitals Revealed
- **WECT-TV** (Wilmington, NC), One local hospital shows improved safety grade in new report
- **WTVA-TV** (Tupelo, MS), New Albany, Amory, Oxford and Starkville hospitals receive top marks for patient safety
- **KLIX-FM** (Twin Falls, ID), Idaho Hospitals Ranked for Spring 2025: These 4 Received an 'A' for Safety



Spring 2025 Hospital Safety Grade
 Media Coverage Report
 May 1 – May 8, 2025

Featured Hospital-Published News

- **AdventHealth**, AdventHealth Ocala achieves elite national status as a straight 'A' for patient safety
- **Duke Health**, Duke Hospitals Earn 'Straight A' Grades for Patient Safety in Leapfrog Survey
- **NYU Langone**, NYU Langone Achieves Its 10th Consecutive Top Safety Rating from Independent Healthcare Watchdog
- **UF Health**, UF Health Shands Hospital once again earns highest grade for safety
- **UNC Health**, UNC Health Hospitals Earn Top Grades from Leapfrog Group
- **UChicago Medicine**, University of Chicago Medical Center maintains streak with 27th 'A' grade in hospital safety from Leapfrog Group
- **LCMC Health**, Five Regional Hospitals Earn Highest Hospitality Grades
- **RUSH University Medical**, Rush University Medical Center Earns 10th Straight Leapfrog A

Featured Tenet Lawsuit Coverage

- **Modern Healthcare**, Leapfrog Group sued by 5 Tenet hospitals over low safety grades
- **Fierce Healthcare**, Leapfrog Group releases Hospital Safety Grades, defying Tenet Healthcare legal threat
- **KFF Health News** (mention), Five Palm Beach County Hospitals Sue Leapfrog Group, Claim Safety Rankings Are Misleading
- **Palm Beach Post**, 5 Palm Beach County hospitals sue Leapfrog Group that failed them: What the surveys found
- **HealthExec**, Florida hospitals sue nonprofit over 'pay-to-play' safety rankings
- **WLRN Public Media**, South Florida hospitals sue watchdog group over allegedly misleading safety rankings
- **Legal Reader**, South Florida Hospitals Sue Over Safety Grades
- **Palm Beach Post**, A national hospital-rating org failed five Palm Beach County hospitals. Now they're suing.
- **Becker's Hospital Review**, Florida hospitals sue Leapfrog over safety rankings
- **Becker's Hospital Review**, 10 recent healthcare industry lawsuits, settlements
- **Becker's ASC Review**, Florida hospitals sue Leapfrog for 'rigged' safety ratings
- **Healthcare Innovation**, The Leapfrog Group Spotlights 'Straight A' Hospitals
- **Miami Herald**, South Florida hospitals say patient safety rankings are rigged, and sue nonprofit
- **MLive**, Michigan hospitals applaud lawsuit filed over poor safety grades
- **SBGTV/WPEC**, Palm Beach County's largest health care provider fires back over online rankings
- **Boca News Now**, Delray Medical Center, West Boca Hospital, Others Sue Hospital Ranking Group



Spring 2025 Hospital Safety Grade

Media Coverage Report

May 1 – May 8, 2025

- **Daily Business Review, Palm Beach Hospitals Sue Leapfrog Over Safety Grade System**

Coverage Insights:

- As of today, CURA has fielded 81 media inquiries—13 inquiries fewer compared to this point last cycle. This includes 63 inquiries related to the Hospital Safety Grades and 18 related to the ongoing Tenet lawsuit. In-line with the trend we've been seeing, we had fewer reporters interested in interviews, but are still seeing a high conversion rate (more than half of inquiries we fielded have converted to coverage). This indicates our press package and process for sharing data/additional materials with reporters are strong, and we plan to continue using the gated press page for future cycles.
- Despite a challenging media landscape, coverage volumes remain consistent with—even exceeding—previous cycles. This success can be attributed in part to our targeted pre-embargo outreach to priority trade and regional/business journal reporters who typically cover the announcement. Additionally, we expanded our embargoed outreach to include more local reporters across states, with a strategic focus on underrepresented markets that don't typically cover the announcement.
- Broadcast coverage continued to grow this cycle, with new placements emerging in the North (Washington, D.C., and Providence), alongside our usual coverage in the Midwest and South. Notably, we observed a slight shift in format—radio placements outpaced TV coverage, which has typically led broadcast media in past cycles.
- Hospital-issued press releases highlighting their A grades continue to drive regional coverage of the announcement, even with a slight decline in volume compared to the previous cycle. Hospitals are actively leveraging Leapfrog's press release—often featuring Leah's quote—which has resulted in strong regional exposure for Leapfrog when picked up by local outlets.
- We saw an increase in coverage by Patch, a network of hyperlocal news sites (21 stories this cycle compared to 13 last cycle). While this is still below the 38 stories Patch published in fall 2024, we're continuing to nurture the relationship with the goal of driving up coverage. We're also building relationships with other syndicated regional outlets, such as Spectrum, which have generated meaningful coverage for this announcement.
- Notably, Becker's published more coverage of the Safety Grades and the Tenet lawsuit than any other health trade outlet, with two HSG stories and three lawsuit-related pieces—up from three total stories last cycle.
- We were surprised by lack of response/interest from some of our trade friends who typically cover the announcement, though we're continuing additional follow-up, bringing in the Tenet lawsuit.

Tenet Lawsuit Insights:

- By the end of the week, we will have reached out to over 120 regional, trade and national reporters regarding the Tenet lawsuit.



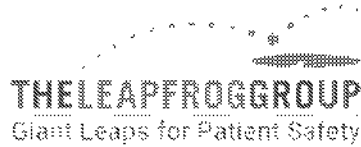
Spring 2025 Hospital Safety Grade
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- We've developed an additional media list targeting alternate reporter contacts in South Florida from key outlets where we haven't heard back from reporters.
- So far, we've seen 31 original articles regarding the suit and 14 pick-ups in smaller regional outlets (Florida and Michigan). Nearly all of those articles pulled directly from Leah's first or second official statement, and five referenced the legal correspondences.
 - Key articles following our last update include: Modern Healthcare, Palm Beach Post, KFF Morning Brief repost, and Health Exec.
- We were pleased to see a transition in media coverage following our outreach, specifically mentioning Tenet versus Palm Beach Health Network. In future outreach, we will continue to leverage the non-profit watchdog versus large for-profit health system angle (David vs Goliath).
- Regional coverage of the news tends to lean into more clickbait-style language and stays more high-level, while the trades have delved into the details of the lawsuit. Following up with reporters who have covered the announcement continues to drive further coverage. For instance, today, the Palm Beach Post published a follow-up piece, detailing the measures where each of the five hospitals have fallen short, pulling information from Leah's follow-up statement and the legal letters.
- We anticipate a story in STAT from Bob Herman, following Leah's interview on Monday. We followed up with him today regarding his timeline.
- Looking ahead, we'd like to pull in additional perspectives to extend the lifespan of the news (patients, providers). CURA and Leapfrog to discuss further on Monday.

Methodology

CURA uses a media monitoring software to track online, broadcast and print articles and report on message pull through. The Boolean search used for this coverage report is: ("Leapfrog Group") AND ("hospital safety grade" OR "safety grades" OR "hospital") NOT ("PRNewswire") NOT ("GlobeNewswire").

Exhibit 47



Talking Points for Regional Leaders about Leapfrog Lawsuit

See Leapfrog's detailed statement published May 2, 2025

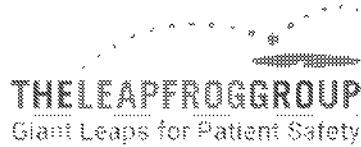
We prefer you avoid talking directly to press about the lawsuit – instead you may direct them to Lauren Bailey, Director of Communications (L.Bailey@Leapfrog-group.org). We are providing the following talking points to help guide responses if you are asked about the lawsuit by hospitals or other community members in your region. We encourage you to focus on the very poor performance of these hospitals on patient safety first and foremost, while still countering the deliberate falsehoods the hospitals are spreading.

Topline Messaging

- Five hospitals that are owned by Tenet Healthcare have filed a lawsuit against The Leapfrog Group to try to suppress publication of the Leapfrog Hospital Safety Grades:
 - Delray Medical Center (Hospital Safety Grade: F)
 - Good Samaritan Medical Center (Hospital Safety Grade: D)
 - Palm Beach Gardens Medical Center (Hospital Safety Grade: F)
 - West Boca Medical Center (Hospital Safety Grade: F)
 - St. Mary's Medical Center (Hospital Safety Grade: D)
- Leapfrog is confident they will win this case as they have for two other similar cases before.
- These five hospitals have extremely poor performance across many measures of preventable errors, accidents, injuries and infections that harm or even kill patients. Most of this data is reported by CMS, the agency that runs Medicare.
- All five hospitals fall well below the national average for patient experience. Patient experience surveys are collected to understand how patients felt about communication with doctors, nurses, and other clinicians, as well as the responsiveness of staff and communication about medications and discharge. Studies show patient experience reports closely correlate with patient safety outcomes.

Hospital-Specific Performance

- **Delray Medical Center** is significantly below the national average on:
 - Patient-reported communication with doctors, nurses, and other clinicians, as well as the responsiveness of staff and communication about medications and discharge
 - Rates of infection in the blood (CLABSI),
 - Rates of surgical site infections after colon surgery
 - Rates of sepsis after surgery
- **Good Samaritan Medical Center** is significantly below the national average on:
 - Patient-reported communication with doctors, nurses, and other clinicians, as well as the responsiveness of staff and communication about medications and discharge
 - Rates of infection in the urinary tract (CAUTI)
 - Rates of surgical site infections after colon surgery
 - Rates of falls and injuries
- **Palm Beach Gardens Medical Center** is significantly below the national average on:
 - Patient-reported communication with doctors, nurses, and other clinicians, as well as the responsiveness of staff and communication about medications and discharge
 - Measures of harmful events (PSI-90) including:
 - Sepsis after surgery
 - Surgical wounds splitting open



- Dangerous bed sores and more
- **West Boca Medical Center** is significantly below the national average on:
 - Patient-reported communication with doctors, nurses, and other clinicians, as well as the responsiveness of staff and communication about medications and discharge
 - Rates of MRSA
 - Rates of infections in the blood (CLABSI)
 - Rates of surgical site infection after colon surgery
- **St. Mary's Medical Center** is significantly below the national average on:
 - Patient-reported communication with doctors, nurses, and other clinicians, as well as the responsiveness of staff and communication about medications and discharge
 - Rates of infections in the urinary tract (CAUTI)
 - Rates of falls and injuries

Countering False Claims

- **The hospitals falsely claim Leapfrog gave the suing hospitals Ds and Fs because the hospitals don't report to the Leapfrog Hospital Survey. They also falsely claim Leapfrog is "pay to play."**
- Hospital participation in the Leapfrog Hospital Survey has no automatic up-or-down impact on a hospital's Safety Grade.
- Over 400 hospitals in the U.S. that don't report to the Survey earned a better Safety Grade than the five hospitals suing Leapfrog.
- Most of the data used in the Hospital Safety Grade comes from CMS, the agency that runs Medicare.
- The charge of "pay to play" is patently false. Leapfrog does not provide or sell consulting services and does not charge hospitals for participation in the Survey or the Safety Grade.

For more detailed questions about how the methodology treats Survey data, refer to Leapfrog or Leapfrog's statement. If you would like to be able to go into detail yourself, please contact us to set up a prep meeting.

Exhibit 48

LFG/CURA Meeting Agenda

May 22, 2025 at 4:00 pm ET

Press Announcements/Events

Media & Announcements

- Recognized Leader (June 4)
 - ADA confirmed ownership of pitching diabetes-specific and some consumer outlets; follow-up expected next week
 - National press release is not yet fully approved - outreach likely delayed until May 29 on ADA side but CURA to continue preparing for outreach on May 28
 - Draft of the national press release will be shared with regional leaders as an FYI
 - Jean-Luc is working with ADA's PR team to potentially expand promotion via ADA's owned channels - including their professional website and podcasts
 - Hospital PR contacts will be shared with CURA to coordinate regional outreach and potential spokesperson partnerships
 - Past successful podcast placements (Stacey Simms' Diabetes Connections) will be repeated this year offering Leah
 - Jean-Luc and Leah are confirmed as spokespeople for key trades and regional
 - Osaki confirmed as ADA's spokesperson
- Tenet lawsuit media planning + updates
 - Op-Ed Strategy
 - Considerations for op-ed placement in Florida outlets
 - Ideal op-ed would come from an external party (employer coalition, patient advocate) to reduce Leapfrog's direct exposure
 - Leah is drafting a personal story tied to Delray Medical Center to humanize the issue and may lead the op-ed if external voices aren't available
 - Possibility of spotlighting a patient story (anonymous if needed) to convey the real-world harm of poor hospital performance

Additional

- CMS proposed rule comment letter
- APIC Webinar [[HYPERLINK "https://youtu.be/-IEYzFOh3VE"](https://youtu.be/-IEYzFOh3VE)]
- In person tour at Jupiter Medical Center

LFG/CURA – Action Items

Thursday, May 22

LFG

- Provide PR contact information for recognized leaders' hospitals
- Share updates on ADA's pitching timeline
- Distribute regional and hospital press release templates for final proofing
- Continue collaborating with ADA to expand promotion across ADA's owned channels (e.g. website, podcasts, publications)
- Develop and publish an infographic with long-term hospital participation data
- Provide updates on:
 - The APIC joint webinar and potential statement rollout
 - Planning for an in-person tour at Jupiter Medical Center with a regional leader

CURA

- Finalize media outreach materials for the Recognized Leader announcement
- Coordinate with PR teams at recognized hospitals to support local press inquiries and spokesperson prep
- Continue brainstorming and drafting potential op-eds, including Leah's personal story (Delray Medical Center) and identifying external voices (e.g. regional partners, advocates)

Exhibit 49

From: Karen van Caulil[/O=EXCHANGELABS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=FD7F73D72F44ADFBC7B4E7D26AEE108-KAREN@FLHCC.COM]
Sent: Wed 5/28/2025 1:07:30 PM (UTC-04:00)
To: Ashley Tait-Dinger[ashley@FLHealthValue.org]
Subject: RE: Jupiter Medical center

This is something different. Leah wants to highlight Jupiter Medical Center's A safety grade because of the lawsuit and poor performing hospitals in Palm Beach County.

Regards,

Karen

Karen L. van Caulil, Ph.D.

President and CEO

Florida Alliance for Healthcare Value

Main Office Line: 407-425-9500, ext. 101

www.FLhealthvalue.org



The Central Florida Health Care Coalition, Incorporated d/b/a Florida Alliance for Healthcare Value is providing this information to our employer members solely in our capacity as a 501c3 nonprofit education organization and not as advice in any capacity. The information that is not in the public domain is private and confidential.

From: Ashley Tait-Dinger <ashley@FLHealthValue.org>

Sent: Wednesday, May 28, 2025 12:16 PM

To: Karen van Caulil <karen@FLHealthValue.org>

Subject: Re: Jupiter Medical center

I thought the meeting was with AdventHealth in June.

My workday may look different than your workday. Please do not feel obligated to respond outside of your normal working hours.

Thank you!

Ashley

Ashley Tait-Dinger, MBA

Vice President
Florida Alliance for Healthcare Value

Main Office Line: 407-425-9500 Ext 102

REMOTE: Tacoma, WA

www.FLhealthvalue.org



The Central Florida Health Care Coalition, Incorporated d/b/a Florida Alliance for Healthcare Value is providing this information to our employer members solely in our capacity as a 501c3 nonprofit education organization and not as advice in any capacity. The information that is not in the public domain is private and confidential.

From: Karen van Caulil <karen@FLHealthValue.org>

Date: Wednesday, May 28, 2025 at 9:04 AM

To: Ashley Tait-Dinger <ashley@FLHealthValue.org>

Subject: FW: Jupiter Medical center

FYI

Regards,

Karen

Karen L. van Caulil, Ph.D.

President and CEO

Florida Alliance for Healthcare Value

Main Office Line: 407-425-9500, ext. 101

www.FLhealthvalue.org



The Central Florida Health Care Coalition, Incorporated d/b/a Florida Alliance for Healthcare Value is providing this information to our employer members solely in our capacity as a 501c3 nonprofit education organization and not as advice in any capacity. The information that is not in the public domain is private and confidential.

From: Leah Binder <lbinder@leapfrog-group.org>
Sent: Wednesday, May 28, 2025 12:01 PM
To: Karen van Caulil <karen@FLHealthValue.org>
Cc: Karen Jupiter <kjupiter@leapfrog-group.org>; Lauren Bailey <L.Bailey@leapfrog-group.org>; Angela Hopkins <ahopkins@leapfrog-group.org>
Subject: Jupiter Medical center

External Message - Please be cautious when opening links or attachments in email

You may recall we spoke about planning a visit of you and some of your members and me to Jupiter Medical Center, one of the Straight A hospitals. I just spoke with the Jupiter CEO, Dr. Amit Rastogi, who is very excited to host a visit. He hadn't heard of your coalition so this will be a good opportunity to build the relationship. I explained how it's helpful for employers to see the difference patient safety can make and to hear their perspectives on how employers can reinforce progress.

We would like to see if we could host this visit. I told Rastogi we'd give him a couple of potential dates.

Hopefully we can talk this week about this?

Angela will coordinate a time this week. Thanks, Leah

Leah Binder
President & CEO
The Leapfrog Group
202-292-6713



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Exhibit 50

Message

From: Alexandra Campione [ACampione@leapfrog-group.org]
Sent: 6/5/2025 12:10:17 PM
To: Sarah Farinelli [sarah.farinelli@curastrategies.com]; Lauren Bailey [LBailey@leapfrog-group.org]; Nate Longmore [nlongmore@leapfrog-group.org]; Karen Jupiter [kjupiter@leapfrog-group.org]
CC: LeapfrogPR [leapfrogpr@curastrategies.com]
Subject: Re: For Leapfrog - AL.com Inquiry Re: Huntsville Hospital

The exact time required to submit the Leapfrog Hospital Survey varies depending on the services the hospital provides. If the hospital is smaller and provides fewer services, some sections will not apply to them and will therefore reduce their workload. Hospitals also have the ability to skip optional sections or answer that they do not measure at this time.

Completing all sections of the Leapfrog Hospital Survey for the first time typically requires around 120 hours, while subsequent annual submissions take approximately 60 hours. Most of this time is spent preparing reports, gathering documentation, and completing the CPOE (Computerized Physician Order Entry) Evaluation Tool.

Alex

From: Sarah Farinelli <sarah.farinelli@curastrategies.com>
Sent: Thursday, June 5, 2025 10:51 AM
To: Lauren Bailey <LBailey@leapfrog-group.org>; Alexandra Campione <ACampione@leapfrog-group.org>; Nate Longmore <nlongmore@leapfrog-group.org>; Karen Jupiter <kjupiter@leapfrog-group.org>
Cc: LeapfrogPR <leapfrogpr@curastrategies.com>
Subject: Re: For Leapfrog - AL.com Inquiry Re: Huntsville Hospital

External Email - Use Caution

Thank you! I was poking around on the Survey website for language on the length/time commitment, so that would be helpful.

Sarah Farinelli
 Account Director
 c 843.377.6610

From: Lauren Bailey <LBailey@leapfrog-group.org>
Date: Thursday, June 5, 2025 at 9:28 AM
To: Sarah Farinelli <sarah.farinelli@curastrategies.com>, Alexandra Campione <ACampione@leapfrog-group.org>, Nate Longmore <nlongmore@leapfrog-group.org>, Karen Jupiter <kjupiter@leapfrog-group.org>
Cc: LeapfrogPR <leapfrogpr@curastrategies.com>
Subject: RE: For Leapfrog - AL.com Inquiry Re: Huntsville Hospital

Thanks Sarah. I rewrote the last one – I think he is asking if hospitals have to get a Safety Grade or choose to/opt in.

Alex- I know there is a talking point somewhere about how long it takes to complete the Hospital Survey. Do you have a Help Desk response to that? It's question two below. I think that response would better answer this question.

From: Sarah Farinelli <sarah.farinelli@curastrategies.com>

Sent: Wednesday, June 4, 2025 5:39 PM

To: Lauren Bailey <LBailey@leapfrog-group.org>; Alexandra Campione <ACampione@leapfrog-group.org>; Nate Longmore <nlongmore@leapfrog-group.org>; Karen Jupiter <kjupiter@leapfrog-group.org>

Cc: LeapfrogPR <leapfrogpr@curastrategies.com>

Subject: Re: For Leapfrog - AL.com Inquiry Re: Huntsville Hospital

External Email - Use Caution

Hi Lauren,

The reporter reached back out with a few follow-up questions. See below with suggested responses in red. Could you let me know of any changes you'd like to make?

Thanks!

Sarah

+++

I have a follow-up question regarding CEO Leah Binder's statement that not filling out the survey affected 4 out of 30 measures. [Hospitals push back on low Leapfrog grades - Becker's Hospital Review | Healthcare News & Analysis] However, in my review, I found the number is actually 7 out of 32 measures.

Specifically, because Huntsville Hospital did not complete the survey, it received the lowest scores in four categories: computerized medication orders by doctors (which prevents errors), safe medication administration, hand hygiene, and whether specialty-trained doctors care for ICU patients. The hospital received no scores in three additional categories: staff working together to prevent errors, effective leadership to prevent mistakes, and nursing and bedside care for patients.

The imputation model applies to those four measures listed (computerized physician order entry, bar code medication administration, ICU physician staffing, hand hygiene), where, if there is not data available, hospitals receive a "limited achievement" point to reflect the lack of data. This methodology is designed to serve the best interest of patients, who have more at stake if Leapfrog overstates the performance of the hospital on critical patient safety measures.

For the other three measures you listed, these scores were not imputed due to missing data. When a hospital is missing data for those measures, the standard weight of that measure is redistributed to the other measures in the same domain. You can see further information on the weight of individual measures on pages 18-20 of the scoring methodology and how measure weights are redistributed due to missing data on page 23.

In addition, how would you respond to the claim by Huntsville Hospital that the survey is 300 pages long.

The Leapfrog Hospital Survey is developed with the intent to capture critical information about a hospital's safety based on peer reviewed, independent methodology. While Leapfrog encourages hospitals to complete the Survey to paint a fuller picture of their safety performance, many hospitals who receive a Safety Grade do not report to the voluntary Survey. In fact, we've seen hospitals achieve all letter Grades, including A's, without completing the Survey.

Also, do Hospitals have to participate in having their grades public, and do they pay to do that, and what is in it for them, even for those with Fs?

~~Hospitals do not have to complete the Leapfrog Hospital Survey nor pay Leapfrog to publicize their Safety Grade. In fact, Leapfrog supports hospitals with tools and guidance to promote their grades at no cost. If a hospital wants to use the trademarked Leapfrog letter grade logo in their promotional materials, they can license the logo for a fee, though this is entirely optional.~~

The Leapfrog Hospital Safety Grade was designed for patients – to give them access to critical data about how hospitals in their area perform on measures of patient safety. Leapfrog assigns Safety Grades to all general acute care hospitals in the U.S. – hospitals cannot opt in or opt out of getting a Safety Grade. This is a transparency initiative. We've seen that transparency galvanizes change.

Sarah Farinelli
Account Director
c 843.377.6610

From: Lauren Bailey <L.Bailey@leapfrog-group.org>
Date: Wednesday, June 4, 2025 at 3:07 PM
To: Sarah Farinelli <sarah.farinelli@curastrategies.com>, Alexandra Campione <ACampione@leapfrog-group.org>, Nate Longmore <nlongmore@leapfrog-group.org>, Karen Jupiter <kjupiter@leapfrog-group.org>
Cc: LeapfrogPR <leapfrogpr@curastrategies.com>
Subject: RE: For Leapfrog - AL.com Inquiry Re: Huntsville Hospital

Sounds good. Thanks!

From: Sarah Farinelli <sarah.farinelli@curastrategies.com>
Sent: Wednesday, June 4, 2025 2:05 PM
To: Lauren Bailey <L.Bailey@leapfrog-group.org>; Alexandra Campione <ACampione@leapfrog-group.org>; Nate Longmore <nlongmore@leapfrog-group.org>; Karen Jupiter <kjupiter@leapfrog-group.org>
Cc: LeapfrogPR <leapfrogpr@curastrategies.com>
Subject: Re: For Leapfrog - AL.com Inquiry Re: Huntsville Hospital

External Email - Use Caution

Sorry, I realize that was unclear – no additional questions since the initial inquiry. Thanks for confirming the spokesperson attribution, will keep you posted! And thanks for calling out the harmful patient safety rates, Alex.

Sarah Farinelli
Account Director
c 843.377.6610

From: Lauren Bailey <L.Bailey@leapfrog-group.org>
Date: Wednesday, June 4, 2025 at 2:40 PM
To: Sarah Farinelli <sarah.farinelli@curastrategies.com>, Alexandra Campione <ACampione@leapfrog-group.org>, Nate Longmore <nlongmore@leapfrog-group.org>, Karen Jupiter <kjupiter@leapfrog-group.org>
Cc: LeapfrogPR <leapfrogpr@curastrategies.com>
Subject: RE: For Leapfrog - AL.com Inquiry Re: Huntsville Hospital

To clarify, did the reporter say they needed more than the archival report? I feel like that data would get at what they're asking for. I'm not sure we have time to do a custom analysis on this.

I'm fine with those edits – thanks! Leah said I can be the spokesperson for this so you can say Leapfrog spokesperson or me – whichever you think is better.

From: Sarah Farinelli <sarah.farinelli@curastrategies.com>
Sent: Wednesday, June 4, 2025 1:31 PM
To: Lauren Bailey <L.Bailey@leapfrog-group.org>; Alexandra Campione <ACampione@leapfrog-group.org>; Nate Longmore <nlongmore@leapfrog-group.org>; Karen Jupiter <kjupiter@leapfrog-group.org>
Cc: LeapfrogPR <leapfrogpr@curastrategies.com>
Subject: Re: For Leapfrog - AL.com Inquiry Re: Huntsville Hospital

External Email - Use Caution

Exactly. We shared the archival report over. The statement looks good- thoughts on the below tweaks to include a link to the methodology?

Sarah Farinelli
Account Director
c 843.377.6610

From: Lauren Bailey <LBailey@leapfrog-group.org>
Date: Wednesday, June 4, 2025 at 2:16 PM
To: Sarah Farinelli <sarah.farinelli@curastrategies.com>, Alexandra Campione <acampione@leapfrog-group.org>, Nate Longmore <nlongmore@leapfrog-group.org>, Karen Jupiter <kjupiter@leapfrog-group.org>
Cc: LeapfrogPR <leapfrogpr@curastrategies.com>
Subject: RE: For Leapfrog - AL.com Inquiry Re: Huntsville Hospital

Oh interesting! So this reporter is saying the hospital put the statement out almost in response to this article? That would make sense.

Have you shared the archival report with the reporter?

Leah is out until Tuesday and I'm not sure that this warrants her needing to do a statement. We'd like to keep this out of press as much as possible. I think our statement should be something like:

Leapfrog does not want hospitals to earn poor Safety Grades. We've seen hospitals that take patient safety seriously move from an "F" all the way to an "A." This saves lives. Patients are the center of what we do at Leapfrog, and they deserve transparency and access to this data. We are glad to see Huntsville Hospital publicly commit to report to the Leapfrog Hospital Survey. In our 25 years, we've seen that transparency galvanizes change and voluntarily reporting quality safety data is the first step. You can find the Hospital Safety Grade [scoring methodology](#) and other materials publicly available for viewing on our [website](#).

Thoughts?

From: Sarah Farinelli <sarah.farinelli@curastrategies.com>
Sent: Wednesday, June 4, 2025 12:59 PM
To: Lauren Bailey <LBailey@leapfrog-group.org>; Alexandra Campione <ACampione@leapfrog-group.org>; Nate Longmore <nlongmore@leapfrog-group.org>; Karen Jupiter <kjupiter@leapfrog-group.org>
Cc: LeapfrogPR <leapfrogpr@curastrategies.com>
Subject: For Leapfrog - AL.com Inquiry Re: Huntsville Hospital

External Email - Use Caution

Hi Lauren,

Kayode Crown, a reporter at AL.com who worked on the [initial story](#) covering Huntsville Hospital's grade reached out to us wanting further data on the hospital's performance as well as a statement from Leapfrog (see the request below).

Looping in Alex to take a look at any notable data trends for Huntsville Hospital over time. We can pull together a quick statement from Leah for approval, pulling from the messaging we shared with the broadcast outlet. Per our previous discussion, we can keep it positive and focus on the fact that they're going to complete the survey in the future, and we've seen many hospitals improve over time. We'd advise passing on a live interview to keep the messaging more controlled.

Let us know if you're aligned or if you have any questions.

Thanks!

Sarah

+++

Hope this email finds you well. I am a reporter with AL.com and I reported on the latest Huntsville Hospital grades. Here is the story: <https://www.al.com/news/2025/05/huntsville-hospital-falls-to-f-in-latest-grade-report-on-medical-errors-and-patient-safety.html>

I want to do a deeper dive into the numbers, wanting to go back years to see how the hospital had been trending (and not just the overall grade), but those data are not available on your website.

- Please let me know what your policy is and what step I should take.*

The hospital also put out a statement following my reporting. Find it here: <https://www.huntsvillehospital.org/community-events/news-publications/item/statement-regarding-leapfrog-score>

- How does The Leapfrog Group respond to the issues raised in the statement?*

###

Sarah Farinelli

Account Director



2011 Crystal Drive, Suite 1005, Arlington, VA 22202

C 843.377.6610

sarah.farinelli@curastrategies.com

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Exhibit 51

Document Produced in Native Format

Exhibit 52



Humana Military
Healthcare Quality
PO Box 2907
Louisville, KY 40207
Humana's Duty to

Dear West Boca Medical Center
21644 State Road 7
Boca Raton, FL 33428-1899

Humana Military strives to ensure the TRICARE beneficiaries we serve receive the highest quality care available. As part of this effort, we continuously review the quality of care provided in our network hospitals. During a recent review of Leapfrog Hospital Safety Grades, we identified your facility as one in our network with a safety grade of **D or below**.

We strive to ensure TRICARE East Region beneficiaries receive healthcare in facilities that provide care in a manner that meets or exceeds the safety measures used in this system. Consequently, we are providing you this information to encourage your facility to review your Leapfrog Hospital Safety Grade to identify any factors that may have contributed to your performance on safety measures. We ask that you respond to this letter within 30 days from receipt regarding your strategy to improve performance.

If you do not currently have a plan in place to address your performance measures, consider reviewing The Leapfrog Group's information regarding the Leapfrog Hospital Safety Grade and scoring methodology used on their website at HospitalSafetyGrade.org.

We look forward to hearing about your improvement strategy. If you have questions or wish to submit your response by email, you may contact us at HealthcareQuality@HumanaMilitary.com.

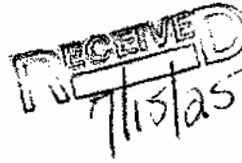
Sincerely,

Humana Military

Exhibit 53



Humana Military
Healthcare Quality
PO Box 2907
Louisville, KY 40207
HumanaMilitary.com



Dear Delray Medical Center
5352 Linton Boulevard
Delray Beach, FL 33484-6580

Humana Military strives to ensure the TRICARE beneficiaries we serve receive the highest quality care available. As part of this effort, we continuously review the quality of care provided in our network hospitals. During a recent review of Leapfrog Hospital Safety Grades, we identified your facility as one in our network with a safety grade of **D or below**.

We strive to ensure TRICARE East Region beneficiaries receive healthcare in facilities that provide care in a manner that meets or exceeds the safety measures used in this system. Consequently, we are providing you this information to encourage your facility to review your Leapfrog Hospital Safety Grade to identify any factors that may have contributed to your performance on safety measures. We ask that you respond to this letter within 30 days from receipt regarding your strategy to improve performance.

If you do not currently have a plan in place to address your performance measures, consider reviewing The Leapfrog Group's information regarding the Leapfrog Hospital Safety Grade and scoring methodology used on their website at HospitalSafetyGrade.org.

We look forward to hearing about your improvement strategy. If you have questions or wish to submit your response by email, you may contact us at HealthcareQuality@HumanaMilitary.com.

Sincerely,

Humana Military

Exhibit 54

- Why Leapfrog
- Data Users & Licensure Programs
- Contact Us
- Data User Login

Leapfrog Hospital Safety Grade

The Leapfrog Hospital Safety Grade is the only hospital rating focused exclusively on hospital safety. Its A, B, C, D or F letter grades are a quick way for consumers to choose the safest hospital to seek care.



Upwards of 200,000 people die annually due to preventable mistakes in hospitals, according to the Journal of Patient Safety. To draw attention to this epidemic, in 2012 The Leapfrog Group decided to expand its focus beyond employers to reach consumers directly. Out of this vision came the Leapfrog Hospital Safety Grade, a letter grade rating of how safe hospitals are for patients. The Safety Grade provides consumers with the critical information on how likely they are to experience accidents, injuries, errors or harm while in the hospital.

How the Safety Grade Keeps it Simple for Users

The Leapfrog Hospital Safety Grade



Updated twice per year, the score regularly garners attention from consumer media and shines a spotlight on the patient safety records of hospitals in local communities.

Data users of the Leapfrog Hospital Safety Grade value its simplicity and easy-to-understand letter grade rating system. The score is used by dozens of national and regional health plans as well as vendors to educate their users on

the importance of choosing a safer hospital. Contact us to access a sample data set.

More resources on hospital safety, including tips for talking to your doctor and videos on how to stay safe, are available on the Leapfrog Hospital Safety Grade website.

**Looking for an easy Contact us to learn more
tool to inform your users about
hospital safety?**

Exhibit 55

Hospital Ethics Committee
West Boca Medical Center
21644 State Road 7
Boca Raton, FL 33428

Subject: Urgent Request for Review of Universal Hepatitis B Vaccination Policy in Newborns of Hepatitis B Negative Mothers

Dear Members of the Ethics Committee,

I was concerned to learn that West Boca Medical Center recently received a D safety grade from The Leapfrog Group, placing it among the lower-rated hospitals in Florida. This moment presents an important opportunity to review policies that impact patient safety, ethics, and public trust.

One such policy deserving urgent attention is the routine administration of the Hepatitis B vaccine to all newborns within 24 hours of birth regardless of the mothers Hepatitis B status.

While I fully support the public health importance of the Hepatitis B vaccine, current research and ethical standards raise questions about whether a universal birth-dose policy is necessary in cases where:

- The mother is confirmed Hepatitis B negative
- There is no known risk of household exposure
- The infant has no immediate or foreseeable route of exposure

In the absence of maternal Hepatitis B or other identifiable risk factors, there is no clinically or ethically compelling reason to administer the vaccine at birth rather than at a later, developmentally appropriate age.

Key Points for Consideration:

- **Risk vs. Benefit:** Outside of vertical transmission (screened prenatally), the risk of Hepatitis B infection in newborns is extremely low.
- **Immune System Maturity:** Studies in *Frontiers in Immunology* show newborns have an immature immune response to Hepatitis B vaccination compared to older infants.
- **Parental Autonomy:** Many parents are unaware they may delay or decline this vaccine when risk is absent. Transparent, informed consent would strengthen community trust.

Proposed Actions:

1. Evaluate a risk-based or consent-based protocol for Hepatitis B negative mothers.
2. Implement a formal consent process with written information and clear provider dialogue.

3. Review this policy in the context of recent safety concerns to demonstrate commitment to improvement.

In light of the hospital's recent safety grade, addressing this issue promptly would send a powerful message of responsiveness and patient-centered care.

Respectfully,

A Concerned Physician in Boca Raton

Select References:

1. Ansari, A., et al. (2023). The Lancet Global Health: Minimal risk of early HBV transmission in infants of HBsAg-negative mothers.
2. Liu, J., et al. (2022). Frontiers in Immunology: Immature neonatal immune response to Hepatitis B vaccine.
3. Vasireddy, D., et al. (2014). Journal of Pediatric Infection: Parental refusal factors and importance of transparent communication.

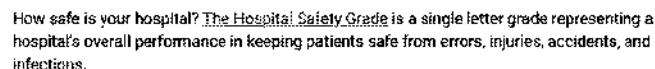
Exhibit 56

Series Search

5135



See the full list of Top ASCs

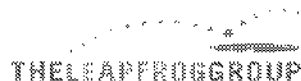


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The Leapfrog Group is a non-profit 501(c)(3) EIN: 52-7369533

Exhibit 57



LEAPFROG DESIGNATED LOGO LICENSE — LETTER OF AGREEMENT

The Leapfrog Group and _____ as of _____ with _____
Name of Hospital (Licensee) Effective Date # of Staffed Beds

agree that Leapfrog grants Licensee a limited, non-transferable, and non-exclusive license to use one or more of the following Leapfrog logos, including their respective program logos (collectively, the "Designated Leapfrog Logos"), as indicated below, in accordance with the terms of this Letter of Agreement for both commercial and non-commercial promotion:

- ☐ Spring 2025 Hospital Safety Grade (e.g. "A" or "B" Logo)
☐ Leapfrog 2024 Top Hospital
☐ 2025 Recognized Leader in Caring for People with Diabetes

Licensee acknowledges that this Agreement applies only to the Designated Leapfrog Logos selected above and all terms and conditions outlined herein govern their use.

Fee Table: Licensee agrees to pay The Leapfrog Group (please indicate tier of staffed beds on the table below):

Hospital Size	Indicate Tier with an "X"	Safety Grade Price	Top Hospital Price	Recognized Leader in Diabetes Care Price	Price with \$1,000 Embargo Discount**
<50 staffed beds		\$6,700	\$6,700	\$6,700	\$5,700
50 – 99 staffed beds		\$7,900	\$7,900	\$7,900	\$6,900
100 – 149 staffed beds		\$9,900	\$9,900	\$9,900	\$8,900
150 – 199 staffed beds		\$10,900	\$10,900	\$10,900	\$9,900
200 – 249 staffed beds		\$12,900	\$12,900	\$12,900	\$11,900
250 – 299 staffed beds		\$17,900	\$17,900	\$17,900	\$16,900
300 – 399 staffed beds		\$19,900	\$19,900	\$19,900	\$18,900
400 – 499 staffed beds		\$26,900	\$26,900	\$26,900	\$25,900
500+ staffed beds		\$29,900	\$29,900	\$29,900	\$28,900

Total Price: _____

* Combined purchase of two or more logo licenses will receive a 20% discount.

**Embargo Discount applied when signed license received by 4/30/2025 and cannot be combined with any other discounts.

This license allows the Licensee to use the Designated Leapfrog Logos in accordance with this Agreement and the Terms of Use attached as Exhibit A and the Leapfrog Group Style Guide for Hospitals. The Agreement becomes effective upon execution. An invoice will be issued within 72 hours of Leapfrog's receipt of the executed Agreement, and payment is due upon receipt.

Leapfrog releases updated Safety Grades twice per year, in Fall and Spring, and the Top Hospital designation once per year in the fall. Recognized Leader in Diabetes Care is designated once annually. This Agreement allows Licensee to use the Leapfrog Hospital Safety Grade "A" or "B" Logo and Leapfrog Hospital Safety Grade Program Logo for the current Spring 2025 ratings cycle plus the subsequent, Fall 2025 ratings cycle if Licensee is deemed eligible to use the respective logo by Leapfrog. The Designated Leapfrog Logos for the year or cycle this license is purchased may be promoted in perpetuity. Congratulations on earning the prestigious accolades.

Accepted and Agreed To:

Hospital Name: _____

Address: _____

Name: _____ **Title:** _____

Email: _____ **Phone:** _____

Signature: _____ **Effective Date:** _____

Designated User (contact will be authorized to access and download the Designated Logos provided through this LOA)

Name: _____ **Email:** _____

Billing Contact:

Name: _____ **Department:** _____

Email: _____ **Phone:** _____

Additional Instructions: _____

Please scan the completed Letter of Agreement and email to Licensing@Leapfrog-Group.Org.

EXHIBIT A

Terms of Use of the Leapfrog Designated Logos

A. Licensee shall have the following rights and obligations:

1. Licensee may announce and display the Designated Leapfrog Logos on its website, hospital signage, through broadcast and radio advertisements, in paid print and online advertisements and through marketing materials (collectively, "Commercial Use"). Licensee may not change the form or display any of the Designated Leapfrog Logos.
2. If part of a multicampus organization or part of a multihospital system, Licensee must make clear that the Designated Leapfrog Logos apply only to specific campuses or to specific hospitals and not to the entire organization or system.
3. Licensee should give credit to The Leapfrog Group and link to Leapfrog's respective program webpage where possible and appropriate, for example:
 - i. Leapfrog Hospital Safety Grade website (www.hospitalsafetygrade.org)
 - ii. Leapfrog Top Hospital: (www.leapfroggroup.org/TopHospitals)
 - iii. Leapfrog and ADA's Recognized Leader in Caring for People Living with Diabetes
<https://www.leapfroggroup.org/diabetes>
4. Licensee may NOT publish or refer to the Leapfrog Hospital Safety Grade underlying numerical values or display numerical values relating to the ratings programs (e.g. Hospital Safety Grade's numerical scores) via web, print, or any other media.
5. When using or displaying the Leapfrog Designated Logos, Licensee must display the most recent, officially licensed Leapfrog Designated Logos during the term of the License. The date-stamped logo (e.g., Spring 20XX or Fall 20XX) corresponding to the applicable Leapfrog Program cycle must be included wherever the designation appears. No alterations, modifications, or removal of date stamps from the logo are permitted.
6. Licensee may not republish the Designated Logos of any facilities other than its own purchased through this Agreement. The Designated Leapfrog Logos may only be used by the specific facility or facilities that have individually purchased a license. Logos may not be transferred, sublicensed, or displayed by any other hospital within a multi-hospital system or by parent organizations that have not obtained an active license for each facility using the logos.
7. Licensees using the Leapfrog Hospital Safety Grade must display the Official Licensure Logo (Leapfrog Hospital Safety Grade "A" or "B" Logo) as displayed below in any printed or web materials. Licensees may choose to display the Leapfrog Hospital Safety Grade Program Logo and/or The Leapfrog Group Logo.

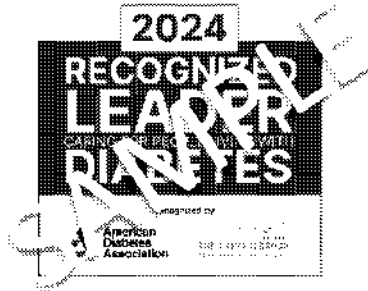


LEAPFROG
**HOSPITAL
SAFETY GRADE**

- i. The Leapfrog Hospital Safety Grade measures patient safety. Licensee must not state or imply that the Leapfrog Hospital Safety Grade measures or describes any other quality, e.g., patient satisfaction, quality of care provided, overall performance, etc.
 - ii. Licensee must not state or imply that it is safer than hospitals receiving lower letter grades on the Leapfrog Hospital Safety Grade unless the statement is qualified to indicate the concept "as measured by the Leapfrog Hospital Safety Grade." Preferred language would be, "X Hospital has received a higher Leapfrog Hospital Safety Grade than other hospitals in our community." Licensee must not state or imply that it is safer than other hospitals receiving the same letter grade on the Leapfrog Hospital Safety Grade. Licensee may not publicly display or otherwise reveal relative rankings among hospitals receiving the same letter grade in any use.
8. Licensees using the Top Hospital Designation must display the Official Licensure Logo (Top Hospital Logo) as displayed below in any printed or web materials. Licensee may additionally choose to display The Leapfrog Group Logo.



9. Licensees using the Leapfrog and American Diabetes Association Recognized Leader in Caring for People With Diabetes Designation Logo as displayed below in any printed or web materials. Licensee may additionally choose to display The Leapfrog Group Logo.



10. Licensees with a current, active license that is purchased within one year of the Effective Date, may also display The Leapfrog Group Logo as displayed below in any printed or web materials.



13. Nothing in this Agreement shall give Licensee any right, title or interest in or to the Designated Leapfrog Logos. Licensee acknowledges and agrees that Leapfrog is the exclusive owner of all rights, title and interest in and to the Designated Leapfrog Logos. Licensee shall not act in any manner that would or might conflict with or compromise Leapfrog's ownership of the Designated Leapfrog Logos, or similarly affect the value or goodwill pertaining to the Designated Leapfrog Logos, such as by applying to register any identical or similar trademark anywhere in the world.
14. The Designated Leapfrog Logos and all Intellectual Property Rights (defined below) therein are owned by Leapfrog. Licensee shall not reproduce, republish, distribute, modify, reverse engineer or otherwise exploit the Designated Leapfrog Logos in whole or in part, in any manner not expressly permitted by this Agreement and must not remove or modify any copyright or trademark notice, or other notice of ownership.

"Intellectual Property Rights" means all intellectual property rights of any kind or nature however denominated throughout the world, including, without limitation all copyrights, patents, patent applications, trade secrets, inventions, propriety know-how, registered and unregistered trademarks, registered and unregistered service marks, domain names, registered and unregistered trade names, rights of privacy and publicity, moral rights, and database rights.

15. Licensee agrees to indemnify and hold each of Leapfrog and any agent appointed by Leapfrog to pursue and enforce its rights and to undertake and fulfill its obligations under this Agreement ("Agent") and their respective affiliates and all of their respective past, present, and future directors, officers, employees, successors and agents and all of their respective successors and assigns, both individually and in their official capacities harmless from and against any and all liabilities, damages, demands, claims, causes of action, fines or penalties (including, without limitation, court costs and reasonable attorneys' fees) arising out of or related to the failure of Licensee to fulfill any of Licensee's obligations under this Agreement or Licensee's use of or access to the Designated Leapfrog Logos.

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17. TO THE FULL EXTENT PERMITTED BY LAW, NEITHER LEAPFROG NOR AGENT IS LIABLE FOR ANY INDIRECT, PUNITIVE, SPECIAL, INCIDENTAL, CONSEQUENTIAL, OR EXEMPLARY DAMAGES OR ANY DAMAGES FOR LOSS OF BUSINESS, REVENUE, OR PROFIT OR ANY OTHER DAMAGES OF ANY KIND OR NATURE ARISING OUT OF OR IN CONNECTION WITH LICENSEE'S USE OF DESIGNATED LEAPFROG LOGOS, EVEN IF LEAPFROG HAS PREVIOUSLY BEEN ADVISED OF, OR REASONABLY COULD HAVE FORESEEN, THE POSSIBILITY OF SUCH DAMAGES, HOWEVER THEY ARISE, WHETHER IN CONTRACT, TORT, WARRANTY, OR ANY OTHER LEGAL THEORY.
18. This Agreement, the rights, and obligations hereunder, and any claims or disputes relating thereto, will be governed by and construed in accordance with the laws of the District of Columbia without regard to the principles of conflicts of laws. Any claim, suit, or action arising under or relating to this Agreement must be brought and maintained exclusively in courts located within the District of Columbia.
19. Licensee may not assign, sublicense, delegate or otherwise transfer this Agreement or any right granted hereunder.
20. This Agreement constitutes the entire agreement between Licensee and Leapfrog relating to this subject matter.
21. This Agreement shall terminate automatically and immediately upon a breach by the Licensee, as determined in Leapfrog's sole and absolute discretion. Upon termination of the License, Licensee must immediately cease use of the Top Hospital Designation and the Hospital Safety Grade and all Designated Leapfrog Logos.
22. If payment is not received by Leapfrog within forty-five (45) days after the due date, or any Licensee violates, or is perceived by Leapfrog to have violated, the terms of this Agreement, as determined within Leapfrog's sole discretion, Leapfrog reserves its rights to: (1) impose interest on its outstanding invoices at a rate of six (6) percent annually; (2) immediately suspend this Agreement, and any rights Licensee has or may have hereunder; and, (3) categorize Licensee as ineligible for licensure under future iterations of this Agreement. Additionally, Leapfrog reserves the right to indefinitely refuse and withhold future licensure to any Licensee or potential Licensee, in its sole discretion, based upon said Licensee being in arrears on payments due to Leapfrog under this Agreement.
23. These Terms of Use shall survive the termination of this Agreement.

Exhibit 58



About The Leapfrog Group

The Leapfrog Hospital Safety Grade was created and is administered by The Leapfrog Group, a national leader and advocate in hospital transparency.



[The Leapfrog Group](#) is an independent, national not-for-profit organization founded more than a decade ago by the nation's leading employers and private health care experts. We strive to make giant "leaps" forward in the safety, quality and affordability of health care in the U.S. by promoting transparency through our data collection and public reporting initiatives.

With our goal of saving lives by reducing errors, injuries, accidents, and infections, The Leapfrog Group focuses on measuring and publicly reporting hospital performance through the annual [Leapfrog Hospital Survey](#).

The survey is a trusted, transparent and evidence-based national tool in which over 2,300 hospitals voluntarily participate free of charge.

The Leapfrog Group advocates for public access to quality and safety data from all U.S. hospitals, and we welcome you to contact your legislators to demand more information to keep your families safe.

Questions? [Contact Us here.](#)



The Leapfrog Hospital Safety Grade

The Leapfrog Hospital Safety Grade is a public service provided by The Leapfrog Group, an independent nonprofit organization committed to driving quality, safety, and transparency in the U.S. health system.

By viewing this website you are agreeing to our [TERMS OF USE](#). The information viewed on this site is not intended to be the only or primary means for evaluating hospital quality nor is it intended to be relied upon as advice or a recommendation or an endorsement about which hospitals to use or the quality of the medical treatment that you receive from a hospital or other health care provider. You are solely responsible for any and all decisions with respect to your medical treatment. Neither Leapfrog nor its affiliates are responsible for any damages or costs you might incur with respect to your use of this site. Never disregard, avoid or delay in obtaining medical advice from your doctor or other health care professional because of something that you have read on this site as the site is not intended to be a substitute for professional medical advice.

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Exhibit 59



Frequently Asked Questions About The Leapfrog Hospital Safety Grade

What is The Leapfrog Hospital Safety Grade?

The Leapfrog Hospital Safety Grade is an "A," "B," "C," "D," or "F" assigned to general hospitals in the U.S., the only such rating program focused exclusively on how safe they are for their patients. The grade uses over 30 measures including rates of preventable errors, injuries and infections, and whether hospitals have systems in place to prevent them. Grades are updated twice annually, in the fall and spring, and are freely available to the public at www.hospitalsafetygrade.org. The Hospital Safety Grade uses a public, peer-reviewed methodology, calculated by top patient safety experts under the guidance of a National Expert

Panel, and is 100% transparent and free to the public.

**Why should people worry about a hospital's patient safety?
Aren't all hospitals the same?**

It is critical to monitor safety before choosing a hospital. Preventable medical errors, accidents, injuries and infections in hospitals kill upwards of 200,000 people every year, the third leading cause of death in the United States. One in four people admitted to a hospital suffers some form of avoidable harm. And all hospitals are not the same; some hospitals are much safer than others. Johns Hopkins Medicine researchers estimate that patients are twice as likely to die of a preventable problem at a "C," "D," or "F" hospital than an "A" hospital, and over 50,000 lives would be saved if all hospitals performed the way A hospitals did.

What is the difference between the Leapfrog Hospital Survey and the Leapfrog Hospital Safety Grade?

The Leapfrog Hospital Survey is an annual voluntary survey in which Leapfrog asks hospitals to report quality and safety data and then publicly reports that

information by hospital. The Leapfrog Hospital Safety Grade is a letter grade Leapfrog bi-annually assigns to general hospitals in the United States, whether they voluntarily report data to Leapfrog or not. If a hospital does not report to the Leapfrog Hospital Survey, other sources of data are used to calculate a Grade. The majority of data used to calculate the Safety Grade comes from the Centers for Medicare and Medicaid Services (CMS).

Does a hospital get a better Safety Grade if it reports to the Leapfrog Hospital Survey?

The Hospital Safety Grade reflects how well a hospital does on safety, not whether they complete the Leapfrog Hospital Survey. The more information Leapfrog has about a hospital's safety, the more opportunity hospitals have to tell their story. Participation in the Leapfrog Hospital Survey gives hospitals the opportunity to report additional information about their safety measures. If a hospital performs well on certain measures on the Leapfrog Hospital Survey, they have the opportunity to earn more points in their Hospital Safety Grade for

those certain measures than they would if they did not report to the Leapfrog Hospital Survey. This is because the data hospitals report to Leapfrog is more comprehensive than data available from other publicly available sources. On the other hand, hospitals that perform poorly on Leapfrog Hospital Survey measures that are included in the Safety Grade will also feel the impact of that performance on their grade.

See the full methodology for spring 2025 [here](#).

Why don't I see my hospital?

Unfortunately, not all hospitals have enough data publicly available to be eligible for a grade. As per the National Expert Panel guidance, The Leapfrog Group has requirements for the minimum amount of data we need to issue an accurate grade. Most of the data Leapfrog uses comes from the federal agency Centers for Medicare and Medicaid Services (CMS), and in some cases, CMS does not publish adequate safety data on an individual hospital. Sometimes the hospital is too small to issue reliable numbers, and sometimes the hospital does not offer services relevant

to the safety data. For instance, a hospital without an Intensive Care Unit (ICU) cannot report ICU safety measures. The absence of a grade does not mean a hospital is unsafe; it means Leapfrog does not have enough data to assign a grade.

How does Leapfrog determine the Grades?

Leapfrog experts and advisors at the Johns Hopkins Armstrong Institute for Patient Safety and Quality regularly review all publicly available measures of safety and the methodology to determine a hospital's letter grade. The National Expert Panel regularly convenes to review the methodology for validity and reliability. The [scoring methodology](#) is published in detail, and hospitals are given tools to analyze how their own grade was derived.

What is a "Straight A" hospital?

For the first time, Leapfrog is spotlighting 346 hospitals nationwide that not only achieved an "A" for spring 2025 but have sustained the grade for five or more grading rounds, designating them "Straight A" hospitals. This select group,

representing 12% of all eligible hospitals, is now highlighted on www.hospitalsafetygrade.org.

Should patients avoid a “C,” “D,” or “F” hospital? What should people do if the only hospital in their community is a “C,” “D,” or “F?”

When they have a choice, the Hospital Safety Grade is the first tool patients should use to select a hospital, because safety should come first. The Hospital Safety Grade is the only public rating exclusively focused on safety—how well the hospital protects patients from medical errors, accidents, injuries and infections that kill more than 200,000 people a year in the United States. Once satisfied with the hospital’s record on safety, then people should consider other aspects of hospital performance in the decision-making process, such as whether the hospital delivers a high level of care for the health concern the patient has, i.e., if the hospital has high-quality obstetrics or orthopedics.

In some cases, the only hospitals available in a community are not highly rated. Leapfrog offers guidance and resources on our website for patients and family

members to protect themselves during a hospital stay, which is important no matter the hospital's grade. It can be difficult, but patients and families must take an assertive role in managing bedside care in order to avoid many of the most common errors that routinely occur in hospitals at all grade levels.

Employers founded The Leapfrog Group in 2000 to improve patient safety. How can they use the Leapfrog Hospital Safety Grade?

Employers use the Hospital Safety Grade in two ways. First, employers can educate and inform their employees about the Hospital Safety Grade and the importance of considering patient safety when choosing a hospital. Second, employers can structure the way they pay for health care to reward excellence in safety. For instance, higher graded hospitals might earn contract incentives. Visit Leapfrog's free Employer Value Toolkit website for resources and more information on where to start.

Who is The Leapfrog Group?

The Leapfrog Group is a national nonprofit organization driving a

movement for giant leaps forward in the quality and safety of American health care. For over 20 years, we have served as the nation's leading independent advocate of health care transparency to drive major improvement in patient safety, rating health care facilities to help people make informed, lifesaving decisions about where to seek services, and giving purchasers tools to tie their purchasing strategy to excellence in safety and quality.



The Leapfrog Hospital Safety Grade

The Leapfrog Hospital Safety Grade is a public service provided by The Leapfrog Group, an

independent nonprofit organization committed to driving quality, safety, and transparency in the U.S. health system.

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Exhibit 60



About the Grade

Leapfrog Hospital Safety Grades (formerly known as Hospital Safety Scores) are assigned to nearly 3,000 general acute-care hospitals across the nation twice annually. The Safety Grade is the gold standard measure of patient safety, cited in [MSNBC](#), [The New York Times](#), and [AARP The Magazine](#).



The Leapfrog Hospital Safety Grade uses up to 30 national performance measures from the Centers for Medicare & Medicaid Services (CMS), the Leapfrog Hospital Survey and information from other supplemental data sources. Taken together, those performance measures produce a single letter grade representing a hospital's overall performance in keeping patients safe from preventable harm and medical errors. The Leapfrog Hospital Safety Grade methodology has

been peer reviewed and published in the Journal of Patient Safety.

Leapfrog works under the guidance of an Expert Panel to select appropriate measures and develop a scoring methodology. The Expert Panel is made up of patient safety experts from across the country:

- David Bates, M.D., M.Sc.,
Harvard University
- Kathy McDonald, PhD, Johns
Hopkins University School of
Nursing
- Matthew D McHugh, Ph.D.,
J.D., M.P.H., R.N., C.R.N.P.,
F.A.A.N., University of
Pennsylvania School of
Nursing
- Arnold Milstein, M.D., M.P.H.,
Stanford University
- Doris Peter, PhD, Consultant
- Peter Pronovost, M.D., Ph.D.,
F.C.C.M., University
Hospitals
- Patrick Romano, M.D.,
M.P.H., University of
California, Davis
- Sara Singer, Ph.D., Stanford
University
- Arjun Srinivasan, M.D., CAPT
U.S. Public Health Service,

Centers for Disease Control
and Prevention

- Tim Vogus, Ph.D., Vanderbilt University

How the Leapfrog Hospital Safety Grade is produced

The Expert Panel selected 22 evidence-based measures of patient safety, including CMS Medicare PSI 90 Patient Safety and Adverse Events composite (which includes 10 component measures of patient safety), analyzed the data, and determined the weight of each measure based on **evidence**, **opportunity for improvement** and **impact**. In some cases where a hospital's information is not available for a certain measure, Leapfrog uses a supplemental data source. In cases where a hospital's information is not available from any data source, Leapfrog has outlined a methodology for dealing with the missing data.

The Leapfrog Hospital Safety Grade places each measure into one of two domains: (1)

Quick Links

- [Scoring Methodology Used in the Spring 2025 Release of the Hospital Safety Grades](#) [May 2025]
- [Explanation of Safety Grades](#) [May 2025]

Process/Structural Measures or
(2) **Outcome Measures**, each
accounting for 50 percent of the
overall score.

- **Process Measures** represent how often a hospital gives patients recommended treatment for a given medical condition or procedure. For example, “Responsiveness of hospital staff” looks at patients’ feedback on how long it takes for a staff member to respond when they request help. **Structural Measures** represent the environment in which patients receive care. For example, “Doctors order medications through a computer” represents whether a hospital uses a special computerized system to prevent errors when prescribing medications.
- **Outcome Measures** represent what happens to a patient while receiving care. For example, “Dangerous object left in patient’s body” measures how many times a patient undergoing surgery had a dangerous foreign

object, like a sponge or tool,
left in his or her body.

A hospital must have enough safety data available for our experts to issue them a letter grade. Hospitals missing more than **six** process measures, more than **five** outcome measures, or **PSI90** are not graded. All hospitals are encouraged to voluntarily report additional safety data through the [Leapfrog Hospital Survey](#), but they are not required to do so to receive a Safety Grade.

The Leapfrog Group's goal is to publicly report patient safety and quality information for the benefit of consumers, purchasers, and referring physicians as they make decisions about where to seek care and where to direct patients. Identifying differences among facilities is critical to inform patients and their family's decision-making. That's why Leapfrog reports results by facility for all programs.

However, some hospitals belong to health systems that report data to the Centers for Medicare & Medicaid Services (CMS) as a single entity with a shared "CMS Certification Number (CCN)." This

means that individual hospitals within these systems will be graded using some of the same aggregate data. Leapfrog encourages these types of hospitals to report additional safety data through the [Leapfrog Hospital Survey](#) so that patients can see how each hospital is doing individually for select measures included in the grade.

At this time, we are unable to assign a grade to VA hospitals, critical access hospitals, specialty hospitals, children's hospitals, outpatient surgery centers, etc. Our experts are studying ways to rate them in the future.



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10/24/25, 4:55 PM

About The Grade

receive from a hospital or other health care provider. You are solely responsible for any and all decisions with respect to your medical treatment. Neither Leapfrog nor its affiliates are responsible for any damages or costs you might incur with respect to your use of this site. Never disregard, avoid or delay in obtaining medical advice from your doctor or other health care professional because of something that you have read on this site as the site is not intended to be a substitute for professional medical advice.

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Exhibit 61

Why the Hospital Safety Grade Works

One of the most significant problems with today's health care system is the failure to make safety and quality information available to the public. But the public deserves this information so they can make informed choices about where to receive care. The purpose of the Leapfrog Hospital Safety Grade is to bring this information to light in a way that is easy for you – the consumer – to use.



Some people do more research on what car to buy than what hospital to go to for medical care. The Leapfrog Hospital Safety Grade provides data and research to help you make informed decisions about a critical aspect of your hospital stay – safety. A hospital may have the best surgeons and greatest technology in the world, but

unless it is preventing infections and eliminating errors, it is not delivering on a very basic premise: ensuring the safety of you and your loved ones. The goal of the Leapfrog Hospital Safety Grade is to reduce the over 200,000 yearly deaths from hospital errors and injuries by publicly recognizing safety and exposing harm.

Our [letter grade scoring system](#) allows consumers to quickly assess the safety of their local hospital, and choose the safest hospital to seek care. As consumers use the Leapfrog Hospital Safety Grade more and more, we hope more hospitals will be compelled to be open about their safety and quality, and participate in meaningful public reporting.



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Exhibit 62

Welcome to the 2025 Leapfrog Hospital Survey



This section of the website is designed for hospitals that are submitting a Hospital Survey.

The 2025 Leapfrog Hospital Survey is free and open to hospitals from April 1 to November 30. The annual survey assesses hospital safety, quality, and efficiency based on national performance measures that are of specific interest to health care purchasers and consumers. Survey Results are publicly reported, and provide hospitals with information to benchmark their progress in improving the care they deliver. For general, acute-care hospitals only, some Survey Results are also used to calculate the Leapfrog Hospital Safety Grade.

2026 Recognized Leaders in Diabetes Care

August 31 Deadline

The 2026 Recognized Leaders in Ca...

To be eligible for a Leapfrog T...

[Download the Application Materials](#)

[Review Survey Deadlines](#)

Prepare to Submit a Survey

Annually, over 2,400 hospitals submit a Leapfrog Hospital Survey. Please review the information on these webpages before you begin. These resources will help you to successfully complete the submission process.



Get Started

Request a security code, learn about our multi-campus reporting policy, and join our NHSN group.

[Learn More](#)

Deadlines

View important deadlines related to the Survey, Leapfrog's NHSN Group, Top Hospitals, and more.

[Learn more](#)

Survey Materials

Download a hard copy of the Survey and supporting materials that you will need to complete the Online Hospital Survey Tool.

[Learn more](#)

Alignment with Other National Programs

Many of the measures included in the Leapfrog Hospital Survey are in use by other national agencies and organizations including the Centers for Medicare & Medicaid Services (CMS), the CDC's National Healthcare Safety Network (NHSN), and The Joint Commission. For general hospitals, some of the measures are used to calculate the Hospital Safety Grade.

[View the Survey Overview](#)



Looking for Extra Help?

The Leapfrog Hospital Survey Webinar Series is designed for Survey coordinators, hospital leaders, and others who would benefit from a more interactive presentation of Survey materials and information. The Webinar Series is held monthly from March to December and includes monthly office hours in addition to monthly webinars.

[Join Now](#)

[Contact the Help Desk](#)



Leapfrog's Rating Programs

Leapfrog administers two different ratings programs for hospitals: the Leapfrog Hospital Survey and the Leapfrog Hospital Safety Grade. Most every hospital is targeted to submit an annual Hospital Survey, but only general hospitals are eligible for a Hospital Safety Grade.



**Learn About the Differences
Between the Survey and Safety
Grade**

Find more information about the Safety Grade

Innovators for Leapfrog

Innovators for Leapfrog (IFL) support Leapfrog's mission to make "giant leaps for patient safety." While The Leapfrog Group does not endorse the products, services, and/or technology showcased in the IFL, we encourage you to explore these offerings that support Leapfrog's work.

**Learn more about Innovators for
Leapfrog**



Exhibit 63



How to Use the Grade

Many hospitals have world-renowned doctors and equipment, but not all hospitals prioritize their patient's safety above all else. You deserve to know which hospitals do the best at protecting their patients from harm. That's why we developed the Leapfrog Hospital Safety Grade. This tool can help guide your decision in a number of situations:

- Has your doctor referred you or a family member to a hospital for surgery?
- Are you preparing to have a baby?
- Is someone in your family suffering from chronic illness that could require immediate or consistent hospital care?
- Is your choice of hospital solely based on location or word-of-mouth?

The Safety Grade rates hospitals on the very basics of medical care, such as handwashing, entering prescriptions through a computer, and the availability of highly-trained nurses. So no matter the reason for a hospital visit, safety should be your number one concern.

Which hospital do I pick?

Choosing your hospital is a matter of personal preference, but we know “A” hospitals [do a better job](#) at preventing errors. If your local hospital rates below an “A,” talk with your doctor at that hospital and urge them to improve their safety. If all your local hospitals score poorly, use these Safety Grades to start a conversation with hospital leadership and local policymakers about improving hospital safety.

A small number of hospitals have consistently achieved “A” grades—an impressive feat. These hospitals are denoted with the “Straight A’s” logo in recognition of their achievement of the highest standards of patient safety year after year. We hope all hospitals will strive to offer this level of dependable care.

You should never refuse care in an emergency because of a hospital's Safety Grade, but use this website as a guide for planned events and a research tool for potential emergencies.

What measures are most important?

Every person will have different ideas about what is most important to them, but we suggest checking out whether your hospital scores well on:

- **Handwashing** Does your hospital have a handwashing policy to ensure all staff members are washing their hands before and after patient contact?
- **Infection in the blood** Hospital patients may be given a central line (a tube inserted into the body to deliver medication and other treatments). Patients with a central line are at high risk for developing a dangerous infection in the blood. Is your hospital showing a low number on this measure?
- **Patient falls** What is your hospital doing to ensure you don't suffer an added injury

from a fall while in the
hospital?

What about past grades?

Since 2012, Leapfrog has released Safety Grades twice per year for nearly 3,000 hospitals across the U.S. To be as transparent as possible, we make those past grades available, just by clicking on “Show Recent Past Grades” underneath a hospital’s current grade.

Displaying past grades makes it clear which hospitals consistently achieve high standards of patient safety and which have demonstrated a steady path of improvement. Patients should always decide on where to receive care based on a hospital’s current Safety Grade. However, past grades can tell you a lot about that hospital’s track record in keeping its patients safe from errors, injuries, accidents and infections. Keeping an eye on your local hospital’s Safety Grades over time also makes it easier to spot patterns—whether a hospital is working to improve or has allowed its focus on safety to slip.

If you’re concerned about past grades, ask your doctor what your

hospital is doing to keep its patients safe. Remember, **you have a choice of where to receive care**. And you deserve to be in the safest hospital possible.

We don't have Safety Grades for every hospital. Here's why:

Certain hospitals are not required to publicly report their safety record, which means that our experts don't have enough information to issue them a Leapfrog Hospital Safety Grade. These hospitals include:

- Specialty hospitals, such as children's hospitals and surgical centers
- Critical access hospitals
- Hospitals in Guam and Puerto Rico

Additionally, many hospitals are not able to provide data to the federal government because they are too small, or lack the necessary data—like military and veteran's hospitals. Leapfrog experts are studying ways to rate them in the future.



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The Leapfrog Hospital Safety Grade

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Exhibit 64



Delray Medical Center

5352 Linton Boulevard
Delray Beach, FL 33484-6580

[View this hospital's Leapfrog Hospital Survey Results](#)

This Hospital's Grade



▼ [Hide Recent Past Grades](#)

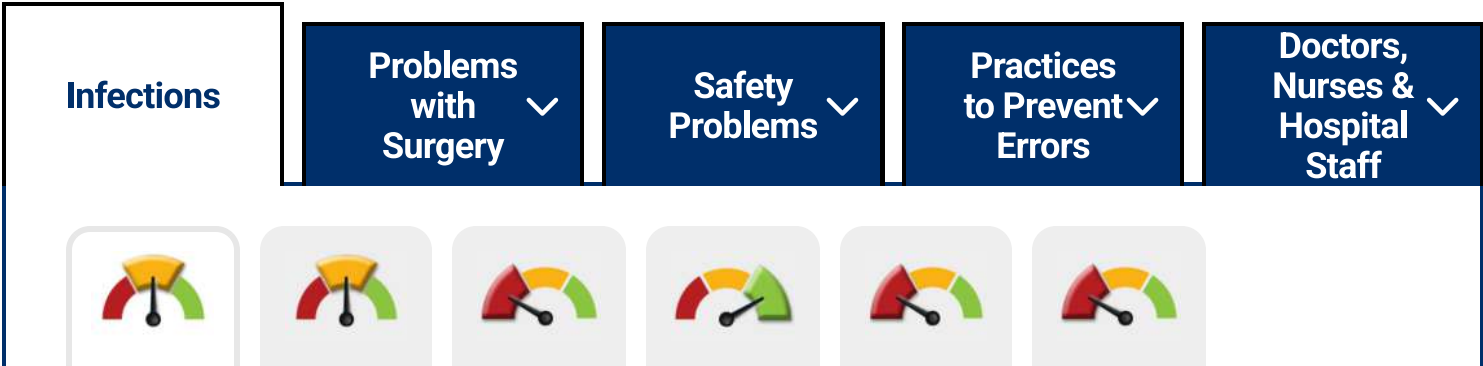


[More about past grades](#)

[Detailed table view](#)

NEW [Order 2½ years of detailed scoring for this hospital for \\$2.95](#)

Learn how to use the Leapfrog Hospital Safety Grade



MRSA
Infection

C. diff
Infection

Infection
in the
blood

Infection
in the
urinary
tract

Surgical
site
infection
after
colon
surgery

Sepsis
infection
after
surgery

Hospital Performs:

Worse Than Average  Better Than Average

This Hospital's Score:

0.922

Best Hospital's Score:

0.000

Average Hospital's Score:

0.719

Worst Hospital's Score:

2.850

MRSA infection

Staph bacteria are common in hospitals, but Methicillin-resistant Staphylococcus aureus (MRSA) is a type of staph bacteria that is resistant to (cannot be killed by) many antibiotics. MRSA can be found in bed linens or medical equipment and can be spread if providers do not properly wash their hands between patients. MRSA can cause life-threatening bloodstream infections, pneumonia and surgical site infections.

This number represents a comparison of the number of infections that actually happened at this hospital to the number of infections expected for this hospital, given the number of patients they care for on a daily basis and how widespread MRSA infection is in their local community. A number lower than one means fewer infections than expected; a number more than one means more infections than expected. [For details on sources, click here.](#)

What safer hospitals do:

Doctors and nurses should clean their hands after caring for every patient. Hospital rooms and medical equipment should be thoroughly cleaned often. Safer hospitals will also keep MRSA patients separate from other patients and require providers and visitors to wear gloves and gowns around these patients.

Notes and Definitions

- 1. Declined to Report:** The hospital was asked to provide this information to the public, but did not.
- 2. Not Available:** "Not Available" means that the hospital does not have data for this measure. This could be because the measure is related to a service the hospital does not provide. For example, a hospital that does not have an ICU would not be able to report data about ICUs. It could also be because the hospital had too few patients or cases to report data for a particular condition or procedure. A "Not Available" result does not mean that the hospital withheld information from the public.
- 3. Straight A:** The hospital has earned an 'A' Grade for five consecutive grading rounds or more, qualifying it for recognition as a "Straight A" hospital.

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Exhibit 65



Good Samaritan Medical Center

1309 N. Flagler Drive
West Palm Beach, FL 33401-3499

[View this hospital's Leapfrog Hospital Survey Results](#)

This Hospital's Grade



▼ [Hide Recent Past Grades](#)

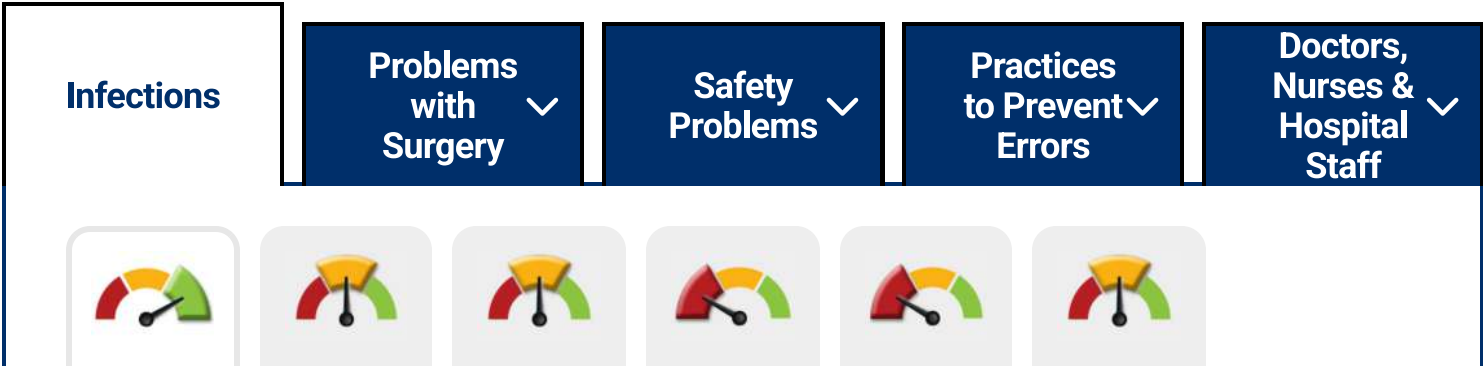


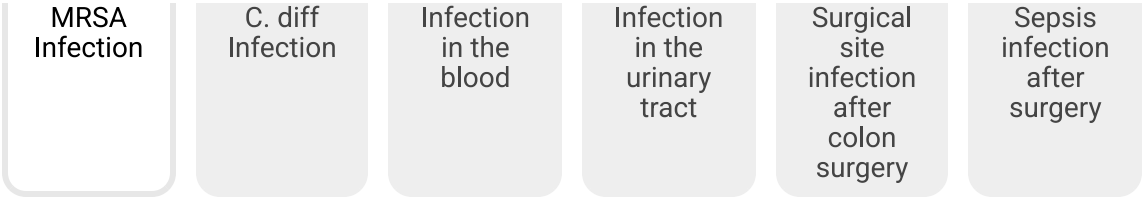
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[Detailed table view](#)

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Learn how to use the Leapfrog Hospital Safety Grade





This Hospital's Score:	MRSA infection
0.000	Staph bacteria are common in hospitals, but Methicillin-resistant Staphylococcus aureus (MRSA) is a type of staph bacteria that is resistant to (cannot be killed by) many antibiotics. MRSA can be found in bed linens or medical equipment and can be spread if providers do not properly wash their hands between patients. MRSA can cause life-threatening bloodstream infections, pneumonia and surgical site infections.
Best Hospital's Score:	
0.000	
Average Hospital's Score:	
0.719	
Worst Hospital's Score:	
2.850	

This number represents a comparison of the number of infections that actually happened at this hospital to the number of infections expected for this hospital, given the number of patients they care for on a daily basis and how widespread MRSA infection is in their local community. A number lower than one means fewer infections than expected; a number more than one means more infections than expected. [For details on sources, click here.](#)

What safer hospitals do:

Doctors and nurses should clean their hands after caring for every patient. Hospital rooms and medical equipment should be thoroughly cleaned often. Safer hospitals will also keep MRSA patients separate from other patients and require providers and visitors to wear gloves and gowns around these patients.

Notes and Definitions

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HOSPITAL

SAFETY GRADE

A program of

THE LEAPFROG GROUP

Palm Beach Gardens Medical Center

3360 Burns Road
Palm Beach Gardens, FL 33410-4304

[View this hospital's Leapfrog Hospital Survey Results](#)

This Hospital's Grade

F

SPRING 2025

▼ [Hide Recent Past Grades](#)

2024

F

FALL 2024

C

SPRING 2024

2023

C

FALL 2023

C

SPRING 2023

2022

C

FALL 2022

C

SPRING 2022

[More about past grades](#)

[Detailed table view](#)

NEW

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Infections

Problems with Surgery

Safety Problems

Practices to Prevent Errors

Doctors, Nurses & Hospital Staff

MRSA
Infection

C. diff
Infection

Infection
in the
blood

Infection
in the
urinary
tract

Surgical
site
infection
after
colon
surgery

Sepsis
infection
after
surgery

Hospital Performs:

Worse Than Average  Better Than Average

This Hospital's Score:

0.278

Best Hospital's Score:

0.000

Average Hospital's Score:

0.719

Worst Hospital's Score:

2.850

MRSA infection

Staph bacteria are common in hospitals, but Methicillin-resistant Staphylococcus aureus (MRSA) is a type of staph bacteria that is resistant to (cannot be killed by) many antibiotics. MRSA can be found in bed linens or medical equipment and can be spread if providers do not properly wash their hands between patients. MRSA can cause life-threatening bloodstream infections, pneumonia and surgical site infections.

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LEAPFROG

HOSPITAL

SAFETY GRADE

A program of

THE LEAPFROG GROUP

St. Mary's Medical Center

901 45th Street
West Palm Beach, FL 33407-2495

[View this hospital's Leapfrog Hospital Survey Results](#)

This Hospital's Grade

D

SPRING 2025

▼ [Hide Recent Past Grades](#)

2024

D

FALL 2024

C

SPRING 2024

2023

C

FALL 2023

C

SPRING 2023

2022

B

FALL 2022

B

SPRING 2022

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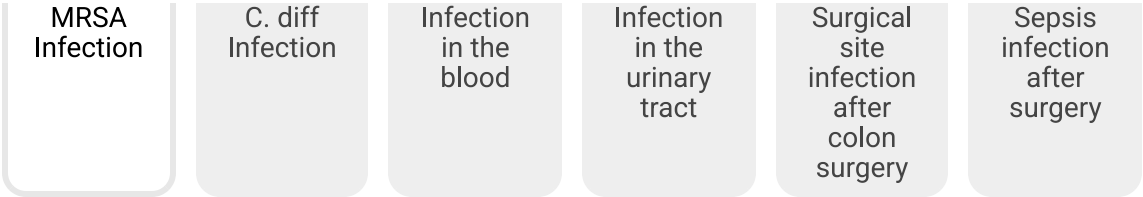
Infections

Problems with Surgery

Safety Problems

Practices to Prevent Errors

Doctors, Nurses & Hospital Staff



This Hospital's Score: 0.829 Best Hospital's Score: 0.000 Average Hospital's Score: 0.719 Worst Hospital's Score: 2.850	MRSA infection Staph bacteria are common in hospitals, but Methicillin-resistant Staphylococcus aureus (MRSA) is a type of staph bacteria that is resistant to (cannot be killed by) many antibiotics. MRSA can be found in bed linens or medical equipment and can be spread if providers do not properly wash their hands between patients. MRSA can cause life-threatening bloodstream infections, pneumonia and surgical site infections.
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What safer hospitals do:

Doctors and nurses should clean their hands after caring for every patient. Hospital rooms and medical equipment should be thoroughly cleaned often. Safer hospitals will also keep MRSA patients separate from other patients and require providers and visitors to wear gloves and gowns around these patients.

Notes and Definitions

- 1. Declined to Report:** The hospital was asked to provide this information to the public, but did not.
- 2. Not Available:** "Not Available" means that the hospital does not have data for this measure. This could be because the measure is related to a service the hospital does not provide. For example, a hospital that does not have an ICU would not be able to report data about ICUs. It could also be because the hospital had too few patients or cases to report data for a particular condition or procedure. A "Not Available" result does not mean that the hospital withheld information from the public.
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Exhibit 68



West Boca Medical Center

21644 State Road 7
Boca Raton, FL 33428-1899

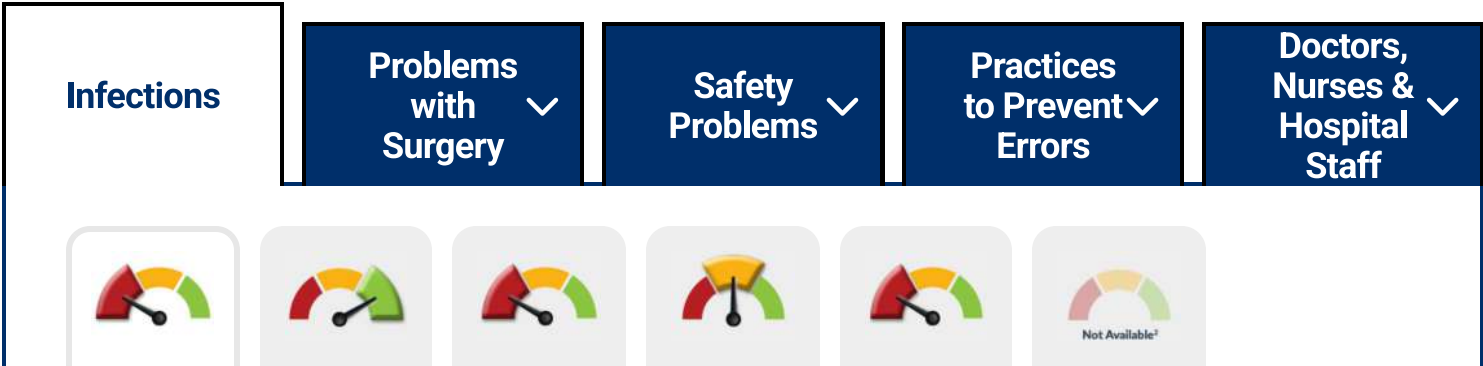
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MRSA
Infection

C. diff
Infection

Infection
in the
blood

Infection
in the
urinary
tract

Surgical
site
infection
after
colon
surgery

Sepsis
infection
after
surgery

Hospital Performs:

Worse Than Average  Better Than Average

This Hospital's Score:

1.318

Best Hospital's Score:

0.000

Average Hospital's Score:

0.719

Worst Hospital's Score:

2.850

MRSA infection

Staph bacteria are common in hospitals, but Methicillin-resistant Staphylococcus aureus (MRSA) is a type of staph bacteria that is resistant to (cannot be killed by) many antibiotics. MRSA can be found in bed linens or medical equipment and can be spread if providers do not properly wash their hands between patients. MRSA can cause life-threatening bloodstream infections, pneumonia and surgical site infections.

This number represents a comparison of the number of infections that actually happened at this hospital to the number of infections expected for this hospital, given the number of patients they care for on a daily basis and how widespread MRSA infection is in their local community. A number lower than one means fewer infections than expected; a number more than one means more infections than expected. [For details on sources, click here.](#)

What safer hospitals do:

Doctors and nurses should clean their hands after caring for every patient. Hospital rooms and medical equipment should be thoroughly cleaned often. Safer hospitals will also keep MRSA patients separate from other patients and require providers and visitors to wear gloves and gowns around these patients.

Notes and Definitions

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Exhibit 69



Delray Medical Center

5352 Linton Boulevard
Delray Beach, FL 33484-6580

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Doctors
order
medications
through a
computer



Safe
medication
administratio



Handwashing



Communicati
about
Medicines



Communicati
about
Discharge



Declined to Report¹
Staff
work
together
to
prevent
errors

Hospital Performs:

Worse Than Average Better Than Average

This Hospital's Score:

15 *

Best Hospital's Score:

100

Average Hospital's Score:

80.23

Worst Hospital's Score:

15

Doctors order medications through a computer

Hospitals can use Computerized Physician Order Entry (CPOE) systems to order medications for patients in the hospital, instead of writing out prescriptions by hand. Good CPOE systems alert the doctor if they try to order a medication that could cause harm, such as prescribing an adult dosage for a child. CPOE systems help to reduce medication errors in the hospital.

Hospitals can earn up to 100 points for using a well-functioning CPOE system in most areas of the hospital. [For details on sources, click here.](#)

What safer hospitals do:

Hospitals use CPOE systems in all areas of the hospital and regularly test those systems to ensure they are alerting doctors to potential ordering errors.

Notes and Definitions

1. **Declined to Report:** The hospital was asked to provide this information to the public, but did not.
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Exhibit 70



Good Samaritan Medical Center

1309 N. Flagler Drive
West Palm Beach, FL 33401-3499

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Handwashing



Communicati
about
Medicines



Communicati
about
Discharge



Declined to Report¹
Staff
work
together
to
prevent
errors

Hospital Performs:

Worse Than Average Better Than Average

This Hospital's Score:	Doctors order medications through a computer
15 *	Hospitals can use Computerized Physician Order Entry (CPOE) systems to order medications for patients in the hospital, instead of writing out prescriptions by hand. Good CPOE systems alert the doctor if they try to order a medication that could cause harm, such as prescribing an adult dosage for a child. CPOE systems help to reduce medication errors in the hospital.
Best Hospital's Score:	
100	
Average Hospital's Score:	
80.23	
Worst Hospital's Score:	
15	

Hospitals can earn up to 100 points for using a well-functioning CPOE system in most areas of the hospital. [For details on sources, click here.](#)

What safer hospitals do:
Hospitals use CPOE systems in all areas of the hospital and regularly test those systems to ensure they are alerting doctors to potential ordering errors.

Notes and Definitions

- Declined to Report:** The hospital was asked to provide this information to the public, but did not.
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- * The hospital declined to report their performance on this measure, so a score was assigned to reflect the lack of information available.**

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Exhibit 71



Palm Beach Gardens Medical Center

3360 Burns Road
Palm Beach Gardens, FL 33410-4304

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This Hospital's Grade



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through a
computer



Safe
medication
administratio



Handwashing



Communicati
about
Medicines



Communicati
about
Discharge



Declined to Report¹
Staff
work
together
to
prevent
errors

Hospital Performs:

Worse Than Average Better Than Average

This Hospital's Score:

15 *

Best Hospital's Score:

100

Average Hospital's Score:

80.23

Worst Hospital's Score:

15

Doctors order medications through a computer

Hospitals can use Computerized Physician Order Entry (CPOE) systems to order medications for patients in the hospital, instead of writing out prescriptions by hand. Good CPOE systems alert the doctor if they try to order a medication that could cause harm, such as prescribing an adult dosage for a child. CPOE systems help to reduce medication errors in the hospital.

Hospitals can earn up to 100 points for using a well-functioning CPOE system in most areas of the hospital. [For details on sources, click here.](#)

What safer hospitals do:

Hospitals use CPOE systems in all areas of the hospital and regularly test those systems to ensure they are alerting doctors to potential ordering errors.

Notes and Definitions

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Exhibit 72

LEAPFROG

HOSPITAL

SAFETY GRADE

A program of
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St. Mary's Medical Center

901 45th Street
West Palm Beach, FL 33407-2495

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This Hospital's Score:

15 *

Best Hospital's Score:

100

Average Hospital's Score:

80.23

Worst Hospital's Score:

15

Doctors order medications through a computer

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Exhibit 73



West Boca Medical Center

21644 State Road 7
Boca Raton, FL 33428-1899

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Declined to Report¹
Staff
work
together
to
prevent
errors

Hospital Performs:

Worse Than Average Better Than Average

This Hospital's Score:

15 *

Best Hospital's Score:

100

Average Hospital's Score:

80.23

Worst Hospital's Score:

15

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Delray Medical Center

5352 Linton Boulevard
Delray Beach, FL 33484-6580

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medication
administratio



Handwashing



Communicati
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Communicati
about
Discharge



Declined to Report¹
Staff
work
together
to
prevent
errors

Hospital Performs:

Worse Than Average Better Than Average

This Hospital's Score:

71

Best Hospital's Score:

97

Average Hospital's Score:

85.25

Worst Hospital's Score:

67

Communication about discharge

Patients' perspectives of care are an important part of patient safety. The Communication about Discharge measure summarizes how well the hospital staff communicated with patients about the help they would need at home after leaving the hospital. The measure also summarizes how often patients reported that they were given written information about symptoms or health problems to watch for during their recovery. Educating patients on the steps they need to take during their recovery at home reduces the chances that a patient will need to be readmitted to the hospital.

Based on a scale of zero-100, this number represents a comparison of patients' perspectives of how effectively this hospital communicated with patients about the help they would need after discharge relative to patients' perspectives of how effectively other hospitals communicated with their patients. Higher scores indicate more effective communication than lower scores.

[For details on sources, click here.](#)

What safer hospitals do:

Hospitals that score well on this measure take time with every patient to clarify the patient's responsibilities during her recovery at home, clarify the responsibilities of caregivers at home, and educate the patient on any symptoms that could point to problems in the recovery process.

Notes and Definitions

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43.6K



3050



8091



29.4K



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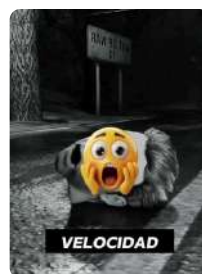
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Go to next video	⬇
Like video	L
Mute / unmute video	M
Play / Pause	⏮
Skip forward	⏭
Skip backward	⏪
Full screen	F

Exhibit 76

Search

For You

Shop

Explore

Following

LIVE

Upload

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More

Log in

Company

Program

Terms & Policies

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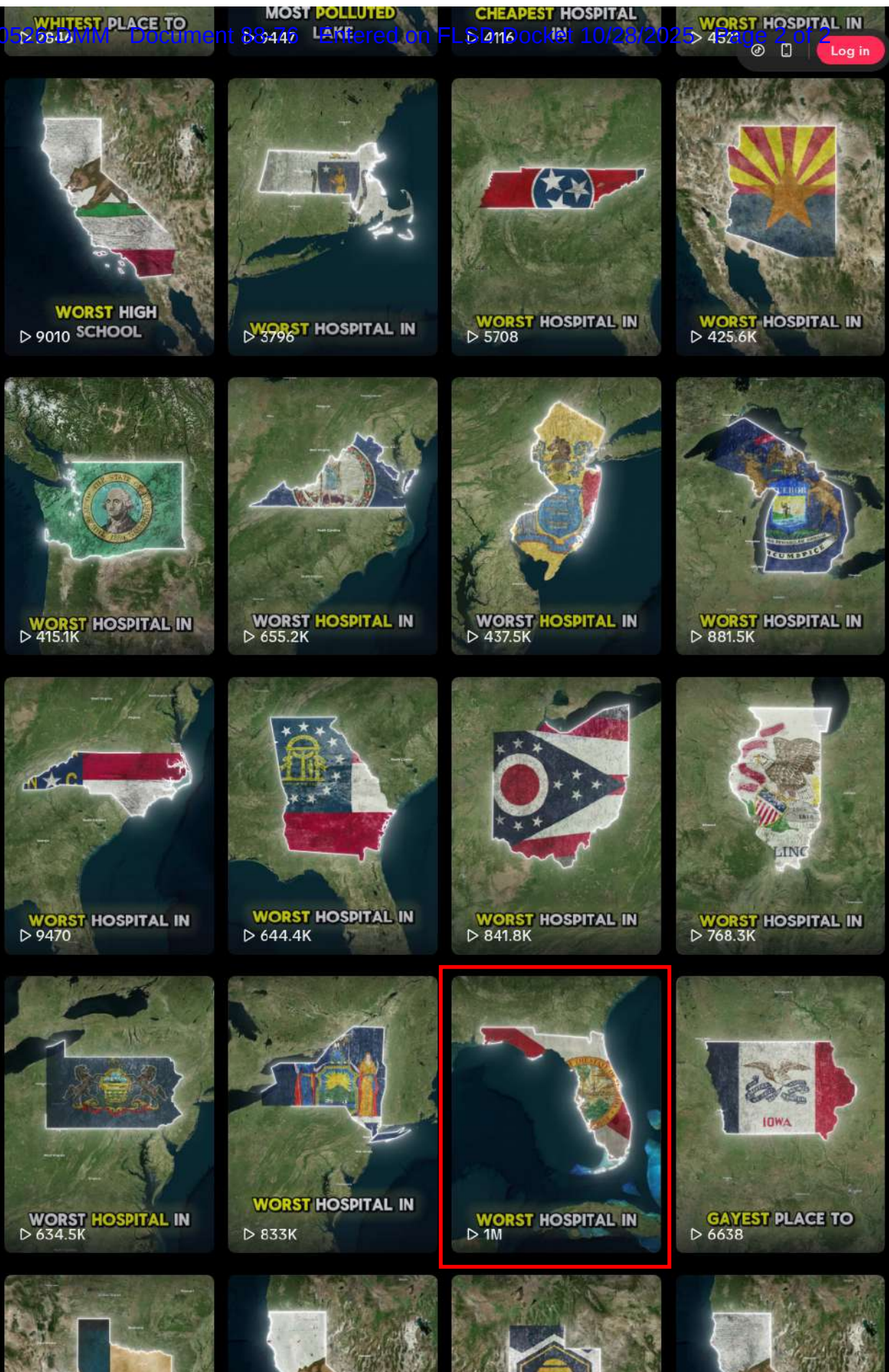


Exhibit 77

M State of legal domicile: DC

Form 990 (2021)

Check if Schedule O contains a response or note to any line in this Part III ☐

1 Briefly describe the organization's mission:

TO TRIGGER GIANT LEAPS FORWARD IN THE SAFETY, QUALITY, AND AFFORDABILITY OF U.S. HEALTH CARE BY USING TRANSPARENCY TO SUPPORT INFORMED HEALTH CARE DECISIONS AND PROMOTE HIGH-VALUE CARE.

2 Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ? ☐ Yes ☒ No

If "Yes," describe these new services on Schedule O.

3 Did the organization cease conducting, or make significant changes in how it conducts, any program services? ☐ Yes ☒ No

If "Yes," describe these changes on Schedule O.

4 Describe the organization's program service accomplishments for each of its three largest program services, as measured by expenses. Section 501(c)(3) and 501(c)(4) organizations are required to report the amount of grants and allocations to others, the total expenses, and revenue, if any, for each program service reported.

4a	(Code:) (Expenses \$ 2,959,937 including grants of \$) (Revenue \$ 255,932)
See Additional Data	

4b	(Code:) (Expenses \$ 1,801,211 including grants of \$) (Revenue \$ 5,496,481)
See Additional Data	

4c	(Code:) (Expenses \$ 1,233,389 including grants of \$) (Revenue \$ 130,718)
See Additional Data	

4d	Other program services (Describe in Schedule O.)
(Expenses \$	including grants of \$) (Revenue \$)

4e	Total program service expenses ▶	5,994,537
-----------	---	-----------

	Yes	No
1 Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? If "Yes," complete Schedule A	1 Yes	
2 Is the organization required to complete Schedule B, Schedule of Contributors? See instructions.	2 Yes	
3 Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? If "Yes," complete Schedule C, Part I	3	No
4 Section 501(c)(3) organizations. Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? If "Yes," complete Schedule C, Part II	4 Yes	
5 Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Rev. Proc. 98-19? If "Yes," complete Schedule C, Part III	5	No
6 Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? If "Yes," complete Schedule D, Part I	6	No
7 Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? If "Yes," complete Schedule D, Part II	7	No
8 Did the organization maintain collections of works of art, historical treasures, or other similar assets? If "Yes," complete Schedule D, Part III	8	No
9 Did the organization report an amount in Part X, line 21 for escrow or custodial account liability; serve as a custodian for amounts not listed in Part X; or provide credit counseling, debt management, credit repair, or debt negotiation services? If "Yes," complete Schedule D, Part IV	9	No
10 Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi endowments? If "Yes," complete Schedule D, Part V	10	No
11 If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X, as applicable.		
a Did the organization report an amount for land, buildings, and equipment in Part X, line 10? If "Yes," complete Schedule D, Part VI	11a Yes	
b Did the organization report an amount for investments—other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part VII	11b	No
c Did the organization report an amount for investments—program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part VIII	11c	No
d Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part IX	11d Yes	
e Did the organization report an amount for other liabilities in Part X, line 25? If "Yes," complete Schedule D, Part X	11e Yes	
f Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? If "Yes," complete Schedule D, Part X	11f Yes	
12a Did the organization obtain separate, independent audited financial statements for the tax year? If "Yes," complete Schedule D, Parts XI and XII	12a	No
b Was the organization included in consolidated, independent audited financial statements for the tax year? If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional	12b Yes	
13 Is the organization a school described in section 170(b)(1)(A)(ii)? If "Yes," complete Schedule E	13	No
14a Did the organization maintain an office, employees, or agents outside of the United States?	14a	No
b Did the organization have aggregate revenues or expenses of more than \$10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at \$100,000 or more? If "Yes," complete Schedule F, Parts I and IV	14b	No
15 Did the organization report on Part IX, column (A), line 3, more than \$5,000 of grants or other assistance to or for any foreign organization? If "Yes," complete Schedule F, Parts II and IV	15	No
16 Did the organization report on Part IX, column (A), line 3, more than \$5,000 of aggregate grants or other assistance to or for foreign individuals? If "Yes," complete Schedule F, Parts III and IV	16	No
17 Did the organization report a total of more than \$15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? If "Yes," complete Schedule G, Part I. See instructions.	17	No
18 Did the organization report more than \$15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? If "Yes," complete Schedule G, Part II	18	No
19 Did the organization report more than \$15,000 of gross income from gaming activities on Part VIII, line 9a? If "Yes," complete Schedule G, Part III	19	No
20a Did the organization operate one or more hospital facilities? If "Yes," complete Schedule H	20a	No
b If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	20b	
21 Did the organization report more than \$5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? If "Yes," complete Schedule I, Parts I and II	21	No

	Yes	No
22 Did the organization report more than \$5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? If "Yes," complete Schedule I, Parts I and III		No
23 Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5, about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? If "Yes," complete Schedule J	Yes	
24a Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than \$100,000 as of the last day of the year, that was issued after December 31, 2002? If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a		No
b Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?		
c Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?		
d Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?		
25a Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations. Did the organization engage in an excess benefit transaction with a disqualified person during the year? If "Yes," complete Schedule L, Part I		No
b Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? If "Yes," complete Schedule L, Part I		No
26 Did the organization report any amount on Part X, line 5 or 22 for receivables from or payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons? If "Yes," complete Schedule L, Part II		No
27 Did the organization provide a grant or other assistance to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or employee thereof, a grant selection committee member, or to a 35% controlled entity (including an employee thereof) or family member of any of these persons? If "Yes," complete Schedule L, Part III		No
28 Was the organization a party to a business transaction with one of the following parties (see the Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions):		
a A current or former officer, director, trustee, key employee, creator or founder, or substantial contributor? If "Yes," complete Schedule L, Part IV		No
b A family member of any individual described in line 28a? If "Yes," complete Schedule L, Part IV		No
c A 35% controlled entity of one or more individuals and/or organizations described in line 28a or 28b? If "Yes," complete Schedule L, Part IV		No
29 Did the organization receive more than \$25,000 in non-cash contributions? If "Yes," complete Schedule M		No
30 Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? If "Yes," complete Schedule M		No
31 Did the organization liquidate, terminate, or dissolve and cease operations? If "Yes," complete Schedule N, Part I		No
32 Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? If "Yes," complete Schedule N, Part II		No
33 Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? If "Yes," complete Schedule R, Part I	Yes	
34 Was the organization related to any tax-exempt or taxable entity? If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1		No
35a Did the organization have a controlled entity within the meaning of section 512(b)(13)?		No
b If "Yes" to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? If "Yes," complete Schedule R, Part V, line 2		
36 Section 501(c)(3) organizations. Did the organization make any transfers to an exempt non-charitable related organization? If "Yes," complete Schedule R, Part V, line 2		No
37 Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? If "Yes," complete Schedule R, Part VI		No
38 Did the organization complete Schedule O and provide explanations on Schedule O for Part VI, lines 11b and 19? Note. All Form 990 filers are required to complete Schedule O.	Yes	

Part V Statements Regarding Other IRS Filings and Tax ComplianceCheck if Schedule O contains a response or note to any line in this Part V ☐

	Yes	No
1a Enter the number reported in box 3 of Form 1096. Enter -0- if not applicable		
b Enter the number of Forms W-2G included on line 1a. Enter -0- if not applicable		
c Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	Yes	

Form 990 (2021)

Section A. Governing Body and Management

	Yes	No
1a Enter the number of voting members of the governing body at the end of the tax year If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O.	1a	20
b Enter the number of voting members included in line 1a, above, who are independent	1b	20
2 Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?	2	No
3 Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person?	3	No
4 Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	4	No
5 Did the organization become aware during the year of a significant diversion of the organization's assets?	5	No
6 Did the organization have members or stockholders?	6	No
7a Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?	7a	No
b Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	7b	No
8 Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:		
a The governing body?	8a	Yes
b Each committee with authority to act on behalf of the governing body?	8b	Yes
9 Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses in Schedule O	9	No

Section B. Policies (This Section B requests information about policies not required by the Internal Revenue Code.)

	Yes	No
10a Did the organization have local chapters, branches, or affiliates?	10a	No
b If "Yes," did the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with the organization's exempt purposes?	10b	
11a Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form?	11a	Yes
b Describe on Schedule O the process, if any, used by the organization to review this Form 990.		
12a Did the organization have a written conflict of interest policy? If "No," go to line 13	12a	Yes
b Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts?	12b	Yes
c Did the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," describe on Schedule O how this was done	12c	Yes
13 Did the organization have a written whistleblower policy?	13	Yes
14 Did the organization have a written document retention and destruction policy?	14	Yes
15 Did the process for determining compensation of the following persons include a review and approval by independent persons, comparability data, and contemporaneous substantiation of the deliberation and decision?		
a The organization's CEO, Executive Director, or top management official	15a	Yes
b Other officers or key employees of the organization	15b	Yes
If "Yes" to line 15a or 15b, describe the process on Schedule O. See instructions.		
16a Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a taxable entity during the year?	16a	No
b If "Yes," did the organization follow a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and take steps to safeguard the organization's exempt status with respect to such arrangements?	16b	

Section C. Disclosure

17 List the states with which a copy of this Form 990 is required to be filed: _____

18 Section 6104 requires an organization to make its Form 1023 (1024 or 1024-A, if applicable), 990, and 990-T (section 501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.

☐ Own website ☐ Another's website ☒ Upon request ☐ Other (explain in Schedule O)

19 Describe in Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.

20 State the name, address, and telephone number of the person who possesses the organization's books and records:
 ▶ LEAH BINDER THE LEAPFROG GROUP 1775 K STREET NW 400 WASHINGTON, DC 20006 (202) 292-6713

and Independent Contractors

Check if Schedule O contains a response or note to any line in this Part VII ☐

Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

1a Complete this table for all persons required to be listed. Report compensation for the calendar year ending with or within the organization's tax year.

- List all of the organization's **current** officers, directors, trustees (whether individuals or organizations), regardless of amount of compensation. Enter -0- in columns (D), (E), and (F) if no compensation was paid.
- List all of the organization's **current** key employees, if any. See the instructions for definition of "key employee."
- List the organization's five **current** highest compensated employees (other than an officer, director, trustee or key employee) who received reportable compensation (box 5 of Form W-2, Form 1099-MISC, and/or box 1 of Form 1099-NEC) of more than \$100,000 from the organization and any related organizations.
- List all of the organization's **former** officers, key employees, or highest compensated employees who received more than \$100,000 of reportable compensation from the organization and any related organizations.
- List all of the organization's **former directors or trustees** that received, in the capacity as a former director or trustee of the organization, more than \$10,000 of reportable compensation from the organization and any related organizations.

See the instructions for the order in which to list the persons above.

☐ Check this box if neither the organization nor any related organization compensated any current officer, director, or trustee.

[illegible]

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC/1099-NEC)	(E) Reportable compensation from related organizations (W-2/1099-MISC/1099-NEC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
See Additional Data Table										
1b Sub-Total										
c Total from continuation sheets to Part VII, Section A										
d Total (add lines 1b and 1c)								1,996,535	0	326,182

2 Total number of individuals (including but not limited to those listed above) who received more than \$100,000 of reportable compensation from the organization ▶ 8

	Yes	No
3 Did the organization list any former officer, director or trustee, key employee, or highest compensated employee on line 1a? <i>If "Yes," complete Schedule J for such individual</i>	3	No
4 For any individual listed on line 1a, is the sum of reportable compensation and other compensation from the organization and related organizations greater than \$150,000? <i>If "Yes," complete Schedule J for such individual</i>	4	Yes
5 Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization? <i>If "Yes," complete Schedule J for such person</i>	5	No

Section B. Independent Contractors

1 Complete this table for your five highest compensated independent contractors that received more than \$100,000 of compensation from the organization. Report compensation for the calendar year ending with or within the organization's tax year.

(A) Name and business address	(B) Description of services	(C) Compensation
THE JOHNS HOPKINS UNIVERSITY 733 NORTH BOARDWAY SUITE 117 BALTIMORE, MD 21205	CONSULTANTS	331,098
SKVARE LLC PO BOX 601033 DALLAS, TX 75360	CONSULTANTS	248,325
JPA HEALTH COMMUNICATIONS 1101 CONNECTICUT AVE NW SUITE 600 WASHINGTON, DC 20001	CONSULTANTS	217,169
TELAFFECTS 300 INTERNATIONAL PKWY SUITE 250 LAKE MARY, FL 32746	CONSULTANTS	204,352
PRICE MODERN 799 9TH STREET NW SUITE 250 WASHINGTON, DC 20001	CONSULTANTS	122,011

2 Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 of compensation from the organization ▶ 6

Check if Schedule O contains a response or note to any line in this Part VIII ☐

			(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512 - 514	
Contributions, Gifts, Grants and Other Similar Amounts	1a Federated campaigns . . .	1a					
	b Membership dues . . .	1b	372,915				
	c Fundraising events . . .	1c					
	d Related organizations	1d					
	e Government grants (contributions)	1e					
	f All other contributions, gifts, grants, and similar amounts not included above	1f	992,904				
	g Noncash contributions included in lines 1a - 1f:\$	1g					
	h Total. Add lines 1a-1f			1,365,819			
Program Service Revenue	2a COMMUNICATIONS AGREEME	Business Code					
		900099	3,280,947	3,280,947			
	b DATA USE AGREEMENTS	900099	2,203,109	2,203,109			
	c EDUCATION PLATFORM	900099	223,707	223,707			
	d CONFERENCE REVENUE	900099	102,426	102,426			
	e MEDIA PARTNERSHIP	900099	59,442	59,442			
	f All other program service revenue.		13,500	13,500			
g Total. Add lines 2a-2f.		5,883,131					
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts)		449			449	
	4 Income from investment of tax-exempt bond proceeds						
	5 Royalties						
		(i) Real	(ii) Personal				
	6a Gross rents	6a					
	b Less: rental expenses	6b					
	c Rental income or (loss)	6c					
	d Net rental income or (loss)						
		(i) Securities	(ii) Other				
	7a Gross amount from sales of assets other than inventory	7a					
	b Less: cost or other basis and sales expenses	7b					
	c Gain or (loss)	7c					
	d Net gain or (loss)						
	8a Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c). See Part IV, line 18	8a					
	b Less: direct expenses	8b					
	c Net income or (loss) from fundraising events						
	9a Gross income from gaming activities. See Part IV, line 19	9a					
	b Less: direct expenses	9b					
	c Net income or (loss) from gaming activities						
	10a Gross sales of inventory, less returns and allowances	10a					
b Less: cost of goods sold	10b						
c Net income or (loss) from sales of inventory							
Miscellaneous Revenue		Business Code					
11a							
b							
c							
d All other revenue							
e Total. Add lines 11a-11d							
12 Total revenue. See instructions			7,249,399	5,883,131	0	449	

Part IX **Statement of Functional Expenses** **Form 990-60576-04M Document 88-77 Entered on FLSD Docket 10/28/2025 Page 11 of 48**
 Section 501(c)(3) and 501(c)(4) organizations must complete all columns. All other organizations must complete column (A).

Check if Schedule O contains a response or note to any line in this Part IX ☐

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21				
2 Grants and other assistance to domestic individuals. See Part IV, line 22				
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16.				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees	1,312,020	1,209,484	72,785	29,751
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)				
7 Other salaries and wages	2,166,744	1,506,757	478,433	181,554
8 Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions)	135,397	108,874	18,020	8,503
9 Other employee benefits	270,928	223,711	29,686	17,531
10 Payroll taxes	200,891	155,682	33,110	12,099
11 Fees for services (non-employees):				
a Management				
b Legal	70,183	5,053	65,130	
c Accounting	135,998		135,998	
d Lobbying				
e Professional fundraising services. See Part IV, line 17				
f Investment management fees				
g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O.)	675,539	669,539	6,000	
12 Advertising and promotion	283,130	268,765		14,365
13 Office expenses	70,994	68,793	1,980	221
14 Information technology	569,820	536,447	12,101	21,272
15 Royalties				
16 Occupancy	401,112		401,112	
17 Travel	98,791	92,250	3,775	2,766
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings	196,651	190,703	5,821	127
20 Interest				
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	238,235	202,712	19,769	15,754
23 Insurance	60,783		60,783	
24 Other expenses. Itemize expenses not covered above (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a COMMUNICATIONS	221,129	221,129		
b DATA AQUISITIONS	48,973	48,973		
c RECRUITING AND TRAINING	46,492	46,049	443	
d DUES AND SUBSCRIPTIONS	30,927	27,695	3,232	
e All other expenses	10,922	411,921	-443,933	42,934
25 Total functional expenses. Add lines 1 through 24e	7,245,659	5,994,537	904,245	346,877
26 Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here ☐ if following SOP 98-2 (ASC 958-720).				

Check if Schedule O contains a response or note to any line in this Part IX ☐

		(A) Beginning of year		(B) End of year
Assets	1 Cash—non-interest-bearing	1,180,297	1	984,762
	2 Savings and temporary cash investments	1,665,903	2	2,875,847
	3 Pledges and grants receivable, net	9,801	3	57,301
	4 Accounts receivable, net	230,690	4	570,021
	5 Loans and other receivables from any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons		5	
	6 Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), and persons described in section 4958(c)(3)(B)		6	
	7 Notes and loans receivable, net		7	
	8 Inventories for sale or use		8	
	9 Prepaid expenses and deferred charges	94,926	9	140,710
	10a Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	1,335,001		
	b Less: accumulated depreciation	627,982		
		805,408	10c	707,019
	11 Investments—publicly traded securities		11	
	12 Investments—other securities. See Part IV, line 11		12	
	13 Investments—program-related. See Part IV, line 11		13	
	14 Intangible assets		14	
15 Other assets. See Part IV, line 11	3,910,253	15	3,516,852	
16 Total assets. Add lines 1 through 15 (must equal line 33)	7,897,278	16	8,852,512	
Liabilities	17 Accounts payable and accrued expenses	580,600	17	467,317
	18 Grants payable		18	
	19 Deferred revenue	959,788	19	1,056,019
	20 Tax-exempt bond liabilities		20	
	21 Escrow or custodial account liability. Complete Part IV of Schedule D		21	
	22 Loans and other payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons		22	
	23 Secured mortgages and notes payable to unrelated third parties		23	
	24 Unsecured notes and loans payable to unrelated third parties		24	
	25 Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17 - 24). Complete Part X of Schedule D	4,196,875	25	5,161,216
	26 Total liabilities. Add lines 17 through 25	5,737,263	26	6,684,552
Net Assets or Fund Balances	Organizations that follow FASB ASC 958, check here ☒ and complete lines 27, 28, 32, and 33.			
	27 Net assets without donor restrictions	2,160,015	27	2,167,960
	28 Net assets with donor restrictions		28	
	Organizations that do not follow FASB ASC 958, check here ☐ and complete lines 29 through 33.			
	29 Capital stock or trust principal, or current funds		29	
	30 Paid-in or capital surplus, or land, building or equipment fund		30	
	31 Retained earnings, endowment, accumulated income, or other funds		31	
	32 Total net assets or fund balances	2,160,015	32	2,167,960
33 Total liabilities and net assets/fund balances	7,897,278	33	8,852,512	

Check if Schedule O contains a response or note to any line in this Part XI ☐

1	Total revenue (must equal Part VIII, column (A), line 12)	1	7,249,399
2	Total expenses (must equal Part IX, column (A), line 25)	2	7,245,659
3	Revenue less expenses. Subtract line 2 from line 1	3	3,740
4	Net assets or fund balances at beginning of year (must equal Part X, line 32, column (A))	4	2,160,015
5	Net unrealized gains (losses) on investments	5	
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	4,205
9	Other changes in net assets or fund balances (explain in Schedule O)	9	0
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 32, column (B))	10	2,167,960

Part XII Financial Statements and Reporting

Check if Schedule O contains a response or note to any line in this Part XII ☒

	Yes	No
1 Accounting method used to prepare the Form 990: ☐ Cash ☒ Accrual ☐ Other _____ If the organization changed its method of accounting from a prior year or checked "Other," explain on Schedule O.		
2a Were the organization's financial statements compiled or reviewed by an independent accountant? If "Yes," check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both: ☐ Separate basis ☐ Consolidated basis ☐ Both consolidated and separate basis		No
b Were the organization's financial statements audited by an independent accountant? If "Yes," check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both: ☐ Separate basis ☒ Consolidated basis ☐ Both consolidated and separate basis	Yes	
c If "Yes," to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant? If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O.	Yes	
3a As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?		No
b If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits.		

Additional Data

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Software ID:

Software Version:

EIN: 52-2359517

Name: THE LEAPFROG GROUP

Form 990 (2021)

Form 990, Part III, Line 4a:

RATINGS: LEAPFROG FIELDS A VOLUNTARY SURVEY OF HOSPITALS AND AMBULATORY SURGERY CENTERS ON QUALITY AND SAFETY PRACTICES. THE SURVEYS INVOLVE MEASURE DEVELOPMENT AND ARE UPDATED ANNUALLY. THE HOSPITAL SURVEY ALSO INCLUDES A TOOL TO EVALUATE SYSTEMS FOR COMPUTERIZED PHYSICIAN ORDER ENTRY OF PHARMACEUTICALS. IN ADDITION, THE DATA FROM THE HOSPITAL SURVEY ARE COMBINED WITH DATA FROM OTHER SOURCES TO FURTHER UNDERSTAND HOSPITAL QUALITY AND SAFETY. THE ORGANIZATION PUBLICLY RATES U.S. HOSPITALS ON THEIR SAFETY IN AN INITIATIVE CALLED THE LEAPFROG HOSPITAL SAFETY GRADE.

Form 990, Part III, Line 4b:

COMMUNICATIONS LEAPFROG COLLECTS, ANALYZES AND DISSEMINATES HEALTH CARE DATA ON QUALITY AND SAFETY TO CONSUMERS AND PURCHASERS TO HELP THEM MAKE DECISIONS ON WHERE TO SEEK CARE. HEALTH CARE PROVIDERS ALSO FIND THE INFORMATION USEFUL FOR THEIR OWN IMPROVEMENT PROGRAMS AND THE OPPORTUNITY TO BENCHMARK AGAINST THEIR PEERS. LEAPFROG WORKS WITH PRINT, RADIO, TELEVISION, DIGITAL AND SOCIAL MEDIA PLATFORMS TO SPREAD INFORMATION ABOUT ITS HEALTH CARE RATINGS AND REPORTS.

Form 990, Part III, Line 4c:

MEMBERSHIP LEAPFROG WORKS WITH EMPLOYERS AND PURCHASERS OF HEALTH CARE TO ENCOURAGE TRANSPARENCY FROM THE HEALTH CARE COMMUNITY AND EDUCATE EMPLOYEES ON THE SAFEST AND HIGHEST QUALITY PROVIDERS. LEAPFROG ALSO COLLECTS DUES FROM AN ADVISORY COMMITTEE OF HEALTH CARE-FOCUSED COMPANIES WHO OFFER ADVICE AND SUGGESTIONS TO LEAPFROG BUT DO NOT HAVE A GOVERNING ROLE.

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
DAVID GOLDHILL IMMEDIATE PAST CHAIR	6.00	X		X				0	0	0
CRISTIE TRAVIS CHAIR, NOMINATIONS COMMITTEE	6.00	X		X				0	0	0
DAVID HOPKINS CHAIR, AUDIT COMMITTEE	6.00	X		X				0	0	0
SALLY WELBORN SECRETARY	6.00	X		X				0	0	0
IRENE FRASER BOARD MEMBER	3.00	X						0	0	0
BILL BONK BOARD MEMBER	3.00	X						0	0	0
RAQUEL C BONO BOARD MEMBER	3.00	X						0	0	0
ARNOLD MILSTEIN BOARD MEMBER	3.00	X						0	0	0
DOLORES MITCHELL BOARD MEMBER	3.00	X						0	0	0
LINDA SCHWIMMER VICE CHAIR	3.00	X						0	0	0

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
MICHELLE MARTIN CHAIR	3.00	X		X				0	0	0
MARSHA MANNING BOARD MEMBER	3.00	X						0	0	0
MAUREEN RYAN BOARD MEMBER	3.00	X						0	0	0
JOHN G ZERN TREASURER	3.00	X		X				0	0	0
LINA WALKER BOARD MEMBER	3.00	X						0	0	0
AARON SCHRADER BOARD MEMBER	3.00	X						0	0	0
KENNETH MENDEZ BOARD MEMBER	3.00	X						0	0	0
G RUMAY ALEXANDER BOARD MEMBER	3.00	X						0	0	0
LEAH BINDER PRESIDENT & CEO	40.00			X				568,717	0	72,895
MELISSA DANFORTH VP, HEALTH CARE RATINGS	40.00				X			350,459	0	58,912

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
ERICA MOBLEY VP FOR ADMINISTRATION	40.00				X			279,300	0	51,288
RALPH JOHNSON VP OF INFORMATICS AND TECH	40.00					X		259,537	0	56,879
KATHRYN BURGGRAFSTEWART DIRECTOR, HEALTH CARE RATJ	40.00					X		124,093	0	25,458
ANGELA HOPKINS OFFICE ADMINISTRATOR	40.00					X		114,051	0	26,144
JILL BERGER DIRECTOR, EMPLOYER AND PAYOR ENGAGEMENT	40.00					X		182,939	0	28,082
RYAN KREISBERG SENIOR PROGRAM ANALYST	40.00					X		117,439	0	6,524

SCHEDULE A (Form 990) Department of the Treasury Internal Revenue Service	Public Charity Status and Public Support 88 Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust. ▶ Attach to Form 990 or Form 990-EZ. ▶ Go to www.irs.gov/Form990 for instructions and the latest information.	2021 Open to Public Inspection
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Name of the organization THE LEAPFROG GROUP	Employer identification number 52-2359517
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Part I Reason for Public Charity Status (All organizations must complete this part.) See instructions.

The organization is not a private foundation because it is: (For lines 1 through 12, check only one box.)

- 1 ☐ A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i).**
- 2 ☐ A school described in **section 170(b)(1)(A)(ii).** (Attach Schedule E (Form 990).)
- 3 ☐ A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii).**
- 4 ☐ A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii).** Enter the hospital's name, city, and state:
- 5 ☐ An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv).** (Complete Part II.)
- 6 ☐ A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v).**
- 7 ☐ An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi).** (Complete Part II.)
- 8 ☐ A community trust described in **section 170(b)(1)(A)(vi).** (Complete Part II.)
- 9 ☐ An agricultural research organization described in **170(b)(1)(A)(ix)** operated in conjunction with a land-grant college or university or a non-land grant college of agriculture. See instructions. Enter the name, city, and state of the college or university:
- 10 ☒ An organization that normally receives: (1) more than 33 1/3% of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions—subject to certain exceptions, and (2) no more than 33 1/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975. See **section 509(a)(2).** (Complete Part III.)
- 11 ☐ An organization organized and operated exclusively to test for public safety. See **section 509(a)(4).**
- 12 ☐ An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in **section 509(a)(1)** or **section 509(a)(2).** See **section 509(a)(3).** Check the box on lines 12a through 12d that describes the type of supporting organization and complete lines 12e, 12f, and 12g.
 - a ☐ **Type I.** A supporting organization operated, supervised, or controlled by its supported organization(s), typically by giving the supported organization(s) the power to regularly appoint or elect a majority of the directors or trustees of the supporting organization. **You must complete Part IV, Sections A and B.**
 - b ☐ **Type II.** A supporting organization supervised or controlled in connection with its supported organization(s), by having control or management of the supporting organization vested in the same persons that control or manage the supported organization(s). **You must complete Part IV, Sections A and C.**
 - c ☐ **Type III functionally integrated.** A supporting organization operated in connection with, and functionally integrated with, its supported organization(s) (see instructions). **You must complete Part IV, Sections A, D, and E.**
 - d ☐ **Type III non-functionally integrated.** A supporting organization operated in connection with its supported organization(s) that is not functionally integrated. The organization generally must satisfy a distribution requirement and an attentiveness requirement (see instructions). **You must complete Part IV, Sections A and D, and Part V.**
 - e ☐ Check this box if the organization received a written determination from the IRS that it is a Type I, Type II, Type III functionally integrated, or Type III non-functionally integrated supporting organization.
 - f Enter the number of supported organizations
 - g Provide the following information about the supported organization(s).

(i) Name of supported organization	(ii) EIN	(iii) Type of organization (described on lines 1- 10 above (see instructions))	(iv) Is the organization listed in your governing document?		(v) Amount of monetary support (see instructions)	(vi) Amount of other support (see instructions)
			Yes	No		
Total						

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2017	(b) 2018	(c) 2019	(d) 2020	(e) 2021	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grant.") . . .						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf. . . .						
3 The value of services or facilities furnished by a governmental unit to the organization without charge..						
4 Total. Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f) . . .						
6 Public support. Subtract line 5 from line 4.						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2017	(b) 2018	(c) 2019	(d) 2020	(e) 2021	(f) Total
7 Amounts from line 4. . .						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources. . . .						
9 Net income from unrelated business activities, whether or not the business is regularly carried on. .						
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.). . .						
11 Total support. Add lines 7 through 10						
12 Gross receipts from related activities, etc. (see instructions)					12	
13 First 5 years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here ▶ ☐						

Section C. Computation of Public Support Percentage

14 Public support percentage for 2021 (line 6, column (f) divided by line 11, column (f))	14	
15 Public support percentage for 2020 Schedule A, Part II, line 14	15	
16a 33 1/3% support test—2021. If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization ▶ ☐		
b 33 1/3% support test—2020. If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization ▶ ☐		
17a 10%-facts-and-circumstances test—2021. If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ▶ ☐		
b 10%-facts-and-circumstances test—2020. If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ▶ ☐		
18 Private foundation. If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions ▶ ☐		

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 Part I Support Schedule for Organizations Described in Section 509(a)(2)
 (Complete only if you checked the box on line 10, Part I or if the organization failed to qualify under Part II. If the organization fails to qualify under the tests listed below, please complete Part II.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2017	(b) 2018	(c) 2019	(d) 2020	(e) 2021	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")	47,172	55,752	435,427	1,419,432	1,365,819	3,323,602
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose	4,321,132	5,738,194	5,446,926	5,560,125	5,883,131	26,949,508
3 Gross receipts from activities that are not an unrelated trade or business under section 513						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 Total. Add lines 1 through 5	4,368,304	5,793,946	5,882,353	6,979,557	7,248,950	30,273,110
7a Amounts included on lines 1, 2, and 3 received from disqualified persons	25,000	52,000	77,500	50,000	127,820	332,320
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of \$5,000 or 1% of the amount on line 13 for the year.	390,205	528,045	896,002	803,522	790,599	3,408,373
c Add lines 7a and 7b.	415,205	580,045	973,502	853,522	918,419	3,740,693
8 Public support. (Subtract line 7c from line 6.)						26,532,417

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2017	(b) 2018	(c) 2019	(d) 2020	(e) 2021	(f) Total
9 Amounts from line 6.	4,368,304	5,793,946	5,882,353	6,979,557	7,248,950	30,273,110
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources	1,014	6,336	1,293	181	449	9,273
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975.						
c Add lines 10a and 10b.	1,014	6,336	1,293	181	449	9,273
11 Net income from unrelated business activities not included on line 10b, whether or not the business is regularly carried on.						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
13 Total support. (Add lines 9, 10c, 11, and 12.)	4,369,318	5,800,282	5,883,646	6,979,738	7,249,399	30,282,383
14 First 5 years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here. ▶ ☐						

Section C. Computation of Public Support Percentage

15 Public support percentage for 2021 (line 8, column (f) divided by line 13, column (f))	15	87.620 %
16 Public support percentage from 2020 Schedule A, Part III, line 15	16	88.260 %

Section D. Computation of Investment Income Percentage

17 Investment income percentage for 2021 (line 10c, column (f) divided by line 13, column (f))	17	0.030 %
18 Investment income percentage from 2020 Schedule A, Part III, line 17	18	0.030 %

- 19a 33 1/3% support tests—2021.** If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization. ▶ ☒
- b 33 1/3% support tests—2020.** If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3% and line 18 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization. ▶ ☐
- 20 Private foundation.** If the organization did not check a box on line 14, 19a, or 19b, check this box and see instructions. ▶ ☐

Part VII Supporting Organizations

(Complete only if you checked a box on line 12 of Part I. If you checked box 12a, of Part I, complete Sections A and B. If you checked box 12b, of Part I, complete Sections A and C. If you checked box 12c, of Part I, complete Sections A, D, and E. If you checked box 12d, of Part I, complete Sections A and D, and complete Part V.)

Section A. All Supporting Organizations

	Yes	No
1 Are all of the organization's supported organizations listed by name in the organization's governing documents? If "No," describe in Part VI how the supported organizations are designated. If designated by class or purpose, describe the designation. If historic and continuing relationship, explain.		
1		
2 Did the organization have any supported organization that does not have an IRS determination of status under section 509(a)(1) or (2)? If "Yes," explain in Part VI how the organization determined that the supported organization was described in section 509(a)(1) or (2).		
2		
3a Did the organization have a supported organization described in section 501(c)(4), (5), or (6)? If "Yes," answer lines 3b and 3c below.		
3a		
b Did the organization confirm that each supported organization qualified under section 501(c)(4), (5), or (6) and satisfied the public support tests under section 509(a)(2)? If "Yes," describe in Part VI when and how the organization made the determination.		
3b		
c Did the organization ensure that all support to such organizations was used exclusively for section 170(c)(2)(B) purposes? If "Yes," explain in Part VI what controls the organization put in place to ensure such use.		
3c		
4a Was any supported organization not organized in the United States ("foreign supported organization")? If "Yes" and if you checked box 12a or 12b in Part I, answer lines 4b and 4c below.		
4a		
b Did the organization have ultimate control and discretion in deciding whether to make grants to the foreign supported organization? If "Yes," describe in Part VI how the organization had such control and discretion despite being controlled or supervised by or in connection with its supported organizations.		
4b		
c Did the organization support any foreign supported organization that does not have an IRS determination under sections 501(c)(3) and 509(a)(1) or (2)? If "Yes," explain in Part VI what controls the organization used to ensure that all support to the foreign supported organization was used exclusively for section 170(c)(2)(B) purposes.		
4c		
5a Did the organization add, substitute, or remove any supported organizations during the tax year? If "Yes," answer lines 5b and 5c below (if applicable). Also, provide detail in Part VI , including (i) the names and EIN numbers of the supported organizations added, substituted, or removed; (ii) the reasons for each such action; (iii) the authority under the organization's organizing document authorizing such action; and (iv) how the action was accomplished (such as by amendment to the organizing document).		
5a		
b Type I or Type II only. Was any added or substituted supported organization part of a class already designated in the organization's organizing document?		
5b		
c Substitutions only. Was the substitution the result of an event beyond the organization's control?		
5c		
6 Did the organization provide support (whether in the form of grants or the provision of services or facilities) to anyone other than (i) its supported organizations, (ii) individuals that are part of the charitable class benefited by one or more of its supported organizations, or (iii) other supporting organizations that also support or benefit one or more of the filing organization's supported organizations? If "Yes," provide detail in Part VI .		
6		
7 Did the organization provide a grant, loan, compensation, or other similar payment to a substantial contributor (defined in section 4958(c)(3)(C)), a family member of a substantial contributor, or a 35% controlled entity with regard to a substantial contributor? If "Yes," complete Part I of Schedule L (Form 990).		
7		
8 Did the organization make a loan to a disqualified person (as defined in section 4958) not described on line 7? If "Yes," complete Part I of Schedule L (Form 990).		
8		
9a Was the organization controlled directly or indirectly at any time during the tax year by one or more disqualified persons, as defined in section 4946 (other than foundation managers and organizations described in section 509(a)(1) or (2))? If "Yes," provide detail in Part VI .		
9a		
b Did one or more disqualified persons (as defined on line 9a) hold a controlling interest in any entity in which the supporting organization had an interest? If "Yes," provide detail in Part VI .		
9b		
c Did a disqualified person (as defined on line 9a) have an ownership interest in, or derive any personal benefit from, assets in which the supporting organization also had an interest? If "Yes," provide detail in Part VI .		
9c		
10a Was the organization subject to the excess business holdings rules of section 4943 because of section 4943(f) (regarding certain Type II supporting organizations, and all Type III non-functionally integrated supporting organizations)? If "Yes," answer line 10b below.		
10a		
b Did the organization have any excess business holdings in the tax year? (Use Schedule C, Form 4720, to determine whether the organization had excess business holdings).		
10b		

Part VII Supporting Organizations (continued)

	Yes	No
11 Has the organization accepted a gift or contribution from any of the following persons?		
a A person who directly or indirectly controls, either alone or together with persons described on lines 11b and 11c below, the governing body of a supported organization?		
b A family member of a person described on 11a above?		
c A 35% controlled entity of a person described on line 11a or 11b above? If "Yes" to 11a, 11b, or 11c, provide detail in Part VI .		

Section B. Type I Supporting Organizations

	Yes	No
1 Did the officers, directors, trustees, or membership of one or more supported organizations have the power to regularly appoint or elect at least a majority of the organization's directors or trustees at all times during the tax year? If "No," describe in Part VI how the supported organization(s) effectively operated, supervised, or controlled the organization's activities. If the organization had more than one supported organization, describe how the powers to appoint and/or remove directors or trustees were allocated among the supported organizations and what conditions or restrictions, if any, applied to such powers during the tax year.		
2 Did the organization operate for the benefit of any supported organization other than the supported organization(s) that operated, supervised, or controlled the supporting organization? If "Yes," explain in Part VI how providing such benefit carried out the purposes of the supported organization(s) that operated, supervised or controlled the supporting organization.		

Section C. Type II Supporting Organizations

	Yes	No
1 Were a majority of the organization's directors or trustees during the tax year also a majority of the directors or trustees of each of the organization's supported organization(s)? If "No," describe in Part VI how control or management of the supporting organization was vested in the same persons that controlled or managed the supported organization(s).		

Section D. All Type III Supporting Organizations

	Yes	No
1 Did the organization provide to each of its supported organizations, by the last day of the fifth month of the organization's tax year, (i) a written notice describing the type and amount of support provided during the prior tax year, (ii) a copy of the Form 990 that was most recently filed as of the date of notification, and (iii) copies of the organization's governing documents in effect on the date of notification, to the extent not previously provided?		
2 Were any of the organization's officers, directors, or trustees either (i) appointed or elected by the supported organization (s) or (ii) serving on the governing body of a supported organization? If "No," explain in Part VI how the organization maintained a close and continuous working relationship with the supported organization(s).		
3 By reason of the relationship described in line 2 above, did the organization's supported organizations have a significant voice in the organization's investment policies and in directing the use of the organization's income or assets at all times during the tax year? If "Yes," describe in Part VI the role the organization's supported organizations played in this regard.		

Section E. Type III Functionally-Integrated Supporting Organizations

1 Check the box next to the method that the organization used to satisfy the Integral Part Test during the year (see instructions):		
a ☐ The organization satisfied the Activities Test. Complete line 2 below.		
b ☐ The organization is the parent of each of its supported organizations. Complete line 3 below.		
c ☐ The organization supported a governmental entity. Describe in Part VI how you supported a government entity (see instructions)		
2 Activities Test. Answer lines 2a and 2b below.		
a Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? If "Yes," then in Part VI identify those supported organizations and explain how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined that these activities constituted substantially all of its activities.		
b Did the activities described on line 2a, above constitute activities that, but for the organization's involvement, one or more of the organization's supported organization(s) would have been engaged in? If "Yes," explain in Part VI the reasons for the organization's position that its supported organization(s) would have engaged in these activities but for the organization's involvement.		
3 Parent of Supported Organizations. Answer lines 3a and 3b below.		
a Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? If "Yes" or "No," provide details in Part VI .		
b Did the organization exercise a substantial degree of direction over the policies, programs and activities of each of its supported organizations? If "Yes," describe in Part VI the role played by the organization in this regard.		

1 ☐ Check here if the organization satisfied the Integral Part Test as a qualifying trust on Nov. 20, 1970 (explain in Part VI). See instructions. All other Type III non-functionally integrated supporting organizations must complete Sections A through E.			
Section A - Adjusted Net Income		(A) Prior Year	(B) Current Year (optional)
1 Net short-term capital gain	1		
2 Recoveries of prior-year distributions	2		
3 Other gross income (see instructions)	3		
4 Add lines 1 through 3	4		
5 Depreciation and depletion	5		
6 Portion of operating expenses paid or incurred for production or collection of gross income or for management, conservation, or maintenance of property held for production of income (see instructions)	6		
7 Other expenses (see instructions)	7		
8 Adjusted Net Income (subtract lines 5, 6 and 7 from line 4)	8		
Section B - Minimum Asset Amount		(A) Prior Year	(B) Current Year (optional)
1 Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year):	1		
a Average monthly value of securities	1a		
b Average monthly cash balances	1b		
c Fair market value of other non-exempt-use assets	1c		
d Total (add lines 1a, 1b, and 1c)	1d		
e Discount claimed for blockage or other factors (explain in detail in Part VI):			
2 Acquisition indebtedness applicable to non-exempt use assets	2		
3 Subtract line 2 from line 1d	3		
4 Cash deemed held for exempt use. Enter 0.015 of line 3 (for greater amount, see instructions).	4		
5 Net value of non-exempt-use assets (subtract line 4 from line 3)	5		
6 Multiply line 5 by 0.035	6		
7 Recoveries of prior-year distributions	7		
8 Minimum Asset Amount (add line 7 to line 6)	8		
Section C - Distributable Amount			Current Year
1 Adjusted net income for prior year (from Section A, line 8, Column A)	1		
2 Enter 85% of line 1	2		
3 Minimum asset amount for prior year (from Section B, line 8, Column A)	3		
4 Enter greater of line 2 or line 3	4		
5 Income tax imposed in prior year	5		
6 Distributable Amount. Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	6		
7 ☐ Check here if the current year is the organization's first as a non-functionally-integrated Type III supporting organization (see instructions)			

Section D - Distributions		Current Year
1	Amounts paid to supported organizations to accomplish exempt purposes	1
2	Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	2
3	Administrative expenses paid to accomplish exempt purposes of supported organizations	3
4	Amounts paid to acquire exempt-use assets	4
5	Qualified set-aside amounts (prior IRS approval required - provide details in Part VI)	5
6	Other distributions (describe in Part VI). See instructions	6
7	Total annual distributions. Add lines 1 through 6.	7
8	Distributions to attentive supported organizations to which the organization is responsive (provide details in Part VI). See instructions	8
9	Distributable amount for 2021 from Section C, line 6	9
10	Line 8 amount divided by Line 9 amount	10

Section E - Distribution Allocations (see instructions)	(i) Excess Distributions	(ii) Underdistributions Pre-2021	(iii) Distributable Amount for 2021
1	Distributable amount for 2021 from Section C, line 6		
2	Underdistributions, if any, for years prior to 2021 (reasonable cause required-- explain in Part VI). See instructions.		
3	Excess distributions carryover, if any, to 2021:		
a	From 2016.		
b	From 2017.		
c	From 2018.		
d	From 2019.		
e	From 2020.		
f	Total of lines 3a through e		
g	Applied to underdistributions of prior years		
h	Applied to 2021 distributable amount		
i	Carryover from 2016 not applied (see instructions)		
j	Remainder. Subtract lines 3g, 3h, and 3i from line 3f.		
4	Distributions for 2021 from Section D, line 7: \$		
a	Applied to underdistributions of prior years		
b	Applied to 2021 distributable amount		
c	Remainder. Subtract lines 4a and 4b from line 4.		
5	Remaining underdistributions for years prior to 2021, if any. Subtract lines 3g and 4a from line 2. If the amount is greater than zero, explain in Part VI . See instructions.		
6	Remaining underdistributions for 2021. Subtract lines 3h and 4b from line 1. If the amount is greater than zero, explain in Part VI . See instructions.		
7	Excess distributions carryover to 2022. Add lines 3j and 4c.		
8	Breakdown of line 7:		
a	Excess from 2017.		
b	Excess from 2018.		
c	Excess from 2019.		
d	Excess from 2020.		
e	Excess from 2021.		

Part III **Supplemental Information.** Provide the explanations required by Part II, line 10; Part III, line 17a or 17b; Part III, line 2; Part IV, Section A, lines 1, 2, 3b, 3c, 4b, 4c, 5a, 6, 9a, 9b, 9c, 11a, 11b, and 11c; Part IV, Section B, lines 1 and 2; Part IV, Section C, line 1; Part IV, Section D, lines 2 and 3; Part IV, Section E, lines 1c, 2a, 2b, 3a and 3b; Part V, line 1; Part V, Section B, line 1e; Part V Section D, lines 5, 6, and 8; and Part V, Section E, lines 2, 5, and 6. Also complete this part for any additional information. (See instructions).

Facts And Circumstances Test

SCHEDULE C (Form 990) Department of the Treasury Internal Revenue Service	Political Campaign and Lobbying Activities For Organizations Exempt From Income Tax Under section 501(c) and section 527 ▶ Complete if the organization is described below. ▶ Attach to Form 990 or Form 990-EZ. ▶ Go to www.irs.gov/Form990 for instructions and the latest information.	2021 Open to Public Inspection
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If the organization answered "Yes" on Form 990, Part IV, Line 3, or Form 990-EZ, Part V, line 46 (Political Campaign Activities), then

- Section 501(c)(3) organizations: Complete Parts I-A and B. Do not complete Part I-C.
- Section 501(c) (other than section 501(c)(3)) organizations: Complete Parts I-A and C below. Do not complete Part I-B.
- Section 527 organizations: Complete Part I-A only.

If the organization answered "Yes" on Form 990, Part IV, Line 4, or Form 990-EZ, Part VI, line 47 (Lobbying Activities), then

- Section 501(c)(3) organizations that have filed Form 5768 (election under section 501(h)): Complete Part II-A. Do not complete Part II-B.
- Section 501(c)(3) organizations that have NOT filed Form 5768 (election under section 501(h)): Complete Part II-B. Do not complete Part II-A.

If the organization answered "Yes" on Form 990, Part IV, Line 5 (Proxy Tax) (see separate instructions) or Form 990-EZ, Part V, line 35c (Proxy Tax) (see separate instructions), then

- Section 501(c)(4), (5), or (6) organizations: Complete Part III.

Name of the organization THE LEAFROG GROUP	Employer identification number 52-2359517
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Part I-A Complete if the organization is exempt under section 501(c) or is a section 527 organization.

1	Provide a description of the organization's direct and indirect political campaign activities in Part IV. See instructions for definition of "political campaign activities."	
2	Political campaign activity expenditures. See instructions	\$
3	Volunteer hours for political campaign activities. See instructions	

Part I-B Complete if the organization is exempt under section 501(c)(3).

1	Enter the amount of any excise tax incurred by the organization under section 4955	\$
2	Enter the amount of any excise tax incurred by organization managers under section 4955	\$
3	If the organization incurred a section 4955 tax, did it file Form 4720 for this year?	☐ Yes ☐ No
4a	Was a correction made?	☐ Yes ☐ No
b	If "Yes," describe in Part IV.	

Part I-C Complete if the organization is exempt under section 501(c), except section 501(c)(3).

1	Enter the amount directly expended by the filing organization for section 527 exempt function activities	\$
2	Enter the amount of the filing organization's funds contributed to other organizations for section 527 exempt function activities	\$
3	Total exempt function expenditures. Add lines 1 and 2. Enter here and on Form 1120-POL, line 17b.....	\$
4	Did the filing organization file Form 1120-POL for this year?	☐ Yes ☐ No
5	Enter the names, addresses and employer identification number (EIN) of all section 527 political organizations to which the filing organization made payments. For each organization listed, enter the amount paid from the filing organization's funds. Also enter the amount of political contributions received that were promptly and directly delivered to a separate political organization, such as a separate segregated fund or a political action committee (PAC). If additional space is needed, provide information in Part IV.	

(a) Name	(b) Address	(c) EIN	(d) Amount paid from filing organization's funds. If none, enter -0-.	(e) Amount of political contributions received and promptly and directly delivered to a separate political organization. If none, enter -0-.
1				
2				
3				
4				
5				
6				

Part II-A

Complete if the organization is exempt under section 501(c)(3) and filed Form 5768 (election under section 501(h)).

- A Check ☐ if the filing organization belongs to an affiliated group (and list in Part IV each affiliated group member's name, address, EIN, expenses, and share of excess lobbying expenditures).
- B Check ☐ if the filing organization checked box A and "limited control" provisions apply.

Limits on Lobbying Expenditures (The term "expenditures" means amounts paid or incurred.)		(a) Filing organization's totals	(b) Affiliated group totals												
1a Total lobbying expenditures to influence public opinion (grass roots lobbying)		0													
b Total lobbying expenditures to influence a legislative body (direct lobbying)		0													
c Total lobbying expenditures (add lines 1a and 1b)		0													
d Other exempt purpose expenditures		7,245,659													
e Total exempt purpose expenditures (add lines 1c and 1d)		7,245,659													
f Lobbying nontaxable amount. Enter the amount from the following table in both columns.		512,283													
<table><thead><tr><th>If the amount on line 1e, column (a) or (b) is:</th><th>The lobbying nontaxable amount is:</th></tr></thead><tbody><tr><td>Not over \$500,000</td><td>20% of the amount on line 1e.</td></tr><tr><td>Over \$500,000 but not over \$1,000,000</td><td>\$100,000 plus 15% of the excess over \$500,000.</td></tr><tr><td>Over \$1,000,000 but not over \$1,500,000</td><td>\$175,000 plus 10% of the excess over \$1,000,000.</td></tr><tr><td>Over \$1,500,000 but not over \$17,000,000</td><td>\$225,000 plus 5% of the excess over \$1,500,000.</td></tr><tr><td>Over \$17,000,000</td><td>\$1,000,000.</td></tr></tbody></table>		If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:	Not over \$500,000	20% of the amount on line 1e.	Over \$500,000 but not over \$1,000,000	\$100,000 plus 15% of the excess over \$500,000.	Over \$1,000,000 but not over \$1,500,000	\$175,000 plus 10% of the excess over \$1,000,000.	Over \$1,500,000 but not over \$17,000,000	\$225,000 plus 5% of the excess over \$1,500,000.	Over \$17,000,000	\$1,000,000.		
If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:														
Not over \$500,000	20% of the amount on line 1e.														
Over \$500,000 but not over \$1,000,000	\$100,000 plus 15% of the excess over \$500,000.														
Over \$1,000,000 but not over \$1,500,000	\$175,000 plus 10% of the excess over \$1,000,000.														
Over \$1,500,000 but not over \$17,000,000	\$225,000 plus 5% of the excess over \$1,500,000.														
Over \$17,000,000	\$1,000,000.														
g Grassroots nontaxable amount (enter 25% of line 1f)		128,071													
h Subtract line 1g from line 1a. If zero or less, enter -0-		0													
i Subtract line 1f from line 1c. If zero or less, enter -0-		0													
j If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year?		☐ Yes ☐ No													

4-Year Averaging Period Under Section 501(h)
(Some organizations that made a section 501(h) election do not have to complete all of the five columns below. See the separate instructions for lines 2a through 2f.)

Lobbying Expenditures During 4-Year Averaging Period					
Calendar year (or fiscal year beginning in)	(a) 2018	(b) 2019	(c) 2020	(d) 2021	(e) Total
2a Lobbying nontaxable amount	420,672	444,043	462,469	512,283	1,839,467
b Lobbying ceiling amount (150% of line 2a, column(e))					2,759,201
c Total lobbying expenditures					
d Grassroots nontaxable amount	105,168	111,011	115,617	128,071	459,867
e Grassroots ceiling amount (150% of line 2d, column (e))					689,801
f Grassroots lobbying expenditures					

Part II-B Complete if the organization is exempt under section 501(c)(3) and has NOT filed Form 5768 (election under section 501(h)).

For each "Yes" response on lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity.

		(a)		(b)
		Yes	No	Amount
1	During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of:			
a	Volunteers?			
b	Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?			
c	Media advertisements?			
d	Mailings to members, legislators, or the public?			
e	Publications, or published or broadcast statements?			
f	Grants to other organizations for lobbying purposes?			
g	Direct contact with legislators, their staffs, government officials, or a legislative body?			
h	Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?			
i	Other activities?			
j	Total. Add lines 1c through 1i			
2a	Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?			
b	If "Yes," enter the amount of any tax incurred under section 4912			
c	If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d	If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

Part III-A Complete if the organization is exempt under section 501(c)(4), section 501(c)(5), or section 501(c)(6).

	Yes	No
1 Were substantially all (90% or more) dues received nondeductible by members?	1	
2 Did the organization make only in-house lobbying expenditures of \$2,000 or less?	2	
3 Did the organization agree to carry over lobbying and political expenditures from the prior year?	3	

Part III-B Complete if the organization is exempt under section 501(c)(4), section 501(c)(5), or section 501(c)(6) and if either (a) BOTH Part III-A, lines 1 and 2, are answered "No" OR (b) Part III-A, line 3, is answered "Yes."

1	Dues, assessments and similar amounts from members	1	
2	Section 162(e) nondeductible lobbying and political expenditures (do not include amounts of political expenses for which the section 527(f) tax was paid).		
a	Current year	2a	
b	Carryover from last year	2b	
c	Total	2c	
3	Aggregate amount reported in section 6033(e)(1)(A) notices of nondeductible section 162(e) dues .	3	
4	If notices were sent and the amount on line 2c exceeds the amount on line 3, what portion of the excess does the organization agree to carryover to the reasonable estimate of nondeductible lobbying and political expenditure next year?	4	
5	Taxable amount of lobbying and political expenditures. See Instructions	5	

Part IV Supplemental Information

Provide the descriptions required for Part I-A, line 1; Part I-B, line 4; Part I-C, line 5; Part II-A (affiliated group list); Part II-A, lines 1 and 2 (see instructions), and Part II-B, line 1. Also, complete this part for any additional information.

Return Reference	Explanation
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SCHEDULE D(Form 990)

Department of the TreasuryInternal Revenue Service

Supplemental Financial Statements

Complete if the organization answered "Yes," on Form 990, Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b.
Attach to Form 990.
Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047

2021

Open to Public Inspection

Name of the organization
THE LEAPFROG GROUP

Employer identification number
52-2359517

Part I

Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts.
Complete if the organization answered "Yes" on Form 990, Part IV, line 6.

1

Total number at end of year

2

Aggregate value of contributions to (during year)

3

Aggregate value of grants from (during year)

4

Aggregate value at end of year

(a) Donor advised funds

(b) Funds and other accounts

5

Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control?

Yes

No

6

Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit?

Yes

No

Part II

Conservation Easements.
Complete if the organization answered "Yes" on Form 990, Part IV, line 7.

1

Purpose(s) of conservation easements held by the organization (check all that apply).

☐ Preservation of land for public use (e.g., recreation or education)

☐ Preservation of an historically important land area

☐ Protection of natural habitat

☐ Preservation of a certified historic structure

☐ Preservation of open space

2

Complete lines 2a through 2d if the organization held a qualified conservation contribution in the form of a conservation easement on the last day of the tax year.

2a

Total number of conservation easements

2b

Total acreage restricted by conservation easements

2c

Number of conservation easements on a certified historic structure included in (a)

2d

Number of conservation easements included in (c) acquired after 7/25/06, and not on a historic structure listed in the National Register

3

Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the tax year ▶

4

Number of states where property subject to conservation easement is located ▶

5

Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds?

Yes

No

6

Staff and volunteer hours devoted to monitoring, inspecting, handling of violations, and enforcing conservation easements during the year ▶

7

Amount of expenses incurred in monitoring, inspecting, handling of violations, and enforcing conservation easements during the year ▶ \$

8

Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)?

Yes

No

9

In Part XIII, describe how the organization reports conservation easements in its revenue and expense statement, and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements.

Part III

Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets.
Complete if the organization answered "Yes" on Form 990, Part IV, line 8.

1a

If the organization elected, as permitted under FASB ASC 958, not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part XIII, the text of the footnote to its financial statements that describes these items.

1b

If the organization elected, as permitted under FASB ASC 958, to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items:

(i) Revenue included on Form 990, Part VIII, line 1 ▶ \$

(ii) Assets included in Form 990, Part X ▶ \$

2

If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under FASB ASC 958 relating to these items:

a

Revenue included on Form 990, Part VIII, line 1 ▶ \$

b

Assets included in Form 990, Part X ▶ \$

For Paperwork Reduction Act Notice, see the Instructions for Form 990.

Cat. No. 52283D

Schedule D (Form 990) 2021

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets (continued)

3 Using the organization's acquisition, accession, and other records, check any of the following that are a significant use of its collection items (check all that apply):

a ☐ Public exhibition

b ☐ Scholarly research

c ☐ Preservation for future generations

d ☐ Loan or exchange programs

e ☐ Other _____

4 Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part XIII.

5 During the year, did the organization solicit or receive donations of art, historical treasures or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection? ☐ Yes ☐ No

Part IV Escrow and Custodial Arrangements.
Complete if the organization answered "Yes" on Form 990, Part IV, line 9, or reported an amount on Form 990, Part X, line 21.

1a Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X? ☐ Yes ☐ No

b If "Yes," explain the arrangement in Part XIII and complete the following table:

	Amount
1c Beginning balance	
1d Additions during the year	
1e Distributions during the year	
1f Ending balance	

2a Did the organization include an amount on Form 990, Part X, line 21, for escrow or custodial account liability? ☐ Yes ☐ No

b If "Yes," explain the arrangement in Part XIII. Check here if the explanation has been provided in Part XIII ☐

Part V Endowment Funds.
Complete if the organization answered "Yes" on Form 990, Part IV, line 10.

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a Beginning of year balance					
b Contributions					
c Net investment earnings, gains, and losses					
d Grants or scholarships					
e Other expenditures for facilities and programs					
f Administrative expenses					
g End of year balance					

2 Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as:

a Board designated or quasi-endowment

b Permanent endowment

c Term endowment

The percentages on lines 2a, 2b, and 2c should equal 100%.

3a Are there endowment funds not in the possession of the organization that are held and administered for the organization by:

	Yes	No
(i) Unrelated organizations		
(ii) Related organizations		
b If "Yes" on 3a(ii), are the related organizations listed as required on Schedule R?		

4 Describe in Part XIII the intended uses of the organization's endowment funds.

Part VI Land, Buildings, and Equipment.
Complete if the organization answered "Yes" on Form 990, Part IV, line 11a. See Form 990, Part X, line 10.

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land				
b Buildings				
c Leasehold improvements		447,431	73,327	374,104
d Equipment		296,578	99,093	197,485
e Other		590,992	455,562	135,430
Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10(c).)				707,019

Part VII Investments - Other Securities.

Complete if the organization answered "Yes" on Form 990, Part IV, line 11b. See Form 990, Part X, line 12.

(a) Description of security or category (including name of security)	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1) Financial derivatives		
(2) Closely-held equity interests		
(3) Other _____		
(A)		
(C)		
(D)		
(E)		
(F)		
(G)		
(H)		
(H)		
Total. (Column (b) must equal Form 990, Part X, col. (B) line 12.) ▶		

Part VIII Investments - Program Related.

Complete if the organization answered "Yes" on Form 990, Part IV, line 11c. See Form 990, Part X, line 13.

(a) Description of investment	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1)		
(2)		
(3)		
(4)		
(5)		
(6)		
(7)		
(8)		
(9)		
(10)		
Total. (Column (b) must equal Form 990, Part X, col. (B) line 13.) ▶		

Part IX Other Assets.

Complete if the organization answered "Yes" on Form 990, Part IV, line 11d. See Form 990, Part X, line 15.

(a) Description	(b) Book value
(1) DEPOSITS	39,253
(2) RIGHT OF USE ASSET	3,477,599
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
(10)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 15.) ▶	3,516,852

Part X Other Liabilities.

Complete if the organization answered "Yes" on Form 990, Part IV, line 11e or 11f. See Form 990, Part X, line 25.

(a) Description of liability	(b) Book value
(1) Federal income taxes	
(2) CAPITAL LEASE	2,178
(3) OPERATING LEASE	3,826,113
(4) REFUNDABLE ADVANCE	1,332,925
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 25.) ▶	5,161,216

2. Liability for uncertain tax positions. In Part XIII, provide the text of the footnote to the organization's financial statements that reports the organization's liability for uncertain tax positions under FIN 48 (ASC 740). Check here if the text of the footnote has been provided in Part XIII ☒

Part XI Reconciliation of Revenue per Audited Financial Statements With Revenue per Return.

Complete if the organization answered 'Yes' on Form 990, Part IV, line 12a.

1	Total revenue, gains, and other support per audited financial statements		1	
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12:			
a	Net unrealized gains (losses) on investments	2a		
b	Donated services and use of facilities	2b		
c	Recoveries of prior year grants	2c		
d	Other (Describe in Part XIII.)	2d		
e	Add lines 2a through 2d		2e	
3	Subtract line 2e from line 1		3	
4	Amounts included on Form 990, Part VIII, line 12, but not on line 1:			
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a		
b	Other (Describe in Part XIII.)	4b		
c	Add lines 4a and 4b		4c	
5	Total revenue. Add lines 3 and 4c . (This must equal Form 990, Part I, line 12.)		5	

Part XII Reconciliation of Expenses per Audited Financial Statements With Expenses per Return.

Complete if the organization answered 'Yes' on Form 990, Part IV, line 12a.

1	Total expenses and losses per audited financial statements		1	
2	Amounts included on line 1 but not on Form 990, Part IX, line 25:			
a	Donated services and use of facilities	2a		
b	Prior year adjustments	2b		
c	Other losses	2c		
d	Other (Describe in Part XIII.)	2d		
e	Add lines 2a through 2d		2e	
3	Subtract line 2e from line 1		3	
4	Amounts included on Form 990, Part IX, line 25, but not on line 1:			
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a		
b	Other (Describe in Part XIII.)	4b		
c	Add lines 4a and 4b		4c	
5	Total expenses. Add lines 3 and 4c . (This must equal Form 990, Part I, line 18.)		5	

Part XIII Supplemental Information

Provide the descriptions required for Part II, lines 3, 5, and 9; Part III, lines 1a and 4; Part IV, lines 1b and 2b; Part V, line 4; Part X, line 2; Part XI, lines 2d and 4b; and Part XII, lines 2d and 4b. Also complete this part to provide any additional information.

Return Reference	Explanation
See Additional Data Table	

Part XIII Supplemental Information (continued)

Return Reference	Explanation

Additional Data

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Software ID:**Software Version:****EIN:** 52-2359517**Name:** THE LEAPFROG GROUP**Supplemental Information**

Return Reference	Explanation
PART X, LINE 2:	FOR THE YEARS ENDED JUNE 30, 2022 AND 2021, LEAPFROG HAS DOCUMENTED ITS CONSIDERATION OF F ASB ASC 740-10, INCOME TAXES, THAT PROVIDES GUIDANCE FOR REPORTING UNCERTAINTY IN INCOME TAXES AND HAS DETERMINED THAT NO MATERIAL UNCERTAIN TAX POSITIONS QUALIFY FOR EITHER RECOGNITION OR DISCLOSURE IN THE COMBINED FINANCIAL STATEMENTS.

Note. The sum of columns (B)(i)-(iii) for each listed individual must equal the total amount of Form 990, Part VII, Section A, line 1a, applicable column (D) and (E) amounts for that individual.

Schedule J (Form 990) 2021

SCHEDULE O
(Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Information to Form 990 or 990-EZ

Complete to provide information for responses to specific questions on
Form 990 or 990-EZ or to provide any additional information.

▶ Attach to Form 990 or 990-EZ.

▶ Go to www.irs.gov/Form990 for the latest information.

2021

**Open to Public
Inspection**

Name of the organization
THE LEAPFROG GROUP

Employer identification number

52-2359517

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 11B	FORM 990 IS REVIEWED BY MANAGEMENT, AND THEN REVIEWED BY THE AUDIT COMMITTEE CHAIR. THE AUDIT COMMITTEE CHAIR, ONCE COMFORTABLE WITH THE RETURN, FORWARDS IT TO THE BOARD FOR REVIEW. THE BOARD REVIEWS THE 990 PRIOR TO SUBMISSION.

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 12C	THE GOVERNANCE COMMITTEE ADVISES BOARD MEMBERS THAT THE BYLAWS REQUIRE COMPLIANCE WITH THE CONFLICT OF INTEREST POLICY. BOARD MEMBERS ARE ASKED TO RECUSE THEMSELVES SHOULD THEY HAVE ANY POSSIBLE CONFLICTS.

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 15	THE EXECUTIVE COMMITTEE UTILIZED A COMPENSATION STUDY TO ESTABLISH THE COMPENSATION OF THE CEO.

Return Reference	Explanation
FORM 990, PART VI, SECTION C, LINE 19	THE LEAPFROG GROUP WILL PROVIDE A COPY OF THEIR FORM 1023 AND FORM 990 UPON REQUEST.

Return Reference	Explanation
FORM 990, PART XII, LINE 2C	THE PROCESS HAS NOT CHANGED FROM THE PREVIOUS YEAR.

**SCHEDULE R
(Form 990)**

Department of the Treasury
Internal Revenue Service

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Related Organizations and Unrelated Partnerships

- Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.
► Attach to Form 990.
► Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047

2021

**Open to Public
Inspection**

Name of the organization
THE LEAPFROG GROUP

Employer identification number

52-2359517

Part I Identification of Disregarded Entities. Complete if the organization answered "Yes" on Form 990, Part IV, line 33.

(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1) THE LEAPFROG GROUP DUE DILLIGENCE COOPERATIVE LLC 1660 L STREET NW SUITE 308 WASHINGTON, DC 20036 45-2397143	TO COLLECT, EVALUATE, AND SUMMARIZE INFORMATION ABOUT COMPANIES	DC	-299	3,906	THE LEAPFROG GROUP

Part II Identification of Related Tax-Exempt Organizations. Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had one or more related tax-exempt organizations during the tax year.

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No

Part III Identification of Related Organizations Taxable as a Partnership. Complete if the organization answered "Yes" on Form 990, Part IV, line 34, because it had one or more related organizations treated as a partnership during the tax year.

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512- 514)	(f) Share of total income	(g) Share of end-of- year assets	(h) Disproportionate allocations?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	

Part IV Identification of Related Organizations Taxable as a Corporation or Trust. Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had one or more related organizations treated as a corporation or trust during the tax year.

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end- of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity?	
								Yes	No

Part V Transactions With Related Organizations. Complete if the organization answered "Yes" on Form 990, Part IV, line 34, 35B, or 36.

Note. Complete line 1 if any entity is listed in Parts II, III, or IV of this schedule.

1 During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?

	Yes	No
a Receipt of (i) interest, (ii) annuities, (iii) royalties, or (iv) rent from a controlled entity		
b Gift, grant, or capital contribution to related organization(s)		
c Gift, grant, or capital contribution from related organization(s)		
d Loans or loan guarantees to or for related organization(s)		
e Loans or loan guarantees by related organization(s)		
f Dividends from related organization(s)		
g Sale of assets to related organization(s)		
h Purchase of assets from related organization(s)		
i Exchange of assets with related organization(s)		
j Lease of facilities, equipment, or other assets to related organization(s)		
k Lease of facilities, equipment, or other assets from related organization(s)		
l Performance of services or membership or fundraising solicitations for related organization(s)		
m Performance of services or membership or fundraising solicitations by related organization(s)		
n Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)		
o Sharing of paid employees with related organization(s)		
p Reimbursement paid to related organization(s) for expenses		
q Reimbursement paid by related organization(s) for expenses		
r Other transfer of cash or property to related organization(s)		
s Other transfer of cash or property from related organization(s)		

2 If the answer to any of the above is "Yes," see the instructions for information on who must complete this line, including covered relationships and transaction thresholds.

(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved

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[illegible]

Part VII **Supplemental Information** [Case 9:25-cv-80526-DMM Document 88-77 Entered on FLSD Docket 10/28/2025 Page 48 of 48](#)

Provide additional information for responses to questions on Schedule R. See instructions.

Return Reference	Explanation
PART I (B)	PROVIDING HEALTHCARE-RELATED SERVICES TO EMPLOYERS.

Exhibit 78

Form **990**

Return of Organization Exempt From Income Tax

Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except private foundations)

Do not enter social security numbers on this form as it may be made public.

Go to www.irs.gov/Form990 for instructions and the latest information.

2022

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

A For the **2022** calendar year, or tax year beginning **07-01-2022** , and ending **06-30-2023**

B Check if applicable:
☐ Address change
☐ Name change
☐ Initial return
☐ Final return/terminated
☐ Amended return
☐ Application
☒ Pending

C Name of organization
THE LEAPFROG GROUP

D Employer identification number
52-2359517

Doing business as

E Telephone number
(202) 292-6713

Number and street (or P.O. box if mail is not delivered to street address) Room/suite
1775 K STREET NW 400

G Gross receipts \$ 7,556,255

City or town, state or province, country, and ZIP or foreign postal code
WASHINGTON, DC 20006

F Name and address of principal officer:
LEAH BINDER
1775 K STREET NW 400
WASHINGTON, DC 20006

H(a) Is this a group return for subordinates? ☐ Yes ☒ No

H(b) Are all subordinates included? ☐ Yes ☐ No

If "No," attach a list. See instructions.

H(c) Group exemption number ▶

I Tax-exempt status: ☒ 501(c)(3) ☐ 501(c) () ◀(insert no.) ☐ 4947(a)(1) or ☐ 527

J Website: ▶ WWW.LEAPFROGGROUP.ORG

K Form of organization: ☒ Corporation ☐ Trust ☐ Association ☐ Other ▶

L Year of formation: 2001

M State of legal domicile: DC

Part I Summary

1 Briefly describe the organization's mission or most significant activities:
TO INITIATE IMPROVEMENTS IN THE SAFETY AND OVERALL VALUE OF HEALTH CARE TO CONSUMERS.

2 Check this box ☐ if the organization discontinued its operations or disposed of more than 25% of its net assets.

3 Number of voting members of the governing body (Part VI, line 1a)	3	18
4 Number of independent voting members of the governing body (Part VI, line 1b)	4	18
5 Total number of individuals employed in calendar year 2022 (Part V, line 2a)	5	24
6 Total number of volunteers (estimate if necessary)	6	50
7a Total unrelated business revenue from Part VIII, column (C), line 12	7a	0
Net unrelated business taxable income from Form 990-T, Part I, line 11	7b	0

	Prior Year	Current Year
8 Contributions and grants (Part VIII, line 1h)	1,365,819	1,722,124
9 Program service revenue (Part VIII, line 2g)	5,883,131	5,784,729
10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)	449	49,402
11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	0	0
12 Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	7,249,399	7,556,255

	Prior Year	Current Year
13 Grants and similar amounts paid (Part IX, column (A), lines 1-3)	0	0
14 Benefits paid to or for members (Part IX, column (A), line 4)	0	0
15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	4,085,980	4,090,405
16a Professional fundraising fees (Part IX, column (A), line 11e)	0	0
b Total fundraising expenses (Part IX, column (D), line 25) ▶417,472		
17 Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	3,159,679	3,885,262
18 Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	7,245,659	7,975,667
19 Revenue less expenses. Subtract line 18 from line 12	3,740	-419,412

	Beginning of Current Year	End of Year
20 Total assets (Part X, line 16)	8,852,512	7,552,764
21 Total liabilities (Part X, line 26)	6,684,552	5,803,995
22 Net assets or fund balances. Subtract line 21 from line 20	2,167,960	1,748,769

Part II Signature Block

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than officer) is based on all information of which preparer has any knowledge.

Sign Here

Signature of officer

2024-05-14

Date

LEAH BINDER PRESIDENT & CEO

Type or print name and title

Print/Type preparer's name	Preparer's signature	Date	Check ☐ if self-employed	PTIN P00238304
Firm's name ▶ DEMBO JONES PC	Firm's EIN ▶ 52-1073331			
Firm's address ▶ 6116 EXECUTIVE BLVD SUITE 500	Phone no. (301) 770-5100			
NORTH BETHESDA, MD 20852				

May the IRS discuss this return with the preparer shown above? (see instructions) ☒ Yes ☐ No

For Paperwork Reduction Act Notice, see the separate instructions.

Cat. No. 11282Y

Form **990** (2022)

Part III Statement of Program Service Accomplishments

Check if Schedule O contains a response or note to any line in this Part III ☐

1 Briefly describe the organization's mission:

TO TRIGGER GIANT LEAPS FORWARD IN THE SAFETY, QUALITY, AND AFFORDABILITY OF U.S. HEALTH CARE BY USING TRANSPARENCY TO SUPPORT INFORMED HEALTH CARE DECISIONS AND PROMOTE HIGH-VALUE CARE.

2 Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ?

☐ Yes ☒ No

If "Yes," describe these new services on Schedule O.

3 Did the organization cease conducting, or make significant changes in how it conducts, any program services?

☐ Yes ☒ No

If "Yes," describe these changes on Schedule O.

4 Describe the organization's program service accomplishments for each of its three largest program services, as measured by expenses. Section 501(c)(3) and 501(c)(4) organizations are required to report the amount of grants and allocations to others, the total expenses, and revenue, if any, for each program service reported.

4a (Code:) (Expenses \$ 3,649,756 including grants of \$) (Revenue \$ 141,135)
RATINGS: LEAPFROG FIELDS A VOLUNTARY SURVEY OF HOSPITALS AND AMBULATORY SURGERY CENTERS ON QUALITY AND SAFETY PRACTICES. THE SURVEYS INVOLVE MEASURE DEVELOPMENT AND ARE UPDATED ANNUALLY. THE HOSPITAL SURVEY ALSO INCLUDES A TOOL TO EVALUATE SYSTEMS FOR COMPUTERIZED PHYSICIAN ORDER ENTRY OF PHARMACEUTICALS. IN ADDITION, THE DATA FROM THE HOSPITAL SURVEY ARE COMBINED WITH DATA FROM OTHER SOURCES TO FURTHER UNDERSTAND HOSPITAL QUALITY AND SAFETY. THE ORGANIZATION PUBLICLY RATES U.S. HOSPITALS ON THEIR SAFETY IN AN INITIATIVE CALLED THE LEAPFROG HOSPITAL SAFETY GRADE.

4b (Code:) (Expenses \$ 1,690,291 including grants of \$) (Revenue \$ 5,541,310)
COMMUNICATIONS: LEAPFROG COLLECTS, ANALYZES AND DISSEMINATES HEALTH CARE DATA ON QUALITY AND SAFETY TO CONSUMERS AND PURCHASERS TO HELP THEM MAKE DECISIONS ON WHERE TO SEEK CARE. HEALTH CARE PROVIDERS ALSO FIND THE INFORMATION USEFUL FOR THEIR OWN IMPROVEMENT PROGRAMS AND THE OPPORTUNITY TO BENCHMARK AGAINST THEIR PEERS. LEAPFROG WORKS WITH PRINT, RADIO, TELEVISION, DIGITAL AND SOCIAL MEDIA PLATFORMS TO SPREAD INFORMATION ABOUT ITS HEALTH CARE RATINGS AND REPORTS.

4c (Code:) (Expenses \$ 1,298,824 including grants of \$) (Revenue \$ 102,284)
MEMBERSHIP: LEAPFROG WORKS WITH EMPLOYERS AND PURCHASERS OF HEALTH CARE TO ENCOURAGE TRANSPARENCY FROM THE HEALTH CARE COMMUNITY AND EDUCATE EMPLOYEES ON THE SAFEST AND HIGHEST QUALITY PROVIDERS. LEAPFROG ALSO COLLECTS DUES FROM AN ADVISORY COMMITTEE OF HEALTH CARE-FOCUSED COMPANIES WHO OFFER ADVICE AND SUGGESTIONS TO LEAPFROG BUT DO NOT HAVE A GOVERNING ROLE.

4d Other program services (Describe in Schedule O.)

(Expenses \$ including grants of \$) (Revenue \$)

4e Total program service expenses 6,638,871

Part IV Checklist of Required Schedules**Case 3:25-cv-00972-OWB Document 88-78 Entered on FLSD Docket 10/28/2025 Page 4 of 37**

	Yes	No
1 Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? <i>If "Yes," complete Schedule A</i>	1 Yes	
2 Is the organization required to complete <i>Schedule B, Schedule of Contributors</i> ? See instructions.	2 Yes	
3 Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? <i>If "Yes," complete Schedule C, Part I</i>	3	No
4 Section 501(c)(3) organizations. Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? <i>If "Yes," complete Schedule C, Part II</i>	4 Yes	
5 Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Rev. Proc. 98-19? <i>If "Yes," complete Schedule C, Part III</i>	5	No
6 Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? <i>If "Yes," complete Schedule D, Part I</i>	6	No
7 Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? <i>If "Yes," complete Schedule D, Part II</i>	7	No
8 Did the organization maintain collections of works of art, historical treasures, or other similar assets? <i>If "Yes," complete Schedule D, Part III</i>	8	No
9 Did the organization report an amount in Part X, line 21 for escrow or custodial account liability; serve as a custodian for amounts not listed in Part X; or provide credit counseling, debt management, credit repair, or debt negotiation services? <i>If "Yes," complete Schedule D, Part IV</i>	9	No
10 Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi endowments? <i>If "Yes," complete Schedule D, Part V</i>	10	No
11 If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X, as applicable.		
a Did the organization report an amount for land, buildings, and equipment in Part X, line 10? <i>If "Yes," complete Schedule D, Part VI.</i>	11a Yes	
b Did the organization report an amount for investments—other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? <i>If "Yes," complete Schedule D, Part VII</i>	11b	No
c Did the organization report an amount for investments—program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? <i>If "Yes," complete Schedule D, Part VIII</i>	11c	No
d Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? <i>If "Yes," complete Schedule D, Part IX</i>	11d Yes	
e Did the organization report an amount for other liabilities in Part X, line 25? <i>If "Yes," complete Schedule D, Part X</i>	11e Yes	
f Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? <i>If "Yes," complete Schedule D, Part X</i>	11f Yes	
12a Did the organization obtain separate, independent audited financial statements for the tax year? <i>If "Yes," complete Schedule D, Parts XI and XII</i>	12a	No
b Was the organization included in consolidated, independent audited financial statements for the tax year? <i>If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional</i>	12b Yes	
13 Is the organization a school described in section 170(b)(1)(A)(ii)? <i>If "Yes," complete Schedule E</i>	13	No
14a Did the organization maintain an office, employees, or agents outside of the United States?	14a	No
b Did the organization have aggregate revenues or expenses of more than \$10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at \$100,000 or more? <i>If "Yes," complete Schedule F, Parts I and IV</i>	14b	No
15 Did the organization report on Part IX, column (A), line 3, more than \$5,000 of grants or other assistance to or for any foreign organization? <i>If "Yes," complete Schedule F, Parts II and IV</i>	15	No
16 Did the organization report on Part IX, column (A), line 3, more than \$5,000 of aggregate grants or other assistance to or for foreign individuals? <i>If "Yes," complete Schedule F, Parts III and IV</i>	16	No
17 Did the organization report a total of more than \$15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? <i>If "Yes," complete Schedule G, Part I.</i> See instructions.	17	No
18 Did the organization report more than \$15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? <i>If "Yes," complete Schedule G, Part II</i>	18	No
19 Did the organization report more than \$15,000 of gross income from gaming activities on Part VIII, line 9a? <i>If "Yes," complete Schedule G, Part III</i>	19	No
20a Did the organization operate one or more hospital facilities? <i>If "Yes," complete Schedule H</i>	20a	No
b If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	20b	
21 Did the organization report more than \$5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? <i>If "Yes," complete Schedule I, Parts I and II</i>	21	No

Part IV Checklist of Required Schedules (continued)

		Yes	No
22	Did the organization report more than \$5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? If "Yes," complete Schedule I, Parts I and III		No
23	Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5, about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? If "Yes," complete Schedule J	Yes	
24a	Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than \$100,000 as of the last day of the year, that was issued after December 31, 2002? If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a		No
b	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?		
c	Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?		
d	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?		
25a	Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations. Did the organization engage in an excess benefit transaction with a disqualified person during the year? If "Yes," complete Schedule L, Part I		No
b	Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? If "Yes," complete Schedule L, Part I		No
26	Did the organization report any amount on Part X, line 5 or 22 for receivables from or payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons? If "Yes," complete Schedule L, Part II		No
27	Did the organization provide a grant or other assistance to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or employee thereof, a grant selection committee member, or to a 35% controlled entity (including an employee thereof) or family member of any of these persons? If "Yes," complete Schedule L, Part III		No
28	Was the organization a party to a business transaction with one of the following parties (see the Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions):		
a	A current or former officer, director, trustee, key employee, creator or founder, or substantial contributor? If "Yes," complete Schedule L, Part IV		No
b	A family member of any individual described in line 28a? If "Yes," complete Schedule L, Part IV		No
c	A 35% controlled entity of one or more individuals and/or organizations described in line 28a or 28b? If "Yes," complete Schedule L, Part IV		No
29	Did the organization receive more than \$25,000 in non-cash contributions? If "Yes," complete Schedule M		No
30	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? If "Yes," complete Schedule M		No
31	Did the organization liquidate, terminate, or dissolve and cease operations? If "Yes," complete Schedule N, Part I		No
32	Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? If "Yes," complete Schedule N, Part II		No
33	Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? If "Yes," complete Schedule R, Part I	Yes	
34	Was the organization related to any tax-exempt or taxable entity? If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1		No
35a	Did the organization have a controlled entity within the meaning of section 512(b)(13)?		No
b	If "Yes" to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? If "Yes," complete Schedule R, Part V, line 2		
36	Section 501(c)(3) organizations. Did the organization make any transfers to an exempt non-charitable related organization? If "Yes," complete Schedule R, Part V, line 2		No
37	Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? If "Yes," complete Schedule R, Part VI		No
38	Did the organization complete Schedule O and provide explanations on Schedule O for Part VI, lines 11b and 19? Note. All Form 990 filers are required to complete Schedule O.	Yes	

Part V Statements Regarding Other IRS Filings and Tax Compliance			Yes	No
Check if Schedule O contains a response or note to any line in this Part V				☐
1a	Enter the number reported in box 3 of Form 1096. Enter -0- if not applicable	1a	26	
b	Enter the number of Forms W-2G included on line 1a. Enter -0- if not applicable	1b	0	
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	1c	Yes	

2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return	2a	24			
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns?	2b		Yes		
3a	Did the organization have unrelated business gross income of \$1,000 or more during the year?	3a			No	
b	If "Yes," has it filed a Form 990-T for this year? <i>If "No" to line 3b, provide an explanation in Schedule O</i>	3b				
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?	4a			No	
b	If "Yes," enter the name of the foreign country: _____ See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR).					
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?	5a			No	
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?	5b			No	
c	If "Yes," to line 5a or 5b, did the organization file Form 8886-T?	5c				
6a	Does the organization have annual gross receipts that are normally greater than \$100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions?	6a			No	
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?	6b				
7	Organizations that may receive deductible contributions under section 170(c).					
a	Did the organization receive a payment in excess of \$75 made partly as a contribution and partly for goods and services provided to the payor?	7a			No	
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?	7b				
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?	7c			No	
d	If "Yes," indicate the number of Forms 8282 filed during the year	7d				
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?	7e			No	
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?	7f			No	
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?	7g				
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?	7h				
8	Sponsoring organizations maintaining donor advised funds. Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?	8				
9	Sponsoring organizations maintaining donor advised funds.					
a	Did the sponsoring organization make any taxable distributions under section 4966?	9a				
b	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person?	9b				
10	Section 501(c)(7) organizations. Enter:					
a	Initiation fees and capital contributions included on Part VIII, line 12	10a				
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	10b				
11	Section 501(c)(12) organizations. Enter:					
a	Gross income from members or shareholders	11a				
b	Gross income from other sources. (Do not net amounts due or paid to other sources against amounts due or received from them.)	11b				
12a	Section 4947(a)(1) non-exempt charitable trusts. Is the organization filing Form 990 in lieu of Form 1041?	12a				
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year.	12b				
13	Section 501(c)(29) qualified nonprofit health insurance issuers.					
a	Is the organization licensed to issue qualified health plans in more than one state? Note. See the instructions for additional information the organization must report on Schedule O.	13a				
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans	13b				
c	Enter the amount of reserves on hand	13c				
14a	Did the organization receive any payments for indoor tanning services during the tax year?	14a			No	
b	If "Yes," has it filed a Form 720 to report these payments? <i>If "No," provide an explanation in Schedule O</i>	14b				
15	Is the organization subject to the section 4960 tax on payment(s) of more than \$1,000,000 in remuneration or excess parachute payment(s) during the year? If "Yes," see the instructions and file Form 4720, Schedule N.	15			No	
16	Is the organization an educational institution subject to the section 4968 excise tax on net investment income? . . . If "Yes," complete Form 4720, Schedule O.	16			No	
17	Section 501(c)(21) organizations. Did the trust, or any disqualified or other person engage in any activities that would result in the imposition of an excise tax under section 4951, 4952, or 4953? . . . If "Yes," complete Form 6069.	17				

Section A. Governing Body and Management

		Yes	No
1a	Enter the number of voting members of the governing body at the end of the tax year If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O.	18	
1b	Enter the number of voting members included in line 1a, above, who are independent	18	
2	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?	2	No
3	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person?	3	No
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	4	No
5	Did the organization become aware during the year of a significant diversion of the organization's assets?	5	No
6	Did the organization have members or stockholders?	6	No
7a	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?	7a	No
7b	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	7b	No
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:		
8a	The governing body?	8a	Yes
8b	Each committee with authority to act on behalf of the governing body?	8b	Yes
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses in Schedule O	9	No

Section B. Policies (This Section B requests information about policies not required by the Internal Revenue Code.)

	Yes	No	
10a	Did the organization have local chapters, branches, or affiliates?	10a	No
10b	If "Yes," did the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with the organization's exempt purposes?	10b	
11a	Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form?	11a	Yes
11b	Describe on Schedule O the process, if any, used by the organization to review this Form 990.		
12a	Did the organization have a written conflict of interest policy? If "No," go to line 13	12a	Yes
12b	Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts?	12b	Yes
12c	Did the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," describe on Schedule O how this was done	12c	Yes
13	Did the organization have a written whistleblower policy?	13	Yes
14	Did the organization have a written document retention and destruction policy?	14	Yes
15	Did the process for determining compensation of the following persons include a review and approval by independent persons, comparability data, and contemporaneous substantiation of the deliberation and decision?		
15a	The organization's CEO, Executive Director, or top management official	15a	Yes
15b	Other officers or key employees of the organization	15b	Yes
	If "Yes" to line 15a or 15b, describe the process on Schedule O. See instructions.		
16a	Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a taxable entity during the year?	16a	No
16b	If "Yes," did the organization follow a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and take steps to safeguard the organization's exempt status with respect to such arrangements?	16b	

Section C. Disclosure

17 List the states with which a copy of this Form 990 is required to be filed

AL, AR, CA, FL, GA, HI, IL, KS, KY, MD, MA, MI, MN, MS, NH, NJ, NM, NY, NC, OR, PA, RI, SC, TN, UT, VA, WV, WI, CT, ND

18 Section 6104 requires an organization to make its Form 1023 (1024 or 1024-A, if applicable), 990, and 990-T (section 501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.

☐ Own website ☐ Another's website ☒ Upon request ☐ Other (explain in Schedule O)

19 Describe in Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.

20 State the name, address, and telephone number of the person who possesses the organization's books and records:

LEAH BINDER THE LEAPFROG GROUP 1775 K STREET NW 400 WASHINGTON, DC 20006 (202) 292-6713

Part VII Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

Check if Schedule O contains a response or note to any line in this Part VII ☐

Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

1a Complete this table for all persons required to be listed. Report compensation for the calendar year ending with or within the organization's tax year.

- List all of the organization's **current** officers, directors, trustees (whether individuals or organizations), regardless of amount of compensation. Enter -0- in columns (D), (E), and (F) if no compensation was paid.
- List all of the organization's **current** key employees, if any. See the instructions for definition of "key employee."
- List the organization's five **current** highest compensated employees (other than an officer, director, trustee or key employee) who received reportable compensation (box 5 of Form W-2, box 6 of Form 1099-MISC, and/or box 1 of Form 1099-NEC) of more than \$100,000 from the organization and any related organizations.
- List all of the organization's **former** officers, key employees, or highest compensated employees who received more than \$100,000 of reportable compensation from the organization and any related organizations.
- List all of the organization's **former directors or trustees** that received, in the capacity as a former director or trustee of the organization, more than \$10,000 of reportable compensation from the organization and any related organizations.

See the instructions for the order in which to list the persons above.

☐ Check this box if neither the organization nor any related organization compensated any current officer, director, or trustee.

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC/1099-NEC)	(E) Reportable compensation from related organizations (W-2/1099-MISC/1099-NEC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
(1) DAVID GOLDHILL IMMEDIATE PAST CHAIR	6.00	X		X				0	0	0
(2) MICHELLE MARTIN CHAIR	6.00	X		X				0	0	0
(3) BILL BONK CHAIR, AUDIT COMMITTEE	6.00	X		X				0	0	0
(4) SALLY WELBORN SECRETARY	6.00	X		X				0	0	0
(5) IRENE FRASER BOARD MEMBER	3.00	X						0	0	0
(6) LINDA J SCHWIMMER VICE CHAIR	6.00	X		X				0	0	0
(7) RAQUEL C BONO CHAIR, NOMINATIONS COMMITTEE	6.00	X		X				0	0	0
(8) ARNOLD MILSTEIN BOARD MEMBER	3.00	X						0	0	0
(9) DOLORES MITCHELL BOARD MEMBER	3.00	X						0	0	0
(10) G RUMAY ALEXANDER BOARD MEMBER	3.00	X						0	0	0
(11) JANET LUCAS- TAYLOR BOARD MEMBER	3.00	X						0	0	0
(12) KENNETH MENDEZ BOARD MEMBER	3.00	X						0	0	0
(13) MAUREEN RYAN BOARD MEMBER	3.00	X						0	0	0
(14) JOHN G ZERN TREASURER	6.00	X		X				0	0	0
(15) SUSAN SHERIDAN BOARD MEMBER	3.00	X						0	0	0
(16) KAREN VAN CAULIL BOARD MEMBER	3.00	X						0	0	0
(17) LINA WALKER BOARD MEMBER	3.00	X						0	0	0

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099- MISC/1099-NEC)	(E) Reportable compensation from related organizations (W-2/1099- MISC/1099-NEC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
(18) AARON SCHRADER BOARD MEMBER	3.00	X						0	0	0
(19) LEAH BINDER PRESIDENT & CEO	40.00			X				669,448	0	84,300
(20) MELISSA DANFORTH VP, HEALTH CARE RATINGS	40.00				X			358,974	0	61,438
(21) RALPH JOHNSON VP OF INFORMATICS AND TECH	40.00					X		272,508	0	58,950
(22) KATHRYN BURGGRAFSTEWART DIRECTOR, HEALTH CARE RATI	40.00					X		137,141	0	30,417
(23) ANGELA HOPKINS OFFICE ADMINISTRATOR	40.00					X		115,109	0	27,645
(24) JILL BERGER DIRECTOR, EMPLOYER AND PAY	40.00					X		224,670	0	35,621
(25) KAREN JUPITER VP DEVELOPMENT	40.00					X		252,426	0	23,131
1b Sub-Total										
c Total from continuation sheets to Part VII, Section A										
d Total (add lines 1b and 1c)								2,030,276	0	321,502

2 Total number of individuals (including but not limited to those listed above) who received more than \$100,000 of reportable compensation from the organization ► 11

	Yes	No
3 Did the organization list any former officer, director or trustee, key employee, or highest compensated employee on line 1a? <i>If "Yes," complete Schedule J for such individual</i>		No
4 For any individual listed on line 1a, is the sum of reportable compensation and other compensation from the organization and related organizations greater than \$150,000? <i>If "Yes," complete Schedule J for such individual</i>	Yes	
5 Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization? <i>If "Yes," complete Schedule J for such person</i>		No

Section B. Independent Contractors

1 Complete this table for your five highest compensated independent contractors that received more than \$100,000 of compensation from the organization. Report compensation for the calendar year ending with or within the organization's tax year.

(A) Name and business address	(B) Description of services	(C) Compensation
THE JOHNS HOPKINS UNIVERSITY 733 NORTH BOARDWAY SUITE 117 BALTIMORE, MD 21205	CONSULTANTS	462,443
SKVARE LLC PO BOX 601033 DALLAS, TX 75360	CONSULTANTS	266,737
TELAFFECTS 300 INTERNATIONAL PKWY SUITE 250 LAKE MARY, FL 32746	CONSULTANTS	221,459
JPA HEALTH COMMUNICATIONS 1101 CONNECTICUT AVE NW SUITE 600 WASHINGTON, DC 20001	CONSULTANTS	124,964
DEMBO JONES 6116 EXECUTIVE BLVD SUITE 500 NORTH BETHESDA, MD 20852	ACCOUNTANT	112,987

2 Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 of compensation from the organization ► 5

Part VIII Statement of Revenue			Check if Schedule O contains a response or note to any line in this Part VIII					
			(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512 - 514		
Contributions, gifts, grants, and other similar amounts	1a	Federated campaigns	1a					
	b	Membership dues	1b	828,250				
	c	Fundraising events	1c					
	d	Related organizations	1d					
	e	Government grants (contributions)	1e					
	f	All other contributions, gifts, grants, and similar amounts not included above	1f	893,874				
	g	Noncash contributions included in lines 1a - 1f:\$	1g					
	h	Total. Add lines 1a-1f		1,722,124				
Program Service Revenue	2a	COMMUNICATIONS AGREEME	Business Code					
			541900	3,208,489	3,208,489			
	b	DATA USE AGREEMENTS	541900	2,219,257	2,219,257			
	c	MEDIA PARTNERSHIP	541900	165,345	165,345			
	d	CONFERENCE REVENUE	541900	103,015	103,015			
	e	EDUCATION PLATFORM	900099	75,973	75,973			
	f	All other program service revenue.		12,650	12,650			
	g	Total. Add lines 2a-2f		5,784,729				
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts)			49,402		49,402		
	4 Income from investment of tax-exempt bond proceeds							
	5 Royalties							
	6a	(i) Real	(ii) Personal					
		6a						
		b	Less: rental expenses	6b				
	c	Rental income or (loss)	6c					
	d	Net rental income or (loss)						
	7a	(i) Securities	(ii) Other					
		7a						
		b	Less: cost or other basis and sales expenses	7b				
	c	Gain or (loss)	7c					
	d	Net gain or (loss)						
	8a	Gross income from fundraising events (not including \$ of contributions reported on line 1c). See Part IV, line 18	8a					
		b	Less: direct expenses	8b				
		c	Net income or (loss) from fundraising events					
	9a	Gross income from gaming activities. See Part IV, line 19	9a					
		b	Less: direct expenses	9b				
		c	Net income or (loss) from gaming activities					
	10a	Gross sales of inventory, less returns and allowances	10a					
b		Less: cost of goods sold	10b					
c		Net income or (loss) from sales of inventory						
Miscellaneous Revenue		Business Code						
11a								
b								
c								
d	All other revenue							
e	Total. Add lines 11a-11d							
12	Total revenue. See instructions			7,556,255	5,784,729	0		

Part IX Statement of Functional Expenses

Section 501(c)(3) and 501(c)(4) organizations must complete all columns. All other organizations must complete column (A).

Check if Schedule O contains a response or note to any line in this Part IX ☒**Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.**

	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21				
2 Grants and other assistance to domestic individuals. See Part IV, line 22				
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16.				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees	1,473,920	1,172,985	268,726	32,209
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)				
7 Other salaries and wages	1,994,128	1,465,957	297,895	230,276
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	180,874	144,321	21,986	14,567
9 Other employee benefits	243,356	203,315	19,244	20,797
10 Payroll taxes	198,127	148,949	34,420	14,758
11 Fees for services (non-employees):				
a Management				
b Legal	77,226	426	76,800	
c Accounting	145,905		145,905	
d Lobbying				
e Professional fundraising services. See Part IV, line 17				
f Investment management fees				
g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O)	1,108,156	1,106,349		1,807
12 Advertising and promotion	308,472	308,472		
13 Office expenses	75,164	37,603	30,790	6,771
14 Information technology	614,702	588,731	7,321	18,650
15 Royalties				
16 Occupancy	401,112	331,486	36,782	32,844
17 Travel	185,051	178,525	5,578	948
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings	331,701	313,267	18,434	
20 Interest				
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	160,421	133,112	14,120	13,189
23 Insurance	62,300	51,486	5,713	5,101
24 Other expenses. Itemize expenses not covered above (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a COMMUNICATIONS	222,948	222,948		
b DATA ACQUISITIONS	68,263	68,263		
c RECRUITING AND TRAINING	59,367	59,367		
d DUES AND SUBSCRIPTIONS	39,394	37,869	1,050	475
e All other expenses	25,080	65,440	-65,440	25,080
25 Total functional expenses. Add lines 1 through 24e	7,975,667	6,638,871	919,324	417,472
26 Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here ☐ if following SOP 98-2 (ASC 958-720).				

Part X Balance Sheet

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Check if Schedule O contains a response or note to any line in this Part IX ☐

				(A) Beginning of year		(B) End of year
Assets	1	Cash-non-interest-bearing		984,762	1	874,505
	2	Savings and temporary cash investments		2,875,847	2	2,125,422
	3	Pledges and grants receivable, net		57,301	3	4,950
	4	Accounts receivable, net		570,021	4	615,765
	5	Loans and other receivables from any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons			5	
	6	Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), and persons described in section 4958(c)(3)(B)			6	
	7	Notes and loans receivable, net			7	
	8	Inventories for sale or use			8	
	9	Prepaid expenses and deferred charges		140,710	9	156,242
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a	1,389,952		
	b	Less: accumulated depreciation	10b	755,110		
				707,019	10c	634,842
	11	Investments—publicly traded securities			11	
	12	Investments—other securities. See Part IV, line 11			12	
	13	Investments—program-related. See Part IV, line 11			13	
	14	Intangible assets			14	
15	Other assets. See Part IV, line 11		3,516,852	15	3,141,038	
16	Total assets. Add lines 1 through 15 (must equal line 33)		8,852,512	16	7,552,764	
Liabilities	17	Accounts payable and accrued expenses		467,317	17	475,069
	18	Grants payable			18	
	19	Deferred revenue		1,056,019	19	1,059,737
	20	Tax-exempt bond liabilities			20	
	21	Escrow or custodial account liability. Complete Part IV of Schedule D			21	
	22	Loans and other payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons			22	
	23	Secured mortgages and notes payable to unrelated third parties			23	
	24	Unsecured notes and loans payable to unrelated third parties			24	
	25	Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17 - 24). Complete Part X of Schedule D		5,161,216	25	4,269,189
	26	Total liabilities. Add lines 17 through 25		6,684,552	26	5,803,995
Net Assets or Fund Balances	Organizations that follow FASB ASC 958, check here ☒ and complete lines 27, 28, 32, and 33.					
	27	Net assets without donor restrictions		1,781,571	27	1,748,769
	28	Net assets with donor restrictions		386,389	28	0
	Organizations that do not follow FASB ASC 958, check here ☐ and complete lines 29 through 33.					
	29	Capital stock or trust principal, or current funds			29	
	30	Paid-in or capital surplus, or land, building or equipment fund			30	
	31	Retained earnings, endowment, accumulated income, or other funds			31	
	32	Total net assets or fund balances		2,167,960	32	1,748,769
	33	Total liabilities and net assets/fund balances		8,852,512	33	7,552,764

Check if Schedule O contains a response or note to any line in this Part XI ☐

1	Total revenue (must equal Part VIII, column (A), line 12)	1	7,556,255
2	Total expenses (must equal Part IX, column (A), line 25)	2	7,975,667
3	Revenue less expenses. Subtract line 2 from line 1	3	-419,412
4	Net assets or fund balances at beginning of year (must equal Part X, line 32, column (A))	4	2,167,960
5	Net unrealized gains (losses) on investments	5	221
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	
9	Other changes in net assets or fund balances (explain in Schedule O)	9	0
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 32, column (B))	10	1,748,769

Part XII Financial Statements and Reporting

Check if Schedule O contains a response or note to any line in this Part XII ☒

1	Accounting method used to prepare the Form 990: ☐ Cash ☒ Accrual ☐ Other _____ If the organization changed its method of accounting from a prior year or checked "Other," explain on Schedule O.		Yes	No
2a	Were the organization's financial statements compiled or reviewed by an independent accountant? If 'Yes,' check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both: ☐ Separate basis ☐ Consolidated basis ☐ Both consolidated and separate basis	2a		No
b	Were the organization's financial statements audited by an independent accountant? If 'Yes,' check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both: ☐ Separate basis ☒ Consolidated basis ☐ Both consolidated and separate basis	2b	Yes	
c	If "Yes," to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant? If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O.	2c	Yes	
3a	As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Uniform Guidance, 2 C.F.R. Part 200, Subpart F?	3a		No
b	If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits.	3b		

SCHEDULE A
(Form 990)

Public Charity Status and Public Support

Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust.
▶ Attach to Form 990 or Form 990-EZ.
▶ Go to www.irs.gov/Form990 for instructions and the latest information.

2022

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

Name of the organization
THE LEAPFROG GROUP

Employer identification number
52-2359517

Part I

Reason for Public Charity Status (All organizations must complete this part.) See instructions.

The organization is not a private foundation because it is: (For lines 1 through 12, check only one box.)

- 1 ☐ A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i).**
- 2 ☐ A school described in **section 170(b)(1)(A)(ii).** (Attach Schedule E (Form 990).)
- 3 ☐ A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii).**
- 4 ☐ A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii).** Enter the hospital's name, city, and state:
- 5 ☐ An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv).** (Complete Part II.)
- 6 ☐ A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v).**
- 7 ☐ An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi).** (Complete Part II.)
- 8 ☐ A community trust described in **section 170(b)(1)(A)(vi).** (Complete Part II.)
- 9 ☐ An agricultural research organization described in **170(b)(1)(A)(ix)** operated in conjunction with a land-grant college or university or a non-land grant college of agriculture. See instructions. Enter the name, city, and state of the college or university:
- 10 ☒ An organization that normally receives: (1) more than 33 1/3% of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions—subject to certain exceptions, and (2) no more than 33 1/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975. See **section 509(a)(2).** (Complete Part III.)
- 11 ☐ An organization organized and operated exclusively to test for public safety. See **section 509(a)(4).**
- 12 ☐ An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in **section 509(a)(1)** or **section 509(a)(2).** See **section 509(a)(3).** Check the box on lines 12a through 12d that describes the type of supporting organization and complete lines 12e, 12f, and 12g.
- a ☐ **Type I.** A supporting organization operated, supervised, or controlled by its supported organization(s), typically by giving the supported organization(s) the power to regularly appoint or elect a majority of the directors or trustees of the supporting organization. **You must complete Part IV, Sections A and B.**
- b ☐ **Type II.** A supporting organization supervised or controlled in connection with its supported organization(s), by having control or management of the supporting organization vested in the same persons that control or manage the supported organization(s). **You must complete Part IV, Sections A and C.**
- c ☐ **Type III functionally integrated.** A supporting organization operated in connection with, and functionally integrated with, its supported organization(s) (see instructions). **You must complete Part IV, Sections A, D, and E.**
- d ☐ **Type III non-functionally integrated.** A supporting organization operated in connection with its supported organization(s) that is not functionally integrated. The organization generally must satisfy a distribution requirement and an attentiveness requirement (see instructions). **You must complete Part IV, Sections A and D, and Part V.**
- e ☐ Check this box if the organization received a written determination from the IRS that it is a Type I, Type II, Type III functionally integrated, or Type III non-functionally integrated supporting organization.
- f Enter the number of supported organizations
- g Provide the following information about the supported organization(s).

(i) Name of supported organization	(ii) EIN	(iii) Type of organization (described on lines 1- 10 above (see instructions))	(iv) Is the organization listed in your governing document?		(v) Amount of monetary support (see instructions)	(vi) Amount of other support (see instructions)
			Yes	No		
Total						

(Complete only if you checked the box on line 5, 7, or 8 of Part I or if the organization failed to qualify under Part III. If the organization failed to qualify under the tests listed below, please complete Part III.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ►	(a) 2018	(b) 2019	(c) 2020	(d) 2021	(e) 2022	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grant.") . . .						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf. . . .						
3 The value of services or facilities furnished by a governmental unit to the organization without charge..						
4 Total. Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f) . .						
6 Public support. Subtract line 5 from line 4.						

Section B. Total Support

Calendar year (or fiscal year beginning in) ►	(a) 2018	(b) 2019	(c) 2020	(d) 2021	(e) 2022	(f) Total
7 Amounts from line 4. . .						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources. . . .						
9 Net income from unrelated business activities, whether or not the business is regularly carried on. .						
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.). . .						
11 Total support. Add lines 7 through 10						

12 Gross receipts from related activities, etc. (see instructions) 12

13 First 5 years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here ☐

Section C. Computation of Public Support Percentage

14 Public support percentage for 2022 (line 6, column (f) divided by line 11, column (f))	14	
15 Public support percentage for 2020 Schedule A, Part II, line 14	15	

16a 33 1/3% support test—2022. If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization ☐

b 33 1/3% support test—2021. If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization ☐

17a 10%-facts-and-circumstances test—2022. If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ☐

b 10%-facts-and-circumstances test—2021. If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ☐

18 Private foundation. If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions ☐

Part III

Support Schedule for Organizations Described in Section 509(a)(2)

(Complete only if you checked the box on line 10 of Part I or if the organization failed to qualify under Part II. If the organization fails to qualify under the tests listed below, please complete Part II.)

Section A. Public Support						
Calendar year (or fiscal year beginning in) ►	(a) 2018	(b) 2019	(c) 2020	(d) 2021	(e) 2022	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.") .	55,752	435,427	1,419,432	1,365,819	1,837,788	5,114,218
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose	5,738,194	5,446,926	5,560,125	5,883,131	5,669,065	28,297,441
3 Gross receipts from activities that are not an unrelated trade or business under section 513						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 Total. Add lines 1 through 5	5,793,946	5,882,353	6,979,557	7,248,950	7,506,853	33,411,659
7a Amounts included on lines 1, 2, and 3 received from disqualified persons	52,000	77,500	50,000	127,820	37,500	344,820
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of \$5,000 or 1% of the amount on line 13 for the year.	528,045	896,002	803,522	790,599	762,322	3,780,490
c Add lines 7a and 7b. .	580,045	973,502	853,522	918,419	799,822	4,125,310
8 Public support. (Subtract line 7c from line 6.)						29,286,349

Section B. Total Support						
Calendar year (or fiscal year beginning in) ►	(a) 2018	(b) 2019	(c) 2020	(d) 2021	(e) 2022	(f) Total
9 Amounts from line 6. . . .	5,793,946	5,882,353	6,979,557	7,248,950	7,506,853	33,411,659
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources. .	6,336	1,293	181	449	49,402	57,661
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975.						
c Add lines 10a and 10b.	6,336	1,293	181	449	49,402	57,661
11 Net income from unrelated business activities not included on line 10b, whether or not the business is regularly carried on.						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.) . .						
13 Total support. (Add lines 9, 10c, 11, and 12.)	5,800,282	5,883,646	6,979,738	7,249,399	7,556,255	33,469,320
14 First 5 years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here.	☐					

Section C. Computation of Public Support Percentage			
15 Public support percentage for 2022 (line 8, column (f) divided by line 13, column (f))	15	87.500 %	
16 Public support percentage from 2021 Schedule A, Part III, line 15	16	87.620 %	

Section D. Computation of Investment Income Percentage			
17	Investment income percentage for 2022 (line 10c, column (f) divided by line 13, column (f))	17	0.170 %
18	Investment income percentage from 2021 Schedule A, Part III, line 17	18	0.030 %
19a	33 1/3% support tests-2022. If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and stop here . The organization qualifies as a publicly supported organization ► ☒		
b	33 1/3% support tests—2021. If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3% and line 18 is not more than 33 1/3%, check this box and stop here . The organization qualifies as a publicly supported organization ► ☐		
20	Private foundation. If the organization did not check a box on line 14, 19a, or 19b, check this box and see instructions ► ☐		

Part IV Supporting Organizations

(Complete only if you checked a box on line 12 of Part I. If you checked box 12a, of Part I, complete Sections A and B. If you checked box 12b, of Part I, complete Sections A and C. If you checked box 12c, of Part I, complete Sections A, D, and E. If you checked box 12d, of Part I, complete Sections A and D, and complete Part V.)

Section A. All Supporting Organizations

		Yes	No
1	Are all of the organization's supported organizations listed by name in the organization's governing documents? If "No," describe in Part VI how the supported organizations are designated. If designated by class or purpose, describe the designation. If historic and continuing relationship, explain.		
2	Did the organization have any supported organization that does not have an IRS determination of status under section 509(a)(1) or (2)? If "Yes," explain in Part VI how the organization determined that the supported organization was described in section 509(a)(1) or (2).		
3a	Did the organization have a supported organization described in section 501(c)(4), (5), or (6)? If "Yes," answer lines 3b and 3c below.		
b	Did the organization confirm that each supported organization qualified under section 501(c)(4), (5), or (6) and satisfied the public support tests under section 509(a)(2)? If "Yes," describe in Part VI when and how the organization made the determination.		
c	Did the organization ensure that all support to such organizations was used exclusively for section 170(c)(2)(B) purposes? If "Yes," explain in Part VI what controls the organization put in place to ensure such use.		
4a	Was any supported organization not organized in the United States ("foreign supported organization")? If "Yes" and if you checked box 12a or 12b in Part I, answer lines 4b and 4c below.		
b	Did the organization have ultimate control and discretion in deciding whether to make grants to the foreign supported organization? If "Yes," describe in Part VI how the organization had such control and discretion despite being controlled or supervised by or in connection with its supported organizations.		
c	Did the organization support any foreign supported organization that does not have an IRS determination under sections 501(c)(3) and 509(a)(1) or (2)? If "Yes," explain in Part VI what controls the organization used to ensure that all support to the foreign supported organization was used exclusively for section 170(c)(2)(B) purposes.		
5a	Did the organization add, substitute, or remove any supported organizations during the tax year? If "Yes," answer lines 5b and 5c below (if applicable). Also, provide detail in Part VI , including (i) the names and EIN numbers of the supported organizations added, substituted, or removed; (ii) the reasons for each such action; (iii) the authority under the organization's organizing document authorizing such action; and (iv) how the action was accomplished (such as by amendment to the organizing document).		
b	Type I or Type II only. Was any added or substituted supported organization part of a class already designated in the organization's organizing document?		
c	Substitutions only. Was the substitution the result of an event beyond the organization's control?		
6	Did the organization provide support (whether in the form of grants or the provision of services or facilities) to anyone other than (i) its supported organizations, (ii) individuals that are part of the charitable class benefited by one or more of its supported organizations, or (iii) other supporting organizations that also support or benefit one or more of the filing organization's supported organizations? If "Yes," provide detail in Part VI .		
7	Did the organization provide a grant, loan, compensation, or other similar payment to a substantial contributor (defined in section 4958(c)(3)(C)), a family member of a substantial contributor, or a 35% controlled entity with regard to a substantial contributor? If "Yes," complete Part I of Schedule L (Form 990) .		
8	Did the organization make a loan to a disqualified person (as defined in section 4958) not described on line 7? If "Yes," complete Part I of Schedule L (Form 990).		
9a	Was the organization controlled directly or indirectly at any time during the tax year by one or more disqualified persons, as defined in section 4946 (other than foundation managers and organizations described in section 509(a)(1) or (2))? If "Yes," provide detail in Part VI .		
b	Did one or more disqualified persons (as defined on line 9a) hold a controlling interest in any entity in which the supporting organization had an interest? If "Yes," provide detail in Part VI .		
c	Did a disqualified person (as defined on line 9a) have an ownership interest in, or derive any personal benefit from, assets in which the supporting organization also had an interest? If "Yes," provide detail in Part VI .		
10a	Was the organization subject to the excess business holdings rules of section 4943 because of section 4943(f) (regarding certain Type II supporting organizations, and all Type III non-functionally integrated supporting organizations)? If "Yes," answer line 10b below.		
b	Did the organization have any excess business holdings in the tax year? (Use Schedule C, Form 4720, to determine whether the organization had excess business holdings).		

Part IV Supporting Organizations (continued)

		Yes	No
11	Has the organization accepted a gift or contribution from any of the following persons?		
a	A person who directly or indirectly controls, either alone or together with persons described on lines 11b and 11c below, the governing body of a supported organization?		
	11a		
b	A family member of a person described on 11a above?		
	11b		
c	A 35% controlled entity of a person described on line 11a or 11b above? If "Yes" to 11a, 11b, or 11c, provide detail in Part VI.		
	11c		

Section B. Type I Supporting Organizations

		Yes	No
1	Did the officers, directors, trustees, or membership of one or more supported organizations have the power to regularly appoint or elect at least a majority of the organization's directors or trustees at all times during the tax year? If "No," describe in Part VI how the supported organization(s) effectively operated, supervised, or controlled the organization's activities. If the organization had more than one supported organization, describe how the powers to appoint and/or remove directors or trustees were allocated among the supported organizations and what conditions or restrictions, if any, applied to such powers during the tax year.		
	1		
2	Did the organization operate for the benefit of any supported organization other than the supported organization(s) that operated, supervised, or controlled the supporting organization? If "Yes," explain in Part VI how providing such benefit carried out the purposes of the supported organization(s) that operated, supervised or controlled the supporting organization.		
	2		

Section C. Type II Supporting Organizations

		Yes	No
1	Were a majority of the organization's directors or trustees during the tax year also a majority of the directors or trustees of each of the organization's supported organization(s)? If "No," describe in Part VI how control or management of the supporting organization was vested in the same persons that controlled or managed the supported organization(s).		
	1		

Section D. All Type III Supporting Organizations

		Yes	No
1	Did the organization provide to each of its supported organizations, by the last day of the fifth month of the organization's tax year, (i) a written notice describing the type and amount of support provided during the prior tax year, (ii) a copy of the Form 990 that was most recently filed as of the date of notification, and (iii) copies of the organization's governing documents in effect on the date of notification, to the extent not previously provided?		
	1		
2	Were any of the organization's officers, directors, or trustees either (i) appointed or elected by the supported organization(s) or (ii) serving on the governing body of a supported organization? If "No," explain in Part VI how the organization maintained a close and continuous working relationship with the supported organization(s).		
	2		
3	By reason of the relationship described in line 2 above, did the organization's supported organizations have a significant voice in the organization's investment policies and in directing the use of the organization's income or assets at all times during the tax year? If "Yes," describe in Part VI the role the organization's supported organizations played in this regard.		
	3		

Section E. Type III Functionally-Integrated Supporting Organizations

1	Check the box next to the method that the organization used to satisfy the Integral Part Test during the year (see instructions):			
a	☐ The organization satisfied the Activities Test. Complete line 2 below.			
b	☐ The organization is the parent of each of its supported organizations. Complete line 3 below.			
c	☐ The organization supported a governmental entity. Describe in Part VI how you supported a government entity (see instructions)			
2	Activities Test. Answer lines 2a and 2b below.			
a	Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? If "Yes," then in Part VI identify those supported organizations and explain how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined that these activities constituted substantially all of its activities.			
	2a			
b	Did the activities described on line 2a, above constitute activities that, but for the organization's involvement, one or more of the organization's supported organization(s) would have been engaged in? If "Yes," explain in Part VI the reasons for the organization's position that its supported organization(s) would have engaged in these activities but for the organization's involvement.			
	2b			
3	Parent of Supported Organizations. Answer lines 3a and 3b below.			
a	Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? If "Yes" or "No", provide details in Part VI.			
	3a			
b	Did the organization exercise a substantial degree of direction over the policies, programs and activities of each of its supported organizations? If "Yes," describe in Part VI. the role played by the organization in this regard.			
	3b			

1

☐ Check here if the organization satisfied the Integral Part Test as a qualifying trust on Nov. 20, 1970 (explain in **Part VI**). See instructions. All other Type III non-functionally integrated supporting organizations must complete Sections A through E.

Section A - Adjusted Net Income		(A) Prior Year	(B) Current Year (optional)
1	Net short-term capital gain	1	
2	Recoveries of prior-year distributions	2	
3	Other gross income (see instructions)	3	
4	Add lines 1 through 3	4	
5	Depreciation and depletion	5	
6	Portion of operating expenses paid or incurred for production or collection of gross income or for management, conservation, or maintenance of property held for production of income (see instructions)	6	
7	Other expenses (see instructions)	7	
8	Adjusted Net Income (subtract lines 5, 6 and 7 from line 4)	8	

Section B - Minimum Asset Amount		(A) Prior Year	(B) Current Year (optional)
1	Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year):	1	
a	Average monthly value of securities	1a	
b	Average monthly cash balances	1b	
c	Fair market value of other non-exempt-use assets	1c	
d	Total (add lines 1a, 1b, and 1c)	1d	
e	Discount claimed for blockage or other factors (explain in detail in Part VI):		
2	Acquisition indebtedness applicable to non-exempt use assets	2	
3	Subtract line 2 from line 1d	3	
4	Cash deemed held for exempt use. Enter 0.015 of line 3 (for greater amount, see instructions).	4	
5	Net value of non-exempt-use assets (subtract line 4 from line 3)	5	
6	Multiply line 5 by 0.035	6	
7	Recoveries of prior-year distributions	7	
8	Minimum Asset Amount (add line 7 to line 6)	8	

Section C - Distributable Amount			Current Year
1	Adjusted net income for prior year (from Section A, line 8, Column A)	1	
2	Enter 85% of line 1	2	
3	Minimum asset amount for prior year (from Section B, line 8, Column A)	3	
4	Enter greater of line 2 or line 3	4	
5	Income tax imposed in prior year	5	
6	Distributable Amount. Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	6	

7

☐ Check here if the current year is the organization's first as a non-functionally-integrated Type III supporting organization (see instructions)

Section D - Distributions		Current Year
1	Amounts paid to supported organizations to accomplish exempt purposes	1
2	Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	2
3	Administrative expenses paid to accomplish exempt purposes of supported organizations	3
4	Amounts paid to acquire exempt-use assets	4
5	Qualified set-aside amounts (prior IRS approval required - provide details in Part VI)	5
6	Other distributions (describe in Part VI). See instructions	6
7	Total annual distributions. Add lines 1 through 6.	7
8	Distributions to attentive supported organizations to which the organization is responsive (provide details in Part VI). See instructions	8
9	Distributable amount for 2022 from Section C, line 6	9
10	Line 8 amount divided by Line 9 amount	10

Section E - Distribution Allocations (see instructions)	(i) Excess Distributions	(ii) Underdistributions Pre-2022	(iii) Distributable Amount for 2022
1	Distributable amount for 2022 from Section C, line 6		
2	Underdistributions, if any, for years prior to 2022 (reasonable cause required-- explain in Part VI). See instructions.		
3	Excess distributions carryover, if any, to 2022:		
a	From 2017.		
b	From 2018.		
c	From 2019.		
d	From 2020.		
e	From 2021.		
f	Total of lines 3a through e		
g	Applied to underdistributions of prior years		
h	Applied to 2022 distributable amount		
i	Carryover from 2017 not applied (see instructions)		
j	Remainder. Subtract lines 3g, 3h, and 3i from line 3f.		
4	Distributions for 2022 from Section D, line 7: \$		
a	Applied to underdistributions of prior years		
b	Applied to 2022 distributable amount		
c	Remainder. Subtract lines 4a and 4b from line 4.		
5	Remaining underdistributions for years prior to 2022, if any. Subtract lines 3g and 4a from line 2. If the amount is greater than zero, explain in Part VI. See instructions.		
6	Remaining underdistributions for 2022. Subtract lines 3h and 4b from line 1. If the amount is greater than zero, explain in Part VI. See instructions.		
7	Excess distributions carryover to 2023. Add lines 3j and 4c.		
8	Breakdown of line 7:		
a	Excess from 2018.		
b	Excess from 2019.		
c	Excess from 2020.		
d	Excess from 2021.		
e	Excess from 2022.		

Part VI

Supplemental Information. Provide the explanations required by Part II, line 10; Part II, line 17a or 17b; Part III, line 12; Part IV, Section A, lines 1, 2, 3b, 3c, 4b, 4c, 5a, 6, 9a, 9b, 9c, 11a, 11b, and 11c; Part IV, Section B, lines 1 and 2; Part IV, Section C, line 1; Part IV, Section D, lines 2 and 3; Part IV, Section E, lines 1c, 2a, 2b, 3a and 3b; Part V, line 1; Part V, Section B, line 1e; Part V Section D, lines 5, 6, and 8; and Part V, Section E, lines 2, 5, and 6. Also complete this part for any additional information. (See instructions).

Facts And Circumstances Test

Return Reference	Explanation
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If the organization answered "Yes" on Form 990, Part IV, Line 3, or Form 990-EZ, Part V, line 46 (Political Campaign Activities), then

- Section 501(c)(3) organizations: Complete Parts I-A and B. Do not complete Part I-C.
- Section 501(c) (other than section 501(c)(3)) organizations: Complete Parts I-A and C below. Do not complete Part I-B.
- Section 527 organizations: Complete Part I-A only.

If the organization answered "Yes" on Form 990, Part IV, Line 4, or Form 990-EZ, Part VI, line 47 (Lobbying Activities), then

- Section 501(c)(3) organizations that have filed Form 5768 (election under section 501(h)): Complete Part II-A. Do not complete Part II-B.
- Section 501(c)(3) organizations that have NOT filed Form 5768 (election under section 501(h)): Complete Part II-B. Do not complete Part II-A.

If the organization answered "Yes" on Form 990, Part IV, Line 5 (Proxy Tax) (see separate instructions) or Form 990-EZ, Part V, line 35c (Proxy Tax) (see separate instructions), then

- Section 501(c)(4), (5), or (6) organizations: Complete Part III.

Name of the organization THE LEAPFROG GROUP	Employer identification number 52-2359517
--	--

Part I-A Complete if the organization is exempt under section 501(c) or is a section 527 organization.

1	Provide a description of the organization's direct and indirect political campaign activities in Part IV. See instructions for definition of "political campaign activities."	
2	Political campaign activity expenditures. See instructions	\$
3	Volunteer hours for political campaign activities. See instructions	

Part I-B Complete if the organization is exempt under section 501(c)(3).

1	Enter the amount of any excise tax incurred by the organization under section 4955	\$
2	Enter the amount of any excise tax incurred by organization managers under section 4955	\$
3	If the organization incurred a section 4955 tax, did it file Form 4720 for this year?	☐ Yes ☐ No
4a	Was a correction made?	☐ Yes ☐ No
b	If "Yes," describe in Part IV.	

Part I-C Complete if the organization is exempt under section 501(c), except section 501(c)(3).

1	Enter the amount directly expended by the filing organization for section 527 exempt function activities	\$
2	Enter the amount of the filing organization's funds contributed to other organizations for section 527 exempt function activities	\$
3	Total exempt function expenditures. Add lines 1 and 2. Enter here and on Form 1120-POL, line 17b	\$
4	Did the filing organization file Form 1120-POL for this year?	☐ Yes ☐ No
5	Enter the names, addresses and employer identification number (EIN) of all section 527 political organizations to which the filing organization made payments. For each organization listed, enter the amount paid from the filing organization's funds. Also enter the amount of political contributions received that were promptly and directly delivered to a separate political organization, such as a separate segregated fund or a political action committee (PAC). If additional space is needed, provide information in Part IV.	

(a) Name	(b) Address	(c) EIN	(d) Amount paid from filing organization's funds. If none, enter -0-.	(e) Amount of political contributions received and promptly and directly delivered to a separate political organization. If none, enter -0-.
1				
2				
3				
4				
5				
6				

- A

Check

☐

if the filing organization belongs to an affiliated group (and list in Part IV each affiliated group member's name, address, EIN, expenses, and share of excess lobbying expenditures).
- B

Check

☐

if the filing organization checked box A and "limited control" provisions apply.

Limits on Lobbying Expenditures (The term "expenditures" means amounts paid or incurred.)		(a) Filing organization's totals	(b) Affiliated group totals												
1a Total lobbying expenditures to influence public opinion (grass roots lobbying)															
b Total lobbying expenditures to influence a legislative body (direct lobbying)															
c Total lobbying expenditures (add lines 1a and 1b)															
d Other exempt purpose expenditures		7,975,667													
e Total exempt purpose expenditures (add lines 1c and 1d)		7,975,667													
f Lobbying nontaxable amount. Enter the amount from the following table in both columns.		548,783													
<table><thead><tr><th>If the amount on line 1e, column (a) or (b) is:</th><th>The lobbying nontaxable amount is:</th></tr></thead><tbody><tr><td>Not over \$500,000</td><td>20% of the amount on line 1e.</td></tr><tr><td>Over \$500,000 but not over \$1,000,000</td><td>\$100,000 plus 15% of the excess over \$500,000.</td></tr><tr><td>Over \$1,000,000 but not over \$1,500,000</td><td>\$175,000 plus 10% of the excess over \$1,000,000.</td></tr><tr><td>Over \$1,500,000 but not over \$17,000,000</td><td>\$225,000 plus 5% of the excess over \$1,500,000.</td></tr><tr><td>Over \$17,000,000</td><td>\$1,000,000.</td></tr></tbody></table>		If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:	Not over \$500,000	20% of the amount on line 1e.	Over \$500,000 but not over \$1,000,000	\$100,000 plus 15% of the excess over \$500,000.	Over \$1,000,000 but not over \$1,500,000	\$175,000 plus 10% of the excess over \$1,000,000.	Over \$1,500,000 but not over \$17,000,000	\$225,000 plus 5% of the excess over \$1,500,000.	Over \$17,000,000	\$1,000,000.		
If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:														
Not over \$500,000	20% of the amount on line 1e.														
Over \$500,000 but not over \$1,000,000	\$100,000 plus 15% of the excess over \$500,000.														
Over \$1,000,000 but not over \$1,500,000	\$175,000 plus 10% of the excess over \$1,000,000.														
Over \$1,500,000 but not over \$17,000,000	\$225,000 plus 5% of the excess over \$1,500,000.														
Over \$17,000,000	\$1,000,000.														
g Grassroots nontaxable amount (enter 25% of line 1f)		137,196													
h Subtract line 1g from line 1a. If zero or less, enter -0-		0													
i Subtract line 1f from line 1c. If zero or less, enter -0-		0													
j If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year?		☐ Yes ☐ No													

4-Year Averaging Period Under Section 501(h)

(Some organizations that made a section 501(h) election do not have to complete all of the five columns below. See the separate instructions for lines 2a through 2f.)

Lobbying Expenditures During 4-Year Averaging Period					
Calendar year (or fiscal year beginning in)	(a) 2019	(b) 2020	(c) 2021	(d) 2022	(e) Total
2a Lobbying nontaxable amount	444,043	462,469	512,283	548,783	1,967,578
b Lobbying ceiling amount (150% of line 2a, column(e))					2,951,367
c Total lobbying expenditures					
d Grassroots nontaxable amount	111,011	115,617	128,071	137,196	491,895
e Grassroots ceiling amount (150% of line 2d, column (e))					737,843
f Grassroots lobbying expenditures					

Part II-B Complete if the organization is exempt under section 501(c)(3) and has NOT filed Form 5768 (election under section 501(h)).

For each "Yes" response on lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity.

		(a)		(b)
		Yes	No	Amount
1	During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of:			
a	Volunteers?			
b	Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?			
c	Media advertisements?			
d	Mailings to members, legislators, or the public?			
e	Publications, or published or broadcast statements?			
f	Grants to other organizations for lobbying purposes?			
g	Direct contact with legislators, their staffs, government officials, or a legislative body?			
h	Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?			
i	Other activities?			
j	Total. Add lines 1c through 1i			
2a	Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?			
b	If "Yes," enter the amount of any tax incurred under section 4912			
c	If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d	If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

Part III-A Complete if the organization is exempt under section 501(c)(4), section 501(c)(5), or section 501(c)(6).

		Yes	No
1	Were substantially all (90% or more) dues received nondeductible by members?	1	
2	Did the organization make only in-house lobbying expenditures of \$2,000 or less?	2	
3	Did the organization agree to carry over lobbying and political expenditures from the prior year?	3	

Part III-B Complete if the organization is exempt under section 501(c)(4), section 501(c)(5), or section 501(c)(6) and if either (a) BOTH Part III-A, lines 1 and 2, are answered "No" OR (b) Part III-A, line 3, is answered "Yes."

1	Dues, assessments and similar amounts from members	1	
2	Section 162(e) nondeductible lobbying and political expenditures (do not include amounts of political expenses for which the section 527(f) tax was paid).		
a	Current year	2a	
b	Carryover from last year	2b	
c	Total	2c	
3	Aggregate amount reported in section 6033(e)(1)(A) notices of nondeductible section 162(e) dues .	3	
4	If notices were sent and the amount on line 2c exceeds the amount on line 3, what portion of the excess does the organization agree to carryover to the reasonable estimate of nondeductible lobbying and political expenditure next year?	4	
5	Taxable amount of lobbying and political expenditures. See Instructions	5	

Part IV Supplemental Information

Provide the descriptions required for Part I-A, line 1; Part I-B, line 4; Part I-C, line 5; Part II-A (affiliated group list); Part II-A, lines 1 and 2 (see instructions), and Part II-B, line 1. Also, complete this part for any additional information.

Return Reference	Explanation
------------------	-------------

Name of the organization THE LEAPFROG GROUP	Employer identification number 52-2359517
--	--

Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts.
Complete if the organization answered "Yes" on Form 990, Part IV, line 6.

	(a) Donor advised funds	(b) Funds and other accounts
1 Total number at end of year		
2 Aggregate value of contributions to (during year)		
3 Aggregate value of grants from (during year)		
4 Aggregate value at end of year		
5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control?		☐ Yes ☐ No
6 Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit?		☐ Yes ☐ No

Part II Conservation Easements.
Complete if the organization answered "Yes" on Form 990, Part IV, line 7.

1 Purpose(s) of conservation easements held by the organization (check all that apply).
☐ Preservation of land for public use (e.g., recreation or education)
☐ Protection of natural habitat
☐ Preservation of open space

☐ Preservation of an historically important land area
☐ Preservation of a certified historic structure

2 Complete lines 2a through 2d if the organization held a qualified conservation contribution in the form of a conservation easement on the last day of the tax year.

	Held at the End of the Year
a Total number of conservation easements	2a
b Total acreage restricted by conservation easements	2b
c Number of conservation easements on a certified historic structure included in (a)	2c
d Number of conservation easements included in (c) acquired after July 25, 2006, and not on a historic structure listed in the National Register	2d

3 Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the tax year ▶ _____

4 Number of states where property subject to conservation easement is located ▶ _____

5 Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds?
☐ Yes ☐ No

6 Staff and volunteer hours devoted to monitoring, inspecting, handling of violations, and enforcing conservation easements during the year ▶ _____

7 Amount of expenses incurred in monitoring, inspecting, handling of violations, and enforcing conservation easements during the year ▶ \$ _____

8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)?
☐ Yes ☐ No

9 In Part XIII, describe how the organization reports conservation easements in its revenue and expense statement, and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements.

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets.
Complete if the organization answered "Yes" on Form 990, Part IV, line 8.

1a If the organization elected, as permitted under FASB ASC 958, not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part XIII, the text of the footnote to its financial statements that describes these items.

1b If the organization elected, as permitted under FASB ASC 958, to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items:
(i) Revenue included on Form 990, Part VIII, line 1 ▶ \$ _____
(ii) Assets included in Form 990, Part X ▶ \$ _____

2 If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under FASB ASC 958 relating to these items:
a Revenue included on Form 990, Part VIII, line 1 ▶ \$ _____
b Assets included in Form 990, Part X ▶ \$ _____

Part III

Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets (continued)

- 3
- Using the organization's acquisition, accession, and other records, check any of the following that are a significant use of its collection items (check all that apply):
- a☐ Public exhibition

b☐ Scholarly research

c☐ Preservation for future generations

d☐ Loan or exchange programs

e☐ Other
- 4
- Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part XIII.
- 5
- During the year, did the organization solicit or receive donations of art, historical treasures or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection? . . .
- ☐ Yes

☐ No

Part IV

Escrow and Custodial Arrangements.

Complete if the organization answered "Yes" on Form 990, Part IV, line 9, or reported an amount on Form 990, Part X, line 21.

- 1a
- Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X?
- ☐ Yes

☐ No
- b
- If "Yes," explain the arrangement in Part XIII and complete the following table:
- c Beginning balance

d Additions during the year

e Distributions during the year

f Ending balance
- | | Amount |
|----|--------|
| 1c | |
| 1d | |
| 1e | |
| 1f | |
- 2a
- Did the organization include an amount on Form 990, Part X, line 21, for escrow or custodial account liability? . . .
- ☐ Yes

☐ No
- b
- If "Yes," explain the arrangement in Part XIII. Check here if the explanation has been provided in Part XIII
- ☐

Part V

Endowment Funds.

Complete if the organization answered "Yes" on Form 990, Part IV, line 10.

- | | (a) Current year | (b) Prior year | (c) Two years back | (d) Three years back | (e) Four years back |
|----|--|----------------|--------------------|----------------------|---------------------|
| 1a | Beginning of year balance | | | | |
| b | Contributions | | | | |
| c | Net investment earnings, gains, and losses | | | | |
| d | Grants or scholarships | | | | |
| e | Other expenditures for facilities and programs | | | | |
| f | Administrative expenses | | | | |
| g | End of year balance | | | | |
- 2
- Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as:
- a Board designated or quasi-endowment ▶

b Permanent endowment ▶

c Term endowment ▶
- The percentages on lines 2a, 2b, and 2c should equal 100%.
- 3a
- Are there endowment funds not in the possession of the organization that are held and administered for the organization by:
- (i) Unrelated organizations

(ii) Related organizations
- | | Yes | No |
|--------|-----|----|
| 3a(i) | | |
| 3a(ii) | | |
| 3b | | |
- b
- If "Yes" on 3a(ii), are the related organizations listed as required on Schedule R?
- 4
- Describe in Part XIII the intended uses of the organization's endowment funds.

Part VI

Land, Buildings, and Equipment.

Complete if the organization answered "Yes" on Form 990, Part IV, line 11a. See Form 990, Part X, line 10.

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land				
b Buildings				
c Leasehold improvements		447,431	115,285	332,146
d Equipment		109,804	72,859	36,945
e Other		832,717	566,966	265,751
Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10(c).) . . . ▶				634,842

Part VII Investments - Other Securities.

Complete if the organization answered "Yes" on Form 990, Part IV, line 11b. See Form 990, Part X, line 12.

(a) Description of security or category (including name of security)	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1) Financial derivatives		
(2) Closely-held equity interests		
(3) Other _____		
(A)		
(B)		
(C)		
(D)		
(E)		
(F)		
(G)		
(H)		
Total. (Column (b) must equal Form 990, Part X, col. (B) line 12.)		

Part VIII Investments - Program Related.

Complete if the organization answered 'Yes' on Form 990, Part IV, line 11c. See Form 990, Part X, line 13.

(a) Description of investment	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1)		
(2)		
(3)		
(4)		
(5)		
(6)		
(7)		
(8)		
(9)		
Total. (Column (b) must equal Form 990, Part X, col.(B) line 13.)		

Part IX Other Assets.

Complete if the organization answered 'Yes' on Form 990, Part IV, line 11d. See Form 990, Part X, line 15.

(a) Description	(b) Book value
(1) DEPOSITS	39,253
(2) OPERATING RIGHT OF USE ASSET	3,101,785
(2)	
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col.(B) line 15.)	3,141,038

Part X Other Liabilities.

Complete if the organization answered 'Yes' on Form 990, Part IV, line 11e or 11f. See Form 990, Part X, line 25.

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
CAPITAL LEASE	5,270
OPERATING LEASE	3,447,896
REFUNDABLE ADVANCE	816,023
Total. (Column (b) must equal Form 990, Part X, col.(B) line 25.)	4,269,189
2. Liability for uncertain tax positions. In Part XIII, provide the text of the footnote to the organization's financial statements that reports the organization's liability for uncertain tax positions under FIN 48 (ASC 740). Check here if the text of the footnote has been provided in Part XIII ☒	

Part XI

Reconciliation of Revenue per Audited Financial Statements With Revenue per Return.

Complete if the organization answered 'Yes' on Form 990, Part IV, line 12a.

1	Total revenue, gains, and other support per audited financial statements		1	
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12:			
a	Net unrealized gains (losses) on investments	2a		
b	Donated services and use of facilities	2b		
c	Recoveries of prior year grants	2c		
d	Other (Describe in Part XIII.)	2d		
e	Add lines 2a through 2d		2e	
3	Subtract line 2e from line 1		3	
4	Amounts included on Form 990, Part VIII, line 12, but not on line 1:			
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a		
b	Other (Describe in Part XIII.)	4b		
c	Add lines 4a and 4b		4c	
5	Total revenue. Add lines 3 and 4c. (This must equal Form 990, Part I, line 12.)		5	

Part XII

Reconciliation of Expenses per Audited Financial Statements With Expenses per Return.

Complete if the organization answered 'Yes' on Form 990, Part IV, line 12a.

1	Total expenses and losses per audited financial statements		1	
2	Amounts included on line 1 but not on Form 990, Part IX, line 25:			
a	Donated services and use of facilities	2a		
b	Prior year adjustments	2b		
c	Other losses	2c		
d	Other (Describe in Part XIII.)	2d		
e	Add lines 2a through 2d		2e	
3	Subtract line 2e from line 1		3	
4	Amounts included on Form 990, Part IX, line 25, but not on line 1:			
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a		
b	Other (Describe in Part XIII.)	4b		
c	Add lines 4a and 4b		4c	
5	Total expenses. Add lines 3 and 4c. (This must equal Form 990, Part I, line 18.)		5	

Part XIII

Supplemental Information

Provide the descriptions required for Part II, lines 3, 5, and 9; Part III, lines 1a and 4; Part IV, lines 1b and 2b; Part V, line 4; Part X, line 2; Part XI, lines 2d and 4b; and Part XII, lines 2d and 4b. Also complete this part to provide any additional information.

Return Reference	Explanation
PART X, LINE 2:	MANAGEMENT EVALUATED LEAPFROG'S TAX POSITIONS AND CONCLUDED THAT LEAPFROG HAS TAKEN NO UNCERTAIN TAX POSITIONS THAT REQUIRE ADJUSTMENT TO THE CONSOLIDATED FINANCIAL STATEMENTS TO COMPLY WITH THE PROVISIONS OF THIS GUIDANCE. GENERALLY, LEAPFROG IS NOT LONGER SUBJECT TO INCOME TAX EXAMINATIONS BY THE U.S. FEDERAL, STATE OR LOCAL TAX AUTHORITIES FOR THE YEAR BEFORE 2019.

Name of the organization THE LEAPFROG GROUP	Employer identification number 52-2359517
--	--

Part I

Questions Regarding Compensation

1a	Check the appropriate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.		Yes	No
	☐ First-class or charter travel ☐ Travel for companions ☐ Tax idemnification and gross-up payments ☐ Discretionary spending account ☐ Housing allowance or residence for personal use ☐ Payments for business use of personal residence ☐ Health or social club dues or initiation fees ☐ Personal services (e.g., maid, chauffeur, chef)			
b	If any of the boxes on Line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain	1b		
2	Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, officers, including the CEO/Executive Director, regarding the items checked on Line 1a?	2		
3	Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III.			
	☐ Compensation committee ☒ Independent compensation consultant ☒ Form 990 of other organizations ☒ Written employment contract ☒ Compensation survey or study ☒ Approval by the board or compensation committee			
4	During the year, did any person listed on Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization:			
a	Receive a severance payment or change-of-control payment?	4a		No
b	Participate in, or receive payment from, a supplemental nonqualified retirement plan?	4b		No
c	Participate in, or receive payment from, an equity-based compensation arrangement?	4c		No
	If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.			
	Only 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.			
5	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of:			
a	The organization?	5a		No
b	Any related organization?	5b		No
	If "Yes," on line 5a or 5b, describe in Part III.			
6	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of:			
a	The organization?	6a		No
b	Any related organization?	6b		No
	If "Yes," on line 6a or 6b, describe in Part III.			
7	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any nonfixed payments not described in lines 5 and 6? If "Yes," describe in Part III	7		No
8	Were any amounts reported on Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III	8		No
9	If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?	9		

Part II Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees. Use duplicate copies if additional space is needed.

For each individual whose compensation must be reported on Schedule J, report compensation from the organization on row (i) and from related organizations, described in the instructions, on row (ii). Do not list any individuals that are not listed on Form 990, Part VII.

Note. The sum of columns (B)(i)-(iii) for each listed individual must equal the total amount of Form 990, Part VII, Section A, line 1a, applicable column (D) and (E) amounts for that individual.

(A) Name and Title		(B) Breakdown of W-2, 1099-MISC compensation, and/or 1099-NEC			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1LEAH BINDER PRESIDENT & CEO	(i)	569,448	100,000	0	30,500	53,800	753,748	0
	(ii)	0	0	0	0	0	0	0
2MELISSA DANFORTH VP, HEALTH CARE RATINGS	(i)	311,586	47,388	0	30,500	30,938	420,412	0
	(ii)	0	0	0	0	0	0	0
3RALPH JOHNSON VP OF INFORMATICS AND TECH	(i)	236,570	35,938	0	27,791	31,159	331,458	0
	(ii)	0	0	0	0	0	0	0
4KAREN JUPITER VP DEVELOPMENT	(i)	221,926	30,500	0	11,875	11,256	275,557	0
	(ii)	0	0	0	0	0	0	0
5JILL BERGER DIRECTOR, EMPLOYER AND PAY	(i)	192,932	31,738	0	22,421	13,200	260,291	0
	(ii)	0	0	0	0	0	0	0
6KATHRYN BURGGRAFWESTWART DIRECTOR, HEALTH CARE RATI	(i)	113,895	23,246	0	13,259	17,158	167,558	0
	(ii)	0	0	0	0	0	0	0
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							

Part III **Supplemental Information**

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Provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 3, 4a, 4b, 4c, 5a, 5b, 6a, 6b, 7, and 8, and for Part II. Also complete this part for any additional information.

Return Reference	Explanation

SCHEDULE O
(Form 990)

Supplemental Information to Form 990 or 990-EZ

Department of the Treasury
Internal Revenue Service
Name of the organization
THE LEAPFROG GROUP

Complete to provide information for responses to specific questions on Form 990 or 990-EZ or to provide any additional information.
▶ Attach to Form 990 or 990-EZ.
▶ Go to www.irs.gov/Form990 for the latest information.

OMB No. 1545-0047

2022

Open to Public Inspection

Employer identification number
52-2359517

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 11B	FORM 990 IS REVIEWED BY MANAGEMENT, AND THEN REVIEWED BY THE AUDIT COMMITTEE CHAIR. THE AUDIT COMMITTEE CHAIR, ONCE COMFORTABLE WITH THE RETURN, FORWARDS IT TO THE BOARD FOR REVIEW. THE BOARD REVIEWS THE 990 PRIOR TO SUBMISSION.
FORM 990, PART VI, SECTION B, LINE 12C	THE GOVERNANCE COMMITTEE ADVISES BOARD MEMBERS THAT THE BYLAWS REQUIRE COMPLIANCE WITH THE CONFLICT OF INTEREST POLICY. BOARD MEMBERS ARE ASKED TO RECUSE THEMSELVES SHOULD THEY HAVE ANY POSSIBLE CONFLICTS.
FORM 990, PART VI, SECTION B, LINE 15	THE EXECUTIVE COMMITTEE UTILIZED A COMPENSATION STUDY TO ESTABLISH THE COMPENSATION OF THE CEO.
FORM 990, PART VI, SECTION C, LINE 19	THE LEAPFROG GROUP WILL PROVIDE A COPY OF THEIR FORM 1023 AND FORM 990 UPON REQUEST.
FORM 990, PART IX, LINE 11G	CONSULTING FEES: PROGRAM SERVICE EXPENSES 1,106,349. MANAGEMENT AND GENERAL EXPENSES 0. FUNDRAISING EXPENSES 1,807. TOTAL EXPENSES 1,108,156.
FORM 990, PART XII, LINE 2C	THE PROCESS HAS NOT CHANGED FROM THE PREVIOUS YEAR.

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SCHEDULE R
(Form 990)

Related Organizations and Unrelated Partnerships

► Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.
► Attach to Form 990.
► Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047

2022

Open to Public Inspection

Name of the organization
THE LEAPFROG GROUP

Employer identification number
52-2359517

Part I Identification of Disregarded Entities. Complete if the organization answered "Yes" on Form 990, Part IV, line 33.					
(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1) THE LEAPFROG GROUP DUE DILLIGENCE COOPERATIVE LLC 1775 K STREET NW SUITE 400 WASHINGTON, DC 20036 45-2397143	TO COLLECT, EVALUATE, AND SUMMARIZE INFORMATION ABOUT COMPANIES	DC	-298	3,608	THE LEAPFROG GROUP

Part II Identification of Related Tax-Exempt Organizations. Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had one or more related tax-exempt organizations during the tax year.							
(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No

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Part III

Identification of Related Organizations Taxable as a Partnership. Complete if the organization answered "Yes" on Form 990, Part IV, line 34, because it had one or more related organizations treated as a partnership during the tax year.

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income(related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of- year assets	(h) Disproportionate allocations?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	

Part IV

Identification of Related Organizations Taxable as a Corporation or Trust. Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had one or more related organizations treated as a corporation or trust during the tax year.

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of- year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity?	
								Yes	No

Part V Transactions With Related Organizations

Complete if the organization answered "Yes" on Form 990, Part IV, line 34, 35b, or 36

37

Note. Complete line 1 if any entity is listed in Parts II, III, or IV of this schedule.

1 During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?

- a

Receipt of (i) interest, (ii) annuities, (iii) royalties, or (iv) rent from a controlled entity
- b

Gift, grant, or capital contribution to related organization(s)
- c

Gift, grant, or capital contribution from related organization(s)
- d

Loans or loan guarantees to or for related organization(s)
- e

Loans or loan guarantees by related organization(s)
- f

Dividends from related organization(s)
- g

Sale of assets to related organization(s)
- h

Purchase of assets from related organization(s)
- i

Exchange of assets with related organization(s)
- j

Lease of facilities, equipment, or other assets to related organization(s)
- k

Lease of facilities, equipment, or other assets from related organization(s)
- l

Performance of services or membership or fundraising solicitations for related organization(s)
- m

Performance of services or membership or fundraising solicitations by related organization(s)
- n

Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)
- o

Sharing of paid employees with related organization(s)
- p

Reimbursement paid to related organization(s) for expenses
- q

Reimbursement paid by related organization(s) for expenses
- r

Other transfer of cash or property to related organization(s)
- s

Other transfer of cash or property from related organization(s)

	Yes	No
1a		
1b		
1c		
1d		
1e		
1f		
1g		
1h		
1i		
1j		
1k		
1l		
1m		
1n		
1o		
1p		
1q		
1r		
1s		

2 If the answer to any of the above is "Yes," see the instructions for information on who must complete this line, including covered relationships and transaction thresholds.

(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved

Part VI Unrelated Organizations Taxable as a Partnership.

Provide the following information for each entity taxed as a partnership through which the organization conducted more than five percent of its activities (measured by total assets or gross revenue) that was not a related organization. See instructions regarding exclusion for certain investment partnerships.

[illegible]

Part VII**Supplemental Information**

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Provide additional information for responses to questions on Schedule R. See instructions.

Return Reference	Explanation
PART I (B)	PROVIDING HEALTHCARE-RELATED SERVICES TO EMPLOYERS.

Exhibit 79

Check if Schedule O contains a response or note to any line in this Part III ☐

1 Briefly describe the organization's mission:

TO TRIGGER GIANT LEAPS FORWARD IN THE SAFETY, QUALITY, AND AFFORDABILITY OF U.S. HEALTH CARE BY USING TRANSPARENCY TO SUPPORT INFORMED HEALTH CARE DECISIONS AND PROMOTE HIGH-VALUE CARE.

2 Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ? ☐ Yes ☒ No
If "Yes," describe these new services on Schedule O.

3 Did the organization cease conducting, or make significant changes in how it conducts, any program services? ☐ Yes ☒ No
If "Yes," describe these changes on Schedule O.

4 Describe the organization's program service accomplishments for each of its three largest program services, as measured by expenses. Section 501(c)(3) and 501(c)(4) organizations are required to report the amount of grants and allocations to others, the total expenses, and revenue, if any, for each program service reported.

4a	(Code:) (Expenses \$ 3,663,443 including grants of \$) (Revenue \$ 272,914)
RATINGS: LEAPFROG FIELDS A VOLUNTARY SURVEY OF HOSPITALS AND AMBULATORY SURGERY CENTERS ON QUALITY AND SAFETY PRACTICES. THE SURVEYS INVOLVE MEASURE DEVELOPMENT AND ARE UPDATED ANNUALLY. THE HOSPITAL SURVEY ALSO INCLUDES A TOOL TO EVALUATE SYSTEMS FOR COMPUTERIZED PHYSICIAN ORDER ENTRY OF PHARMACEUTICALS. IN ADDITION, THE DATA FROM THE HOSPITAL SURVEY ARE COMBINED WITH DATA FROM OTHER SOURCES TO FURTHER UNDERSTAND HOSPITAL QUALITY AND SAFETY. THE ORGANIZATION PUBLICLY RATES U.S. HOSPITALS ON THEIR SAFETY IN AN INITIATIVE CALLED THE LEAPFROG HOSPITAL SAFETY GRADE.	

4b	(Code:) (Expenses \$ 2,064,535 including grants of \$) (Revenue \$ 5,469,784)
COMMUNICATIONS: LEAPFROG COLLECTS, ANALYZES AND DISSEMINATES HEALTH CARE DATA ON QUALITY AND SAFETY TO CONSUMERS AND PURCHASERS TO HELP THEM MAKE DECISIONS ON WHERE TO SEEK CARE. HEALTH CARE PROVIDERS ALSO FIND THE INFORMATION USEFUL FOR THEIR OWN IMPROVEMENT PROGRAMS AND THE OPPORTUNITY TO BENCHMARK AGAINST THEIR PEERS. LEAPFROG WORKS WITH PRINT, RADIO, TELEVISION, DIGITAL AND SOCIAL MEDIA PLATFORMS TO SPREAD INFORMATION ABOUT ITS HEALTH CARE RATINGS AND REPORTS.	

4c	(Code:) (Expenses \$ 1,439,172 including grants of \$) (Revenue \$ 73,955)
MEMBERSHIP: LEAPFROG WORKS WITH EMPLOYERS AND PURCHASERS OF HEALTH CARE TO ENCOURAGE TRANSPARENCY FROM THE HEALTH CARE COMMUNITY AND EDUCATE EMPLOYEES ON THE SAFEST AND HIGHEST QUALITY PROVIDERS. LEAPFROG ALSO COLLECTS DUES FROM AN ADVISORY COMMITTEE OF HEALTH CARE-FOCUSED COMPANIES WHO OFFER ADVICE AND SUGGESTIONS TO LEAPFROG BUT DO NOT HAVE A GOVERNING ROLE.	

4d	Other program services (Describe in Schedule O.)
(Expenses \$	including grants of \$) (Revenue \$)

4e	Total program service expenses	7,167,150
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		Yes	No
1	Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? <i>If "Yes," complete Schedule A</i>	Yes	
2	Is the organization required to complete <i>Schedule B, Schedule of Contributors</i> ? See instructions.	Yes	
3	Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? <i>If "Yes," complete Schedule C, Part I</i>		No
4	Section 501(c)(3) organizations. Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? <i>If "Yes," complete Schedule C, Part II</i>	Yes	
5	Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Rev. Proc. 98-19? <i>If "Yes," complete Schedule C, Part III</i>		No
6	Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? <i>If "Yes," complete Schedule D, Part I</i>		No
7	Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? <i>If "Yes," complete Schedule D, Part II</i>		No
8	Did the organization maintain collections of works of art, historical treasures, or other similar assets? <i>If "Yes," complete Schedule D, Part III</i>		No
9	Did the organization report an amount in Part X, line 21 for escrow or custodial account liability; serve as a custodian for amounts not listed in Part X; or provide credit counseling, debt management, credit repair, or debt negotiation services? <i>If "Yes," complete Schedule D, Part IV</i>		No
10	Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi endowments? <i>If "Yes," complete Schedule D, Part V</i>		No
11	If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X, as applicable.		
a	Did the organization report an amount for land, buildings, and equipment in Part X, line 10? <i>If "Yes," complete Schedule D, Part VI.</i>	Yes	
b	Did the organization report an amount for investments—other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? <i>If "Yes," complete Schedule D, Part VII</i>		No
c	Did the organization report an amount for investments—program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? <i>If "Yes," complete Schedule D, Part VIII</i>		No
d	Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? <i>If "Yes," complete Schedule D, Part IX</i>	Yes	
e	Did the organization report an amount for other liabilities in Part X, line 25? <i>If "Yes," complete Schedule D, Part X</i>	Yes	
f	Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? <i>If "Yes," complete Schedule D, Part X</i>	Yes	
12a	Did the organization obtain separate, independent audited financial statements for the tax year? <i>If "Yes," complete Schedule D, Parts XI and XII</i>		No
b	Was the organization included in consolidated, independent audited financial statements for the tax year? <i>If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional</i>	Yes	
13	Is the organization a school described in section 170(b)(1)(A)(ii)? <i>If "Yes," complete Schedule E</i>		No
14a	Did the organization maintain an office, employees, or agents outside of the United States?		No
b	Did the organization have aggregate revenues or expenses of more than \$10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at \$100,000 or more? <i>If "Yes," complete Schedule F, Parts I and IV</i>		No
15	Did the organization report on Part IX, column (A), line 3, more than \$5,000 of grants or other assistance to or for any foreign organization? <i>If "Yes," complete Schedule F, Parts II and IV</i>		No
16	Did the organization report on Part IX, column (A), line 3, more than \$5,000 of aggregate grants or other assistance to or for foreign individuals? <i>If "Yes," complete Schedule F, Parts III and IV</i>		No
17	Did the organization report a total of more than \$15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? <i>If "Yes," complete Schedule G, Part I.</i> See instructions.		No
18	Did the organization report more than \$15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? <i>If "Yes," complete Schedule G, Part II</i>		No
19	Did the organization report more than \$15,000 of gross income from gaming activities on Part VIII, line 9a? <i>If "Yes," complete Schedule G, Part III</i>		No
20a	Did the organization operate one or more hospital facilities? <i>If "Yes," complete Schedule H</i>		No
b	If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?		
21	Did the organization report more than \$5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? <i>If "Yes," complete Schedule I, Parts I and II</i>		No

Part IV Checklist of Required Schedules (continued)

		Yes	No
22	Did the organization report more than \$5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? If "Yes," complete Schedule I, Parts I and III		No
23	Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5, about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? If "Yes," complete Schedule J	Yes	
24a	Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than \$100,000 as of the last day of the year, that was issued after December 31, 2002? If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a		No
b	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?		
c	Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?		
d	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?		
25a	Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations. Did the organization engage in an excess benefit transaction with a disqualified person during the year? If "Yes," complete Schedule L, Part I		No
b	Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? If "Yes," complete Schedule L, Part I		No
26	Did the organization report any amount on Part X, line 5 or 22 for receivables from or payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons? If "Yes," complete Schedule L, Part II		No
27	Did the organization provide a grant or other assistance to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or employee thereof, a grant selection committee member, or to a 35% controlled entity (including an employee thereof) or family member of any of these persons? If "Yes," complete Schedule L, Part III		No
28	Was the organization a party to a business transaction with one of the following parties (see the Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions):		
a	A current or former officer, director, trustee, key employee, creator or founder, or substantial contributor? If "Yes," complete Schedule L, Part IV		No
b	A family member of any individual described in line 28a? If "Yes," complete Schedule L, Part IV		No
c	A 35% controlled entity of one or more individuals and/or organizations described in line 28a or 28b? If "Yes," complete Schedule L, Part IV		No
29	Did the organization receive more than \$25,000 in non-cash contributions? If "Yes," complete Schedule M		No
30	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? If "Yes," complete Schedule M		No
31	Did the organization liquidate, terminate, or dissolve and cease operations? If "Yes," complete Schedule N, Part I		No
32	Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? If "Yes," complete Schedule N, Part II		No
33	Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? If "Yes," complete Schedule R, Part I	Yes	
34	Was the organization related to any tax-exempt or taxable entity? If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1		No
35a	Did the organization have a controlled entity within the meaning of section 512(b)(13)?		No
b	If "Yes" to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? If "Yes," complete Schedule R, Part V, line 2		
36	Section 501(c)(3) organizations. Did the organization make any transfers to an exempt non-charitable related organization? If "Yes," complete Schedule R, Part V, line 2		No
37	Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? If "Yes," complete Schedule R, Part VI		No
38	Did the organization complete Schedule O and provide explanations on Schedule O for Part VI, lines 11b and 19? Note. All Form 990 filers are required to complete Schedule O.	Yes	

Part V Statements Regarding Other IRS Filings and Tax Compliance		Yes	No
Check if Schedule O contains a response or note to any line in this Part V ☐			
1a	Enter the number reported in box 3 of Form 1096. Enter -0- if not applicable	33	
b	Enter the number of Forms W-2G included on line 1a. Enter -0- if not applicable	0	
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	Yes	

2a Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return	2a	22			
b If at least one is reported on line 2a, did the organization file all required federal employment tax returns?	2b	Yes			
3a Did the organization have unrelated business gross income of \$1,000 or more during the year?	3a			No	
b If "Yes," has it filed a Form 990-T for this year? <i>If "No" to line 3b, provide an explanation in Schedule O</i>	3b				
4a At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?	4a			No	
b If "Yes," enter the name of the foreign country: _____ See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR).					
5a Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?	5a			No	
b Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?	5b			No	
c If "Yes," to line 5a or 5b, did the organization file Form 8886-T?	5c				
6a Does the organization have annual gross receipts that are normally greater than \$100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions?	6a			No	
b If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?	6b				
7 Organizations that may receive deductible contributions under section 170(c).					
a Did the organization receive a payment in excess of \$75 made partly as a contribution and partly for goods and services provided to the payor?	7a			No	
b If "Yes," did the organization notify the donor of the value of the goods or services provided?	7b				
c Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?	7c			No	
d If "Yes," indicate the number of Forms 8282 filed during the year	7d				
e Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?	7e			No	
f Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?	7f			No	
g If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?	7g				
h If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?	7h				
8 Sponsoring organizations maintaining donor advised funds. Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?	8				
9 Sponsoring organizations maintaining donor advised funds.					
a Did the sponsoring organization make any taxable distributions under section 4966?	9a				
b Did the sponsoring organization make a distribution to a donor, donor advisor, or related person?	9b				
10 Section 501(c)(7) organizations. Enter:					
a Initiation fees and capital contributions included on Part VIII, line 12	10a				
b Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	10b				
11 Section 501(c)(12) organizations. Enter:					
a Gross income from members or shareholders	11a				
b Gross income from other sources. (Do not net amounts due or paid to other sources against amounts due or received from them.)	11b				
12a Section 4947(a)(1) non-exempt charitable trusts. Is the organization filing Form 990 in lieu of Form 1041?	12a				
b If "Yes," enter the amount of tax-exempt interest received or accrued during the year.	12b				
13 Section 501(c)(29) qualified nonprofit health insurance issuers.					
a Is the organization licensed to issue qualified health plans in more than one state? Note. See the instructions for additional information the organization must report on Schedule O.	13a				
b Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans	13b				
c Enter the amount of reserves on hand	13c				
14a Did the organization receive any payments for indoor tanning services during the tax year?	14a			No	
b If "Yes," has it filed a Form 720 to report these payments? <i>If "No," provide an explanation in Schedule O</i>	14b				
15 Is the organization subject to the section 4960 tax on payment(s) of more than \$1,000,000 in remuneration or excess parachute payment(s) during the year? If "Yes," see the instructions and file Form 4720, Schedule N.	15			No	
16 Is the organization an educational institution subject to the section 4968 excise tax on net investment income? . . . If "Yes," complete Form 4720, Schedule O.	16			No	
17 Section 501(c)(21) organizations. Did the trust, or any disqualified or other person engage in any activities that would result in the imposition of an excise tax under section 4951, 4952, or 4953? If "Yes," complete Form 6069.	17				

Section A. Governing Body and Management

		Yes	No
1a	Enter the number of voting members of the governing body at the end of the tax year If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O.	17	
1b	Enter the number of voting members included in line 1a, above, who are independent	17	
2	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?	2	No
3	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person?	3	No
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	4	No
5	Did the organization become aware during the year of a significant diversion of the organization's assets?	5	No
6	Did the organization have members or stockholders?	6	No
7a	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?	7a	No
7b	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	7b	No
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:		
8a	The governing body?	8a	Yes
8b	Each committee with authority to act on behalf of the governing body?	8b	Yes
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses in Schedule O	9	No

Section B. Policies (This Section B requests information about policies not required by the Internal Revenue Code.)

		Yes	No
10a	Did the organization have local chapters, branches, or affiliates?	10a	No
10b	If "Yes," did the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with the organization's exempt purposes?	10b	
11a	Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form?	11a	Yes
11b	Describe on Schedule O the process, if any, used by the organization to review this Form 990.		
12a	Did the organization have a written conflict of interest policy? If "No," go to line 13	12a	Yes
12b	Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts?	12b	Yes
12c	Did the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," describe on Schedule O how this was done	12c	Yes
13	Did the organization have a written whistleblower policy?	13	Yes
14	Did the organization have a written document retention and destruction policy?	14	Yes
15	Did the process for determining compensation of the following persons include a review and approval by independent persons, comparability data, and contemporaneous substantiation of the deliberation and decision?		
15a	The organization's CEO, Executive Director, or top management official	15a	Yes
15b	Other officers or key employees of the organization	15b	Yes
	If "Yes" to line 15a or 15b, describe the process on Schedule O. See instructions.		
16a	Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a taxable entity during the year?	16a	No
16b	If "Yes," did the organization follow a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and take steps to safeguard the organization's exempt status with respect to such arrangements?	16b	

Section C. Disclosure

17	List the states with which a copy of this Form 990 is required to be filed	AL, AR, CA, FL, GA, HI, IL, KS, KY, MD, MA, MI, MN, MS, NH, NJ, NM, NY, ND, OR, PA, RI, SC, TN, UT, WV, WI, CT
18	Section 6104 requires an organization to make its Form 1023 (1024 or 1024-A, if applicable), 990, and 990-T (section 501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply. ☐ Own website ☐ Another's website ☒ Upon request ☐ Other (explain in Schedule O)	
19	Describe in Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.	
20	State the name, address, and telephone number of the person who possesses the organization's books and records: LEAH BINDER THE LEAPFROG GROUP 1775 K STREET NW 400 WASHINGTON, DC 20006 (202) 292-6713	

Check if Schedule O contains a response or note to any line in this Part VII ☐

Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

1a Complete this table for all persons required to be listed. Report compensation for the calendar year ending with or within the organization's tax year.

- List all of the organization's **current** officers, directors, trustees (whether individuals or organizations), regardless of amount of compensation. Enter -0- in columns (D), (E), and (F) if no compensation was paid.
- List all of the organization's **current** key employees, if any. See the instructions for definition of "key employee."
- List the organization's five **current** highest compensated employees (other than an officer, director, trustee or key employee) who received reportable compensation (box 5 of Form W-2, box 6 of Form 1099-MISC, and/or box 1 of Form 1099-NEC) of more than \$100,000 from the organization and any related organizations.
- List all of the organization's **former** officers, key employees, or highest compensated employees who received more than \$100,000 of reportable compensation from the organization and any related organizations.
- List all of the organization's **former directors or trustees** that received, in the capacity as a former director or trustee of the organization, more than \$10,000 of reportable compensation from the organization and any related organizations.

See the instructions for the order in which to list the persons above.

☐ Check this box if neither the organization nor any related organization compensated any current officer, director, or trustee.

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC/1099-NEC)	(E) Reportable compensation from related organizations (W-2/1099-MISC/1099-NEC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(1) LINDA SCHWIMMER VICE CHAIR	3.00	X		X				0	0	0
(2) JOHN G ZERN TREASURER	3.00	X		X				0	0	0
(3) SALLY WELBORN SECRETARY	3.00	X		X				0	0	0
(4) MICHELLE MARTIN CHAIR	3.00	X		X				0	0	0
(5) IRENE FRASER BOARD MEMBER	1.00	X						0	0	0
(6) DOLORES MITCHELL BOARD MEMBER	1.00	X						0	0	0
(7) AARON SCHRADER BOARD MEMBER	1.00	X						0	0	0
(8) RAQUEL C BONO BOARD MEMBER	1.00	X						0	0	0
(9) MAUREEN RYAN BOARD MEMBER	1.00	X						0	0	0
(10) LINA WALKER BOARD MEMBER	1.00	X						0	0	0
(11) G RUMAY ALEXANDER BOARD MEMBER	1.00	X						0	0	0
(12) KENNETH MENDEZ BOARD MEMBER	1.00	X						0	0	0
(13) BILL BONK BOARD MEMBER	1.00	X						0	0	0
(14) ARNOLD MILSTEIN BOARD MEMBER	1.00	X						0	0	0
(15) JANET LUCAS-TAYLOR DIRECTOR	1.00	X						0	0	0
(16) SUE SHERIDAN DIRECTOR	1.00	X						0	0	0
(17) KAREN VAN CAULIL DIRECTOR	1.00	X						0	0	0

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099- MISC/1099-NEC)	(E) Reportable compensation from related organizations (W- 2/1099- MISC/1099-NEC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(18) LEAH BINDER PRESIDENT & CEO	40.00			X				669,446	0	91,616
(19) MELISSA DANFORTH VP, HEALTH CARE RATINGS	40.00				X			376,743	0	69,997
(20) PATRICE BROWN CHIEF OPERATING OFFICER	40.00				X			206,603	0	18,164
(21) RALPH JOHNSON VP OF INFORMATICS AND TECH	40.00					X		275,145	0	65,983
(22) JILL BERGER DIRECTOR, EMPLOYER AND PAY	40.00					X		191,079	0	37,727
(23) KAREN JUPITER VP OF DEVELOPMENT	40.00					X		261,285	0	41,885
(24) KAYLEE C SCARIM SENIOR PROGRAM ANALYST	40.00					X		121,533	0	21,195
(25) JEAN-LUC TILLY PROGRAM MANAGER	40.00					X		125,050	0	15,854
1b Sub-Total										
c Total from continuation sheets to Part VII, Section A . . .										
d Total (add lines 1b and 1c)								2,226,884	0	362,421

2 Total number of individuals (including but not limited to those listed above) who received more than \$100,000 of reportable compensation from the organization 12

- 3 Did the organization list any **former** officer, director or trustee, key employee, or highest compensated employee on line 1a? If "Yes," complete Schedule J for such individual

4 For any individual listed on line 1a, is the sum of reportable compensation and other compensation from the organization and related organizations greater than \$150,000? If "Yes," complete Schedule J for such individual

5 Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization? If "Yes," complete Schedule J for such person

	Yes	No
3		No
4	Yes	
5		No

Section B. Independent Contractors

1 Complete this table for your five highest compensated independent contractors that received more than \$100,000 of compensation from the organization. Report compensation for the calendar year ending with or within the organization's tax year.

(A) Name and business address	(B) Description of services	(C) Compensation
SKVARE LLC 5900 BALCONES DRIVE STE 12032 AUSTIN, TX 78731	CONSULTANTS	361,225
JOHNS HOPKINS UNIVERSITY 733 NORTH BROADWAY SUITE 117 BALTIMORE, MD 21205	CONSULTANTS	330,115
TELEAFFECTS 195 INTERNATIONAL PKWY SSTE 211 LAKE MARY, FL 32746	CONSULTANTS	254,608
NEXT LEVEL STRATEGIES 2 STARBRIDGE CT SAVANNAH, GA 31411	CONSULTANTS	243,250
CURA STRATEGIES LLC 2011 CRYSTAL DR 1005 ARLINGTON, VA 22202	CONSULTANTS	145,750

2 Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 of compensation from the organization 8

			(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512 - 514
Contributions, gifts, grants, and other similar amounts	1a	Federated campaigns . . .	1a			
	b	Membership dues . . .	1b	1,141,413		
	c	Fundraising events . . .	1c			
	d	Related organizations	1d			
	e	Government grants (contributions)	1e			
	f	All other contributions, gifts, grants, and similar amounts not included above	1f	1,354,923		
	g	Noncash contributions included in lines 1a - 1f:\$	1g			
	h	Total. Add lines 1a-1f		2,496,336		
Program Service Revenue	2a	LICENSING REVENUE	Business Code 611430	3,288,926	3,288,926	
	b	DATA LICENSURE	611430	2,174,816	2,174,816	
	c	DATA PRODUCTS AND REPO	611430	314,499	314,499	
	d	MEDIA PARTNERSHIP	611430	11,775	11,775	
	e					
	f	All other program service revenue.				
	g	Total. Add lines 2a-2f.		5,790,016		
Other Revenue	3	Investment income (including dividends, interest, and other similar amounts)		43,878		43,878
	4	Income from investment of tax-exempt bond proceeds				
	5	Royalties				
	6a	Gross rents	(i) Real (ii) Personal			
	b	Less: rental expenses				
	c	Rental income or (loss)				
	d	Net rental income or (loss)				
	7a	Gross amount from sales of assets other than inventory	(i) Securities (ii) Other			
	b	Less: cost or other basis and sales expenses				
	c	Gain or (loss)				
	d	Net gain or (loss)				
	8a	Gross income from fundraising events (not including \$ of contributions reported on line 1c). See Part IV, line 18	8a			
	b	Less: direct expenses	8b			
	c	Net income or (loss) from fundraising events				
	9a	Gross income from gaming activities. See Part IV, line 19	9a			
b	Less: direct expenses	9b				
c	Net income or (loss) from gaming activities					
10a	Gross sales of inventory, less returns and allowances	10a				
b	Less: cost of goods sold	10b				
c	Net income or (loss) from sales of inventory					
Miscellaneous Revenue	11a	MISCELLANEOUS INCOME	Business Code 900099	26,637	26,637	
	b					
	c					
	d	All other revenue				
	e	Total. Add lines 11a-11d		26,637		
12	Total revenue. See instructions		8,356,867	5,816,653	0	43,878

Part IX Statement of Functional Expenses **Case 9:23-cv-80926-DMM Document 88-79 Entered on FLSD Docket 10/28/2025 Page 11 of 38**

Section 501(c)(3) and 501(c)(4) organizations must complete all columns. All other organizations must complete column (A).

Check if Schedule O contains a response or note to any line in this Part IX ☒

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.

	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21				
2 Grants and other assistance to domestic individuals. See Part IV, line 22				
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16.				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees	1,290,454	1,095,780	168,253	26,421
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)				
7 Other salaries and wages	2,102,415	1,619,707	276,857	205,851
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	197,568	162,028	21,749	13,791
9 Other employee benefits	234,412	197,324	20,378	16,710
10 Payroll taxes	203,610	161,902	27,841	13,867
11 Fees for services (non-employees):				
a Management				
b Legal				
c Accounting				
d Lobbying				
e Professional fundraising services. See Part IV, line 17				
f Investment management fees				
g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O)	1,364,596	1,364,596		
12 Advertising and promotion	358,116	355,896		2,220
13 Office expenses				
14 Information technology	558,310	536,603	5,583	16,124
15 Royalties				
16 Occupancy				
17 Travel	239,504	235,727	2,926	851
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings	337,157	324,071	12,987	99
20 Interest				
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	189,333	162,006	13,451	13,876
23 Insurance				
24 Other expenses. Itemize expenses not covered above (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a OPERATIONS	940,897	626,319	278,097	36,481
b COMMUNICATIONS	271,902	271,902		
c RECRUITING AND TRAINING	42,368	40,460	1,500	408
d DUES AND SUBSCRIPTIONS	21,275	12,829	8,446	
e All other expenses	4,293			4,293
25 Total functional expenses. Add lines 1 through 24e	8,356,210	7,167,150	838,068	350,992
26 Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here ☐ if following SOP 98-2 (ASC 958-720).				

Part X Balance Sheet

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Check if Schedule O contains a response or note to any line in this Part IX ☐

				(A) Beginning of year		(B) End of year
Assets	1	Cash-non-interest-bearing		874,505	1	1,028,887
	2	Savings and temporary cash investments		2,125,422	2	752,983
	3	Pledges and grants receivable, net		4,950	3	2,450
	4	Accounts receivable, net		615,765	4	697,530
	5	Loans and other receivables from any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons			5	
	6	Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), and persons described in section 4958(c)(3)(B)			6	
	7	Notes and loans receivable, net			7	
	8	Inventories for sale or use			8	
	9	Prepaid expenses and deferred charges		156,242	9	308,181
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a	1,968,130		
	b	Less: accumulated depreciation	10b	945,093		
				634,842	10c	1,023,037
	11	Investments—publicly traded securities			11	
	12	Investments—other securities. See Part IV, line 11			12	
	13	Investments—program-related. See Part IV, line 11			13	
	14	Intangible assets			14	
15	Other assets. See Part IV, line 11		3,141,038	15	2,758,559	
16	Total assets. Add lines 1 through 15 (must equal line 33)		7,552,764	16	6,571,627	
Liabilities	17	Accounts payable and accrued expenses		475,069	17	701,453
	18	Grants payable			18	
	19	Deferred revenue		1,059,737	19	881,398
	20	Tax-exempt bond liabilities			20	
	21	Escrow or custodial account liability. Complete Part IV of Schedule D			21	
	22	Loans and other payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons			22	
	23	Secured mortgages and notes payable to unrelated third parties			23	
	24	Unsecured notes and loans payable to unrelated third parties			24	
	25	Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17 - 24). Complete Part X of Schedule D		4,269,189	25	3,238,898
	26	Total liabilities. Add lines 17 through 25		5,803,995	26	4,821,749
Net Assets or Fund Balances	Organizations that follow FASB ASC 958, check here ☒ and complete lines 27, 28, 32, and 33.					
	27	Net assets without donor restrictions		1,748,769	27	1,610,866
	28	Net assets with donor restrictions			28	139,012
	Organizations that do not follow FASB ASC 958, check here ☐ and complete lines 29 through 33.					
	29	Capital stock or trust principal, or current funds			29	
	30	Paid-in or capital surplus, or land, building or equipment fund			30	
	31	Retained earnings, endowment, accumulated income, or other funds			31	
	32	Total net assets or fund balances		1,748,769	32	1,749,878
	33	Total liabilities and net assets/fund balances		7,552,764	33	6,571,627

Part XI Reconciliation of Net Assets

Check if Schedule O contains a response or note to any line in this Part XI ☐

1	Total revenue (must equal Part VIII, column (A), line 12)	1	8,356,867
2	Total expenses (must equal Part IX, column (A), line 25)	2	8,356,210
3	Revenue less expenses. Subtract line 2 from line 1	3	657
4	Net assets or fund balances at beginning of year (must equal Part X, line 32, column (A))	4	1,748,769
5	Net unrealized gains (losses) on investments	5	452
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	
9	Other changes in net assets or fund balances (explain in Schedule O)	9	0
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 32, column (B))	10	1,749,878

Part XII Financial Statements and Reporting

Check if Schedule O contains a response or note to any line in this Part XII ☒

- 1** Accounting method used to prepare the Form 990: ☐ Cash ☒ Accrual ☐ Other _____
If the organization changed its method of accounting from a prior year or checked "Other," explain on Schedule O.
- 2a** Were the organization's financial statements compiled or reviewed by an independent accountant?
If 'Yes,' check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both:
☐ Separate basis ☐ Consolidated basis ☐ Both consolidated and separate basis
- b** Were the organization's financial statements audited by an independent accountant?
If 'Yes,' check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both:
☐ Separate basis ☒ Consolidated basis ☐ Both consolidated and separate basis
- c** If "Yes," to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant?
If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O.
- 3a** As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Uniform Guidance, 2 C.F.R. Part 200, Subpart F?
- b** If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits.

	Yes	No
2a		No
2b	Yes	
2c	Yes	
3a		No
3b		

SCHEDULE A
(Form 990)

Public Charity Status and Public Support

Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust.
▶ Attach to Form 990 or Form 990-EZ.
▶ Go to www.irs.gov/Form990 for instructions and the latest information.

2023
Open to Public Inspection

Department of the Treasury
Internal Revenue Service

Name of the organization THE LEAPFROG GROUP	Employer identification number 52-2359517
--	--

Part I Reason for Public Charity Status (All organizations must complete this part.) See instructions.

The organization is not a private foundation because it is: (For lines 1 through 12, check only one box.)

- 1 ☐ A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i).**
- 2 ☐ A school described in **section 170(b)(1)(A)(ii).** (Attach Schedule E (Form 990).)
- 3 ☐ A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii).**
- 4 ☐ A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii).** Enter the hospital's name, city, and state:
- 5 ☐ An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv).** (Complete Part II.)
- 6 ☐ A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v).**
- 7 ☐ An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi).** (Complete Part II.)
- 8 ☐ A community trust described in **section 170(b)(1)(A)(vi).** (Complete Part II.)
- 9 ☐ An agricultural research organization described in **170(b)(1)(A)(ix)** operated in conjunction with a land-grant college or university or a non-land grant college of agriculture. See instructions. Enter the name, city, and state of the college or university:
- 10 ☒ An organization that normally receives: (1) more than 33 1/3% of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions—subject to certain exceptions, and (2) no more than 33 1/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975. See **section 509(a)(2).** (Complete Part III.)
- 11 ☐ An organization organized and operated exclusively to test for public safety. See **section 509(a)(4).**
- 12 ☐ An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in **section 509(a)(1)** or **section 509(a)(2).** See **section 509(a)(3).** Check the box on lines 12a through 12d that describes the type of supporting organization and complete lines 12e, 12f, and 12g.
- a ☐ **Type I.** A supporting organization operated, supervised, or controlled by its supported organization(s), typically by giving the supported organization(s) the power to regularly appoint or elect a majority of the directors or trustees of the supporting organization. **You must complete Part IV, Sections A and B.**
- b ☐ **Type II.** A supporting organization supervised or controlled in connection with its supported organization(s), by having control or management of the supporting organization vested in the same persons that control or manage the supported organization(s). **You must complete Part IV, Sections A and C.**
- c ☐ **Type III functionally integrated.** A supporting organization operated in connection with, and functionally integrated with, its supported organization(s) (see instructions). **You must complete Part IV, Sections A, D, and E.**
- d ☐ **Type III non-functionally integrated.** A supporting organization operated in connection with its supported organization(s) that is not functionally integrated. The organization generally must satisfy a distribution requirement and an attentiveness requirement (see instructions). **You must complete Part IV, Sections A and D, and Part V.**
- e ☐ Check this box if the organization received a written determination from the IRS that it is a Type I, Type II, Type III functionally integrated, or Type III non-functionally integrated supporting organization.
- f Enter the number of supported organizations
- g Provide the following information about the supported organization(s).

(i) Name of supported organization	(ii) EIN	(iii) Type of organization (described on lines 1- 10 above (see instructions))	(iv) Is the organization listed in your governing document?		(v) Amount of monetary support (see instructions)	(vi) Amount of other support (see instructions)
			Yes	No		
Total						

Part II

Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv) and 170(b)(1)(A)(vi)

(Complete only if you checked the box on line 5, 7, or 8 of Part I or if the organization failed to qualify under Part III. If the organization failed to qualify under the tests listed below, please complete Part III.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2019	(b) 2020	(c) 2021	(d) 2022	(e) 2023	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grant.") . . .						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge..						
4 Total. Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f) . .						
6 Public support. Subtract line 5 from line 4.						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2019	(b) 2020	(c) 2021	(d) 2022	(e) 2023	(f) Total
7 Amounts from line 4. . .						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources. . . .						
9 Net income from unrelated business activities, whether or not the business is regularly carried on. .						
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.). . .						
11 Total support. Add lines 7 through 10						

12

Gross receipts from related activities, etc. (see instructions)

12

13

First 5 years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and **stop here** ☐

Section C. Computation of Public Support Percentage

14	Public support percentage for 2023 (line 6, column (f) divided by line 11, column (f))	14	
15	Public support percentage for 2022 Schedule A, Part II, line 14	15	

16a

33 1/3% support test—2023. If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and **stop here**. The organization qualifies as a publicly supported organization ☐

b

33 1/3% support test—2022. If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and **stop here**. The organization qualifies as a publicly supported organization ☐

17a

10%-facts-and-circumstances test—2023. If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here**. Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ☐

b

10%-facts-and-circumstances test—2022. If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here**. Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ☐

18

Private foundation. If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions ☐

Part III

Support Schedule for Organizations Described in Section 509(a)(2)

(Complete only if you checked the box on line 10 of Part I or if the organization failed to qualify under Part II. If the organization fails to qualify under the tests listed below, please complete Part II.)

Section A. Public Support						
Calendar year (or fiscal year beginning in) ►	(a) 2019	(b) 2020	(c) 2021	(d) 2022	(e) 2023	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.") .	435,427	1,419,432	1,365,819	1,837,788	2,496,336	7,554,802
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose	5,446,926	5,560,125	5,883,131	5,669,065	5,816,653	28,375,900
3 Gross receipts from activities that are not an unrelated trade or business under section 513						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 Total. Add lines 1 through 5	5,882,353	6,979,557	7,248,950	7,506,853	8,312,989	35,930,702
7a Amounts included on lines 1, 2, and 3 received from disqualified persons	77,500	641,243	765,594	554,402	814,353	2,853,092
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of \$5,000 or 1% of the amount on line 13 for the year.	911,002	828,522	815,599	1,550,539	625,846	4,731,508
c Add lines 7a and 7b. .	988,502	1,469,765	1,581,193	2,104,941	1,440,199	7,584,600
8 Public support. (Subtract line 7c from line 6.)						28,346,102

Section B. Total Support						
Calendar year (or fiscal year beginning in) ►	(a) 2019	(b) 2020	(c) 2021	(d) 2022	(e) 2023	(f) Total
9 Amounts from line 6.	5,882,353	6,979,557	7,248,950	7,506,853	8,312,989	35,930,702
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources. .	1,293	181	449	49,402	43,878	95,203
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975.						
c Add lines 10a and 10b.	1,293	181	449	49,402	43,878	95,203
11 Net income from unrelated business activities not included on line 10b, whether or not the business is regularly carried on.						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.) . . .						
13 Total support. (Add lines 9, 10c, 11, and 12.)	5,883,646	6,979,738	7,249,399	7,556,255	8,356,867	36,025,905
14 First 5 years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here.	☐					

Section C. Computation of Public Support Percentage		
15 Public support percentage for 2023 (line 8, column (f) divided by line 13, column (f))	15	78.680 %
16 Public support percentage from 2022 Schedule A, Part III, line 15	16	87.130 %

Section D. Computation of Investment Income Percentage		
17 Investment income percentage for 2023 (line 10c, column (f) divided by line 13, column (f))	17	0.260 %
18 Investment income percentage from 2022 Schedule A, Part III, line 17	18	0.030 %
19a 33 1/3% support tests-2023. If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and stop here. The organization qualifies as a publicly supported organization	☒	
b 33 1/3% support tests—2022. If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3% and line 18 is not more than 33 1/3%, check this box and stop here. The organization qualifies as a publicly supported organization	☐	
20 Private foundation. If the organization did not check a box on line 14, 19a, or 19b, check this box and see instructions	☐	

Part IV Supporting Organizations

(Complete only if you checked a box on line 12 of Part I. If you checked box 12a, of Part I, complete Sections A and B. If you checked box 12b, of Part I, complete Sections A and C. If you checked box 12c, of Part I, complete Sections A, D, and E. If you checked box 12d, of Part I, complete Sections A and D, and complete Part V.)

Section A. All Supporting Organizations

		Yes	No
1	Are all of the organization's supported organizations listed by name in the organization's governing documents? If "No," describe in Part VI how the supported organizations are designated. If designated by class or purpose, describe the designation. If historic and continuing relationship, explain.		
1			
2	Did the organization have any supported organization that does not have an IRS determination of status under section 509(a)(1) or (2)? If "Yes," explain in Part VI how the organization determined that the supported organization was described in section 509(a)(1) or (2).		
2			
3a	Did the organization have a supported organization described in section 501(c)(4), (5), or (6)? If "Yes," answer lines 3b and 3c below.		
3a			
b	Did the organization confirm that each supported organization qualified under section 501(c)(4), (5), or (6) and satisfied the public support tests under section 509(a)(2)? If "Yes," describe in Part VI when and how the organization made the determination.		
3b			
c	Did the organization ensure that all support to such organizations was used exclusively for section 170(c)(2)(B) purposes? If "Yes," explain in Part VI what controls the organization put in place to ensure such use.		
3c			
4a	Was any supported organization not organized in the United States ("foreign supported organization")? If "Yes" and if you checked box 12a or 12b in Part I, answer lines 4b and 4c below.		
4a			
b	Did the organization have ultimate control and discretion in deciding whether to make grants to the foreign supported organization? If "Yes," describe in Part VI how the organization had such control and discretion despite being controlled or supervised by or in connection with its supported organizations.		
4b			
c	Did the organization support any foreign supported organization that does not have an IRS determination under sections 501(c)(3) and 509(a)(1) or (2)? If "Yes," explain in Part VI what controls the organization used to ensure that all support to the foreign supported organization was used exclusively for section 170(c)(2)(B) purposes.		
4c			
5a	Did the organization add, substitute, or remove any supported organizations during the tax year? If "Yes," answer lines 5b and 5c below (if applicable). Also, provide detail in Part VI , including (i) the names and EIN numbers of the supported organizations added, substituted, or removed; (ii) the reasons for each such action; (iii) the authority under the organization's organizing document authorizing such action; and (iv) how the action was accomplished (such as by amendment to the organizing document).		
5a			
b	Type I or Type II only. Was any added or substituted supported organization part of a class already designated in the organization's organizing document?		
5b			
c	Substitutions only. Was the substitution the result of an event beyond the organization's control?		
5c			
6	Did the organization provide support (whether in the form of grants or the provision of services or facilities) to anyone other than (i) its supported organizations, (ii) individuals that are part of the charitable class benefited by one or more of its supported organizations, or (iii) other supporting organizations that also support or benefit one or more of the filing organization's supported organizations? If "Yes," provide detail in Part VI .		
6			
7	Did the organization provide a grant, loan, compensation, or other similar payment to a substantial contributor (defined in section 4958(c)(3)(C)), a family member of a substantial contributor, or a 35% controlled entity with regard to a substantial contributor? If "Yes," complete Part I of Schedule L (Form 990) .		
7			
8	Did the organization make a loan to a disqualified person (as defined in section 4958) not described on line 7? If "Yes," complete Part I of Schedule L (Form 990).		
8			
9a	Was the organization controlled directly or indirectly at any time during the tax year by one or more disqualified persons, as defined in section 4946 (other than foundation managers and organizations described in section 509(a)(1) or (2))? If "Yes," provide detail in Part VI .		
9a			
b	Did one or more disqualified persons (as defined on line 9a) hold a controlling interest in any entity in which the supporting organization had an interest? If "Yes," provide detail in Part VI .		
9b			
c	Did a disqualified person (as defined on line 9a) have an ownership interest in, or derive any personal benefit from, assets in which the supporting organization also had an interest? If "Yes," provide detail in Part VI .		
9c			
10a	Was the organization subject to the excess business holdings rules of section 4943 because of section 4943(f) (regarding certain Type II supporting organizations, and all Type III non-functionally integrated supporting organizations)? If "Yes," answer line 10b below.		
10a			
b	Did the organization have any excess business holdings in the tax year? (Use Schedule C, Form 4720, to determine whether the organization had excess business holdings).		
10b			

Part IV Supporting Organizations (continued)

		Yes	No
11	Has the organization accepted a gift or contribution from any of the following persons?		
a	A person who directly or indirectly controls, either alone or together with persons described on lines 11b and 11c below, the governing body of a supported organization?		
	11a		
b	A family member of a person described on 11a above?		
	11b		
c	A 35% controlled entity of a person described on line 11a or 11b above? If "Yes" to 11a, 11b, or 11c, provide detail in Part VI.		
	11c		

Section B. Type I Supporting Organizations

		Yes	No
1	Did the officers, directors, trustees, or membership of one or more supported organizations have the power to regularly appoint or elect at least a majority of the organization's directors or trustees at all times during the tax year? If "No," describe in Part VI how the supported organization(s) effectively operated, supervised, or controlled the organization's activities. If the organization had more than one supported organization, describe how the powers to appoint and/or remove directors or trustees were allocated among the supported organizations and what conditions or restrictions, if any, applied to such powers during the tax year.		
	1		
2	Did the organization operate for the benefit of any supported organization other than the supported organization(s) that operated, supervised, or controlled the supporting organization? If "Yes," explain in Part VI how providing such benefit carried out the purposes of the supported organization(s) that operated, supervised or controlled the supporting organization.		
	2		

Section C. Type II Supporting Organizations

		Yes	No
1	Were a majority of the organization's directors or trustees during the tax year also a majority of the directors or trustees of each of the organization's supported organization(s)? If "No," describe in Part VI how control or management of the supporting organization was vested in the same persons that controlled or managed the supported organization(s).		
	1		

Section D. All Type III Supporting Organizations

		Yes	No
1	Did the organization provide to each of its supported organizations, by the last day of the fifth month of the organization's tax year, (i) a written notice describing the type and amount of support provided during the prior tax year, (ii) a copy of the Form 990 that was most recently filed as of the date of notification, and (iii) copies of the organization's governing documents in effect on the date of notification, to the extent not previously provided?		
	1		
2	Were any of the organization's officers, directors, or trustees either (i) appointed or elected by the supported organization(s) or (ii) serving on the governing body of a supported organization? If "No," explain in Part VI how the organization maintained a close and continuous working relationship with the supported organization(s).		
	2		
3	By reason of the relationship described in line 2 above, did the organization's supported organizations have a significant voice in the organization's investment policies and in directing the use of the organization's income or assets at all times during the tax year? If "Yes," describe in Part VI the role the organization's supported organizations played in this regard.		
	3		

Section E. Type III Functionally-Integrated Supporting Organizations

1	Check the box next to the method that the organization used to satisfy the Integral Part Test during the year (see instructions):			
a	☐ The organization satisfied the Activities Test. Complete line 2 below.			
b	☐ The organization is the parent of each of its supported organizations. Complete line 3 below.			
c	☐ The organization supported a governmental entity. Describe in Part VI how you supported a government entity (see instructions)			
2	Activities Test. Answer lines 2a and 2b below.			
a	Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? If "Yes," then in Part VI identify those supported organizations and explain how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined that these activities constituted substantially all of its activities.			
	2a			
b	Did the activities described on line 2a, above constitute activities that, but for the organization's involvement, one or more of the organization's supported organization(s) would have been engaged in? If "Yes," explain in Part VI the reasons for the organization's position that its supported organization(s) would have engaged in these activities but for the organization's involvement.			
	2b			
3	Parent of Supported Organizations. Answer lines 3a and 3b below.			
a	Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? If "Yes" or "No", provide details in Part VI.			
	3a			
b	Did the organization exercise a substantial degree of direction over the policies, programs and activities of each of its supported organizations? If "Yes," describe in Part VI. the role played by the organization in this regard.			
	3b			

1

☐ Check here if the organization satisfied the Integral Part Test as a qualifying trust on Nov. 20, 1970 (explain in **Part VI**). See instructions. All other Type III non-functionally integrated supporting organizations must complete Sections A through E.

Section A - Adjusted Net Income		(A) Prior Year	(B) Current Year (optional)
1	Net short-term capital gain	1	
2	Recoveries of prior-year distributions	2	
3	Other gross income (see instructions)	3	
4	Add lines 1 through 3	4	
5	Depreciation and depletion	5	
6	Portion of operating expenses paid or incurred for production or collection of gross income or for management, conservation, or maintenance of property held for production of income (see instructions)	6	
7	Other expenses (see instructions)	7	
8	Adjusted Net Income (subtract lines 5, 6 and 7 from line 4)	8	

Section B - Minimum Asset Amount		(A) Prior Year	(B) Current Year (optional)
1	Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year):	1	
a	Average monthly value of securities	1a	
b	Average monthly cash balances	1b	
c	Fair market value of other non-exempt-use assets	1c	
d	Total (add lines 1a, 1b, and 1c)	1d	
e	Discount claimed for blockage or other factors (explain in detail in Part VI):		
2	Acquisition indebtedness applicable to non-exempt use assets	2	
3	Subtract line 2 from line 1d	3	
4	Cash deemed held for exempt use. Enter 0.015 of line 3 (for greater amount, see instructions).	4	
5	Net value of non-exempt-use assets (subtract line 4 from line 3)	5	
6	Multiply line 5 by 0.035	6	
7	Recoveries of prior-year distributions	7	
8	Minimum Asset Amount (add line 7 to line 6)	8	

Section C - Distributable Amount			Current Year
1	Adjusted net income for prior year (from Section A, line 8, Column A)	1	
2	Enter 85% of line 1	2	
3	Minimum asset amount for prior year (from Section B, line 8, Column A)	3	
4	Enter greater of line 2 or line 3	4	
5	Income tax imposed in prior year	5	
6	Distributable Amount. Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	6	

7

☐ Check here if the current year is the organization's first as a non-functionally-integrated Type III supporting organization (see instructions)

Part V

Type III Non-Functionally Integrated 509(a)(3) Supporting Organizations (continued)

Section D - Distributions		Current Year
1	Amounts paid to supported organizations to accomplish exempt purposes	1
2	Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	2
3	Administrative expenses paid to accomplish exempt purposes of supported organizations	3
4	Amounts paid to acquire exempt-use assets	4
5	Qualified set-aside amounts (prior IRS approval required - provide details in Part VI)	5
6	Other distributions (describe in Part VI). See instructions	6
7	Total annual distributions. Add lines 1 through 6.	7
8	Distributions to attentive supported organizations to which the organization is responsive (provide details in Part VI). See instructions	8
9	Distributable amount for 2023 from Section C, line 6	9
10	Line 8 amount divided by Line 9 amount	10

Section E - Distribution Allocations (see instructions)	(i) Excess Distributions	(ii) Underdistributions Pre-2023	(iii) Distributable Amount for 2023
1	Distributable amount for 2023 from Section C, line 6		
2	Underdistributions, if any, for years prior to 2023 (reasonable cause required-- explain in Part VI). See instructions.		
3	Excess distributions carryover, if any, to 2023:		
a	From 2018.		
b	From 2019.		
c	From 2020.		
d	From 2021.		
e	From 2022.		
f	Total of lines 3a through e		
g	Applied to underdistributions of prior years		
h	Applied to 2023 distributable amount		
i	Carryover from 2018 not applied (see instructions)		
j	Remainder. Subtract lines 3g, 3h, and 3i from line 3f.		
4	Distributions for 2023 from Section D, line 7: \$		
a	Applied to underdistributions of prior years		
b	Applied to 2023 distributable amount		
c	Remainder. Subtract lines 4a and 4b from line 4.		
5	Remaining underdistributions for years prior to 2023, if any. Subtract lines 3g and 4a from line 2. If the amount is greater than zero, explain in Part VI. See instructions.		
6	Remaining underdistributions for 2023. Subtract lines 3h and 4b from line 1. If the amount is greater than zero, explain in Part VI. See instructions.		
7	Excess distributions carryover to 2024. Add lines 3j and 4c.		
8	Breakdown of line 7:		
a	Excess from 2019.		
b	Excess from 2020.		
c	Excess from 2021.		
d	Excess from 2022.		
e	Excess from 2023.		

Part VI

Supplemental information. Provide the explanations required by Part II, line 10; Part II, line 17a or 17b; Part III, line 12; Part IV, Section A, lines 1, 2, 3b, 3c, 4b, 4c, 5a, 6, 9a, 9b, 9c, 11a, 11b, and 11c; Part IV, Section B, lines 1 and 2; Part IV, Section C, line 1; Part IV, Section D, lines 2 and 3; Part IV, Section E, lines 1c, 2a, 2b, 3a and 3b; Part V, line 1; Part V, Section B, line 1e; Part V Section D, lines 5, 6, and 8; and Part V, Section E, lines 2, 5, and 6. Also complete this part for any additional information. (See instructions).

Facts And Circumstances Test

Return Reference	Explanation
Case 9:25-cv-80526-DMM	Document 88-79 Entered on FLSD Docket 10/28/2025 Page 22 of 38

If the organization answered "Yes" on Form 990, Part IV, Line 3, or Form 990-EZ, Part V, line 46 (Political Campaign Activities), then

- Section 501(c)(3) organizations: Complete Parts I-A and B. Do not complete Part I-C.
- Section 501(c) (other than section 501(c)(3)) organizations: Complete Parts I-A and C below. Do not complete Part I-B.
- Section 527 organizations: Complete Part I-A only.

If the organization answered "Yes" on Form 990, Part IV, Line 4, or Form 990-EZ, Part VI, line 47 (Lobbying Activities), then

- Section 501(c)(3) organizations that have filed Form 5768 (election under section 501(h)): Complete Part II-A. Do not complete Part II-B.
- Section 501(c)(3) organizations that have NOT filed Form 5768 (election under section 501(h)): Complete Part II-B. Do not complete Part II-A.

If the organization answered "Yes" on Form 990, Part IV, Line 5 (Proxy Tax) (see separate instructions) or Form 990-EZ, Part V, line 35c (Proxy Tax) (see separate instructions), then

- Section 501(c)(4), (5), or (6) organizations: Complete Part III.

Name of the organization THE LEAPFROG GROUP	Employer identification number 52-2359517
--	--

Part I-A Complete if the organization is exempt under section 501(c) or is a section 527 organization.

1	Provide a description of the organization's direct and indirect political campaign activities in Part IV. See instructions for definition of "political campaign activities."	
2	Political campaign activity expenditures. See instructions	\$
3	Volunteer hours for political campaign activities. See instructions	

Part I-B Complete if the organization is exempt under section 501(c)(3).

1	Enter the amount of any excise tax incurred by the organization under section 4955	\$
2	Enter the amount of any excise tax incurred by organization managers under section 4955	\$
3	If the organization incurred a section 4955 tax, did it file Form 4720 for this year?	☐ Yes ☐ No
4a	Was a correction made?	☐ Yes ☐ No
b	If "Yes," describe in Part IV.	

Part I-C Complete if the organization is exempt under section 501(c), except section 501(c)(3).

1	Enter the amount directly expended by the filing organization for section 527 exempt function activities	\$
2	Enter the amount of the filing organization's funds contributed to other organizations for section 527 exempt function activities	\$
3	Total exempt function expenditures. Add lines 1 and 2. Enter here and on Form 1120-POL, line 17b	\$
4	Did the filing organization file Form 1120-POL for this year?	☐ Yes ☐ No
5	Enter the names, addresses and employer identification number (EIN) of all section 527 political organizations to which the filing organization made payments. For each organization listed, enter the amount paid from the filing organization's funds. Also enter the amount of political contributions received that were promptly and directly delivered to a separate political organization, such as a separate segregated fund or a political action committee (PAC). If additional space is needed, provide information in Part IV.	

(a) Name	(b) Address	(c) EIN	(d) Amount paid from filing organization's funds. If none, enter -0-.	(e) Amount of political contributions received and promptly and directly delivered to a separate political organization. If none, enter -0-.
1				
2				
3				
4				
5				
6				

- A

Check

☐

if the filing organization belongs to an affiliated group (and list in Part IV each affiliated group member's name, address, EIN, expenses, and share of excess lobbying expenditures).
- B

Check

☐

if the filing organization checked box A and "limited control" provisions apply.

Limits on Lobbying Expenditures (The term "expenditures" means amounts paid or incurred.)		(a) Filing organization's totals	(b) Affiliated group totals												
1a Total lobbying expenditures to influence public opinion (grass roots lobbying)															
b Total lobbying expenditures to influence a legislative body (direct lobbying)															
c Total lobbying expenditures (add lines 1a and 1b)															
d Other exempt purpose expenditures		8,356,210													
e Total exempt purpose expenditures (add lines 1c and 1d)		8,356,210													
f Lobbying nontaxable amount. Enter the amount from the following table in both columns.		567,811													
<table><thead><tr><th>If the amount on line 1e, column (a) or (b) is:</th><th>The lobbying nontaxable amount is:</th></tr></thead><tbody><tr><td>Not over \$500,000</td><td>20% of the amount on line 1e.</td></tr><tr><td>Over \$500,000 but not over \$1,000,000</td><td>\$100,000 plus 15% of the excess over \$500,000.</td></tr><tr><td>Over \$1,000,000 but not over \$1,500,000</td><td>\$175,000 plus 10% of the excess over \$1,000,000.</td></tr><tr><td>Over \$1,500,000 but not over \$17,000,000</td><td>\$225,000 plus 5% of the excess over \$1,500,000.</td></tr><tr><td>Over \$17,000,000</td><td>\$1,000,000.</td></tr></tbody></table>		If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:	Not over \$500,000	20% of the amount on line 1e.	Over \$500,000 but not over \$1,000,000	\$100,000 plus 15% of the excess over \$500,000.	Over \$1,000,000 but not over \$1,500,000	\$175,000 plus 10% of the excess over \$1,000,000.	Over \$1,500,000 but not over \$17,000,000	\$225,000 plus 5% of the excess over \$1,500,000.	Over \$17,000,000	\$1,000,000.		
If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:														
Not over \$500,000	20% of the amount on line 1e.														
Over \$500,000 but not over \$1,000,000	\$100,000 plus 15% of the excess over \$500,000.														
Over \$1,000,000 but not over \$1,500,000	\$175,000 plus 10% of the excess over \$1,000,000.														
Over \$1,500,000 but not over \$17,000,000	\$225,000 plus 5% of the excess over \$1,500,000.														
Over \$17,000,000	\$1,000,000.														
g Grassroots nontaxable amount (enter 25% of line 1f)		141,953													
h Subtract line 1g from line 1a. If zero or less, enter -0-		0													
i Subtract line 1f from line 1c. If zero or less, enter -0-		0													
j If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year?		☐ Yes ☐ No													

4-Year Averaging Period Under Section 501(h)

(Some organizations that made a section 501(h) election do not have to complete all of the five columns below. See the separate instructions for lines 2a through 2f.)

Lobbying Expenditures During 4-Year Averaging Period					
Calendar year (or fiscal year beginning in)	(a) 2019	(b) 2020	(c) 2021	(d) 2022	(e) Total
2a Lobbying nontaxable amount	462,469	512,283	548,783	567,811	2,091,346
b Lobbying ceiling amount (150% of line 2a, column(e))					3,137,019
c Total lobbying expenditures					
d Grassroots nontaxable amount	115,617	128,071	137,196	141,953	522,837
e Grassroots ceiling amount (150% of line 2d, column (e))					784,256
f Grassroots lobbying expenditures					

Part II-B Complete if the organization is exempt under section 501(c)(3) and has NOT filed Form 5768 (election under section 501(h)).

For each "Yes" response on lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity.

		(a)		(b)
		Yes	No	Amount
1	During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of:			
a	Volunteers?			
b	Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?			
c	Media advertisements?			
d	Mailings to members, legislators, or the public?			
e	Publications, or published or broadcast statements?			
f	Grants to other organizations for lobbying purposes?			
g	Direct contact with legislators, their staffs, government officials, or a legislative body?			
h	Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?			
i	Other activities?			
j	Total. Add lines 1c through 1i			
2a	Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?			
b	If "Yes," enter the amount of any tax incurred under section 4912			
c	If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d	If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

Part III-A Complete if the organization is exempt under section 501(c)(4), section 501(c)(5), or section 501(c)(6).

	Yes	No
1 Were substantially all (90% or more) dues received nondeductible by members?	1	
2 Did the organization make only in-house lobbying expenditures of \$2,000 or less?	2	
3 Did the organization agree to carry over lobbying and political expenditures from the prior year?	3	

Part III-B Complete if the organization is exempt under section 501(c)(4), section 501(c)(5), or section 501(c)(6) and if either (a) BOTH Part III-A, lines 1 and 2, are answered "No" OR (b) Part III-A, line 3, is answered "Yes."

1	Dues, assessments and similar amounts from members	1	
2	Section 162(e) nondeductible lobbying and political expenditures (do not include amounts of political expenses for which the section 527(f) tax was paid).		
a	Current year	2a	
b	Carryover from last year	2b	
c	Total	2c	
3	Aggregate amount reported in section 6033(e)(1)(A) notices of nondeductible section 162(e) dues .	3	
4	If notices were sent and the amount on line 2c exceeds the amount on line 3, what portion of the excess does the organization agree to carryover to the reasonable estimate of nondeductible lobbying and political expenditure next year?	4	
5	Taxable amount of lobbying and political expenditures. See Instructions	5	

Part IV Supplemental Information

Provide the descriptions required for Part I-A, line 1; Part I-B, line 4; Part I-C, line 5; Part II-A (affiliated group list); Part II-A, lines 1 and 2 (see instructions), and Part II-B, line 1. Also, complete this part for any additional information.

Return Reference	Explanation
------------------	-------------

Name of the organization THE LEAPFROG GROUP	Employer identification number 52-2359517
---	---

Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts.
Complete if the organization answered "Yes" on Form 990, Part IV, line 6.

	(a) Donor advised funds	(b) Funds and other accounts
1 Total number at end of year		
2 Aggregate value of contributions to (during year)		
3 Aggregate value of grants from (during year)		
4 Aggregate value at end of year		

5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control?

☐ Yes ☐ No

6 Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit?

☐ Yes ☐ No

Part II Conservation Easements.
Complete if the organization answered "Yes" on Form 990, Part IV, line 7.

1 Purpose(s) of conservation easements held by the organization (check all that apply).
☐ Preservation of land for public use (e.g., recreation or education) ☐ Preservation of an historically important land area
☐ Protection of natural habitat ☐ Preservation of a certified historic structure
☐ Preservation of open space

2 Complete lines 2a through 2d if the organization held a qualified conservation contribution in the form of a conservation easement on the last day of the tax year.

	Held at the End of the Year
a Total number of conservation easements	2a
b Total acreage restricted by conservation easements	2b
c Number of conservation easements on a certified historic structure included in (a)	2c
d Number of conservation easements included in (c) acquired after July 25, 2006, and not on a historic structure listed in the National Register	2d

3 Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the tax year ▶ _____

4 Number of states where property subject to conservation easement is located ▶ _____

5 Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds? ☐ Yes ☐ No

6 Staff and volunteer hours devoted to monitoring, inspecting, handling of violations, and enforcing conservation easements during the year ▶ _____

7 Amount of expenses incurred in monitoring, inspecting, handling of violations, and enforcing conservation easements during the year ▶ \$ _____

8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)? ☐ Yes ☐ No

9 In Part XIII, describe how the organization reports conservation easements in its revenue and expense statement, and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements.

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets.
Complete if the organization answered "Yes" on Form 990, Part IV, line 8.

1a If the organization elected, as permitted under FASB ASC 958, not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part XIII, the text of the footnote to its financial statements that describes these items.

b If the organization elected, as permitted under FASB ASC 958, to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items:
(i) Revenue included on Form 990, Part VIII, line 1 ▶ \$ _____
(ii) Assets included in Form 990, Part X ▶ \$ _____

2 If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under FASB ASC 958 relating to these items:
a Revenue included on Form 990, Part VIII, line 1 ▶ \$ _____
b Assets included in Form 990, Part X ▶ \$ _____

Part III

Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets (continued)

3

Using the organization's acquisition, accession, and other records, check any of the following that are a significant use of its collection items (check all that apply):

a

☐ Public exhibition

b

☐ Scholarly research

c

☐ Preservation for future generations

d

☐ Loan or exchange programs

e

☐ Other

4

Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part XIII.

5

During the year, did the organization solicit or receive donations of art, historical treasures or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection? . . .

☐ Yes

☐ No

Part IV

Escrow and Custodial Arrangements.

Complete if the organization answered "Yes" on Form 990, Part IV, line 9, or reported an amount on Form 990, Part X, line 21.

1a

Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X?

☐ Yes

☐ No

b

If "Yes," explain the arrangement in Part XIII and complete the following table:

c

Beginning balance

d

Additions during the year

e

Distributions during the year

f

Ending balance

	Amount
1c	
1d	
1e	
1f	

2a

Did the organization include an amount on Form 990, Part X, line 21, for escrow or custodial account liability? . . .

☐ Yes

☐ No

b

If "Yes," explain the arrangement in Part XIII. Check here if the explanation has been provided in Part XIII

☐

Part V

Endowment Funds.

Complete if the organization answered "Yes" on Form 990, Part IV, line 10.

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a	Beginning of year balance				
b	Contributions				
c	Net investment earnings, gains, and losses				
d	Grants or scholarships				
e	Other expenditures for facilities and programs				
f	Administrative expenses				
g	End of year balance				

2

Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as:

a

Board designated or quasi-endowment ▶

b

Permanent endowment ▶

c

Term endowment ▶

The percentages on lines 2a, 2b, and 2c should equal 100%.

3a

Are there endowment funds not in the possession of the organization that are held and administered for the organization by:

(i)

Unrelated organizations

(ii)

Related organizations

b

If "Yes" on 3a(ii), are the related organizations listed as required on Schedule R?

	Yes	No
3a(i)		
3a(ii)		
3b		

4

Describe in Part XIII the intended uses of the organization's endowment funds.

Part VI

Land, Buildings, and Equipment.

Complete if the organization answered "Yes" on Form 990, Part IV, line 11a. See Form 990, Part X, line 10.

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a	Land			
b	Buildings			
c	Leasehold improvements	447,431	157,242	290,189
d	Equipment	122,243	95,917	26,326
e	Other	1,398,456	691,934	706,522
Total.	Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10(c).) . . . ▶			1,023,037

Schedule D (Form 990) 2022

Part VII Investments - Other Securities.

Complete if the organization answered "Yes" on Form 990, Part IV, line 11b. See Form 990, Part X, line 12.

(a) Description of security or category (including name of security)	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1) Financial derivatives		
(2) Closely-held equity interests		
(3) Other _____		
(A)		
(B)		
(C)		
(D)		
(E)		
(F)		
(G)		
(H)		
Total. (Column (b) must equal Form 990, Part X, col. (B) line 12.)		

Part VIII Investments - Program Related.

Complete if the organization answered 'Yes' on Form 990, Part IV, line 11c. See Form 990, Part X, line 13.

(a) Description of investment	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1)		
(2)		
(3)		
(4)		
(5)		
(6)		
(7)		
(8)		
(9)		
Total. (Column (b) must equal Form 990, Part X, col.(B) line 13.)		

Part IX Other Assets.

Complete if the organization answered 'Yes' on Form 990, Part IV, line 11d. See Form 990, Part X, line 15.

(a) Description	(b) Book value
(1) DEPOSIT	39,253
(2) OPERATING RIGHT OF USE ASSET	2,719,306
(2)	
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col.(B) line 15.)	2,758,559

Part X Other Liabilities.

Complete if the organization answered 'Yes' on Form 990, Part IV, line 11e or 11f. See Form 990, Part X, line 25.

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
CAPITAL LEASE	3,412
OPERATING LEASE	3,057,608
REFUNDABLE ADVANCE	177,878
Total. (Column (b) must equal Form 990, Part X, col.(B) line 25.)	3,238,898

2. Liability for uncertain tax positions. In Part XIII, provide the text of the footnote to the organization's financial statements that reports the organization's liability for uncertain tax positions under FIN 48 (ASC 740). Check here if the text of the footnote has been provided in Part XIII ☒

Part XI

Reconciliation of Revenue per Audited Financial Statements With Revenue per Return.

Complete if the organization answered 'Yes' on Form 990, Part IV, line 12a.

1	Total revenue, gains, and other support per audited financial statements		1	
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12:			
a	Net unrealized gains (losses) on investments	2a		
b	Donated services and use of facilities	2b		
c	Recoveries of prior year grants	2c		
d	Other (Describe in Part XIII.)	2d		
e	Add lines 2a through 2d		2e	
3	Subtract line 2e from line 1		3	
4	Amounts included on Form 990, Part VIII, line 12, but not on line 1:			
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a		
b	Other (Describe in Part XIII.)	4b		
c	Add lines 4a and 4b		4c	
5	Total revenue. Add lines 3 and 4c. (This must equal Form 990, Part I, line 12.)		5	

Part XII

Reconciliation of Expenses per Audited Financial Statements With Expenses per Return.

Complete if the organization answered 'Yes' on Form 990, Part IV, line 12a.

1	Total expenses and losses per audited financial statements		1	
2	Amounts included on line 1 but not on Form 990, Part IX, line 25:			
a	Donated services and use of facilities	2a		
b	Prior year adjustments	2b		
c	Other losses	2c		
d	Other (Describe in Part XIII.)	2d		
e	Add lines 2a through 2d		2e	
3	Subtract line 2e from line 1		3	
4	Amounts included on Form 990, Part IX, line 25, but not on line 1:			
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a		
b	Other (Describe in Part XIII.)	4b		
c	Add lines 4a and 4b		4c	
5	Total expenses. Add lines 3 and 4c. (This must equal Form 990, Part I, line 18.)		5	

Part XIII

Supplemental Information

Provide the descriptions required for Part II, lines 3, 5, and 9; Part III, lines 1a and 4; Part IV, lines 1b and 2b; Part V, line 4; Part X, line 2; Part XI, lines 2d and 4b; and Part XII, lines 2d and 4b. Also complete this part to provide any additional information.

Return Reference	Explanation
PART X, LINE 2:	MANAGEMENT EVALUATED LEAPFROG'S TAX POSITIONS AND CONCLUDED THAT LEAPFROG HAS TAKEN NO UNCERTAIN TAX POSITIONS THAT REQUIRE ADJUSTMENT TO THE CONSOLIDATED FINANCIAL STATEMENTS TO COMPLY WITH THE PROVISIONS OF THIS GUIDANCE. GENERALLY, LEAPFROG IS NO LONGER SUBJECT TO INCOME TAX EXAMINATIONS BY THE U.S. FEDERAL, STATE OR LOCAL TAX AUTHORITIES FOR YEARS BEFORE 2020.

Name of the organization THE LEAPFROG GROUP	Employer identification number 52-2359517
--	--

Part I

Questions Regarding Compensation

1a Check the appropriate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items. ☐ First-class or charter travel ☐ Travel for companions ☐ Tax idemnification and gross-up payments ☐ Discretionary spending account ☐ Housing allowance or residence for personal use ☐ Payments for business use of personal residence ☐ Health or social club dues or initiation fees ☐ Personal services (e.g., maid, chauffeur, chef)		Yes	No
b If any of the boxes on Line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain	1b		
2 Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, officers, including the CEO/Executive Director, regarding the items checked on Line 1a?	2		
3 Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III. ☐ Compensation committee ☒ Independent compensation consultant ☒ Form 990 of other organizations ☒ Written employment contract ☒ Compensation survey or study ☒ Approval by the board or compensation committee			
4 During the year, did any person listed on Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization:			
a Receive a severance payment or change-of-control payment?	4a		No
b Participate in, or receive payment from, a supplemental nonqualified retirement plan?	4b		No
c Participate in, or receive payment from, an equity-based compensation arrangement?	4c		No
If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.			
Only 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.			
5 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of:			
a The organization?	5a		No
b Any related organization?	5b		No
If "Yes," on line 5a or 5b, describe in Part III.			
6 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of:			
a The organization?	6a		No
b Any related organization?	6b		No
If "Yes," on line 6a or 6b, describe in Part III.			
7 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any nonfixed payments not described in lines 5 and 6? If "Yes," describe in Part III	7		No
8 Were any amounts reported on Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III	8		No
9 If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?	9		

Part II Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees.

For each individual whose compensation must be reported on Schedule J, report compensation from the organization on row (i) and from related organizations, described in the instructions, on row (ii). Do not list any individuals that are not listed on Form 990, Part VII.

Note. The sum of columns (B)(i)-(iii) for each listed individual must equal the total amount of Form 990, Part VII, Section A, line 1a, applicable column (D) and (E) amounts for that individual.

[illegible]

Part III **Supplemental Information**

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Provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 3, 4a, 4b, 4c, 5a, 5b, 6a, 6b, 7, and 8, and for Part II. Also complete this part for any additional information.

Return Reference	Explanation

SCHEDULE O
(Form 990)

Department of the Treasury
Internal Revenue Service

Name of the organization
THE LEAPFROG GROUP

Supplemental Information to Form 990 or 990-EZ

Complete to provide information for responses to specific questions on Form 990 or 990-EZ or to provide any additional information.
Attach to Form 990 or 990-EZ.
Go to www.irs.gov/Form990 for the latest information.

OMB No. 1545-0047

2023

Open to Public Inspection

Name of the organization
THE LEAPFROG GROUP

Employer identification number
52-2359517

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 11B	FORM 990 IS REVIEWED BY MANAGEMENT THEN FORWARDED TO THE BOARD FOR REVIEW PRIOR TO SUBMISSION.
FORM 990, PART VI, SECTION B, LINE 12C	THE AUDIT COMMITTEE CHAIR ADVISES THE BOARD THAT BYLAWS REQUIRE COMPLIANCE WITH THE CONFLICT OF INTEREST POLICY. BOARD MEMBERS ARE ASKED TO RECUSE THEMSELVES IF THEY HAVE ANY PERCEIVED OR ACTUAL CONFLICTS ON THE MATTER UNDER DISCUSSION. THE CONFLICT OF INTEREST POLICY ALSO APPLIES TO SENIOR MANAGEMENT AND VOLUNTEER EXPERT PANELS.
FORM 990, PART VI, SECTION B, LINE 15	THE EXECUTIVE COMMITTEE UTILIZED A COMPENSATION STUDY TO ESTABLISH THE COMPENSATION OF THE CEO.
FORM 990, PART VI, SECTION C, LINE 19	THE LEAPFROG GROUP WILL PROVIDE A COPY OF THEIR FORM 1023 AND FORM 990 UPON REQUEST.
FORM 990, PART IX, LINE 11G	CONSULTING FEES: PROGRAM SERVICE EXPENSES 1,364,596. MANAGEMENT AND GENERAL EXPENSES 0. FUNDRAISING EXPENSES 0. TOTAL EXPENSES 1,364,596.
FORM 990, PART XII, LINE 2C	THE PROCESS HAS NOT CHANGED FROM THE PREVIOUS YEAR.

For Paperwork Reduction Act Notice, see the Instructions for Form 990 Cat. No. 51056K or 990-EZ.

Schedule O (Form 990) 2023

Name of the organization THE LEAPFROG GROUP	Employer identification number 52-2359517
--	--

Part I Identification of Disregarded Entities. Complete if the organization answered "Yes" on Form 990, Part IV, line 33.					
(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1) THE LEAPFROG GROUP DUE DILLIGENCE COOPERATIVE LLC 1660 L STREET NW SUITE 308 WASHINGTON, DC 20036 45-2397143	TO COLLECT, EVALUATE, AND SUMMARIZE INFORMATION ABOUT COMPANIES	DC	-298	3,310	THE LEAPFROG GROUP

Part II Identification of Related Tax-Exempt Organizations. Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had one or more related tax-exempt organizations during the tax year.							
(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No

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Part III

Identification of Related Organizations Taxable as a Partnership. Complete if the organization answered "Yes" on Form 990, Part IV, line 34, because it had one or more related organizations treated as a partnership during the tax year.

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income(related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of- year assets	(h) Disproportionate allocations?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	

Part IV

Identification of Related Organizations Taxable as a Corporation or Trust. Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had one or more related organizations treated as a corporation or trust during the tax year.

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of- year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity?	
								Yes	No

Part V Transactions With Related Organizations

Note. Complete line 1 if any entity is listed in Parts II, III, or IV of this schedule.

1 During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?

- a** Receipt of **(i)** interest, **(ii)** annuities, **(iii)** royalties, or **(iv)** rent from a controlled entity
- b** Gift, grant, or capital contribution to related organization(s)
- c** Gift, grant, or capital contribution from related organization(s)
- d** Loans or loan guarantees to or for related organization(s)
- e** Loans or loan guarantees by related organization(s)
- f** Dividends from related organization(s)
- g** Sale of assets to related organization(s)
- h** Purchase of assets from related organization(s)
- i** Exchange of assets with related organization(s)
- j** Lease of facilities, equipment, or other assets to related organization(s)
- k** Lease of facilities, equipment, or other assets from related organization(s)
- l** Performance of services or membership or fundraising solicitations for related organization(s)
- m** Performance of services or membership or fundraising solicitations by related organization(s)
- n** Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)
- o** Sharing of paid employees with related organization(s)
- p** Reimbursement paid to related organization(s) for expenses
- q** Reimbursement paid by related organization(s) for expenses
- r** Other transfer of cash or property to related organization(s)
- s** Other transfer of cash or property from related organization(s)

	Yes	No
1a		
1b		
1c		
1d		
1e		
1f		
1g		
1h		
1i		
1j		
1k		
1l		
1m		
1n		
1o		
1p		
1q		
1r		
1s		

2 If the answer to any of the above is "Yes," see the instructions for information on who must complete this line, including covered relationships and transaction thresholds.

(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved

Part VI Unrelated Organizations Taxable as a Partnership. Complete if the organization answered "Yes" on Form 990, Part IV, line 37.

Provide the following information for each entity taxed as a partnership through which the organization conducted more than five percent of its activities (measured by total assets or gross revenue) that was not a related organization. See instructions regarding exclusion for certain investment partnerships.

[illegible]

Part VII

Supplemental Information

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Provide additional information for responses to questions on Schedule R. See instructions.

Return Reference	Explanation
PART I (B)	PROVIDING HEALTHCARE-RELATED SERVICES TO EMPLOYERS.

Exhibit 80

Expert Panel's Guiding Principles on the Development of the Composite Leapfrog Hospital Safety Grade for U.S. Hospitals

The expert panel guiding The Leapfrog Group on the development of the Leapfrog Hospital Safety Grade has reached consensus that the following principles will guide their recommendations to Leapfrog for calculating the grade.

Purpose of Composite Score

The purpose of the composite score is to create a simple metric that will improve consumer and purchaser engagement around patient safety in U.S. hospitals. Ideally, this increased engagement will create additional market forces for hospitals to improve the safety of care delivery. In the dissemination of the grades, hospitals will be engaged to help them understand, prepare, and communicate about this score in a manner that promotes both respect and improvement.

Construct

The focus of this composite score is patient safety, which is being defined as "freedom from harm." We recognize that patient safety is a different, and a narrower, construct than hospital quality. The composite score should recognize both a hospital's efforts toward patient safety and the hospital's patient safety outcomes.

Inclusion of Measures

The performance measures that are used in creating the composite grade should have the following characteristics:

- Ideally can be obtained from a data source that publicly releases hospital-level data at the national level.
 - If no such data source exists, preference will be given to data sources with the following characteristics: provide consistent data across geographic locations, are transparent with their data, do not represent a financial burden for hospitals to report data or for Leapfrog to access the data, and have a mechanism in place to ensure the integrity of the data reported (e.g., attestation, audit, verification process).
- The measure is clearly related to patient safety.
- Measures that focus on outcomes are generally preferred to measures that focus on processes of care or structural factors. When outcome measures are unavailable, or are insufficiently robust (i.e., case-mix adjustment methods have not been fully worked out), proven process or structural measures will be utilized.
- If the measure focuses on processes of care or structural factors, it should have strong evidence of being correlated with safer patient outcomes.

Expert Panel's Guiding Principles on the Development of the Composite Leapfrog Hospital Safety Grade for U.S. Hospitals

- Measures should not be limited to those that are collected and publicly reported through the Leapfrog Hospital Survey.

Scientific Soundness of Measures

Measures that have been shown to be scientifically sound (e.g., valid, reliable) are preferred; however, lack of existing research on the scientific soundness of a measure does not preclude the inclusion of the measure in the composite. The scientific soundness of a measure is one consideration, amongst many, in deciding whether to include the measure in the composite. In addition, techniques such as reliability-adjustment should be used, when possible, to compensate for differences in the reliability of a measure.

Weighting Measures

The composite grade should recognize both a hospital's efforts toward patient safety and their achievements in patient safety. The composite grade shall have two domains – one made up of process/structural measures and the other of outcome measures. Each of the two measure domains should receive approximately 50% of the total weight of the composite, though this balance may need to evolve over time as the science matures.

The assignment of weights to individual measure within a domain should reflect criteria used by other national measurement entities to determine importance, such as NQF. These criteria include:

- The strength of evidence behind the measure
- The opportunity for improvement in hospital performance on the measure
- The impact of hospitals improving their performance, both on the severity of harm averted, as well as the number of patients who will avoid harm. That is, the weights should reflect both the severity of the problem and how often the problem occurs.

Imputing missing data

When a hospital is missing data for a particular performance measure, we recommend ignoring the measure and re-calibrating the weights within the domain so that hospitals are scored only on the measures for which their performance data are available.

In situations where a hospital does not have data available from the primary data source for a particular performance measure, but an alternative data source is available, data from the alternative or secondary data source can be used in the composite. If data are used from a secondary data source, attempts should be made to provide a grade that is equitable to what the hospital would have earned had the data been available from the primary data source.

Expert Panel's Guiding Principles on the Development of the Composite Leapfrog Hospital Safety Grade for U.S. Hospitals

If a hospital is missing data for a large number of performance measures, then a grade cannot be reliably calculated. In this situation, no grade should be issued for the hospital.

Evolution of the Composite Grade

The composite grade will evolve as the science of performance measurement improves. On a regular basis, the methods used to calculate the composite grade will be revisited; possible methodology modifications will be generated from analyses, expert panel input, and stakeholder comments. In addition, the individual performance measures that make-up the composite grade will be revisited on an regular basis, with structured processes to reassess the current measures and to identify new measures that could be added to and/or replace the current measures. The composite grade will also ideally serve as a 'living laboratory' to help push forward the science of patient safety performance measurement.

Transparency

The process of developing this composite score will be transparent to all parties that are interested. The weighting and calculation process will be transparent to hospitals, consumers, and others. Hospitals will have the opportunity to review their composite grades prior to public release.

Exhibit 81

Not Found

The requested URL /media/file/Expert_Panel_Guiding_Principles_Nov12_updated.pdf was not found on this server.

Apache/2.2.34 (Amazon) Server at www.hospitalsafetygrade.org Port 80

Exhibit 82

INTERNET ARCHIVE <https://www.hospitalsafetygrade.org/LivesLost> Go JUL AUG SEP
 WayBackMachine 39 captures 18 May 2020 - 19 Aug 2025 19 2024 2025 2026

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LEAPFROG HOSPITAL SAFETY GRADE What is Patient Safety? Your Hospital's Safety Grade What You Can Do to Stay Safe For Hospitals Licensure & Permissions About Our Movement A program of THE LEAPFROG GROUP

How Safe is Your Hospital? Search By City/State City - Choose - Search

Lives Lost and Lives Saved

The Leapfrog Group recently contracted with the Johns Hopkins Armstrong Institute for Patient Safety and Quality to update its estimate of deaths due to errors, accidents, injuries and infections at "A", "B", "C", "D" and "F" hospitals. Overall, an estimated 160,000 lives are lost annually from the avoidable medical errors that are accounted for in the Leapfrog Hospital Safety Grade, a significant improvement from 2016, when researchers estimated 205,000 avoidable deaths. The analysis also found that D and F hospitals carry nearly twice the risk of mortality of A hospitals. **Over 50,000 lives could be saved if all hospitals performed at the level of A graded hospitals.**

For more details, [view the full white paper](#).

FEWER AVOIDABLE PATIENT DEATHS IN AMERICA'S HOSPITALS



BUT YOUR RISK OF DYING DEPENDS ON THE HOSPITAL YOU CHOOSE

The Leapfrog Hospital Safety Grade is a letter grade that scores hospitals on how well they protect patients from errors, injuries, accidents and infections.

Compared to an **A** hospital, your risk of dying increases...



50,215

lives could be saved every year if **B**, **C**, **D** and **F** hospitals improved their patient safety record to that achieved by **A** hospitals.

While **A** hospitals have better performance on safety than hospitals with lower grades, they still have opportunities for improvement and to save lives.

Visit hospitalsafetygrade.org
to see how your local hospital
performed in the Leapfrog
Hospital Safety Grade.

LEAPFROG
HOSPITAL
SAFETY GRADE

THE LEAPFROG GROUP
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*Data from Leapfrog Hospital Safety Grade.

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The Leapfrog Hospital Safety Grade

The Leapfrog Hospital Safety Grade is a public service provided by The Leapfrog Group, an independent nonprofit organization committed to driving quality, safety, and transparency in the U.S. health system.

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What is Patient Safety?

- Errors, Injuries, Accidents, Infections
- Why the Hospital Safety Grade Works

Your Hospital's Safety Grade

- About the Grade
- How to Use the Grade
- Choosing the Best Hospital
- Lives Lost and Lives Saved
- Frequently Asked Questions

What You Can Do to Stay Safe

- Preparing for Your Hospital Stay
- Talking with Your Doctor About Safety
- Other Patient Resources
- Employers and Purchasers

For Hospitals

- Methodology
- Updates and Timelines for Hospitals
- Data Review
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Exhibit 83

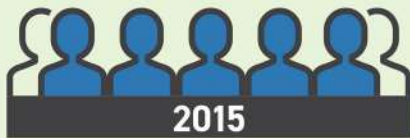


Lives Lost and Lives Saved

The Leapfrog Group recently contracted with the Johns Hopkins Armstrong Institute for Patient Safety and Quality to update its estimate of deaths due to errors, accidents, injuries and infections at “A”, “B”, “C”, “D” and “F” hospitals. Overall, an estimated 160,000 lives are lost annually from the avoidable medical errors that are accounted for in the Leapfrog Hospital Safety Grade, a significant improvement from 2016, when researchers estimated 205,000 avoidable deaths. The analysis also found that D and F hospitals carry nearly twice the risk of mortality of A hospitals. **Over 50,000 lives could be saved if all hospitals performed at the level of A graded hospitals.**

For more details, view the full white paper.

FEWER AVOIDABLE PATIENT DEATHS IN AMERICA'S HOSPITALS



205,000* Deaths

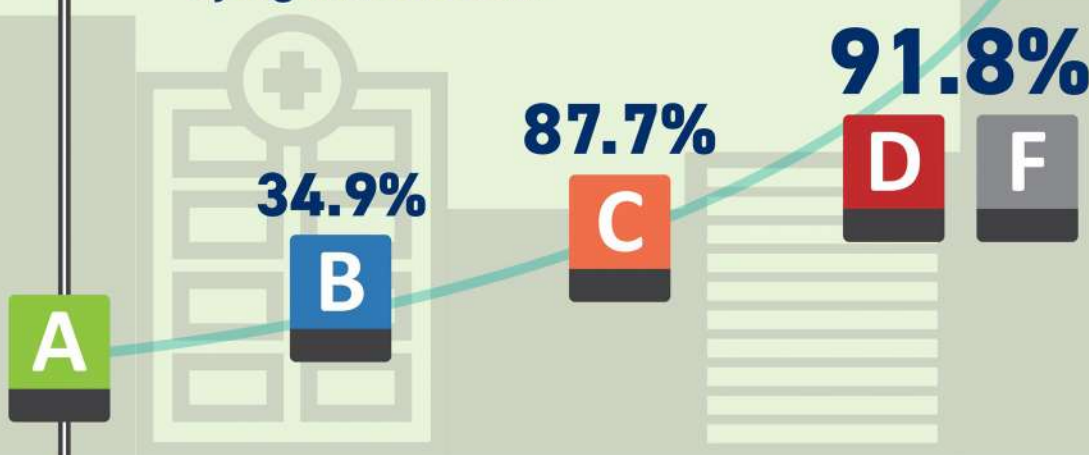


160,000* Deaths

BUT YOUR RISK OF DYING DEPENDS ON THE HOSPITAL YOU CHOOSE

The Leapfrog Hospital Safety Grade is a letter grade that scores hospitals on how well they protect patients from errors, injuries, accidents and infections.

Compared to an **A** hospital, your risk of dying increases...



50,215

lives could be saved every year if **B**, **C**, **D** and **F** hospitals improved their patient safety record to that achieved by **A** hospitals.

While **A** hospitals have better performance on safety than hospitals with lower grades, they still have opportunities for improvement and to save lives.

Visit [hospitalsafetygrade.org](https://www.hospitalsafetygrade.org)

to see how your local hospital
performed in the Leapfrog
Hospital Safety Grade.

LEAPFROG
HOSPITAL
SAFETY GRADE

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*Estimated annual deaths due to medical errors.

Austin, M. & Derk, J. (May 2019). "Lives Lost, Lives Saved: An Updated Comparative Analysis of Avoidable Deaths at Hospitals Graded by The Leapfrog Group," Armstrong Institute for Patient Safety and Quality, Johns Hopkins Medicine. Prepared for The Leapfrog Group, Washington, D.C.

Based on Spring 2019 Leapfrog Hospital Safety Grades.



The Leapfrog Hospital Safety Grade

The Leapfrog Hospital Safety Grade is a public
service provided by The Leapfrog Group, an

independent nonprofit organization committed to driving quality, safety, and transparency in the U.S. health
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Exhibit 84

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA
WEST PALM BEACH DIVISION

GOOD SAMARITAN MEDICAL)
CENTER, et al.,)
)
Plaintiffs,) CASE NO.
)
v.) 9:25-CV-80526-DMM
)
THE LEAPFROG GROUP,)
)
Defendant.)
_____)

The in-person, video-recorded deposition of Matthew Austin, taken pursuant to Federal Rule of Civil Procedure 45 and Southern District of Florida Local Rule 26.1, at the offices of Zuckerman Spaeder, LLP, 100 E. Pratt Street, Suite 2440, Baltimore, Maryland 21202, by Plaintiffs in the above-referenced action, beginning at 9:09 a.m. The deposition was taken before Marlene Kerr, a Certified Shorthand Reporter, Registered Professional Reporter, Registered Merit Reporter, Certified Realtime Reporter, Federal Certified Realtime Reporter, Notary Public.

Job No. 7616361

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11 CURTIS ROGINSKI - Videographer

12

13

14

15

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P R O C E E D I N G S

THE VIDEOGRAPHER: Good morning.

We are going on the record at 9:09 a.m., on September 25th, 2025. This is media unit one of the video-recorded deposition of Dr. Matthew Austin taken in the matter of Good Samaritan Medical Center, Inc., et al., v. The Leapfrog Group, the United States District Court for the Southern District of Florida, West Palm Beach Division; Case No. 9:25-CV-08526 [sic.] -DMM.

My name is Curtis Roginski, representing Veritext. I'm the videographer. The court reporter is Marlene Kerr, also with Veritext.

Will counsel please identify yourselves and state whom you represent.

MS. LAWSON: Sara Lawson from Zuckerman Spaeder on behalf of the witness, Dr. Matthew Austin, and the Armstrong Institute.

MR. CRAIN: Lee Crain from Gibson Dunn & Crutcher for Plaintiffs.

MS. WOOD: Courtney Wood, Wilson Elser, on behalf of the Defendant, The Leapfrog Group.

1 MR. TOGIAS: Iason Togias on behalf of
2 Plaintiffs with Gibson Dunn & Crutcher.

3 THE VIDEOGRAPHER: Thank you.

4 Would the court reporter please swear in
5 the witness.

6 THE COURT REPORTER: Sure.

7 Would you please raise your right hand to
8 be sworn.

9 (Witness complied.)

10 THE COURT REPORTER: Do you promise and declare
11 under penalty of perjury the testimony you are about to
12 give will be the truth, the whole truth, and nothing but
13 the truth?

14 THE WITNESS: Yes.

15 THE COURT REPORTER: Thank you.

16 (Witness sworn.)

17 MR. CRAIN: I'm sorry. Could we pause for a
18 second?

19 THE COURT REPORTER: Sure.

20 MR. CRAIN: Do we have the realtime?

21 THE COURT REPORTER: You should.

1 MR. CRAIN: Oh, okay. We've got it there.

2 THE COURT REPORTER: Okay.

3 MR. TOGIAS: Is it on, though?

4 THE COURT REPORTER: It's up and running.

5 MR. CRAIN: Actually, can we go off for a
6 second? I'm sorry.

7 (Discussion held off the record regarding
8 the realtime feed.)

9 THE VIDEOGRAPHER: Off the record. The time is
10 9:10 a.m.

11 (Brief pause.)

12 THE VIDEOGRAPHER: This marks the beginning of
13 media unit number two. We're going back on the record.
14 The time is 9:12 a.m.

15 EXAMINATION

16 BY MR. CRAIN:

17 Q. Good morning, Dr. Austin.

18 A. Good morning.

19 Q. My name is Lee Crain. I am counsel for
20 Plaintiffs in this action.

21 Could you please just state your full name

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1 for the record.

2 A. Yeah, my full legal name is John Matthew
3 Austin, but I go by Matt Austin.

4 Q. And have you gone by any other names besides
5 those two?

6 A. No, I have not.

7 Q. Okay.

8 Have you ever been deposed before?

9 A. I have not.

10 Q. Okay.

11 I want to go through just some ground rules
12 at the start so we're on the same page. A couple of key
13 rules. You understand the court reporter is taking down
14 what you and I say to create a written transcript?

15 A. Uh-huh.

16 Q. And you understand this deposition is being
17 video-recorded?

18 A. Yes, I do.

19 Q. Because of Marlene and to help her out, we want
20 to make sure that we're taking time between the
21 questions and answers. So I'll do my best to let you

1 finish, and you do your best to let me finish. Fair
2 enough?

3 A. Sounds good. I'll do my best.

4 Q. It's a little unnatural, but we'll get through
5 it.

6 Answers need to be audible, so no shaking
7 heads or nodding, that sort of thing. Fair enough?

8 A. Fair enough.

9 Q. You understand you're under oath today as if
10 you were testifying in court?

11 A. Yes.

12 Q. Are you under any medications that would impair
13 your ability to testify truthfully today?

14 A. No.

15 Q. Is there any other reason you can't give
16 truthful testimony today?

17 A. No.

18 Q. Okay.

19 Occasionally, it will happen where I will
20 ask a bad question. Don't hesitate to ask if you have
21 questions, if you want me to restate the question, or if

1 you're confused. If you don't, I'm going to assume you
2 understand the question, but feel free to clarify any
3 time. Fair enough?

4 A. Fair enough.

5 Q. And then the last -- two last things. From
6 time to time, your attorney or Ms. Wood may object.
7 Unless they're instructing you not to answer, we're
8 going to ask you to answer the question. Clear enough?

9 A. That's clear enough.

10 Q. And then the last thing is we can take a break
11 any time, any time you need, any time anybody else
12 needs. The only thing we ask is not while a question is
13 pending. So we'll go through the question and answer
14 and then we can take a break, if that makes sense?

15 A. Yeah, that makes sense.

16 Q. Great.

17 Okay. So I want to just start right at the
18 top. Did you prepare for this deposition?

19 A. I did.

20 Q. Can you tell me what you did to prepare for the
21 deposition?

1 A. I met with my attorney and a paralegal
2 yesterday and also reviewed some documents that they had
3 sent me.

4 Q. Did you only meet with counsel one time?

5 A. To prepare for the deposition, yes.

6 Q. Did you meet with counsel other times regarding
7 this case?

8 A. We did have an early sort of exploratory call
9 shortly after Sara was named as my counsel.

10 Q. Okay.

11 MS. LAWSON: And I'm just going to object, just
12 interpose an objection just to make sure that Dr. Austin
13 understands that you can answer with respect to sort of
14 basic details, the who, what, where, when, why, and how
15 of our discussions, but those discussions are protected
16 by the attorney-client privilege. So I would just ask
17 and instruct you not to reveal the substance of any
18 discussions that you've had with me or any other of your
19 counsel from Zuckerman Spaeder, like my partner Marty
20 Himeles as well. So just to make that clear.

21

1 BY MR. CRAIN:

2 Q. Yes. And none of my questions are getting at
3 that. So I do not want the substance of your
4 communications with counsel. Fair enough?

5 A. Fair enough.

6 MR. TOGIAS: And just to flag, this is -- the
7 Zoom link, I don't see a live feed.

8 MR. CRAIN: We'll do it after.

9 BY MR. CRAIN:

10 Q. So how long did you meet with counsel --
11 yesterday, you said?

12 A. Yesterday, correct.

13 Q. And how long was that meeting?

14 A. It was approximately three hours.

15 Q. Was anybody else in attendance besides
16 Ms. Lawson -- did I get that right? I'm sorry -- and a
17 paralegal?

18 A. That was it.

19 Q. Okay. And you reviewed documents during that
20 session?

21 A. We reviewed some documents.

1 Q. Okay. Did you review documents outside of that
2 session with your counsel to prepare today?

3 A. No.

4 Q. Okay. Did you watch any videos?

5 A. No.

6 Q. Did you listen to any audio recordings?

7 A. No.

8 Q. Okay. Did you review any other -- any
9 transcripts from depositions in this case?

10 A. No.

11 Q. Did you review any transcripts of anything
12 else?

13 A. No.

14 Q. Let's see. Who have you talked to about this
15 deposition besides counsel?

16 A. So I've talked to my boss, Allen Kachalia, to
17 let him know that I was being deposed. I spoke to
18 Jordan Derk who at the time of -- or at least at the
19 start of the period was working with me on The Leapfrog
20 Group contract; and with Preeti Joshi, who currently is
21 working with me on the Leapfrog contract, my partner at

1 home, and my father who is an attorney.

2 Q. And just going down the line, what did you tell
3 Mr. Kachalia about the deposition?

4 A. I had let him know that there was a lawsuit and
5 that I was being deposed for testimony.

6 Q. And what did you talk to Mr. Derk about?

7 A. I let Mr. Derk know that he was going to be
8 receiving a subpoena for documents. We talked a little
9 bit about the lawsuit, as well as some other related
10 items.

11 Q. Did you talk about the methodology, the
12 Leapfrog Hospital Safety Grade methodology with him?

13 A. We didn't talk about that in detail.

14 Q. And what did you talk about with Ms. Joshi?

15 A. I let her know that there was going to be a
16 lawsuit and that she should come to me with any
17 questions or concerns that she had about that. And then
18 when she received notice that she needed to supply
19 documents, we talked about what she needed to supply and
20 how that would go.

21 Q. Okay. And she's a current employee at

1 Armstrong?

2 A. Correct.

3 Q. Okay.

4 And then with regard to your partner and
5 your father, did you talk about the substance of this
6 case at all?

7 A. I talked about what I was aware of based on the
8 public press releases that both organizations had put
9 out.

10 Q. And what did you say? Just can you give us a
11 general sense?

12 A. Yeah. My general sense is it felt like there
13 was a lot of factual errors in the press release in
14 terms of what tenant was claiming, that those things
15 were just factually wrong.

16 Q. I guess we'll come back to that.

17 And then a couple of other questions. Did
18 you talk to anybody at Leapfrog about this case?

19 A. Not -- so Leapfrog did give me a heads-up that
20 I was going to be receiving a subpoena. So that was the
21 sort of extent of the conversation.

1 Q. Okay.

2 And then did you also speak with counsel at
3 Wilson Elser, Ms. Wood's firm?

4 A. We had a brief conversation the day that I was
5 notified that I was going to be receiving a subpoena.

6 Q. Okay. And have you exchanged emails with
7 Wilson Elser?

8 A. I have not beyond the counsel at Johns Hopkins
9 requested Courtney and Kim's names and emails, and so I
10 supplied them with those.

11 Q. Okay.

12 Now, I want to just start with an exhibit
13 just to mark it. This will be Exhibit 1.

14 (Exhibit No. 1 was marked for
15 identification as of 9/25/2025.)

16 BY MR. CRAIN:

17 Q. Dr. Austin, do you recognize this document?

18 A. I do.

19 Q. And it was produced, if you see the bottom
20 right, by the Armstrong Institute?

21 A. Correct.

1 Q. And it's an email from Ms. Binder to a number
2 of folks, including yourself. Do you see that?

3 A. Yes, I do.

4 Q. And Ms. Binder told you, if you look towards
5 the bottom, she asked everybody in the email not to
6 email or talk about the case in writing. Do you see
7 that?

8 A. Can you point me to where that says that?

9 Q. Yes. So it says, number two: "Do not
10 communicate in writing about this matter, such as on
11 slack or email or texting."

12 Do you see that?

13 A. Yes.

14 Q. Did you adhere to that guidance?

15 A. So outside of sort of the need to communicate
16 with, say, my boss or with counsel, I did follow that.

17 Q. Okay.

18 And then she asks -- she says, number
19 one -- do you see that right above? -- "Please refer all
20 questions or concerns, whether you have them personally
21 or you hear them from external sources, to me, Missy,

1 Lauren, or Karen. Do not put them in writing. Call us
2 or come by my office."

3 Do you see that?

4 A. I do.

5 Q. Did you call any of those folks listed in
6 bullet one?

7 A. I did not.

8 Q. Okay.

9 And then did you come by her office?

10 A. I did not.

11 Q. Okay.

12 Now, did -- I want to talk just for a
13 second about the safety grade expert panel. Do you know
14 what I mean when I say that?

15 A. Yes.

16 Q. I assume you spent a decent bit of time with
17 that group.

18 A. Correct.

19 Q. Did you discuss the lawsuit with the expert,
20 the safety grade expert panel?

21 A. So we did have a meeting with the expert panel

1 already scheduled, and at that meeting, the decision was
2 to share with the expert panel that a lawsuit had been
3 filed.

4 Q. And what was discussed at the meeting? Like,
5 can you give a little more of a play-by-play?

6 A. I don't know if I can give a play-by-play
7 without specific notes in front of me. I don't even
8 remember who shared with the panel that the lawsuit had
9 been filed. I don't know if that was Ms. Binder,
10 Ms. Danforth, if it was counsel for Leapfrog. I really
11 don't remember who shared that information with them.
12 And it was more just to let them know since they had
13 been involved in the safety grade.

14 Q. Okay.

15 I'm going to mark another exhibit. This is
16 Exhibit 2, another Armstrong document.

17 (Exhibit No. 2 was marked for
18 identification as of 9/25/2025.)

19 BY MR. CRAIN:

20 Q. So Dr. Austin, do you recognize this document?

21 A. I do.

1 Q. And it's another, if you look at the bottom
2 right, another Armstrong-produced document?

3 A. Correct.

4 Q. And the email at the top, which you'll see as
5 we go through that usually the first email is the last
6 one in the way it's printed out, but you'll see it's
7 from you to Ms. Danforth. Do you see that?

8 A. Yes.

9 Q. And if you go to the next page, there's an
10 email -- actually, it starts on the bottom of page 1
11 from you. Do you see that, that May 1?

12 A. Correct.

13 Q. And then it's an email from you, it looks like,
14 to the Hospital Safety Grade Expert Panelists. Do you
15 see that?

16 A. Correct.

17 Q. And just to get a sense, take a second if you
18 haven't read it. I just want to know was anything
19 discussed on the expert panel that goes beyond what was
20 said in this email?

21 (Witness peruses document.)

1 THE WITNESS: I don't remember it being much
2 discussion beyond what's in the email.

3 BY MR. CRAIN:

4 Q. Does the email accurately depict what was
5 discussed?

6 A. Yes.

7 Q. Okay.

8 And if you go up in the email, there's an
9 email response from Ms. Danforth to you on May 1 at
10 12:35, p.m. Do you see that?

11 A. Yes.

12 Q. And she says, "Thanks, Matt. I've added Leah
13 Binder and Thomas Duff from Wilson Elser for the first
14 agenda item." Do you see that?

15 A. Correct.

16 Q. Does that refresh your recollection as to
17 whether Ms. Binder was there or whether she spoke at the
18 meeting?

19 A. I know that Ms. Binder was there, and I know
20 counsel was there, but I can't remember exactly who
21 actually led the conversation.

1 Q. Okay.

2 Do you typically lead the conversations in
3 those meetings?

4 A. We have a formal agenda, and we have sometimes
5 different individuals leading different agenda items
6 depending on the item. But I would say I'm one of the
7 primary folks for doing that.

8 Q. Okay.

9 And then just going to the top email, this
10 is an email from you to Ms. Danforth later that day. Do
11 you see that?

12 A. Yes.

13 Q. And it looks -- you say -- it's three lines
14 down -- "I quickly pulled the breakdown of Spring 2025
15 grades by survey submission status. Will work on adding
16 in percentages." Do you see that?

17 A. Yes.

18 Q. Percentages. I just -- I assume that refers to
19 the percentages that these numbers reflect?

20 A. Correct.

21 Q. Okay. And why did you pull these stats?

1 A. To have ready for the expert panel an
2 understanding of how hospital grades break down by the
3 imputation status that Leapfrog uses or did use in the
4 Spring 2025 grades.

5 Q. And just so we're on the same page, can you
6 tell me in your words what's Step 1, what's Step 2?

7 A. Yeah. So Step 1 is that if the hospital has
8 completed a recent Leapfrog Hospital Survey, which I
9 believe is currently defined as within the last survey
10 cycle, that that historical information is used for the
11 hospital.

12 Step 2 is if the hospital does not have a
13 recent survey on record, there is an imputation
14 methodology that is laid out in the methodology document
15 that explains how those scores will be imputed.

16 Q. And just to be clear, the methodology document,
17 is it the one that's linked on the website that's about
18 28, 29 pages?

19 A. I would need to --

20 MS. LAWSON: Object to form but go ahead. Go
21 ahead.

1 THE WITNESS: I would need to see it to
2 confirm.

3 BY MR. CRAIN:

4 Q. Okay. Yeah, let me -- what did you mean when
5 you said the methodology document?

6 A. Leapfrog makes available a public document that
7 explains the Hospital Safety Grade methodology.

8 Q. We'll grab additional documents.

9 And then on Step 1, you said survey cycle.
10 How long is that?

11 A. So if the hospital had completed a survey --
12 this is where I'm doing this from memory. So this is
13 where --

14 Q. It's not a memory test.

15 A. -- I want to be -- I believe what we've changed
16 it to is if the hospital had completed a survey in the
17 prior survey cycle, so if you're looking at 2025, if
18 they completed a 2024 survey, we'll use the 2024 survey
19 results.

20 Q. Okay.

21 So each cycle, just so I understand, is

1 once a year?

2 A. The survey itself is a once-a-year cycle.

3 Q. And the grades are issued twice a year?

4 A. Correct.

5 Q. I think we have that document for you just to
6 make sure we're on the same page.

7 MR. CRAIN: So we'll mark this as Exhibit 3.
8 I'm taking good notes today.

9 (Exhibit No. 3 was marked for
10 identification as of 9/25/2025.)

11 BY MR. CRAIN:

12 Q. You'll see there are other exhibit markings --
13 oh, sorry.

14 You'll see there are other deposition
15 stickers on here, but is Exhibit 3 of your deposition
16 the document you're referring to?

17 A. Yes.

18 Q. Okay.

19 Is there another document you're aware of
20 that outlines the methodology besides this?

21 A. There is a second document that explains how

1 numerical scores are converted into letter grades.

2 Q. What's the name of that document?

3 A. I don't know the official name of it. It is
4 publicly available on Leapfrog's Hospital Safety Grade
5 website.

6 Q. Got it.

7 Does that document includes also the
8 imputation methodology?

9 A. It does not.

10 Q. Okay.

11 All right. Keep on going.

12 MR. CRAIN: And then just for completeness, can
13 we do 64. And then I'm going to mark this Exhibit 4.

14 (Exhibit No. 4 was marked for
15 identification as of 9/25/2025.)

16 BY MR. CRAIN:

17 Q. This is another email produced by the Armstrong
18 Institute. Do you see that on the bottom right?

19 A. Uh-huh.

20 Q. And it's -- the top one is from you to
21 Ms. Danforth, cc'ing our friend Ms. Wood across the

1 table. Is that correct?

2 A. Correct.

3 Q. And you say, "Missy, thanks so much for putting
4 me in touch with Courtney and Kim. I just spoke with
5 Jordan about the lawsuit. I've copied Jordan on the
6 email chain so he has Courtney and Kim's contact
7 information."

8 Do you see that email?

9 A. Yeah, I do.

10 Q. Do this reflect what we discussed earlier, the
11 discussions you had with Mr. Derk and with Wilson Elser?

12 A. Correct.

13 Q. Any other discussions beyond those talked about
14 in this email?

15 MS. LAWSON: Object to form.

16 BY MR. CRAIN:

17 Q. Yeah, let me fix it.

18 About the case?

19 A. I had had a -- yeah, I had had a conversation
20 with Jordan earlier that day.

21 Q. Okay.

1 A. We talked about the subpoena coming.

2 Q. Okay.

3 And did you have conversations, either
4 phone or Zoom or in person, with Ms. Wood and Ms. Blair?

5 A. On the 25th of July, I had a call scheduled
6 with The Leapfrog Group to discuss regular work. That
7 was the day that the subpoenas were issued for Jordan
8 and myself. So as I remember, Courtney and Kim joined
9 that call to talk about the subpoenas and that we should
10 contact Johns Hopkins University to let them know we
11 were receiving subpoenas, and also that we shouldn't be
12 chatting with our colleagues at The Leapfrog Group about
13 the lawsuit.

14 Q. Conventional wisdom.

15 A. Yeah. But that we could talk about regular
16 business.

17 Q. Okay.

18 One other question before we shift gears.
19 You came today with a folio.

20 A. Uh-huh.

21 Q. What's in that folio?

1 A. It's actually the subpoenas.

2 Q. Okay.

3 A. And my pad of paper and a pen.

4 Q. Okay. I have to ask.

5 And when you say "the subpoenas," you mean
6 the document and the deposition subpoenas that led to us
7 being here today?

8 A. Correct.

9 Q. Okay. Anything else?

10 A. No.

11 Q. Okay.

12 I want to shift gears and just talk a
13 little more about your history and your education.

14 A. Uh-huh.

15 Q. So you went to the University of Michigan for
16 undergraduate?

17 A. Correct.

18 Q. Go blue!

19 And you graduated in 1995?

20 A. Correct.

21 Q. You later went to the University of Wisconsin,

1 Madison, right?

2 A. Correct.

3 Q. Okay. And you graduated with a Masters of
4 Science in Industrial Systems Engineering?

5 A. Correct.

6 Q. And then you went on to do your Ph.D.?

7 A. Correct.

8 Q. And just in a brief nugget, what is your Ph.D.
9 in?

10 A. My Ph.D. is in Industrial and Systems
11 Engineering with a focus on Healthcare Systems.

12 Q. When did you start getting interested in
13 healthcare?

14 A. 2005.

15 Q. Okay. And that was during -- that was at
16 Wisconsin, Madison?

17 A. Prior to Wisconsin, Madison.

18 Q. Got it.

19 What were you doing then?

20 A. I actually was working for Continental
21 Airlines.

1 Q. Interesting. How did that convert into a
2 healthcare interest?

3 A. I was interested in transitioning out of the
4 airline industry, and healthcare felt like a prime
5 opportunity for that.

6 Q. Okay.

7 And then you earned your Ph.D. I think in
8 2011. Is that right?

9 A. Correct. Yeah.

10 Q. And then between I think 2008 and 2012, you
11 were a director for The Leapfrog Group. Is that right?

12 A. That was my title --

13 Q. Okay.

14 A. -- that Leapfrog gave me, but I was not
15 employed by The Leapfrog Group.

16 Q. Okay.

17 Let's, just to ground us, I'm going to give
18 you everybody's favorite. LinkedIn.

19 MR. CRAIN: This will be Exhibit 5.

20 (Exhibit No. 5 was marked for
21 identification as of 9/25/2025.)

1 BY MR. CRAIN:

2 Q. Dr. Austin, what I've handed you is what --
3 well, tell me what I've handed you.

4 A. This is what appears to be my LinkedIn profile.

5 Q. Does it look generally accurate to you?

6 A. It does.

7 Q. Great.

8 And just going back, because it's not a
9 memory test, so I figured I'd ground you on the dates,
10 it says you were a director of Leapfrog Hospital Survey
11 from January 2008 to May 2012. Do you see that?

12 A. Correct.

13 Q. Is that -- is that generally right?

14 A. That is -- I actually was employed by the
15 Center for Health Systems Research and Analysis. So my
16 employer was --

17 Q. Got it.

18 A. -- actually CHSRA.

19 Q. Okay. The one right below?
20
21

1 (Whereupon, the court reporter seeks
2 clarification, which colloquy will not be
3 captured on the written record.)

4 BY MR. CRAIN:

5 Q. So you said you were employed by CHSRA during
6 that period?

7 A. Correct.

8 Q. Okay.

9 And you said a moment ago you weren't
10 employed by Leapfrog then. Have you ever been employed
11 by Leapfrog?

12 A. No.

13 Q. Okay.

14 Can you tell us the nature of your title as
15 director?

16 A. So in my role as a researcher at the Center for
17 Health Systems Research and Analysis, I was on a
18 contract with a PI who had a contract -- PI, principal
19 investigator -- with The Leapfrog Group, and I was
20 helping support that work.

21 Leapfrog wanted me to have the title

1 director of Leapfrog Hospital Survey, but that was not
2 my official work title. My official work title at
3 University of Wisconsin was researcher.

4 Q. Was the relationship you had between CHSRA and
5 Leapfrog a contractual relationship?

6 A. Yes.

7 Q. Got it. So Leapfrog had a contract with CHSRA?

8 A. Correct.

9 Q. And who was the PI at the time?

10 A. Barb Rudolph.

11 Q. Okay. And who is she?

12 A. She -- Dr. Barb Rudolph, she has a Ph.D. in
13 social work. She was a senior scientist at the Center
14 for Health Systems Research and Analysis.

15 Q. And what was her role at Leapfrog?

16 A. She helped support them with their measurement
17 and public reporting activities.

18 Q. Was she on the Leapfrog board?

19 A. She was not.

20 Q. Okay.

21 And who was the -- I can't recall if it's

1 president or CEO, but who was the leader of Leapfrog at
2 the time?

3 A. So Suzanne Delbanco was the CEO at that time.

4 Q. Okay.

5 And when did Ms. Binder take that role?

6 A. I believe it was early 2008.

7 Q. Okay. So approximately at the start of your
8 time working with Leapfrog. Is that right?

9 A. So I actually started working with The Leapfrog
10 Group in March of 2007 as part of a student research
11 assistantship.

12 Q. Okay. Got it.

13 So Ms. Binder came in towards the first
14 year or two of your time?

15 A. Correct.

16 Q. Okay.

17 What were your responsibilities either as a
18 director or researcher at the time?

19 A. Yeah. So I was responsible for developing
20 survey questions, analyses of data, working with experts
21 on developing measures, measure specifications, scoring

1 algorithms. Really everything related to putting out a
2 survey around quality and safety of hospitals.

3 Q. And at that time, did Leapfrog assign hospital
4 safety grades?

5 A. No.

6 Q. Approximately, when did that start?

7 A. That started in the Spring of 2012.

8 Q. Okay. We'll come to that a little bit more.

9 Just to round out, after you left
10 Wisconsin, where did you go?

11 A. I came here to Baltimore and to Johns Hopkins
12 University.

13 Q. And you've been here for about 12 years. Is
14 that right?

15 A. Correct.

16 Q. And during that whole time, have you worked
17 with The Leapfrog Group continuously?

18 A. Technically, my contract with The Leapfrog
19 Group didn't start until I think July of 2012, and I had
20 arrived here in May.

21 Q. Got it.

1 A. So just to clarify that.

2 Q. So from July 2012 to the present?

3 A. Correct.

4 Q. I want to shift gears and just talk about your
5 relationship and Armstrong's relationship with Leapfrog.

6 A. Uh-huh.

7 Q. So you said before, I think, there's a
8 contractual relationship between Armstrong and Leapfrog.
9 Is that right?

10 A. Correct.

11 Q. Tell me generally about how that works.

12 A. Yeah. So I serve as the principal investigator
13 on the contract for a portion of my time. So as a
14 research faculty member, I need to cover my effort with
15 grants and contracts, and so Leapfrog is part of that
16 coverage for the work I do.

17 Q. And forgive me. I just don't know. Generally,
18 what is a principal investigator?

19 A. The lead, the lead on a grant or contract.

20 Q. Got it. Okay.

21 And you said it covers a certain portion of

1 your time. Approximately, what time percentage is that?

2 A. It has ranged between [REDACTED].

3 Q. [REDACTED]. Okay. [REDACTED]

4 [REDACTED] percent of your time?

5 A. Correct.

6 Q. And Leapfrog also covers funding for you,
7 correct?

8 A. That is the funding that I'm speaking of.

9 Q. Got it.

10 And does that come to you in the form of
11 compensation?

12 A. That money is paid to Johns Hopkins University
13 --

14 Q. Okay.

15 A. -- who pays me a salary.

16 Q. Got it.

17 Let's look at a couple of documents.

18 MR. CRAIN: Maybe start with -- let's start
19 with 4. I'm going to mark this Exhibit 6.

20 (Exhibit No. 6 was marked for
21 identification as of 9/25/2025.)

1 BY MR. CRAIN:

2 Q. So Dr. Austin, do you recognize this document?

3 A. I do.

4 Q. And it's another Armstrong-produced document,
5 right?

6 A. Correct.

7 Q. What is it?

8 A. This is the contract between Johns Hopkins
9 University and The Leapfrog Group.

10 Q. And this is a 2018 version. Do you see that?

11 A. Correct.

12 Q. And if you look at Fees and Payment, it's
13 number 4A on the first page. Do you see that?

14 A. Yes.

15 Q. And it says: "Contractor shall be paid a fee
16 not to exceed \$[REDACTED]." Do you see that?

17 A. Yes.

18 Q. Does this reflect the funding that you were
19 talking about, the payment to Armstrong?

20 A. The payment goes to Johns Hopkins University.

21 Q. Got it. Not specifically to Armstrong?

1 A. Correct.

2 Q. And then if we can keep going to page -- I'm
3 going to refer to these numbers as Bates numbers. Do
4 you know what I mean when I say that? And I can tell
5 you if not.

6 A. Page number?

7 Q. Bates numbers.

8 A. No, I don't know what that is.

9 Q. So Bates numbers are these Armstrong numbers on
10 the bottom right.

11 A. Oh, okay. Okay.

12 Q. They're just a stamp that folks give when they
13 produced. And for some reason, there are two of them on
14 these pages, but I'm going to look at the top little
15 one, which is the page number.

16 So if you could go to Armstrong ending in
17 Bates 006, which also happens to be page 6 of the
18 contract.

19 A. Uh-huh.

20 Q. And do you see there first at the top it's
21 signed by Erica Mobley and Thomas F. Burns? Do you see

1 that?

2 A. Yes.

3 Q. And Erica Mobley, who is she?

4 A. She was at the time the director of operations
5 for The Leapfrog Group.

6 Q. She's since moved on?

7 A. Correct.

8 Q. Okay.

9 And then there's a budget further down,
10 down there. Do you see that?

11 A. Uh-huh.

12 Q. And it sort of delineates faculty, analysts,
13 and a few other things. Do you see it says faculty
14 \$[REDACTED]?

15 A. Correct.

16 Q. And that says: "[REDACTED] percent of J. Matt Austin's
17 time." Do you see that?

18 A. Uh-huh.

19 Q. And that refers to you, correct?

20 A. Correct.

21 Q. And does that reflect an amount that's

1 earmarked to you ultimately at the end of the day, or
2 how does that work?

3 A. That is an amount that the university will bill
4 Leapfrog Group for my efforts on the project.

5 Q. Okay. So the university bills Leapfrog for
6 your time, correct?

7 A. Correct.

8 Q. Is it hourly or just a flat fee?

9 A. I don't know for sure.

10 Q. Got it. Okay.

11 And does your compensation rise with this
12 -- or rise -- let me strike that. Bad question. That's
13 the first of many bad questions today.

14 If Leapfrog didn't pay this money, would
15 that affect your compensation?

16 A. Can you clarify that?

17 Q. Yeah.

18 I'm trying to understand -- so this, you
19 said, doesn't get paid to you directly, correct?

20 A. Correct.

21 Q. It gets paid to the university, right?

1 A. Correct.

2 Q. And the university gives you a salary, right?

3 A. Correct.

4 Q. What is the relationship between your salary
5 and grants generally? Let's start with that.

6 A. So as a faculty member, I'm on a three-year
7 contract, and that contract is at risk for nonrenewal if
8 I'm not covering a portion of myself in terms of grants
9 and contracts.

10 Q. Got it. Okay.

11 A. So there would be long-term impact to -- if
12 Leapfrog didn't pay the money to the university, but the
13 short-term is that there isn't an impact. I still
14 receive my salary.

15 Q. Got it. Okay.

16 So it affects your future contract with the
17 university, if any, right?

18 A. Correct.

19 Q. Okay.

20 A. As one of many grants and contracts that I've
21 had.

1 Q. Yeah, how many --

2 A. So it's not --

3 Q. Can you ballpark how many do you have in a
4 year?

5 A. Most contracts or grants last multiple years.
6 In my 12 years at Hopkins, I've probably had 10 to 11
7 different grants and contracts.

8 Q. Okay. All toll. And that includes Leapfrog as
9 one of those 10?

10 A. Correct.

11 Q. Okay. And the reason I clarify is there are
12 multiple contracts, right?

13 A. Yeah, right.

14 Q. Yeah.

15 Okay. And then what -- so I understand
16 this number is not directly paid to you. Can you give a
17 ballpark of what percentage that number is of your total
18 compensation?

19 A. The [REDACTED] percent.

20 Q. So this \$[REDACTED] is [REDACTED] percent of your salary in
21 that year, correct?

1 A. Correct. And then direct costs are added in
2 overhead as well.

3 Q. Yeah. And those are things like -- like what?

4 A. That includes fringe rights, so coverage of
5 health benefits --

6 Q. Got it.

7 A. -- and that stuff and --

8 Q. Got it.

9 A. -- then the university tacks on a percentage.

10 Q. Commission.

11 A. Yeah.

12 MS. LAWSON: Objection.

13 MR. CRAIN: Fair enough.

14 BY MR. CRAIN:

15 Q. Okay. So I just want to go through a couple of
16 these. Over -- do you have a general sense of over
17 time -- so this is a 2018 contract, correct? Has the
18 grant amount changed during -- you know, in the
19 preceding -- in the last six years?

20 A. Can you clarify when you say the grant has
21 changed?

1 Q. Yeah.

2 So I'm trying to get a sense of where the
3 numbers have gone. So there's the total number we saw
4 on the first page that's paid to Johns Hopkins.

5 A. Uh-huh.

6 Q. Has that generally gone up year over year?

7 A. There has been some fluctuation.

8 Q. Okay.

9 A. I'm trying to -- so there have been times where
10 Leapfrog has requested additional researchers at Hopkins
11 be included in the work, and so just by pure numbers,
12 the value, the dollar value of the contract has gone up
13 for that.

14 Q. Okay.

15 A. My salary has changed over time. So it has
16 increased based on just sort of salary changes, and
17 there's been some fluctuation in efforts.

18 Q. So when your salary has changed, the number
19 sort of earmarked to you as a percentage of your salary
20 goes up, correct?

21 MS. LAWSON: Object to form, but you can

1 answer.

2 THE WITNESS: Yeah, I mean, right. Leapfrog is
3 paying for a portion of my effort, of my total effort,
4 right. So if my salary goes up, they're paying more for
5 the portion of the effort that they're paying for.

6 BY MR. CRAIN:

7 Q. And when you say a portion of your effort, just
8 so it's clear, that means like your time on the job?

9 A. Correct.

10 Q. Let's take a look just before we move off this.
11 I want to look at Exhibit A, which is page little number
12 7.

13 A. Uh-huh.

14 Q. And this -- it says scope of work. Do you see
15 that?

16 A. Yes.

17 Q. And are you familiar generally with -- it's a
18 couple -- it's a few pages. Are you familiar with the
19 scope?

20 A. Yes, I am.

21 Q. Does this accurately depict the scope of work,

1 I'll say plus or minus, that you performed in your role
2 for Leapfrog?

3 A. Yes.

4 Q. Okay.

5 And I want to focus on particularly page
6 little Bates 9. Do you see that?

7 A. Uh-huh.

8 Q. And there's -- about halfway down the page, it
9 says: "Manage the hospital safety score expert panel
10 process." Do you see that?

11 A. Uh-huh.

12 Q. And it says -- I think it's bullet A -- "Have
13 periodic communications with client-approved national
14 expert panel either via teleconferences and/or written
15 communication, to solicit guidance on: One, which
16 performance measures should be considered for inclusion
17 in future versions of the safety score composite; and,
18 two, suggested adjustments for weighting individual
19 measures within the composite. The polling of panel
20 members of these topics will involve the use of
21 structured communication techniques; e.g., the Delphi

1 method."

2 Do you see that paragraph?

3 A. Uh-huh.

4 Q. Does this reflect your work with the Hospital
5 Safety Grade expert panel?

6 A. It does generally reflect that work.

7 Q. What -- are there any meaningful differences
8 between this language and what you actually do?

9 A. We've moved away recently from doing formal
10 polling of panel members.

11 Q. Okay. Does that -- is that what the Delphi
12 method refers to?

13 A. Yeah, that would be a --

14 Q. What is the Delphi method?

15 A. The Delphi method is a -- an approach to gain
16 and understand consensus where you basically go through
17 different rounds of voting where based on the first
18 round, you sort of narrow down to a smaller subset and
19 work towards where there's consensus.

20 Q. And is that -- I see it in here, but is that
21 how it actually worked at the expert -- at the safety

1 grade expert panel?

2 A. In earlier meetings of the safety grade expert
3 panel, 2011, 2012, 2013, we did put a little more of a
4 focus on having a formal process for that.

5 Q. Okay.

6 And I think you said that you -- I don't
7 have the realtime, so I don't remember exactly what you
8 said, but you said in recent years, you've sort of
9 gotten rid of the polling feature. Is that what you
10 testified to?

11 A. Correct.

12 Q. And approximately, when did that dissipate?

13 A. Probably 2014, 2015.

14 Q. Okay. So a little while ago?

15 A. Yeah.

16 Q. Yeah, okay.

17 And then B says -- if you go back to the
18 document, it says: "Work with the national expert panel
19 to gain consensus on the direction of future versions of
20 the safety score composite and/or understand and
21 document the differences among panel members on their

1 future visions."

2 Do you see that as well?

3 A. Yes.

4 Q. Accurate depiction of what you've done for
5 Leapfrog over the years?

6 A. Yes.

7 Q. Okay.

8 And then C: "Understand the direction set
9 by client's Board of Directors on the hospital safety
10 score and keep the national expert panel conceptually
11 aligned with the board's direction."

12 Do you see that?

13 A. Yes.

14 Q. Is that -- so the first question is, is that an
15 accurate statement of what you've done for Leapfrog, you
16 know, since, let's say, 2018 to the present?

17 A. Yes. My one caveat is I think the Board of
18 Directors has been less hands-on with the safety grade
19 as they were early on.

20 Q. Okay. And when you say "early on," what time
21 period are we talking about?

1 A. 2011 through 2014.

2 Q. Okay.

3 So is it fair to say in the early days when
4 the safety grade was being created, the Board was more
5 active?

6 A. Yes, that would be a fair statement.

7 Q. And over the years, the Board has been less
8 involved with respect to changes to the safety grade
9 methodology?

10 A. I have become less involved in communicating
11 with Leapfrog's board. So I can't speak to what
12 Ms. Binder or Ms. Danforth have been communicating to
13 the Board but --

14 Q. Got it. Okay.

15 So let me ask it this way then. This
16 document says one of your services -- if you look at the
17 top, it says: "Contractor will provide client with the
18 following services: Understand the direction set by the
19 client's Board of Directors on the hospital safety
20 score."

21 Do you feel since those early days that

1 you've had a sense of the direction set by the Board of
2 Directors?

3 A. I have not received any feedback that the
4 direction we're going is conflicting with what the Board
5 would want to do.

6 Q. Okay.

7 And have you received feedback that it's
8 consistent with what the Board would want to do?

9 A. As mentioned, I don't have as much
10 communication with the Board members. So Leapfrog staff
11 is sort of the filter for that. So I have not heard any
12 feedback that it's one way or another.

13 Q. Okay. So your understanding comes from
14 Leapfrog staff?

15 A. Correct.

16 Q. And it's your understanding of what the
17 organization wants, as opposed to the Board?

18 MS. LAWSON: Object to form.

19 BY MR. CRAIN:

20 Q. Well, what is your understanding? I'm trying
21 to get a sense of do you have an understanding of what

1 the Board wants, or do you have an understanding of what
2 Leapfrog staff want?

3 A. My direction that I've been given has been from
4 Leapfrog staff.

5 Q. Okay.

6 A. I don't know if that represents their own
7 thoughts or it represents their own thoughts and the
8 Board. I can't speak to that piece.

9 Q. And when you say "staff," who are we talking
10 about?

11 A. Leah Binder, the CEO, and Missy Danforth, the
12 senior vice president of healthcare ratings.

13 Q. Are those folks your primary contacts for
14 Leapfrog?

15 A. Yes.

16 Q. Are there others as well that you interact
17 with?

18 A. A couple of Missy Danforth's direct reports, so
19 Katie Burgraff Stewart and Jean-Luc Tilly. I have quite
20 a bit of contact with them as well.

21 Q. And Ms. Campione?

1 A. Yes, and Alex as well.

2 Q. And what's Ms. Campione's role?

3 A. She -- I don't know her exact title, but she's
4 the one that supports the Hospital Safety Grade program
5 from Leapfrog's side in terms of the analytics and all
6 that goes with that.

7 Q. And does she work with you closely in that
8 regard?

9 A. Yeah.

10 Q. And Mr. Tilly, what's his role?

11 A. Jean-Luc Tilly has a couple of areas of the
12 Leapfrog Hospital Survey that he champions and leads, as
13 well the ambulatory surgery center survey.

14 Q. Okay.

15 And then Ms. Stewart, what's her role?

16 A. Once again, she has certain areas of the
17 Leapfrog Hospital Survey that she champions.

18 Q. Okay.

19 Who do you interact with most at Leapfrog?

20 A. Missy Danforth.

21 Q. Who is the second?

1 A. Probably Katie --

2 Q. Okay.

3 A. -- Stewart.

4 Q. Stewart, yeah.

5 Okay. Let's just keep going. Okay. You
6 can set that -- or wait, actually. Sorry. There's one
7 other thing I want to take a look at.

8 If you go to page 7, just one page back --

9 A. Uh-huh.

10 Q. -- and there's a list of services called manage
11 the research base. Do you see that?

12 A. Yes.

13 Q. Can you just say generally what that entails?

14 A. Yeah. So this item is related to the Leapfrog
15 annual hospital survey, and it's just sort of being
16 aware of where -- what performance measures have been
17 recently endorsed, which are sort of out there in
18 national programs, doing literature reviews on topics.
19 So basically, ensuring that the measures that Leapfrog
20 is using in its Leapfrog Hospital Survey are valid,
21 reliable, evidence-based measures.

1 Q. Got it.

2 So stepping back a little bit, Leapfrog has
3 its hospital survey and its safety grades, right?

4 A. Correct.

5 Q. Are those the primary, like, sides of the
6 house, so to speak?

7 A. Those are their two primary reporting
8 initiatives, but there is the Leapfrog Ambulatory
9 Surgery Center Survey as well.

10 Q. Are you involved in any capacity in all three?

11 A. I am in all three.

12 Q. You are what? Sorry.

13 A. I am involved in all three.

14 Q. Okay. I thought you said I am an author. I
15 was going to say an author of what? But I guess I'll
16 ask that question. Do you author any of the hospital
17 survey? Do you draft any of it?

18 A. I do draft some of the survey questions,
19 measure specifications, end notes, FAQs.

20 Q. A lot of work.

21 A. It is a lot of work, yeah.

1 Q. Do you review each iteration of the hospital
2 survey?

3 A. I do.

4 Q. Top to bottom?

5 A. Not top to bottom.

6 Q. Okay. I would think that would take some time.

7 A. Yeah.

8 Q. Yeah.

9 The survey is about 350 pages. Am I right?

10 A. Correct.

11 Q. Okay.

12 And then with respect to the safety grade,
13 can you just explain your role?

14 A. Yeah. So the role has been to provide Leapfrog
15 with guidance and recommendations on the methodology,
16 and that includes what measures should be included in
17 the safety grade, how we might assign relative weights
18 to each of those measures.

19 Are you asking about currently or sort of
20 historically through the last 11 years?

21 Q. Fair question. I guess I'll start with has it

1 changed meaningfully in the past 11 years?

2 A. I would assess that my role has actually
3 diminished as Alex, Leapfrog, has gained more sort of
4 independence in what they're doing.

5 Q. Got it.

6 So let me ask you about that. The contract
7 in here says that you're being retained to provide
8 strategic -- let me just find the right word. What does
9 it say? Strategic counseling I think. Is that the --
10 do you recall that language?

11 A. I don't recall that language. The language I
12 typically use is to say strategic guidance.

13 Q. Guidance. That's it. Yeah, it's on page 7
14 under background, second paragraph, last sentence. You
15 see it says --

16 A. Uh-huh.

17 Q. -- you were retained to provide client, meaning
18 Leapfrog, with strategic guidance. Do you see that?

19 A. Uh-huh.

20 Q. So to your point of Leapfrog gaining more
21 independence, has the need for strategic guidance

1 diminished over the years?

2 A. Not for strategic guidance, no.

3 Q. So what is diminished as compared to strategic
4 guidance?

5 A. So as an example, in the early years of the
6 Hospital Safety Grade, I actually would be the one to
7 put together a histogram of the hospital safety scores
8 from the prior round, the current round, and we would
9 discuss that as a group in terms of what changes we were
10 seeing. That is now something that Alex would do.

11 So there's sort of an analytic piece that
12 has moved more internal to Leapfrog --

13 Q. Got it. Okay.

14 A. -- but not the strategic guidance part.

15 Q. And just what does strategic guidance mean?

16 A. Yeah. Strategic guidance is thinking about
17 what measures do we currently have in the composite
18 score, what are the changes that are happening like
19 within national programs, CMS, like measures that might
20 be retired, what are new measures that are out there,
21 what are gaps that we would like to try to fill, and are

1 there measures out there that we could use for that.

2 So it's trying to sort of think about
3 what's the right combination of measures to have in a
4 composite score of patient safety and then to also help
5 them think about how we might relatively weight those
6 against each other.

7 Q. So fair to say it's like more holistic as
8 opposed to something more granular that Ms. Campione
9 might do?

10 A. Correct.

11 Q. Okay.

12 I'm not going to put every contract in
13 front of you. You see me flipping.

14 Let me ask a question about just grants
15 before we move on.

16 A. Uh-huh.

17 Q. So you said, for instance -- so we see in the
18 contracts the percentage has changed over time as well,
19 that the grant towards your salary goes to. Do you
20 recall that?

21 A. Correct.

1 Q. Okay.

2 So we saw in 2018 the number allocated to
3 you was ■ percent, right? Of the remaining ■ percent,
4 does that come from other grants?

5 A. Correct.

6 Q. Okay. And how many grants fill that ■,
7 ballpark?

8 A. Two or three depending on the size of them.

9 Q. Okay. And are any of them as significant in
10 proportion as Leapfrog?

11 Let me -- let me -- that's a sort of
12 unwieldy question. Let me fix that. I saw you
13 thinking. So I'll build it a little more clearly.

14 So in 2018, the amount allocated to your
15 salary was ■ percent. Is that right?

16 A. Correct.

17 Q. Okay.

18 You said of the remaining ■ percent, there
19 were two or three other grants that filled that,
20 essentially, right?

21 A. Correct.

1 Q. Are any of those two to three grants also
2 ■ percent?

3 MS. LAWSON: And are you asking just specific
4 to 2018?

5 BY MR. CRAIN:

6 Q. Specific to 2018, yeah, if you recall.

7 A. I don't recall, but I could find that out.

8 Q. Okay.

9 A. I just don't remember offhand.

10 Q. Generally, you know, to the extent you know, do
11 you -- have you had other grants that were the same
12 significance in size as Leapfrog over the years?

13 A. This would be the most significant --

14 Q. Okay.

15 A. -- ongoing contract.

16 Q. Okay. Got it.

17 And the other two or three grants, as a
18 percentage of your compensation, can you ballpark
19 generally what they are?

20 MS. LAWSON: Object -- objection to form. And
21 maybe if you can clarify over time --

1 MR. CRAIN: Yeah.

2 MS. LAWSON: -- because I think he testified
3 earlier that he's had like nine or ten other grants.

4 MR. CRAIN: Yeah, I hear you.

5 MS. LAWSON: Yeah.

6 BY MR. CRAIN:

7 Q. So in a given year, let's say between 2018 and
8 2025, the other grants that are not Leapfrog, if you
9 can, approximately what percentage of your compensation
10 do they -- are they?

11 A. It varies from year to year. I'm more trying
12 to just think about what's on my CV and what those
13 efforts are. They might total up to another ■ percent.

14 Q. Total. Okay. Got it. Okay, so --

15 A. So a typical breakdown might be one that's ■,
16 one that's ■, and one that's ■.

17 Q. Okay. Got it. Okay. And I didn't mean it to
18 be a memory test.

19 A. No, no, no, no, no. I'm trying to answer
20 truthfully, but I don't really remember.

21 Q. Just your best estimate.

1 A. My best estimate, yeah.

2 Q. Okay.

3 MS. LAWSON: And if you're not sure, it's okay
4 to tell him that you're not sure because he wants to
5 know --

6 MR. CRAIN: Yeah.

7 MS. LAWSON: -- what you know.

8 THE WITNESS: Okay.

9 MR. CRAIN: I'm not asking you to guess.

10 THE WITNESS: Okay. Okay.

11 MS. LAWSON: Yes, he's not asking you to guess.

12 THE WITNESS: Okay.

13 MR. CRAIN: But your best estimate --

14 THE WITNESS: Okay.

15 MR. CRAIN: -- approximation as the expert of
16 you.

17 THE WITNESS: Right. Okay.

18 BY MR. CRAIN:

19 Q. So let's shift gears a little bit. Are you
20 doing okay on time?

21 A. Yeah.

1 Q. Okay, good. I mean break.

2 A. Yeah.

3 Q. Okay.

4 So I want to talk a little bit more about
5 the safety grade and what it does and what's it's
6 purpose. So --

7 MS. LAWSON: Actually, if we're going to
8 totally switch gears --

9 MR. CRAIN: Yeah. You want to --

10 MS. LAWSON: -- do you mind if we take a --

11 MR. CRAIN: Yeah, yeah. No, now is fine.

12 MS. LAWSON: A break? Yeah.

13 MR. CRAIN: Yeah. Good.

14 THE VIDEOGRAPHER: This marks the end of media
15 unit number two. We're going off the record. The time
16 is 10:05 a.m.

17 THE COURT REPORTER: This gives us a chance to
18 get the realtime going, too.

19 MR. CRAIN: Oh, yeah.

20

21

1 (Whereupon a short break was had, after
2 which the proceedings continued as
3 follows:)

4 (Exhibit No. 7 was marked for
5 identification as of 9/25/2025.)

6 THE VIDEOGRAPHER: This marks the beginning of
7 media unit number three. We're going back on the
8 record. The time is 10:22 a.m.

9 BY MR. CRAIN:

10 Q. Welcome back, Dr. Austin.

11 A. Thank you.

12 Q. It's like a commercial break on TV.

13 So I've given you what's been marked as
14 Exhibit 7. Do you recognize this document?

15 A. I do not.

16 Q. Okay. So I'll represent to you this is from
17 the Leapfrog Safety Grade website,
18 hospitalsafetygrades.org. Is that familiar to your?

19 A. I'm familiar with that website.

20 Q. Do you know -- like, are you -- do you look at
21 the website periodically or no?

1 A. Once in a great while.

2 Q. Okay.

3 So I'm just going to -- I sort of want to
4 walk through what the safety grade is and focus on some
5 of the language in this document if we can. And I -- so
6 starting with paragraph -- the first paragraph, you see
7 there's a sentence "the purpose" -- do you see that --

8 A. Uh-huh.

9 Q. -- at the bottom?

10 A. Uh-huh.

11 Q. "The purpose of the Leapfrog Hospital Safety
12 Grade is to bring this information to light in a way
13 that's easy for you, the consumer, to use."

14 I realize it says "this information," so I
15 probably need to go back. So I'll start at the top.

16 "One of the most significant problems with
17 today's healthcare system is the failure to make safety
18 and quality information available to the public. But
19 the public deserves this information so they can make
20 informed choices about where to receive care.

21 "The purpose of the Leapfrog Hospital

1 Safety Grade is to bring this information to light in a
2 way that's easy for you, the consumer, to use."

3 Do you see that?

4 A. Yep, I do.

5 Q. Do you agree with that paragraph?

6 MS. LAWSON: So I'll just object to form.

7 And just I want to clarify. I think
8 Dr. Austin, you testified you had not seen this before.

9 THE WITNESS: Correct.

10 I would generally agree. I would maybe
11 reframe the first sentence slightly differently.

12 BY MR. CRAIN:

13 Q. How so?

14 A. I might say that one of the significant
15 problems of today's healthcare system is how to best
16 share safety and quality information with the public.

17 Q. Okay.

18 A. I think information is available. I think
19 we've struggled to help people connect to that.

20 Q. So the difference being the failure language?

21 A. Yeah. I wouldn't say failure to make.

1 Q. Okay.

2 And then do you agree that the purpose of
3 the Leapfrog Hospital Safety Grade is to bring this
4 information to light in a way that it's easy for you,
5 the consumer, to use?

6 A. Yes.

7 Q. Okay.

8 And then is it right that -- if you go down
9 to the second page -- "Our letter grade scoring system
10 allows consumers to quickly assess the safety of their
11 local hospital and choose the safest hospital to seek
12 care." Do you see that?

13 A. Yes.

14 Q. Do you agree with that statement?

15 A. Yes.

16 Q. And then it says: "As consumers use the
17 Leapfrog Hospital Safety Grade more and more, we hope
18 more hospitals will be compelled to be open about their
19 safety and quality and participate in meaningful public
20 reporting."

21 Do you see that as well?

1 A. I do.

2 Q. And do you agree with that sentiment?

3 A. I don't know what the evidence or research
4 supporting the first clause is. I wouldn't necessarily
5 be able to speak to that part, about whether consumers
6 are using the safety grade more and more, but I would
7 agree with the last part.

8 Q. The last part being we hope more hospitals will
9 be compelled to be open about their safety and quality
10 and participate in meaningful public reporting?

11 A. Yes.

12 Q. Okay.

13 And just to be clear, do you have any role
14 in the creation, drafting, revision of Leapfrog's
15 websites?

16 A. If I'm asked to review something, I will review
17 it --

18 Q. Okay.

19 A. -- and provide back comments and feedback. But
20 they don't ask me to review every single thing on their
21 website.

1 Q. Okay. How often do they ask you to review the
2 website?

3 MS. LAWSON: Object to form.

4 BY MR. CRAIN:

5 Q. Generally, just over, you know, the last six
6 years.

7 A. Not very often. I mean, I don't know
8 everything that's on their website. You know, so I
9 don't know what the full scope is, so I can't speak
10 to --

11 Q. No, I hear you. Just so we're on the same
12 page, I'm talking about hospitalsafetygrades.org.

13 A. Right.

14 Q. Are you familiar generally with that website?

15 A. Right. Yeah, yeah, yeah, yeah. Right.

16 Q. And Leapfrog -- I forget the other one but the
17 Leapfrog.org website.

18 A. Uh-huh, right.

19 Q. And one of them refers typically to the survey,
20 right?

21 A. Uh-huh.

1 Q. And the other one is about the safety grades,
2 correct?

3 A. Correct.

4 Q. And do you have any specific recollection
5 sitting here today of any particular page on either of
6 those two websites you were asked to opine on?

7 A. I don't remember exactly. I'm sure through
8 12 years there has been something that I have reviewed,
9 but I couldn't speak to what that is and if it's still
10 up or if it's been taken down.

11 Q. Just asking for your memory today.

12 A. Yeah, yeah. I don't. I don't know.

13 Q. And just to fine-tune it a little bit, do you
14 have any specific recollection of opining on any part of
15 the website regarding the imputation methodology?

16 A. Can you be more specific with what exactly
17 you're referencing there?

18 Q. Yeah. So are you aware of any part of
19 Leapfrog's website that articulates its imputation
20 methodology on the safety grades for nonparticipating
21 hospitals in the survey?

1 A. I know there's some information in a prior
2 exhibit that we discussed that talks about the
3 imputation. I don't know if there's something on a
4 webpage itself. I just don't know what is actually --
5 what all the pages are and what's on them.

6 Q. Okay. Just to my question, do you have any
7 specific memory --

8 A. No, I don't have any specific memory.

9 Q. Let me just finish the question so it's clear.

10 Do you have any specific memory of being
11 asked the opine or otherwise opining on any portion of
12 Leapfrog's website regarding the imputation methodology?

13 A. I don't remember being asked to do that.

14 Q. Okay.

15 MR. CRAIN: Let's go to 67. I'll mark another
16 document. This will be Exhibit 8.

17 (Exhibit No. 8 was marked for
18 identification as of 9/25/2025.)

19 BY MR. CRAIN:

20 Q. Dr. Austin, do you recognize this document?

21 A. I recognize that this is a printout of a

1 webpage from Leapfrog's Hospital Safety Grade website.

2 Q. Do you have any reason to think that it's not
3 an accurate depiction of the website?

4 A. No, I have no reason to think so.

5 Q. Are you familiar generally with the "About the
6 Grade" website?

7 A. I'm familiar with that webpage, yes.

8 Q. I want to ask you a couple of questions about
9 the language on this page, just to your understanding.
10 Did you -- do you recall having any role in drafting
11 this page?

12 A. It is possible but I don't remember exactly
13 today.

14 Q. So page 1 -- and I apologize. There's no page
15 numbers on it but the first page and the second
16 paragraph, it says: "The Leapfrog Hospital Safety Grade
17 uses up to 30 national performance measures from the
18 Centers for Medicare & Medicaid Services, CMS, the
19 Leapfrog Hospital Survey, and information from other
20 sources of supplemental data."

21 Do you see that?

1 A. Yes.

2 Q. Is that a correct articulation of what the
3 Leapfrog Hospital Safety Grade uses?

4 A. That represents a summary of what has been the
5 formation of the Hospital Safety Grade in sort of its
6 entirety.

7 Q. Okay, fair enough. So let me ask you it this
8 way. Is that correct for the methodology as it exists
9 today?

10 A. Yes, minus that currently the safety grade I do
11 not believe is using information from other supplemental
12 data sources.

13 Q. Okay. What is the safety grade currently using
14 as a data source?

15 A. We're using data from the Centers for Medicare
16 & Medicaid Services and from the Leapfrog Hospital
17 Survey.

18 Q. Okay. So today there's no other supplemental
19 data sources being used with the grade, correct?

20 A. That is my recollection from the current
21 methodology.

1 Q. And when did that change? Approximately.

2 MS. LAWSON: So it really is a memory test.

3 THE WITNESS: It is a memory test.

4 BY MR. CRAIN:

5 Q. If he has a memory.

6 A. I don't know the year.

7 Q. Okay. Let me refresh your recollection a
8 little bit.

9 A. Okay.

10 Q. So in 2024, am I right that the imputation
11 methodology changed?

12 A. That is my recollection, yes.

13 Q. And then prior to that, there was a different
14 imputation methodology, right?

15 A. Correct. We've actually used four or five
16 different imputation methodologies over the 11, 12 years
17 of the Hospital Safety Grade.

18 Q. Okay.

19 Can you, at a high level, I'm not asking
20 for a memory test, just generally trace what you recall
21 of those four or five different models?

1 A. Yeah, yeah, yeah.

2 So when we met with the expert panel early
3 on to talk about the idea of the Hospital Safety Grade,
4 one of the identified issues was that we were likely to
5 encounter missing data, and how did we want to address
6 the issue of missing data.

7 The expert panel laid out five different
8 ideas of sort of generally-accepted approaches of how
9 that has been addressed.

10 The -- if I can remember the five --

11 Q. I can show you a document.

12 A. Okay.

13 And so we started initially with if we
14 didn't have data for a hospital for our measure, we
15 ignored that measure and put greater weight on the
16 measures for which we did have data. That evolved into
17 using supplementary data sources, specifically the
18 American Hospital Association survey was one of the key
19 data sources for that.

20 That evolved into calculating or assigning
21 the mean performance for hospitals based on cohorts, so

1 sort of the national mean based on the cohort that the
2 hospital fell into, and that has since evolved into
3 assigning the hospitals a lower performance score.

4 Q. That's the current methodology?

5 A. That's the current methodology.

6 Q. And when you say "lower performance score,"
7 that's limited achievement?

8 A. That is correct, how Leapfrog has
9 operationalized that.

10 Q. And in the current model, am I right that there
11 are two steps, right? The first step is the historical,
12 as you said earlier?

13 A. Correct.

14 Q. The second step is the limited achievement that
15 you were referring to, correct?

16 A. Correct.

17 Q. Okay.

18 So going back to the document, when we talk
19 about supplemental data sources, generally, am I right
20 that the AHA data was a supplemental data source?

21 A. Correct.

1 Q. And AHA is American Hospital Association?

2 A. Correct.

3 Q. I always mess that up. That's my aha moment.
4 I've been playing with that one.

5 MS. LAWSON: You delivered it well.

6 MR. CRAIN: Thank you. I'm going to use that
7 one at trial.

8 BY MR. CRAIN:

9 Q. So other forms of supplemental data, is there
10 any -- because CMS is not supplemental data, right?
11 Because it's covered on this page otherwise, correct?

12 A. Correct.

13 Q. Are there any other supplemental data that you
14 can recall Leapfrog using in the Hospital Safety Grade
15 scoring at any time?

16 A. Yes. So the American Hospital Association did
17 a separate survey around health information technology,
18 and we did use that to inform the scores for
19 computerized prescriber order entry. And that's one
20 that comes to my mind. There's none others that
21 immediately come to my mind, but that's not to say there

1 weren't others.

2 Q. Okay.

3 A. I just don't recall.

4 Q. Yeah, okay. So that's helpful.

5 I want to keep going down this document.

6 If you go to the bottom of that paragraph: "The
7 Leapfrog Hospital Safety Grade methodology has been peer
8 reviewed and published in the Journal of Patient
9 Safety."

10 Do you see that?

11 A. Yes.

12 Q. Now, does the Journal of Patient Safety --
13 there's a hyperlink there. Do you see that?

14 A. Uh-huh.

15 Q. And I don't have the document with me, but I'll
16 represent to you it goes to what I think is a 2014
17 article.

18 A. Correct.

19 Q. Does that article, the peer review that this
20 sentence is talking about to your knowledge?

21 A. Yes.

1 Q. And what does peer review mean, generally?

2 A. Peer reviewed, in at least the medical world,
3 which is really the only world I know, so that's all I
4 can speak to, when you submit to a journal, they
5 actually identify two to three external individuals to
6 actually read the manuscript, provide feedback, provide
7 recommendations of how to improve it. Those go back to
8 the editor of the journal, and the editor makes the
9 decision of what to share back with the authors in terms
10 of requested updates or revisions.

11 The peer reviewers could decide -- could
12 recommend that the article be rejected, right. They
13 don't feel like it's a high enough quality. And so it's
14 a process to sort of have some external review of the
15 work.

16 Q. And the 2014 article was peer reviewed?

17 A. Correct.

18 Q. Do you recall generally by whom?

19 A. I don't -- as an author, you're unaware of who
20 the peer reviewers are.

21 Q. Oh, interesting.

1 A. There's a movement recently toward moving --
2 making that transparent, but that has not necessarily
3 been the practice.

4 Q. Got it. Okay.

5 Do you remember any feedback they gave on
6 the article?

7 A. You're really testing my memory here.

8 Q. If you don't, that's okay.

9 A. Yeah, I don't. That was 10 years ago, 11 years
10 ago. I don't remember. I'm sure there was feedback
11 from -- almost every article has some degree of
12 feedback, but I don't remember what the feedback was or
13 to the degree.

14 Q. And I don't at all mean to stretch your memory.
15 If you don't remember --

16 A. Right. I don't.

17 Q. -- that's a perfectly fine answer, yeah, but I
18 have to ask.

19 So now going back, this article, it
20 analyzes an older methodology, right?

21 A. Correct. It was the methodology that was in

1 place at the time for the Hospital Safety Grade.

2 Q. In 2014, correct?

3 A. 2014, although -- it got published in 2014. We
4 wrote it in 2013, so this is probably an earlier
5 version.

6 Q. So do you think it's fair to say that the
7 current methodology has been peer reviewed?

8 A. I think it's fair to say that the general
9 approach remains consistent from 2013, 2014. The
10 individual measures that are included in the safety
11 grade has evolved over time.

12 Q. And just to be clear, though, to my question,
13 is it a fair statement to say the Leapfrog Hospital
14 Safety Grade methodology has been peer reviewed and
15 published in the Journal of Patient Safety in 2025?

16 A. I could argue that it does not say the current
17 Leapfrog Hospital Safety Grade methodology. It just
18 says that the methodology has been peer reviewed.

19 Q. If this is on the public consumer-facing
20 website today, do you think the consumer would
21 understand, looking at this, that this is referring to a

1 2014 methodology, not a 2025 methodology?

2 MS. LAWSON: Object to form. Go ahead.

3 BY MR. CRAIN:

4 Q. You can answer.

5 MS. LAWSON: You can answer.

6 THE WITNESS: I don't know what a consumer
7 would think or not think. Like, I haven't studied that.

8 BY MR. CRAIN:

9 Q. When you first -- this was the first time you
10 recall reading this sentence in a while, at least,
11 right?

12 A. The sentence meaning the one about the patient
13 safety?

14 Q. No, the one I read back to you. The Leapfrog
15 Hospital Safety Grade methodology has been peer reviewed
16 and published in the Journal of Patient Safety.

17 A. Uh-huh.

18 Q. You knew what that referred to, right?

19 A. Yes, I did.

20 Q. Did you think to yourself that's the same for
21 2025 as it was for 2014?

1 MS. LAWSON: Object to form, but you can
2 answer.

3 THE WITNESS: As I mentioned, I think the
4 general format of what we're doing with a composite
5 score made up of 25 measures that are weighted in two
6 domains remains consistent and solid throughout that
7 time frame.

8 Measures, for whatever -- I mean, measures
9 are going to come and go, right. CMS makes decisions
10 about retiring certain measures. They've added new
11 measures. So the safety grade does continue to evolve,
12 and I would say appropriately, right, like to sort of
13 keep up with the latest information and evidence.

14 BY MR. CRAIN:

15 Q. Has the imputation methodology or the
16 imputation model been peer reviewed?

17 A. That has not.

18 Q. Okay.

19 Okay. Let's keep going. I want to go to
20 -- let's see. Here we go. It's -- and I apologize.
21 There's no page number. If you go to the document, it's

1 the first, second, third, fourth, fifth page to the
2 paragraph starting "A hospital."

3 A. Uh-huh.

4 Q. Do you see that?

5 A. Yep.

6 Q. "A hospital must have enough safety data
7 available for our experts to issue them a letter grade.
8 Hospitals missing more than six process measures, more
9 than five outcome measures, or PSI90 are not graded.
10 All hospitals are encouraged to voluntarily report
11 additional safety data through the Leapfrog Hospital
12 Survey, but they are not required to do so to receive a
13 safety grade."

14 Do you see that language?

15 A. I do.

16 Q. So let's start with process measures. Do you
17 see it says hospitals missing more than six process
18 measures...are not graded?

19 A. Uh-huh.

20 Q. Is that an accurate statement?

21 A. As far as I know. I'm not the one implementing

1 the methodology, so I don't -- I can't speak to --

2 Q. Fair enough.

3 A. -- how it got implemented.

4 Q. Yeah, let me fix the question.

5 Based on your knowledge of how the
6 methodology works, not whether it's been implemented
7 faithfully or not, but purely based on your
8 understanding of the methodology, is that an accurate
9 explanation or articulation of the methodology?

10 A. Yes.

11 Q. Okay.

12 A. That is what we have set as minimum data
13 thresholds.

14 Q. So I want to talk about some process measures.
15 BCMA, are you familiar with that term?

16 A. Uh-huh.

17 Q. What is BCMA?

18 A. Barcode medication administration.

19 Q. And what is CPOE?

20 A. Computerized physician order entry.

21 Q. And you're familiar with hand hygiene?

1 A. Correct.

2 Q. As a measure, not generally.

3 And are you familiar with IC -- IPS?

4 A. Yes, ICU physician staffing.

5 Q. And those I'm going to generally talk about now
6 as we move forward as the four imputed measures.

7 A. Uh-huh.

8 Q. Do you understand what I'm talking about?

9 A. Uh-huh. Yes, I do.

10 Q. When a hospital does not report to Leapfrog's
11 survey, does Leapfrog have any data about the hospital's
12 performance on any of those four measures?

13 A. In the imputation method for Step 1, if a
14 hospital submitted a survey in the prior year, there may
15 be data on one or more of those four measures.

16 Q. Fair enough. What about for Step 2?

17 A. For Step 2, there wouldn't be recent data,
18 right. So there wouldn't be either a survey that was
19 submitted the prior year or a survey submitted this
20 year.

21 Q. Yeah. So if a hospital has never reported to

1 Leapfrog's survey, is it fair to say that Leapfrog has
2 no data on the actual performance of that hospital on
3 those four imputed measures?

4 A. We do not have any data that's been reported
5 through the survey, correct.

6 Q. So why is that not missing data?

7 A. Some I guess it could be one's definition of
8 missing. Those missing data thresholds were really
9 intended to not assign grades to small hospitals that
10 may not have enough data from CMS. So, as an example,
11 there are smaller hospitals that may not have had enough
12 central lines inserted during the reporting period to
13 actually have a central line associated blood stream
14 infection rate.

15 And so the intent of those missing data
16 thresholds was really to make sure we weren't assigning
17 grades to hospitals for which we had unreliable
18 information. It was not necessarily intended to allow
19 hospitals not to report.

20 Q. So is missing data really supposed to be absent
21 data? Like, you mentioned folks that don't have enough

1 central lines.

2 A. Missing data would refer to a measure for which
3 we don't have a value.

4 Q. And so just to put it concretely, when you say
5 "we don't have a value," who do you mean?

6 A. Meaning The Leapfrog Group doesn't have a
7 value.

8 Q. So how is that different -- so one of my
9 clients is Delray Medical Center in Florida, right. And
10 we always use Delray as the example. I don't know why,
11 but Delray is the example. We can pick any of them.

12 Leapfrog gave Delray a limited achievement
13 for hand hygiene. Are you generally aware of that?

14 A. I have not reviewed Delray's results but I --

15 Q. But you understand, as the plaintiff in this
16 case, it's a nonparticipating hospital, right?

17 A. Yes, that's my understanding.

18 Q. And it's -- one of the core elements of the
19 case is the Step 2 methodology, right, for imputation?

20 A. Correct.

21 Q. So based on that, you understand that Leapfrog

1 gave Delray a limited achievement for hand hygiene,
2 right?

3 A. That would be my understanding of how that
4 would get applied.

5 Q. And but -- so there's -- to your point a minute
6 ago, which I've now lost but I will find, you said
7 missing data would refer to a measure for which we don't
8 have a value. Isn't it right that Leapfrog has no value
9 for hand hygiene for Delray?

10 A. That would be correct.

11 Q. Okay.

12 So this paragraph is not correct, right,
13 the one we looked at on the document?

14 A. I think the distinction I would make is whether
15 an imputed score is considered missing or if it's
16 considered a value.

17 Q. You're going to have to say more about that
18 one. What do you mean by that?

19 A. Right. So Leapfrog imputed a score for Delray
20 for hand hygiene of 15 points out of 100.

21 Q. Yes.

1 A. So to me it sort of comes down to is that -- we
2 have a score for Delray for that measure. So it's not
3 missing.

4 Q. And how did Leapfrog pick that score?

5 A. Leapfrog -- so the reason Leapfrog chose
6 limited achievement is that has always been the bottom
7 performance category and it -- basically, given the lack
8 of information that we have about the hospital's
9 performance in hand hygiene, it felt like that was the
10 appropriate score to give, given the absence of
11 information that would tell us something otherwise, that
12 they were performing on a higher level.

13 Q. So is the assumption that Delray is performing
14 at the lowest level for hand wipe -- hand hygiene?

15 A. Given the lack of other information from them,
16 that is our assumption.

17 Q. One of the things that hand hygiene evaluates
18 is whether a hospital has a handwashing policy, right?

19 Let me strike that.

20 One of the things that the survey asks
21 about handwashing is about handwashing training. Are

1 you aware --

2 A. Correct. Yes.

3 Q. Do you have any knowledge of any hospital that
4 does not train doctors and nurses on hand hygiene?

5 MS. LAWSON: Object to form. You can answer.

6 BY MR. CRAIN:

7 Q. Your knowledge.

8 A. There are -- to be clear, what's asked in this
9 survey isn't just about training. It's the way that the
10 training is done, who is trained, and that was not
11 necessarily universally done across all hospitals. So
12 it extends just beyond training employees.

13 Q. Okay. Fair enough.

14 So coming back to this document again, so
15 the four imputed measures, do you agree that they are
16 process measures?

17 A. They are considered either process or
18 structural measures.

19 Q. But in terms of -- I understand that Leapfrog
20 puts its measures into two buckets, process or
21 structural or outcome. Is that right?

1 A. Correct.

2 Q. They all fit the process or structural, right?

3 A. Correct.

4 Q. There are also three others, three other
5 process measures that when a nonreporting hospital is
6 graded are left out of the scoring methodology, right?

7 A. Can you clarify that?

8 Q. Yeah.

9 Are you familiar with safe practice one?

10 A. Yes.

11 Q. And can you remind me what it is? If you
12 don't, I can pull it out.

13 A. Yeah, it's like leadership.

14 Q. Yeah. And are you familiar with safe practice
15 two?

16 A. Yes, which is culture measurement.

17 Q. And are you familiar with total nursing care
18 per patient hour?

19 A. Yes.

20 Q. Those are the three measures that -- for
21 nonparticipating hospitals that do not go into the

1 grade, correct?

2 A. Those are not imputed, correct.

3 Q. Those are not imputed. They're just discarded,
4 right?

5 A. They are ignored, and their relative weights
6 are assigned proportionately to the others.

7 Q. Redistributed, right?

8 A. Redistributed.

9 Q. Yeah. I don't mean to put words in your mouth,
10 but I think it's the word I've seen.

11 So then those are process and structural
12 measures, too, right?

13 A. Correct.

14 Q. So that's seven, right?

15 A. Correct.

16 Q. Okay.

17 And just to be clear, this document doesn't
18 say -- this is the Leapfrog website. I'm looking at it
19 again. Hospitals missing more than six process measures
20 are not graded. That's what it says. It doesn't say
21 hospitals -- strike that.

1 We just walked through Leapfrog does not
2 have data for seven process measures, right?

3 MS. LAWSON: Object to form. You can answer.

4 THE WITNESS: Okay.

5 BY MR. CRAIN:

6 Q. If you're confused, I can rephrase. Let me
7 build it up.

8 So we talked about the four imputed
9 measures, right?

10 A. Correct.

11 Q. We talked about the three what I'll call
12 discarded measures, correct? Do you understand what I'm
13 saying when I say that?

14 A. Yeah, I know the three you're referring to.

15 Q. And they're all process or structural measures,
16 right?

17 A. Correct.

18 Q. And there are seven of them?

19 A. Correct.

20 Q. And yet this document tells consumers that
21 hospitals missing more than six process measures are not

1 graded. Do you see that?

2 A. That is what the document says.

3 Q. And can you tell me again why that's accurate?

4 A. For me, it comes back to the question of is it
5 an imputed score, a score, or is it missing. And I
6 would argue it's a score. So for those four imputed
7 measures, those hospitals have scores. They aren't
8 missing data.

9 Q. Aren't missing data even though Leapfrog has no
10 data for those scores?

11 A. Even though Leapfrog does not have any
12 information that was reported by the hospital through
13 the Leapfrog Hospital Survey.

14 Q. Okay.

15 Okay. All right. Let's keep going. I
16 want to also talk about -- let's see if it's on this
17 page.

18 MR. CRAIN: Can we go to tab 65. This will be
19 Exhibit 9.

20 (Exhibit No. 9 was marked for
21 identification as of 9/25/2025.)

1 BY MR. CRAIN:

2 Q. So Dr. Austin, I've been giving you a document.
3 This one has, fortunately, a URL at the bottom. Do you
4 see that?

5 A. Uh-huh.

6 Q. And has page numbers, fortunately, too.

7 Do you recognize this document?

8 A. I do not.

9 Q. Okay. Do you have a general sense just from
10 looking at it what it purports to be at least?

11 A. Yeah, I do.

12 Q. Okay.

13 So I'll represent to you -- and you can see
14 on the URL at the bottom we pulled this off of
15 hospitalsafetygrades.org, which we talked about earlier
16 that's one of Leapfrog's websites, right?

17 A. Uh-huh.

18 Q. And this is a frequently asked questions page.
19 Do you see that?

20 A. Yes.

21 Q. Okay.

1 And I want to talk through a few things on
2 this document. First I want to start with there is a
3 "why." "Why should people" -- yeah. "Why should people
4 worry about a hospital's patient safety. Aren't all
5 hospitals the same?"

6 Do you see that on page 2?

7 A. Yes.

8 Q. And if you go down to about midway down the
9 paragraph, it says "and all." Do you see that?

10 A. Uh-huh.

11 Q. And it says: "And all hospitals are not the
12 same. Some hospitals are much safer than others. Johns
13 Hopkins Medicine researchers estimate that patients are
14 twice as likely to die of a preventable problem at a
15 "C," "D," or "F" hospital than an "A" hospital, and over
16 50,000 lives would be saved if all hospitals performed
17 the way "A" hospitals did."

18 Do you see that?

19 A. Yes.

20 Q. And I know you didn't write this, but do you
21 have any reason to think you are not the Johns Hopkins

1 researcher?

2 A. No, that is me.

3 Q. And do you have any reason to think that's not
4 referring to your white paper?

5 A. I have no reason to believe that it does not
6 refer to the white paper.

7 Q. And tell me, just so we're on the same page,
8 what is the white paper to which this is referring?

9 A. The white paper that -- so we, in 2016, did a
10 white paper that was referred to as "lives lost, lives
11 saved." And in 2019, we did an update to that. So I
12 don't know -- I believe this is referring to the 2019
13 updated white paper.

14 Q. And the 2019 updated white paper did not
15 analyze "A," "B," "C," "D," and "F" hospitals under the
16 current methodology, right?

17 A. No. They were -- that was done through -- I
18 would have to go back and look at the document but
19 probably based on like the Fall 2018 safety grades. I
20 don't -- yeah. I think we put it out in 2019, but I
21 think it may have been Fall of 2018 that we actually

1 used.

2 Q. And have you published any estimates of that
3 patients are twice as likely to die of a preventable
4 problem at a "C," "D," or "F" hospital than an "A"
5 hospital based on the 2025 methodology?

6 A. No, we have not.

7 Q. Do you have any understanding as to whether
8 that is correct today, or you just don't know?

9 A. We have done some early analysis around this
10 based on 2025, and these statements would remain true.

11 Q. Okay. Based on that early analysis?

12 A. Correct.

13 Q. Okay. And when did you conduct that analysis?

14 A. We started that back in March, April, somewhere
15 in that time frame.

16 Q. Okay. And so even though this is referencing
17 the 2019 white paper and the prior methodology, you're
18 saying based on the current imputed methodology the
19 twice as likely to die language is still correct?

20 A. Yes, I would stand by that.

21 Q. You would stand by it or you do?

1 A. I do.

2 Q. Okay.

3 And how did that analysis transpire?

4 A. Transpire? Can you clarify?

5 Q. How did it come to -- how did you -- why did
6 you conduct that analysis?

7 A. Yeah. So The Leapfrog Group asked that we look
8 at doing an update from the 2019 in 2025. So it was an
9 effort to follow through on that request and to provide
10 an updated analysis of where we're at.

11 Q. And have those analyses been released publicly
12 yet?

13 A. No.

14 Q. Okay, and why is that?

15 A. We -- you would have to ask The Leapfrog Group
16 on their decision and timing on that.

17 Q. Okay.

18 And you've not -- have you drafted a new
19 white paper?

20 A. I have started working on drafting a new white
21 paper. I have not finished that.

1 Q. Okay. Do you have any sense of when you're
2 going to publish that?

3 A. I don't have a sense of it.

4 Q. How far into the drafting are you?

5 A. I don't know how to estimate that. I mean,
6 it's actually updating the 2019 white paper. So I've
7 gone through at this point and made notes on which
8 values need to be updated, where we need to update
9 tables, but all that work would still need to be done.

10 Q. And is your analysis, would you say, an apples
11 to apples analysis between what you're doing today and
12 what was done in 2019?

13 A. It mirrors the spirit of what we did in 2019 in
14 that the measures themselves have changed between 2019
15 and now, but the approach of how we've estimated lives
16 lost and lives saved has remained consistent.

17 Q. And can you explain generally what that
18 approach is?

19 A. Yes. So what we've done is we have -- to
20 estimate the lives lost for looking at "A" hospital as
21 an aggregate, "B" hospital as an aggregate, "C" an

1 aggregate, and "D" and "F" hospitals an aggregate, we
2 look at the mean incidence rates of each of the patient
3 safety events that are included in the Hospital Safety
4 Grade. And from the literature, we've identified an
5 attributable mortality rate to each of those events.

6 So as an example, for central line
7 associated blood stream infections, one in every seven
8 patients who acquires one in the hospital passes away
9 from that. So if you are in a hospital that has a
10 higher rate of those, your risk of dying from one of
11 those increases.

12 And so we apply that against the admissions
13 that are in each of those buckets, so "A" hospitals,
14 "Bs", "Cs", "Ds", and "Fs" to estimate the number of
15 lives lost due to the preventable medical mistakes that
16 are included in the Hospital Safety Grade.

17 And we estimate. Let me put that word out
18 there very clearly. It's an estimate of the number of
19 lives that are lost.

20 Q. And why do you emphasize estimate?

21 A. Because we're -- for example, one assumption

1 that we have to make is the attributable mortality rate,
2 right. We're using that same rate in all four buckets,
3 "As," "Bs," "Cs," "Ds," and "Fs." The reality is we
4 might actually see that "A" hospitals have a lower
5 mortality rate when a patient develops a CLABSI than,
6 say, like a "D" and "F." But we're assuming that that
7 mortality rate is similar across all hospitals.

8 Q. Got it. Okay. Okay, we'll come back to that a
9 little bit more.

10 Okay. So then I want to go back to this
11 FAQ just before we go into other topics.

12 A. Sure.

13 Q. I want to talk about -- let's see. I lost the
14 question. Oh, here it is, page 3. It says: "Does a
15 hospital get a better safety grade if it reports to the
16 Leapfrog Hospital Survey?" Do you see that?

17 A. Uh-huh.

18 Q. And it says: "The Hospital Safety Grade
19 reflects how well a hospital does on safety, not whether
20 they complete the Leapfrog Hospital Survey." Do you see
21 that?

1 A. Uh-huh.

2 Q. And just one question on this line. Do you
3 believe, as, you know, familiar as you were with the
4 methodology, is that accurate with respect to
5 nonparticipating hospitals?

6 A. There are nonparticipating hospitals that have
7 received "As," "Bs," "Cs," "Ds," and "Fs."

8 Q. And do you think that is -- the Hospital Safety
9 Grade reflects how well a hospital does on safety, not
10 whether they complete the hospital survey. Do you agree
11 with that statement?

12 A. I do agree with that statement. I think
13 transparency is an important component of safety.

14 Q. Okay. Why do you say that?

15 A. Yeah. So hospitals that are choosing to share
16 their data through the Leapfrog Hospital Survey are
17 making that information transparent, and I think that
18 does tie to a safety culture of one where we want to
19 make information publicly available, hold ourselves
20 accountable. So I do think there is a link between
21 transparency and safety.

1 Q. Have you conducted any analysis to assess
2 whether hospitals that do not participate in the
3 Leapfrog survey are actually less safe than hospitals
4 that do?

5 A. Not that I can think of.

6 Q. Okay.

7 MR. CRAIN: I'm going to shift gears.
8 Everybody good on time? I'm going to switch topics.
9 You good?

10 BY MR. CRAIN:

11 Q. So I want to talk about the development of the
12 imputation models. So I'm going to focus you on the
13 2024 period. Is that fair enough?

14 A. Yep.

15 Q. Okay.

16 So in April 2024, the expert panel met to
17 discuss, among other things, imputation model. Do you
18 recall that meeting?

19 A. That sounds correct. I know we had a meeting
20 with them, and I think that was the timing of when we
21 talked about that topic.

1 Q. Yeah. And I'll get you a document.

2 MR. CRAIN: Can we get 32A, just to ground the
3 discussion. This will be Exhibit 10.

4 (Exhibit No. 10 was marked for
5 identification as of 9/25/2025.)

6 BY MR. CRAIN:

7 Q. Dr. Austin, do you recognize this document?

8 A. Yes.

9 Q. Okay. And this is an email thread leading up
10 to before and after I think the April 12th, 2024, expert
11 panel meeting. Do you see that?

12 A. Yes.

13 Q. Okay. And I want to just start at the -- where
14 is the attachment?

15 MR. CRAIN: Do we have the slide deck? 32 I
16 need also. Sorry. We have them separately.

17 So let's look at the deck, which was
18 attached to this email, but I think it's separate.
19 This will be Exhibit 11.

20 (Exhibit No. 11 was marked for
21 identification as of 9/25/2025.)

1 BY MR. CRAIN:

2 Q. Okay. So now this is the deck. Do you see
3 that, Dr. Austin?

4 A. I do, yeah.

5 Q. Okay. And it's attached to a Zoom invite -- or
6 to a meeting invite you sent on -- at some point but for
7 a meeting at April 12th at 4 to 5 p.m. Do you see that?

8 A. Yes.

9 Q. Okay.

10 And this was for the safety grade expert
11 panel's meeting for I think that year, right?

12 A. I believe that was the only meeting we held
13 with them in 2024.

14 Q. Okay.

15 And so going to the deck, I'm just going to
16 walk through it with you. And if you go to slide two,
17 which is Bates ending 437364 -- do you see that?

18 A. Uh-huh.

19 Q. And you lay out three topics, right?

20 A. Uh-huh.

21 Q. The first topic is update on swearing DHA

1 military treatment facilities.

2 (Whereupon, the court reporter seeks
3 clarification, which colloquy will not be
4 captured on the written record.)

5 BY MR. CRAIN:

6 Q. The second is feedback on reevaluating
7 imputation model, and the third is feedback on two
8 possible new outcome measures.

9 Do you see that?

10 A. Yes, I do.

11 Q. Okay.

12 And I want to focus on the middle one. So
13 if we can skip to what is page 7366 [sic].

14 A. Uh-huh.

15 Q. Now, do you see this slide is entitled "Problem
16 that We are Working to Solve?"

17 A. Uh-huh.

18 Q. And I want to just go back to the prior
19 exhibit. Well, I'll ask before we go there. Do you
20 recall who drafted this slide? If you don't, I can
21 refresh you.

1 A. I believe I actually am the one who probably
2 drafted this.

3 Q. Yeah. So if you look at the prior exhibit --

4 A. Uh-huh.

5 Q. -- this is Exhibit 10.

6 A. Uh-huh.

7 Q. On page 74782, do you see that?

8 A. 782, yes.

9 Q. And there's an email at the bottom from you to
10 Ms. Campione, Ms. Danforth, and Ms. Joshi. Do you see
11 that?

12 A. Yes.

13 Q. And it goes to the next page. And you say,
14 "Attached is an updated version of the slides. Alex,
15 these are looking good. I added in a slide at the start
16 of the imputation section that outlines the problems we
17 are trying to solve." Do you see that?

18 A. Yep.

19 Q. Does that refresh your recollection as to
20 whether you drafted --

21 A. Yep --

1 Q. -- this slide?

2 A. -- it does.

3 Q. Okay.

4 Just remember to let me finish before --

5 A. I'm sorry.

6 Q. -- and vice versa, just for Marlene.

7 So going back to the slide, why did you
8 draft this slide?

9 A. I thought it was helpful to remind the expert
10 panel of what are some of the challenges we are facing
11 with the current Hospital Safety Grade methodology and
12 why we might want to consider moving in a different
13 direction for imputation.

14 Q. Okay. And the challenges you're talking about
15 are the two bottom bullets, right?

16 A. Correct.

17 Q. Okay. And so the first one is imputed scores
18 have crept up, making imputation a more favorable choice
19 for lots of hospitals and has de incentivized true
20 transparency of performance, right?

21 A. Correct.

1 Q. Now, when you say imputation scores have crept
2 up, what's that based on?

3 A. So the imputation methodology at the time was
4 that it involved -- there was still the historic element
5 of Step 1.

6 Q. And I'll help you. I don't mean to interrupt,
7 but there's a slide that lays it out if it's helpful to
8 you.

9 A. Okay.

10 Q. It's 7369.

11 A. Uh-huh.

12 Q. Do you see that?

13 A. Yep, I do.

14 Q. Okay. Just in case it's helpful. But go on.

15 A. So the Step 1 was assigning the most recent
16 scores from the four past rounds of the safety grade,
17 and then Step 2 was actually looking at two different
18 mean performances. And what we had seen was a trend
19 with those scores were creeping up, which incentivized
20 hospitals to not report to the survey and, instead, to
21 take the imputed score.

1 Q. And how did you know it was driving that
2 incentive, that was the reason they were not reporting?

3 A. That feedback was clear from hospitals. They
4 had verbally shared that with Leapfrog.

5 Q. With you?

6 A. Not with me, with Leapfrog.

7 Q. Did you talk to any hospital that shared that
8 with you personally?

9 A. No.

10 Q. Okay.

11 And who did they share it with at Leapfrog?

12 A. From what I remember, Missy Danforth.

13 Q. Any sense of how many hospitals?

14 A. I don't have a sense of that.

15 Q. And do you have any other basis of knowledge to
16 support that statement besides what you said about
17 Ms. Danforth?

18 A. We have -- we numerically had been tracking the
19 mean score. So we did have empirical evidence of that
20 going up.

21 Q. Empirical evidence of scores going up?

1 A. Correct.

2 Q. But not necessarily empirical evidence of
3 nonparticipating hospitals making the decision not to
4 participate because the scores were going up?

5 A. I don't remember any evidence in that way.

6 Q. Okay.

7 Then the second -- just going back to slide
8 I think it's five, which is 7367 on the Bates number,
9 you see -- so the first bullet we just talked about is
10 primarily a problem with Step 2 in this old methodology.
11 Is that right?

12 A. Correct.

13 Q. And the second bullet is about Step 1, right?

14 A. Correct.

15 Q. And it says: "Hospitals are using Step 1
16 imputation, using their individual hospital's historical
17 data as a reason to not report on the current year
18 survey." Right?

19 A. Correct.

20 Q. Okay. So tell me a little bit about that
21 issue.

1 A. Yeah. Leapfrog had seen patterns where
2 hospitals were choosing to report one year, not report
3 the next year, report the next year as a way to sort of
4 keep their scores sort of used in the Hospital Safety
5 Grade without having to report to the survey every year.

6 Q. And what was your understanding of why those
7 hospitals weren't reporting every year?

8 A. I can't speak to why the hospitals were
9 choosing not to report.

10 Q. You have no understanding?

11 A. I have theories but I don't -- I haven't had
12 conversations with hospitals specifically about their
13 decision not to report.

14 Q. So same thing with respect to Step 1 -- 2 that
15 we just talked about, right? You said you --

16 MS. LAWSON: Object to form.

17 BY MR. CRAIN:

18 Q. Yeah, let me fix it.

19 So you said I have theories but I haven't
20 had conversations with hospitals specifically about
21 their decision not to report. That goes for either

1 decision not to report about Step 1 or Step 2, right?

2 A. That is for me personally I never had
3 conversations with hospitals about that.

4 Q. And did you ever have conversations with
5 Ms. Danforth about the hospitals that are deciding not
6 to report in the Step 1 context?

7 A. Yes.

8 Q. Okay. Tell me about those conversations.

9 A. So that was a similar point of feedback, that
10 she had had conversations with hospitals who had
11 indicated -- Leapfrog also has regional leaders, which
12 you may be familiar with. I think the regional leaders
13 were also hearing from hospitals that, oh, yeah, we're
14 not going to report this year because our scores still
15 get used in the Hospital Safety Grade.

16 So there had been sort of a current of
17 we're choosing to bypass transparency.

18 Q. And was that in relation to the burden of
19 completing the survey?

20 A. That's what I can't speak to.

21 Q. So you have no knowledge about the why?

1 A. I don't have any firsthand knowledge of the
2 why.

3 Q. Do you have any secondhand knowledge about the
4 why?

5 A. My secondhand knowledge would be burden would
6 be a consideration.

7 Q. Okay. And when you say "burden would be a
8 consideration," what do you mean by that?

9 A. So what I hear from hospitals generally, not
10 specific to this, is that at times, they feel like they
11 need to prioritize other quality improvement efforts and
12 may make a decision on where those priorities exist from
13 year to year.

14 Q. And when you say what you hear from hospitals,
15 that's not firsthand, right?

16 A. That has been firsthand, yes.

17 Q. So you do talk to hospitals?

18 A. I do talk to hospitals, not specifically about
19 whether they are reporting every year or every other
20 year.

21 Q. Okay.

1 A. I have had conversations with hospitals --
2 well, I guess I have had conversations with hospitals
3 about their decision to pause reporting.

4 Q. Okay. How many conversations, approximately?

5 A. Five to ten through ten years.

6 Q. Okay.

7 And have you had conversations with
8 hospitals about this imputation methodology at all at
9 any time?

10 MS. LAWSON: Well, I just want to object to
11 form.

12 Just to clarify, the imputation -- this
13 imputation methodology, are you asking about the current
14 2024?

15 MR. CRAIN: Yes.

16 MS. LAWSON: Yes. So just to clarify that.

17 THE WITNESS: I do not believe I've had any
18 conversations with hospitals about that.

19 BY MR. CRAIN:

20 Q. Okay.

21 So your knowledge today about hospitals'

1 decision-making with respect to reporting onto the
2 survey primarily comes from Ms. Danforth?

3 A. That would be a fair statement.

4 Q. Okay.

5 Okay. So going back to the deck, there's a
6 number of tables, and I want to go to slide -- it's the
7 slide with your proposal. Oh, here we go. Slide 13,
8 which is 7375.

9 A. Uh-huh.

10 Q. And this is the proposed future imputation
11 methodology. Do you see that?

12 A. Yes.

13 Q. Okay. This is not the methodology that
14 Leapfrog ultimately adopted, right?

15 A. Correct.

16 Q. Okay. Was this the methodology discussed at
17 the meeting?

18 A. Yes. This is what we put forward to the expert
19 panel.

20 Q. Okay. And you received feedback about this
21 proposal?

1 A. Correct.

2 Q. Right.

3 Okay. And just generally, can you explain
4 what the proposal was?

5 A. The proposal was that we would basically move
6 to a single form of imputation which would be the --
7 that we would use Step 2b imputation for all hospitals.

8 Q. And you would -- to your point, a single form
9 of imputation, that's the retire Step 1 bullet?

10 A. Correct. We would retire Step 1, and we would
11 move all hospitals to Step 2b.

12 Q. Okay. And which is 2b?

13 A. 2b, as it's described here, is that hospitals
14 would be assigned to cohorts and then the means of
15 scores from the first year of reporting would be used to
16 calculate the means.

17 Q. Okay.

18 A. And then the hospital would be assigned that
19 mean.

20 Q. Got it. Okay.

21 And then I just want to go -- so that was

1 the proposal you put out, correct?

2 A. Correct.

3 Q. And it was not the one that was adopted?

4 A. Correct.

5 Q. And we'll get to the why, but before we do
6 that, if you could go one slide back, slide 12.

7 A. Uh-huh.

8 Q. You see it says: "A slight dip in survey
9 participation occurred this past year as hospitals opted
10 to use past survey results in Step 1 imputation." Do
11 you see that?

12 A. Correct.

13 Q. So what is that based on? How did you know
14 that the slight dip was caused by hospitals using past
15 survey results in Step 1 imputation?

16 A. That is probably more just a -- based on
17 conversations that Ms. Danforth had had with hospitals.
18 I don't know if that's -- if we have anything
19 empirically to back up that statement.

20 Q. Okay. So you don't know whether that's
21 accurate or not?

1 A. I don't know whether that is -- yeah, correct.

2 Q. Okay.

3 So I want to talk a little bit about the
4 meeting itself. Do you recall whether other expert
5 panelists proposed alternative imputation methodologies?

6 A. I really don't remember the details of that
7 call.

8 Q. Okay.

9 Do you remember who was on it?

10 A. We have meeting notes of -- from that meeting,
11 but I don't recall who exactly was on that call.

12 Q. Okay.

13 So I want to go to tab 33. This is a
14 document I don't think you've seen before, so I'll just
15 preface that so you know.

16 A. Okay.

17 MR. CRAIN: And this will be Exhibit 12.

18 (Exhibit No. 12 was marked for
19 identification as of 9/25/2025.)

20 BY MR. CRAIN:

21 Q. It's huge. I'll walk you through it. So are

1 we good?

2 A. We're good.

3 Q. Okay.

4 So if you look back at exhibit -- the
5 exhibit with the email, which I think is Exhibit 10.

6 A. Uh-huh.

7 Q. Okay?

8 Do you see at the top there'd an email from
9 Ms. Campione to you?

10 A. Uh-huh.

11 Q. And it says, "Here is the link to the recording
12 if you need it for notes. Please let me know if you
13 have any issues with it."

14 A. Uh-huh.

15 Q. And it gives a URL and password, right?

16 A. Uh-huh.

17 Q. So the expert panel meeting was recorded?

18 A. Correct.

19 Q. Was that typically how it was done?

20 A. Yes.

21 Q. Okay.

1 And do you recall watching the video of the
2 recording at any point?

3 A. I did not.

4 Q. Okay. Do you recall reviewing a Zoom
5 transcript at any point?

6 A. I do not.

7 Q. Okay.

8 So I will represent to you this, what you
9 have in front of you, is a certified transcript of that
10 recording --

11 A. Okay.

12 Q. -- just for discussion purposes. And so I want
13 to just walk through a couple of things with you. So --
14 and I know you haven't seen this before, so I'll walk
15 you through it.

16 So if you go to the back of the document,
17 there's an index. Do you see that?

18 A. Uh-huh -- yes.

19 Q. Sorry. Yes?

20 A. Yes.

21 Q. Okay.

1 So the index, I want to just focus on a few
2 things. If you go to page 9 and you go to "L," do you
3 see the word "limited" appear on the index?

4 A. I do not.

5 Q. And I want to go to the word A -- excuse me, to
6 the portion of the index for "A." Do you see the word
7 "achievement"?

8 A. I see achieving but not achievement.

9 Q. Okay. And where is achieving? There it is.
10 Do you want to -- let's flip to 36.3. So page 36, line
11 3. Tell me when you're there.

12 A. I am there.

13 Q. And it says: "But achieving consensus is
14 difficult." Do you see that?

15 A. Yes.

16 Q. So that doesn't refer to limited achievement,
17 right?

18 A. It does not use that phrase.

19 Q. So based on this index, and to the best of your
20 recollection, did anybody at any time during the meeting
21 raise the idea that you could impute limited achievement

1 scores to nonparticipating hospitals?

2 A. I don't remember what was exactly said. I
3 would not be surprised if the Hospital Safety Grade
4 expert panelists weren't familiar with the term "limited
5 achievement."

6 Q. Sorry. Say that again. I think that was a
7 double negative.

8 A. I would not be surprised if the Hospital Safety
9 Grade expert panelists were not familiar with the term
10 limited achievement.

11 Q. Got it. Okay.

12 Is there another term they might use?

13 A. They might have used lowest performance score.

14 Q. Okay. What about zero?

15 A. It's possible that zero could have been
16 mentioned.

17 Q. Okay.

18 So I want to go to zero, too, in the index,
19 just to close that loop.

20 MS. WOOD: And Lee, I do just want to object to
21 form. I've never seen this document before either. Has

1 this been produced in discovery?

2 MR. CRAIN: It is being produced today.

3 MS. WOOD: Okay. And when was it -- was it
4 prepared on September 11th?

5 MR. CRAIN: I do not know the date, but we can
6 talk off the record. So your objection is noted.

7 BY MR. CRAIN:

8 Q. So do you see zero, Dr. Austin, in the index?

9 A. Uh-huh.

10 Q. Okay.

11 If you go to 40, it said -- in the index,
12 it said line 7, 7 to 11. Do you see that?

13 A. Yes.

14 Q. And I just want you to look at this page from,
15 say, line 6 to 11. Does this reflect anybody proposing
16 to impose a zero score for nonparticipating hospitals?

17 A. No, it doesn't.

18 Q. Okay.

19 Okay. So is it accurate to say that no one
20 suggested, based on the index, based on your memory,
21 that imposing a zero score for nonparticipating

1 hospitals?

2 MS. LAWSON: Object to form.

3 THE WITNESS: I honestly don't remember the
4 conversation.

5 BY MR. CRAIN:

6 Q. Okay.

7 A. I will clarify that what has been assigned is
8 not zero to hospitals.

9 Q. I understand.

10 So do you remember any other proposal made
11 during the expert panel meeting besides the one that you
12 proposed in the slides that we looked at?

13 A. I don't remember.

14 Q. Okay.

15 So I'll take you to one other that is in
16 here. Do you recall -- who is Dr. Pronovost, Peter
17 Pronovost?

18 A. He is one of the Hospital Safety Grade expert
19 panelists.

20 Q. Okay. And you worked with him previously at
21 Armstrong, right?

1 A. Correct.

2 Q. Okay.

3 Now, he proposes -- if you go to pages --
4 if you go to page 25 --

5 A. Uh-huh.

6 Q. -- oh, wait. Sorry. Page 26.

7 A. Uh-huh.

8 Q. And you see at line 18 it says Peter Pronovost
9 and colon?

10 A. Uh-huh.

11 Q. And he says, "Peter Pronovost: Missy, though,
12 to Arjun's point, I wonder in our model do we include
13 that if they're in the lowest quartile, that they stay
14 in that? You know what I mean? At least to reduce the
15 gaming."

16 Do you recall him saying that?

17 A. That's what it says here.

18 Q. Yeah. Do you have any independent --

19 A. I don't remember.

20 Q. Okay.

21 Do you know generally what that means, the

1 lowest quartile?

2 A. I would need to go back further up in the
3 document --

4 Q. If you want to take a look and --

5 A. -- to understand what the context was --

6 Q. Yeah, why don't you go back to page --

7 A. -- because I don't know what the discussion was
8 at that point.

9 Q. Go back to page 24 and start with
10 Dr. Srinivasan.

11 Who is Dr. Srinivasan?

12 A. He's at the Centers for Disease Control and
13 Prevention.

14 Q. Okay. And take a second.

15 (Witness peruses document.)

16 THE WITNESS: So I've read it. And can you
17 repeat your question?

18 BY MR. CRAIN:

19 Q. Yeah. I wanted to know if you have an
20 understanding of what Dr. Pronovost was referring to
21 when he's talking about the bottom quartile. And I

1 think Dr. Srinivasan talks about the bottom quartile,
2 too. And I will also preface, if you don't remember, I
3 can show you an email subsequently about the bottom
4 quartile, but I wanted to know if you have an
5 independent recollection.

6 A. I don't have a recollection of that.

7 Q. Okay. That's fine. It's not a memory test.
8 Again, we'll get to another document. I'm just going
9 through this.

10 I want to look at one other quick thing in
11 the index. If you go to "W," do you see the word
12 "willing"?

13 A. I do.

14 Q. Let's see. Where is it?

15 A. Oh, no. I don't see it.

16 Q. Yeah, I didn't see it.

17 Just to confirm, do you see the word
18 "willing" in the index?

19 A. I do not.

20 Q. Okay.

21 Do you know what the phrase "willing to

1 report" means?

2 A. That is the term that Leapfrog used prior to
3 limited achievement.

4 Q. Okay. So that was the lowest performing score,
5 right?

6 A. That was the phrase that was used for that in
7 the past.

8 Q. Okay. Do you recall when it was retired?

9 A. I could estimate 2018, 2019, somewhere around
10 there.

11 Q. And just -- I'm representing to you that the
12 index is from a certified court reporter. Based on this
13 index, the phrase "willing to report" or even just the
14 word "willing" was not discussed at this meeting,
15 correct?

16 A. I do not see the word "willing" in the index.

17 Q. Okay.

18 And you have no independent recollection of
19 a discussion of the phrase "willing to report" at the
20 meeting, right?

21 A. I do not.

1 Q. Okay.

2 Okay. I'm going to set this aside, and
3 we'll come back to it, so don't lose it.

4 (Whereupon, a discussion was held between
5 counsel regarding lunch schedule, which
6 portion was not included in the written
7 record.)

8 BY MR. CRAIN:

9 Q. Okay. So let's keep going.

10 So you mentioned there were minutes after
11 the meeting, right?

12 A. Correct.

13 Q. I want to start with tab 33A, which will be
14 Exhibit 13.

15 (Exhibit No. 13 was marked for
16 identification as of 9/25/2025.)

17 BY MR. CRAIN:

18 Q. So Dr. Austin, do you recognize this document?

19 A. I recognize the meeting notes that are behind
20 it.

21 Q. Behind it. Okay.

1 A. And I recognize the email.

2 Q. Yeah. Okay. So you have no reason to think
3 this wasn't sent and received?

4 A. Correct. Yes.

5 Q. Okay.

6 And you'll note in the bottom it's an
7 Armstrong-produced document, right?

8 A. Correct.

9 Q. So it's an email originally from the 16th from
10 Preeti Joshi. And remind us, who is she again?

11 A. Preeti is an analyst that works for me.

12 Q. Okay. And she works on the Leapfrog account?

13 A. Correct.

14 Q. Okay.

15 And she says first in that email, "Matt,
16 please review the attached Leapfrog Hospital Safety
17 Grade HSG" -- is that Hospital Safety Grade?

18 A. Uh-huh. Correct.

19 Q. -- "expert panel meeting notes, and let me know
20 your suggestions."

21 Then she follows up, right?

1 A. Correct.

2 Q. And she says -- it looks like it's a few hours
3 later that same day, April 16th -- "Matt, please
4 disregard the attachment of previous email and consider
5 the attached document for review. I accidentally attached
6 a different file with previous email."

7 Do you see that?

8 A. Yes.

9 Q. Okay.

10 And then going on to the notes, this is,
11 fair to say, her draft of the notes, right?

12 A. Correct.

13 Q. Okay.

14 And then just stepping back, does every
15 expert panel, safety grade expert panel have meeting
16 notes like these?

17 A. Yes. Could there be one or two for which we
18 just somehow didn't do them? Possibly. But the intent
19 is, yes, to have meeting notes like this.

20 Q. And is this the normal process where the person
21 who is reporting to you starts the first draft and you

1 revise?

2 A. Correct.

3 Q. Okay. And do you generally try to be accurate
4 with the meeting minutes?

5 A. Yes.

6 Q. Okay. What do you look for when you revise?

7 A. I look for accuracy. I try to highlight
8 broader themes. So as an example, often when the
9 analyst first starts working with me, the notes will be
10 incredibly, like, detailed. Sara said this. Bob said
11 this, right. So I try to sort of move it up a level,
12 right, and I try to be clear with sort of action items
13 of what we need to do next and to be clear with decision
14 points.

15 Q. Okay. And you still try to be faithful to the
16 discussion, right?

17 A. Correct.

18 Q. Okay.

19 So I'm going to set this one aside, and I
20 want to go to your version of the notes. Let's see.
21 Oh, wait. Come back. Sorry. Sorry. Let's start with

1 this. I'm all out of order.

2 Okay. So if we go down to Preeti's version
3 of the notes, do you see number two?

4 A. Uh-huh.

5 Q. Proposed changes to the imputation model,
6 right?

7 A. Uh-huh.

8 Q. And if you go, it looks like one, two, three
9 bullets down, it says "Peter asked."

10 A. Uh-huh.

11 Q. "Peter asked whether Leapfrog has a way to keep
12 the low-performing hospitals in the lowest quartile
13 using this Step 2 imputation model." Do you see that?

14 A. Uh-huh.

15 Q. Okay. Was that what we looked at in the
16 transcript a little while ago?

17 A. I don't know because I actually didn't fully
18 follow what Peter was trying to ask there.

19 Q. Okay. Got it.

20 A. To be really, really honest, I -- it didn't
21 make much sense to me.

1 Q. I've been trying to understand it, too, so I
2 get it.

3 Does this seem like a fair articulation of
4 what he was saying in the call?

5 A. If it's in the notes, I would say it's probably
6 a fair articulation, but I don't remember that myself.

7 Q. Okay.

8 Now, just to be clear, looking at this,
9 there is no indication -- and you can read the bullets.
10 They're pretty short -- that anyone was proposing giving
11 hospitals a zero or limited achievement or willing to
12 report, right?

13 A. Can you repeat your question, please?

14 Q. Yeah.

15 Is there any indication in these notes that
16 someone raised the idea during the meeting of giving
17 nonparticipating hospitals a zero or limited achievement
18 or willing to report for the imputed measures?

19 MS. LAWSON: Object to form, but you can
20 answer.

21 THE WITNESS: It doesn't necessarily explicitly

1 say that in these notes.

2 BY MR. CRAIN:

3 Q. Okay.

4 You say "explicitly." Do you have a reason
5 to believe those topics were discussed?

6 A. There was concerns about -- that Arjun raised
7 about a hospital that was performing very poorly and
8 that they would actually get an imputed score, so a
9 better score than what they would actually be -- so to
10 me that seems to be raising the question of whether the
11 current imputation model was rewarding poor performing
12 hospitals.

13 So, I mean, there could be an
14 interpretation of that.

15 Q. So you said the question was raised. My
16 question is was the answer provided, proposed answer?

17 A. I don't remember.

18 Q. Okay.

19 And do you see anything on this page from
20 what you read a few minutes ago from the transcript to
21 suggest that those solutions were proposed that I just

1 mentioned?

2 A. I don't see anything here that would indicate
3 that the actual solution that we landed on is what was
4 explicitly proposed by the expert panel.

5 Q. Okay. Let me ask you this question. Who
6 proposed the solution that you landed on?

7 A. I don't recall with certainty.

8 Q. Okay. Do you think it was Leapfrog, or do you
9 think it was the expert panel?

10 A. I'm guessing it was Leapfrog that proposed that
11 solution based on the concerns that the expert panel was
12 raising.

13 Q. Got it.

14 So to your framing before, the question was
15 raised and Leapfrog was supplying an answer?

16 A. Is your question during this call?

17 Q. During this period. April 2024 --

18 A. I don't remember with certainty how the
19 solution that is currently in use was developed.

20 Q. Okay.

21 I want to also take a look a couple bullets

1 down. It says, "Matt mentioned." Do you see that?

2 A. Uh-huh.

3 Q. And Matt, I take it, is you?

4 A. Correct.

5 Q. "Matt mentioned it is important to see whether
6 there is an actual difference in hospitals' performance
7 and whether there is some sort of bias in the
8 measurement against them. He said to minimize the
9 second, and if there are differences in hospitals'
10 performance, we can address the structural issues to fix
11 them."

12 Do you see that?

13 A. I do.

14 Q. So taking that one by one, what does the first
15 sentence mean?

16 MS. LAWSON: Might it be helpful for him to
17 just review the transcript of what he said?

18 MR. CRAIN: Yeah. I'm pulling that out now.

19 THE WITNESS: That would be helpful.

20 BY MR. CRAIN:

21 Q. But you know what, let's start with this

1 document and what's your understanding of this sentence,
2 and I'll try to find a line.

3 A. It's unclear to me what "them" is referring to
4 in this sentence. Like, I don't have the context to
5 remember what "them" is. To me, I was suggesting that,
6 perhaps, we needed to look at difference in performance
7 between -- yeah, I don't have a great sense just from --

8 Q. I can take you where the -- if you go back to
9 the transcript, page 27 is where you talk about bias.

10 MS. LAWSON: And you might want to just start
11 from the page preceding, which is the page we reviewed
12 previously, and just keep going on the discussion. I
13 think that might help.

14 (Witness peruses document.)

15 THE WITNESS: The context from the transcript
16 is such that we were talking about safety net hospitals
17 and some sort of concerns about bias in measurement for
18 those safety net hospitals.

19 BY MR. CRAIN:

20 Q. Only for them?

21 A. That is the context that Kathy McDonald had

1 brought up was the safety net hospitals.

2 Q. Fair enough. I get that she says that from
3 lines 3 to 11 on page 27, but you follow up, and you
4 say, "I think where I struggle is what is a true --
5 well, where is there a true difference in performance,
6 right, and where is there some sort of bias in the
7 measurement against them. Right?" And then Kathy says,
8 "Right." And then you say, "And I think we want to
9 minimize the second."

10 And so I guess the question I have out of
11 that is what does bias mean in that context?

12 A. Bias would refer to that there is some sort
13 of -- that there is some sort of structural -- I'm
14 trying to think of the right words for this. That there
15 is some sort of structural sort of -- there's something
16 structural about safety net hospitals that disadvantages
17 them.

18 Q. So you're talking about bias about the
19 hospitals or bias about the scoring methodology?

20 A. The bias in the hospitals. And I say that
21 because I think on the next page I talk about that

1 marginalized communities tend to receive care at less
2 safe hospitals. So I think the concern is that there is
3 a bias against safety net hospitals in terms of quality
4 and safety.

5 Q. So this doesn't refer to bias in the survey --
6 in the scoring methodology -- excuse me -- against
7 safety net hospitals?

8 A. I believe what this is referring to is actually
9 the bias in the challenges that safety net hospitals
10 face to prioritize quality and safety of care.

11 Q. And how does that factor into the imputation
12 methodology?

13 A. So safety -- well, to be clear, safety net,
14 there is no formal definition of that. If they are a
15 critical access hospital, they don't receive a Hospital
16 Safety Grade.

17 Q. What is a critical access hospital?

18 A. Critical access hospital, there is about 1,400
19 of them in the United States. They're small hospitals
20 that have 25 beds or less --

21 Q. Got it.

1 A. -- that are generally in rural areas and for
2 which the funding from the government is different,
3 basically to keep their doors open, and they are
4 generally in small, rural communities.

5 Q. And so I get there is no definition of safety
6 net hospital. What's your general understanding of what
7 that means?

8 A. One definition that I commonly use is it's
9 hospitals that care for greater proportions of patients
10 who have Medicaid as their primary insurance.

11 Q. Got it. And they can be for-profit or
12 nonprofit hospitals?

13 A. Correct.

14 Q. Okay. And so what type of -- so how does the
15 safety -- how does the imputation -- like, how does that
16 fact -- let me state the question in a real way rather
17 than stuttering way.

18 How does the safety net bias that you're
19 talking about here relate to the imputation methodology
20 that was the topic of the agenda here?

21 A. I believe what Kathy is looking at is -- was

1 looking at some of the safety net hospitals and just
2 making sure that they were going to be treated fairly.

3 Q. Okay. And is that -- is a difference in the
4 safety net hospitals, as compared to non-safety net
5 hospitals, their capacity to complete the survey?

6 A. I couldn't speak to that.

7 Q. Do they have fewer resources than non-safety
8 net hospitals?

9 A. They typically are more resource constrained
10 hospitals than larger hospitals -- or not larger
11 hospitals, than hospitals that are better funded.

12 Q. So did you understand Kathy to be saying that
13 she wanted to recognize the burden that they were
14 experiencing as compared to non-safety net hospitals?

15 A. I don't know if that was what she was implying
16 there.

17 Q. Okay.

18 So and then going back to your point about
19 bias, how would the imputation methodology -- strike
20 that. Sorry.

21 Going back to your point about bias, how

1 could the imputation methodology take that into account?

2 A. Which imputation methodology are we discussing?

3 Q. Any one, whether -- well, how could any
4 imputation methodology take into account the bias that
5 you're identifying here apparently as to safety net
6 hospitals?

7 A. Well, there's the concern that -- I mean, one
8 potential bias is that if other safety net hospitals are
9 performing less well and you choose to not complete the
10 survey, you're going to maybe get assigned the same
11 value as your average safety net hospital. So that
12 would be one way that a safety net hospital might face a
13 bias.

14 Q. Okay. But you need the definition of what
15 qualifies as a safety net hospital, right?

16 A. Correct. And Leapfrog has its own definition
17 that it uses for that.

18 Q. Is it different from yours?

19 A. I don't know.

20 Q. Okay. You have no knowledge of what that
21 definition is?

1 A. I couldn't say with exact certainty what their
2 definition is.

3 Q. Do you know in what context they have that
4 definition?

5 A. They have it in some of their data files
6 because a lot of their data licensees like to be able to
7 drill down on that type of detail, but I don't know what
8 -- how they get that source or what they are using for
9 them.

10 Q. Okay. Okay.

11 So going back to the notes, which I believe
12 is Exhibit 13, I want to go back to the bullet. Preeti
13 said, "Matt mentioned it is important to see whether
14 there is an actual difference in hospitals' performance
15 and whether there is some sort of bias in the measures
16 against them. He said to minimize the second, and if
17 there are differences in hospitals' performance, we can
18 address the structural issues to fix them."

19 Do you see that?

20 A. I do.

21 Q. Now, she doesn't mention safety net hospitals

1 there, right?

2 A. She does not.

3 Q. Okay. So -- okay. I'll leave it there.

4 MR. CRAIN: I think maybe we'll take a break
5 now. Do you want to do the lunch break now?

6 MS. LAWSON: We're off the record.

7 THE VIDEOGRAPHER: This marks the end of media
8 unit number three. We're going off the record. The
9 time is 11:49 a.m.

10 (Whereupon a lunch break was had, after
11 which the proceedings continued as
12 follows:)

13 THE VIDEOGRAPHER: This marks the beginning of
14 media unit number four. We're back on the record. The
15 time is 12:56 p.m.

16 BY MR. CRAIN:

17 Q. Okay. Welcome back.

18 A. Thank you.

19 Q. I hope you had a nice lunch.

20 A. Yeah. Thank you.

21 Q. So we were talking about the April 12th meeting

1 before we broke. Do you recall that?

2 A. Yes.

3 Q. I want to go back in time just a little bit.

4 The April 12th meeting, if you recall correctly from the
5 notes we saw, was between 4 and 5 o'clock.

6 A. Correct.

7 Q. And if you keep the notes out, if you look at
8 the portion where it says the attendees, do you see
9 that?

10 A. Yes.

11 Q. Dr. Romano is not on that list, right?

12 A. Correct.

13 Q. Okay. And do you recall that -- whether you
14 met with Dr. Romano earlier that day with regard to the
15 safety grade expert panel?

16 A. I can't say with certainty.

17 Q. Okay.

18 A. But I believe we met with him at some point
19 around that meeting.

20 Q. Okay. And that was -- do you recall who
21 attended that meeting?

1 A. I don't recall with certainty. I could
2 estimate who I think would be there, but I can't say
3 with certainty.

4 Q. That's okay. That's okay.

5 And before we go to -- I'll refresh you
6 with a document, but before we go there, who is
7 Dr. Patrick Romano?

8 A. So Dr. Patrick Romano is one of the Hospital
9 Safety Grade expert panelists.

10 Q. And what's his background?

11 A. He is a physician and health services
12 researcher at the University of California, Davis.

13 Q. And fair to say he's an expert in something?

14 A. He is.

15 MS. LAWSON: Object to form but go ahead.

16 THE WITNESS: Yeah. He would be perceived as
17 being an expert in quality measurements in healthcare.

18 BY MR. CRAIN:

19 Q. And have you worked with him for a long time?

20 A. Yes, I have.

21 Q. Did you work with him in the early days when

1 the safety grade was being developed?

2 A. Yes.

3 Q. And was he involved in the development of the
4 first imputation model around 2020, 2021?

5 A. We worked with Dr. Romano in thinking through
6 different options for the imputation.

7 Q. Okay. And do you know how long Dr. Romano has
8 been involved in any capacity with Leapfrog?

9 THE COURT REPORTER: I'm sorry. We just lost
10 connection.

11 MR. CRAIN: Should we go off?

12 THE COURT REPORTER: Could we?

13 MR. CRAIN: Can we go off the record.

14 THE COURT REPORTER: Just one quick second.

15 THE VIDEOGRAPHER: This marks the end of media
16 unit number four. We're going off the record. The time
17 is 12:58 p.m.

18 (Whereupon, the proceedings paused due to
19 technical difficulty, after which the
20 proceedings continued as follows:)

21 THE VIDEOGRAPHER: This marks the beginning of

1 media unit number five. We're going back on the record.

2 The time is 1 o'clock p.m.

3 BY MR. CRAIN:

4 Q. Great. Okay. We're back after a technical
5 glitch, and I'm going to ask the question that we
6 started before.

7 So was Dr. Romano involved in the
8 development of the first imputation model around
9 2020/21?

10 A. He was. To clarify, that wasn't -- it depends
11 on your definition of what is an imputation model. We
12 had had other imputation approaches prior to '20 to '21.

13 Q. Fair enough.

14 Was he involved in the development of that
15 model in --

16 A. Yes. He helped provide input and guidance.

17 Q. Okay.

18 MS. LAWSON: And just make sure that Mr. Crain
19 has finished his question, yes.

20 BY MR. CRAIN:

21 Q. And I think I had asked during the technical

1 glitch, so I'll make sure we get it, how long has
2 Dr. Romano been involved with Leapfrog?

3 A. Since 2011.

4 Q. Okay. So he came on after you joined or after
5 you got involved with Leapfrog, let's say?

6 A. He was part of the Hospital Safety Grade expert
7 panel that was formed in 2011.

8 Q. When the safety grade was originally being
9 developed?

10 A. Correct.

11 Q. Okay.

12 MR. CRAIN: Okay. So I'm going to mark as
13 Exhibit 14...

14 (Exhibit No. 14 was marked for
15 identification as of 9/25/2025.)

16 BY MR. CRAIN:

17 Q. Dr. Austin, do you see this is an
18 Armstrong-produced document?

19 A. Yes.

20 Q. And it's an email from you to you. Do you see
21 that?

1 A. Correct.

2 Q. Does this reflect notes that you took on
3 April 12th, 2024?

4 A. It reflects --

5 Q. I'll direct you to the subject matter, the
6 subject of the email.

7 A. Yes. It was my notes from the Hospital Safety
8 Grade expert panel meeting.

9 Q. And do you have a practice of sending yourself
10 notes over email?

11 A. I do.

12 Q. Okay. So this is a true and accurate, to the
13 best of your knowledge, copy of your notes from that
14 day?

15 A. Yes.

16 Q. Okay.

17 And on the top, it says: "Patrick
18 recommend keep Step 1." Do you see that?

19 A. Yes.

20 Q. Does that refresh your recollection of whether
21 you had a meeting with Dr. Romano on April 12th?

1 A. As I mentioned, I know we met with Dr. Romano
2 around that time because he was unable to make the
3 primary call, but I don't remember the exact timing of
4 when that was.

5 Q. Okay.

6 Do you -- is it correct that these bullets
7 one, two, and three below, "Patrick recommend keep Step
8 1," reflect your notes from the discussion with
9 Dr. Romano?

10 A. That would be likely to be true, yes.

11 Q. Okay. You don't have a specific memory, but
12 that's what the document --

13 A. Correct.

14 Q. -- indicates?

15 A. Yes.

16 Q. Okay. Again, just let's try not to talk over
17 each other.

18 Okay. And then the remainder of this
19 email, just going down, do those reflect your notes from
20 the subsequent expert safety grade panel meeting later
21 that day?

1 A. Yes.

2 Q. Okay.

3 That's all we need to talk about with this
4 document. You can set it aside.

5 MR. CRAIN: Now, I want to go to another
6 document. This will be 15, tab 34.

7 (Exhibit No. 15 was marked for
8 identification as of 9/25/2025.)

9 BY MR. CRAIN:

10 Q. And you will see on the bottom this was a
11 deposition exhibit from Ms. Campione as well. Do you
12 see that blue sticker?

13 A. Yes.

14 Q. Okay.

15 So the top email is from you to
16 Ms. Campione, Ms. Danforth, and Ms. Joshi. Do you see
17 that?

18 A. Yes.

19 Q. And I want to just go through -- if we could
20 start at the bottom, which is the first email, this will
21 be page -- if you could go to page 8331, the second to

1 the last page to orient. Good? Are you there?

2 A. Can you repeat that, please?

3 Q. Sorry.

4 Can you go to page 8331, the second to the
5 last page.

6 A. Yes.

7 Q. Okay.

8 And there's an email from Ms. Campione to,
9 among others, you at 12:17 p.m.?

10 A. Yes.

11 Q. And the subject is imputation changes. Do you
12 see that?

13 A. Yes.

14 Q. So Ms. Campione writes to you and others, "Hi
15 all, please find the table we discussed below. I also
16 included the underlying issues. Please feel free to
17 edit the response to this email." Do you see that?

18 A. Yes.

19 Q. Okay.

20 Do you have a recollection of her sending
21 this email?

1 A. I do remember seeing that table at the bottom
2 of the email, but I didn't remember the context of the
3 email.

4 Q. Do you remember seeing it from back then? Do
5 you remember from seeing it more recently?

6 A. I -- in showing this to me today, I very
7 distinctly remember her sending an email with this
8 table.

9 Q. Okay. Do you remember -- and you said you
10 don't remember the context. Do you remember anything
11 about why she sent it?

12 A. I would guess, based on what's here, it was to
13 sort of further refine a potential direction that we
14 would go for the imputation models.

15 Q. And this was about 10 days after the expert
16 panel meeting, right?

17 A. Correct.

18 Q. Okay.

19 So I want to just go through this chart a
20 little bit just to make sure we're on the same page.
21 Are you looking at the chart on 8332?

1 A. Uh-huh.

2 Q. Okay. So "no change" is the left-most column.
3 Do you see that?

4 A. Yes.

5 Q. And that's -- is it right that's basically the
6 model you had, right, at the time?

7 A. Correct.

8 Q. "Small change" says: "Shorten imputation to
9 past two rounds for Step 1." Do you see that?

10 A. Yes.

11 Q. Is that what you ultimately did, or is it
12 "moderate change" that Leapfrog ultimately imposed?

13 A. Are you asking about recent survey
14 participants?

15 Q. I'm asking -- yeah, I'm asking about Step 1 for
16 recent survey participants. I'll walk you through it.
17 I'll build it a little more clearly.

18 Under "small change" for Step 1, it says:
19 Shorten imputation to two past rounds. Do you see that?

20 A. Uh-huh.

21 Q. Does that reflect, to the best of your

1 understanding, an imputation of a historical score in
2 the past two rounds of the hospital survey?

3 A. Can you repeat that again, please?

4 Q. Yeah.

5 To the best of your understanding, does
6 this column, does this "small change" box in Step 1
7 reflect that you would propose to impute the historical
8 score for a nonparticipating hospital for the past two
9 rounds of the hospital survey? Am I reading that right?

10 A. That is not exactly my understanding.

11 Q. Okay. Can you give me your understanding?

12 A. Yeah. My understanding is what's being
13 proposed is for hospitals that have recently completed
14 the survey, how far of a lookback would we do to see if
15 there was a recent survey.

16 Q. Got it. And was that different from what I
17 said because I said nonparticipating hospitals?

18 A. Correct.

19 Q. Yeah, okay. Let me fix that. That's a fair
20 point.

21 For hospitals that are not participating

1 every year, is that a more apt understanding of what the
2 Step 1 is?

3 A. I would frame it as hospitals that have not
4 submitted the most recent hospital survey.

5 Q. Got it. But for which there exists a
6 historical survey response?

7 A. Correct.

8 Q. Okay.

9 So on the top in Step 1, small change, you
10 go back to the two past rounds of the survey, right?

11 A. That is what's being proposed under small
12 change.

13 Q. Then moderate change is you shorten imputation
14 to one past round, right?

15 A. Correct.

16 Q. And is that what you testified earlier -- is
17 that what ultimately Leapfrog did for Step 1?

18 A. I would have to defer to the methodology --

19 Q. Okay.

20 A. -- document on how that gets phrased or framed.

21 Q. Okay.

1 What do you think is the difference?

2 A. Difference from what?

3 Q. What's your hesitation as to why this is not
4 the same thing as you understand Leapfrog is doing today
5 for Step 1?

6 A. I guess I'm a little unclear on what moderate
7 change would actually be. So that's where I'm now sort
8 of second-guessing like, well, did we implement moderate
9 or did we implement small change?

10 Q. Okay.

11 A. My understanding, putting the words aside, is
12 that what we moved to was the ability for a hospital --
13 we would look back and see if a hospital submitted a
14 survey last year --

15 Q. Got it.

16 A. -- and if we did, we would use that.

17 Q. Okay.

18 A. But we wouldn't go any further back than that.

19 Q. Okay.

20 A. So I don't know how that translates into these
21 exact words.

1 Q. Okay.

2 I mean, I would read one past round to be
3 last year, but I don't know if that's right. You're not
4 sure about that either?

5 A. I'm not sure about that either.

6 Q. Okay.

7 Okay. And then "drastic change" is
8 eliminate Step 1. Do you see that?

9 A. Yes.

10 Q. And that you did not do, right?

11 A. Correct.

12 Q. But that was the proposal at the April 12th
13 meeting, to retire Step 1?

14 MS. LAWSON: Object to form.

15 THE WITNESS: The proposal that we introduced
16 at the Hospital Safety Grade expert panel meeting was to
17 eliminate Step 1.

18 BY MR. CRAIN:

19 Q. Yeah. Okay.

20 Now, in Step 2, if you could just go -- I
21 don't know if you feel more comfortable walking me

1 through it, or I could walk you through it, but Step 2,
2 the no change, it says: "Impute with the mean of first
3 time scores for their cohort." Do you see that?

4 A. Yes.

5 Q. And is that a no change, or is that sort of an
6 adaptation? I had understood the Step 2 to be the mean
7 of first time versus the mean of the cohort generally,
8 right?

9 A. At the time, the nonsurvey -- so Step 2 was --
10 yes, it was the lower of the mean of either first time
11 respondents or the mean of the cohort.

12 Q. Yeah, okay. So slightly different from what
13 the no change says here, right?

14 A. Correct.

15 Q. Okay.

16 And that small change -- there's a no
17 change, which is interesting. Do you see that?

18 A. Correct.

19 Q. Okay.

20 And then moderate change says: "Assign
21 hospitals to the bottom quartile or several standard

1 deviations below the mean." Do you see that?

2 A. Yes.

3 Q. Now, we saw in the transcript that we looked at
4 in the notes the discussion of the lowest quartile. Is
5 this what that's referring to, to the best of your
6 understanding?

7 MS. LAWSON: Object to form.

8 THE WITNESS: I would need to re-review the
9 transcript to refresh myself on what exactly the
10 conversation was about lowest quartile.

11 BY MR. CRAIN:

12 Q. Okay. I'm trying to think should we do that.
13 Would you like to do that? I'm happy to take you back
14 to it unless you have an understanding.

15 A. I don't have -- I mean, I saw in the
16 transcript there was conversation about lowest quartile.

17 Q. Yeah.

18 A. And there's, obviously, conversation here about
19 bottom quartile. I don't know if those two
20 conversations are the same thing. That's what I don't
21 know.

1 Q. Okay. So you don't have an independent
2 recollection of whether this column comes from the
3 discussion of the expert panel meeting or not?

4 A. Correct. I do not have an independent
5 recollection.

6 Q. Okay.

7 And then on the last one, the drastic
8 change, it says: "Impute with limited achievement
9 scores," right?

10 A. Correct.

11 Q. Okay.

12 And, again, we looked at the index, and
13 there was no discussion of limited achievement, right,
14 at least based --

15 MS. LAWSON: Object to form.

16 BY MR. CRAIN:

17 Q. At least based on the index?

18 MS. LAWSON: Object to form.

19 THE WITNESS: Correct. There was no use of
20 that explicit term.

21 BY MR. CRAIN:

1 Q. Yeah.

2 And there was no use of the term
3 willingness, as in willingness to report, right?

4 MS. LAWSON: Object to form.

5 THE WITNESS: Correct.

6 BY MR. CRAIN:

7 Q. Okay.

8 And in the index at least, when we looked
9 at the word "zero," there was no discussion of anybody
10 proposing that nonparticipating hospitals should get
11 zero in Step 2, right?

12 MS. LAWSON: Object to form. Go ahead.

13 THE WITNESS: Correct.

14 BY MR. CRAIN:

15 Q. Okay.

16 So let's go up a little bit on this box.
17 And you respond, do you see that, 12:27 p.m.?

18 A. I --

19 Q. I can give you a page number if you need it.

20 A. I do -- yep.

21 Q. Got it?

1 A. Yep. I do, yes.

2 Q. And you said, "Alex, this looks great. I'm
3 wondering do we, one, want to reflect that we're
4 already" -- doing -- "using" -- sorry -- "drastic change
5 for Step 2 for IPS? And, two, do we want to use a
6 different term for drastic change, like large change?"

7 Do you see that?

8 A. Yes.

9 Q. So just breaking that down, number one, can you
10 tell me what you understood yourself to mean when you
11 said: Do we want to reflect that we're already using
12 drastic change for Step 2 for IPS?

13 A. So as I remember it, we had already moved
14 imputation for IPS to be limited achievement.

15 Q. And when did that come about?

16 A. I don't remember exactly.

17 Q. Okay. And do you remember the basis?

18 A. The basis is we actually had information from
19 CMS, Centers for Medicare and Medicaid Services, that
20 could tell us whether a hospital operated an ICU. And
21 if they operated an ICU, and they had not submitted

1 information to the Leapfrog Hospital Survey about their
2 staffing, we were coming to the conclusion that they
3 didn't meet the staffing model that Leapfrog requires.

4 Q. Got it.

5 So you made the assumption based on the
6 existence of an ICU that they were performing at a level
7 of limited achievement?

8 A. To clarify, I'm not sure we were making an
9 assumption. We were -- we had a lack of information
10 about their staffing models. That would be the
11 equivalent of assigning limited achievement.

12 Q. Got it.

13 And is that, to your knowledge,
14 communicated anywhere on the Leapfrog website to
15 consumers?

16 A. I don't know.

17 Q. Okay.

18 Is that communicated in the methodology
19 document, that that's why Leapfrog assigns limited
20 achievement for IPS for nonparticipating hospitals?

21 A. I don't know for certainty.

1 Q. Okay. Do you want to take a look?

2 A. I can.

3 Q. I'm happy to take you there. That's Exhibit 3.

4 A. That sounds correct.

5 Q. I wrote them down today.

6 A. If my memory serves me right.

7 Q. Do you have it, Dr. Austin?

8 A. I do.

9 Q. And if you go to page 10, it talks about the
10 IPS model -- or the measure.

11 MS. LAWSON: This is for Spring 2025?

12 MR. CRAIN: Correct.

13 BY MR. CRAIN:

14 Q. The IPS, as you testified a minute ago, I
15 think, did not change, right, the imputation
16 methodology?

17 A. That was my comment back to Alex.

18 Q. Okay. Yeah.

19 But to the best of your recollection today,
20 between 2024 and 2025, Step 2 for IPS was always limited
21 achievement, right?

1 A. Correct.

2 Q. Okay.

3 So are you on page 10?

4 A. I am.

5 Q. Okay. So just take a look and read the IPS
6 block.

7 A. Yep. I have, yes.

8 Q. And does it provide any explanation, the
9 explanation you just gave for why hospitals receive
10 limited achievement if they don't participate in the
11 survey?

12 A. You would need to follow the last line that
13 says if a hospital didn't submit a survey, you need to
14 look at using secondary data sources.

15 Q. Okay. Let's go to that page. That's page 15?
16 Take a look. And it's on 15 and 16?

17 A. Yes.

18 Q. Yeah. Is there an explanation there?

19 A. On page 16 there is.

20 Q. Let's see. Where is it?

21 A. Note about IPS: Only hospitals that operate an

1 adult or pediatric medical and/or surgical or neuro ICU
2 are eligible for Step 2 imputation of the IPS measure.
3 A hospital's ICU designation is determined from the
4 number of beds reported on Worksheet 5-3 Part 1 of the
5 hospital's most recent CMS cost report. If your
6 hospital does not operate an ICU but shares a CMS
7 certification number, please contact the help desk.

8 Q. Sorry. I see that on page 15. You see it on
9 16?

10 A. I see it on 16.

11 MS. LAWSON: I also see it on 16.

12 THE WITNESS: Under Step 2.

13 BY MR. CRAIN:

14 Q. Step 2. Okay.

15 And your testimony is that language
16 communicates that if a hospital has an ICU and doesn't
17 participate, it automatically gets limited achievement?

18 A. That is the first sentence under Step 2.

19 Q. Okay.

20 A. If the hospital does not have historical data
21 from the last two rounds of the safety grade, the

1 hospital is assigned a point value that is equivalent to
2 receiving limited achievement for this measure on the
3 Leapfrog Hospital Survey.

4 Q. And so what you testified a minute ago, though,
5 was that the -- tell me if I'm misunderstanding -- that
6 the assumption is if a hospital has an ICU and is not
7 reporting, it's not meeting Leapfrog's standards, right?

8 A. We have assigned a score to hospitals. If we
9 know they operate an ICU based on the CMS cost report,
10 and they don't report to the Leapfrog Hospital Survey,
11 we are assigning them a score of limited achievement.

12 Q. Yes, but that was not directly responsive to my
13 question which was -- and I'll go back just to make sure
14 I say it the right way.

15 What you said a minute ago was that the
16 assumption is that if a hospital has an ICU, and they
17 are not reporting, that they are not meeting Leapfrog's
18 standards, right? That's what you said.

19 A. Correct. And then I corrected myself and did
20 not use the word "assumption." That was a poor choice
21 of word there.

1 Q. Okay. That's what I'm trying to understand.

2 A. Correct.

3 Q. Okay.

4 So maybe you tell me in your words then,
5 because now I'm a little confused by the change, why
6 does a hospital get assigned limited achievement if it
7 has an ICU and does not participate?

8 A. They receive a score of limited achievement
9 because we know they have an ICU, and we don't have any
10 information that would tell us whether or not they are
11 meeting the staffing models that Leapfrog asks hospitals
12 to have in the ICU.

13 Q. So why not impose some achievement and not
14 limited achievement?

15 A. Because the way Leapfrog's standards are set in
16 the survey is there are clear criteria of what needs to
17 be met for some achievement, considerable achievement,
18 and achieved the standard. And if you don't meet the
19 criteria for some achievement, you're in the limited
20 achievement bucket.

21 Q. But, again, you don't know either way whether a

1 given hospital is meeting some versus limited or -- I
2 forgot -- the top one, right?

3 A. Correct.

4 Q. Okay.

5 Okay. So let's go back to this document.
6 So that covers IPS Step 2.

7 The second part says, "Do we want to use a
8 different term for drastic change like large change?"
9 Why did you not like the phrase "drastic change"?

10 MS. LAWSON: Object to form.

11 BY MR. CRAIN:

12 Q. Did you not like the word "drastic change"?

13 A. I did not like the word "drastic change."

14 Q. With that now established, why did you not like
15 the phrase "drastic change"?

16 A. I'm trying to think. It felt -- it felt
17 sensational.

18 Q. Okay. What do you mean by sensational?

19 A. I personally think of the word "drastic" as
20 having sort of a sensational connotation, right. It's
21 extreme.

1 Q. Got it. Dramatic?

2 A. Dramatic. That would be a better word.

3 Q. We work with words for a living.

4 MS. LAWSON: I struggled not to interpose my
5 own.

6 BY MR. CRAIN:

7 Q. So did you feel dramatic was inaccurate or it
8 was a problem with the messaging and how it might be
9 received?

10 A. My concern was the messaging and how it would
11 be received.

12 Q. Okay.

13 MR. CRAIN: Oh, I'm sorry. Iason tells me I
14 said dramatic. No, I meant dramatic.

15 MR. TOGIAS: Oh, you meant it?

16 MR. CRAIN: Yeah.

17 MR. TOGIAS: Okay. Sorry.

18 MR. CRAIN: I meant dramatic.

19 BY MR. CRAIN:

20 Q. Let's see. Okay. So let's keep going up. Let
21 me see if there's anything else here. So you see the

1 chart is revised on page 8330?

2 A. Yes.

3 Q. And that, as best I can tell, is just changing
4 to reflect the limited achievement, you know, for IPS,
5 right?

6 MS. LAWSON: And Dr. Austin, you can read --
7 feel free to read through the whole email chain if you
8 need that to refresh your recollection.

9 (Witness peruses document.)

10 THE WITNESS: Can you repeat your question,
11 please?

12 BY MR. CRAIN:

13 Q. Yeah. I'm just looking at 8330, and it looks
14 like the change on the chart is just as you noted
15 before, that IPS was already doing the impute limited
16 achievement.

17 A. Correct.

18 Q. So there's no change there, right?

19 A. That is the only change from the prior chart.

20 Q. Yeah. Sorry. There's no change to IPS under
21 this chart?

1 A. Correct.

2 Q. Yeah.

3 Okay. Let's set this aside. Keep it at
4 the ready.

5 MR. CRAIN: Can I get 36. I'll mark this as
6 Exhibit 16.

7 (Exhibit No. 16 was marked for
8 identification as of 9/25/2025.)

9 BY MR. CRAIN:

10 Q. So Dr. Austin, do you recognize this document?

11 A. Yes. It's an email between myself and Leapfrog
12 staff.

13 Q. You get the hang of it now, these documents.

14 And you see on the bottom right it's an
15 Armstrong-produced document, right?

16 A. Correct.

17 Q. Okay. I want to start -- just go to the bottom
18 again to the first email in the chain, and if you need a
19 minute, take it. Whenever you're ready.

20 (Witness peruses document.)

21 THE WITNESS: Yes.

1 BY MR. CRAIN:

2 Q. Okay.

3 So the first email on the bottom is from
4 Ms. Campione, and it's to Ms. Danforth, you, and
5 Ms. Joshi. Do you see that at 5:41 p.m.?

6 A. Yes.

7 Q. And the subject is Step 2 imputation scores.
8 Do you see that?

9 A. Yes.

10 Q. And she says, "Hi all. I have some bad/good
11 news. The Step 2 scores aren't what we would like.
12 Turns out the hospitals that do the survey perform very
13 well. The BCMA scores below will likely drop with the
14 methodology changes, though."

15 Do you see that?

16 A. Yes.

17 Q. Do you have any understanding today of what she
18 meant by the Step 2 scores aren't what we would like?

19 MS. LAWSON: Object to form. Go ahead.

20 (Witness peruses documents.)

21 THE WITNESS: Where I'm hesitating is my sense

1 is she was looking at a subset of hospitals, and I don't
2 remember what that subset of hospitals was.

3 BY MR. CRAIN:

4 Q. Okay.

5 Do you remember the purpose of her running
6 that subset?

7 A. My recollection is it's somehow connected back
8 to conversations with the expert panel about imputation
9 and one of the scenarios that maybe someone suggested we
10 look at, but I couldn't explicitly say which scenario
11 that was.

12 Q. So we talked a little bit about quartile,
13 right? Do you remember that discussion?

14 A. Uh-huh.

15 Q. If you look at the chart right below her text,
16 do you see it says Mean of Bottom Quartile?

17 A. Yes.

18 Q. Okay. And it says the CPOE, hand hygiene, and
19 BCMA scores. Do you see that?

20 A. Yes.

21 Q. And I'll work you up the email now.

1 (Whereupon, the court reporter seeks
2 clarification, which colloquy will not be
3 captured on the written record.)

4 BY MR. CRAIN:

5 Q. Let's go up. You respond. Do you see that?

6 A. Yes.

7 Q. And you say, "Alex, would it be easy to look at
8 the same for first time reporters? We may have to
9 consider the option of just assigning the score for
10 limited achievement, which is actually consistent with
11 how we are approaching IPS."

12 Do you see that?

13 A. Yes.

14 Q. Okay.

15 Does this refresh your recollection as to
16 what she was running and why she was doing this?

17 A. Not really.

18 Q. Okay. It doesn't have to. That's okay.

19 A. Okay.

20 Q. Okay. So she responds it looks like five
21 minutes later. She says, "Not too difficult. I would

1 predict they're just slightly lower." And then you
2 respond at the top, "Thanks. Then maybe not worth the
3 effort."

4 Do you see all of that?

5 A. Yes.

6 Q. Okay.

7 Do you have any recollection today about
8 why you would say it's not worth the effort?

9 A. What I interpreted from Alex's statement was
10 that the results wouldn't be much different than what
11 she had originally produced.

12 Q. And the -- go ahead. Sorry.

13 A. So it didn't seem worth the analytical effort
14 to update it for something that wasn't meaningful
15 different -- meaningfully different in terms of Leapfrog
16 deciding how it wanted to move forward.

17 Q. And meaningfully different in this case meaning
18 lower, right?

19 A. Correct. She indicated that they would be
20 slightly lower.

21 Q. And you all wanted the numbers to be lower,

1 right?

2 MS. LAWSON: Object to form.

3 BY MR. CRAIN:

4 Q. You can answer.

5 A. There were concerns that the mean scores that
6 we had been using for imputation had been going up
7 considerably which created a disincentive for hospitals
8 to actually complete the survey.

9 Q. Yes. We saw that in the safety grade meeting,
10 right, that there were concerns that imputation scores
11 were creeping up?

12 A. That was one of the noted -- yeah.

13 Q. Right. On the slide that you drafted.

14 A. Correct.

15 Q. That was one of the bullets, right?

16 A. Correct.

17 Q. And in response to that, we saw that
18 Dr. Pronovost suggested a quartile approach, right?

19 MS. LAWSON: Object to form.

20 THE WITNESS: Once again, I -- in reading the
21 transcript, it wasn't super clear what Peter was exactly

1 discussing or suggesting.

2 BY MR. CRAIN:

3 Q. Let me phrase it a little bit differently that
4 I hope will be easier.

5 At the expert panel meeting, in the
6 transcript we saw him say the word "quartile." Fair?

7 A. Fair.

8 Q. Okay.

9 And then 10 days later -- let me just
10 double check. More than 10 days later we have
11 Ms. Campione sending around a chart that lays out, among
12 other things, the mean of bottom quartile. Do you see
13 that? That's on the last page.

14 A. Yes.

15 Q. Okay.

16 But the numbers are too high there, right?

17 MS. LAWSON: Object to form.

18 THE WITNESS: I don't know how to respond to
19 that. I mean, all of the data are here.

20 BY MR. CRAIN:

21 Q. So let's go to Ms. Danforth's email of

1 9:11 p.m. This is on page 2128. Do you see it?

2 A. Uh-huh.

3 Q. She said, "This is sort of what I was afraid of
4 but somehow more stark seeing the actual numbers. I do
5 think that we need to at least go wider" -- which I
6 understand to mean consider -- "going to limited
7 achievement." Do you see that?

8 A. Yes.

9 Q. Okay.

10 Do you understand what she is saying in
11 this email?

12 A. My understanding is she was indicating that the
13 numbers aligned with what she thought might be the case
14 and was recommending that we need to consider going to
15 limited achievement.

16 Q. Okay.

17 So just to build this out a little bit, at
18 this time, under the methodology that was governing, the
19 imputation under Step 2 was a straight mean, not a
20 lowest quartile mean but a straight mean, right? Do you
21 understand what I mean?

1 A. It was a -- there were two values that were
2 calculated for each hospital. There was the overall
3 mean and I believe that of -- the first time reporters
4 in the hospital got the lower of those two values.

5 Q. And the concern was those means were too high,
6 right?

7 A. The concern was that those means
8 disincentivized hospitals to report into the survey.

9 Q. Yes. Okay. Because they were too high, right?

10 A. Because they would give hospitals a lot of
11 credit when they wouldn't have to necessarily
12 demonstrate anything for that.

13 Q. Okay.

14 And you say when they wouldn't have to
15 demonstrate anything for that, but do you have any
16 empirical knowledge of whether that credit, so to speak,
17 would have been due as a matter of performance?

18 A. We don't have any empirical evidence on what a
19 hospital's performance would be when they don't report
20 because we don't actually have those data.

21 Q. On the measures for which you don't have data,

1 right? What I mean is you have other data, like CMS
2 data for those hospitals?

3 A. Correct.

4 Q. That's all I meant.

5 So then Ms. Campione runs a different mean,
6 right? The mean in this email is not the mean that you
7 all had been imputing as a part of Step 2 in the prior
8 methodology. Is that right?

9 A. My understanding is the very bottom table --

10 Q. Uh-huh.

11 A. -- where it says current Step 2 means for
12 reference are what the means had been that we were using
13 at the time.

14 Q. Okay.

15 And so but the mean in the top part where
16 it says the Mean of Bottom Quartile, am I understanding
17 right that that's taking the bottom quartile of
18 hospitals and calculating the mean of those hospitals?

19 A. That's what I don't know was what sample of
20 hospitals she was using for that calculation. I don't
21 know if it was all hospitals or if it was a subset of

1 hospitals.

2 Q. Okay.

3 So how would it work to calculate the mean
4 of bottom quartile for all hospitals?

5 A. I would take the full dataset of hospitals for
6 which we have data, identify the bottom 25 percent, and
7 calculate the mean of that sample.

8 Q. Okay. And do you have any reason to think
9 that's not what she did?

10 A. I don't have any reason to think it's not what
11 she did, but I also don't know that is what she did.

12 Q. Okay. Okay.

13 Okay. So we can set that aside.

14 MR. CRAIN: Okay. Let's go to tab 38. This
15 will be Exhibit 17.

16 (Exhibit No. 17 was marked for
17 identification as of 9/25/2025.)

18 BY MR. CRAIN:

19 Q. Okay. Dr. Austin, you have Exhibit 17, and you
20 see on the bottom it's an Armstrong document ending
21 16473?

1 A. Yes.

2 Q. And this is an email thread between you and
3 Ms. Joshi, right?

4 A. Yes.

5 Q. And this, if you look at the bottom two emails
6 on the first page, that's the emails we saw at a prior
7 exhibit where she's sending you her draft of the notes,
8 right?

9 A. Yes.

10 Q. Okay. And you say -- this is on May 14th. Do
11 you see that date?

12 A. Yes.

13 Q. So it's a few days after the email we just
14 looked at, which was dated April 22nd. Do you see that?

15 A. Yes.

16 Q. Okay. So this is after you've gone through the
17 analysis of the bottom quartile mean. It's after you've
18 gone through that email thread we just saw, right?

19 A. Yes.

20 Q. Okay.

21 In between that period of April 12th and

1 now May 14th, do you recall any other discussions you
2 had with members of the expert panel about the
3 imputation model?

4 A. I don't remember.

5 Q. Okay. You don't -- just to be clear, you don't
6 remember either way?

7 A. I don't remember either way.

8 Q. Okay.

9 So I want to go to the Word document here
10 of the attachment. And do you see -- is it -- these are
11 your revisions to the notes, correct?

12 A. Yes.

13 Q. And I want to walk through a few of these. You
14 start by at the top adding Tim Vogus to the attendees?

15 A. Yes.

16 Q. Any idea how you remembered he was there a
17 month later?

18 A. To be clear, I sent the edits back to Preeti a
19 month later.

20 Q. That's what the email suggests. If you look --
21 look on page 1.

1 A. But that doesn't mean I made the edits a month
2 later.

3 Q. Oh, so I'll represent to you that the metadata
4 shows that these are your changes.

5 A. Okay.

6 Q. I'm trying to see if there is a comment, too.
7 No. But I'll represent to you that the attachment shows
8 that you -- like you inserted the track changes.

9 Do you have any reason to think you didn't?

10 A. No. I'm wondering about the timing of when I
11 made the edits.

12 Q. Got it. Okay. That I don't know as well. So
13 you're saying you could have made these edits earlier?

14 A. Correct.

15 Q. Got it. Okay.

16 Do you recall, to do these edits, did you
17 watch the video of the meeting?

18 A. No.

19 Q. Okay. So you were going from memory, you
20 think?

21 A. Yes, and my own notes.

1 Q. And your own notes. And your own notes, would
2 they have been different from the email we saw earlier
3 where you sent it to and from yourself?

4 A. No. That was the extent.

5 Q. So I'm going to skip bullet one, which is on
6 the military treatment facilities again, and I want to
7 focus on your edits to bullet two. Do you see those?

8 A. Yes.

9 Q. Okay. And you say, "Matt provided the expert
10 panel with a quick overview of the current imputation
11 model approaches Leapfrog has been using and some of the
12 challenges those approaches have created for issuing
13 accurate grades." Do you see that?

14 A. Yes.

15 Q. Okay. And to the best of your recollection,
16 that is an accurate statement of what occurred at the
17 meeting, right?

18 A. Yes.

19 Q. Okay.

20 Then you say, "The current imputation model
21 has two steps when data are missing." Do you see that?

1 A. Yes.

2 Q. And I won't read them because we've been
3 through them, but just looking yourself at Step 1 and
4 Step 2, consistent with the slide deck that we saw?

5 A. Yes.

6 Q. And then you say, "Leapfrog's proposal was to
7 retire Step 1 of the model and use only Step 2,
8 assigning hospitals the mean score for their cohort."
9 Do you see that?

10 A. Yes.

11 Q. And then I want to skip down a bullet that you
12 delete. Do you see that?

13 A. Yes.

14 Q. And it says, "Missy gave an example of Stewart
15 Health System and said that Leapfrog's purpose by
16 implementing the Step 2 imputation model is not to
17 penalize hospitals or to motivate them to submit a
18 survey, but they don't want to report hospitals with the
19 highest scores when hospitals are not submitting the
20 hospital survey."

21 Do you recall why you deleted that bullet?

1 A. I believe I deleted that bullet because it felt
2 like a little too micro of a note to include in a
3 meeting summary.

4 Q. Got it. So it was not an edit for substance?

5 A. Can you define that?

6 Q. Yeah. Fair enough.

7 Did you delete it because you disagreed
8 that anything -- with anything in that bullet?

9 A. No, that was not my reason for deleting it.

10 Q. Okay.

11 Then let's keep going. So you then go --
12 there's a bullet we looked at before. "Matt mentioned
13 it's important to see whether there is an actual
14 difference in hospitals' performance and whether there
15 is some sort of bias in the measurement against them.
16 He said to minimize the second, and if there are
17 differences in hospitals' performance, we can address
18 the structural issues to fix them."

19 Do you see that?

20 A. Yes.

21 Q. And you deleted that one as well, right?

1 A. Yes.

2 Q. And similar, not to be so granular in the
3 meetings?

4 A. Yes.

5 Q. And then you added a bullet and you say, "The
6 experts' panel were in support of having hospitals share
7 their current performance, so liked the idea of imputing
8 the equivalent of willing to report to hospitals that do
9 not submit a survey."

10 Do you see that?

11 A. Yes.

12 Q. Now, you recall looking at the index of the
13 transcript, right?

14 A. Yes.

15 Q. And we saw the phrase "willing" did not appear
16 at least in the index, correct?

17 A. Yes.

18 Q. Where did this line come from?

19 A. So as mentioned, I'm not sure the expert panel
20 would have necessarily used the term "willing to report"
21 in their conversation. I would need to go back to the

1 transcript, but my guess is that there was communication
2 about putting them in the lowest performance category.

3 Q. Okay. So the phrase you would be looking for
4 is lowest performance category?

5 A. Or some context of that.

6 Q. Okay. And presumably you would want to review
7 the whole thing before committing one way or another?

8 A. Correct.

9 Q. Fair enough.

10 Okay. So to the best of your
11 recollection -- so strike that.

12 When creating the notes, you would have
13 wanted to be accurate, right?

14 A. Correct.

15 Q. Okay. And so just looking at these notes and
16 your edits, your best understanding of these edits is
17 that at some point somebody discussed the concept of
18 giving them the willing to report grade, right?

19 A. Correct.

20 Q. Okay.

21 A. And that others agreed with that point of view.

1 Q. Okay.

2 And then just to go back, do you remember
3 the chart we looked at, the drastic change chart?

4 A. Yes.

5 Q. You want to look at it again just so we're
6 not -- and that is exhibit --

7 A. Fifteen.

8 Q. Fifteen. Let's look at 15. And we can go to
9 the last page, 18332. Do you see that?

10 A. Yes.

11 Q. Okay.

12 And is it your testimony that the bottom
13 right box is the same as this willing to report?

14 A. Yes.

15 Q. Okay. And the bottom right box says impute
16 with limited achievement scores, right?

17 A. Yes.

18 Q. So your testimony is that at the meeting at
19 least somebody discussed the notion of imputing limited
20 achievement scores, maybe not by that word, and that
21 others agreed, right?

1 MS. LAWSON: Object to form.

2 THE WITNESS: From my notes here, it indicates
3 that the expert panel supported the idea of assigning
4 the bottom performance category.

5 BY MR. CRAIN:

6 Q. Okay. And do you recall -- strike that.

7 Okay. You can set that aside.

8 MR. CRAIN: Let's go to tab 43. This is going
9 to be Exhibit 18.

10 (Exhibit No. 18 was marked for
11 identification as of 9/25/2025.)

12 BY MR. CRAIN:

13 Q. All right. This is an email. The top one is
14 from Ms. Binder to Ms. Campione, cc'ing you and
15 Ms. Danforth. Do you see that?

16 A. Yes.

17 Q. Okay. And do you recognize this document?

18 MS. LAWSON: You can take a minute to read
19 through it all.

20 THE WITNESS: The email or the --

21 BY MR. CRAIN:

1 Q. Let's start with the email. Do you recognize
2 the email?

3 A. Yes.

4 Q. Okay. You recall it today?

5 A. Can you clarify that?

6 Q. Yeah. Do you recall receiving it?

7 A. I do recall Alex putting together a document
8 with the proposed changes to the methodology that would
9 go out for public comment.

10 Q. And is that the document, at least in edited
11 form, on page 9813?

12 A. Yes.

13 Q. Okay. And do you recall did any members of the
14 expert panel review and revise the document?

15 A. I don't remember explicitly if we shared this
16 document with them.

17 Q. Yeah. Okay. I mean -- I'll move on from that.
18 I'll move on from that.

19 So the attachment, do you see it says
20 Request for Public Comment?

21 A. Yes.

1 Q. Do you recall reviewing the document?

2 A. I don't recall.

3 Q. Okay. Just your best answer. That's all we
4 ask.

5 So I want to go -- I'll represent to you on
6 page 9814 these are Ms. Binder's tracked change edits to
7 the documents, and I want to just note a few things that
8 she tweaked. So if you go to the second -- tell me when
9 you're ready. No worries.

10 MS. LAWSON: The font is so small.

11 MR. CRAIN: Yeah, it is small. Sorry about
12 that.

13 BY MR. CRAIN:

14 Q. Are you good, Dr. Austin?

15 A. Yes.

16 Q. Okay.

17 So if you go to the second paragraph, to
18 ensure, do you see that?

19 A. Yes.

20 Q. And I apologize. It's in black and white, too,
21 which makes it harder.

1 But go down to the third line. The
2 original text said: "The panel recognized that the
3 current imputation method, which is used to fill in
4 missing data among hospitals that did not complete the
5 most recent Leapfrog survey, have influenced hospital
6 survey participation and may no longer be valid."

7 Do you see that?

8 A. Yes.

9 Q. Okay. She changed it to: "The panel advised
10 that Leapfrog modify the current imputation method,
11 which is used to fill in missing data among hospitals
12 that did not complete the most recent Leapfrog survey."

13 Is that consistent with your recollection
14 of who was advising? Did the panel actually advise
15 Leapfrog to change the methodology?

16 MS. LAWSON: Object to form but go ahead.

17 THE WITNESS: The Leapfrog Group has full
18 decision-making authority around its ratings and rating
19 systems and methodologies. So myself and all of the
20 expert panels are acting in an advisory capacity to
21 Leapfrog for that.

1 BY MR. CRAIN:

2 Q. Okay.

3 So is this accurate, this change?

4 A. Yeah, that change would be accurate.

5 Q. Okay.

6 And then if we go down, I want you to look
7 at -- can you read what she cut in the next paragraph?

8 A. Yes.

9 Q. Okay. "Note that Step 1 imputation will be
10 temporarily paused" -- oh, sorry. That's not the one I
11 wanted.

12 Go back up, excuse me, to the prior
13 paragraph. She cut a sentence: "The collective
14 recommendation was for Leapfrog to modify its current
15 imputation approach to encourage survey participation
16 and to improve user's confidence in the data that are
17 used to calculate scores."

18 Do you see that?

19 A. Yes.

20 Q. Okay. Was that accurate?

21 MS. LAWSON: Just to be clear, you're asking

1 was the sentence that she struck, that the collective
2 recommendation, was that sentence accurate?

3 MR. CRAIN: Correct. Not the strike. I don't
4 want to know if the strike was accurate. I want to know
5 if the sentence as written was accurate.

6 THE WITNESS: Okay.

7 (Witness peruses document.)

8 THE WITNESS: Yes.

9 BY MR. CRAIN:

10 Q. Okay.

11 Now, I want to go to her email. And what
12 she says is -- are you at the top?

13 A. Yes.

14 Q. The second paragraph: "I don't think we need
15 the sentence about influencing survey participation and
16 giving people confidence in validity. It sounds
17 defensive, like nobody participates in the survey and
18 our own TEP questions our validity. Actually, this
19 change affects a minority of hospitals and optimizes the
20 grade's already strong validity. Anyway, it's not
21 necessary to get into the why. It's enough that the

1 expert panel advised us to do the imputation in a
2 different way and not treat older, better data in an
3 equivalent way to new data."

4 Do you see that?

5 A. Yes.

6 Q. Okay.

7 And then did you agree that it sounded
8 defensive -- that's my first question -- the changes
9 that she cut?

10 MS. LAWSON: Object to form.

11 I think, just to clarify, do you agree that
12 the sentence she cut sounded defensive?

13 MR. CRAIN: Correct.

14 (Witness peruses document).

15 THE WITNESS: That wouldn't be the word I would
16 use to describe that sentence.

17 BY MR. CRAIN:

18 Q. What word would you use?

19 A. Explanatory.

20 Q. Okay.

21 And do you agree -- I mean, she says it

1 sounds like nobody participates in the survey and our on
2 TEP questions our validity. Did you have that same
3 reaction reading it?

4 A. That wasn't my own read of that sentence.

5 Q. What was your read of the sentence?

6 A. That we wanted to improve confidence in the
7 data that we were using and the score.

8 Q. And to encourage participation?

9 A. That would be a byproduct of that change.

10 Q. How would that be a byproduct?

11 A. If we're no longer imputing the mean scores, it
12 might encourage some hospitals, specifically those that
13 are performing better than the mean, to actually come in
14 and share their performance. I take that back. They
15 would have been already incentivized to do that.

16 It would incentivize hospitals that didn't
17 report and were below the mean to come in and report.

18 Q. Because the new score would be lower than their
19 performance?

20 A. Correct.

21 Q. Okay. And the new score would not necessarily

1 reflect their actual performance?

2 A. It's undetermined whether it would reflect
3 their performance or not.

4 Q. Because you don't know either way?

5 A. Because we don't know, exactly, where each
6 hospital is at.

7 Q. Yes. Okay.

8 And then I want to go back to her email.
9 And she says, "I think when we respond to the public
10 comments, we can be more pointed and specific about the
11 survey and imputation reasoning, if necessary. The
12 comments will give us a good gauge on the extent to
13 which we need to reveal all our reasoning and whether
14 the expert panelists will truly stand up for it when
15 push comes to shove."

16 Do you see that paragraph?

17 A. Yes.

18 Q. What's your understanding of what she meant
19 here?

20 A. That the -- putting out the proposed changes
21 wasn't the time to share all of the logic which led to

1 the decision to propose this, that that could come out
2 during the responses to the comments.

3 Q. And do you have any understanding by what she
4 means of whether the expert panelists will truly stand
5 up for it when push comes to shove?

6 A. I believe she meant that there could be some
7 pushback from hospitals about this proposed change and
8 would the expert panel stand with Leapfrog in this -- in
9 moving forward in this direction.

10 Q. Had the expert panel ever not stood with
11 Leapfrog in a change to the methodology?

12 A. No.

13 Q. Okay. So any understanding as to why this
14 might be different?

15 A. This change was the most direct in confronting
16 hospitals about their lack of participation in the
17 survey.

18 Q. What do you mean by direct?

19 A. In the past, all the imputation models, from
20 ignoring the measure to using secondary data sources to
21 calculating, assigning you the national mean didn't

1 necessarily direct -- confront a hospital to say you're
2 not submitting data and that's a problem with us.

3 We gave them sort of a pass. We found
4 another way to give them a score. So this was the most
5 direct confrontation on that.

6 Q. Was that the goal of the change?

7 A. I think the goal was multifold.

8 Q. Okay.

9 A. I think one, as mentioned, was to improve the
10 confidence of the data in terms of what data we were
11 using to calculate the scores. A secondary goal was to
12 increase or incentivize survey participation.

13 Q. Okay.

14 And then the confidence of the data, how
15 does it improve the confidence of the data to
16 automatically assign nonparticipating hospitals limited
17 achievement on the four imputed measures?

18 A. In the framework of the idea being that if we
19 don't have any information about your hospital -- so the
20 historical use of willing to report, the idea was that
21 was to acknowledge hospitals who were willing to be

1 transparent but didn't meet the standards that Leapfrog
2 had set.

3 So we don't have -- can you repeat your
4 question again, please?

5 Q. Sure. Sure.

6 I said -- you said -- so you talked about
7 one goal was the confidence of the data, right, and what
8 I asked was how does it improve the confidence of the
9 data to automatically assign nonparticipating hospitals
10 limited achievement on the four imputed metrics?

11 A. So when we were calculating the national mean
12 for hospitals, we don't necessarily have any information
13 that that hospital is an average performer in that area.
14 We are assuming they are average, and in a normal
15 distribution, half of hospitals are below the average.

16 So because we don't know anything about the
17 hospital and their performance in that way, in some ways
18 this idea of willing to report actually better reflects
19 what we do know.

20 Q. Better -- okay.

21 So I want to go and look at -- let's get

1 concrete with this.

2 MR. CRAIN: So this is Exhibit 19.

3 (Exhibit No. 19 was marked for
4 identification as of 9/25/2025.)

5 BY MR. CRAIN:

6 Q. So Dr. Austin, do you recognize this page, at
7 least generally?

8 A. Yes.

9 Q. Okay. This is the Delray Medical Center
10 Hospital Safety Grade page, right?

11 A. Yes.

12 Q. Have you ever seen Delray in particular?

13 A. No.

14 Q. Okay. But you know generally the format of how
15 these pages work, right?

16 A. Yes.

17 Q. Okay. So it's not necessarily the best because
18 it's a paper, and you can see it on a website instead,
19 but you get the gist, right?

20 A. Yes.

21 Q. So I want to go down the page. You see at the

1 top it says big "F," right, for Delray?

2 A. Yes.

3 Q. Okay.

4 And I want to go to page 2. And so this is
5 specifically on the handwashing measure, right?

6 A. Yes.

7 Q. And if you go just back to page 1, and it's a
8 little hard to tell because -- but if you line up the
9 handwashing at the top of page 2 with the gas gauge, do
10 you see that?

11 A. Yes.

12 Q. And there's a red gas gauge above handwashing,
13 right? And then it says: The hospital's score is 15,
14 right?

15 A. Yes.

16 Q. And it says: Worst hospital's score is 15,
17 correct?

18 A. Yes.

19 Q. And then it says: What safer hospitals do.

20 And before I go into that, I just want to
21 clarify again. Did you have any role in editing this

1 website, not specific to Delray but the safety grade
2 pages, generally?

3 A. I did review and help edit the descriptions
4 that are -- the handwashing and what safer hospitals do.

5 Q. Okay. So you're familiar with this language?

6 A. Yes.

7 Q. Okay.

8 And it says: "What safer hospitals do.
9 Hospitals provide training and implement policies to
10 make sure all hospital staff cleans their hands before
11 touching a patient." Do you see that?

12 A. Yes.

13 Q. Okay.

14 Now, you said a goal of the new
15 methodology, the first goal was -- let me just go back
16 to what it was. It's confidence in the data, right?

17 A. Correct.

18 Q. How does putting Delray at a 15 for handwashing
19 give confidence in the data?

20 A. Once again, we don't have any information from
21 Delray Medical Center about how they are doing toward

1 meeting Leapfrog's standard for hand hygiene, and,
2 therefore, in the absence of information, we're going to
3 assign the equivalent of willing to report, which is now
4 limited achievement.

5 Q. Even though they're not willing to report,
6 right? Correct?

7 A. Correct.

8 Q. Yeah.

9 So how does a consumer looking at this
10 page, though, feel confidence that the grade is
11 accurate?

12 A. I haven't studied how consumers review and
13 interpret this information, so I don't know if I can
14 speak to how they would interpret this.

15 Q. You buy things, right?

16 A. I do.

17 Q. And do you look at consumer reports, other
18 ratings types for products?

19 A. Yes.

20 Q. Do you trust that the rating is accurate that
21 those reports provide?

1 MS. LAWSON: Object to form. Go ahead.

2 THE WITNESS: I think it depends on the source.

3 BY MR. CRAIN:

4 Q. Fair enough. Give me one that you trust.

5 A. I can't think of one offhand, but I'd be more
6 inclined to trust something that was an individual
7 reviewing products against similar products.

8 Q. Okay. I'm not sure I understood that, but can
9 you clarify? Sorry.

10 A. Yeah. Meaning like if I wanted to buy a new
11 coffee maker --

12 Q. Yeah.

13 A. -- I would be more inclined to trust someone
14 who has reviewed coffee maker A against B, C, and D --

15 Q. Okay. Got it.

16 A. -- than someone just chiming in about coffee
17 maker A and what their experience was.

18 Q. Okay. That's -- okay. We can work with that
19 one.

20 So my question is if you have coffee maker
21 -- in your first analogy, right, coffee maker A, B, C,

1 and D, he's reviewing them all. If you find out that
2 for a subset of the coffee makers he's giving you
3 information about the quality of the product without
4 actually having reviewed it, does that instill
5 confidence in you or no?

6 A. It might give me pause.

7 Q. And how is that different from what we see
8 here?

9 A. Can you clarify that question?

10 Q. Yeah. So you said it might give you pause if
11 for certain of the coffee makers the ultimate rating
12 included measures for which the reviewer didn't have any
13 information, right? How is that different from
14 handwashing for Delray?

15 A. So I think what's notable is that the score has
16 an asterisk, which explains, I believe, how that score
17 was arrived at.

18 Q. So we'll come to the asterisk in a second. I'm
19 trying to get a sense of you said one of the goals of
20 the new model was to instill confidence in the data.
21 And you said another goal was to encourage

1 participation, right? How does it instill confidence in
2 data to represent that a hospital got the lowest score
3 on hand hygiene when you have no information about their
4 performance otherwise? Doesn't that undermine
5 confidence in the data?

6 MS. LAWSON: Object to form.

7 MR. CRAIN: Two questions.

8 MS. LAWSON: Two questions.

9 BY MR. CRAIN:

10 Q. You can pick either one or I can restart,
11 either or.

12 A. Can you restart?

13 Q. Sure. So -- that's a fair ask.

14 So I want to understand how does it instill
15 confidence in data to represent that a hospital got the
16 lowest score in hand hygiene where this page says
17 hospitals that are safer provide training and implement
18 policies to make sure all hospital staff cleans their
19 hands before touching a patient. How does it instill
20 confidence in data to give a hospital the lowest score
21 on that metric with no information?

1 A. That's what we're representing here is that we
2 have no information. That's what the asterisk is
3 telling you is we have no information.

4 Q. Okay. So the asterisk, you're saying -- so
5 does the asterisk undermine the score?

6 A. No. The asterisk is saying the hospital
7 declined to report their performance, so the score
8 reflects the lack of information available.

9 Q. So then how can the consumer feel confident
10 that the ultimate grade is accurate?

11 A. So Leapfrog is fully transparent with the
12 information it presents. A patient can review each of
13 the measures, decides what's important to them, what's
14 not important to them, and make decisions based on that
15 and other pieces of information that they may look for
16 and acquire.

17 Q. So I take the talking point. Do -- when you
18 say they're fully transparent, is that referring to the
19 methodology document that we looked at as Exhibit 3?

20 A. That is the methodology document. That is how
21 each of the individual scores on each of the individual

1 measures make up the composite.

2 Q. So let's take a different hospital. Delray,
3 you understand, got Step 2 imputation, right?

4 A. Yes.

5 Q. If I showed you a hospital for Step 1
6 imputation, is the website any different?

7 A. I don't know the answer to that.

8 Q. Okay. I will represent to you it's the same
9 asterisk. How does a consumer know whether a
10 nonparticipating hospital got Step 1 or Step 2
11 imputation?

12 A. I don't know enough about what those different
13 scenarios are on the website, so I can't.

14 Q. Do you have any reason to believe that Leapfrog
15 actually communicates to the consumer that Wood hospital
16 or Austin hospital got Step 1, as opposed to Crain
17 hospital Step 2?

18 MS. LAWSON: Object to form. Go ahead.

19 THE WITNESS: To answer that, I would need to
20 see an example of a hospital that had Step 1 imputation.

21 BY MR. CRAIN:

1 Q. Okay. But you have no reason today to think
2 that there is any difference in the presentation?

3 A. I don't know whether there is or is not.

4 Q. Okay.

5 Where on the page in front of you does it
6 say how the score was assigned?

7 A. Can you clarify that question?

8 Q. Yes.

9 So you pointed to the asterisk on this
10 package, right, and it says a score was assigned, right?

11 A. Correct.

12 Q. And you said you had a role in at least
13 reviewing that asterisk, right?

14 A. I don't know that that's true or not true.

15 Q. Okay. You said you had a role in reviewing
16 something on this page.

17 A. I reviewed the descriptions underneath
18 handwashing and what safer hospitals do.

19 Q. Got it. But you don't recall whether you
20 reviewed the asterisk?

21 A. Correct.

1 Q. Okay.

2 So it says a score was assigned, right?

3 Where does it say how the score was assigned?

4 A. Can you clarify the "how"?

5 Q. Sure. I'll give you an example. This was --
6 let's say a hospital is assigned a score through Step 1.

7 Where would it say that on this page?

8 A. I don't know where Leapfrog chose to put that.

9 Q. Okay.

10 Where does it say that Delray received a
11 score under Step 2?

12 A. That's what the asterisk is noting is that it
13 was -- they declined to report their performance, so a
14 score was assigned to reflect the lack of information
15 available.

16 Q. So you're saying that somebody reading that
17 will understand that the assignment of the score was
18 under Step 2?

19 MS. LAWSON: Object to form.

20

21 BY MR. CRAIN:

1 Q. Is that what you're saying?

2 A. I don't know how people read and interpret
3 things.

4 Q. Okay.

5 Do you think this is a clear explication of
6 how the score was assigned?

7 A. I think it puts in words what Leapfrog did. It
8 puts Step 2 into words.

9 Q. How does it put Step 2 into words?

10 A. There was a lack of information available --

11 Q. Uh-huh.

12 A. -- so a score was assigned to reflect the lack
13 of information.

14 Q. But a score could be assigned in any way,
15 right? How would a consumer know that it was assigned
16 with an automatic limited achievement?

17 MS. LAWSON: Object to form.

18 THE WITNESS: From the text that's there and
19 the asterisk, I'm not sure they would know how that was
20 assigned.

21 BY MR. CRAIN:

1 Q. Okay. Thank you.

2 And are you aware of any other page on
3 Leapfrog's website where that's explained besides
4 Exhibit 3, the methodology document?

5 A. I don't know if it is or not.

6 Q. Okay.

7 MR. CRAIN: Okay. Let's -- let's see. How
8 long have we been going? About an hour. Are you good
9 to keep going, or do you want a break?

10 THE WITNESS: Yep. I'm good.

11 MS. LAWSON: I was going to say can we take a
12 quick break?

13 MR. CRAIN: Yeah, that's fine. It's been about
14 an hour. It's not an endurance test.

15 THE VIDEOGRAPHER: This marks the end of media
16 unit number five. We're off the record. The time is
17 2:13 p.m.

18 (Whereupon a short break was had, after
19 which the proceedings continued as
20 follows:)

21 THE VIDEOGRAPHER: This marks the beginning of

1 media unit number six. We're going back on record. The
2 time is 2:38 p.m.

3 BY MR. CRAIN:

4 Q. So Dr. Austin, we were talking about the
5 website, and I think that's what you have in your hand.
6 You can put that aside for now. We're going to go back
7 to what we were talking about before we went down the
8 website rabbit hole.

9 You recall we were looking at Ms. Binder's
10 edits to the -- the public comment document. Do you
11 recall that?

12 A. Yes.

13 Q. Okay.

14 I just want to show you another email.

15 MR. CRAIN: This will be Exhibit 20.

16 (Exhibit No. 20 was marked for
17 identification as of 9/25/2025.)

18 BY MR. CRAIN:

19 Q. All right. Dr. Austin, you see the document,
20 the email at the top is from you?

21 A. Yes.

1 Q. Okay. Do you recognize this email thread?

2 A. Yeah. It's a continuation of the prior one.

3 Q. Yeah, the one -- the prior one being where

4 Ms. Binder gave her comments, right?

5 A. Correct.

6 Q. And do you see Ms. Danforth forwards you

7 Ms. Binder's email that we were looking at before, and

8 she says, "Hi, Matt. Since she mostly updated the parts

9 Peter and Patrick helped with, you can take a look and

10 let us know if you have any concerns? We'd love to get

11 this out Monday or Tuesday next week."

12 Do you see that?

13 A. Yes.

14 Q. First of all, does this refresh your

15 recollection as to whether Peter and Patrick helped with

16 this document?

17 A. Yeah. I will take it at its value or face

18 value. That's what it says, so that's what they had

19 done.

20 Q. And Peter refers to Dr. Pronovost?

21 A. Correct.

1 Q. And Patrick refers to Dr. Romano?

2 A. Correct.

3 Q. Okay. Both of whom have been involved with
4 Leapfrog for many years, right?

5 A. Correct.

6 Q. And you respond at 4:25. Do you see that?

7 A. Yes.

8 Q. And you say, "My only note is the "why" has
9 been edited out the explanation. So you don't really
10 explain why this change is being done. But it reads
11 fine. No concerns." Do you see that?

12 A. Yes.

13 Q. So you noted that the "why" was edited out,
14 right?

15 A. Yes.

16 Q. Would you have preferred to keep it in?

17 A. Prefer is, perhaps, a strong term. The
18 communication is coming from The Leapfrog Group, so they
19 get the final call on what it says. I thought it was --
20 it would be stronger to sort of explain why we were
21 doing this.

1 Q. So you thought -- okay. Got it.

2 And why did you think it would be stronger
3 to explain why you were doing it?

4 A. I think generally people like a context to why
5 something is being done.

6 Q. Would it have been more transparent to explain
7 the reasoning?

8 A. I don't know if transparent is the word I would
9 use for that. It would have been more complete.

10 Q. Okay.

11 Okay. You can set that one aside.

12 Let's see. So just going back to the
13 comment document, right, that we saw. You're aware that
14 it was issued to the public, right?

15 A. Yes.

16 Q. And you're aware that the public commented on
17 the proposal, right?

18 A. Yes.

19 Q. Did you have any role in reviewing the
20 comments?

21 A. I don't remember.

1 Q. Okay. Do you remember anything about the
2 comments generally?

3 A. I don't.

4 Q. Okay. Let's take a look at some and just see
5 if it jogs your memory.

6 MR. CRAIN: Iason, can you give me 45.

7 This will be Exhibit 21.

8 (Exhibit No. 21 was marked for
9 identification as of 9/25/2025.)

10 BY MR. CRAIN:

11 Q. Okay. Exhibit 21. So take a look at this
12 document, Dr. Austin. Do you recognize it at all?

13 A. I do not.

14 Q. Okay. I'm just going to read -- this is an
15 email from the Leapfrog help desk to Ms. Campione. I'm
16 just going to read -- do you see down the page it says
17 Becky Wenthold?

18 A. Yes.

19 Q. And she said, "I was [sic.] disappointed with
20 the 2024 proposed changes. These changes will penalize
21 hospitals that do not submit a Leapfrog survey. The

1 public will not understand nor dig into the methodology
2 of these grades, and hospitals will be falsely
3 represented with a lower grade because they choose not
4 to complete a survey. The survey is extremely time
5 intensive and, in a time when hospitals are barely
6 breaking even financially, they do not have the
7 resources to commit to this survey."

8 Do you see that?

9 A. Yes.

10 Q. You don't recall comments to this effect?

11 A. I do not remember reviewing Ms. Wenthold's
12 comments.

13 Q. Do you recall any other comments?

14 A. I don't remember reviewing the comments.

15 Q. Do you recall comments in favor of the change?

16 A. I don't remember seeing the comments that came
17 in from the public comment period.

18 Q. Okay. So just to close the loop, you have no
19 memory either way?

20 A. I have no memory of seeing them, but I see a
21 lot of information and a lot of -- so if someone

1 produced something and said I had reviewed it, it's
2 probably true, but I don't remember reviewing the
3 comments.

4 Q. Okay. It's possible but you just don't have a
5 recollection?

6 A. Correct.

7 Q. Okay.

8 And fair to say you disagree with what I
9 read, with her comment, or no?

10 MS. LAWSON: Object to form but go ahead.

11 BY MR. CRAIN:

12 Q. I can rephrase if it's helpful.

13 A. Could you rephrase?

14 Q. Yeah.

15 Is there any portion of what I read to you
16 from her comment that you agree with?

17 A. Of the sentences you've read or the ones that
18 go beyond that?

19 Q. Will your answer change?

20 A. It will.

21 Q. Okay. Start with the sentences I've read.

1 A. The sentences you have read, obviously, the
2 first sentence is her own opinion of what she sort of
3 sees the situation as. I don't disagree that the
4 changes will penalize hospitals that don't submit a
5 Leapfrog survey.

6 Q. Okay.

7 A. Her statement about the public won't understand
8 or dig into the methodology of these grades, I'm not
9 sure her nor I really know that to be the truth.

10 Q. Okay.

11 A. Hospitals will be falsely represented with a
12 lower grade I don't think is necessarily a truthful
13 statement.

14 Q. Is it possible because you don't know the
15 actual performance of nonrepresenting hospitals --
16 nonparticipating hospitals, excuse me?

17 A. Correct. So if she said possibly represented
18 with a lower grade.

19 Q. So let me ask it this way. Is it possible that
20 at least some hospitals will be falsely represented with
21 a lower grade than they otherwise would achieve based on

1 performance?

2 A. Right. So imputation by definition is trying
3 to estimate performance, and there is almost, by
4 definition, going to be some error, and that error may
5 be in the measured entity's favorite. It may be in the
6 measured entity's unfavor or disfavor.

7 But, I mean, it's imputation, right. So we
8 don't know the answer. So, therefore, we're trying to
9 estimate or guess an answer. So by definition,
10 imputation is going to have an error associated with it.

11 So when we were imputing higher scores with
12 a means for many hospitals, there was an error
13 associated with that as well.

14 Q. So it's your testimony that imputation is an
15 estimation of actual performance?

16 A. Correct.

17 Q. And is that true with regard to the automatic
18 assignment of limited achievement?

19 A. If we're imputing a score like we were doing
20 with limited achievement, there is the possibility for
21 error.

1 Q. So my question is a little bit different. So
2 let's break it down a little bit.

3 A. Okay.

4 Q. In the prior model for imputation, prior to
5 2024, let's go prior to 2021, you used American Hospital
6 Association data -- we had our aha moment -- to impute a
7 score for the hospitals, right?

8 A. Correct.

9 Q. Okay. And was that an estimation based on the
10 AHA data?

11 A. Yes.

12 Q. Okay.

13 Then when you get to 2024, you impute
14 limited achievement, correct?

15 A. Correct.

16 Q. Is that an estimation of performance or no?

17 A. That is an estimation of performance.

18 Q. Okay.

19 So going back to the website we looked at,
20 again for Delray you impute limited achievement on
21 handwashing, right?

1 A. Correct.

2 Q. So you are saying that's an estimation of their
3 actual performance on handwashing?

4 A. Yes.

5 Q. Okay. And that, again, is based on no data to
6 support it, right?

7 A. That is based on a lack of data.

8 Q. Yes. Okay. But it's an estimate, right?

9 A. It's an estimate.

10 Q. Okay.

11 Okay. Let's go back to the comment.

12 A. Okay. This extremely time intensive, once
13 again, extremely is a relative term, so I don't know how
14 Ms. Wenthold would define extremely.

15 Q. How would you characterize the burden?

16 A. What I hear from hospitals or I've heard from
17 hospitals is that it takes about 40-person hours to
18 complete it the first time but that in future years, as
19 hospitals refine their internal processes for reporting,
20 that that burden decreases.

21 Q. Okay. And which hospitals have you heard that

1 from?

2 A. I've heard that from Johns Hopkins Hospital
3 when I queried them on that question. I've heard that
4 from other hospitals that I couldn't necessarily name,
5 but that's just from poor memory.

6 Q. Fair enough.

7 Ballpark, how many did you ask?

8 A. I've maybe have heard that from three or four.

9 Q. Okay.

10 So going back to the comment.

11 A. Yeah. So what I would -- she is correct that
12 there is no option for the submission for a survey for a
13 health system; that Leapfrog's policy, since its
14 inception, has been for each individual brick and mortar
15 hospital to complete its own survey.

16 And her statement about excellent outcomes
17 will no longer be able to receive an A is actually
18 incorrect because there were two hospitals that actually
19 did get an A that did not complete a survey.

20 Q. Nationwide, right?

21 A. Nationwide.

1 Q. And that was on that first email we looked at
2 where you were pulling information --

3 A. Yes.

4 Q. -- for the lawsuit, right?

5 A. Yes.

6 Q. Just to make sure, I think that was Exhibit 1.

7 Okay. That's helpful.

8 MR. CRAIN: Okay. Let's go to tab 47. This
9 will be Exhibit 22.

10 (Exhibit No. 22 was marked for
11 identification as of 9/25/2025.)

12 BY MR. CRAIN:

13 Q. I'm sorry. This one is very small.

14 Dr. Austin, this is another comment, which
15 I think was submitted through what I believe is
16 Leapfrog's Zendesk platform. Do you see that?

17 A. Yes.

18 Q. My guess is -- have you not -- have you seen
19 this document before?

20 A. No, I haven't.

21 Q. Okay. So I want to just take you to the

1 bottom, and I think that's the comment. Do you see it's
2 from it looks like Alana Noble?

3 A. Yes.

4 Q. And she says, "We strongly disagree with the
5 proposed Fall 2024 Step 2 imputation. If Leapfrog is
6 going to implement this change, they need to offer
7 hospitals an option to opt out of being graded rather
8 than penalize a hospital for not submitting the resource
9 intensive survey. The survey is very resource intensive
10 outside of existing regulatory, quality operations and
11 quality improvement efforts. Hospitals that do not have
12 the resources to do the survey annually should not be so
13 adversely punished, especially in the post-COVID era
14 when resources are increasingly hard to come by and
15 retain."

16 And my question to you is: Why can't
17 Leapfrog give hospitals an option to opt out of being
18 graded?

19 MS. LAWSON: Object to form.

20 You can answer.

21 BY MR. CRAIN:

1 Q. To your understanding.

2 MS. LAWSON: I mean to your understanding.

3 BY MR. CRAIN:

4 Q. It's always to your understanding.

5 A. Right.

6 So the impetus for the Hospital Safety
7 Grade -- let me take us back a little bit in time.

8 So since 2001, Leapfrog has been doing a
9 voluntary survey of hospitals around quality and safety
10 practices. It has collected those data and made those
11 publicly available. One of the concerns for that model
12 is Leapfrog was collecting a lot of different data
13 points and reporting those out as individual data
14 points.

15 And what we know from conversations with
16 consumers and patients is that they strongly prefer
17 composite scores, star ratings, letter grades, that they
18 find that much more digestible.

19 Q. Easier to understand?

20 A. Easier to understand.

21 In addition to wanting to move towards a

1 letter grade, Leapfrog also wanted to -- the model that
2 Leapfrog was working from was the restaurant ratings in
3 like New York City, Los Angeles, right, where the health
4 department comes in. They do an assessment of the
5 restaurant, and the hospital has to post a letter grade
6 in their window with an A, a B, or a C.

7 And one of Leapfrog's board members
8 supposedly thought, oh, wouldn't it be great if we could
9 ask hospitals to do the same thing around the idea of
10 patient safety.

11 The concern with making it voluntary is
12 that it is a relative score, right. So the methodology
13 is such that hospitals are being compared to the
14 national mean, the standard deviation of the national
15 sample. And so it would be difficult to issue grades if
16 we were pulling from a selected subset of hospitals.

17 Q. Is that still true today where 80 percent of
18 inpatient beds are I think represented on the Leapfrog
19 survey?

20 A. So I see that as a little bit of a chicken and
21 egg situation.

1 Q. Okay. Tell me why.

2 A. That if Leapfrog made it voluntary, one
3 potential consequence of that would be fewer hospitals
4 would report to the survey, and, therefore, you would
5 lose that 80 percent capture that is currently there.

6 Q. Is it fair to characterize that as a slippery
7 slope problem?

8 A. I don't know how to characterize a slippery
9 slope.

10 Q. Okay.

11 I guess what I mean by that is you're
12 suggesting that if you make it voluntary, the number
13 20 percent of inpatient beds that were not responding
14 would increase, right?

15 A. That could be a potential consequence.

16 Q. Okay.

17 So to encourage greater participation, it
18 cannot be voluntary. Is that right? Take your time.

19 A. So one of the challenges Leapfrog was trying to
20 address with the Hospital Safety Grade was that there
21 had been a plateauing of hospital participation in the

1 survey.

2 Q. Okay.

3 A. And, therefore, we only had quality and safety
4 information for a -- not a small, a fraction of the
5 hospitals in the United States. And so by making it
6 nonvoluntary was an opportunity to have safety
7 information out there about as many hospitals in the
8 U.S. as possible.

9 And so if you make it voluntary, you sort
10 of defeat that goal of trying to have safety information
11 for as many as possible.

12 Q. Has that goal overtaken any goal to report
13 accurately on safety?

14 A. No.

15 Q. Okay. And why is that? Because -- strike
16 that.

17 We've talked a lot about how there are
18 errors, right, with any imputation methodology. Isn't
19 the most accurate way to get safety information out
20 there to not impute?

21 A. Can you rephrase the question?

1 Q. Yeah.

2 A. Or not rephrase but repeat the question.

3 Q. Oh, repeat? Yeah, repeat I can do because I
4 have the realtime.

5 We've talked a lot about how there are
6 errors with any imputation methodology, correct?

7 A. Correct.

8 Q. Isn't the most accurate way to get safety
9 information out there to not impute?

10 A. Are we discussing the scores, or are we
11 discussing the grades?

12 Q. Let's do both. Start with the score.

13 A. So for the score, I think that would have a
14 little more of an influence -- let me say that again.
15 The decision to impute a score would impact the overall
16 score.

17 Q. The overall grade?

18 A. The overall -- so just to clarify, when we
19 calculate the grade, what we're actually calculating is
20 a score, a numerical score. So each hospital has a
21 numerical score that's calculated. Those numerical

1 scores then get converted into letter grades.

2 Q. Yes. Got it.

3 A. So the letter grade, by definition, is a range
4 of scores, right. So it's less sensitive to the
5 decision to impute one measure or not to impute a
6 measure.

7 If we're talking about the actual numerical
8 score, the accuracy would be improved without
9 imputation.

10 Q. Okay.

11 So is it right that Leapfrog has
12 prioritized as a goal increasing participation as
13 compared to the accuracy of the score?

14 A. So when you say participation, what are you
15 referring to?

16 Q. Participation in the survey. Let me rephrase
17 it so it's clear.

18 Is it fair to say that Leapfrog has
19 prioritized encouraging greater participation in the
20 survey as compared to greater accuracy in the scoring of
21 a safety grade?

1 A. I don't see it as an absolute tradeoff in that
2 way.

3 Q. Okay. Is it -- why is that?

4 A. Because I think you can work towards both
5 goals. I don't think you necessarily have to completely
6 have one goal be worked towards at the detriment of the
7 other goal.

8 Q. You don't think that's what's happening with
9 imputation?

10 A. So to be clear, the decision to impute scores
11 is primarily driven by the desire to have more accuracy
12 in what we are issuing as a score grade. A potential
13 benefit of that is that hospitals may choose to come in
14 and report to the survey.

15 So that's why I don't see them as
16 necessarily diametrically opposed goals.

17 Q. Is the most accurate way to score excluding
18 imputation altogether?

19 A. Yes. As previously stated, you would have a
20 more accurate score without imputation.

21 Q. Okay.

1 And so going -- I don't know if I got an
2 answer to this question, though, but let me just be
3 really clear. So this comment says if Leapfrog is going
4 to implement this change, they need to offer hospitals
5 an option to opt out, right?

6 First, I guess stepping back, do you recall
7 any discussion of an opt out internally to either the
8 expert panel or Leapfrog?

9 A. No. That's never been the conversation.

10 Q. Okay. And why can an opt out not be provided?

11 A. If -- is your question is it possible for
12 Leapfrog to implement an opt out?

13 Q. Well, so --

14 A. Or --

15 Q. Yeah, fair question.

16 So there's the question of whether it's
17 physically possible. I assume it's physically possible
18 to implement an opt out, right?

19 A. Yes.

20 Q. Yeah.

21 Why does -- to your knowledge, why does

1 Leapfrog feel it can't allow an opt out?

2 A. This is my own speculation because I have not
3 discussed with Leapfrog this scenario. One might be
4 concerned that if you allow hospitals to opt out, most
5 of them will, and now what is your rating program if you
6 don't have many participates.

7 Q. And it's also -- what is your rating program,
8 meaning the grade, the survey, or both?

9 A. Potentially both.

10 Q. And going back to the restaurant analogy. You
11 mentioned the L.A. restaurant grades. Do you think
12 that's a fair analogy to what Leapfrog is able to do?

13 MS. LAWSON: Object to form.

14 BY MR. CRAIN:

15 Q. To your knowledge.

16 A. So Leapfrog can't require hospitals to post a
17 letter grade in their window.

18 Q. It also, unlike a regulatory agency, can't
19 compel participation, right? As a legal matter, right?

20 A. I will defer to lawyers on that.

21 Q. Fair enough. Okay.

1 Let me ask --

2 A. Leapfrog, what it's doing is it's using
3 publicly available data to make an assessment of a
4 hospital's patient safety performance.

5 Q. And it's also using the lack of data, right, to
6 make an assessment of performance?

7 A. That's using what data are available.

8 Q. Yeah.

9 A. And in some situations, that is data that's not
10 available.

11 Q. Yeah. Okay.

12 Okay. You can set that one aside.

13 I want to talk a little bit about the
14 imputed measures themselves so -- and we talked about
15 earlier in the day, it feels like hours ago, BCMA, CPOE,
16 IPS, and hand hygiene, right?

17 A. Correct.

18 Q. So I've been trying to understand why are those
19 the four that are imputed as compared to the three what
20 I called earlier in the day discarded measures. You may
21 feel free to call them something else, but why are those

1 different?

2 A. It is somewhat a function of historical
3 artifact and when the measure was introduced to the
4 Leapfrog Hospital Survey. So within those three
5 measures, we put the two safe practices into one bucket
6 and hand hygiene in the other bucket.

7 Q. Okay.

8 A. The safe practices I put in the sort of
9 historical artifact bucket in that when the decision was
10 to move towards secondary data sources, like the aha,
11 AHA hospital survey --

12 Q. That's my favorite.

13 A. There wasn't any data within that AHA survey
14 that matched up with those safe practices. Like, there
15 was nothing about leadership. There was nothing about
16 culture measurement.

17 So at that time, the decision was, okay,
18 we're going to continue to hold those in the
19 we're-just-going-to-ignore-the-measure-if-you-don't-have
20 -it bucket, which was the original imputation.

21 That historical sort of artifact has just

1 sort of rolled forward.

2 Q. Okay. Fair to say it was grandfathered in?

3 A. Yeah. It's a historical artifact of where we
4 started and where we're at.

5 The nursing workforce --

6 Q. Yep.

7 A. -- was just recently introduced to the Leapfrog
8 Hospital Survey, and the collective wisdom was perhaps
9 we don't have enough experience in data with that to
10 impute scores.

11 Q. So very helpful on the three.

12 I want to ask you also about the four, why
13 they are imputed, and I have a document that I think
14 might help us in what I've been trying to figure out.

15 MR. CRAIN: So this will be Exhibit 23.

16 (Exhibit No. 23 was marked for
17 identification as of 9/25/2025.)

18 BY MR. CRAIN:

19 Q. So this is another Armstrong-produced document.
20 You see that on the bottom, right?

21 A. Yes.

1 Q. And it's one of your notes to yourself. Do you
2 see that?

3 A. Yes.

4 Q. And it says: "Notes for today's call with
5 Dr. Romano." [sic] Right?

6 A. Yes.

7 Q. Okay.

8 April 12th, coincidentally, 2019. Do you
9 see that? I say coincidentally because the expert panel
10 meeting was also April 12th.

11 A. Okay.

12 MS. LAWSON: Of 2024.

13 MR. CRAIN: Yeah, of 2024. Sorry. It was my
14 own aha moment.

15 BY MR. CRAIN:

16 Q. So going down, you say, "Patrick, to guide
17 today's call, I put together some quick notes." Do you
18 see that?

19 A. Yes.

20 Q. And I can't tell if you sent this to him or
21 they were just talking points. Any sense?

1 A. They were notes for myself, I believe, for the
2 conversation with Dr. Romano.

3 Q. And do you remember this conversation? Feel
4 free to take a second to read through it if it's
5 helpful.

6 (Witness peruses document.)

7 THE WITNESS: Okay.

8 BY MR. CRAIN:

9 Q. Do you remember the context of this discussion?

10 A. I don't with certainty but based on the --

11 Q. Context clues?

12 A. -- context clues, it would be to talk about
13 maybe changing the imputation approach --

14 Q. And --

15 A. -- and missing data thresholds.

16 Q. Okay.

17 And you see it mentions AHA responses sort
18 of towards the bottom third of the page?

19 A. AHA responses?

20 Q. There's a bullet that says exceptions are BCMA.

21 A. Yes.

1 Q. Okay.

2 And just stepping back for a second, do you
3 recall a time where Leapfrog no longer had access to the
4 AHA data?

5 A. There was a point where AHA revoked Leapfrog's
6 license to use the data.

7 Q. Do you know why they did that?

8 A. My understanding is they had gotten -- strike
9 that.

10 I don't know why AHA revoked the license.

11 Q. When you said "my understanding," did you have
12 something that you heard about it?

13 A. I had heard that, you know, they were getting
14 complaints from their member hospitals about how those
15 data were being used by Leapfrog.

16 Q. Got it.

17 And complaints with respect to the
18 imputation into the methodology?

19 A. Complaints on two fronts. One was how the data
20 were being translated into scores for Leapfrog. Also,
21 some of the hospitals' data were pretty old, and they

1 felt like it was outdated and there really wasn't a
2 mechanism for them to update it. And there were sort of
3 logistical challenges, and my understanding is I think
4 AHA was like, we're out.

5 Q. We're out of this business?

6 A. Right -- what's that?

7 Q. We're out of this business?

8 A. We're out of this business.

9 Q. And when you say old, so I know like CMS data
10 has a lag, right? Yes?

11 A. Some of it does, yes.

12 Q. Was the AHA data a bigger lag than CMS?

13 A. I don't know the exact lag period for the AHA
14 survey.

15 Q. And what you had heard about why the AHA did
16 not want to license anymore, do you recall who that came
17 from?

18 A. The information that I heard from?

19 Q. Yeah, that you just shared with us about --

20 A. From Missy Danforth.

21 Q. Got it. Okay. So Ms. Danforth told you that.

1 Do you know where she got it?

2 A. I don't know.

3 Q. Okay.

4 Anything else you remember about why AHA
5 stopped licensing?

6 A. That's all I'm aware of.

7 Q. Okay.

8 So I want to look specifically at -- you
9 see in this document imputing data?

10 A. Yes.

11 Q. If you go down to the third bullet -- well,
12 let's go to the second bullet first for context. It
13 says: "Current Approach: Exclude the measure and
14 recalibrate the weights for the affected hospitals using
15 only those measures for which data are available."

16 Do you see that?

17 A. Yes.

18 Q. And can you sort of translate what that means?

19 A. Yeah. So the earliest approach of imputation
20 that we followed was to -- if a hospital was missing a
21 measure, we ignored that measure and we redistributed

1 the weights to other measures for which they did have
2 data.

3 Q. Okay.

4 And then there's a -- the next bullet says
5 exceptions, right?

6 A. Correct.

7 Q. And it says: "Exceptions are BCMA, CPOE, and
8 IPS, in which case we have created crosswalks between
9 the AHA responses and Leapfrog performance categories."

10 Do you see that?

11 A. Yes.

12 Q. What does the crosswalk mean?

13 A. The crosswalk was we looked at -- for hospitals
14 that reported to both the AHA survey and to the Leapfrog
15 Hospital Survey, we were able to compare their responses
16 on both and understand in an aggregate way what the
17 relationship was between a hospital's responses to the
18 AHA survey and how they were performing on the Leapfrog
19 Hospital Survey standards.

20 Q. So just to rearticulate, is it fair to say that
21 you had identified that the AHA data was a reasonable

1 enough proxy for the BCMA, CPOE, and IPS scores for
2 Leapfrog?

3 A. In our review and discussions of the AHA
4 survey, we felt like it represented a reasonable
5 approximation of the same quality -- or the same safety
6 standards.

7 Q. And is that the original reason why those three
8 became imputed measures, as opposed to discarded
9 measures?

10 A. Yes.

11 Q. Okay.

12 After Leapfrog lost the AHA data, do you
13 recall any time at which other crosswalks were
14 considered?

15 A. We explored other potential secondary data
16 sources. I can specifically remember having lots of
17 calls with HIMMS, H-I-M-M-S, which is a technology
18 consortium, to see if we could get relevant data related
19 to computerized physician order entry. And as we
20 reviewed their data, we didn't feel confident in that it
21 was getting us the same thing that we needed.

1 So we explored other options, just nothing
2 met.

3 Q. Okay.

4 So is it fair to say that those three
5 measures were essentially grandfathered in from the
6 period in which Leapfrog was using AHA as the crosswalks
7 to the Leapfrog scores?

8 A. We had been imputing scores for those measures
9 using the AHA datasets. That would be true.

10 Q. And it was grandfathered into the next
11 instantiation of the imputation methodology?

12 A. I would need to have better notes on what was
13 the next phase of the imputation methodology --

14 Q. Okay.

15 A. -- to remember what came next after that.

16 Q. Fair enough. Fair enough.

17 So subsequently -- like, the current
18 methodology still imputes on these three measures,
19 right?

20 A. Correct.

21 Q. Is there any particular reason, except for the

1 historical fact of Leapfrog having those crosswalks to
2 the AHA data, that those three are imputed as opposed to
3 other measures that are discarded that you're aware of?

4 A. I could argue that there is, perhaps, some
5 clinical, additional clinical relevance to those. I
6 mean, they do get higher weights in the safety grade.
7 They have been shown to be more effective as it relates
8 to safety and improving safety. So that's what I would
9 speak to.

10 Q. So my question is a little different, though.
11 You are, I think, providing a reason for why those are
12 valuable measures, right?

13 A. Correct.

14 Q. And, in fact, I could show you websites. I'll
15 just represent to you that sometimes Leapfrog puts out
16 information that says those are among the most important
17 measures. It sounds like you might agree with that?

18 A. Correct.

19 Q. Yeah. And they're significantly weighted,
20 right?

21 A. They have higher weights than some other

1 measures.

2 Q. I think the four imputed measures are
3 approximately a quarter to 30 percent of the grade. Are
4 you aware of that?

5 A. I couldn't agree or disagree with that.

6 Q. I mean, it's in the methodology document.

7 A. Right.

8 Q. We can set it aside. I'm not trying to, you
9 know, test you on it. It's all right.

10 So you're giving me reasons for why they
11 are important measures, correct? I want to know the --
12 whether there's an empirical reason or an evidence-based
13 reason for continuing imputation of them outside of the
14 crosswalks that we see in this email.

15 MS. LAWSON: Do you understand the question?
16 Are you clear on what the question is?

17 THE WITNESS: I think I am.

18 MS. LAWSON: Okay. I think he's asking is
19 there a historical -- like, other than the historical
20 experience --

21 MR. CRAIN: I think I'd asked just for no

1 speaking objections or coaching.

2 MS. LAWSON: Yeah, but I just want to make sure
3 that he's clear because we're covering this a second
4 time. We've asked it a -- you know, and I understand.
5 So I understand what your question is, and I just want
6 to make sure he understands so he can answer what you're
7 asking.

8 BY MR. CRAIN:

9 Q. Let me ask it again because I want to make sure
10 the record is clear.

11 So I said: You're giving me reasons for
12 why they are important measures, correct?

13 A. Correct.

14 Q. And I want to know whether there is an
15 empirical reason or some evidence-based reason for
16 continuing to impute these three measures in this email
17 outside of the crosswalks that Leapfrog had identified
18 between the AHA responses and Leapfrog performance
19 categories.

20 A. So the reason it would be important to keep
21 those measures in and to be imputed is because they have

1 a significant impact to patient safety. So to create a
2 composite score that doesn't include those measures
3 would be missing some very key components.

4 Q. For Step 2, where you're automatically
5 assigning limited achievement, doesn't that rationale
6 cut the other way?

7 A. I would disagree. We're actually imputing a
8 score for those because those measures are important.

9 Q. So I take it that those measures are important.
10 Set that aside for a second.

11 We've talked about the limited achievement,
12 right, the automatic assignment is not grounded in any
13 actual evidence about a given hospital's performance,
14 right, today?

15 A. The imputation is -- has an error component to
16 it by definition.

17 Q. Yes. So just -- I want you to answer my
18 question yes or no. The automatic assignment is not
19 grounded in any actual evidence about a given hospital's
20 performance today, correct?

21 A. Can you repeat that?

1 Q. Yeah. Glad to.

2 The automatic assignment of limited
3 achievement for the four imputed measures for a
4 nonparticipating hospital is not grounded in any actual
5 evidence about a nonparticipating hospital's performance
6 today, correct?

7 A. Back to the earlier point, we know the hospital
8 is not being transparent about their safety performance
9 and that safety is an important component of a culture
10 of safety.

11 Q. Okay. So I'll go down the line. An automatic
12 assignment of limited achievement for BCMA is not
13 grounded in any actual facts about a hospital's
14 performance on BCMA, right?

15 A. An imputed score is based on an assumption.

16 Q. Okay. And not actual facts on the ground about
17 performance, right?

18 A. Correct.

19 Q. Okay.

20 A. And that's true of all imputation.

21 Q. It wasn't necessarily true when you had the

1 crosswalks, right?

2 A. That's not completely true.

3 Q. Okay. Explain it for me.

4 A. Because when we had the crosswalks, we were
5 looking at large numbers of hospitals. So we might have
6 had 500 hospitals that reported to both the Leapfrog
7 Hospital Survey and the AHA survey. What we looked at
8 was what was basically the average performance.

9 If a hospital answered this in the AHA
10 survey, how did they, on average, perform on the
11 Leapfrog Hospital Survey? Some of the hospitals
12 performed better. Some performed worse. So there is a
13 degree of error there in imputation.

14 Q. But you had some sort of analysis to build that
15 out, right?

16 A. We had some secondary data sources to help us
17 inform those imputed scores.

18 Q. And today, for the methodology, there is no
19 secondary data source to help you inform the imputed
20 assignment of limited achievement?

21 A. Correct.

1 Q. Okay.

2 So is it fair to say that the reason these
3 three remain as imputed measures is largely, as you said
4 for the other ones, a historical artifact or no?

5 A. I think it's a combination of historical
6 artifact and their importance to the broad concept of
7 patient safety.

8 Q. Got it. Okay. So they're significant, so
9 Leapfrog didn't want to lose them, and also they had
10 been imputing based on other secondary data sources.
11 That combination is why they are still imputed measures
12 today. Is that fair?

13 A. Fair.

14 Q. Okay.

15 Why hand hygiene, which is not represented
16 here? Can you give me the history of that one?

17 A. So hand hygiene was introduced to the Leapfrog
18 Hospital Survey after -- well, don't quote me on this.
19 I believe after the AHA had pulled their data license.

20 Q. Okay. Got it.

21 Okay. So you had no opportunity to create

1 the crosswalk, correct?

2 A. Correct.

3 Q. Okay.

4 I want to show a document. So talking
5 about hand hygiene, again, is it your testimony today
6 that the limited achievement automatic assignment of
7 hand hygiene for nonparticipating hospitals in Step 2 --
8 stay with me -- is an accurate reflection of a
9 hospital's hand hygiene performance, an accurate
10 estimation?

11 A. My testimony is that it's an imputed score for
12 that hospital's performance on hand hygiene.

13 Q. And is it an accurate estimation of their
14 performance on the ground?

15 A. Imputation, by definition, has error.

16 Q. Okay. So for certain hospitals it may be
17 inaccurate?

18 A. Correct.

19 Q. Okay.

20 So I want to look at --

21 MR. CRAIN: This will be Exhibit 24.

1 (Exhibit No. 24 was marked for
2 identification as of 9/25/2025.)

3 BY MR. CRAIN:

4 Q. This is an Armstrong-produced document. Do you
5 see that on the bottom right?

6 A. Yes.

7 Q. And the top email is from you to a group of
8 folks at Leapfrog, I think, and Preeti Joshi. Do you
9 see that? And maybe a couple others.

10 A. Yes.

11 Q. And there's an attachment. It says: Leapfrog
12 Hand Hygiene Report Analysis June 3, 2024. Do you see
13 that?

14 A. Yes.

15 Q. And you write to the group, "As a follow-up
16 from our meeting a few weeks ago, attached are the
17 requested analyses for the hand hygiene report. I think
18 the analyses are pretty self-explanatory, but we are
19 happy to have a call to review if that would be
20 helpful."

21 Do you see that?

1 A. Yes.

2 Q. And then you go in I guess starting with --
3 first question: Did you draft -- I'm looking at page
4 5116. Do you see that?

5 A. Yes.

6 Q. Did you draft what looks like it's titled
7 Leapfrog Hand Hygiene Analysis for Landslide Report?

8 A. Preeti Joshi did this.

9 Q. Okay. Did you review it?

10 A. Yes.

11 Q. Okay. And what was the purpose of this
12 document?

13 A. Leapfrog was interested in putting out a
14 national report on its hand hygiene standard and where
15 hospitals had -- how they've improved over time on the
16 standard.

17 Q. Okay.

18 And so you go, it looks like to me, you go
19 question by question through the Leapfrog survey. Is
20 that right?

21 A. We looked at it both at the individual question

1 level -- yes. In this first part, it's looking at each
2 individual question.

3 Q. Okay. And fair to say for some questions there
4 is pretty -- you know, there's change between 2020 and
5 2023, and for others there's less change. Is that
6 right? I can be more concrete.

7 MS. LAWSON: I was going to object to form
8 there.

9 MR. CRAIN: Fair enough. I'll take it back.

10 BY MR. CRAIN:

11 Q. So question number one is provision of hand
12 hygiene training. Do you see that?

13 A. Yes.

14 Q. And in 2020, it looks like 92.8 percent --
15 well, tell me what the percentage reflects.

16 A. Yeah, that represents the percentage of
17 hospitals -- yeah, the denominator is the number of
18 hospitals that submitted responses to the hand hygiene
19 section of the Leapfrog survey. So the numerator would
20 be those that answered yes, that they meet Leapfrog's
21 requirements for that question.

1 Q. So 92.8 percent of hospitals in 2020 responding
2 to the survey met question one. Is that right?

3 A. Yes.

4 Q. Okay.

5 And that increases to 96.8 percent in 2021,
6 96.8 percent in 2022, and 97.9 percent in 2023. Do you
7 see that?

8 A. Yes.

9 Q. Okay.

10 And I guess the question that I have on any
11 of these, really, is: Is it your assumption that a
12 hospital that is not participating in the survey will
13 perform worse than these numbers as compared to the
14 participating hospitals?

15 A. Can you say that one more time, please?

16 Q. Yeah. So I'm trying to get at -- let's back up
17 a little bit.

18 So I'm trying to understand why Leapfrog
19 imputes for hand hygiene, right. And my question is it
20 seems like, at least based on this analysis, that most
21 hospitals, at least that report, do fairly well on the

1 hand hygiene questions. Is that fair to say or no?

2 A. So Leapfrog actually has fairly high standards,
3 and so for a hospital to meet a domain, they actually
4 have to answer "yes" to all of the questions in that
5 domain.

6 So, for example, in domain training and
7 education, only 85.7 percent answered yes to question
8 two in 2023. So at most, 85.7 percent of hospitals meet
9 that domain, and it's probably something less than that,
10 right.

11 So looking at individual questions may not
12 be the most accurate indicator of how hospitals are
13 doing on each of the domains as Leapfrog has defined
14 them.

15 Q. Okay. So in each of these four domains, you're
16 saying only the lowest denominator respondent are those
17 that passed the domain?

18 A. The lowest percentage within a domain would be
19 the absolute ceiling of the percentage of hospitals that
20 can meet that domain.

21 Q. Got it. Okay.

1 So for domain one, the most -- the highest
2 number of hospitals that would have met that domain are
3 85.7 percent of responding hospitals in 2023, correct?

4 A. Correct.

5 Q. Okay.

6 And do you have any basis to suggest that
7 nonperforming hospitals would be so much worse in
8 performance than 85.7 percent?

9 A. We don't have any information to know how they
10 would perform.

11 Q. So why is it fair to those hospitals to give
12 them the lowest score when the gross majority of
13 hospitals, at least in this domain, pass?

14 MS. LAWSON: Object to form. Go ahead.

15 THE WITNESS: So there are 15 percent of
16 hospitals, at least, that are not meeting the domain,
17 right. So how would we know if hospitals that don't
18 report are part of that 15 percent or part of the
19 85 percent?

20

21 BY MR. CRAIN:

1 Q. You don't know either way, right?

2 A. We don't know either way.

3 Q. Okay. But you assume that the hospitals in
4 that domain that are not reporting are necessarily part
5 of the 15 percent, right?

6 A. We don't have any information about those
7 hospitals, so we are imputing a score.

8 Q. You're imputing a score that estimates that
9 their performance is failing, essentially?

10 A. That they are in the bottom performance
11 category.

12 Q. Okay.

13 And then if you go to domain two, this is
14 infrastructure, do you see that?

15 A. Yes.

16 Q. And this is things like hand sanitizers?

17 A. Correct.

18 Q. Okay.

19 Forgive the question, but have you ever
20 been to a hospital for care?

21 A. Yes.

1 Q. Do you recall any room that you were in without
2 a sanitizer?

3 MS. LAWSON: Object to form.

4 THE WITNESS: So the Leapfrog survey questions
5 about hand sanitizers are fairly specific about the
6 location of them, whether they produce the correct
7 amount of alcohol-based hand gel, and whether or not the
8 hospital does audits to know if they actually have hand
9 gel in them. Because I think we've all experienced
10 going up to one and nothing comes out.

11 BY MR. CRAIN:

12 Q. Not fun.

13 A. So there is more than just about do you have
14 hand sanitizer dispensers. There's a lot more to that
15 standard.

16 Q. Fair enough.

17 So taking your bottom number, if you look
18 at domain two, this would imply that 90.5 percent, at a
19 maximum, passed this domain, right?

20 A. Ninety-one -- 90.5 --

21 Q. Ninety point five, right.

1 A. -- in 2023 --

2 Q. In 2023, correct.

3 A. -- would be the absolute ceiling.

4 Q. Yes.

5 Do you have any sense for what the number
6 actually is for the number of hospitals that passed this
7 domain?

8 A. I don't know offhand.

9 Q. Okay. Fair to say it's likely quite high
10 because of these numbers?

11 MS. LAWSON: Object to form but go ahead.

12 THE WITNESS: Yeah, I mean, I could -- you
13 know, you could assume that all of these were
14 independent, and if you multiply them together, you
15 would come up with an answer that's somewhere in the
16 63 percent, which is probably the floor. So it's
17 somewhere between 63 and 90.5.

18 BY MR. CRAIN:

19 Q. Okay.

20 So but, again, for hospitals that don't
21 participate, for this domain, effectively, they get the

1 lowest possible score, right?

2 A. So to be clear, the hand hygiene standard has
3 five domains. For a hospital to be in achieved the
4 standard, they need to -- if they're only collecting 100
5 hand hygiene observations a month, they need to meet all
6 five domains, which means they're saying "yes" to every
7 single question.

8 Q. Okay.

9 A. Seventy-four percent of hospitals in 2023
10 achieved the standard, so 26 percent did not.

11 Q. Yep. Okay. And that achieved the standard is
12 the highest, right?

13 A. Correct.

14 Q. Then how do you quantify the next three down?

15 A. We have a scoring algorithm that's available
16 online that details that. I couldn't recite what that
17 is, but the idea is basically if you meet a subset of
18 the domains, you get one category; if you meet fewer
19 domains, you get a lower category.

20 Q. Okay.

21 A. It's sort of assessed at the domain level but

1 then it rolls up into an overall score.

2 Q. Okay. No, fair enough.

3 So I guess then my question is why is hand
4 hygiene one of the imputed measures and not one of the
5 discarded measures?

6 A. Because its clinical relevance to patient
7 safety is paramount.

8 Q. Okay.

9 So, again, it's the same point. When we
10 talked about the other three, there were two reasons.
11 The first was the historical what I call grandfathering
12 in combined with the significance, right?

13 A. Correct.

14 Q. For this one, there's no historical, but it's
15 just, you're saying, it's so important, Leapfrog feels
16 it has to impute?

17 A. Correct.

18 Q. Okay. Okay. Let's leave it at that.

19 A. Okay.

20 MR. CRAIN: All right. I think we've been
21 going about an hour. Do you mind if we take a break?

1 MS. LAWSON: That's fine.

2 MR. CRAIN: Okay. Courtney, are you good?

3 MS. WOOD: Uh-huh.

4 THE VIDEOGRAPHER: This marks the end of media
5 unit number six. We're going off the record. The time
6 is 3:26 p.m.

7 (Whereupon a short break was had, after
8 which the proceedings continued as
9 follows:)

10 (Exhibit No. 25 was marked for
11 identification as of 9/25/2025.)

12 THE VIDEOGRAPHER: This marks the beginning of
13 media unit number seven. We're going back on the
14 record. The time is 3:43 p.m.

15 BY MR. CRAIN:

16 Q. Thank you, Dr. Austin.

17 So I've handed you what has been marked as
18 Exhibit 25. Do you see that document?

19 A. Yes.

20 Q. And this is an email from you to what I think
21 is the safety grade expert panel. Do you see that?

1 A. Yes.

2 Q. Okay. And the subject is: Final updates to
3 Leapfrog Hospital Safety Grade methodology for Fall of
4 2024. Do you see that?

5 A. Yes.

6 Q. And generally, can you tell me what this email
7 is?

8 A. This email is an email to the expert panel with
9 the attachment of the final updates to the safety grade
10 methodology for Fall of 2024.

11 Q. Okay. And you say, "Based on the expert
12 panel's thoughtful input and guidance, Leapfrog has
13 decided to move forward with updates to imputation
14 methodology used in the Hospital Safety Grade, effective
15 Fall '24." Do you see that?

16 A. Yes.

17 Q. Okay. Fall of 2024. Sorry. I think I said
18 that wrong. Do you see that as well?

19 A. Yes.

20 Q. Okay.

21 Now, just for the record, I want to be

1 clear. Did Leapfrog decide to adopt this methodology,
2 or did the expert panel decide to adopt it?

3 A. Leapfrog makes all the decisions about their
4 ratings and ratings programs. The work of the expert
5 panel, expert panels, myself, is all in a recommendation
6 advisory capacity.

7 Q. Okay. And are you aware of any document in
8 which the expert panel weighed in on this final proposal
9 as a group?

10 A. Not that I am aware of. Not that I'm aware of.

11 Q. Okay.

12 Do you know sitting today whether the
13 entire expert panel approved of this path forward?

14 A. We did not query the expert panel about whether
15 they approved this or not.

16 Q. Okay. Is it your view that they did approve
17 it?

18 A. It is -- from my point of view, we heard their
19 input and guidance. Leapfrog made a decision of how it
20 wanted to move forward, and we communicated that to the
21 expert panel.

1 Q. Okay.

2 Okay. All right. You can set that aside.

3 MR. CRAIN: Okay. I want to move on to another
4 topic. Tab 15, please. This will be Exhibit 26.

5 (Exhibit No. 26 was marked for
6 identification as of 9/25/2025.)

7 BY MR. CRAIN:

8 Q. All right. So Dr. Austin, you have in front --
9 well, what do you have in front of you?

10 A. I have in front of me our 2013 prepublished
11 ahead of print publication from the Journal of Patient
12 Safety.

13 Q. And we talked about this document a little bit
14 earlier today, right?

15 A. Correct.

16 Q. Okay. This is the document that was peer
17 reviewed that analyzed the methodology at least as it
18 stood back in 2023, right?

19 A. This was the methodology in 2012, early 2013.

20 Q. Okay. And you are the lead author on this
21 paper, correct?

1 A. Correct.

2 Q. As well as it looks like other folks on the
3 expert panel, safety grade expert panel?

4 A. Correct.

5 Q. And I see, for instance, Dr. Romano is here,
6 right?

7 A. Correct.

8 Q. Okay.

9 I want to ask you a few questions about
10 this. I'm going to go to -- starting at the top, do you
11 see the little -- on the left side at the top it says
12 "Methods."

13 A. Yes.

14 Q. And it says: "The Leapfrog Group sought advice
15 [sic.] from a panel of national patient safety experts
16 to develop a composite score." Do you see that?

17 A. Yes.

18 Q. Does that describe generally what this paper is
19 about?

20 A. The paper describes how -- the process Leapfrog
21 used to develop a composite score.

1 Q. Okay. And it says, the next sentence --

2 A. And we do some analyses of early rounds of the
3 grades to demonstrate what that looks like.

4 Q. Some early rounds of the grades to
5 demonstrate -- say more about what you mean.

6 A. Yeah. So let me look in the -- so we had done
7 some data analysis using composite safety scores for
8 2,652 general acute care hospitals, and we calculated
9 safety scores for those.

10 Q. Okay.

11 A. And we show that in figure one.

12 And then in tables two and three, we did
13 some analysis to look at how those safety scores varied
14 by different hospital characteristics, as well as by
15 state in the United States.

16 Q. Okay. And this is the document that we saw
17 that was linked to Leapfrog's website, right?

18 A. Correct.

19 Q. Okay.

20 I want to go to page 4, and I think it's
21 Bates number 668.

1 A. Yes.

2 Q. And there's a section, Dealing with Missing
3 Data. Do you see that?

4 A. Yes.

5 Q. And it says: "Although the expert panel
6 selected nationally reported measures, some data were
7 missing for hospitals that did not report to The
8 Leapfrog Group, and other data were missing because
9 hospitals did not meet CMS's minimum sample requirements
10 to publicly report their results."

11 Do you see that?

12 A. Yes.

13 Q. So this is the section that's, for lack of a
14 better word, dealing with missing data, right?

15 A. Correct.

16 Q. Okay.

17 So the next paragraph lays out, what it
18 looks like, five possible approaches for assessing
19 hospital performance when data were missing. Do you see
20 that?

21 A. Yes.

1 Q. Okay. And I'm going to not march through, but
2 it looks like number four is: "Give the hospital zero
3 credit for the measure." Do you see that?

4 A. Yes.

5 Q. And that's not -- Leapfrog has never done zero,
6 right?

7 A. Correct.

8 Q. They've done limited achievement, correct?

9 A. Correct.

10 Q. Okay. And limited achievement, just to be
11 clear, is the lowest measure, which can range anywhere
12 from 5 to 25 depending on the measure, right?

13 A. Correct.

14 Q. Okay.

15 And then number five says: "Exclude the
16 measure and recalibrate the weights for the affected
17 hospitals using only those measures for which data are
18 available." Right?

19 A. Correct.

20 Q. Now, the -- if you look at -- further down
21 there's a paragraph that says "After." Do you see that?

1 A. Yes.

2 Q. Okay. And it says: "After conducting
3 sensitivity analyses using each of the above approaches,
4 the panel recommended approach number five to address
5 missing data, excluding the measure for a hospital and
6 recalibrating the weights for those measures for which
7 performance data were available, for most measures."

8 Do you see that?

9 A. Yes.

10 Q. Okay. And was that generally the approach that
11 Leapfrog took in the ensuing years?

12 A. That was the approach Leapfrog used initially
13 with the hospital safety grades.

14 Q. Okay.

15 A. As previously mentioned, Leapfrog has evolved
16 its imputation approaches, working through actually at
17 least four out of the five here.

18 Q. Fair enough, yeah. So it's been a moving
19 target.

20 A. It's been evolving.

21 Q. Evolving. Fair enough.

1 So then the paragraph keeps going. The
2 next sentence is -- let's see. It's on the top of page
3 4 on the right side. "In this way." Do you see that?

4 A. Yes.

5 Q. "In this way, we avoided making questionable
6 assumptions about the performance of hospitals with
7 missing data, and we also maintain variation of the
8 final calculated scores by not imputing identical values
9 for all missing observations."

10 Do you see that language?

11 A. Yes.

12 Q. Okay.

13 So at least as of 2013, Leapfrog -- this
14 group of authors peer reviewed, came to the conclusion
15 that excluding the measure was the way to avoid making
16 questionable assumptions about the performance for
17 hospitals. Do you see that?

18 A. Yes.

19 Q. Okay. That changed, right?

20 A. That has evolved.

21 Q. Okay. Is it your view that Leapfrog is making

1 questionable assumptions today about the performance of
2 hospitals?

3 A. I don't believe that to be true.

4 Q. Okay. What's changed between this analysis and
5 today?

6 A. So what has changed is that the -- that we've
7 actually evolved through different imputation
8 approaches. So we started with number five, right.
9 Then we moved to number two, imputing based on other
10 available data. Then we moved to number one, which is
11 imputing performance at the national mean or median,
12 although we did that by cohorts. And then we eventually
13 landed here now at number three, which is imputing a
14 score above or below the median or mean.

15 So all of these are valid imputation
16 approaches. I think the choice of an imputation
17 approach needs to be in the context of sort of time,
18 place, situation.

19 So in 2012, when Leapfrog rolled out these
20 hospital safety grades, hospitals did not know these
21 were coming. So that needed to be sort of the context

1 in which an imputation decision was made.

2 If we fast-forward to 2024, now we've been
3 issuing safety grades for 25 rounds. Hospitals are very
4 aware of the grades. They're very aware of the measures
5 that go into the survey, and so you might have your
6 imputation approach evolve with that.

7 Q. So the assumptions change?

8 A. I don't know if assumptions have changed, but
9 the context has changed.

10 Q. So let me -- so first going back, you said
11 number three, impute a score above or below the median
12 or mean; e.g., minus one standard deviation. Do you see
13 that?

14 A. Yes.

15 Q. That's not what Leapfrog does today, right?

16 A. It is imputing a score below the mean.

17 Q. Below the mean, fair, but not by one standard
18 deviation, right?

19 A. That was just an example of how that could be
20 operationalized.

21 Q. The measure of limited achievement is more than

1 one standard deviation below, right?

2 A. I have not looked at a distribution of scores
3 to be able to answer that.

4 Q. Do you have an estimate as to what -- how much
5 lower than the standard deviation below -- one standard
6 deviation below the mean it is?

7 A. I don't know what that would be.

8 Q. Okay.

9 Okay. So going back, do you recall what
10 the questionable assumption the authors were worried
11 about in this paper was?

12 A. So I think the biggest concern was around
13 option number four, which would be to give the hospitals
14 zero credit for not reporting to Leapfrog.

15 Q. Why is that the biggest concern?

16 A. That was a concern in that hospitals didn't
17 know that this was coming, that we weren't really being
18 fair to hospitals to just assign zero right from the
19 get-go for not reporting.

20 Q. Is it more fair to assign -- would it be more
21 fair to assign zero now?

1 A. From my point of view, it feels like the
2 context and times have changed, and so I would say, yes,
3 that would feel like a more fair decision to make.

4 Q. More fair. Okay.

5 Is it more or less fair than limited
6 achievement?

7 A. It's probably less fair to assign zero than
8 limited achievement. With limited achievement,
9 hospitals are getting some credit. They're not getting
10 zero credits.

11 Q. No one gets zero, right?

12 A. No one gets zero.

13 Q. Okay. Zero is not an available score, correct?

14 A. Correct.

15 Q. Okay.

16 Then so the questionable assumption, just
17 to make sure I understand it, is about the startup of
18 the safety grade, as opposed to assumptions about
19 performance generally?

20 A. It's assumptions about the rollout of the
21 imputation and whether or not it was fair to assign a

1 score that penalized hospitals when they didn't know
2 that the safety grades were coming.

3 Q. Do you know if that language is in this paper?

4 A. I'm not sure that that -- I would have to
5 reread it.

6 Q. I mean, if you want to take a second and read
7 this section, which I think is the only section dealing
8 with this and just goes to the next page, I'm curious
9 does it articulate that as the questionable assumption
10 in here.

11 A. So in the -- that paragraph at the top of page
12 4, in the second paragraph it says: Finally, the third
13 and fourth approaches were rejected to avoid creating a
14 structural bias in favor of Leapfrog reporting
15 hospitals.

16 So as I mentioned, there was a concern
17 about doing that right from the get-go.

18 Q. But that doesn't say get-go, though. It's
19 talking about reporting versus nonreporting, right?

20 A. It was at that -- the article was written at a
21 point in time with experience only up until that point

1 of time, and that was our experience up 'til that point.

2 Q. Is there any structural bias today in favor of
3 reporting hospitals?

4 A. There are hospitals that report to the Leapfrog
5 Hospital Survey that score limited achievement. So a
6 score of limited achievement is not just for hospitals
7 that don't report. There are some hospitals that report
8 that receive that score as well.

9 Q. What does structural bias mean?

10 A. I guess in that context I would think of it as
11 some sort of bias in how we assign scores based on
12 whether they report or don't report to Leapfrog.

13 Q. And so based on that definition, you're still
14 maintaining there's no structural bias in favor of
15 reporting hospitals?

16 A. Based on what we just discussed, I would say
17 there is a structural bias against nonreporting
18 Leapfrog -- nonreporting hospitals.

19 Q. Okay. There is a structural bias?

20 A. There is a structural bias.

21 Q. Okay. That makes sense. Okay.

1 And that's one of the reasons this group of
2 authors, which included yourself and many of the safety
3 grade expert panelists, like Dr. Romano, rejected this,
4 it looks like, the third and four approaches, right?

5 A. At that point in time.

6 Q. Okay. And your position is the structural bias
7 has changed?

8 A. It's not that it has changed. It is more
9 apparent and can be addressed, right. So in the early
10 days of the safety grade, hospitals didn't even know
11 these grades were coming. A lot of them had never
12 completed the Leapfrog Hospital Survey.

13 Fast-forward 12 years, we're in a different
14 place where hospitals are very aware of the safety
15 grades. They're very aware of the survey, and so the
16 context has changed.

17 Q. So just to be clear, when you say addressed,
18 that's not addressing within the methodology. That's an
19 addressing in the context of hospitals could decide to
20 report?

21 A. Correct.

1 Q. Got it.

2 So the methodology doesn't take any
3 measures to address that structural bias?

4 A. Correct.

5 Q. Okay.

6 Okay. And then the other -- if you keep
7 going on that paragraph, it says: "By scoring hospitals
8 on" -- tell me when you're ready.

9 "By scoring hospitals on the available
10 data, the composite scores were based on what was known
11 about the hospital's performance, with no penalties for
12 missing data."

13 Do you see that?

14 A. Yes.

15 Q. Okay. Now, that also is different for today,
16 right?

17 A. That is different than today.

18 Q. Okay.

19 And at this time, scoring hospitals based
20 on what was known about the hospital's performance was
21 something this group of authors deemed advisable, right?

1 A. So to be clear, what we're representing is the
2 Hospital Safety Grade methodology. Not all authors were
3 part of the expert panel. And just to remind you, all
4 of the decisions about the methodology are ultimately
5 Leapfrog's to make.

6 Q. Yes.

7 A. So what we're writing up is the implications of
8 that decision. So when you asked about whether authors
9 agreed, to me it's not an agreement or disagreement.
10 It's were we stating what the facts were at that time.

11 Q. Okay. No, that's fair. So I got it. So
12 you're saying it's an empirical observation?

13 A. Correct.

14 Q. So the observation is by scoring hospitals on
15 the available data, the composite scores were based on
16 what was known about the hospital's performance with no
17 penalties for missing data. You're saying, just to make
18 sure I understand, you're not making a judgment about
19 whether that's good or bad. You're saying it's what's
20 being done?

21 A. Correct.

1 Q. Okay. Got it.

2 Now, this is the paper that Leapfrog touts
3 as having peer reviewed its methodology, right?

4 A. Correct.

5 Q. But there are multiple components, at least in
6 this paragraph that we've seen, that don't apply
7 anymore, right?

8 A. There are -- can you repeat the question?

9 Q. So we've walked through this paragraph about
10 different observations, the questionable assumptions,
11 the structural bias, and then the penalties for missing
12 data, all of which you said are not what Leapfrog does
13 today. They're not reflective of the methodology
14 Leapfrog uses today, correct?

15 A. Correct.

16 Q. Is it fair to say that this paper is a peer
17 reviewed assessment of the methodology today?

18 A. I'm going to be a little careful because I
19 don't know if Leapfrog's website says that it's a peer
20 reviewed of today, right. It's a peer reviewed of their
21 methodology, right.

1 So I'll go back to the previous point that
2 I think the overall structure of the composite score,
3 that it's based on two domains of measures, the data
4 sources, we're going to do relative weights, has
5 remained consistent and constant through time.

6 Have some of the individual decisions about
7 imputation -- obviously, some of that has evolved and
8 changed. So I don't know how to say whether or not it's
9 a fair representation of Leapfrog's methodology or not.

10 Q. Do you agree, yes or no, that Leapfrog's
11 current methodology has been peer reviewed?

12 A. Are you speaking of the Fall 2024 methodology?

13 Q. The one that's operative today.

14 A. I think it sort of depends on your definition
15 of what we mean by methodology. And I don't mean to get
16 into semantics, but I would still come back to like the
17 general structure of all of this is still the same.
18 Some of the nuance differences are different, but that
19 happens continuously throughout the last 12 years.

20 So I don't know how you would write a new
21 paper every time we change one measure or re-weight one

1 measure.

2 Q. So we talked about, maybe an hour ago, that the
3 imputed measures are significant, right?

4 A. I don't know if that's what we discussed.

5 Q. Okay. You talked about how they're
6 clinically -- they matter, right?

7 A. Correct. They're important elements of patient
8 safety.

9 Q. Yes.

10 A. Yes.

11 Q. And they weight quite heavily, right?

12 A. They make up somewhere between 20 and
13 30 percent.

14 Q. Yes, as we talked about.

15 A. Yeah.

16 Q. Is it -- so 30 percent, 20 to 30 percent of the
17 methodology is derived from an imputation model that
18 this paper did not comment on, correct?

19 MS. LAWSON: Object to form. Go ahead.

20 THE WITNESS: As listed under the imputation
21 methods, one of them is exactly what we're doing today.

1 BY MR. CRAIN:

2 Q. Which one? Three?

3 A. Number three.

4 Q. Okay. Impute a score below the mean, correct?

5 A. Correct.

6 Q. Okay. I guess this doesn't say how much far
7 below, right?

8 A. Correct.

9 Q. Because if the means that we saw earlier from
10 Ms. Campione's emails were in the 70s, 80s, and 90s, and
11 the imputation is 15, was that the type of difference
12 below the mean that you were contemplating when you
13 wrote this piece?

14 A. I think there was room for -- there was room
15 for decisions to be made around number three and what
16 sort of score above or below the mean or median. The
17 minus one standard deviation was just an example.
18 Obviously, number four is a more extreme example of
19 zero. So there's a range of options in between those
20 two.

21 Q. Okay.

1 So then I guess going back to my question,
2 we've talked about the imputation methodologies being 20
3 or 30 percent, being significant. Is it fair to say
4 that the current methodology has been peer reviewed
5 given that that substantial portion of it was never
6 reviewed?

7 A. I don't know how to answer that. I feel like
8 it is fair to say that because the primary structure of
9 the methodology has remained the same. Now, others
10 could have a different assessment of that. Some could
11 say, oh, wow, the imputation approaches make this
12 nonrepresentative. I guess that's just a disagreement
13 in how maybe we see the world.

14 Q. Okay. Fair enough.

15 So let me ask this question. The
16 imputation model, has that been peer reviewed?

17 A. No.

18 Q. Okay.

19 Okay. You can set that aside.

20 MR. CRAIN: Let's go to tab 21. This will be
21 Exhibit 27.

1 (Exhibit No. 27 was marked for
2 identification as of 9/25/2025.)

3 BY MR. CRAIN:

4 Q. Okay. So this is another, you see at the
5 bottom, Armstrong-produced document?

6 A. Yes.

7 Q. Do you recognize this one?

8 A. Yes. Well, it's been a while.

9 Q. What does it look like?

10 A. It says it's the meeting agenda. What it
11 actually represents is notes from the meeting.

12 Q. Maybe somebody built out the notes within the
13 agenda?

14 A. Correct.

15 Q. Okay.

16 A. And we just forgot to change the title.

17 Q. Any reason to think this isn't a true and
18 accurate depiction?

19 A. No.

20 Q. So I just have a couple of questions. If you
21 go to -- where is it again -- page 76, do you see theirs

1 is a big, bold "Unintentional consequences of how we
2 currently treat missing data"? Do you see that header
3 on page -- it's the first page?

4 A. Yes.

5 Q. Okay. And I want to go to page 2. And do you
6 see the bullet number two?

7 A. Yes.

8 Q. It says: "Imputation of the score when we have
9 missing data."

10 A. Yes.

11 Q. And it says: "Matt mentioned that expert panel
12 discussed this in the past and did not feel it supported
13 the goal of the safety grade." Do you see that?

14 A. Yes.

15 Q. So I want to break this down a little bit.

16 Now, do you recall making this statement at
17 an expert panel meeting? I recognize it's a while ago.

18 A. I don't remember --

19 Q. Okay.

20 A. -- that conversation.

21 Q. Is it accurate, to the best of your knowledge

1 today, that, looking at the top bullet, imputation of
2 the score when you have missing data is something the
3 expert panel discussed in the past?

4 A. So, yes, we have discussed imputation with
5 them.

6 Q. Okay. Just to build out the --

7 A. Right. Yes, that's fine.

8 Q. Just to get on the same page.

9 A. Yes.

10 Q. And now it says: Did not feel it supported the
11 goal of the safety grade.

12 A. I don't know what that refers to.

13 Q. Okay.

14 A. I will take ownership that the note-taking here
15 may not have been all that accurate, because I don't
16 even know what that refers to because I don't think they
17 -- they have never indicated that imputing scores
18 doesn't support the goal of the safety grade.

19 Q. Okay.

20 A. So I'm thinking that there might have been some
21 nuance to that that wasn't captured in the notes.

1 Q. What could the goal have been referring to?

2 A. I don't know for sure.

3 Q. Okay.

4 So if you go to the next bullet, do you see
5 how -- "Imputing scores for individual measures, like
6 safe practices, would incentivize them to report on the
7 survey." Do you see that?

8 A. Yes.

9 Q. First of all, does that reflect that the safety
10 grade expert panel considered imputing for safe
11 practices?

12 A. That was something that was, I guess, discussed
13 at that meeting.

14 Q. And as we talked about before, was decided
15 against, right?

16 A. Leapfrog has never imputed scores for --

17 Q. Safe practices?

18 A. -- safe practices.

19 Q. One or two?

20 A. One or two.

21 Q. Now, imputing -- it says: "Imputing scores for

1 individual measures would incentivize them to report on
2 the survey." Is that different from the goal reflective
3 in bullet one?

4 A. That I don't know how those connect.

5 Q. We've talked a little bit today about what the
6 goals of the safety grade are. I think we've talked
7 about information, right, as one goal, getting
8 information out there, correct?

9 A. Correct.

10 Q. We've talked about accuracy as another goal,
11 correct?

12 A. Yes.

13 Q. Are there any other goals that you can think
14 of, of the safety grade, that we haven't -- besides
15 those two?

16 A. None come to -- immediately come to mind.

17 Q. Okay.

18 So looking at this bullet, you noted
19 earlier today you endeavor to be accurate in these
20 notes, right?

21 A. That is our goal.

1 Q. And goal -- we talked about goals.

2 So you have no recollection or
3 understanding as to why imputation, at least at this
4 time, would be deemed not supportive of the goal of the
5 safety grade, at least the two goals that we've talked
6 about?

7 A. Yeah. I do not understand how that note ties
8 to everything else I know and understand.

9 Q. Okay. So you just don't remember, or it just
10 doesn't make sense anymore?

11 A. I don't remember what that was intending to --

12 Q. To say?

13 A. To say.

14 Q. Okay. I have to ask.

15 Okay. Let me just see. Yeah. Okay. You
16 can set that aside.

17 MR. CRAIN: And then just one more historical
18 document. Can we do tab 30. This is Exhibit 28.

19 (Exhibit No. 28 was marked for
20 identification as of 9/25/2025.)

21

1 BY MR. CRAIN:

2 Q. Dr. Austin, you have in front of you an email
3 thread between you, Ms. Danforth, Mr. Card, and Emma
4 Domico. Do you see that?

5 A. Correct.

6 Q. Who is Emma Domico?

7 A. Emma was the research analyst who was working
8 for me at the time on the Leapfrog contract.

9 Q. What Ms. Joshi does now?

10 A. Correct. She was in between Jordan and Preeti.

11 Q. Got it.

12 And who is Mr. Card?

13 A. Mr. Card worked for The Leapfrog Group and was
14 the analyst who was supporting the Hospital Safety
15 Grade. So he preceded Alex.

16 Q. Got it.

17 So I want to just look -- so it's a little
18 bit of a confusing email, but I'm going to walk you
19 through at least how I think I read it. So go to the
20 bottom, which is the first one.

21 A. Yes.

1 Q. And it's from you and it's dated August 25th,
2 2021, right?

3 A. Yes.

4 Q. And just for context, is this around the time
5 where AHA was rescinding the license?

6 A. I don't know -- I don't know the timing of the
7 AHA license.

8 Q. Okay. Do you remember generally what was
9 happening in 2021?

10 A. I don't other than COVID was.

11 Q. Fair enough. We all remember that one.

12 A. Yeah, but I don't remember what -- I don't
13 remember the timing of the AHA data because that was all
14 between Leapfrog and --

15 Q. Got it. Okay.

16 So I will at least represent to you that
17 this was -- well, we'll go through the document.

18 A. Okay.

19 Q. So you write -- you say, "Missy, Andrew: Next
20 Friday is the HSG" -- Hospital Safety Grade. Yes? Is
21 that right?

1 A. Yes.

2 Q. Okay.

3 A. Correct.

4 Q. -- "expert panel call. As Emma and I were
5 walking through agenda items, we would benefit from your
6 input/expertise." Do you see that?

7 A. Yes.

8 Q. And I want to focus on number two and start
9 with the bold. Do you see there's two pieces of text.
10 There's a bold and a sort of grayer one on each line?

11 A. Yes.

12 Q. Okay. So let's start with the bold. You say,
13 number two: "How to score hospitals missing
14 process/structural measures. Are we looking for
15 suggestions on imputation methods?" Do you see that?

16 A. Yes.

17 Q. And then if you go to four, it says:
18 "Penalizing hospitals if they don't report. Is this
19 part of agenda item number two? And is Leapfrog really
20 open to this idea? If not, I don't want to keep asking
21 their opinions."

1 Do you see that?

2 A. Yes.

3 Q. Now, we'll come back to this, but I just want
4 to explain to you what the gray is. So if you go one
5 up, the prior page, you see Ms. Danforth writes: "See
6 below"?

7 A. Yes.

8 Q. Okay.

9 So the gray, is it correct to say, those
10 are her comments interlined with your agenda?

11 A. Yes.

12 Q. Okay.

13 So on number two, she says in response to
14 your agenda point, she says, "Yes, and the idea to
15 impute for all missing, including safe practices and HH.
16 I will send a follow-up to the email that Andrew sent."

17 So can you tell me generally what are you
18 proposing as an agenda item, and what did you
19 understanding her response was?

20 A. So what we were proposing as an agenda item was
21 to discuss with the expert panel our imputation methods

1 for process and structural measures.

2 Q. Okay.

3 A. And Missy suggested back the idea that maybe we
4 impute for all missing, including safe practices and
5 hand hygiene.

6 Q. Okay.

7 And then if you go to four, you say -- you
8 have a separate agenda item, right?

9 A. Correct.

10 Q. And it says: "Penalizing hospitals if they
11 don't report. Is this part of agenda item number two?
12 And is Leapfrog really open to this idea?" You all caps
13 "really." Do you see that?

14 A. Yes.

15 Q. So why were you all capping really?

16 A. So back to attachment 27, back to Old Town
17 Alexandria, the Hilton, that was actually a point where
18 the expert panel actually brought up the idea of moving
19 towards an imputation approach where -- to penalize
20 hospitals --

21 Q. Okay.

1 A. -- if they didn't complete the Leapfrog
2 Hospital Survey.

3 So even though it got implemented in 2024,
4 as far back as 2017 conversations were happening about
5 whether or not this was the direction to go into.

6 Q. Okay.

7 A. So in 2021, it was like, is Leapfrog open to
8 this? Are they not open to this? I don't want to keep
9 asking the expert panel over and over again about this
10 if Leapfrog is not open to moving in this direction.

11 Q. Okay.

12 A. So that was the intent of that.

13 Q. And by this direction, you mean a penalty?

14 A. It could be a penalty. It could be an
15 imputation below the mean or median. It could take many
16 different forms, and I don't think a specific proposal
17 had been floated at that point.

18 Q. Okay.

19 And then -- so look at her response. She
20 says: "Remove. This is really covered in number two."
21 Do you see that?

1 A. Correct.

2 Q. Okay. And it sounds like you agree with that?

3 A. Well, I agree that that decision is part of
4 imputation, right. So as we go back to the five
5 imputation methods, number three was one of the possible
6 options, right. So that is part of the imputation
7 discussion is do we impute that a hospital is an average
8 performer? Do we impute that they're a better
9 performer? Right? Like, those are all decisions around
10 imputation.

11 Q. So and when you say "those," you mean the
12 decision of whether to penalize a hospital is part of
13 the analysis of how to impute or whether to impute?

14 A. So there were a couple of approaches that could
15 be taken, right. So if we go back to number 27, Old
16 Town Alexandria, one suggestion from the expert panel
17 was, well, would we want to assign some sort of explicit
18 negative penalty.

19 So we wouldn't necessarily work that into
20 the imputation of individual scores, but we would take
21 so much off of the final score for not being

1 transparent. So that was one idea of how that could be
2 manifested. This could be other ways of manifesting it.

3 Q. Yeah. No, I get that. I'm just trying to
4 understand. So the agenda item number two is how to
5 score hospitals missing process and structural measures.
6 Do you see that?

7 A. Correct.

8 Q. And the question of penalizing hospitals is
9 bound up in that discussion as well, correct?

10 A. I think what Missy was saying is she didn't see
11 that as being a unique part of the agenda, that that
12 would be -- could be incorporated into number two.

13 Q. Well, she said covered in number two, right?

14 A. Correct.

15 Q. And you agree with her?

16 A. I would agree that that, as we've discussed,
17 that that is an option for imputation.

18 Q. And is it fair to say over the years when this
19 topic has come up, the notion of penalizing hospitals
20 has been covered by the topic in number two?

21 A. It's been brought up in that space, yeah.

1 Q. Okay. Okay.

2 Let me take another look. I think that may
3 be it for this email. Yeah, we can set this one aside.

4 So I'm going to shift gears again. We're
5 getting there.

6 A. How many gears are there on this car?

7 Q. I've got a lot of gears. I've got a lot of
8 gears. We're getting close to the end gear. I've only
9 got so much time.

10 I want to talk about the 2019 white paper.

11 A. Okay.

12 Q. Okay? Oh, you seem excited for it.

13 A. I love it.

14 Q. Okay.

15 MR. CRAIN: So I want to start with -- let's go
16 to tab 58. And this is Exhibit 29.

17 (Exhibit No. 29 was marked for
18 identification as of 9/25/2025.)

19 BY MR. CRAIN:

20 Q. So, Dr. Austin, you see this is an email from
21 you to Ms. Campione, Ms. Danforth, and Ms. Bailey from

1 2025.

2 A. Yes. So this is not in reference to the
3 2019 --

4 Q. Yes.

5 A. -- report.

6 Q. It's the lives saved, lives lost, right?

7 A. Correct.

8 Q. Okay. This was the update you were talking
9 about, right?

10 A. This is the update that we've worked on but
11 have not published.

12 Q. Okay. I want to walk through this one, if I
13 can.

14 A. Okay.

15 Q. Okay. So maybe I was a little unfair. I'm
16 starting with 2025 and then I want to lead into the
17 white paper --

18 A. Okay.

19 Q. -- but I want to talk about your numbers here.

20 A. Okay.

21 Q. Okay?

1 So let's go to page -- so I want to look
2 at -- you see Ms. Campione's email on the bottom? It's
3 from her to you, and there's a table on page 0900. Do
4 you see that?

5 A. Yes.

6 Q. Okay. Now, this table -- tell me what this
7 table is.

8 A. So what this table represents is for three
9 points in time, 2016, 2019, and 2025, we have estimated
10 the number of lives lost due to preventable medical
11 mistakes that are captured through the Leapfrog Hospital
12 Safety Grade measures.

13 We also have estimated the number of lives
14 that could be saved if "B," "C," "D," and "F" hospitals
15 all performed as well as "A" hospitals. So we've
16 estimated that at three different points in time.

17 We also have done relative comparisons
18 between "B" and "A" hospitals, "C" and "A", "D" and "A"
19 and "F", and then we break the numbers down.

20 Q. So the chart that we're looking at here on page
21 0900, is it correct that the 2016 column reflects the

1 analysis done on the 2016 white paper, and the 2019
2 reflects the update?

3 A. Correct.

4 Q. Okay. And 2025 reflects, at least in draft
5 form, what the current numbers would be?

6 A. They represent, if we were to maintain the same
7 methodology we used in 2019, what the numbers would look
8 like in 2025.

9 Q. Okay. Can you -- and I'm happy to give you
10 documents if it's helpful, but can you generally
11 describe what that methodology is?

12 A. Yep.

13 Q. And if you need a document, we can get you that
14 document.

15 A. No, no. I can.

16 So what we do is for each grade, "A", "B",
17 "C", and we lump "D" and "Fs" together --

18 Q. Why is that?

19 A. Primarily due to small sample sizes of "F"
20 hospitals.

21 Q. Got it.

1 A. We're looking at less than 20 or 25.

2 Q. Okay.

3 A. For each of the outcome measures that are
4 included in the Hospital Safety Grade, we calculate a
5 mean incidence rate for each cohort of hospitals. So
6 "A" hospitals, how do they do on foreign objects
7 retained? "B" hospitals, how do they do on foreign
8 objects retained?

9 So we have basically an estimated incidence
10 rate of these events by hospitals.

11 Q. And just to translate that, estimated incidence
12 rate means how many times this thing happened?

13 A. Correct.

14 So we display it as a percentage, right?
15 You can think of like, oh, 1.2 percent of patients
16 develop a central line associated blood stream infection
17 in an "A" hospital. Some of those measures, outcome
18 measures are applicable just to patients who have had
19 surgery. Some are just applicable to patients who have
20 been in the intensive care unit.

21 And so we discount the total patients based

1 on who those -- who those measures apply to.

2 Q. Yep.

3 A. Then in terms of estimating the lives lost,
4 from the literature, we've identified the attributable
5 mortality rate to that event happening to a patient in a
6 hospital and their -- yeah, attributable mortality rate.

7 So as previously discussed, like for
8 central line associated blood stream infections, one out
9 of every seven patients who develop C infection in the
10 hospital will die.

11 And we're using that same attributable
12 mortality rate for all categories of hospitals. So that
13 is one of our limitations. We may have variation in
14 that "A" hospitals could actually have a lower mortality
15 rate than "D" and "F" hospitals, but we're making the
16 assumption of that mortality rate.

17 And so that is -- and then in addition to
18 the outcome measures, we're also using ICU physician
19 staffing because there is strong evidence linking
20 improvements in intensivists managing and comanaging
21 patients in the ICU and reduced mortality hospital-wide.

1 Q. Okay.

2 A. Well, both in the ICU and hospital-wide. And
3 so that's the one process and structural method that we
4 use as part of the analysis.

5 Q. So looking at this chart again, just as a
6 grounding mechanism, it looks like to me that there are
7 19 outcome measures and 1 process measure. Is that
8 right? That's what I'm seeing, the 19 and the 1.

9 A. Correct.

10 Q. Okay. And the one is, as you said, ICU
11 physician staffing, correct?

12 A. Correct.

13 Q. Okay. And so basically you're taking the
14 incidence times the mortality and outputting the amount
15 of estimated deaths?

16 A. We are for the outcome measures.

17 Q. Okay.

18 A. What we're doing for ICU physician staffing is
19 we're going back to the historical literature that
20 established the standard to say that there is a
21 30 percent reduction in hospital-wide mortality between

1 no intensivist and high intensivist staffing.

2 And so we actually go back to seventh or
3 eighth grade math, and we have the slope of a line. And
4 this is where hospitals are now at, and, therefore, if
5 we calculate the slope, it would be this point on the
6 line.

7 Q. Oh, boy. You're testing my math skills.

8 A. I test my own as well.

9 And so basically, hospitals that are fully
10 implemented we think have -- we estimate that they have
11 achieved the full impact of that.

12 Q. Okay.

13 A. And if hospitals are somewhere along that
14 continuum, they've achieved a portion of that impact.

15 Q. Okay.

16 So the mortality rating for ICU physician
17 staffing, am I right that it is based on a 2004 article
18 by Dr. Pronovost?

19 A. It's definitely by an article by Dr. Pronovost.
20 I couldn't speak to the year.

21 Q. Okay. Can we grab it?

1 A. I don't disagree with you that it was 2004.

2 Q. You don't know for sure?

3 A. I don't know for sure.

4 Q. I'll represent to you it's 2004. We may as
5 well pull it out. We have it if you want to take a
6 look.

7 A. Okay.

8 Q. My question is have you looked at the research
9 that's come sense to test that estimate?

10 A. So Leah Binder at The Leapfrog Group has asked
11 us to look at that. We have not found anything recently
12 that would be a better way for us to estimate that
13 value.

14 Q. Okay.

15 So I guess, one, have you heard of --
16 there's an article by -- do you know who Deena Kelly
17 Costa is?

18 A. I do not.

19 Q. Okay. I guess I'll just mark it to see if
20 you've seen this article before.

21 MR. CRAIN: Let's mark it as Exhibit 30.

1 (Exhibit No. 30 was marked for
2 identification as of 9/25/2025.)

3 BY MR. CRAIN:

4 Q. Does this article look familiar to you at all?

5 A. I'm not familiar with it.

6 Q. Okay.

7 So the title is: The Association Between
8 Daytime Intensivist Physician Staffing and Mortality in
9 the Context of Other ICU Organizational Practices: A
10 Multicenter Cohort Study.

11 Do you see that?

12 A. Yes.

13 Q. Do any of the authors -- are they familiar to
14 you, Dr. Wallace, Dr. Kahn, and Dr. Costa?

15 A. I do not know any of them.

16 Q. Okay.

17 Do you know the journal here?

18 A. I am familiar with critical care medicine, yes.

19 Q. Reputable journal?

20 A. As far as I know.

21 Q. Okay.

1 Now, I want to go down to Measurements and
2 Main Results, and there's a sentence just at the end
3 which seems to sort of give the bottom line starting
4 with "there." Do you see that?

5 A. Yes.

6 Q. "There was no association between daytime
7 intensivist physician staffing and in-hospital
8 mortality. After adjusting for interprofessional rounds
9 and protocols for mechanical ventilation, the effect of
10 daytime intensivist physician staffing remained
11 nonsignificant."

12 Do you see that?

13 A. Yes.

14 Q. I know you haven't read this article, but at
15 least based on the first page -- and feel free if you
16 want to flip through -- does this undermine the
17 assumptions that the white paper makes with respect to
18 IPS and mortality?

19 MS. LAWSON: Object to form.

20 THE WITNESS: So I think in research there
21 is -- I don't think one can look at one study

1 individually to assess whether there is a relationship
2 or not a relationship, right. I think if we think about
3 -- through humankind, there's lots of studies that have
4 been done. One will show red wine is good for the
5 heart. The next one will show, oh, no, you should stay
6 away from alcohol, right. And over time we sort of
7 build a body of literature.

8 What an additional -- one of the strengths
9 of the Pronovost article, if I'm remembering it
10 correctly, is it was actually a meta analysis. So it
11 actually looked at 15 to 20 different studies and
12 synthesized those results.

13 So it's not to say that every study is
14 going to show a relationship, but one study doesn't
15 necessarily negate a wider body of literature.

16 BY MR. CRAIN:

17 Q. Okay.

18 This is dated 2015. Do you see that?

19 A. Correct.

20 Q. And you've not seen this article, right?

21 A. I have not seen this.

1 Q. Okay. Is it something that you think you
2 should review in the next iteration or no?

3 A. I would be happy to review it and see what we
4 come to in terms of a conclusion.

5 Q. Okay. Okay.

6 So I want to go back to -- I want to just
7 go back to the chart again.

8 A. Yeah. Okay.

9 MS. LAWSON: Is that Exhibit 29?

10 MR. CRAIN: Yeah, 29, the email and the invite.

11 BY MR. CRAIN:

12 Q. Now, I want to just look at the differences in
13 mortality, right. So when you look at -- just take --
14 starting with "D" and "F," right, at the bottom. Do you
15 see that?

16 A. Yes.

17 Q. It says, focusing primarily -- focusing on the
18 outcome measures. It says 1.46 in 2019. Do you see
19 that?

20 A. For "D" and "F," correct.

21 Q. Correct.

1 And is that, just to make sure I understand
2 the numbers, is 1.46, that's 1.46 deaths?

3 A. Correct.

4 Q. Okay.

5 And then if you go down to "C," it's 1.40,
6 right?

7 A. Correct.

8 Q. To "B," it's 1.31, right?

9 A. Correct.

10 Q. And 1.22 for "A." Do you see that?

11 A. Correct.

12 Q. Is the difference just for outcome measures
13 between 1.22 for an "A" and 1.46 statistically
14 significant in your view?

15 A. I would need to do a statistical test to
16 determine whether that there is a statistical difference
17 there.

18 Q. Okay. It's not twice, right? There are not
19 two times as many deaths between -- in that comparison,
20 right?

21 A. Not in just comparing the outcome measures.

1 Q. Just comparing the outcome measures.

2 A. Correct.

3 Q. With respect to the ICU physician staffing,
4 fair to say the difference is more substantial, right?

5 A. Correct.

6 Q. Is the -- would you agree that the analysis
7 places -- like the number of deaths in the analysis is
8 significantly weighted to the ICU physician staffing
9 metric?

10 A. Yes. Although, there is a methodological
11 clarification that I should make because this will help
12 explain it to some degree. We actually take the number
13 of outcome measures, or we take the lives lost in the
14 outcome measures and actually divide that by two.

15 Q. Okay.

16 A. And the reason we do that is because we
17 recognize that there are some deaths that are probably
18 occurring in the ICU that are a result of not good care,
19 right.

20 So you may have developed a central line
21 blood stream infection. We didn't want to count that

1 twice, both in the outcome measures and the ICU
2 physician staffing.

3 So the methodological decision was to cut
4 the outcome measures in half. So we take each value and
5 divide by two so that we aren't double counting between
6 the two.

7 Q. And what was that based on? That's the
8 50 percent number?

9 A. Yeah, the 50 percent. That was just an
10 educated guess.

11 Q. Okay. Is it based on a study or is it based on
12 --

13 A. No. It was just sort of a collective wisdom of
14 people.

15 Q. The authors or other people?

16 A. Other people as well.

17 Q. Who were the other people?

18 A. So the initial work for this actually came out
19 of some work that The Leapfrog Group had done, Leah
20 Binder, with another consultant.

21 Q. Okay. Who is that?

1 A. I don't remember his name.

2 Q. Okay.

3 A. I can sort of picture him, but I don't remember
4 the name. And so it was out of that that the decision
5 was made to multiply it by 50 percent.

6 Q. Okay.

7 So if we look at the bottom, you're saying
8 that "D" and "F," the actual number is closer to 3 than
9 1.46?

10 A. Correct.

11 Q. Okay. Got it.

12 Okay. So then that's still I guess -- my
13 question still remains. The biggest difference, at
14 least it appears to me, between a "D" and "F" hospital
15 and an "A" hospital is the physician staffing mortality.
16 Is that right?

17 A. That is -- from what we're able to quantify in
18 terms of harm, that is where the biggest differences
19 are.

20 Q. Okay. And the mortality rating for that is
21 based on the Pronovost article, right?

1 A. Correct.

2 Q. Okay.

3 And then so let's go to another document.
4 I want to look primarily -- let's look at the chart,
5 actually, on the right side, so the 2025 metric.

6 A. Okay.

7 Q. Now, in all -- this is the first time, at least
8 for IPS and I think everywhere else, there's a slash.
9 Do you see that?

10 A. Yes.

11 Q. What does the slash reflect?

12 A. The slash is reflecting if we -- the value to
13 the right of the slash would be if we were to remove the
14 imputed scores for IPS.

15 Q. Yeah. And say more about that. You mean
16 remove the mortality for nonparticipating hospitals?

17 A. No. We would remove -- if a hospital had an
18 IPS score that was imputed, we would remove that from
19 the calculation.

20 Q. Okay. And that's the right side?

21 A. That is the right side.

1 Q. So the left side reflects -- tell me if this is
2 wrong. I'm just trying to understand. The left side of
3 the slash reflects the hospitals that are participating
4 with IPS scores based on their actual performance data,
5 and the right side includes nonparticipating hospitals
6 with the limited achievement assignment?

7 A. So the left-hand side would be the scores for
8 all hospitals that received a safety grade, including
9 those that were imputed.

10 Q. Okay.

11 A. The right-hand side would be just hospitals
12 that had a score reported through the Leapfrog Hospital
13 Survey.

14 Q. And that's the 80 percent of inpatient beds
15 we've been talking about?

16 A. Correct.

17 Q. Okay. Got it.

18 So the numbers are pretty different, right,
19 at least in certain categories?

20 MS. LAWSON: Object to form. Go ahead.

21 THE WITNESS: I don't know how you would define

1 pretty different.

2 BY MR. CRAIN:

3 Q. Fair enough.

4 If you go to "D" and "F," the difference is
5 7.98 on the left and 3.89 on the right. Do you see
6 that?

7 A. Correct.

8 Q. And if you go to "C," 4.92 and 2.52, right?

9 A. Correct.

10 Q. Now, the differences get smaller. So "B," it's
11 2.12 and 2.01, right?

12 A. Correct.

13 Q. And then "A," it's 1.53 versus 1.5, right?

14 A. Correct.

15 Q. And if I recall correctly, there were only two
16 hospitals that got an "A" with imputed scores, right?

17 A. Correct.

18 Q. So that -- did that explain why that's so close
19 together? Correct?

20 A. I would need to go back and look at the math,
21 but your statement about that there's two hospitals is

1 correct.

2 Q. Yeah. Okay.

3 Do you have a theory as to why the numbers
4 are so different left and right, at least for "D" and
5 "F" and "C"?

6 A. The difference between the two values is the
7 inclusion or exclusion of the imputed values.

8 Q. Is the number on the left or the right more
9 likely an accurate estimate?

10 MS. LAWSON: Object to form.

11 BY MR. CRAIN:

12 Q. Let me step back. You're trying to estimate
13 mortality of "A," "B," "C," "D," and "F" hospitals,
14 right?

15 A. Correct.

16 Q. You want to be accurate in the estimate as best
17 you can?

18 A. Yes, recognizing it's an estimate.

19 Q. Yes. So I'm going to posit that 4.92 versus
20 2.52 for the "C" hospitals, pretty different number of
21 deaths. Is that fair to say or you disagree? I mean,

1 it's almost double, right, on the left side.

2 A. That last part is true. It is almost double.

3 Q. So we'll just go with numerical. It's almost
4 double.

5 What is a more accurate estimate of the
6 mortality of "C" hospitals as a result of ICU physician
7 staffing? Is it 4.92 or is it 2.52?

8 A. I will say both are incorrect.

9 Q. Okay. I'm eager to hear why.

10 A. Well, one includes imputed values, which, by
11 definition, are not exact values.

12 Q. Okay.

13 A. The other one is excluding hospitals that we
14 don't have any data for. So there is some lives lost
15 attached to them. So both of them are actually -- both
16 of them are estimates in two different scenarios.

17 Q. You said a moment ago both of them are
18 incorrect.

19 A. Okay. Both of them are incorrect.

20 Q. Okay.

21 A. It's an estimate, so unless you hit it right on

1 the dot, an estimate is going to be incorrect.

2 Q. Which one is more incorrect?

3 A. I don't know how to judge that.

4 Q. Okay. So you don't know one way or another?

5 A. I don't know one way or another.

6 Q. Okay.

7 MR. CRAIN: So I want to take a look at a few
8 documents here. Give me one second. Oh, no wonder I
9 can't find it. It's actually in this document. Iason
10 knows them better than I do.

11 THE WITNESS: Which one?

12 BY MR. CRAIN:

13 Q. So this is Exhibit 30, what we were just
14 looking at -- oh, sorry, 29 I mean was the chart.

15 MS. LAWSON: 29.

16 MR. CRAIN: Yeah, Exhibit 29 with the chart.

17 BY MR. CRAIN:

18 Q. Okay. And this is from you to Ms. Campione,
19 Ms. Danforth, and Ms. Bailey, right?

20 A. Correct.

21 Q. Okay. So you send an email, and the tenor -- I

1 can read it all, but the tenor seems to be there's a
2 discussion about whether you include the imputed scores
3 in the mortality or not, right?

4 MS. LAWSON: Take a minute and read the email.

5 MR. CRAIN: Yeah, take a second.

6 (Witness peruses document.)

7 THE WITNESS: So, yeah, this is -- the tenor is
8 about the table that we just went through.

9 BY MR. CRAIN:

10 Q. Whether to include the imputed scores or not,
11 right?

12 A. Correct.

13 Q. Okay.

14 And you at the end say, "I would vote for
15 keeping the imputed IPS scores in place. My guess is
16 the averages with the imputed scores are closer to the
17 truth than averages excluding the imputed scores."
18 Right?

19 A. Correct.

20 Q. So what's that based on?

21 A. Well, I think I used the word "guess," so I

1 will qualify that. I guess it's somewhat informed by
2 that, you know, hospitals that choose not to disclose
3 likely may not be meeting Leapfrog's standards. Because
4 if they were meeting them, they would be more likely to
5 disclose them. So it was probably with that assumption.

6 Q. So that -- so okay. But it's multiple levels
7 of assumptions, right? I can build it out to see what I
8 mean.

9 So assumption one is that hospitals that
10 are not reporting are not meeting Leapfrog's standards,
11 right?

12 A. That is the assumption I just stated.

13 Q. And assumption two is that the failure to meet
14 Leapfrog's standards yields a higher mortality rate?

15 A. Correct, based on the literature.

16 Q. Okay. So it's an assumption, but you're saying
17 it's backed by literature?

18 A. Correct.

19 Q. And, again, meaning the Pronovost article?

20 A. Correct.

21 Q. Okay. So your guess is based on those two

1 assumptions?

2 A. Correct.

3 Q. Okay.

4 Do you have any understanding of where
5 Leapfrog is landing on this question, whether to include
6 the imputed or nonimputed?

7 A. I do not know.

8 Q. And just going back to the chart, I want to
9 just look at the numbers. Just go right to the top.
10 You see lives lost, lives saved? Do you see that?

11 A. Yes.

12 Q. Okay. And it's -- the numbers, again, you
13 know, are -- so I'll be factual about it. Lives lost,
14 if you exclude the imputed hospitals, it's about 30,000
15 fewer, right?

16 A. Correct.

17 Q. Okay. And if you exclude the imputed values,
18 it's also about 30,000 fewer on lives saved, right?

19 A. Correct.

20 Q. Okay. And so your view is that it is -- your
21 best guess is that those 30,000 are -- bear some

1 relation -- have some accuracy to them -- strike that.
2 That was a bad question. I know you were going to
3 object. And it was fair.

4 So let me ask another question then.

5 You said the numbers bear out the twice as
6 likely mortality point. Do you remember earlier in the
7 day we talked about Leapfrog says on its website that
8 Johns Hopkins researchers say you're two times likely to
9 die if you go to a "D" or an "F" hospital, as opposed to
10 an "A"?

11 A. I remember that conversation, but I don't
12 remember in what context.

13 Q. We were looking at the website, which we can
14 look at if someone will tell me the exhibit number, and
15 we talked about -- so maybe we can get that document out
16 just to ground us. I think it's exhibit --

17 MR. TOGIAS: It was tab 65.

18 MR. CRAIN: Sixty-five. So that's Exhibit 9.

19 MR. TOGIAS: Frequently asked questions.

20 MR. CRAIN: Yeah.

21 MS. LAWSON: It's on page 2.

1 MR. CRAIN: Yeah, I think that's right.

2 BY MR. CRAIN:

3 Q. Page 2 and it's under the second -- we talked
4 about -- remember this question? "Why should people
5 worry about a hospital's patient safety?" Do you
6 remember that?

7 A. Yes.

8 Q. And if you go to the end of that paragraph:
9 "All hospitals are not the same. Some hospitals are
10 much safer than others. John Hopkins Medicine
11 researchers estimate that patients are twice as likely
12 to die of a preventable problem at a "C," "D," or "F"
13 hospital than an "A" hospital, and over 50,000 lives
14 would be saved if all hospitals performed the way "A"
15 hospitals did."

16 Do you see that?

17 A. Yes.

18 Q. Okay. Now, first of all, the 50,000 lives,
19 based on this chart, going back to Exhibit 29, refers to
20 2019, right?

21 A. Correct.

1 Q. Okay.

2 Your 2025 numbers, I understand, are in
3 draft form, but it would either be 49,000 or 20,000
4 depending on the imputed scores, right?

5 A. Correct.

6 Q. Okay.

7 Now, this Johns Hopkins Medicine
8 researchers estimate that patients are twice as likely
9 to die of a preventable problem at a "C," "D," or "F"
10 hospital than an "A" hospital, do you see that?

11 A. Yes.

12 Q. Now, that -- is that based on the 2019 numbers?

13 A. Yes.

14 Q. Okay.

15 Now, you had said that that was also true
16 as for 2025, albeit in draft form. Do you recall that
17 testimony?

18 A. I think I mentioned that we were seeing
19 probably similar trends.

20 Q. Okay. Is that reflected here? Can you explain
21 to me just on this chart how that works?

1 A. Yeah. So I think Leapfrog took a little
2 liberty with the "twice," but if you take the 87 and the
3 91.8 --

4 Q. Where are you on that?

5 A. Sorry. 2019.

6 Q. Yep. Yep. I see that.

7 A. Those are close to 100 percent, or one could
8 make the argument, so that would be twice as likely --

9 Q. From 2019?

10 A. From 2019.

11 Q. Okay.

12 And what about today?

13 A. And then today the numbers are actually higher.
14 I was just sort of hedging a little bit about what that
15 would be because they range anywhere between
16 46.6 percent and 353.6.

17 Q. Okay. So that's -- it's different whether you
18 include the imputed or not, right?

19 A. Correct.

20 Now, as I look at this further, what I
21 think I would argue is that the number of lives saved

1 when we take out the imputed scores, the 20,252, is such
2 a significant drop-off. I don't know if that's --
3 that's where I had caution about why I thought that
4 seemed questionable to exclude the imputed scores.

5 Same with the 105. To be more clear, the
6 105 is quite a drop, and I don't think we've seen that
7 level of improvement in patient safety in the country,
8 and so I think that would oversell our efforts in
9 patient safety.

10 Q. Is this an annual number?

11 A. That would be an annual number.

12 Q. Okay.

13 A. Correct.

14 Q. So you're saying it would surprise you if it
15 was only 105,000 patients dying, as opposed to 161,000?

16 A. Correct.

17 Q. Okay. Got it. Okay.

18 A. So the 134 on the face felt like more of a
19 reasonable level of improvement that we would have seen.

20 Q. Because it's fewer lives -- it's more lives
21 lost?

1 A. It's fewer lives lost. So we've seen
2 improvements. We've gone from 161,000 lives lost due to
3 medical error to 134,000.

4 Q. It's fewer lives lost than 2019 but more lives
5 lost than without the imputed values?

6 A. Correct.

7 Q. Okay.

8 And then you're saying -- so how does that
9 equate now to the twice as likely to die for "C," "D,"
10 and "F"? Can you walk me through that?

11 A. Yeah, yeah. So that's what I was -- if you
12 look at the --

13 Q. The percent.

14 A. -- 2019 column --

15 Q. Yes, that I'm clear on.

16 A. The "C" versus "A", "D" and "F" versus "A,"
17 those are somewhere in the 100 percent range. Like I
18 said, I think Leapfrog took a little liberty there.

19 Q. Yeah.

20 But 2025?

21 A. For 2025, if we exclude -- if we include the

1 imputed scores, it's actually 133 to 353,000. We would
2 have to do some sort of blended average of those since
3 it says "C," "D," and "F."

4 Q. Yeah. And if you don't include it, it's 46 to
5 204?

6 A. Correct.

7 Q. Okay. And as you said, blended average because
8 there are -- I think there are more "C" hospitals --

9 A. There's a lot more "C" hospitals, right.

10 Q. Okay. Got it.

11 So maybe you just don't know today, but do
12 you have an estimate today as to whether it's really
13 accurate that you're twice as likely to die if you go to
14 a "C," "D," or "F" hospital as compared to an "A"
15 hospital?

16 A. Well, given my statement in the email about
17 Leapfrog, that I feel like the numbers with the imputed
18 scores are more reflective of the actual reality, that
19 would be something greater than twice. It would be
20 probably two and a half times.

21 Q. So --

1 A. So what we're seeing nationally is bigger gaps
2 between "A" hospitals and hospitals at the back of the
3 pack.

4 Q. And what's driving that in your view?

5 A. I believe it's -- I think hospitals have --
6 some hospitals have chosen to really invest time,
7 resources, energy, have created more of a learning
8 health system. I think they have just prioritized
9 safety in ways that other hospitals have chosen not to.

10 Q. And when you say those hospitals, you're
11 talking about the ones that report or the ones that
12 don't report?

13 A. A combination.

14 Q. Okay.

15 Okay. And then I'm going to show you one
16 more document.

17 So if you actually keep that exhibit in
18 front of you, 29, do you see there's a document -- go to
19 the first page.

20 A. Of 29?

21 Q. Of 29, yeah.

1 A. Okay.

2 Q. The email that we've been talking about with
3 the chart.

4 A. Yeah.

5 Q. Do you see there's an attachment that says
6 Lives Lost, Lives Saved Calculator 250515?

7 A. Yeah.

8 Q. Okay.

9 MR. CRAIN: So I just want to mark this as
10 Exhibit 31.

11 (Exhibit No. 31 was marked for
12 identification as of 9/25/2025.)

13 BY MR. CRAIN:

14 Q. So this is an Excel Spreadsheet. Do you see
15 the document?

16 A. Yes, I do.

17 Q. Do you know what this document is?

18 A. Yeah. It's the excel file we use to calculate
19 the lives lost and lives saved.

20 Q. And is that the one attached to this email?

21 A. This is the 2025 -- actually, this is the '25

1 version, yeah, 2025 version.

2 Q. And are you the author of this document?

3 A. Myself and the analyst together.

4 Q. Okay. Got it.

5 Okay. And this is a true and correct copy
6 of the Excel Spreadsheet we're talking about?

7 A. As far as from what I can see, yes.

8 Q. Yeah. And the two pages, right?

9 A. Yeah.

10 Q. Okay.

11 MR. CRAIN: Okay. Can we take five? Go off.

12 THE VIDEOGRAPHER: This marks the end of media
13 unit number seven. We're going off the record. The
14 time is 4:55 p.m.

15 (Whereupon a short break was had, after
16 which the proceedings continued as
17 follows:)

18 (Exhibit No. 32 was marked for
19 identification as of 9/25/2025.)

20 THE VIDEOGRAPHER: This marks the beginning of
21 media unit number eight. We're going back on the

1 record. The time is 5:07 p.m.

2 BY MR. CRAIN:

3 Q. All right. Thank you, Dr. Austin. We're in
4 the home stretch.

5 I've given you what's been marked as
6 Exhibit 32. Do you see it's an Armstrong-produced
7 Document, 14327?

8 A. Yes.

9 Q. Okay. And it's an email from Mr. Derk to you.
10 Do you see that?

11 A. Yes.

12 Q. And it's dated June 5th, 2019?

13 A. Yes.

14 Q. And it says, Subject: Lives Saved
15 Presentation. Do you see that?

16 A. Correct.

17 Q. And there's an attachment. Can you read that
18 attachment into the record?

19 A. Lives lost, Leapfrog partners 02190610.pptx
20 [sic.]

21 Q. And the rest of the document, is that the pptx

1 you just mentioned?

2 A. In reviewing it, I believe that is the case,
3 but there's nothing on here indicating the file name
4 so --

5 Q. Fair enough.

6 If you look at the title, it says: Lives
7 Lost, Lives Saved: The Comparative Analysis.

8 Do you see that?

9 A. Yes.

10 Q. And it's dated June 10th, 2019?

11 A. Yes.

12 Q. Okay.

13 So to the best of your understanding, this
14 is the PowerPoint attached to the email?

15 A. Yes.

16 Q. And I'll also note Armstrong produced it
17 sequentially from 14327 and forward.

18 A. Yeah. The only thing that strikes me as a bit
19 odd is how the presentation is dated June 10th, 2019,
20 but he sent the email on June 5th, 2019.

21 Q. Could it have been a draft?

1 A. That's a possibility.

2 Q. Like for a future presentation?

3 A. Yeah. That makes sense.

4 Q. So flip through the PowerPoint and just -- you
5 know, does it look like a true and accurate depiction of
6 the PowerPoint presentation that either you or he
7 prepared?

8 A. Are you asking me to verify whether each slide
9 is accurate?

10 Q. No, no. Fair enough. Let me start over.

11 Do you recognize this PowerPoint
12 presentation?

13 A. I don't remember this PowerPoint presentation.

14 Q. Okay. Do you recall giving a presentation in
15 2019 on the lives lost, lives saved?

16 A. I don't remember that --

17 Q. Okay.

18 A. -- but that's not to say I didn't do it.

19 Q. Okay.

20 Any reason to think this is not -- you
21 know, again, produced by Armstrong -- this is not a true

1 and accurate depiction of the email and the attachment?

2 A. No, there's no reason to believe that.

3 Q. Okay.

4 Do you remember anything about this
5 presentation at all?

6 A. I don't other than I think we were trying to
7 summarize the lives lost, lives saved analysis.

8 Q. Okay. So just flipping through, that's what
9 this PowerPoint does, it summarizes the methodology?

10 A. Yes.

11 Q. Okay.

12 And then I think you can set that one
13 aside.

14 And then just a question going back to the
15 2019 white paper. Was the 2019 white paper peer
16 reviewed?

17 A. It was not peer reviewed.

18 Q. Was the 2016 white paper peer reviewed?

19 A. The 2016 paper was reviewed by a couple of my
20 colleagues.

21 Q. Is that peer reviewed in the way that we talked

1 about earlier?

2 A. Peer reviewed in terms of journal articles is
3 usually the editors selecting who is going to review
4 your paper. This was me asking two colleagues who I
5 knew and trusted to look through it and provide input
6 and comments.

7 Q. So not peer reviewed in the academic sense?

8 A. Correct.

9 Q. Okay.

10 And 2019 was not peer reviewed in any
11 sense?

12 A. Correct, in the sense that it was an update
13 from 2016. So all we had done was update numbers.

14 Q. Is it right that Ms. Binder edited the white
15 paper in 2019?

16 A. It is possible that Ms. Binder provided some
17 edits to the white paper.

18 Q. Okay.

19 MR. CRAIN: With that, I will, pursuant to the
20 agreement of the parties, for division of time, pass the
21 witness and reserve the balance for recross.

1 MS. WOOD: You want to go off the record while
2 I get mic'd up?

3 MR. CRAIN: It's up to you. I'm happy to go
4 off. Yeah, that's fine. Let's go off.

5 THE VIDEOGRAPHER: This marks the end of media
6 unit number eight. We're going off the record. The
7 time is 5:11 p.m.

8 (Whereupon a short break was had, after
9 which the proceedings continued as
10 follows:)

11 THE VIDEOGRAPHER: This marks the beginning of
12 unit number nine. We're going back on the record. The
13 time is 5:13 p.m.

14 EXAMINATION

15 BY MS. WOOD:

16 Q. Dr. Austin, my name is Courtney Wood. I
17 represent the defendant, The Leapfrog Group, in this
18 matter.

19 I know you testified earlier that we had
20 met before previously when the subpoena came in. It's
21 good to see you again.

1 A. Good to see you as well.

2 Q. I don't have much to ask you today. However, I
3 have enjoyed listening to all of your testimony today,
4 and we appreciate you being here, so I just want to
5 thank you for that.

6 But to start, are you familiar with the
7 hospital grade calculator?

8 A. Yes, I am.

9 Q. Okay. And so is it fair to me -- fair for me
10 to say that there are 10 outcome measures that are
11 included on that grade calculator?

12 A. I couldn't speak to the current version of the
13 calculator. I have not seen it.

14 Q. Okay. But to your knowledge, are there 10
15 outcome measures that are used in the methodology
16 currently?

17 A. Can I refer to the --

18 Q. Sure. Yeah.

19 A. Okay.

20 Q. Was that Exhibit 3?

21 A. I think it's Exhibit 3, yeah.

1 Q. My apologies because I'm not going to know what
2 page it's on but --

3 A. That's fine. I actually know. It is actually
4 on page 6 and 7; 10, correct.

5 Q. Okay. Perfect.

6 And then is it fair to me -- for me to say
7 that those 10 outcome measures all come from CMS data?

8 A. For the five healthcare-associated infections,
9 the primary data source is the Leapfrog Hospital Survey,
10 and a secondary data source is the Centers for Medicare
11 & Medicaid Services.

12 Q. Correct.

13 And then for the process and structural
14 measures, there are 12 of those. Is that correct?

15 A. Correct.

16 Q. Okay.

17 And then are you aware that of those --
18 well, let's strike that.

19 So the 12 structural and process measures
20 come from survey data. Is that correct?

21 A. The seven of them, the Leapfrog Hospital Survey

1 is the primary data source. For 5 out of the 12, the
2 Centers for Medicare & Medicaid Services is the primary
3 data source.

4 Q. Right. And then we call those HCAHPS.

5 A. Correct.

6 (Whereupon, the court reporter seeks
7 clarification, which colloquy will not be
8 captured on the written record.)

9 BY MS. WOOD:

10 Q. Okay. And so to your knowledge, if a hospital
11 does not respond to the Leapfrog survey, then it does
12 not receive a score for the safe practices 1, safe
13 practices 2, and then the nursing care hours per patient
14 day. We were talking about that earlier. Is that still
15 correct?

16 A. Correct.

17 Q. Okay.

18 And so then to your knowledge, when a
19 nonreporting hospital does not respond to the hospital
20 survey, then those weights are redistributed to the
21 other nine measures in that process and structural?

1 A. Correct.

2 Q. Okay.

3 MR. CRAIN: I'm just going to object to form.

4 BY MS. WOOD:

5 Q. Okay. And then of those nine measures, we had
6 just indicated that five of those are the HCAHPS and
7 then the other four are the imputed measures that we
8 were talking about earlier. Is that correct?

9 A. So of the 12, process and structural measures,
10 5 of them come from HCAHPS, which is a patient
11 experience survey that goes to patients. The other
12 seven, the Leapfrog Hospital Survey is the primary data
13 source.

14 As previously discussed, four of those are
15 imputed if the hospital doesn't respond to the survey
16 and three are not imputed.

17 Q. Right. Okay.

18 So what I'm trying to get at is when the
19 hospital doesn't respond -- so those three that we were
20 talking about, the safe practice 1, the safe practice 2,
21 and then the nursing, we take those out and then the

1 weights are redistributed on those other nine, which are
2 the five HCAHPS and then the four imputed measures. Is
3 that correct?

4 MR. CRAIN: Objection to form. I just want to
5 lodge a standing objection to the leading, and then I
6 won't interrupt. But is it okay to stipulate to that?

7 MS. WOOD: Sure.

8 BY MS. WOOD:

9 Q. Is that your understanding?

10 A. Yes.

11 Q. Okay.

12 And would you agree with me when I say --
13 if I made the assertion that if a hospital performed
14 poorly on their HCAHPS scores, then those measures now
15 are getting greater impact on the overall grade?

16 MS. LAWSON: Object to form.

17 BY MS. WOOD:

18 Q. Yeah, let me rephrase it.

19 So since the weights are now a little bit
20 heavier on those HCAHPS scores and the four imputed
21 scores, it would be arguable that those five HCAHPS

1 scores now play a bigger role in going into the Hospital
2 Safety Grade. Is that correct?

3 MS. LAWSON: Object to form.

4 MR. CRAIN: Objection.

5 MS. LAWSON: You can still answer.

6 THE WITNESS: If the hospital does not have
7 data for those three measures, safe practice 1, safe
8 practice 2, nursing workforce, or nursing hours per
9 patient day, more weight is put on the remaining nine
10 measures and that would include the five HCAHPS
11 measures.

12 BY MS. WOOD:

13 Q. Right.

14 So is it fair to say then that if a
15 hospital had poor HCAHPS scores, then those would be
16 weighed heavier and could have a greater impact on the
17 Hospital Safety Grade?

18 MR. CRAIN: Objection to form.

19 THE WITNESS: So independent of the hospital's
20 performance, more weight would be put on those nine
21 measures. So I guess I'm just clarifying that whether

1 they're a good performer or poor performer, more weight
2 is going to be put on those.

3 BY MS. WOOD:

4 Q. Understood. And I would agree with that.

5 And do you have any opinion on how
6 significant that impact can be, whether, you know, say
7 if you're a great hospital and you have great HCAHPS
8 scores, and say you have bad -- and then you get the
9 imputed score because you're a nonresponding hospital,
10 do you have any opinion on what that impact might look
11 like on the Hospital Safety Grade?

12 MR. CRAIN: Object to form.

13 MS. LAWSON: Object to form.

14 THE WITNESS: So the -- I mean, one could test
15 out different scenarios of that question, right. So one
16 could -- the hospital may do really well on certain
17 measures, may not do well on others. There's not
18 necessarily universal, like, just because you're doing
19 well on one HCAHPS, that you're doing well on all
20 HCAHPS.

21 So one could sort of empirically test

1 different what-if scenarios, but I don't know if there's
2 a universal answer to your question.

3 BY MS. WOOD:

4 Q. Okay.

5 And so would it be true that if a hospital
6 was performing well on those five HCAHPS scores and then
7 still got those low imputed scores, that maybe those
8 five HCAHPS scores would actually -- let me rephrase
9 that.

10 So if the five HCAHPS scores were really
11 great scores and then you got those four imputed scores,
12 would it be fair to say that maybe those four imputed
13 scores wouldn't really have an impact then on the
14 overall Hospital Safety Grade?

15 MR. CRAIN: Objection to form.

16 THE WITNESS: There would be a potential
17 scenario where if the hospital does well on the HCAHPS
18 scores and does well on the outcome measures, that they
19 could have a pretty good safety score and safety grade.

20 BY MS. WOOD:

21 Q. Okay. And then would that be applicable as

1 well if there were poor scores for the HCAHPS?

2 A. Once again, it's -- the measures are not looked
3 at simply in isolation, right, because I think one would
4 also need to look at the outcome measures. So just --
5 it needs to be a slightly more holistic view of
6 performance.

7 Q. Okay.

8 And then we were talking about earlier how
9 there is never a zero that is imputed for any of those
10 four measures. Is that correct?

11 A. To the best of my recollection, that is
12 correct.

13 Q. Okay. And do you know why that is?

14 A. So we -- for the Leapfrog Hospital Survey
15 measures, we did have to come up with a way to assign a
16 numerical value to the performance categories, right.
17 So in the Leapfrog Hospital Survey, for those four
18 imputed measures hospitals get reported out as achieved
19 the standard, considerable achievement, some
20 achievement, and limited achievement. But for purposes
21 of incorporating those into the Hospital Safety Grade,

1 we needed to translate those into some sort of numerical
2 value.

3 And so we've used different approaches
4 through the years and for different measures for how to
5 assign those values. If we use hand hygiene as an
6 example, the assigned values are 100, 75, 50, and 25.
7 It was basically to give hospitals some numerical credit
8 for being in a performance category.

9 Q. And is it true that those numerical values on
10 the performance is used for both reporting and
11 nonreporting hospitals?

12 A. So the imputed values for those four measures
13 match what hospitals who report and get limited
14 achievement receive.

15 Q. Okay.

16 And do you ever recall speaking with
17 anybody, whether it's the expert panel or anybody at
18 Leapfrog, about considering imputing a zero for any of
19 those four measures rather than doing the limited
20 achievement, the considerable achievement?

21 A. I don't remember any explicit discussion about

1 zero; although, it's not to say that that hasn't come up
2 as a potential option.

3 Q. Okay.

4 And I want to look at Exhibit 27 again, and
5 this is the -- I think you had said earlier that these
6 were actually your notes from this expert panel meeting.
7 Was that right?

8 A. These were a set of notes.

9 Q. Okay. Because it just had said agenda at the
10 top, but then I think you had said that these were notes
11 following --

12 A. These are notes. I don't -- your question was
13 are these my notes. I don't know if they were my notes
14 or if these were notes prepared by someone else.

15 Q. Oh, okay. That's fair. But these would have
16 been notes following that meeting on this day?

17 A. Correct.

18 Q. And then if we can flip to that second page and
19 number three, and it's the last bullet point under
20 number three. It says: "The panel wondered what the
21 distributions would look like if Leapfrog assigned a

1 score of zero or lowest score possible for the missing
2 elements. Matt and Jordan will look into this following
3 the meeting."

4 Does that refresh your recollection in any
5 way on whether you or Jordan looked into that?

6 A. I don't remember what scenarios we actually ran
7 as a result of that meeting. It's possible that we -- I
8 don't remember. We could have just ran the lowest
9 possible scores. I don't know if we ran zero. I would
10 have to be refreshed on that.

11 Q. Yeah. That's okay.

12 And then do you remember anything else
13 regarding -- any other discussions during this meeting
14 about imputing zeros for those imputed measures?

15 A. Other than what's in the notes --

16 Q. Okay.

17 A. -- that the panel discussed that as a potential
18 scenario.

19 Q. Okay.

20 And then even after seeing this bullet
21 point, you don't recall speaking to anybody else on the

1 expert panel about this?

2 A. I don't remember.

3 Q. Do you recall if you ever spoke with Arjun
4 about this?

5 MR. CRAIN: Objection to form.

6 THE WITNESS: I don't remember if I spoke to
7 Arjun in particular about this topic.

8 BY MS. WOOD:

9 Q. Okay.

10 And usually, after following expert panel
11 meetings, do you ever reach out to some of the panelists
12 to discuss bullet points like this independently?

13 A. Yeah, we do.

14 Q. Okay. So it wouldn't be weird if you had
15 spoken with Arjun, but you just don't recall today?
16 That's something that you might do?

17 A. Correct.

18 Q. Okay. In addition to other panel members as
19 well. Arjun is just an example.

20 A. Correct.

21 MR. CRAIN: Objection to form.

1 BY MS. WOOD:

2 Q. Okay. And so then we were -- I was going to
3 use the handwashing as an example as well. So it's your
4 understanding that 15 is the imputed score for limited
5 achievement for handwashing?

6 A. Let me refer to Exhibit No. 3.

7 Q. Sure. No problem.

8 A. So slide 16 hand hygiene. Was that your --

9 Q. Yep.

10 A. Fifteen is the --

11 Q. Limited?

12 A. -- yep, limited achievement.

13 Q. Perfect. Thank you.

14 And then we were looking at Exhibit 3 again
15 for that, page 16. Hand hygiene, limited achievement,
16 the corresponding measure score is 15.

17 And so I think what you had just testified,
18 that that is both for nonreporting and reporting
19 hospitals, correct?

20 A. That is the score that's assigned to
21 nonreporting hospitals as well as reporting hospitals

1 who failed to meet the some achievement criteria.

2 Q. Right.

3 And so would you agree with me that
4 nonreporting hospitals are actually still receiving a
5 benefit by reviewing a score -- receiving a score that
6 is based on responding hospitals?

7 MS. LAWSON: Object to form.

8 MR. CRAIN: Object to form.

9 THE WITNESS: They are receiving a score -- can
10 you maybe explain more about when you say benefit?

11 BY MS. WOOD:

12 Q. Sure.

13 So if I'm a reporting hospital and I meet
14 the criteria for limited achievement, I get a 15
15 imputed. Is that correct?

16 A. Repeat that one more time.

17 Q. Sure.

18 So a hospital that responds to the survey
19 and they are filling out the hand hygiene portion of the
20 survey and based on the criteria they receive a 15 and
21 they get the limited achievement?

1 A. If the hospital doesn't meet the criteria for a
2 higher performance category --

3 Q. Correct.

4 A. -- they will get limited achievement.

5 Q. Right.

6 But then for the nonresponding hospitals,
7 we don't necessarily know what their hand hygiene
8 policies may be -- or I think earlier we were talking
9 about the hand sanitizer. You had mentioned that there
10 were several different criteria, correct?

11 A. Correct.

12 Q. And so would you say to me -- or would you
13 agree with me when I say that assigning a nonresponding
14 hospital the same score for limited achievement as a
15 responding hospital is giving the nonresponding hospital
16 a benefit?

17 MR. CRAIN: Objection to form.

18 MS. LAWSON: Object to form also.

19 THE WITNESS: I think that's a little bit in
20 the eye of the beholder. Is it better than zero? Yes.
21 Is it as good as 50? No.

1 BY MS. WOOD:

2 Q. Right.

3 A. So I don't know how to really answer that.

4 Q. Okay. So I guess I can ask it another way.

5 So if Leapfrog is not imputing a zero,
6 rather, they're imputing the 15, is Leapfrog making an
7 assumption that the hospitals who are not reporting are
8 actually performing to some extent rather than not
9 performing at all?

10 MR. CRAIN: Objection to form.

11 THE WITNESS: So Leapfrog in that situation is
12 giving nonreporting hospitals an equivalent score to
13 hospitals that have not met the criteria for some
14 achievement, and that can be a range, right. That can
15 be from a hospital that barely missed some achievement
16 to a hospital who has done nothing.

17 So there is a range of hospitals that are
18 getting the limited achievement based on responding.

19 BY MS. WOOD:

20 Q. Understood.

21 And now I want to look at Exhibit 19

1 quickly, and I will have you -- I'm sorry. I'll wait
2 until you're there. And then it's like this webpage.
3 Yes.

4 Okay. And can you flip to the second page
5 that we were talking about earlier. And then you see
6 the asterisk next to the number 15, and it says "This
7 Hospital's Score"?

8 A. Yes.

9 Q. And you would agree with me that that's the
10 limited achievement score for handwashing, correct?

11 A. That 15 is the same value that's assigned, yes,
12 to hospitals that receive limited achievement.

13 Q. Okay.

14 And then right next to it on the right
15 there it says "handwashing." So this would indicate
16 that this hospital, Delray Medical Center, received a 15
17 on the handwashing measure?

18 A. Yes.

19 Q. Okay.

20 And then I know earlier we were talking
21 about the asterisk next to the number 15 indicates to

1 the reader to go down to the end of the webpage there to
2 that disclosure.

3 A. Yes.

4 Q. Okay. And that disclosure says: "The hospital
5 declined to report their performance on this measure, so
6 a score was assigned to reflect the lack of information
7 available." Is that right?

8 A. Yes.

9 Q. Okay.

10 And I think earlier we were talking about
11 the "how," and I believe the question that you were
12 asked was does this webpage show how the score was
13 assigned. Do you recall being asked that question?

14 A. Yes.

15 Q. Okay. And would you agree with me that when it
16 says, so a score was assigned to reflect the lack of
17 information available, that that does indicate the how
18 here?

19 MR. CRAIN: Objection to form.

20 THE WITNESS: So I personally would agree with
21 that. I think the opposing counsel saw that

1 differently.

2 BY MS. WOOD:

3 Q. That's fair. I would agree with you on that
4 one.

5 So let's take it one step further. So if
6 we go back up to where the asterisk is linked to under
7 the hospital safety score 15 asterisk, and then do you
8 see right below that it says best hospital's score 100?

9 A. Yes.

10 Q. And then right below that it says average
11 hospital's score 74.40?

12 A. Yes.

13 Q. And then right below that it says worst
14 hospital's score 15?

15 A. Yes.

16 Q. Okay.

17 And so would you agree with me now, looking
18 at it from this perspective, considering those four
19 hospital scores in conjunction with the asterisk and the
20 disclosure at the bottom, that that shows how the scores
21 are assigned for this handwashing measure?

1 MS. LAWSON: Object to form.

2 MR. CRAIN: Object to form.

3 THE WITNESS: I personally don't think that the
4 display of the other three scores, the best hospital
5 average and worst, helps nor hurts the explanation of
6 how that 15 was assigned.

7 BY MS. WOOD:

8 Q. Okay. But do you think it makes it easier for
9 the reader of this webpage to look and see that if 15 is
10 this hospital's score and 15 is the worst hospital's
11 score, they can come to the conclusion that this
12 hospital is being assigned the worst hospital's score?

13 MS. LAWSON: Object to form.

14 MR. CRAIN: Objection to form.

15 THE WITNESS: I don't want to speculate what
16 people who come to the website, how they understand the
17 material.

18 BY MS. WOOD:

19 Q. That's fair.

20 But you would agree with me that at the
21 top, when it says this hospital's score 15 asterisk,

1 that matches at the bottom the worst hospital's score
2 15? It just doesn't include the asterisk?

3 A. Correct.

4 Q. Okay.

5 And I think earlier you may have testified
6 about whether or not the imputation model and the
7 current methodology penalizes hospitals. Do you
8 remember testifying about that?

9 A. We had a lot of conversation about imputation
10 today, so I would need to be refreshed on what --

11 Q. Sure.

12 A. Yeah, more detail might be needed there.

13 Q. Sure.

14 In your view, when Leapfrog was considering
15 the Fall 2024 methodology change, was the intent or the
16 purpose to change this imputation model to penalize
17 hospitals?

18 A. The goal was not to assess a penalty. The
19 goals were to improve the accuracy of the data and to
20 incentivize -- as a sub goal, incentivize survey
21 participation.

1 Q. Okay.

2 And then would it be fair to say that,
3 rather, the result then of the Fall 2024 methodology
4 change may be that hospitals feel penalized by receiving
5 those limited achievement scores?

6 MS. LAWSON: Object to form.

7 MR. CRAIN: Object to form.

8 THE WITNESS: I can't speak to how hospitals
9 feel.

10 BY MS. WOOD:

11 Q. Okay.

12 I think you said earlier that the
13 penalization is a byproduct of the imputation score. Do
14 you remember? And I'm not trying to mischaracterize
15 your testimony in any way. I just remember you
16 referencing it as being a byproduct.

17 A. Yeah, there may be a feeling of, yes, a
18 penalty.

19 Q. Okay. But that wasn't the intent or the
20 purpose of Leapfrog, to your knowledge?

21 A. That was not the stated intent.

1 Q. Okay.

2 Do you believe that hospitals should report
3 to the Leapfrog Hospital Survey?

4 A. I do.

5 Q. And why do you believe that?

6 A. Because I am a strong believer in transparency.
7 I think in transparency we create a better healthcare
8 system where we understand where our successes are,
9 where our failures are, and that those who are using the
10 healthcare system and those who are paying for the
11 healthcare system know how it's operated.

12 Q. And I know you have testified earlier that
13 sometimes you speak with hospitals in various
14 capacities. Have you ever heard any hospitals refer to
15 the Leapfrog Hospital Survey as kind of a benchmark or
16 an outline to improve their patient safety?

17 A. I -- can you repeat the question?

18 Q. Sure. Yeah.

19 I just know earlier you had testified that
20 sometimes you speak to hospitals in different
21 capacities. So the question I'm about to ask you, I'm

1 not insinuating that you have heard this before. I'm
2 asking if anybody at a hospital has discussed this with
3 you before.

4 But have any of the hospitals told you
5 that -- sorry. Now I'm forgetting my own question --
6 oh, that the Leapfrog Hospital Survey helps them put in
7 benchmarks and outline how they can improve on patient
8 safety measures?

9 A. So for purposes of the Leapfrog Hospital
10 Survey, I have had at least one conversation with a
11 hospital who does see the survey as an opportunity for
12 benchmarking their performance relative to others.

13 Q. And do you believe that to be true?

14 A. I believe it is a source of information for
15 hospitals on a very broad quality improvement journey.

16 Q. And based on your experience in working with
17 Leapfrog, would you understand that you -- or would you
18 testify to me that you understand the mission of
19 Leapfrog?

20 MR. CRAIN: Objection to form.

21 MS. WOOD: Yeah, I can fix that. I tripped

1 over that one.

2 BY MS. WOOD:

3 Q. Based on all your experience and working with
4 Leapfrog, it's been over a decade, almost two decades,
5 would you say that you understand what Leapfrog's
6 mission is?

7 A. Yes.

8 Q. And can you explain that to me in your own
9 words?

10 A. To me, it would be to drive improvements in the
11 quality of our healthcare system primarily using
12 transparency as the mechanism to do that.

13 Q. And do you believe that that's always been
14 Leapfrog's mission?

15 A. Yes.

16 Q. And do you believe that continues to be
17 Leapfrog's mission today?

18 A. Yes.

19 Q. Okay.

20 And so in your experience as a researcher
21 and as a principal faculty member at the Armstrong

1 Institute for patient safety and quality, do you believe
2 that Leapfrog's Hospital Safety Grade provides a benefit
3 to consumers?

4 A. I think sharing information in summary form is
5 what patients and consumers are seeking. So whether
6 that be a star rating, a letter grade, the research is
7 clear that that is what they find helpful for their
8 decision-making.

9 Q. Okay.

10 And have you done any research on whether
11 or not the patients benefit from those star ratings or
12 the Hospital Safety Grade?

13 A. No, I have not done any research on that.

14 Q. Have you read any research or peer reviewed
15 articles on that?

16 A. I have read some research on consumers' use of
17 publicly available quality and safety information. I
18 can't say it's the most recent. There may be more
19 recent information out there.

20 Q. And do you believe that consumers would lose
21 any sort of benefit if hospitals were not graded through

1 the Hospital Safety Grade?

2 MR. CRAIN: Objection to form.

3 THE WITNESS: Can you repeat the question one
4 time?

5 BY MS. WOOD:

6 Q. Sure.

7 If Leapfrog stopped grading hospitals, do
8 you think that that would have any negative impact on
9 consumers?

10 A. So the greatest benefit that's been noted for
11 public reporting of quality and safety information has
12 actually been the hospital's use of that information to
13 drive improvements within their own healthcare system.

14 -- hospital or healthcare system.

15 I don't want to be the bottom performer,
16 right, so I'm going to do what I need to do to get out
17 of the bottom. So in a sense, that improvement in
18 quality and safety has universal benefit, right.

19 Every patient that comes to that hospital
20 has some benefit of the hospital working to improve
21 their quality and safety.

1 Q. And would you say that the Hospital Safety
2 Grade also creates some competition between the
3 hospitals?

4 A. I don't know enough about that.

5 Q. Okay. I just wasn't sure if that's what you
6 were getting at. So that's okay.

7 And so then is it fair to say that if
8 Leapfrog stopped grading hospitals and now patients did
9 not have access to information on patient safety and
10 these measures, that could potentially harm patients?

11 A. I don't know about what the implications of
12 that would be.

13 Q. Okay.

14 Do you think that when patients have the
15 most accurate and transparent data when making their
16 informed decisions on where to treat, that that makes
17 them safer and protects them?

18 MS. LAWSON: Object to form.

19 MR. CRAIN: Object to form.

20 THE WITNESS: I believe that having information
21 is helpful in making a decision to where to receive

1 care.

2 BY MS. WOOD:

3 Q. And are you aware of any other rating systems
4 that are comparable to Leapfrog?

5 MR. CRAIN: Objection to form.

6 THE WITNESS: Can you define comparable?

7 BY MS. WOOD:

8 Q. Sure.

9 Do you believe think -- do you believe that
10 Leapfrog has any direct competitors?

11 A. There's no other entity I know that's putting
12 out a composite, composite and noncomposite
13 information -- well, let me start again.

14 I'm not aware of any other entity that's
15 putting out a composite score around the specific area
16 of patient safety. There are other entities, like the
17 Centers for Medicare & Medicaid Services that do publish
18 information about the quality and safety of care,
19 similar to what Leapfrog does.

20 Q. And do you have any knowledge about the CMS
21 star ratings?

1 A. I do.

2 Q. And what is your knowledge with regard to the
3 CMS star ratings?

4 MR. CRAIN: Object to form.

5 BY MS. WOOD:

6 Q. I guess we can start with do you have
7 experience with working with CMS in regard to those CMS
8 star ratings?

9 A. I do. I served on their technical expert
10 panel.

11 Q. Okay. Can you explain to me a little bit what
12 that was like?

13 A. Yeah. So that is a -- this is actually written
14 into federal legislation that CMS needs to publish a
15 star rating for hospitals. It is considered to be a
16 summary of all of the information that is shared on
17 their care compare website.

18 So early on in the technical expert panel
19 meetings, I would say, well, what are we actually trying
20 to measure? And the contractor was like, well, we're
21 supposed to summarize all the information. I'm like,

1 well, what's the underlying construct? We're just
2 supposed to summarize the information.

3 So it's not clear exactly what CMS is
4 measuring, but it is intended to be a summary of
5 information. And so what they do is they take the
6 measures that are publicly reported and have put those
7 into domains, and different domains get different
8 weights. They use Z-scores. It's all -- it's very
9 similar to how Leapfrog has gone about calculating
10 scores but just with a different set of measures and a
11 different set of constructs.

12 Q. To your knowledge, does CMS have any patient
13 safety measures that go into that star rating system?

14 A. They do.

15 Q. Okay.

16 And I know Leapfrog on their website
17 usually says, when looking at the Hospital Safety Grade,
18 consider other options or look to other sources. Does
19 that sound familiar to you?

20 MS. LAWSON: Object to form.

21 MR. CRAIN: Object to form.

1 THE WITNESS: I don't know what's said on the
2 website so...

3 BY MS. WOOD:

4 Q. Okay. Have you ever heard people at Leapfrog
5 discuss that patients should not only consider the
6 Hospital Safety Grade when choosing where to seek care?

7 A. Yes.

8 Q. Okay. And would you say that other -- strike
9 that.

10 Another source that patients could look at
11 is CMS star ratings. Is that correct?

12 MR. CRAIN: Object to form.

13 THE WITNESS: That is another publicly
14 available rating of hospitals.

15 BY MS. WOOD:

16 Q. And do you have any knowledge on how, I guess,
17 popular those star ratings are? You know, in your line
18 of business or speaking with hospitals, do you tend to
19 see that people rely on them or talked about relying on
20 them?

21 MS. LAWSON: Object to form.

1 MR. CRAIN: Objection to form.

2 THE WITNESS: So I can speak to my experience
3 with Johns Hopkins Medicine. The Board of Directors for
4 Johns Hopkins Medicine, as well as senior leaders,
5 have -- are very, very interested in the hospital safety
6 grades. And when they see that the safety grades are
7 dropping, there is usually a call for what's going to be
8 done to get us back to an "A" or to a "B."

9 So I think it's been a way to engage health
10 system leaders, Board of Directors, around the issue of
11 patient safety. That's just my experience with Johns
12 Hopkins Medicine.

13 BY MS. WOOD:

14 Q. Yeah.

15 And then does Johns Hopkins Medicine also
16 discuss their star ratings?

17 A. I believe so.

18 MS. WOOD: I think that's all that I have for
19 you.

20 THE WITNESS: Thank you.

21 MR. CRAIN: I have a little recross.

FURTHER EXAMINATION

BY MR. CRAIN:

Q. So just a few questions, Dr. Austin.

At one point counsel was asking you questions about whether the Leapfrog survey was a benchmark. Do you recall that line of questions?

A. Correct.

Q. And you said something like hospitals don't want to be the bottom performers. Do you recall testifying something to that effect?

A. Correct.

Q. Why don't hospitals want to be a bottom performer?

A. What I hear is that, specifically when you're dealing with physicians, they generally are individuals who have excelled throughout their lifetime in terms of academics and don't want to be perceived as being at the bottom.

Q. So to put it concretely, doctors working at a hospital don't want to work for an "F." Is that fair to say?

1 A. I can't speak for doctors working at "F"
2 hospitals.

3 Q. But the ones, the doctors you were just talking
4 about --

5 A. Yeah, they would -- yes. They would not want
6 to work at an "F" hospital.

7 Q. And fair to say that an "F" can damage a
8 hospital's reputation?

9 MS. LAWSON: Object to form.

10 THE WITNESS: I don't know -- well, what
11 reputation are you referring to?

12 BY MR. CRAIN:

13 Q. Fair enough.

14 So hospitals -- in your experience, do
15 hospitals have reputation in their communities, just
16 reputations for quality of care, for safety, that sort
17 of thing?

18 A. I think there are perceptions within
19 communities around which hospitals have higher quality
20 care than others.

21 Q. Can an "F" hospital -- can an "F" grade from

1 Leapfrog influence that perception?

2 A. I don't know.

3 Q. You have no opinion one way or another?

4 A. You didn't ask my opinion. You asked what I
5 knew.

6 Q. Okay. Fair enough. Fair enough.

7 Do you have an opinion?

8 You're getting good at this.

9 A. I don't know how much -- if reputation is --
10 well, let me start over.

11 I don't know how -- I don't know the
12 literature well enough to know how hospitals form
13 reputations in their communities.

14 Q. Okay.

15 A. Obviously, a component of that is consumers and
16 patients directly. There is media. There's a lot of
17 different influences, and I don't know how each of those
18 is tying into the Hospital Safety Grade and influencing
19 the reputation.

20 Q. Okay. Fair enough. I get it.

21 Okay. We talked -- you went back --

1 counsel went back to look at the Delray website again,
2 right. And you testified something to the effect of the
3 asterisk at the bottom of the page explains the how a
4 grade is assigned, right?

5 So I don't have a piece of paper for you,
6 but I'm going to do something a little avant-garde and
7 show you a website.

8 So I want to just direct you -- and just so
9 counsel can see, it's another Hospital Safety Grade
10 website. Do you see that?

11 So this is a hospitalsafetygrade.org
12 website. Can you see it okay?

13 A. I can.

14 Q. And do you see it says Pikeville Medical
15 Center? Do you see that?

16 A. Yes.

17 Q. And Pikeville is in Pikeville, Kentucky. Do
18 you know anything about Pikeville, Kentucky?

19 A. I do not.

20 Q. Okay.

21 What's the grade it gets?

1 A. They received a "D" in the Spring 2025 Hospital
2 Safety Grade.

3 Q. Okay.

4 So I want to go down and just look at safe
5 medication administration. Do you see that's toggled
6 there?

7 A. Yes.

8 Q. And that is the BCMA?

9 A. Correct.

10 Q. Okay.

11 So now, do you see what their score is?

12 A. It's a 25.

13 Q. Okay. And what's the worst score?

14 A. Twenty-five.

15 Q. Okay. And it has the little asterisk, right?

16 A. Correct.

17 Q. Now, read the asterisk for me. Can you read it
18 into the record?

19 A. The hospital declined to report their
20 performance on this measure, so a score was assigned to
21 reflect the lack of information available.

1 Q. Do you have any idea how the score was imputed?

2 A. Are you asking me do I know that, or do I know
3 that from what I'm reading there?

4 Q. From the information you have gathered from
5 this website or otherwise -- but you don't know
6 Pikeville, so I assume it's from this website -- how was
7 Pikeville's limited achievement score assigned?

8 A. I, Matt Austin, know that it was assigned based
9 on them not reporting to the survey, and they get
10 assigned a score based on that nonsubmission.

11 Q. So that's why it was assigned, right? It was
12 assigned because they didn't report, right?

13 A. Uh-huh.

14 Q. The question of how it was assigned I see as
15 conceptually different. Does that seem fair to you or
16 no?

17 A. I guess I see them as linked and maybe one in
18 the same. That's where I'm struggling to distinguish.

19 Q. So let me -- I can make it more concrete.

20 The imputation methodology as it applies
21 today has two steps, right?

1 A. Correct.

2 Q. Right? There is Step 1, historical, and Step
3 2, limited achievement, right?

4 A. Correct.

5 Q. Do you have any idea how Pikeville -- which
6 step was applied to Pikeville?

7 A. I know from the Hospital Safety Grade
8 methodology that declining to report on the measure is
9 what resulted in them getting a score assigned.

10 Q. But I'm asking a different question. I'll just
11 do it more directly. Did Pikeville get assigned limited
12 achievement through Step 1 or Step 2?

13 A. I don't know from what this is telling me
14 whether --

15 Q. And yet, to be clear, you testified earlier
16 that this asterisk explained how the score was assigned,
17 right?

18 A. I testified that the why and how to me were
19 sort of one in the same.

20 Q. Okay. So then just setting the semantics
21 aside, just looking at this asterisk, you have no idea

1 whether Pikeville got limited achievement through Step 1
2 or Step 2, correct?

3 A. I don't know that.

4 Q. Now, you -- sorry. Just to be clear. Correct?

5 A. Correct. I do not know whether they were
6 assigned a Step 1 or Step 2.

7 Q. Now, is it fair to say Step 1 is a little more
8 accurate because it relies at least on the prior year's
9 survey that Pikeville or another hospital might submit?

10 A. The underlying assumption is that a hospital's
11 specific information from a recent time period would be
12 a better indicator of current performance than just a
13 general imputed score.

14 Q. So Step 1 can be a better, I think you said,
15 better indicator of current performance, right?

16 A. Correct.

17 Q. Okay. And yet you have no idea whether
18 Pikeville is Step 1 or Step 2, right?

19 A. Not from what's shown here.

20 Q. Which, again -- can you state for the record
21 what is being shown here?

1 A. What's being shown here is the hospital's score
2 with an asterisk, which says the hospital declined to
3 report their performance on this measure, so a score was
4 assigned to reflect the lack of information available.
5 So that could be either Step 1 or Step 2.

6 Q. Great. Okay.

7 So we'll set Pikeville aside, our dear
8 friends in Kentucky.

9 A couple other questions. So counsel
10 raised the question of whether the limited achievement
11 score was a benefit, right? Do you recall that line?

12 A. Yes.

13 Q. Okay. Is it your testimony that assigning
14 limited achievement automatically in Step 2 is a
15 benefit?

16 A. I did not testify to that.

17 Q. I just want to understand if it is your
18 testimony.

19 A. That is my testimony, that it is not
20 necessarily a benefit.

21 Q. Can it be a benefit ever?

1 A. For some hospitals it could be a benefit.

2 Q. Now, why is that, though?

3 A. If the alternative was to assign zero,
4 assigning a 15 is better than a zero. But if we
5 assign -- if the decision was to assign 50, assigning 15
6 would be a negative. So I don't know if there's a
7 universal way of answering that question.

8 Q. Fair enough. So let me just lay it out this
9 way. If a hospital participated in the survey and
10 failed on every hand hygiene question, what score did
11 they get?

12 A. They would receive limited achievement.

13 Q. They wouldn't achieve zero, right?

14 A. They would be scored as limited achievement.

15 Q. So what is the benefit vis-à-vis the
16 nonparticipating hospital and the hospital that scores
17 zero down the line? Is there a benefit? Let's start
18 with that.

19 A. Can you repeat that again?

20 Q. Yeah.

21 Counsel was suggesting there's a benefit

1 that Leapfrog gives limited achievement versus zero.

2 But just to be clear, no hospital gets zero, right?

3 A. In the current scoring methodology, no hospital
4 gets zero.

5 Q. Even if the hospital failed every one of the
6 questions we looked at for hand hygiene, they would get
7 I think it's 15, right?

8 A. Correct.

9 Q. Okay.

10 A couple other lines. So we talked about
11 the Alexandria, Virginia notes. Do you remember that
12 document?

13 A. Yes.

14 Q. I think that was Exhibit --

15 A. Twenty-seven.

16 Q. -- 27. And you said at one point other than
17 the notes, I don't remember anything. I just want the
18 record to be clear. Do you remember the meeting, or are
19 you just looking at the notes?

20 A. I remember having an in-person meeting with the
21 expert panel. I can picture a conference room. I

1 honestly can't remember if it was this meeting or a
2 different meeting.

3 Q. I guess what I'll say is do you remember,
4 actually have a memory of what was said, or you just
5 have no reason to doubt the notes?

6 A. I have -- I do remember at this in-person
7 meeting, I do remember the conversation about whether an
8 explicit penalty should be something that's on the table
9 or if Leapfrog should consider assigning an explicit
10 penalty.

11 Q. Okay.

12 A. I do remember that, but I don't remember
13 whether it was this meeting or another meeting. But
14 when I look at these notes, this seems to corroborate
15 that it was this meeting.

16 Q. Okay. Fair enough.

17 And then I want you to just tell me
18 everything you remember about the discussion about the
19 penalty you're referring to just so it's clear.

20 A. So what I remember, which may be different than
21 what's in the notes, is specifically Dr. Andrew Bindman,

1 who at the time was the head of -- the director of the
2 Agency for Healthcare Research and Quality, which is the
3 federal agency that oversees quality and safety work.
4 From what I remember, Andy is -- broached the subject
5 of, well, hospitals should just be reporting to the
6 survey. Shouldn't we just like assign some sort of
7 penalty for them if they aren't reporting? That will
8 get them to report.

9 Q. Fair enough. Okay.

10 A. So that's what I remember.

11 Q. Yep.

12 A. Because I sort of remember where I was sitting,
13 where he was sitting.

14 Q. Okay. And anything else you remember about
15 that --

16 A. No. That's what I remember.

17 Q. Okay.

18 A couple of last questions. HCAHPS. So
19 you talked a little bit with counsel about HCAHPS,
20 right?

21 A. Correct.

1 Q. What does HCAHPS measure?

2 A. HCAHPS measures the patient experience of their
3 inpatient hospital stay.

4 Q. Okay. So if a hospital is loud, is that
5 reflected in HCAHPS?

6 A. So there are different domains within the
7 HCAHPS survey. One is quietness of the hospital
8 environment.

9 Q. Okay. Can you give us a sense of the others?

10 A. Yeah. So the five that are included in the
11 Hospital Safety Grade include physician communication,
12 nurse communication, communication about medicines.

13 Q. Not a memory test.

14 A. The other -- the five that we've included are
15 all related to communication --

16 Q. Okay.

17 A. -- and sort of the importance of communication
18 as it relates to patient safety.

19 Q. And there are other HCAHPS domains that are not
20 included?

21 A. Correct.

1 Q. Okay.

2 And HCAHPS, as you said, relates primarily
3 to patient satisfaction?

4 A. Patient experience.

5 Q. Experience. I'm sorry.

6 A. Yes, which is considered a different construct
7 than patient satisfaction.

8 Q. Got it. And is it a different construct from
9 safety?

10 A. There are -- there is probably some conceptual
11 overlap between safety and patient experience.

12 Q. Okay.

13 A. There's probably some overlap between patient
14 experience and patient satisfaction, to be fair.

15 Q. So like a Venn diagram?

16 A. Correct.

17 Q. Okay. Got it.

18 I think the last sequence, I want to go
19 back to Exhibit 3, the methodology document that you
20 were asked about. Do you recall that?

21 A. I remember being asked about the number of

1 measures --

2 Q. Yes.

3 A. Yes, in each domain.

4 Q. So I want to just -- a quick question for you.

5 Does Leapfrog -- for nonparticipating hospitals that are
6 imputed, does Leapfrog impute secondary data to assign a
7 score?

8 A. Is -- can you repeat that?

9 Q. Yeah, let me break it down. So let's go back
10 to the AHA days, right. So back then when Leapfrog was
11 using the American Hospital Association data, it was
12 using the AHA data as a secondary source that it was
13 imputing into the safety grade score. Is that fair or
14 no?

15 A. Correct. So the AHA data was the data that was
16 being used to impute a score.

17 Q. Okay. Because the imputation model is not
18 secondary data itself. It's a method of imputing
19 secondary data, right?

20 A. Correct.

21 Q. Okay. To impute, one needs secondary data,

1 right?

2 A. No.

3 Q. No. Okay. Tell me why.

4 A. So as outlined in the famous email where we
5 list the five different imputation options, one of them
6 is using secondary data to arrive at some sort of
7 estimate of the hospital's performance.

8 Q. Got it.

9 A. But one could just assign zero. One could
10 assign some value above or below the mean, right. So
11 one does not necessarily require secondary data to
12 impute a score.

13 Q. Okay. But if one is imputing secondary data,
14 there needs to be a secondary data source, in theory,
15 right?

16 A. Correct.

17 Q. Okay.

18 So I want to go to page 5 of the
19 methodology document, Exhibit 3. You see it's the
20 measures you were talking about before?

21 A. Yes.

1 Q. And do you see the top three at least are three
2 of the imputed measures, right?

3 A. Which page are you on?

4 Q. I'm looking at five.

5 A. Okay.

6 MS. LAWSON: Is it four of the slide, or is it
7 five of the slide?

8 BY MR. CRAIN:

9 Q. Oh, I'm sorry. It's the one -- I may be --
10 page 4. You're right. Page 4.

11 A. Okay.

12 Q. Okay. I'm pulling it off my electronic
13 version.

14 So my question is do you see where it says
15 Computerized Physician Order Entry right there?

16 A. Yes.

17 Q. And Primary Data Source is the 2024 Leapfrog
18 Hospital Survey, right?

19 A. Right.

20 Q. That's accurate, correct?

21 A. Correct.

1 Q. Secondary data source says the imputation model
2 applied, right?

3 A. Correct.

4 Q. For any hospital under Step 2, there isn't a
5 secondary data, right?

6 A. In the -- are you asking about the current?

7 Q. Yes.

8 A. In the current methodology, there is not
9 secondary data, correct.

10 Q. Under Step 2?

11 A. Under Step 2.

12 Q. Is there under Step 1, or would you not call
13 the historical secondary data?

14 A. I wouldn't call that secondary data.

15 Q. Okay.

16 So fair to say for CPOE, BCMA, IPS, and
17 hand hygiene there is no secondary data?

18 A. We are currently not using secondary data as
19 part of the imputation models.

20 Q. Okay.

21 MR. CRAIN: Okay. Nothing further from me.

1 You good?

2 You're free to go unless Sara wants to go.

3 MS. LAWSON: We can go off the record.

4 MR. CRAIN: Off the record.

5 THE VIDEOGRAPHER: This concludes the
6 deposition of Dr. Matthew Austin. This ends media unit
7 number nine. We're off the record. The time is
8 6:06 p.m.

9 THE COURT REPORTER: Ms. Lawson, will you be
10 handling signature for the witness, or are you waiving
11 signature?

12 MS. LAWSON: We'll read and sign.

13 She'll prepare a transcript of it so that
14 you can review your testimony and note any corrections.

15 THE COURT REPORTER: Ms. Wood, do you need a
16 rough draft as well?

17 MS. WOOD: Yes, if I can get a rough as soon as
18 possible.

19 (The deposition adjourned at 6:06 P.M.)
20
21

1 I, Marlene Kerr, a Notary Public of the
2 District of Columbia, do hereby certify that the
3 within-named witness personally appeared before me at
4 the time and place herein set out, and after having been
5 duly sworn by me, according to law, was examined by
6 counsel.

7 I further certify that the examination was
8 recorded stenographically by me, and this transcript is
9 a true record of the proceedings.

10 I further certify that I am not of counsel
11 to any of the parties, nor in any way interested in the
12 outcome of this action.

13 As witness my hand this 29th day of
14 September, 2025.

15 
16

Marlene Kerr

17 Notary Public
18

My Commission Expires:

19 July 28, 2026.
20
21

CERTIFICATE OF DEPONENT

I hereby certify that I have read and examined the foregoing transcript, and the same is a true and accurate record of the testimony given by me.

Any additions or corrections that I feel are necessary will be made on the Errata Sheet.

Matthew Austin

Date

(If needed, make additional copies of the Errata Sheet on the next page or use a blank piece of paper.)

Job Number: 7616361

September 29, 2025

Good Samaritan Medical Center Inc, Et Al. v. The Leapfrog Group

DEPOSITION OF: Dr. Matthew Austin (# 7616361)

The above-referenced witness transcript is available for read and sign.

Within the applicable timeframe, the witness should read the testimony to verify its accuracy. If there are any changes, the witness should note those on the attached Errata Sheet.

The witness should sign and notarize the attached Errata pages and return to Veritext at errata-tx@veritext.com.

According to applicable rules or agreements, if the witness fails to do so within the time allotted, a certified copy of the transcript may be used as if signed.

Yours,

Veritext Legal Solutions

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Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

DISCLAIMER: THE FOREGOING FEDERAL PROCEDURE RULES ARE PROVIDED FOR INFORMATIONAL PURPOSES ONLY.

THE ABOVE RULES ARE CURRENT AS OF APRIL 1, 2019. PLEASE REFER TO THE APPLICABLE FEDERAL RULES OF CIVIL PROCEDURE FOR UP-TO-DATE INFORMATION.

VERITEXT LEGAL SOLUTIONS

COMPANY CERTIFICATE AND DISCLOSURE STATEMENT

Veritext Legal Solutions represents that the foregoing transcript is a true, correct and complete transcript of the colloquies, questions and answers as submitted by the court reporter. Veritext Legal Solutions further represents that the attached exhibits, if any, are true, correct and complete documents as submitted by the court reporter and/or attorneys in relation to this deposition and that the documents were processed in accordance with our litigation support and production standards.

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Exhibit 85

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA
WEST PALM BEACH DIVISION

- - - - - x
GOOD SAMARITAN MEDICAL :
CENTER, INC., et al., :
Plaintiffs, : Case No.
v. : 9:25-CV-80526-DMM
THE LEAPFROG GROUP, :
Defendant. :

- - - - - x

Wednesday, September 10, 2025

Washington, D.C.

Videotaped Deposition of:

LAUREN L. BAILEY,
called for oral examination by counsel for the
Plaintiffs, pursuant to notice, at the law offices of
Gibson Dunn & Crutcher, LLP, 1700 M Street,
Northwest, Washington, D.C. 20036-4504, before
Christina S. Hotsko, RPR, CRR, CA CSR, of Veritext
Legal Solutions, a Notary Public in and for the
District of Columbia, beginning at 9:06 a.m., when
were present on behalf of the respective parties:

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C O N T E N T S

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Counsel for Plaintiffs 07

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21 * (Exhibits attached to transcript.)

22

P R O C E E D I N G S

VIDEO TECHNICIAN: Good morning. We are going on the record at 9:06 a.m. on September 10th, 2025.

Please note that the microphones are sensitive and may pick up whispering and private conversations.

Please mute your phones at this time. Audio and video recording will continue to take place unless all parties agree to go off the record.

This is media unit 1 of the video-recorded deposition of Ms. Lauren Bailey in the matter of Good Samaritan Medical Center, Inc., et al. versus The Leapfrog Group, filed in the United States District Court for the Southern District of Florida, West Palm Beach Division, case number 9:25-cv-80526-DMM.

My name is Orson Braithwaite representing Veritext Legal Solutions, and I am the videographer.

The court reporter is Christina Hotsko

1 from the firm Veritext Legal Solutions.

2 Counsel will now state their appearances
3 and affiliations for the record, beginning with
4 the noticing attorney.

5 MR. CHUNG: Daniel Chung of Gibson Dunn &
6 Crutcher for plaintiffs.

7 MR. KUNTZ: Andrew Kuntz, Gibson Dunn &
8 Crutcher, for plaintiffs.

9 MS. BLAIR: Kim Blair, Wilson Elser, for
10 defendants -- defendant.

11 MS. WOOD: Courtney Wood, Wilson Elser,
12 for defendant Leapfrog.

13 VIDEO TECHNICIAN: Thank you. Will the
14 court reporter please swear in the witness.
15 Whereupon,

16 LAUREN L. BAILEY,
17 being first duly sworn or affirmed to testify to
18 the truth, the whole truth, and nothing but the
19 truth, was examined and testified as follows:

20 EXAMINATION BY COUNSEL FOR PLAINTIFFS
21 BY MR. CHUNG:

22 Q. Good morning. Could you please state

1 your full name for the record.

2 A. Lauren Lytle Bailey.

3 Q. Have you gone by any other names?

4 A. No.

5 Q. Okay. Do you understand that the court
6 reporter sitting next to you is taking down
7 everything that's being said today, all the
8 questions and answers?

9 A. Yes.

10 Q. Okay. So before we start, I wanted to go
11 over some basic ground rules for the deposition.
12 Most of the ground rules are just to keep our
13 court reporter sane, so let's start with number
14 one.

15 Let's try not to talk over each other.
16 So if you can wait for me to finish a question
17 before you answer, and I'll do the same; I'll
18 wait until you finish your answer before I ask
19 the next question because the court reporter
20 can't take down two people talking at the same
21 time.

22 The next ground rule is to make sure that

1 your answers are audible and they're words. So
2 try to stay away from uh-huh or huh-uhs because
3 that's hard for the court reporter to take down.

4 You understand that you're testifying
5 under oath, Ms. Bailey?

6 A. Yes.

7 Q. All right. And you understand that by
8 taking that oath you're obligated to provide
9 truthful and accurate answers to the best of your
10 ability?

11 A. Yes.

12 Q. Okay. Are you taking any medications or
13 under the influence of any substances or is there
14 any reason that makes it difficult for you to
15 understand the questions I'm asking you or really
16 to understand what's happening today?

17 A. No.

18 Q. Okay. If you don't understand one of my
19 questions, please ask me to clarify them. I want
20 to make sure that you understand the questions
21 before you answer them.

22 Do you understand that?

1 A. Yes.

2 Q. Okay. From time to time, Ms. Blair may
3 lodge objections to my questions. In those
4 instances, unless Ms. Blair instructs you not to
5 answer the question, you must answer the
6 question.

7 Do you understand that?

8 A. Yes.

9 Q. Okay. You can take a break whenever you
10 want. Just let us know. The only thing we ask
11 is that we finish a question and answer before
12 taking a break. So no questions pending when we
13 take a break.

14 Do you understand that?

15 A. Yes.

16 Q. Okay. Terrific.

17 So just some background questions.

18 Have you ever had your deposition taken
19 before?

20 A. No.

21 Q. So this is your first time?

22 A. Yes.

1 Q. All right. Did you prepare for your
2 deposition today?

3 A. Yes.

4 Q. Okay. How did you go about preparing?

5 A. Met with our counsel, Kim and Courtney --

6 Q. Okay.

7 A. -- who are here in this room.

8 Q. Approximately how many times?

9 A. About three times.

10 Q. All right. And in the course of those
11 about three times you met with your counsel, did
12 you review any documents?

13 A. Yes. We reviewed documents, e-mails,
14 Slack messages.

15 Q. Okay. Terrific.

16 Did you review any documents outside of
17 those preparation sessions with your counsel?

18 A. Not without counsel, no.

19 Q. Your educational history. Can you just
20 go over your educational history?

21 A. Sure. I graduated from Brigham Young
22 University in 2011 with a bachelor of arts in

1 communications with an emphasis in public
2 relations and a minor in psychology.

3 Q. Okay. Apart from the bachelor of arts
4 degree from BYU, do you have any certifications
5 or licenses?

6 A. No.

7 Q. No? Okay. Any kind of advanced degrees?

8 A. No.

9 Q. No? Okay.

10 Any training in your field that you
11 regularly take?

12 A. I've regularly stay up to date on trends
13 within public relations. We use online classes,
14 like, from Udemy and things like that just to
15 stay as up to date as possible.

16 Q. Okay. Now, you mentioned that, with your
17 degree, you had a specialization in public
18 relations.

19 In the course of your -- and we'll get
20 into your employment history.

21 In the course of your -- the various jobs
22 you've held, are there any -- has it continued to

1 focus on public relations?

2 A. Yes.

3 Q. Okay. Let's get into your employment
4 history.

5 So can you just kind of outline for us
6 your employment history?

7 A. Yes. So when I graduated college, I
8 moved back to Seattle and I worked for Weber
9 Shandwick, which is a large global public
10 relations firm. I was hired into the consumer
11 technology practice. Within a year, when I got a
12 promotion, I changed to the healthcare practice.
13 And I've been working in healthcare PR for 13
14 years, since then.

15 So I transferred from the Seattle office
16 in Weber Shandwick to the D.C. office. And a
17 little while later, I got a new job working
18 in-house for Children's National Hospital here in
19 D.C. as a senior media relations specialist. So
20 I managed press that came onsite at the hospital.
21 I did celebrity events, crisis communications,
22 awards, things like that. That's actually how I

1 became familiar with Leapfrog Group. Children's
2 National Hospital had been awarded the top
3 children's hospital award by Leapfrog. And
4 coincidentally, I had just finished writing a
5 press release about it, and I got an e-mail from
6 a recruiter at the Leapfrog group about a
7 communications position at Leapfrog.

8 My only contacts with Leapfrog was from
9 that one press release I had written. I thought
10 it sounded interesting, so talked to the
11 recruiter, and I learned a lot more about
12 Leapfrog and a different part of healthcare,
13 which has been really interesting. I'm not sure
14 if you're aware, but Leapfrog represents
15 employers. So we were founded 25 years ago by a
16 lot of big companies, GM, GE, Boeing, Marriott.
17 They got together and they said, we don't know
18 what the quality and transparency of the
19 healthcare in hospitals for our employees is, and
20 we want to change that. And they started
21 Leapfrog in 2000, and we've been around since
22 then.

1 So again, I've been in healthcare for a
2 long time, but that wasn't a side of it I'd
3 thought of before. So I've been with Leapfrog
4 since 2017.

5 Q. Okay. And so when you -- at the time
6 when you first heard about f Leapfrog when you
7 were at Children's Hospital, at the time, did
8 Leapfrog have the hospital safety grade program
9 at the time?

10 A. Yes.

11 Q. Okay. What was your first position or
12 title at Leapfrog?

13 A. Communications manager.

14 Q. Okay. And is that the title you hold
15 today, or has that changed?

16 A. That's changed.

17 Q. Okay. And what is -- just tell us kind
18 of the progression since approximately 2017 in
19 terms of titles?

20 A. Sure. So I started as communications
21 manager in January of 2017. In 2020, I had my
22 first baby and made a decision that fall, for

1 personal reasons, to work part time. So at that
2 point, I was senior communications advisor until
3 June of 2024, when I was promoted to director of
4 communications, which is my title today.

5 Q. Okay. So as your -- as director of
6 communications since June of 2024, what are
7 your -- generally speaking, what are your roles
8 and responsibilities?

9 A. I oversee all external communications.
10 So that is generally public relations, media
11 relations. I manage our agency of record for PR,
12 CURA Strategies. I oversee the content of our
13 website. I oversee social media. I help with
14 speeches. I am in charge of the brand overall,
15 brand guidelines, things like that.

16 Q. Okay. So in terms of -- in terms of --
17 and we're taking this from Leapfrog's website --
18 right? -- the description of your -- are you a
19 member of the executive staff at Leapfrog?

20 A. I am a member of the management team.

21 Q. Right.

22 A. But I know on our website it says

1 executive staff, and that includes our CEO, VPs
2 and directors.

3 Q. Okay. According to the website, your --
4 as director of communications, you oversee all
5 strategic communications for Leapfrog, including
6 media relations, social media, and content
7 development, which is consistent with your
8 testimony.

9 Does that include communications with
10 hospitals themselves?

11 A. No.

12 Q. Okay. Who is in charge of or who
13 oversees communications with the hospitals
14 themselves?

15 A. Missy Danforth and her team.

16 Q. Okay. Do you have any interaction with
17 hospitals in your role?

18 A. Rarely. The only time I do is if I'm
19 working on a case study or something like that.

20 Q. Okay. And why is it that from -- so why
21 is it that, as director of communications, your
22 role doesn't include communications with

1 hospitals?

2 A. We're a really small organization. So it
3 may appear that we have roles that seem different
4 than maybe in large organizations. So I am one
5 person. I have one other full-time staff member.
6 We are the communications team. So we don't have
7 it in our bandwidth.

8 And the communications we have with
9 hospitals is very technical, so it's managed on
10 the ratings team side.

11 Q. Okay. You mention that you have one
12 other person on your team.

13 Who is that?

14 A. Nate Longmore. He's the communications
15 coordinator.

16 Q. All right. And what is his role?

17 A. He is the day-to-day for posting on
18 social media. He is the day-to-day for actually
19 doing the content posting on our website. He
20 does a lot of graphic design and just other
21 communications tasks.

22 Q. Okay. And he -- is he the only employee

1 at Leapfrog that reports to you, or do you have
2 other folks reporting to you?

3 A. He's the only one who reports to me.

4 Q. And who do you report to?

5 A. Karen Jupiter.

6 Q. All right. Anyone else at Leapfrog that
7 you report to?

8 A. No.

9 Q. Okay. And Karen Jupiter, what is her
10 role?

11 A. She's VP of development.

12 Q. What forms of communication do Leapfrog
13 employees use? And I mean internally within the
14 organization.

15 A. Outlook for e-mail. And we use Slack.

16 Q. And Slack is -- for purpose of chatting
17 or instant messaging?

18 A. Yes.

19 Q. Okay. Any other messaging platforms or
20 other forms of electronic communication that
21 Leapfrog employees use?

22 A. No, not that I can think of right now.

1 Q. Okay. We're going to turn to our first
2 exhibit.

3 MR. CHUNG: We're going to mark this
4 Exhibit 1.

5 (Bailey Deposition Exhibit 1 marked for
6 identification and attached to the
7 transcript.)

8 THE WITNESS: Thank you.

9 BY MR. CHUNG:

10 Q. All right. Ms. Bailey, just take a few
11 moments to look through it. Let me know if you
12 recognize it.

13 A. Yes. I recognize it.

14 Q. All right. And what is it?

15 A. It's my performance review from
16 January of this year.

17 Q. Okay. And so this is -- by this point
18 you had spent several months as director of
19 communications, which is your current role,
20 correct?

21 A. Yes.

22 Q. Okay. And who drafted this particular

1 document?

2 A. The first part of it is a
3 self-evaluation, so I drafted that part.

4 Q. Okay. And then the -- there's a second
5 part, right?

6 A. Yes.

7 Q. And -- which starts at -- if you look at
8 the bottom -- generally throughout this
9 deposition, I'll be referring -- in terms of
10 page numbers, I'll be referring to what's called
11 a Bates number, which is typically at the bottom
12 right-hand corner.

13 So the page with Bates number Leapfrog
14 395525, is this the second half that you're
15 referring to --

16 A. Yes.

17 Q. -- of the document?

18 And the author of that part is Karen
19 Jupiter, the VP of development that you
20 referenced earlier was your supervisor; is that
21 right?

22 A. Yes.

1 Q. Okay. I want to direct your attention to
2 the page before that, Bates number Leapfrog
3 395524. If you can turn to that.

4 There are a series of bullet points at
5 the top.

6 If you look at the fourth bullet point it
7 reads, Demonstrate deep knowledge of Leapfrog's
8 programs and initiatives with extensive knowledge
9 of Leapfrog's initiatives, including the hospital
10 safety grade and Leapfrog surveys. I remain a
11 go-to resource for staff seeking guidance or
12 clarity on programs and stakeholder relations.

13 Do you see that?

14 A. Yes.

15 Q. And is that a bullet point that you,
16 yourself, drafted?

17 A. Yes.

18 Q. All right. How did you go about -- or
19 how do you go about obtaining deep knowledge of
20 Leapfrog's programs and initiatives in your role?

21 A. I've been working at Leapfrog for over
22 eight-and-a-half years. So over the time, I have

1 learned more about Leapfrog's programs. As part
2 of my job, I am in charge of talking points and
3 preparing people for media interviews and
4 speaking engagements, so I have learned a lot
5 throughout the years from a communications
6 perspective.

7 Q. Okay. Does that include any kind of
8 focused discussion or trainings around the
9 organization's programs and initiatives?

10 MS. BLAIR: Objection to form.

11 THE WITNESS: Can you restate the
12 question?

13 BY MR. CHUNG:

14 Q. Sure.

15 Does this deep knowledge come about also
16 as a result of any trainings that you received on
17 the organization's programs and initiatives?

18 A. No, not that I can recall.

19 Q. So just kind of on-the-job training is
20 how you obtained this knowledge --

21 A. Yes.

22 Q. -- would you say? All right.

1 If you look at -- we're still in the same
2 document. Turn a couple pages before that. So
3 Bates ending in 5522.

4 If you look at the second-to-last bullet
5 point there it reads, Draft and edit
6 publications, articles, and blogs. I drafted
7 nine blog posts in 2024, providing valuable
8 thought leadership and supporting Leapfrog's
9 communications efforts.

10 Does -- are those blog posts written or
11 authored under your own name? Are they
12 ghostwriting for others?

13 What's the nature of those blog posts?

14 A. The blog is part of our newsroom. So I
15 when I write, I represent Leapfrog.

16 Q. Okay. So that's -- so they're -- is your
17 name kind of attached or explicitly named as the
18 author for those blog posts?

19 A. No. There's no specific author listed.

20 Q. Okay. The last sentence there regarding
21 the comprehensive brand guide in 2024, is that a
22 written document?

1 A. It is.

2 Q. Okay. And what -- can you just describe
3 generally what it is?

4 A. It's a general brand guide. It's pretty
5 standard in communications. It needed a refresh.
6 The one that we had was in Word. We use Canva
7 for graphic design now, primarily. So we
8 moved -- I moved it into Canva and ensured that
9 we were all on the same page. We've had some new
10 programs in the last couple of years started at
11 Leapfrog that weren't part of the previous brand
12 guide. So just getting it up to date.

13 Q. What were the new programs that weren't
14 in the previous version of the brand guide?

15 A. The Recognized Leader Program, which is
16 our partnership with the American Diabetes
17 Association.

18 Q. Any other programs?

19 A. Recognizing Excellence in Diagnosis I
20 think would be the other one.

21 Q. So let's get into the hospital safety
22 grade, which I'm sure you understand is one of

1 the topics -- right? -- involved in the matter
2 here.

3 What is Leapfrog's hospital safety grade?

4 A. It's a letter grade that we assign to all
5 general acute care hospitals in the United States
6 based on patient safety. So we look at
7 accidents, errors, injuries, infections.

8 Q. And what's the purpose of assigning
9 hospitals a hospital safety grade?

10 MS. BLAIR: Objection to form.

11 THE WITNESS: We created the safety grade
12 for consumers. Healthcare ratings can be
13 confusing, and consumers generally understand a
14 letter grade, A, B, C, D, F. So it was created
15 for consumers to have a place to start when
16 they're looking at hospitals.

17 BY MR. CHUNG:

18 Q. You just testified that we created the
19 hospital safety grade for consumers.

20 Who is the "we"?

21 A. I'm a communications professional, so I'm
22 used to saying "we," as in the Leapfrog Group. I

1 was not at Leapfrog personally when the safety
2 grade began.

3 Q. Do you know who -- understanding that you
4 came onboard, you know, after the safety grade
5 was created, do you know who originated or
6 created the hospital safety grade?

7 A. Leah Binder.

8 Q. Okay. And -- who is the founder of the
9 organization, correct?

10 A. She is not the founder. She's the second
11 CEO.

12 Q. Okay. Why does Leapfrog assign a single
13 letter grade to hospitals rather than using some
14 other form of rating like a numerical rating or a
15 percentage rating?

16 MS. BLAIR: Objection. Form.

17 THE WITNESS: I can only speak to that
18 from a communications perspective. And it's just
19 that -- like I said before, that consumers
20 generally understand a letter grade.

21 BY MR. CHUNG:

22 Q. Okay. Because it just -- reminds them of

1 school, basically, it's easy to understand, kind
2 of an A to F concept; is that right?

3 A. Yes.

4 Q. Do you know how the cutoff for each
5 grade -- let's say A to B, B to C -- is decided?

6 A. No. I'm not part of those conversations.

7 Q. Okay. Does Leapfrog intend for consumers
8 to rely on the hospital safety grade when they
9 make a decision about which hospital to go to?

10 A. Our communications messaging is that it's
11 a place to start. We recommend that patients
12 look at the safety grade for general patient
13 safety and then use other ratings, including the
14 Leapfrog hospital survey, U.S. News & World
15 Report, et cetera, to look at quality as well.

16 Q. Okay. So your -- does Leapfrog
17 explicitly tell or advise consumers to look at
18 other hospital ratings other than Leapfrog in
19 making their decisions where to go for their
20 care?

21 A. Yes. It's part of my regular
22 communications messaging.

1 Q. Okay. How is it determined which
2 hospitals are assigned a hospital safety grade?

3 A. In --

4 MS. BLAIR: Objection to form. Sorry.

5 THE WITNESS: In my understanding, it's
6 all general acute care hospitals in the U.S.

7 BY MR. CHUNG:

8 Q. Okay. Are there -- let's look at another
9 one.

10 Are there certain hospitals that are not
11 assigned a safety grade?

12 A. Specialty hospitals, like children's
13 hospitals, critical access hospitals.

14 Q. You testified earlier when you were in
15 the Children's Hospital system here in D.C. that
16 they received a recognition, correct?

17 A. No, I didn't say that. I said the safety
18 grade did exist when I was at Children's
19 National, but they're a children's hospital. So
20 they did the Leapfrog hospital survey, and that
21 was the top children's hospital award.

22 Q. I see. So they submitted a -- they

1 responded to Leapfrog's survey but did not
2 receive the safety grade; is that correct?

3 A. Correct. Children's hospitals do not
4 receive a safety grade at this time.

5 Q. Okay. And how often does Leapfrog
6 release hospital safety grades?

7 A. Twice a year.

8 Q. And why is it twice in a year as opposed
9 to annually or more frequently?

10 A. We want to include the most recent data
11 possible.

12 Q. Okay. Let's move on to how Leapfrog
13 arrives at hospital safety grades for individual
14 hospitals.

15 Are you familiar with Leapfrog's scoring
16 methodology behind the safety grade?

17 A. Yes. From a communications perspective,
18 I am.

19 Q. Okay. When you say -- you've testified a
20 number of times or you've prefaced your responses
21 with "from a communications perspective."

22 What does that mean?

1 A. I am not involved in the technical
2 aspects. I'm not a data scientist. I'm a
3 communications person. So I consider myself an
4 expert in our messaging but not in the data
5 science.

6 Q. Understood. All right. But you -- at
7 least in our first exhibit, Exhibit 1, in your
8 writeup of your evaluation, you represented that
9 you have deep knowledge, right, of the -- of the
10 organization's programs and initiatives,
11 including the hospital safety grade and the
12 hospital survey; is that right?

13 A. Yes. Within my role. Yes.

14 Q. Okay. Why don't we put at least two
15 versions of the scoring methodology as exhibits.

16 MR. CHUNG: So 41 and 45.

17 (Bailey Deposition Exhibit 2 marked for
18 identification and attached to the
19 transcript.)

20 BY MR. CHUNG:

21 Q. As we're getting the exhibits,
22 Ms. Bailey, do you have any role in designing

1 Leapfrog's scoring methodology behind the safety
2 grades?

3 A. No.

4 Q. All right. How about any role in
5 implementing that scoring methodology to specific
6 hospitals?

7 A. No.

8 Q. Do you have any role with respect to the
9 scoring methodology in terms of its content?

10 A. No.

11 Q. Do you have any input on the content or
12 provide feedback on the content?

13 A. No.

14 Q. Who at Leapfrog is, number one, involved
15 in the design of the scoring methodology?

16 A. Missy Danforth and Alex Campione.

17 Q. All right. And what are their roles?

18 A. Missy Danforth is the senior
19 vice-president for healthcare ratings. Alex
20 Campione is a program analyst for the safety
21 grade.

22 MR. CHUNG: All right. So we're going to

1 mark two exhibits, Exhibits 2 and 3.

2 And Exhibit 2 will be the spring 2025
3 safety grade scoring methodology and Exhibit 3
4 will be the preceding version, the spring 2024
5 scoring methodology.

6 (Bailey Deposition Exhibit 3 marked for
7 identification and attached to the
8 transcript.)

9 BY MR. CHUNG:

10 Q. Okay. So you mentioned Ms. Danforth and
11 Ms. Campione in being involved in the design of
12 the scoring methodology.

13 Is there anyone outside -- first of all,
14 is there anyone else within Leapfrog that's
15 involved in the design of the scoring
16 methodology?

17 A. Leah Binder I'm sure has a role in it.

18 Q. Okay. Anyone --

19 A. That's all I can recall.

20 Q. I'm sorry?

21 A. That's all.

22 Q. Okay. Anyone outside of the organization

1 involved in the design of the scoring
2 methodology?

3 A. The expert panel has a role in advising
4 on the methodology.

5 Q. Okay. And that's a good segue.

6 What is the expert panel?

7 A. The expert panel is a group of experts
8 who volunteer their time to Leapfrog to advise us
9 on methodology.

10 Q. Okay. Now, from the website, Leapfrog
11 tells consumers that Leapfrog works under the
12 guidance of an expert panel to select appropriate
13 measures and develop a scoring methodology.

14 Are you familiar with that language from
15 the website?

16 A. Yes.

17 Q. Okay. Did you have a -- were you
18 involved in putting together that particular
19 language?

20 A. No. It precedes my time.

21 Q. Okay. Now, there is -- do you understand
22 that there is -- there's a panel that consists of

1 patient safety experts? Are you aware of that?

2 A. For the Leapfrog hospital survey.

3 Q. Okay. Which -- and do you -- are you
4 aware that there was a change in the scoring
5 methodology in the spring to fall of 2024?

6 Are you aware of that?

7 A. Yes.

8 Q. Okay. Were there any experts from the
9 experts panel that were involved in that
10 methodology change in 2024?

11 A. I don't talk to the expert panel, so I
12 wouldn't know.

13 Q. Okay.

14 A. I assume.

15 Q. Well, I'm not asking you whether you
16 spoke to the expert panel.

17 Are you aware whether any experts from
18 the expert panel were involved in that
19 methodology change in 2024?

20 A. I don't know. It wasn't discussed with
21 me.

22 Q. Okay. How are panelists for that expert

1 panel selected?

2 A. I don't know.

3 Q. Do you know whether any of those
4 panelists are experts in disclosures to
5 consumers?

6 A. I don't know.

7 Q. Okay. How about in website design?

8 A. I don't know.

9 Q. Digital literacy?

10 A. I don't know.

11 Q. All right. Any of those -- do you know
12 whether any of those experts on the experts panel
13 have a background or are experts in
14 communications strategy?

15 A. I don't know.

16 Q. Okay. Do those panelists have to come
17 from organizations that participate in the
18 Leapfrog survey?

19 A. No.

20 Q. All right. Are there panelists that --
21 from organizations that do participate in the
22 Leapfrog survey?

1 A. I believe so. I'm not an expert in
2 everyone who's on the panel.

3 Q. Okay. Can you think of any members of
4 the expert panel that are from organizations that
5 participate in the hospital survey?

6 A. Not that I can recall off the top of my
7 head.

8 Q. Okay. Are you aware of any instances
9 where Leapfrog ended its relationship with a
10 patient safety expert on that expert panel
11 because their organization stopped participating
12 in the hospital survey?

13 A. I don't know. It would surprise me if
14 so.

15 Q. Okay. But you're not aware of an
16 instance?

17 A. I'm not aware, no.

18 Q. You testified I think in the first or
19 second question on this topic that these expert
20 panelists volunteer their time to Leapfrog; is
21 that right?

22 A. That's my understanding. Yes.

1 Q. So are panelists on this expert panel
2 compensated at all?

3 A. Not to my knowledge.

4 Q. Are the organizations that they came from
5 compensated in connection with the expert
6 panelists being on the expert panel?

7 A. Not to my knowledge.

8 Q. All right. What role does the expert
9 panel play in developing a scoring methodology?
10 And that's the language we just went over from
11 the website.

12 What's their role in developing a scoring
13 methodology?

14 A. I only know that generally they advise on
15 measures and help ensure that the safety grade is
16 up to the latest science.

17 Q. Okay. Who at Leapfrog works with the
18 safety grade? Do you work with them at all?

19 A. I do not. It's run by Missy Danforth.

20 Q. All right. Anyone else within Leapfrog
21 that works with them?

22 A. The safety grade expert panel? Not to my

1 knowledge.

2 Q. Okay. So it's just Missy Danforth that
3 works with the safety grade expert panel --

4 MS. BLAIR: Objection to form.

5 BY MR. CHUNG:

6 Q. -- is that right?

7 A. To my knowledge.

8 Q. Okay. So what is the process by which
9 these -- the hospital safety grade experts advise
10 on the hospital safety grade?

11 A. Can you restate the question?

12 Q. Is there a process or protocol that
13 Leapfrog follows in getting advice from the
14 patient safety health -- patient safety experts
15 on the experts panel?

16 A. I don't know.

17 Q. Are there any regular meetings with these
18 experts?

19 A. I'm not aware of when they meet.

20 Q. Okay. If a patient safety -- if the
21 patient safety experts make a recommendation with
22 respect to the scoring method- -- scoring

1 methodology, is Leapfrog obligated to implement
2 that recommendation?

3 A. No.

4 Q. And why not?

5 A. The Leapfrog hospital safety grade is
6 Leapfrog's program. So Missy Danforth and Leah
7 Binder would have the final decision.

8 Q. All right. So Leapfrog could reject a --
9 theoretically could reject a recommendation by
10 the patient safety experts.

11 A. Theoretically, yes.

12 Q. Do you know whether, if there's a
13 recommendation from the patient safety experts,
14 whether that recommendation has to be unanimous
15 among the members of that particular panel?

16 A. I don't know.

17 Q. Do the safety experts patient have to
18 approve the wording of any change in the scoring
19 methodology that Leapfrog adopts?

20 A. I don't know.

21 Q. On the website it says a hospital must
22 have enough safety data available for our experts

1 to issue them a letter grade.

2 So is it correct that the patient safety
3 experts themselves issue the letter grades?

4 MS. BLAIR: Objection to form.

5 THE WITNESS: I don't know. I'm not
6 involved in the assigning of safety grades.

7 BY MR. CHUNG:

8 Q. Does that -- just reading again, A
9 hospital must have enough safety data available
10 for experts to issue them a letter grade.

11 Is that accurate?

12 MS. BLAIR: Objection to form.

13 THE WITNESS: I think it's accurate
14 because it says "our experts." I mean, that
15 could include the expert panel; that could
16 include experts within Leapfrog.

17 BY MR. CHUNG:

18 Q. Which experts within Leapfrog are you
19 referring to?

20 MS. BLAIR: Objection to form as to the
21 document you're reading from.

22 THE WITNESS: Missy Danforth and Leah

1 Binder are experts.

2 BY MR. CHUNG:

3 Q. Are the patient safety experts involved
4 in the disclosures on Leapfrog's websites?

5 A. Can you repeat the question?

6 Q. Are the patient safety experts involved
7 in the disclosures on Leapfrog's websites?

8 A. I don't know. I don't talk to the expert
9 panel.

10 Q. So no -- just to be clear, you have no
11 communication whatsoever with members of the
12 expert panel?

13 A. Not that I can recall unless there's a
14 specific media opportunity or -- but I can't
15 recall something right now.

16 Q. Let's go to the next document.

17 MR. CHUNG: Tab 31.

18 THE WITNESS: Is that Exhibit 2?

19 MR. CHUNG: Oh, no, we're going to put
20 another document in front of you.

21 THE WITNESS: Okay. We don't open these.

22 MR. CHUNG: Yeah. We may go back to

1 those later.

2 THE WITNESS: Okay. I'll just put them
3 over here.

4 MR. CHUNG: So this will be Exhibit 4.
5 (Bailey Deposition Exhibit 4 marked for
6 identification and attached to the
7 transcript.)

8 BY MR. CHUNG:

9 Q. Ms. Binder [sic], we're putting Exhibit 4
10 in front of you. It's a series of Slack
11 messages.

12 A. Okay.

13 Q. Take a few moments to take a look at it.
14 Let me know when you recognize it.

15 Oh, Bailey, I'm sorry.

16 All right. So Ms. Bailey, these are
17 Slack Messages from May 1 of this year between
18 you and Ms. Jupiter.

19 What are you working on with Ms. Jupiter
20 in the course of this Slack conversation?

21 A. A lot of different things.

22 Q. Let's go through -- just let me know --

1 if you can tell us what you're working on.

2 A. We discussed IPPS, which is a proposed
3 rule with CMS. We provide comment letters.

4 We discussed some materials with our
5 American Diabetes Association program.

6 We discussed a contract for a
7 photographer.

8 Q. Is there also a discussion about a
9 followup statement that Ms. Binder is going to
10 make on the -- on this lawsuit?

11 A. Do you know what page you're looking at?

12 Q. Yeah. Why don't I focus you on Leapfrog
13 9912.

14 A. 9912? Okay. The last page?

15 Q. That's right. Yeah.

16 A. Yes. A statement for our website.

17 Q. Okay. Now, at about 6:12 p.m. -- just
18 looking at the markers on the right side -- you
19 write, I think we should link to results for each
20 hospital too so people can see their fully
21 transparent grades.

22 What are you referring to here?

1 A. From what I remember, the statement
2 that's currently on our website links to each of
3 the five plaintiff hospitals and their safety
4 grades.

5 Q. All right. And -- so what did you mean
6 by "so people can see fully transparent grades"?

7 A. The Leapfrog hospital safety grade is
8 fully transparent. Leapfrog stands for
9 transparency, so you'll probably see me saying
10 transparent a lot because we focus on being
11 transparent.

12 Q. So that's kind of -- that's language that
13 you often use from kind of a communications
14 perspective; is that right?

15 A. Yes.

16 Q. Then Ms. Jupiter writes, Not sure we want
17 to link expert panel, followed by we don't really
18 want them contacted.

19 Why didn't Ms. Jupiter want the expert
20 panel to be contacted in this context?

21 MS. BLAIR: Objection to form.

22 THE WITNESS: I don't know. You can see

1 in here that I was going to link to it. I don't
2 remember -- I don't know what she meant.

3 BY MR. CHUNG:

4 Q. All right. And then you write in
5 response, like you just testified, It's on our
6 website so I think it's okay. It is a point we
7 make a lot that we have the national expert
8 panel.

9 What does that mean? Why is the national
10 expert panel appointment -- a point that Leapfrog
11 makes a lot?

12 A. It's part of our standard messaging.

13 Q. Okay. And that standard messaging is
14 what, as relevant to this exchange here?

15 A. That we have a national expert panel
16 that's part of developing the safety grade
17 methodology.

18 Q. Again, just going back to what
19 Ms. Jupiter wrote here kind of in the middle of
20 your conversation, Not sure we want to link
21 expert panel. We don't really want them
22 contacted.

1 Was there a concern between you and
2 Ms. Bailey and others at Leapfrog about members
3 of that expert panel being contacted by the
4 press?

5 A. I'm Ms. Bailey.

6 Q. Ms. Bailey -- I'm sorry. Ms. Bailey.
7 We're going to do that again.

8 A. Okay.

9 Q. Was there a concern between you and
10 Ms. Jupiter and others at Leapfrog about the
11 press contacting members of the expert panel?

12 A. I don't know what Karen meant by this.

13 Q. All right. I'm not asking what
14 Ms. Jupiter meant by this.

15 But did you have any concerns about
16 members of the expert panel being contacted by
17 the press?

18 A. No.

19 Q. How about other members of Leapfrog? Did
20 Ms. Binder have any concerns about the expert
21 panel being contacted by the press?

22 A. I didn't discuss it with her.

1 Q. Okay. How about with Ms. Danforth?

2 A. I didn't discuss it with her.

3 Q. Ms. Campione?

4 A. I don't discuss that kind of thing with
5 Alex, no.

6 Q. Okay. Let's move on to the hospital
7 survey.

8 What is Leapfrog's hospital survey?

9 A. It is a voluntary survey that is annual
10 that all hospitals can choose to report to
11 Leapfrog on. And it measures quality and safety.

12 Q. Do you have any role in designing the
13 hospital survey?

14 A. No.

15 Q. Do you have any input on the content of
16 the hospital survey?

17 A. No.

18 Q. Have you ever reviewed the hospital
19 survey?

20 A. I proofread it.

21 Q. All right. Proofread it. So you have --
22 so what's the purpose of proofreading it?

1 A. Catch any typos or anything the ratings
2 team may have missed as far as grammar.

3 Q. All right. So it's just a hard
4 proofread. Doesn't have anything to do with the
5 content?

6 A. Correct.

7 Q. All right. Is there anyone -- so who
8 within Leapfrog is involved in designing the
9 hospital survey?

10 A. Missy Danforth and Katie Stewart
11 primarily.

12 Q. And what's Ms. Stewart's role?

13 A. She is the director of healthcare ratings
14 for Leapfrog.

15 Q. Is there anyone outside of Leapfrog
16 that's involved in the design of the hospital
17 survey?

18 A. We have an expert panel for every section
19 of the survey.

20 Q. And when you say every section of the
21 survey, what do you mean by that?

22 A. So some examples are medication safety,

1 maternity care. We have a patient and family
2 expert panel.

3 Q. Okay. And so each of those areas has a
4 corresponding section in the survey; is that
5 right?

6 A. Yes.

7 Q. All right. And what is the role of each
8 of those specific expert panels with respect to
9 their respective sections in the hospital survey?

10 A. It's very similar to the role with the
11 safety grade. They advise on measures and
12 methodology, share research that they're working
13 on, can stay up to the latest science.

14 Q. Okay. Do they -- do members of the
15 expert panels have to approve final versions of
16 the Hospital -- of the survey before it's issued?

17 A. I don't know.

18 Q. All right. Do the expert panels make
19 recommendations with respect to their respective
20 sections in the hospital survey?

21 A. As far as I understand, yes, that's their
22 role.

1 Q. All right. Is Leapfrog obligated to
2 adopt those recommendations?

3 A. No, not to my understanding.

4 Q. Are you aware of any instances when a
5 recommendation by the expert panel on the
6 hospital survey was not adopted by Leapfrog?

7 A. Not that I can recall.

8 Q. Okay. Do you have any role in reviewing
9 hospitals' responses to the survey?

10 A. No.

11 Q. Have you ever done that, reviewed any
12 responses to the hospital survey?

13 A. No.

14 Q. Who at Leapfrog is responsible for
15 reviewing those responses?

16 A. Missy Danforth's team. They work
17 together on it.

18 Q. All right. Now, Missy Danforth's team.
19 How many -- approximately how many members of the
20 team are there?

21 A. Eight to ten.

22 Q. And is it their responsibility to review

1 the many responses that the organization gets the
2 survey?

3 A. Yes.

4 MR. CHUNG: Let's go to the next
5 document.

6 So this will be Exhibit 5.

7 (Bailey Deposition Exhibit 5 marked for
8 identification and attached to the
9 transcript.)

10 BY MR. CHUNG:

11 Q. Now, Ms. Bailey, I've put in front of you
12 the hospital survey that's taken from the
13 website, a version taken from the website.

14 Do you recognize it?

15 A. Yes.

16 Q. Okay. Now, you see that the survey is
17 approximately 350 pages long.

18 Do you see that?

19 A. Yes.

20 Q. Okay. Have you -- do you know whether
21 Leapfrog has conducted any studies or collected
22 data on how long it takes hospitals to respond to

1 the survey?

2 A. I don't believe we've done anything
3 formally.

4 Q. Okay.

5 A. No.

6 Q. Do you know generally -- and this can be
7 a range -- how long it takes for hospitals to
8 respond or fill out the survey?

9 A. We've heard 40 to 80 hours.

10 Q. Okay. Where is that from? Where do you
11 hear that from?

12 A. The ratings team told me that, just
13 talking to hospitals I believe anecdotally.

14 Q. Okay. Are you aware of any concerns that
15 hospitals have raised about the amount of time or
16 resources it takes to respond to the survey?

17 A. Any hospital I talk to, they prioritize
18 Leapfrog and patient safety. So to them, it's no
19 time. To them, they spend a lot more time on
20 other ratings than they do on Leapfrog and don't
21 see it as a burden, so I haven't personally heard
22 complaints.

1 Q. Okay. You testified earlier that you
2 don't speak to hospitals.

3 So what's the nature of the
4 communications you're referring to here?

5 A. I testified earlier that I do case
6 studies. So that's the only specific instance I
7 can think of when I would talk to a hospital.

8 Q. Okay. And what -- did you conduct a case
9 study of how long hospitals or what -- kind of
10 the extent of resources hospitals have to
11 undertake to complete these surveys?

12 A. No.

13 Q. So what was the context in which you
14 got -- in which you heard from hospitals that --
15 about how long it takes for them to fill out this
16 survey?

17 A. When I'm preparing for a case study, we
18 usually do an interview. And I do a
19 pre-interview, which is very standard in
20 communications, where I just try to understand,
21 you know, their role with Leapfrog. You know,
22 what is your stance on Leapfrog? How long have

1 you done the survey? What parts of it are most
2 valuable to your organization?

3 And that helps me, as a communications
4 person, come up with the questions for the formal
5 interview. So we always ask them about the
6 survey as part of that.

7 Q. Okay. So apart from the conversations
8 you've had with hospitals, have you heard of any
9 concerns or complaints raised by hospitals about
10 the amount of time or resources it takes to
11 respond to the survey?

12 A. Not personally.

13 Q. Okay. Have you just -- from colleagues,
14 have you heard about -- heard a complaint or
15 concern along these lines?

16 A. Not that I can recall.

17 Q. Okay. Never heard a concern about -- or
18 a complaint about how long it takes?

19 A. Not particularly from hospital. I don't
20 work on the help desk, so I wouldn't -- I
21 wouldn't know.

22 Q. Okay. This is not -- this sort of issue

1 is not -- you mentioned the help desk. What is
2 that?

3 A. The help desk is in-house for Leapfrog.
4 We use nDesk. So hospitals and ambulatory
5 surgery centers, if they have questions, they
6 reach out to our staff through the help desk and
7 they get back to them.

8 Q. Okay. Have -- so putting aside kind of
9 how much time it takes to fill out or respond to
10 the survey, have any of the hospitals that you've
11 spoken to expressed concerns or complaint about
12 the content or the fairness of the hospital
13 survey?

14 A. No.

15 Q. All right. How about apart from --
16 putting aside your personal communications with
17 hospitals -- right? -- have you heard from
18 colleagues about hospitals expressing concerns
19 about the fairness of the hospital survey?

20 A. Not that I can recall.

21 Q. Okay. So is it -- have you heard -- in
22 your conversations with hospitals, have the

1 hospitals expressed anything kind of negative or
2 even ambivalent about the hospital survey?

3 A. Not that I can recall.

4 Q. Okay. So it's all been positive about
5 the hospital survey; is that right?

6 A. From a communications perspective? Yes.
7 Because we focus on hospitals that do the survey
8 for the case studies.

9 Q. Okay. Can you explain that? I'm not
10 quite sure I understand.

11 A. So as I said before, I do case studies
12 with hospitals occasionally. That's the only
13 time I could think of that I would have a direct
14 conversation with a hospital and would
15 potentially get feedback from them.

16 But we do case studies on hospitals that
17 complete the survey.

18 Q. Understood. So is it -- so is it fair to
19 say that, because you conduct case studies of
20 hospitals that complete the survey, that the
21 feedback you receive from those hospitals is
22 positive?

1 A. Yes.

2 Q. All right. Have you conducted any case
3 studies of hospitals that did not fill out the
4 survey?

5 A. Not that I can recall.

6 Q. Okay. Why not?

7 A. My job is to promote Leapfrog as a
8 communications person, so it -- it would be --
9 it's beneficial to do case studies on hospitals
10 that do the survey.

11 Q. So for these case studies, because it's
12 from a -- for a communications purpose, is the
13 goal with these case studies to basically
14 highlight or showcase hospitals that completed
15 the survey?

16 A. Yes. And use the survey to spur
17 change --

18 Q. All right.

19 A. -- and use it for benchmarking.

20 Q. And are these hospitals that received an
21 A for their hospital safety grade?

22 A. They are different programs. The

1 Leapfrog hospital survey and the Leapfrog
2 hospital safety grade are different.

3 So we've done case studies on children's
4 hospitals that don't get a safety grade.

5 We've done case studies on an hospital
6 that had an F on the safety grade and now has an
7 A on the safety grade.

8 So we've had a lot of different types of
9 stories.

10 Q. How often does Leapfrog make changes to
11 the hospital survey?

12 A. I know it's reviewed regularly and
13 changes are made just when necessary. Every year
14 we put out proposed changes if there are any
15 changes that are put out for public comment.

16 Q. So that's every year because the hospital
17 survey is issued annually, correct?

18 A. Yes. It is annual.

19 Q. Can you tell us about -- can you describe
20 for us step by step how that public comment
21 process works?

22 A. I'm not intimately involved in it, but

1 from my understanding, we -- my team posts it on
2 the website. And any public comments go through
3 the help desk. So again, Missy Danforth's team
4 reviews the public comments.

5 Q. All right. So it is -- public comment is
6 invited -- is it just on the website itself, or
7 are there other avenues for inviting public
8 comment?

9 A. From my understanding, it's through the
10 help desk.

11 Q. Okay. And who monitors that help desk
12 again?

13 A. Missy Danforth's team. They all do.

14 Q. Are any -- are any posts or feedback on
15 the help desk ever elevated to you for
16 communications purposes?

17 A. Sometimes reporters will reach out on the
18 help desk just because they're in the wrong
19 place, so they get sent to me.

20 Q. Do you ever -- have you ever monitored
21 the help desk because sometimes reporters or
22 members of the media placed their questions on

1 the help desk?

2 A. No. They'll just forward it to me and I
3 e-mail the reporter.

4 Q. Okay. Are you familiar with Leapfrog's
5 imputation model in its scoring methodology?

6 A. Yes. Generally.

7 Q. All right. And what is it, generally?

8 A. If we have a situation where we don't
9 have the data, we use an imputation model to
10 assign scores.

11 Q. All right. And how long has Leapfrog
12 used an imputation model in its scoring
13 methodology?

14 A. I believe at least for as long as I've
15 been at Leapfrog.

16 Q. Okay. And just to be clear, this is the
17 scoring methodology behind the hospital safety
18 grades, correct?

19 A. Correct.

20 Q. Why did -- so let's -- actually, let's
21 move on to the next document.

22 MR. CHUNG: This will be Exhibit 6.

1 (Bailey Deposition Exhibit 6 marked for
2 identification and attached to the
3 transcript.)

4 BY MR. CHUNG:

5 Q. So we've put Exhibit 6 in front of you,
6 Ms. Bailey. It's an e-mail exchange from
7 October 24, 2024.

8 Just let us know when you've had a chance
9 to look at it.

10 Have you had a chance to review it?

11 A. Yes.

12 Q. All right. What's being discussed here?

13 A. The imputation messaging. So anytime
14 there is a change in the methodology, we try to
15 be as transparent and definitely as accurate as
16 possible, so we update the frequently asked
17 questions on our website, as well as spokesperson
18 talking points, things like that.

19 Q. Okay. So you write here to Ms. Danforth
20 that you're working on synthesizing for FAQs,
21 messaging, et cetera.

22 So in terms of this imputation messaging,

1 where does it show up? You touched on it
2 earlier, but can you kind of list for us where
3 this messaging is incorporated?

4 A. Off the top of my head, it's in our
5 FAQs -- or at the time of this e-mail, like when
6 the fall 2024 safety grade was issued, it was in
7 our FAQs which we give to every press member that
8 we do any outreach to. It's linked at least
9 twice on our website.

10 That's all I can think -- it's an
11 internal talking points.

12 Q. Okay. In the first bullet point you
13 wrote, for purposes of this messaging, Annually,
14 Leapfrog's expert panel and researches at John
15 Hopkins Medicine review the scoring methodology
16 and have recommended modifying the current
17 imputation method used for filling in missing
18 data from hospitals that did not complete the
19 latest Leapfrog survey.

20 So is it correct that Leapfrog's expert
21 panel that we discussed earlier were the ones
22 that recommended adopting an imputation model?

1 A. From my understanding, yes.

2 Q. What is that understanding based on?

3 A. This messaging that I wrote was based on
4 a much longer writeup that Missy and her team put
5 together. So often my job as communications
6 manager is to take more complicated data science
7 type language and to make it make sense to the
8 lay public.

9 So that's what I was doing in this e-mail
10 exchange.

11 Q. Okay. So in that longer writeup that
12 Ms. Danforth and her team put together,
13 Ms. Danforth was -- and that team were
14 representing that the expert panel themselves
15 were recommending -- were recommending this
16 change in the imputation methodology?

17 A. Yes. That's my understanding.

18 Q. Did you -- was that consistent with your
19 own understanding, that it was the expert panel
20 that recommended this change in the imputation
21 methodology?

22 A. Yes.

1 Q. And what is your personal understanding
2 based on?

3 A. Being at Leapfrog for as long as I have
4 been. I generally know that the expert panel --
5 like, what their role is.

6 Q. All right. And so in this particular
7 instance with the change in the scoring
8 methodology, you -- your understanding was that
9 the expert panelists recommended this change just
10 based on your general understanding of their
11 role?

12 A. Yes.

13 Q. Okay. It also says here, just looking at
14 the same sentence, Annually, Leapfrog's expert
15 panel and researchers at John Hopkins Medicine
16 review the scoring methodology.

17 Is that annual review that's represented
18 here, is it consistent with your personal
19 understanding?

20 A. Yes.

21 Q. Okay. It also mentions that it's not
22 just the expert panel but researchers at John

1 Hopkins Medicine reviewed the scoring methodology
2 and made the recommendation here.

3 In this instance, do you have an
4 understanding as to why researchers at John
5 Hopkins Medicine were involved as well, in
6 addition to the members of the expert panel?

7 A. John Hopkins Medicine, the Armstrong
8 Institute for Patient Safety and Quality, they're
9 our research partner.

10 Q. What does that mean, research partner?

11 A. So Matt Austin is our research -- so he
12 is a researcher, from my understanding of what he
13 does, and he oftentimes, with me and the rest of
14 the staff, he's sharing the most up-to-date
15 research on things with us. He works with our
16 expert panels. He works closely with Missy
17 Danforth and has, as far as I know, for over
18 20 years.

19 Q. So for purposes of the review here of the
20 scoring methodology and the recommendation, is it
21 your -- let me put it another way, Ms. Bailey.

22 Is it typical for the expert panels --

1 for John Hopkins Medicine researchers to be
2 involved in this process?

3 A. Yes.

4 Q. So for all the -- so it's typical that,
5 annually, John Hopkins Medicine researchers
6 review Leapfrog's scoring methodology and make
7 recommendations?

8 A. Yes.

9 Q. So it's not just the expert panel that
10 engages in this; is that your understanding?

11 A. Yes.

12 Q. Okay. So this is about a change -- this
13 e-mail is about messaging around a change in the
14 imputation methodology in 2024.

15 What was that change?

16 A. It's this last bullet here, where we were
17 changing the way that the data for these four
18 measures -- CPOE, BCMA, ICU physician staffing
19 and hand hygiene -- were scored. So instead of,
20 I believe, four rounds of safety grade data, we
21 changed it to two rounds. And then if we don't
22 have that data, we assign hospitals a point value

1 equivalent to limited achievement, which reflects
2 the lack of data available.

3 Q. What do you mean by the four rounds
4 versus the two rounds?

5 A. So we call -- so we have safety grades
6 twice a year, in the spring and the fall, and we
7 call each of those a round; sometimes call them a
8 cycle.

9 Q. So what is that -- how is that relevant
10 here to the change in the imputation methodology?

11 A. Just reading from the paper. I don't --
12 can you restate the question?

13 Q. Sure. So what exactly is the change as
14 it relates to the number of rounds?

15 A. It's less.

16 Q. So there are fewer rounds -- so there are
17 fewer rounds -- I'm just trying to understand --
18 right? -- in terms of the number of rounds
19 involved -- right? -- in the safety grades, how
20 that's relevant to the change in the imputation
21 methodology.

22 A. So there are two steps to the imputation

1 methodology. Step 1 is using, if we don't have
2 the data for right now -- so, like, for the fall
3 safety grade, the data cutoff point snapshot date
4 is August 31st. So if we don't have the data for
5 2025 survey, we'll go back to safety grade
6 rounds. So I think six months, six more months.
7 And we can use those scores.

8 It used to be longer. Again, one of the
9 reasons a safety grade is twice a year is we want
10 to have the most up-to-date information possible.
11 So from my understanding, that's why we made that
12 specific change to step 1 of the imputation
13 model.

14 Q. Understood.

15 It also says here -- just going back to
16 Exhibit 6 -- if there's no data available for the
17 measure within the last two safety grade cycles,
18 Leapfrog will assign the hospital a point value
19 equivalent to receiving limited achievement.

20 So is this -- you just went over step 1.
21 Right?

22 Is this messaging around step 2 of a new

1 imputation methodology?

2 A. Yes.

3 Q. All right. Limited achievement. What
4 does that mean?

5 A. Limited achievement is a term that we use
6 in the Leapfrog hospital survey. And these four
7 measures come from the Leapfrog hospital survey.

8 We have performance categories, so
9 depending on how you score as a hospital, limited
10 achievement is the lowest.

11 Q. Okay. So where there's no data available
12 for a specific measure -- right? -- at least
13 among the four here involved, within the last two
14 safety grade cycles, is it correct that, under
15 step 2 of this change, Leapfrog will assign
16 automatically to that hospital a limited
17 achievement score for those particular -- for
18 that particular measure? Is that right?

19 A. Yes. For those four measures.

20 Q. Just taking a step back, why was it these
21 four metrics -- CPOE, BCMA, IPS and hand
22 hygiene -- why are they the four metrics involved

1 here?

2 A. I wasn't part of the conversations
3 exactly to choose measures. I'm not part of
4 that.

5 But from a communications perspective,
6 these measures are critical to patient safety.
7 We're talking CPOE and BCMA; that's medication
8 safety. Medication errors are the number one
9 most common type of error that happen in a
10 hospital. Very, very important that these
11 systems -- most hospitals have them -- but that
12 they actually work and are protecting patients.

13 ICU physician staffing. Again, very,
14 very important. There are studies that we
15 reference that having critical care doctors in
16 the ICU taking care of patients can reduce
17 mortality by 40 percent, which is huge for
18 patients.

19 And hand hygiene, washing your hands, is
20 the most effective way to reduce the spread of
21 infections.

22 Q. Okay. Well, I'm glad that you went one

1 by one, but I'm going to take you back through
2 each of them.

3 A. Okay.

4 Q. So starting with CPOE, why is it
5 appropriate for Leapfrog to use an imputation
6 model for CPOE?

7 MS. BLAIR: Objection to form.

8 THE WITNESS: I can't speak to that. I'm
9 not a data scientist.

10 BY MR. CHUNG:

11 Q. Okay. Well, from a communications
12 perspective?

13 A. I don't know.

14 Q. Okay. Why is it -- let's put it another
15 way.

16 Why do you understand it's appropriate
17 for Leapfrog to automatically assign a limited
18 achievement score for CPOE where it doesn't have
19 data according to step 2 of this change in
20 methodology?

21 MS. BLAIR: Objection to form.

22 THE WITNESS: From a communications

1 perspective, okay, would be patients have the
2 most at risk for this and they are the most at
3 risk if we understated a hospital's performance
4 on any of these four measures.

5 That's my opinion on it.

6 BY MR. CHUNG:

7 Q. That's your opinion? Okay.

8 So what do you mean by understating?

9 A. So limited achievement, as I testified
10 before, is the lowest achievement. If we
11 overstated that performance, patients have the
12 most to lose if they go into the hospital
13 thinking that this hospital scores high on
14 something that they actually don't report on.

15 Q. Okay. Is there a concern -- is there a
16 concern at all by automatically assigning the
17 lowest possible score -- right? -- the limited
18 achievement, in the absence of data on CPOE that
19 consumers might be misled?

20 MS. BLAIR: Objection to form.

21 THE WITNESS: I don't think so.

22

1 BY MR. CHUNG:

2 Q. Why not?

3 A. Because we've made it clear on the
4 website that the score is assigned.

5 Q. Okay. And which website are you
6 referring to?

7 A. Hospitalsafetygrade.org.

8 Q. So that's one of the two websites that
9 Leapfrog runs, correct?

10 A. Correct.

11 Q. Okay. Same series of questions for BCMA,
12 another one of the four imputed metrics.

13 Why is it appropriate for Leapfrog to use
14 an imputation model for BCMA with this -- this
15 change two-step process?

16 MS. BLAIR: Objection to form.

17 THE WITNESS: The same answer that I had
18 to the CPOE. Again, as I testified before, this
19 has to do with medication safety. It's the most
20 common type of error that happens in hospitals.
21 Patients have the most at risk if these systems
22 aren't working.

1 BY MR. CHUNG:

2 Q. Okay. Same question with respect to IPS.

3 MS. BLAIR: Objection. Form.

4 THE WITNESS: Same answer. That patients
5 have the most at risk. As I testified before,
6 having critical care doctors in the ICU is very
7 important for patients who are in critical
8 states.

9 BY MR. CHUNG:

10 Q. Okay. And then how about for the fourth
11 and final, hand hygiene?

12 A. Again, patients have the most at risk.
13 Hand hygiene is arguably the most important part
14 of not spreading infections.

15 Q. Okay. So why does Leapfrog use the
16 imputation model for CPOE, BCMA, IPS, and hand
17 hygiene, but does not use an imputation model for
18 a number of other measures? And in particular,
19 we're looking at safe practice 1, safe practice
20 2, and total nursing care hours per patient day
21 when there isn't a response from the hospital.

22 A. I don't know.

1 MS. BLAIR: Objection to form.

2 BY MR. CHUNG:

3 Q. Okay. Are you -- has Leapfrog received
4 complaints or concerns about the change in the
5 imputation methodology from last year?

6 A. I'm not aware. I'm not in those
7 conversations.

8 Q. Not aware of any feedback, negative or at
9 least -- negative feedback or concerns about the
10 change in imputation methodology?

11 A. No. I don't talk to hospitals in the
12 help desk.

13 Q. Okay. How about from your colleagues?

14 A. Not that I can recall.

15 Q. Do you know whether there are any plans
16 to further revise or update the imputation
17 methodology in the future?

18 A. I don't know.

19 Q. Did you have any role in the change to
20 the imputation methodology from last year?

21 A. No.

22 Q. Who at Leapfrog was involved in the

1 change?

2 A. It would be Missy Danforth, Leah Binder
3 primarily.

4 Q. All right. Any others within Leapfrog?

5 A. I'm not sure.

6 Q. All right. How about from outside of
7 Leapfrog? Anyone involved in the methodology
8 change? We went over some -- we went over the
9 messaging -- right? -- as it relates to the
10 expert panel and the John Hopkins researchers.
11 But apart from those individuals or institutions,
12 any others outside of Leapfrog that were involved
13 in the change to the imputation methodology from
14 last year?

15 A. I don't know. I don't think so.

16 Q. Okay. Are you aware whether -- in terms
17 of the expert panel itself, do you know which
18 section or group of the expert panelists were
19 involved in the imputation methodology change?

20 A. It's the safety grade expert panel.

21 Q. So none of the other -- you testified
22 earlier, at least with respect to the hospital

1 survey -- right? -- that there are separate,
2 we'll call them subpanels that are focused on
3 each of the sections.

4 Were any of those other expert panels
5 involved in the imputation methodology change?

6 A. I don't know.

7 Q. Okay. So in terms of the change, why --
8 as you understand it, why did Leapfrog decide to
9 automatically assign this lowest score, the
10 limited achievement score, for these imputed
11 metrics instead of the average hospital score, as
12 it had done previously?

13 MS. BLAIR: Objection to form.

14 THE WITNESS: I don't know.

15 BY MR. CHUNG:

16 Q. Was there any -- as the communications
17 director -- right? -- was there any messaging,
18 communications-focused messaging, around that
19 very question, the question being why the change,
20 right?

21 A. Can you restate that?

22 Q. Sure.

1 Was there any messaging -- right? -- from
2 a communications perspective, around the question
3 of why Leapfrog decided to change the imputation
4 methodology from using the average hospital score
5 for step 2 to automatically assign the lowest
6 score under step 2?

7 A. Nothing beyond what's in Exhibit 6.

8 Q. Okay. So there's no -- so if we're
9 looking at Exhibit 6 -- right? -- am I correct
10 that there's -- in these bullet point messaging,
11 that there's nothing about -- that goes to why
12 Leapfrog went from just using the average
13 hospital score to automatically assign the
14 limited achievement score?

15 A. Yeah, no, that's generally too in the
16 weeds for communications messaging.

17 Q. Why is that too in the weeds?

18 A. I don't know. I'm not usually -- we
19 don't usually get that specific. As far as
20 communications goes, generally having too much
21 information can be confusing.

22 Q. But why -- if you could kind of explain

1 why messaging around that question -- right? --
2 the question that focuses on the actual change to
3 the imputation methodology, why that would be --
4 why that would be too confusing to include.

5 A. I mean, this is a small part of the
6 safety grade. I have a lot of other messaging
7 for the safety grade. This is four of the
8 measures.

9 So as a communications person, you only
10 have so much attention with people and there's a
11 lot of other messages. So this is what we chose
12 to do.

13 Q. What are the other messages around the
14 hospital safety grade?

15 A. What is the hospital safety grade? Why
16 is it important? What types of measures does it
17 include? Have there been any changes -- which is
18 where this comes in. Et cetera.

19 Q. Did you -- I asked you earlier whether
20 you had heard any feedback or complaints about
21 changes to the imputation methodology. Let me
22 just be a little bit more specific with that

1 question.

2 Have you heard from hospitals or just
3 more generally any concerns or complaints about
4 the scores, the limited achievement scores that
5 non-participating hospitals were automatically
6 receiving on these imputed metrics?

7 A. I can't recall any specifics, no.

8 Q. Okay. And is it correct that, with this
9 change in the imputation methodology, that
10 hospitals who don't participate in the survey get
11 lower hospital safety grades?

12 MS. BLAIR: Objection to form.

13 THE WITNESS: Can you restate the
14 question?

15 BY MR. CHUNG:

16 Q. Sure.

17 And is it correct that hospitals that do
18 not respond to the survey -- right? -- get lower
19 hospital safety grades as a result of this new
20 imputation methodology?

21 A. Not necessarily lower.

22 Q. Not necessarily? So can you explain

1 that?

2 A. So the -- if you did participate in the
3 hospital survey, you could score limited
4 achievement and you would get the same measure
5 score for these four measures.

6 So it doesn't necessarily mean it would
7 be better or worse.

8 Q. Okay. Are you aware that -- was -- what
9 was the purpose of the change in this
10 methodology?

11 MS. BLAIR: Objection to form.

12 THE WITNESS: I don't know.

13 BY MR. CHUNG:

14 Q. Okay. Are you aware that one of the
15 purposes of the change in methodology was to
16 penalize hospitals that did not participate in
17 the survey?

18 MS. BLAIR: Objection to form.

19 THE WITNESS: That's not my viewpoint.

20 BY MR. CHUNG:

21 Q. I understand -- I'm not asking for your
22 viewpoint.

1 Are you aware that that was one of the
2 purposes?

3 A. No. I don't think it's one of the
4 purposes.

5 Q. Okay. Are you aware that one of the
6 purposes of the change in the methodology was to
7 induce hospitals to participate in the survey?

8 A. No.

9 Q. No, you're not aware of it or, no, that's
10 not one of the purposes?

11 A. I'm not generally aware of it, no.

12 Q. What do you mean by generally aware of
13 it?

14 A. Like, I mean, logically, it is an
15 incentive. It's not the only incentive, major
16 incentive. I'd say the major incentive of doing
17 the survey is to be transparent and to show the
18 public how you're performing.

19 Q. So -- understand the logic, right? But
20 is that -- the purpose of incentivizing hospitals
21 to participate in the survey, was that a purpose
22 that you and your colleagues at Leapfrog

1 discussed?

2 MS. BLAIR: Objection to form. Mis- --

3 THE WITNESS: Can you restate?

4 BY MR. CHUNG:

5 Q. Did you and your Leapfrog colleagues
6 discuss that one of the purposes of the change in
7 methodology here was to induce hospitals to
8 participate in the survey?

9 A. Our job at Leapfrog is always to have
10 more hospitals do the survey. We would love if
11 every hospital did the survey, so it's always a
12 part of our conversation.

13 Q. My question is, with respect to the
14 change in the imputation methodology -- right?
15 Understand that, fine, that's generally something
16 that you discuss. Right? But specific to the
17 change in the imputation methodology, did you and
18 your colleagues at Leapfrog discuss that this
19 would be a way to induce more hospitals to
20 participate in the survey?

21 A. I don't remember having those
22 conversations myself.

1 Q. Was Leapfrog trying to induce hospitals
2 to participate by automatically giving
3 non-participating hospitals the lowest score on
4 the four imputed metrics?

5 MS. BLAIR: Objection to form. Asked and
6 answered.

7 THE WITNESS: I don't know.

8 BY MR. CHUNG:

9 Q. You don't know? Okay.

10 Was Leapfrog -- looking at another
11 perspective, for hospitals that actually
12 participated in the survey, that responded to the
13 survey, was this change in methodology a way to
14 appease those hospitals that were participating
15 in the survey?

16 A. No, I don't think so.

17 Q. Okay.

18 MR. CHUNG: Let's go to the next
19 document.

20 MS. BLAIR: Daniel, is it okay to take a
21 break?

22 MR. CHUNG: Yes. Of course. We've been

1 going for a while.

2 VIDEO TECHNICIAN: The time is 10:29 a.m.
3 Ending unit 1. We're off the record.

4 (A recess was taken.)

5 VIDEO TECHNICIAN: The time is 10:40 a.m.
6 This begins unit number 2. We're on the record.

7 MR. CHUNG: All right. Ms. Bailey, we're
8 going to mark the next document Exhibit 7.

9 (Bailey Deposition Exhibit 7 marked for
10 identification and attached to the
11 transcript.)

12 BY MR. CHUNG:

13 Q. And it's an e-mail chain from April of
14 this year, 2025.

15 Just take a few moments to look at it.

16 A. Okay. I read it.

17 Q. All right. So what's being discussed
18 here in this chain?

19 A. We were doing -- from what I remember, we
20 were preparing a presentation for our board of
21 directors. We had some newer board of directors.
22 We wanted to give them an overview of Leapfrog

1 programs.

2 Q. And let's turn your -- and was -- part of
3 this overview, did that include the new
4 imputation methodology?

5 A. I don't recall.

6 Q. Okay. Well, let's just focus on a few
7 pieces. In particular, Ms. Binder's -- the
8 initial kind of long e-mail that kicks off the
9 discussion.

10 So if you look at Bates ending 500, the
11 fourth bullet down of a series in Ms. Binder's
12 e-mail, she notes that -- the most important
13 things to convey in this speech.

14 So what is "this speech" referring to?

15 A. Meeting with our board of directors.

16 Q. Okay. And the fourth bullet down is, Why
17 the imputation strategy is controversial was
18 among the most important things to convey in this
19 speech.

20 Why was the imputation -- why is or was
21 the imputation strategy controversial?

22 A. I don't know why she necessarily used

1 this word. I don't remember exactly what was in
2 this presentation. It was a lot of our standard
3 slides.

4 But anytime there's a change at Leapfrog,
5 you know, we make sure our board knows about it.

6 Q. What is your understanding as to why the
7 imputation strategy was controversial?

8 A. From my history at Leapfrog, anytime
9 there is a change on the survey or the safety
10 grade, it could be controversial. It depends on
11 the person you talk to.

12 Q. Controversial to whom?

13 A. I don't know.

14 Q. Okay. But you said based on your time or
15 your experience at Leapfrog. Right?

16 So have there been experiences or
17 instances during your time there where a change
18 in the imputation strategy was controversial?

19 A. I mean, we're talking about the change
20 from fall 2024, and this --

21 Q. Well, I'm talking about what she is
22 referring to here in the fourth bullet point, why

1 the imputation strategy is controversial. Right?

2 So let's just start with have there been
3 instances during your time at Leapfrog where
4 there was controversy around the imputation
5 strategy?

6 A. I can't recall a specific instance.

7 Q. Okay. Do you have an understanding as to
8 why Ms. Binder wrote here that this particular --
9 that why the imputation strategy is controversial
10 was an important thing to convey to the board?

11 A. If this was written in April, that would
12 mean that it was about to be the second safety
13 grade since the new change. So it still was a
14 new change.

15 So again, any new changes would be
16 something we would make sure the board knew.

17 Q. Okay. Was the board involved in the
18 decision to change the imputation methodology?

19 A. Leah reports to the board, so they're
20 aware of changes.

21 Q. Okay. Putting aside awareness of the
22 changes, does the board have input into -- did

1 the board have input into the change in the
2 imputation methodology?

3 A. I believe so, from what I can remember.

4 Q. How were they involved? Or what sort of
5 input did they have?

6 A. It was discussed in board meetings before
7 it went out for public comment.

8 Q. So this is -- these were discussions
9 before the actual imputation methodology was
10 implemented and finalized?

11 A. Correct. While we were developing the
12 proposed changes.

13 Q. Okay. And so what were -- can you
14 describe those discussions with the board about
15 the -- about the proposed or the contemplated
16 change in imputation methodology?

17 A. I don't remember.

18 Q. Are you -- do you participate or are you
19 present at Leapfrog board meetings?

20 A. I take minutes.

21 Q. So you're there?

22 A. Yes.

1 Q. Okay. But you don't remember even just a
2 sketch -- right? -- of discussions at these board
3 meetings about the upcoming change in the
4 imputation methodology?

5 A. I don't remember. We've had a lot of
6 board meetings since then, and it's a small part
7 of my job.

8 Q. Okay. In the second-to last bullet
9 point -- we're looking at the same page, Bates
10 500 -- again, the most important things to convey
11 in this speech are the levers we pull to get
12 hospitals and ASCs to participate.

13 What were those -- what are or what were
14 those levers?

15 A. So as I mentioned earlier on, we're
16 founded by employers. And our board represents
17 employers. So they are employers themselves. We
18 also have patient advocates. So, you know,
19 that's the audience that we're talking to and
20 that's the audience that we're talking about with
21 the levers.

22 So we educate them on why the surveys are

1 important and how facilities can utilize them and
2 also how employers -- I think, in this instance,
3 we're talking specifically about hospitals and
4 ASCs. Our general messaging focuses on showing
5 your commitment to transparency and that you put
6 patient safety first in talking to hospitals and
7 ASCs, as well as you can use it for benchmarking
8 purposes.

9 Q. So how are those -- just to kind of break
10 that down, how are those levers to get hospitals
11 and ASCs to participate -- do you take this to
12 mean to participate in the survey?

13 A. Yes. To participate in the survey.

14 Q. Okay. So just going back to the
15 question.

16 How are each of those -- can you just
17 kind of describe how each of those are levers to
18 get hospitals to participate in the survey?

19 A. I wouldn't use the word "levers." I
20 would use the word, maybe, incentives or
21 advantages. Like how do we -- what are the
22 interests of hospitals, like --

1 Q. Why wouldn't --

2 A. -- how do they benefit.

3 Q. I'm sorry to interrupt you.

4 Why wouldn't you use the term "levers"
5 that Ms. Binder used here?

6 A. That's not a word I would use. I don't
7 really know what it means in this context
8 exactly.

9 Q. Okay. So using incentives -- right? --
10 as another word, how are each of those incentives
11 to get hospitals and ASCs to participate in this
12 survey?

13 A. If we're talking about benchmarking,
14 there are a lot of hospitals and ASCs that use
15 their survey results in benchmarking so they can
16 see year over year where the changes are.
17 Especially at the system level. A lot of systems
18 who really embrace transparency will use the
19 survey as a benchmark so they can see with all
20 their hospitals and their systems, you know,
21 where there may be opportunities to improve.

22 So that's a good incentive for them to

1 have that.

2 Q. Is the imputation methodology itself a
3 lever to get hospitals to participate in the
4 survey?

5 A. It's not one we use in messaging. I
6 wouldn't have been included in this from my
7 knowledge.

8 Q. Putting aside that it's not included in
9 messaging -- right? -- is it a lever, the
10 imputation methodology itself a lever to get
11 hospitals to participate in the survey?

12 MS. BLAIR: Objection to form.

13 THE WITNESS: I'd say it's an incentive.

14 BY MR. CHUNG:

15 Q. Okay. And how is it an incentive?

16 A. Because they have the opportunity to give
17 us more information about patient safety in those
18 measures. Potentially would have the opportunity
19 to score differently, potentially not. There's
20 no guarantee either way.

21 Q. Okay. At least -- would it be fair to
22 say that it is -- the imputation methodology is

1 an incentive to hospitals to participate at least
2 so that they don't get automatically scored --
3 given automatically a limited achievement score
4 in the four imputed metrics?

5 MS. BLAIR: Objection to form.

6 THE WITNESS: Can you repeat the
7 question?

8 BY MR. CHUNG:

9 Q. Sure.

10 Is it fair to say that it's an incentive
11 to hospitals to participate in the survey so that
12 they don't get the lowest score on the four
13 imputed metrics?

14 MS. BLAIR: Objection to form.

15 THE WITNESS: Possibly.

16 BY MR. CHUNG:

17 Q. Okay. She continues -- Ms. Binder in
18 this e-mail continues with, in other words --
19 well, we're looking at Bates 501. Let's just go
20 on to the next page.

21 About halfway down there's a
22 paragraph that starts, Then there needs to be a

1 slide.

2 Do you see that?

3 A. Yes.

4 Q. Okay. Then there needs to be a slide
5 about what Leapfrog does to grade a hospital when
6 they decline to report the survey. I think it's
7 very important for the board to understand what
8 we moved over time toward imputing the lowest
9 level of performance when we don't have recent
10 Leapfrog data.

11 Why was that important for the board to
12 understand?

13 A. Again, it was a change. Our board is not
14 made of healthcare professionals. It's made of
15 employers and patient safety advocates. So it's
16 not the same as talking to a data scientist, so
17 she wanted to make sure they understood since it
18 is a change.

19 Q. Okay. And then she continues, In other
20 words, the slides should not detail the
21 step-by-step imputation process. It should
22 summarize the strategic import of the imputation

1 process. This has been a shift over time and one
2 with significant policy ramifications for the
3 organization.

4 First, what was the strategic import that
5 she's referring to here?

6 A. I don't know.

7 Q. Don't know?

8 A. (No verbal response.)

9 Q. Do you recall having conversations with
10 Ms. Binder about that language around this time?

11 A. No. I mean, this is like a stream of
12 consciousness e-mail of edits, so I wouldn't take
13 it as a directive.

14 Q. Okay. What do you mean by a stream of
15 consciousness, stream of edits?

16 A. There's, you know, two pages,
17 single-spaced, of edits, so she was just quickly
18 writing her edits down.

19 Q. Okay. What were the significant policy
20 ramifications for Leapfrog that she was referring
21 to here?

22 A. I don't know.

1 Q. Okay. Just going back to that sentence,
2 The slide should not detail the step-by-step;
3 imputation process. It should summarize the
4 strategic import of the imputation process.

5 Why didn't she want the board to be
6 provided detail about the step-by-step imputation
7 process?

8 MS. BLAIR: Objection to form.

9 THE WITNESS: They had been provided the
10 step-by-step, in my recollection. At this time,
11 we had one hour to do this presentation, and this
12 was not the only focus of the presentation. So I
13 think she was giving a directive of, you know,
14 she recommends that this is what we show on the
15 slide for purpose of this meeting.

16 BY MR. CHUNG:

17 Q. Okay. But where the -- where there's a
18 change -- right? -- in the imputation
19 methodology -- right? -- don't you think it would
20 be important for the board to know what the
21 change itself was in terms of the steps of the
22 imputation methodology?

1 MS. BLAIR: Objection to form.

2 THE WITNESS: I mean, from my knowledge,
3 we're talking about, what, April 2025? So it was
4 already in place. So it's not that this was the
5 first time we talked to them. It had been
6 several times --

7 BY MR. CHUNG:

8 Q. So --

9 A. -- in my recollection.

10 Q. Okay. So you know that they'd -- they
11 had been already given the details about the
12 changes in the steps to the imputation
13 methodology by this time?

14 A. Yes.

15 Q. Okay. How?

16 A. As I testified before, in board meetings.

17 Q. Okay.

18 MR. CHUNG: Let's go to the next
19 document. This will be Exhibit 8.

20 (Bailey Deposition Exhibit 8 marked for
21 identification and attached to the
22 transcript.)

1 BY MR. CHUNG:

2 Q. Now, Ms. Danforth [sic], this is a -- it
3 looks like a presentation to the Leapfrog board
4 of directors dated April 28, 2025, that we
5 believe corresponds to the discussion over the
6 e-mail that we were looking at. But if you could
7 take a few moments to flip through it. Let me
8 know if you recognize it.

9 A. Sure. Ms. Bailey.

10 Q. Ms. Bailey. All right.

11 A. Too many.

12 Q. We'll get there.

13 Just for the record, what you're looking
14 at, Exhibit 8, we believe is what's discussed
15 and -- but it wasn't technically attached --
16 right? -- to the e-mail that we saw in Exhibit 7.

17 MR. CHUNG: And just for counsel, I think
18 the document attached as a child to the e-mail
19 earlier had a technical slip sheet.

20 MS. BLAIR: Oh, okay.

21 MR. CHUNG: So this is what we believe --
22 it's another copy that we believe should have

1 been attached to that e-mail.

2 THE WITNESS: I'm not sure if this was
3 the final version, but --

4 BY MR. CHUNG:

5 Q. Okay.

6 A. -- generally it looks...

7 The only piece of this presentation that
8 I really remember is this last piece. And this
9 looks like an old draft.

10 Q. When you say "last piece," it's the
11 last --

12 A. The very last -- the common objections to
13 Leapfrog.

14 Q. Okay.

15 A. I had a different format, I remember.

16 Q. The format was different in the final --

17 A. Yeah --

18 Q. -- so far as you remember?

19 A. -- this isn't the final. Yeah, this
20 looks like it was the very first draft.

21 Q. Okay. Let's go to 1092. Leapfrog 1092.
22 It's a slide titled, Leapfrog Strategy.

1 A. Okay.

2 Q. So here, the second bullet point reads,
3 Influence consumer decisionmaking and purchaser
4 payment strategy like contracting, network
5 design, and steerage.

6 What's being referenced here?

7 A. So this slide here is referencing back to
8 our founding. So these logos right here are
9 talking about -- these are some of the companies
10 that founded The Leapfrog Group. So we represent
11 employers and purchasers.

12 So that's what this slide number 2 is
13 about in the context of employers.

14 Q. Okay. What does it mean by influencing
15 consumer decisionmaking?

16 A. One of the purposes of Leapfrog is for
17 patients to know that not all hospitals are the
18 same.

19 Q. Okay. And what does purchaser payment
20 strategy mean?

21 A. I'm not an expert in this, but I believe
22 the next three that follow explain it. So direct

1 contracting might be -- maybe you've heard of
2 centers of excellence that some employers set up.
3 Network design is, I think -- I believe designing
4 which hospitals are in the network.

5 And steerage, kind of the same thing,
6 which hospitals are in the network.

7 Q. All right. Let's go to 1096.

8 So Leapfrog By the Numbers is the title
9 of this slide, and you see that it has a series
10 of statistics, Ms. Bailey?

11 A. Yes.

12 Q. Okay. So in the center of the top row it
13 says, Leapfrog websites received more than
14 2.3 million page views per year.

15 Do you see that?

16 A. Yes.

17 Q. Okay. And is that -- that encompasses
18 the two websites that we discussed earlier,
19 correct?

20 A. From my understanding, yes.

21 Q. Okay. And do you have -- as part of your
22 role as communications director, you oversee and

1 manage those two websites; is that right?

2 A. I do, but our PR firm is the one who
3 looks at Google Analytics, so they would be the
4 one to provide me stats like this.

5 Q. So the PR firm is CURA Strategies; is
6 that right?

7 A. Yes.

8 Q. Okay. So the grade, the hospital safety
9 grade, that Leapfrog gives to hospitals is seen
10 by an audience in the millions of people; is that
11 right?

12 MS. BLAIR: Objection to form.

13 THE WITNESS: Our website
14 receives millions of views. Yes.

15 BY MR. CHUNG:

16 Q. Okay. So in the bottom row on the right
17 it says, Every year Leapfrog ratings and data are
18 acceptable -- are accessible to 200 million-plus
19 employees, health plan members, and consumers
20 through Leapfrog's various partners and
21 resellers.

22 Do you see that?

1 A. Yes.

2 Q. Okay. So just putting those two
3 statistics together, the 2.3 million views of the
4 websites and then the 200 million-plus employees
5 and the other individuals that are referenced
6 here, is it fair to say that this is the universe
7 of people that at least potentially see the
8 hospital safety grades that are assigned to
9 hospitals?

10 A. That's my understanding, but there's a
11 very big overlap in that 2.3 million with the
12 2 million.

13 Q. 2 million or 200 million?

14 A. I'm saying, of the 200 million, the
15 website views, it's probably a lot of the same
16 people.

17 Q. And what makes you say that?

18 A. You can't see in Google Analytics who it
19 is, who they are, who's clicking on your website,
20 but just based on our communication strategy and
21 how Leapfrog is set up representing employers,
22 the primary way that we reach patients is not

1 necessarily them knowing what a safety grade is;
2 it's through employers.

3 Q. Okay. Understood.

4 Let's go to 1094.

5 So this is titled, Why hospitals
6 participate in the survey. And then we see a
7 series of statements here.

8 Are these the different reasons why
9 hospitals participate in the Leapfrog survey, the
10 hospital survey?

11 A. Yes. This is similar to what we were
12 talking about before with the incentives.

13 Q. Okay. So fair to say that hospitals --
14 various hospitals participate in the hospital
15 survey for different reasons?

16 A. Yes.

17 Q. All right. Just looking at the
18 page here, do any of the reasons given here
19 include that the hospitals have good patient
20 safety?

21 A. Can you restate the question?

22 Q. Sure.

1 Do any of the reasons enumerated here,
2 included here, include that the hospitals have
3 good patient safety?

4 MS. BLAIR: Objection to form.

5 BY MR. CHUNG:

6 Q. Is that one of the reasons included here?

7 A. I don't understand the question.

8 Q. Sure.

9 Do you see anywhere -- among the
10 reasons -- right? -- here -- you just testified
11 that these are the various reasons that hospitals
12 participate in the survey, correct?

13 A. Right.

14 Q. Right. And this is -- this is a
15 presentation being made to the board of Leapfrog,
16 correct?

17 A. Correct.

18 Q. All right. So of the reasons set forth
19 here -- right? -- are there any reasons that
20 point to hospitals having good patient safety?

21 A. No, not as written on this
22 page necessarily. I guess number 2 could kind of

1 be, make it easy for the public to find
2 information about their safety and quality.

3 Q. Okay. But fair to say that hospitals
4 that participate in the survey can do so or
5 actually do so for reasons other than their
6 safety record; is that right?

7 MS. BLAIR: Objection to form.

8 THE WITNESS: I don't understand the
9 question.

10 BY MR. CHUNG:

11 Q. Right. Are there -- based on what we see
12 on this slide here -- right? -- are there -- is
13 it fair to say that participating hospitals
14 respond to the survey for reasons other than
15 their safety record?

16 A. Yes. These are some of the reasons.

17 Q. Okay. Let's go to Bates 1116, which is
18 the last page you were referring to earlier.

19 A. Okay. Thank you.

20 Q. This one is titled, Common objections to
21 Leapfrog, and we're looking at Bates
22 Leapfrog 1116.

1 So again, this is presented to the board.

2 Is it correct that the statements on this
3 slide are common objections to the Leapfrog
4 survey? Is that right?

5 A. To be clear, yeah, common objections is a
6 communications term, so it doesn't mean that it's
7 -- we hear it all the time or anything. It's
8 just like an FAQ. So...

9 Q. Okay. I'm not sure I quite understand
10 that. Why is it like an FAQ?

11 A. So, like, common objections, it's kind
12 of, like, commonly asked questions, which doesn't
13 mean that they're asked all the time, it's just
14 what we think is important in our messaging.

15 Q. So why -- why are these objections called
16 common objections?

17 A. It's just a PR term.

18 Q. Okay. But fair to say that these are
19 objections or statements that appear in actual
20 feedback?

21 A. Probably.

22 Q. Well, where do you obtain these -- how do

1 you determine whether an objection is common or
2 not?

3 A. I know it says, "common objection," but
4 it's just a communications term. The way that we
5 came up with these bullets was just talking to
6 staff internally of what do we think that the
7 board should know and be able to answer.

8 Q. So this is -- so just to ask the question
9 again: Do these objections -- are these
10 objections based on actual objections from
11 hospitals and other parties?

12 A. Not things necessarily they actually
13 said, just a summary of types of topics.

14 Q. Okay. So taking what you just said, is
15 it -- it's not uncommon for hospitals to object
16 that Leapfrog data is self-reported?

17 A. That's a common question that we get.

18 Q. From hospitals; is that right?

19 A. I wouldn't necessarily know from
20 hospitals. But from reporters or people who are
21 new to Leapfrog, that's something they want to
22 know about.

1 Q. Okay. And this is -- you testified
2 earlier that, based on -- at least in part these
3 common objections were based on discussion
4 internally, right, within Leapfrog?

5 A. Correct.

6 Q. Right? So was this -- did those -- in
7 the course of those internal discussions, did you
8 learn from your colleagues that this particular
9 objection, that Leapfrog data is self-reported,
10 was one that came from hospitals?

11 A. No. This was -- I know this one because
12 this is one that reporters will ask.

13 Q. Okay. So I guess similar question: It's
14 not uncommon for hospitals to object that their
15 quality is evidenced in other ways; is that
16 right?

17 A. Which bullet are you referring to?

18 Q. Well, I guess the third one: Our efforts
19 to promote quality is evidenced by many accolades
20 received within the past year, so we don't need
21 to report to Leapfrog.

22 A. It's -- I'm not saying it's exact. The

1 reason there are quotes, to be clear, is so that
2 they know this isn't something that Leapfrog is
3 saying. That's why there are quotes in here.
4 It's just a form. It doesn't mean it's a pull
5 quote from a specific hospital or something.
6 Just to be clear.

7 This is something in general, a sentiment
8 that we've heard before, not me personally, but
9 from the ratings team that we've heard. And we
10 want -- you can't see the answers here, which
11 is -- if you had seen the final draft, I think it
12 would display it more clearly.

13 But what we're really getting at here is
14 what makes Leapfrog different.

15 Q. But the question is, is this an
16 objection -- right -- or at least a statement
17 that hospitals have made?

18 A. In my understanding, yes.

19 Q. Just going down the line here, is it not
20 uncommon for hospitals to object that their poor
21 safety grade is only because they did not
22 participate in the Leapfrog hospital survey?

1 A. Yeah. Hospitals have said that.

2 Q. Okay.

3 A. In this lawsuit they say that.

4 Q. And it's not uncommon to hear that
5 consumers are confused by having too many ratings
6 programs; is that right?

7 A. So the -- I wouldn't say that. I think
8 consumers can get confused. And this answer
9 leads in to why we created the hospital safety
10 grade as a single letter, for them to be more --
11 it's easier for consumers to understand that.

12 Q. So where -- so is this objection --
13 right? -- consumers are confused by having too
14 many ratings programs, why does Leapfrog
15 matter? -- is that coming from hospitals?

16 A. I don't know.

17 Q. Where is this coming from? Where is this
18 common objection coming from?

19 A. Again, this is a collective effort with
20 the Leapfrog team. We've had these for a long
21 time. So they come from various -- some of them
22 could just come from, you know, us talking as a

1 staff and saying, this is an important message
2 point and something someone might say.

3 Q. All right. But where is this --
4 understanding that it may come from your
5 discussions with your colleagues, but where does
6 this objection come from? Where -- kind of --
7 where was it -- where has it been heard or
8 observed?

9 MS. BLAIR: Objection to form. Asked and
10 answered.

11 THE WITNESS: In my opinion, it is the
12 reason we created the safety grade. And this
13 specific line I believe is on our safety grade
14 website.

15 BY MR. CHUNG:

16 Q. No, but my question is, where did this
17 statement come from? Where are you hearing this
18 concern or objection?

19 A. I don't know. Precedes my time.

20 Q. This slide or this deck precedes your
21 time?

22 A. No. This line, I said, we've used as a

1 reason why we created the safety grade, which
2 precedes my time.

3 Q. Okay. So this is -- I mean, are you
4 testifying that this is kind of -- this bullet
5 point is recycled from previous board
6 presentation decks from before your time?

7 MS. BLAIR: Objection to form.

8 THE WITNESS: Our messaging doesn't
9 change very much, so all of these bullets we've
10 been using for a long time.

11 BY MR. CHUNG:

12 Q. Okay. So -- but my question is this
13 particular bullet point.

14 Are you telling us that this is a bullet
15 point that's been recycled or has been used to
16 present to the board since before your time in?

17 A. I would assume so. I've seen it the
18 whole time I've been at Leapfrog.

19 Q. Okay. Has Leapfrog received any feedback
20 from insurers regarding the reliability of
21 hospital safety grades for non-responding
22 hospitals?

1 A. I don't know.

2 Q. All right. How about from consumers,
3 generally?

4 A. I haven't seen any. I don't know.

5 Q. Do you know whether Leapfrog has
6 considered not grading hospitals that don't
7 respond to the survey?

8 A. I don't know.

9 Q. Is that something that's ever discussed
10 between you and your colleagues?

11 A. I personally haven't heard it discussed,
12 no.

13 Q. Okay. Let's turn to our next document,
14 tab -- let's go with tab 7.

15 This will be Exhibit 10.

16 THE REPORTER: 9.

17 MR. CHUNG: 9, sorry.

18 (Bailey Deposition Exhibit 9 marked for
19 identification and attached to the
20 transcript.)

21 BY MR. CHUNG:

22 Q. Okay. Ms. Bailey, we put in front of you

1 Exhibit 9, which is The Leapfrog Group and
2 affiliate consolidated financial statements dated
3 June 30, 2024.

4 Have you seen this document before?

5 A. I believe I've seen it in the context of
6 it being presented at a board meeting.

7 Q. And are you -- what involvement do you
8 have at all in putting together the financial
9 statements of the organization?

10 A. No involvement.

11 Q. Do you have any input, provide any data,
12 for purposes of putting together the financial
13 statements?

14 A. No.

15 Q. Okay. Who is? Who's involved?

16 A. I know Leah is involved.

17 Q. Okay. If you look at page 5, or Bates
18 ending in 9789 -- and where you see two Bates
19 numbers in the lower right-hand corner, I'm going
20 to point to the one that's -- the top one. Okay?

21 A. Okay.

22 Q. You'll see here that this outlines the

1 revenue and support for the organization.

2 Do you see that?

3 A. Yes.

4 Q. The first line there, accolade licensing
5 revenue.

6 What is accolade licensing revenue?

7 A. The accolade licensing is licensing our
8 safety grade A and our top hospital logos to
9 hospitals.

10 Q. All right. And is this -- at least based
11 on this document, is this the single biggest
12 revenue source for the organization?

13 A. Looks like it in this document.

14 Q. Yeah. So 3. -- about \$3.29 million for
15 2024, correct?

16 A. Yes.

17 Q. Okay. And then there's -- the next item
18 down is data licensure.

19 What is that referring to?

20 A. We sell our data to, like, solutions
21 providers, health plans, companies like that.

22 Q. And which data is this referring to?

1 A. I believe this includes the safety grade
2 and the survey.

3 Q. Okay. So data collected from hospitals
4 that respond to the survey?

5 A. Yes.

6 Q. Okay. And what is the data around the
7 hospital safety grade that's licensed?

8 A. I don't know the specifics on that.

9 Q. Okay. But your understanding is that
10 this data licensure revenue encompasses licensing
11 of the hospital safety grade and the data
12 collected from hospitals to the survey?

13 A. Yes. That's my understanding.

14 Q. Okay. And is that the -- it looks like
15 that's the second highest revenue source, is that
16 right, \$2.17 million for 2024?

17 A. Yes.

18 Q. Okay. Membership is the third line down,
19 \$1.14 million in revenue.

20 What does this encompass?

21 A. I believe it's our partners advisory
22 committee dues.

1 Q. Okay. And what is the partners advisory
2 committee?

3 A. So as I mentioned before, our board
4 doesn't include -- if your business is 30 percent
5 or more healthcare, you're not on our board.

6 So we created the partners advisory
7 committee over ten years ago as a way to have a
8 formal relationship with healthcare companies
9 that want to be involved with Leapfrog. They
10 have no governance over Leapfrog.

11 Q. Okay. And so these entities or these
12 companies pay a membership fee -- is it an annual
13 membership fee to Leapfrog -- to be part of this
14 partners advisory committee?

15 A. Yes.

16 Q. And approximately how much is that
17 membership fee?

18 A. 35,000 is what I believe it is.

19 Q. Okay. Just a few lines down there's a
20 revenue source data products and reports that
21 corresponds to about \$314,000 in revenue for
22 2024.

1 What does this refer to?

2 A. I don't know.

3 Q. Now, do you have any involvement in the
4 Leapfrog annual meeting? We understand that the
5 organization has an annual meeting.

6 A. Yes. As the communications director, I'm
7 involved in the annual meeting.

8 Q. All right. How are you involved in that,
9 in the annual meeting?

10 A. I am part of our planning committee.
11 Again, we have a small staff, so we might do
12 things that wouldn't be particular in other
13 groups. We all really work together on this.

14 So Karen and Angela Hopkins, who is our
15 office administrator, really run point. I help
16 with whatever is needed but, of course, oversee
17 all of the printed publications, all of the
18 marketing, all of the social media, that kind of
19 thing.

20 Q. All right. And is the annual meeting a
21 source of revenue as well?

22 A. I don't think we consider it a source of

1 revenue. All I've heard is that we generally
2 lose money.

3 Q. All right. But in order to attend the
4 annual meeting, there's a fee required of
5 attendees; is that right?

6 A. Correct.

7 Q. Just going -- kind of stepping back, we
8 looked at a few of the line items here on the
9 financial -- from the statement.

10 How does Leapfrog raise money from the
11 hospital safety grades and the hospital survey
12 specifically?

13 A. Can you restate your question?

14 Q. Yes. So how does Leapfrog raise revenue
15 or money from the hospital safety grades and
16 hospital survey?

17 A. So I see it as we raise revenue so that
18 we can cover the costs of those programs. It
19 costs a lot in staff time, in website, in
20 everything that goes into these programs so it's
21 not --

22 Q. Ms. Bailey, that's not my question.

1 How does -- right? How does the
2 organization raise revenue or money from those
3 two programs?

4 A. I think it's just what's on here.

5 Q. Okay. Can you just --

6 A. All of these things.

7 Q. Can you just describe how it's done?

8 A. Oh. We just talked about accolade
9 licensing. We just talked about data licensure.

10 Q. Okay.

11 A. That's all I know.

12 Q. Okay. And what is -- can you break down
13 kind of how -- under the types of accolade
14 licensing, how that raises revenue for the
15 organization?

16 A. I don't understand the question.

17 Q. All right. Let's put it another way.

18 How many hospitals pay Leapfrog to
19 advertise their hospital safety grades?

20 A. I don't know the numbers.

21 Q. Okay. What does a hospital that does pay
22 Leapfrog to advertise their hospital safety

1 grade, what do they get through that payment?

2 A. They get the logo; it's like a badge they
3 can use in advertising.

4 Q. Okay. Is there any way for a hospital to
5 freely advertise their hospital safety grade
6 without paying Leapfrog?

7 A. Yes. Many do. That's the part I'm
8 involved in. I'm not involved in accolades. I'm
9 involved in that part, which is we provide
10 detailed press kits for hospitals they use for
11 free.

12 Q. Okay. Has Leapfrog ever told a hospital
13 to stop advertising a safety grade unless it paid
14 Leapfrog the fee?

15 A. Not that I can recall.

16 Q. Do you know whether Leapfrog receives any
17 advertising revenue from hospitals with, let's
18 say, a C or a lower than a C grade?

19 A. I don't know.

20 Q. All right. Generally speaking, when --
21 do you have any kind of statistics or do you know
22 generally whether -- in terms of kind of the

1 marketing for advertising of the hospital safety
2 grade, does Leapfrog focus on the hospitals that
3 have an A grade?

4 A. Can you restate? I don't understand the
5 question.

6 Q. In terms of the marketing -- right? --
7 for the advertising of the hospital safety grade,
8 does Leapfrog focus on hospitals that have
9 received an A grade? Or does it market more
10 generally to all hospitals that have received a
11 grade?

12 A. I don't do marketing. But if we're
13 talking about accolade licensing, that's -- A and
14 B are the only logos that I know my team creates.

15 MR. CHUNG: Let's go to tab 16.

16 This will be Exhibit 10.

17 (Bailey Deposition Exhibit 10 marked for
18 identification and attached to the
19 transcript.)

20 BY MR. CHUNG:

21 Q. So Ms. Bailey, Exhibit 10 is a short set
22 of Slack messages. Just let me know when you've

1 had a chance to look at it.

2 A. Okay. Yes. I've looked at it.

3 Q. Okay. So this is from March 21 of 2024,
4 a discussion with Ms. Jupiter.

5 And you write, at about 11:30 a.m., She
6 wants CURA to be ready to ask and help staff
7 answer common questions we get. Right?

8 So first of all, what's being discussed
9 here?

10 A. From what I remember -- so CURA is our PR
11 firm. And we had them come into the office and
12 give staff a presentation about PR 101.

13 Q. Okay. And so how does this -- the "she"
14 that you're discussing here, is that Leah Binder?
15 She wants CURA to be ready to ask and help staff
16 answer common questions we get.

17 A. I believe so.

18 Q. Okay. Now, these are -- when we went
19 over the board presentation earlier -- right? --
20 you said that -- kind of the common questions or
21 common objections there were based on discussions
22 you had internally within Leapfrog, right?

1 A. Yes.

2 Q. Here, the -- what you're writing here is
3 that Ms. Binder wants CURA to be ready and ask
4 and help staff answer common questions we get.

5 What did you mean by "common questions we
6 get"?

7 A. So this was for all of our staff. And a
8 good majority of our staff is the ratings team.
9 And part of my job as communications manager -- I
10 mean, director of communications, sorry -- is to
11 make sure we're all on the same page with how
12 we're responding to things. Even if I don't talk
13 to hospitals, they're talking to people, I have
14 an interest in ensuring we're on the same page.

15 Q. Okay. So the members of the ratings
16 team, this is the team under Ms. Danforth; is
17 that right?

18 A. Correct.

19 Q. Okay. And they're interacting or
20 communicating with hospitals?

21 A. Correct.

22 Q. All right. And they're the ones -- and

1 when we say -- when you're writing here to help
2 staff answer common questions we get, does that
3 mean common questions we or you're getting from
4 hospitals?

5 A. I don't remember exactly what I meant,
6 but I would infer that. Yes.

7 Q. Okay. You see where you write, just the
8 next line down, So, like, Leapfrog is pay for
9 play, where a hospital gets a bad CMS star rating
10 but an A. Why?

11 So this is -- the question about pay for
12 play, do you agree that's a common question
13 Leapfrog receives from hospitals?

14 A. Yes. I mean, that's what this -- it's
15 mentioned a lot in this current lawsuit we're
16 talking about.

17 Q. Well, we're talking about -- I'm talking
18 about in the context of this Slack messages -- of
19 these Slack messages from March 2024.

20 So at this time -- right? -- which
21 obviously preceded this lawsuit --

22 A. Uh-huh.

1 Q. -- is it fair to say that pay to play, a
2 question whether Leapfrog is pay to play, was
3 common enough that it's listed in the list of
4 commonly asked questions?

5 A. Yes. I'd say a lot of people are
6 confused about that. There's a lot of ratings,
7 and a lot of them are pay to play. Leapfrog is
8 not.

9 Q. Okay. The next one down, Or a hospital
10 gets a bad CMS star rating but an A,
11 presumably --

12 A. Uh-huh.

13 Q. -- from Leapfrog, right?

14 A. Uh-huh.

15 Q. Do you agree that that's a common
16 question Leapfrog receives from hospitals?

17 A. It was just an example. I don't know if
18 that's a common question. It's just -- I was
19 giving an example to Karen, who is not as
20 familiar with this.

21 Q. Right. But you started the discussion,
22 or at least kind of introduced these two items as

1 helping staff answer common questions we get.
2 Right? And I think you testified we get from
3 hospitals. Right?

4 A. Uh-huh.

5 Q. So just going back to the original
6 question, is this -- the question of a hospital
7 getting a bad CMS star rating but an A from
8 Leapfrog, is that a common question Leapfrog gets
9 from hospitals?

10 A. In my knowledge, it actually doesn't
11 happen that often that that's the case.

12 Q. My question is, is this a question -- a
13 common question you get from hospitals?

14 MS. BLAIR: Objection to form. Asked and
15 answered.

16 THE WITNESS: It's part of our commonly
17 asked question, which I explained is a
18 communications term. I don't know how often it's
19 asked. I just know that it comes up in
20 conversations internally, so it's one of my PR
21 priorities.

22

1 BY MR. CHUNG:

2 Q. Okay. Is this -- the pay for play
3 question -- right? -- is Leapfrog a pay for play
4 question [sic], is it a common question or
5 concern that you hear from regional leaders,
6 Leapfrog's regional leaders?

7 A. Can you restate the question?

8 Q. Right. The question of or the concern of
9 whether Leapfrog is pay to play -- right? -- is
10 that a concern or question that's relayed to you
11 by Leapfrog's regional leaders?

12 A. I believe they had heard -- like, some of
13 them have probably heard that before. Because
14 like I said, it can be confusing. There's a lot
15 of ratings, and a lot of them are pay for play.
16 Leapfrog is not.

17 MR. CHUNG: Let's go to tab --

18 BY MR. CHUNG:

19 Q. Ms. Bailey, are you aware that hospitals
20 that participate in the survey are required to
21 affirm that Leapfrog may use the survey
22 information in a commercial manner for profit?

1 A. Yes. I'm generally aware of that.

2 Q. Okay. And you're aware that that is
3 explicitly in the hospital survey?

4 A. I've heard that.

5 Q. Okay. Do you know how long Leapfrog has
6 required that affirmation from participating
7 hospitals?

8 A. I don't know.

9 Q. Does it precede your time, fair to say?

10 A. I don't know.

11 Q. Okay. Can a hospital opt out of that
12 affirmation and still respond to the survey?

13 A. I don't know.

14 Q. All right. Do you know whether -- have
15 you heard of any hospital voicing concerns or
16 asking that question, can they opt out of that
17 affirmation?

18 A. I haven't heard of it, no.

19 Q. All right. Any complaints from hospitals
20 about not being able to opt out of that
21 affirmation?

22 A. No, I haven't heard of any.

1 Q. Okay. All right. Going back to kind of
2 the revenue streams that we discussed earlier, am
3 I right that Leapfrog licenses the hospital
4 safety grades to insurance companies? We already
5 talked about hospitals, but do they also license
6 the hospital safety grades to insurance
7 companies?

8 MS. BLAIR: Objection to form.

9 THE WITNESS: I know we have before.

10 BY MR. CHUNG:

11 Q. Is that still in effect?

12 A. I don't know who our current licensees
13 are. I'm not involved in that.

14 Q. Okay. Do you know how -- in your
15 communications director role, do you have -- do
16 you communicate with insurance companies?

17 A. Not that I can think of.

18 Q. Okay. Have you ever communicated with
19 insurance companies while at Leapfrog?

20 A. We have -- some members of our partners
21 advisory committee are from health plans, so I've
22 talked to them before.

1 Q. All right. And what was the nature of
2 those discussions?

3 A. Very early on at Leapfrog, there were
4 only 12 staff members, so my job was bigger than
5 it is now, where I oversaw our stakeholder group,
6 so I oversaw our partners advisory committee from
7 2017 to 2020 and then also our regional leaders.

8 And during that time, our -- we have
9 co-chairs of all of our committees who are actual
10 members, and the co-chairs were from health
11 plans. So I talked to them about planning our
12 partners advisory committees quarterly.

13 Q. Okay. So you're at least generally aware
14 that Leapfrog licenses the hospital safety grades
15 to insurance companies, right?

16 A. Yes.

17 Q. Okay. How do those licensing deals work?

18 A. I don't know.

19 Q. Okay. What do the insurance companies --
20 what exactly are the insurance companies
21 licensing from Leapfrog?

22 MS. BLAIR: Objection to form.

1 THE WITNESS: Data.

2 BY MR. CHUNG:

3 Q. Which data?

4 A. Whatever data they're interested in. I
5 believe it's custom. Customized to the client.

6 Q. Okay. And this is the survey data
7 collected from hospitals, correct?

8 A. Yeah, it could be.

9 Q. Okay. Do they also license the hospital
10 safety grades themselves, the letter grades?

11 A. They could. Yes.

12 MS. BLAIR: Objection to form.

13 BY MR. CHUNG:

14 Q. Okay. So isn't Leapfrog incentivized to
15 have as many hospitals as possible participate in
16 the survey so that it can convince insurers that
17 the ratings have value?

18 A. I've never heard that as a primary goal.

19 Q. Okay. Does Leapfrog license hospital
20 survey data to researchers?

21 A. Yes.

22 Q. Okay. And are these researchers -- are

1 they institutions? Are they sole researchers?

2 What kind of researchers are they?

3 A. It's a variety. These sometimes come in
4 through our communications e-mail or through our
5 PR firm. Oftentimes it's even college students.
6 It's anyone who could be working on a research
7 paper and wanting to use Leapfrog data.

8 Q. And how does Leapfrog market this aspect,
9 the licensing of hospital survey data, to
10 researchers?

11 A. We don't market it to my knowledge.

12 Q. So so far as you're aware, these deals
13 come about as a result of researchers approaching
14 Leapfrog?

15 A. Correct.

16 Q. All right. And isn't Leapfrog
17 incentivized to have as many hospitals as
18 possible participate in the survey to convince
19 researchers that the data has value?

20 MS. BLAIR: Objection to form.

21 THE WITNESS: No, I don't think that's
22 what our focus is. I've never heard that as a

1 focus.

2 BY MR. CHUNG:

3 Q. Okay. Leapfrog also licenses hospital
4 survey data to businesses; is that right?

5 A. Yes. Like solution providers.

6 Q. Okay. And you've mentioned solution
7 providers before. But generally, who are these
8 solution providers?

9 A. I can't speak to who currently licenses.
10 I know that, you know, types of companies might
11 be, like, hand hygiene companies, like, GOJO who
12 owns Purell, like BioVigil, companies who have a
13 solution for hospitals and they want the data.

14 Q. Okay. Does Leapfrog market this hospital
15 survey data to these solutions providers?

16 A. I believe so. I'm not involved in the
17 marketing.

18 Q. Okay. So no with respect to researchers,
19 but yes or maybe with respect to solutions
20 providers; is that --

21 A. Yes.

22 Q. Okay. And how does it go about doing

1 that for the solutions providers?

2 MS. BLAIR: Objection to form.

3 THE WITNESS: I don't know. I'm not
4 involved in it.

5 BY MR. CHUNG:

6 Q. Okay. Do you know whether the survey
7 data -- the sale of the survey data is marketed
8 to solutions providers as part of their
9 participation in the partners advisory committee?

10 MS. BLAIR: Objection to form.

11 THE WITNESS: I know that they get a
12 discount on the data as part of the member
13 benefits.

14 BY MR. CHUNG:

15 Q. And how much is that discount?

16 A. I don't know.

17 Q. Okay. Are -- in terms of the kinds of
18 businesses that license hospital survey data, do
19 hospitals, competitor hospitals, license hospital
20 survey data? So let me just put it another way.

21 Do hospitals license the data of
22 competitor hospitals from Leapfrog?

1 MS. BLAIR: Objection to form.

2 THE WITNESS: I've never heard of that.

3 MR. CHUNG: Okay. Let's go to 72.

4 Exhibit 11.

5 (Bailey Deposition Exhibit 11 marked for
6 identification and attached to the
7 transcript.)

8 BY MR. CHUNG:

9 Q. All right. Ms. Bailey, Exhibit 11 is an
10 e-mail chain from July of 2024.

11 Okay. Have you had a chance to look
12 through it?

13 A. Yes.

14 Q. So let's just start with the first e-mail
15 from Ms. Binder to you --

16 A. Okay.

17 Q. -- July 9, 2024. She writes to you, I'm
18 at a meeting July 26 where they ask me to discuss
19 our work with HT and Turquoise Health and compare
20 price transparency and safety grade.

21 What is or who are HTA and Turquoise
22 Health?

1 A. HTA is the Healthcare Transformation
2 Alliance.

3 Turquoise Health, I don't know. I
4 actually didn't write that press release.

5 Q. Okay. So you don't know who or what
6 Turquoise Health is?

7 A. I can't remember right now.

8 Q. Okay. She continues, We did it last
9 year, and there was a press announcement,
10 et cetera. Could you give me the
11 background/press release on -- when you get a
12 chance? They're interested in other possible
13 uses of our data and what can be done to improve
14 survey reporting.

15 And then she concludes asking for any
16 further ideas from you or others.

17 And then you then describe in response,
18 Ms. Bailey, I think it's four ideas that we came
19 up with.

20 Do you see that?

21 A. Yes.

22 Q. Okay. And that is to -- and that you

1 wanted to get feedback from Kush Banerjee; is
2 that right?

3 A. Yes.

4 Q. And who is Kush Banerjee?

5 A. Kush Banerjee is the director of
6 licensure and -- I don't remember his exact
7 title, sorry. He just changed it.

8 Q. So, generally, what does he do?

9 A. He oversees the accolades and data
10 licensure programs.

11 Q. Okay. So this corresponds to the revenue
12 streams we were looking at earlier in the
13 financial statement?

14 A. Yes.

15 Q. Okay. So he responds after, it looks
16 like, reviewing four ideas that you came up with
17 for other possible uses of data.

18 Well, just to --

19 A. Uh-huh.

20 Q. -- let's go back to the e-mail -- the
21 second e-mail to Ms. [sic] Banerjee copying Jill
22 Berger. Who is Jill Berger?

1 A. She's the director of employer and payor
2 engagement, I think is her title.

3 Q. Okay. And what does that role involve?

4 A. She oversees our employer panel, as well
5 as our regional leaders.

6 Q. Okay. And so is this -- and so these
7 four additional ideas for use of the data, for
8 the hospital survey data, these are four ideas
9 that you came up with after brainstorming with
10 Ms. Berger; is that right?

11 A. Yes. I forgot to mention, she also
12 oversees our Bruce Bradley fellows, who are HR
13 mid-career professionals.

14 So these ideas -- I vaguely remember this
15 conversation, and these ideas were based on
16 projects that these fellows had done as part of
17 the fellowship.

18 Q. Okay. Now, Mr. Banerjee responds on
19 July 23rd. He writes -- it's fair to say that
20 he's commenting on the four ideas that you
21 presented to him?

22 A. Looks like it.

1 Q. Okay. He writes, Similarly, LF data
2 versus medical device or technologies is
3 interesting to measure a variation effectiveness
4 for the technologies and enable technology
5 companies to engage with us through the PAC or
6 data licensing.

7 Do you see that?

8 A. Yes.

9 Q. Okay. And the PAC, is that a reference
10 to the partners advisory committee?

11 A. Yes.

12 Q. Okay. So is he -- what's he saying here?

13 MS. BLAIR: Objection to form.

14 THE WITNESS: I don't know. Let me read
15 it again.

16 BY MR. CHUNG:

17 Q. Sure.

18 A. I don't really understand the way he
19 worded this, but it looks like he's talking about
20 medical device --

21 Q. Yeah.

22 A. -- companies and --

1 Q. So is --

2 A. -- that they could license the data.

3 Q. I'm sorry. Is he referring to the fourth
4 idea that you raised with him, the Leapfrog data
5 and medical device and technology data?

6 A. That's what it looks like.

7 Q. Okay. So what is that -- can you
8 describe what idea that was, what that idea
9 encompassed?

10 So let's just kind of break it down.
11 Right?

12 A. Okay.

13 Q. So is the audience here -- right? -- the
14 potential partners or the purchasers of the data,
15 they are medical device companies and technology
16 companies; is that right?

17 A. Yes.

18 Q. Okay. And then it looks like this
19 sub-bullet there, technology's role in enhancing
20 hospital safety and quality, is that just kind of
21 a basic concept behind the idea?

22 A. Yes. That's what it looks like.

1 Q. Okay. And then, underneath that, data
2 sources, safety grades, and data on medical
3 devices and healthcare technologies, is that a
4 reference to the types of data sources at
5 Leapfrog that could be marketed to medical device
6 and technology companies, that could be of use to
7 them?

8 MS. BLAIR: Objection to form.

9 THE WITNESS: I don't know. I think so.

10 BY MR. CHUNG:

11 Q. Okay. Well, this is your idea, so --

12 A. Well, it's not -- this isn't my idea, so
13 let's be clear. Kush was on paternity leave, and
14 I was trying to fill in something while he was
15 coming back from paternity leave. Normally, he
16 would have brainstormed these ideas. This isn't
17 a regular part of my job. Leah just asked me to
18 talk to Jill.

19 Q. Okay.

20 A. And Jill works part time, so she doesn't
21 have time to send e-mails all the time. So this
22 was a compilation. It wasn't necessarily my

1 idea.

2 Q. Okay.

3 A. It was just my job to communicate it.
4 And there's -- a lot of that happens in my job at
5 Leapfrog.

6 Q. Okay. But these are ideas that, working
7 with Ms. Burger, that you compiled and sent on to
8 Kush, correct?

9 A. That's what it looks like.

10 Q. Okay. And so the idea here, Ms. Bailey,
11 that this is a proposal to approach --
12 potentially approach medical device and
13 technology companies to license safety grade --
14 the safety grades and data on medical devices and
15 healthcare technologies?

16 MS. BLAIR: Objection to form.

17 THE WITNESS: That's what it looks like.

18 BY MR. CHUNG:

19 Q. Okay. And to potentially engage medical
20 device and healthcare technologies to become
21 members of the partner advisory committee; is
22 that right?

1 A. Yes. That was part of Jill's job at the
2 time.

3 Q. Okay. Now, Mr. Banerjee continues --
4 just going back to his e-mail, The first two --
5 so the last paragraph of this e-mail.

6 The first two are interesting as well,
7 but I don't see that they can have the same
8 impact on driving data licensing and PAC
9 engagement from my revenue lens as the other two.

10 Is he saying here that the first two of
11 the four ideas that were presented in your
12 e-mail -- and this is the Leapfrog data and
13 public health data and Leapfrog data and social
14 determinants of health data -- right? Those are
15 the first two. That in his view don't have the
16 same impact as the third and fourth ideas from a
17 revenue perspective; is that right?

18 MS. BLAIR: Objection to form.

19 THE WITNESS: I take that to mean maybe
20 those are good PR ideas, but not for his job.

21 BY MR. CHUNG:

22 Q. Where does he refer to PR?

1 A. I'm just inferring that because my job is
2 PR. So that's the lens that I have when I do
3 things. Again, I don't normally do stuff like
4 that. I very vaguely remember this. And that's
5 what I take him to mean, is that it probably
6 wouldn't make sense for him, but like I said --
7 so in the second one, it says, Note, Stacy looked
8 at a fellow project, so that's, again, part of a
9 fellowship. So --

10 Q. Okay.

11 A. -- I think he was just saying it
12 wouldn't -- it doesn't make sense for him.

13 Q. So -- and then you respond up top,
14 Thanks, Kush. Great points re driving data
15 licensing. I think I'll just share 3 and 4 with
16 Leah from that lens. So happy you're back.

17 Do you see that?

18 A. Yes.

19 Q. Okay. So did you -- why did you only
20 share 3 and 4 with Leah, as opposed to the first
21 and second that Ms. [sic] Banerjee said would not
22 have the same impact from a revenue lens?

1 A. I don't remember. I just -- it looks
2 like I took his advice on it.

3 Q. Okay. Do you know whether Leapfrog
4 implemented any of these ideas?

5 A. I don't know.

6 MR. CHUNG: Let's go to tab 47.

7 This is Exhibit 12.

8 (Bailey Deposition Exhibit 12 marked for
9 identification and attached to the
10 transcript.)

11 BY MR. CHUNG:

12 Q. All right. Ms. Bailey, this is an e-mail
13 chain. You're not on the chain, but let me know
14 if any of it looks familiar to you. The e-mail
15 chain and the attachment.

16 A. I haven't seen this before, but it looks
17 like they're talking about the budget.

18 Q. Okay. If you look at the first page
19 Bates ending in 8278, there's an e-mail from
20 Ms. Binder to Ben Choi.

21 And I understand that Ben Choi was the
22 former CFO, am I right, of the organization?

1 A. Yeah, the interim.

2 Q. Interim CFO? Okay.

3 And she writes here, If we move toward
4 cost reduction as the primary strategy, it will
5 be much more severe than this, but I'm not going
6 there for now. We can address incremental
7 spending issues, but let's not lose focus on what
8 managers should be thinking about 24/7, which is
9 revenues.

10 That particular sentence, let's not lose
11 focus on what managers should be thinking about
12 24/7, which is revenues, is that a sentiment or
13 directive that Ms. Binder has shared with you or
14 communicated to you?

15 A. Not for the communications team, no.

16 Q. Okay. Have you heard from your
17 colleagues -- right? -- whether they're in
18 finance or in licensing, or really any
19 colleagues, about Ms. Binder communicating this
20 directive to them?

21 A. No, not that I can recall.

22 Q. Okay. Any -- is it a -- is generating

1 revenue -- ways of generating revenue, is it a
2 focus of Ms. Binder in running the organization?

3 A. Yeah. She's the CEO, so yes.

4 Q. Okay. And in what -- in your
5 interactions with her, in what ways has she
6 communicated with you that it is a focus?

7 A. I just know it's part of her job because
8 if we didn't have money, we couldn't run any of
9 our programs.

10 Q. All right. Are there any specific ways
11 of raising revenue that she -- that you've heard
12 her -- that you've heard her discuss?

13 A. No, not beyond what we've talked about.
14 Just accolades and data licensure is all I know.

15 Q. Okay. And in terms of the accolades and
16 data licensure, what has she said about those
17 particular programs for purposes of raising
18 revenue?

19 A. Just that they are revenue.

20 Q. Just that they are revenue? Is that what
21 you're testifying to?

22 A. Right. In the financial statements.

1 That's the extent that I'm involved in these
2 discussions.

3 Q. What has she said about raising more
4 revenue through those particular programs?

5 A. Nothing I can recall to me.

6 Q. Okay. Maybe not to you but to your
7 colleagues?

8 A. I don't know.

9 Q. All right. Has she discussed how to
10 change the hospital grading methodology in order
11 to generate more revenue through the accolade
12 licensing and the data licensure program?

13 A. Can you restate the question?

14 Q. Yes.

15 Has she discussed how the organization
16 can change the grading methodology or the scoring
17 methodology in order to generate more revenue
18 from accolade licensing?

19 A. I -- no, I don't recall her saying that.

20 Q. Who is Leapfrog's competition?

21 A. I've never heard Leah or anyone use the
22 word "competition." There's a lot of ratings

1 systems out there, but we're all fairly
2 consistent, us and other ratings organizations,
3 that we're different and unique and that
4 consumers should use what resonates with them.

5 Q. In your view -- putting aside what
6 Ms. Binder might have said or not said, in your
7 view, who are Leapfrog's competitors?

8 A. I mean, rating -- other large rating
9 systems, like U.S. News and World Report,
10 Healthgrades are the ones that come to mind.

11 Q. Okay. So those two. Any others?

12 A. Those are the only that come to mind.
13 But again, we tell people, like, even in our
14 social media, like, look at these ratings. When
15 the new U.S. World and News Report honor roll
16 comes out, we promote it on social media. And
17 they do the same for us. Like, we -- I wouldn't
18 say we're, like, normal competitors. We're a
19 nonprofit, so it's a bit different.

20 Q. Do you -- does Leapfrog track those
21 competitors, U.S. News and World Report and
22 Healthgrades, in terms of their -- in terms of

1 the products or developments in their products?

2 A. I don't know.

3 Q. Does Leapfrog engage directly with
4 hospitals, whether it's the leadership or
5 administrative staff, to encourage participation
6 in the hospital survey?

7 A. Can you restate the question?

8 Q. Yeah.

9 Does Leapfrog engage directly with
10 hospitals to encourage hospitals to participate
11 in the survey?

12 A. That's all done through our regional
13 leaders.

14 Q. Okay. Are there any resources, like
15 toolkits or consultants, that are provided to
16 hospitals to basically help them participate in
17 the survey?

18 A. Not that I can recall.

19 Q. Are there any partnerships with employers
20 or insurers or other third parties that use
21 hospital participation in the survey as a
22 criterion for contracting or inclusion in the

1 network?

2 A. I don't know.

3 Q. Does Leapfrog track hospital
4 participation rates over time?

5 A. Yes.

6 Q. All right. And what has Leapfrog kind of
7 witnessed in terms of that tracking?

8 A. Overall, it continues to increase every
9 year. During COVID, we saw it go down, just like
10 everything else in the world.

11 Q. Okay. And what steps -- where
12 participation declines -- right? -- or fails to
13 meet organizational goals, what does Leapfrog do
14 to address those declines or those changes?

15 A. From my knowledge, it only happened
16 during the pandemic. And that was a very unique
17 situation, so we kind of let it ride out. And as
18 soon as it was over, participation went back up.
19 That's my understanding.

20 Q. Okay. Did participation in the hospital
21 survey increase after the fall 2024 change to the
22 imputation methodology?

1 A. I don't know.

2 Q. Okay. Has Leapfrog conducted any studies
3 or analyzed whether survey participation improves
4 a hospital's safety grade over time?

5 MS. BLAIR: Objection to form.

6 THE WITNESS: Can you restate that?

7 BY MR. CHUNG:

8 Q. Yeah.

9 Has Leapfrog conducted any studies or
10 analyzed whether participation in the survey
11 improves a hospital's safety grade over time?

12 A. I don't know. I don't think so.

13 Q. You don't think that Leapfrog has ever
14 studied that?

15 A. Yeah, I don't know.

16 Q. Okay. All right. Let's move on to the
17 websites which we've discussed already a bit. So
18 what --

19 (Discussion off the record.)

20 MR. CHUNG: We're about to enter a new
21 section. Are you folks okay with taking a break
22 right now for lunch?

1 MS. BLAIR: Sure.

2 THE WITNESS: Sure.

3 MR. CHUNG: Let's do that, then.

4 VIDEO TECHNICIAN: The time is 11:56 a.m.
5 This ends unit 2. We're off the record.

6 (A recess was taken.)

7 VIDEO TECHNICIAN: The time is 12:59 p.m.
8 This begins unit number 3. We're on the record.

9 BY MR. CHUNG:

10 Q. So Ms. Bailey, we're now going to discuss
11 the two websites that we referenced earlier.

12 And am I correct that the two websites
13 that Leapfrog -- operated by Leapfrog are
14 the leapfroggroup.org and the
15 hospitalsafetygrade.org sites? Is that correct?

16 A. Yes.

17 Q. So what's the distinction between the
18 two? What's the purpose of each?

19 A. So on leapfroggroup.org, we house our
20 hospital and ASC survey results.

21 And on hospitalsafetygrade.org we house
22 the hospital safety grade results.

1 So the reason why we have the distinction
2 is because they are two distinct programs, so we
3 want to keep them separate.

4 Q. Okay. On the -- but do both websites --
5 can a consumer go on both websites and look up
6 their local hospital?

7 A. Yes.

8 Q. Okay. And just to be clear, both are
9 operated by Leapfrog, correct?

10 A. Correct.

11 Q. And as director of communications, can
12 you just tell us again what is your role with
13 respect to the websites?

14 A. I oversee the content that's on the
15 website and I work with the ratings team before
16 each survey year when we refresh the survey data
17 and then before each safety grade cycle to do
18 testing to make sure all the data went through
19 correctly.

20 Q. Okay. And in terms of the content of the
21 websites, to be clear, you oversee the content of
22 both websites; is that right?

1 A. Correct.

2 Q. Okay. And how does that work? What is
3 the process by which you oversee the content for
4 both websites?

5 A. Can you restate the question?

6 Q. Sure.

7 What I'm getting at is, how do you do it?
8 How do you oversee the contents of the websites?
9 Are there periodic checks that you conduct? Are
10 there -- how does it work?

11 A. Okay. So as I've testified before,
12 Leapfrog is a small organization, and we work
13 together in a lot of areas.

14 So there are sections of our website,
15 particularly leapfroggroup.org, that are actually
16 fully managed by the ratings team. So that would
17 be anything relating -- to do -- like, you
18 actually can fill out your survey through our
19 website. Like, it's all housed there.

20 So leapfroggroup.org has a lot more in
21 that aspect, and that's managed by the ratings
22 team. So I can't speak for that. We'll

1 sometimes make some changes, but that's overseen
2 by Missy Danforth and her team.

3 The other aspects of the website that I
4 am regularly updating would be, like, the
5 newsroom, our blog. Anytime there's things going
6 on that are, you know, PR worthy, they'll go in
7 either of those spots, or maybe both.

8 I also update the home page quite
9 frequently and updating program pages or
10 things -- the process there is just, if there is
11 a change, we'll update it. If there's a broken
12 link, we'll change it.

13 Q. Okay. How do you know or how do you
14 monitor or determine whether the website -- and
15 let's just focus on the leapfroggroup.org
16 website -- is up to date.

17 A. Sorry, can you restate the question?

18 Q. Sure.

19 How do you monitor or confirm that the
20 leapfroggroup.org website is up to date at any
21 given time?

22 A. It's a -- it's a team effort. So we're

1 all -- we all work on the back end of the
2 website.

3 Q. Okay. So that's the Leapfrog -- I think
4 you specified your response with respect to the
5 leapfroggroup.org website.

6 How about the hospitalsafetygrade.org
7 website? How do you oversee or monitor the
8 content on that website?

9 A. So that website is much more focused. So
10 that is just focused solely on the hospital
11 safety grade. So for that site, we update it
12 twice a year around the launch of a new round of
13 the safety grade.

14 Q. Okay. And so you are -- you oversee that
15 process?

16 A. Yes. I work with the ratings team on
17 that.

18 Q. Okay. So what we're going to do is,
19 because it's, I think, easier to follow, we're
20 going to, instead of using -- relying solely on
21 just printouts from the websites, we're actually
22 going to go on the websites themselves. We're

1 going to put a laptop in front of you and just
2 kind of --

3 A. Okay.

4 Q. -- have you kind of help us navigate
5 through both of the websites. Okay?

6 A. Okay.

7 MR. CHUNG: So why don't we do that.

8 THE WITNESS: Do you want me to put it
9 like this? Or --

10 BY MR. CHUNG:

11 Q. No, you can just put it in right front of
12 you.

13 A. Oh, okay.

14 Q. All right. So first things first, who
15 designed these websites?

16 A. I don't know. It was before my time.

17 Q. Okay. And I think the first thing we're
18 going to do is, are you aware that, upon a --
19 kind of a basic Google search of hospital safety
20 grade, that the two top website hits that come up
21 are the Hospital Safety Grade and then
22 The Leapfrog Group websites?

1 A. That makes sense.

2 Q. Okay. Why don't we just -- go ahead and
3 do that. If you can just type in --

4 A. Okay.

5 Q. -- hospital safety grade as a Google
6 search.

7 And do the search results reflect that --

8 A. Yes.

9 Q. -- Hospital Safety Grade up top and then
10 The Leapfrog Group below that?

11 A. Yes.

12 Q. Now, before we navigate through the --
13 actually, what we'll do is, let's look first at
14 the leapfroggroup.org website.

15 A. Okay.

16 Q. So if you can click on that. And then
17 what we'll do is...

18 MR. CHUNG: If you can get tab 19.

19 (Bailey Deposition Exhibits 13 and 14
20 marked for identification and attached to
21 the transcript.)
22

1 BY MR. CHUNG:

2 Q. Now, we're also going to put in front
3 of you a couple of exhibits marked Exhibits 13
4 and 14.

5 So looking at the leapfroggroup.org
6 webpage, can you just run a search for Delray
7 Medical Center, which is one of the plaintiff
8 hospitals in this matter?

9 A. Okay.

10 Q. Okay. And do you see that the first kind
11 of result of the page, after running that search,
12 there's a window that says there are four
13 facilities in your search that declined to
14 respond to Leapfrog's request for patient safety
15 and quality data.

16 Do you see that?

17 A. I see Delray Medical Center has declined
18 to respond.

19 Q. Okay. Got it. And so -- and you
20 understand that Delray Medical Center is one of
21 the plaintiff hospitals --

22 A. Yes.

1 Q. -- in this matter, one of the five,
2 correct?

3 A. Yes.

4 Q. Okay. And I think you testified that you
5 see -- is it a red box that says, Declined to
6 respond?

7 A. Yeah. The top is red.

8 Q. Top is red. Okay.

9 And does that correspond to Exhibit 13 in
10 front of you?

11 A. Yes.

12 Q. Okay. And then underneath that red box
13 that says, Delray Medical Center has declined to
14 respond, it says, What does this mean? Thousands
15 of hospitals nationwide report to Leapfrog
16 hospital survey to help patients and purchasers
17 make better healthcare decisions. This hospital
18 did not participate.

19 Do you see that?

20 A. Yes.

21 Q. Okay. So -- and you can't -- with this
22 pop-up, with the red bar across the top, does

1 that kind of obscure what's behind the pop-out
2 box in terms of the webpage?

3 A. It's gray behind the box.

4 Q. Yup. Okay. So I'm going to ask you to
5 click out of the pop-up.

6 A. Okay.

7 Q. And is it correct that, of all the
8 measures that are listed once you pop out of the
9 pop-up -- click out of the pop-up, the
10 webpage says that the hospital declined to
11 respond; is that right?

12 A. Yes.

13 Q. Okay. And is that reflected on
14 Exhibit 14 in front of you?

15 A. Yes.

16 Q. Okay. Just using the Delray Medical
17 Center example, right?

18 A. Yes.

19 Q. Okay. And am I right that there's no
20 hospital safety grade on this page? Am I right?

21 A. Correct. This is Leapfrog hospital
22 survey data.

1 Q. Okay. And then if you click on
2 preventing patient harm on that page.

3 Do you see that?

4 A. Yes.

5 Q. Okay. And just as an example, there's
6 a -- under the handwashing metric, it says,
7 Declined to respond.

8 Do you see that?

9 A. Yes.

10 Q. Okay. And there's no imputed score
11 delineated there; is that right?

12 A. Correct.

13 Q. Okay. Now, let's turn to -- we're now
14 going to turn to the other website, the
15 hospitalsafetygrade.org-

16 A. Okay.

17 Q. -- website. So if you can kind of toggle
18 back and then click on -- I think it was the
19 first --

20 A. Yeah --

21 Q. -- result.

22 A. Sorry, I didn't mean to interrupt you.

1 At the bottom of -- if you scroll to the
2 bottom of the page that we were just on, it says,
3 See this facility's safety grade. So that's what
4 I clicked on.

5 Q. Okay. If you can go back to the Google
6 results. Okay?

7 A. Okay.

8 Q. And then I think you said that the
9 hospitalsafetygrade.org website was the first
10 hit, right?

11 A. Yes.

12 Q. Okay. So let's just go to that.

13 A. Okay.

14 MR. CHUNG: This will be Exhibit 15.

15 (Bailey Deposition Exhibit 15 marked for
16 identification and attached to the
17 transcript.)

18 BY MR. CHUNG:

19 Q. All right. So kind of a similar
20 exercise, Ms. Bailey. If you can run a search
21 for Delray Medical Center on the
22 hospitalsafetygrade.org website.

1 A. Okay.

2 Q. And does the page specific to the Delray
3 Medical Center show up?

4 A. Yes.

5 Q. Okay. Great.

6 And is that, what we see on Exhibit 15,
7 what shows up on the computer?

8 A. Yes.

9 Q. Okay. And it shows that -- a box, a gray
10 box, that says this hospital grade is F, correct?

11 A. Yes.

12 Q. And in particular to the spring 2025,
13 which I believe is the most recent round of
14 safety grades; is that right?

15 A. Yes.

16 Q. Okay. So in contrast -- unlike on the
17 leapfroggroup.org website that we looked at
18 earlier, this website does not immediately have a
19 pop-up box indicating that the hospital did not
20 provide data to Leapfrog sufficient to rate the
21 hospital, correct?

22 A. Correct.

1 Q. Okay. Now, going to see full score, it
2 shows -- when we click on the tab -- I'm sorry.
3 When we click on tab practices to prevent
4 errors -- do you see that?

5 A. Yes.

6 Q. It's the fourth one across, right?
7 We see, for doctors order medications
8 through a computer, does it show that this
9 hospital scores a 15?

10 Do you see that?

11 A. Yes.

12 Q. And does this measure on the website
13 correspond to CPOE, so far as you understand?

14 A. Yes.

15 Q. Okay. And so is this one of the imputed
16 metrics under the new methodology?

17 A. Yes.

18 Q. Okay. And then for safe medication
19 administration, which is the next one over --
20 right? -- am I correct that it shows a score of
21 25?

22 A. Yes.

1 Q. And is the safe medication administration
2 measure, does that correspond to BCMA?

3 A. Yes.

4 Q. All right. And then for hand washing,
5 which is the next one over, it shows a score of
6 15, correct?

7 A. Yes.

8 Q. All right. And this measure is --
9 corresponds to hand hygiene that we already
10 discussed, correct?

11 A. Yes.

12 Q. All right. And these are all -- the ones
13 we've gone over so far, the three, are all,
14 again, imputed metrics under the new methodology,
15 correct?

16 A. Yes.

17 Q. All right. Now, if we go under the next
18 tab, doctors, nurses, and hospital staff, the one
19 on the right, there's a measure underneath
20 specially trained doctors for ICU patients.

21 Do you see that?

22 A. Yes.

1 Q. And do you see that the score there
2 for -- is a 15? Is that right?

3 A. It's a 5.

4 Q. 5, I'm sorry.

5 It's a 5, correct?

6 A. Yes.

7 Q. And does this measure correspond to IPS?

8 A. Yes.

9 Q. All right. And then for -- and again, is
10 this also one of the imputed metrics under the
11 methodology?

12 A. Yes.

13 Q. All right. And so for all of these
14 scores, the scores for Delray Medical Center
15 under these four imputed metrics, these are all
16 limited achievement scores, correct?

17 A. For the survey. Yes.

18 Q. Yes. For the survey. Right.

19 And if you look at the gas gauge type,
20 kind of the -- the picture or the scores for
21 these four imputed metrics, they're all set to
22 the lowest possible value.

1 Do you see that? Is that right?

2 A. Yes. Worse than average.

3 Q. Right. Worse than average. And they're
4 kind of -- the gas gauge is to the red, to the
5 left, right?

6 A. Yes.

7 Q. Okay. But they're not -- there isn't any
8 wording in those gas gauges along the lines of
9 decline to report, right, or not enough data,
10 correct?

11 A. Not on the gas gauge.

12 Q. Not in the gas gauge. Right.

13 So -- but there are certain measures on
14 this website where it is indicated that the
15 hospital declined to report; is that right?

16 A. Correct.

17 Q. Okay. And can you give us one or two
18 examples of -- for which measures that declined
19 to report pictorial shows up?

20 A. On this page, the one right now, it's
21 effective leadership to prevent errors and
22 nursing and bedside care for patients.

1 Q. Okay. And so it's only at the -- we're
2 looking right now above the fold, the
3 webpage above the fold; is that right?

4 A. I don't -- that's a newspaper term, so I
5 don't...

6 Q. Okay. That's a really unfair response.
7 So we're looking at kind of the
8 webpage as the consumer sees it, right?

9 A. Yes. We're reading the webpage.

10 Q. All right. So are there any
11 disclosures -- just looking at the webpage now,
12 without scrolling at all -- right? -- are there
13 any disclosures on the webpage about -- that
14 disclose that the hospital here, in this case
15 Delray Medical Center, did not provide data to
16 The Leapfrog Group?

17 A. There's only an asterisk, which is the
18 normal communication that there's more
19 information below.

20 Q. Okay. That asterisk corresponds to a
21 footnote, correct, toward the bottom of the page
22 as you scroll down to the bottom of the page,

1 correct?

2 A. Yes.

3 Q. All right. And you're familiar with all
4 of this because you oversee this website and the
5 other website, correct?

6 A. Correct.

7 Q. Okay. So -- and it's at the bottom of
8 the page in -- let's just go to it -- in the
9 smaller font where Leapfrog discloses that this
10 hospital did not provide data to The Leapfrog
11 Group, correct?

12 A. In notes and definitions, we're referring
13 to number 4 --

14 Q. Right.

15 A. -- which is an asterisk in bold red.

16 Q. Okay. And it says, Hospital declined to
17 report the performance on this measure, so a
18 score was assigned to reflect lack of information
19 available, correct?

20 A. Correct.

21 Q. And this footnote is in reference to the
22 four imputed metrics that are laid out above it,

1 correct?

2 A. Correct. There's an asterisk that --
3 yes.

4 Q. Right. Now, does this -- the footnote,
5 however, does not explain how that score was
6 assigned, correct?

7 A. Correct.

8 Q. Okay. So we have looked at -- we've kind
9 of scrolled through it and we've looked at each
10 of the two Leapfrog websites, or the websites
11 that are operated by Leapfrog.

12 Why doesn't Leapfrog use the same
13 disclosures as they relate to hospitals that
14 don't participate in the survey -- right? -- why
15 doesn't Leapfrog use the same disclosures on each
16 website?

17 MS. BLAIR: Objection to form.

18 THE WITNESS: They're complete -- they're
19 different programs. So the Leapfrog hospital
20 survey is a different program than the Leapfrog
21 hospital safety grade. The Leapfrog hospital
22 survey includes safety and quality.

1 BY MR. CHUNG:

2 Q. Okay. But we looked at -- so how does
3 that explain the difference between the
4 website -- the two websites as we just went over,
5 the parts that we went over?

6 A. They're different. So maybe a better way
7 to say it: So the survey is voluntary.
8 Hospitals choose or not choose to do the survey.

9 The safety grade is not voluntary. The
10 safety grade was designed so that it was assigned
11 to all general acute care hospitals for patients
12 to get as much information as possible.

13 Q. Okay. Was there ever a concern at
14 Leapfrog -- right? -- that consumers or visitors
15 to both websites would be confused about the
16 imputed metric scores for hospitals that did not
17 participate in the hospital survey?

18 MS. BLAIR: Objection to form.

19 THE WITNESS: Can you restate the
20 question?

21 BY MR. CHUNG:

22 Q. Yes.

1 Was there ever any concern at Leapfrog
2 that visitors to the websites, including
3 consumers, would be confused about imputed metric
4 scores for hospitals that did not participate in
5 the hospital survey?

6 A. No. That's the reason we did the
7 asterisk with the note. We feel that it's a
8 clear description that this was a score that was
9 assigned.

10 Q. Okay. Though the footnote -- the
11 asterisk and the footnote does not describe how
12 that automatic low score was assigned, correct?

13 MS. BLAIR: Objection to form.

14 THE WITNESS: That's in our methodology.
15 We only have a certain amount of real estate on
16 the website. It wouldn't make sense -- it's
17 something in communications that's also important
18 to know -- this is our philosophy in
19 communications just generally in the field,
20 actually6 -- is that too much information can
21 actually be more confusing to consumers.

22 Consumers don't generally understand

1 what "imputed" means, but they understand basic
2 language, that this hospital declined to report
3 their performance on this measure, so a score was
4 assigned to reflect the lack of information
5 available.

6 BY MR. CHUNG:

7 Q. Okay. So I'm just going to ask the
8 question again: Was there ever any concern --
9 right? -- at Leapfrog that visitors to the
10 websites might be confused about the imputed
11 metric scores for hospitals that didn't report to
12 the survey?

13 A. Well, we made this so that they wouldn't
14 be confused.

15 Q. So the question -- yes? No? Were there
16 concerns or were there not concerns?

17 A. There were concerns, which is the reason
18 why we did the asterisk and disclosed it in bold
19 red as clear as possible.

20 Q. When you say as clear as possible, what
21 do you mean by that?

22 A. Like, we have it in bold in red, which

1 will draw people's eyes.

2 Q. Okay. But the -- it doesn't -- but the
3 footnote does not describe how that lowest
4 possible score was assigned to the hospital,
5 correct? Just to be clear.

6 MS. BLAIR: Objection to form.

7 THE WITNESS: Can you restate the
8 question?

9 BY MR. CHUNG:

10 Q. Yes. But am I correct that that
11 footnote does not inform the consumer --
12 right? -- the visitor to the website how that
13 lowest possible score was assigned to that
14 hospital, correct?

15 MS. BLAIR: Objection. Form.

16 THE WITNESS: That's not the purpose of
17 this part of the website.

18 BY MR. CHUNG:

19 Q. Okay.

20 A. It's the methodology.

21 Q. And so are -- when you say that's not the
22 purpose of the website, are consumers expected,

1 then, to be knowledgeable about the methodology?

2 A. No, I'm not saying that. Like, if you
3 look at all of the measures, it doesn't very
4 clearly explain how each thing was scored. We
5 put the most clear information possible for each
6 of the measures for consumers.

7 Q. Okay. Has Leapfrog -- all right. So you
8 testified about kind of -- well, has Leapfrog
9 received any feedback, first of all, from
10 hospitals regarding any confusion or
11 inconsistencies between the information presented
12 on the two websites?

13 A. Not that I can recall.

14 Q. Okay. How about any feedback -- has
15 Leapfrog received any feedback from patients --
16 right? -- consumers, regarding confusion or
17 possible inconsistencies between the information
18 presented on the websites?

19 A. Not that I can recall.

20 Q. Okay. Have you -- has Leapfrog received
21 any feedback from any party about confusion or
22 potential inconsistencies in the information

1 presented between the two websites?

2 A. Not that I can recall.

3 Q. Okay. Has Leapfrog ever conducted any
4 testing or surveys or other research to assess
5 whether consumers see the disclosures on each
6 website as opposed to -- Ms. Bailey, as opposed
7 to just seeing, for one, the grade -- right? --
8 on the website?

9 So the question is, yeah, has Leapfrog
10 ever studied whether consumers actually --
11 whether they actually look at or see the
12 disclosures on each of the websites?

13 A. I know that when the website was created,
14 I wasn't here. But from -- my understanding is
15 that we hired a low literacy expert. We also had
16 focus groups.

17 And the whole structure in general of the
18 website has not changed since then. So it was
19 developed with feedback from those experts.

20 Q. So -- I think you said low literacy
21 expert.

22 What is that?

1 A. We want to ensure that our website is
2 written to an eighth grade level of education.

3 Q. Okay. Is another word for that digital
4 literacy expert?

5 A. I don't know.

6 Q. Okay. Has there been -- do you know
7 when, approximately, that low literacy expert was
8 retained to advise on the website?

9 A. It was whenever we created this website,
10 and it was prior to my time at Leapfrog.

11 Q. Okay. Do you know whether that expert
12 looked at both websites or just one of them?

13 A. I don't know.

14 Q. All right. Have there been -- during
15 your time at Leapfrog over the last several
16 years, has a low literacy or a digital literacy
17 expert ever reviewed either or both of these
18 websites?

19 A. Not to my knowledge. We haven't made
20 substantial changes to how the data is displayed.

21 Q. Okay. Do you think it's realistic to
22 assume or to think that visitors, particularly

1 one with -- let's assume one with an eighth grade
2 literacy level -- right? -- low literacy, will
3 read a footnote at the bottom of the page on the
4 hospitalsafetygrade.org website?

5 A. I think -- yes, I think someone at an
6 eighth grade level would understand what an
7 asterisk means, and if they were interested, they
8 could learn more, scroll down.

9 Q. Okay. Do you -- so I'll ask it again.
10 Do you think it's reasonable or realistic
11 for such a consumer with the eighth grade
12 literacy level to read through that entire page,
13 to scroll down and then study the information at
14 the bottom of the page?

15 A. Yes. I think if they're interested in
16 the data, they'll read it.

17 Q. Okay. Does Leapfrog want consumers to
18 believe that the imputed metrics are based on
19 actual data?

20 MS. BLAIR: Objection to form.

21 THE WITNESS: No. I mean, we really --
22 we clearly say on this, a score was assigned to

1 reflect the lack of information available.

2 BY MR. CHUNG:

3 Q. Okay. And it's not disclosed here
4 that -- is it disclosed anywhere on the Hospital
5 Safety Grade website that the scores, the limited
6 achievement scores are automatically assigned to
7 these hospitals on these imputed metrics?

8 A. Can you say that again?

9 Q. Yeah. Is it anywhere disclosed -- is it
10 disclosed on the website, the
11 hospitalsafetygrade.org website, that
12 non-participating hospitals are automatically
13 assigned a limited achievement score on these
14 imputed metrics?

15 A. I think that it's clear because it says,
16 again, a score was assigned. And then if you see
17 this hospital score and you see worst hospital
18 score, you see that it was the lowest.

19 Q. Okay. Has Leapfrog ever considered
20 standardizing the disclosures or the presentation
21 of information across these two websites as it
22 relates to non-responding hospitals?

1 When I say non-responding, hospitals that
2 didn't respond to the hospital survey.

3 MS. BLAIR: Objection. Form.

4 THE WITNESS: Can you say the question
5 again.

6 BY MR. CHUNG:

7 Q. Sure has Leapfrog ever considered
8 standardizing -- right? -- making consistent
9 between the two websites the disclosures or the
10 presentation of information as it relates to
11 hospitals that do not participate in the hospital
12 survey?

13 MS. BLAIR: Objection to form.

14 THE WITNESS: Because they're different
15 programs -- Leapfrog hospital safety grade and
16 Leapfrog hospital survey are different -- no.

17 BY MR. CHUNG:

18 Q. Okay. Let's talk about Leapfrog's
19 marketing.

20 So are you -- you're the communications
21 director. Do you have responsibilities with
22 respect to Leapfrog's marketing function?

1 A. Marketing is different than
2 communications, so --

3 Q. Okay.

4 A. -- I wouldn't consider that, no. What's
5 your definitions of marketing?

6 Q. Who's in charge of marketing?

7 A. We don't have a marketing person.

8 Q. All right. And you mentioned that --
9 other than CURA Strategies, are there any other
10 outside contractors or consultants that provide,
11 you know, public relations or communications
12 services?

13 A. We have a few services that we will use.
14 CURA Strategies is our agency of record.

15 We work with Nonprofit Megaphone, which
16 is a vendor who helps us with our Google ads. We
17 have a Google ad grant since we're a nonprofit.

18 We work with North American Network,
19 which is a radio vendor, around the safety grade
20 to help us get the safety grade out.

21 We work with ForeMedia, which kind of
22 does the same thing but for broadcast TV.

1 Q. Okay.

2 MR. CHUNG: Let's go to tab 22. This
3 will Exhibit 16.

4 (Bailey Deposition Exhibit 16 marked for
5 identification and attached to the
6 transcript.)

7 BY MR. CHUNG:

8 Q. All right. Ms. Bailey, I've put in front
9 of you Exhibit 16, which is titled, 2025 Regional
10 Leader Communications Toolkit: Launching
11 Leapfrog Surveys.

12 Take a few moments. Let me know if it
13 looks familiar to you.

14 A. Yes. I'm familiar with this.

15 Q. Okay. Is this a document that provides
16 instructions to Leapfrog regional leaders on how
17 to market the hospital survey?

18 A. I wouldn't use the word "market."
19 There's no money exchanged in our relationship
20 with regional leaders.

21 This is a toolkit that lives on their
22 intranet, you could call it, on our website, and

1 they can refer back to it throughout the year.

2 One of the primary responsibilities of
3 regional leaders are really to represent Leapfrog
4 in their markets, and so a really big part of
5 that is sending out physical letters to all the
6 hospitals on their rosters. So for our regional
7 leader in Seattle, they do all of the hospitals
8 in Seattle. And they also have ambulatory
9 surgery centers on their rosters.

10 Q. And so what is the purpose of regional
11 leaders reaching out to hospitals in their
12 markets?

13 A. Healthcare is local.

14 Q. So what's the purpose?

15 A. The purpose is that they represent
16 Leapfrog in their markets and they are -- as
17 employers, they represent employers in their
18 markets. So Leapfrog, again, was founded by
19 employers. And so the ask to participate in the
20 survey comes from the employer community.

21 Q. All right. So just in short, they are --
22 the regional leaders are responsible for

1 communicating with hospitals in their market to
2 try to get them to participate in the survey,
3 correct?

4 A. Yes. They send letters. Yes.

5 Q. Now, how do they -- what are the typical
6 kind of ways in which regional leaders try to
7 achieve that?

8 A. Most of them just send letters, physical
9 letters and e-mails.

10 Q. And does this toolkit -- it looks like
11 this toolkit includes suggestions of how to
12 format those letters --

13 A. Yes.

14 Q. -- or word those letters, correct?

15 A. Yes.

16 Q. Okay. If you look at, later in the
17 document, Bates ending 517, there's a chart.

18 A. Yes.

19 Q. And it's beginning to sound like a broken
20 record, but it's titled, Common objections and
21 frequently asked questions about Leapfrog and its
22 ratings.

1 Do you see that?

2 A. Yes.

3 Q. Okay. And there's a table that goes on
4 for, I think, several pages --

5 A. Yes.

6 Q. -- till the end of the document, correct?

7 The -- on this first page, the second
8 row, reads, under objection, Leapfrog data is
9 self-reported and, therefore, unreliable.

10 Do you see that?

11 A. Yes.

12 Q. And that is a common objection that we've
13 seen kind of in prior documents, including the
14 presentation to the board that we looked at,
15 correct?

16 A. The presentation to the board came from
17 this document. Yes.

18 Q. Okay. Now, turning to -- and is it --
19 looking at this document now, for this toolkit
20 for regional leaders, is this objection, Leapfrog
21 data is self-reported and, therefore, unreliable,
22 an objection that -- a common objection from

1 hospitals?

2 A. We've -- I testified before about this,
3 that, yes, we've heard this.

4 Q. Okay. Turning to the next page, so Bates
5 ending 518, it is the fifth objection down. It
6 reads, We believe something on the survey is not
7 risk-adjusted adequately and/or invalid or
8 unscientific.

9 Do you see that particular objection?

10 A. Yes, I do.

11 Q. Okay. And is it correct that that is
12 another common objection to the Leapfrog survey
13 from hospitals?

14 A. Again, in my testimony earlier, common
15 is -- common objections is just a PR term. It
16 doesn't mean we hear it all the time. It means
17 we think it's important for regional leaders to
18 have the answer to this question. Maybe we've
19 heard it before; maybe it was discussed with
20 staff that it could be asked.

21 Q. Okay. So this is -- but where does this
22 common objection come from?

1 A. We came up with these as staff members.

2 Q. So this is not based at all on feedback
3 or anything you've heard from hospitals; is that
4 your testimony?

5 A. I testified already about this, that,
6 yes, it is based on maybe conversations people
7 have had. It's not direct quotes. It's in
8 combination of maybe things we've heard over the
9 last, you know, 25 years and we are compiling
10 them into a PR document.

11 Q. All right. And what is the purpose of --
12 what's the purpose of listing out all of these
13 common objections for the regional leaders?

14 A. It helps to have all of our messaging in
15 one place. It's just a strategy that we use.
16 Again, this lives on the intranet. So we have a
17 very small staff. We have limited resources.
18 There's more regional leaders than there are
19 Leapfrog staff members, to be clear, so we don't
20 have the ability to, you know, be available all
21 the time to answer every question, so this saves
22 us a little time for them to have the common --

1 you know, our idea of what potentially they could
2 be asked, and they have an approved response.

3 And if they ask anything beyond this,
4 they know that they go -- they come to us.

5 Q. Okay. So -- you're right, that for each
6 of these common objections, there is a
7 proposed -- a proposed or recommended response
8 next to it, correct?

9 A. Yes.

10 Q. And am I correct that the purpose of
11 providing the common objections and the responses
12 is to give regional leaders a tool or a proposed
13 response in the event that a hospital voices one
14 or more of these common objections, correct?

15 A. Or one of their employers.

16 Q. Okay. But the hospitals as well,
17 correct?

18 A. Yes.

19 Q. All right. And the purpose of providing
20 these responses to the objections is it helps
21 regional leaders enlist more hospitals to
22 participate in the survey, correct?

1 A. Yeah. It helps them with their outreach
2 efforts.

3 Q. Okay. And the more hospitals that
4 respond to the survey, the more data that's
5 submitted to Leapfrog in conjunction with those
6 responses, correct?

7 A. Correct. But if you look at the safety
8 grade, 80 percent of hospitals respond, so we
9 already have a very full data set.

10 Q. Okay. It's also correct that -- can you
11 say that again? That 80 percent -- I'm sorry, I
12 didn't catch that response.

13 A. Yes. I believe that it's 80 percent of
14 hospitals report to Leapfrog that get a safety
15 grade.

16 Q. Okay. But there are still hospitals that
17 don't respond to the survey, correct?

18 A. Correct.

19 Q. All right. And there are hospitals that
20 have responded in the past but at some point
21 stopped responding to the survey, correct?

22 A. I've heard of that happening. Yes.

1 Q. And so one of the purposes of providing
2 this toolkit of common objections and responses
3 to the regional leaders is to try to convince
4 those hospitals either to participate in the
5 survey in the first instance or resume their
6 responses to the survey, correct?

7 A. Yes. It's important to our mission --

8 Q. All right.

9 A. -- that hospitals are transparent.

10 Q. It's also important to your mission to
11 have as many hospitals participate in the survey
12 as possible, correct?

13 A. Yes. We would love if all hospitals did
14 in the survey. We would have a lot of data for
15 patients.

16 Q. All right. And it also allows -- the
17 more hospitals that participate in the survey,
18 the more data from those hospitals you have,
19 correct?

20 A. Correct.

21 Q. And the more data you have, the more you
22 can license that data to third parties; is that

1 correct?

2 MS. BLAIR: Objection to form.

3 THE WITNESS: No, I wouldn't agree with
4 that. We don't -- we don't charge more based on
5 how much data is available.

6 BY MR. CHUNG:

7 Q. That's not my question. The question is,
8 the more data, hospitals' data you have
9 available, the more marketable that data is to
10 third parties, correct?

11 MS. BLAIR: Objection to form.

12 THE WITNESS: Yes. But I'd say it's
13 already very marketable. We already have a lot
14 of hospitals participating.

15 BY MR. CHUNG:

16 Q. Okay. Does Leapfrog pay for search
17 engine optimization for either or both of its
18 websites?

19 A. We just started this in July of this
20 year.

21 Q. All right. And what exactly is it paying
22 for in terms of that search engine optimization?

1 A. We're on month two of it, so I'm not
2 completely well versed. This is something that
3 Nate Longmore, our communications coordinator,
4 works on with Nonprofit Megaphone. It's a
5 service that they provide.

6 As of right now, we're in the very early
7 stages. So when you're in the very early stages
8 of SEL, my understanding is that, first, we're
9 looking for any pages that have broken links that
10 we may have missed or things like that to clean
11 up, and then we kind of move on from there.

12 Q. Okay. And is that for both websites?

13 A. I believe so.

14 Q. All right. Does Leapfrog partner with
15 any journalists or media outlets in anticipation
16 of publishing the hospital safety grades?

17 A. I would not use the word "partner." We
18 do pitch media, yes.

19 Q. All right. And approximately how many
20 journalists or these media outlets do you
21 pitch -- pitch what, exactly?

22 A. Leapfrog hospital safety grades and

1 trends in the safety grades. And again,
2 healthcare is local, and so it's a really
3 important of [sic] our strategy to get the safety
4 grades out to these local publications.

5 Q. Okay. Does Leapfrog embargo the hospital
6 grade results with these media outlets and
7 journalists?

8 A. Yes.

9 Q. And why does it do that?

10 A. To give the reporters more time to work
11 on their stories.

12 Q. All right.

13 MR. CHUNG: Let's go to tab 42.

14 (Bailey Deposition Exhibit 17 marked for
15 identification and attached to the
16 transcript.)

17 BY MR. CHUNG:

18 Q. We're going to look at a few other
19 sections of the websites, Ms. Bailey.

20 A. Okay.

21 Q. We're going to look at printouts.

22 And this is 17, I think.

1 Okay. Exhibit 17 is taken from the
2 hospitalsafetygrade.org website.

3 Do you recognize it?

4 A. Yes.

5 Q. Okay. It's a section, How to use the
6 grade.

7 And if you look at page 4 of the
8 document, in the second paragraph under the
9 heading What About Past Grades, in the second
10 paragraph there's a sentence that reads, Patients
11 should always decide on where to receive care
12 based on a hospital's current safety grade.

13 Do you see that?

14 A. Yes.

15 Q. Okay. So is the message to the consumers
16 here that a drop in a hospital's safety grade
17 means that the hospital has become more
18 dangerous?

19 A. That's not what that says. It says in
20 the context -- this is the context of past
21 grades. If you look at the beginning, it says,
22 What about past grades? So on the website, you

1 can click, View past grades. So we're saying,
2 look at the current safety grade; don't rely on
3 the old safety grade. The new data will be more
4 reflective of your experience today.

5 Q. Okay. So if -- my question is, is the
6 message here -- or one of the messages from this
7 sentence, from this section, that if the current
8 safety grade is lower or has dropped -- right? --
9 from previous safety grades, that that hospital
10 has become more dangerous? Is that part of the
11 message?

12 A. Not that it's become more dangerous, but
13 their patient safety has decreased.

14 Q. Okay. Does the messaging also include
15 that the consumer, as a result of seeing this
16 decrease or the drop in the safety grade, should
17 be more cautious about visiting that hospital?

18 A. Consumers should be cautious when
19 visiting any hospital. And we're very clear that
20 no hospital is perfectly safe. Not A-hospitals;
21 no hospital is safe. You should always be
22 cautious. We have a lot of tools on our website

1 for questions you should ask.

2 Q. I'm asking specific -- not generally,
3 Ms. Bailey, but specific to the message here that
4 we just went over.

5 Is the message or part of the message at
6 least that a consumer should, upon seeing this
7 change in the safety grade, be more cautious
8 about visiting that hospital?

9 A. Yes. We're not saying you shouldn't go
10 to a hospital. We're just saying, be aware of
11 the safety; ask questions.

12 Q. Okay. There is -- if we turn to the
13 previous page, so page 3 of the document, under
14 What measures are most important, there's a
15 handwashing bullet point.

16 Do you see that?

17 A. Yes.

18 Q. And handwashing is one of the imputed
19 metrics that we've gone over; is that right?

20 A. Yes.

21 Q. Now, it says, Does your hospital have a
22 handwashing policy to ensure that all staff

1 members are washing their hands before and after
2 patient contact.

3 Do you see that?

4 A. Yes.

5 Q. All right. So is Leapfrog telling
6 consumers here that one of the most important
7 measures they should consider when choosing a
8 hospital is handwashing?

9 A. Yes.

10 Q. Okay. Does it disclose here at all that
11 Leapfrog, under its imputation methodology,
12 automatically gives non-participating hospitals
13 the lowest grade possible on handwashing?

14 A. No. That wouldn't make sense in this
15 context.

16 Q. But no, correct?

17 A. No.

18 Q. That's not disclosed. All right.

19 MR. CHUNG: Let's go to document 43.
20 This will be Exhibit 18.

21

22

1 (Bailey Deposition Exhibit 18 marked for
2 identification and attached to the
3 transcript.)

4 BY MR. CHUNG:

5 Q. Okay. This is another section or excerpt
6 of the Hospital Grade -- Safety Grade website
7 titled, Choosing the best hospital.

8 Are you familiar with this section of the
9 website?

10 A. Yes.

11 Q. Okay. And is this a part of the website
12 that you oversee for content?

13 A. This is a page that we would consider
14 evergreen content. So I don't remember
15 personally making edits to this page.

16 Q. What do you mean by evergreen content?

17 A. It's something that -- I mean, I would,
18 like, triple check, but it's something that
19 really wouldn't change. A lot of our content on
20 some of the first half in the safety grade is
21 just, like, consumer information.

22 Q. Okay. So this is Exhibit 18.

1 So is it your testimony that you,
2 yourself, don't monitor this particular page for
3 any updates or whether it's accurate?

4 A. I mean, we look at the whole website all
5 the time, but I don't remember making changes to
6 this page personally.

7 Q. Okay. If you look at the first page, the
8 second paragraph, it reads, Your choice of
9 hospitals -- your choice of hospital could be a
10 life or death decision.

11 Do you see that?

12 A. Yes.

13 Q. All right. Is that messaging designed to
14 scare consumers upon reading -- coming to the
15 website?

16 MS. BLAIR: Objection to form.

17 THE WITNESS: I wouldn't use the
18 word "scare." It's to make them understand it's
19 an important decision.

20 BY MR. CHUNG:

21 Q. Okay. Is it, in fact, a life or death
22 decision, in your view?

1 A. Yes. It can be.

2 Q. Okay. To put it another way, does
3 Leapfrog expect consumers not to be scared when
4 they read that?

5 MS. BLAIR: Objection to form.

6 THE WITNESS: I don't know.

7 BY MR. CHUNG:

8 Q. Is this message, Your choice of hospital
9 could be a life or death decision, is it designed
10 to encourage consumers to use Leapfrog's hospital
11 safety grades when choosing a hospital?

12 A. Yes.

13 MR. CHUNG: Let's go to tab 44. This
14 will be Exhibit 19.

15 (Bailey Deposition Exhibit 19 marked for
16 identification and attached to the
17 transcript.)

18 BY MR. CHUNG:

19 Q. So Exhibit 19 is another section of the
20 same website. It's the frequently asked
21 questions about the Leapfrog hospital safety
22 grade.

1 Do you recognize this section?

2 A. Yes.

3 Q. All right. Is this evergreen as well
4 or --

5 A. No.

6 Q. All right. And so is this a section that
7 you check for accuracy and that it's up to date?

8 A. We update it before each safety grade
9 round.

10 Q. Okay. And do you also check for
11 accuracy?

12 A. Can you restate the question?

13 Q. Yes. Do you check this section, this FAQ
14 section, for accuracy?

15 A. Yes.

16 Q. Okay. How often do you do that?

17 A. Prior to each safety grade round, we
18 update the FAQs.

19 Q. Okay. Let's look at the second page.

20 This section tells the consumers or
21 readers that patients are twice as likely to die
22 of a prevental [sic] problem at a C, D, or

1 F-hospital than an A-hospital.

2 Do you see that?

3 A. Yes.

4 Q. All right. So similar question: Is the
5 strategy here to scare consumers away from
6 hospitals with C, D, or F safety grades?

7 MS. BLAIR: Objection to form.

8 THE WITNESS: It is not. It's just to
9 give information that not all hospitals are the
10 same.

11 BY MR. CHUNG:

12 Q. Do you think that this is an effective
13 way of -- of communicating that, that not all
14 hospitals are the same?

15 A. Can you restate your question?

16 Q. Do you think this sentence is an
17 effective way of communicating that not all
18 hospitals are the same?

19 A. Yes. That hospitals differ in their
20 patient safety.

21 Q. Why not just -- why not just tell the
22 consumer not all hospitals are the same, as

1 opposed to telling them that -- or representing
2 to them that patients are twice as likely to die
3 of a preventable problem at a C, D, or F?

4 MS. BLAIR: Objection to form.

5 THE WITNESS: Can you restate the
6 question?

7 BY MR. CHUNG:

8 Q. Yeah. Why not -- just kind of presenting
9 your own testimony, why not just tell consumers
10 that not all hospitals are the same?

11 MS. BLAIR: Objection to form.

12 THE WITNESS: We do say that as well.
13 But this is a study from John Hopkins that we
14 cite.

15 BY MR. CHUNG:

16 Q. Okay. Does Leapfrog want consumers to
17 think that visiting a hospital with a D or F
18 grade could seriously injure or kill them? Is
19 that part of the messaging?

20 A. The messaging is that you're more likely,
21 based on the preventable problems that are
22 represented in the safety grade.

1 Q. All right. And like the other message,
2 is this messaging designed to encourage consumers
3 to use the hospital safety grades when choosing a
4 hospital?

5 A. Yes.

6 Q. Now, the website also tells consumers
7 that the hospital safety grade reflects how well
8 a hospital does on safety, not whether they
9 complete the Leapfrog hospital survey.

10 Are you familiar with that?

11 A. Where are you reading from?

12 Q. This is from the frequently -- this is
13 actually --

14 A. Oh, it's --

15 Q. -- on page 3, I'm sorry.

16 A. Thank you.

17 Q. I should have directed you to that.

18 A. Thank you.

19 Q. So page 3, under that question, Does a
20 hospital get a better safety grade if it reports
21 the Leapfrog hospital survey -- there's a
22 sentence right underneath it.

1 Do you see that?

2 A. Yes.

3 Q. Okay. It's -- is that true?

4 A. Yes.

5 Q. All right. But if a hospital does not
6 respond to the survey or does not complete the
7 survey, it automatically receives the lowest
8 possible score on the four imputed metrics,
9 correct?

10 A. Just on those four metrics. Yes.

11 Q. Okay. And these are among the most
12 important metrics, I think you testified earlier,
13 correct?

14 A. Correct. But there are hospitals, let's
15 be clear, that don't get a safety grade that
16 still get an A. It's not automatically that you
17 get a bad grade.

18 Q. But on those four critical imputed
19 metrics, these non-participating hospitals are
20 given the lowest possible score without the
21 benefit of any actual data on those four metrics,
22 correct?

1 A. Correct. They're assigned that score.

2 MR. CHUNG: Let's go to tab 58.

3 So this will be 20.

4 (Bailey Deposition Exhibit 20 marked for
5 identification and attached to the
6 transcript.)

7 BY MR. CHUNG:

8 Q. So Ms. Bailey, Exhibit 20 is -- you've
9 got an e-mail chain from October 29 of 2024, and
10 then there's an attachment to it with what looks
11 like a markup of an FAQ about the hospital safety
12 grade.

13 A. Yes.

14 Q. So take a few moments. Let me know when
15 you've had a chance...

16 A. Yes.

17 Q. Okay. Do you recognize what's being
18 discussed in this e-mail chain?

19 A. Yes.

20 Q. So it appears that this is discussion
21 around frequently asked questions about the
22 Leapfrog hospital safety grade, correct?

1 A. Yes. The document we were just looking
2 at.

3 Q. Okay. This is coming off of the website,
4 the section that we just looked at, in
5 Exhibit 19, right?

6 A. Yes.

7 Q. All right. Now, if you look at the
8 page Bates ending 7096, it's the first page of
9 the markup of the FAQs.

10 And just to be clear, are the edits that
11 we see here on this document -- whose edits are
12 these?

13 Are they Ms. Binder's edits?

14 A. Yes. And this was to the fall 2024 FAQs.
15 And the one we just looked at was the spring 2025
16 FAQs.

17 Q. Okay. So on the first page of -- so
18 Bates ending 7096, toward the bottom there, one
19 of the FAQs is, Why did hospital X get an F and
20 why did hospital Y get an A?

21 Do you see that?

22 A. Yes. A little hard to read.

1 Q. Yes, I'm sorry. It's a little bit faint.

2 In brackets it says, Answer these
3 questions by being very specific about how the
4 asked-about hospital did on specific measures but
5 don't say how those measures caused the bad
6 grade. In other words, talk about the safety
7 measures, not the methodology.

8 Do you see that?

9 A. Yes. It's hard to read.

10 Q. Okay. Why did Ms. Binder not want to
11 talk about the methodology?

12 MS. BLAIR: Objection to form.

13 THE WITNESS: I don't know.

14 BY MR. CHUNG:

15 Q. Okay. On the next page, 7097, there's
16 another header titled, Does a hospital get a
17 better safety grade if it reports the Leapfrog
18 hospital survey?

19 Do you see that?

20 A. Yes.

21 Q. Okay. It's the very next one.

22 And then underneath it, the markup reads,

1 The hospital safety grade reflects how well a
2 hospital does on safety, not whether they
3 complete the Leapfrog hospital survey.

4 That corresponds to the sentence or the
5 response that we read on the preceding exhibit,
6 correct?

7 A. Yes. It looks like it's the same.

8 Q. So is that Ms. Binder's kind of edit with
9 respect to that FAQ?

10 A. Let me see. Track changes are hard
11 sometimes.

12 It looks like she actually may have just
13 moved that from -- if you look two paragraphs
14 down -- sorry, this is kind of hard to explain --
15 it says, Does a hospital get a better safety
16 grade if -- do you see how that's X'd out? I
17 think she just moved that paragraph up.

18 Q. Okay.

19 A. It's really hard to read with the
20 crosses, so I can't really tell if there are
21 differences or not.

22 Q. All right. When you saw the edit or her

1 comment about not wanting to talk about
2 methodology in the first part of the markup as to
3 why did hospital X get an F while another
4 hospital got an A -- right? -- did that concern
5 you at all about not -- about the consumer here
6 not getting an explanation for how the hospital
7 gets a grade under the new methodology?

8 MS. BLAIR: Objection to form.

9 THE WITNESS: No. I don't think she
10 meant that by -- what I take from this is that
11 this is an FAQ document. It's meant for
12 reporters. We keep it short. They get the
13 methodology printout as well separately. Every
14 reporter gets that.

15 BY MR. CHUNG:

16 Q. Well, I thought that this FAQ was on the
17 website.

18 A. It is.

19 Q. Isn't it addressed to consumers, visitors
20 to the website?

21 A. It is. It has multi purposes. We send
22 it to reporters as well.

1 Q. Okay. But the content here is on the
2 website, correct?

3 A. It's also on the website, yes.

4 Q. Okay. So we're staying on this document,
5 the markup of the FAQs. Let's go to Bates ending
6 in 7098, so the very next page.

7 There is -- one of the questions is, Are
8 there methodology changes in the fall 2024
9 Leapfrog hospital safety grade?

10 Do you see that?

11 A. Yes.

12 Q. Okay. Now, the original -- so if you
13 kind of try to kind of parse out what's been
14 deleted or edited -- right? -- part of the
15 original language here -- actually, do you know
16 who in the first instance drafted the FAQs as
17 well as the responses?

18 A. Me, in combination with Nate.

19 Q. Okay. And is -- are those -- is that
20 kind of taken what Ms. Binder edited here taken
21 directly from the website? Is she editing what's
22 on the website?

1 A. This right here is in addition to the
2 FAQs.

3 Q. All right. So this is new material?

4 A. Yes. This corresponds with -- I don't
5 know what exhibit at this point, but the e-mail
6 to Missy where we were talking about messaging
7 for the imputation change.

8 Q. Okay.

9 A. That's where this came from.

10 Q. So if you look at the language that's
11 been struck -- right? -- it reads, The Leapfrog
12 Group aims to provide the public with timely,
13 transparent information on hospitals' safety
14 performance. To uphold this commitment, Leapfrog
15 utilizes the best available data for calculating
16 hospital safety grades. Annually, Leapfrog's
17 expert panel and researchers at John Hopkins
18 Institute for Patient Safety and Quality --
19 actually, it's the Armstrong Institute, right?

20 A. Yes.

21 Q. -- and Leapfrog's expert panel and
22 researchers at the Armstrong Institute review the

1 scoring methodology and have recommended
2 modifying the current imputation method used for
3 filling in missing data from hospitals that did
4 not complete the latest Leapfrog survey.

5 Do you see that?

6 A. Yes.

7 Q. Okay. Now, according to the edits
8 here -- right? -- to the red-line here, what
9 comes out of it is in line with the
10 recommendations from the national expert panel
11 and John Hopkins advisors, Leapfrog changed the
12 way it estimates performance for hospitals that
13 declined to report to the Leapfrog hospital
14 survey.

15 So why was that change made from
16 basically an answer that says that the expert
17 panel, John Hopkins, Armstrong Institute, and
18 researchers have recommended modifying the
19 current imputation model -- right? -- to in
20 line with recommendations from the national
21 expert panel and John Hopkins advisors, Leapfrog
22 changed the way it estimates performance?

1 Do you have an understanding as to why
2 the change was made from the experts and John
3 Hopkins making that recommendation -- right? --
4 to Leapfrog changing the way -- changing the
5 imputation methodology in line with the
6 recommendation from the experts?

7 A. I don't know. And this isn't the final,
8 so it's -- I don't remember what the final text
9 even said.

10 Q. Okay. Putting aside whether it's final
11 or not, do you have an understanding as to why
12 that change was made?

13 A. No, I don't.

14 Q. Okay. Then we see for four out of the 30
15 measures -- and we see the four imputed
16 metrics -- right? --

17 A. Yes.

18 Q. -- that we've already discussed --
19 Leapfrog will first check the last two safety
20 grade cycles for available data. If none exist,
21 hospitals will receive a point value of 15 for
22 the measure, the lowest performance category.

1 This reflects analysis of actual performance of
2 hospitals with prior missing data as well as
3 expert consultation.

4 Do you see that?

5 A. Yes.

6 Q. Okay. How does this -- as you understand
7 it, how does this -- the description of the
8 change in imputation methodology, how does it
9 reflect analysis of actual performance of
10 hospitals with prior missing data?

11 A. I don't know. I didn't write it. I
12 don't know what she meant.

13 Q. Okay. And how does it reflect expert
14 consultation?

15 A. I don't know. Among our expert -- aside
16 from our expert panel, I don't know.

17 Q. Okay. But this is -- as communications
18 director, these frequently asked questions that
19 go out to, I think, by your testimony, to
20 reporters as well as to consumers on the website,
21 this is one of your responsibilities, correct?

22 A. Correct. But these are Leah's edits, and

1 I don't remember what we decided on.

2 Q. Are you responsible for understanding
3 Leah's edits?

4 A. Not necessarily what she meant by it
5 always. If we don't understand something, we'll
6 go to her and talk to her about it, but it looks
7 like Nate is the one who had those conversations.

8 Q. And Nate is a communications -- I think
9 manager?

10 A. Coordinator.

11 Q. -- coordinator who reports to you,
12 correct?

13 A. Correct.

14 Q. So as his manager, as his supervisor, do
15 you have responsible for at least understanding
16 Ms. Binder's edits?

17 A. I think it's unrealistic that I'd
18 understand her intention of every single edit she
19 makes.

20 Q. Okay. Is this an important edit?

21 A. I don't know.

22 Q. Do you agree that the change in the

1 imputation methodology in 2024 was an important
2 change to the methodology?

3 A. Yes. And this isn't the final. I
4 don't -- I honestly do not remember what the
5 final text was.

6 Q. Right. I'm not asking about the final
7 text. We're just focusing on this document here.

8 So given that the change in the
9 imputation methodology in the fall of 2024 was an
10 important change, was it important for you to
11 understand the messaging around that change in
12 the imputation methodology?

13 A. Yes.

14 Q. Okay. And was it important for you to
15 understand how the leader of the organization,
16 Leah Binder, viewed that change in the imputation
17 methodology?

18 A. Yes.

19 Q. All right. And was it important for you
20 to understand changes or edits she was making to
21 the messaging around that change in the
22 imputation methodology?

1 A. Yes.

2 Q. Okay. But your testimony here today is
3 that you do not understand where these changes
4 are coming from?

5 MS. BLAIR: Objection to form.

6 THE WITNESS: This line right here, I
7 mean, this was an edit almost a year ago. I
8 don't remember edits from a year ago.

9 BY MR. CHUNG:

10 Q. Okay. Does this -- sitting here today,
11 looking at these edits, does it raise any
12 concerns for you about whether Leapfrog was being
13 transparent about the effect of the methodology
14 change?

15 A. No. My understanding is Leah hasn't
16 shown me any instances where she's trying to not
17 be transparent. Our goal is always transparency.

18 Q. I'm not talking about generally. Right?
19 Looking at these edits here -- right? -- which I
20 understand, based on your testimony, you don't
21 remember -- right?

22 But reading these changes here today, do

1 they give you pause or any concerns about whether
2 Leapfrog was being transparent about the effect
3 of the methodology change?

4 A. No.

5 MS. BLAIR: Objection to form.

6 THE WITNESS: No.

7 BY MR. CHUNG:

8 Q. Okay. I think we went into this a bit
9 previously, but what processes does Leapfrog have
10 in place for soliciting or collecting consumer
11 patient feedback regarding the scoring
12 methodology and the hospital safety grades?

13 A. We publish proposed changes to both
14 annually, from what I can recall at the moment.
15 It's published on our website, on our home page.
16 I mean, technically, anyone could submit a public
17 comment.

18 Q. Okay. Has Leapfrog received -- and is
19 that -- that's directly through the website,
20 correct?

21 A. Correct.

22 Q. Other than the website, is there any

1 affirmative outreach by Leapfrog to hospitals or
2 other third parties about -- to solicit feedback
3 about changes in the scoring methodology or the
4 hospital safety grades?

5 A. It's all through their proposed changes.
6 So we'll send it out through our e-mail
7 newsletters, through social media. We'll send it
8 to our stakeholders.

9 Q. Okay. Has Leapfrog ever put together any
10 panels or committees or working groups to discuss
11 or address consumer feedback about the scoring
12 methodology or the safety grades?

13 A. Can you repeat the question?

14 Q. Sure.

15 Has Leapfrog ever convened any panels or
16 committees or working groups to assess consumer
17 feedback about the scoring methodology or the
18 safety grades?

19 A. In my understanding, creating the patient
20 and family expert panel was a piece of that.

21 Q. Okay. And how was -- can you just go
22 more into that?

1 A. I don't know any more about that. I just
2 know we created it to have a direct conversation
3 with patients and families.

4 Q. Okay. Have there been any instances
5 where consumer feedback has led to a change or a
6 revision in Leapfrog's scoring methodology?

7 A. Not that I can recall.

8 Q. All right. Any instances where consumer
9 feedback has led to a change in the way hospital
10 safety grades are assigned or reported?

11 A. Not that I can recall.

12 Q. Okay. Does Leapfrog have any formal
13 policies or guidelines that govern how consumer
14 feedback is to be considered or incorporated into
15 the scoring methodology of the safety grades?

16 A. I don't know.

17 Q. Can you think of any instances where
18 consumer feedback was explicitly rejected or
19 disregarded in the process of updating or
20 maintaining the scoring methodology?

21 A. Not to my knowledge.

22 Q. Are you aware of any instances in which

1 patients or members of the public have told you,
2 told Leapfrog, that they've delayed necessary
3 medical care as a result of the safety grades?

4 A. Not that I can recall.

5 Q. All right. Are you aware of any
6 instances in which patients or members of the
7 public have reported forgoing necessary medical
8 care as a result of Leapfrog's safety grades?

9 A. Not that I can recall.

10 Q. Are you aware of any instances in which
11 patients or members of the public have reported
12 having to transfer to a hospital that they had
13 previously avoided based on Leapfrog's safety
14 grade?

15 MS. BLAIR: Objection to form.

16 THE WITNESS: Can you restate the
17 question?

18 BY MR. CHUNG:

19 Q. Yes.

20 Are you aware of any instance when a
21 patient of -- a patient or a member of the public
22 telling Leapfrog that they had to transfer to a

1 hospital that they had previously avoided because
2 of the safety grade assigned to that hospital?

3 A. Sorry, I don't understand the question.

4 Q. Okay. We can move on.

5 A. Okay.

6 Q. Has Leapfrog received any feedback from
7 patients or their families indicating that the
8 safety grades have caused confusion about which
9 hospital to go to?

10 A. Not that I can recall.

11 Q. All right. Any feedback or complaints
12 from patients and their families that safety
13 grades have led them to make unsafe healthcare
14 decisions?

15 A. Not that I can recall.

16 Q. Okay. Has Leapfrog -- has Leapfrog heard
17 from any patients or family members about
18 instances that they had to travel further to
19 hospitals as a result of the hospital safety
20 grades?

21 A. Yes. I've done that myself for planned
22 care.

1 Q. I'm not talking about yourself. I'm
2 talking about patients or their family members.

3 Have you heard any instances like that?

4 A. We have a story in our annual report, our
5 last annual report, about a patient who traveled
6 to a hospital that had an A when he was injured
7 for something. It was a non-emergent injury.

8 Q. Okay. Any instances for an emergent
9 injury where a patient had to travel further to a
10 hospital based on the hospital safety grade?

11 A. No, I have not heard of that. And our
12 messaging explicitly says go to the closest
13 hospital in an emergency.

14 Q. Okay. Where is that messaging?

15 A. It's in the -- about the gray tab. Like,
16 the first tab on -- I'm visualizing it. It's the
17 first tab on our website. And it's a very normal
18 part of our communications, our talking points.

19 Q. Okay. Are you aware of any cases where
20 patients have gone to hospitals based on
21 Leapfrog's safety grades to hospitals that were
22 under investigation or had significant safety

1 concerns?

2 A. Can you repeat the question?

3 Q. Yeah. Are you aware of any cases where,
4 based on Leapfrog's safety grades, patients have
5 gone to hospitals that were under investigation
6 or had significant safety concerns?

7 A. Not that I can think of.

8 MR. CHUNG: Let's go to tab 29.

9 This will be Exhibit 21.

10 (Bailey Deposition Exhibit 21 marked for
11 identification and attached to the
12 transcript.)

13 BY MR. CHUNG:

14 Q. All right. Ms. Bailey, Exhibit 21 is an
15 e-mail chain from February of 2023.

16 A. Okay. I've read it.

17 Q. So in this e-mail chain -- it's a thread
18 about a reporter asking why a hospital -- the
19 Mission Hospital in Asheville, North Carolina --
20 had received A grades -- right? -- from Leapfrog,
21 despite low ratings from CMS for patient
22 experience and reports of poor quality care.

1 First of all, do you remember what's kind
2 of generally being discussed in this e-mail
3 chain?

4 A. Generally.

5 Q. Okay. So on the first page -- so Bates
6 ending 649 -- Ms. Binder responds to Elizabeth
7 Harmon and Patrice Brown.

8 Who are Elizabeth Harmon and Patrice
9 Brown?

10 A. Elizabeth Harmon was the senior
11 communications coordinator, I believe, was her
12 title.

13 Patrice Brown was the chief operating
14 officer.

15 Q. Okay. She writes, Missy or I can do
16 this. I really like help from a PR firm refining
17 our talking points because this is officially a
18 serious PR issue.

19 Why was this a serious PR issue?

20 A. This -- hold on, let me look at this
21 again.

22 Q. Let me just put it another way.

1 Was -- just reading Ms. Binder's e-mail
2 response here, was this a serious PR issue
3 because of potential news around Leapfrog's
4 methodology not being supported by CMS?

5 A. No.

6 Q. How do you know that?

7 A. I don't take it as that. I mean, that's
8 not my interpretation.

9 Just -- I interpret this as -- and this
10 was a couple of years ago, so I'm trying to
11 remember.

12 I interpret this as let's discuss the
13 messaging around A-hospitals. We know no
14 hospital is perfectly safe, not even an
15 A-hospital. We need to make sure we're on the
16 same page.

17 That's what I take this as.

18 Q. Okay. But there are -- if you look at
19 the reporter's e-mail here, what's kind of cut
20 and pasted from what the reporter wrote, there
21 are specific allegations here, correct --

22 A. Yes.

1 Q. -- that Mission -- that the hospital at
2 issue gets only two stars from CMS for patient
3 experience, yet Leapfrog, which intends to rank
4 for patient safety and regularly rates Mission an
5 A, and that rating is used by Mission in its
6 marketing.

7 So how is that disjunction or disparity a
8 serious PR issue?

9 A. I take it, again, as Leah just said, we
10 need to discuss -- I don't know, this was a
11 couple of years ago, but this isn't something
12 that comes up all the time. So I took it as her
13 saying, you know, this is something we do need to
14 discuss and take seriously.

15 Q. Okay. Was she -- there's another
16 sentence in that same paragraph from the
17 reporter's allegations: But I would like to know
18 how much of Leapfrog's annual revenue is earned
19 from fees that hospitals pay for using its rating
20 in their marketing.

21 How is that -- how did that contribute to
22 this being a serious PR issue?

1 A. I don't remember that part of this.

2 Q. Okay. Was there a concern that the
3 public relations or the PR around this issue
4 would allege that Leapfrog was a pay-to-play
5 scheme?

6 A. No, I don't think so.

7 Q. Okay. He go on to write, I'd also like
8 to learn if there are other ways in which
9 Leapfrog earns fees from the hospitals that it
10 rates.

11 What was the serious PR issue around that
12 allegation?

13 A. I don't think --

14 MS. BLAIR: Objection to form.

15 THE WITNESS: I don't think that's a
16 serious PR issue.

17 BY MR. CHUNG:

18 Q. Why not?

19 A. We're transparent about this stuff. I
20 don't see it as a PR issue.

21 Q. Okay. What did Ms. Binder think was a
22 serious PR issue around this allegation?

1 A. I don't know. I told you my opinion,
2 that I think it's just the two stars from CMS.
3 Although in this e-mail, it says, for patient
4 experience, which is just one part of the
5 Leapfrog hospital safety grade.

6 Q. Is -- Ms. Binder [sic], we've looked at
7 common objections, you know, common issues
8 previously, and one of them was allegations that
9 Leapfrog was pay to play, correct? We've seen
10 that.

11 A. Correct. Ms. Bailey.

12 Q. Ms. Bailey. I'm sorry.

13 Is this an example of one of the common
14 objections or observations from the public about
15 Leapfrog being a pay-to-play scheme?

16 A. Which? Can you specifically say which
17 part for me?

18 Q. The part that we just read: But I would
19 like to know how much of Leapfrog's annual
20 revenue is earned from fees that hospitals pay
21 for using its rating in their marketplace [sic].
22 I'd also like to learn if there are other ways in

1 which Leapfrog earns fees from hospitals that it
2 rates.

3 A. I infer the patient was trying to
4 understand -- again, there's a lot of ratings out
5 there that are completely pay for play, like
6 Healthgrades, so I think there is some
7 clarification there that we likely made. I
8 wasn't part of this.

9 Q. Okay. Has Leapfrog ever issued a
10 correction or a retraction of a safety grade
11 after learning that the grade it issued may have
12 misrepresented a hospital's actual safety or
13 quality of care? Has that ever happened?

14 A. Not that I can recall. Not that I can
15 recall.

16 Q. Okay. Has there ever been discussion
17 among your colleagues of the potential public
18 health risks associated with publishing safety
19 grades for hospitals where it lacks sufficient or
20 reliable data?

21 A. Can you restate the question?

22 Q. Yes.

1 Has there been any discussion among your
2 colleagues about the potential public health
3 risks associated with publishing safety grades
4 for hospitals where Leapfrog lacks sufficient or
5 reliable data?

6 A. I don't know.

7 Q. Okay. Is that -- given part of what
8 we've been discussing during this deposition is
9 about non-participating hospitals -- right? --
10 and that they're automatically assigned the
11 lowest possible score in the four imputed metrics
12 where there isn't data, has there ever been any
13 discussion among you and your colleagues about
14 whether assigning that lowest score on imputed
15 metrics might present a public health risk?

16 A. Not that I can recall.

17 Q. All right. I asked you, I think,
18 previously whether you're aware of any feedback
19 or complaints from hospitals regarding the
20 accuracy or fairness of their assigned safety
21 grades, but I'll ask again.

22 Are you aware of any feedback or

1 complaints from hospitals along those lines?

2 A. Can you restate the question?

3 Q. Yes.

4 Are you aware of any feedback or
5 complaints from hospitals regarding the accuracy
6 or fairness of the safety grades assigned to
7 them?

8 A. Besides the obvious, we're sitting in
9 this room today because your clients are very
10 unhappy with their safety grades.

11 Q. Apart from the -- the plaintiff hospitals
12 involved here.

13 A. Not that I can recall.

14 Q. Okay.

15 MR. CHUNG: Let's go to tab 23.

16 This is Exhibit 22.

17 (Bailey Deposition Exhibit 22 marked for
18 identification and attached to the
19 transcript.)

20 THE WITNESS: Okay. I've read it.

21 BY MR. CHUNG:

22 Q. Okay. Ms. Bailey, have you seen this --

1 the comment here, or this -- the feedback from
2 the help desk?

3 A. No.

4 Q. Do you recognize the format of this
5 document, that it's a comment submitted to the
6 help desk?

7 A. I don't look at the help desk, but I can
8 infer that it's from the help desk. Yes.

9 Q. All right. Now, the commenter here
10 writes that they're disappointed with the 2024
11 proposed changes.

12 And I should note, this is from May 21 of
13 2024.

14 And she writes that the changes will
15 penalize hospitals that do not submit a Leapfrog
16 survey. The public will not understand nor dig
17 into methodology of these grades, and hospitals
18 will be falsely represented with a lower grade
19 because they chose not to complete a survey.

20 Is that -- have you seen this feedback
21 before?

22 A. No, I haven't seen feedback from this.

1 Q. Okay. Is it a fair -- do you think
2 that's a fair characterization, that the proposed
3 changes in the imputation methodology will
4 penalize hospitals that do not submit a Leapfrog
5 survey by automatically assigning them the lowest
6 possible score on the four imputed metrics?

7 A. Can you restate the question?

8 Q. Yes.

9 Do you think it's a fair assessment, a
10 fair statement here, that the changes here will
11 penalize hospitals that do not submit a Leapfrog
12 survey?

13 A. No. I mean, I wouldn't agree with that.

14 Q. Okay. Why not?

15 A. I mean, I don't see it that way.

16 Q. Aren't -- well, aren't the hospitals, in
17 fact, being penalized for not participating in
18 the survey by being automatically assigned these
19 lowest possible scores on the four metrics?

20 MS. BLAIR: Objection to form.

21 THE WITNESS: I don't see it that way.
22

1 BY MR. CHUNG:

2 Q. Okay. How about the statement here that
3 the public will not understand nor dig into the
4 methodology of these grades?

5 I think you would agree with that, right?

6 A. It --

7 MS. BLAIR: Objection to form.

8 THE WITNESS: You'll see that Missy -- I
9 don't understand exactly how this works, but it
10 looks like Missy said that we should do a symbol.

11 So this was part of the -- from what I
12 understand. I'm not involved in looking at the
13 comments, but what I would -- here -- would --
14 what Missy said above, which -- let's make sure
15 it's clear on the website.

16 That's what I take from that.

17 BY MR. CHUNG:

18 Q. My question is -- I'm not -- we haven't
19 gotten to Missy's comment and your response yet.
20 Right?

21 But the comment or statement here that
22 the public will not understand nor dig into the

1 methodology of these grades -- right? -- wouldn't
2 you agree with that?

3 A. No.

4 MS. BLAIR: Objection to form.

5 THE WITNESS: I don't know if the public
6 will look into it or not.

7 BY MR. CHUNG:

8 Q. Okay. Well, you're a communications
9 director, right? I mean, you are -- you're a
10 communications professional.

11 Isn't it part of your expertise to at
12 least have a hypothesis as to what the public
13 will understand or delve into?

14 A. I mean, I don't -- I don't know what any
15 one person is going to understand or not
16 understand. My goal is just always to be as
17 transparent as we can be on the website.

18 Q. Right. But I think you've testified, I
19 think, repeatedly throughout your deposition that
20 describing the steps in the changed imputation
21 methodology is too in the weeds, correct?

22 A. Correct.

1 MS. BLAIR: Objection to form.

2 BY MR. CHUNG:

3 Q. All right. And I think that's consistent
4 with what the commenter here is saying, that the
5 public will not understand nor dig into the
6 methodology of these grades, correct?

7 A. Can you restate that?

8 Q. Yeah.

9 And is that -- the position you've taken
10 with respect to the changes in the imputation
11 methodology being too in the weeds, that's
12 basically what the commenter is saying here,
13 right? That the public will not understand nor
14 dig into the methodology of these grades,
15 correct?

16 A. Yes.

17 Q. Okay. And is it -- the next part of the
18 sentence here, that hospitals will be falsely
19 represented with a lower grade because they chose
20 not to complete a survey, isn't that a fair
21 observation, given that the public will not
22 understand how they got the grade in the first

1 place?

2 MS. BLAIR: Objection to form.

3 THE WITNESS: I don't think so. I don't
4 think that it's necessarily falsely
5 representative if a hospital did the survey; you
6 get the same score.

7 BY MR. CHUNG:

8 Q. Okay. But for those hospitals that do
9 end up getting a lower score -- right? -- isn't
10 it true -- isn't it a fair assessment that that
11 score is a false representation of that hospital?

12 MS. BLAIR: Objection to form.

13 THE WITNESS: I don't think so.

14 MR. CHUNG: Let's go on to the next tab,
15 24.

16 BY MR. CHUNG:

17 Q. Actually, before we go on to the next
18 one, the next sentence in the comment is the
19 survey is -- we're still on Exhibit 22 -- the
20 survey is extremely time-sensitive [sic] and in a
21 time when hospitals are barely breaking even
22 financially; they do not have the resources to

1 commit to this survey.

2 Is that -- what is your reaction to that
3 statement?

4 A. My reaction to that statement is that the
5 opposite of that is also true: If hospitals --
6 we've seen hospitals that do prioritize patient
7 safety make the time for this, and they spend a
8 lot less time on Leapfrog than a lot of other
9 ratings.

10 Q. Okay. But what do you make of this
11 particular statement itself? Is the survey
12 extremely time-intensive?

13 A. I don't think it is.

14 Q. Okay. And what is that based on?

15 A. My opinion.

16 Q. What is that opinion based on?

17 A. That we've heard from hospitals it takes
18 40 to 80 hours, and we're talking about an entire
19 year.

20 Q. Okay.

21 A. So I don't think that's a lot of time.

22 Q. All right. Have you heard also of

1 hospitals that do not have the resources to
2 commit to responding to the survey?

3 A. No, not personally, no.

4 Q. Okay.

5 MR. CHUNG: All right. Let's move on to
6 24, which will be Exhibit 23.

7 (Bailey Deposition Exhibit 23 marked for
8 identification and attached to the
9 transcript.)

10 BY MR. CHUNG:

11 Q. Now, Exhibit 23 is another comment
12 submitted through the help desk, we believe, in
13 response to the planned safety grade methodology
14 changes in 2024.

15 And Ms. Bailey, if you look at the --
16 kind of the last entry there, it reads, We
17 strongly disagree with the proposed fall 2024
18 step 2 imputation.

19 Do you see that?

20 A. Yes.

21 Q. Okay. If Leapfrog is going to implement
22 this change, they need to offer hospitals an

1 option to opt out of being graded rather than
2 penalize a hospital for not submitting the
3 resource-intensive survey.

4 Do you see that?

5 A. Yes.

6 Q. Okay. What is your reaction to that
7 particular comment?

8 MS. BLAIR: Objection to form.

9 THE WITNESS: My initial reaction is that
10 a theoretical option to opt out is completely
11 against the whole point of the safety grade,
12 which is to assign grades to hospitals and have
13 as much data as possible for patients.

14 BY MR. CHUNG:

15 Q. Okay. So part of -- I think you said
16 that one of the aims of the hospital safety grade
17 is to have as much data as possible for patients,
18 correct?

19 A. Correct.

20 Q. All right. But where, for
21 non-participating hospitals, the hospital safety
22 grades are based at least in part -- right? -- on

1 the absence of data, does that achieve that
2 mission?

3 MS. BLAIR: Objection to form.

4 THE WITNESS: I mean, I was specifically
5 talking about grades, like having more hospitals
6 graded available.

7 BY MR. CHUNG:

8 Q. Okay. But for a number of those
9 hospitals that are being graded -- right? -- that
10 didn't participate in the survey, that's not
11 based on actual data, correct?

12 MS. BLAIR: Objection to form.

13 BY MR. CHUNG:

14 Q. At least with respect to the four imputed
15 metrics; is that right?

16 A. It's our methodology.

17 Q. Okay. Hospitals who do not -- I'm just
18 reading further here: Hospitals who do not have
19 the resources to do the survey annually should
20 not be so adversely punished, especially in the
21 post-COVID era where resources are increasingly
22 hard to come by and retain.

1 What's your reaction to that comment?

2 A. My reaction to that comment is that -- I
3 mean, I think they're talking about burden --
4 right? -- of the survey. And we look at burden
5 differently at Leapfrog. We don't look at burden
6 as how long it takes a hospital to fill out a
7 survey. We think of burden -- of [sic] patients
8 of having the absence of that data.

9 Q. Okay. So the fact that a hospital does
10 not have resources or resources can -- are taken
11 away from actual care of patients is not a factor
12 that concerns Leapfrog?

13 MS. BLAIR: Objection to form.

14 THE WITNESS: In my understanding, it's
15 not the actual clinicians who are doing the
16 survey. They're not the ones providing patient
17 care, in my understanding.

18 BY MR. CHUNG:

19 Q. Okay. What is your understanding as to
20 who is responding to the survey, then?

21 A. It's quality people. People are
22 specifically hired to do ratings programs, from

1 my knowledge of working in a hospital.

2 Q. There are -- so you're saying that there
3 are -- so no patient care resources are diverted
4 at all when having to respond to the survey? Is
5 that your testimony?

6 A. I'm not saying that. I'm not an expert
7 in hospitals.

8 I'm saying, from my understanding, it's
9 not the same people who are, you know, performing
10 surgeries that are doing the survey.

11 Q. Okay.

12 MR. CHUNG: Let's go to tab 25. This
13 will be Exhibit 24.

14 (Bailey Deposition Exhibit 24 marked for
15 identification and attached to the
16 transcript.)

17 BY MR. CHUNG:

18 Q. Similarly, Ms. Bailey, another comment in
19 response to the change in methodology in 2024.

20 So if you look at the second page toward
21 the bottom, the comment reads, Imputation step 2
22 model.

1 Do you see that?

2 A. Yes.

3 Q. Yes. And the commenter -- commentator
4 writes, We feel like this model is unnecessarily
5 punitive. We often skip survey submission
6 because the responses provided for IPS, hand
7 hygiene, BMCA [sic] and CPOE are largely
8 unchanged in the two-year period that was
9 allotted before negatively impacting grades, and
10 the FTE resource commitment to complete the
11 survey is already significant. There's no value
12 added by completed a survey every year or every
13 other year when practices in our hospitals have
14 not changed.

15 Is that a fair response to the change in
16 the imputation methodology? The -- first, that
17 the model is unnecessarily punitive?

18 A. I mean, I don't agree with that.

19 Q. Why don't you agree with that?

20 A. I've already testified that I don't think
21 it's unnecessarily punitive.

22 Q. Okay. What about the fact that at least

1 this particular hospital skips survey submission
2 because the responses provided for the four
3 imputed metrics is largely unchanged in the
4 two-year period?

5 MS. BLAIR: Objection.

6 BY MR. CHUNG:

7 Q. What's your reaction to that?

8 A. That I have -- I don't have any
9 information about that. I wouldn't be able to
10 speak to if it's accurate or not.

11 Q. If it is accurate, is it a fair criticism
12 of the change in the imputation methodology?

13 MS. BLAIR: Objection to form.

14 THE WITNESS: I don't think so.

15 BY MR. CHUNG:

16 Q. And why not?

17 A. I don't -- I mean, I don't know -- I
18 don't run a hospital, so I don't know how this
19 is. I just know that these measures are
20 important, and our goal at Leapfrog is to have
21 the most up-to-date data possible.

22 Q. Right. But where that data for the four

1 imputed metrics has been largely unchanged in the
2 two-year period -- right? -- is it a fair reason
3 for a hospital then to not respond to the survey
4 in a given year?

5 MS. BLAIR: Objection to form.

6 BY MR. CHUNG:

7 Q. Especially where there are resource
8 constraints.

9 A. I don't know that it's not unchanged.

10 Q. I'm just asking you, if we assume that
11 what the commenter here is saying is true.

12 A. I don't know.

13 Q. Okay.

14 A. Not my area.

15 MR. CHUNG: Exhibit 25.

16 (Bailey Deposition Exhibit 25 marked for
17 identification and attached to the
18 transcript.)

19 BY MR. CHUNG:

20 Q. All right. Ms. Bailey, different format
21 here, but another response to the change --
22 proposed change in imputation methodology. This

1 is from June 2024 from Ascension.

2 Are you familiar with Ascension?

3 A. Just that it's a hospital system.

4 Q. Okay. Now, this is coming from the chief
5 advocacy officer, a Peter Leibold.

6 At the bottom of the first page of this
7 letter he writes, Ascension cannot support
8 Leapfrog's proposed update and strongly
9 encourages Leapfrog to refrain from implementing
10 it. We fundamentally believe that the hospital
11 safety grade and the hospital survey should
12 remain separate. The survey should not affect
13 the grades. We don't -- we believe this is not
14 in the best interest of public policy as not all
15 the hospitals have the information or
16 capabilities to complete the hospital survey. We
17 further believe it is unreasonable for an
18 optional survey to have such a significant
19 impact.

20 Is it your view that the survey is
21 optional?

22 A. Yes. It's voluntary.

1 Q. Okay. But where -- after the change in
2 the imputation methodology in 2024, is it fair to
3 say that the survey has effectively become a
4 required one for hospitals?

5 A. No, I don't think so.

6 MS. BLAIR: Objection.

7 Sorry. Objection to form.

8 BY MR. CHUNG:

9 Q. Go ahead.

10 A. There's still hospitals that get As that
11 don't do the survey.

12 Q. Okay. But where a non- -- formerly a
13 non-participating hospital risks a lower grade
14 because it's automatically assigned the lowest
15 possible grade on four imputed metrics, is it
16 fair to say that more hospitals will feel that
17 this is a required survey, as opposed to an
18 optional survey?

19 A. I don't know how hospitals will feel.
20 It's four of, you know, up to 32 measures.

21 Q. Okay. But by your own testimony,
22 these -- the four measures are among the most

1 critical for purpose of patient safety, correct?

2 MS. BLAIR: Objection to form.

3 THE WITNESS: Yeah. Yes.

4 BY MR. CHUNG:

5 Q. Isn't that part of the reason that they
6 were -- that they are the -- four of the metrics
7 that were selected for this imputation
8 methodology?

9 MS. BLAIR: Objection to form.

10 THE WITNESS: Yes. It still doesn't
11 change that it's just four of up to 32.

12 BY MR. CHUNG:

13 Q. Okay. But getting the lowest possible --
14 automatically getting the lowest possible score
15 on those four imputed metrics does increase the
16 risk that the hospital will get a lower resulting
17 safety grade; is that fair?

18 MS. BLAIR: Objection to form.

19 THE WITNESS: Not necessarily.

20 MR. CHUNG: Okay. Let's go to tab 27.

21 This will be 26.

22

1 (Bailey Deposition Exhibit 26 marked for
2 identification and attached to the
3 transcript.)

4 BY MR. CHUNG:

5 Q. Okay. Another comment and response to
6 the proposed imputation methodology.

7 So if you look at the final entry on the
8 second page, Ms. Bailey, the commenter here
9 outlines a number of what she calls more accurate
10 options.

11 Do you see that?

12 A. I'm not there yet.

13 Q. Okay.

14 A. Oh, I see the line now. Okay.

15 Q. Okay.

16 A. It starts with "rather"?

17 Q. Yup.

18 A. Is that where you're at?

19 Okay.

20 Q. And my question is, were any of these
21 alternatives discussed at Leapfrog?

22 A. I don't know.

1 MR. CHUNG: Let's go to -- let's skip
2 that.

3 THE WITNESS: Can we take a break next
4 time we're pending?

5 MR. CHUNG: We can take a break right
6 now.

7 THE WITNESS: Great.

8 VIDEO TECHNICIAN: The time is 2:49 p.m.
9 This ends unit 3. We're on the record.

10 (A recess was taken.)

11 VIDEO TECHNICIAN: The time is 3:04 p.m.
12 This begins unit number 4. We're on the record.

13 MR. CHUNG: All right. Ms. Bailey, we're
14 going to put another document in front of you
15 marked 27, Exhibit 27.

16 (Bailey Deposition Exhibit 27 marked for
17 identification and attached to the
18 transcript.)

19 BY MR. CHUNG:

20 Q. It's another Slack chat between yourself
21 and, I think, Katie Stewart.

22 A. Okay.

1 Q. And to start with, who is Katie Stewart?

2 A. Katie Stewart is the director of
3 healthcare ratings.

4 Q. And she works under Ms. Danforth; is that
5 right?

6 A. Yes.

7 Q. Why don't you take a few moments to
8 review that.

9 And so this is from November 15, 2024. I
10 want to direct your attention -- at 2:46 p.m., it
11 looks like Ms. Stewart asks you, Any thoughts on
12 what to say when a reporter is interested in two
13 hospitals that got worse because of the
14 imputation change?

15 Is this a particular -- specific instance
16 that she's referring to, so far as you're aware?

17 A. I don't remember this conversation, but
18 that's what I would infer, yes.

19 Q. Okay. And you respond, I know Leah said
20 she didn't want to lean in on the transparency
21 side, but that's what this is.

22 What did you mean here when Leah said she

1 didn't want in on the transparency side? Do you
2 remember?

3 A. I don't really remember this.

4 Q. Okay. Do you remember her saying that
5 she didn't want to lean in on the transparency
6 side?

7 A. I don't recall this -- like, talking
8 about this specifically.

9 Q. Okay. If we go down several lines, at
10 2:52 -- or, actually, up at 2:51, Ms. Stewart
11 writes, Not sure what else we can say.

12 And she continues, They should report.
13 LOL.

14 And you respond, Right. Totally. We are
15 focused on accuracy and having the most recent
16 data possible.

17 Does that refresh your recollection as to
18 what Ms. Binder was saying when she did not want
19 to lean in on the transparency side?

20 A. I really don't remember that
21 conversation. I remember the second half of that
22 sentence, that we want to encourage hospitals to

1 be transparent and report their data.

2 That's in line with our regular
3 messaging.

4 Q. Okay. But you don't recall what Leah
5 specifically was saying about not wanting to lean
6 in on the transparency side?

7 A. I don't remember. This was almost a year
8 ago.

9 Q. Okay.

10 A. I don't remember.

11 MR. CHUNG: Let's go to 59.

12 The story as well.

13 This will be 28 and 29.

14 (Bailey Deposition Exhibits 28 and 29
15 marked for identification and attached to
16 the transcript.)

17 BY MR. CHUNG:

18 Q. So Exhibit 28 is an e-mail chain.
19 Exhibit 29 is basically a statement, a public
20 statement, that's referenced in the e-mail chain.

21 So just take a few moments to review
22 that.

1 A. So I vaguely recall this.

2 Q. Okay. So you have a vague recollection
3 as to what's being discussed here.

4 A. Yes.

5 Q. So what is being discussed? And then
6 we'll go into more specifics.

7 A. A media request from AL.com, which is an
8 outlet in Alabama, about a Huntsville hospital.

9 Q. Okay. And is it that this Huntsville
10 hospital was issued a statement disputing
11 Leapfrog's spring 2025 hospital safety grade that
12 penalized the hospital for not completing the
13 survey? Is that what this is about?

14 MS. BLAIR: Objection to form.

15 THE WITNESS: From reading the context of
16 the e-mail and from what I remember, it was
17 actually -- the reporter first did a story about
18 their F, and then, in response, the hospital did
19 this statement.

20 BY MR. CHUNG:

21 Q. Okay.

22 A. That's my understanding.

1 Q. Have you had a chance to review the
2 statement as well that's Exhibit 29.

3 A. It's been a few months, so let me dig in.

4 Q. Okay. So Ms. Bailey, just focus in on
5 the first instance in the first paragraph of the
6 statement.

7 A. Okay.

8 Q. And this is a statement issued by
9 Huntsville Hospital.

10 The first paragraph reads, The Leapfrog
11 survey is not an accurate measure of patient
12 safety at Huntsville Hospital. The hospital did
13 not complete this voluntary 353-page survey, yet
14 Leapfrog chose to publish a rating with
15 incomplete information. This process is unfair
16 to the thousands of dedicated clinicians working
17 around the clock to care for the community and
18 response -- and respond to the emergencies
19 anytime they are called.

20 So is that kind of the gist of what the
21 reporter wants Leapfrog to respond to?

22 A. It looks like the reporter is just asking

1 for more data about the hospital.

2 Q. Okay.

3 A. And then how does Leapfrog respond to the
4 issues raised in the statement. That's what they
5 asked.

6 Q. All right. If you look at -- in the
7 e-mail chain, Bates ending in 1050, you write
8 June 4, 2025, to members of CURA Strategies,
9 Alexander [sic] Campione, Nate Longmore, and
10 Karen Jupiter.

11 You write, in the middle of your e-mail,
12 Leah is out until Tuesday. I'm not sure that
13 this warrants her needing to do a statement.
14 We'd like to keep this out of the press as much
15 as possible.

16 Why did you want to keep this out of the
17 press as much as possible?

18 A. It's not standard practice that we
19 publicize F grades.

20 Q. Okay. Is this -- is this publicizing an
21 F grade? Is that what is at issue here?

22 A. I mean, the original story that we're

1 talking about in this, from Huntsville Hospital,
2 is a story just about one F-hospital, and that's
3 not something that we proactively will pitch.
4 Our pitches are typically -- our priority is
5 focused on promoting positive stories,
6 A-hospitals.

7 Q. Okay. Even in response to a statement, a
8 public statement, from the hospital?

9 A. Can you restate your question?

10 Q. Yeah.

11 So even where the hospital has made a
12 public statement -- right? -- challenging its
13 grade and the process --

14 MS. BLAIR: Objection to form.

15 BY MR. CHUNG:

16 Q. -- you wanted to -- well, let me put it
17 another way.

18 What is the "this"? When you read that
19 sentence, We'd like to keep this out of press as
20 much as possible.

21 Right? So there's no -- I don't think
22 this is referring to a proactive press effort on

1 this issue. But how -- why did you want to keep
2 this out of the press as much as possible?

3 A. Just from my memory, specifically we just
4 didn't want more stories about F-hospitals in the
5 news.

6 Q. Okay. Did you -- was it keeping stories
7 about F-hospitals out of the news or was it
8 keeping stories out of the hospitals challenging
9 their hospital safety grades out of the news? Or
10 both?

11 A. From what I remember, it was the first,
12 keeping the -- like, our focus is not the
13 F-hospitals. We didn't want more stories in the
14 press about F-hospitals.

15 Q. Okay. Now, you suggested that, in
16 response, that the focus should be on how the
17 hospital is now going to participate in the
18 Leapfrog survey.

19 Do you see that?

20 A. Yes.

21 Q. Do you have an understanding as to why
22 where the hospital -- here, Huntsville

1 Hospital -- has called the Leapfrog survey not an
2 accurate measure of patient safety and that the
3 process is unfair -- do you have an understanding
4 as to why the hospital would now agree to commit
5 significant resources to complete the survey?

6 MS. BLAIR: Objection to form.

7 BY MR. CHUNG:

8 Q. Why is it doing that?

9 MS. BLAIR: Same objection.

10 THE WITNESS: I don't know why they're
11 doing the survey. They put in their statement
12 they're going to do the survey. I only know
13 what's written on this paper.

14 BY MR. CHUNG:

15 Q. All right. Fair to say that they're
16 feeling coerced into completing the survey?

17 MS. BLAIR: Objection to form.

18 THE WITNESS: I wouldn't say that, no.

19 BY MR. CHUNG:

20 Q. Have you gotten any sort of feedback from
21 hospitals that they feel like they're being
22 coerced into the survey because of this

1 methodology change?

2 A. Not that I can recall.

3 Q. Okay.

4 MR. CHUNG: Let's go to tab 60.

5 BY MR. CHUNG:

6 Q. Actually, before we go there, let's go --
7 we have another document relating to this
8 Huntsville, Alabama -- Huntsville Hospital.

9 A. Okay.

10 MR. CHUNG: And this will be Exhibit 30.
11 (Bailey Deposition Exhibit 30 marked for
12 identification and attached to the
13 transcript.)

14 BY MR. CHUNG:

15 Q. Now, relatedly, Ms. Bailey, Exhibit 30 is
16 an article I believe from AL.com as a follow-up
17 to this exchange regarding the Huntsville
18 Hospital.

19 Just let me know if you've seen it
20 before.

21 A. Yeah, that's what it looks like.

22 Q. Okay. And you'll see that it's based on

1 an interview with the Huntsville Hospital CEO
2 Jeff Samz; is that right?

3 A. Yes.

4 Q. And you'll see on the third page of the
5 document, in the middle of the page, he's quoted,
6 Now, because of the coercive nature of Leapfrog
7 creating a false score that is going to coerce
8 our hospital into completing a survey, I'm going
9 to take resources that could be used for patient
10 care or doing something productive and I'm going
11 to have to dedicate them for months to fill out a
12 survey. So publishing a score that is, by the
13 way they do it, low creates a false perception of
14 the safety of the organizations that don't
15 participate in the survey.

16 Does this refresh your recollection as to
17 why the Huntsville Hospital decided eventually to
18 fill out the survey?

19 A. I don't know that they have done the
20 survey. I only know what we're reading. I don't
21 have any other context.

22 Q. Okay. So this doesn't refresh your

1 recollection as to why they decided to eventually
2 submit to the survey?

3 A. I don't know if they do do the survey
4 today, and I don't know anything besides what
5 we're reading.

6 Q. Okay. So you've never -- you haven't
7 seen this article before?

8 A. I have seen this article. I'm just
9 saying I don't know anything beyond what we're
10 reading in this.

11 Q. Okay. Do you know whether there have
12 been any discussions with the Huntsville
13 Hospital -- with the CEO or other members of the
14 staff about their decision to respond to the
15 survey eventually?

16 A. I don't know, actually.

17 Q. Okay.

18 MR. CHUNG: Let's move on to 60. So this
19 will be Exhibits 31 and 32.

20 (Bailey Deposition Exhibits 31 and 32
21 marked for identification and attached to
22 the transcript.)

1 BY MR. CHUNG:

2 Q. All right. Ms. Bailey, Exhibits 31 and
3 32 are an e-mail chain and then an article that's
4 referenced in that e-mail chain arising from an
5 e-mail with a healthcare reporter in Cleveland
6 about another hospital disputing its spring 2025
7 hospital safety grade.

8 And I want to direct you first to the
9 e-mail from Julie Washington from Cleveland.com.

10 A. Yes.

11 Q. And this is on Bates ending 7440.

12 She addresses you, Hi, Lauren. I am a
13 healthcare reporter at the Cleveland Plain Dealer
14 and Cleveland.com, and I'm wanting to -- and I'm
15 writing about the spring Leapfrog grades. A
16 local hospital leader made the statement below,
17 and I wanted to run it past you because it
18 doesn't align with an explanation from Leapfrog's
19 CEO Leah Binder that I saw in Becker's. Can you
20 please clarify?

21 So -- it looks like Ms. Washington
22 excerpts from a statement from a local hospital

1 leader: In the past, Leapfrog carried forward
2 past responses for hospitals that did not fill
3 out a survey. Now, the safety nonprofit will no
4 longer carry four-year-old scores, and they
5 basically assign you the lowest ranking of the
6 people who completed the survey.

7 Do you recall, at least generally, this
8 discussion?

9 A. Yes. I remember generally.

10 Q. Okay. Now, what -- the second document,
11 so Exhibit 32, is the -- what we understand to be
12 the Becker's article that Ms. Washington is
13 alluding to. Okay? And it quotes Ms. Binder.

14 Do you see that?

15 A. Yes. I'm just reading it.

16 Q. In the fourth paragraph down it says --
17 or she says, We use the Leapfrog data when we
18 have that data. We impute scores for the data
19 when we don't have it. I think that the measures
20 that the hospitals are concerned about are four
21 out of the 30 measures we use in the hospital
22 safety grades.

1 Do you see that?

2 A. Yes.

3 Q. Okay. Is this the statement the reporter
4 was referring to as not aligning with what she
5 was hearing from the hospital?

6 A. I'd assume so. She's quoted one more
7 time in the next page.

8 Q. Okay.

9 A. Or two more times.

10 Q. Have you -- it sounds like you've
11 interacted with this reporter before, who's a
12 healthcare reporter for the Cleveland Plain
13 Dealer. Am I right?

14 A. Most likely. We talk to a lot of
15 reporters, so I don't remember specifically. But
16 Cleveland.com is an outlet that covers Leapfrog.
17 Yes.

18 Q. Okay. So if the healthcare reporter here
19 thought that these statements did align -- I
20 mean, what's your view as to whether ordinary
21 consumers or patients would think? Wouldn't they
22 also believe that these statements didn't align?

1 MS. BLAIR: Objection to form.

2 THE WITNESS: I don't know what the first
3 statement is that we're comparing. I don't see
4 what the first statement is.

5 BY MR. CHUNG:

6 Q. The first statement from -- the excerpt
7 from the hospital itself. At the bottom --

8 A. Where?

9 Q. -- of Bates ending 7440.

10 A. 7440?

11 Q. Yes.

12 A. Oh, this (indicating)?

13 Q. Correct. Yeah. Below the...

14 A. I mean, that's not accurate, what the
15 hospital said. We do still use past scores; it's
16 just a different time period.

17 Q. Right. That's if -- that's with respect
18 to step 1 of the imputation methodology, correct?

19 A. Right. That's what it looks like the
20 hospital is referring to, is step 1.

21 Q. Okay. But what -- doesn't this actually
22 refer to step 2, actually?

1 MS. BLAIR: Objection to form.

2 BY MR. CHUNG:

3 Q. If your old scores aren't applicable
4 under step 1, the hospital is assigned a lowest
5 ranking of all the hospitals who complete the
6 survey, correct?

7 A. I mean, to me, it sounds like this
8 hospital is confused. They didn't know that
9 step 1 was still in place.

10 I'm not sure. I don't know what the
11 hospital meant.

12 Q. Okay. Ms. Washington is asking you,
13 though -- she's observing that it does not align
14 with Ms. Binder's explanation, correct, in
15 Becker's.

16 A. That's what she's saying. Yes.

17 Q. Okay. So do you agree with her that the
18 two statements did not align?

19 MS. BLAIR: Objection to form.

20 THE WITNESS: I mean, I agree that the
21 hospital seems to be confused.

22

1 BY MR. CHUNG:

2 Q. Okay. How are they confused?

3 A. I just testified to that, that it seems
4 that they don't understand that the step 1 of the
5 imputation still exists.

6 Q. Okay. But is it incorrect that if --
7 that, in step 2, hospitals are assigned the
8 lowest possible grade or the lowest ranking of
9 the people who completed the survey?

10 A. Yeah, that's correct.

11 Q. Okay. So does that align with
12 Ms. Binder's statement from the Becker's article
13 that we use the Leapfrog survey when we have that
14 data; we impute scores for the data when we don't
15 have it?

16 Does Ms. Binder, in the Becker's article,
17 say anything about assigning those non-reporting
18 hospitals the lowest possible score?

19 A. Not in the quote, but I'm -- like, she
20 very well might have said it in an interview. We
21 can't control what pieces the reporter decides to
22 quote.

1 Q. Understood. But in what was published in
2 the article, it's not mentioned at all, it's not
3 disclosed at all, by Ms. Binder that the lowest
4 possible score is assigned to those
5 non-participating hospitals on those four
6 metrics, correct?

7 A. She didn't quote that part, but like I
8 said, Leah very well could have said it. We
9 can't control what a reporter reports.

10 Q. Do you know if she did?

11 A. I don't know. I don't staff her
12 interviews. You'd have to ask her.

13 Q. Okay. So the hospital -- so I think your
14 testimony is that the hospital at issue here is
15 confused about the methodology; is that right?

16 A. That's what I -- that's how I read it.
17 And that's how I read it at the time, too.

18 Q. Going back to one of my questions
19 earlier: If a hospital is confused about the
20 methodology, do you expect consumers -- isn't it
21 fair to say that consumers would be confused by
22 the methodology as well?

1 MS. BLAIR: Objection to form.

2 THE WITNESS: She's saying a local
3 hospital leader. I have no idea who this person
4 is, what their role is. They could very well
5 have the same knowledge as a consumer, so I can't
6 draw that inference.

7 MR. CHUNG: Okay. Let's go to tab 61.
8 This will be 33, Exhibit 33.

9 (Bailey Deposition Exhibit 33 marked for
10 identification and attached to the
11 transcript.)

12 BY MR. CHUNG:

13 Q. Okay. Exhibit 33 is an e-mail chain from
14 June 2024. And then you'll see a second part of
15 the document, Final updates to Leapfrog hospital
16 safety grade methodology for fall 2024.

17 Do you recognize this document?

18 A. I've seen it before. Yes.

19 Q. Okay. And what is it?

20 A. It looks like it's a draft of the final
21 updates for the safety grade methodology for fall
22 2024.

1 Q. Okay. So on the page ending Bates 0454,
2 Ms. Danforth writes to Ms. Binder, Mr. Austin,
3 and copying Alexandra Campione, Hi, Leah and
4 Matt. Alex did a great job responding to the
5 public comments we received and finalizing the
6 changes to the fall 2024 hospital safety grade
7 methodology.

8 Is that correct? Is that -- Alexander
9 [sic] Campione was responsible for responding to
10 the public comments here?

11 A. I don't know. I'm not her manager. I
12 don't know what she does. Like, I don't -- I
13 don't know.

14 Q. You don't know what she does?

15 A. Like, I don't know how they divide up
16 roles, but that's -- it looks like that's what
17 Missy said. So...

18 Q. Okay. Did you -- let's put it another
19 way.

20 As director of communications, did you
21 regularly communicate with Ms. Campione about the
22 change to the imputation methodology?

1 A. We talked about the changes. We -- not
2 that I recall we talked about the public
3 comments. That's typically separate.

4 Q. Okay. So do you know whether
5 Ms. Campione finalized the changes to the
6 imputation methodology?

7 A. I don't -- I don't know. That's what
8 this says. It looks like she proposed this draft
9 of the final changes, and they potentially
10 provided edits. I don't think I was on this
11 e-mail chain.

12 Q. Okay. Just looking at the next e-mail --
13 so Bates ending 0453 -- Ms. Binder writes,
14 responding to Ms. Danforth, Thanks, Missy and
15 Alex. This is a hard one to do.

16 Did you have an understanding as to what
17 she meant by that?

18 A. I don't know what she meant.

19 Q. Okay. Did you have any conversations
20 with Ms. Campione about this being a particularly
21 difficult project to work on? The imputation
22 methodology.

1 A. I don't -- I don't recall.

2 Q. Okay. You don't recall having any
3 conversations like that with Ms. Campione?

4 A. We talked about the messaging. Any
5 change comes with different challenges. I don't
6 recall any.

7 Q. Any change comes with -- I don't
8 understand.

9 A. Like -- can you restate your original
10 question?

11 Q. Yeah.

12 Did you have any discussions with
13 Ms. Campione about difficulties -- right? -- or
14 challenges relating to the changes to the
15 imputation methodology in fall 2024?

16 A. Yeah, I don't recall this specifically.
17 I know that anytime we're getting a final update
18 done, it can be challenging. There's a lot of
19 people you have to collaborate with, and it's a
20 big project. I think -- I mean, that's what I
21 think.

22 Q. Generally speaking? I'm asking specific

1 to this particular change in the imputation
2 methodology.

3 A. I don't know.

4 Q. You don't know?

5 A. I just said what I know.

6 Q. Okay. All right. Let's discuss the
7 lawsuit itself.

8 When did you first learn about the
9 lawsuit that's in front of us?

10 A. On April 30th.

11 Q. And was that the date the lawsuit was
12 filed?

13 A. I think so.

14 Q. Okay. How did you learn about the
15 lawsuit?

16 A. I was up late getting the website ready
17 for the safe grade launch the next morning and
18 got a call that it had been filed.

19 Q. Okay. Have you been involved in
20 Leapfrog's response to the lawsuit?

21 A. From a communications perspective, yes.

22 Q. Okay. And what do you mean by that, from

1 a communications perspective you've been involved
2 in the response to the lawsuit?

3 A. Well, in a lot of ways, there was -- we
4 needed a public relations response right away
5 because there were very aggressive lies being
6 told by, actually, your firm in the media, and we
7 needed to reply right away. So that was a public
8 relations concern.

9 Q. Okay. So what specific things did you do
10 as part of that effort?

11 A. We that evening, from my recollection,
12 put a short statement up on the website. The
13 next day we did a more detailed statement when we
14 had a little more time.

15 We reached out to local reporters with
16 publicly filed -- your publicly filed complaint.

17 Q. Anything else?

18 A. That's what I can recall right now.

19 Q. Okay. Who else has worked with you on
20 this response to the lawsuit from a
21 communications perspective?

22 MS. BLAIR: I'm going to just object to

1 the extent any of your communications involved
2 lawyers. But you can answer it to the extent it
3 did not involve communications with lawyers.

4 MR. CHUNG: Yes.

5 THE WITNESS: Can you repeat the
6 question?

7 BY MR. CHUNG:

8 Q. Yes.

9 Who else has worked with you on this
10 response to the lawsuit from a communications
11 perspective?

12 A. Generally, CURA Strategies. Leah Binder
13 has been involved. Missy Danforth, Karen
14 Jupiter.

15 Q. Okay. And has the -- and CURA
16 Strategies, am I correct that they have been --
17 that they were Leapfrog's PR consultant even
18 before this lawsuit?

19 A. Yes. We've been working with them for a
20 few years.

21 Q. And what role does CURA Strategies serve
22 in the context of the response to the lawsuit?

1 A. They manage the majority of our media
2 relations. So in this case, they did the same.
3 They did some research on what the local media is
4 like in the area and sent our statement and your
5 clients' complaint.

6 Q. Okay. Do you remember whose idea it was
7 to hire CURA in the first place? I'm not talking
8 about with respect to the lawsuit, but just going
9 back to when they first were hired.

10 A. It was a joint decision. I -- we did an
11 RFP. We do RFPs every three to four years with
12 our PR firms. This is the third firm I've worked
13 with since I've been at Leapfrog.

14 Q. And what were the other two -- so there
15 were two predecessor public relations firms that
16 Leapfrog worked with before CURA Strategies?

17 A. Yes.

18 Q. Okay. And which firms were those?

19 A. The Stern Group was the first one when I
20 first started. And then JPA Health
21 Communications. And now CURA Strategies.

22 Q. So why did you move on from those two

1 other PR firms to CURA Strategies?

2 A. For Stern, they were hired before I
3 started at Leapfrog. It's very normal for a
4 comms manager to start and to choose a new firm.
5 So I, as soon as I got comfortable with my job,
6 did an RFP and chose a firm that I thought would
7 meet our needs more.

8 With JPA, there was a lot of staff
9 turnover at the agency, very normal for PR firms.
10 They weren't meeting our needs. Decided to do an
11 RFP. Chose CURA Strategies.

12 Q. Okay. And you've testified that you've
13 worked with CURA Strategies for a few years now.

14 Is it since 2023?

15 A. Yes. Yes.

16 Q. Okay. So you've worked -- so CURA
17 Strategies has been the only PR consultant since
18 2023 for Leapfrog; is that correct? Have there
19 been any other PR consultants that you've worked
20 with during that time?

21 A. Not that I can recall.

22 Q. Okay. So do you have a sense of how much

1 Leapfrog has paid CURA Strategies since 2023
2 while they've been the PR consultant?

3 A. We pay them about \$1500 a month as a
4 retainer.

5 Q. Okay. Does --

6 A. Sorry, I meant 15,000. Is that what I
7 said?

8 MS. BLAIR: No. You said --

9 THE WITNESS: Sorry. 15,000 is how much
10 we pay.

11 BY MR. CHUNG:

12 Q. Okay. So is it just -- over the last two
13 or so years, is it correct that Leapfrog has
14 spent about \$400,000 on CURA Strategies?

15 A. I'm not great at mental math, but that
16 seems correct.

17 Q. Okay. And then, going forward, do you
18 have a budget for how much you're spending on
19 CURA Strategies?

20 A. In our budget, it's still the 15,000 a
21 month.

22 Q. Okay. And for 2025 and 2026, is it

1 accurate that Leapfrog has budgeted about
2 \$180,000 for CURA Strategies?

3 A. Per year?

4 Q. For 2025 to 2026. Yes.

5 A. Per year, that seems right.

6 Q. Okay. So that roughly translates to
7 about the \$15,000 per month kind of retention
8 arrangement you have with CURA Strategies?

9 A. Correct.

10 Q. Okay. How would you describe -- you
11 testified that you've been involved in the
12 communications aspect -- right? -- of responding
13 to the lawsuit.

14 How would you describe Leapfrog's
15 communication strategy regarding the lawsuit?

16 MS. BLAIR: Objection to form.

17 Also, to the extent it calls for any
18 attorney-client communications, do not reveal
19 those. But to the extent it calls for -- you can
20 answer that without revealing conversations your
21 attorney, you need to answer.

22 MR. CHUNG: Yup.

1 BY MR. CHUNG:

2 Q. I'm not interested in conversations with
3 counsel.

4 A. Right.

5 Q. But how would you describe that -- the
6 communication strategy of the organization
7 regarding the lawsuit.

8 A. I think our public statement on our
9 website is a great example of what our strategy
10 is, which is just to counter the false claims in
11 the complaint and to stand -- that we stand
12 behind our missions, that we are transparent,
13 that we are accurate.

14 Q. Okay. Has Leapfrog sought to promote
15 negative publicity regarding the five plaintiff
16 hospitals?

17 A. To counter false claims that we were
18 attacked with.

19 Q. Okay. And how have you gone -- how have
20 you achieved that, promoting negative publicity
21 about the five plaintiff hospitals?

22 MS. BLAIR: Objection to form.

1 THE WITNESS: I wouldn't say that -- can
2 you say it again?

3 BY MR. CHUNG:

4 Q. Yes.

5 How have you gone about doing that,
6 promoting negative publicity regarding the five
7 plaintiff hospitals?

8 MS. BLAIR: Same objection.

9 THE WITNESS: I wouldn't say negative
10 publicity. I mean, we've said -- we promote the
11 statement that's on our website, which is just
12 reiterating that these are the grades, that they
13 are poor grades. We stand behind our
14 methodology. You know, click on the safety grade
15 link and see their full grade.

16 BY MR. CHUNG:

17 Q. And that is -- that's just on the
18 website, correct?

19 A. Yes. It's a statement on the website and
20 we direct press to that.

21 Q. Okay. Any other measures that you have
22 taken with respect to promoting negative

1 publicity about the plaintiff hospitals in
2 response to the lawsuit?

3 MS. BLAIR: Objection to form.

4 THE WITNESS: We ran some Google ads.

5 BY MR. CHUNG:

6 Q. Can you tell us about that?

7 A. We have a Google ad grant, and we
8 regularly have, I'd say, like, 170-ish Google ads
9 running at a time, and we change them up,
10 depending on what's going on. Usually, because
11 of what we do, we want people to be searching
12 their local hospital ratings.

13 So it's normal for us for about, I'd say,
14 half or more of those Google ads to be directly
15 linking to hospitals' survey results or safety
16 grade results. So we had -- for just a couple of
17 the months, we had five of those running towards
18 the plaintiff hospitals.

19 Q. Okay. And how was that -- so just to be
20 clear, this Google ad strategy was if -- can you
21 just kind of go step by step what you had Google
22 do with respect to the strategy?

1 A. We have a -- Nonprofit Megaphone is the
2 one that administrates -- administers the ads.
3 But as far as my knowledge goes, it's just a
4 direct link to the safety grades for the five
5 hospitals.

6 Q. Okay. How do -- when does this direct
7 link show up, according to the strategy,
8 according to what you're describing?

9 A. I don't know. I assume -- I'm not a
10 Google ad expert, so we have a contractor who
11 works on it.

12 From my understanding, it's when you
13 Google the hospital, I think.

14 Q. So when you run a Google search for one
15 of the hospital names, the hospital safety grade
16 will show up? How does it work exactly?

17 A. From my understanding, in Google ads,
18 you'll see "sponsored," and you can click on it.
19 So it would say, Leapfrog hospital safety grade.

20 Q. So upon a Google search for one of the
21 plaintiff hospitals, a sponsored advertisement
22 linking to that particular hospital's hospital

1 safety grade will show up for the person running
2 the search, correct?

3 A. Yeah, not every person, but yes.

4 Q. What do you mean by not every person?

5 A. Like, if you look at the analytics, I
6 think five people saw it, so clearly it's not
7 every person. I hope -- I mean, I think there's
8 more than five people searching for these
9 hospitals. So...

10 Q. Okay. Who -- so who was responsible --
11 kind of who was tasked with devising Leapfrog's
12 communication strategy regarding the lawsuit?

13 A. Can you restate the question?

14 Q. Yeah.

15 Who was tasked? Was there a specific
16 person that was tasked with putting together
17 Leapfrog's strategy regarding the lawsuit?

18 A. I'd say me. It's my primary responsible.

19 Q. Okay. How was Leah Binder involved in
20 it, if at all?

21 A. She's involved in almost everything at
22 Leapfrog.

1 Q. Okay. So how was she involved in the
2 communication strategy?

3 A. Approving it. Giving input.

4 Q. Okay. Was it also approved by Leapfrog's
5 board?

6 A. The board usually doesn't get involved in
7 these kinds of things, but the board knew what we
8 were doing.

9 Q. Okay. Did they know that you were
10 engaging in this Google ads strategy as well?

11 A. I'm not sure. It's a very, very small
12 part of what we've been doing. It wasn't the
13 focus. It was just one tiny part of it.

14 Q. Okay. So the question is, was the board
15 aware of this Google ad strategy?

16 A. I don't know. They don't know
17 everything -- we don't tell them every single
18 thing we are doing. That would be way too much
19 information.

20 Q. Okay.

21 A. But we give them in our quarterly
22 reports, which I believe you've seen, we give

1 Google ad and Google analytics information.

2 Q. Okay.

3 MR. CHUNG: Let's go to tab 30. This
4 will be Exhibit 34.

5 (Bailey Deposition Exhibit 34 marked for
6 identification and attached to the
7 transcript.)

8 BY MR. CHUNG:

9 Q. Exhibit 34 is an e-mail chain from
10 March of 2025.

11 What's being discussed here with
12 Ms. Jupiter?

13 A. I don't remember. I don't remember this.

14 Q. In the first sentence you write that you
15 looked at articles that Ms. Jupiter sent you; is
16 that right?

17 A. That's what I said. Yes.

18 Q. Okay. Do you have an understanding as to
19 why Ms. Jupiter was sending these articles to
20 you?

21 A. I don't remember this. Let me read it.

22 Q. Okay. Take your time.

1 A. I don't remember this.

2 Q. Okay.

3 A. Looking at the time frame, it looks like
4 it may have had something to do with the letter
5 sent from your client.

6 Q. What do you mean by that?

7 A. Just looking at the time frame in March,
8 that I know that there were letters sent.

9 I wasn't involved in it, but I know that
10 a lot of these things were referenced in the
11 complaint letters.

12 Q. So are these -- are these articles, are
13 these references to instances in the past when
14 hospitals or other parties had criticized or
15 challenged Leapfrog's hospital safety grade
16 system?

17 MS. BLAIR: Objection to form.

18 THE WITNESS: I think that they were --
19 it looks it me that they were things that, yeah,
20 your firm brought up in the complaint, in the
21 letters.

22

1 BY MR. CHUNG:

2 Q. Okay. And how generally did -- how
3 generally did Leapfrog respond to these types of
4 complaints?

5 MS. BLAIR: Objection to form.

6 THE WITNESS: I don't understand the
7 question.

8 BY MR. CHUNG:

9 Q. How did -- with respect to all these
10 prior instances of hospitals challenging or
11 complaining about the hospital safety grades,
12 what was Leapfrog's general strategy of
13 responding to these complaints?

14 A. I mean, these are ten -- eight, ten very
15 unique situations. There isn't a -- like, we
16 handle everything on a case-by-case basis. I...

17 Q. How were they very unique situations?

18 A. We're talking about eight different
19 instances. We're -- like, they're all different
20 bullets. There's no connection that I see.

21 Q. Okay. But how are they -- why do you say
22 that they're very unique? What about them makes

1 you say that they're very unique?

2 A. They're different. Like, we're talking
3 about a study, talking about a report. And I
4 don't have any of the attachments, I can't tell
5 you specifics on these. I don't remember all of
6 these.

7 Q. Okay.

8 A. Mission Hospital, which we mentioned
9 earlier...

10 Q. So you don't have a recollection as to
11 why Ms. Jupiter was collecting and sending you
12 these articles?

13 A. I don't remember.

14 Q. Okay.

15 MR. CHUNG: Let's go on to 32. This will
16 be Exhibit 35.

17 (Bailey Deposition Exhibit 35 marked for
18 identification and attached to the
19 transcript.)

20 MR. CHUNG: Let's do 33 as well, the
21 talking points.

22

1 (Bailey Deposition Exhibit 36 marked for
2 identification and attached to the
3 transcript.)

4 BY MR. CHUNG:

5 Q. So Exhibit 35 and 36, we have got an
6 e-mail chain with Ms. Jupiter sending updated
7 talking points to regional leaders -- right? And
8 then Exhibit 36 are the talking points
9 themselves.

10 Do you recognize these documents?

11 A. Yes.

12 Q. All right. Why are talking points about
13 the lawsuit being sent to Leapfrog's regional
14 leaders?

15 A. In my understanding, we wanted them to be
16 informed in case they had questions.

17 Q. Okay. What's in those talking points?

18 A. Really nothing different than what's in
19 our public statement on our website.

20 Q. Okay.

21 A. It's just organized a little differently.

22 Q. Can you just tell us what's in the

1 talking points?

2 A. Sure. Starts with top-line messaging.
3 We talk about hospital-specific performance. And
4 then a section countering false claims.

5 Q. All right. So the top line, I think,
6 is -- the top-line message is, We encourage you
7 to focus on the very poor performance of these
8 hospitals on patient safety, first and foremost,
9 correct?

10 A. Oh, you're reading the --

11 Q. Yeah, the talking points --

12 A. The preamble?

13 Q. -- Exhibit 36.

14 Do you see that?

15 A. Yes, I see that.

16 Q. Okay. And you are -- above that you say
17 that We prefer you to avoid talking directly to
18 the press about the lawsuit. Instead, you may
19 direct them to Lauren -- to you.

20 Why did you express a preference to have
21 them avoid talking directly to the press about
22 the lawsuit?

1 A. Just standard operating procedure for us.

2 Q. And why is that standard operating
3 procedure? Is that standard operating procedure
4 specific to the regional leaders?

5 A. For the regional leaders, yes. I mean,
6 they don't know everything about Leapfrog and
7 they really only know what their coalition does.
8 So that's just standard operating procedure for
9 press. We always prefer that they direct them to
10 us.

11 Q. Okay. Now, turning to the second bullet
12 point under the countering false claims -- this
13 is on the second page, Bates ending 6116 --
14 you'll see there that Hospital participation in
15 the Leapfrog hospital survey has no automatic up
16 or down impact on a hospital's safety grade.

17 Do you see that particular bullet point?

18 A. Yes.

19 Q. All right. But doesn't declining to
20 participate in the survey automatically drop four
21 of the metrics down to the limited achievement
22 score?

1 MS. BLAIR: Objection to form. Asked and
2 answered.

3 THE WITNESS: Yeah, I've already talked
4 about this. No, it -- I stand by the statement,
5 it doesn't have an automatic up or down impact.
6 A hospital could do the survey and score the
7 same.

8 BY MR. CHUNG:

9 Q. That's not my question.

10 So my question was, doesn't declining to
11 participate in the survey automatically drop four
12 of the metrics down to the limited achievement
13 score?

14 A. No, it's not automatic. Because if
15 they -- if they had the data and they scored
16 that, it would be...

17 Q. That's --

18 A. I don't understand the question.

19 Q. No.

20 My question is, for hospitals that do not
21 participate in the survey -- right? -- aren't
22 their scores on the four imputed metrics

1 automatically assigned the limited achievement
2 score?

3 A. For those four --

4 Q. Yes.

5 A. -- not for the entire safety grade.

6 Q. That's been my question. For those
7 four --

8 A. Okay.

9 Q. -- imputed metrics.

10 A. Yes, for its four imputed metrics.

11 Q. Okay. So with respect to this bullet
12 point here that you're asking the regional
13 leaders to basically disseminate, is it accurate
14 to say that hospital participation or
15 non-participation in the survey has no automatic
16 up or down impact on a hospital's safety grade?

17 A. Yes. I already said yes. We stand by
18 these.

19 Also, we're telling them, do not talk to
20 people. This is just giving them background
21 information.

22 Q. Okay. Would you agree that

1 non-participation in the survey at least raises
2 the risk of that hospital getting a lower overall
3 hospital safety grade?

4 A. Possibly. As I've testified before,
5 there are hospitals that get As that don't do the
6 survey.

7 Q. Okay.

8 MR. CHUNG: Let's go to tab 34. This
9 will be Exhibit 37.

10 (Bailey Deposition Exhibit 37 marked for
11 identification and attached to the
12 transcript.)

13 BY MR. CHUNG:

14 Q. So it's an e-mail chain from May of 2025,
15 and it looks like CURA Strategies, a Lula
16 Hailesilassie, is attaching a day one coverage
17 report from the hospital safety grade
18 announcement.

19 Do you see that?

20 A. Yes.

21 Q. Okay. And then you, responding to -- or
22 forwarding this to Ms. Binder, Flagging this in

1 case you didn't see it. There hasn't been
2 anything new today on the lawsuit that we've seen
3 in the press.

4 Do you see that?

5 A. Yes.

6 Q. Okay. And Ms. Binder responds, Thanks,
7 Lauren. This coverage is great. Let's make a
8 goal to have one story at minimum every three
9 days about Tenet or one of the hospitals.

10 Now, you forward that message to
11 Ms. Jupiter with just an ellipses, dot-dot-dot.

12 What did you mean by that?

13 A. From what I can recall, like, we need to
14 talk about this.

15 Q. To Ms. Jupiter?

16 A. Yes.

17 Q. What do you mean by -- what did you need
18 to talk about?

19 A. Just I had never heard Leah say this
20 before. So -- she's my boss. I want to talk to
21 her about it.

22 Q. What about this directive did you need to

1 talk about, making it a goal to have one story at
2 a minimum every three days about Tenet or one of
3 the hospitals?

4 A. Just that it was something that Leah said
5 and we hadn't discussed the strategy and I wanted
6 to talk to my boss about it. That -- I...

7 Q. Did you have concerns about what Leah was
8 directing you to do?

9 A. I don't think I understood. And we
10 didn't do it, so...

11 Q. I'm not asking whether it eventually
12 happened or whether you eventually did it.

13 But did you have concerns about what Leah
14 was directing you to do here?

15 A. I didn't understand the goal of it.
16 This -- I can't recall exactly what -- this week
17 was incredibly stressful for us.

18 Q. Okay. So you didn't understand the goal
19 of it.

20 Did Ms. Jupiter share that concern about
21 what the goal of having this many stories was?

22 A. I don't recall this specific conversation

1 that we had. I only recall the outcome.

2 Q. Did you raise your question with Leah as
3 to what the goal of this strategy was?

4 A. I'm sure I did. I don't remember
5 exactly. Like I said, I only remember the
6 outcome.

7 Q. Okay. Not asking about the outcome.
8 Right?

9 What do you remember about discussions
10 you had with Ms. Binder about this strategy? And
11 the strategy, to be specific, is what she's
12 directing you to do here, right? One story -- at
13 least one story every three days about Tenet or
14 one of the hospitals.

15 A. From what I remember about the
16 conversation, the follow-up conversations we had,
17 understanding what she meant from it was simply
18 that we needed to do what we could to counter all
19 the false claims that were out there. We didn't
20 know what else was coming. We saw Mary Beth
21 Maloney saying a lot of very untrue things in the
22 press. We didn't know what else was planned.

1 Leah wanted to make sure we had a plan
2 and that we could defend ourselves.

3 That's what she meant, in my
4 understanding.

5 Q. So how was having one story at minimum
6 every three days about Tenet or one of the
7 hospitals consistent with that, with what you
8 just described?

9 A. I mean, I'd say just, again, getting our
10 side out there. And to me, it was about the
11 safety grades. I mean, if you look at our
12 statement, that's the very first thing, we stand
13 behind our safety grades, here's a link to them,
14 making sure the press locally know what the
15 safety grades were.

16 Q. Okay. Did you talk to Ms. Jupiter about
17 Ms. Binder's request after you had forwarded this
18 e-mail?

19 A. I really -- I don't remember the
20 specifics.

21 Q. I understand. But a moment ago you
22 didn't remember your discussions with -- anything

1 about your discussions with Ms. Binder, but then
2 you actually described them later on.

3 So can you give another shot at trying to
4 remember discussions with Ms. Jupiter about this?

5 MS. BLAIR: Objection to form.

6 THE WITNESS: I told you I remembered the
7 outcome, and the outcome was that discussion I
8 just explained. And that's all I remember.

9 BY MR. CHUNG:

10 Q. Okay. What kinds of stories? So the
11 directive here is to have one story at minimum
12 every three days about Tenet or one of the
13 hospitals, right?

14 A. That's what it says.

15 Q. All right. What about Tenet and/or the
16 hospitals did Ms. Binder want stories about every
17 few days?

18 A. I don't recall. We didn't do it, so I --
19 I don't know what she meant, specifics.

20 Q. Okay.

21 MR. CHUNG: Let's go to tab 35. This is
22 Exhibit 38.

1 (Bailey Deposition Exhibit 38 marked for
2 identification and attached to the
3 transcript.)

4 BY MR. CHUNG:

5 Q. So this is an e-mail chain from June 3rd,
6 2025 -- or May and June 2025.

7 And in the top e-mail, Ms. Bailey, to
8 Ms. Jupiter, there is a section about the lawsuit
9 itself, correct?

10 A. Correct.

11 Q. We've also been proactively pitching
12 updates around the Tenet Healthcare lawsuit to
13 national and local press to own the narrative.

14 Do you see that?

15 A. Yes.

16 Q. Okay. So these are outreaches to
17 national and local press outlets proactively to
18 give them updates, correct?

19 A. It's what I testified to before, that we
20 were sending the complaint and our statement.
21 Again, in this situation, we're being attacked by
22 a large healthcare system. We're a very small

1 nonprofit. We're doing anything we can to defend
2 ourselves and our reputation because this is a
3 huge reputational risk for us.

4 Q. Right. So what you just testified to now
5 and earlier were basically reactive strategy,
6 right? Reactive outreaches to press outlets to
7 counter what you're alleging are falsehoods,
8 correct?

9 A. Correct. Depends on how you look at it.

10 Q. So -- but here, what you're describing to
11 Ms. Jupiter are proactive pitching updates around
12 the Tenet Healthcare lawsuit to all these press
13 outlets to own the narrative.

14 A. Right.

15 Q. Do you see that?

16 A. Yes.

17 Q. So this is -- fair to say that this is a
18 different, but complementary strategy to the
19 reactive measures that you described?

20 A. It's the same strategy. I think it just
21 depends on how you look at it. We're at a
22 disadvantage when we're the ones being sued and

1 we're the ones being attacked in the press.

2 And so yes, I could see how you could see
3 that you might think it's reactive. But when I
4 use this word, proactive, what I remember is that
5 we wanted to send the complaint and countering
6 the false claims to reporters before we got a
7 reactive question from them.

8 Does that make sense?

9 Q. So what were you -- so you sent them the
10 complaint and the Leapfrog statement.

11 What else were you sending to these press
12 outlets in this proactive approach?

13 A. That's all I recall. Just anything
14 that's publicly filed.

15 Q. Okay. You're saying here that you're
16 proactively pitching updates around the Tenet
17 Healthcare lawsuit to national and local press.

18 What were these updates?

19 A. Anything that's publicly filed in the
20 suit.

21 Q. Okay. So can you give us -- can you kind
22 of outline for us what those updates were?

1 A. I am not a lawyer, so I don't know these
2 terms.

3 Q. I don't think you have to have a lawyer.

4 A. There was a -- well, there are. There
5 are documents that were filed by you, your firm.

6 Q. Okay.

7 A. So --

8 Q. So what were those --

9 A. Preliminary injunction. I remember that
10 one.

11 Q. Yeah.

12 A. I don't remember the rest of them.

13 Q. Okay. In addition to providing
14 filings -- right? -- from the lawsuit, were you
15 supplying these -- the national and local press
16 outlets with any other information or commentary
17 on the filings?

18 A. Leah did some interviews.

19 Q. Okay. How was -- just looking at the
20 second part of this sentence, you're pitching --
21 proactively pitching updates to own the
22 narrative.

1 How was Leapfrog trying to own the
2 narrative? What was this referring to?

3 A. Just a standard PR term. Again, in the
4 situation we're in, we're in the disadvantage.
5 We're the ones being sued. We're the ones being
6 attacked in the press. We're a very small
7 nonprofit. Our strategy was to do what we could
8 to own the narrative, to stand up for ourselves,
9 to show that we are transparent.

10 Q. Okay. How were -- what was the narrative
11 that you were trying to own?

12 A. That our safety grades are transparent
13 and accurate; we're not pay to play.

14 Q. Okay. Was part of that -- was part of
15 that -- did you include in that narrative how
16 non-participating hospitals are assigned their
17 safety grades?

18 A. I don't recall. I don't think so.

19 Q. Okay. Was that, I think in your words
20 earlier, too detailed to be included in the
21 narrative?

22 MS. BLAIR: Objection to form.

1 THE WITNESS: That wasn't the story that
2 we were pitching.

3 BY MR. CHUNG:

4 Q. Okay. Because it was inconvenient to
5 your story, correct?

6 MS. BLAIR: Objection to form.

7 THE WITNESS: No. We're pitching the
8 story that your firm is attacking our small
9 nonprofit that's trying to do a public service.
10 That's the story we're pitching.

11 BY MR. CHUNG:

12 Q. Okay. But as part -- what you're calling
13 an attack, wasn't that an attack on Leapfrog's
14 methodology for arriving at safety grades for
15 non-participating hospitals? Wasn't that part of
16 what you're calling the attack on Leapfrog?

17 A. The attack I'm referring to is what
18 Mary Beth Maloney did in the press.

19 Q. Okay. But I'm asking you, wasn't the
20 attack that you're alleging that you were
21 responding to -- right? -- part of that attack
22 was a criticism or a challenge to Leapfrog's

1 methodology for non-participating hospitals;
2 isn't that correct?

3 A. I mean, your complaint was over 50 pages
4 long. We're not going to outline every single
5 thing in it, but we attached it, shared it with
6 reporters proactively.

7 Q. Okay. I'm asking you to respond to my
8 question. All right?

9 Wasn't the criticism or challenge to the
10 methodology for non-participating hospitals part
11 of what you're calling the attack on Leapfrog?

12 MS. BLAIR: Objection to form. Asked and
13 answered.

14 THE WITNESS: It was one of the elements
15 in this 50-plus page complaint. Yes.

16 BY MR. CHUNG:

17 Q. Okay. And it wasn't part of your
18 narrative to comment -- to even comment on that
19 criticism of the methodology, correct?

20 MS. BLAIR: Objection to form.

21 THE WITNESS: It wasn't our primary
22 focus.

1 BY MR. CHUNG:

2 Q. Okay. And is it fair to say that it
3 wasn't part of your primary focus because it was,
4 in fact, a valid criticism of -- of the
5 methodology?

6 MS. BLAIR: Objection to form.

7 THE WITNESS: No.

8 MR. CHUNG: Okay. Let's go to 36.

9 Tab 36.

10 This is Exhibit 39.

11 (Bailey Deposition Exhibit 39 marked for
12 identification and attached to the
13 transcript.)

14 BY MR. CHUNG:

15 Q. Ms. Bailey, Exhibit 39 is an e-mail
16 exchange with CURA Strategies, and it includes a
17 meeting agenda with Leapfrog and CURA.

18 Do you see that?

19 A. Yes.

20 Q. All right. And on that agenda, there are
21 a handful of items.

22 The Tenet lawsuit coordination, what is

1 that referring to?

2 A. What we just talked about, the press
3 strategy.

4 Q. Okay. And underneath that it looks like
5 kind of an indentation: Patient story.

6 What is that referring to?

7 A. We, at the time -- so May 8th -- again,
8 this was the first week of the lawsuit. We were
9 really trying to figure out what our strategy
10 was, what was going on. We were considering
11 looking at patient stories. We had several
12 patients reach out to us with stories. We were
13 looking into that. We didn't pitch any to press
14 at this time.

15 Q. Okay. So this particular bullet point or
16 this idea did not come to fruition eventually?

17 A. Not at this time.

18 Q. Okay. And why not?

19 A. We just decided not to pursue it right
20 now.

21 Q. Understood that you decided not to pursue
22 it. But why not?

1 A. We just -- we just didn't do it. I
2 don't -- there were so many things going on at
3 this time, it just didn't -- it was not the
4 priority anymore.

5 Q. Were there not enough patient stories to
6 support that project?

7 A. No, that's not it.

8 Q. Were the --

9 A. We just -- sorry, go ahead.

10 Q. Were the patient stories not what you
11 were looking for in terms of this strategy?

12 A. No. We were just brainstorming
13 strategies and decided to not go with that one.

14 Q. Okay. The second kind of indented point
15 is paid media campaign.

16 What is that referring to?

17 A. The Google ads.

18 Q. Okay. The Google ads that you were
19 testifying to earlier where the hospital safety
20 grades for the five hospitals pop up upon a
21 search for those hospitals?

22 A. Correct.

1 Q. Okay. Any other aspects of a paid media
2 campaign that this included?

3 A. Not that I can recall.

4 MR. CHUNG: Let's go to tab 37. This
5 will be Exhibit 40.

6 (Bailey Deposition Exhibit 40 marked for
7 identification and attached to the
8 transcript.)

9 BY MR. CHUNG:

10 Q. Okay. This is a series of Slack messages
11 between yourself, Ms. Jupiter, and Nate Longmore
12 from May 12 of 2025.

13 A. Yes. I vaguely remember this.

14 Q. Okay. What's being discussed here?

15 A. I believe we were on the call -- a call,
16 and we were discussing the Google ads.

17 Q. Okay. And you write -- or Ms. Jupiter
18 writes up top, She has no clue how this works.

19 Who is the "she" she's referring to?

20 A. I think Leah. She doesn't know how
21 Google ads work.

22 Q. Okay. So just to be specific, what is

1 she referring to? What does Ms. Binder have no
2 idea -- has no clue about how what works?

3 MS. BLAIR: Objection. Form. Asked and
4 answered.

5 THE WITNESS: Yeah, I just said. The
6 Google ads -- she doesn't understand how Google
7 ads work.

8 BY MR. CHUNG:

9 Q. What is she not understanding about it?

10 A. She doesn't understand, like, how they
11 work. Like, just generally how they work.

12 Q. Okay. What did you -- you responded with
13 this emoji on the next line. What did you mean
14 by that emoji?

15 A. I don't know. It was a really stressful
16 call. I send a lot of emojis. I can't even tell
17 what it is.

18 Q. Okay. And Ms. Jupiter next asks, Why,
19 though? What would be the point?

20 And you responded, I don't get it.

21 And you note, further below, I'm afraid
22 to ask.

1 What did you not get?

2 A. I don't recall everything about this
3 conversation. There was back and forth about
4 what we would do with Google ads. I...

5 Q. Okay. Were you expressing that you did
6 not get or you did not understand what Ms. Binder
7 was trying to achieve with this Google ads idea?

8 A. That's what it looks like. Yeah.

9 Q. Okay. And what were you afraid to ask?

10 A. I don't remember.

11 Q. Okay. Why were you afraid to ask?

12 A. I don't remember.

13 Q. Now, further down, you wrote that Leah
14 said she wants to know if we can do ads where, if
15 someone searches those five hospitals, it shows
16 an ad with their safety grade URL and says they
17 have an X grade.

18 Why did Ms. Binder want to know if we can
19 do ads where, if someone searches those five
20 hospitals, it shows an ad with their safety grade
21 URL? Why did she want to know about this?

22 A. I was just recapping to Nate what she had

1 said because his WiFi was unstable, so it's just
2 what I testified to before.

3 Q. Yeah, but why did Leah want to know about
4 this?

5 MS. BLAIR: Objection to form.

6 THE WITNESS: Can you restate the
7 question?

8 BY MR. CHUNG:

9 Q. Yeah.

10 So you wrote, Leah said she wants to
11 know -- right? -- if we can do ads -- I'm not
12 going to repeat everything, but just this
13 line here.

14 Why did she want to know this?

15 A. She wanted us to do it.

16 Q. Okay. Did Ms. Binder want to further
17 publicize the hospital safety grades?

18 A. I already testified to what we did the
19 Google ads for. But again, at this time, we were
20 being attacked in the press. And we're a small
21 nonprofit. Trying to figure out what resources
22 we have.

1 Q. So my question was, did Ms. Binder want
2 to further publicize the plaintiff hospitals'
3 safety grades through this Google ads proposal?

4 A. Yes. We want to publicize the safety
5 grades.

6 Q. Okay. And was the purpose of that, a
7 further publicizing the plaintiff hospitals'
8 safety grades, to show more people the safety
9 grades that had been assigned to these plaintiff
10 hospitals?

11 A. I think more than anything it was just
12 feeling like there was something that we could do
13 in the midst of feeling attacked, and this was
14 something we could do. Got five clicks. Not
15 like a ton of people saw the ads.

16 Q. But putting aside kind of the result
17 here -- right? -- was the idea behind tying these
18 safety grades to the Google ads was to get the
19 maximum possible impact?

20 MS. BLAIR: Objection. Form.

21 THE WITNESS: Can you restate the
22 question?

1 BY MR. CHUNG:

2 Q. Were you trying to reach as many people
3 as possible in publicizing the hospital safety
4 grades of these hospitals?

5 A. Clearly, we weren't, since we got five
6 clicks, it wasn't, like, we put a lot of effort
7 towards it, so no.

8 Q. I'm not talking about the results.
9 Right? But was the goal here to reach as many
10 people as possible?

11 A. I don't think so.

12 Q. Okay. Then what was the goal here?

13 A. I don't know what the goal was. That's
14 what this whole Slack conversation is about.

15 Q. All right. Did you think this was a good
16 idea?

17 A. At this point, like I said, this was a
18 super-stressful meeting. It was a very stressful
19 couple of weeks. I'm one of two communications
20 persons dealing with all of this stuff. Like, I
21 was just trying to figure out my life in general
22 at this point.

1 Q. Ms. Binder [sic], that's not responsive.
2 Did you think that this was a good idea?

3 MS. BLAIR: Objection to form.

4 THE WITNESS: Ms. Bailey.

5 BY MR. CHUNG:

6 Q. Ms. Bailey. I'm sorry.

7 Did you think that this was a good idea?

8 A. I didn't think it would make an impact,
9 no.

10 Q. Okay. What did Ms. Jupiter think about
11 this idea?

12 MS. BLAIR: Objection to form.

13 THE WITNESS: She doesn't understand
14 Google ads, so she -- I mean, it's clear in the
15 Slack conversation she had no idea what was going
16 on.

17 BY MR. CHUNG:

18 Q. Okay. Let's go to the next page of the
19 Slack messages. This is Bates ending 1321.
20 Okay? And there's a continuing discussion, it
21 looks like, of this Google ads idea.

22 And at 2:36 p.m., Ms. Jupiter writes, So

1 she just wants to harass them?

2 And Mr. Longmore responds, I love that
3 the strategy is to become a Disney villain.

4 Is the "she" here Ms. Binder that they're
5 referring to?

6 A. Yes. I think Karen was trying to figure
7 out what she was saying.

8 Q. Okay. And is the "them" the plaintiff
9 hospitals?

10 A. I assume so, yes.

11 Q. Okay. Was that the view -- was that your
12 view, that Ms. Binder was -- just wanted to
13 harass the plaintiff hospitals by having their
14 hospital safety grades pop up with Google
15 searches?

16 A. My view is that we were trying to do what
17 we could to defend ourselves.

18 Q. I'm talking about specifically with this
19 idea. Right? With the -- with the Google
20 results.

21 Was it your view that this was just a
22 measure to just harass the plaintiff hospitals?

1 A. No, I don't think so.

2 Q. Okay. So it wasn't -- it looks like it
3 was Ms. Jupiter's view that this was a form of
4 harassment; is that right?

5 A. She was --

6 MS. BLAIR: Objection to form.

7 BY MR. CHUNG:

8 Q. Is that --

9 A. She wasn't asking. I don't think she --
10 she wasn't saying that she was harassing them.
11 She was asking what is the strategy; what is she
12 saying? That was my interpretation of her
13 message.

14 Q. Okay. In discussions -- putting aside
15 the Slack messages, did Ms. Jupiter express to
16 you that she believed that this strategy was just
17 harassment of the hospitals?

18 A. No. I don't remember her saying that.

19 Q. Okay. Now, Mr. Longmore writes, I love
20 that the strategy is to become a Disney villain.

21 What did Nate mean here?

22 MS. BLAIR: Objection.

1 BY MR. CHUNG:

2 Q. Or Mr. Longmore.

3 MS. BLAIR: Objection to form.

4 THE WITNESS: Nate, he's just making a
5 joke. He -- that's kind of his mood in the
6 office. He just tries to lighten the mood. We
7 were extremely stressed out these weeks, and
8 that's just -- it's a normal -- he just makes
9 jokes.

10 BY MR. CHUNG:

11 Q. Okay. Do you agree that, with this
12 Google results strategy, that Leapfrog was
13 responding to this lawsuit by becoming a Disney
14 villain? Did you agree with this sentence?

15 MS. BLAIR: Objection.

16 THE WITNESS: No. I knew it was a joke.
17 Like, that's how I read it. I read it as a joke.

18 BY MR. CHUNG:

19 Q. Okay. But it follows Ms. Jupiter's
20 comment that she was wondering whether Ms. Binder
21 just wanted to harass the hospitals -- right? --
22 with this Google ads idea; is that right?

1 A. Yes. He sent it right after.

2 MR. CHUNG: Let's go to tab 39. This
3 will be Exhibit 41.

4 (Bailey Deposition Exhibit 41 marked for
5 identification and attached to the
6 transcript.)

7 THE WITNESS: Can I ask the time? I'm
8 just curious how much time has passed.

9 VIDEO TECHNICIAN: 5 hours and 49
10 minutes.

11 THE WITNESS: Thank you.

12 BY MR. CHUNG:

13 Q. Okay. Exhibit 41 is an e-mail chain
14 involving Nonprofit Megaphone. I think you
15 testified to it earlier, but what is Nonprofit
16 Megaphone?

17 A. They're a vendor that administrates our
18 Google ads.

19 Q. Okay. And just looking through this
20 e-mail chain, is this a discussion about how
21 Nonprofit Megaphone is helping you use the grant
22 from Google for nonprofits?

1 A. Can you restate the question?

2 Q. Yes. Is this a discussion about how
3 Nonprofit Megaphone is helping Leapfrog use a
4 grant from Google for nonprofits?

5 A. Yes. It's about our Google ads.

6 Q. Okay. So what is -- I want to direct
7 your attention to -- so what exactly are the
8 services that Nonprofit Megaphone provides to
9 Leapfrog? What do they do for you?

10 A. We tell them what we want to promote, and
11 they develop and administer the Google ads based
12 on the money we get from Google every month as
13 part of our grant.

14 We can only publicize our website.
15 That's what we do.

16 Q. Okay. Turning your attention to Bates
17 ending in Leapfrog 1876.

18 A. Okay.

19 Q. You'll see there's an e-mail from you to
20 Noah Shelgren at Nonprofit Megaphone and others.

21 There's a list of what looks like ZIP
22 codes -- right? -- and cities and states.

1 What's the purpose of all of this?

2 A. It looks like we are geotargeting these
3 markets.

4 Q. Okay. So this is a way for -- this is a
5 list of markets that -- what is -- what do you
6 mean by geotargeting markets?

7 A. Just what I said in my e-mail, that it
8 was the -- so the Google ads that we have been
9 discussing --

10 Q. Right.

11 A. -- would just go to these specific
12 markets.

13 Q. Okay. And so when you look at the
14 preceding page, Bates ending in Leapfrog 1875,
15 Mr. Longmore's e-mail to Noah, he writes, We'd
16 also like to set it up so that, when someone
17 searches for any of the five specific hospitals,
18 it shows an ad displaying their hospital safety
19 grade.

20 Do you see that?

21 A. Yes.

22 Q. And this is kind of the proposal or the

1 idea that we've been discussing so far, correct?

2 A. Yes.

3 Q. Okay. And then the five plaintiff
4 hospitals are listed there?

5 A. Yes.

6 Q. Okay. Now, Mr. Shelgren responds, Hi,
7 Nate -- and this is going on to Bates ending in
8 1874 -- I believe we should be able to do this.
9 It's possible that Google might flag specific
10 hospital names, but as far as I know, this
11 wouldn't break any of the regulations for the
12 grant.

13 What do they mean by that?

14 MS. BLAIR: Objection to form.

15 THE WITNESS: I'm actually not sure
16 because we do regularly run links to specific
17 hospitals' ratings, so I'm actually not sure.

18 BY MR. CHUNG:

19 Q. Okay. How much in the Google grant money
20 has Leapfrog spent on the response to this
21 lawsuit?

22 A. For the Google grant?

1 Q. Yes.

2 A. Does it say in here? Not a lot. Looks
3 like 75 percent impressions and five clicks.
4 That's very, very low in comparison to the rest
5 of our ads.

6 I don't know what that equates to in
7 dollars.

8 Q. Okay.

9 MR. CHUNG: Let's move on to tab 50.

10 BY MR. CHUNG:

11 Q. Okay. Before, actually, we go into the
12 document, we discussed earlier about the board
13 meetings.

14 How often does Leapfrog's board of
15 directors meet?

16 A. Quarterly.

17 Q. And do you help prepare materials for
18 these board meetings?

19 A. Sometimes I help prepare the
20 communications updates as part of Leah's CEO
21 reports.

22 Q. And do you attend the meetings?

1 A. Yes. I take minutes during the meetings.

2 Q. So every quarterly board meeting, you're
3 there taking minutes at the meetings, correct?

4 A. Unless I am out for some reason. Yes.

5 Q. Okay. Do you ever present at the
6 meetings?

7 A. Not usually.

8 Q. All right. In the case -- in the
9 instances that you do, what do you typically
10 present on?

11 A. I don't recall having a specific
12 presentation. Typically, I'm just there to take
13 minutes.

14 Q. Okay.

15 MR. CHUNG: So I -- this will be
16 Exhibit 42.

17 (Bailey Deposition Exhibit 42 marked for
18 identification and attached to the
19 transcript.)

20 BY MR. CHUNG:

21 Q. So Ms. Binder, this is a document --
22 Ms. Bailey, this is a document that was produced

1 to us. It had a file name, board notes for
2 ME 6/25.

3 We don't have a parent e-mail or anything
4 that this was attached to.

5 But with that said, is this document
6 familiar to you?

7 A. Let me read it.

8 Q. Sure. And I can represent that this
9 document, actually, came from your custodial
10 files.

11 A. Okay. Yes, it looks like it's maybe
12 pasted from an e-mail with counsel.

13 Q. Okay. So is this document familiar to
14 you?

15 A. Not immediately.

16 Q. Okay. Did you participate in drafting
17 this document?

18 A. I don't remember this document.

19 I don't know where this document
20 originated from, but --

21 Q. Okay. Does the document, just reading
22 through the document, refresh your recollection

1 as to whether you presented at any board -- at a
2 board meeting regarding communication strategies?

3 A. We did have a special meeting with the
4 board about the lawsuit with counsel.

5 Q. Okay. So I'm just going to focus on a
6 few items here.

7 So under the -- on the first page, Bates
8 ending 21, there's a slide 2. Right? Do you see
9 that?

10 A. Yes.

11 Q. Up top. It reads, Our overall goal is to
12 make it clear to all hospitals that Leapfrog will
13 not compromise or back down. We will make it
14 painful for Tenet by drawing further attention to
15 their very poor performance with strategic media
16 coverage in local and national press?

17 Do you see that?

18 A. Yes.

19 Q. Okay. Is it correct to say that
20 Leapfrog's use of the Google advertisements was
21 part of this plan to make it painful for the
22 plaintiff hospitals?

1 A. That's -- no, that's not what we said.
2 We're talking specifically about media coverage
3 in this.

4 Q. Okay. So media coverage does not include
5 the Google advertisement strategy?

6 A. I wouldn't include that as part of media
7 coverage.

8 Q. All right. But the media coverage
9 itself, does that include the efforts to put out
10 a story about Tenet or one of the plaintiff
11 hospitals at minimum every three days? Is that
12 part of the strategy to make it painful for the
13 hospitals?

14 A. That didn't -- that wasn't our strategy.
15 That's just something that was brought up in an
16 e-mail.

17 Q. Right. But was that the intent of that
18 strategy, to make it painful for the hospitals?

19 A. Again, we're being attacked by Tenet
20 Healthcare, one of the biggest systems in the
21 country. We're a small nonprofit. So we're
22 trying to defend ourselves. That's what this

1 means to me.

2 Q. But would you agree here -- right? --
3 that the intent behind that strategy was to make
4 it painful for Tenet by drawing further attention
5 to their very poor performance?

6 MS. BLAIR: Objection to form.

7 THE WITNESS: Again, we're just defending
8 ourselves.

9 BY MR. CHUNG:

10 Q. Okay. Can you just respond to the
11 question?

12 Is this an accurate description of the
13 media strategy, to make it painful for Tenet and
14 the plaintiff hospitals?

15 MS. BLAIR: Objection to form. Asked and
16 answered.

17 THE WITNESS: I mean, that's what's
18 written.

19 BY MR. CHUNG:

20 Q. Okay. Do you recall -- many of these --
21 of what's -- much of what's in this document
22 seems to correspond to slides.

1 Do you remember preparing a slide
2 presentation that corresponds to these comments?

3 A. Vaguely. Again, this looks like it's
4 referring to a meeting that we had with counsel.

5 Q. Now, when we move -- if we go to the
6 third page of the document -- this is Bates
7 ending 2158, Ms. Bailey -- it reads, Here's an
8 overview of what's next for our media strategy.
9 Leah wrote an op-ed about an experience she had
10 with her grandmother at Delray, one of the
11 hospitals in the suit, in 2014 when they had an A
12 grade. We are actively pitching this to local
13 press now.

14 Were you involved in putting together
15 that op-ed?

16 A. Leah wrote it, I edited it, and Kara
17 pitched it.

18 Q. Okay. Next, we will file our motion to
19 dismiss, as Kim mentioned, this week and will
20 share that with reporters.

21 And then, the third paragraph there is,
22 Leah and Karen van Caulil are visiting Jupiter

1 Medical Center, which is a straight-A-hospital in
2 the area, with some of Karen's employer members.
3 We will pitch some in-person media interviews for
4 Leah while she's in town.

5 That particular paragraph, who is Karen
6 van Caulil?

7 A. She's on our board and she's our regional
8 leader for Florida.

9 Q. All right. And Jupiter Medical Center,
10 is that one of the hospitals in the same market
11 or similar market as the five plaintiff
12 hospitals?

13 A. To my understanding, yes.

14 Q. Okay. So it's one of the kind of
15 competitor hospitals to at least one of the
16 plaintiff hospitals; is that right?

17 MS. BLAIR: Objection to form.

18 THE WITNESS: I don't know who the
19 competitor hospitals are, but I know it's in the
20 area.

21 BY MR. CHUNG:

22 Q. Okay. And so this is under an overview

1 of what's next for the media strategy.

2 How was this visit by Ms. Binder and
3 Ms. van Caulil to Jupiter Medical Center part of
4 the media strategy related to the lawsuit?

5 MS. BLAIR: Objection to form.

6 THE WITNESS: This didn't end up
7 happening -- sorry, what was the question?

8 BY MR. CHUNG:

9 Q. My question is, putting aside whether it
10 happened or not --

11 A. Right.

12 Q. -- right? -- how was this visit by
13 Ms. Binder and Ms. van Caulil to Jupiter Medical
14 Center part of the media strategy in response to
15 the lawsuit?

16 MS. BLAIR: Objection to form.

17 THE WITNESS: I testified before that,
18 generally, our strategy for media is we prefer to
19 talk about improvement, positive stories. This
20 is a positive story in the market. So --
21 counteracting some negative stories.

22

1 BY MR. CHUNG:

2 Q. Were there negative stories about Jupiter
3 Medical Center that you were trying to counteract
4 as part of the lawsuit?

5 A. Oh, no, that's not what I meant. I meant
6 the other stories in the market are all about D-
7 and F-hospitals.

8 Q. Okay. So how was a visit to Jupiter
9 Medical Center part of this media strategy
10 related to the lawsuit?

11 MS. BLAIR: Objection to form.

12 THE WITNESS: We were going to pitch it
13 to -- it says right here, we're going to pitch it
14 to press that we're going to Jupiter Medical
15 Center.

16 BY MR. CHUNG:

17 Q. I understand that's what it says. But
18 why? Why was a visit to Jupiter Medical Center
19 part of the media strategy for responding to the
20 lawsuit?

21 MS. BLAIR: Objection to form.

22 THE WITNESS: Like I said before, we --

1 our strategy was to tell a positive story in the
2 market.

3 BY MR. CHUNG:

4 Q. Okay. Was the purpose here to highlight
5 Jupiter Medical Center and to steer patients or
6 consumers away from the plaintiff hospitals?

7 A. No.

8 Q. Okay. So I'm going to ask again: What
9 was the purpose, in the context of the lawsuit,
10 of Ms. Binder and Ms. van Caulil visiting Jupiter
11 Medical Center --

12 MS. BLAIR: Objection to --

13 BY MR. CHUNG:

14 Q. -- and pitching in-person media
15 interviews there?

16 MS. BLAIR: Objection to form. Asked and
17 answered.

18 THE WITNESS: Just to highlight a
19 straight-A-hospital.

20 BY MR. CHUNG:

21 Q. Okay. So by highlighting a
22 straight-A-hospital -- in this case, not just any

1 straight-A-hospital; Jupiter Medical Center,
2 competitor hospital to plaintiff hospitals --
3 what other reason is there, as it's relevant to
4 the media strategy, than to dissuade consumers
5 from going to the plaintiff hospitals?

6 A. I don't think, and I never thought, that
7 them going to Jupiter Medical Center would
8 dissuade patients or persuade them.

9 Q. So what was the purpose of, in your
10 words, highlighting Jupiter Medical Center in the
11 context of this media strategy?

12 MS. BLAIR: Objection to form. Asked and
13 answered.

14 THE WITNESS: To display a hospital that
15 has a straight-A and -- in the area and that does
16 well in the -- on the safety grade.

17 BY MR. CHUNG:

18 Q. Right. To -- that does well on the
19 safety grade in contrast -- right? -- to how the
20 five plaintiff hospitals did on their hospital
21 safety grade; is that correct?

22 MS. BLAIR: Objection to form.

1 THE WITNESS: No, we weren't going to
2 pitch that contrast story, no.

3 BY MR. CHUNG:

4 Q. What other purpose can there be, then, in
5 the context of the media strategy for this
6 litigation?

7 A. That's what we decided -- like, that --
8 we didn't do it, but that was what we wanted to
9 do. We were looking for any other types of
10 stories in the market. This was a
11 straight-A-hospital. Something we could talk
12 about to get Leapfrog's name out in local press.
13 It's not about the reputation of another
14 hospital. It's about Leapfrog's reputation.

15 Q. Okay. And it just so happens you're
16 focusing on a hospital that is a direct
17 competitor of certain of the plaintiff hospitals;
18 is that right?

19 A. Again, Mary Beth Maloney was attacking
20 Leapfrog in that market. We're looking for ways
21 to show Leapfrog's reputation. One way, by
22 telling a positive story in the market.

1 Q. Okay.

2 MR. CHUNG: Let's go to tab 51 and 52.

3 All right. This will be Exhibits --
4 let's go with the e-mail first -- 43 and 45. 43
5 and 44.

6 (Bailey Deposition Exhibits 43 and 44
7 marked for identification and attached to
8 the transcript.)

9 BY MR. CHUNG:

10 Q. All right. So Ms. Bailey, Exhibits 43
11 and 44 are an e-mail as well the Leah Binder
12 op-ed in the Palm Beach Post I think that you
13 alluded to earlier -- or that we were discussing
14 earlier.

15 A. Yes.

16 Q. And I think you testified that you helped
17 at least edit this op-ed; is that right?

18 A. Yes.

19 Q. And whose idea was it to do this op-ed?

20 A. Leah's.

21 Q. And why was the Palm Beach Post selected
22 for placement of the op-ed?

1 A. There aren't that many outlets in Palm
2 Beach. It's just the one that accepted op-eds.

3 Q. Okay. And in your e-mail, you write that
4 you think that the Palm Beach Post is the good
5 target for this since they are so hyper-local.

6 Do you see that?

7 A. Yes.

8 Q. Why was being hyper-local a good thing
9 for purposes of placing this op-ed?

10 A. Again, healthcare is local. So if we're
11 talking about a hospital, we want to place it in
12 that market.

13 Q. What do you mean by healthcare being
14 local? Why is that important?

15 A. Generally, people aren't traveling from
16 different markets to go to a hospital. So...

17 Q. Okay. So because healthcare is local,
18 meaning that generally people are not traveling
19 long distances to visit hospitals, the purpose
20 of -- is it correct that placing it in the Palm
21 Beach Post, the goal was reach local consumers;
22 is that right?

1 A. Yes.

2 Q. Okay. And to get Leapfrog's message
3 about the lawsuit to those local consumers in the
4 Palm Beach area, correct?

5 A. Yes.

6 Q. All right. And to -- and these are
7 consumers -- this is a relevant universe of
8 consumers of the five plaintiff hospitals,
9 correct?

10 A. Can you restate the question?

11 Q. Right.

12 This is the universe of consumers that
13 are going or not going to the five plaintiff
14 hospitals, correct?

15 A. It's Palm Beach, so I assume yes.

16 Q. Okay. And that -- not only for these
17 five plaintiff hospitals but for Jupiter Medical
18 Center as well, correct?

19 A. We don't talk about Jupiter in this, but
20 I assume that --

21 Q. That they're in this market, correct?

22 A. I think they are.

1 Q. They're in the market covered by the Palm
2 Beach -- by the Palm Beach Post here?

3 A. I don't know that for sure. I know that
4 they're close. I don't know Florida geography.

5 Q. Okay. So in the course of drafting
6 this -- the op-ed, was discussing or talking
7 about Leapfrog's change in imputation methodology
8 ever discussed as a possibility?

9 A. No. Leah drafted this independently. I
10 just looked at the draft that we see in this
11 e-mail here.

12 Q. Okay. Did you have -- did you ever
13 propose to or suggest to her maybe we should
14 disclose or be transparent about the imputation
15 methodology in your op-ed?

16 A. We never really talked about her op-ed.
17 She said she wanted to write an op-ed. She wrote
18 it and she sent it to me. We didn't have
19 conversations prior to this e-mail that I recall.

20 Q. Okay. So was the -- was one of the
21 purposes of the op-ed to basically impact the
22 reputation of the plaintiff hospitals here within

1 the Palm Beach market?

2 A. I don't see it that way. I see it as,
3 again, we're getting our side of the story out.

4 Q. Right. But do you see -- but is it fair
5 to say that at least one of the impacts of this
6 op-ed is to affect the reputation of the
7 plaintiff hospitals? Is that fair to say?

8 A. I mean, I don't think so. She talks
9 about how they -- how Delray Medical Center had
10 an A; her own grandmother went there. So I don't
11 think that's a reputation.

12 Q. Right. But she also focuses on the
13 performance -- right? -- of these hospitals; is
14 that right?

15 A. Right.

16 Q. Right. So by focusing on the
17 performance, isn't at least one of the potential
18 impacts of that focus to impact the reputation of
19 the plaintiff hospitals?

20 A. Maybe. I mean, the sole focus is
21 promoting Leapfrog.

22 Q. Okay.

1 MR. CHUNG: Let's go to -- actually,
2 we've been going a while. Why don't we take a
3 short break and come back.

4 THE WITNESS: Okay.

5 MR. CHUNG: So off the record.

6 MS. BLAIR: The time is 4:47 p.m. This
7 ends media 4. We're off the record.

8 (A recess was taken.)

9 VIDEO TECHNICIAN: The time is 5:02 p.m.
10 This begins unit number 5. We're on the record.

11 (Bailey Deposition Exhibit 45 marked for
12 identification and attached to the
13 transcript.)

14 BY MR. CHUNG:

15 Q. All right. Ms. Bailey, you have
16 Exhibit 45 already in front of you. It is a --
17 e-mails exchanged between Ms. Van Caulil and Leah
18 Binder regarding Ms. Binder's plan to visit
19 Jupiter Hospital.

20 Do you see that?

21 A. Yes.

22 Q. Okay. I want to direct your attention to

1 the second page Bates ending Leapfrog 8771.

2 And Ms. Binder writes here, We are
3 thinking of reaching out to Jupiter Medical
4 Center to see if they'd give a tour to me, and
5 hopefully you and some of your members. They are
6 a straight-A-hospital and happen to be in Palm
7 Beach County. Do you know them at all?

8 Do you see that?

9 A. Yes.

10 Q. Okay. And this is in May of 2025, right?
11 After the launch of the lawsuit; is that right?

12 A. Yes.

13 Q. Okay. And as we saw earlier in the
14 exhibit regarding the board presentation, a
15 potential visit, or at least the visit and media
16 strategy around Jupiter Medical Center, was part
17 of the PR strategy in response to the lawsuit,
18 correct?

19 A. Yes.

20 Q. Okay. And so are these discussions about
21 that particular strategy, about the potential
22 visit to Jupiter Medical Center?

1 A. Yes. It's what it looks like.

2 Q. Okay. Now, she goes on to write, The key
3 issue is keeping the safety grade in the news in
4 Palm Beach County.

5 Do you see that?

6 A. Yes.

7 Q. All right. Why was keeping the safety
8 grade in the news in Palm Beach County a key
9 issue, as Ms. Binder writes here?

10 A. Similar to what I testified to earlier,
11 that there was a lot of news in the Palm Beach
12 area. It was all focused on D- and F-hospitals.
13 We wanted a story out there about A-hospitals.

14 Q. All right. So there was a lot of -- now,
15 these -- the coverage of the D- and F-hospitals
16 in the Palm Beach market that you're referring to
17 are the plaintiff hospitals, correct?

18 A. Right. As a result to your clients
19 filing the lawsuit. Yes.

20 Q. So there was -- as you say, there was
21 some amount -- there was coverage already in the
22 market -- right? -- about the grades that had

1 been assigned to those particular hospitals,
2 correct?

3 A. Yes.

4 Q. Right. And the -- the purpose of -- the
5 purpose of this visit or this planned visit to
6 Jupiter Medical Center was because Jupiter
7 Medical Center was a, as it's written here, a
8 straight-A-hospital, right?

9 A. Yes.

10 Q. Okay. And straight-A-hospital is -- does
11 that mean that Jupiter Medical Center had
12 received a series of As over a period of time for
13 its hospital safety grade?

14 A. Yes.

15 Q. Right. And this is -- Jupiter Medical
16 Center is in the same kind of market as at least
17 some of the plaintiff hospitals, correct?

18 A. Yes.

19 MS. BLAIR: Objection to form.

20 BY MR. CHUNG:

21 Q. And so the purpose here was to
22 essentially provide a contrast -- right? --

1 between a straight-A-hospital and the D- and
2 F-hospitals that had already been covered in the
3 market, correct?

4 MS. BLAIR: Objection to form. Asked and
5 answered.

6 THE WITNESS: Right. It was to tell
7 another Leapfrog story in the market but of an
8 A-hospital.

9 BY MR. CHUNG:

10 Q. Okay. And so Leapfrog wanted to keep the
11 safety grade in the traditional news media, like
12 in the Palm Beach Post; was that part of kind of
13 the strategy here?

14 A. Right. Yes.

15 Q. All right. Is that true of the
16 online news media as well?

17 A. Yes. That's news media.

18 Q. Okay. How about social media? Was it a
19 goal here to keep the safety grade in the news as
20 it's reflected in social media?

21 A. No, that's not part of this.

22 Q. Okay. I think you had testified that one

1 of your responsibilities as communications
2 director is over social media, correct?

3 A. Yes. I oversee it.

4 Q. And what about social media do you
5 oversee?

6 A. The strategy.

7 Q. What do you mean by that?

8 A. Like, Nate Longmore does the everyday
9 posting. I don't micromanage everything he
10 posts, but we talk weekly about what's planned
11 for social media and brainstorm ideas.

12 Q. All right. Is it correct that Leapfrog
13 wanted to have people in this market or in
14 Florida talking about the Leapfrog grades on
15 social media?

16 A. I don't recall that. This is just
17 talking about media. That's what our focus --

18 Q. Just media generally; is that right?

19 A. Social -- sorry. We're talking about
20 traditional media in this.

21 Q. Okay. Was there anything that Leapfrog
22 did to try to get the plaintiff hospitals' grades

1 in the news on social media?

2 A. We posted our statement on social media.
3 That's all I can recall.

4 Q. Okay. And was the goal for other -- for
5 social media outlets or influencers or other
6 social media accounts to pick up on that posting?

7 A. No. It was to let our constituents know
8 that we're in this lawsuit.

9 Q. Okay. Are you aware that there is a
10 TikTok posting that broadcasts the hospital
11 safety grades for the plaintiff hospitals? Are
12 you aware of that TikTok posting?

13 MS. BLAIR: Objection to form.

14 THE WITNESS: We don't deal with TikTok
15 really at all at Leapfrog, so I wouldn't --

16 BY MR. CHUNG:

17 Q. I'm not asking whether you deal with
18 TikTok. Are you aware that there's a TikTok
19 posting out there that basically broadcasts or
20 publicizes the D and F grades for the plaintiff
21 hospitals?

22 MS. BLAIR: Objection to form.

1 THE WITNESS: No, I don't recall seeing
2 it.

3 BY MR. CHUNG:

4 Q. Okay. You do realize -- I just want to
5 confirm that you realize that you're testifying
6 under oath.

7 A. Yes.

8 Q. Okay. And you're testifying that you're
9 not aware of any TikTok posting as it relates to
10 the D and F grades for these plaintiff hospitals?

11 A. Like, there might be TikToks out there,
12 but we don't have a TikTok account. We don't
13 reach out to TikTokers, so I don't -- I don't
14 understand the question.

15 Q. I'm not asking -- are you aware of any
16 TikTok postings -- right? -- that include or
17 broadcast the D and F safety grades for the five
18 plaintiff hospitals?

19 A. I don't know about the five plaintiff
20 hospitals in general. The only thing I could
21 think of that might be on TikTok is, like, the
22 really click-baity TikToks that --

1 Q. Okay.

2 A. They might pick up the safety grade, but
3 I don't --

4 Q. Are you aware of any click-bait TikTok
5 postings that have included or broadcast the D
6 and F grades for the plaintiff hospitals?

7 A. I don't recall the exact -- I mean, I
8 think -- there may have been something on TikTok.
9 I can't recall the exact TikTok. I don't -- I
10 don't understand the question.

11 Q. The question is, have you seen or heard
12 of any TikTok postings or TikTok accounts that
13 have -- that have broadcast or have mentioned the
14 D and F grades for the plaintiff safety -- the
15 plaintiff hospitals?

16 A. Have I heard of?

17 Q. Yes.

18 A. Maybe.

19 Q. Okay.

20 MR. CHUNG: Tab 64. Okay. This will be
21 Exhibit 46.

22

1 (Bailey Deposition Exhibit 46 marked for
2 identification and attached to the
3 transcript.)

4 BY MR. CHUNG:

5 Q. All right. This is an e-mail chain from
6 June of 2025. And I want to direct your
7 attention to the e-mail from Ms. van Caulil on
8 the first page where she writes, I have an
9 enthusiastic "yes" from Susan McBroom, the
10 director of human resources at Patriot Rail. She
11 serves on my board and executive committee, and
12 this year they won our "most engaged employer"
13 award. Waiting to hear back from Nancy Bolton at
14 Palm Beach Schools.

15 Do you see that?

16 A. Yes.

17 Q. Okay. And are these -- what is Patriot
18 Rail?

19 A. I don't know.

20 Q. Okay. How about Palm Beach Schools? How
21 are they relevant to Leapfrog?

22 A. It looks like they're some of the

1 employer members of the Florida Alliance for
2 Healthcare Value.

3 Q. Okay. Patriot Rail as well?

4 A. That's what it appears.

5 Q. Okay. Why was Ms. van Caulil scheduling
6 these entities to attend the planned visit to
7 Jupiter Medical Center by Ms. Binder?

8 A. It's normal. Again, Leapfrog represents
9 employers. So if we're going to a hospital,
10 typically with a regional leader, we'll have them
11 invite employer members.

12 Q. Okay. Has Ms. van Caulil been contacting
13 other Florida employers about the plaintiff
14 hospitals in particular?

15 A. I don't know.

16 Q. Okay. Is that part of -- a part of the
17 communications strategy?

18 A. Can you restate the question?

19 Q. Is part of the communications strategy in
20 the context of the lawsuit to have regional
21 leaders reach out to employers within their
22 networks about the lawsuit?

1 A. Not that I can recall about the lawsuit.

2 Q. Okay. Has Ms. van Caulil been contacting
3 other -- so was -- are there any other employers
4 within the network that Ms. van Caulil contacted
5 about possibly joining this Jupiter Medical
6 Center visit?

7 A. I don't see anything else in this e-mail.
8 I don't know anything beyond this e-mail.

9 Q. Okay. Has Leapfrog in any way broadcast
10 or shared specifically the D and F grades of the
11 plaintiff hospitals to employers within these
12 networks?

13 A. Can you restate the question?

14 Q. Yeah.

15 Has Leapfrog in any way publicized or
16 broadcast the D and F grades for the plaintiff
17 hospitals to employers within the Florida
18 network?

19 A. Not that I can recall. We have a
20 statement on our website.

21 Q. Okay. Has it engaged in any direct
22 outreach to employers in Florida within this

1 network about this lawsuit?

2 A. Not that I know of.

3 Q. Well, you're the director of
4 communications. Do you know whether that's
5 happened?

6 A. I don't know. I don't know.

7 Q. Was that part of the strategy, though? A
8 communications strategy?

9 A. No.

10 Q. All right.

11 MR. CHUNG: Let's go to tab 78.

12 Okay. This will be Exhibit 47, I think.

13 (Bailey Deposition Exhibit 47 marked for
14 identification and attached to the
15 transcript.)

16 BY MR. CHUNG:

17 Q. So Ms. Bailey, Exhibit 47 that you have
18 in front of you is -- I can represent to you that
19 this is another Slack conversation that was
20 produced to us yesterday by CURA Strategies,
21 Leapfrog's PR firm.

22 Now, do you -- are you on any Slack

1 conversations with members -- with personnel from
2 CURA?

3 A. No.

4 Q. No? Okay. So for the Slack messaging
5 that you engage in, that's all internal to
6 Leapfrog; is that right?

7 A. Yes.

8 Q. Okay. I want to direct -- this is kind
9 of a long document. I want to direct your
10 attention to the page with Bates 000466.

11 And who is Sarah Farinelli?

12 A. She's our day-to-day account lead at
13 CURA.

14 Q. Okay. And Lula -- whose name we've seen
15 a number of times -- who is Lulu?

16 A. She's another member of the team.

17 Q. And then Anne. Does that ring a bell?

18 A. Yes. She's the CEO of CURA Strategies.

19 Q. All right. How about Ariel Le?

20 A. I actually don't know her.

21 Q. Okay. So we're looking here, just based
22 on kind of the format of the document here, from

1 July 2025, going on to the next page Bates ending
2 467. I just want to turn to the next page.

3 And it says, under Anne, FYI from Lauren.
4 Hi, Anne and Sarah. We just received notice that
5 our motion to dismiss was unfortunately denied.
6 I wanted to give your team a heads-up in case you
7 receive any press inquiries. Please let us know
8 if anyone reaches out to you. We are regrouping
9 internally on Thursday afternoon and then I'll
10 follow up with any PR next steps. Best, Lauren.

11 Does this refer to an e-mail or some sort
12 of message that you sent to CURA after the motion
13 to dismiss in this case was denied?

14 A. That's what it looks like, yes.

15 Q. Okay. Do you recall sending this
16 message, at least the substance of the message,
17 just letting CURA know about the status of the
18 motion to dismiss?

19 A. Yes.

20 Q. Okay. And then Ms. Farinelli or -- Sarah
21 Farinelli responds, Crap. I was so sure it would
22 be dismissed.

1 If we look down several -- or in the
2 middle of the page, Stephanie Wright.

3 Who is Stephanie Wright?

4 A. She's another member of the team.

5 Q. Okay. And she writes, On Leah's e-mail,
6 I agree about having talking points ready, but I
7 don't know about complaining to Bloomberg. It
8 would be different if they had gone to the other
9 side for comment.

10 Do you see that?

11 A. Yes.

12 Q. And is she -- is Ms. Wright referring
13 to -- it looks like an e-mail that Ms. Binder
14 sent to CURA; is that right?

15 A. Yes.

16 Q. Okay. Do you recall this e-mail that
17 Ms. Binder sent to CURA?

18 A. Yes. Generally.

19 Q. All right. What was it about? We don't
20 have the e-mail, but what was it about?

21 A. So if you look at the Slack message right
22 before -- sorry.

1 Q. Yeah.

2 A. Yeah, so there's a story in Bloomberg Law
3 that came out and, from what I remember, Sarah
4 sent an e-mail flagging the news coverage, which
5 is normal. Anytime there's a new news story,
6 lawsuit or not, CURA will flag it to us; it's
7 part of their job responsibilities.

8 Q. Yes.

9 A. We were not contacted by Bloomberg Law.
10 So -- sometimes when there are stories that come
11 out and we weren't contacted, it can be
12 frustrating.

13 Q. Okay.

14 A. That's what I remember.

15 Q. Now, the CURA personnel here continue the
16 discussion. And Ms. Farinelli writes, What does
17 complain to Bloomberg mean? They didn't feature
18 commentary from Tenet either, just pulled from
19 the legal docs.

20 A. Uh-huh.

21 Q. Do you recall that being part of the
22 discussion with CURA around the motion to dismiss

1 coverage?

2 A. Yes. Yes. I remember more about this
3 now.

4 So I believe when Leah had sent this
5 e-mail that they're referencing, this was behind
6 a paywall, and I don't think she had seen the
7 full article. I think she just opened it and
8 read a few lines and she hadn't seen it in full
9 context and was assuming, I think, that the
10 reporter had interviewed the plaintiffs but not
11 us.

12 And I think that's what they're
13 discussing.

14 Q. Okay. So if you go on to the next page,
15 Bates ending CURA 468, Anne -- and what's Anne's
16 last name? I'm sorry.

17 A. Why am I blanking on her last name?

18 Q. That's fine. This is not a name memory
19 test.

20 A. It may come to me. I'm sorry. It's been
21 a lot of hours at this point.

22 Q. So -- Anne Woodbury.

1 A. Thank you. Thank you. I know her. I
2 just...

3 Q. So Ms. Woodbury -- I'm just trying to be
4 polite here -- she writes --

5 A. Thank you.

6 Q. -- the fact that it is Bloomberg, too, I
7 think is influencing her. She wants to hurt
8 Tenet and, to do that, she has to hit them
9 financially.

10 Do you see that?

11 A. Yes.

12 Q. All right. So after this motion to
13 dismiss was denied, is it correct that
14 Ms. Binder's goal was to hurt Tenet financially?

15 A. No, I don't agree that that was her goal.

16 Q. All right. Where is -- where is Anne
17 Woodbury getting this from, then?

18 A. I don't know. Like, I don't understand
19 the jump that happened in this Slack --

20 Q. Okay.

21 A. -- conversation.

22 Q. Well, we've gone over -- in terms of the

1 strategy of linking the D and F grades for the
2 plaintiff hospitals to Google search results --
3 right? -- wasn't the -- fair to say that at least
4 one of the purposes or goals of that strategy was
5 to hurt Tenet, correct?

6 A. Yes. Defending ourselves.

7 Q. Okay. Is it also fair to say that by --
8 is it also fair to say that the -- putting out
9 kind of negative publicity or stories -- one of
10 the purposes -- I'm not saying the sole
11 purpose -- that one of the purposes of trying to
12 get a story out about Tenet or one of the
13 hospitals at a minimum every three days was to
14 hurt Tenet? Is that fair?

15 MS. BLAIR: Objection to form.

16 THE WITNESS: Yes. We didn't do it.

17 BY MR. CHUNG:

18 Q. Okay. And is it fair to say that by --
19 at least this plan -- that one of the purposes of
20 this planned visit to Jupiter Medical Center, as
21 you said, was to highlight Jupiter, which was a
22 straight-A-hospital, correct?

1 A. Yes.

2 Q. Right. And Jupiter Medical Center is in
3 the same Palm Beach market of -- with at least
4 some of the plaintiff hospitals, correct?

5 A. Yes.

6 Q. And at least one of the purposes of that
7 planned visit was to basically provide a contrast
8 between a straight-A-hospital -- Jupiter Medical
9 Center -- and the D- and F-hospitals that were
10 the plaintiff hospitals, correct?

11 MS. BLAIR: Objection to form.

12 THE WITNESS: We were not talking about
13 the plaintiff hospitals as part of the visit.
14 No. We were just focusing on Jupiter.

15 BY MR. CHUNG:

16 Q. Okay. But would you say it's common
17 knowledge that Jupiter Medical Center and the
18 plaintiff hospitals are competitors in the Palm
19 Beach market?

20 MS. BLAIR: Objection to form. Asked and
21 answered.

22 THE WITNESS: Yes, I know that they're in

1 the same market.

2 BY MR. CHUNG:

3 Q. Okay. What is -- Leapfrog is a nonprofit
4 organization, correct?

5 A. Yes.

6 Q. All right. And it's also tax-exempt; is
7 that right?

8 A. Yes.

9 Q. All right. What is kind of the stated
10 goal of Leapfrog, consistent with this nonprofit
11 status?

12 A. Our mission is to improve American
13 healthcare through transparency.

14 Q. Okay. Do you know why it gets its
15 tax-exempt status?

16 A. Because we're a nonprofit.

17 Q. Okay. Do you -- I want to get your view
18 on this.

19 Do you think that paying a PR firm like
20 CURA Strategies to generate bad media against the
21 hospitals here is consistent with that nonprofit
22 purpose?

1 MS. BLAIR: Objection to form.

2 THE WITNESS: Our mission is to promote
3 our ratings, and we're promoting our ratings.

4 BY MR. CHUNG:

5 Q. Okay. But do you think that paying a
6 public relations firm to generate negative
7 publicity, bad media, against hospitals is
8 consistent with that purpose?

9 MS. BLAIR: Objection to form. Asked and
10 answered.

11 THE WITNESS: I don't understand the
12 question. Can you restate it?

13 BY MR. CHUNG:

14 Q. Well, I think -- what did you -- your
15 testimony regarding that -- you testified that
16 your mission, Leapfrog's mission, is to promote
17 ratings, right? You are promoting your ratings;
18 is that right?

19 MS. BLAIR: Objection to form.

20 THE WITNESS: We're promoting our
21 programs, yes.

22

1 BY MR. CHUNG:

2 Q. Okay. I think your testimony is that
3 you're promoting specifically ratings, correct?

4 A. Yes. Our programs are ratings programs.
5 Yes.

6 Q. Okay. And those ratings programs depend
7 on participation by as many hospitals as
8 possible, correct?

9 MS. BLAIR: Objection to form.

10 THE WITNESS: No. Leapfrog hospital
11 safety grades are assigned.

12 BY MR. CHUNG:

13 Q. Okay. But the -- but in terms of the
14 survey -- right? -- that depends on responses --
15 the success of the survey program depends on
16 more -- as many hospitals participating in that
17 survey as possible, correct?

18 MS. BLAIR: Objection to form.

19 THE WITNESS: Yes. We want hospitals to
20 participate in the survey.

21 BY MR. CHUNG:

22 Q. Okay. And so is generating -- is

1 generating bad media against hospitals that do
2 not participate in hospitals [sic], is that
3 consistent with that mission to get as many
4 hospitals to participate in the survey as
5 possible?

6 MS. BLAIR: Objection to form.

7 THE WITNESS: Our mission is not to
8 get -- that is not our mission. Our mission is
9 to improve healthcare through transparency.
10 We're talking about two different programs.

11 In the press we're talking -- what we're
12 talking about right now with the plaintiff
13 hospitals is the safety grade, not the survey.

14 BY MR. CHUNG:

15 Q. All right. But in order to -- I think
16 we're also talking about a survey as well. This
17 is -- these are hospitals that did not -- that
18 did not participate in the survey, correct?

19 A. Yes, but it's a different program. We're
20 not talking about the survey. We're talking
21 about the safety grade.

22 Q. When we're talking about the safety

1 grade, which context are you talking about?

2 A. You just said we're generating press
3 about the plaintiff hospitals. We're talking
4 about the safety grade.

5 Q. Right. But these are safety grades for
6 hospitals that did not participate in the survey,
7 correct?

8 A. Correct, but that's a different issue.

9 Q. And these hospitals, because they didn't
10 participate -- or at least in part because they
11 didn't participate in the survey, they received
12 the D and F grades, correct?

13 MS. BLAIR: Objection to form. Asked and
14 answered.

15 THE WITNESS: Like I've said before, we
16 don't know that their grade would change if they
17 participated in the survey.

18 MR. CHUNG: Okay. Why don't we take a
19 short break. I think we're almost done. Why
20 don't we take a short break.

21 MS. BLAIR: Okay.

22 VIDEO TECHNICIAN: The time is 5:27 p.m.

1 We're off the record.

2 (A recess was taken.)

3 VIDEO TECHNICIAN: The time is 5:32 p.m.

4 We're on the record.

5 BY MR. CHUNG:

6 Q. So Ms. Bailey, on the topic of your
7 compensation from Leapfrog, are there certain key
8 performance indicators that at least influence or
9 guide how much compensation you get from
10 Leapfrog?

11 A. Not beyond just fulfilling what's in my
12 job description.

13 Q. Okay. So just specifically, are -- you
14 know, the number of kind of views that the
15 Leapfrog websites get, is that a key performance
16 indicator or at least an indicator that you look
17 to or your supervisors or your managers look to
18 in terms of your performance?

19 A. Not in terms of my performance that I can
20 think of. We do track it and report it to the
21 board quarterly.

22 Q. Okay. Is that something that you'll look

1 to as at least one measure of -- of how the
2 communications strategy or the function of
3 Leapfrog is performing?

4 A. Yes. At least one of the aspects. Yes.

5 Q. Okay. What other kind of metrics --
6 right? -- or indicators do you track or do you
7 view as some indicator of how well the
8 communications function or strategy is working at
9 Leapfrog?

10 A. What we regularly track are social media
11 metrics, engagement rate on social media. We
12 track really basic Google analytics. By "we" I
13 mean CURA tracks that for that and reports to us
14 on a quarterly basis, which we report it to the
15 board. Really basic things like page views,
16 length of time on a page, top referral sources,
17 and then media coverage.

18 Q. Okay. And so is the goal then with
19 respect to those metrics, whether it's on the
20 webpage or social media, to increase that
21 engagement as much as possible as part of the
22 communications strategy?

1 A. Can you restate the question?

2 Q. Yeah. Is the goal with respect to the
3 metrics to increase those metrics?

4 A. Yes.

5 Q. Okay. And the -- and the idea behind
6 increasing those metrics is to reach as many
7 consumers as possible; is that the idea?

8 A. Right. We want to increase our reach.
9 Yes.

10 Q. Okay. And that includes increasing the
11 reach and impact of the hospital safety grades;
12 is that right?

13 A. Can you restate the question?

14 Q. And is part of that -- increasing the
15 reach wanting to broadcast as much as possible
16 the hospital safety grades program?

17 A. Yes.

18 Q. Okay. And as -- okay.

19 The -- I think last -- this past year,
20 your compensation was -- or your base
21 compensation was \$160,000; is that right?

22 A. Yes.

1 Q. Okay. And did you -- we understand that
2 you -- a bonus of 10 percent of that salary, of
3 \$16,000, was authorized?

4 A. Yes.

5 Q. Okay. And so what do you understand to
6 be kind of the reason for getting that bonus?
7 Why were you awarded that bonus?

8 A. My understanding is that it was just
9 always part of -- like, when I signed the
10 contract -- signed the offer letter to be a
11 director of communications, my understanding was
12 that probably most years I would get that bonus
13 as long as I did my job.

14 Q. Okay. Are you aware whether other
15 personnel, whether they're managers or executives
16 at Leapfrog, whether their compensation is tied
17 to certain metrics?

18 A. I don't know.

19 Q. Okay. So you're not aware how --
20 whether, let's say, for example, Ms. Binder's
21 compensation is tied to reaching certain
22 milestones or metrics?

1 A. I'm not sure.

2 Q. Okay. Your salary and the bonus, the
3 160,000 and the \$16,000 bonus, relatively
4 speaking, is that kind of high, mid, low for a
5 role of your type?

6 A. I'd say average.

7 Q. Average? Okay.

8 MR. CHUNG: No further questions. Thank
9 you.

10 THE WITNESS: Oh. Okay.

11 MS. BLAIR: That's it. I will order a
12 rough draft, as well as regular delivery of an
13 e-tran.

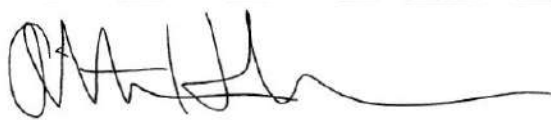
14 VIDEO TECHNICIAN: The time is 5:36 p.m.
15 This concludes today's deposition. We're off the
16 record.

17 (Whereupon, at 5:36 p.m., the videotaped
18 deposition of LAUREN L. BAILEY was
19 concluded.)
20
21
22

CERTIFICATE OF NOTARY PUBLIC

I, CHRISTINA S. HOTSKO, the officer before whom the foregoing deposition was taken, do hereby certify that the witness whose testimony appears in the foregoing deposition was duly sworn by me; that the testimony of said witness was taken by me in stenotypy and thereafter reduced to typewriting under my direction; that said statement is a true record of the proceedings; that I am neither counsel for, related to, nor employed by any of the parties to the action in which this statement was taken; and, further, that I am not a relative or employee of any counsel or attorney employed by the parties hereto, nor financially or otherwise interested in the outcome of this action.

September 12, 2025



CHRISTINA S. HOTSKO

Notary Public in and for the
District of Columbia

My commission expires:

1 January 2027

Good Samaritan Medical Center Inc, Et Al. v. The Leapfrog Group
Lauren L. Bailey Job No. 7574631

E R R A T A S H E E T

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Lauren L. Bailey

Date

1 Good Samaritan Medical Center Inc, Et Al. v. The Leapfrog Group
2 Lauren L. Bailey 7574631

3 ACKNOWLEDGEMENT OF DEPONENT

4 I, Lauren L. Bailey, do hereby declare that I
5 have read the foregoing transcript, I have made any
6 corrections, additions, or changes I deemed necessary as
7 noted above to be appended hereto, and that the same is
8 a true, correct and complete transcript of the testimony
9 given by me.

10
11 _____
12 Lauren L. Bailey

Date

13 *If notary is required

14 SUBSCRIBED AND SWORN TO BEFORE ME THIS

15 _____ DAY OF _____, 20____.

16
17
18 _____
19 NOTARY PUBLIC
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[& - 2024]

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Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

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Exhibit 86

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA
WEST PALM BEACH DIVISION

GOOD SAMARITAN MEDICAL
CENTER, INC., et al.,

Plaintiffs,

vs.

THE LEAPFROG GROUP,

Defendant.

Case Number:

9:25-cv-80526-DMM

Video Deposition of

KUSHAGRA BANERJEE

Tuesday, September 16, 2025

9:03 a.m.

Veritext 7574647

Reported by: Laurie Donovan, RPR, CRR, CLR

September 16, 2025

9:03 a.m.

Video deposition of KUSHAGRA BANERJEE, held in person, with the witness and all parties participating in person, pursuant to the Rules of the United States District Court for the Southern District of Florida, West Palm Beach Division, subject to such stipulations as may be recited herein or attached hereto, before Laurie Donovan, a Registered Professional Reporter and notary public of the District of Columbia, who officiated in administering the oath to the witness.

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A P P E A R A N C E S

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P R O C E E D I N G S

9:03 a.m.

THE VIDEOGRAPHER: Good morning. We are going on the record at 9:03 a.m. The date today is September 16, 2025. Please note that the microphones are sensitive and may pick up whispering and private conversations. Please mute your phones at this time. Audio and video recording will continue to take place unless all parties agree to go off the record.

This is media unit number 1 of the video-recorded deposition of Kushagra Banerjee, taken by counsel for the plaintiffs, in the matter of Good Samaritan Medical Center, Incorporated et al versus The LeapFrog Group, filed in the United States District Court for the Southern District of Florida, West Palm Beach Division. Case number 9:25-CV-80526-DMM.

The location of the deposition is Gibson Dunn & Crutcher LLP at 1700 M Street, Northwest, Washington, D.C. My name is Ellen Hebert, representing Veritext. I am the videographer. The court reporter is Laurie Donovan from

1 Veritext.

2 If there are any objections to proceeding,
3 please state them at the time of your appearance.
4 Counsel and all present will now state their
5 appearances and affiliations for the record,
6 beginning with the noticing attorney.

7 MR. CHUNG: Daniel Chung, Gibson Dunn &
8 Crutcher, for plaintiffs.

9 MR. DELWICHE: Noah Delwiche, Gibson Dunn &
10 Crutcher, for plaintiffs.

11 MS. WOOD: Courtney Wood, Wilson Elser, on
12 behalf of defendant LeapFrog.

13 THE VIDEOGRAPHER: Thank you.

14 Will the court reporter please swear in the
15 witness, and then counsel may proceed.

16 * * * * *

17 Whereupon,

18 KUSHAGRA BANERJEE,
19 having been first duly sworn, testified
20 upon his oath as follows:

21 EXAMINATION BY COUNSEL FOR PLAINTIFFS

22 BY MR. CHUNG:

23 Q Good morning. Could you please state your
24 full name for the record.

25 A Kushagra Banerjee.

1 Q And have you gone by any other names?

2 A I go by "Kush" --

3 Q Okay.

4 A -- day to day.

5 Q Great, and you understand that the court
6 reporter is taking down every question I ask and every
7 answer you give?

8 A Yes.

9 Q So before we start, I just want to go over a
10 few ground rules just to make things go as smoothly as
11 possible today.

12 The first is: Because the court reporter
13 cannot take down two people talking at the same time,
14 I ask you to wait until I finish my question before
15 your -- before you answer, and I'll do my best to wait
16 for you to finish your answer before I ask the next
17 question.

18 Do you understand that?

19 A Yes.

20 Q It's important that your answers are
21 audible, so an "uh-huh" or "huh-uh" are tough for our
22 court reporter to take down, so just know to, to make
23 your answers audible.

24 You, you also understand that you are
25 testifying under oath, correct?

1 A Yes.

2 Q Okay, and you understand by taking that
3 oath, you're promising to answer every question I ask
4 truthfully and to the best of your knowledge.

5 Do you understand that?

6 A Yes.

7 Q Okay. Are you taking any medications or
8 under the influence of any substance, or any reason
9 that might cause you not to understand my questions or
10 not understand what's happening today?

11 A No.

12 Q If you don't understand any of my questions,
13 please ask me to clarify it or rephrase it to
14 understand. It's important that you understand the
15 questions before you answer them.

16 Okay?

17 A Yes.

18 Q All right. From time to time, Ms. Wood may
19 object objections to questions I ask. In those
20 instances, you should answer the question unless
21 Ms. Wood instructs you specifically not to answer that
22 question.

23 Do you understand that?

24 A Yes.

25 Q Okay. You can take a break whenever you

1 want. The only ground rule with respect to breaks is
2 if there is a question pending, meaning you haven't
3 answered a question, let's wait until you answer the
4 question first before taking a break.

5 Do you understand that?

6 A Yes.

7 Q All right. Have you had your deposition
8 taken before today?

9 A No.

10 Q This is your first time?

11 A Yes.

12 Q Okay, and did you prepare for your
13 deposition in any way?

14 A Yes.

15 Q All right, and how -- just generally
16 describe how you prepared.

17 A I met with my counsel twice.

18 Q Twice, and is that with Ms. Wood, or were
19 there others?

20 A With -- yeah, with Courtney and Kim.

21 Q Okay. How many times did you meet with,
22 with your counsel?

23 A Twice.

24 Q Okay, and approximately how long did each of
25 those meetings take?

1 A Like five to eight hours --

2 Q Okay.

3 A -- each.

4 Q Did either or both of those meetings -- at
5 either or both of those meetings, were there -- was
6 there anyone else present besides yourself, Ms. Wood,
7 or Ms. Blair?

8 A Yes. The first meeting, others that were a
9 part of the, the deposition.

10 Q Okay. Who specifically?

11 A Leah Binder, Missy Danforth, Alex Campione,
12 Lauren Bailey, Karen Jupiter, Ralph Johnson, Katie
13 Stewart.

14 Q And it's your understanding -- and these are
15 all colleagues of yours from LeapFrog; is that right?

16 A Yes.

17 Q All right, and is -- was it your
18 understanding that all of those individuals were going
19 to be deposed as well?

20 A Yes. Josh Berlin was there as well.

21 Q Josh Berlin is another colleague?

22 A Josh is another colleague that was there.

23 Q And were -- and that was the first meeting
24 or second meeting?

25 A That was the first meeting.

1 Q All right, and were all of the individuals
2 that your list -- that you -- that listed there for
3 the entirety of the, the several hours?

4 A No, no. Just at the beginning and then,
5 then we met individually with Kim and Courtney.

6 Q Okay. Approximately how long did the
7 beginning of that meeting take where all of you were
8 present?

9 A Like two, three hours.

10 Q So roughly half of, half of the, of the
11 entirety of the session?

12 A Yes.

13 Q Okay. In your, in your preparation
14 sessions, did you go over any documents?

15 A Yes.

16 Q Okay. Just generally -- generally, what
17 kinds of documents did you go over?

18 A Some emails. The website. Generally emails
19 and websites.

20 Q Which website in particular?

21 A The Hospital Safety Grade website.

22 Q What about -- I understand that there's a
23 second website, The LeapFrog Group website. Did you
24 go over that website in connection with your
25 preparation?

1 A I don't, I don't know if we -- I don't know
2 if we did.

3 Q So other than meeting with counsel and a
4 number of your colleagues, did you -- how else did you
5 prepare for your deposition?

6 A That was really the extent of, of the, the
7 preparation --

8 Q Did you --

9 A -- that, that I did. That was, that was
10 the, the extent of the preparation that, that I, that
11 I did.

12 Q Did you review any documents on your own, so
13 outside of the couple meetings that you met with
14 counsel?

15 A No. I mean it was just those documents that
16 were, that were in question.

17 Q Okay, and then other than the two or three
18 hours at the beginning of the first meeting, did you
19 have any other discussions with LeapFrog colleagues to
20 prepare for your deposition?

21 A I, I spoke to Lauren and Karen briefly just
22 about how it went, and they -- I mean nothing of
23 substance, but I asked them about the deposition, and
24 they responded. I mean we didn't talk about anything
25 of substance about the deposition.

1 Q So this was -- so you spoke to Karen Jupiter
2 and Lauren Bailey after their respective depositions;
3 is that right?

4 A Yes. I just wanted to clarify. I did
5 review Karen's deposition, like the rough draft of it.
6 I, I forgot that one, that one piece.

7 Q Karen's deposition, Ms. Jupiter's deposition
8 transcript?

9 A Transcript, yes.

10 Q And was that provided to you by counsel?

11 A Yes.

12 Q Did you ask for it, or was it -- they just
13 provided it to you?

14 A It was provided to me.

15 Q Okay, and how about -- and you understand
16 that Ms. Bailey, Ms. Lauren Bailey was deposed as
17 well?

18 A Yes.

19 Q Okay. Did you -- were you provided her
20 deposition transcript?

21 A No, I was not.

22 Q And then in your -- so reviewing
23 Ms. Jupiter's deposition transcript was part of your
24 preparation as well; is that right?

25 A Yes. I, I skimmed through it.

1 Q In your discussions with -- in the
2 conversations that you had -- the conversation you had
3 with Ms. Jupiter after her deposition, I know you
4 said -- I know you testified that there was -- you
5 didn't discuss anything of substance, but what, what
6 did you discuss?

7 A I just asked her how it went, and she said
8 it went fine, and she, she just told me that she
9 mentioned me a couple times, so whenever I did get her
10 deposition, I was just kind of looking for like where,
11 where I was mentioned.

12 Q Did you discuss with her any of the topics
13 or questions that came up during the deposition, other
14 than mentions of you?

15 A Not, not really. It was, it was just how it
16 went, like, like how -- like did it go the whole time,
17 just generally about how the deposition -- I had never
18 done one before, and I was curious how that -- how it
19 worked.

20 Q Okay. How about with -- you also mentioned
21 that you had a conversation with Ms. Bailey after her
22 deposition, right? So what did you discuss with
23 Ms. Bailey?

24 A Just similar, how she was feeling and, and
25 how it went, and she mentioned the setup was similar

1 to how Karen described it. That was what, what I was
2 interested in.

3 Q Other than Ms. Bailey and, and Ms. Jupiter,
4 have you discussed your deposition with anyone else
5 from, from LeapFrog? And again other than the two or
6 three hours you spent with them at the beginning of
7 the first session.

8 A No.

9 Q Okay. Have you -- so putting aside
10 LeapFrog, folks from LeapFrog, have you discussed your
11 deposition with, with anyone else?

12 A No.

13 Q Let's go over your educational history.
14 Can you just go over your educational
15 history, undergraduate going forward.

16 A Yeah, so I went to undergrad at Washington
17 University in St. Louis, majored in biology and
18 anthropology. I completed a master's of healthcare
19 administration from the University of Pittsburgh.
20 Graduated in 2015.

21 I worked while I was doing the master's in
22 healthcare administration at a health plan, doing an
23 administrative residency program. They did manage
24 Medicare and Medicaid, and so I worked as an analyst
25 in strategic planning and new market development.

1 And then in 2015, that's when I started at
2 The LeapFrog Group.

3 Q So this was -- so is it, is it accurate that
4 your first -- well, let's actually go over your, your
5 employment history.

6 So you mentioned you worked as an, as an
7 analyst, and this was while you were in the master's
8 program at the University of Pittsburgh; is that
9 right?

10 A Yes.

11 Q Okay, and was that at -- what institution
12 did you work at?

13 A It was called Gateway Health Plan. It's now
14 called Highmark Wholecare. It's like a subsidiary of
15 Highmark Blue Cross/Blue Shield in western
16 Pennsylvania.

17 Q And when did you first become interested in
18 healthcare? Was it during college?

19 A Yes. Well, I, I've always been -- I feel
20 like I've been interested in healthcare at a young
21 age. I was pre-med and wanted some -- thinking I
22 wanted to become a doctor, so I took all those, all
23 the pre-med classes.

24 And during that -- during college, the
25 Affordable Healthcare Act was signed and put into

1 effect, and it made me kind of look, take a step back
2 and look at the healthcare industry and all the things
3 that go into -- it's not just -- it made me realize
4 it's not just about like a doctor and patient in a
5 room together. There's a lot more factors in play,
6 and there's, there's a lot of ways to make an impact.

7 So I started to explore other, other ways of
8 making an, an impact that didn't, you know, have the
9 time commitment of like going through medical school
10 and residency and the, the whole path they put you on.

11 So I, I was, I was looking at like
12 healthcare administration programs and the different
13 ways to, you know, to be involved in -- and the
14 different players that are involved, and -- in the,
15 the healthcare system, which, you know, still needs
16 fixing, but there's a, there's an opportunity --
17 there's lots of opportunities to make an impact.

18 So that's what kind of led me into the
19 healthcare administration, and when I -- even when I
20 was in that program, I realized that, you know,
21 there's health, health insurance companies and
22 providers and hospitals and ACOs, and there's lots
23 of -- there's even more nuance to it than I even
24 realized.

25 So that, that's kind of like the -- how I

1 kind of got to be -- get, get on that path, and then
2 there's been branching in paths ever, ever since.

3 Q Right. It's -- well, it's, it's certainly a
4 complex industry.

5 So while you were at Gateway Health, Gateway
6 Health Plan, what did you do there? What did your
7 role entail?

8 A So Gateway Health does managed Medicaid.
9 For like 20 years, they were in just the managed
10 Medicare space. They did dual eligibles. They're a
11 dual eligible health plan, so people that qualified
12 for Medicare and, and Medicaid, so very special needs
13 population, and were very successful in the model that
14 they set up there, but with increasing incentives for
15 being a high-quality health plan from NCQA and
16 reimbursement.

17 Medicare Advantage has continued to have an
18 increased I think footprint in the Medicare space.
19 They, they saw opportunity to take that model that was
20 successful in caring for patients and apply it to
21 Medicare Advantage, and so I -- as part of my role, I
22 was involved in some of the market research to
23 identify specific markets that would be, would be kind
24 of opportune for Gateway to consider entering, and
25 then all the logistics that go into a health plan

1 entering in a new market, to be able to even offer a
2 Medicare Advantage product.

3 So there are -- in order for a health plan
4 to offer a Medicare Advantage product, they have to
5 have contracts with hospitals and physicians, a
6 variety of different specialties, and be able to offer
7 them to the members.

8 So there's -- I call them adequacy and
9 access requirements, and one of my roles was kind of
10 like lay out like a project management system to kind
11 of coordinate the different departments and what they
12 needed so that we could do this effort, but also like
13 review some of the like provider contracts that, that
14 were -- that -- they called them like field sales
15 agents were, were going to try to contract with
16 individual hospitals and facilities and making sure we
17 have the 42 specialties that you need in order to, to,
18 to do that.

19 So it was, it was kind like a market
20 research role, and ultimately, by the end of my tenure
21 there, they were able to successfully launch into
22 three new states.

23 Q And it, and it sounds like it provided at
24 least part of a good transition to eventually what you
25 did at LeapFrog; is that right?

1 A Yeah, it was -- it's different, but it, it
2 did involve, you know, like kind of a business,
3 business development, business strategy, kind of
4 strategic thinking about taking, you know, a business
5 model that's success, that, that is successful and
6 kind of applying it and like see where there are needs
7 in the market and where, where the organization can
8 make further impact in the industry.

9 Q So am I right that you then went on to
10 LeapFrog after working first for a period of time at
11 Gateway?

12 A Yes.

13 Q All right, and how did that opportunity come
14 about?

15 A So my wife -- so we were living in
16 Pittsburgh. We graduated. My wife knew she was going
17 to Georgetown for, for her MBA program in the fall, so
18 I was looking for opportunities in the DC area so I
19 could move with her.

20 And so I actually had learned about LeapFrog
21 in my, in my MHA training. I took a quality in
22 patient safety course, and LeapFrog was one of the
23 many, many different organizations that we covered,
24 and so I saw -- I think I saw an article from, from
25 Leah that was posted in Forbes, and so I was, I was in

1 the job, job-hunting mode at that point.

2 And so I was looking at different companies,
3 and I saw that there was a business development role,
4 a coordinator role, and so I believe I reached out to
5 either through the website or to the contact that was
6 listed, listed there, and then I got an interview,
7 and, and I've been at LeapFrog ever since.

8 Q And was, was that in 2015, approximately?

9 A Yes.

10 Q So your first role; am I correct, it was a
11 marketing and business development coordinator role?

12 A Yes.

13 Q All right, and what -- just describe
14 generally what that role was.

15 A So I had the -- so I was under the -- I was
16 reporting to the director of communications, who had
17 been the, kind of the main liaison between LeapFrog's
18 current data licensees, which are organizations that,
19 that access rights to use the LeapFrog data, and part
20 of that was transitioning to be kind of the day-to-day
21 contact for some of, some of those, some of those data
22 licensees, and also kind of getting initiated into the
23 accolades licensing program that LeapFrog had.

24 Q And who was the director of communications
25 at that time?

1 A Erica Mobley.

2 Q So you were, it sounds like, the principal,
3 or at least initially you had responsibility with
4 respect to data licensing; is that right?

5 A Yes.

6 Q And then eventually the role or the
7 responsibilities expanded to the accolade licensing;
8 is that correct?

9 A Yes. I had -- I mean I had some, I had some
10 like initiation on, on both of them. Erica actually
11 went on maternity leave shortly after I started, so
12 part of it was kind of like just kind of getting up to
13 speed. It was kind of a crash course to get kind of
14 up to speed on both of those programs, but I, I did
15 have some responsibilities in both accolades and, and
16 the -- the accolades licensing program and the data
17 licensing program initially.

18 Q And then how -- what was your next role
19 after that?

20 A So I think a couple years in, I became
21 senior coordinator of business development or -- and
22 then I was in a manager level role, and then now a
23 director of licensing. It's all been kind of
24 increasing responsibilities to what is now like
25 oversight of the -- of both data licensing and the

1 accolades licensing.

2 Q Right now you're at a director level,
3 correct?

4 A Correct.

5 THE REPORTER: You said at --

6 BY MR. CHUNG:

7 Q At a director level, and as a director, is
8 it right -- is it correct that you are a member of the
9 executive staff at LeapFrog?

10 A I'm a member of the management team.

11 Q So -- and your current role is director of
12 licensing programs, correct?

13 A Correct.

14 Q And you started that -- when was that? When
15 did that begin?

16 A I think October of '24.

17 Q The -- you mentioned data licensing and
18 accolade licensing. What other programs do, do you
19 oversee at LeapFrog?

20 A Those are the primary two programs that I,
21 that I, that I work on.

22 Q Are there any other kind of products or
23 items that LeapFrog markets or derives a revenue from
24 that are not included within the, kind of the
25 umbrellas of data licensing and accolade licensing?

1 A No. Every -- I think every project that I
2 am on or involved with is directly related to, to the
3 licensing program, either data licensing or accolade
4 licensing.

5 Q Now, we're going to spend a fair amount of
6 time just digging into what exactly those programs are
7 made up of, but just so that we're clear kind of on
8 the universe of programs, on your, on your LinkedIn
9 page, there's a sentence in just the top summary where
10 it says, "I've launched new programs that generate
11 sustained revenue, expanded our market presence, and
12 built enduring relationships with stakeholders" and so
13 forth.

14 What are those -- are those -- what are
15 those new programs, first of all?

16 A Yeah, so it's all within either data
17 licensing or, or accolade -- or accolade licensing.
18 So for, for example, recently, in 2024, we launched
19 the diabetes recognized leader program. It's our new
20 rating for LeapFrog, based on excellence in diabetes
21 care, and hospitals complete an application survey,
22 and, and answer questions about how they manage care
23 for diabetes.

24 There is an -- for those that do well on it
25 and get the recognition, and they want to use the

1 recognition badge, they have, they have an opportunity
2 to purchase that, that badge and use it in promotions.
3 So we had an accolades badge program, and we did
4 outreach to those through, through a third-party
5 licensing firm, did that, did that outreach and that
6 was kind of the launch of our -- of that, of that
7 accolades program, so we kind of expanded into, into a
8 new program.

9 So I guess that's kind of one example of
10 expanding the accolades program, and that's, that's
11 one part of what I meant by that.

12 Q Okay. So new types of accolades programs is
13 what you meant?

14 A And similarly on data licensing as well.

15 Q Okay. Can you provide an example of a, of a
16 new program in the licensing program, data licensing
17 program?

18 A Let's see. Yeah, so, so there, there was a,
19 there was a program that we, that we launched. There
20 was a development of a, kind of a CPOE report,
21 computerized physician order entry report --

22 THE REPORTER: Computerized what?

23 THE WITNESS: Sorry. Computerized physician
24 order entry report, and the goal there was to
25 create a report from the information that we have

1 published on, on the, on the CPOE tool and
2 information that we have on the CPOE tool.

3 There are electronic health records
4 companies that are very familiar with, with
5 LeapFrog's reporting, and one of the things, my
6 understanding, is that we ask on the survey is
7 what EHR companies are admin-, administering
8 that -- their CPOE systems.

9 So this report was kind of designed to help
10 those organizations, those EHR companies, to
11 understand the performance of their systems in
12 catching common medication errors, and we wanted
13 to make that available to them so that it can
14 improve patient safety.

15 And so we, we tried to, you know, reach out
16 to some of those organizations, so we kind of
17 like launched that. Unfortunately, none of them
18 were, were interested in, in, in using it.

19 BY MR. CHUNG:

20 Q Okay. In terms of reporting, do you have
21 any LeapFrog employees that report to you?

22 A Not directly.

23 Q All right, and who do you report to?

24 A Missy Danforth.

25 Q Do you have any reporting relationship with,

1 with Leah, Leah Binder?

2 A I, I do not. I mean not, not -- I, I
3 report -- I guess I kind of report to her through,
4 through Missy right now.

5 Q Okay. You also -- just going back to your
6 LinkedIn. So we talked about the launch, at least a
7 couple examples of new programs that, that you
8 launched that generate sustained revenue.

9 What, what do -- what do you mean by
10 "sustained revenue"?

11 A Yeah, so not necessarily in the data
12 licensing example, because we --

13 THE REPORTER: Not necessarily in the what?

14 THE WITNESS: Not necessarily in the data
15 licensing example, because that, that, that
16 program we did wasn't successful right now. It's
17 relatively recent, but the, the accolades
18 programs, we have been able to get hospitals
19 to -- and, and other facilities -- to use the
20 LeapFrog marks, which is aligned with our
21 mission, and getting hospitals to be aware of
22 their patient safety, as, as assessed by
23 LeapFrog, and realize the value of that, and
24 continue, whenever they, you know, get an A again
25 or they reach LeapFrog Top Hospital status, to

1 come, to come back and tell their communities
2 about it, and that, in effect -- one of the end
3 results of that is increased revenue for, for
4 LeapFrog, because the program has, has continued
5 to grow along with the recognition and, and brand
6 of LeapFrog.

7 BY MR. CHUNG:

8 Q In, in your role as director of licensing
9 programs, would you say that generating or sustaining
10 or increasing revenue through the licensing programs
11 is one of, one of your primary goals?

12 A Yes, I would say that, because it is, and it
13 is -- because the program is so aligned with our
14 mission, the -- both data licensing and accolades
15 licensing, the more, the more organizations that are
16 using our data to assess quality and safety and making
17 that a component of how healthcare is decided, or in
18 educating the public through the accolades licensing
19 program, that, in effect, expands the brand
20 recognition of LeapFrog, increases awareness of
21 patient safety, and one of the results of that is, is
22 increased revenue, which goes back into sustaining our
23 mission.

24 Q The other component here is "expanding our
25 market presence."

1 What do you mean by that?

2 A So could you read the full, the full
3 sentence?

4 Q Yes. "I've launched new programs that
5 generate sustained revenue, expanded our market
6 presence." That's the sentence.

7 A Yeah, so LeapFrog is, is a relatively small
8 but I think mighty organization. I don't think
9 there's a hospital in the U.S. or health system that
10 hasn't heard of LeapFrog. So our, our -- the
11 awareness around LeapFrog with hospitals is I think
12 well-known, but the general public I think has --
13 there's still, there's still room to expand, expand
14 our presence among the general public.

15 And when you think about how people that are
16 paying for healthcare -- and really it's like, it's
17 individuals who are paying through premiums, but the
18 way the system is, employers and people that purchase
19 healthcare, health plans that are, that are making
20 the, you know, the big payments, there is not enough
21 awareness in, in those -- in a lot of -- for a lot of
22 employers about what's out there with -- in terms of
23 quality and safety, and I think the focus has been
24 kind of detracted into costs and getting the lowest
25 cost and not enough information about, about quality.

1 So LeapFrog has very important quality and
2 safety information, and some health purchasers know
3 about it, but there -- that has been an increasing --
4 that has been a focus of ours, to create more market
5 presence in those, in those areas and educating those
6 stakeholders about the importance, and we have made,
7 you know, some traction in being able to sustain that
8 and expand that market presence, and that's one of the
9 goals of, of mine in my role is try to expand our
10 market presence.

11 Q And is at least one purpose of expanding
12 that market presence to, to basically increase or
13 augment LeapFrog's brand? Is that one of the
14 purposes?

15 A Can you -- could you restate that.

16 Q Yes. Is one the purposes in expanding
17 LeapFrog's market presence to make LeapFrog's brand
18 more recognizable? Is that correct?

19 A Yes, I would say that's true.

20 Q And is at least one of the purposes also to
21 garner more interest in the licensing programs from,
22 from potential consumers?

23 A Can you, can you say that again? Which
24 licensing program?

25 Q Either or both.

1 A Yeah, so expanding -- could you just repeat
2 the question one more time.

3 Q Is at least one of the purposes of expanding
4 LeapFrog's market presence to get more hospitals and
5 other parties, right, to participate in LeapFrog's
6 licensing programs?

7 A Yes, yes. So like the -- so, for example,
8 the accolades program, there -- we want hospitals to
9 compete on not just like we have the shortest waiting,
10 waiting times or cafeteria, or the cafeteria food, you
11 know, Google reviews. We -- you might have seen
12 Google reviews. We want them to compete and do well
13 on areas that, you know, they work hard on, and to
14 improve patient care, first and foremost.

15 And the, the hospitals that do well and
16 receive these distinctions from LeapFrog, they have --
17 we want them to talk about it, and they are not
18 required in any way to purchase the logo. It's a
19 trademark logo, and the reason we license it is
20 because it is our brand, our branded logo, and so if
21 they want to use it, we give them a license to be able
22 to purchase that.

23 We want them to tell their communities that
24 they have an A or the Top Hospital, and they're --
25 they can do that for free by, by posting it on social

1 media, writing it on their website, but they want to
2 use the branded trademark logo. That's what the
3 licensing program is, to be clear on that.

4 And then so we -- whether it's plain text,
5 whether they use the logo, all of those things
6 contribute to expanding the, the brand awareness of
7 LeapFrog, which is what the purpose of creating the
8 safety grade was, was all about. So that makes it
9 kind of a mission-aligned program, in that we want to
10 create awareness. There's not enough awareness about
11 the importance of patient safety, and that is, that is
12 one of the primary -- that is the, that is the, one of
13 the main missions of LeapFrog Group.

14 MR. CHUNG: Understood.

15 All right. Why don't we go to tab 3. We're
16 going to mark this Exhibit 1.

17 (Exhibit 1 was marked for
18 identification.)

19 BY MR. CHUNG:

20 Q Mr. Banerjee, Exhibit 1 is an annual review
21 from LeapFrog, your -- one of the, one of your annual
22 reviews when you were data licensure program manager,
23 and I think it's from 2024, submitted to Ms. Danforth.

24 Do you see that?

25 A Yes.

1 Q Do you recognize the document just
2 generally?

3 A Yes.

4 Q What's the purpose of this? Just generally
5 describe what the purpose of the document is.

6 A So this is my annual review where I do kind
7 of a self-evaluation about my key responsibilities,
8 kind of outline the -- my goals for the year, and I
9 want to highlight the, some of the contributions that
10 I made and ideas that I, that I have going forward to
11 help the organization.

12 Q All right. In the very first sentence of
13 the attachment under "Key Responsibilities," you wrote
14 that it's "a bit tumultuous for the data licensure
15 program."

16 Do you see that?

17 A Yes.

18 Q Yeah, what did you mean by that?

19 A So probably what I meant was that we --
20 there were a couple of data licensees that we had that
21 chose to -- they chose to cancel their, their
22 agreement with us. We've had some new, some new ones
23 that came this year. So it was a bit of an
24 up-and-down year for, for the program, in that we, we
25 had -- we, we gained some and we lost some.

1 Q Okay, and toward the bottom of the page, you
2 wrote, "As I have learned, data license sales are a
3 hard game. Our data license sales funnel has 70 to
4 100 inbound inquiries per year that can result in just
5 a handful of licenses, and some sales such as MMO can
6 take over one year to close from the first meeting."

7 So I just want to focus on the time period
8 there. Why, why does it take over one year to close a
9 data license sale in at least some circumstances?

10 A I wish I knew, but there are a variety of
11 different organizations that, that license LeapFrog
12 data. Some of them, as I mentioned, are health plans.
13 Some of them -- in organizations like that, there is a
14 long legal review process. We have a relatively
15 complex data use agreement that has a lot of terms and
16 conditions in it, and so there is a lot of
17 back-and-forth on, on those terms.

18 There's, there's things like getting,
19 getting the internal funding, getting approval. I had
20 worked at a health plan before, so I know that there's
21 a lot of red tape and silos that, that happen, so in,
22 in, in getting something like this closed or executed.
23 So that -- all those things kind of play into why,
24 from my understanding, why it takes so long. They
25 don't all take a year, but we, we do see some take a

1 year. Sometimes it's even longer than a year.

2 Q You then write, "As Leah has said, closing a
3 data license sale is a big freaking deal, because most
4 of the LeapFrog's data licensees stay licensees for a
5 long time. Well, most of them, at least."

6 Are those -- are you just repeating kind of
7 what Ms. Binder said to you at some point about
8 closing a data license, license sale being "a big
9 freaking deal"?

10 A Yeah, I mean I think it was the, kind of the
11 essence of what she said.

12 Q Yeah.

13 A I can't remember the exact like when she
14 said that, but I do know that she does believe, and we
15 believe that the -- that these are hard to close.
16 It's hard to get somebody or an organization that is a
17 new licensee of LeapFrog data, and from what we have
18 seen, when they do license, many of them appreciate
19 the benefits of it for a long time.

20 And, and in a tumultuous year where some
21 have been added, some have, some have been lost, and
22 some of them that had been, you know, licensees,
23 customers for a very long time, when you, when you
24 lose that, that relationship, it hurts, but, but the
25 ones that, that stay, a lot of them have been

1 long-term committed partners for LeapFrog.

2 Q So just to -- if I understand, if I
3 understand correctly, because data licenses are often
4 hard to close or obtain, and second, once a party
5 becomes a data licensee, the likelihood of them
6 continuing to be a licensee is relatively high; is
7 that right?

8 A Yes.

9 Q Okay, and, and for those -- and is it
10 correct that data licensing, the data licensing
11 program is a relatively significant source of revenue
12 for the organization?

13 A Yes, yes.

14 Q So looking at -- actually, on that point, if
15 you look at the next page -- so when I refer to page
16 numbers, Mr. Banerjee, I'll be referring to what's
17 called a Bates number, so you look in the lower
18 right-hand corner, there's sometimes one or two Bates
19 numbers starting with "LeapFrog," so if you look at
20 the one ending in 4197; do you see that, LEAPFROG
21 4197?

22 A Yes.

23 Q Okay. So there is a section in the bottom
24 half called "Plan for Personal Goals for Upcoming
25 Year."

1 Do you see that in the middle of the page?

2 A Oh, yes.

3 Q And then below, "Become more involved in the
4 budgeting process." Why was that -- why did you
5 include this as a personal goal for the upcoming year,
6 to become more involved in the budgeting process?

7 A Well, I want to continue to grow in my
8 responsibilities at, at LeapFrog, and I was a manager
9 at the time of writing this, and so I wanted to show
10 that I have an aptitude to continue to grow.

11 And I know part of the oversight of being a
12 director of the licensing program is to have some
13 responsibility or more connection to the success of
14 the, the data, the data licensing program and accolade
15 licensing program.

16 And the primary goal is to expand use of, of
17 our data and get accolades use. One of the end
18 results of that is revenue, and, and so being a part
19 of the budgeting process and forecasting like where we
20 can be and how that can ultimately contribute to the
21 impact that we're making is -- was kind of my thinking
22 behind suggesting that I wanted to be part of the
23 budgeting process.

24 Q So the first sentence under that bullet
25 point, you wrote, "Accolades and data licensure are

1 the two biggest revenue line items on LeapFrog's
2 budget."

3 And is that true today as well?

4 A My understanding is yes.

5 Q Do you -- as a, as a director for the
6 licensing programs, do you now have involvement in the
7 budgeting process?

8 A I have -- I talked to, to Missy about --
9 Missy still, like I report to Missy, and she has --
10 she's more directly involved in the, the budgeting
11 process and getting the expenses and the, the
12 official -- getting the official numbers approved, but
13 I do have some input. I work with her daily,
14 frequently.

15 On the -- under the accolades program in
16 general and the data licensing program, I don't -- I'm
17 not yet like fully -- like I don't have like, like
18 leadership over the accolades and data licensing
19 program, but I, I do help in kind of determining like
20 specific numbers on -- that help contribute to what,
21 you know, what costs are going to be or what, what,
22 what potential -- like what revenue might look like
23 for, for the budget that will be presented later to
24 the board.

25 Q So just continuing in this paragraph, you

1 wrote, "I am for the most part aware, by customer, of
2 each program's strengths, weaknesses, opportunities,
3 and threats impact on revenue."

4 And then you continue to write that, "I know
5 that I can provide an additional context and lens to
6 help the organization to make realistic projections or
7 alert to areas that may need more support and
8 attention."

9 At the time that you wrote this in 2024, did
10 you have a sense that, that projections, budget and
11 projections for the licensure programs were not
12 realistic or aligned with what you were outlining here
13 in terms of your familiarity with the programs by
14 customer?

15 A Can you, can you restate the question.

16 Q So just looking at the sentence here, right,
17 did you, did you believe or at least have a sense that
18 the projections for revenue from the licensing
19 programs was in any way not realistic?

20 A So in the data licensing program, like we
21 had -- as I mentioned, like we had some ups and downs,
22 and -- in my view, looking, looking at the, like what
23 the budget numbers were, it seems like it's a, it's
24 kind of like a, the real, like the real -- the actuals
25 are kind of like a, up and, up and down, and the,

1 the -- like the budget didn't seem like it was kind of
2 accounting to what was happening in actuality.

3 So, so I, I think for the -- myself in my
4 role, doing the day-to-day of data licensing and
5 accolade licensing, I felt like I had my hands more on
6 the pulse of what is happening in realtime at the
7 organization, where the budget is I think more like a
8 static number that did not account for what was
9 happening in realtime, both positives and negatives.

10 So I think what I was trying to say here is
11 that I have my hands more on the pulse of what's
12 happening in the organization, for these specific
13 programs, which are the higher or the highest in terms
14 of revenue programs, and I can make a contribution to
15 making the budgets in the future more aligned with
16 what's happening day-to-day, if that, if that was of
17 interest to the organization to do that.

18 Q Like the word you used here is "realistic,"
19 or actually words, "realistic projections." So your
20 testimony was that you believed you could make
21 contributions, because you were closer to the
22 day-to-day, right, and then kind of the fluctuations
23 in the, in the program.

24 And you also mentioned that the budget
25 was -- I think the word you used is "static" number,

1 right? But was that static number, which is in the
2 budget, a, a realistic static number at the end of the
3 day for the programs?

4 A I don't -- I actually don't remember what
5 the numbers were at this point. This was last year's,
6 last year's budget.

7 Q I'm just taking you back to the --

8 A Right.

9 Q -- statement you're making here.

10 A Sure, yeah.

11 Q What the, what the thought or the sentiment
12 was.

13 A So I, I, I think my -- and just to go back
14 to what, what I was saying before, I, I -- the idea of
15 writing "realistic" was, was that I can get closer to
16 what the actuals are, because I have more of a sense
17 of the day-to-day of like what would actually come in,
18 in terms of revenue, for these specific programs,
19 which have I think high impact on what the --
20 percentage-wise, on what those actual numbers are
21 expected, expected to be.

22 Q Okay.

23 A And then -- so that's for the current year,
24 but also for, for future years.

25 Q You wanted to make sure that the, that the

1 projections in the budget were realistic, correct?

2 A Yes. I, I was suggesting that's a
3 contribution that I could help make to make a more,
4 more accurate type of forecasting of where we could
5 be, because that is, I know, an interest of -- like on
6 the, on the finance side of it and making, making the
7 budgets and what we present to the board.

8 All I'm saying here is I can help make a
9 contribution, because that is, that is of interest.
10 I'm not involved directly in the finance and putting
11 together those, those, you know, financial statements,
12 but to the extent that I can contribute, I, I was just
13 suggesting what I can provide to help in that, that
14 capacity, because I do know that on the senior
15 leadership team, they are all involved in -- they are
16 more so involved in constructing those numbers, and
17 that's, that's where I'd like to be eventually, which
18 is why I said that in my, in my annual review.

19 Q Okay. We're going to get into some basic
20 concepts now.

21 The first is the Hospital Safety Grade.
22 You're familiar with the Hospital Safety Grade, right?

23 A Yes.

24 Q What is that?

25 A The Hospital Safety Grade is, is an

1 initiative program that LeapFrog put together. I
2 believe it was -- it was before I started at LeapFrog
3 in, it was in 2012, and my understanding is that it
4 started with a, a grant LeapFrog received from the
5 Robert Wood Johnson Foundation --

6 THE REPORTER: Received from the what?

7 THE WITNESS: Sorry. From the Robert Wood
8 Johnson Foundation to create more awareness about
9 patient safety to the public, and it was -- that
10 is something that I think LeapFrog has become
11 widely recognized for through the, the Hospital
12 Safety Grade.

13 There are -- we gather some of the foremost
14 experts, researchers and clinicians that are
15 known in industry to help us to create a
16 methodology that we, we use to put together a
17 grading system for hospitals based exclusively on
18 patient safety. To my knowledge, it's the only
19 rating system on -- that looks at exclusively
20 patient safety and, and making the assessment.

21 So twice a year, we put out the hospital
22 safety grades for general acute care facilities.
23 Approximately 2,800 to 3,000 facilities are
24 graded, and the information is updated with the
25 latest available data that, that we have, are

1 able to find, and put into the methodology, and,
2 and then, and then publish the grades.

3 Transparency has been core to LeapFrog's
4 mission throughout, throughout our history, and
5 we apply that in the Hospital Safety Grade by
6 publishing not just what the overall grades are,
7 but the underlying measures that go into that, so
8 that -- and it was designed to be a very
9 consumer-friendly website so that anyone can --
10 any patient or family member can go and see the
11 information about the facilities and how, and how
12 they got -- and, and where they are performing
13 well and where they are not performing well.

14 And so that continues to be a, a focus for,
15 for LeapFrog to make, make this information
16 available to the public, making it easy to,
17 making it easy to understand, and, and now I
18 think it's going on 13 years of, of, of rating
19 facilities --

20 BY MR. CHUNG:

21 Q You mentioned --

22 A -- on patient safety.

23 Q You mentioned "methodology." Are you
24 involved in any way with the methodology that goes
25 into the Hospital Safety Grade?

1 A I'm not involved in the methodology.

2 Q You also mentioned "transparency." Do you
3 know whether LeapFrog discloses or explains the
4 methodology by which hospitals are assigned a
5 safety -- hospital safety grade?

6 A Yes. I know we publish the methodology on
7 our, on our website.

8 Q Okay. The actual methodology document
9 itself? Is that what you're referring to?

10 A Yes.

11 Q All right. Other than publishing or linking
12 that methodology, are you aware of anything on the
13 website that explains to consumers the methodology
14 behind how hospitals are assigned a safety grade?

15 A There, there's a number of pages on our
16 website that explain the Hospital Safety Grade, but
17 the, the full methodology is, is published on, on the
18 website.

19 Q And is the -- and is the expectation that
20 consumers read the, the full methodology?

21 A The -- it is there if they are interested to
22 explore the website. We try to make it as easy to
23 understand as possible.

24 Q And so how does, how does LeapFrog do that,
25 to make it as easy to understand as possible? I'm

1 focusing just on the methodology.

2 A Oh. So I -- well, I'm not involved in the
3 methodology, in the methodology or, or in the creation
4 of the website, so I'm just speaking like in, in
5 general about LeapFrog's philosophy of the LeapFrog
6 website, and, and so we -- our, our -- I know one of
7 our goals, LeapFrog's goals is to make it as easy and
8 transparent as possible, but I'm not directly involved
9 in, in making the website and, and, and doing that,
10 but that is a focus of, of the team that does that at
11 LeapFrog.

12 Q Okay. Well, I mean you testified that
13 LeapFrog tries to make it as easy to understand as
14 possible with respect to the methodology.

15 How does it do that?

16 MS. WOOD: Objection to form.

17 THE WITNESS: I, I don't know how they do
18 that.

19 BY MR. CHUNG:

20 Q Are you -- do you interact at all with --
21 you mentioned "experts" contribute to the methodology
22 behind the hospital safety grades. Do you have any
23 interaction with the experts that you described?

24 A No, I do not.

25 Q And who is responsible? Who has that

1 interaction from LeapFrog?

2 A Missy Danforth.

3 Q Do you have -- do you have an understanding
4 of the types of measures or metrics that LeapFrog uses
5 in its scoring methodology that generates the Hospital
6 Safety Grade?

7 A I have a, I have a general understanding.

8 Q Can you tell me just briefly what that
9 general understanding is.

10 A So there -- we published a methodology.
11 There's an -- we, we look at publicly available data
12 in the scoring on what our expert panel has determined
13 to be some of the most important measures that are
14 available to the public, or published anywhere, on
15 these facilities that help contribute in preventing
16 errors, accidents, injuries and infections that happen
17 in, in hospitals. They are what, from my
18 understanding, what are the most impactful for
19 specifically patient safety concerns.

20 So there are, there are outcomes measures.
21 There is some process and structural measures, and
22 they -- through the methodology, they assess the
23 performance on each of those. There's -- percentages
24 at each of the measures are, are assigned, and, and
25 then ultimately a score is produced, a numerical

1 score.

2 And then there's specific cutpoints, and the
3 cutpoints determine what the, what the letter grades
4 are. It takes the most publicly available data.
5 There's data snapshot dates for each cycle, spring or
6 fall, so it's the latest data that's available at
7 those -- during those specific cutpoints, and so that
8 we are able to appropriately score and report the data
9 for, for hospitals looking at the same time period,
10 reporting periods.

11 And, and then there's, of course, there's a
12 lot of processes that go into it that I'm -- I'm not
13 directly involved in it, but that's my general
14 understanding, and Missy can definitely speak to it a
15 lot better.

16 Q It sounds like you actually know a lot about
17 it. So what are -- you mentioned that -- you
18 mentioned publicly available data, right, that the
19 hospital safety grades are based on publicly available
20 data; is that right?

21 A Yes.

22 Q Okay. What are the, what are the sources of
23 that publicly available data?

24 A CMS is a significant source of the data.
25 The LeapFrog Hospital Survey is also considered

1 publicly available data, so -- because we publish all
2 the results on our, on our website.

3 I know those are two, two of the main
4 sources.

5 Q When you say that the LeapFrog -- which
6 we'll get into -- the LeapFrog Hospital Survey is
7 publicly available data, are you saying that all of
8 the data that participating hospitals submit in
9 response to the survey is available to the -- freely
10 available to the public?

11 A No. Their score. LeapFrog publishes scored
12 data on the, on the website, but yeah.

13 Q So you're referring to the scores
14 themselves, not the underlying data; is that correct?

15 A So primarily the score, yeah, the score, the
16 score data for the Hospital Safety Grade website.

17 Q So just to be clear, the data that hospitals
18 submit in response to the LeapFrog Hospital Survey,
19 are you testifying that that is publicly available?

20 MS. WOOD: Objection to form.

21 THE WITNESS: Can you repeat the question.

22 BY MR. CHUNG:

23 Q Yeah. The actual -- so I'm referring to the
24 data that hospitals that participate in the hospital
25 survey submit to LeapFrog; is that data publicly

1 available to the public?

2 A So, so like if -- for example, if they say I
3 have 504 beds, that's data they're submitting on the
4 survey. We're not scoring that data, but we are
5 putting that data, that information that they're
6 writing on there -- they're publishing on the website.

7 Separately, we, we also have -- like there's
8 a scoring algorithm. If we're talking about the
9 LeapFrog hospital survey and the ratings at
10 leapfroggroup.org, we, we do score information inputs,
11 and, and I'm not involved in that, to be clear, in, in
12 any, in any sense. I have a general understanding,
13 and I, I do answer questions from people that are
14 interested in the, the, the kind of output datasets
15 that LeapFrog has as part of the data licensing
16 program. So I'm just speaking from my experience,
17 which is kind of very high-level about it, about the
18 program.

19 So I, I do not work directly on the, on the
20 website or on the methodology, but, but just to answer
21 your question, yeah, data, data can mean a lot of
22 things, and so hospitals enter in information when
23 taking the survey. Some of that information is on the
24 website, like their -- what they've put in as their
25 hospital name, but they --

1 Q But, Mr. Banerjee, I'm talking about the
2 entirety, right, of the data that hospitals submit in
3 response to the hospital survey.

4 Are you saying that that is all publicly
5 available?

6 A No.

7 Q Okay, and, in fact, as, as the director in
8 charge of the licensing programs, one of those
9 programs is data licensure, correct?

10 A Yes.

11 Q Right, and at least a good portion of the
12 data that's being licensed is not publicly available;
13 otherwise, there wouldn't be a purpose to licensing
14 that data, correct?

15 A Can you repeat that again.

16 Q A good portion, good portion of the data
17 that, that LeapFrog licenses is not publicly
18 available, correct?

19 A Most of the data that is licensed by
20 organizations is publicly available, almost all,
21 almost all of it.

22 Q Okay. We can move on.

23 The, the hospital survey that you mentioned
24 a few times already, do you have any role in designing
25 that, that hospital survey?

1 A No, I don't. I have not.

2 Q Have you ever reviewed the hospital survey?

3 A I, I have looked at it.

4 Q Okay. What does looking at it mean?

5 A Oh, I mean I -- there's -- as I mentioned,
6 there's -- I talk to a lot of different types of
7 organizations that are interested in LeapFrog's
8 ratings and, and the data.

9 Sometimes they have specific questions about
10 the survey, so in those cases -- and I've worked at
11 LeapFrog for ten years now -- sometimes they ask
12 specific questions from the survey, and sometimes I
13 have someone on our team that's more familiar with it
14 answer those questions, but there are other times I go
15 into the survey and look up what the specific
16 questions are. So I have spent some, some time
17 looking at the, the survey before.

18 Q All right. Do you have any role in
19 reviewing the hospital responses to the hospital
20 survey?

21 A No.

22 Q So you don't review the data that, that
23 hospitals submit in response to the hospital survey?

24 A No.

25 Q Even in connection with your overseeing the

1 data licensure program?

2 A Right.

3 Q LeapFrog requires hospital survey
4 participants to affirm that LeapFrog can use the
5 survey information in a commercial manner for profit.

6 Are you aware of that provision in the, in
7 the hospital survey?

8 A I have seen that before.

9 Q Okay. Do you know how long LeapFrog has
10 required that affirmation?

11 A I do not.

12 Q All right. Do you know whether a hospital
13 can opt out of that affirmation and still complete the
14 survey?

15 A I, I do not know that. No, I do not know
16 that, but I do -- as a part of that affirmation, I
17 have seen that they, they do not own the data. It's
18 like higher up in that, in that paragraph. So they
19 don't -- the hospital is, does not -- they're
20 submitting this data. LeapFrog fully owns it, and so
21 just for full transparency, I think LeapFrog is kind
22 of doing a -- is telling them that in addition to not
23 owning it, this is what we are able to do with it, the
24 data.

25 Q And the purpose of essentially giving

1 ownership of the data to LeapFrog is so that LeapFrog
2 can license that data, correct?

3 A I, I believe -- that was -- I wasn't
4 involved when that was written.

5 Q I understand.

6 A But I suppose that would be, that would be
7 one of the reasons why.

8 Q Are you aware of any hospital that's ever
9 complained or has expressed a desire -- have you heard
10 any hospital complaining about not being able to opt
11 out of this affirmation?

12 A No, and I don't, I don't talk directly to
13 hospitals. I don't talk directly to the hospitals
14 anyway, but I -- no, I have not heard that.

15 Q You don't --

16 A Even anecdotally.

17 Q You don't interact with any hospital or
18 hospital systems at all?

19 A Not, not concerning completing the survey.
20 I have interacted with health systems before. As a
21 part of the data licensing programs, one of the things
22 we have available -- and actually, that was actually a
23 part of expanding the -- I couldn't think of an
24 example for, for data licensing, but we, we have a
25 health system support subscription, where a health

1 system that is trying to understand LeapFrog ratings
2 and get the most accurate timely data for their system
3 hospitals.

4 Sometimes there's like one, one person that
5 works in a health system that has, you know, 20
6 hospitals or 40 hospitals, and they wanted to get the
7 latest available information on those facilities. We
8 launched like a subscription to give them timely
9 datasets about -- that have the information for their
10 specific facilities.

11 So there's -- a component of that is their
12 hospital survey results, the responses for their
13 specific facilities, the safety -- for the safety
14 grade, the data that we're going to be using in order
15 to grade them are given to them well in advance of
16 when we publish the data.

17 And so that is all information that they can
18 get -- that the individual facilities can get -- I
19 mean there's no cost to them to get that, but we
20 launched this program, because we had a lot -- there
21 were a lot of health systems that were asking for this
22 timely information, and it requires an analyst on our
23 part --

24 THE REPORTER: What?

25 THE WITNESS: It requires an analyst from

1 our team to kind of coordinate and create those
2 files. So we, we began to make those, those
3 files available, and so there is a data use
4 agreement that, that the health system needs to
5 complete in order to get these, these files.

6 And so when we launched that program, I
7 started talking to health systems and people that
8 were in these roles, and kind of initiating them
9 what's, what's in this subscription, and, and so
10 that is kind of the capacity that I have talked
11 to, talked to health systems primarily.

12 BY MR. CHUNG:

13 Q How much is that subscription that you just
14 described?

15 A The pricing of that is based on the number
16 of hospitals that the health system has. So if it's a
17 two to five hospital health system, it's about \$2,500.
18 On the high end, I don't think it's above like
19 \$19,000.

20 Q Is this among the new programs that you
21 mentioned in your LinkedIn profile?

22 A Yes.

23 Q And this is -- so this is another way,
24 another program that basically packages or leverages
25 the data that's submitted by hospitals in response to

1 the survey, correct?

2 A So this is a, this is a program that
3 LeapFrog is taking information from -- that, that
4 we're -- for the survey. It's information that we own
5 from, from the survey.

6 Q Right.

7 A About these specific facilities.

8 Q Right.

9 A So not like the universe of, of hospitals
10 taking the survey. It's just their specific
11 facilities that they are interested in, and we're
12 giving them back the data that's already published on
13 our website, or that their hospitals have submitted to
14 the survey, and it's in a file so that they can kind
15 of look at it all in one place. They can get that
16 information from those hospitals. It's, it's just
17 kind of a coordination exercise on, on our part that
18 we're doing for, for those specific facilities.

19 Q LeapFrog has the data, and it basically
20 packages it, it packages it for the hospital systems,
21 correct?

22 A Yes, and so part of it is like the
23 coordination. The other thing is like the timing of,
24 of getting, of getting it. It might take a single
25 person at that health system some time to like reach

1 out to all these people, but LeapFrog has this
2 information that we can kind of package and give to
3 them for convenience.

4 Q Okay, and this is -- so this product, this
5 new product is marketed to hospital systems; is that
6 right?

7 A Yes, it is.

8 Q Okay, and, and when did that -- when did
9 this kind of new product -- when did you start this
10 new product?

11 A I want to say maybe like -- I don't remember
12 exactly, but 2018 maybe we started with -- and there's
13 a few that were interested, and then slowly, over
14 time, we -- based on requests that -- usually they
15 come in through the HelpDesk. We, we kind of initiate
16 those people that we have this available. It's
17 usually on request. We, we do have like a webpage
18 where we, where we show like what's available on it,
19 but usually it's at the request of somebody from the
20 system, saying like do you have anything that can help
21 us with getting these in a timely way, so -- and so
22 that's, that's why we made that available.

23 Q And so am I correct that in order for this
24 particular product to, to work or be successful, that
25 you need all of the hospitals within this particular

1 system to have actually responded to the survey; is
2 that right?

3 A We do not -- no, we do not need all the
4 hospitals in the system to, to respond to the, to the,
5 to the survey. I think -- I mean it's to their
6 benefit to -- if they, if -- they are usually health
7 systems that are very engaged with LeapFrog,
8 participating in the, in the survey, and so they would
9 want that information, but, but no, we don't, we don't
10 require them to, to have them all.

11 Q But if, but if let's say one or more
12 hospitals within their system actually did not respond
13 to the survey, the dataset would be incomplete,
14 correct?

15 A It would be incomplete for their purposes,
16 yes.

17 Q So for their purposes, it would be important
18 to have all the hospitals at least within their,
19 within their system to have actually responded to the
20 survey; is that right?

21 A Well -- well, I guess I don't really know
22 what they are using it for, but -- so if they were
23 just interested in the specific hospitals that were
24 completing the survey, then, then I guess it would
25 fill their purpose, but if they -- yeah, if they had

1 some that were not participating and it wasn't
2 important to them, then I guess they would -- if they,
3 if they wanted them to participate, and they weren't,
4 then, then, yeah, it would be incomplete for their
5 purposes.

6 MR. CHUNG: Why don't what go on to the next
7 document, seven.

8 (Discussion was held off the record
9 regarding a possible break.)

10 THE VIDEOGRAPHER: This marks the end of
11 media unit number 1. Going off the record, the
12 time is 10:22 a.m.

13 (Whereupon, a short recess was taken.)

14 THE VIDEOGRAPHER: This marks the beginning
15 of media unit number 2. Going back on the
16 record. The time is 10:38 a.m.

17 MR. CHUNG: Mr. Banerjee, we're going to put
18 in front of you our next exhibit, which will be
19 Exhibit 2.

20 (Exhibit 2 was marked for
21 identification.)

22 BY MR. CHUNG:

23 Q And this is financial statements for
24 LeapFrog. It's dated June 30, 2024.

25 Are you familiar with this document? Have

1 you seen it before? Just leaf through it. Take some
2 time.

3 A Okay. I've seen -- I have not seen this --
4 I have not, I have not seen this full document before,
5 but I have generally seen some financial statements
6 before.

7 Q Okay. So substantively you're familiar with
8 kind of the, the component statements that are in this
9 financial statement?

10 A Yes.

11 Q Okay. So I'm going to direct your attention
12 to -- if you look at LeapFrog Bates ending 9789, it's
13 like page five, basically.

14 A Yep.

15 Q Under "Revenue and Support," you'll see
16 that, according to this financial statement, LeapFrog
17 had revenues of about \$8.36 million.

18 Do you see that?

19 A Yes.

20 Q And has that -- so far as you're aware, has
21 that figure fluctuated over the past five years, or
22 has it remained steady?

23 A I'm, I'm not sure how -- I'm, I'm not sure
24 if it, if it has, but I believe it's been pretty
25 steady.

1 Q Okay.

2 Now, in terms of the particular line items,
3 you'll see that the first is accolade, accolade
4 licensing revenue, and the revenue from there for at
5 least 2024 was about \$3.29 million.

6 Do you see that?

7 A Yes.

8 Q And for the previous year, just a tick
9 below; about \$3.21 million.

10 Do you see that?

11 A Oh, I see. Let me see. Yes.

12 Q Is this the -- you testified earlier that
13 the licensing programs, accolade and data licensing,
14 are the two biggest revenue sources for the, for the
15 organization, correct?

16 A Yes.

17 Q And does this -- and between the two,
18 accolade licensing -- the accolade licensing program
19 is, is the bigger one; hence, the biggest revenue
20 source for the organization?

21 A Yes.

22 Q Okay. The "Data Licensure" line item,
23 you'll see there the revenue here for 2024 was
24 \$2.17 million; is that right?

25 A Yes.

1 Q Okay, and just -- I'm sorry. Going back to
2 the accolade licensing, just to be clear, that revenue
3 source depends on the, the hospital grades, correct?
4 That's licensing of the, the hospital safety grades,
5 correct?

6 A No. The -- so it's -- the accolades
7 licensing program, we're, yeah, we're licensing the
8 rights to use the logo --

9 Q Yes.

10 A -- for the safety grade, the Top Hospital
11 logo, and Diabetes Recognition logo, so not just the
12 safety grade, to clarify.

13 Q Right. So among those three, three sources
14 or programs that you mentioned, is it correct that
15 the, the licensing -- the right to use the Hospital
16 Safety Grade logo is the biggest component of those
17 three in terms of revenue?

18 A Oh, yes. Of those, yes, that's correct.
19 That's accurate.

20 Q So with respect to the Data Licensure line
21 item, am I correct that that revenue source depends on
22 LeapFrog basically commercializing the data that
23 hospitals submit in response to the hospital survey?

24 MS. WOOD: Objection to form.

25 THE WITNESS: Can you, can you clarify what

1 you mean by "commercializing"?

2 BY MR. CHUNG:

3 Q Monetizing, selling basically the right to
4 use that data.

5 A Yes. Selling the right to use the data and,
6 in some cases, the logos that are associated with the,
7 the programs.

8 Q The logos -- the right to use the logos is
9 also part of the data licensure program as well?

10 A It can be if it's specified in the data use
11 agreement.

12 Q Okay, but that's separate from the accolade
13 licensing?

14 A That, that is separate from the accolade
15 licensing.

16 Q The "Membership" line item here, it says for
17 2024 the revenue is about \$1.14 million. How is
18 this -- is this revenue source related in any way to
19 the hospital survey or the hospital grades?

20 A I believe that is for the partners advisory
21 committee. That's a separate program. Is it
22 associated -- what's the question?

23 Q Yeah, is it associated or related in any way
24 to the hospital survey and the hospital safety grades?

25 A The licensing programs. You're asking if

1 it's related to the licensing programs?

2 Q Yes.

3 A Okay. There are some organizations that are
4 partners, partners advisory committee members that
5 also license data as part of the data licensing
6 program, so there are, there are, I guess,
7 contributions that are the same organization.

8 One of the benefits in the partners advisory
9 committee, which I'm, I'm not a part of administering
10 that program, but there is a, like a discount on the
11 data that's available, if they are partners and
12 they're interested in accessing and the right --
13 having the rights to use the datasets.

14 Q How much of a discount is there for
15 companies that become part of the PAC?

16 A It's a 20 percent discount on, on data
17 licensing.

18 Q Just across the board, a 20 percent
19 discount?

20 A Yes.

21 Q Okay. The "Data Products and Reports," just
22 looking back at Exhibit 2, line item for, responsible
23 for about \$314,000 in revenue, what is -- what did
24 this refer to?

25 A So the Data Products and Reports are -- I

1 believe those are one-time reports. So the Data
2 Licensing line item is referring to organizations that
3 have completed a data use agreement that are getting
4 the latest of the -- they're typically one-year terms
5 agreements, standard, and all the data that's
6 available in that year, they're getting an update to
7 the latest available data that's available on the
8 respective websites, the Hospital Safety Grade or the
9 ratings on our leapfroggroup.org website. So there's
10 multiple deliverables, and getting access to, to those
11 datasets.

12 The Data Products and Reports are one-time
13 reports that LeapFrog creates for, for someone or some
14 organization that wants like a snapshot of, of data.
15 So I think there are specific benchmarking reports
16 that are available to hospitals that are included in
17 there. If there's an organization for some reason
18 that wanted just a snapshot of, of the data for -- and
19 with one specific measure, we'd create a report for
20 them, and that would be qualified under, under Data
21 Products and Reports.

22 Q So who are the customers for these kind of
23 the one-time reports? Are they hospitals? Are they
24 solution providers? Who is, who is getting these?

25 A I actually don't know the full scope.

1 That's, that's kind not -- I'm not really involved in
2 a lot of the one-time reports.

3 Q Who oversees that?

4 A Missy, Missy Danforth has oversight on those
5 data, data products and reports.

6 Q Okay. Do you know how these, these data
7 products and reports, this particular line item is
8 marketed?

9 A I don't know all the specific details of the
10 different -- of what's included under, under that line
11 item, to be, to be honest.

12 MR. CHUNG: Let's go to tab 20. This will
13 be Exhibit 3.

14 (Exhibit 3 was marked for
15 identification.)

16 BY MR. CHUNG:

17 Q So Exhibit 3 is a document titled "Business
18 Development Discovery Report." It's dated from
19 February of 2018. It says it's prepared by a Stephen
20 Gaus.

21 Does that -- do you know who Stephen Gaus
22 is?

23 A Yes. He's a former employee of LeapFrog.

24 Q What was his role?

25 A I believe it was the director of business

1 development.

2 Q All right. Did you work with him when he
3 was at, when he was at the organization?

4 A I did.

5 Q How did you -- what was the, kind of the
6 nature of the relationship with him?

7 A I reported to him for some period of time.

8 Q And this is when -- what role were you in
9 when you reported to him?

10 A I think I was a coordinator, senior
11 coordinator of business development, I believe.

12 Q Is there a business development director or
13 even manager role at the organization now?

14 A No, there is not.

15 Q Why is that?

16 A We -- I mean -- so let me, let me think
17 about why, why --

18 Q If you know.

19 A No, I don't, I don't know why there --

20 Q Okay.

21 A I don't know why there isn't.

22 Q All right.

23 So just if you've had a chance to look
24 through it, just let me know if you recognize it,
25 either specifically or generally familiar with it.

1 A I have -- I haven't seen this before, or I
2 don't remember seeing this.

3 Q Have you seen similar reports, you know,
4 later or other iterations of a business development
5 discovery report?

6 A No.

7 Q Okay, but at the time in February 2018, you
8 were reporting to Mr. Gaus when he was director of
9 business development; is that right?

10 A I, I reported to him for some period of
11 time, and then I -- while he was working at -- while
12 he was working at LeapFrog, I moved to report under
13 somebody else, so I don't, I don't remember the timing
14 of when I was reporting to him.

15 Q Okay. So if you turn to Bates ending 7484.
16 It's basically the second page.

17 So up top, the document reads, "The scope of
18 this document is to report on my assessment of The
19 LeapFrog Group's current state and the opportunity to
20 monetize its IP (intellectual property) to sustain
21 current transparency reporting on U.S. Healthcare's
22 Safety and Quality of Care for Acute Care Hospitals."

23 Now, in terms of the IP that is seeking to
24 be monetized here, is it your understanding that --
25 what's covered under LeapFrog's IP, as you understand

1 it?

2 A Actually, I don't, I don't really know like
3 what that -- I'm, I'm not really sure what this is
4 referring to. I mean I know that we have copyrights
5 on the survey and the trademark of the, of the logos
6 and that we own the data. That's what I understand to
7 be our, our intellectual property.

8 Q Okay, and then it says under "Hospital
9 Survey Participation," basically the next section,
10 "The participation rate by acute care hospitals
11 continues to grow, and currently 66 percent of
12 representative beds in the U.S. participate in The
13 LeapFrog Group's annual survey."

14 And then let's move on to the -- we'll skip
15 that next paragraph. Then there's a paragraph that
16 starts, "To maximize the value of The LeapFrog Group's
17 Data for licensing purposes, the level of
18 participation should continue to be increased so it
19 can be perceived as the most complete dataset, and
20 thus allowing defense of our pricing model and its
21 price points."

22 Do you see that?

23 A Sorry. Can you --

24 Q Yeah, if you can just focus on the paragraph
25 that starts "To maximize the value" --

1 A Oh, yes.

2 Q -- "of The LeapFrog" --

3 A Got it.

4 Q -- "Group's data."

5 A Got it.

6 Q All right.

7 A Yep.

8 Q "To maximize the value of The LeapFrog
9 Group's Data for licensing purposes, the level of
10 participation should continue to be increased so it
11 can be perceived as the most complete dataset, and
12 thus allowing defense of our pricing model and its
13 price points."

14 Do you see that?

15 A Yes.

16 Q So is it correct that the value, according
17 to this presentation here, the value of LeapFrog's
18 data that it licenses increases as more hospitals
19 respond to the survey with their data?

20 A I, I guess "value" meaning -- sorry. What
21 do you mean by "value"?

22 Q How do you -- I'm, I'm reading off the
23 document here, right?

24 A Yeah, I've never -- I haven't seen the --
25 I've actually never, never have seen this document

1 before.

2 Q Okay. Well, do you disagree with this, with
3 this sentence here?

4 A I think -- I'm sorry. I disagree with the
5 word "value," but like the price of the data, we
6 don't, we don't price it based on the number of
7 hospitals that are reporting. It's the same price,
8 regardless, but it is -- if there are specific markets
9 that -- where there is more participation in the
10 survey, then yeah, purchasers of, of healthcare could
11 utilize that information, then inform higher value
12 care.

13 So in that sense, it would, it would be more
14 valuable in the market and to the public, but for, for
15 LeapFrog, it would kind of be the same, regardless of
16 whether they're participating or not, in terms of like
17 our, our pricing model, which is referred to here.

18 Q Well, how about the, that the level of
19 participation, right? So he, kind of the, the middle
20 of the sentence, he writes that "the level of
21 participation should continue to be increased so it
22 can be perceived as the most complete dataset," right?

23 So let's put aside the pricing. We'll get
24 to --

25 A Oh, okay.

1 Q -- that later, right?

2 Do you agree with that, that the, the
3 greater the participation by hospitals, right, in the
4 Hospital Survey, the more complete the dataset is?

5 Do you agree with that?

6 A Yes. The more that participate, the more
7 complete the dataset is, yes.

8 Q And the more complete the dataset is, the
9 more valuable hospitals and solution providers and
10 other parties view that dataset; is that correct?

11 MS. WOOD: Objection to form.

12 THE WITNESS: Yes, so I will say that they
13 will -- the more that participate in the survey,
14 the more in alignment with LeapFrog's mission to
15 make this information usable in informing care
16 for patients, for purchasers, for the hospitals
17 that have assessment of their performance, it is
18 more valuable to, to the public and, as a result,
19 LeapFrog to have more participation in the
20 survey.

21 BY MR. CHUNG:

22 Q Right, because that, that -- understood.

23 And then this, the final part of this
24 sentence, "thus allowing defense of our pricing model
25 and its price points." Is it, is it fair to say -- I

1 mean just either based on what's written here or
2 otherwise, right, the, the more, the more complete the
3 dataset is, based on increased participation from
4 hospitals, it's not -- well, let me put it this way.

5 Is it correct that the greater the value
6 that hospitals and solution providers and other
7 parties see in the dataset, right, the easier it is
8 for you, as director of licensing programs, to
9 basically defend or sell the price at which you're
10 licensing these products?

11 MS. WOOD: Objection to form.

12 THE WITNESS: I mean I don't know if it, if
13 it makes it easier. I don't know if it makes it
14 easier or harder, but if -- it kind of depends on
15 the situation, the organization, because I mean
16 depending on the organization, it could be a, you
17 know, solution provider, that they are using the
18 data for just internal research and market
19 intelligence. They want to look at their, their
20 customers to see, you know, what the hand hygiene
21 performance is on the, on the survey.

22 They want to see prospective customers. Are
23 they participating in the survey or not? And is
24 there any case that they can make in working --
25 in doing that type of, of work with the hospitals

1 to improve performance, say, on the hand hygiene,
2 for, for example.

3 So, so yeah, I don't know exactly if it
4 would help in every situation with the -- in
5 terms of convincing them that this is, this is
6 something that they're interested in, but yeah,
7 they would have to make that assessment, if it,
8 if it makes, if it makes a difference or, or not,
9 and I'm not really sure how the price point
10 comes, comes into that.

11 BY MR. CHUNG:

12 Q Well, I'm looking at it from -- I'm asking
13 for your perspective, right, in, in marketing and
14 selling, right, the licenses -- the licenses.

15 In each of the examples that you just gave,
16 right, LeapFrog needs the data, right, that they're --
17 that each of these parties are asking for in order to
18 sell them a license, correct?

19 A Yes. So we, we do need -- we do need
20 participation from, from hospitals for the survey in
21 order to make the LeapFrog Hospital Survey dataset
22 available, and yeah, there, there have -- even when I
23 started at LeapFrog, I think there was maybe like
24 1,700, 1,800 hospitals that were participating in, in
25 the survey, and it is -- I, I -- and, and I know

1 there's, there's more today, but it's -- I don't think
2 it -- the, the pricing has never been on, on like the
3 number of, of hospitals that are participating.

4 THE REPORTER: The pricing has never been
5 on --

6 THE WITNESS: The, the price -- the pricing
7 has not been correlated with the number of
8 hospitals that are, that are participating.

9 BY MR. CHUNG:

10 Q Well, let's put aside the pricing, right?
11 In terms of attracting more customers, more consumers,
12 whether it's solution providers or hospitals or other
13 parties, is greater survey participation important to
14 attracting more of those customers to license the
15 products?

16 Is that fair to say?

17 A Yeah. In certain, in certain circumstances,
18 more participation could garner the interest of
19 specific types of organizations to, to look at, to
20 look at the, the LeapFrog Hospital Survey data, but it
21 could also -- even lack of participation in, in the
22 survey could still encourage, for example, a health
23 plan to work with, work with LeapFrog, get the, the
24 information about the survey, and then go to their
25 network hospitals and encourage participation in the,

1 in the survey to, to get that, get that assessment.

2 So in both cases, they would -- whether they
3 have the participation or not, that would be --
4 whether we had the participation or not, they would
5 still want to engage with us.

6 Q I see.

7 So for, for a hospital or say number of
8 hospitals that don't participate in the survey, you're
9 saying that, that that lack of participation in the
10 survey can incentivize hospitals, let's say, within
11 the same network to try to get those nonresponding
12 hospitals to, to respond to the survey?

13 A Could you repeat that again.

14 Q Sure. So I'm just kind of understanding
15 what you just testified to, right?

16 So for certain hospitals within a hospital
17 network that did not participate in the survey, that,
18 that hospitals within the same network are
19 incentivized to encourage those other nonparticipating
20 hospitals to actually participate in the survey; is
21 that correct?

22 A The health, the health plan can, can
23 encourage or incentivize the, the hospitals, even
24 nonparticipating hospitals, to, to participate in, in
25 the survey, and when -- yeah, when I say

1 "incentivize," I mean like potentially be like a
2 monetary incentive, but it could also be like a
3 quality improvement --

4 THE REPORTER: It could also be what?

5 THE WITNESS: I think I said there could be
6 a monetary incentive, but there could be a
7 quality improvement initiative that the health
8 plan is doing to raise the quality and awareness
9 of -- quality that uses some of the LeapFrog
10 Hospital Survey measures or the Hospital Safety
11 Grade.

12 And, and so they, they may use some of the
13 information. This is all -- this is all from my
14 understanding in talking to some of the current
15 data licensees. We give them the data, and then
16 they kind of take it and use it within the terms
17 of the data use agreement. So some of them use
18 it internally and in these types of initiatives,
19 so this is all from what I hear from our, our
20 data licensees.

21 BY MR. CHUNG:

22 Q Okay. So LeapFrog -- I mean is it fair to
23 say that LeapFrog has an incentive to get as many
24 hospitals as possible to respond to the hospital
25 survey?

1 A We want, we want as many hospitals as
2 possible to participate in the, in the LeapFrog
3 Hospital Survey.

4 Q And at least part of that incentive is a
5 financial incentive, correct?

6 A There I don't see a direct financial
7 incentive.

8 Q How is that -- how is that not a direct
9 financial incentive if, if you have more hospitals
10 participating in the survey, and, as you testified,
11 the dataset becomes more complete, right, and
12 hospitals and other customers see greater value,
13 right, in a more complete dataset, correct?

14 A There is no direct incentive, because if we
15 get more hospitals to participate in the survey, we,
16 we do not -- we're not charging -- if we have all of
17 our current customers, there is no change in what we
18 are charging them, because our pricing is not based on
19 the number of hospitals that are participating in the
20 survey.

21 Q Right. It's not so much the pricing
22 necessarily, Mr. Banerjee, but what I'm getting at --
23 and we went over this earlier -- is the number, right,
24 of, of hospitals and just other parties that
25 participate in the licensing programs; wouldn't you

1 say that that, there's a direct relationship with
2 respect to the number of participants, not
3 participants, but licensees or potential licensees?

4 A There, there -- more participation may, may
5 create more interest in, in specific markets with
6 specific organizations, that's true.

7 MR. CHUNG: Okay. Let's go to tab 9. This
8 will be Exhibit 4 for Mr. Banerjee.

9 (Exhibit 4 was marked for
10 identification.)

11 BY MR. CHUNG:

12 Q So Exhibit 4 is, is a document entitled "The
13 LeapFrog Long-Range Strategy Intent" for fiscal years
14 2026 to 2032, so I want to flip through that. Let me
15 know if you recognize it or are at least familiar with
16 the substance of the document.

17 (Witness peruses document.)

18 BY MR. CHUNG:

19 Q Have you had a chance to look at it?

20 A Yes, I have seen this. I believe I've seen
21 this before.

22 Q Okay. In what context have you seen it
23 before?

24 A I believe it was discussed at a, at a
25 management team meeting.

1 Q Okay, and approximately when?

2 A Looks like it was -- the board approved
3 December '24, so probably in -- I would imagine in
4 January.

5 Q If we look at the second page, Bates ending
6 17794, you'll see that there's an Objective 1. It's
7 the second page.

8 A Yes.

9 Q And under the Goal, the first goal is
10 "expand revenue from existing sources."

11 Do you see that?

12 A Yes.

13 Q All right, and in terms of the "Benchmark
14 Indicators" column, you'll see that the goal from 2025
15 to 2028 is to increase revenue -- first of all, in
16 September 2025, to set revenue at \$9 million.

17 Do you see that?

18 A Yes.

19 Q Okay, and then by 2028, \$12 million, and
20 then by 2031, \$18 million.

21 Do you know how those goals are determined?

22 A I do not.

23 Q Okay. Do you know whether these goals are
24 communicated to LeapFrog staff?

25 A I do not believe they, they were

1 communicated to LeapFrog staff.

2 Q All right. In your view, are these goals
3 realistic? Just kind of borrowing a term that you
4 used in the prior document.

5 A I think, I think they were discussed as
6 aspirational.

7 Q Okay. What does that mean to you?

8 A Something to shoot for.

9 Q Okay. Realistic?

10 A Um, realistic?

11 Q I'm just asking for your view.

12 A Oh. With, with the right strategies in
13 place, I think there's -- and the, and the time
14 horizon, which is, you know, three to five years out,
15 I feel like a lot is possible in that time, and I
16 think the discussion was around like, okay, if these
17 were the -- if these are the aspirational goals, like
18 what are the things we can do.

19 This is in the context of this being in the
20 management team meeting, and there are people that
21 have oversight of different programs, and we're all
22 looking at, you know, strengths of the program and
23 opportunities where -- where could we focus to kind of
24 maximize our efforts to drive the mission and then --
25 and, and reach these new heights.

1 Q So that's -- so we've already kind of --
2 you've already testified to and established that the
3 accolade licensing and the data licensing programs are
4 the two biggest sources of revenue for the
5 organization, correct?

6 A Yes.

7 Q So, so is it fair to say -- and again, I
8 want, I want your view. Is it fair to say that those
9 two licensing programs are critical to achieving
10 possibly, realistically, whatever you want to say,
11 right, these benchmark indicators?

12 A I, yeah, I think that they're important,
13 important components to be able to, to be able to, to
14 reach those, those goals.

15 Q Fair to say that they're the most important
16 components in terms of just pure numbers?

17 A From where we -- I guess from where we stand
18 now, it would, it would be the most important
19 component, but depending on where we focus
20 strategically to try and grow, they could become
21 diluted and become less of a -- a less part of the
22 increase goals, but, but I, I think that they, they
23 could be, they could be, still be significant, and
24 there's opportunity to expand licensing, the, the
25 licensing program.

1 And so I, I think that they will be -- I
2 think they will be -- maintain the percentage or maybe
3 increase, but depending on some of the other strategic
4 parts of the plan, we may, may see, and other ideas
5 that maybe not, are not even listed on here, they may
6 become a part of the -- a part of the pie,
7 percentage-wise.

8 Q So I heard a lot of "mays" in there. What,
9 what are these other ideas?

10 A I'm saying "may" because this is, this is
11 all like very aspirational, like brainstorming type of
12 session, so some of these ideas are not concrete.

13 Q Well, this is, as you see, a board-approved
14 document, correct?

15 A Yes.

16 Q So is this a -- is it, is it right to say
17 that this is a brainstorming session, this document,
18 if it's board-approved?

19 A So I'm, I'm not involved in the board --
20 like I don't attend the board meetings, and so I don't
21 know -- I, from what I understand, this was approved
22 by the board.

23 Q Yes.

24 A And then we identified the specific metrics
25 and, and goals, and how we're -- metrics and how we're

1 going to achieve specific aspirational goals to try,
2 try and reach some of these, some of these benchmarks.

3 Q So from, from your vantage point as director
4 of the licensing programs, how is -- how are your
5 programs? What are the goals or the plans behind your
6 programs to reach these benchmark indicators of
7 \$12 million by 2028 and \$18 million by 2031?

8 A So I think within my specific role, some of
9 the things I work on day-to-day is trying to
10 understand what our, what our current data licensees
11 are, like what they're doing and what they're
12 interested in, and how we can take that to, first,
13 like kind of retain those relationships and improve
14 them, if there's any level of analysis that we can
15 kind of provide to them about the, the information
16 that we have, the data we have about our ratings.

17 So one thing is -- so we don't have those
18 like kind of tumultuous years, we want to create
19 longstanding relationships with, with a lot of these
20 organizations and making it most useful to them.

21 In the process of doing that, identifying
22 what are those things that are making these
23 relationships, relationships successful, and kind of
24 presenting that to new, new audiences that, you know,
25 that reach out to us or that we interact with to show

1 them the value proposition of, of licensing the
2 LeapFrog -- having access to these ratings in a timely
3 way.

4 So being able to, to do that, to truly
5 understand what we offer in the, you know,
6 marketplace, and further enhance that, make it more,
7 make it more visible, part of it is improving --
8 increasing the brand awareness of LeapFrog in these
9 specific markets, increasing our market presence, as
10 we discussed earlier, I think all those things will
11 contribute to growing the, the brand that is, that is
12 LeapFrog and the programs that, that are associated
13 with it.

14 Q So let's look at specifically -- under the
15 "Benchmark Indicators" table, there's a section on
16 "data licensing revenue."

17 Do you see that? September 2025,
18 \$2.3 million data licensing revenue, and then there
19 are benchmarks for September 2028, for a 20 percent
20 increase from 2025, and then a further 20 percent
21 increase going to 2031. It's the same page.

22 A The same page? Okay, yeah.

23 Q Yes.

24 A I didn't see the 20 percent increase. So
25 the September 2025, eight new? Is that --

1 Q Yes, the data licensing revenue section. Do
2 you see that? We're looking at Bates ending 7794.

3 A Okay.

4 Q I see a look of confusion.

5 A I'm sorry. I'm --

6 Q There's a table. It's the next -- under
7 "Benchmark Indicators."

8 A Okay.

9 Q Okay, September -- it's the third cell on
10 down, below "Benchmark Indicators," it says
11 "September 2025, \$2.3 million dollars data licensing
12 revenue."

13 Do you see that?

14 A No, I don't. I can't see it.

15 Q Why don't you give me the --

16 A Yes, please.

17 Q Now do you see it?

18 A Yes.

19 Q Okay.

20 A Okay.

21 Q There's benchmarks going up 20 percent every
22 three years. Do you see that? From 2028 --

23 A Yes.

24 Q -- to 2031?

25 Are those benchmark indicators that you had

1 input in?

2 A No.

3 Q Okay. Are these -- from your viewpoint, are
4 these realistic benchmarks?

5 A For September 2025 -- well, I guess we're in
6 September 2025.

7 Q Yep.

8 A We were not there, so no.

9 Q Well, let's look at 2028, then. A
10 20 percent increase from 2025, is that realistic from
11 your viewpoint as the director of --

12 A Yeah.

13 Q -- this program?

14 A Yeah. I mean we have three years to get
15 there, so yes, I, I think that -- it seems reasonable.

16 Q How about for 2031?

17 A I guess it's possible, possible.

18 Q Okay. Are there benchmarks -- are there
19 benchmarks for these same time periods, 2028, 2031,
20 for the accolade licensing program?

21 A I don't, I don't think so.

22 Q Are you aware of any?

23 A No, I'm not.

24 Q Okay. So let's turn to Bates ending 7797.

25 A Okay.

1 Q All right. Do you see that -- this is under
2 an Objective 3, "Build communities that achieve the
3 mission."

4 If you go down several cells, there's
5 "Purchaser/employers: Enable purchasers and their
6 contractors to tie LeapFrog ratings to payment
7 decisions."

8 What does this -- what does this mean? What
9 do you understand this to mean?

10 A So I understand this to mean -- like so
11 LeapFrog was, was founded by employers and purchasers.
12 We want our data to be used to inform higher, higher
13 value care.

14 So we want to engage -- continue to engage
15 with employers and organizations purchasing
16 healthcare, and incorporating information from
17 LeapFrog and other, and other sources to -- that are
18 important in driving that higher value care.

19 So one of, one of the goals with employers
20 and purchasers that are listed here is that, is that
21 we want to continue to do that, and have those
22 stakeholders incorporated into, into, into contracting
23 with those, with those providers, so that they're --

24 Q "Providers" meaning hospitals?

25 A Sorry, yes, meaning hospitals.

1 Q Okay.

2 A And so that -- I mean that has been -- that
3 is a goal, one of the goals in, in, in providing that
4 data and making it actionable, is making that
5 available to employers and those types of
6 stakeholders.

7 Q In order to accomplish this goal, though, to
8 enable purchasers and contractors to tie LeapFrog
9 ratings to payment decisions, is it right that --
10 isn't it correct that LeapFrog has to have data
11 relating to those hospitals to provide to --

12 A Yeah.

13 Q -- to the purchasers and the contractors; is
14 that right?

15 A Yes.

16 Q Okay, and that means that in order to have
17 that data, they need, they need hospitals to basically
18 respond to the survey, correct, with their data?

19 A So it says "LeapFrog data," so it's
20 including the safety grade.

21 Q Right.

22 A So we, we -- it doesn't -- it's not just
23 necessarily talking about the, the survey, but the
24 safety grade as well, which LeapFrog can grade
25 facilities, regardless of whether they participate in

1 the survey.

2 Q Right, but in order for the -- but would you
3 say that, that purchasers and their contractors would
4 like to see data that's submitted by hospitals in
5 response to the survey data in order to make these
6 decisions about whether to tie payments to --

7 A Yes.

8 THE REPORTER: About whether to tie
9 payments to --

10 BY MR. CHUNG:

11 Q Whether to tie LeapFrog ratings to payment
12 decisions.

13 And so in that same vein, LeapFrog is
14 incentivized to get as many of those hospitals to
15 respond to the survey with their data, correct?

16 A Yes. We, we want to see as many hospitals
17 participating in the survey as possible.

18 Q So under "Health Plan," so just a couple
19 cells down on the same page, it reads, "Pressure plans
20 to tie LeapFrog ratings from payment decisions."

21 Do you see that? Under "Goal," right, so --

22 A Okay.

23 Q On the left-hand column, "Health Plans:
24 Pressure plans to tie LeapFrog ratings to payment
25 decisions."

1 A Yes.

2 Q Do you see that?

3 A I see it.

4 Q What does that mean?

5 A Okay. So I didn't write this, but what it
6 means is like -- is that we want to encourage, we want
7 to encourage health plans to tie LeapFrog ratings to
8 the payment decisions in, in working with, with
9 hospitals.

10 Q Why is the word "pressure" --
11 understanding --

12 A Yeah.

13 Q -- that you may not have --

14 A Yeah.

15 Q But it was, but it was a document for
16 discussion, right, at a management meeting --

17 A Yeah.

18 Q -- as you testified.

19 Why is, why is there pressure being applied
20 to plans to, to tie LeapFrog ratings to payment
21 decisions as a goal here?

22 A Yeah, so, I don't -- yeah, I don't know why
23 the word "pressure" is written, but we -- there is --
24 actually, nothing -- we, we don't have -- it's kind of
25 like an indirect encouragement, and I don't know how

1 we could directly pressure, but there are different
2 ways in which LeapFrog can make the case, either
3 through employers that are, that are working with
4 health plans, and some of them are self-insured. Some
5 of them have -- are, are, are group insured.

6 And some, somewhere along the lines between
7 the employer or the health plan or the, the TPA, they
8 are ultimately going back and having a contract with,
9 with the hospital, and so LeapFrog needs to -- you
10 know, we, we can do a better job of making the case of
11 why our, our -- there are ratings, and information is,
12 is valuable to, to impacting outcomes, and in a world
13 where the -- their payment -- the payment is not based
14 on outcomes, we want to factor into the payment
15 decision so that quality and safety is a
16 consideration, and so that's why that's, that's listed
17 as a goal.

18 But there's certainly more nuance than the
19 word "pressure," that is like we are many steps away
20 from even reaching the health plan and the contracting
21 process, so that, that's like the -- we don't have a
22 direct impact. We're not directly connected to the,
23 the contract, but we know that is a major way of, of
24 improving care that's happening at, at hospitals.

25 And so we're looking kind of upstream of

1 where -- what are the factors at play that make -- to
2 help make hospitals accountable to their patients in,
3 in preventing some of these, you know, terrible things
4 that, that can happen that often can be prevented, and
5 so we want to make that data actionable, and one of
6 the ways that we've identified -- and a lot of our
7 data licensees have, have shared with us is why
8 they're interested in, in LeapFrog data, is to have
9 actionable data by facility, and that's what they get
10 from, from LeapFrog data.

11 Q Right, and so in order to have actionable
12 data, right, for these hospitals -- and this is, this
13 is -- as you testified, this is what the health plans
14 want, correct? They want the actionable data for
15 these hospitals in order to make decisions regarding
16 payment, correct?

17 A They, they want actionable data.

18 Q Right.

19 A They want -- yeah.

20 Q So in order to have that actionable data,
21 the hospitals have to respond to the surveys, correct?

22 A So in order to have the actionable data --

23 Q Yes, to present to these health plans.

24 A Depending on the data -- so for the safety
25 grade, they don't necessarily need to, to -- they

1 don't, they don't necessarily need the, the, the
2 survey, but, but yes, for, for the LeapFrog Hospital
3 Survey, they, they do.

4 Q Okay. Do you know whether LeapFrog has been
5 successful in this goal of pressuring plans, health
6 plans to tie LeapFrog ratings to payment decisions?

7 A Have we been successful in that goal? I
8 mean I do know that there are a number of health plans
9 that, that use the LeapFrog data, and as I mentioned,
10 we don't know the full scope of how they're actually
11 implementing it in their contracting processes, but I
12 do know that is, that is a part of it for, for some of
13 them.

14 Q Do you have any involvement, Mr. Banerjee,
15 in the annual meeting, LeapFrog's annual meeting?

16 A I am not involved in, in organizing it, but
17 I do attend the annual meeting, and it is a, it is an
18 event, it's like an all-day event with sessions and
19 then a dinner at night, and it's kind of a
20 all-hands-on-deck type of event.

21 So every member of the LeapFrog staff is
22 trying to help in some capacity to coordinate the
23 event, but I'm not involved in, in the planning of it.

24 Q Okay.

25 A Just tell me what I need to do.

1 Q How about in -- are you involved in any way
2 in soliciting donations or contributions?

3 A No, I am not.

4 Q Your, your job is truly focused on the
5 licensing programs, correct?

6 A Yes.

7 Q Okay.

8 So in terms of -- let's just focus on the
9 licensing program of the Hospital Safety Grades. Is
10 it just A-graded hospitals, the hospitals that receive
11 an A grade, that are eligible to license their safety
12 grades?

13 A So the licensing program, the accolade
14 licensing program.

15 Q Yes.

16 A So the, the, the Hospital Safety Grade
17 accolade licensing program -- we're just talking about
18 the safe -- just for the safety grades?

19 Q Yes.

20 A We have A hospitals that are licensing
21 their -- the, the rights to use the, the A logo, but
22 there are some B hospitals that are also interested
23 in, in licensing, a few of them, but, but some of them
24 do --

25 Q Okay.

1 A -- license that B logo.

2 Q So there's not a hard eligibility
3 requirement that a hospital needs to have an A grade
4 in order to be able to license that grade; is that
5 your testimony?

6 A Yes.

7 Q Okay. So is it -- so is it that any
8 hospital, regardless of grade A, B, C, D, F, can
9 license their Hospital Safety Grade?

10 A We've never gotten a request for anything
11 lower than a B, but --

12 Q Okay.

13 A -- but I -- if someone wanted to . . .

14 Q So the target population of hospitals for
15 this licensing program are the A hospitals; fair to
16 say?

17 A Yes.

18 Q All right, but you've had possibly some B
19 hospitals?

20 A Yes.

21 Q Okay. Approximately how many hospitals pay
22 LeapFrog to, to license their Hospital Safety Grades,
23 just currently?

24 A For the safety grades, about 22 percent of,
25 of hospitals that receive an A choose to, choose to,

1 to license the logo, yep.

2 Q Okay. Can a hospital freely advertise their
3 Hospital Safety Grade without paying LeapFrog?

4 A Yes.

5 Q It's just the logo that's the issue; is that
6 correct?

7 A Exactly. Yeah, they, they can, they can,
8 they can write it plain text. They can't create their
9 own -- they can't create their own logo, but they are
10 encouraged to -- they're encouraged to promote
11 through, through plain text on their website, tell
12 their board, congratulate their staff.

13 We give them a free press release to -- that
14 they can share with their community that doesn't have
15 a logo on it. It has a quote from Leah about what the
16 safety grade means, and then we have a, a license -- a
17 website that shows what they can do with the Hospital
18 Safety Grade logo. It is kind of geared toward
19 educating about the, what they can do with licensing
20 the logo, but also tells them some of the free things
21 that they can do.

22 For hospitals that, you know, choose to
23 license, we give them template ads that talks about
24 some -- this is very aligned with our mission, and
25 these hospitals that receive As do a lot of things and

1 have very good outcomes on important patient safety
2 metrics, and part of our job is to help them to
3 communicate to the community about what some of those
4 things are.

5 So we have some template ads that have like
6 very, I think, good communication about hand hygiene
7 practices or their nursing workforce, that are all
8 things that contribute to patient safety, and I think
9 where they kind of someone struggle is how am I going
10 to communicate this to the community. We post those
11 template ads, so every hospital that gets an A can
12 see, even if they're not licensing the logo, how they
13 can communicate those things to the, to their
14 communities.

15 Q But as I understand it, all of these kind of
16 templates, right, and, and suggestions are part of
17 almost a package, right, that LeapFrog presents to
18 hospitals that get A grades; is that right?

19 A Yeah, so if I can --

20 Q Is that right?

21 A So, so no, no. No, not package in the sense
22 that they're -- they're not paying anything for it.

23 Q I'm not talking about --

24 A Okay.

25 Q I'm not talking about, you know --

1 A Yeah.

2 Q -- hospitals paying for the program, but
3 once it's determined, right, once it's determined that
4 a particular hospital has gotten, right, an A, an A
5 hospital grade, right, this is part of a -- this is
6 all -- everything that you described is part of
7 basically an orientation to the hospital about what
8 they can, what they can or should do with their, with
9 their hospital grade; is that correct?

10 A The licensing website shows what they can do
11 for free.

12 Q Right.

13 A And so there's a page that talks about these
14 are the things that you can do for free. This is when
15 we're like notifying them that they got -- we're
16 notifying them that they got an A.

17 Q And they're specifically referred to the
18 licensing website, right, when they are first notified
19 that they got an A, correct?

20 A Yeah, so ahead of the, the public release,
21 we -- when I say "we," we have a, we have a consultant
22 that we work with, TelAffects, and their job is to
23 reach out to all the facilities for the safety grade
24 program that received an A, and let them know that
25 your facility is receiving -- will be receiving an A

1 with the next release of the Hospital Safety Grade,
2 and, and the date.

3 This is, this is when it's going to be
4 announced. These are the, these are the free things
5 that you can do to, to make the announcement, and then
6 if you're interested in using the LeapFrog logo, we
7 have a license agreement that you can complete to get
8 access to those ahead of the, the public announcement,
9 to coordinate with whatever plans that they have or
10 they don't have to, to make the announcement.

11 Q And so we'll get into TelAffects later. We
12 have some documents --

13 A Oh, okay.

14 Q -- but TelAffects is a vendor that, that
15 LeapFrog has retained to assist with basically
16 marketing the licensing programs to A-grade hospitals;
17 is that correct?

18 A Yes.

19 MR. CHUNG: Okay. Let's go to the next
20 document, tab 11.

21 (Exhibit 5 was marked for
22 identification.)

23 BY MR. CHUNG:

24 Q All right. Mr. Banerjee, Exhibit 5 is an
25 email chain about the data licensing sales, and you're

1 on this with -- it looks like a forward from you to
2 TelAffects.

3 Do you see that?

4 A Yes.

5 Q Okay, and I just wanted to go briefly over
6 the email attachment, which is the LeapFrog Accolade
7 Licensure Letter of Agreement.

8 Do you see that?

9 A Yes.

10 Q All right. Is this the current letter of
11 agreement for accolade licensing for the organization?

12 A No. This is, this is from fall, fall 2024.

13 Q So there have been changes since then?

14 A Yes.

15 Q Okay. What, what changes to -- and I want
16 to focus just --

17 A Oh.

18 Q -- on the kind of prices here for the safety
19 grade.

20 A No.

21 Q Have there been --

22 A I'm sorry.

23 Q -- any changes to the pricing?

24 A No.

25 Q Okay. So it's still -- it still costs

1 \$29,900 for a hospital with 500 plus staffed beds to
2 license its Hospital Safety Grade or Top Hospital
3 designation?

4 A To license the logo, yes, that's right.

5 Q Why do the prices vary by the number of
6 staffed beds? What's your understanding there?

7 A So the staffed beds, they're -- so we try to
8 make the pricing equitable for different types of
9 hospitals. There's all sorts of different sized
10 hospitals that, that can receive this, that receive
11 the designation.

12 And so from our understanding, there are
13 facilities that, you know, they don't have any, any
14 marketing budget at all, and they -- or very little,
15 but they want to be able to promote their, their A
16 grade, and using the logo and having the LeapFrog
17 brand is an important component of that for them.

18 And then there are, there are others that
19 are very large health systems and hospitals, and they
20 can take out full-page ads in the Wall Street Journal,
21 and so they are -- we try to make it kind of
22 commensurate with what the, what the brand value is
23 worth, but kind of making it accessible for smaller
24 facilities versus larger facilities.

25 Q So the pricing is kind of scaled to the size

1 of, size of the hospital, correct?

2 A Yes.

3 Q And, and one, I suppose, manifestation or
4 measure of the size of the hospital is how many
5 staffed beds the hospital has, correct?

6 A Yes.

7 Q And is -- you mentioned that this is kind
8 of -- that this is a, an equitable kind of range of
9 prices, but is it also part of the rationale, part of
10 the rationale behind the pricing that it's better to
11 at least get some revenue, even if it's at a lower
12 price from, from let's say smaller hospitals, than no
13 revenue at all?

14 A We want smaller hospitals to be able to
15 promote the Hospital Safety Grade.

16 Q But you're charging them for that --

17 A Yeah.

18 Q -- correct?

19 A Right, yeah, yeah, we want to, we want to be
20 able to charge them, but if we price it too high, then
21 they won't have -- so these hospitals see value in
22 promoting with the logo. That's why they're choosing
23 to make that additional purchase, but -- so we, we
24 want to be able to make that available to them, and if
25 we price it too high so that they're not doing that,

1 we're kind of doing them a disservice, because they
2 are not able to use that to educate their patients and
3 the community in the same way.

4 Q They won't be able to pay for it, bottom
5 line?

6 A They won't be able to pay for it, but that's
7 why we want to make it equitable, not just because we
8 won't be able to charge them.

9 Q So the, the safety -- just on the safety --
10 continuing on the hospital safety grades, LeapFrog
11 also licenses the hospital safety grades to insurance
12 companies, correct?

13 A Yes.

14 Q All right, and we went over this a bit
15 earlier with respect to the, to the board-approved
16 document.

17 Do you know how many insurance companies
18 have licensing agreements with LeapFrog?

19 A I don't, I don't have -- I don't know the
20 exact number offhand.

21 Q How does LeapFrog go about approaching or
22 marketing to insurers about licensing the hospital
23 safety grades?

24 A So we don't do a lot of like outbound
25 marketing. Most of --

1 Q What do you do?

2 A Sorry?

3 Q What do you do?

4 A Oh, yeah, we -- most of it is inbound
5 inquiries that we get, primarily after the, like a
6 release of the Hospital Safety Grade release,
7 there's -- we see some inbound interest and, and
8 inquiries. We -- you know, I think we have some, some
9 posts on, on LinkedIn. Not recently, but we have
10 attended some, some conferences before for -- some
11 industry conferences to create some awareness and
12 education about, about what, what LeapFrog has in
13 terms of, of the data available.

14 Q How do these insurance companies that
15 license the hospital safety grades -- where do they
16 feature the hospital safety grades? How, how do they
17 use them?

18 A So there's two main ways. The first is they
19 want to -- they want to educate their members about
20 hospital, hospital safety and quality measures that
21 LeapFrog collects on, so they will take our data, they
22 have the rights to use it, and then some of the logos
23 that we provide them --

24 Q I'm actually focusing just on the hospital
25 safety grades, not the data.

1 A Okay. All right. So for the hospital
2 safety grades, they want to -- you know, LeapFrog is
3 widely recognized as a, as a brand in patient safety,
4 and they want to stand behind the, the transparency
5 and the accuracy and rigor that goes into the Hospital
6 Safety Grade. They don't want to just say like our
7 health plan assessment is -- that this is a
8 high-quality hospital, or just post the CMS star
9 ratings on there.

10 For whatever reason, some of them have -- do
11 post it, but they -- there's provider directory tools
12 that are available to members --

13 THE REPORTER: Provider what?

14 THE WITNESS: Provider directory tools that
15 are available to members, so that when those
16 members are seeking care through the resources
17 that the health plan makes available, there is
18 some information available from LeapFrog about
19 the facility.

20 Sometimes they have provider-level
21 information about specific doctors, but largely
22 what -- a lot of the health plans are interested
23 in supplementing, or some of them don't have any
24 facility-level information, and they want to use
25 the Hospital Safety Grade to show their members

1 and inform them about the quality and safety of
2 the data.

3 BY MR. CHUNG:

4 Q And it's, it's -- so these insurance
5 companies are basically just showing, featuring the
6 logo itself containing the Hospital Safety Grade to,
7 to the consumers; is that right?

8 A No. Well, yes. Sometimes they are --
9 they're kind of --

10 Q Isn't that what they're licensing, the logo
11 itself?

12 A They are licensing the logo and the
13 underlying data, so --

14 Q Okay.

15 A -- they have access, full access to the --
16 all the data that is on the Hospital Safety Grade
17 website. The, the grade for, for the current period,
18 the -- all the measures, the reporting periods, the
19 sources, the past grades; everything is all on the
20 safety grade website, but it's essentially kind of
21 like an offload from that website. They have access
22 to that. They can represent that individual
23 underlying data information on their website, or we
24 also give them the URL links to the specific hospital
25 page.

1 So if someone -- if a member is interested
2 in, in learning more information about the facility,
3 they can click on that, and it will direct to that
4 specific hospital page. Some of them choose to link
5 directly to the, the main LeapFrog website, because
6 they like the representation --

7 Q So that's one way.

8 A -- on our website.

9 Q What's the second way that you testified to?

10 A Oh, the other, the other way is -- it's more
11 internal use. So doing assessment, like internal
12 assessment of the quality and safety of, of, of the
13 hospitals that are in their, in their network or even
14 outside of their network; quality improvement
15 initiatives, different contracting use cases. We
16 don't have like full visibility on all, what all those
17 internal use cases are.

18 MR. CHUNG: Let's turn to tab 17. This will
19 be Exhibit 6.

20 (Exhibit 6 was marked for
21 identification.)

22 BY MR. CHUNG:

23 Q So Mr. Banerjee, Exhibit 6 is an email chain
24 from May of 2020. Take a look at that. Let me know
25 when you've had a chance to flip through it. It has

1 do with kind of the spring '22 accolade licensing
2 cycle.

3 A Okay. Spring '20.

4 Q 2020, yep.

5 A All right.

6 Q Yep. So I want to direct your attention to,
7 first of all, to Bates page -- it's really the second
8 page, Bates ending 5321.

9 A Okay.

10 Q And you write to Ms. Binder, copying
11 Ms. Mobley and Ms. Eidson, "Hi, Leah. We had six more
12 sales and \$60,000 in yesterday, including for Inova
13 hospitals (\$34,000). Our spring total is at 59
14 licenses," and then you kind of go on and provide
15 additional numbers there, right, "and we are following
16 up with rogue hospitals who posted ads without a
17 license, which sometimes translates into licenses. So
18 I believe there's still a significant opportunity left
19 for us . . . in the cycle."

20 How many hospitals per cycle do you find
21 that, typically, that post ads without a license?
22 First of all, what do you mean by "ads" here? Is it
23 the, the logo itself that they're posting without a
24 license?

25 A Yeah, so they sometimes -- so you're asking

1 how many?

2 Q Yeah, generally.

3 A I mean not -- most of them are -- comply
4 with, with like our, our terms of use in using the
5 logo, but there's, there's sometimes -- there's like a
6 handful, maybe like --

7 Q Okay.

8 A I don't know. Like five to ten.

9 Q So when you learn about a specific hospital
10 using the logo, right, without a license, what, what
11 do you do?

12 A So TelAffects handles, from beginning to
13 end, every part of the outreach. I don't interact
14 with any, any hospitals --

15 Q Understood, but --

16 A -- with that -- so, so --

17 Q -- what does, what does LeapFrog --

18 A Yeah, yeah.

19 Q -- do in these circumstance?

20 A So, so TelAffects does do the outreach to
21 inform them that we -- that they are not allowed to
22 create their own logo, and, and that they need to
23 take, they need to take down any -- if they have like
24 a different representation of, of the A logo, we let
25 them know that, that they need to take it down.

1 But maybe if they're not aware that we have
2 reached out to them about, about the rights to use the
3 logo, so they kindly introduce the idea and, and give
4 them a licensing agreement, if they are interested in
5 using that, to do that type of promotion, we kind of
6 have TelAffects inform them how to go about doing it
7 in the right way.

8 Q Okay. Let's --

9 A And so that's what I was kind of referring
10 to here, that like, oh, some of them were -- they
11 posted without a license, but some of those might be
12 interested in, in licensing.

13 Q Right, but when you make contact with them,
14 basically, that you might actually convert these
15 rogue --

16 A Right.

17 Q -- hospitals to actual licensees --

18 A Yes.

19 Q -- right? Okay.

20 So let's go to Bates ending 5323. You're
21 writing to Leah Binder, "Hi, Leah. We had a nice
22 sales day yesterday."

23 Do you see that?

24 A Yes.

25 Q Okay, and there are a few numbered items.

1 If you look at the second numbered item, "AHN's
2 biggest area competitor, UPMC, began licensing all
3 UPMC's A hospitals from us last fall, following their
4 100 percent system survey participation in 2018," and
5 then you write, "Got to love competition (\$130,000 in
6 new licensure sales in western PA in the last year),"
7 and then you say, "As a former Pittsburgher, I'm happy
8 to see our influence spread and factor in this
9 ultra-competitive environment."

10 What did you mean by "ultra-competitive
11 environment" here? What, what is that describing?

12 A So I lived in Pittsburgh for, for a little
13 bit.

14 Q Yep.

15 A And there's -- it's a, it's a -- having
16 lived there, I didn't really, really appreciate before
17 that that there are two major health systems and
18 health plans. Like it's kind of integrated finance
19 and delivery systems, where you have a health plan
20 that owns a health system, which in this case is
21 Allegheny Health Network, and then there's UPMC, which
22 has their own health plan, and they are very big
23 players in all of Pennsylvania.

24 And so I had -- I think I had a little bit
25 of extra insight into what the competition is. I

1 never lived anywhere where there's health systems that
2 are like actively attacking each other on TV. They're
3 like political ads, but for healthcare, and some
4 people are not in network, and they don't have access
5 to like well-known hospitals that they live very
6 close, close by to.

7 So I was just like adding in this internal
8 email some extra insight that I had from having lived
9 in -- lived there, that this is a very competitive
10 environment, and there, there are hospitals that are,
11 you know, attacking each other for all sorts of
12 different reasons, but they learn to, in this case,
13 kind of showcase that they're, they're competing on
14 patient safety, which is directly relevant to us, and
15 kind of using the Hospital Safety Grade to kind of
16 make that case to their constituents or stakeholders.

17 Q Right, and that's so -- and you highlight
18 here "\$130,000 in new licensure sales in western PA in
19 the last year," so this -- just based on kind of the
20 fact that you lived there, you observed this
21 ultra-competitive environment between these two health
22 systems. They are -- they're licensing their
23 health -- their hospital safety grades to compete
24 against one another, is that right, as part of the
25 competition against one another, correct?

1 A Right. They want to license the logo to use
2 LeapFrog as a, as a way of showcasing their patient
3 safety to their, to their communities.

4 Q Right, and in this, in this environment, the
5 ultracompetitive environment between these two,
6 that's -- that actually translated into, to benefit to
7 LeapFrog, correct, in terms of the revenue?

8 A Yes.

9 Q Okay.

10 Do you, in terms of -- does LeapFrog analyze
11 or have research on kind of competition, kind of the
12 competitiveness in certain markets among hospitals or
13 hospital networks?

14 A We -- I'm sure over time we've, we've looked
15 at specific health systems and regions to see, yeah,
16 where there's more competition, but it's kind of like
17 a moving landscape with different mergers and
18 acquisitions that are happening.

19 So in certain markets with different, you
20 know, like new acquisitions, we may like take a look
21 at, at seeing, you know, some of the different factors
22 of -- I mean specifically like with accolade
23 licensing, to see like, oh, is there any, is there any
24 impact on, on this change to, to the licensing
25 program, for example, like the licensing, accolade

1 licensing program, for example, to see if there's any
2 impact on, on any of like mergers or acquisitions or
3 like any -- I can't think of any specific examples,
4 but it is something that we could potentially look at,
5 that we have looked at.

6 Q Okay. Have the -- so just to break that
7 down, you have looked at kind of the competitiveness
8 among hospitals or hospital systems in markets for the
9 purposes of how to market or where to market the
10 licensing, the accolades licensing program?

11 A I can't think of any specific examples.

12 MR. CHUNG: Okay. Let's go to the next
13 document, tab 12. This will be Exhibit 7.

14 (Exhibit 7 was marked for
15 identification.)

16 BY MR. CHUNG:

17 Q So now we're going to -- you mentioned
18 TelAffects. We'll go over a document or two regarding
19 TelAffects.

20 So Exhibit 7 is a spring 2022 -- it looks
21 like a training presentation for TelAffects.

22 Do you see that?

23 A Yes.

24 Q How long has LeapFrog worked with
25 TelAffects, so far as you know?

1 A I think it was around 2016, 2017.

2 Q So around the time you started at the
3 organization?

4 A It was, it was after I started at the
5 organization.

6 Q Okay. Did you a role in, in retaining
7 TelAffects?

8 A I was -- we had a consultant that helped us
9 to find and initiate the relationship with TelAffects,
10 but I was kind of loosely involved in some of the, in
11 some of the informing and getting, getting them up to
12 speed on the, on the program.

13 Q Okay. So what, what do they do for -- just
14 briefly, what do they do for LeapFrog?

15 A So from the -- even this was before my time
16 at LeapFrog, but from the inception of the Hospital
17 Safety Grade program in 2012, we have always had an
18 independent licensing agent that does the accolade
19 sales for LeapFrog, and so the purpose of having an
20 independent licensing firm is to separate LeapFrog and
21 ensure that there's no conflict of interest between
22 the ratings that we're putting out and the licensing
23 of the logo, and so we have continued to maintain that
24 separation from the very beginning of the licensing
25 program.

1 When the licensing program started in 2012,
2 we had one individual licensing agent, just one person
3 that was responsible for sending emails to all the
4 facilities, letting them know about this, that, that
5 they -- that they're going to be -- that they have the
6 opportunity to use the, the LeapFrog logo, and they
7 can pay for it if, if they want.

8 So one of the purposes of moving from that
9 one to, to TelAffects -- TelAffects is a, is a
10 telesales firm. That's what they specialize in.
11 They're located in Florida.

12 Q What do you mean by "telesales"? It's like
13 telemarketing?

14 A Yes. It's kind of like they, they call --
15 they -- their projects and their, and their clients,
16 they call and -- it's pretty much like what -- they
17 run campaigns, like calling campaigns generally for,
18 for their other clients, to make, make sales to do
19 customer -- do customer engagement initiatives.

20 They, they actually do a lot more work than
21 even like that's in -- like our scope of work that I
22 don't, I don't have the full visibility on, but what
23 we -- when we worked -- when we started working with
24 them, we made it -- we tried to make it clear that we
25 wanted to create like, kind of like a customized

1 program, and we want them to be representatives of us,
2 of, of LeapFrog, to do this outreach to, to hospitals
3 and give them the opportunity to, to license the
4 LeapFrog marks and for -- well, it's -- there's a
5 couple different steps.

6 So one, make the notification about what the
7 grade is going to be.

8 Q Right.

9 A Tell them what they can do for free, and
10 most, probably most importantly, that this is -- they
11 are representing us in this, make it clear that they
12 are independent sales agents, and that we are -- that
13 they're not going to use any type of hard sales
14 tactics, and we're an independent nonprofit
15 organization.

16 If a hospital is not interested in, in using
17 the LeapFrog marks, the badge, then you kind of just
18 close the book on, on that specific hospital and kind
19 of move on to the next one. We just want to make sure
20 that every hospital that gets an A or the Top Hospital
21 award knows that they have -- if they want, they have
22 an opportunity to use, to use these marks. So that
23 is -- that's why we, we have them.

24 One of the other benefits we have of using
25 TelAffects is that this is, this has kind of in their,

1 in their wheelhouse. They're customizable, but then
2 they can also expand and shrink their consultants that
3 they have during the year, during times where LeapFrog
4 may need them more.

5 So during the weeks leading up to the public
6 release, where, you know, a lot of hospitals might be
7 interested in preparing for the public release, they
8 can have, you know, six or seven people that are
9 trained up.

10 Q So they can scale up or down --

11 A Yeah.

12 Q -- depending on, depending on the time,
13 right, but ultimately -- and thank you for going over,
14 you know, the services they, that they provide for
15 you.

16 They are an agent, am I right, for LeapFrog,
17 as you, as you testified to, to, to obtain or try to
18 obtain licensing agreements, right, with, with
19 hospitals; is that correct?

20 A Yes.

21 Q Okay. How much does LeapFrog pay
22 TelAffects? What's the compensation arrangement?

23 A They are paid hourly. There's some startup
24 fees, but I think we pay them around like 40 something
25 dollars an hour.

1 Q Okay. Per representative --

2 A Per representative.

3 Q -- that they send over?

4 A Yeah.

5 Q Okay. Do they receive -- are there any sort
6 of incentive components to the compensation tied to
7 specific licensing sales goals or the number of
8 agreements reached?

9 A We, we have -- for the, the frontline
10 salespeople, we do look at our, our goals for the
11 licensing, accolade licensing program --

12 Q Yes.

13 A -- and try to, during the cycle, forecast
14 where -- the trajectory of how we reach those goals,
15 and then align based on, based on how the accolade
16 sales have trended the year before. That's one
17 consideration, but our goal is, we try to set certain
18 benchmarks at certain days to, to make as realistic as
19 possible certain goals for them so that we can give
20 some type of compensation bonus for, for having a
21 specific set point, like number of sales through a
22 certain number of days.

23 Q Okay. So how much are those bonuses as a
24 percentage or just as an absolute number?

25 A Yeah, so they are -- they're generally

1 around five hundred -- \$500 for -- so there's
2 typically probably like eight dates in a year, in a,
3 in a cycle where we set those benchmarks, and they
4 start at like five hundred, and then if they reach
5 like a second level, it could be a thousand.

6 In one entire cycle, it could be somewhere
7 in the neighborhood of like \$8,000 to \$10,000 that are
8 potentially available if they, if they hit every,
9 every goal.

10 Q So this training, the training deck, this
11 is -- am I correct that this is a PowerPoint or
12 training deck that LeapFrog puts together and updates;
13 is that right?

14 A So this is, this is a training deck I think
15 that TelAffects has put -- this is something that
16 TelAffects has put together, based on information that
17 we have given, we've given them about the program.
18 What they do is we have a front --

19 Q Let me take you to the cover email -- I'm
20 sorry to interrupt you -- just to kind of -- it says
21 here "Alicia Vann."

22 Who is Alicia Vann? Looking at the very
23 first page of the exhibit.

24 A Oh, yeah, Alicia Vann was the senior
25 licensing agent for, for LeapFrog that works at

1 TelAffects.

2 Q Understood. Okay, but she has a LeapFrog
3 Group email address?

4 A Yes. She, she -- we, we give the, the
5 TelAffects agents LeapFrog Group email addresses.

6 Q Okay. So let's go to -- let's go into the
7 deck itself. If you'd go to Bates ending 4946.

8 A Oh, sorry. I was looking at the wrong
9 number.

10 Q Objectives. There you go.

11 All right. So it says here "LeapFrog
12 Group's Objectives," and for TelAffects, it's
13 "increase awareness of The LeapFrog Group and the
14 Hospital Safety Grades," and to "obtain signed
15 Agreement from hospitals to license the Hospital
16 Safety Grade for use in external and internal
17 marketing."

18 Do you see that?

19 A Yes.

20 Q All right, so one of the objectives -- the
21 two objectives is to get basically licenses, secure
22 licenses, right, from hospitals, correct?

23 A Yes.

24 Q And then it says that "The LeapFrog Group's
25 long-term goals" are "increase license sales to grow

1 resources that will help develop new strategies and
2 tools to support their mission to trigger giant leaps
3 in improvement of patient safety."

4 Do you see that?

5 A Yes.

6 Q And do you agree with that long-, that's a
7 long-term goal?

8 A Yes.

9 Q Okay. On the -- if we flip to Bates ending
10 958, it's a slide titled "Why license your A?"

11 Do you see that?

12 A Yes.

13 Q And the top bullet is "External Marketing,"
14 and it says "gain competitive edge on local
15 marketplace to drive increased patient traffic,
16 revenue," and then the next bullet point is
17 "recruitment of better doctors and medical
18 professionals," and the third is "educate patients on
19 hospital safety and reassure them of safe care."

20 So is this a part -- so this is a training
21 deck to train TelAffects representatives who are going
22 to be going out to solicit potential licensing
23 agreements from hospitals, correct?

24 A Yes.

25 Q So in essence, these are kind of talking

1 points that those TelAffects telemarketers are using
2 kind of out in the field?

3 A Yes.

4 Q Okay, and so fair to say that this
5 particular slide or this set of talking points is
6 directed for TelAffects telemarketers who are
7 targeting hospitals that have just received or maybe
8 have a -- have gotten repeat A hospital safety grades,
9 correct?

10 A Yes.

11 Q All right, and then so in terms of the --
12 the external marketing here refers to -- it looks like
13 the hospital's external marketing; is that correct?

14 A Yes. Right.

15 Q What they're able to market to the world,
16 using a license of the Hospital Safety Grade; is that
17 right?

18 A Yes.

19 Q All right, and so the first kind of piece of
20 external marketing is for that hospital to "gain
21 competitive edge in [the] local marketplace to drive
22 increased patient traffic."

23 Do you see that? I'm just looking up top.

24 A Oh, sorry. Was it under -- is that under
25 "Internal"?

1 Q Under "External Marketing."

2 A Oh, yes. Sorry. Yes, patient traffic, yes.

3 Q Right, so "gain a competitive edge" with
4 increased patient traffic and revenue, correct?

5 A Yes.

6 Q So part of the, kind of the pitch here that
7 TelAffects and LeapFrog are using is that if you
8 license -- by licensing your A health safety grade,
9 you can help drive upward patient traffic and revenue,
10 correct? That's part of the message?

11 A Yes.

12 Q Okay, and then the other message below that
13 is if you license your A health safety grade, you can
14 drive "recruitment of better doctors and medical
15 professionals"; is that right?

16 A Yes.

17 Q All right, and is it true that if this is --
18 if these are kind of external marketing messages, the
19 drivers for an A, for a hospital that receives an A
20 Hospital Safety Grade, would you agree that the
21 converse is true? And I'll just kind of lay it out
22 for you, that -- let's say a D or an F hospital, that
23 publicity of their D or F Hospital Safety Grade
24 lessens or hurts their competitive edge in the local
25 marketplace?

1 MS. WOOD: Objection to form.

2 THE WITNESS: Yes. I mean I think that,
3 that would, that would be -- yeah, I think that
4 could be -- yeah, it wouldn't help, it wouldn't
5 help their, their reputation, right.

6 BY MR. CHUNG:

7 Q And just kind of breaking it down, because
8 I'm very interested kind of in this line right here in
9 terms of the messaging.

10 So would the converse be true in the sense
11 that a D or, even worse, an F hospital would be
12 impacted or harmed with less patient traffic because
13 of the publicity surrounding that particular grade?

14 MS. WOOD: Objection to form.

15 THE WITNESS: I mean my focus has been on
16 the A hospital. I hadn't really thought about
17 the converse of -- like the impact of the safety
18 grades on D and F hospitals.

19 BY MR. CHUNG:

20 Q Okay. How about in terms of recruitment or
21 even retention, right, of staff, including doctors?
22 Do you think that a D or an F Hospital Safety Grade
23 would impact -- I think you testified earlier it would
24 certainly impact the reputation, but, by extension,
25 would impact their ability to recruit or maintain kind

1 of talented staff at a hospital?

2 A So the recruitment of better doctors and
3 medical professionals, that is an idea that came from
4 us, from, from TelAffects talking to some of the
5 hospitals and health systems that the license, the
6 Hospital Safety Grade, and that they see it as a way
7 to promote the, the safety.

8 There's connections to just the culture at
9 that facility that is represented, embodied in the
10 Hospital Safety Grade, and so we've kind of taken that
11 message and, and put it in here and kind of like, kind
12 of like -- in talking to -- having the licensing team
13 talking to some of these other facilities, that this
14 is another way to kind of think about what the
15 Hospital Safety Grade and the A means.

16 So that's just like -- that's why that's on
17 here, and I had not thought about what, what -- if
18 other hospitals -- and I don't know if other hospitals
19 are thinking about that from, from the opposite
20 perspective for -- I don't imagine that they're using
21 that to -- in recruitment or retention of medical
22 professionals.

23 Q Yeah, understood, because if, if this is
24 true for an A hospital, that an A grade helps with
25 recruitment of doctors and other staff, a D and F

1 grade would have the opposite effect, correct?

2 A Well, I think that the A hospitals that want
3 to use it this way are actively promoting it. I don't
4 think a D or F hospital would -- I think they just
5 wouldn't do anything about what -- in terms of
6 recruitment or retention.

7 Q Understood, but not so much that the
8 hospital itself, right, putting forward a D or an F
9 grade, but that the publication or the publicity
10 surrounding a D and F grade would have this impact.

11 Would you agree with that?

12 A I, I don't know if doctors and nurses, when
13 they're considering hospitals, if they're looking at
14 the hospital's safety grades.

15 I do, I do, I do know that the hospitals
16 that license have told us that they want to actively
17 use it for that purpose, but I'm just not -- I just
18 don't know if, if -- I mean certainly the D and F
19 hospitals aren't telling --

20 THE REPORTER: Hold on. Certainly the what?

21 THE WITNESS: Certainly the D and F
22 hospitals are not actively promoting it, and then
23 the other side of that is the doctors and nurses.
24 I don't know if they're looking at that whenever
25 they are considering the current place that

1 they're working at or considering working at one
2 of those facilities. I just don't know if that
3 hospital safety grade has any impact on that at
4 all.

5 BY MR. CHUNG:

6 Q Okay, but -- I kind of understand your
7 point, but fair to say that if a doctor or nurse or
8 other sort of professional staff, right, were exposed
9 to or learned of a D and F hospital safety grade for a
10 particular hospital, that that would make that
11 hospital less attractive, right --

12 MS. WOOD: Objection to form.

13 BY MR. CHUNG:

14 Q -- in terms of employment for that
15 particular professional?

16 Would you agree with that?

17 A I just, I just don't know what impact that
18 would have, honestly.

19 Q Well, in, in a competitive -- in terms of
20 the competitive edge, or to use the Pittsburgh
21 example, right, if you had a D and F hospital, you
22 know, competing with an A hospital, at least according
23 to the hospital safety grades, right; in terms of
24 recruitment and retention, the A hospital would have
25 the competitive edge over the D and F hospital,

1 correct?

2 MS. WOOD: Objection to form.

3 THE WITNESS: I think they would -- each
4 individual I think would have to make their own
5 assessment of, if what they, if they value it, if
6 they, if they want to go and look up the hospital
7 safety grades and see like what goes into it, I
8 think -- I just don't know. I haven't thought
9 about that before.

10 BY MR. CHUNG:

11 Q Let's go to --

12 (Discussion was held off the record
13 concerning a possible break.)

14 MR. CHUNG: Why don't we stop here and why
15 don't we take a break.

16 THE VIDEOGRAPHER: This marks the end of
17 media unit number 2. Going off the record, the
18 time is 12:20 p.m.

19 (Whereupon, the lunch recess was
20 taken.)

21 THE VIDEOGRAPHER: This marks the beginning
22 of media unit number 3. Going back on the
23 record, the time is 13:20 p.m.

24 BY MR. CHUNG:

25 Q All right. Before the break, we were

1 looking at Exhibit 7, basically the training deck for
2 TelAffects, Mr. Banerjee. Let's go back to that
3 document.

4 Now, let's turn to Bates stamp ending 5022.
5 It's basically page 63 or slide 63, just as another
6 shortcut.

7 Are you there?

8 A Yes.

9 Q All right. So this slide is titled
10 "Overcoming Common Objections." Do you know -- where
11 do these common objections come from? Are they what
12 you've heard from hospitals in previous cycles?

13 A Yeah, some of these we've heard from
14 other -- from hospitals. That's a feedback that we
15 received or, or questions where we might anticipate
16 there being an objection.

17 Q Okay, and so one of -- there are several
18 here, and the last one here is "people haven't heard
19 of the LeapFrog Group, it's not as recognized as U.S.
20 News or Consumer Reports."

21 Do you see that common objection?

22 A So we have, we have -- I don't know if we've
23 heard that specifically, but it's just --

24 THE REPORTER: You said I don't know?

25 THE WITNESS: I don't know if we've heard --

1 this was, this was from many years ago, but we --
2 as I mentioned before, LeapFrog is well-known
3 among hospitals, and I think there's probably
4 less general brand recognition amongst the
5 general public from LeapFrog compared to U.S.
6 News, which has lots of other accolades, even
7 extending beyond healthcare.

8 So it's probably a more recognizable brand
9 from a consumer perspective, and so as, you know,
10 hospitals are trying to determine how they want
11 to be perceived by the public and what brands
12 they want to connect themselves to and awards
13 they want to recognize, that is -- that may have
14 been an objection that we have heard, that we
15 have limited resources to allocate, limited
16 marketing budget, and we'd like to utilize
17 another recognition that's not related to patient
18 safety.

19 BY MR. CHUNG:

20 Q So let's, let's flip a few more. There are
21 some approved responses to these common objections, so
22 if you look at slide 66, Bates ending 5025, there is
23 an approved response corresponding to this "people
24 haven't heard of The LeapFrog" common objection.

25 Do you see that? Are you on the slide?

1 A Is that still --

2 Q 66.

3 A Yes, I see it.

4 Q All right. So you'll see there the
5 response, right, for the TelAffects telemarketers is
6 if you're presented with this common objection,
7 respond with "each year we are featured in hundreds of
8 magazine, newspaper, TV, and radio reports to
9 consumers everywhere. In 2020, over 2,300 hospitals
10 devoted time and resources to LeapFrog Group's
11 Hospital Safety Survey, one of our other hospital
12 safety initiatives."

13 So is it fair to say that LeapFrog, at least
14 in this response, uses the participation rate in the
15 hospital survey as basically an indication, a signal
16 to hospitals of LeapFrog's kind of brand?

17 A So one thing I'll say is we did not draft
18 this, this PowerPoint deck. No one at LeapFrog would
19 call it the Hospital Safety Survey.

20 Q Right, but my question is -- but my question
21 is -- so the number of -- at least in 2020, right? I
22 understand that there are probably successor versions
23 of this. The number of hospitals, 2,300 hospitals,
24 that devoted time and resources to the Hospital Safety
25 Survey, right, are highlighted here.

1 So is it, is it fair to say that LeapFrog is
2 using the number of hospitals or the kind of the
3 participation rate as an indicator of kind of the
4 extent of its brand at this time?

5 A I think what TelAffects was trying to do
6 here in drafting this statement is understanding, as
7 to my point earlier, about a lot of hospitals have
8 heard of LeapFrog, and so I think they're trying to
9 educate about we have -- we're very well-known amongst
10 other hospitals.

11 This is how other hospitals, including
12 hospitals that, that you were familiar with, may be
13 competing against on for patients, and LeapFrog's, you
14 know, safety and quality initiatives, specifically the
15 LeapFrog Hospital Survey is, is one of the things that
16 they devote time and resources to, because it's
17 important.

18 So I think it's kind of just using not the
19 general public -- so the first sentence is about
20 the -- how, how LeapFrog is featured in public-facing
21 media.

22 Q This "hundreds of magazines, newspaper, TV,
23 and radio reports to consumers everywhere," right?

24 A Right.

25 Q So it's featured -- it's signaling to the

1 objector, right --

2 A Right.

3 Q -- that the organization is featured in a
4 lot of media; is that correct?

5 A Yes.

6 Q Okay.

7 A And then the second sentence is about how
8 LeapFrog is recognized amongst other hospitals, so --

9 Q 2,300 hospitals, correct?

10 A Yes.

11 Q Right. So the number of hospitals that
12 participate in the survey is specifically called out,
13 correct?

14 A Yes.

15 Q Okay, and so the reason for that is that the
16 greater number of hospitals or the participation rate
17 among hospitals, the, the greater the brand of
18 LeapFrog is to, to potential licensing customers; is
19 that right?

20 A Yes, because the question is people have not
21 heard of the LeapFrog Group.

22 Q Right.

23 A And so the response to that is a lot of
24 hospitals have heard of it and a lot of the general
25 media has heard of it, so that's what those two

1 sentences are addressing.

2 Q So LeapFrog -- so LeapFrog then is better
3 positioned to sell accolade licensing when it can say
4 that more hospitals have participated in the hospital
5 survey and that LeapFrog has a lot of exposure in the
6 media; is that right?

7 A Yeah, that's generally true.

8 MR. CHUNG: All right. Let's move on to
9 next document, tab 18.

10 This will be Exhibit 8.

11 (Exhibit 8 was marked for
12 identification.)

13 BY MR. CHUNG:

14 Q All right, Mr. Banerjee, Exhibit 8 is a
15 document titled "Fall 2023 HSG and Top Hospital Sales,
16 December 11, 2023."

17 Do you recognize this document?

18 A I don't, I don't remember it specifically.

19 Q Okay. Well, let's focus just on a couple of
20 numbers, go through this quickly. So at the top it
21 shows -- it lists 72 percent renewal rate for hospital
22 safety grades.

23 Do you see that?

24 A Yes.

25 Q All right, and that's 57 out of 79

1 hospitals. Does that line up with kind of your,
2 generally with your recollection of the renewal rate
3 among Hospital Safety Grade licensees at this time?

4 A Yeah, I think that's in the range.

5 Q Okay. Just based on your experience in this
6 area, is that a relatively high renewal rate, kind of
7 when it comes to licensing in this world?

8 A That is -- and I've only had experience in
9 this program, but, but yeah, I think 70 percent has
10 been, has been among the, the higher renewal rates.
11 Sometimes 80 percent.

12 Q We went over this previously, but is it, is
13 it correct that the, that the majority of the accolade
14 licensees are A-grade hospitals?

15 A The majority of accolade licenses are
16 A-grade hospitals, yes.

17 Q So fair to say that the majority of the
18 renewals here are of A-grade hospitals?

19 A Yeah, this is -- HSG, Hospital Safety
20 Grade --

21 Q Hospital Safety Grade.

22 A Yeah, "HSG" written here is Hospital Safety
23 Grade renewal, so those are, those are A hospitals
24 that have licensed the year before, and then it is
25 a -- I don't think we have discussed this, but it's a

1 one-year licensing agreement, and there's two cycles.

2 So if they have an A and they want to use
3 the logo, we give them the current cycle logo. In the
4 subsequent cycle, if they get an A again, we give them
5 that logo again, updated for the current date stamp,
6 and then it expires, and then the subsequent cycle, if
7 they get an A again, they have an opportunity to, to
8 purchase the new logo.

9 Q Okay.

10 A So that's what the renewals are.

11 Q If we look at the next page, so Bates ending
12 8598, under the "No Interest Details," which is toward
13 the bottom of the page.

14 Do you see that?

15 A Yes.

16 Q Just looking that over, do you know what's
17 being -- can you describe what's being -- what's laid
18 out here in the bullet points?

19 A So this is information that the licensing
20 team collects on facilities they have reached out to
21 about licensing that have told them that they're not
22 interested in licensing, and so they're -- when they
23 provide any type of detail, try to, sometimes they --
24 most of the times we don't get any feedback, just no
25 responses, but sometimes they do give some level of

1 insight, and we try to track the reasoning for that.

2 Q And when you say "licensing team," that's
3 the TelAffects team?

4 A Yes.

5 Q Now, the penultimate bullet is "Chelsea
6 Hospital don't do pay-to-play licensing."

7 What did you take that to mean?

8 A Some -- well, some hospitals that we reach
9 out to, they, they don't -- we talked when they call
10 in. It could be to any, any, anyone that really works
11 at the hospital. Sometimes it's like the marketing
12 department, sometimes it's the quality, sometimes it's
13 people that have not heard of LeapFrog.

14 And so they talk to a lot of different types
15 of people. Some people are more educated on what
16 LeapFrog does, they have an understanding, and some do
17 not. I assume this is someone that doesn't know a lot
18 about what LeapFrog does. We don't do pay-to-play
19 licensing, but that is the response that they got, and
20 it's feedback that we, we welcome, because there's
21 still opportunities to educate people --

22 Q Is that a --

23 A -- when we have the opportunity.

24 Q Is that a comment that you have heard from,
25 from other hospitals or potential licensees?

1 A No --

2 Q Is this the first time --

3 A -- not --

4 Q This is the first time you're seeing it?

5 A I mean I don't -- it's not -- it is not
6 something we, we commonly hear. It doesn't, it
7 doesn't surprise me that, that there are -- that, that
8 there was someone at this hospital that, that thinks
9 that, but we do tell TelAffects we want to hear the
10 feedback, both positive and negative, of what, what
11 the perceptions of us are, and we want to take that
12 and take it as a, either a one -- take it as a
13 one-off, but really track it to see if like is this a
14 trend and a commonplace theme that we're, that we're
15 hearing, because it, it's not --

16 Q Why doesn't it surprise you to see this
17 comment?

18 A Why doesn't it surprise me?

19 Q Yes.

20 A Because I mean people have all sorts of
21 different perceptions of brands without really
22 understanding. Maybe they had a bad experience with
23 a -- they think we're a different type of
24 organization, like health grades that actually, from
25 my understanding, does do the ratings for, for

1 hospitals, but they also do consulting on how to
2 improve those grades.

3 So Hospital Safety Grade kind of sounds like
4 health grades, and someone that is picking up the
5 phone, I don't know what they're going through, they
6 hear Hospital Safety Grade, maybe they're thinking
7 health grade. I just don't know -- there's not enough
8 context around this specific situation, but it doesn't
9 surprise me that there would be confusion among brands
10 if this person has other experience with other
11 organizations, or maybe it's not even in healthcare,
12 and they think that -- they're distrustful of any type
13 of, of rating system.

14 Q Is that what it says here?

15 A It, it doesn't say that here, but there's no
16 context around what's written here.

17 Q But the fact is -- and this what we've been
18 discussing up until this point. The fact is that in
19 order for a hospital to use the Hospital Safety Grade
20 logo, right, it has to pay LeapFrog in order to use
21 that logo, correct?

22 A Yeah, in order to use the logo, they have to
23 pay LeapFrog for the logo.

24 MR. CHUNG: Okay. Let's go to tab 16. This
25 will be Exhibit 9.

1 (Exhibit 9 was marked for
2 identification.)

3 BY MR. CHUNG:

4 Q So Mr. Banerjee, this is an email chain from
5 November of 2023 that includes you and Missy Danforth
6 and Alexandra Campione, and you testified that you
7 report to Ms. Danforth, correct?

8 A Yes.

9 Q How about Ms. -- how about Ms. Campione?
10 What is her -- what is her role?

11 A She's a data analyst, a data manager for --
12 and she reports to Missy, and she works on the, the
13 Hospital Safety Grade program.

14 Q Okay. So she's on Ms. Danforth's team?

15 A Yes.

16 Q Right, and these are two of your colleagues
17 that were present at that initial prep meeting for,
18 for purposes of preparing for this deposition,
19 correct?

20 A That's right.

21 Q So let's start with the earliest or the
22 first email in the chain from November 8, 11:32 a.m.
23 Ms. Danforth is addressing you and Ms. Campione, "I'd
24 like to get a sense of the number of licensees that
25 don't submit a survey and the percentage of accolade

1 revenue those facilities represent for say the past
2 two years (last four rounds)."

3 Do you see that?

4 A Yes.

5 Q Okay. So why, why was she, Ms. Danforth,
6 asking you about the, the number of licensees that
7 don't submit a survey and the percentage of accolades
8 revenue those facilities represent for the past couple
9 years?

10 A I, I don't know why she was asking. I mean
11 this is from 2023, so I'm not sure what conversations
12 she had before with other teams, with Leah. I'm not
13 sure what the -- what prompted her to ask this
14 question.

15 Q Okay. What is she -- why do you think she
16 was asking for, for this information?

17 A I, I don't -- I'm not sure why -- I don't
18 know if I can say why I think that she -- I just don't
19 have any --

20 Q You have zero idea?

21 A No, I have no idea what, what the context
22 is, what prompted her to ask that, that question.

23 Q Okay. Well, let's go on to the next
24 paragraph.

25 "Due to Step 1 imputation and as the means

1 for the Step 2 imputed data increase over time, there
2 is the risk of reducing incentive to submit a survey
3 every year, and I'm starting to see this come through
4 in some of the questions we are getting on the
5 HelpDesk."

6 Okay. So what did you, what did you
7 understand her to be saying here?

8 A I mean she -- Missy knows the methodology a
9 lot more than I do. I don't work with the
10 methodology.

11 Q But she is, she is writing to you, correct,
12 to you and Alex?

13 A Yes, and Alex is a lot more familiar, but I
14 mean she worked -- she, she, she works with Missy --

15 Q Understood, but Alex --

16 A -- and Alex.

17 Q It's not just Alex. She's addressing this
18 to you and -- she's actually asking you and Alex,
19 correct?

20 A Well, there isn't a -- okay. There isn't a
21 question in the second -- on the second line.

22 Q So I'm asking, I'm asking you what did you
23 understand her to mean in this second paragraph?

24 A I assume that second line is more so for
25 Alex, because it's about the methodology, than for me.

1 Q Okay. Putting aside who you think it's
2 meant for, what do you understand this sentence to
3 mean?

4 A I'm understanding that this -- what she's
5 writing up is addressed to me and Alex. That line
6 about the methodology, I don't think she's expecting
7 me to like fully understand what she's talking about.
8 I think that outline is more for Alex. What I think
9 about it is I don't, I don't understand it.

10 Q You have no understanding whatsoever is your
11 testimony? Remember -- Mr. Banerjee, I'm going to
12 remind you that you're, you're under oath, so as such,
13 you have promised to answer my questions truthfully
14 and to the best of your ability.

15 So I'm going to ask: You have no -- what
16 did you understand her to be --

17 MS. WOOD: Objection to form; asked and
18 answered.

19 MR. CHUNG: The witness is not, not
20 responsive.

21 BY MR. CHUNG:

22 Q So please answer the question.

23 A My -- I mean my understanding is she, she's
24 telling Alex -- she's asking -- she's -- I don't have
25 the context of this, of this email, what's prompting

1 it.

2 The statement that she's writing here about
3 the imputation and the impact of it, I think it's a -
4 something she's reporting, an observation that, that
5 she's seeing.

6 The next line talks about financial risk,
7 and I think that is probably more directed for me, but
8 I don't, I don't see the -- I don't believe she's even
9 addressing me in this question, so I don't think I
10 should be expected to understand what it's saying,
11 what it's saying.

12 Q Let's start -- then let's skip to the third,
13 because it, it is -- you're, you're saying that one
14 was directed to you specifically.

15 All right. "I'd like to understand how
16 financial risk if we make changes to how we display
17 grades for hospitals that don't submit," do not
18 submit.

19 All right. If that one was meant for you,
20 what did it mean?

21 A Again, I think you would have to ask her
22 what she means.

23 Q This is your deposition, Mr. Banerjee.

24 A I know.

25 Q I'm asking for your understanding of what

1 this means --

2 A Right.

3 Q -- because it was directed to you.

4 A Right. So this, this was directed to me two
5 years ago, and I don't quite understand what, what it
6 means, but it sounds like -- I know Missy was new to
7 this role like for under -- so there was some
8 transitions that happened. I think earlier this year
9 in 2023, I started reporting to Missy, and so Missy
10 was not -- did not have oversight of the accolades
11 program or data licensing at that time, before that,
12 and then I was reporting to Missy.

13 And so I think she is -- and this is just
14 all speculating based on the timing of it, that she is
15 trying to put together like the impact of the
16 methodology with impact on programs that we
17 administer, like the licensing program.

18 So I think that's -- I think she's trying to
19 understand that, but you'd have to ask her, because
20 I -- you asked me for what I think.

21 Q Okay. So let's, let's take that. The --
22 going back to the first sentence, she writes, "I'd
23 like to get a sense of the number of licensees that
24 don't submit a survey and the percentage of accolades
25 revenue those facilities represent for say the past

1 two years."

2 So is that data that you would have had? As
3 at that time I think you were a manager or a senior
4 coordinator for the data licensing. Is that data that
5 you would have had? "The number of licensees that do
6 not submit a survey and the percentage of accolades
7 revenue those facilities represent for the past two
8 years."

9 A Yeah, I think, I think we could -- I mean I
10 think we, I think we were able to pull together those
11 data.

12 Q Okay, and then -- so in terms of -- and then
13 we go to the second paragraph, "Due to Step 1
14 imputation."

15 Now, do you under- -- do you have kind of a
16 general understanding of what "imputation" means here
17 in this context?

18 A I don't, I don't know the different steps of
19 imputation, but I do know that imputation is a, is a
20 part of the, the methodology of the safety grade.

21 Q Is it, is it correct that it is -- the
22 imputation methodology is the methodology that
23 LeapFrog uses when -- in circumstances where a
24 hospital has not responded to the survey with data?

25 A Yes. That's my, that's my understanding.

1 Q All right, and so what did you understand at
2 this time to be step, the Step 1 of the imputation
3 methodology?

4 A I, I don't know what the -- I don't know
5 what the different steps are of the imputation
6 methodology.

7 Q Okay.

8 A I just know what the output is.

9 Q What did you -- what do you understand the
10 output to be?

11 A I think with -- as you described the --
12 it -- the, the output of the imputation methodology
13 helps to fill the gaps in specific measures that
14 hospitals are now reporting on, on the survey.

15 Q Where LeapFrog does not have the data for
16 certain metrics, correct?

17 A Yes.

18 Q And then for the Step 2, she writes here,
19 "and as the means for the Step 2 imputed data increase
20 over time," right? Did you understand that to mean --
21 to be the step, the second step in the imputation
22 methodology, right, where again you don't have the
23 hospital's data because they didn't participate, that
24 the methodology basically takes the average, right, of
25 certain scores and then assigns a score to that

1 hospital?

2 MS. WOOD: Objection to form.

3 THE WITNESS: Sorry. Could you repeat --

4 BY MR. CHUNG:

5 Q Do you understand -- I take, I take your --
6 I mean I take your point that you're not intimately
7 familiar with the methodology, right, but are you kind
8 of generally familiar that at least as of the time
9 here in 2023, a few years ago, that the step -- second
10 step in this imputation methodology is where a
11 hospital has not submitted data, that the methodology
12 then takes basically an average, right, of available
13 data from certain cohorts of hospitals or certain
14 universe of hospitals, and then assigns that score to
15 the hospital?

16 A Yes.

17 Q Okay, and she's saying here, "as" -- she
18 writes here, "and as the means," right, for that
19 score, for that step, "Step 2 imputed data increase
20 over time," right?

21 So is it fair to say that she's at least
22 observing or she's telling you and Ms. Campione that
23 the means or that number, right, for that Step 2, Step
24 2 metric are increasing over time, there is a risk of
25 reducing incentive to submit a survey every year,

1 okay?

2 So I'm just kind of -- because this was
3 addressed to you, I'm kind of trying to get your
4 reaction or your understanding here.

5 Is it correct that, as she is observing that
6 Step 2 kind of average, right, that score increasing
7 over time for hospitals that did not participate in
8 the survey, that there is a risk that these hospitals
9 will not submit a survey every year?

10 MS. WOOD: Objection to form.

11 THE WITNESS: So yes, I think her concern is
12 that the way -- I mean you have to -- and I'm,
13 I'm --

14 BY MR. CHUNG:

15 Q We will.

16 A -- just speculating, but that there is some
17 sort of reverse incentive for participating, because
18 we are using I think the mean of reporting hospitals.

19 Q Right.

20 A And they -- by not reporting, they're
21 getting a score that's potentially higher than a
22 hospital that is reporting and not, not doing as well,
23 and so it is -- does not seem to be working, because
24 that doesn't quite make sense that the hospital that
25 does not report would get a higher score than someone

1 who does report that doesn't do well, and they're
2 still not submitting data.

3 Q Well, is she saying anything here about
4 nonparticipating hospitals getting a higher grade or
5 score than reporting hospitals?

6 A I guess I was kind of inferring that that,
7 that that would be the case, because that would --
8 because, because of the line where she says there's a,
9 there's a "risk of reducing incentive to submit,"
10 because the hospitals could get a higher score by not
11 submitting.

12 Q Right. At least a high, potentially a
13 higher score, right, because of this, because of this
14 pre- -- this, this version of the imputation
15 methodology that assigns kind of the average score,
16 correct?

17 A It, it seems that way.

18 Q Okay. So let's go back to the first
19 sentence; all right? "I'd like to get a sense of the
20 number of licensees that don't submit a survey," so
21 that kind of ties into the second sentence, "and the
22 percentage of accolades revenue," which is in your
23 wheelhouse, "the percentage of accolades revenue"
24 those hospitals, those nonparticipating hospitals
25 represent for the past two years, right?

1 So is she asking here for -- how much money
2 are we making in terms of accolades revenue from
3 hospitals that did not submit a survey, right? Is
4 that basically what she's asking?

5 A Yes.

6 Q All right. So she -- is it fair to say that
7 in asking or kind of relaying these observations to
8 you and asking for this info request, that she's
9 seeing kind of a relationship between participation or
10 nonparticipation in the hospital survey and accolades
11 licensing revenue?

12 MS. WOOD: Objection to form.

13 THE WITNESS: It seems -- with the context
14 that she is just coming in, she was more
15 intimately familiar with survey participation,
16 and Alex had those numbers. I have accolades
17 revenue information.

18 I think that she is coming into this role
19 and trying to understand what the, what the
20 connection there is, if any, between, between
21 these two things.

22 BY MR. CHUNG:

23 Q Okay. So let's go to the third, finally the
24 third line. "I'd like to understand how financial
25 risk if we make changes to how we display grades for

1 hospitals that don't submit."

2 What did you understand her to mean? What
3 was the change to "how we display grades for hospitals
4 that don't submit"? What is that a reference to?

5 A I'm actually -- I'm confused on that line
6 and what she means.

7 Q Okay. What do you think she, she meant or
8 means there -- meant there?

9 A I don't, I don't think it quite makes sense
10 to me, how we display grades, but -- yeah, it doesn't,
11 it doesn't quite make sense to me, but I guess if we
12 make any type of changes, she wanted to see what the
13 impact is on accolades, which she has just come into
14 taking responsibility for that and, and survey
15 participation, and I guess in relation to making
16 changes to the methodology, but that's a, that's a
17 guess.

18 Q Okay, but she's -- but in this email, she's
19 basically combining the two concepts, right, or
20 looking at both concepts?

21 A I think anytime a change is made on, on
22 anything that we do, we want to see like what kind of
23 impact that has in the organization or any of the
24 stakeholders that we, that we work with.

25 Q So what change are we -- are you referring

1 to here?

2 A She says if we make any changes, so if we
3 make any changes in how we display grades for
4 hospitals that don't submit. I assume she's talking
5 about the methodology, so any changes that we make,
6 she wants to see how, how that would impact anything,
7 anything else that we, that we do.

8 Q Okay. So a change in the imputation
9 methodology, she would want to, Ms. Danforth, and the
10 organization would want to see how a change in the
11 imputation methodology affects accolade licensing
12 revenue; is that correct?

13 MS. WOOD: Objection to form.

14 THE WITNESS: Yeah, it seems like she's,
15 she's trying to see if, if there are any
16 connections between people that don't submit and
17 accolades, and accolades revenue.

18 BY MR. CHUNG:

19 Q Okay, and so would the purpose -- is the
20 purpose of seeing if there's a connection, right,
21 between nonparticipating hospitals and accolade
22 licensing revenue, is the purpose of, of trying to
23 find out whether there's a connection there is whether
24 the, that accolade, that accolades licensing revenue
25 should in any way kind of inform how that methodology

1 should be changed?

2 Let me put it, let me put it another way,
3 all right?

4 So given kind of our discussion of this
5 email here and what Ms. Danforth -- you testified that
6 it looks like she's making connection, right, between
7 nonparticipation by certain hospitals, right, and
8 accolades licensing revenue, correct?

9 A Mm-hmm.

10 Q All right, and part of that connection is
11 how those nonparticipating hospitals are basically
12 using or perhaps taking advantage of the imputation
13 methodology, correct?

14 A So the, just to clarify, the accolades
15 revenue is for licensing -- licensing the right to use
16 the LeapFrog logo for A hospitals.

17 Q Right.

18 A So there's, probably on the face of it, like
19 very little, and I think there was some work that went
20 into this afterwards, that there's no really
21 connection between those two people that don't
22 license -- people that don't participate in the survey
23 are less engaged with LeapFrog.

24 Q Okay.

25 THE REPORTER: Are less engaged?

1 THE WITNESS: They are less engaged.

2 BY MR. CHUNG:

3 Q Right. So is she -- based on kind our
4 discussion right now of this email, is Ms. Danforth
5 thinking about whether the accolade licensing revenue,
6 right, the patterns in the accolade licensing revenue
7 should impact a potential change to the imputation
8 methodology?

9 MS. WOOD: Objection to form.

10 THE WITNESS: I, I'm not sure what -- I'm
11 not sure what she was thinking in, in asking, in
12 asking those, what the motivation served, asking
13 these questions and what she was going to like --
14 going to -- what she was really looking for in
15 the output of, of that, but I do -- I, I'm -- so
16 I'm speculating that it is to see what impact
17 there is to any substantial change that we make
18 in -- it's just an observation about the
19 imputation methodology, and she wants to see what
20 kind of impact it -- that might have on, on, on
21 the accolades program and what, what that means
22 for nonparticipating hospitals, and if there is
23 any connection there. I think it's kind of
24 like -- kind of an exploratory question.

25

1 BY MR. CHUNG:

2 Q Okay. So Ms. Campione responds -- we're
3 just going to the more recent emails. "Not a problem
4 I already have the previous licensing data, but if we
5 want to include this round's licensing, I'll need
6 data. Kush, do you have the licensing so far? We
7 could wait a few weeks so it's more accurate."

8 What does she mean here, "we could wait a
9 few weeks so it's more accurate"?

10 A So on November 8, it looks like it was in
11 the middle of the fall 2023 licensing, accolade
12 licensing campaign, probably ahead of the fall '23
13 announcement, which happens in November. I'm not sure
14 what the date, the date was, but generally that is
15 kind of a higher time for -- a lot of hospitals are
16 interested in the, the logo, so if you want -- so
17 if -- I think she's suggesting here that if we waited
18 a few weeks, we would have more information, more
19 accurate information of like what the fall 2023
20 license and sales look like.

21 Q Okay, and you, you respond, just looking at
22 top here of the document, "Could that be why HCA
23 suddenly stopped submitting? I think we looked at
24 this trend many years ago, and I believe there was
25 correlation to survey participation and As, as well as

1 participation and licensing."

2 What, what are you referring to here in your
3 response?

4 A Sorry. For which part?

5 Q What I just said up top, your response.

6 A Like the first sentence?

7 Q Yeah, let's start with the first sentence.

8 A Okay. So "could that be why HCA stopped" --
9 so HCA is a health, health system that, that didn't
10 submit to the LeapFrog Hospital Survey that year, and
11 so I think that was kind of maybe top of mind. I'm
12 not sure exactly what I was thinking. Maybe I
13 interpreted this email differently when I read it in
14 2023, but perhaps that was top of mind that they had
15 stopped submitting.

16 Missy; it sounds like she suggested that
17 there was a reverse incentive, and we know that
18 hospitals are keenly aware of what their hospital
19 safety grades are and, and the methodology, they pay
20 attention, and so I'm not sure if I knew the context,
21 if she was even talking about that, but I, I said that
22 in this internal email.

23 Q But you continue, "I think we looked at this
24 trend many years ago, and I believe there was
25 correlation to survey participation and As."

1 Do you -- is it still correct that there is
2 a correlation between hospital survey participation
3 and A grades?

4 A So survey participation and A grades, yes, I
5 think there is a correlation.

6 Q Okay, and what exactly is the correlation?
7 So is it hospitals that are -- hospitals that do
8 participate in the survey -- there's a positive
9 correlation between hospitals that do participate in
10 the survey and their receiving an A grade? What
11 exactly is the correlation being referred to here?

12 A So I don't know if, if there is an official
13 like correlation, because we kind of -- I think I
14 looked at this just kind of on the fly. I was looking
15 to see like what the percentages were. I don't
16 remember what the percentages are, but I think just
17 generally, hospitals that have As are -- hospitals
18 that participate in the survey are more engaged, and
19 they are more, I think, committed to transparency and,
20 and a lot -- some of the patient safety metrics.

21 Hospitals that get As, we hear that they are
22 kind of obsessive about patient safety and looking at
23 the LeapFrog measures, and making sure that their
24 facility is adhering to what's in the LeapFrog
25 Hospital Survey, which is represents industry best

1 practices and evidence-based care.

2 Q So the question, the question --

3 A Yeah, yeah.

4 Q -- Mr. Banerjee, was: Is there a -- does
5 there continue to be a correlation between survey
6 participation and A grades?

7 A Yes.

8 Q Okay. How about does there continue to be a
9 correlation between survey participation and accolades
10 licensing?

11 A Yes, I think there, there is a correlation
12 between those as well.

13 Q Okay. So the -- before we kind of move on
14 to another topic, I want to ask you some more
15 questions about the imputation methodology that was at
16 least referenced in this, in this particular exhibit.

17 To start, are you familiar with LeapFrog's
18 current imputation methodology?

19 A I'm, I'm not that familiar with it. I'm
20 just like loosely familiar that we use an imputation
21 methodology for, for a few measures on the, on the
22 Hospital Safety Grade.

23 Q Okay. Are you familiar -- did you -- do, do
24 you know that the imputation methodology that's in, in
25 effect now was the product of changes in the last

1 year, fall of 2024?

2 A Yes.

3 Q Okay. So the imputation methodology that
4 before the fall 2024 was different from what it is
5 today, correct?

6 A Yes.

7 Q All right. Does LeapFrog's imputation model
8 or the methodology allow it to give more hospitals
9 hospital safety grades?

10 A I don't know that.

11 Q Okay. So if -- when, when does -- as you
12 understand it, when does -- in what circumstances does
13 LeapFrog use the imputation methodology for a
14 particular hospital?

15 A There's certain measures. If the hospital
16 doesn't participate in the, in the survey, then
17 LeapFrog assigns, assigns a score for those.

18 Q For certain of the metrics?

19 A For certain of the measures, yeah.

20 Q Okay. So where a hospital -- where a
21 hospital does not respond to a survey, right, without
22 the imputation methodology, would LeapFrog be able to
23 give a hospital safety grade to that nonparticipating
24 hospital?

25 A I don't know. I know there's some details

1 on the methodology about having enough data and
2 measures, but I don't know what the -- I don't know
3 what the details of that are and the scoring, because
4 I'm not involved in the scoring --

5 Q Okay.

6 A -- in that assessment.

7 Q Well, I'm glad that you brought that up.

8 So isn't it the purpose of the imputation --
9 isn't the purpose of the imputation methodology, at
10 least in part, to give a nonparticipating hospital
11 the, basically the, the minimum, at least the minimum
12 number of measures so that LeapFrog can give it a
13 hospital safety grade?

14 MS. WOOD: Objection to form.

15 THE WITNESS: My only understanding is that
16 the, the measures that are imputed are, like are
17 determined by our expert panel to be critically
18 important for patient safety, and that's why they
19 are a part of the methodology and the imputation
20 model.

21 BY MR. CHUNG:

22 Q Right. I'm glad you raised that.

23 So because those imputed metrics, right,
24 that this methodology is designed to address are so
25 critical, without the imputation methodology, a

1 nonparticipating hospital -- you wouldn't have any
2 sort of number, right, for those four critical metrics
3 to base a hospital safety grade on, correct?

4 MS. WOOD: Objection to form.

5 THE WITNESS: The, the imputation
6 methodology I think kind of generously gives
7 hospitals that don't participate in the survey a
8 score that's equivalent to a hospital that does
9 take the survey and performs at the lowest level
10 on those measures. So that's my understanding of
11 the, of the imputation methodology.

12 BY MR. CHUNG:

13 Q Are you referring to the current imputation
14 methodology?

15 A I believe so.

16 Q And you're saying that -- I think you used
17 the word "generously."

18 Why did you use the word "generously"?

19 A Because hospitals -- and this is my
20 understanding of it, because I'm, I'm not an expert in
21 the methodology, but things like computerized
22 physician order entry and medication safety, it's like
23 the most -- one of the most common errors that happens
24 in, in hospitals.

25 There are, there are hospitals that want to

1 improve and even assess to see what level of safety
2 they have for their, their patients, and they take the
3 LeapFrog Hospital Survey. They don't do -- they don't
4 do well, but they learn from it, and they make
5 improvements.

6 Meanwhile, another hospital that is not
7 taking the survey, and doing that same assessment and,
8 and taking accountability and showing transparency,
9 they're getting the same score in the, in the
10 methodology, which is why I used the word "generous."

11 Q Okay.

12 A Because they are getting -- they're not
13 getting a zero. They're getting the lowest available
14 score, which is above zero.

15 Q The lowest available score, which is above
16 zero. So you're saying that the assignment of that
17 lowest available score to a nonparticipating hospital
18 is, is generous is your testimony?

19 A Can you repeat that last part.

20 Q Well, I'm just --

21 A I'm just making -- yeah.

22 Q I'm basically repeating your testimony.

23 A Yeah.

24 Q So you're saying that the assignment of that
25 lowest available score to a nonparticipating hospital

1 is, is generous?

2 A To a nonparticipating hospital, yes.

3 Q Okay. Is it -- are you aware that a number
4 of hospitals have not responded to the survey because
5 of, of resource constraints in responding to the
6 survey?

7 MS. WOOD: Objection to form.

8 THE WITNESS: I, I don't hear from
9 hospitals. I'm not on the -- I don't see
10 questions on the HelpDesk from hospitals about,
11 about participating in the survey. I haven't
12 heard that --

13 BY MR. CHUNG:

14 Q Okay.

15 A -- anecdotally from hospitals or anything
16 like that.

17 Q So in making that -- in, in comment --
18 making, commenting that the assignment of the lowest
19 available score is "generous" for these
20 nonparticipating hospitals, is this -- do you know --
21 are you assuming that these hospitals would have
22 received zero scores had they reported -- had they
23 responded to the survey?

24 A Can, can you repeat that?

25 Q Yep. Are you assuming that these

1 nonparticipating hospitals would have received a zero
2 score or a score lower than, than the limited
3 achievement score, had they reported?

4 A No. So on the ratings website,
5 ratings@leapfroggroup.org for the, for the survey,
6 the -- for a reporting hospital that receives the
7 lowest score gets one out of four bars, which is
8 called "limited achievement." A hospital that does
9 not submit to the survey is just reported as "declined
10 to respond" on that, on that website, and I'm not -- I
11 don't do the methodology or the website, but I have
12 been at LeapFrog for a while, so my understanding is
13 that it is better to be transparent.

14 Take the, take the survey, report on these
15 measures, but we still don't show zero out of four
16 bars. We show one out of four bars, limited
17 achievement, because that is a testament to
18 accountability and transparency that we want to see
19 all hospitals do, and that's why --

20 Q Is it a testament to accuracy? Do you think
21 it is an accurate score for those nonparticipating
22 hospitals?

23 A What do you mean by "accurate"?

24 Q Is it an accurate -- is it an accurate
25 assessment of their performance on those metrics?

1 A If a hospital takes the test and gets one
2 out of four bars for limited achievement, is it
3 accurate?

4 Q If a nonparticipating -- if a
5 nonparticipating hospital, right, that chose not to
6 submit data on one or more of these -- chose not to
7 submit or respond to the survey at all, are you
8 testifying that the assignment of the limited
9 achievement score -- automatic assignment of the
10 limited achievement score to that nonparticipating
11 hospital is an accurate reflection of that hospital's
12 performance on that metric?

13 A For the safety grade? So I don't know -- I
14 don't know if -- I don't know if it's accurate. I
15 do --

16 Q You don't, you don't know if it's accurate,
17 because it's not based on any data that the, that the
18 hospital submitted, correct?

19 MS. WOOD: Objection to form.

20 THE WITNESS: It is, it is based on publicly
21 available data. The hospital has not taken --

22 BY MR. CHUNG:

23 Q Which --

24 A -- accountability --

25 Q For the four imputed metrics --

1 A I, I -- do you mind?

2 Q -- which publicly available data is that
3 based on?

4 You're not answering the question,
5 Mr. Banerjee. I'm looking --

6 A What you asked me is if it was accurate.

7 Q Right. So what -- and I'm asking what --
8 and we've already gone over these imputed metrics,
9 right, that there's an imputation methodology, because
10 they're for, they're for metrics where the hospital
11 has not submitted any data, right? I think we went
12 over that, correct?

13 A Yes.

14 Q Right, because they haven't responded to the
15 survey, correct?

16 A Yes.

17 Q Right. On these four imputed metrics,
18 what's your understanding of the publicly available
19 data that they're based on?

20 A It's information from what hospitals report
21 on the LeapFrog Hospital Survey for those specific
22 measures.

23 Q What, what are the -- what are the public
24 sources that you're referring to where LeapFrog has
25 provided this information?

1 A Sorry. We're talking about the -- the
2 LeapFrog Hospital Survey is, is publicly available
3 data. So at the beginning of this, you asked me about
4 the Hospital Safety Grade and the data sources. CMS
5 data is one source. The LeapFrog Hospital Survey is
6 another data source that is used. Both are publicly
7 available data sources.

8 Q Right.

9 A These hospitals have chosen -- some
10 hospitals have chosen not to report to, to the
11 LeapFrog Hospital Survey.

12 Q Yes.

13 A Some hospitals choose not to report their
14 data to CMS. Like -- so we wouldn't have, we wouldn't
15 have that, that data.

16 Q Okay. So the, the question comes back to:
17 Is automatically assigning a limited achievement
18 score, the lowest available score on these four
19 imputed metrics, to a nonparticipating hospital, is
20 that an accurate -- is that accurate?

21 A Yes. I think that's -- that is, that is
22 what we do in the imputation methodology.

23 Q I understand that's what you do in the
24 imputation methodology, but is that -- is assigning
25 that limited achievement score an accurate reflection

1 of the hospital's performance on those imputed
2 metrics?

3 A I mean personally I think that we are giving
4 them the same score as somebody that does report and
5 does, does poorly, so that's why I had said that I
6 thought I was being, being generous.

7 Q I'm not talking about generous. Is it
8 accurate? My question is: Is it accurate?

9 A Accurate. Well, yes, I think it's, I think
10 it's accurate. I think it's accurate.

11 Q How is it accurate if there's no data?

12 A Because, because a part of -- these are
13 important measures. Our expert panel has determined
14 these are important measures for assessing patient
15 safety. These hospitals have an opportunity to submit
16 this information, because they are critically
17 important on patient care. Having a fully staffed ICU
18 with a physician that is certified in critical care
19 seven days a week impacts outcomes.

20 So that, that is -- I think that's one of
21 the reasons why that's on there and is important in
22 making that assessment. So it is in the methodology,
23 from my understanding, because that's, that's very
24 important.

25 So if a hospital reports to the survey, and

1 they have -- they're not meeting those criteria, they
2 will get the lowest score available, limited
3 achievement.

4 If a hospital does not report to the survey,
5 it seems accurate to me that they should get the
6 lowest score available, at the, at the most, and not,
7 and not above that in an imputation methodology. That
8 makes sense to me personally, but it's just what I
9 think personally. I don't, I don't have any
10 interaction with the methodology.

11 Q Well, let's put it another way.

12 Is at least one of the purposes of the
13 imputation methodology of automatically assigning the
14 lowest available score, right, to these
15 nonparticipating hospitals, is at least one the
16 purposes basically to penalize these hospitals for not
17 participating in the survey?

18 MS. WOOD: Objection to form.

19 THE WITNESS: I mean I don't know if it's
20 penalizing. I mean I don't know if it's
21 penalizing the hospital. It's not rewarding the
22 hospitals for not participating in the survey.

23 BY MR. CHUNG:

24 Q Okay. Is it, is it -- is one, at least one
25 of the purposes to penalize the hospital for not

1 responding to the survey?

2 A I mean these are --

3 Q Yes or no? Let's start with that.

4 A I don't think it's -- I don't think it's
5 penalizing them.

6 Q Okay. Is it punishing them for not
7 responding to the survey? One of the -- at least one
8 of the purposes -- may not be the sole purpose, but is
9 it one of the purposes?

10 A I mean "punishing" seems like a harsh, harsh
11 word. A hospital can take -- it cannot respond to
12 these and still get an A is my understanding, so I
13 don't, I don't think it's punishing them. I think
14 there's still opportunities. If they really don't
15 want to participate in the survey, they're not being
16 forced to.

17 Q Let's put it another way.

18 Is at least one of the purposes of this, the
19 imputation methodology of assigning the limited
20 achievement score automatically to nonparticipating
21 hospitals to encourage or incentivize those
22 nonparticipating hospitals in the future to
23 participate in the survey?

24 A We want every hospital to participate in, in
25 the survey.

1 Q Right. So is this imputation, this new
2 imputation methodology one of the ways in which
3 LeapFrog is trying to incentivize or encourage these
4 hospitals to participate in the survey?

5 A I don't know if that's the --

6 Q I asked: Is it one of the purposes?

7 A I was not involved in the determination of
8 the imputation methodology.

9 Q I understand that, Mr. Banerjee.

10 A So, so I don't know --

11 Q I'm asking you: In your view, is at least
12 one of the purposes behind this new imputation, the
13 current imputation methodology, to encourage -- let's,
14 let's start with encourage -- to encourage hospitals
15 that didn't -- that chose not to participate in the
16 survey to do so in the future?

17 A If, if I were to guess, it seems like that
18 could be, that could be an -- that could be something
19 that comes out of it. If a hospital even took enough
20 time to -- that didn't participate in the survey, to,
21 to look at the methodology and then made that
22 determination, I just don't know.

23 Q Why are you hesitating about this? Why is
24 there -- why are you hesitating about this --

25 A I've just never given it a lot of thought,

1 because I'm not involved in the methodology or thought
2 of it like, oh, from the perspective of a hospital,
3 how would I approach this if I was -- that is, that is
4 not in my day-to-day job description, so I haven't, I
5 haven't given a lot of thought to the methodology or
6 the impact of the imputation methodology in that way.

7 Q My question is not asking you whether you've
8 given this question that I just put in front of you a
9 lot of thought, all right?

10 My question is: Given that -- I mean we've,
11 we've discussed at least a few times that, you know,
12 hospitals -- the kind of the rate, right, or the
13 number of hospitals that participate in the survey is,
14 is important, right, to the licensing programs,
15 correct?

16 A Yes.

17 Q So because -- and you are the director of
18 the licensing program, correct?

19 A Yes.

20 Q All right. So the -- with this current
21 imputation methodology, right, is it, in your view, by
22 basically -- by assigning nonparticipating hospitals
23 the lowest -- I think it was your testimony, the
24 lowest available score on these imputed metrics, to
25 encourage these hospitals, hey, participate in the

1 future, and you may get something higher possibly than
2 the lowest available score?

3 MS. WOOD: Objection to form; asked and
4 answered.

5 BY MR. CHUNG:

6 Q You can answer.

7 A You asked me if, if this was the purpose of,
8 of doing it. I was not privy to the meetings when we
9 were determining what the purpose was, and so if, if
10 that is a byproduct of making these changes, then,
11 then that's, that's what it is, but if it was stated
12 as one of the purposes, then I would not know that.

13 And so are you asking me personally is it
14 one of the purposes? I wouldn't use the word
15 "purposes," but do I think it could have an impact? I
16 think it, I think it could have an impact.

17 Q What did you understand the purpose of the
18 change in the imputation methodology to be?

19 A Right. So it sounds like the -- it, it
20 seemed that the former methodology was rewarding
21 hospitals that did not participate in the survey and
22 gave them a higher score than a hospital that took the
23 survey and achieved the lowest available score, and so
24 it appears that the imputation had an effect in
25 righting that, but yeah, I don't -- that's the -- I

1 think that, that -- maybe that is the purpose. I
2 don't -- I just don't -- I don't know. I wasn't
3 involved in any part of that, those conversations,
4 so --

5 Q So what is even that understanding based on
6 if you -- I mean in response to my previous question
7 about whether one of the purposes was encouraging
8 hospitals to participate, you just, you just described
9 a purpose.

10 What, what is that based on, if you
11 hadn't --

12 A Yeah.

13 Q -- if you weren't involved in the
14 conversations at all?

15 A So, so yeah, perhaps they -- perhaps it was
16 one of the purposes. I, I just don't think about it
17 on, on the daily, so I'm, I'm kind of having a hard
18 time to kind of put it into words, like what, what my
19 role is. I'm -- this is kind of here in my role now.
20 I feel like I'm being asked to like speculate on, on
21 what the purpose was that, you know, other people were
22 more involved in and like actively deciding the, the
23 reasoning for what -- for, for the methodology.

24 Q Okay. Understood.

25 Let's look at it from your role, right, as

1 director of the licensing programs.

2 From your perspective -- let's put aside
3 what was discussed, the discussions that you were not
4 privy to, right, regarding why exactly LeapFrog
5 instituted this change in the imputation methodology.
6 Doesn't the, the current imputation methodology, you
7 know, positively serve your purposes in terms of
8 licensing programs?

9 MS. WOOD: Objection to form.

10 BY MR. CHUNG:

11 Q Let me put it another way.

12 Doesn't, doesn't the new imputation
13 methodology help you and, by extension, LeapFrog by,
14 by potentially encouraging more hospitals to
15 participate in the survey?

16 MS. WOOD: Objection to form.

17 THE WITNESS: So I don't think that's
18 necessarily true. I don't think more hospitals
19 participating in the survey impacts the --
20 directly impacts the data licensing program. We
21 do want more hospitals to participate in the
22 survey. There -- so for the, yeah, data
23 licensing, there, there are more hospitals
24 participating in the survey in specific markets,
25 and there might be more -- there might be more

1 interest in it, in the survey, the survey data.
2 For the safety grade, though. I'm not sure if
3 there would be, if there would be any impact on
4 that for data licensing and -- either that or
5 even for accolades that, that I can, that I can
6 think of right now.

7 BY MR. CHUNG:

8 Q Have any of potential or, you know, actual
9 licensing customers asked you or others about the
10 change in the imputation methodology in 2024?

11 A No, not that I can recall.

12 MS. WOOD: We've been going for an hour. I
13 think it's a good time to take a break.

14 MR. CHUNG: Okay. Why don't we take a
15 break.

16 THE VIDEOGRAPHER: This marks the end of
17 media unit number 3. Going off the record. The
18 time is 14:28 p.m.

19 (Whereupon, a short recess was taken.)

20 THE VIDEOGRAPHER: This marks the beginning
21 of media unit number 4. Going back on the
22 record. The time is 14:43 p.m.

23 BY MR. CHUNG:

24 Q Mr. Banerjee, before we get into documents,
25 did you -- your compensation at LeapFrog, is it -- is

1 any part of it tied to any revenue targets?

2 A No.

3 Q No? Okay. So there's nothing kind of in
4 your employment agreement or compensation package
5 where there's a bonus that's tied to revenue targets
6 or sales targets?

7 A No.

8 Q Okay. So is -- okay. We'll get into that
9 further. Why don't we move on to our next document.

10 A Thank you.

11 (Exhibit 10 was marked for
12 identification.)

13 BY MR. CHUNG:

14 Q All right. Exhibit 10 is an email and then
15 a presentation attached to it, a January 2024
16 presentation about 2023 hospital safety grade accolade
17 licensing.

18 Did you help put this together? I see that
19 Ms. Campione's name is across the front, but do you --
20 did you help put this together?

21 A No, I didn't. I didn't help put this
22 together. I think this was follow-up from some
23 analysis that Alex did. She may have needed the, like
24 some of the numbers on, on, on the, the latest sales,
25 but she, she has access -- she actually has access to

1 those. So she, she -- I mean she may have sent this
2 email in advance of this meeting where, where I looked
3 at it. I don't remember if I commented on it or not,
4 but I, I don't recall --

5 Q Do you recognize it?

6 A I do recognize --

7 Q Okay.

8 A I do recognize it.

9 Q And did it come out of -- was it part of a
10 follow-up to the discussion, the email discussion we
11 saw earlier among you, Ms. Danforth, and Ms. Campione
12 about the relationship between accolades licensing
13 revenue and the, basically the participation rate and
14 how non-, nonparticipating hospitals are scored?

15 A Yeah, it, it does appear that there -- that
16 that was -- this was in connection to that earlier
17 email.

18 Q Okay. So let's go to the second page, so
19 the Bates ending 3569. If you can turn to it, about
20 the second page of the presentation. In small writing
21 up top, there's "Slide 1 Notes."

22 Do you see that?

23 A Oh, yes. "Slide 1 Notes," yep.

24 Q It reads, "This analysis looked at the
25 relationship between individual hospitals

1 characteristic and the likelihood of hospitals
2 licensing their A grade, as well as our media coverage
3 in metropolitan areas. We wanted to understand what
4 hospital types were licensing and if increased media
5 coverage resulted in more licenses in the cities."

6 Who directed -- who at LeapFrog directed
7 this study to be done?

8 A Appears Missy.

9 Q Missy? Okay, and was the purpose of this
10 analysis in looking at these relationships to figure
11 out a strategy on, on the licensing program?

12 A Sorry. Can you repeat --

13 Q Yeah.

14 A -- the question.

15 Q Was, was a -- was the purpose of this
16 analysis and this PowerPoint to figure out how more
17 licenses could be sold from the accolade --

18 A Oh.

19 Q -- licensing program?

20 A No. I think, I think it has to do with
21 understanding the -- any type of relationship there,
22 there is between the licensing program and
23 characteristics of -- that we have on, on hospitals
24 that are -- the characteristics that we have on
25 hospitals.

1 Q Well, that's what the note says --

2 A Yeah.

3 Q -- but what's the purpose of the analysis?

4 A To see -- because this, this is a
5 presentation to, to TelAffects, this -- to identify
6 specific opportunities for, for the licensing program.

7 Q Okay.

8 A Yeah.

9 Q To sell more licenses, correct, bottom line?

10 A Yes.

11 Q All right. So on the next slide, Bates
12 ending 570, we have a graphic here that shows that
13 Hospital Safety Grade revenue had declined from fiscal
14 year 2022 to fiscal year 2023.

15 Do you see that?

16 A Yes. I mean kind of looks like it
17 plateaued.

18 Q Plateaued. Do you know why that was?

19 A No.

20 Q Okay. Flip a few more pages to Bates ending
21 573.

22 These are -- the title of the slide is --
23 are you there?

24 A Yes.

25 Q "Estimating the likelihood of licensing

1 modeled using fall 2023 licensing data."

2 And it says here that "survey" -- the first
3 kind of graphic there says, "Survey participants are
4 ten times more likely to license."

5 Do you see that?

6 A Yes.

7 Q All right, and is this consistent with your
8 kind of understanding of the correlation between
9 survey participation and licensing decisions? Is that
10 right?

11 A Yes.

12 Q All right. So is it correct that, based on
13 this correlation, LeapFrog has a financial incentive
14 to, to make sure that its grading methodology favors
15 participants in the hospital survey?

16 A No. I don't, I don't know if that's true.

17 Q Okay. How would you, how would you describe
18 the, the kind of the relationship, then, between the
19 grading methodology and participation in the hospital
20 survey?

21 A Well, so -- can you repeat the question. I
22 just --

23 Q Sure.

24 A -- want to make sure I'm answering --

25 Q I'm just asking -- so it doesn't -- given

1 this correlation, right, a positive correlation
2 between hospitals that participate in the survey,
3 right, and the likelihood that they license, right,
4 it's a, it's a -- they're ten times more likely to
5 license, doesn't -- just looking at this statistic,
6 doesn't LeapFrog have an incentive financially, right,
7 just economically, to have its grading methodology
8 favor participants -- hospitals that actually
9 participate in the survey?

10 MS. WOOD: Objection to form.

11 THE WITNESS: No, I don't, I don't think so.

12 BY MR. CHUNG:

13 Q Why not?

14 A Yeah, because I think it's -- the survey --
15 I think LeapFrog wants more participation in the
16 LeapFrog Hospital Survey --

17 Q Right.

18 A -- and have more engaged hospitals, more
19 engaged hospitals in LeapFrog.

20 What we found is hospitals that are more
21 engaged in, in doing the LeapFrog Hospital Survey --
22 this is not a surprising stat that they're ten times
23 more likely to license, because more engaged hospitals
24 are more interested in, if they have the Hospital
25 Safety Grade that's an A, to stand behind the LeapFrog

1 logo and marks and, and advertise it, because that's
2 what, that's what licensing is. It's using, using
3 that logo.

4 So if a hospital does not take the survey,
5 they wouldn't have any interest in standing behind
6 LeapFrog in the, in the marks if they got it -- if
7 they also got an A grade.

8 Q I understand that relationship, but by
9 virtue of this positive correlation, right, the more
10 participants, survey participants you have, right, the
11 more hospitals you have that are ten times more likely
12 to license their safety grade, correct?

13 A The more participants we have -- I just
14 don't know if I can say definitively that that -- if
15 that would, if that would be true. Right now, with
16 the people that are currently participating, they are
17 ten times more likely --

18 Q Right.

19 A -- to, to license, but for those that are
20 not participating, if they were participating, I don't
21 know if that would be impacted, if it would go down.
22 I don't know how -- what the impact would be on that,
23 on that, on that number.

24 Q Okay. Now, is it -- based on this -- well,
25 let's look at the second graphic.

1 "Renewals are ten times more likely to
2 license."

3 What does, what does that mean?

4 A Yeah, so that means hospitals that chose to
5 license their Hospital Safety Grade in one cycle, a
6 year has gone by, it's -- their license expires, they
7 learn they got an A again --

8 Q Right.

9 A -- and they want to continue to get access
10 to the latest logo and feature it. They are ten times
11 more likely -- those are renewals. Those would be ten
12 times more likely to license.

13 Q Okay. So -- understood. So by virtue of
14 this statistic, right, doesn't LeapFrog have at least
15 a financial incentive to give hospitals that licensed
16 before and had an A grade, to give the -- to continue
17 to give those hospitals A grades? Doesn't it at least
18 have a financial incentive to do so?

19 A Well, we know -- we separate the licensing
20 from, from the people that are doing the ratings at,
21 at LeapFrog, and so we try to make sure that there is
22 no incentive in, in doing the licensing, and that
23 there is no, there is no consideration of who is
24 licensing that's going into anything to do with the,
25 the methodology, which is why I have such limited

1 knowledge of -- I have knowledge of the accolades
2 licensing program, but I have like virtually no, no
3 insight or -- into like what actually goes into, to
4 making the, the methodology.

5 Q But isn't -- you report to Ms. Danforth,
6 right? You've testified to that a number of times,
7 right?

8 A Yes.

9 Q And -- but she also oversees -- one of her
10 principal responsibilities is overseeing the ratings
11 team, correct?

12 A Yes.

13 Q All right. So that whole team that's in
14 charge of the ratings and reviewing responses to the
15 hospital surveys and, and issuing the grades is --
16 reports to her, correct?

17 A Yes.

18 Q Right. So you got the same person
19 overseeing both of these functions, correct?

20 A Yes, relatively. In 2023, I started
21 reporting to, to Missy during a transition. I was
22 reporting to somebody else, but then --

23 Q So she is -- so Ms. Danforth -- at least
24 Ms. Danforth, then, is privy to discussion and
25 strategy around licensing program on the one hand; is

1 that correct?

2 A She, she is, yeah.

3 Q And that -- but she's also privy to what her
4 ratings team is doing in terms of scoring and grading
5 hospitals, correct?

6 A Yes.

7 Q Okay, and this is -- and in the discussion
8 we saw earlier where she was asking about the, the
9 connection, right, between accolades licensing and
10 participation in the survey and the financial risk,
11 right, of making changes in the imputation
12 methodology, she was directing you and Ms. Campione to
13 basically collect that information, correct?

14 A Yes.

15 Q Yeah, and Ms. Campione is -- she's kind of
16 on the, on the ratings team side of the house,
17 correct?

18 A Yes.

19 Q Right, and you're on the licensing side of
20 the house, correct?

21 A Yes.

22 Q Right, but she's asking you together to come
23 up with this, this information related to the
24 connection between licensing revenue and, and the
25 hospital survey responses, correct?

1 A Yes.

2 Q Okay. So let's look at the next graphic.
3 "Hospitals that have licensed in the past two years
4 are five times more likely to license."

5 What does this mean?

6 A So I think this is saying the hospitals that
7 have licensed -- that had a history of purchasing the
8 rights to use the logo have a higher likelihood than,
9 than the average, I guess, licensee to purchase the,
10 the logo and license again.

11 Q So, but this is basically the same measure
12 as the second graphic but kind of over a longer
13 timeframe; is that right?

14 A Than the previous graphic?

15 Q Right.

16 A I think the renewal is a back-to-back year,
17 whereas this is -- yeah, this is -- yeah, exactly,
18 longer timeframe, looking back two years.

19 Q Okay. So looking at this graphic and the
20 previous graphic, is it fair to say that LeapFrog has
21 at least a financial incentive to, to give hospitals
22 that license in the past two years, that they continue
23 to receive an A grade so that they can continue to
24 renew their license; is that right?

25 A I, I mean we -- that is not how we are

1 incentivized, and we make a lot of efforts to, to keep
2 it separate, and --

3 Q You have the same, you have the same
4 director, or I think it's vice president, right,
5 overseeing both functions, correct? And we have -- we
6 saw multiple emails where you, as director of
7 licensing, and Ms. Campione on the, on the ratings
8 team, are collecting the very information that feeds
9 into this presentation; isn't that right?

10 A Yeah, but the -- for the accolades program,
11 Missy has like high-level oversight of the program, so
12 that's why she, she asks, she asks for things. She
13 doesn't have direct access to the, the -- in, in the
14 day-to-day of like who is licensing and, and, and all
15 those, all those things, but she, she does get reports
16 on, on information like, like this.

17 Q Do you have any visibility into -- do you --
18 you work regularly with Ms. Campione; is that right?

19 A Right. No, I don't -- I mean I work with
20 her on like an as-needed basis, but we don't have like
21 a -- I don't interact with her even like weekly.
22 Sometimes, depending on the time of year, sometimes
23 we, we interact more or less.

24 Q Okay, and do you have, do you have
25 visibility into Ms. Danforth's kind of interaction

1 with her ratings team?

2 A Yes. I, I attend ratings team meetings --

3 Q And what's the purpose --

4 A -- and --

5 Q And what's the purpose of your attending
6 those ratings team meetings?

7 A Yeah, just to get a sense of what is, what's
8 the, the, the latest -- so I have -- there, there
9 is -- sorry. Let me think about the different ways.

10 So I report to Missy. We -- one of the ways
11 in which we -- I interact with the ratings team is
12 that we have a lot of data analysts that are on the
13 ratings team, and so one of the things we have done,
14 especially recently, is we want to make different
15 visualizations for their data available to data
16 licensees.

17 And so a lot of those analysts are on the,
18 on the ratings team, and the more interface that I can
19 get with them and get feedback about like -- about our
20 data licensees and how they are using our data, it
21 kind of becomes a more collaborative environment where
22 we can help -- we can work together to improve our
23 offerings to, to data, data licensees.

24 It's mostly on the data licensing side that
25 I'm interacting with a lot of the, the ratings team

1 members, but I do -- for accolades, Alex does -- has
2 helped with -- she's like very good at Excel and doing
3 data crunching, and it's kind of helped create
4 different reports and understandings like this about,
5 about data licensing and who is using, who is using
6 the -- licensing the, the LeapFrog marks for, for
7 promotion.

8 Q Okay. Even though she's on the ratings
9 team?

10 A Yes.

11 Q All right. Well, let's look at the next
12 page, so Bates ending 3575.

13 It says here that only three non-survey
14 participants licensed their safety grades in fall
15 2023; is that right?

16 A Yes.

17 Q All right, and that's compared to 133
18 participants who did participate in the survey,
19 correct?

20 A Yes.

21 Q All right, and then if we flip a few more
22 pages, Bates ending in 579, there is a graphic, it
23 says, "Hospitals projected to be eligible for spring
24 2024 accolades."

25 Do you see that?

1 A Mm-hmm.

2 Q All right. That graphic charts hospitals
3 from "more likely to license" to "less likely to
4 license."

5 Do you see that, going up and down?

6 A Yes.

7 Q All right. At the very top of the "More
8 Likely to License" end are -- "Renewals" has a "100"
9 next to it.

10 A All right. Yes.

11 Q And 100; what does that denote, that number?

12 A I think it's the number of hospitals.

13 Q That actually renewed?

14 A I think it's that are eligible to be for --
15 so they're not --

16 Q You're right.

17 A -- they, they have not renewed. I think
18 it's eligible --

19 Q Okay.

20 A -- for, for potentially licensing, and
21 they'll have the opportunity to license again.

22 Q And at the very bottom of the "Less Likely
23 to License" end are hospitals that did not complete
24 the 2023 survey, correct?

25 A Right.

1 Q All right, and that's 115 hospitals,
2 eligible hospitals, correct?

3 A Right.

4 Q All right. So if we look at the, the very
5 last page of the slides, so Bates ending 3581, you can
6 turn to it.

7 The bottom line recommendation here of, of
8 the deck that Alexandra put here -- put together is
9 "to target groups" -- to "update campaigns to target
10 groups with a high probability of licensing."

11 And the campaigns; are they the, the, the
12 accolades licensing and the survey licensing
13 campaigns?

14 A No. So within accolades licensing, there's
15 different -- so there's the eligible pool, so it's all
16 the A hospitals that do not currently have a license,
17 and so then those can be segmented into different
18 campaigns. So there's like a renewal campaign.

19 There's a system, system campaign, because
20 there's some health systems that have multiple
21 hospitals that make purchasing decisions together. So
22 we kind of segment those out.

23 I think there's probably some other ones
24 that I'm not, not listing, but those were -- yeah, we,
25 we try to segment them into different campaigns,

1 and -- because for some of them, like renewals, we
2 have specific percentages that we've seen, you know,
3 that renewals are in the 70 to 80 percent, but that's,
4 that's pretty normal. So we wanted to see if we were
5 tracking under that or, or doing, or doing more.

6 MR. CHUNG: Okay. Let's go to tab 32. This
7 will be Exhibit 11.

8 (Exhibit 11 was marked for
9 identification.)

10 BY MR. CHUNG:

11 Q So, Mr. Banerjee, Exhibit 11 is a, an email
12 chain that starts -- if you go to the back, the first
13 is from March 27 of 2025, and then going all the way
14 to most recently, May 5, so covering about, about a
15 month and a couple weeks.

16 Do you see that?

17 A Okay.

18 Q All right, and it's you -- is it a fair
19 summary of this email chain, you're providing
20 Ms. Binder daily or close to near daily updates on
21 sales revenues from the licensing programs?

22 A Yes.

23 Q Okay. Why are you giving Ms. Binder daily
24 or near daily updates on the, on the revenues from the
25 programs?

1 A Because accolades is, is a significant
2 contributor to LeapFrog's revenue, and our fiscal year
3 ends June 30, and so I keep her apprised on the, kind
4 of the daily activities during this, this time, which
5 is, I think -- I think it's the spring safety grade
6 release, about the, the latest daily sales, where we,
7 where we are.

8 And for her, I anticipate it has, you know,
9 a meaning in the overall financial picture and where
10 we can potentially be at the, at the year end, fiscal
11 year end.

12 Q Had she asked you to provide this -- the
13 frequency of updates here?

14 A Yes.

15 Q All right, and then on -- and how did --
16 when did she ask you for these frequent updates? This
17 is from this year.

18 A Yeah, I, I provide them for, for a lot of
19 cycles. I, I give daily, daily updates during a one-,
20 one- to two-month period, because there are -- like
21 from pretty much the day we start the early
22 notification period for the hospitals, going up to
23 like when the, when the public release is, just so she
24 has a sense of, of where we are and can factor that
25 into, you know, other discussions that she has about,

1 about the finance of the organization.

2 Q Okay. So this is spring, like, like you
3 said, about spring 2025.

4 Did Ms. Binder, when she gave you the
5 instruction, right, to provide these nearly, near
6 updates, did she explain why she wanted to see this --
7 the frequency of updates?

8 A I don't believe so, but I was, I was
9 inferring from the, just the nature of the importance
10 of the accolades program to the, to the finances of --
11 and just the timing of it with, you know, specific
12 board meetings and committee meetings that she has.

13 Q Okay, and so let's take a look at the second
14 page of the chain, Bates ending 5933, second page.

15 A Oh.

16 Q The email in the middle there from May 1,
17 2025 where you tell Ms. Binder, "Excited to share we
18 are at an all-time record for revenue for the spring
19 cycle and did so all before the public release," and
20 you set out a number of statistics, statistics there.

21 Do you see that?

22 A Yes.

23 Q All right. Okay, and then on 932, so the
24 first page of the document, you share -- it's four
25 days later -- that "accolades just crossed \$4 million

1 for FY25."

2 Do you see that?

3 A Oh, sorry. 5932?

4 Q The very first page.

5 A Oh, the very first page. Okay. Yes.

6 Q Okay. So she responds, "Wow! This is
7 fantastic!! Thank you."

8 Did she share with you any kind of other
9 response to this, kind of this record that, that
10 accolade licensing had broken just a couple days
11 earlier?

12 A No, not that I, not that I recall.

13 Q Okay. Fair to say that the accolade
14 licensing at this time had become even a greater
15 percentage of, of the organization's overall revenue,
16 is that right, given that you had broken a previous
17 record?

18 A I, I would think so.

19 Q Okay.

20 A But I don't know. Yeah, I don't know the
21 exact numbers.

22 MR. CHUNG: Let's go to 34, tab 34. This
23 will be Exhibit 12.

24 (Exhibit 12 was marked for
25 identification.)

1 BY MR. CHUNG:

2 Q So tab 34, Ms. Binder is forwarding a -- her
3 CEO report to the board from June 2025, and I want to
4 direct your attention to the first page of the report
5 itself, Bates ending 0828.

6 Do you see that?

7 A Yes.

8 Q All right, and close to the top there, she
9 writes, "LeapFrog rides the economic rollercoaster of
10 tariff policies and federal cost-cutting alongside the
11 rest of the world. We've already seen incremental
12 reductions in some of our revenues, including
13 licensure, partnership dues, and report sales."

14 Does that -- is that kind of consistent with
15 your recollection?

16 A Yes.

17 Q Okay. In contrast, if you look at the
18 second paragraph, she writes, "Surprisingly, we are
19 witnessing significant growth in one revenue area,"
20 and that's "accolade sales, the fees hospitals pay us
21 for the right to advertise a LeapFrog award like an A
22 Hospital Safety Grade," and this is -- dovetails from
23 your email earlier, that the total will be -- exceed
24 \$4 million, an all-time record for fiscal year 2025.

25 So with -- it sounds like other licensing

1 sales declined at the same time accolade licensing
2 revenue was increasing, correct?

3 A Yes.

4 Q Okay, and did Ms. Binder tell you or
5 underscore for you that in these circumstances, that
6 in this kind of climate, that there needs to be more
7 focus on accolade licensing?

8 A No. No, she, she didn't.

9 Q Okay. How about from Ms. Danforth; did she
10 place an emphasis during this time on accolade
11 licensing, given how well it was doing at this time?

12 A No.

13 Q Okay. What were the discussions kind of
14 among the organization around these, kind of the
15 trends in the, you know, revenue?

16 A I think at least in my role, LeapFrog in --
17 with the licensing programs -- in my role at LeapFrog
18 with the licensing programs, the, the focus has always
19 been primarily in -- on the data licensing program
20 more so than the, the accolade licensing program, but
21 that said, we, we did make -- and it had been a long
22 time before we made significant investments in the
23 accolade licensing program, but in the fall, or last
24 year, we did do a number of things.

25 This is like a website revamp for the

1 licensing program. We made some new logos and
2 template ads, and so I do think that kind of helped to
3 kind of revamp and establish the -- that, that program
4 and brand, and I think that we saw some, some benefit
5 in terms of revenue and better, I think, renewal
6 rates, and, and a positive impact of, of some of those
7 investments that we made into the program.

8 But the -- I think the focus has always
9 been, in my role -- and I spend more time, I think, on
10 data licensing than the -- than, than accolades, but
11 has always been on trying to improve the, the traction
12 of, of retention and engagement with our current data
13 licensees, but, but also to try to help expand
14 different -- and reach new use cases and, and
15 partnerships that we can use to, you know, further
16 enhance the, the use of, of the LeapFrog data.

17 Q So speaking of what I think what you're
18 referring to of new use cases, if you turn to Bates
19 ending 0830, there's a "Data Visualization Platform"
20 section.

21 Do you see that?

22 A Yes.

23 Q What is that?

24 A So that is a, a website that we established
25 where data licensees can go in to download the latest

1 available data that's available for the, for the
2 programs that they, that they purchase and, and
3 license the rights to use. If they have the rights to
4 use the logos, they can download and use those with
5 the terms of use of their agreement, but then we also
6 give them access to a data visualization tool.

7 It's a license to Amazon QuickSight, where
8 they can go in, and it allows them to create different
9 charts and filters on the data for the program that
10 they subscribe to and they license for -- if they are
11 a survey licensee, they can see the survey data
12 segmented by hospitals, specific measures, customized
13 like cohort for the type of hospitals -- for the
14 hospitals that they want to look at, and then export a
15 report that they can share with their internal teams,
16 or -- depending on what their rights are to use the
17 data, they can use it in that way.

18 MR. CHUNG: Let's -- I think this is a
19 segue, a good segue from accolade licensing to
20 the data licensing program.

21 Let's go to, let's go to tab 25. This will
22 be Exhibit 13.

23 (Exhibit 13 was marked for
24 identification.)
25

1 BY MR. CHUNG:

2 Q All right. So this -- Exhibit 13 from
3 January 2023, "Overview of Business Revenue Programs"
4 presentation.

5 Do you recognize this document?

6 A Yes, yes.

7 Q Did you participate in putting together this
8 document at all?

9 A Oh, January '23? I think, I think this was
10 initially made by one of my previous -- one of the
11 previous people that I reported to, and then I think I
12 refreshed this with some more updated data.

13 Q Okay.

14 A I'm not -- I can't remember if I'm -- I
15 looked at it and contributed to it. I don't remember
16 if I was like the primary.

17 Q Okay. Let's look at the slide 4, Bates
18 ending 5898, and you'll see that there are a number of
19 use cases, right?

20 You went -- you flipped too far.

21 A Oh.

22 Q 5898.

23 A I keep looking at the wrong number. Sorry.
24 Okay, got it.

25 Q The one up top.

1 The -- under the use cases, the "Value-
2 Purchasing Incentives/Quality Improvement" use case,
3 looks like it's responsible for 32 percent of the
4 annual revenue, at least for fiscal year '22.

5 What is that? What is the value-purchasing
6 incentives use case?

7 A So value -- so it's value-based purchasing.
8 LeapFrog has a value-based purchasing program that is
9 a series of reports that we provide to health plans
10 based on performance on the LeapFrog Hospital Survey,
11 and makes zero to 100 composite scores that allows the
12 health plan or purchaser to be able to rank facilities
13 based on metrics from the, the LeapFrog Hospital
14 Survey.

15 There were two health plans that purchased
16 those, those reports, and we provide them. So those
17 are the first two that are listed, Horizon and, and
18 Capital.

19 Q Okay.

20 A Where -- what I think this table is showing
21 is categorizing by licensees the different types of
22 use cases just generally. So those two are listed
23 under value-purchasing incentives.

24 The other two that are listed there are not
25 purchasing that program, the value-based purchasing

1 program. They are purchasing the, the LeapFrog
2 Hospital Survey datasets, and they're using it --
3 they're not purchasing the official value-based
4 purchasing program, but they're kind of making their
5 own program that's doing some type of quality
6 improvement and contracting.

7 So this table is kind of categorizing them
8 together.

9 Q Okay. So is this value-purchasing incentive
10 in the value-based program access to kind of the
11 totality of, of the data that all the hospitals have
12 submitted in response to the survey?

13 A They get, they get -- for, for two of them
14 that are listed here, for -- if someone purchases the
15 survey data, they get what amounts to a, essentially
16 like if you did an offload of our website, like a
17 download from ratings@leapfroggroup.org, there's
18 nowhere on our website where you can download all
19 the --

20 THE REPORTER: Slow down. There's
21 nowhere --

22 THE WITNESS: Sorry.

23 THE REPORTER: That you can --

24 THE WITNESS: There's nowhere on our website
25 where you can download everything that's on

1 ratings@leapfroggroup.org.

2 BY MR. CHUNG:

3 Q All right.

4 A What the licensees get is essentially,
5 essentially an Excel file that has all the hospitals
6 that are on our website. The net -- the like
7 demographic information, the scores, like official
8 scores for each measure, the reporting period, and
9 that is what they get, and what they do with that is
10 kind of based on their data use agreement.

11 And what we've -- I listed in this table is
12 how we generally understand these licensees to be
13 using, using the data, just for our, our general
14 understanding of who our licensees are and like
15 where -- how they're using it and what percentage
16 that, that accounts for.

17 Q Okay. So based on that description, right,
18 is the value -- the more data that's available, right,
19 through this value-purchasing incentive program, the
20 more valuable that program is to, to hospitals; is
21 that fair to say?

22 A So it is -- the more data that's available,
23 they want, they want to see is, is -- they want to see
24 all the hospitals reporting. So if there are
25 hospitals that, that are not reporting, they want to

1 see that, and, and so yes, it would be -- it would be
2 more --

3 Q So --

4 A -- more valuable to them, but it would not
5 change -- the, the word "valuable," like it's not,
6 it's not necessarily more valuable to LeapFrog,
7 because it wouldn't change our cost based on the, if
8 they're -- if individual hospitals are reporting or
9 not.

10 Q Well, wouldn't it make it more valuable to
11 LeapFrog, because then there are -- there might be
12 more hospitals out there that, that would license
13 through this program, given that more data makes it
14 more attractive?

15 A Why would, why would -- more hospitals would
16 license?

17 Q Yeah, more -- I mean you testified that the
18 more data that's available through this program --

19 A The hospitals wouldn't license.

20 Q The -- not the hospitals, but like solution
21 providers and other -- so who are, who are the
22 customers of this program that you're referring to?
23 These are the health plans?

24 A Yeah, these are -- yeah, some of these are,
25 are health plans that are listed.

1 Q All right. So let me just go back to -- so
2 the more data, right, that's available through this
3 value-based program, the more attractive the program
4 is to customers like Horizon and Capital, correct?

5 A Yes.

6 Q Yeah?

7 A Yeah, right, yeah.

8 Q So, and the more, the more data that this
9 value-based program encompasses, the -- I guess the
10 more chances, right, the more attractive it is to, to
11 potential additional licensees of this program,
12 correct?

13 A Well, I mean so Horizon and Capital all
14 have -- they both have like 100 percent participation
15 in their --

16 Q Right.

17 A -- in their markets, so --

18 Q But are there other -- I mean are there
19 other health plans, right, or insurance companies or
20 benefits providers, right, that potentially would be
21 interested in licensing or accessing this value-based
22 program?

23 A Yes.

24 Q Okay. What is a "value-added reseller"
25 licensee? Looks like they account for about

1 41 percent of the revenue. What are they?

2 A Yeah, so we, we license our data to
3 different organizations that have -- sometimes they
4 have applications and products that they want to
5 incorporate the LeapFrog data into, and then resell
6 that data and the ratings in an application, and
7 distribute it to other health plans or other specific
8 employer clients that they work with, or on a, like on
9 an actual application or website to reach members or
10 users.

11 So that's kind of what value-added resellers
12 are. It kind of encompasses a variety of different
13 types of organizations that -- they have the rights to
14 incorporate LeapFrog data and, and products for, for
15 resale.

16 Q Is the data in these programs more valuable
17 to these resellers if more hospitals participate and
18 submit data to the survey?

19 A Most of them, most of them are licensing the
20 Hospital Safety Grade.

21 Q They're only licensing the safety grade; is
22 that your testimony?

23 A Yeah, most of, most, most of our licensees
24 are, are using the Hospital Safety Grade. There
25 are -- I mean there are a few that use the, the

1 LeapFrog Hospital Survey dataset, but there is
2 definitely a skew towards the Hospital Safety Grade,
3 because it is a more publicly recognizable brand.

4 Q Including the value-added resellers, are you
5 saying that these -- testifying these value-added
6 resellers are, for the most part, licensing the
7 Hospital Safety Grade?

8 A Yes, a lot, a lot of them are. A lot of
9 them are, are doing the safety grade. Probably most
10 of them.

11 MR. CHUNG: Okay. Let's go to tab 26, which
12 will be Exhibit 14, I think.

13 (Exhibit 14 was marked for
14 identification.)

15 BY MR. CHUNG:

16 Q Mr. Banerjee, are you -- do you work with
17 regional -- LeapFrog's regional leaders at all?

18 A No, not, not a, not a lot. Just
19 occasionally.

20 Q Okay. So this presentation here that's
21 attached is from July 2023. It goes over how
22 employers and particular members of these regional
23 leader groups use LeapFrog data.

24 So how, how do they use LeapFrog data?

25 A The regional leaders?

1 Q Yes.

2 A So LeapFrog was founded by, you know, very
3 large employers. We continue to work with employers
4 through these regional business coalitions on health
5 that have employers in their areas and markets, and
6 they're keenly interested in the quality and safety of
7 the, of the hospitals in their area, and they, they
8 encourage participation in the LeapFrog Hospital
9 Survey and educate health plans in --

10 Q So my question is -- so let's go back to the
11 question. How do they, how do they use --

12 A Right.

13 Q -- LeapFrog data?

14 A So as a part of that, we give them access to
15 the datasets.

16 Q For free?

17 A For free.

18 Q Okay. So there's no regional leaders that
19 license data from LeapFrog?

20 A Yeah, they have a, they have a no-fee data
21 use agreement with LeapFrog to, to enable access to
22 the, the data.

23 Q Okay, and that covers both the, the data
24 licensure as well as the accolades licensing?

25 A No. The accolades licensing is just the

1 logos. So we, we give them the, the Excel datasets
2 for, for the survey and the, the safety grade.

3 MR. CHUNG: Okay. Let's go to tab 50, which
4 will be Exhibit 15.

5 (Exhibit 15 was marked for
6 identification.)

7 BY MR. CHUNG:

8 Q Okay. So Exhibit 15 is -- it's an email
9 chain from June and August of 2023 between you,
10 Ms. Danforth, and a potential purchaser of the VBP
11 program, and I think the hospital and an accolade.

12 Do you see that?

13 A Sorry. Is this on the front page?

14 Q If you can just go through --

15 A Oh, okay.

16 Q -- go through it.

17 A Oh, okay.

18 (Witness peruses document.)

19 BY MR. CHUNG:

20 Q Mr. Banerjee, are you at least kind of
21 generally familiar with what's being discussed here?

22 A Yeah, I think so.

23 Q Okay. I want to direct your attention to --
24 it's Bates ending 1 -- 5815. 5815.

25 Do you see that?

1 A Yes.

2 Q Okay. So Barbara Havens; there's a Barbara
3 Havens from Med Mutual.

4 Is that a health system in Ohio?

5 A That's -- it's a health plan.

6 Q A health plan in Ohio, and what is she
7 discussing in this email?

8 A So Barb Havens is -- she's a VP of network
9 management for Medical Mutual. She reached out to us
10 because she was interested in developing a, a strategy
11 for contracting with hospitals in, in her market, but
12 there was some -- and they -- and she was interested
13 in using LeapFrog data and, and metrics. So she had
14 some feedback from a facility, a health system in Ohio
15 that had concerns about, about doing that, so --

16 Q And I think you're referring to that these
17 certain hospitals, right, institutions were concerned
18 that "it would require additional resources and
19 staffing on their end to respond," it sounds like, to
20 the Hospital Survey; is that right?

21 A Yes.

22 Q Okay, "and were concerned about the full
23 scope of information being requested."

24 So safe to say that there was concern about
25 whether some of these hospitals were willing or able

1 to respond to the hospital survey, just given kind of
2 the resource constraints; is that right?

3 A It sounds like it.

4 Q Yeah, and then she says, "This was a
5 facility we were having discussions around including
6 LeapFrog as a quality incentive as part of their 2025
7 rates. If other facilities are feeling the same way
8 and move away from submitting their quality data, it
9 will be difficult to implement an incentive around
10 LeapFrog."

11 Is this a common -- a concern that you've
12 heard -- putting aside Ms. Havens and Med Mutual, is
13 this a concern that you've heard from other health
14 plans or consumers, that because of the, I guess the
15 possibility that hospitals won't respond to the
16 survey, given resource constraints, that there will be
17 less data, and hence, the, the data will be less
18 valuable?

19 A I can't think of a -- I can't think of
20 another --

21 Q Okay.

22 A -- instance.

23 Q Let me put it another way.

24 Why would hospital non-participation make it
25 difficult to, in her words, "implement an incentive

1 around LeapFrog"?

2 MS. WOOD: Objection to form.

3 THE WITNESS: Actually, I don't, I don't
4 quite understand the, I think the rationale in,
5 in that. It's -- I, I can kind of speculate, but
6 I don't --

7 BY MR. CHUNG:

8 Q Sure.

9 A Yeah.

10 Q Can you just tell us what, what you
11 understand?

12 A Yeah, what -- yeah, what I understand is
13 like they -- she was -- when you're in conversations
14 with her, it sounded like she wanted something that
15 she could run with, like immediately, for like a
16 contracting strategy, and if they did get, you know,
17 the survey data -- and, and actually, it's a -- she
18 was -- we specifically showed her the value-based
19 purchasing program, which is a derivative of, of the
20 survey, that not having that information at the start
21 would be difficult for them to implement a strategy,
22 especially for those hospitals that don't, that don't
23 report.

24 So they could, you know, create an
25 incentive, but then the hospitals, they would start

1 their relationship not being happy, not getting that
2 incentive program.

3 So yeah, that -- I guess that's my general
4 understanding.

5 Q And this is all sourced from hospitals
6 either declining or at least hesitating at submitting
7 their data, because it's a resource-intensive
8 exercise, right?

9 A This -- I mean this was one hospital, it
10 sounded like. I don't know if there were others that
11 had the same, but that -- she, she was concerned with
12 that, that one.

13 Q Okay.

14 A And it -- yeah.

15 Q And then if we look at -- if you direct your
16 attention to Bates ending 5811. 5811.

17 A Okay.

18 Q Okay. There's a paragraph toward the bottom
19 there, "Administrative Burden and Internal Costs," and
20 Ms. Havens writes, "Addressing the breadth of
21 measures/reporting expectations from LeapFrog, for the
22 hospital survey and safety grade, is very
23 resource-intensive."

24 Is that a fair -- do you think that's fair
25 feedback with respect to the hospital survey?

1 A Let me take a look at the email again.

2 Q Okay.

3 A Okay. Sorry. So I guess can you repeat the
4 question.

5 Q Yep. I mean is this, is this a fair
6 criticism of the hospital survey?

7 A That it's resource-intensive?

8 Q Yep.

9 A So from my understanding of -- and I haven't
10 gotten a lot of feedback directly, but I just heard
11 anecdotally about the, the hospital survey. I know it
12 is not for, especially the first time a hospital is
13 responding to the survey, it can take more time,
14 because it takes, you know, understanding the measures
15 and asking the right people for, for -- and trying to
16 understand like how to, how to collect the
17 information.

18 My understanding is that in subsequent
19 times, collecting it becomes a lot easier, and it's
20 not as burdensome, and that, you know, the LeapFrog
21 Hospital Survey, we -- the measures are -- largely, a
22 lot of the measures the hospitals are already
23 collecting, and they're -- they harmonize with other
24 reporting agencies.

25 There are, as I mentioned, EHR vendors that

1 have like specific LeapFrog reports that, that have
2 been designed. So I think the more little due
3 diligence that they do, the easier it is and the less
4 burdensome it is.

5 Q Have you ever --

6 A Do I, do I think it's intensive? I, I think
7 it's a, like a necessary thing, and I think it shows
8 accountability, and accountability is difficult, but
9 we're talking about patients and people's lives, and
10 so I, I think it makes an impact, and so I, I do think
11 that it is worth the effort.

12 MR. CHUNG: Okay. Let's turn to tab 13.

13 This will be Exhibit 16.

14 (Exhibit 16 was marked for
15 identification.)

16 BY MR. CHUNG:

17 Q All right. Now, this -- it appears to be
18 kind of a follow-on to that chain, Mr. Banerjee.

19 Do you see that?

20 A Yes.

21 Q All right, and on the Bates ending 129, so
22 on the second page of the document, Ms. Havens replies
23 to you, "We really want to move forward with the
24 LeapFrog VBC [sic] program," one of the programs that
25 you testified to earlier, "but really think we'll have

1 challenges from our providers in submission of the
2 data necessary to get their results."

3 Do you see that?

4 A Yes.

5 Q Okay. Did you take her to mean the "VBP"
6 program here?

7 A Yes.

8 Q Not "VBC"; is that right?

9 A Correct, correct.

10 Q And, and this necessary data that she's
11 referring to here is data from the hospital survey?

12 A Yes.

13 Q All right. So to really sell -- just based
14 on this particular instance, to, to be able to sell
15 the VBP program, it's -- would you say it's important
16 to have as many hospitals as possible complete the
17 hospital survey?

18 A I, I think it -- for this specific person,
19 they -- Barb, she -- it was important for her to have
20 more participation in the outset of implementing this
21 program, so, so yes, I do think it, it impacted the --
22 their willingness to start with the, with the VBP
23 program.

24 Q So Ms. Havens then writes that she would
25 "like to understand how complete the Safety Grade

1 Survey is, based on that secondary data."

2 Do you see that?

3 A Yes.

4 Q Okay, because the preceding, it says, "It
5 also says that if they don't submit, [LeapFrog] will
6 use secondary data when available."

7 What did you take her to mean in terms of
8 the secondary data? What does that mean?

9 A So she, she wanted to have an expanded --
10 she wanted to have -- she wanted an understanding, if
11 they license the Safety Grade data, that we would be
12 able to provide ratings that they could implement
13 their, their program on for, for the -- their network
14 facilities, and so there were more hospitals that,
15 that had ratings for the Hospital Safety Grade, and
16 they could use that as their -- as one of the factors
17 in their contracting process.

18 Q But what is she referring to when she says
19 she "would like to understand how complete the Safety
20 Grade Survey is, based on that secondary data"? What
21 was her concern there?

22 A I think she wanted to, to understand how
23 many hospitals we would have a, have a grade for after
24 using the, the, the secondary -- the -- after using
25 the secondary data.

1 So they had a bunch of hospitals in their
2 network that did not receive a -- they didn't receive
3 a safety grade, were ineligible for, for a safety
4 grade, but there were some that were perhaps eligible
5 for, for a survey.

6 And so I think in this exercise that she was
7 doing, she was looking at her list of eligible -- of,
8 of facilities and seeing how many applied to the
9 safety grade, and then how many applied to the survey,
10 and, and, and tried to see, would, would the safety
11 grade be an appropriate thing to use for their, their
12 hospitals. I mean they have like other specialty
13 hospitals that we don't give safety grades for, but
14 that they may be eligible to take the survey.

15 So I think she was trying to see where that,
16 where that delta was, and if there was an appropriate
17 use case for her in, in what she was trying to
18 accomplish.

19 MR. CHUNG: Okay. Why don't we, why don't
20 we take a break at this point. I think we've
21 gone a while.

22 THE WITNESS: Okay.

23 MR. CHUNG: All right?

24 THE WITNESS: Thank you.

25 THE VIDEOGRAPHER: This marks the end of

1 media unit number 4. Going off the record, the
2 time is 15:46 p.m.

3 (Whereupon, a short recess was taken.)

4 THE VIDEOGRAPHER: This marks the beginning
5 of media unit number 5. Going back on the
6 record, the time is 15:58 p.m.

7 (Exhibit 17 was marked for
8 identification.)

9 BY MR. CHUNG:

10 Q The next document, Exhibit 17, you'll see
11 that it's an email from a Paul Alper to a Todd
12 Fessler, copying you.

13 Who is Paul Alper?

14 A He's a consultant that LeapFrog has that
15 works on finding new partners advisory committee
16 members.

17 Q Okay. So not a LeapFrog employee, but an
18 outside consultant; is that right?

19 A Yes.

20 Q Okay. Do you work with him?

21 A No, not, not really.

22 Q Okay. So why -- now, there's a PowerPoint
23 attached to this entitled "LeapFrog's Data Available
24 for Licensing" from March of 2024.

25 Why is he sending -- first of all, who is

1 Todd Fessler at Milliman.com?

2 A So, so I don't know who Todd Fessler is
3 specifically, but he is probably someone that Paul
4 talked to about partners advisory committee, and
5 sometimes people that are approaching LeapFrog about
6 the partners advisory committee, there is like a, like
7 an orientation that LeapFrog also has data, and so
8 sometimes there is cross --

9 Q It's like a cross-selling?

10 A Cross-selling, handing off to, to me and
11 our -- sometimes there's people that reach out about,
12 about data, but they're also interested in
13 partnership, and so I might --

14 THE REPORTER: But they're what?

15 THE WITNESS: I'm sorry. They might also be
16 interested in partnership, so I would pass it
17 over to, pass it over to him.

18 BY MR. CHUNG:

19 Q So the presentation, the PowerPoint itself,
20 is this something that you put together?

21 A I think I had a hand in it, but I was not --
22 I don't think I was the lead in putting, in putting
23 this together.

24 Q Who was?

25 A I'm trying to remember from, from this time.

1 We, we, we have different consultants that we work
2 with that help us to make marketing materials.

3 Q So TelAffects is one of them?

4 A No, no. This -- so this is -- this would be
5 for data licensing, so either perhaps Rule of Three
6 or -- I mean I may have had a hand in, in like doing
7 some of the edits. I may have had a hand in doing
8 some of the edits.

9 Q Okay, so but this is, but this is -- given
10 that its focused on marketing of data licensing --

11 A Yes.

12 Q -- data licensing program, you would have
13 overseen putting together a presentation like this,
14 correct?

15 A Yes.

16 Q Okay. So let's focus on Bates ending in
17 450. It's slide number 5.

18 A Okay.

19 Q And it refers to "LeapFrog data on the
20 quality and safety of named hospitals and ASCs," and
21 up top, the first line is "Exclusive Data: LeapFrog
22 collects unique data by named facility at a national
23 level -- only available from LeapFrog."

24 And is this referring -- this encompasses
25 the data collected from hospitals in response to the

1 hospital survey, correct?

2 A Yes.

3 Q All right, and this is -- and you're kind of
4 marketing this to potential customers as LeapFrog --
5 data that's exclusive to LeapFrog; is that correct?

6 A Yes.

7 Q That it makes exclusively available to
8 potential licensees; is that right?

9 A Yes.

10 Q Okay, and in terms of -- and we've gone over
11 kind of this concept before, but the more hospitals
12 that respond to the survey, would it be fair to say
13 that the more exclusive that data becomes?

14 A I mean I guess "exclusive" -- it seems like
15 it means here that -- LeapFrog has data by facility,
16 and that's not available anywhere else, so I think
17 that's what is mostly meant by "exclusive."

18 Q And by "facilities," we mean hospitals?

19 A Hospitals, yes.

20 Q Hospitals that participate in the, in the
21 hospital survey, correct?

22 A Yes. LeapFrog is the, is the only reporting
23 entity that is doing it by individual
24 bricks-and-mortar facility, and that's different than
25 how others are reporting the data. So that's what

1 kind of makes it unique and exclusive, in that there
2 is no other way to get that level of detail on, on
3 like what the -- what's happening within the four
4 walls of that facility when it comes to some of these
5 measures.

6 Q But it's not only -- because we looked at
7 prior marketing materials that underscored the number
8 of hospitals that have responded to the survey, right?
9 I think we've gone at least over a couple of decks
10 that reference that.

11 So it's -- is it -- it's the level of detail
12 for each of the participating hospitals, but also just
13 the breadth and number of hospitals that have
14 participated that make this product, this data
15 exclusive; would you, would you agree with that?

16 A I, I mean we may mention that somewhere
17 else, but I guess we don't normally -- when we're
18 talking about that exclusive, we're talking about
19 what, what makes it -- it's kind of more specific to
20 the measures that we have in, in like the hospital-
21 level details.

22 Q Are you aware of any other organizations,
23 LeapFrog, U.S. News, health grades or otherwise, that
24 has data for the, the sheer number of hospitals that,
25 that LeapFrog has?

1 A I don't know what's available through those.

2 Q In terms of patient safety data, are you
3 aware of any other businesses, publications, you know,
4 organizations that have data for literally thousands
5 of -- most of the acute care hospitals in the United
6 States?

7 A Yes, CMS has data on --

8 Q Putting aside the government, any other
9 organizations?

10 A Oh, no, I'm not, I'm not aware.

11 Q Okay.

12 The next slide, and this is Bates ending in
13 451, this is a summary list of all the data licensing
14 options for customers; is that correct? 451. It's
15 the next page.

16 A Oh, okay. Got it. Yes. Okay.

17 Q All right. Is this a summary of data
18 licensing options for customers? What is this a list
19 of?

20 A This is highlighting some of the areas, like
21 general, like high-level areas that we look at on
22 all our -- across all of our programs, including
23 specific survey sections, like maternity care,
24 pediatric care, and -- but then -- well, it's a lot of
25 the survey, what we call "survey domains," and then

1 it's highlighting some of the composite scores that we
2 have, including the overall Hospital Safety Grade
3 rating, and the, the value-based purchasing composite
4 score.

5 Q Okay. So this is not -- these are not
6 licensing products or options for customers.
7 They're -- are you testifying -- are you saying that
8 these are general areas that are covered by the
9 exclusive data?

10 A Yes. This, this is highlighting, in
11 LeapFrog's data licensing offering, the, the various
12 areas of, of -- that are included in the survey
13 dataset and in the Hospital Safety Grade dataset and
14 in the value-based purchasing program.

15 Q So let's go to -- this would be LeapFrog
16 Bates ending 460. 460. Just keep going several
17 pages. There's a graphic there, "VBP Example:
18 Calculate Payments or Penalties."

19 THE REPORTER: Say it again. I'm sorry.

20 THE WITNESS: "VBP Example: Calculate
21 Payments or Penalties."

22 BY MR. CHUNG:

23 Q All right. Is this an example of how a
24 customer could use a VBP program?

25 A Yeah, so I, I don't remember seeing this

1 before, but, but yes, it is an example of how they
2 could use it.

3 Q Can you explain how this works or what, what
4 this represents?

5 A Yes. So the value-based purchasing program,
6 as I mentioned before, it's a series of reports that
7 gives a zero to 100 composite score for facilities
8 using the LeapFrog Hospital Survey. So we can only
9 create those reports for hospitals that take the
10 survey.

11 So what it is showing is the performance
12 using the overall value score on a, on a, like a
13 distribution to show where the hospital ranks like on,
14 on the distribution and like which decile -- I think
15 there's probably a key in here that's not shown.
16 There's probably a decile ranking, and then it's
17 making suggestions on how they can assign an, an
18 incentive program around using the, the value-based
19 purchasing program reports.

20 Q So what is the -- just looking at the, the
21 heading here, what, what is the -- what are the
22 payments? What is the payment referring to?

23 A So the, the payment is -- the value-based
24 purchasing program is designed for health plans that
25 are interested in using the LeapFrog value-based

1 purchasing reports as a way of -- to use in
2 contracting with hospitals.

3 So this is making suggestions on how they
4 can implement this program and make payments or, or
5 penalties, as determined by the information that's on
6 the, the report, or using it as like a supplement to
7 an existing program that they have. So it's meant to
8 be kind of a flexible program that they can kind of
9 implement however fits their, their contracting
10 process.

11 Q But the utility of this program to, to a
12 health plan depends on whether the hospitals that it's
13 interested in have actually responded to the survey,
14 correct?

15 A Yes. So we can only make reports for those
16 hospitals that, that participate in the survey.

17 Q Right. So to kind of effectuate this
18 particular program for health plans, it's important
19 for -- it's important for LeapFrog to, to have
20 hospitals respond to the survey, correct?

21 A Yes. So to -- we can make the reports for
22 the health plan, whether they have all the
23 participation in the, in the survey or not. It's kind
24 of up to the health plan to, if they want -- they see
25 value in getting 100 percent participation, they can

1 create the incentives to do that.

2 And we have seen that with -- we only have
3 two customers, actually only going down to one,
4 unfortunately, but they, they have, they have the
5 value-based purchasing program, and some of them, when
6 they had the program, they didn't have 100 percent
7 participation, and they decided to, to provide that
8 kind of incentive.

9 And I don't know exactly how it was, how it
10 was implemented, but they did get to 100 percent
11 participation, but they were paying the same, whether
12 they had, you know, 50 percent participation or
13 75 percent participation or 100 percent participation.
14 The value was, to them was getting the data, and so
15 they wanted to create the incentives to be able to do
16 that, and sometimes it works and sometimes it doesn't,
17 for them, but for LeapFrog, it's all kind of the same.
18 We can only create the reports if they submit to the
19 voluntary survey.

20 Q Understood. Okay.

21 So do you have a licensee, a health plan
22 that has actually implemented the example set out in
23 this slide?

24 A No. So to my knowledge, those health plans
25 are not currently doing any type of incentive

1 programs, but we don't have the full visibility of, of
2 how they're doing it. At some point they, they had
3 been doing it. I don't know if they're currently, if
4 they're currently doing this, but this is a suggestion
5 on how it could be, how it could potentially be used.

6 MR. CHUNG: Let's move on to the next
7 document, tab 15, and this will be Exhibit 18.

8 (Exhibit 18 was marked for
9 identification.)

10 BY MR. CHUNG:

11 Q Mr. Banerjee, Exhibit 18 is an email with a
12 PowerPoint attachment from around August of 2024, and
13 you are on this email with a Mallory Fries or Fries.

14 Who is Mallory Fries?

15 A Mallory is -- she's an employee of, of
16 LeapFrog, and works closely with me on data licensing
17 and accolades, accolades licensing.

18 Q Does she report to you?

19 A She doesn't report to me. She reports to
20 Missy.

21 Q All right. Which team is she on?

22 A She's on the -- she's on the ratings team.

23 Q Okay. So this is another example of a
24 member of the ratings team working directly with you
25 with respect to the licensing programs, correct?

1 A Yes. So I, I work, I work closely with
2 Mallory. I don't work with Alex very frequently at
3 all.

4 Q I'm just, I'm just asking about Mallory.

5 A Sure, yeah.

6 Q Did you draft the PowerPoint presentation?
7 Well, let's start with this. Do you recognize this,
8 the substance?

9 A Yes, I do, I do recognize it, and I do think
10 I, I do think I drafted it.

11 Q Okay. Now, in the cover email up top, you
12 write, "For the price increase target" -- second
13 paragraph. "For the price increase target, you can
14 reference this PPT presentation that has all the price
15 increase targets we approved for the documented price
16 increases from prior years."

17 Who, who directed you to make pricing
18 increases?

19 A I think I had -- I, so I track our data
20 licensees and --

21 Q Who directed -- the question is: Who
22 directed you to at least come up with these price
23 increases?

24 A Yeah, so I had a conversation with Missy
25 about how we haven't done a price increase on many

1 licensees.

2 Q So did Missy, did Missy Danforth direct you
3 to make these price increases?

4 A Yes. I, I know I, I talked to Missy and,
5 and Leah about these, about these price increases,
6 and, and so --

7 Q What did you discuss with them?

8 A Yeah, just the, the idea that we have --
9 there are several licensees that we have not increased
10 the price for some time, and that we want to make sure
11 that the data license is at fair market value.

12 There's also consideration about our current
13 price sheets for new customers, and there was
14 discussions on how we should think about how we are
15 pricing the data for new customers, for existing
16 customers, and understanding the current market value
17 of our, of our, of our datasets.

18 Q So who, who kind of initiated this
19 conversation about the price increases? Was it you or
20 Ms. Danforth or Ms. Binder or someone else?

21 A I can't recall who did, but it was
22 potentially me, because I, I look at the pricing and
23 do the invoicing on customers, so I can see -- I
24 regularly look at what the current rate is, what the
25 previous rate is. I can see that for certain

1 customers, that we have not increased the price for
2 some time.

3 So I imagine it was probably myself that
4 brought it up that we have not done this, and then I'm
5 not sure what initiated me to make this, but it could
6 be that I suggested that I could put together a
7 presentation to kind of highlight and show all of our
8 customers, where the price that they're currently
9 paying and --

10 Q Why don't we tie the discussion to an actual
11 slide, right?

12 So this is Bates ending 8167, page 2 of the
13 PowerPoint, titled "LeapFrog's current approach to
14 pricing and fee increases."

15 Do you see that?

16 A Yes.

17 Q Okay, and it says that for -- that LeapFrog
18 has targeted price "increases during renewals at three
19 to seven percent every two to three years."

20 Do you see that?

21 A Mm-hmm.

22 Q Okay. So where does -- can you describe for
23 us the process by which price increases are
24 determined -- or price changes. Let's say price
25 changes are determined.

1 A So we, we had -- what this was kind of
2 establishing was that we create more of a structure
3 for how price increases are, are determined.

4 Q So previous to this, there was no process or
5 structure; is that your testimony?

6 A I think we generally followed this
7 structure. It's just never been like formalized.

8 Q It's never been memorialized?

9 A Right.

10 Q So this -- so what, what's being described
11 here is what you understood or maybe recall to be kind
12 of generally what's happened over time; is that right?

13 A Yes.

14 Q Okay. So in terms of the, the rates of the
15 increases, three to five percent increases for larger
16 contracts, and how is a larger contract defined? Is
17 there a cutoff for that?

18 A I, I don't think we defined what a larger
19 contract is.

20 Q Can you give me a ballpark for what a,
21 quote-unquote, "larger contract" is?

22 A Above \$50,000. I mean I'm not -- we didn't
23 have a hard and fast rule, but it was just kind of
24 determined -- I mean I think on the subsequent page,
25 we, we did specify --

1 Q Yep.

2 A -- by the, by the customer, so we can kind
3 of look at that to see what, what that means.

4 Q And then "five to seven percent increases
5 for smaller contracts (business intelligence)."

6 What does "business intelligence" refer to?

7 A Yeah, so those are for like health solutions
8 -- healthcare solutions providers that do -- they work
9 with hospitals. They have devices, technology. They
10 do -- they're the ones that do consulting with, with
11 the hospitals, and they want insights into the
12 LeapFrog ratings and data, and so they are generally
13 using it -- they are all using it for internal use,
14 and so we have a, like a lesser fee for, for accessing
15 it for those internal use purposes.

16 Q So each time -- so there's a discussion
17 here, and this is August of 2024, right, and there
18 you're discussing with, with -- you had discussions
19 with Ms. Binder and Ms. Danforth about increasing
20 these licensing rates, right?

21 A Mm-hmm.

22 Q What -- at this time, did you have a
23 discussion as to how you could justify raising these
24 licensing rates?

25 A I, I know that inflation was very high

1 during that time.

2 Q So inflation is one?

3 A Yeah, but even like doing three to seven
4 percent every two years, with the rate at which things
5 had increased, and we hadn't increased in quite some
6 time, I think there was -- like a major concern was
7 like that's not even keeping up with, with inflation.

8 Q Other than -- so other than inflation, are
9 there other factors or kind of justifications --

10 A Yeah, so --

11 Q -- behind the, behind the rate increase that
12 you're discussing here?

13 A So there was -- I think there was inflation.
14 That was I think top of mind for a lot of people. The
15 other fact is that we had not increased for, for a
16 number of years from any of the customers.

17 And then I mentioned like fair market value
18 as understanding where -- how our datasets are
19 positioned in the market, and, and the, and the value
20 of them, especially concerning our current, our
21 current fee structure, which also had not moved for
22 new customers in quite a while.

23 I think those were the, some of the main
24 considerations.

25 Q So in terms of the fair market value,

1 presumably, its relevance is that fair market value
2 for the dataset had increased over time, correct?

3 A Yes, it has.

4 Q And what accounted for, in terms -- going
5 back to the justification of the price increases, what
6 accounted for -- what's your understanding or the
7 justification for why there was an increase in fair
8 market value of the dataset?

9 A Well, largely, LeapFrog has, has had a
10 growing brand recognition for, for a number, for a
11 number of years, especially with the, the safety
12 grade, which is most of what the inquiries are about,
13 about data licensing. More -- there's more and more
14 promotion amongst hospitals using that and touting
15 their, their safety records.

16 Q And is part of it also the competition
17 between the hospitals that we went over earlier, in
18 terms of kind of using the Hospital Safety Grade as a
19 way to compete with other hospitals; is that right?

20 A Yes, and I think all that contributes to the
21 increasing the brand, yeah, recognition, exactly.

22 Q And in particular -- we went over this
23 earlier, but in terms of increasing the, increasing
24 the brand, is it fair to say that this all ties back
25 to kind of our discussion about fair market value,

1 that more hospitals and markets were interested or
2 actually purchasing licenses of the Hospital Safety
3 Grades because of that better brand recognition; is
4 that right?

5 A Yeah, I think that was one of the
6 contributing factors.

7 Q Okay, because the, the ability to license
8 the hospital safety grades allowed -- allows at least
9 A-graded hospitals to enhance their reputation in
10 their markets; is that right?

11 A I believe that's the, the motivation,
12 because -- and it's -- and they want to specifically
13 use the logo to be able to do that, which they saw
14 value in, in using the logo specifically, and that's
15 why they chose licensing, and that, that way, they can
16 kind of tie themselves to the patient safety brand
17 that LeapFrog I think embodies.

18 Q Okay.

19 All right. Any other factors that go into
20 the increase in fair market value? The brand
21 recognition was one. Anything else?

22 A I mean I know -- I said it before, but
23 the -- I think the inflation was a significant cost --

24 Q We know that for sure.

25 A -- because the, like the -- I think we

1 talked about changing -- I don't know if we talked
2 about -- sorry. I'm just --

3 Q Mr. Banerjee, how about the size, just
4 overall size and breadth of the dataset? Does that --
5 did that contribute to the fair market value?

6 A I mean that wasn't a specific consideration
7 in, in this, in the, the price increase.

8 Q Let's turn to Bates ending 8172. That's
9 slide number 5.

10 So there are a series of increases,
11 recommended increases here for specific, looks like
12 customers, for Humana Government Business, and they
13 have a survey license.

14 Are you familiar with that?

15 A Yes.

16 Q Okay. There is a recommended increase of
17 20 percent.

18 Why such a high -- at least
19 percentage-wise -- price increase for this particular
20 customer and license?

21 A Yeah, so the -- Humana Government Business
22 is a federal contractor for the Defense Health Agency,
23 and they oversee their, the benefits or a health plan
24 for the TRICARE population.

25 So in 2018, they approached us because the

1 Defense Health Agency was making it a requirement to,
2 to purchase the LeapFrog Hospital Survey data, and
3 make the ratings available to, to members. Their
4 contract kind of locked them into a like a five-year
5 contract, and it was -- the pricing is based on the
6 number of covered lives or members that the data is
7 applied to.

8 So they had not had an increase in --
9 because of their contract with us, we had maintained
10 their rate. They were awarded another contract for
11 eight years, starting in -- actually, I think it was
12 delayed, and now it started this year, where they
13 expanded the number of members that they were applying
14 the data to.

15 So they gave us what the number of members
16 it was expanding to in the next contract, and as a
17 result of that and the, the pricing structure which
18 incrementally increased, their net increase was
19 20 percent.

20 MR. CHUNG: Understood.

21 Let's go to tab 30. This will be Exhibit
22 19.

23 (Exhibit 19 was marked for
24 identification.)
25

1 BY MR. CHUNG:

2 Q So Exhibit 19, an email -- we got an email
3 chain among Leah Binder, Ben Choi, Josh Berlin, and
4 Ms. Danforth.

5 First of all, who is Ben Choi?

6 A Ben Choi is a consultant for -- he was our
7 consultant for Rule of Three that we work with, and in
8 his role, he was essentially the interim chief
9 financial officer.

10 THE REPORTER: He was the what?

11 THE WITNESS: Interim CFO.

12 BY MR. CHUNG:

13 Q Did you ever report to him?

14 A No, I did not directly report to him.

15 Q Okay. How about Josh Berlin; who is that?

16 A Josh Berlin is the CEO of Rule of Three, and
17 is a strategic advisor for LeapFrog as a consultant.

18 Q Okay. So this is -- you can take a look.
19 There's an email chain and then a series of
20 attachments with historical accolade license and data
21 sales.

22 Did you ever work with -- did you work with
23 Ben Choi, or do you work with Ben Choi?

24 A No. He doesn't work at LeapFrog -- with
25 LeapFrog anymore, but I, I had worked with him in

1 different capacities to inform him, as he did the, the
2 finances, with the information he needed around
3 accolades or data sales.

4 Q Okay. So she -- Ms. Binder -- this is the
5 April 24th email on the first page. She writes, "If
6 we move toward cost reduction as the primary strategy,
7 it will be much more severe than this, but I'm not
8 going there for now. We can address incremental
9 spending issues, but let's not lose focus on what
10 managers should be thinking about 24/7, which is
11 revenues," right?

12 And at this time in 2024, were you, were you
13 a director by this point?

14 A No.

15 Q You were still a manager on -- in the data
16 licensing area, correct?

17 A Yes.

18 Q Is this consistent with what you, as a
19 manager -- and this is, this is an email kind of
20 discussing among, with Mr. Choi, around the licensing
21 programs.

22 Was this kind of the messaging at this time,
23 that managers should be thinking about, 24/7,
24 revenues?

25 A No. I mean I wasn't privy to this email.

1 Q You're not on the email, that's correct.

2 A I wasn't on it, so I'm not sure what she's
3 thinking at this time. I haven't heard her say that.
4 I've never heard -- I haven't heard her say that
5 before.

6 Q Okay. Is there anything that she has said
7 around this time or at any, any point, right, that,
8 that there needs to be a push for revenue generation?

9 A Yeah, we've had conversations about the
10 importance of revenues and to the mission, and, and
11 yeah, it is a, it is an important factor that, that we
12 consider.

13 Q Okay. Is there -- had there been -- at any
14 point, had she articulated concerns about revenues as
15 being important to cover for operations of the
16 organization?

17 A Revenues to operate -- could you restate
18 that.

19 Q Yeah, I mean you, you testified that
20 revenues were -- we had discussions around revenues
21 being important to the mission, right? How about to,
22 to LeapFrog's basic operations?

23 A Yeah, I mean I think it's -- I, I've heard
24 her say before that we want -- you know, we have, we
25 have expenses to do, to do all the work that we do in

1 the operations, and we want to continue to --
2 especially in my view -- the accolades and -- the
3 accolades program and the data licensing program
4 continue to look for new ways and use cases and
5 opportunities, even within the current work that we're
6 doing, to expand our presence, enhance use of our
7 data, further the mission, and the results of that is
8 revenue generation, which is also vitally important to
9 the organization.

10 Q Have there been -- I'm just kind of focusing
11 on the, on the language here. Did you have any
12 discussions with Ms. Binder about revenue generation
13 being important to compensating LeapFrog's executives?

14 A No.

15 Q No discussion about that?

16 A No.

17 Q Okay. Do you have a general -- do you have
18 a sense of how much LeapFrog's executives make in
19 terms of their -- in terms of their compensation?

20 A No. I mean I, I have -- I may have like a
21 general idea, but not -- I mean I, I have a general
22 idea, but I don't, I don't know like specifically how
23 much each executive makes.

24 Q Okay. Is there like a source where you can
25 learn how much each executive makes?

1 A Yeah, I think LeapFrog files a 990 that's
2 published online.

3 Q Okay. Have you ever looked at that, or --

4 A I haven't looked at it recently, but I've
5 looked at it in the past.

6 Q Are you aware that Ms. Binder made about
7 \$760,000 in total compensation during fiscal year
8 ending in June 2024?

9 MS. WOOD: Objection to form.

10 THE WITNESS: I -- yeah, I was aware that
11 she made a fair compensation during, during that
12 time.

13 BY MR. CHUNG:

14 Q Okay. When you first saw that, was it a
15 surprise to you? What was your reaction to it?

16 A I didn't really have a reaction to it.

17 Q You had no reaction?

18 A No, not, not really.

19 Q Okay. Is that a high level of compensation
20 for a nonprofit CEO?

21 A I don't really have a comparison to judge
22 that against.

23 Q How about Ms. Danforth; are you aware that
24 she made about \$446,000 during the same period?

25 A I was not aware of that.

1 Q Okay. Does that, does that surprise you?

2 A No.

3 Q Why not?

4 A Well, both -- I mean I know both Missy and
5 Leah are very committed to, to LeapFrog, and they have
6 been at LeapFrog for a very long time, even much
7 longer than I have, and have helped to really further
8 our, our mission and enhance our value, and they're so
9 committed to transparency and accountability and
10 accuracy in our programs. They have really helped to
11 grow and make the program what it is today, so for
12 those reasons.

13 MR. CHUNG: I'm going to show you -- let's
14 go to tab 54.

15 This will be Exhibit 20.

16 (Exhibit 20 was marked for
17 identification.)

18 BY MR. CHUNG:

19 Q Have you seen this document before?

20 A No, I have not.

21 Q Okay. Do you see there that with respect to
22 the current contract, there's discussion of CEO
23 compensation being "a proportion of revenue" of the
24 organization?

25 Do you see that?

1 A Sorry. Which line is that?

2 Q We're looking under "Current Contract."

3 A Oh, okay.

4 Q All right. Do you know why Ms. Binder would
5 be using the organization's total annual revenue as a
6 metric to determine her salary?

7 A No.

8 Q Have you had any discussions with her about
9 that?

10 A No.

11 Q Have you had any discussions between you and
12 your LeapFrog colleagues about how much Ms. Binder
13 makes as CEO of LeapFrog?

14 A No.

15 Q Zero discussion whatsoever?

16 A No.

17 Q All right.

18 Do you think it's appropriate for a CEO of a
19 501(c)(3) organization to tie their compensation to
20 the organization's total revenues?

21 MS. WOOD: Objection to form.

22 THE WITNESS: I mean I don't, I don't have
23 an opinion on it.

24 BY MR. CHUNG:

25 Q You don't have an opinion on, on what?

1 A On, on how, on how her compensation is, is
2 determined.

3 MR. CHUNG: Okay. Let's go -- let's go to
4 tab 51, and this will be Exhibit 21.

5 (Exhibit 21 was marked for
6 identification.)

7 BY MR. CHUNG:

8 Q So Exhibit 21 is an email around your annual
9 review. It looks like from mid-2023.

10 Do you see that?

11 A Yes.

12 Q Okay, and you're discussing your annual
13 compensation in this email chain, correct?

14 A Yes.

15 Q And you're asking for increased
16 compensation; is that right?

17 A Yes.

18 Q All right, and about how much were you
19 making at this time?

20 A Probably like \$100,000.

21 Q Okay, and you mentioned the fiscal year 2023
22 licensing budget goals in the context of, of your
23 compensation.

24 Did your compensation at this time depend in
25 any way on the licensing budget goals?

1 A No.

2 Q Okay, but you say here, "To address the
3 concern about not meeting FY23 licensing budget goals"
4 as kind of the top bullet point here.

5 So you write here, "Although I recognize the
6 FY23 licensing revenue was under the initial
7 benchmarks, where we ended up (just under) are a
8 direct result of my tireless efforts to engage and
9 retain our licensees," right?

10 So if you're -- I mean if you're testifying,
11 testifying here that the licensing budget goals did
12 not in any way play a factor in your compensation,
13 then why would you be raising it here, basically kind
14 of in an appeal to increase your compensation?

15 A So I'm trying to make the, the argument
16 that -- so I'm responsible for the, the data licensing
17 programs, and I understand that although I'm not
18 directly tied to the revenue, the revenue, that I
19 don't receive any type of bonus for reaching a certain
20 benchmark, that those will be considerations in my, in
21 my request for additional compensation during, during
22 my annual review.

23 Q Right. So to address the concern about not
24 meeting the licensing budget goals, so was -- the
25 concern was articulated to you, correct, that the

1 licensing budget goals had not been met; is that
2 right?

3 A It was, it was either articulated or, or
4 implied from, from my time at LeapFrog, understanding
5 that that is, that is something that is under
6 consideration.

7 Q So who articulated or implied that this was
8 a -- that not meeting the licensing budget goals was a
9 factor that would impact your compensation?

10 A From -- I've had a variety of people that I
11 have reported to over the years, and this, at this
12 point it was Patrice, so Patrice and Leah -- I've had
13 conversations with Leah during that time.

14 Q Okay, and what did she say in this vein?
15 Leah Binder. What did she say in this vein? What did
16 she specifically say on this topic?

17 A That, that the data licensing program, she'd
18 like to see more strides and specifically retention
19 of, of data licensees, and putting together kind of a
20 concrete plan to, to keep those relationships active,
21 understand how they're using it, and then look for and
22 advise on new ways to engage more types of
23 organizations that can use LeapFrog data.

24 THE REPORTER: That can use what?

25 THE WITNESS: That can use LeapFrog data.

1 BY MR. CHUNG:

2 Q And was this, was this in the context of a
3 discussion that, that the licensing budget goals had
4 not been met?

5 A I, I think this was like kind of preempting
6 that point that, that I think that was going to be
7 re-raised, and so to kind of get ahead of that, I was
8 trying to make the argument that we had, we had a lot
9 of moving pieces, and that we, we did sign new
10 licensees, but, much like that other year that we
11 discussed, we gained some and we lose some, and so I
12 was trying to give some context to -- in making my
13 case for increased compensation.

14 Q You said you also reported to Patrice Brown
15 at this time.

16 Who is Patrice Brown?

17 A Patrice Brown was the chief operating
18 officer for, for LeapFrog.

19 Q Okay. Did you -- so you had -- you
20 testified you had discussions with Ms. Binder and
21 Patrice Brown around licensing budget goals as a, kind
22 of a factor in your compensation.

23 How about Ms. Danforth? Did you have any
24 discussions with Ms. Danforth on that topic?

25 A I -- yeah, I believe so. In my, in my

1 annual review, we had a similar type of, type of
2 discussion.

3 Q Okay. Can you tell us about those
4 discussions?

5 A So I think in that one, that exhibit and my
6 annual review we reviewed earlier, I think I made a
7 similar, a similar type of discussion, that it was,
8 you know, an up-and-down year, but these are the
9 things that I'd like to do, and here are my goals and
10 benchmarks.

11 Q Okay.

12 Now, in the second bullet point, looking at
13 the same exhibit, Exhibit 20, you write, "I feel an
14 urgency to make my compensation fair. I don't believe
15 it is fair with my current market value or what we
16 would offer -- be offered to my current position
17 (i.e., I feel my tenure at LeapFrog has effectively
18 held me back by comparison)."

19 So just kind of focusing on that you don't
20 believe it's fair with your current market value, why
21 is that?

22 A I, I felt like I needed increased
23 compensation, because I feel like I work hard, and I
24 thought it was fair that they reconsider what my
25 salary is.

1 Q Okay. Did you, did you feel that the, the
2 licensing budget goals, right, that you were being
3 measured against were, were unfair?

4 A I guess I was -- there was really, I think,
5 no like demarcation of like where I needed to be --
6 like where we needed to be in order to get this type
7 of compensation, so for me to reach a, like that next
8 level that I was looking for, and so I think I was
9 just kind of expressing my frustration.

10 Q Well, understood, but you testified that you
11 had discussions with Ms. Patrice Brown, Ms. Binder,
12 and Ms. Danforth about your compensation in the
13 context, right, of not meeting these, these licensing
14 budget goals, right?

15 Then you also testified that -- it looks
16 like here you were also kind of leaning into the fact
17 that your -- you had a long tenure, right, at
18 LeapFrog, and is it -- was it your position that that
19 should be a factor in increased compensation?

20 A Yeah, I wasn't suggesting that my long
21 tenure means I should have more compensation, but I
22 was saying that if, if my position was open, then I
23 feel like it would have been a higher level position
24 with, with a higher level of compensation.

25 Q Okay, so but just going back to my, to my

1 previous question, do you, do you think that -- did
2 you think that your -- the, the fact that licensing
3 budget goals had not been met, right, was unfairly or
4 disproportionately a factor in your compensation
5 relative to your tenure at the, at the organization?

6 A Sorry. Can you repeat it? I just want to
7 make sure I understand.

8 Q Yeah. Did you think that -- did you think
9 that, that the not meeting the licensing budget goals,
10 right, was disproportionately a factor in how, how you
11 were compensated?

12 A I, I think I -- I don't know exactly. It's
13 always been kind of unclear to me what the criteria
14 is, but my, my conversations with, you know, all of,
15 all of my managers has led me to believe that, that if
16 there was a certain, you know, benchmark that we
17 reached and that -- for, for licensing, that, that
18 yes, I perhaps would have elevated, elevated sooner.

19 Q Okay. Do you think that's fair?

20 A I mean I don't know, I don't know if it's
21 fair, but I don't, I don't really get to decide.

22 Q Well, you're, you're voicing --

23 A Yeah.

24 Q -- your opinions here, actually kind of
25 asserting your opinions about whether your

1 compensation is fair.

2 So if you're able to voice these, at these
3 positions, is it fair or was it fair, in the context
4 of this kind of review, that the licensing budget
5 goals, where they were set, were factored into your
6 compensation to the point where you were not satisfied
7 with it?

8 A Yeah, I mean I did voice that I thought my
9 compensation should be, should be more fair. So yeah,
10 that was factored -- if it was one -- if the budget
11 goals were one of the things that factored into it,
12 I'm just trying to make the argument that it -- that
13 my compensation needed to be elevated, and other
14 things should be considered with all the other, like
15 the full breadth and scope of, of the work that I do.

16 Q Do you, do you believe you should be
17 compensated more as you bring in more revenue,
18 licensing revenue for LeapFrog?

19 A I mean I think that could, I think that
20 could factor -- that could factor and does not factor
21 into it. It continues to not factor into it.

22 Q It did in the past, right, in the context of
23 this email, right?

24 A Well, my, my -- well, my, my salary has
25 never been tied to the -- it has, it has not been tied

1 to the performance of . . .

2 Q Well, let's look at it another way.

3 The, the, the failure to meet the licensing
4 budget goals for fiscal year '23 held you back in
5 terms of your compensation, correct?

6 A I think that's a, that's not a question that
7 I can answer, because I don't determine my, my
8 compensation.

9 Q Okay.

10 So just going back to Ms. Binder's
11 compensation, right, of \$760,000 and it being -- we
12 looked at the document -- it being a percentage or
13 tied to the revenue, right, basically the economics,
14 the financial situation of, of the organization, would
15 you say that her -- you testified that your
16 compensation never tied to revenue, right? Do you
17 think it's appropriate for her compensation to be tied
18 to revenue?

19 A Well, we have very different jobs. I don't
20 even know the full scope of everything that she does.
21 I do know that she -- I mean her -- not just her
22 tenure at LeapFrog, but she is -- I mean she has
23 oversight of every part of the -- and responsibility
24 for every part of the organization as, as the leader
25 of the organization.

1 So I feel like it's not a, not a fair
2 comparison in comparing my, my role with, with hers,
3 and --

4 Q I'm not --

5 A -- looking at the compensation structure, I,
6 I, I don't -- I don't know how you can equate those.

7 Q I'm, I'm not asking -- I'm not asking about
8 the fairness or appropriateness of her --

9 A Oh.

10 Q -- compensation compared relative to
11 yours --

12 A Yeah.

13 Q -- right, but do you, do you think it's
14 appropriate for her compensation to be -- at least in,
15 in one way -- tied to the, the financial performance
16 of the organization?

17 A I don't have really an opinion on her
18 compensation structure.

19 Q Okay. You had an opinion as to your own
20 compensation, right? So what, what's stopping you
21 from offering at least a view on her compensation
22 structure?

23 A Because I know, I know my -- I know what I
24 do, and it affects my day-to-day and my life, but I
25 don't know, I don't know everything that -- I don't

1 even know everything that Leah does.

2 So, so yeah, I don't, I don't have an
3 opinion of it, because I'm not -- I feel like I'm not
4 informed enough about what, what she does for the
5 organization. I do know some of the things that she
6 does, and it is very different than, than the work
7 that I do.

8 Q Well, one of her -- one of the things that
9 she does, right, or oversees at the organization is
10 overseeing what you do; is that right?

11 A Yes.

12 Q To the point where, for certain periods of
13 the year, you're sending her your daily updates,
14 right, on revenue and number of licenses coming in
15 through licensing programs, correct?

16 A Right.

17 Q Right. So you do know one significant kind
18 of responsibility that she has or oversees with
19 respect to the organization, correct?

20 A Can you say that again.

21 Q Yes. So you are aware that she -- and I
22 think you testified earlier that the, the revenue from
23 the data licensing programs, right, is -- they are the
24 two most -- the data and the accolade licensing, the
25 two most significant components of the organization's

1 revenue, correct?

2 A Yes, the two highest, yes.

3 Q So fair to say that Ms. Binder's oversight
4 of those programs, right, working with you is one of
5 her -- a major responsibility for her, correct?

6 A Yes.

7 Q Okay, and do you think kind of in that, in
8 that context, that it's appropriate for her
9 compensation to be tied to, to revenue generation?

10 A So those are the top two things, but there's
11 so much more that goes into those top two things, that
12 contribute to those top two things.

13 So like the general brand awareness of
14 LeapFrog, the PR communications that we do with the
15 release of the Hospital Safety Grade, all of those
16 things feed into the brand reputation and contribute
17 to the accolades licensing, and wanting -- getting
18 hospitals to want to use the LeapFrog marks, the, the
19 data licensing, it's -- a lot of is on brand
20 reputation.

21 You know, as I mentioned, I learned about
22 LeapFrog -- Leah wrote an article in Forbes, and, and
23 so that is all contributing to LeapFrog's reputation,
24 and she has been the major driver of that. There's a
25 lot of things that she does that I'm not even aware

1 of. That's why I said we have very different jobs.

2 And then there's, of course, all these other
3 things that were on the, on the revenue and cost sheet
4 that she is actively involved in, more or less, and
5 all of those things are feeding into the mission, and
6 so although those two things seem like those are the
7 top two revenue drivers, which they are, a lot of it
8 is on building the brand, and Leah has helped, been
9 very instrumental in building the brand since she
10 started LeapFrog.

11 Q Right, and in fact, building all those, all
12 those things that you described that Ms. Binder does
13 toward building the brand are critical to your job,
14 correct?

15 A Yes.

16 Q Right. In order to be able to market and
17 sell licenses to solution providers and hospitals and
18 all the other parties, all of Ms. Binder's efforts and
19 others' efforts are critical toward -- critical toward
20 those efforts, right?

21 A Can you --

22 Q Let me -- so in trying to convince or trying
23 to obtain licenses, right, from solution providers,
24 hospitals and other, and other consumers of the
25 licensing products, what Ms. Binder does, right, in

1 terms of elevating or promoting the brand, are --
2 they're integral to your own efforts, correct?

3 A Yes.

4 Q And so at least one purpose of, of all the
5 things that you kind of enumerated that Ms. Binder and
6 others do is toward revenue generation; is that right?

7 A Yes.

8 Q Okay, and in fact, we looked at earlier at
9 Exhibit 15, she, she wrote to Ben Choi and Josh
10 Berlin -- you saw the earlier document -- that
11 managers should be thinking about revenues 24/7,
12 right? So that is -- is that -- kind of going back to
13 that, is that a sentiment or a message that you think
14 is important at LeapFrog?

15 A Yes, I do think it's -- I do think that the
16 revenue is important and helps to drive the mission.

17 MR. CHUNG: All right. Let's go to tab 14.
18 Exhibit 22.

19 (Exhibit 22 was marked for
20 identification.)

21 BY MR. CHUNG:

22 Q All right. So, Mr. Banerjee, Exhibit 22 is
23 an email chain involving you and Lauren Bailey, and
24 Leah Binder initially, right, from July of 2024, and
25 let's start with Ms. Binder's initial email, right,

1 where she is asking Ms. Bailey about "other possible
2 use of our data and what can be done to improve survey
3 reporting," right, stating that "any further ideas
4 from you or others you talk with," I think "[are]
5 welcome."

6 Do you see that?

7 A Mm-hmm.

8 Q All right, and then Ms. Bailey -- looks like
9 she forwards the message to you and to Ms. Berger. It
10 says, "Welcome back."

11 Were you, were you coming back from like
12 paternity leave?

13 A Yes.

14 Q Okay, and she lists four -- one, two, three,
15 four, four ideas where she wanted to get your feedback
16 in response to Ms. Binder's request.

17 Do you see that?

18 A Yes.

19 Q Okay, and so on the -- if we turn to the
20 first page, you respond with I think comments on the
21 four ideas, and you write, "Similarly, LF data" --
22 it's in the middle of the -- yeah. "Similarly, LF
23 data versus medical device or technologies is
24 interesting to measure of variation effectiveness for
25 the technologies, and enables the technology companies

1 to engage with us through the (PAC) partners advisory
2 committee," is that right, "or data licensing."

3 A Yes.

4 Q Okay. What did you -- what were you kind of
5 discussing here?

6 A In the, in the chain generally?

7 Q No, in that sentence that I just read.

8 A In that sentence, okay.

9 So they outlined some ideas, and one of the
10 ones that stuck out to me in that first sentence is
11 that looking at -- because we're thinking about
12 different ways of using -- how organizations can use
13 LeapFrog data, that we could examine -- I thought it
14 was interesting if we could examine the LeapFrog data,
15 so the survey or the safety grade data, and different
16 medical device companies, and what they were doing and
17 what they're interested in, to see like what the
18 effectiveness is of, like of those technologies.

19 So we have members of our partners advisory
20 committee that are hand hygiene solution providers.
21 They do electronic monitoring that helps the hospitals
22 that they work with meet specific standards in hygiene
23 measure, and so I thought it would be interesting if
24 we put together a report that had -- like I connected
25 with this idea that if we made a report for hand

1 hygiene solution providers, as an example, that
2 specifically had, you know, the list of hospitals and
3 who met the standard using electronic compliance
4 versus observation, and then made that available as a
5 potential use case of the data.

6 I mean maybe that's what we were saying. I
7 wasn't -- I didn't --

8 Q Well, I want to focus actually on the
9 second -- I understand that, but you responded to it,
10 correct?

11 A Yes.

12 Q And you assessed each of the four ideas,
13 correct --

14 A Yes.

15 Q -- in your response, and then you continue,
16 "The first two are interesting as well, but I don't
17 see that they can have the same impact on driving data
18 licensing and PAC engagement (from my revenue lens) as
19 the other two."

20 Do you see that?

21 A Yes.

22 Q All right, and so when you say that the
23 first two on her list, right, that you "don't see that
24 they can have the same impact on driving data
25 licensing from a revenue lens," are you meaning

1 that -- are you saying that the first two ideas on her
2 list aren't -- you don't see them as, as impactful
3 potential sources of revenue, right, from potential
4 licensees; is that right?

5 A So the question is always like how can our
6 data be useful and who would, and who would be
7 interested in it.

8 Q Right.

9 A So those two ideas I was interested in. I
10 can see who would be interested in it. So LeapFrog
11 data and medical device technology data, I think would
12 be able to identify like, oh, hand hygiene providers
13 would be interested in, in this information to
14 improve, improve hand hygiene compliance as measured
15 by the LeapFrog standard.

16 So it's like who, who would be able to use
17 that information to improve, improve performance
18 aligned with our mission, and then a byproduct of that
19 is, is revenue.

20 The value-based --

21 Q Why do you say that it's a -- you used the,
22 the word "byproduct" a number of times.

23 A Oh.

24 Q Why, why, why is this a byproduct?

25 A Oh, well, like one of the results of people

1 using our data is that they are paying for the data
2 and getting the rights to use and access the data, and
3 that generates revenue, and --

4 Q Are you, are you really saying that revenue
5 generation is a byproduct of -- a potential byproduct
6 of these two ideas when you say that you're looking at
7 this from my revenue lens? Is that your testimony,
8 Mr. Banerjee?

9 A Yeah, in this internal email, I was jumping
10 ahead, that the focus is always the -- getting people
11 to use our data, and revenue is a result of that. I
12 used the word byproduct. Result. So just to --

13 Q Are you testifying that you're not focused
14 on -- you weren't thinking primarily of -- in
15 assessing these four ideas, thinking about are these
16 revenue generations? Is that your testimony, that
17 wasn't your primary focus?

18 A So the primary -- the using of the data and
19 revenue kind of go -- they go kind of hand in -- they
20 go hand in hand.

21 Q Yes, but that's different from revenue being
22 a byproduct; is that right?

23 A It's a, it is a result of -- it's a result
24 of people using the data. If there isn't anyone to
25 use the data, there is no revenue.

1 Q Understood.

2 All right. So we -- Ms. Bailey responds
3 "Thanks, Kush. Great points re driving data
4 licensing. I think I'll just share 3 and 4 with Leah
5 from that lens. So happy you're back," right?

6 So she makes the decision -- is it fair to
7 say from this she's making the decision to just
8 highlight the third and fourth idea, based on your
9 kind of feedback that they were more viable from --
10 again, she borrows your, your language, from a
11 "revenue lens"?

12 A Yeah, just to be clear, the first two ideas,
13 I can't envision, from my perspective, who would use
14 the data, and I also can't envision who would pay for
15 the data with these, these ideas, but they go kind of
16 hand in hand. These are -- they don't name specific
17 types of organizations that would use the data.

18 Idea 3 and 4, I can directly see why there
19 would be interest from organizations to examine the
20 LeapFrog data, next to some of these other, some of
21 these other areas. They're of keen interest to, to
22 hospitals and people that work with hospitals.

23 The first two ideas are generally -- there's
24 no -- at least to me, nothing clear cut that can --
25 that have applicability, and so that's what -- that's

1 all I was saying in this email, that I can't see who
2 would use these data.

3 I can't, I can't, I can't see the path
4 forward with those first two, but 3 and 4, I can kind
5 of see it, based on what we currently do at LeapFrog,
6 and from the, from the data licensing program and my
7 experience, that there, there might be some
8 applicability in organizations that would be
9 interested in using our data, if we could make some
10 type of case, if there could be some kind of white
11 paper, you know, that we could, we could put out some
12 kind of report that comes out of this, then -- that
13 we, we can make available, like hand hygiene.

14 Q Were either of these ideas implemented?

15 A No.

16 MR. CHUNG: Okay. Why don't we take a short
17 break. We've been going a little while.

18 THE VIDEOGRAPHER: This marks the end of
19 media unit number 5. Going off the record, the
20 time is 17:11 p.m.

21 (Whereupon, a short recess was taken.)

22 THE VIDEOGRAPHER: This marks the beginning
23 of media unit number 6. Going back on the
24 record, the time is 17:20 p.m.

25

1 (Exhibit 23 was marked for
2 identification.)

3 BY MR. CHUNG:

4 Q So Mr. Banerjee, Exhibit 23 is an email
5 chain from December of 2024, if you just take a moment
6 to review it.

7 A Okay.

8 Q All right, and is it correct that this is a
9 thread between you and Ms. Danforth where you're
10 discussing a data licensee that was trying planning to
11 cancel its, its subscription?

12 A Yes.

13 Q Okay, and they were planning to cancel
14 because of budgetary issues; is that right?

15 A Yes.

16 Q All right, and -- so what is -- in the top
17 email on December 12, 2024, she writes, "FYI -- if it
18 comes to it, I want to push for them to get one year
19 of PAC for free and keep their license going -- harder
20 to restart license that PAC," right?

21 What did you understand her to be -- her
22 desire to be here?

23 A So HealthNet is a health plan, and as we
24 shared earlier, the contracts for data licensing
25 are -- they're long, and they take, they take a long

1 time.

2 The partners advisory committee does not
3 have a contract, even, so the idea of canceling a data
4 license, and if in the future they have budget, and
5 they wanted to restart, this is a very engaged health
6 plan that's a member of the partners advisory
7 committee and a data licensee.

8 We saw that the -- and so we did have
9 conversations with her from -- Barb from HealthNet
10 about, about this, and the -- canceling the license
11 would necessitate them to have a new contract, if they
12 were ever interested in doing it in the future, and so
13 this was kind of swapping the, the partners advisory
14 committee for the, the license, so they could continue
15 to access and use the data, and we would be giving
16 them a year of PAC membership for free.

17 Q All right, and she writes, "We'll need to
18 talk to Leah, but that is my preference," right?

19 So do you remember having a discussion with
20 Ms. Binder about this kind of "trade" that
21 Ms. Danforth was contemplating here?

22 A Yeah, I don't, I don't recall having the
23 conversation with Leah, but I believe Missy did, at
24 least, and, and then yeah, we decided to offer that.

25 Q Okay. Did they accept --

1 A They did.

2 Q -- the offer?

3 All right, and so did they continue to be a
4 data licensee?

5 A Yes. This, this all happened in the, in the
6 last year, and it's a one-year contract, so they're
7 still, they're still under contract.

8 MR. CHUNG: Understood. All right.

9 Let's go to tab 33. This will be Exhibit
10 24.

11 (Exhibit 24 was marked for
12 identification.)

13 BY MR. CHUNG:

14 Q So Exhibit 24, Mr. Banerjee, if you look at
15 the initial email you wrote, "I think this was one of
16 the invoices we were holding to pay during the cash
17 flow issues."

18 Do you see that? I think you're referring
19 to a TelAffects invoice.

20 A Oh, sorry. Which page was it?

21 Q The very first --

22 A Oh.

23 Q The original email, so going back --

24 A Oh, okay.

25 Q -- to the last page. Do you see that?

1 A Oh, the last page. Yes.

2 Q All right. You mentioned "the cash flow
3 issues" here.

4 What cash flow issues were you referring to?

5 A So I don't know all of the, all the details
6 around the, the cash flow issues that we were having
7 during this time, but my general understanding is that
8 we had -- because of the timing in which certain
9 invoices are created and paid, and expenses, the way
10 expenses were coming in, there was a period of time
11 where we had a lower level of cash reserves than we
12 would have liked to have.

13 And so that was creating a little bit of an
14 urgency in collecting some of those invoices that we
15 had not received yet, and even like some of the
16 payments that were going out for expenses, I know
17 those were -- there was a period of time when those
18 were closely being monitored, and I think that's the
19 timing of when these emails happened.

20 Q So a couple emails later, you, you ask
21 Mr. Johnson, "any update I can share with TA on when
22 they can expect the payment?"

23 Do you see that?

24 A Mm-hmm, oh, I did see that.

25 Q It's on the second page.

1 A Okay, yes.

2 Q Do you see that?

3 A Yes.

4 Q And then Mr. Johnson forwards the email to
5 Ms. Danforth, saying, "I'm not sure how to answer
6 Kush. Leah does not want us telling staff we still
7 have cash flow issues."

8 Do you have an understanding as to why
9 Ms. Binder did not want to tell staff that LeapFrog
10 was having cash flow issues?

11 A No, I don't, I don't know why.

12 Q Okay. Do you recall any kind of discussion
13 among the organization at this time around, around
14 cash flow problems and the need for revenue?

15 A I know there -- I mean there were, there
16 were discussions about it, but it's like to the extent
17 of -- we, we want to collect some of these -- like
18 especially some of the larger invoices that we were
19 expecting, and they had been like far overdue, and
20 that was kind of resulting in, in this little bit of
21 a, of a crunch, and then some of the expenses that
22 needed to be paid.

23 I mean that's, that's really the extent of
24 what, what I know about, and, and so any conversations
25 I had were about those -- collecting those invoices

1 that were outstanding or, like in this case, with
2 TelAffects delaying a payment a little bit, just so
3 that everything could be kind of smoothed, smoothed
4 out with what was coming in, what needed to go out.

5 Q Okay, and so in terms of collecting
6 invoices, these were invoices from licensees; is that
7 right?

8 A Yeah, some of them, some of them were
9 invoices from, from licensees.

10 Q Okay. So how -- what, what came of that?
11 Were you able to get invoices paid, or --

12 A Yes.

13 MR. CHUNG: Okay. Let's move on to the next
14 document, 35, and this will be Exhibit 25.

15 (Exhibit 25 was marked for
16 identification.)

17 BY MR. CHUNG:

18 Q All right. Exhibit 25 is -- it's an email
19 thread from June of this year between Ms. Binder and
20 Mr. Johnson, and there's a presentation attached to it
21 about LeapFrog's 2025 financials.

22 Do you see that?

23 A Yes.

24 Q All right, and if you look at the slide
25 ending in Bates number 285 -- it's the page behind the

1 cover page.

2 A Okay. Yes.

3 Q It says that "for the last ten years,
4 LeapFrog's revenue has grown 11.6 percent per year,"
5 right?

6 Just generally speaking, you've been at the,
7 at the organization for let's say roughly, roughly ten
8 years, right? Nine years? What has accounted for
9 that revenue growth of 11.6 percent per year?

10 A I think we have a lot more sources of, of
11 revenue than we had, but I -- so I haven't seen this
12 before. I think this was presented to the board, it
13 sounds like.

14 Q So the question --

15 A So --

16 Q -- is what --

17 A But, but --

18 Q From your understanding, what accounts for
19 that growth --

20 A Yeah.

21 Q -- in the revenue?

22 A So I think all the, all like the revenue
23 items that, that we saw, some of those didn't exist
24 when we started -- when I started ten years ago.

25 Q Which ones were those?

1 A I don't have the list in front of me, but I
2 know like donations were, were on there, and we, I
3 think, just started that around the time that Karen
4 Jupiter started to lead that initiative.

5 I think there's expansion of the, like the
6 reports that we make available, like those, like those
7 data products. I think the partners advisory
8 committee has grown a lot, especially in the last ten
9 years, and it kind of -- it looks different in terms
10 of this, how we, I mean how we, how we like run that,
11 run that program.

12 So yeah, I think a lot of those things have
13 contributed, and then, of course, like accolades have
14 contributed to those, and that program has grown a lot
15 over the years, and then, of course, data licensing,
16 which I know those are the, those are the top two, but
17 there's -- yeah, the pie has kind of grown in terms of
18 like the different sections, and, and then the --
19 yeah, the types of, the types of programs and the work
20 that we're doing even on existing programs, I think
21 they're all kind of growing.

22 Q All right. The next slide, Bates ending
23 286, for the fiscal year 2026 proposed budget, we have
24 an estimate that LeapFrog will make about six and a
25 half million dollars combined from accolades and data

1 licensure.

2 Do you see that?

3 A This is 86286?

4 Q 6286, yes.

5 A Okay. Yes.

6 Q All right. So \$4.3 million from accolades,
7 then about \$2.3 million from data licensure, correct?

8 A Yes.

9 Q And they -- as we've seen in other
10 documents, they are the two top revenue sources, among
11 at least the sources that are enumerated in these
12 documents, right?

13 A Right.

14 Q Okay, and in the following page, Bates 6287,
15 it says here that it estimates that LeapFrog will make
16 about a \$400,000 profit for fiscal year '26.

17 Do you see that at the bottom --

18 A Oh, yes.

19 Q -- that income?

20 Okay, and is that -- I mean based on your
21 understanding, is that typical for, for LeapFrog to
22 make some amount of profit during a fiscal year?

23 A I haven't seen the, the, like the, the net
24 income in most, most years. I know in the last couple
25 years we've been around, around break-even or under

1 break-even in the last couple years.

2 Q Okay. Next slide, Bates ending 6288, it
3 says "Key Assumptions: Revenues." The first bullet
4 point --

5 A Yes.

6 Q The first bullet point reads, "Accolades:
7 Projected growth in line with prior performance
8 trends; with growth, there are more eligible renewals
9 each round," and "Renewals have a much higher sales
10 rate."

11 Do you see that?

12 A Okay.

13 Q Okay. When it says "with growth, there are
14 more eligible renewals each round," what is the growth
15 that this presentation is referring to?

16 A Okay. So I don't even know who, I don't
17 know who, who drafted this, but if I were to, if I
18 were to guess, that "with growth," the growth of the
19 licensing program, there's more hospitals, presumably,
20 that are licensing the rights to use the marks, the
21 badge, that that creates more initiation to using, to
22 using it to promote patient safety.

23 And as a result, if those hospitals that got
24 an A, use the marks, if they happen to get an A again,
25 they would be eligible to be a renewal, and we see

1 that renewals have, have a higher conversion rate than
2 non-, than hospitals that have not used the marks
3 before.

4 So I think that, that idea is, is kind of
5 outlined here.

6 Q Okay. So is it -- just to -- are you saying
7 that the kind of initial step in this growth is that
8 there are more hospitals that are, that are
9 participating in the survey; is that right?

10 A I, I thought we were talking about the
11 safety grade.

12 Q Yeah, so I'm asking you what is the kind
13 of -- in terms of the growth that's referenced here,
14 right, you said that there are more hospitals -- the
15 growth there is a reference to more hospitals that are
16 licensing; is that right?

17 A Yes, more A hospitals that are licensing. I
18 think that's what it's, what it's, what it's referring
19 to.

20 Q So there's an increase over time, or
21 projected for this year, there's an increase in the
22 number of A hospitals, number one; is that correct?

23 A No. Number of A hospitals that are
24 licensing.

25 Q Okay.

1 A So we're seeing more hospitals are
2 interested in licensing, because there's -- we've seen
3 that actually the number of hospitals that are
4 licensing is kind of like pretty much stuck at
5 22 percent, so -- but, but we have, you know, a
6 significant number. If we see some growth in that,
7 and that there are more hospitals that are interested
8 in, in licensing, then we are seeing high, a high
9 renewal rate, and so those hospitals that are using
10 the logo would be more likely, we think, to renew each
11 round.

12 Q But going back to that first step, it's --
13 is another way of putting it that the projection here
14 is that you're going to get more than 22 percent of
15 the A hospitals to sign licensing agreements; is that
16 the idea?

17 A Yeah, we would, we would like more hospitals
18 to, to use, to use the, to use the logo to promote
19 patient safety.

20 Q And so once you're able to convert or get
21 more of those A hospitals, right, to, to license, the
22 next step there then is -- the next round or in
23 subsequent rounds, there are more eligible renewals
24 among those hospitals; is that right?

25 A Yes. Yeah.

1 Q All right.

2 A No, so they would be eligible renewals if
3 they got an A again.

4 Q Correct.

5 A Right?

6 Q Right. So in order for LeapFrog to obtain
7 renewals from these hospitals, these -- like you said,
8 the hospitals, they must continue to receive A grades,
9 correct?

10 A Yes.

11 Q Okay, and so that is, that is part of the
12 projection here, that with the growth, there will be
13 more eligible renewals each round, right?

14 A Yes.

15 Q It's projected that those A hospitals,
16 right, those greater number of A hospitals that enter
17 into licensing agreements will continue to get, to get
18 A's in subsequent rounds; is that correct?

19 A Yes. If they get, if they get A's in
20 subsequent rounds, they will be more likely than an
21 average hospital to, to license, and that is what we
22 were seeing in the, in the numbers.

23 Q Okay.

24 So how -- in order for this, in order for
25 this projection to come to fruition, right, how does,

1 how does LeapFrog -- what is the -- do you know what
2 the likelihood or what the patterns are, what the
3 likelihood is that a hospital that gets an A grade in
4 one round will repeat, will get an A grade in the next
5 round?

6 A No, I don't know that.

7 Q Okay. Does that -- is that something that
8 you've, that you've ever -- even if you don't know it
9 now, is that something that you ever looked into?

10 A I, I think, you know, Alex has probably done
11 an analysis on that before to see like what the, what
12 the changes are, just generally, from, from one round
13 to the other with respect to the grade, like with A
14 hospitals that move to B hospitals and B's that move
15 to A's.

16 MR. CHUNG: Okay. All right. Mr. Banerjee,
17 I don't have any more questions.

18 MS. WOOD: Okay.

19 MR. CHUNG: Thank you.

20 MS. WOOD: I'm good.

21 THE VIDEOGRAPHER: Thank you. We are off
22 the record at 17:42 p.m. This concludes today's
23 testimony given by Kushagra Banerjee. The total
24 number of media units used is 6 and will be
25 retained by Veritext.

(Signature having not been waived, the
video deposition of KUSHAGRA BANERJEE
was concluded at 5:42 p.m.)

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ACKNOWLEDGEMENT OF WITNESS

I, Kushagra Banerjee, do hereby acknowledge
that I have read and examined the foregoing
testimony, and the same is a true, correct and
complete transcription of the testimony given by
me, and any corrections appear on the attached
Errata sheet signed by me.

(DATE)

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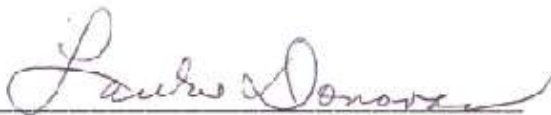
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5 CERTIFICATE OF SHORTHAND REPORTER -- NOTARY PUBLIC

6 I, Laurie Donovan, Registered Professional
7 Reporter, Certified Realtime Reporter, and notary
8 public for the District of Columbia, the officer
9 before whom the foregoing deposition was taken,
10 do hereby certify that the foregoing transcript
11 is a true and correct record of the testimony
12 given; that said testimony was taken by me
13 stenographically and thereafter reduced to
14 typewriting under my supervision; and that I am
15 neither counsel for, related to, nor employed by
16 any of the parties to this case and have no
17 interest, financial or otherwise, in its outcome.
18

19 IN WITNESS WHEREOF, I have hereunto set my
20 hand and affixed my notarial seal this 18th day
21 of September 2025.

22 My commission expires: July 14, 2027
23
24
25



19 LAURIE DONOVAN
20 NOTARY PUBLIC IN AND FOR
21 THE DISTRICT OF COLUMBIA
22
23
24
25

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Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

DISCLAIMER: THE FOREGOING FEDERAL PROCEDURE RULES ARE PROVIDED FOR INFORMATIONAL PURPOSES ONLY.

THE ABOVE RULES ARE CURRENT AS OF APRIL 1, 2019. PLEASE REFER TO THE APPLICABLE FEDERAL RULES OF CIVIL PROCEDURE FOR UP-TO-DATE INFORMATION.

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Veritext Legal Solutions represents that the foregoing transcript is a true, correct and complete transcript of the colloquies, questions and answers as submitted by the court reporter. Veritext Legal Solutions further represents that the attached exhibits, if any, are true, correct and complete documents as submitted by the court reporter and/or attorneys in relation to this deposition and that the documents were processed in accordance with our litigation support and production standards.

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Exhibit 87

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA
WEST PALM BEACH DIVISION

- - - - - x
GOOD SAMARITAN MEDICAL :
CENTER, INC., et al., :
Plaintiffs, : Case No.
v. : 9:25-CV-80526-DMM
THE LEAPFROG GROUP, :
Defendant. :

- - - - - x
Monday, September 22, 2025
Washington, D.C.

Videotaped Deposition of:

LEAH F. BINDER,
called for oral examination by counsel for the
Plaintiffs, pursuant to notice, at the law offices of
Gibson Dunn & Crutcher, LLP, 1700 M Street,
Northwest, Washington, D.C. 20036-4504, before
Christina S. Hotsko, RPR, CRR, CA CSR, of Veritext
Legal Solutions, a Notary Public in and for the
District of Columbia, beginning at 9:06 a.m., when
were present on behalf of the respective parties:

A P P E A R A N C E S

On behalf of Plaintiffs:

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On behalf of Defendant:

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COURTNEY L. WOOD, ESQUIRE
Wilson Elser Moskowitz Edelman & Dicker, LLP
161 N Clark, Suite 4500
Chicago, Illinois 60601
(312) 704-0550

Also Present:

Orson Braithwaite, Video Technician

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P R O C E E D I N G S

VIDEO TECHNICIAN: Good morning. We are going on the record at 9:06 a.m. on September 22nd, 2025.

Please note that the microphones are sensitive and may pick up whispering and private conversations.

Please mute your phones at this time.

Audio and video recording will continue to take place unless all parties agree to go off the record.

This is media unit 1 of the video-recorded deposition of Ms. Leah Binder in the matter of Good Samaritan Medical Center, Inc., et al., versus The Leapfrog Group, filed in the United States District Court for the Southern District of Florida, West Palm Beach Division, case number 9:25-CV-80526-DMM.

My name is Orson Braithwaite representing Veritext Legal Solutions, and I am the videographer.

The Court Reporter is Christina Hotsko

1 from the firm Veritext Legal Solutions.

2 Counsel will now state their appearances
3 and affiliations for the record, beginning with
4 the noticing attorney.

5 MR. CHUNG: Daniel Chung, Gibson, Dunn &
6 Crutcher, for plaintiffs.

7 MR. TAKAGAKI: Mark Aaron Takagaki,
8 Gibson, Dunn & Crutcher, for plaintiffs.

9 MS. BLAIR: Kim Blair, Wilson Elser, for
10 Leapfrog Group.

11 MS. WOOD: Courtney Wood, Wilson Elser,
12 on behalf of defendant Leapfrog Group.

13 VIDEO TECHNICIAN: Thank you. Will the
14 court reporter please swear in the witness.
15 Whereupon,

16 LEAH F. BINDER,
17 being first duly sworn or affirmed to testify to
18 the truth, the whole truth, and nothing but the
19 truth, was examined and testified as follows:

20 EXAMINATION BY COUNSEL FOR PLAINTIFFS
21 BY MR. CHUNG:

22 Q. Good morning. Could you please state

1 your name -- full name for the record, please.

2 A. Leah Frieda Binder.

3 Q. Have you gone by any other names?

4 A. No.

5 Q. And you understand that the court
6 reporter is taking down everything that's being
7 said during this proceeding.

8 Do you understand that?

9 A. Yes.

10 Q. So before we get into the substance, I
11 just want to go over some basic ground rules that
12 are applicable to all depositions.

13 The first is that we should try our best
14 not to talk over each other. So if you could
15 wait for me to finish my question before you
16 answer, and I'll wait for you to finish your
17 answer before I move on to the next question.
18 It's important that you -- that any response you
19 give is with words. So an uh-huh or an huh-uh is
20 very tough for the court reporter to take down.
21 So that's very important.

22 You also understand that you're

1 testifying under oath and you understand that, by
2 taking that oath, you're promising to answer my
3 questions truthfully and accurately as possible.

4 Do you understand that?

5 A. Yes.

6 Q. All right. Are you taking any
7 medications or under the influence of any
8 substances or is there any reason today that
9 might prevent you or hinder you from
10 understanding my questions or what's happening
11 here today?

12 A. No.

13 Q. All right. If you don't understand one
14 of my questions, just ask me to clarify it and
15 I'll do my best to do that.

16 From time to time, your attorney may
17 object to certain of my questions. Unless
18 Ms. Blair instructs you not to answer the
19 question, though, you have to answer the
20 question.

21 Do you understand that?

22 A. Yes.

1 Q. All right. If you need a break at any
2 time, just let us know. The only ground rule
3 with respect to breaks is that I ask you to
4 answer any pending questions before we take a
5 break.

6 Do you understand that?

7 A. Yes.

8 Q. All right. So let's get started.

9 Have you ever had your deposition taken
10 prior to today?

11 A. Once, 30 years ago.

12 Q. Okay. And what kind of case was that?

13 A. It was a car accident I witnessed.

14 Q. All right. So you were not a party. You
15 were a witness to the car accident?

16 A. Yes.

17 Q. All right. And where was that -- where
18 was the case filed or where did it take place?

19 A. In New York.

20 Q. All right. And for today's purposes, do
21 you understand that you're testifying not only on
22 behalf of yourself in your personal capacity but

1 also with respect to certain topics on behalf of
2 The Leapfrog Group?

3 Do you understand that?

4 A. Yes.

5 Q. All right. And are you aware of what the
6 topics are generally based on discussions with
7 your counsel?

8 A. Yes.

9 Q. Okay. So at various points throughout
10 the deposition, I'll kind of identify for you
11 whether there's a topic tied to the questions I'm
12 going to ask you so you know when you'll be
13 testifying in your corporate representative
14 capacity and when you're testifying in your
15 personal capacity. Okay?

16 A. Yes.

17 Q. Did you prepare for your deposition
18 today?

19 A. Yes.

20 Q. And how did you prepare?

21 A. I met with counsel four times. And I
22 studied up, you know, read over our website,

1 looked at our materials, looked at our public
2 relations and our finances.

3 Q. Okay. When did you -- when did you --
4 when was the first preparation session with your
5 counsel?

6 A. About four weeks ago. It was a joint
7 session with all of the Leapfrog employees who
8 were deposed in this matter.

9 Q. Deposed or to be deposed?

10 A. To be deposed.

11 Q. To be --

12 A. I mean, nobody had been deposed yet.

13 Q. Okay. So that first session about four
14 weeks ago was with all of the Leapfrog employees
15 who had been noticed for deposition; is that
16 right?

17 A. Right. To sort of give us kind of the
18 deposition 101, what -- what it's going to be
19 like and et cetera. So...

20 Q. Okay. And who -- approximately how long
21 did that meeting take?

22 A. I can't remember. Two hours, something

1 like that.

2 Q. All right. And who led that meeting?

3 A. Counsel, Kim Blair.

4 Q. All right. Was there, like, an agenda
5 for that meeting or talking points for that
6 meeting?

7 MS. BLAIR: Objection to form.

8 To the extent you're asking her about
9 specific communications from counsel, I'm going
10 to instruct you not to answer that. You can
11 answer yes or no as to whether there was an
12 agenda, but the content of the agenda you cannot
13 disclose.

14 THE WITNESS: Okay. Yes, there was an
15 agenda.

16 BY MR. CHUNG:

17 Q. Okay. And thereafter -- so that initial
18 meeting was just a joint meeting with all the
19 other folks who had been noticed; is that right?

20 A. Yes.

21 Q. Okay. And then there were subsequently
22 three additional preparation sessions; is that

1 right?

2 A. Yeah, there was one short one and then
3 there was -- there were two longer ones.

4 Q. Okay. And were those subsequent -- the
5 other three -- just with yourself or were there
6 other Leapfrog employees present at those
7 sessions?

8 A. Just myself.

9 Q. All right. Did you review any documents
10 in preparation for this deposition. You
11 mentioned that you reviewed some materials, but
12 if you could go over what you reviewed.

13 A. I reviewed our board minutes and packets,
14 all of the materials that were given to our board
15 over the past couple of years. And I reviewed
16 some of the materials that had been given out in
17 prior depositions of employees. I reviewed our
18 website and I reviewed some of the information on
19 our methodology just to refresh myself, make sure
20 I had a memory for all the details -- or as many
21 of them as I'm aware of -- for the methodology.

22 Q. All right. And so -- you mentioned that

1 you reviewed the materials for other depositions
2 that have taken place --

3 A. Uh-huh.

4 Q. -- in this case.

5 And were those depositions of other
6 Leapfrog employees?

7 A. Yes.

8 Q. All right. Did you review the
9 deposition -- deposition transcripts of --

10 A. Yes.

11 Q. -- any -- anyone other than Leapfrog
12 employees?

13 A. No.

14 Q. All right. And so in terms of the other
15 depositions -- the transcripts of the other
16 depositions, did you review the one for Melissa
17 Danforth?

18 A. Yes.

19 Q. All right. How about Lauren Bailey?

20 A. Yes.

21 Q. Karen Jupiter?

22 A. Yes.

1 Q. Kush Banerjee?

2 A. Yes.

3 Q. Alexandra Campione?

4 A. Yes.

5 Q. All right. Any others?

6 A. I don't think so. Those are all the
7 employees --

8 Q. Those are all the folks who have been
9 deposed so far.

10 A. Right. Okay. Yeah. Yes.

11 Q. All right. Did you watch any videos in
12 preparation for today's deposition?

13 A. No.

14 Q. Did you listen to any audio recordings of
15 meetings or calls?

16 A. No.

17 Q. Did you -- what about transcripts of any
18 meetings?

19 A. I didn't -- for this deposition, I did
20 not review the -- any transcripts.

21 Q. Okay. But you mentioned I think you
22 reviewed board materials, like, minutes for board

1 meetings.

2 A. Right.

3 Q. Okay. But those are not transcripts,
4 correct?

5 A. Right. No, those are minutes.

6 Q. Did you speak with any of the other
7 Leapfrog deponents before their deposition? And
8 I'm not talking about that initial joint prep
9 session.

10 A. Uh-huh.

11 Q. But other than that.

12 MS. BLAIR: I'll object to form to the
13 extent counsel may have been involved.

14 But if counsel was not involved, please
15 answer the question.

16 BY MR. CHUNG:

17 Q. I'm not interested in any communications
18 you had with any of your colleagues that was
19 involved in the presence of counsel or involved
20 counsel.

21 A. I -- when counsel was not present, I
22 spoke to employees to give -- offer encouragement

1 and thanks for doing this.

2 Q. Okay. And who in particular?

3 A. All of them.

4 Q. All right. Did you -- in addition to
5 offering them thanks for doing this, did you
6 discuss anything else about the case with any of
7 the deponents?

8 A. I just said, speak from your heart, tell
9 the truth. That's it. That's all I said to my
10 employees outside of counsel, but even with
11 counsel.

12 Q. Okay. How about after their depositions?
13 You mentioned that you reviewed their deposition
14 transcripts, but did you have any conversations
15 with any of the other deponents after they had
16 finished their depositions?

17 A. Yes, with counsel present.

18 Q. Okay. And so were there -- so were there
19 discussions with other deponents after their
20 depositions but with counsel present? Is that
21 right?

22 A. Yes.

1 Q. All right. And were those meetings or
2 calls?

3 A. Yes.

4 Q. Okay. And were those with just -- again,
5 joint discussions with multiple deponents or with
6 just single deponents who had just finished their
7 depositions?

8 A. With counsel and with single deponents
9 and sometimes -- I don't think anybody else was
10 there -- and myself and maybe one other person
11 sometimes depending on who it was.

12 Q. Okay. And this was after each
13 deposition; is that right?

14 A. Uh-huh.

15 Q. And is it with -- was it for each -- for
16 all the folks who had been deposed: Ms. Jupiter,
17 Ms. Bailey, Ms. Campione, Mr. Banerjee, and then
18 Ms. Danforth?

19 A. Yes.

20 Q. Okay. So after each deposition there was
21 a meeting or a discussion with counsel present
22 and you?

1 A. Yes.

2 Q. Okay. Let's go into your background. If
3 we can just start with your educational
4 background, your schooling from college on
5 forward.

6 A. I went to Brandeis University, and I
7 graduated officially in 1985, but I was actually
8 the class of '84. My father died at the end
9 of '84, so I had delayed my graduation. But I am
10 very much a proud '84 graduate.

11 I then worked -- I worked in publishing
12 for a little while. And -- I liked books, so I
13 decided at the age of 22 -- that's kind of how
14 you make decisions about your career -- is, I
15 like books, I think I'll get into publishing. So
16 I got a job at a publisher in Cambridge,
17 Massachusetts, worked there for about a year, two
18 years. Then ended up moving to New York for -- I
19 was recruited for another job, another publisher,
20 worked there for a while.

21 And then real -- well, I worked for a
22 family-owned publisher that had a fascinating

1 background. They were called Schocken Books, and
2 they were founded by -- they were founded by a
3 Jewish family in -- I think, in Europe that had
4 fled Nazi Germany and burned their warehouse down
5 with all the books because they didn't want the
6 Nazis to take down the manuscripts. And they
7 just took one copy of each book, fled to New York
8 and Israel -- anyway, it was an incredible story.
9 And they had classic books, like Kafka, things
10 like that. It was a fascinating place to work.

11 And so -- and I worked for Miriam
12 Schocken, who was the granddaughter of the family
13 that fled. It was just an incredible experience.
14 However, that was a time period in the '80s when
15 a lot of businesses were -- especially in
16 publishing, medium-sized publishers, like this
17 one, were really not doing well. So they were
18 bought by Pantheon Books, which was part of
19 Random House. They retained two employees. One
20 was the editor, who was the acquisitions editor,
21 and one was me. I was the publicist.

22 And -- so I went over to Random House,

1 and it was very different. It wasn't this
2 family-owned business anymore. And it -- I --

3 Q. Ms. Binder, I'm going to stop you there.
4 Your educational history.

5 A. Oh, okay. After working there for a
6 while, I went to University of Pennsylvania and I
7 got two master's degrees, one from the Fels
8 Institute of Government and one from Annenberg
9 School for Communication.

10 Q. Okay. And those -- I think those degrees
11 you received in 1994; is that right?

12 A. Yes.

13 Q. Okay. Let's -- so post the advanced
14 degree, the master's degree, can you talk about
15 your employment history?

16 A. So after I was working in publishing in
17 New York, I wanted to go into nonprofit and I saw
18 this position for a special assistant to the CEO
19 of an organization called the National League for
20 Nursing. And I had not been particularly
21 interested in healthcare as a career, but I
22 decided to interview because it sounded

1 interesting. And -- the job sounded interesting.

2 So I interviewed with Pam Maraldo, who
3 was the CEO. And I really just wanted to work
4 for her. She was amazing.

5 Q. And when was that?

6 A. '86, something like that.

7 Q. I'm talking about after you got your
8 master's degree. Your employment history. That
9 was my question. What was --

10 A. Oh, I missed the part that -- you wanted
11 after my master's?

12 Q. Yes.

13 A. Okay. After my master's -- well, I was
14 working during my master's. I worked while I was
15 in school.

16 Q. Okay.

17 A. But -- I was working for the National
18 League for Nursing while I was in school. And
19 then I -- then what did I do? I went to Planned
20 Parenthood for one year. I was there -- I ended
21 up being their Senate lobbyist.

22 And then I went to -- then I was

1 recruited to go to New York City to work in the
2 Giuliani administration for Maria Mitchell, who
3 was the deputy -- I forgot her title; it wasn't
4 deputy mayor, but it was equivalent -- for
5 healthcare.

6 And then I worked there for four years
7 and then moved to Maine, where I was CEO of a
8 nonprofit called Healthy Community Coalition,
9 which was an affiliate of a health system called
10 the Franklin Community Health Network.

11 And I worked for the CEO of the network
12 and, over time, we grew it. We raised a lot of
13 money through grants and things like that, so it
14 grew.

15 And so I had more people. And he -- my
16 boss, Rick Batt, asked me to take on a few other
17 things within the hospital. So I started working
18 on, like, education in the hospital, public
19 relations in the hospital. I did a lot of stuff
20 in the hospital.

21 Q. And you mentioned that this network was a
22 not-for-profit organization --

1 A. Yes.

2 Q. -- is that right? Okay.

3 And am I right that you were there for
4 about nine years?

5 A. Eight.

6 Q. Eight years? Okay.

7 A. Uh-huh.

8 Q. 1999 to about 2000- --

9 A. 2008.

10 Q. '8, okay.

11 A. So -- yeah, but I was -- so
12 eight-and-a-half, maybe, something like that.

13 Q. Okay. So -- and then you moved on to
14 The Leapfrog Group, am I right, after that?

15 A. Yes.

16 Q. Okay. And how did that opportunity come
17 about?

18 A. Well, my boss, Rick, had announced he was
19 retiring in a year, and so I started to think
20 about what's my next step. And this was a rural
21 community with not that many opportunities unless
22 I wanted to compete for his position, which --

1 they certainly wanted me to, but I didn't want
2 that particular position.

3 So I started looking online and I saw
4 that there was a national search for the CEO of
5 The Leapfrog Group, and so I thought, wow, well,
6 I'll put my hat in the ring. The reason I was
7 interested in particular was because I had seen
8 the impact of the Leapfrog survey and the process
9 of Leapfrog, I had seen an impact at our system
10 that was extremely powerful. It was even more
11 impactful than, say, Joint Commission
12 accreditation in those visits. It had a huge
13 impact on really transforming our patient safety.

14 So I had seen that, and so I was very
15 supportive and very excited about the
16 opportunity, but really didn't think that they
17 would find me out of nowhere. You know, I was in
18 the middle of nowhere, literally.

19 And they -- obviously they did. I mean,
20 I went through several interviews with the search
21 committee and -- et cetera, and then they offered
22 me the position. So...

1 Q. Okay. Just backtracking a little bit.

2 In your several years at the Franklin
3 Community Health Network in the middle of
4 nowhere -- don't tell that to Maine folks -- in
5 your role there, am I right that kind of the
6 ultimate position that you reached was
7 vice-president --

8 A. Yes.

9 Q. -- of that organization?

10 A. I was, like, vice-president and CEO of
11 the Healthy Community Coalition.

12 Q. Understood. Okay.

13 And as part of and as vice-president and
14 CEO of that organization -- and again, it was a
15 501(c)(3), correct?

16 A. Yeah.

17 Q. Right. It sounds like, based on kind of
18 what you were talking about in terms of the
19 growth of the organization while you were there,
20 that one of the your responsibilities as CEO was
21 basically fundraising; is that right?

22 A. Yeah. Raising money primarily through

1 grant writing.

2 Q. Right. Raising money to fund the
3 operations of the organization; is that right?

4 A. Partly the operations, but also
5 particular projects that we wanted to do, such as
6 we had a mobile health unit that went around
7 giving flu shots and screenings throughout this
8 very poor community. And we had an adolescent
9 anti-tobacco campaign we got funding for. We had
10 a breast cancer screening program. Things like
11 that. Things that would be related to preventive
12 care.

13 Q. Okay. So you joined The Leapfrog Group
14 in 2008 as the CEO and president; is that right?

15 A. No. I joined as CEO.

16 Q. And then -- was the president title added
17 later on?

18 A. Yes.

19 Q. All right. And who are your direct
20 reports currently?

21 A. Missy Danforth, Ralph Johnson, Karen
22 Jupiter, Daran Gaus.

1 I think that's it.

2 Q. Okay. And Leapfrog, safe to assume, was
3 founded before you joined, correct?

4 A. Yes.

5 Q. In about 2000 or so?

6 A. 2000.

7 Q. All right. Now, I want to allude to
8 the -- Leapfrog's mission statement as it's set
9 forth on the website. I'm sure you're familiar
10 with it. Let me know if you're not.

11 But it says that the mission is to
12 trigger giant leaps forward in the safety,
13 quality, and affordability of U.S. healthcare by
14 using transparency to support informed healthcare
15 decisions and promote high-value care.

16 Are you familiar with that language from
17 the website?

18 A. Yes.

19 Q. Okay. Was that the mission or the
20 mission statement when you first joined as CEO in
21 2008?

22 A. "Trigger giant leaps forward" was always

1 the tagline. There was variations on the full
2 mission statement --

3 Q. Okay.

4 A. -- over time.

5 Q. But at least kind of in its current
6 version, whenever --

7 A. Uh-huh.

8 Q. -- it came into being, Leapfrog's mission
9 is -- the foundation of it is in transparency,
10 correct?

11 A. And patient safety in particular.

12 Q. Right. And the goal of using
13 transparency is to equip healthcare consumers
14 with information that really helps them make
15 informed healthcare decisions, right?

16 A. Yes. And also to inform purchasers who
17 are employers of companies that offer health
18 benefits -- to give them information as well to
19 ensure that their employees can get the very best
20 care.

21 Q. Okay. Has Leapfrog always been a
22 not-profit [sic]?

1 A. Yes.

2 Q. All right. When you started out in 2008,
3 how did Leapfrog fund its operations? Where did
4 it get its revenue?

5 A. They had a couple of grants that were
6 finishing. And Leapfrog also had a little bit of
7 revenue from licensing its data.

8 And -- I'm trying to remember. I think
9 those were the two main sources, the grants
10 and -- for different projects. And -- oh, and
11 they had -- I'm sorry. They had partners. They
12 had a partners program. These were industry
13 partners who paid dues to be part of Leapfrog.
14 Not in a governance way. They were never part of
15 governance.

16 And then they also had sponsorships and
17 things like that for annual meeting.

18 Q. Okay. So at the time when you joined,
19 what was the most significant source of revenue
20 among the ones that you enumerated?

21 A. I think it -- I'm not sure. It might
22 have been licensure, the licensure programs, but

1 I'm not sure.

2 Q. Okay. You mentioned that there was a
3 little bit of revenue from the data licensure
4 programs.

5 A. Yeah, yeah, but there was also lots of
6 revenue from -- not lots. There was not that
7 much revenue at all, but there was some revenue
8 from some programs. And they had a grant -- I
9 say "they" because I wasn't here when they got
10 it, but they got a grant from ARC. They had a
11 conference -- some conference sponsorships. They
12 had probably about 200,000 -- well, I'm trying to
13 remember. They had some money from the
14 partnerships. I just can't remember which was
15 the largest source.

16 Q. Okay. Now, what are the most significant
17 sources of revenue for the organization?

18 A. The number one source of revenue for us
19 right now is accolade sales. These are sales of
20 the logo for an A to hospitals that earn an A
21 from the hospital safety grade.

22 The second highest source of income is

1 licensure of our data.

2 Q. All right. And that's what you mentioned
3 earlier? This is the --

4 A. Uh-huh.

5 Q. -- licensure of data that the --

6 A. Yeah.

7 Q. -- organization collects or the hospital
8 survey; is that right?

9 A. From a variety of -- primarily the
10 survey, but also the safety grade itself.

11 Q. Okay. Now, you were the CEO when
12 Leapfrog launched the hospital safety grade
13 program in 2012, correct?

14 A. Yes.

15 Q. Was that the first year of the hospital
16 safety grade?

17 A. 2012. Yes.

18 Q. 2012. Okay.

19 How did that come to be, the safety grade
20 program?

21 A. There was a conversation at our board in
22 the year 2010. In 2010, we were reflecting as an

1 organization on progress of the United States
2 since To Err is Human.

3 To Err is Human was a report that was
4 issued by the Institute of Medicine, which -- now
5 called the National Academy of Medicine. That
6 report suggested that upwards of 100,000 people
7 were dying every year from preventable errors in
8 hospitals.

9 And the employers who formed Leapfrog
10 were outraged by that and wanted to form Leapfrog
11 as a way of getting more transparency so they
12 could identify where the issues were and they
13 could inform their employees about where the
14 hazards are.

15 So that was what -- and also, primarily,
16 they wanted to see a reduction in these problems
17 in hospitals and save some lives.

18 So in 2010, there was a reflection ten
19 years out, ten years after To Err is Human, how
20 are we doing as a country? How are we doing at
21 Leapfrog?

22 And there were a number of studies that

1 came out that year asking that question. And the
2 answer was, we're not doing well at all. It's
3 gotten -- the only evidence we have is it's
4 gotten worse. And -- in part because we can
5 measure it better.

6 So we can -- we're not -- To Err is
7 Human, they had to really estimate a lot because
8 there was just no measurement; there was no data.
9 They had to really bring some experts in and try
10 to figure it out from pulling records from
11 hospitals. And it was -- so it was an estimate.

12 And now they think -- they thought in
13 2010 it's more like twice that at least.

14 So the only evidence we had in 2010 was
15 that things got worse, that we made no progress;
16 things probably got worse.

17 And so that was a really big issue for
18 the board at Leapfrog. What does that mean for
19 us as an organization? Are we headed in the
20 right direction?

21 And we talked a lot about what's the
22 problem, and we -- I think the board felt -- I

1 completely agree -- that the problem with what
2 the Leapfrog model is is not that it's a bad idea
3 to have transparency in the marketplace. That
4 works in every market. It will work in
5 healthcare.

6 The problem we had was that hospitals
7 that chose not to be transparent and declined to
8 report to the survey just got a pass. So that
9 wasn't going to be a functional market if
10 hospitals were declining to report to the survey.
11 So -- and you don't have data from every
12 competitor in a market. So -- and there was no
13 other data source.

14 So we decided that what we had to do was
15 figure out how we can get enough data to be able
16 to have a functional market in healthcare so that
17 hospitals can compete to deliver top quality care
18 to the employees of these businesses that were
19 part of Leapfrog.

20 So that was what we set out to do. Then
21 the following year, one of our board members
22 said, you know, in L.A. -- I think he was talking

1 about L.A. -- they have this thing with
2 restaurants where restaurants -- they used to
3 have -- we've always had reporting publicly in
4 the newspaper of hygiene problems at restaurants.

5 Q. Yup. I'm familiar with it?

6 A. Yeah. So most people don't like reading
7 those because they're, like, gross. It's, like,
8 you've got to read about rats and stuff like
9 that. Right? So -- but -- most people ignored
10 them until they started grading the restaurants
11 and requiring the restaurants to post the grade
12 in their front window.

13 And once they started doing that, all of
14 a sudden -- the way our board member put it is
15 there's no more C-restaurants because no one
16 wants to go to a C-restaurants. And -- or it
17 just -- people don't -- they're scared of that.
18 So it had a real impact. People paid attention
19 to that.

20 So he said, why can't we just do that
21 with healthcare? Why can't we do that with
22 hospitals? And we put our heads together.

1 At that time, thanks to the Affordable
2 Care Act, there was suddenly data available from
3 CMS. That had not been available before, but we
4 now had it. We had some very good data on
5 patient safety by hospital, and we could use it.

6 So we suddenly realized that we could
7 grade hospitals and we could get all of them and
8 not wait for just the ones that are willing to be
9 transparent. We could do that.

10 Now, the data we had was not -- it was
11 good, but it wasn't enough. We wanted more. And
12 we wanted more comprehensive data, especially on
13 some of the areas that are the most dangerous for
14 patients, such as medication safety, which is the
15 number one error that hospitals make.

16 So we wanted more data. And so we
17 thought, well, let's get some experts together
18 and figure out how we could do it with CMS data.
19 AHA had some data. And Leapfrog had some data.
20 Let's see if we could put it all together into a
21 grade.

22 So I worked with Arnie Milstein, who is

1 still on our board. He came back to our board.
2 Actually, he was on the original board of
3 Leapfrog, and a founder of Leapfrog and very much
4 involved. He's now at Stanford. At the time, he
5 was at Pacific Business Group on Health. And
6 he -- and also, he worked as a consultant to
7 Boeing as part of -- he was part of Mercer.

8 Anyway, so Arnie and I worked together to
9 identify people for the expert panel. And the
10 first person I called beside Arnie was Lucian
11 Leape, who's, like -- he's sort of considered
12 like the father of the patient safety movement.
13 He sadly passed just about a month ago.

14 But, anyway, Lucian Leape gave me a
15 couple of people that he thought would be great.
16 He himself really was enthusiastic and joined the
17 expert panel.

18 And we -- the different -- he said, I've
19 got this young guy, he's brilliant, he's
20 written -- he's got tons of published research
21 already, he's at Harvard with me. I think he's
22 going places. And he wanted him. His name was

1 Ashish Jha who is now pretty well-known. He's
2 now the dean at Brown and he was the COVID
3 coordinator for a while --

4 Q. So Ms. Binder, I'm going to stop you
5 there because we are going to get to the expert
6 panel topic --

7 A. Okay.

8 Q. -- so why don't we -- you're kind of
9 skipping ahead to an area that I wanted to get
10 to --

11 A. Sure --

12 Q. -- later, but --

13 A. Well, anyway, I personally recruited the
14 expert -- you asked me how this -- founded, so
15 I'm going to tell you --

16 Q. Yeah.

17 A. So I personally recruited that expert
18 panel, along with Arnie and Lucian Leape. And
19 then they met, and we worked with -- we worked
20 with the scientific team that we had at the time
21 and we developed a whole -- a protocol for
22 figuring out how we take all this data and how we

1 weight it so that it will turn into, ultimately,
2 composite scores.

3 And there was a process to that that was
4 built on -- it was built on a platform, a
5 research platform, from ARC that Patrick Romano
6 had been instrumental in developing, which was we
7 weighed each measure by impact, opportunity, and
8 evidence based.

9 Q. And these are the 30 measures; is that
10 right?

11 A. At the time, it wasn't -- at the time,
12 actually, we had 40 or 45 that --

13 Q. So the number of --

14 A. -- we were looking at.

15 Q. -- total measures or metrics has changed
16 over time, correct?

17 A. Yeah. As the methodology has evolved
18 with the science and the evidence. But at the
19 time, we were looking at about 45 measures, some
20 of which were not very good that were available.

21 So they had to weight it, and some of
22 them they cut out because they didn't think they

1 were good.

2 Q. You testified just a little while ago
3 that a purpose -- or one of the purposes of the
4 health safety grade was to -- hospital safety
5 grade was to basically create a marketplace.

6 Right? Do you remember your testimony --

7 MS. BLAIR: Objection to form.

8 BY MR. CHUNG:

9 Q. -- on that?

10 A. I didn't say the safety grade was to
11 develop a marketplace. That was The Leapfrog
12 Group -- that Leapfrog wanted a marketplace --

13 Q. Okay.

14 A. -- that was functional.

15 Q. A --

16 A. That was before, they wanted --

17 THE REPORTER: I just can't get you both.

18 BY MR. CHUNG:

19 Q. Go ahead.

20 A. I was saying Leapfrog in 2010, which was
21 before the safety grade, wanted a functional
22 marketplace. They needed to have all hospitals

1 in.

2 Q. Okay. And am I correct that at least one
3 purpose of the hospital safety grade or -- that
4 came into being was to build or promote that
5 marketplace? Is that right?

6 A. Yes.

7 Q. And in this marketplace, hospitals would
8 be essentially competing against one another
9 based on the hospital safety grades that had been
10 assigned to them; is that right?

11 MS. BLAIR: Objection to form.

12 THE WITNESS: I don't think our goal was
13 to do anything with hospitals. Our goal was to
14 help patients and families and communities and
15 the employees of the purchasers to select the
16 right place to go. So I don't -- we weren't
17 focused on what impact specifically that would
18 have on hospitals except for the fact we hoped
19 that it would cause them to aim for an A.

20 BY MR. CHUNG:

21 Q. Right. And participate in the survey,
22 correct?

1 A. No. That wasn't a goal, per se. We just
2 wanted to have a letter grade available.

3 Q. Well, how would they -- how would the
4 hospital -- you said that one of the goals, at
5 least with respect to hospitals, was to encourage
6 them or -- encourage them to aim for an A,
7 correct?

8 A. Yes.

9 Q. Right? But in order to aim for an A, is
10 it correct that they would have to participate in
11 the hospital survey?

12 MS. BLAIR: Objection to form.

13 THE WITNESS: In order to aim for an A,
14 they would have to do well on most of the
15 measures in the grade, and most of the measures
16 come from CMS. So they would need to do very
17 well on patient safety. And CMS, if they
18 participated in the survey, they would have to do
19 well on that, too.

20 BY MR. CHUNG:

21 Q. Okay. Some questions about Leapfrog's
22 organizational structure. And this is topic 1

1 from the list of topics in the 30(b)(6) notice.

2 How many employees does Leapfrog have
3 currently?

4 A. 20.

5 Q. Any part-time employees?

6 A. No.

7 Q. All right. Does Leapfrog hire any
8 independent contractors or consultants?

9 A. Oh, yes. On occasion.

10 Q. Okay. And who are they currently?

11 A. We have a -- we have -- let's see. We
12 have a lot of contractors.

13 So John Hopkins Medicine. Matt Austin is
14 a contractor for the science behind the survey.

15 We have Raven -- we have -- which handles
16 some of the programming on our websites.

17 We have a company called Square that does
18 other kinds of programming for the data analysis
19 and the data collection through the survey and
20 safety grade.

21 Mathematica helps us with double-checking
22 calculations now and also helped us -- helps us

1 with some statistical analysis, things like that,
2 on occasion.

3 We have -- we have a number of -- let's
4 see. We have CURA, which is our public relations
5 firm.

6 We have a number of different consultants
7 who help us with, like -- we do radio -- we do,
8 like, some radio announcements around some of our
9 PR.

10 We have a photographer who works with us.
11 A videographer who works with us on the annual
12 meeting.

13 Q. Okay. Well, we'll discuss I think in
14 more detail some of the consultants.

15 But it sounds like a lot of contractors
16 and consultants --

17 A. Yes.

18 Q. -- is that right? All right.

19 And the organization has a board of
20 directors, right?

21 A. Yes.

22 Q. And what's the process for selecting

1 members of the board?

2 A. We have a nominations committee that
3 reviews a matrix of -- it's a matrix of the
4 skills and experiences, diversity, geographic
5 diversity and other kinds of diversity, of board
6 members, and then sets goals for what we are
7 going to need in the coming year, or coming two
8 years, and helps to identify candidates.

9 Then the nominations committee screens
10 those candidates by interviewing them and
11 ultimately decides on -- if they wish, they
12 decide on candidates they want to bring forward
13 to the board for election to the board.

14 Q. Okay.

15 A. And the board elects them.

16 Q. And do you attend board meetings?

17 A. Yes.

18 Q. All right. Does Leapfrog have any
19 advisory committees?

20 A. Yes.

21 Q. And what do they do?

22 A. We have a hospital advisory committee

1 that is offering us insights into the hospital
2 industry and concerns and priorities around
3 quality. They look at long-terms issues only.
4 We make it very clear in every communication with
5 them that they have no influence on current
6 programs, like the current survey or the current
7 safety grade. But we will ask them things like,
8 we know there's a nursing shortage; how is that
9 impacting hospitals and what are the kinds of
10 things you look to to improve nursing? For
11 instance, something that we would talk to the
12 hospital advisory committee about.

13 That -- so that's one committee. Do you
14 want to know more about their composition or any
15 of that? Or you just want me to tell you what --

16 Q. Just kind of high level, yeah.

17 A. Yeah. And then we have a partners
18 advisory committee that's industry partners,
19 meaning representatives of companies that do
20 business in the healthcare industry.

21 Leapfrog's board deliberately does not
22 have anyone on it who is in the healthcare

1 industry. If a board member gets a job within
2 the healthcare industry, they resign. They're --
3 and that's happened a few times.

4 Q. Okay.

5 A. So the partners advisory committee is an
6 opportunity for us to get some insight from
7 people who are clearly committed to the Leapfrog
8 mission because they pay dues to the organization
9 and we are able to get some insights from them.

10 We also have an ASC advisory committee,
11 because we now have an ASC survey.

12 I'm sure I'm -- let me think.

13 Q. Okay. We may come back to other advisory
14 committees, but --

15 A. Sure.

16 Q. All right. Let's -- I want to ask you a
17 few questions -- looping back to the expert panel
18 that you mentioned earlier, what's your role with
19 respect to the expert panel?

20 A. I watch it from a distance. So --

21 Q. What do you mean by that?

22 A. I rarely go to any of their meetings.

1 When they've had in-person one-day meetings,
2 which is, like, twice, I want to say, we've had,
3 I will go to those. But otherwise -- and those
4 are more like long-term planning kinds of
5 meetings.

6 But in terms of their deliberations,
7 which are sometimes in group meetings and
8 sometimes just one-on-one with Matt or Missy or
9 others, I do not -- I try to stay away from
10 those. I don't want the expert panelists to have
11 the impression that they're being watched by the
12 CEO. I want them to be independent and feel
13 comfortable being as absolutely candid as
14 possible.

15 So I have -- I learn about what their
16 views are by reading minutes or looking at, you
17 know, transcripts or -- and talking to,
18 particularly, Missy Danforth or Matt Austin. I
19 speak to those two very frequently to really
20 understand where the expert panel is on various
21 issues.

22 Q. So you may not attend many of the expert

1 panel meetings, but Ms. Danforth does; is that
2 right?

3 A. Yes.

4 Q. All right. And in addition to members of
5 her -- the ratings team; am I right about that?

6 A. Usually one member of -- I don't think
7 she wants to populate the whole meeting with --

8 Q. Right. But at --

9 A. -- just Leapfrog people.

10 Q. -- least Ms. Danforth and a member of
11 her --

12 A. Yeah.

13 Q. -- team.

14 A. Yes.

15 Q. Okay.

16 A. And Matt Austin also facilitates the
17 expert panel process.

18 Q. Is Matt Austin a member of the expert
19 panel?

20 A. No.

21 Q. All right. What is his role, then?

22 A. He's a facilitator. And he's also our

1 key scientific advisor. So he will -- so when
2 there's frequently follow-up from an expert --
3 any expert panel meeting, whether it's a
4 one-on-one with one member or the whole group,
5 they will often say, well, can you run some
6 analysis of something, or this or that, or can
7 you do a 0statistical -- blah, blah, blah.
8 There's often follow-up. He will do that.

9 And he will also -- or they'll say
10 there's been a couple of studies we just heard
11 about that came out; we need to look at those.
12 He'll get those studies, he'll do analyses for
13 them.

14 So the follow-up that has to do with the
15 scientific analysis and evidence base of our --
16 both our survey and our safety grade he works on.

17 And so for the process for the hospital
18 safety grade, he does that kind of analysis.

19 Q. Okay. Does Leapfrog itself present
20 proposed changes to the expert panel?

21 A. Uh-huh. Yeah.

22 Q. All right. And does the panel -- and is

1 the panel then expected to make a decision on
2 whether to adopt that change?

3 MS. BLAIR: Objection to form.

4 THE WITNESS: The panel is not -- they
5 don't make a group decision. It's a -- they --
6 they have a process for evaluating anything we
7 bring forward or anything that they bring
8 forward. Sometimes they bring it, or an
9 individual will bring it.

10 But they have a process that is sometimes
11 in a group meeting and sometimes separately for
12 ultimately reaching consensus on a particular
13 issue. But it is not a -- it's not a one
14 decision.

15 BY MR. CHUNG:

16 Q. What do you mean --

17 A. They don't vote. They don't vote.

18 Q. Oh. So there's no process --

19 A. It's a traditional -- it's a traditional
20 expert panel.

21 Q. So there's no process by which they vote
22 on a proposed change?

1 A. No. But they reach consensus and they
2 are -- and I make sure that there's consensus
3 whenever I agree to any change.

4 Q. How do you make sure that there's
5 consensus among all members of that panel?

6 A. Well, I will ask, first of all, Matt and
7 Missy exactly where each member of the expert
8 panel is on this issue or that issue. And
9 there's often lots of follow-up with individual
10 members of the expert panel to find that out.

11 If I actually really want to know, I'll
12 call one of the members myself. That has
13 happened occasionally.

14 But I would never go forward -- we're not
15 going to go forward with anything on the survey
16 or the safety grade where the expert panel
17 disagrees -- or any member of the expert panel
18 disagrees. We're very careful about making sure
19 that there's agreement.

20 And these are not -- these are not shy
21 people, so I know they'll tell me if there's a
22 problem. And -- or they'll tell Missy or Matt.

1 And so that -- so the process is not
2 Congress. This is a process that's, like, very
3 traditional expert panel -- scientific expert
4 panel process where they meet, they confer, they
5 ask for further follow-up, they look at other
6 studies, they look over time, we call someone;
7 they say -- you know, there's a process to and
8 it, and then ultimately they reach a consensus.

9 Q. And how is that -- is that consensus
10 memorialized?

11 A. It's memorialized because we put out for
12 public comment what we ultimately want to make
13 for a change, and --

14 Q. But my question is, is the -- you said
15 that the -- with respect to any proposed
16 change --

17 A. Yeah.

18 Q. -- the consensus has to be unanimous
19 among the members of the expert panel, correct?

20 A. There has to be --

21 Q. Right. But is --

22 A. -- there has to be consensus, yeah.

1 Q. You said unanimous consen- -- is it
2 unanimous consensus?

3 A. Yeah, I want unanimous consensus.
4 They're advisors to us so, in theory, if it
5 wasn't unanimous, we could still go forward with
6 it. But I like it unanimous.

7 Q. So how is that unanimity in the consensus
8 among the expert panel members memorialized?

9 A. It isn't.

10 Q. Okay.

11 A. It just -- we have the --

12 Q. Why not?

13 A. It's memorialized by the fact that -- we
14 don't have anything that says we voted on this or
15 this is the final thing. We don't -- because we
16 don't vote.

17 It's memorialized by the fact that the
18 expert panelists are okay when we put out for
19 public comment. They get a copy of what we're
20 putting out for public comment in advance, and
21 they will tell us in about two seconds if they
22 don't agree with something on there. But they've

1 agreed to it already.

2 So it's memorialized by the fact that
3 it's out for public comment, and they support it.

4 Q. But there isn't a separate documentation
5 or minutes or any sort of document where it's
6 memorialized that each member of the expert panel
7 has agreed to the proposed change; is that right?

8 A. Right.

9 MS. BLAIR: Objection to form. Asked and
10 answered.

11 BY MR. CHUNG:

12 Q. Does the expert panel make
13 recommendations?

14 A. Yes.

15 Q. All right. And is Leapfrog bound to
16 follow those recommendations?

17 A. Individuals within the expert panel make
18 recommendations all the time. Does the whole
19 expert panel end up agreeing that that's where it
20 should all go? Not always.

21 Q. I'm actually asking, does the whole
22 expert panel -- right? -- as a group, make

1 recommendations to Leapfrog?

2 A. No. Well, I mean -- I'm sorry. I'm not
3 sure I can even understand that. How does a
4 whole group make one recommendation?

5 Q. That's exactly my question.

6 Does the -- are there recommendations
7 that the expert panel makes to Leapfrog?

8 A. Recommendations that go out for public
9 comment are the consensus of the expert panel.

10 Q. But those recommendations -- but those
11 recommendations are coming from Leapfrog,
12 correct?

13 MS. BLAIR: Objection to form.

14 THE WITNESS: They're coming from the
15 expert panel. These are not -- these are not
16 rubber stamp people. These are, like, in some
17 cases, world experts. They don't rubber stamp
18 what we bring them, and they didn't in this --

19 BY MR. CHUNG:

20 Q. I'm not asking about --

21 A. -- case either.

22 Q. -- rubber stamping, Ms. Binder.

1 You testified earlier that, with respect
2 to -- actually, why don't we illustrate it with a
3 specific example later on. We'll get to that
4 later.

5 All right. Let's talk about the scoring
6 methodology behind the hospital safety grade.

7 How did Leapfrog -- or actually, in terms
8 of the hospital safety grade itself, I understand
9 that Leapfrog uses, like, a report card scale --
10 right? -- A, B, C, D, F, for purposes of the
11 hospital safety grade.

12 Why not assign a numerical score, like 60
13 out of 100 or 80 out of 100 or 100 out of 100?

14 A. We chose to use a Z-score methodology.

15 Q. What does that mean?

16 A. A Z-score methodology is kind of like
17 grading on a curve. It allows you to score based
18 on how a hospital performs relative to others in
19 the cohort.

20 Q. Okay. So why use the A, B, C, D, F
21 scale?

22 MS. BLAIR: Objection to form.

1 THE WITNESS: The Z-score methodology is
2 what is behind the A, B, C, D, or F. So for
3 instance, a hospital that scores three
4 standard -- on the Z-score scores three standard
5 deviations below the mean would be like an F.

6 BY MR. CHUNG:

7 Q. Okay. Well, is one of the purposes -- at
8 least one of the purposes of using the A, B, C,
9 D, F scale of grades is that it's easy for
10 consumers to understand?

11 A. Yes.

12 Q. All right. Are you familiar with
13 Leapfrog's scoring methodology behind the
14 hospital safety grades?

15 A. Yes.

16 Q. All right. Do you have any role in
17 designing that scoring methodology?

18 A. Well, I'm the decisionmaker. So if
19 there's any fundamental change, yes, I would -- I
20 better be familiar with what's going on.

21 Q. Okay.

22 A. But I'm not a -- I'm not a, you know,

1 expert on -- I'm not an expert on statistics or
2 on healthcare measurement. I'm not Patrick
3 Romano. But I am -- obviously I do have to have
4 a strong familiarity with the methodology
5 because, ultimately, the buck stops with me; I
6 have to make the decisions.

7 Q. Okay. Who within Leapfrog is responsible
8 for designing the methodology?

9 A. There's a number of people who design
10 various aspects of the methodology.

11 Q. Okay. Can you just briefly go over them?

12 A. Well, Missy Danforth designs some
13 methodology for some of it.

14 Matt Austin has a lot to do with some
15 methodology for the survey, some aspects of --
16 for instance, when there's a new measure on the
17 survey, like, we'll need to come up with a
18 scoring methodology for it, and he will help us
19 and work with sometimes -- sometimes we'll hire a
20 statistician, even within Johns Hopkins, to help
21 us with that, to figure out how we're going to
22 score things, so --

1 Q. Do you have any role in designing the
2 survey, the hospital survey?

3 A. Do I have any role in --

4 Q. Yes.

5 A. -- the hospital survey?

6 Q. Yes.

7 A. I'm not sure what you mean by designing.

8 Q. Do you have any role in coming up with
9 the content or the questions or the requests in
10 the hospital survey?

11 A. I often will have a role in looking at a
12 particular issue that we know is coming to the
13 fore that is of great importance, and I will then
14 ask the team to start researching to see if this
15 is an area we should add to the survey that --
16 for instance, we have added to the survey
17 something on ER boarding, which is clearly
18 becoming an increasing major problem, and there's
19 been some studies recently that I was seeing.
20 And some physicians, actually, from Yale New
21 Haven Hospital had come to me personally and
22 said, we really want you to look at this issue;

1 it's a big problem in patient safety; it's
2 emerging nationally.

3 And so I asked the team to start
4 researching it. They did find a significant
5 amount of peer-reviewed research, which is very
6 important to us --

7 Q. Right.

8 A. And --

9 Q. And did that feedback make its way into
10 the survey eventually?

11 A. Yes.

12 Q. All right. Do you have any role in
13 reviewing responses from hospitals to the
14 hospital survey?

15 A. Yes. I read every one of them.

16 Q. Okay.

17 A. Or -- I'm sorry, wait a minute. Let me
18 be clear about that. Wait a minute.

19 The responses to the actual surveys that
20 are submitted? No, I don't read all those.

21 Q. What are you --

22 A. I'm sorry. What --

1 Q. -- referring to then?

2 A. -- I meant -- what I meant was the public
3 comments. So we have --

4 Q. Oh.

5 A. -- public comments that come in for the
6 safety grade, for the survey, frequently during
7 the year, and I read those.

8 Q. Okay. But not the actual survey -- the
9 data that's submitted in response to the survey,
10 you don't review that?

11 A. Sometimes, but rarely.

12 Q. Okay. How does Leapfrog verify the
13 accuracy of the information, the data --
14 right? -- submitted by hospitals in response to
15 the survey?

16 Let me kind of break that down.

17 A. Okay.

18 Q. Does Leapfrog conduct onsite audits of
19 hospitals pursuant to their survey responses?

20 A. For four or five hospitals, yes, we do.

21 Q. Four or five hospitals out of every
22 cycle; is that right?

1 A. Are you talking about the safety grade or
2 the survey?

3 Q. The survey.

4 A. The survey?

5 Q. Yeah.

6 A. For each year, we do the onsite -- the
7 onsite verification is about five hospitals.

8 Q. Okay. And that's out of the entire
9 population of hospitals --

10 A. For onsite only.

11 Q. If you can let me finish the question.

12 A. Sorry.

13 Q. And that's out of the entire population
14 of hospitals that have responded to the survey --

15 A. Yes.

16 Q. -- is that right?

17 A. Yes.

18 Q. All right. And how are those four or
19 five chosen?

20 A. They are fairly randomly selected.

21 Q. Okay.

22 A. I wouldn't say it's perfect random, but

1 they -- but fairly randomly.

2 Q. All right. And does -- am I right that
3 Leapfrog does not require sworn attestations from
4 responding hospitals?

5 A. They require attestations in order to
6 submit the survey.

7 Q. Are they sworn, though?

8 MS. BLAIR: Objection to form.

9 THE WITNESS: What's sworn mean?

10 BY MR. CHUNG:

11 Q. Are they -- sworn means --

12 A. By who? Who would swear them other than
13 the CEO at- -- attesting to when they submit the
14 survey.

15 Q. Are they notarized?

16 A. No, they're not notarized.

17 Q. All right. Does Leapfrog have mechanisms
18 to verify the truthfulness of survey responses?

19 A. Yes. Significantly.

20 Q. All right. How does it do that?

21 A. It has several layers of it, actually.

22 It has -- it has a verification at the

1 submission, which looks at patterns that don't
2 make sense or issues that don't make sense that
3 are quite complex.

4 So for instance, if a hospital says that
5 they're reporting on maternity care and they
6 said, we had 300 births this year, the electronic
7 programming within the survey will spit it back
8 and say, wait, you said 400 last year.

9 So there's very -- there's some pretty
10 significant built-in safeguards to assure the --
11 or not assure always, but to look at the
12 accuracy.

13 Then, once the survey arrives at us, once
14 it gets through that, then that's when our team
15 gets started. And our team has -- spends
16 enormous amounts of time requiring documentation
17 from a selection of hospitals. Every month they
18 demand documentation.

19 So for instance, there's a section on the
20 survey on a never-events policy. We ask
21 hospitals, do you have a never-events policy that
22 follows Leapfrog's guidelines? They require a

1 selection of hospitals every month to send us
2 their never-events policy and show us the board
3 minutes where it was approved.

4 Things like that. So it is extensively
5 verified every single month. So those -- so it's
6 a very intensive process.

7 And most hospitals that complete the
8 survey say this drives them crazy because we are
9 so picky and our team is so on top of things.

10 Q. Does every section of the survey have a
11 verification process?

12 A. Uh-huh.

13 Q. Okay. And when you mentioned earlier
14 that first step -- right? -- is it -- the first
15 step of the verification, is that an algorithm or
16 some sort of automated process?

17 A. It's an automated process.

18 Q. All right. Does a hospital face any
19 consequences for submitting inaccurate
20 information?

21 A. We'll decertify their survey and remove
22 it.

1 Q. What do you mean by remove it?

2 A. Remove it from public reporting. Or
3 sometimes we'll decertify the section where the
4 inaccuracy occurred.

5 Q. Okay. Does that mean it's basically as
6 if they never submitted it?

7 A. Yes. And then sometimes we will then ask
8 them to resubmit, which we'll then verify again.

9 Q. All right. Do they -- so can hospitals
10 update or correct their survey responses after
11 that initial submission?

12 A. Yes.

13 Q. All right. And what's the process for
14 correcting responses?

15 A. We send -- first we send notification to
16 them that they have 30 days to verify and/or
17 correct a particular issue that we've observed.
18 If they don't come back, we decertify that
19 section and then we come back to them again. And
20 we report it as either -- yeah, we -- we take
21 down that section of the survey or we take down
22 their entire hospital's results and we don't use

1 them in other programs such as the top hospital
2 qualification or the safety grade.

3 Q. Have hospitals -- has a hospital ever
4 been asked to revise their submission?

5 A. Yes. Well, they're asked to correct it.

6 Q. Okay. Has Leapfrog ever changed a
7 hospital's safety grade after it's been issued?

8 A. No.

9 Q. No? Okay. So once it's issued, that's
10 it?

11 A. One thing we will do, if we find that
12 there's something wrong with data underlying
13 it -- and that happened a lot with the AHA
14 data -- is we will remove their grade from
15 reporting. We have, I believe, done that in a
16 small handful of times.

17 Q. Okay.

18 A. But we have never changed a grade.

19 Q. All right.

20 MR. CHUNG: Why don't we turn to our
21 first document, which is tab 8.

22 So this will be Exhibit 1.

1 (Binder Deposition Exhibit 1 marked for
2 identification and attached to the
3 transcript.)

4 BY MR. CHUNG:

5 Q. So Ms. Binder, Exhibit 1 is an e-mail
6 chain from July through August of 2023 between
7 you and an Adhi Sharma from -- the CEO, Mount
8 Sinai South Nassau Hospital.

9 And I want to direct your attention first
10 to -- if you look at the lower right-hand -- on
11 these documents, I'll be identifying page numbers
12 by what's called the Bates number on the lower
13 right-hand corner.

14 A. Uh-huh.

15 Q. You'll see that. So this will be --
16 let's focus on Bates ending in 3130.

17 A. I'm probably going to need to read
18 through this because I don't recall this.

19 Q. Okay. Well, I'm going to direct your
20 attention to -- Mr. Sharma says he wanted to
21 bring to items to your attention for your
22 consideration.

1 Do you see that at the bottom of Bates
2 number 3130?

3 A. Yes.

4 Q. All right. And then he continues on to
5 the next page, The Leapfrog survey is lengthy,
6 with over 500 questions and data gathering
7 required for many of the questions. It is one of
8 the more resource-intensive surveys in many
9 hospitals, and health systems are still
10 struggling with significant workforce shortages.

11 Is it right that Mr. -- I think it's
12 Dr. Sharma -- is expressing that the survey is
13 burdensome for hospitals to complete? Is that
14 right?

15 A. That --

16 MS. BLAIR: Objection to form.

17 THE WITNESS: As I'm reading this, he
18 says that it's resource-intensive and many
19 hospitals are still struggling with workforce
20 shortages.

21 He also says that -- so is the Magnet
22 status survey.

1 BY MR. CHUNG:

2 Q. Yeah. I mean, do you agree with
3 Dr. Sharma's characterization of Leapfrog's
4 survey?

5 A. I don't agree that it's burdensome,
6 but -- no, I don't agree with his
7 characterization.

8 Q. Okay. So you don't agree that it's a
9 resource-intensive survey while hospitals are
10 facing staffing shortages?

11 A. Resource-intensive is relative. It's
12 nowhere near as resource-intensive as most of the
13 other kinds of work that a quality department
14 will do, such as prepare for accreditation,
15 handle registry reporting and things like that.

16 So those are extremely
17 resource-intensive. Those require the hiring of
18 full-time people all year to work on them.

19 This --

20 Q. But the --

21 A. -- ours is --

22 Q. -- survey is a voluntary survey --

1 A. -- a --

2 Q. -- correct? But the survey is a
3 voluntary survey, correct?

4 A. Yes.

5 Q. Okay. And the other items that you
6 mentioned that you called resource-intensive, are
7 those voluntary as well?

8 A. Registries are voluntary. They're
9 just -- the difference between registries and
10 Leapfrog is that registries almost never make the
11 data public. So there's no transparency
12 whatsoever.

13 Same with accreditation, which they -- I
14 mean, I guess they could choose not to be
15 accredited, but they will be accredited.

16 But that's still very resource-intensive.
17 Most of what a quality department is doing is
18 extensive -- extensive and requires -- some
19 registries require hiring at least one full-time
20 equivalent for the entire year.

21 Q. Okay.

22 A. Leapfrog requires about 80 hours of staff

1 time.

2 Q. Okay. And what is that based on?

3 A. That's based on conversations over time
4 that both Missy Danforth and myself have had.
5 We've asked repeatedly how long does it take, and
6 we get answers anywhere from 20 to 100 hours, and
7 most of them are around 80.

8 Q. So on the same page Dr. Sharma continues
9 that, The weight given to the patient experience
10 survey is disproportionate, and that one of the
11 reasons we -- or his hospital -- did not submit
12 in the past was simply because we knew that,
13 despite very strong quality measures, our patient
14 satisfaction scores would prevent us from --

15 A. Oh, I --

16 Q. -- performing as well --

17 A. -- am seeing this now.

18 Q. Do you see that?

19 A. Sorry.

20 Q. And so the question is, do you agree with
21 Dr. Sharma's statement here, position here, that
22 patient satisfaction scores can prevent a

1 hospital with strong quality measures from
2 performing well on the survey?

3 MS. BLAIR: Objection to form.

4 THE WITNESS: Yeah, I'm going to need to
5 read this because now, as you're saying this, I'm
6 realizing this is a gentleman who had the very
7 common problem of confusing the safety grade and
8 the survey.

9 So what I was just referring to was the
10 survey.

11 BY MR. CHUNG:

12 Q. Okay.

13 A. He's not actually talking about that.
14 He's talking -- even though he says it's the
15 survey, it's not the survey. He's talking about
16 the safety grade, because patient satisfaction,
17 which isn't patient -- it's patient experience
18 scores that are on the safety grade have been
19 correlated with good evidence, are the ones that
20 are correlated with outcomes in patient safety,
21 and that's where we use them.

22 But -- yeah, so that's what he's talking

1 about, as I read this.

2 Q. Okay. Now, in response to Dr. Sharma --
3 and I'm looking at Bates ending in 3129. So it's
4 basically -- it's your response, your first
5 response, to his e-mail.

6 You write, Hi, Rob.

7 And then in third paragraph you write,
8 There are -- but there are 30 measures considered
9 overall, so outstanding performance on some
10 measures can tip the scales in a hospital's favor
11 even when some other measures are mediocre.

12 Do you see that?

13 A. Yeah. I'm just going to take a minute to
14 read this --

15 Q. Sure.

16 A. -- because I don't recall it.

17 Okay. So --

18 Q. So just reading that sentence, does this
19 mean that a hospital can perform poorly in one
20 category but highly in another and receive a high
21 hospital safety grade?

22 A. Yes.

1 Q. Okay.

2 A. In fact, I'm -- probably most hospitals
3 will have some measures where they perform
4 poorly.

5 Q. Okay. Are -- just on a separate topic,
6 are pediatric or children's hospitals, included
7 in the hospital survey?

8 A. They're invited and -- they're invited to
9 participate and they can, and some do.

10 Q. All right. What do you consider to be
11 the definitions of a children's hospital?

12 A. A hospital that serves pediatric
13 patients.

14 Q. Okay. You're familiar with the
15 plaintiff -- the five plaintiff hospitals that
16 are involved in this case?

17 A. Yes.

18 Q. Okay. Are you aware that the St. Mary's
19 Hospital is a combined adult and children's
20 hospital? Do you understand -- do you know that?

21 A. I'm not sure --

22 Q. Not sure?

1 A. I'm not sure.

2 Q. Okay.

3 A. Most hospitals -- most general hospitals
4 also have pediatric patients. They have
5 patients -- so -- are you saying they serve
6 pediatric patients and -- or you're saying
7 they're two hospitals?

8 Q. They are -- it's a combined adult and
9 children's hospital.

10 Are you aware of that?

11 A. Now I am.

12 Q. Okay.

13 A. But you're saying that -- most general
14 hospitals --

15 Q. Let me just --

16 A. -- do serve --

17 Q. Let me --

18 A. -- pediatric patients, so I'm not
19 understanding how that makes them different from
20 other general hospitals.

21 Q. Do you know whether the Leapfrog safety
22 grade that's been assigned to St. Mary's accounts

1 for the fact that it serves both adults and
2 children?

3 MS. BLAIR: Objection to form.

4 THE WITNESS: The safety grade uses CMS
5 data, and CMS data is tied to adult patients. So
6 it's only going to be looking at the adult --
7 measures of how adult patients are treated.

8 BY MR. CHUNG:

9 Q. Okay. So it focuses on the adult
10 treatment, the adult population --

11 A. The safety --

12 Q. -- being treated at -- at that hospital,
13 correct?

14 A. The safety grade does. The survey is an
15 opportunity if they -- if it's a separate
16 hospital, the pediatric hospital is a separate
17 hospital, they would be able to also report on
18 their pediatric patients to the survey.

19 Q. Okay.

20 A. But it has nothing to do with the safety
21 grade.

22 Q. Understood. Thank you for making that

1 clear.

2 So with respect -- if a hospital that has
3 both an adult hospital and a children's hospital
4 is assigned, let's say, a D grade or an F grade,
5 that hospital safety grade is -- that grade is
6 solely for the adult -- the treatment or the
7 patient safety around adult -- the adult
8 population, right?

9 MS. BLAIR: Objection to form.

10 THE WITNESS: The safety grade measures
11 are primarily from CMS, and those measures apply
12 to -- those measures apply to adult populations.

13 However, some of the measures,
14 particularly the Leapfrog measures, would be
15 applicable to the pediatric patients as well. So
16 for instance, CPOE would be applicable. If they
17 are using a CPOE system, that would be applicable
18 to the -- that would affect the care of the
19 pediatric patients.

20 BY MR. CHUNG:

21 Q. Okay. But the CMS data that is -- that
22 the hospital safety grade is based on is focused

1 on the adult population; is that right?

2 A. I believe so, but I guess I would need
3 to -- I would need to check on that.

4 Q. Okay. I mean, if that's correct --
5 assuming that's correct, then a -- isn't the -- I
6 mean, for a consumer, let's say the parent of a
7 child -- right? -- that's looking for a hospital
8 in their area to send their child to for
9 pediatric care, if they see a D grade or an
10 F grade for a hospital that serves both adult and
11 children population and for want -- and for a
12 hospital that didn't report -- respond to the
13 survey, how does Leapfrog communicate to the
14 consumer, to that parent, that the hospital
15 safety grade is based on just CMS data that's
16 focused on the adult population?

17 MS. BLAIR: Objection to form.

18 THE WITNESS: We communicate the letter
19 grades. A hospital that has high rates of
20 problems that are in the CMS data is not going to
21 be safe for any of the patients. General. So
22 for instance, if they have a high rate of leaving

1 objects in after surgery or they have a high rate
2 of infection or central line infections, that's
3 not a safe environment. That's a problem.

4 So it is -- even though it's -- I'm not
5 sure, and I would have to check -- I'm not sure,
6 but I don't believe the CMS data is accounting
7 for pediatric patients, per se. It is still --
8 safety problems that are happening within a
9 hospital's four walls are going to affect all the
10 patients that are there.

11 BY MR. CHUNG:

12 Q. But assuming that the CMS data is just
13 focused on the adult population, I think what
14 you're saying is you would just extrapolate that
15 data to the children's population; is that right?

16 MS. BLAIR: Objection to form.

17 THE WITNESS: I don't extrapolate. I
18 would -- we provide --

19 BY MR. CHUNG:

20 Q. Isn't that what --

21 A. -- the information --

22 Q. -- you just did, though?

1 MS. BLAIR: Can you let her answer,
2 Daniel?

3 BY MR. CHUNG:

4 Q. Isn't that what you just did, though?

5 MS. BLAIR: No. Let her answer the
6 question.

7 BY MR. CHUNG:

8 Q. You testified, Ms. Binder, that if there
9 are certain issues relating to patient safety for
10 the adult population, that you're sure or that --
11 that will generally apply to the rest of the
12 hospital; isn't that what you testified to?

13 MS. BLAIR: Objection to form.
14 Mischaracterizes her testimony.

15 THE WITNESS: We provide the information
16 that people need to understand --

17 BY MR. CHUNG:

18 Q. If you can just answer the question,
19 Ms. Binder.

20 MS. BLAIR: Can you just let her give an
21 answer?

22 MR. CHUNG: I'm trying --

1 MS. BLAIR: You're asking very long --

2 MR. CHUNG: I'm trying -- actually, that
3 one was quite short.

4 BY MR. CHUNG:

5 Q. So if you could answer that question.

6 A. I would expect consumers to look at the
7 data that we provide and make their own
8 decisions.

9 Q. Okay.

10 A. That's why we provide them with as much
11 data as we do.

12 Q. Which data are you referring to?

13 A. How hospitals perform on each of the
14 measures that we use in the safety grade.

15 Q. On the hospital -- so you're referring to
16 the hospitalsafetygrade.org website.

17 A. Yes.

18 Q. Okay. The -- I wanted to ask you a few
19 questions about the certificate coach program.

20 Are you familiar with that?

21 A. No.

22 Q. All right. Is there --

1 A. We have a coach program, but it's not
2 certificate.

3 Q. Which coach program are you referring to?

4 A. Certified coach -- I don't think we call
5 it certified. It's a coach -- coach program.

6 Q. Okay. And what is that?

7 A. That is an opportunity for healthcare
8 industry leaders who are interested in
9 understanding the survey process and the hospital
10 safety grade, the measurement of it and the data
11 that's used, they want to understand that better,
12 it's an opportunity for them to have -- to be
13 educated on it and then take a test to see that
14 they know and understand the elements of the
15 survey and the elements of the safety grade.
16 It's only about the measures.

17 It's because a lot of industry leaders
18 had approached us and said, well, some of my
19 hospital clients are asking me if, you know -- if
20 this is going to help us with the intensivists
21 coverage in the ICU standard or something, and
22 they don't really understand the Leapfrog survey.

1 It's not really aimed at hospitals. They
2 haven't been interested in it because the
3 hospitals that report to the survey, and those
4 hospitals that get safety grades, do already know
5 a lot about their own measurement because they're
6 immersed in it, and that's their business. But
7 for somebody who's selling a product or involved
8 in the industry in some way, they often do not
9 have that level of familiarity with Leapfrog's
10 measurement.

11 Q. So is there any program, whether it's
12 coach, a consultant, whatever the verbiage may
13 be, is there any program that Leapfrog has
14 that -- where hospitals can take on -- you know,
15 pay for a consultant or a coach to help them with
16 the survey?

17 MS. BLAIR: Objection to form.

18 THE WITNESS: To help them with the
19 survey or to help -- well, first of all, we don't
20 offer consulting, but we do offer support for
21 quality leaders completing the survey.

22

1 BY MR. CHUNG:

2 Q. Quality leaders at the hospitals; is that
3 right?

4 A. Yeah. But we don't go to the hospitals,
5 but we do offer additional -- we offer a variety
6 of different supports for hospitals in completing
7 the survey and understanding the measures,
8 understanding the questions, understanding the
9 evidence behind them and what they should
10 prepare. We help them to prepare for our
11 verification process because pretty much every
12 hospital encounters that. So what kinds of
13 documents they should have -- they should have
14 prepared in advance.

15 We also educate them on some of the
16 topics that come up and why they matter. But
17 we -- that's all about --

18 Q. Is there a cost --

19 A. -- the survey --

20 Q. -- associated with this -- the
21 counseling, everything you described in the
22 program?

1 MS. BLAIR: Objection to form
2 regarding "counseling."

3 THE WITNESS: Again, we don't offer
4 consulting.

5 BY MR. CHUNG:

6 Q. Right.

7 A. We do offer -- there is -- most of it is
8 at no cost. We do a lot of one-on-one
9 conversations. There is one webinar series that
10 hospitals that want a really deep dive and want
11 extra can sign up for. Those typically are
12 signed up for by hospitals that have been in the
13 survey a long time and want even more nuanced
14 understanding of it. But 99 percent of what
15 we're offering is all free to all hospitals.
16 Help desk, lots of webinars, town hall calls we
17 call them. Also one-on-one -- numerous
18 one-on-one meetings and conversations between our
19 team and teams at hospitals.

20 Q. Okay. Just going back to the survey,
21 Leapfrog requires survey participants to affirm
22 that they may use the survey information in a

1 commercial manner for profit.

2 Do you -- does that language sound
3 familiar to you from the survey?

4 A. Yes.

5 Q. Okay. Can a hospital opt out of that
6 affirmation and still complete the survey?

7 A. They can complete the survey, but to
8 submit the survey, they do need to attest to it.

9 Q. Okay. Has any hospital ever complained
10 about not being able to opt out of that
11 attestation or affirmation regarding the
12 commercial use?

13 A. The attestation is longer than that and
14 it does require them to attest to the
15 truthfulness of what's on the survey --

16 Q. Right.

17 A. -- so that's why it's very important to
18 us. And we are as candid as possible about the
19 fact that we license the data.

20 Q. Okay.

21 A. Now, we license the ratings and our
22 assessment of their data, not what they submit to

1 us, per se.

2 Q. So in terms of -- and, in practice,
3 Leapfrog does use the survey information in a
4 commercial manner for profit; is that right?

5 MS. BLAIR: Objection to form.

6 THE WITNESS: We use the ratings that we
7 derive from the surveys that are submitted. We
8 use that for licensure.

9 BY MR. CHUNG:

10 Q. That's the hospital safety grade, the
11 accolade licensing program, or is that different?

12 A. No. That's different.

13 Q. Okay.

14 A. So you're asking me about the survey.

15 Q. Right.

16 A. You just asked me -- attestation that's
17 only on the survey; it's not on the safety grade.

18 Q. Right.

19 A. Okay. That data that's provided to us on
20 the survey that we ask hospitals to attest to its
21 truthfulness -- that's what that attestation is.

22 Q. Right.

1 A. -- and we, in turn, are truthful about
2 the fact that we license it -- that data, what
3 they submit to us, we score and we determine to
4 what extent that hospital meets our very high
5 standards for each one of the measures.

6 That is what we license, is their scores
7 on the variety of measures. We do not license
8 the raw content of their survey.

9 Q. Okay. But without the data that the
10 hospital is submitting in response to the survey,
11 you would not have the scores that you're
12 licensing; is that right?

13 A. That we're licensing for the survey.
14 Right.

15 Q. Okay. And then -- so in terms of the
16 licensing program, the data licensing program,
17 Leapfrog licenses that data to researchers; is
18 that right?

19 A. Yes.

20 Q. Okay. And they also license the data to
21 businesses; is that right?

22 A. Yes.

1 Q. Okay. What kinds of businesses?

2 A. Well, health plans are probably the
3 primary -- primary ones.

4 Also businesses that are themselves in --
5 publishers of data.

6 And also -- so for instance, companies --
7 well, companies that also publish data and they
8 incorporate Leapfrog data into their reporting.
9 One of the companies provides employers with
10 information that they can use to tell their
11 employees about various -- the quality of various
12 providers. They incorporate Leapfrog data. They
13 license the data to do that.

14 Q. So researchers, health plans, other
15 businesses.

16 Any persons or entities that also license
17 the survey data from Leapfrog?

18 A. Other than businesses and health plans,
19 not that I can think of.

20 Q. Do other hospitals -- do hospitals
21 license data from Leapfrog?

22 A. We provide some hospital systems, upon

1 request, with reports about their own systems.

2 Q. How about reports or data about other
3 hospitals?

4 A. Only insofar as their system will give
5 them benchmarks on how they compare nationally.
6 So the national part of the data, the national
7 numbers, are coming from our broader database,
8 but we'll give them their own performance
9 compared nationally.

10 Q. So --

11 A. So no, we -- to my knowledge, we have not
12 licensed the full data set to any hospitals. I
13 don't think they want that.

14 Q. Have any hospitals asked for license --
15 licensure to data for hospitals within their
16 regional market?

17 A. No.

18 Q. Okay. Your --

19 A. By the way, if they want to know their
20 regional market, we are public, so we're
21 transparent. I'm sorry to interrupt you, but I
22 just thought of something to add to the answer.

1 Q. Okay.

2 A. So if you're in the regional market, you
3 can look up on Leapfrog for free to see how your
4 other hospitals are doing or to go and find other
5 hospitals somewhere else in the country that
6 might be doing better than you on a particular
7 measure and so that you can ask them for advice.
8 We see that happen quite frequently, and I think
9 it's a positive trend.

10 Q. Okay.

11 MR. CHUNG: We've been going for about an
12 hour and a half or so. We're going to move on to
13 the next topic, so why don't we take a break.

14 MS. BLAIR: Sure.

15 VIDEO TECHNICIAN: The time is 10:28 a.m.
16 This ends unit 1. We're off the record.

17 (A recess was taken.)

18 VIDEO TECHNICIAN: The time is 10:55 a.m.
19 This begins unit number 2. We're on the record.

20 BY MR. CHUNG:

21 Q. So Ms. Binder, I wanted to ask you
22 questions about the scoring methodology behind

1 the hospital safety grades.

2 Fair to say that that methodology has
3 changed over time at least during your time as
4 CEO at Leapfrog?

5 A. It has changed a bit. Yes.

6 Q. Okay. And I want to put in front of you
7 the second exhibit, Exhibit 2.

8 (Binder Deposition Exhibit 2 marked for
9 identification and attached to the
10 transcript.)

11 BY MR. CHUNG:

12 Q. So Exhibit 2 is --

13 MS. BLAIR: Do you have copies of that?

14 MR. CHUNG: Yeah.

15 MS. BLAIR: Sorry. Thank you.

16 BY MR. CHUNG:

17 Q. -- is an in-person meeting agenda,
18 including expert panelists, and it says that
19 you're an attendee in terms of the board and
20 staff of Leapfrog.

21 Do you see that?

22 A. Yes, I do.

1 Q. And it's from June 14, 2017.

2 And these are -- these are meeting notes
3 from a meeting of the expert panel from that
4 date; is that right?

5 A. I'm not familiar with this document, so
6 I -- I don't know.

7 Q. Okay.

8 A. Looks like it.

9 Q. So there is -- towards the bottom of the
10 page, so Bates ending 3576 -- the first page, I
11 mean -- there is a heading, Unintentional
12 consequences of how we currently treat missing
13 data.

14 Do you see that?

15 A. Yes.

16 Q. And do you see that, towards the bottom,
17 that there are three possible solutions proposed?

18 A. Yes.

19 Q. All right. And then, on the second
20 page -- so Bates 3577 -- under number 2 it says,
21 Imputation of the score when we have missing
22 data.

1 Do you see that?

2 A. Yes.

3 Q. And then the first bullet point says,
4 Matt -- and fair to say that's referring to Matt
5 Austin, who you testified about earlier?

6 A. Yes.

7 Q. Okay. Matt mentioned that expert panel
8 discussed this in the past and did not feel it
9 supported the goal of the safety grade but that
10 imputation would incentivize hospitals to report.

11 Do you see that? I'm looking at the
12 second page, Ms. Binder.

13 A. Uh-huh.

14 Q. Do you see that language?

15 A. Yeah, I'm just going to need to read this
16 through --

17 Q. Okay.

18 A. -- to be sure that I understand the
19 context --

20 Q. Okay.

21 A. -- of what you just said.

22 Yeah, so I'm remembering this meeting

1 was --

2 Q. So I'm going to ask a question.

3 So is it -- so based on the language that
4 we just read across the top here, Matt mentioned
5 that expert panel discussed this in the past and
6 did not feel it supported the goal of the safety
7 grade but that imputing scores for individual
8 measures like safe practices would incentive them
9 to report on the survey -- so does this reflect
10 that members of the expert panel believe that
11 using the imputation method did not support the
12 goal of the safety grade? Is that right?

13 MS. BLAIR: Objection to form.

14 THE WITNESS: It says that Matt mentioned
15 that the expert panel discussed this.

16 BY MR. CHUNG:

17 Q. Uh-huh.

18 A. So it's not altogether clear to me
19 what "this" is, because they seem to be talking
20 about safe practices, which they had discussed in
21 the past, should not be imputed.

22 Q. Okay.

1 A. So to the extent it's about safe
2 practices, they had discussed not applying
3 imputation to certain of the safe practices.

4 Q. Right. And that's --

5 A. That's probably what he's talking about,
6 but I don't know for certain.

7 Q. And is that because imputed scores on
8 safe practices would not actually reflect the
9 safety conditions or the safe practices at the
10 hospitals, correct?

11 MS. BLAIR: Object to form.

12 THE WITNESS: It's not described here
13 what the reasoning was in the past. But as I
14 recall, Sara Singer, one of the expert panelists
15 who is an expert on quality improvement, had
16 specifically cited three safe practices that she
17 felt that we did not have adequate evidence and
18 experience to impute in an accurate way. But she
19 was specifically referring to three safe
20 practices --

21 BY MR. CHUNG:

22 Q. Okay.

1 A. -- in the past.

2 Q. And at this point, in June 2017, our
3 understanding is that Leapfrog decided not to use
4 an imputation model for -- in the circumstances
5 where there was missing data for hospitals; is
6 that correct?

7 MS. BLAIR: Objection to form.

8 THE WITNESS: For the safe practices, the
9 specific safe practices, yes. We decided early
10 on, earlier in the course of it, not to apply an
11 imputation model for certain safe practices.

12 BY MR. CHUNG:

13 Q. Was there an imputation model or
14 imputation method for any of the metrics at this
15 time? I get your point regarding the safe
16 practice --

17 A. Uh-huh.

18 Q. -- but any, any metrics?

19 A. Yeah, I don't believe so. We had
20 secondary data from AHA, and we used that.

21 Q. Right. And fair to say that AHA was one
22 of your -- one of Leapfrog's principal sources

1 for secondary data on a number of metrics? Is
2 that right?

3 MS. BLAIR: Objection to form.

4 THE WITNESS: Well, CMS was also
5 secondary for the infection measures.

6 BY MR. CHUNG:

7 Q. Okay.

8 A. So we had two sources of secondary data.

9 Q. And AHA, as a source of secondary data,
10 that's data that is submitted or reported by the
11 hospitals to AHA, correct?

12 A. Yes.

13 Q. All right.

14 MR. CHUNG: Let's move on to 82 and 82a.

15 And this document -- we'll say Exhibits 3
16 and 4.

17 (Binder Deposition Exhibits 3 and 4
18 marked for identification and attached to
19 the transcript.)

20 BY MR. CHUNG:

21 Q. So Ms. Binder, what you have in front of
22 you, Exhibit 3 is an e-mail that Mr. Austin, Matt

1 Austin, sent to himself, and he's attached a file
2 that's named, Expert panel guiding principles.

3 Do you see that?

4 A. Yes.

5 Q. And it looks like Matt forwards an e-mail
6 from himself from July 3 of 2017.

7 Do you see that?

8 A. I see --

9 Q. Okay.

10 A. -- October 27th.

11 Q. That's right.

12 And then Exhibit 4, which is the
13 attachment to that e-mail, it's titled, Expert
14 Panel's Guiding Principles on the Development of
15 Leapfrog's Composite Patient Safety Score for
16 U.S. Hospitals.

17 Do you see that?

18 A. Yes.

19 Q. All right. Is this a document that
20 describes guiding principles that the expert
21 panel uses for any recommendations it makes in
22 calculating the hospital safety grade?

1 MS. BLAIR: Objection to form.

2 THE WITNESS: This is a draft.

3 BY MR. CHUNG:

4 Q. Right. A draft of that type of document,
5 correct? A draft of the guiding principles,
6 correct?

7 A. A draft of guiding principles that I'm
8 unclear have actually gone to the expert panel.
9 So it would be a draft they have not necessarily
10 seen. I don't know for sure.

11 Q. Okay. And we're looking at the second
12 page of this attachment, Bates ending in 4494.

13 And the first paragraph says, under
14 imputing missing data toward the bottom -- do you
15 see that?

16 A. Yes.

17 Q. -- When a hospital is missing data for a
18 particular performance measure, we recommend
19 ignoring the measure and recalibrating the weight
20 within the domain so that hospitals are scored
21 only on the measures for which their performance
22 data are available.

1 Did the expert panel recommend ignoring
2 measures when hospitals had missing data with
3 respect to those measures at any point during
4 this time?

5 A. As I mentioned, the safe practices, that
6 is the methodology that we've used for the three
7 safe practices that Sara Singer first brought up.
8 That is how we do it for those three safe
9 practices.

10 Q. Okay. Well, how about generally at this
11 time?

12 MS. BLAIR: Object to form.

13 BY MR. CHUNG:

14 Q. This is not --

15 A. I don't know generally.

16 Q. -- you will see that he doesn't qualify
17 this -- that he doesn't limit this to the safe
18 practices, right?

19 A. Okay. So there's no "he." I don't know
20 who drafted this. Maybe Matt did, but this is a
21 draft. So I don't know who's -- made these
22 comments.

1 Q. Understood.

2 So the question is, you recalled that
3 this -- this statement is applicable to the safe
4 practices that we were -- that we were discussing
5 earlier, correct?

6 MS. BLAIR: Objection to form.

7 BY MR. CHUNG:

8 Q. At least at this time?

9 A. I mean, that's a -- one wording of what
10 we do with three safe practices currently.

11 Q. Okay.

12 A. I don't know if it's perfectly accurate
13 wording. So -- this is a draft. We often have
14 drafts go back and forth quite a bit.

15 Q. Okay. Well, there's a comment bubble
16 next to it with an MA, and it states, May need to
17 update based on panel's final recommendation.

18 Did the panel, expert panel, make a final
19 recommendation along these lines to ignore --
20 when a hospital is missing data for a particular
21 performance measure, to ignore that measure and
22 recalibrate the weights within the domain so that

1 the hospital is scored only on the measures for
2 which their performance data is available?

3 A. You're asking me if the expert panel
4 followed up from this draft?

5 Q. Right.

6 A. I don't know. I don't know what they did
7 with this draft. I don't even know if they saw
8 it.

9 Q. Okay. If you turn to the next page,
10 Ms. Binder. Same section under this imputing
11 missing data, but the next page.

12 The last paragraph, it reads, If a
13 hospital is missing data for a large number of
14 performance measures, then a score cannot be
15 reliably calculated. In this situation, no score
16 should be issued for the hospital.

17 Is this a recommendation that the expert
18 panel made at this time?

19 MS. BLAIR: Objection to form.

20 THE WITNESS: Well, it --

21 BY MR. CHUNG:

22 Q. Is this a recommendation that the expert

1 panel made at this time?

2 A. This is a draft.

3 Q. I understand. But I'm asking -- I'm
4 not -- I'm asking -- I read this sentence from
5 the draft. But --

6 A. Yeah, this --

7 Q. -- did they make that recommendation?

8 A. Yes. That is a fundamental part of the
9 methodology from day one.

10 Q. So they did make that recommendation.

11 A. Uh-huh.

12 Q. Okay.

13 A. If they're missing a large number of
14 measures, yes. They have defined that over time,
15 but yes, they have -- if they're missing too much
16 data, they don't get a grade.

17 Q. Okay. Now, going back to the AHA data,
18 which was one of the secondary sources, along
19 with CMS -- CMS data, at some point, am I right
20 that Leapfrog stopped using AHA data as a
21 secondary source of data?

22 A. We were forced to.

1 Q. Yeah. And is it because the license ran
2 out? What was the issue there?

3 A. AHA told us they would no longer sell us
4 the data. They gave us one-year notice on that
5 and told us they wouldn't sell it to us.

6 Q. And that was -- when was that? About
7 2021?

8 A. Something like that.

9 Q. Okay. So did that -- that development
10 kind of spur Leapfrog to try to figure out a new
11 way to score hospitals when they were missing
12 data from the hospital?

13 MS. BLAIR: Objection to form.

14 THE WITNESS: It spurred us to identify
15 an alternative secondary source, which we spent
16 considerable amount of time looking for. So we
17 looked at other organizations that collect data,
18 such as HIMSS, et cetera. We looked at surveys
19 that are out there. There's a number of them,
20 but none were either not [sic] available publicly
21 by a hospital or -- in fact, that's 90 percent of
22 them are not publicly available by hospitals.

1 Almost nothing publicly available by hospital,
2 hence the need for Leapfrog.

3 BY MR. CHUNG:

4 Q. Okay.

5 A. But there was no source that we could
6 identify as a secondary source that would be
7 adequate, meet our needs, and be publicly
8 available. So we -- that is -- so we looked at
9 imputation strategies and brought that to the
10 expert panel for sure.

11 Q. Okay.

12 MR. CHUNG: 71. This will be Exhibit 5.
13 (Binder Deposition Exhibit 5 marked for
14 identification and attached to the
15 transcript.)

16 BY MR. CHUNG:

17 Q. So Ms. Binder, Exhibit 5, it's an e-mail
18 chain from March 2021.

19 And is it correct that the participants
20 in this e-mail chain are members of the expert
21 panel and Leapfrog personnel?

22 A. Yes. I wasn't on this chain, that I can

1 see anyway --

2 Q. Yes.

3 A. -- so I'm going to need to read it.

4 Q. Okay. And just to kind of focus the
5 discussion -- please read it, but I will be
6 focusing first on -- it's really the Bates ending
7 in 1532.

8 A. Okay.

9 Q. So Ms. Binder --

10 A. Okay.

11 Q. -- I have, like, basically, two or three
12 questions --

13 A. Okay.

14 Q. -- for this document.

15 A. I'm now finished reading it.

16 Q. So on that page that I directed you to,
17 Bates 1532, Matt Austin writes to the group here
18 with a quick update on -- with respect to the
19 imputation approach, correct? Is that right?

20 A. On 32?

21 Q. Yes. 1532.

22 A. Oh, yes.

1 Q. And he writes that Leapfrog would no
2 longer use the step 2, using the mode of scores
3 assigned to hospitals in the same health system,
4 and instead the methodology would use step 1, use
5 a hospital's most recent score on the measure.

6 And then, as a step 3, use the mean of
7 the scores assigned to other like hospitals in
8 the U.S.

9 Do you see that?

10 A. Yes.

11 Q. All right. And is this the imputation
12 methodology that went into effect following this
13 update?

14 A. I believe so. I'd have to check with
15 Missy Danforth and Matt Austin about that, but I
16 believe that is --

17 Q. Okay.

18 A. -- the methodology that went into effect.

19 Q. So why don't we go to --

20 MR. CHUNG: 89 and 89a.

21 BY MR. CHUNG:

22 Q. Actually, one more question on that

1 e-mail. He writes on the next page, Bates ending
2 1533, after he goes through the steps, To offer
3 you some perspective on the implementation of the
4 imputation model, of the 101 hospitals that will
5 have one or more scores imputed and receive a
6 grade in the last round, 78 of the 101 will
7 receive the same grade as fall 2020.

8 And then he says, We were pleased to see
9 that the imputation of the scores didn't cause a
10 drastic shift in scoring.

11 Do you see that?

12 A. Yes.

13 Q. All right. Do you have an understanding
14 as to why he -- why the expert panel was pleased
15 to see that this imputation method didn't cause a
16 drastic shift in scoring?

17 MS. BLAIR: Object to form.

18 THE WITNESS: My assumption is because it
19 suggests that the imputation was clearly accurate
20 and was consistent with earlier data.

21 MR. CHUNG: All right. Okay.

22 THE WITNESS: I'd also say that this

1 exhibit is an excellent example of our expert
2 panel process. It really does show how it works.

3 MR. CHUNG: So next exhibits will be 6
4 and 7.

5 (Binder Deposition Exhibits 6 and 7
6 marked for identification and attached to
7 the transcript.)

8 BY MR. CHUNG:

9 Q. So Ms. Binder, kind of similar to other
10 exhibits, Exhibits 6 and 7 is an e-mail and then
11 you have an attachment which is titled, Final
12 Updates to the Leapfrog Hospital Safety Grade
13 Methodology for fall 2022.

14 You'll see that you're on the e-mail
15 chain.

16 A. Yes.

17 Q. Am I right that, for Exhibit 7 -- so with
18 the attachment -- that you edited this document
19 and tracked changes?

20 A. Yes.

21 Q. All right. And is this document -- this
22 document, am I right, responds to comments, or

1 public comments, about Leapfrog's 2022 hospital
2 safety grade methodology? Is that right?

3 A. This is a draft of the responses to
4 public comments.

5 Q. Right. Correct.

6 And then, by this time, 2022, Leapfrog
7 was using an imputation method for -- with
8 respect to hospitals for which it was missing
9 data, correct?

10 A. In fall of '22?

11 Q. Yeah.

12 A. We were using an imputation method.

13 Q. Okay.

14 A. Not the same one that we use now.

15 Q. Right.

16 So under responses to public comments the
17 document reads, Several commenters shared
18 concerns about allowing hospitals that did not
19 submit a 2022 Leapfrog hospital survey to receive
20 points for the hand hygiene score through the
21 safety grade imputation model.

22 Do you see that?

1 A. Yes.

2 Q. All right. And then you left a comment
3 here -- looking off to the right, and I apologize
4 for the size of the font here -- that We need to
5 emphasize survey participation is important.
6 Please clarify that available data is superior to
7 imputed data and up-to-date data is superior to
8 older data, but in testing for accuracy on this
9 measure, we have found reliability is maximized
10 for missing data when -- blah, blah, blah. Just
11 be honest, it's a tradeoff.

12 So is it correct that the imputation
13 method you are using in 2022 maximized
14 reliability in your view?

15 MS. BLAIR: Objection to form.

16 THE WITNESS: I'm sorry, I don't even
17 understand that question.

18 Are you asking me what I was talking
19 about in this document or are you asking me
20 something else?

21 BY MR. CHUNG:

22 Q. I'm asking you based on what you wrote as

1 a comment here --

2 A. Yes.

3 Q. -- in this document: Did you believe
4 that the imputation method that Leapfrog was
5 using in 2022 maximized reliability?

6 MS. BLAIR: Objection to form. Misstates
7 the comment.

8 BY MR. CHUNG:

9 Q. I should say, let me be more --

10 A. I --

11 Q. Let me be more precise.

12 A. Okay.

13 Q. Is it correct that, in 2022, you believed
14 that the imputation method that Leapfrog was
15 using maximized reliability with respect to
16 scoring hospitals in metrics for which you were
17 missing data?

18 A. That the prior -- so you're asking me,
19 did the prior method for imputation maximize
20 reliability?

21 Q. Yes. At the time. The imputation at the
22 time. Which you're right, it's different from

1 what it is now. Right.

2 A. Right.

3 MS. BLAIR: I'm going to object to form.

4 THE WITNESS: Okay. The maximum
5 reliability that we can get is when we have the
6 actual survey data, period.

7 BY MR. CHUNG:

8 Q. Okay.

9 A. And the survey -- what I was -- what
10 we're getting at in this comment is that the
11 survey is actually an extremely high standard,
12 that hospitals that complete the survey and do
13 well on it -- that's an "and" -- deserve the
14 credit for that within the methodology, and that
15 imputed --

16 Q. So --

17 A. -- data cannot --

18 Q. I'm just going to stop you there.

19 MS. BLAIR: Let her finish --

20 BY MR. CHUNG:

21 Q. You're not answering the question,
22 Ms. Binder.

1 My question was, based on your comment
2 here, was the imputation method that Leapfrog was
3 using at this time -- right? -- not now, but at
4 this time -- in your view, did that imputation
5 method maximize the reliability with respect to
6 metrics for which you didn't have data for a
7 particular hospital?

8 MS. BLAIR: Objection to form.

9 BY MR. CHUNG:

10 Q. Not reliability overall, but for these
11 hospitals on metrics for which you had missing
12 data.

13 A. At the time period that we were using
14 that older imputation method, it was the maximum
15 reliability that we could determine. However --

16 Q. Okay. Now --

17 A. -- times --

18 Q. -- I'm going to go on to --

19 A. No, I would like to finish my --

20 Q. I'm going to go on to --

21 A. You said we were going to -- I was able
22 to answer, and we were interrupting each other on

1 that.

2 Q. Okay. Let's hear that --

3 A. Can I answer?

4 Q. Yes.

5 A. Yes, thank you.

6 So at the time that we were using that
7 imputation methodology, it was appropriate. But
8 times change. Data changes. It evolves, and so
9 does the performance and so do the -- so as the
10 expert panel talked about in your earlier
11 exhibit, there are -- there's lots of evidence to
12 show that performance changes over time and that
13 we no longer can consider this imputation
14 strategy the most reliable.

15 Q. Okay. I was just asking at this time.

16 So -- all right. You also wrote in this
17 comment at the top, I prefer Alex's comment
18 below.

19 Do you see that?

20 A. I don't think so. I don't see it.

21 Q. Well, in the same comment bubble that we
22 were just going over, it's actually at the top of

1 that comment bubble.

2 A. Oh, okay.

3 Q. I prefer Alex's comment below.

4 Do you see that?

5 A. Uh-huh.

6 Q. All right. And is Alex referring to Alex
7 Campione --

8 A. Yes.

9 Q. -- Alexandra Campione?

10 A. Yes.

11 Q. Okay. And is she a member of the ratings
12 team?

13 A. Yes.

14 Q. Okay. And that is referring to
15 Ms. Campione's comment I think immediately below
16 yours; is that right?

17 A. I'm not sure. Probably.

18 Q. Okay. She writes in that comment bubble,
19 We could include language from spring 2022 public
20 comments: When hospitals decline to provide key
21 data, Leapfrog imputes scores using a methodology
22 designed to estimate their performance as

1 accurately as possible.

2 Do you see that?

3 A. I think so.

4 Q. Okay. She also wrote, Several different
5 options for imputation were tested for both
6 validity and reliability. Using the mean
7 performance rather than the bottom quartile or
8 decile produced the strongest agreement between
9 predicted and actual scores, meaning the use of
10 the mean most accurately resembled the actual
11 performance we could expect if hospitals were to
12 report to the Leapfrog hospital survey.

13 Do you see that in --

14 A. I don't. Where is that?

15 MS. BLAIR: It's in this bubble, the
16 second bubble.

17 THE WITNESS: The second bubble?

18 BY MR. CHUNG:

19 Q. Yes.

20 A. Okay. I just --

21 Q. If you could just read it.

22 A. I need to read it.

1 Q. If you could just read that comment
2 bubble that I just read from.

3 So Ms. Binder, my question is, was
4 Leapfrog's goal to estimate non-participating
5 hospitals' performance as accurately as possible?
6 Is that right?

7 A. Our goal is to estimate in -- as
8 accurately as possible in a way that will be most
9 useful for consumers.

10 Q. Right. So do the imputed scores -- and
11 we're just looking at the imputation method that
12 was used at this time, Ms. Binder.

13 The imputed scores, do they reflect a
14 hospital's actual performance on the metrics for
15 which you're missing data?

16 A. It's an imputed score. So...

17 Q. Not an actual performance, correct?

18 A. Well, what's actual? Like, is --
19 sometimes data is not even actual, so...

20 It is an imputation.

21 Q. Okay. And that imputation, was it
22 designed to get an estimate of the hospital's

1 performance on --

2 A. Yes.

3 Q. -- such a metric? All right.

4 But do they also -- do the metrics, where
5 you used the imputation method, do they also --
6 do they also reflect a lack of data with respect
7 to that metric?

8 MS. BLAIR: Objection to form.

9 THE WITNESS: I'm not sure I understand.

10 BY MR. CHUNG:

11 Q. Well, if you're estimating -- if the
12 imputation method here is to get an estimate of a
13 hospital's performance on a particular metric
14 where you didn't have the data, isn't it true
15 also that imputation assumes a lack of data for
16 that metric?

17 MS. BLAIR: Objection to form.

18 BY MR. CHUNG:

19 Q. Otherwise, you wouldn't need imputation,
20 correct?

21 MS. BLAIR: Same objection.

22 THE WITNESS: Not always. Not always.

1 For instance, as I think Patrick Romano talked
2 about in your earlier exhibit, you can use data
3 from last year's survey. And we have, you know,
4 25 years of experience with hospitals and
5 hospital surveys and ratings and some very good
6 information about how we could anticipate
7 hospital performance based on certain factors,
8 which are, I think, really nicely discussed and
9 debated by the expert panel in that last exhibit.

10 So, yeah, imputation is not just a wild
11 guess. Imputation is a very well-thought-through
12 estimate that's based on real evidence.

13 BY MR. CHUNG:

14 Q. All right. Leapfrog -- is it correct
15 that Leapfrog changed its scoring methodology
16 again in 2024?

17 A. Yes.

18 Q. All right. And that change was where it
19 started using the limited achievement score for
20 imputed metrics for hospitals that did not
21 participate in the survey; is that right?

22 A. Yes.

1 Q. All right.

2 A. For certain measures, yes.

3 Q. Yes, for certain measures. Exactly.

4 What was your role with respect to that
5 particular change in the imputation methodology?
6 We're looking at fall 2024.

7 A. I reviewed -- I reviewed information
8 about how the expert panel had discussed and
9 debated the issues around imputation.

10 I talked extensively with Matt Austin and
11 Missy Danforth and -- repeatedly. So this was a
12 series of discussions.

13 And I looked at some of the background
14 information that they had put together around
15 this and then made the decision that we would go
16 forward.

17 Q. What materials? You just testified that
18 there were materials --

19 A. Well, like this public comments. Things
20 like that.

21 Q. Okay. I think you mentioned materials
22 where the expert panelists were discussing the

1 methodology change.

2 Can you describe? What were those
3 materials exactly?

4 A. Well, they had a meeting, and I reviewed
5 the transcription of that meeting. And in
6 addition, there were some one-on-one
7 conversations that were recounted to me.

8 Q. Okay.

9 A. I needed to be reassured that every
10 member of the expert panel was solidly behind
11 this and really wanted this to go forward.

12 Q. Okay. And the meeting that you're
13 referring to, is that an April 12, 2024, meeting?

14 A. I don't recall the exact date but
15 something like that.

16 Q. Okay. Did you review any slides or other
17 materials that came out of that meeting?

18 A. Yes.

19 Q. Okay. Do you remember reviewing the
20 meeting agenda?

21 A. No.

22 Q. Okay. Did you actually attend that

1 meeting?

2 A. No.

3 Q. Okay. Why not?

4 A. As I said earlier, I don't attend most
5 expert panel meetings because I want the expert
6 panel to feel free to be as independent as
7 possible. I don't want them to get the
8 impression that there's some kind of executive
9 oversight on their deliberations. There isn't.
10 They're expected to be totally independent
11 volunteers.

12 Q. Okay. But Ms. Danforth and I think
13 Ms. Campione were there, right?

14 A. Yes.

15 Q. Okay. What did you understand occurred
16 at that April 12, 2024, meeting as it relates to
17 the imputation methodology?

18 A. There was some discussion about what
19 would be the best method. There were some that
20 felt that hospitals should get zero points for
21 the -- for the four measures that they were --
22 that was under discussion about imputation.

1 There was a lot of discussion about the
2 fact that, for those four measures, we've seen
3 what we call topping out. We've seen those
4 scores in hospitals that report to the survey
5 have gone way up. And so when we impute the
6 mean, we are giving hospitals a very, very high
7 score on these four very difficult standards in
8 the Leapfrog survey.

9 So it's like saying someone has gotten,
10 you know, a gold medal in the Olympics when they
11 are just playing JV soccer.

12 Q. And is this based on your review of, I
13 think you mentioned, a transcript of that
14 meeting; is that right?

15 A. I looked at the transcript. Yes.

16 Q. Okay. Was the -- based on your review of
17 the transcript of that meeting, was there any
18 discussion of the limited achievement proposal
19 that eventually became the methodology for
20 imputation?

21 A. There was a discussion about scoring
22 hospitals that don't complete the survey at

1 the -- either at the lowest quartile or the
2 lowest score of any hospital in the survey. Or
3 there was one very credible member of the expert
4 panel, just a superstar --

5 Q. Who was that?

6 A. Arjun Srinivasan. He's a superstar at
7 the CDC. He wanted zero points, which we didn't
8 go forward with that. But he was strongly
9 advocating for that.

10 Q. Okay.

11 A. We ended up giving, depending on the
12 measure, about 15 -- 5 to 15 points.

13 Q. Okay.

14 MR. CHUNG: Let's go to 73 and 73a.

15 So these are Exhibits 8 and 9.

16 (Binder Deposition Exhibits 8 and 9
17 marked for identification and attached to
18 the transcript.)

19 BY MR. CHUNG:

20 Q. So you'll see here, Ms. Binder, this is
21 an e-mail chain from May 15, 2024, where Preeti
22 Joshi is sending -- circulating expert panel

1 meeting notes.

2 Do you see that?

3 A. Yes.

4 Q. And who is Preeti Joshi?

5 A. She's a research analyst at Johns Hopkins
6 Medicine.

7 Q. Okay. Is she on the expert panel?

8 A. No.

9 Q. Okay. And then let's take a look at
10 Exhibit 9, which is what she circulated.

11 And then if you look at page 1, there's a
12 section under number 2, Proposed changes to the
13 imputation model.

14 Do you see that?

15 A. Yes. Again, I'm going to need to read
16 this now --

17 Q. Okay.

18 A. -- because I wasn't on this chain.

19 Q. All right.

20 A. Okay.

21 Q. Okay. So the notes -- under that
22 section, you'll see that Matt Austin provided the

1 expert panel with a quick overview of the current
2 imputation model/approaches Leapfrog has been
3 using and some of the challenges those approaches
4 have created for issuing accurate grades.

5 And then the notes continue, The current
6 imputation model has two steps when data are
7 missing -- and you'll see here it just describes
8 the imputation method at the time -- right? --
9 the two-step method --

10 A. Yes.

11 Q. -- and then the -- step 2 has been to
12 assign such a hospital the mean score of their
13 assigned cohort.

14 Do you see that?

15 A. Yes.

16 Q. Okay. And then the proposed change from
17 Leapfrog, the very next bullet point, is -- was
18 to retire step 1 of the model, which was to use a
19 hospital's historical data up to four rounds old,
20 and use only step 2, which was assigning
21 hospitals the mean score for their cohort.

22 Do you see that?

1 A. Yes.

2 Q. All right. Do you have an understanding
3 as to how Leapfrog reached the decision in this
4 proposal to remove step 1 from the imputation
5 process?

6 A. It's proposed changes. It's not a
7 decision.

8 Q. Okay. So --

9 A. And it didn't go forward that way.

10 Q. And this is from -- and these are notes
11 from the April 12, 2024, meeting that we've been
12 discussing, correct?

13 A. Right. And that was the discussion at
14 the April 12th meeting. Yes.

15 Q. Okay. So Leapfrog discussed with the
16 expert panel during the April 12, 2024, meeting
17 the possibility of removing a hospital's
18 historical data from that imputation process,
19 correct?

20 A. They did discuss that, and I think the
21 group was in favor of it. However, Patrick
22 Romano was not at the meeting, so they did follow

1 up with him, and he had, I think, a very
2 important and insightful perspective on that,
3 which we then shared, and that ended up being
4 what informed the final decision.

5 So this is not a decision; this was a
6 proposed --

7 Q. Right.

8 A. -- change. That's how the expert panel
9 process works.

10 Q. But there's no discussion in the -- in
11 the meeting notes here, there's no discussion of
12 assigning a limited achievement score, right?

13 A. Limited --

14 Q. On this -- in this document, the notes of
15 the April 12, 2024, meeting. Is that right?

16 A. They discussed assigning very low scores
17 or zero in the expert panel meeting.

18 Q. Where is that reflected here?

19 A. It's not here, but I read the transcripts
20 and they did discuss that.

21 Q. Okay. So a transcript would reveal that
22 they discussed --

1 A. I --

2 Q. -- assigning a zero score --

3 A. Yeah.

4 Q. -- or a limited achievement score; is
5 that right?

6 A. Yeah. And this is a summary. So the
7 summary of the meeting, he's showing what they --
8 sort of the consensus the group reached at the
9 end, proposed changes, and that's why --

10 Q. But limited achievement scores are not
11 mentioned anywhere in these notes, correct?

12 A. Well, limited achievement is 15 on CPOE
13 and 5 points on IPS. It already has a score
14 assigned.

15 Q. Okay.

16 A. If you complete the survey and you get
17 limited achievement on IPS, you get 5 points on
18 the safety grade. That's -- it's not -- it's
19 assumed.

20 Q. So after this expert panel meeting --
21 again, we're just focusing on this April 12,
22 2024, meeting -- the plan was to impute the mean

1 score for missing data only and not to use a
2 hospital's historical data; is that right?

3 MS. BLAIR: Object to form.

4 BY MR. CHUNG:

5 Q. This is based on what we just read, that
6 Leapfrog's proposal was to retire step 1 of the
7 model and use only step 2.

8 Do you see that?

9 Again, I'm just focusing on April 12,
10 2024, what came out of that meeting, Ms. Binder.

11 A. Okay. Yeah. That's the -- yeah, that's
12 the prior imputation model he's describing in
13 this. Current as of April 2024.

14 Q. Right. And then Leapfrog's proposal
15 during this April 12, 2024, meeting, Leapfrog's
16 proposal in this discussion with the expert
17 panel, was from the model at that time, let's
18 retire step 1 of that model --

19 A. Right.

20 Q. -- and just use step 2, i.e., let's just
21 assign non-reporting hospitals the mean score for
22 their cohort; is that right?

1 A. Right. And then Arjun -- that was
2 apparently what was presented to them, but then
3 they disagreed with that, and Arjun and Peter
4 Pronovost said, no, let's -- let's give them
5 lower scores than that.

6 Q. Where does it say that any of the expert
7 panelists disagreed with that proposal?

8 A. Peter asked whether Leapfrog has a way to
9 keep low-performing hospitals in the lowest
10 quartile. That's not the mean.

11 And then Arjun mentioned one of his
12 concerns with the current step 2 imputation
13 method is if a hospital is performing very
14 poorly, they would choose to not a submit a
15 survey and they'd get a better score than their
16 actual performance.

17 So that's disagreement. I mean, that's
18 how the expert panel debates and deliberates.

19 Q. You take that to mean disagreement with
20 the proposal.

21 A. No, I just take it to me deliberation
22 that the expert panel does. They were pushing

1 back on the original proposal from, apparently,
2 Matt, just -- what Matt would be presenting as
3 something from our team in general. And they
4 were saying, I think they should probably impute
5 a lower score, be more -- it would be more
6 accurate.

7 Q. Okay. Now -- so after this, the March --
8 or the April 2024 meeting, it's fair to say that
9 Leapfrog ultimately did not approach -- adopt the
10 approach of the proposal laid out in the bullet
11 point that we just --

12 A. Correct.

13 Q. -- read, right?

14 It settled on a different approach,
15 correct?

16 A. With the full consensus of the expert
17 panel, it settled -- it came up with a new
18 approach.

19 Q. All right. And it ultimately adopted a
20 different approach, correct?

21 A. Yes.

22 Q. All right. And instead of assigning

1 hospitals a mean score pursuant to step 2, as
2 it's described here, the new plan was to assign
3 non-participating hospitals the limited
4 achievement score; is that right? On the
5 selected metrics; is that right?

6 A. On the selected metrics, on the advice of
7 several expert panelists who proposed it --

8 Q. Okay. We'll get to that.

9 A. Uh-huh.

10 Q. And the limited achievement score was the
11 lowest score possible, is that right, on those
12 metrics?

13 MS. BLAIR: Objection to form.

14 THE WITNESS: Limited achievement is on
15 the survey. And the hospital safety grade
16 interprets a limited achievement for each of the
17 four measures with a certain number of points
18 already, and that was retained. So example being
19 IPS is 5 points. A hospital that completes the
20 Leapfrog hospital survey and it gets limited
21 achievement on IPS would get automatically 5
22 points for IPS on the -- in their hospital safety

1 grade.

2 So it's a well-established scoring
3 methodology that is related to their performance
4 on the Leapfrog hospital survey.

5 BY MR. CHUNG:

6 Q. What do you mean by well-established?

7 A. It's been in place since the beginning of
8 the hospital safety grade.

9 Q. Okay.

10 MR. CHUNG: Let's go to 75 and 75a.

11 THE WITNESS: Oh, it says here,
12 actually -- no, they did discuss that. The
13 expert panel got a -- So like the idea of
14 imputing the equivalent of willing-to-report to
15 hospitals that do not submit a survey.

16 So actually, they do discuss that.

17 BY MR. CHUNG:

18 Q. What are you referring to?

19 A. On 8532 --

20 Q. Which exhibit --

21 A. -- Exhibit 9.

22 Q. -- are you referring to?

1 A. Exhibit 9, under the section 2, proposed
2 changes to the imputation model, the last dash,
3 The expert panel were in support of having
4 hospitals share their current performance, so
5 like the idea of imputing the equivalent of
6 willing-to-report to hospitals that do not submit
7 a survey.

8 So that -- so, yeah, they were aware that
9 willing-to-report equals the lowest score.

10 Q. Okay. Willing-to-report. What does that
11 mean?

12 A. Actually, that's how we used to refer to
13 one out of four bars.

14 So the hospital survey, which is, as you
15 know, different from the hospital safety grade,
16 for each measure, we score hospitals on the
17 extent to which they achieve the standard. And
18 they get one -- it's like cell phone bars -- one,
19 two, three, or four bars. Four bars mean you've
20 met the standard. Leapfrog's standards are very
21 high, so it's an excellent performance. One bar
22 means -- we used to call it willing-to-report.

1 So it's referred to here as willing-to-report.

2 Q. Okay.

3 A. Just means they're willing to be public
4 and transparent, which we give them one bar for.
5 But they didn't meet the standard otherwise.

6 Q. But these are -- but this
7 willing-to-report designation is for hospitals
8 that actually did respond to the survey, correct?

9 A. Yes.

10 Q. Okay. So this is different from the
11 scenario that we've been discussing of hospitals
12 that don't respond to the survey, correct?

13 MS. BLAIR: Objection to form.

14 THE WITNESS: I don't think so. Can you
15 restate the question? I'm not -- I don't think
16 that's right.

17 BY MR. CHUNG:

18 Q. What -- so in terms of -- how do you take
19 this to mean that the limited achievement
20 imputation methodology that was eventually --
21 that was adopted, right? --

22 A. Uh-huh.

1 Q. -- was discussed during this April 12,
2 2024, meeting?

3 A. Right. So they -- they basically said
4 that they want to -- they liked the idea of
5 imputing the equivalent of willing-to-report,
6 which is one out of four bars, for each of those
7 four measures. And the equivalent of
8 willing-to-report is a scored amount on the
9 hospital safety grade.

10 Q. Okay. And you take that to mean what was
11 eventually adopted?

12 A. Well, that's part of what was adopted.
13 Yes.

14 Q. Okay.

15 A. Part of it. It's not the whole thing.

16 MR. CHUNG: Let's go on to our next
17 exhibits. These will be 10 and 11.

18 (Binder Deposition Exhibits 10 and 11
19 marked for identification and attached to
20 the transcript.)

21 BY MR. CHUNG:

22 Q. All right. So exhibits 10 and 11,

1 Ms. Binder, is an e-mail chain involving Patrick
2 Romano, Matt Austin, Missy Danforth, and
3 Alexandra Campione. It's from May 14, 2024.

4 A. Yes.

5 Q. And you'll see here Matt Austin e-mails
6 Mr. -- or Patrick Romano attaching what he
7 describes as language to share with hospitals
8 about the proposed changes; is that right?

9 A. Yes.

10 Q. Okay. And then at the bottom of page 1,
11 Dr. Austin follows up and writes, Peter offered
12 some suggested edits to clarify the concept of
13 imputation.

14 And --

15 A. I'm sorry, where is that? Am I
16 missing -- is that --

17 MS. BLAIR: It's at the bottom --

18 MR. CHUNG: Toward the bottom.

19 MS. BLAIR: -- very bottom. Other side.

20 THE WITNESS: Oh, okay.

21 MS. BLAIR: No, other side. He's
22 referring you to the bottom of 8275.

1 MR. CHUNG: Yes. Thank you.

2 THE WITNESS: Oh, I see. Yes.

3 BY MR. CHUNG:

4 Q. And is the Peter here likely referring to
5 Peter Pronovost? Is that right?

6 A. Yes.

7 Q. And he's a member of the expert panel,
8 correct?

9 A. Yes.

10 Q. Okay. And then Dr. Romano responds on
11 May 14 up above.

12 Do you see that?

13 A. Yes.

14 Q. All right. And he writes, I like the
15 simpler and more direct approach here. If the
16 goal is to penalize non-participants, you might
17 as well do so in a clear and unmistakable manner
18 while allowing for hospitals to manage their
19 burden and jump back on the wagon after a year.

20 Do you see that?

21 A. Yes.

22 Q. Okay. Is it correct that the new

1 imputation model will penalize non-participants?

2 MS. BLAIR: Objection to form.

3 THE WITNESS: That's not the intention.

4 We don't penalize -- we don't penalize hospitals.

5 That's not our goal. Our goal is to inform

6 consumers. So we don't do penalizing. We

7 don't -- that's not what we're about.

8 BY MR. CHUNG:

9 Q. So do you disagree with Dr. Romano's view
10 here?

11 A. I agreed with his -- I agreed in the end
12 with his recommendation in here. I don't agree
13 with the idea of penalize- -- that we are trying
14 to penalize hospitals. We aren't.

15 Q. But do you agree that the limited
16 achievement imputation model -- right? -- is --
17 it's punitive to non-participating hospitals?

18 Do you agree with that?

19 MS. BLAIR: Objection to form.

20 THE WITNESS: It's meant to be helpful to
21 consumers so that we are not overestimating the
22 performance of a hospital when we don't have --

1 when they've declined to report their data.

2 BY MR. CHUNG:

3 Q. I'm asking with respect to hospitals, not
4 consumers. Okay?

5 With respect to the non-participating
6 hospitals -- right? -- hospitals that have not
7 filled out the survey, responded to the hospital
8 survey, by automatically assigning those
9 hospitals on four of the most critical metrics a
10 limited achievement score, is that not punitive
11 to those non-participating hospitals for not
12 participating?

13 MS. BLAIR: Objection to form.

14 THE WITNESS: It's not meant to be
15 punitive. It's meant to be informative to
16 consumers. That's what we're about.

17 BY MR. CHUNG:

18 Q. Okay.

19 A. Now, he has a different approach, which
20 he's laid out here, but I also thought his
21 recommendation was excellent -- it was a really
22 good compromise and a really good way to do it --

1 which was accepting the results from one year's
2 worth of survey results. And I think he makes a
3 good case for that, and that's what we ended up
4 doing.

5 So -- and we then brought that back to
6 the others on the expert panel who were the ones
7 recommending the original proposal that was sent
8 out to Patrick, as you can see from this chain,
9 actually, that they were supportive of.

10 And I think I think this is just another
11 great example of a very strong expert panel.

12 Q. So he writes, The underlying hypothesis
13 behind your proposed step 2 approach was that
14 hospitals stop reporting because their true
15 performance deteriorated relative to their
16 cohort.

17 Do you see that?

18 A. Yes.

19 Q. All right. And then he writes, My
20 hypothesis, by comparison, was that most
21 hospitals stop reporting because it is too
22 burdensome and because they only find market

1 value in an A grade, which proves impossible to
2 attain or maintain.

3 Do you see that?

4 A. Yes.

5 Q. Okay. And so he's articulating his view
6 that hospitals that don't -- do not participate
7 in this survey do so because they find it, in his
8 words, too burdensome, right?

9 MS. BLAIR: Objection to form.

10 THE WITNESS: If --

11 BY MR. CHUNG:

12 Q. I'm just asking you whether that's his
13 view, as it's articulated in this e-mail?

14 A. In this e-mail --

15 Q. Can you please answer the question? I'm
16 asking you --

17 MS. BLAIR: She's trying to answer the
18 question, Daniel.

19 MR. CHUNG: I don't think she is.

20 BY MR. CHUNG:

21 Q. The question is --

22 MS. BLAIR: She hasn't even started her

1 answer. I don't know how you know --

2 BY MR. CHUNG:

3 Q. The question is, is that his view as
4 articulated in this e-mail?

5 MS. BLAIR: Objection to form.

6 THE WITNESS: Say that -- what view,
7 again?

8 BY MR. CHUNG:

9 Q. That hospitals that do not participate in
10 the survey, they don't do it because they find it
11 too burdensome.

12 MS. BLAIR: Same objection.

13 THE WITNESS: In this e-mail, that
14 appears to be his view.

15 BY MR. CHUNG:

16 Q. All right. And --

17 A. But in the earlier exhibits --

18 Q. -- do you agree --

19 A. -- just so --

20 Q. -- with that hypothesis?

21 A. In the earlier exhibits --

22 Q. Do you agree with that hypothesis?

1 A. In the earlier exhibits --

2 Q. Do you agree with that hypothesis?

3 A. No, absolutely not. I --

4 Q. All right.

5 A. -- disagree with that --

6 Q. Now, at the end --

7 A. -- hypothesis.

8 THE REPORTER: I'm sorry. I can't take
9 both of you talking at the same time.

10 BY MR. CHUNG:

11 Q. Now, at the end of the e-mail, Dr. Romano
12 writes, If you want to penalize non-participants,
13 then don't pretend that you are imputing missing
14 values in a statistically optimal way. Just be
15 honest about your goal.

16 He's saying here that Leapfrog's approach
17 is pretending that the missing values are being
18 imputed in a statistically optimal way; is that
19 right?

20 MS. BLAIR: Objection to form.

21 THE WITNESS: No, I don't believe that's
22 what he's saying. But you should ask him.

1 BY MR. CHUNG:

2 Q. This is your deposition, Ms. Binder.

3 What do you understand him to be saying
4 here? What do you understand him to be saying?

5 A. That --

6 MS. BLAIR: Objection to form.

7 THE WITNESS: He seems to have a
8 perception of the intention of his colleagues on
9 the expert panel, as well as Leapfrog people,
10 Matt and Missy in particular. He seems to have a
11 perception of their intention, which is not, in
12 fact, their intention.

13 BY MR. CHUNG:

14 Q. Would you call his e-mail supportive of
15 the proposed methodology?

16 A. Yes. He comes up with a very good
17 recommendation.

18 Q. Okay. So even though he views the
19 methodology as penalizing non-participating
20 hospitals, you believe that he's supportive of
21 the proposed methodology?

22 MS. BLAIR: Objection to form.

1 THE WITNESS: You're asking about the
2 proposed methodology or the methodology that we
3 ended up with? Because we ended up with a
4 methodology at the end of this process --

5 BY MR. CHUNG:

6 Q. Right.

7 A. -- that is laid out quite elegantly in
8 these e-mails -- we ended up with a methodology
9 that I know he supports.

10 Q. Okay. And how do you know that he
11 supports that?

12 A. Because I know him personally, and Missy
13 has talked to him at length. He supports it.

14 I will not approve something if I have
15 any evidence that any expert panel member does
16 not approve it.

17 Q. Okay. And where was that memorialized?
18 Where was his support memorialized?

19 A. By conversations with Missy and
20 reassurances from Missy and also by sharing the
21 proposal that went out publicly for comment with
22 him and the others and, in the end, we did

1 actually do what he recommended.

2 Q. So these are verbal conversations that
3 you're referring to.

4 I asked, how was this memorialized in
5 writing?

6 A. I don't know.

7 Q. Okay.

8 A. I'm not -- it doesn't need to be. It
9 needs to be -- I need to be reassured. I'm
10 reassured from a variety of ways.

11 If any one of these expert panelists --
12 they are not shy. If they disagreed with the
13 proposal that we put out for public comment, they
14 would tell me instantly. They would be calling
15 me. And I would be very unhappy to hear that I
16 was misled.

17 I am not misled. I have an absolutely
18 incredible survey team and staff, and they are
19 accurate to me about what the perception of these
20 expert panelists are.

21 And the -- the conversation that you have
22 in e-mail here is really -- it's good to see.

1 Q. Okay.

2 A. -- because it's clearly well thought
3 through, and there's debate, there's no rubber
4 stamping here. There's a lot of thought. And we
5 ended up going with, I think, the right
6 methodology in the end.

7 Q. So just to be clear, after these
8 discussions, Leapfrog proposed an imputation
9 model where hospitals that were missing
10 historical data from the prior two rounds would
11 be given the limited achievement score for hand
12 hygiene, BCMA, CPOE, and the ICU physician
13 staffing; is that right?

14 MS. BLAIR: Objection to form.

15 THE WITNESS: I believe that's -- yeah.
16 I believe that's right.

17 BY MR. CHUNG:

18 Q. And this methodology replaced the mean
19 scores approach that had been used previously; is
20 that right?

21 A. It was -- yes. That's -- yes.

22 Q. Okay.

1 MR. CHUNG: Let's go to tab 14. This
2 will be Exhibit 12.

3 (Binder Deposition Exhibit 12 marked for
4 identification and attached to the
5 transcript.)

6 BY MR. CHUNG:

7 Q. So Ms. Binder, Exhibit 12 is an e-mail
8 discussing feedback on the hospital safety grade
9 changes.

10 And you see that on the second page Bates
11 ending 9812, Ms. Campione writes, We have
12 finalized the changes to the imputation
13 methodology. Both Peter and Patrick have
14 reviewed and signed off on the messaging.

15 And then she asked for your feedback; is
16 that right?

17 A. Yes.

18 Q. Okay. And this is on May 17, 2024; is
19 that right?

20 A. Yes.

21 Q. Okay. And then later that day you
22 respond that you provided some tweaks in an

1 attachment; is that right?

2 A. Yes.

3 Q. Okay. So let's go to -- so the
4 attachment is actually right after the e-mail
5 chain here. It's the request for public
6 comments, planned updates, the Leapfrog hospital
7 safety grade methodology for fall 2024.

8 If you turn to Bates ending -- and this
9 is -- is this a document here, the attachment,
10 that's intended to be put on Leapfrog's website?
11 Is that right?

12 A. Yes. We have a public comment process.
13 We put it out for public comment and then we
14 adver- -- not -- we publicize the fact that it's
15 available and we -- to encourage people to look
16 at it and offer public comments.

17 Q. Okay. If you look at Bates ending
18 9184 -- this is under the background section --
19 you'll see here that there is a sentence here
20 that's struck that reads, The collective
21 recommendation was for Leapfrog to modify its
22 current imputation approach to encourage survey

1 participation and to improve users' confidence in
2 the data that are used to calculate the score.

3 Do you see that?

4 A. Yes.

5 Q. Okay. And so the explanation that the
6 methodology change was to encourage participation
7 was struck, correct?

8 A. Yes.

9 Q. All right. And then looking back to your
10 e-mail -- so Bates ending in 9811, the very first
11 page of this document.

12 A. Yeah.

13 Q. You wrote that -- I don't think we need
14 the sentence about influencing survey
15 participation and giving people confidence and
16 validity. It sounds defensive.

17 Why did you think explaining how the
18 imputation methodology would influence
19 participation was defensive?

20 A. The purpose of the change -- proposed --
21 at this time proposed -- to the safety grade was
22 to be as accurate as possible. And that is what

1 the expert panel talked about. In all of the
2 documents that you've just provided in your
3 exhibits, they're not talking about -- the expert
4 panel is not saying, well, we're going to get
5 more participation in the survey.

6 So that was not the purpose of this
7 change. The purpose of this change was to
8 improve the accuracy.

9 Q. Okay.

10 A. So I felt that it sounds -- doesn't make
11 sense. I didn't think it made sense.

12 Q. Are you saying that it's inaccurate to
13 say that the change in the imputation model would
14 influence participation?

15 A. I don't know if it would influence
16 participation. Probably. Maybe. Depends.
17 Because if someone doesn't do well on the survey,
18 they can hurt their grade. So not necessarily.
19 It wouldn't -- certainly wouldn't be the purpose
20 for this methodology change. And nor do I see
21 that in the discussions by the expert panel.

22 Q. Okay. And then you write -- again,

1 focusing on the e-mail here -- It's enough that
2 the expert panel advised us to do the imputation
3 in a different way and not treat older better
4 data in an equivalent way to new data.

5 A. That they did discuss at length.

6 Q. Okay. And as I think we discussed
7 earlier, in terms of the -- in terms of the
8 limited achievement proposal that eventually was
9 put into place, did you get -- did every single
10 member of the expert panel approve that
11 methodology?

12 A. Yes.

13 Q. Okay. And how did you go about getting
14 the approval of every single member?

15 MS. BLAIR: Objection to form.

16 THE WITNESS: From -- my normal way of
17 finding out for sure that the expert panel is
18 fully behind methodology, which is I ask my
19 senior vice-president for healthcare ratings and
20 our --

21 BY MR. CHUNG:

22 Q. And that's Ms. Danforth?

1 A. Ms. Danforth. And Matt Austin. And I
2 meet with them extensively and we go over how --
3 the perspective of each member of the panel and
4 that they've looked at it.

5 You can see from the e-mails they have
6 plenty of evidence that the expert panel was
7 behind it.

8 And in addition, I make sure that this is
9 shared with the expert panelists prior to going
10 out for public comment. And so certainly if
11 there was disagreement by any member, I would --
12 we would have heard about it, you know,
13 instantly, because we put it out -- we gave it to
14 them prior to the public comment period.

15 Q. Okay. And so the imputation
16 methodology -- and again -- I'm going to ask
17 again, is the approval of every member of the
18 expert panel of the -- of this methodology
19 memorialized anywhere?

20 A. No. This isn't Congress. This is a
21 classic scientific expert panel. The process
22 that you see in these e-mails is exactly the way

1 the scientific process works.

2 Q. So the answer is no.

3 MS. BLAIR: Objection to form.

4 THE WITNESS: Memorialized? Other than
5 the usual method by which I know the expert
6 panelists are behind it, I -- I don't know --
7 well, there's no vote.

8 BY MR. CHUNG:

9 Q. Okay. Now, towards the end of your
10 e-mail to Ms. Campione here you write that the
11 public comments on the methodology will give us a
12 good gauge on the extent to which we need to
13 reveal all our reasoning and whether the expert
14 panelists will truly stand up for it when push
15 comes to shove.

16 Is it fair to say at this point you were
17 not sure if the expert panel would stand up for
18 the new methodology?

19 A. Yeah. As I said earlier, for me, it's
20 very important that not only do we have the okay,
21 so to speak, from each member of the expert panel
22 that they do support it -- which I was assured of

1 and I believed strongly, and still do -- but what
2 happens when you have a methodology change like
3 this is you sometimes get very strong opposition,
4 and they will go -- the opponents, which we would
5 hear from in the public comment period, or the
6 supporters sometimes -- would go directly to
7 individual members of the expert panel. So if
8 for some reason they were to change their mind or
9 not be able to say, no, this is -- I own this,
10 this is our methodology, then I would want to
11 know that right away. I wouldn't go forward with
12 something unless I had the strongest possible
13 support, even in the face of opposition.

14 And so that is another value of the
15 public comment period and why we are so -- why
16 Leapfrog is so interested in public comment and
17 why we reach out so frequently to the larger
18 communities that we serve, to make sure we're
19 getting the right kind of feedback and insights.
20 And we often make changes as a result of those
21 insights.

22 Q. Okay. When was this methodology

1 change -- when was the board notified of this
2 methodology change?

3 A. I believe I previewed it with them. I'm
4 trying -- I'll have to look through -- look
5 through all the board packets. But I believe I
6 previewed it with them --

7 Q. When was that?

8 A. -- in the spring. I believe in March.
9 And then also in June I told them about it.

10 Q. Okay. So in June --

11 MR. CHUNG: Why don't we go to the next
12 document. 91.

13 (Binder Deposition Exhibit 13 marked for
14 identification and attached to the
15 transcript.)

16 BY MR. CHUNG:

17 Q. Okay. This is -- Exhibit 13 is the CEO
18 report --

19 A. Yes.

20 Q. -- to the board from June 2024.

21 Is this a document that's distributed to
22 the board --

1 A. Yes.

2 Q. -- in connection with board meetings?

3 A. Yes.

4 Q. Prior to the meeting or when exactly?

5 A. Like a week prior to the meeting.

6 Q. Okay. Now, we look at the first page,
7 Bates ending in 072 under hospital safety grade
8 successful spring update.

9 You write that Leapfrog published its
10 planned updates to the safety grade methodology
11 and that the update dramatically lowers imputed
12 scores for certain measures for hospitals that
13 decline to report to the survey.

14 Do you see that?

15 A. Yes.

16 Q. Okay. And it says here, This should have
17 some impact on hospital reporting to the survey,
18 correct?

19 A. Yes.

20 Q. All right. So you -- and is this the
21 first time that you're apprising the board of the
22 change in methodology?

1 A. No.

2 Q. When did you --

3 A. I said in March.

4 Q. Okay.

5 A. And --

6 Q. And where -- where -- would it have been
7 in the CEO report for March?

8 A. Probably. But I certainly would have
9 verbally told them that we were working on it and
10 the expert panel was meeting.

11 Q. So it should -- so it should be reflected
12 in the board minutes; is that right?

13 A. I think so. Yeah. It should be.

14 Q. Okay.

15 MR. CHUNG: Why don't we go to -- this
16 will be Exhibit 14.

17 (Binder Deposition Exhibit 14 marked for
18 identification and attached to the
19 transcript.)

20 BY MR. CHUNG:

21 Q. So Exhibit 14 are the board minutes,
22 Ms. Binder, from the March 2024 meeting.

1 Do you see that?

2 A. Yes.

3 Q. Okay. Do you see anywhere here any
4 discussion of the new methodology?

5 A. No, I don't see it.

6 Q. Okay. So fair to say that June 2024 is
7 the first time the board is apprised of the
8 change in methodology?

9 A. No.

10 MS. BLAIR: Objection to form.

11 THE WITNESS: No. I did talk to them
12 about the fact that the expert panel was meeting
13 to discuss an update to the methodology.

14 BY MR. CHUNG:

15 Q. Is that reflected anywhere in the
16 minutes, the fact --

17 A. It's not --

18 Q. -- of the meeting?

19 A. -- reflected in the minutes.

20 Q. It's not.

21 A. No.

22 Q. Okay?

1 A. But I did discuss it with them.

2 Q. All right. Why would that not be
3 reflected in the minutes, Ms. Binder? Isn't that
4 something of -- that's pretty important?

5 MS. BLAIR: Objection to form.

6 THE WITNESS: I don't know why it's not
7 in the minutes.

8 BY MR. CHUNG:

9 Q. Okay. And during -- let's go back to the
10 June 2024 meeting.

11 Did you explain the two steps in the new
12 method -- imputation methodology with the board?

13 A. I believe -- I don't recall exactly
14 how -- what we did. The board does not typically
15 delve into the details of any methodology, but we
16 highlight where we think there are issues that
17 they should be aware of, which is what I'm sure I
18 did.

19 And then if the board feels like there's
20 board-level issues that they should address, they
21 will ask for an agenda item and they'll ask to
22 have it formally presented and discussed.

1 They did not do so in -- at least two
2 times that I talked to the board about this.

3 Q. Okay. But you did underscore in the CEO
4 report and at the meeting that the methodology
5 change should have some impact on hospital
6 reporting --

7 A. Yes.

8 Q. -- to the survey, correct?

9 A. Yes.

10 Q. And that was important to the board,
11 correct?

12 A. Oh, yes.

13 Q. And that's important to Leapfrog, right?

14 A. It's very important to Leapfrog. It's
15 the core of our mission.

16 Q. Right. To have as many hospitals respond
17 to the survey as possible, correct?

18 A. To have full hospital transparency.

19 Q. Right. Impact on hospital reporting is a
20 reference to participation in the hospital
21 survey --

22 A. Yes.

1 Q. -- is that right?

2 Okay. And so that was one of the goals
3 behind this change in the imputation methodology,
4 correct?

5 MS. BLAIR: Objection to form.

6 THE WITNESS: No.

7 BY MR. CHUNG:

8 Q. All right.

9 A. No, that was not the goal of the change
10 in the imputation methodology.

11 Q. Not the goal, but you're mentioning that
12 it's going to have some impact, correct?

13 A. Yes. This is the board of Leapfrog.
14 They need to know what the implications are to
15 The Leapfrog Group.

16 Q. Okay. Did the board approve the
17 methodology change?

18 A. The board does not ask -- delegates to me
19 the authority to approve methodology changes
20 or -- of this sort or changes to the survey. But
21 I do bring forward to inform them of when these
22 are -- such changes are on the table, and I tell

1 them what's going on and I explain what the
2 situation is and what I see as implications to
3 the organization. And if they wish, we will
4 certainly do a deep dive within the board level,
5 and they certainly have the authority to approve.

6 This is not a board of measurement
7 experts or clinicians. None of them come from
8 the healthcare industry. As I've talked earlier,
9 we're careful about the fact that the board does
10 not include industry leaders. So they really are
11 depending on the expert panel and the staff of
12 Leapfrog and Johns Hopkins to advise them.

13 Q. Okay.

14 MR. CHUNG: Let's go to tab 83.

15 BY MR. CHUNG:

16 Q. You mentioned a delegation.

17 Where is that delegation memorialized?

18 A. It's in the bylaws. The CEO is -- acts
19 on behalf of the board.

20 Q. With respect to the methodology as well?

21 A. I don't think it specifically says the
22 methodology, but I report to the board and...

1 Q. Okay.

2 A. That's how it works.

3 MR. CHUNG: So this will be Exhibit 15.

4 (Binder Deposition Exhibit 15 marked for
5 identification and attached to the
6 transcript.)

7 BY MR. CHUNG:

8 Q. So Exhibit 15 is -- it's a slide deck
9 entitled, Technical overview of the hospital
10 safety score from fall of 2012.

11 And you were CEO, what, four years in --
12 right? -- of the organization by this time?

13 A. Three-and-a-half. Yes.

14 Q. Okay. And you'll see that Ms. Danforth
15 and Matt Austin are the authors of the document.

16 Turn your attention to the Bates ending
17 8512. So it's the fourth page. Just let me know
18 when you get there. It's entitled, Role of the
19 expert panel and Leapfrog's board of directors.

20 Do you see that?

21 A. Uh-huh.

22 Q. And under Leapfrog's board of directors

1 it says, Final decisions related to measure set
2 scoring methodology.

3 Do you see that?

4 A. Yes.

5 Q. Final decisions relating to letter grade
6 assignments and oversight of all policies that
7 guide the hospital safety score.

8 A. Uh-huh.

9 Q. So isn't it correct that the board, board
10 of directors, their role includes final decisions
11 related to scoring methodology?

12 MS. BLAIR: Objection to form.

13 THE WITNESS: The board delegates to me
14 the authority to make these final decisions.

15 BY MR. CHUNG:

16 Q. Does it say that on here?

17 A. It doesn't have to. That's how it works.

18 Q. Okay.

19 A. That's how 99 percent of organizations
20 work.

21 Q. So this --

22 A. The board does not make operational

1 decisions. And the board is informed of these.
2 And when I believe it's something that has
3 enormous need for board involvement, then they
4 make the decision. But they're informed of the
5 decisions that I'm making, and they're holding me
6 accountable for doing so in a way that makes
7 sense.

8 And this slide is meant to distinguish
9 between the role of the board and the role of the
10 expert panel. The expert panel is not a
11 governing board, is what it's trying to say.

12 Q. So this -- are you saying that this
13 document is inaccurate --

14 MS. BLAIR: Objection to form.

15 BY MR. CHUNG:

16 Q. -- with respect to the --

17 A. It's --

18 Q. -- with respect to the board's role when
19 it --

20 A. It's perfectly --

21 Q. -- comes to --

22 A. -- accurate.

1 Q. -- the scoring methodology?

2 A. It's accurate.

3 Q. Okay. Even though they did not make the
4 final decision with respect to the change of
5 imputation methodology in 2024; is that --

6 A. They delegate to me the responsibility
7 for that.

8 Q. Okay. But that's not reflected on this
9 document, correct, the delegation itself?

10 A. The delegation is not reflected, no. But
11 that is assumed.

12 Q. Okay. Is it your view that the changes
13 in the imputation methodology are really
14 decisions to be made by you and the executive
15 staff of Leapfrog?

16 MS. BLAIR: Objection to form.

17 THE WITNESS: Is it --

18 BY MR. CHUNG:

19 Q. As opposed to the board.

20 A. It's not opposed to the board. I do it
21 with the full knowledge of the board.

22 Q. Okay. And we saw that, in the March 2024

1 board meeting minutes, there's no mention of your
2 mentioning the imputation methodology, right?

3 A. Yeah, I'd -- I should look at the full
4 agenda of that meeting. There may have been a
5 presentation on the agenda on the methodology.
6 But I definitely have discussed it with the
7 board, actually, repeatedly, board members, board
8 chair, executive committee, et cetera. It's been
9 a subject that we have discussed at length.
10 They're fully aware of it. And frankly, it's not
11 in my interest -- since they have delegated the
12 authority to me, it's not in my interest to not
13 let them know when something like this is
14 occurring and that it's important and that -- and
15 how the expert panel has advised us and what we
16 ultimately are -- and what we're learning from
17 public comment.

18 Q. Did you have separate conversations about
19 the methodology change with individual board
20 members?

21 A. Yes.

22 Q. Okay. Who did you have separate

1 conversations with?

2 A. Our board chair in particular that I
3 recall.

4 Q. Okay. And when were those conversations?

5 A. Over the course of at least March, maybe
6 earlier. Probably March --

7 Q. Okay.

8 A. -- through -- through the later board
9 meetings where it was discussed and approved.

10 Q. And is that with Linda Schwimmer? Is
11 that right?

12 A. Yes.

13 Q. Okay. Did you have conversations with
14 Vice Admiral -- I think it's Vice Chair or Vice
15 Admiral Raquel Bono?

16 A. I'm going to assume I did. I don't
17 recall specifically. But she is on the executive
18 committee, so I definitely discussed this with
19 the executive committee, as well as the board.

20 Q. Okay. Did you have conversations with
21 Michelle Martin?

22 A. I don't recall.

1 Q. How about Sally Welborn?

2 A. She is on the executive committee, so
3 yes, I would have in the context of the executive
4 committee.

5 Q. John Zern?

6 A. He's also on the executive committee.

7 Q. Rumay Alexander?

8 A. She is on the board, so she would have
9 heard it as part of a board -- I don't recall a
10 one-on-one conversation with her about this?

11 Q. Any one-on-ones with Irene Fraser?

12 A. Not that I recall.

13 Q. Carole Hemmelgarn?

14 A. Not that I recall specifically.

15 Q. Ellen Kelsay?

16 A. Not that I recall.

17 Q. Janet Lucas-Taylor?

18 A. Not that I recall.

19 Q. Kenneth Mendez?

20 A. Not that I recall.

21 Q. Arnold Mistein [sic]?

22 A. Arnold Milstein, yes. He's on the expert

1 panel as well as the board, and we talk
2 extensively.

3 Q. Dolores Mitchell?

4 A. Not that I recall.

5 Q. Aaron Schrader?

6 A. Not that I recall.

7 Q. Susan Sheridan?

8 A. Not that I recall.

9 Q. Karen van Caulil?

10 A. Not that I recall.

11 Q. Lina Walker?

12 A. Not that I recall.

13 Q. Kimberly Blair?

14 MS. BLAIR: Objection to form. I'm not
15 on the board.

16 BY MR. CHUNG:

17 Q. Did you have one-on-one conversations
18 about the change in imputation methodology with
19 Ms. --

20 A. I mean, not early on --

21 Q. -- Blair --

22 A. -- no.

1 MS. BLAIR: I'm going to object to form
2 and instruct you not to answer any conversations
3 you had with me as your legal counsel related to
4 a change in methodology.

5 BY MR. CHUNG:

6 Q. Did you have conversations with Ms. Blair
7 in 2024 about the change in methodology?

8 A. I've been instructed not to answer that
9 by counsel.

10 Q. The question is, yes or no.

11 Did you --

12 MS. BLAIR: You can answer yes or no.

13 THE WITNESS: Oh. Yes.

14 BY MR. CHUNG:

15 Q. Okay. Michelle Schreiber?

16 A. Yes.

17 Q. Okay. Christa-Marie Singleton?

18 A. No.

19 Q. Okay. Now -- so looking at the -- in
20 terms of just general -- taking a step back, the
21 board of directors meetings, they covered topics
22 including topics relating to Leapfrog's business;

1 is that right?

2 A. Yes.

3 Q. Okay. And those matters cover -- and I'm
4 not saying every -- that's the sole function of
5 the board meetings, but they covered topics like
6 the financial updates; is that right?

7 A. Yes.

8 Q. And operations updates?

9 A. Yes.

10 Q. And --

11 A. It's not -- they're not involved in
12 operations at any detailed level, but yes,
13 operations. Yes.

14 Q. Okay. And I think there's some long-term
15 planning discussions that happened at the board
16 meeting; is that right?

17 A. Long-term strategic intent.

18 Q. Okay. That's right. I think there's
19 some documents with that very title.

20 A. Yes.

21 Q. Do the board meetings, do they cover
22 legal advice at all?

1 A. What do you mean by that?

2 Q. Like, is there any component of the board
3 meetings where you're discussing legal matters?

4 MS. BLAIR: You can answer --

5 THE WITNESS: Yes.

6 MS. BLAIR: -- that yes or no.

7 BY MR. CHUNG:

8 Q. Okay. Sometimes, right? At some board
9 meetings where it's relevant; is that right?

10 A. Yes.

11 Q. Okay. Would you agree that financial
12 updates to the board are not -- don't involve
13 legal advice?

14 A. I'm trying to understand. Financial --

15 Q. Yeah.

16 A. -- updates don't involve legal advice?

17 Q. Right.

18 A. Right.

19 Q. Okay. How about the -- we mentioned the
20 operational updates to the board.

21 Do those involve legal advice?

22 A. I don't know.

1 Q. Okay. Does the organization have
2 in-house counsel, like a general counsel or --

3 A. No.

4 Q. No? Okay. Does Leapfrog use the Wilson
5 Elser firm as an equivalent to an in-house
6 counsel, though?

7 A. Yes.

8 Q. Okay. And you know that Ms. Blair
9 works -- is a partner at Wilson Elser; is that
10 right?

11 A. Yes.

12 Q. Okay. Is Ms. Blair essentially
13 Leapfrog's general counsel?

14 A. She's counsel to Leapfrog.

15 Q. Okay. But she attends board meetings,
16 correct?

17 A. Yes.

18 Q. And in fact, she attended the board
19 meetings throughout 2024, correct?

20 A. Yes.

21 Q. All right. And just generally, how long
22 has Ms. Blair been involved with Leapfrog?

1 A. I'm not certain of that, but something
2 like -- I don't know, actually. Five years?
3 Seven years? Something like that.

4 Q. Okay. So certainly before 2024.

5 A. Yes.

6 Q. Okay. Does Ms. Blair consult Leapfrog on
7 non-legal business matters?

8 A. No.

9 Q. Okay. What do you understand Ms. Blair
10 to be responsible for, then, with respect to
11 Leapfrog, other than this matter we have in front
12 of us?

13 A. Well, our board wants to know that
14 there's legal counsel at the table to assure that
15 we are compliant with all the laws.

16 Q. Okay. And that requires Ms. Blair's
17 attendance at all the board meetings?

18 A. Yes.

19 Q. Okay. What issues are you -- what laws
20 and what compliance with those laws are you
21 referring to?

22 A. I don't know, but things come up every

1 now and then. We'll be having a conversation and
2 discussing something and it seems like, well, I
3 wonder if that's right or that's right, and we
4 want to make sure that we have counsel present to
5 advise us.

6 Q. Okay. Just in case something comes up;
7 is that right?

8 A. Yeah. It's a common practice among
9 boards.

10 Q. Okay. Does Ms. Blair advise on licensing
11 agreements?

12 A. Yes. She looks at the contracts and
13 works, I believe, with the team when a licensee
14 wants to have a change to their agreement. So
15 she'll help to make sure that the language in our
16 contracts are compliant.

17 Q. This is Mr. Banerjee's team; is that
18 right?

19 A. Mr. Banerjee and also Missy Danforth and
20 the team.

21 Q. Okay. Because Missy -- because Ms.
22 Danforth oversees the licensing team --

1 A. Right.

2 Q. -- as well as the ratings team, correct?

3 A. Yes. It's typically Kush Banerjee who is
4 working with the contracts with individual
5 licensees.

6 Q. Okay. Does Ms. Blair advise on 990
7 filings?

8 A. No.

9 Q. Okay. How about on any sort of
10 employment issues?

11 A. Rarely. We have a -- we have a
12 contractor called Engage Healthcare that has
13 attorneys, and we typically rely on them for
14 advice regarding employment issues.

15 Q. Okay. Does Ms. Blair advise on any
16 issues relating to changes in the hospital
17 survey?

18 A. No. I don't believe so.

19 Q. Okay. How about changes with respect to
20 the scoring methodology?

21 A. No.

22 Q. Okay. Does Ms. Blair give Leapfrog

1 business advice in any -- in any way?

2 A. Other than looking at the legal language
3 in our contracts, no.

4 Q. Okay. Does -- so Ms. Blair -- it's
5 correct that Ms. Blair attends board meetings to
6 this day, correct?

7 A. Yes.

8 Q. All right.

9 A. We've always had counsel attend board
10 meetings.

11 Q. Okay. And can you just kind of tell us
12 again, what is Ms. Blair doing at the board
13 meetings?

14 A. She is listening and assuring that our
15 deliberations and our discussions and any issues
16 that come up are compliant with the law.

17 Q. Okay. Does Ms. Blair attend any other
18 Leapfrog meetings other than the board meetings?

19 A. Once in a while she's asked to attend
20 meetings, but rarely.

21 Q. Okay. Let's go to our next document.

22 MR. CHUNG: Tab 14. Oh, tab 15, I'm

1 sorry.

2 This will be Exhibit 16.

3 (Binder Deposition Exhibit 16 marked for
4 identification and attached to the
5 transcript.)

6 BY MR. CHUNG:

7 Q. All right. Ms. Binder, did -- in the
8 fall of 2024, did Leapfrog -- did the Leapfrog
9 website have a frequently asked questions
10 section?

11 A. Yes.

12 Q. Okay. Now, I'm just going to direct your
13 attention to the very first page of the exhibit,
14 which is an e-mail.

15 And towards the bottom of the e-mail you
16 write, Are you giving more A's now because of all
17 this improvement? Explain sliding scale. A's
18 tend to be better now.

19 Do you see that?

20 A. Yes. I'm going to have to refresh my
21 memory on this. But frequently asked questions
22 on our website are different from frequently

1 asked questions that we use internally for
2 spokespeople and people who are going in front of
3 the press or talking to hospitals or talking to
4 the public, et cetera. We have a set of talking
5 points to address those issues.

6 Q. But both are external facing, correct?

7 A. The frequently-asked questions, no,
8 they're not external -- there are some on our
9 website. There are actually lots of different
10 places on our website we have frequently asked
11 questions.

12 But I believe -- and I'd need to refresh
13 my memory on this particular e-mail, but I
14 believe these are internal talking points --

15 Q. Okay.

16 A. -- frequently asked questions that we use
17 for our own internal spokespeople. I believe
18 that's what he's talking about.

19 Q. Okay. So just focusing on that sentence,
20 Are you giving more A's now because of all this
21 improvement?

22 Do you see that?

1 A. Where is that?

2 Q. In the paragraph starting, Where are we
3 seeing improvements in patient safety?

4 Do you see that paragraph?

5 A. Oh, yeah. Okay.

6 Q. If you go down four lines -- or three
7 lines.

8 A. Right.

9 Q. Do you see that?

10 A. Uh-huh.

11 Q. Was Leapfrog giving out more A grades in
12 2023 and 2024 than in prior years?

13 A. No. We've given out pretty much
14 consistently the same number of A's.

15 Q. Same --

16 A. Slight changes up and down, up and down
17 depending on how the CMS data plays out. But
18 pretty much the same amount of A's every year.

19 Again, there are slight changes, but not
20 substantially.

21 These questions are -- this is definitely
22 for an internal document of questions that we do

1 hear and -- to be prepared to answer them.

2 Q. Okay. Let's go to the actual markup of
3 the frequently asked questions document. And if
4 you go to 397096 -- do you see that at the
5 bottom?

6 A. Yes.

7 Q. It's the first page of the document.

8 At the bottom of the page -- and are
9 these markups your -- is it your markup?

10 A. It looks like it is mine.

11 Q. Okay. You added a question here that
12 reads, Why did hospital X get an F? Why did
13 hospital Y get an A?

14 A. Yeah.

15 Q. And then under that, in brackets, you
16 wrote, at least in part, Don't say how those
17 measures caused a bad grade. In other words,
18 talk about the safety measures, not the
19 methodology.

20 Do you see that?

21 A. Yes.

22 Q. Okay. Why did you not want to talk about

1 the methodology?

2 A. Because when you're talking to a reporter
3 who is, in turn, talking to the lay public or
4 reporting for the lay public, they don't want to
5 hear about long explanations of methodology.
6 What's important about the safety grade is errors
7 and accidents and injuries and infections
8 happening in hospitals. So I want to make sure
9 that our spokespeople are continuing to talk
10 about those issues and not getting -- not going
11 on about the methodology.

12 Q. But don't reporters or even consumers
13 want to know -- the question here is -- why a
14 particular hospital got an F grade?

15 A. Uh-huh. Yeah. So what we advise people
16 to do in this case -- and I don't know, maybe you
17 have another exhibit with the final that this
18 ended up.

19 But what we advise our spokespeople to
20 say is, well, they did poorly on central
21 line infections, they were among the worst in the
22 country on patient experience reports or they --

1 you know, to be very specific to the reasons --
2 the specific measures of problems that happen in
3 hospitals. We should be very specific about
4 those when we're discussing the grades.

5 Q. But if it's -- but for specific measures,
6 including -- I'm focusing on the four imputed
7 metrics, which I think you testified earlier are
8 among the most important metrics; is that right?

9 MS. BLAIR: Objection to form.

10 THE WITNESS: I didn't say that. I
11 didn't testify that.

12 BY MR. CHUNG:

13 Q. All right. Well, let me put it another
14 way.

15 Are the four imputed metrics among the
16 most heavily weighted metrics in the scoring
17 methodology?

18 MS. BLAIR: Objection to form.

19 THE WITNESS: I think it depends on which
20 hospital is -- which hospital you're scoring.

21 BY MR. CHUNG:

22 Q. Okay. But specifically with respect to

1 those four imputed metrics, isn't it correct that
2 why a particular hospital got a limited
3 achievement score on that metric is because they
4 were automatically assigned that score because
5 they didn't participate?

6 MS. BLAIR: Objection to form.

7 THE WITNESS: If a reporter is to ask why
8 did that hospital get limited achievement and
9 they didn't report to the survey, and I look on
10 the website and I see that's what we say, that we
11 assigned a grade, that's what I would tell the
12 reporter.

13 But this is not what the question is on
14 here that I was editing and suggesting that the
15 team write this answer that the spokespeople at
16 Leapfrog would have, which is to have an
17 orientation toward advising reporters on what are
18 these problems in hospitals that we are noting in
19 each hospital's grade.

20 BY MR. CHUNG:

21 Q. Okay. If we -- and then under that
22 section in brackets you write, Terminology should

1 say the hospital earned their grade.

2 Do you see that?

3 A. Yes.

4 Q. Why did you add that comment? Let me put
5 it another way.

6 Why was it important to use the
7 word "earned"?

8 A. Because a hospital's performance is such
9 that they earned the grade that they get.

10 Q. But hospitals that don't respond to the
11 survey are still assigned a grade, right?

12 MS. BLAIR: Objection to form.

13 THE WITNESS: They -- according to the
14 methodology and with the advice of the expert
15 panel, they are -- they get a grade that is
16 reflective of their performance.

17 BY MR. CHUNG:

18 Q. Okay. And would you say that
19 non-participating hospitals earned their grade,
20 just using the verbiage here?

21 A. Absolutely they earned their grade. And
22 it's based on 28 of the 38 -- 32 measures in

1 particular.

2 Q. 28 of the --

3 A. Well, there's 32 measures in the grade,
4 so it's based on all 32 measures. But it is
5 based on the data that we have.

6 Q. But not on the four -- but not on --

7 A. Imputed --

8 Q. -- four, correct?

9 A. No. Imputed values are real -- that's
10 real measures to me.

11 Q. Okay. Though they're automatically
12 assigned a grade, correct, without the benefit of
13 any data on those metrics; is that right?

14 MS. BLAIR: Objection to form to the use
15 of "grade."

16 THE WITNESS: They're not assigned a
17 grade on those imputed measures at all.

18 BY MR. CHUNG:

19 Q. A score.

20 A. Each of those imputed measures, the
21 imputation is a score.

22 Q. Okay. And that score is a limited

1 achievement score that is automatically assigned
2 to those metrics without the benefit of any data
3 on those metrics, correct?

4 A. If the hospital has reported to the
5 survey in the past two cycles of the grade, then
6 we will use that data.

7 Q. But absent that?

8 A. Absent that, in the step 2, they will --
9 they are imputed with a one bar equivalent in
10 each of those four measures.

11 Q. All right.

12 A. Yes.

13 Q. And that imputation is not based on data,
14 actual data, submitted by the hospital, right?

15 A. It's based on --

16 Q. My question is --

17 A. -- extremely --

18 Q. -- that imputation is not based on -- is
19 not reflective of actual data submitted by the
20 hospital, correct?

21 A. Submitted by the hospital?

22 Q. Correct. That's what I asked.

1 A. It's reflective of data from -- it's
2 reflective of data --

3 Q. What --

4 A. -- based on our knowledge of how
5 hospitals perform when they don't report to the
6 survey --

7 Q. Okay.

8 A. -- and expert opinion.

9 Q. Okay. Let's turn to page 3 of the FAQ --
10 this FAQ document, Bates ending 7098.

11 Okay? Do you see that?

12 A. Actually, I see --

13 Q. The top number.

14 MS. BLAIR: Yeah.

15 THE WITNESS: Oh. Oh, I see. Okay.

16 Yes.

17 BY MR. CHUNG:

18 Q. So there is a question here that reads,
19 Are there methodology changes in the fall 2024
20 Leapfrog hospital safety grade.

21 Do you see that?

22 A. Yes.

1 Q. All right. And it says -- under that
2 question you wrote, In line with recommendations
3 from the national expert panel and Johns Hopkins
4 advisors, Leapfrog changed the way it estimates
5 performance for hospitals that declines to report
6 to the Leapfrog hospital survey; is that right?

7 A. Yes.

8 Q. Okay. Now, looking at the second half of
9 that sentence, is it correct that -- does it ever
10 -- is it correct that the change in methodology
11 is to estimate performance for hospitals that
12 decline to report to the hospital survey?

13 A. This is a draft, and I corrected their
14 draft.

15 Q. Okay.

16 A. So I probably would word that -- and it's
17 not the final. I'm sure it's not the final
18 because that is not quite how we would word it.

19 Q. Okay.

20 A. Changed the way it to...

21 Yeah.

22 Q. All right.

1 A. Yeah. I would tweak the wording to be a
2 little bit more accurate to be clear that it's
3 those -- that it's four of the measures.

4 Q. Okay.

5 MR. CHUNG: Let's go to tab 16.

6 So this will be Exhibits 17 and 18.

7 (Binder Deposition Exhibits 17 and 18
8 marked for identification and attached to
9 the transcript.)

10 BY MR. CHUNG:

11 Q. Okay. Exhibits 17 and 18, you have got
12 an e-mail and a PowerPoint that was attached to
13 it. And let's just focus on 17 for the time
14 being.

15 A. Oh, yeah. This was my PowerPoint skills.

16 Q. Okay. And just looking at the e-mail --
17 so Bates ending 0327 -- this is an e-mail from
18 you to a Paul Alper who I understand is a
19 consultant --

20 MS. BLAIR: Wait.

21 THE WITNESS: I don't think I have that.

22 MS. BLAIR: 0327? We don't have that

1 one. That's not what we have.

2 MR. CHUNG: Just a moment.

3 THE WITNESS: I have 2499.

4 MR. CHUNG: Just a moment.

5 BY MR. CHUNG:

6 Q. Ah. Okay. So Exhibit 17. We're looking
7 at the e-mail Bates ending 2499.

8 Are we now looking at the same thing?

9 Yes.

10 A. Yes.

11 Q. Okay. So let's look at the second
12 page of the document, Bates ending 2500.

13 A. Uh-huh. Yes.

14 Q. And you're writing to Ms. Bailey, who's
15 director of communications at this time; is that
16 right?

17 A. Yes.

18 Q. Okay. This Leapfrog 101 presentation
19 that's being referenced here, what is -- who's
20 the audience for this presentation?

21 A. I can't exactly recall. We do a lot of
22 Leapfrog 101 presentations. I can't recall what

1 this one was meant for.

2 Q. Well, let's go back to the e-mail. Just
3 going down to Bates ending 2500, it's the
4 paragraph starting, First, the most important
5 things to convey in this speech are -- and then,
6 going down a few bullets -- Why the imputation
7 strategy is controversial -- right?

8 Do you see that?

9 A. Yes.

10 Q. All right. What do you mean here? What
11 did you mean?

12 A. Why we're sitting here today is it's
13 controversial to hospitals that don't report --
14 decline to report to the survey.

15 It's also controversial, and has been in
16 the past, the imputation strategy, to hospitals
17 that do report to the survey and have expressed
18 their concern that we are inflating these scores
19 for hospitals that don't report.

20 Q. Okay. The next bullet point, The levers
21 we pull to get hospitals and ASCs to participate.

22 A. Yes.

1 Q. In terms of in terms of the levers --
2 right? -- is one of those levers the risk of a
3 failing grade to a hospital that doesn't
4 participate?

5 MS. BLAIR: Objection to form.

6 THE WITNESS: Well, first of all,
7 participation in the survey is not the same as
8 getting a hospital safety grade.

9 BY MR. CHUNG:

10 Q. Right.

11 A. So no.

12 Q. So what do you -- what do you mean by
13 levers here?

14 A. Well, we -- like any organization, we
15 have to find ways to influence the public in ways
16 that meet our mission. So one lever is, for
17 instance, our work with regional leaders who are
18 typically business groups on health. They have
19 memberships consisting of employers and other
20 purchasers in their community. And those
21 purchasers are the ones that ask hospitals to
22 please participate in the Leapfrog survey because

1 we would like to see that data publicly reported.

2 So that's a lever. We use -- like any
3 organization -- really, any organization of any
4 sort -- we use whatever we have in terms of our
5 influence to see change and to meet our mission.

6 Q. Okay. That's an example of one lever.

7 A. Yes.

8 Q. Is another lever the imputation strategy
9 itself in that it gets hospitals to participate
10 in the survey?

11 A. No. That's not the purpose of the
12 imputation strategy. We didn't see it that way.
13 Because the imputation strategy actually -- it
14 doesn't help or hurt the participation in the
15 survey necessarily. It can for some hospitals;
16 it cannot for others.

17 Q. But isn't it correct that in discussions
18 with members of your own expert panel, that the
19 experts themselves believed that this imputation
20 strategy was, at least in part, designed to get
21 more hospitals to participate that formerly were
22 not participating? Is that correct?

1 MS. BLAIR: Object to form.

2 THE WITNESS: I saw Patrick Romano
3 discuss that. But other than him, I don't think
4 they were seeing it that way. I think they did
5 see implications that they felt were of
6 importance for hospitals that declined to
7 participate. They definitely saw that as a
8 signal of performance in some way, and they
9 talked about that.

10 But that's -- you know, again, what I'm
11 concerned about is that -- from the expert panel
12 is that they agree with the ultimate
13 recommendation, and they did.

14 BY MR. CHUNG:

15 Q. Okay. I'm going to direct your attention
16 to the next page, Bates ending 2501.

17 There's a paragraph that starts, There
18 needs to be a slide about what Leapfrog does to
19 grade a hospital when they decline to report to
20 the survey.

21 Do you see that paragraph?

22 A. Yes.

1 Q. Okay. I think it's very important for
2 the board to understand that we moved over time
3 toward imputing the lowest level of performance
4 when we don't have recent Leapfrog data. In
5 other words, the slide should not detail the
6 step-by-step imputation process. It should
7 summarize the strategic import of the imputation
8 process. This has been a shift over time and one
9 with significant policy ramifications for the
10 organization.

11 A. Uh-huh.

12 Q. This is the second time we're seeing
13 you're saying that we shouldn't get into the
14 methodology. In this case, it's, we should not
15 detail the step-by-step imputation process.

16 With respect to the board, why isn't it
17 important to detail the step-by-step imputation
18 process?

19 MS. BLAIR: Object to form.

20 BY MR. CHUNG:

21 Q. You can answer.

22 A. So you're saying, with respect to the

1 board, why is it important not to detail the
2 imputation process?

3 Q. Why -- why -- why is it not important --
4 right? -- to share with them the steps in the new
5 imputation process?

6 A. Well, in the context of this
7 presentation, which I believe -- I would like to
8 know which we were talking about, but I believe
9 this was to new members of the board. I think
10 this was their orientation.

11 So this is a slide presentation that's
12 probably 30 slides. And this is -- these are new
13 members of the board who are not measurement
14 scientists or clinicians and they're not engaged
15 in the healthcare world, so they will not see the
16 forest for the trees. They won't understand
17 what's important about this.

18 It's very important to me to be as candid
19 and absolutely blunt as possible in our
20 communications so that they understand what's
21 most important about this. If you showed board
22 members who are, like, laypeople, here's this

1 step 1, step 2 imputation, they go -- they're not
2 necessarily going to realize what happened and
3 how this has evolved over time and why, and
4 why -- and the explanations that the expert panel
5 gave us for why that was important.

6 Q. So are you saying that board members, the
7 new board members, will not understand the
8 imputation process?

9 A. No. I just think that they -- they will
10 understand it, for sure, but this presentation
11 has 30 slides with 30 different areas of import.
12 And in this context, that would not convey the
13 message appropriately.

14 Q. Okay.

15 A. When you're speaking to people who --
16 you're trying to give them a broad overview of
17 everything that's going on, and I want to make
18 sure that they understand this very important
19 thing. That's how I felt was the best strategy
20 to do it in this context.

21 Q. Okay. Let's actually go to the slide
22 presentation itself. So if you go to Bates

1 ending in 104. It's 1104. And the slide is
2 titled, How the Survey Compares to Other
3 Measurement Programs.

4 A. Oh, I'm sorry, where is that then? It's
5 not this?

6 MS. BLAIR: It is.

7 MR. CHUNG: It is, yeah.

8 MS. BLAIR: It looks like this. It's
9 1104.

10 MR. CHUNG: Yeah. Exhibit 18.

11 THE WITNESS: Oh.

12 MR. CHUNG: Okay.

13 THE WITNESS: 1104? Okay.

14 BY MR. CHUNG:

15 Q. And the title of the slide is, How the
16 Survey Compares to Other Measurement Programs.

17 Do you see that?

18 A. Yes.

19 Q. Okay. And this includes -- shows a chart
20 listing Leapfrog, CMS, TJC, clinical registries,
21 and health plans; is that correct?

22 A. Yes.

1 Q. Okay. And what are these -- we know what
2 Leapfrog is.

3 CMS is -- what are these other entities
4 and why are they included here in this chart?

5 A. I think that people who are not immersed
6 in the measurement world will say, well, how is
7 Leapfrog different from the Joint Commission or
8 from all these registries, from all the other
9 stuff that hospitals are doing when they are
10 reporting on their quality and safety? Or how is
11 it different from what health plans do?

12 And so we're trying to sort of lay that
13 out, why we needed Leapfrog, because it plays a
14 very unique role amid all of those other efforts
15 at assessing and reporting on quality and safety.

16 Q. Okay. Now, it says here, under TJC and
17 then clinical registries, that one can opt out.

18 Do you see that?

19 A. Yes.

20 Q. Okay. And so, according to this chart,
21 hospitals can opt out of reporting to TJC and
22 these clinical registries; is that right?

1 A. No. It's tied to -- the row is publicly
2 reports by facility. They can opt out of
3 publicly reporting their Joint Commission
4 results.

5 Q. Okay. Does Leapfrog allow hospitals to
6 opt out of that?

7 A. If they report to our survey? If they
8 submit to our survey, they attest to the veracity
9 of the survey and they submit it. It is publicly
10 reported. That is our core mission.

11 Q. So the question is, can a hospital opt
12 out of that public disclosure, that public
13 reporting of that data?

14 A. By not reporting to the survey, they can
15 opt out.

16 Q. Okay. After submitting the data, can
17 they opt out?

18 A. No.

19 Q. Okay.

20 A. Of reporting their performance, I might
21 add. Their scores by Leapfrog.

22 Q. Can they get an exemption for completing

1 the survey?

2 MS. BLAIR: Object to form.

3 THE WITNESS: An exemption for completing
4 the survey?

5 BY MR. CHUNG:

6 Q. From completing the survey.

7 A. They just don't report. It's -- you
8 know, it's voluntary.

9 Q. Okay. And you're aware that the
10 plaintiff hospitals in this matter, they sought
11 to opt out of participating in the survey; is
12 that right?

13 A. They don't participate in the survey. So
14 they didn't just seek to opt out; they didn't --

15 Q. They just didn't, right?

16 A. Uh-huh.

17 Q. Okay.

18 A. Though I do see from some of the
19 discovery materials that they were interested in
20 reporting, but were told they couldn't, which was
21 interesting.

22 Q. The last row in the chart is a -- the

1 five-step verification process.

2 Do you see that?

3 A. Yes.

4 Q. Okay. And Leapfrog has an X in the
5 column next to it, right?

6 A. Yes.

7 Q. And does this mean that the other surveys
8 on this slide don't verify their data?

9 MS. BLAIR: Objection to form.

10 THE WITNESS: No, that's not what this
11 means.

12 BY MR. CHUNG:

13 Q. Okay. It just means that they don't have
14 the five-step verification process that Leapfrog
15 has?

16 A. Exactly.

17 Q. Okay.

18 A. But they each have their own processes,
19 I'm sure.

20 Q. The -- we're going back to -- earlier in
21 the morning we were discussing ways that Leapfrog
22 does and does not verify the data that it -- that

1 it receives from the hospitals.

2 Does Leapfrog visit hospitals that do not
3 participate in the survey and receive limited
4 achievement scores?

5 MS. BLAIR: Objection to form.

6 THE WITNESS: Visit for what purpose?

7 BY MR. CHUNG:

8 Q. Just for any purpose.

9 A. No formal visits, but I've certainly been
10 to hospitals and visited hospitals that don't
11 report to the survey.

12 Q. Okay. All right.

13 MR. CHUNG: We've been going a while.
14 We're going to the next section.

15 So why don't we -- should we break for
16 lunch now?

17 MS. BLAIR: Sure. Yeah.

18 MR. CHUNG: Why don't we do that.

19 VIDEO TECHNICIAN: The time is 12:54 p.m.
20 This ends unit 2. We're off the record.

21 (A recess was taken.)

22 VIDEO TECHNICIAN: The time is 1:52 p.m.

1 This begins unit number 3. We're on the record.

2 (Binder Deposition Exhibits 19 and 20
3 marked for identification and attached to
4 the transcript.)

5 BY MR. CHUNG:

6 Q. So Ms. Binder, our next document,
7 Exhibits 19 and 20, are an e-mail chain and short
8 attachments from July 15 of 2024. And I want to
9 direct your attention to -- you mentioned -- who
10 is Paul Alper?

11 A. He is a consultant to Leapfrog.

12 Q. Okay. And it appears that he sent a set
13 of slides or a slide for you to review; is that
14 right?

15 A. I believe so. I have to refresh my
16 memory on this e-mail.

17 Q. Okay. Just take a moment to review it.

18 Ms. Binder, I'm just going to ask a few
19 questions about that last bullet point in the
20 e-mail that starts with, We did change the
21 methodology for fall 2024.

22 A. Okay. I'm just getting to reading that

1 right this second.

2 Yes. Okay.

3 Q. All right. So by this time, is it right
4 that the methodology -- the imputation
5 methodology that we've been discussing all day so
6 far was put into effect?

7 A. I believe by July 15th, yes, I believe
8 so.

9 Q. Okay. And you're writing to Mr. Alper
10 that it would change the methodology so that
11 hospitals that don't report to the Leapfrog
12 survey this year or last year will be imputed
13 with the lowest score on hand hygiene and I'm
14 sure the survey team has a slide on that.

15 And then you continue to write, But
16 please be sure you thoroughly understand this
17 change and the talking points around it if you
18 decide -- if you do decide to use it. It's a
19 very big deal to hospitals and a major incentive
20 to report to the survey and you could easily get
21 a question on it.

22 So you wrote that the methodology change

1 was a major incentive to report -- for these
2 hospitals to report to the survey; is that
3 correct?

4 A. It's a very big deal to hospitals and a
5 major incentive to report to the survey. Yes --

6 Q. Right.

7 A. -- I wrote that here.

8 Q. And it would be a major -- it is a major
9 incentive for these hospitals to report to the
10 survey because they would face a higher risk of
11 receiving a low grade if they did not report; is
12 that right?

13 A. Not necessarily.

14 Q. But that was behind your comment here
15 that it would be a major incentive for hospitals
16 to report to the survey; is that right?

17 A. For some hospitals to report to the
18 survey because, if they do well -- particularly I
19 think he was at a conference where he was
20 speaking about hand hygiene, so he was going to
21 be speaking to hospitals that are very actively
22 involved in hand hygiene work. And so to that

1 audience, they would want to be able to report
2 that performance so they would -- you know, that
3 would help their grade.

4 For a lot of hospitals, they -- reporting
5 to the survey doesn't help their grade because
6 they don't do well.

7 Q. Okay. But that was -- that was one of
8 the kind of effects -- right? -- of this change
9 in the methodology that more hospitals would
10 respond to the survey, correct?

11 MS. BLAIR: Objection to form.

12 THE WITNESS: It's potentially an effect,
13 but --

14 BY MR. CHUNG:

15 Q. Right.

16 A. -- potentially not an effect.

17 Q. And, in fact, that was a purpose of --
18 one of the purposes of the imputation methodology
19 change; isn't that right?

20 A. No, that wasn't --

21 MS. BLAIR: Objection to form.

22 THE WITNESS: -- the purpose of the

1 methodology change.

2 BY MR. CHUNG:

3 Q. Well, does -- okay. Just to summarize,
4 Leapfrog assigns the limited achievement score
5 for a non-participating hospital on the imputed
6 metrics under this methodology change; is that
7 right?

8 A. Well, what I didn't say in this
9 paragraph was that there's also the -- if they
10 report -- you know, there's a step 1 where, if
11 they report in the prior year, they can get
12 scored from the prior year survey.

13 I didn't -- so I didn't go into the
14 details of it. I did tell him to go to the
15 survey team and get briefed and get the
16 information.

17 Q. Right. And you actually told him, be
18 sure you thoroughly understand this change,
19 correct?

20 A. Exactly.

21 Q. All right. But in this e-mail, you're
22 telling him that those that don't report to the

1 survey this year or last year will be assigned
2 the lowest score on hand hygiene, right? There's
3 no mention of the step 1 here, correct?

4 A. I didn't go into the full details of the
5 methodology. I told him to go and get that
6 information to make sure it's accurate.

7 Q. And your testimony is that it was not a
8 purpose at all behind the change in the
9 imputation methodology to encourage more
10 hospitals to respond to the survey. Not at all.

11 A. The purpose was to not overinflate -- you
12 asked me if --

13 Q. If you can answer the question. All
14 right?

15 Are you testifying that it was not a
16 purpose at all -- right? -- whether it's one of
17 the purposes or the purpose, to encourage
18 hospitals to report to the survey?

19 MS. BLAIR: Object to form.

20 THE WITNESS: We always want hospitals to
21 report to the survey. Like a hundred percent
22 participation in the survey. But that was not

1 the reason that we set out to change this
2 methodology.

3 BY MR. CHUNG:

4 Q. Okay. But did it at least become a
5 purpose or a reason to use this methodology?

6 MS. BLAIR: Objection to form.

7 THE WITNESS: No.

8 BY MR. CHUNG:

9 Q. So your -- the organization's desire to
10 have as many hospitals participate in the survey
11 as possible is completely divorced from this --
12 from the change in imputation methodology. They
13 have no relationship to each other whatsoever; is
14 that right?

15 MS. BLAIR: Objection. Form.

16 THE WITNESS: You're saying the
17 imputation methodology has no relationship to the
18 survey participation?

19 BY MR. CHUNG:

20 Q. I'm asking you, based on your testimony
21 so far, are you saying that there is absolutely
22 no relationship, no connection, between

1 Leapfrog's wish to have as many hospitals
2 participate in the survey as possible and the
3 change in this imputation methodology.

4 A. Certainly they're related. Absolutely
5 they're related. I just said they're related.
6 But it's not the purpose of changing the
7 methodology.

8 Q. Right. Despite your saying to Mr. Alper
9 that it's a -- the change in methodology is a
10 major incentive for hospitals to report to the
11 survey, correct?

12 A. That was the implication of this change,
13 but that was not the purpose of the change to the
14 methodology.

15 Q. Let's put it another way: Was it
16 contemplated, was it expected -- was it
17 contemplated that, in coming up with this
18 imputation methodology change, that it would be a
19 major incentive for hospitals to respond to the
20 survey?

21 MS. BLAIR: Objection to form.

22 THE WITNESS: It wasn't the purpose. I

1 mean, it wasn't the centerpiece or the purpose.
2 That wasn't what prompted it; that wasn't the
3 purpose.

4 BY MR. CHUNG:

5 Q. No, my question was, did Leapfrog
6 contemplate that the change in methodology, this
7 new methodology, would be a major incentive for
8 hospitals to report to the survey?

9 A. Yeah, we looked at it. We looked at that
10 issue. Certainly. It's right here. Definitely
11 looked at it.

12 Q. Okay. Are you aware of criticisms from
13 various hospitals about the change in the
14 imputation methodology?

15 A. I'm aware of hospitals critical on --
16 about the change from both a positive and a
17 negative way.

18 Q. Are you aware of criticisms from
19 hospitals that the change was unnecessarily
20 punitive?

21 A. I believe there were a couple of public
22 comments to that effect.

1 Q. Are you aware that there have been
2 criticisms from hospitals that it was penalizing
3 hospitals with insufficient resources?

4 A. I don't recall a particular public
5 comment to that effect, but there may have been
6 one.

7 Q. Okay. How about criticisms that the
8 public, the consumers, would not understand nor
9 dig into the change in methodology? Are you
10 aware of any criticisms along those lines?

11 A. That I'm not aware of.

12 Q. Okay. Are you aware of any criticisms
13 that hospitals -- from hospitals that the change
14 in methodology would cause hospitals with
15 insufficient resources to complete the survey?

16 A. It would cause hospitals with
17 insufficient resources to complete the survey?

18 Q. To divert -- to divert resources toward
19 complete the survey.

20 A. No, I haven't heard that criticism.

21 Q. All right. Have you heard the criticism
22 that, according to this imputation methodology,

1 that hospitals would be falsely represented with
2 a lower grade?

3 A. I have heard that criticism in public
4 comments.

5 Q. Okay. How about criticisms that the
6 change in methodology would result in an
7 inaccurate portrayal of the actual status of
8 patient safety at a hospital?

9 A. I've heard that comment from hospitals
10 that report to the survey as well as those that
11 don't.

12 Q. Okay. Do you recall, from your June 2024
13 CEO report that we saw before to the board, that
14 the change in the imputation methodology should
15 have some impact on hospital participation in the
16 survey?

17 Do you remember that comment?

18 A. Yes.

19 Q. All right. Are you aware that there is
20 not a single non-participating hospital in
21 Florida that received an A during the spring 2024
22 grade release?

1 A. In the State of Florida?

2 Q. Yes.

3 A. Yes.

4 Q. Okay. So you're aware of no A-hospitals
5 that were non-participants, correct?

6 A. In the State of Florida. Florida has a
7 high participation rate in general.

8 Q. Okay.

9 (Binder Deposition Exhibits 21 and 22
10 marked for identification and attached to
11 the transcript.)

12 BY MR. CHUNG:

13 Q. So Exhibits 21 and 22.

14 MS. BLAIR: Are you done with 20?

15 MR. CHUNG: Yes.

16 MS. BLAIR: Okay.

17 BY MR. CHUNG:

18 Q. So if you can look first, Ms. Binder, at
19 Exhibit 22, which is the standalone letter from
20 you to Kenneth Sands at HCA.

21 Do you see that?

22 A. Yes. I see that.

1 Q. All right. So directing your attention
2 to the fourth paragraph that starts, Our
3 successful partnership.

4 Do you see that?

5 A. Yes.

6 Q. All right. Our successful partnership is
7 why this letter is particularly difficult to
8 write. Unfortunately, you are no longer
9 qualified to serve on Leapfrog's hospital
10 advisory committee.

11 A. Right.

12 Q. And then, in the next sentence, you
13 write, Because of the board requirements, members
14 of the committee have to come from basically
15 hospitals that have participated in the most
16 recent survey; is that right?

17 A. Yes.

18 Q. Okay. And because HCA hospitals did not
19 participate in the 2023 survey, you're no longer
20 eligible.

21 A. Correct.

22 Q. So is it correct that because HCA did not

1 participate in the 2023 survey, Dr. Sands was not
2 allowed to serve on the hospital advisory
3 committee?

4 A. I'm trying to think if it's '23 or '24.
5 Probably '23 survey --

6 Q. Yeah.

7 A. -- that we would have written on
8 March 29th. Yeah, sounds right.

9 Q. Okay. So why was it necessary to remove
10 him from the committee?

11 A. Well, Leapfrog has a hospital advisory
12 committee that actually is competitive to get on.
13 A lot of hospitals submit nominations to get
14 themselves onto that committee. It is -- advises
15 Leapfrog and our board on -- as I said earlier,
16 about hospital industry trends in quality and
17 safety, long-term issues that they would advise
18 us to be looking forward to.

19 It's just a very important committee to
20 us and it's a very important committee, I think,
21 to hospitals just from the nominations we get.

22 So this letter -- the members of the

1 hospital advisory committee are hospitals -- are
2 from hospitals that report to the Leapfrog
3 hospital survey.

4 Q. So why was it necessary to remove
5 Dr. Sands from that committee?

6 A. Because his hospital system, all of them
7 stopped reporting to the Leapfrog survey in the
8 prior year.

9 Q. Okay. So was this a way of kind of
10 penalizing HCA for not participating in the
11 survey the prior year?

12 A. No, it's not penalizing. It's just
13 saying you're no longer. He's not qualified. We
14 want -- our hospital advisory committee should be
15 hospitals that participate in the survey.
16 Hospitals that don't participate clearly don't
17 want to be part of Leapfrog, but we certainly
18 welcome them if they want to participate in the
19 survey. But those are the folks that we need to
20 be working closely with.

21 Q. Okay.

22 MR. CHUNG: All right. This will be

1 Exhibit 23.

2 (Binder Deposition Exhibit 23 marked for
3 identification and attached to the
4 transcript.)

5 BY MR. CHUNG:

6 Q. So Exhibit 23, Ms. Binder, is a Slack
7 chat from October 4 of 2023 between Alexandra
8 Campione and Paige Lipscomb, who are both
9 employees of Leapfrog; is that right?

10 A. Paige is a former employee. But yes,
11 they were at the time.

12 Q. Okay. And I want to direct your
13 attention to page 2, Bates ending 0361.

14 A. I don't believe I've seen this one. I'm
15 going to need to read it.

16 Q. Okay. You're not on this chat. You're
17 not --

18 A. Right.

19 Q. It's just between the two ladies.
20 And so Paige writes, Why are convos so
21 bizarre?

22 Alex responds, This was the last meeting,

1 in a nutshell.

2 And then Alex continues, We were talking
3 about changing the scoring methodology to
4 penalize HCA?

5 So HCA refers to HCA Healthcare; is that
6 right? Or the HCA group of hospitals?

7 A. HCA Healthcare. Yes. The group.

8 Q. And these are hospitals, the HCA
9 hospitals, that had participated in the Leapfrog
10 surveys in the past, right?

11 A. Yes.

12 Q. Okay. But --

13 A. And they do now.

14 Q. But per the letter we saw earlier from
15 Dr. -- to Dr. Sands, they had stopped -- they had
16 not participated in the 2023 Leapfrog survey; is
17 that right?

18 A. I believe it was the '23. They paused
19 participation for one year.

20 Q. Right. And I think they eventually
21 rejoined, right? Or responded to surveys in the
22 future?

1 A. Yes. They've -- yes.

2 Q. Okay. Why would the new scoring
3 methodology here penalize HCA?

4 A. I don't know.

5 Q. Okay. Well --

6 A. I can tell you why HCA -- why they paused
7 participation, because they told me.

8 Q. Okay. Well, let's finish with this
9 document here and then we will get into that.

10 A. Okay.

11 Q. So Ms. Lipscomb, Paige, writes, I hate
12 that we don't do our ting -- or thing -- like we
13 manipulate everything.

14 Is it fair to say that she's referring to
15 the scoring methodology that Ms. Campione had
16 just mentioned?

17 MS. BLAIR: Objection to form.

18 THE WITNESS: I really don't know. I
19 haven't seen this before and I don't know.

20 BY MR. CHUNG:

21 Q. Okay. And then Ms. Campione responds,
22 Leah keeps grudges.

1 Do you think that she is referring to
2 you?

3 A. Yeah.

4 Q. Okay. And --

5 A. I'm not sure -- yeah.

6 Q. And what grudges is she talking about
7 here, so far as you understand it?

8 A. I have no idea.

9 Q. Is it a grudge --

10 A. I don't keep grudges.

11 Q. Is it a grudge -- you do not keep
12 grudges?

13 A. No.

14 Q. Okay. Is it a grudge against HCA for not
15 participating in the survey in 2023?

16 MS. BLAIR: Objection to form.

17 THE WITNESS: I don't know what she's
18 referring to.

19 BY MR. CHUNG:

20 Q. Okay. Well, you had just -- you
21 eventually, some months later, removed Dr. Sands
22 from the hospital advisory committee, correct?

1 A. He was no longer eligible to be on it, so
2 yes, I told him he cannot be on it --

3 Q. Right.

4 A. -- in a letter that was quite
5 conciliatory and open.

6 Q. But -- and then, during that same time,
7 the -- Leapfrog was discussing or contemplating a
8 change in the imputation methodology, correct?

9 A. Same time as what?

10 Q. As the time when you removed Dr. Sands
11 from the hospital advisory committee.

12 A. I don't recall --

13 MS. BLAIR: Objection to form.

14 THE WITNESS: -- the date.

15 BY MR. CHUNG:

16 Q. Okay. The -- you mentioned --

17 A. Something around there.

18 Q. The requirements to be qualified on the
19 hospital advisory committee, Ms. Binder, are
20 those enumerated somewhere? Memorialized
21 somewhere?

22 A. I'm sure there are.

1 Q. Okay. Where would they be memorialized?

2 A. In the file for the hospital advisory
3 committee, probably from whenever it was formed.
4 We've always opened it up to representatives from
5 hospitals that report to the survey.

6 Q. So what did you refer to -- it sounds
7 like you're not sure if or where it's
8 memorialized.

9 What did you refer to when removing
10 Dr. Sands from the hospital advisory committee?
11 What document containing the qualifications were
12 you relying on?

13 MS. BLAIR: Objection to form.

14 THE WITNESS: I don't have it in front of
15 me, but we have lots of documents that discuss
16 the hospital advisory committee, its purpose, why
17 it was formed, why the board formed it, and who's
18 on it. And it does say that it is hospitals that
19 report to Leapfrog. It talks about there needs
20 to be, you know, a range of members from
21 different parts of the country from different
22 size of hospitals, from different roles within

1 hospitals. It's quite explicit about that.

2 I mean, we've had a lot of documents like
3 that --

4 BY MR. CHUNG:

5 Q. Okay.

6 A. -- but I obviously can't pull them out
7 right now.

8 Q. So just going back to the Slack chat that
9 we just discussed between Ms. Lipscomb and
10 Ms. Campione.

11 Do you recall any discussions with either
12 of them about penalizing HCA for not
13 participating in the 2023 survey?

14 A. I'm sorry, can you say that again.

15 Q. Yeah. Do you recall any discussions or
16 conversations you had with Ms. Lipscomb or
17 Ms. Campione around this time about punishing or
18 penalizing HCA for not responding to the 2023
19 survey?

20 A. No. I don't talk about penalizing
21 anyone.

22 Q. Okay.

1 A. And certainly not hospitals. That's not
2 my -- that's not language I use.

3 Q. HCA, the -- HCA Healthcare is a
4 relatively large group of hospitals; is that
5 correct?

6 A. Yes.

7 Q. So they were -- until he was removed,
8 HCA, would you say, is among the bigger kind of
9 hospital systems that were -- that participated
10 in the survey?

11 A. Among participants in the survey, I think
12 they would be among the larger ones, I guess.
13 But in general, they're a very large health
14 system.

15 Q. Okay. So when they declined or did not
16 participate in the 2023 survey, did you view that
17 as kind of a loss to Leapfrog in terms of
18 hospital participation in the survey? Just given
19 the relative size.

20 A. Yeah. I mean, in terms of the hospital
21 participation numbers, it was maybe, like, a
22 3 percent drop for the year. But that's not

1 definitive of anything. I mean, I certainly
2 would want -- what I really wanted was HCA to
3 continue to participate because they had a
4 hundred percent participation for many, many
5 years, and, you know, we were very proud of them
6 for that.

7 Q. Did it upset you when they told you that
8 they weren't going to participate in the 2023
9 survey?

10 A. It was -- sure. I was very disappointed.
11 Because, again, they've been participating every
12 year at a hundred percent. And it's also been,
13 for me, inspiring that they participate like that
14 because they participate even though some of
15 their hospitals don't actually do that well in
16 the survey, but they're publicly reporting;
17 they're transparent to me. That is just a really
18 inspiring sign that the hospital industry
19 believes in transparency and really wants to do
20 something about patient safety.

21 So for me, they were inspirational. They
22 were an important player.

1 In terms of participation in the survey,
2 it caused a slight drop, but it wasn't anything
3 noticeable in terms of any -- it was noticeable
4 but it wasn't a big deal in terms of
5 participation. But in terms of our mission and
6 inspiration and really wanting role-model
7 hospitals involved in the survey, it was
8 disappointing.

9 Q. So was their declining to participate in
10 2023 one of the reasons that Leapfrog decided to
11 change its imputation methodology?

12 A. No.

13 Q. Okay. Did you, in fact, hold a grudge
14 against HCA for this period of time for not
15 participating in the survey?

16 A. No.

17 Q. Disappointed, but not a grudge?

18 A. Right. I talked to them a few times. I
19 actually met with them and -- to find out -- to
20 understand what the suspension was. I know what
21 it was. They told me what it was repeatedly, and
22 that is that they did not like the new measure on

1 the Leapfrog hospital survey on nursing
2 workforce, which was causing -- they felt could
3 cause them some problems with some unions.

4 So they, you know, had said they wanted
5 us to take that off or reframe that question,
6 et cetera. We did not do that in the end and --
7 because we are independent, we didn't do it. And
8 they still came back, which -- to their credit.

9 Q. Okay.

10 A. But that is the sole reason that they
11 suspended their participation, at least according
12 to them.

13 Q. Okay. Just one moment.

14 We're now going to move on to the
15 websites, Leapfrog's websites, that is. And
16 that's one of the topics that you've been
17 designated to testify as a representative from
18 Leapfrog.

19 A. Yes.

20 Q. How many websites does Leapfrog operate?

21 A. Two.

22 Q. Two. And those are --

1 hospitalsafetygrade.org is one of them, and then
2 the second one is leapfroggroup.org?

3 A. Yes.

4 Q. Is there another one called ratings.org?

5 A. Ratings.org is incorporated into
6 leapfroggroup.org.

7 Q. Okay. Do you know roughly how many views
8 each of these websites receives annually?

9 A. Yes. Since I prepared because I am the
10 34 -- what is it? 340(b)? Is that what I'm
11 called?

12 MS. BLAIR: 30(b)(6).

13 MR. CHUNG: 30(b)(6).

14 THE WITNESS: 30(b)(6), sorry.

15 Okay. So The Leapfrog Group website got
16 915,000 views from September 24 to September 25.

17 The Hospital Safety Grade website got 2.5
18 million in that same time period.

19 BY MR. CHUNG:

20 Q. Okay. Ms. Binder, so the notebook in
21 front of you contains -- is it notes to kind of
22 aid your testimony here today?

1 A. To prepare, yeah --

2 Q. Okay.

3 A. -- for things I thought you would ask me,
4 particularly around -- in my role as
5 spokesperson --

6 MR. CHUNG: We're going to ask your
7 counsel to make a copy of those --

8 MS. BLAIR: Absolutely.

9 MR. CHUNG: -- and produce thereafter.

10 THE WITNESS: Happy to do that.

11 MS. BLAIR: Absolutely.

12 BY MR. CHUNG:

13 Q. Okay. Are you aware that, upon a Google
14 search of the words "hospital safety grade,"
15 these are the two top website hits that come up:
16 Hospitalsafetygrade.org first and then followed
17 by leapfroggroup.org?

18 A. I think it depends on who's Googling.
19 Right? But --

20 Q. Do you know?

21 A. Usually I see leapfroggroup first, but --
22 I don't know.

1 Q. Okay.

2 A. One of them.

3 Q. Do either or both of Leapfrog's
4 websites -- those two -- provide an explanation
5 of Leapfrog's methodology behind its scoring?

6 A. I'm confused. So -- which one? Which
7 scoring?

8 Q. The scoring methodology.

9 A. For what? For the safety grade or for
10 the hospital -- the survey? Or --

11 Q. The hospital safety grade.

12 A. So do either of the websites offer --

13 Q. An explanation --

14 A. -- of the scoring --

15 Q. -- of that scoring --

16 A. -- of the --

17 Q. -- methodology.

18 A. -- hospital safety grade? The Hospital
19 Safety Grade website has the methodology spelled
20 out, and it has links to the methodology in
21 numerous places on the website.

22 Q. Okay. And the methodology is the

1 18-or-so-page methodology document?

2 MS. BLAIR: Objection to form.

3 THE WITNESS: The methodology document
4 is -- I don't know how many pages it is, but it's
5 the document that's on the website.

6 BY MR. CHUNG:

7 Q. Okay. Has Leapfrog ever received
8 feedback from members of the public that the
9 scoring methodology for the hospital safety grade
10 is difficult to understand?

11 A. I don't recall any -- I don't recall
12 anybody complaining about that.

13 Q. Okay. Have either or both of the
14 websites been assessed by a low literacy or a
15 digital literacy expert?

16 A. The hospital safety grade website, yes,
17 has been.

18 Q. When was that?

19 A. When we launched it in about 2014.

20 Q. Okay.

21 A. And then it's -- every year periodically
22 we assess it ourselves and -- to see the literacy

1 level that the site is appearing at.

2 Q. How do you assess it yourself?

3 A. You can -- you can run through a series
4 of questions about the literacy level and figure
5 it out to be, like, eighth grade or something, I
6 think, was the last one.

7 Q. Who does that from Leapfrog?

8 A. Trying to -- I think our communications
9 team looks at it.

10 It's not a -- they're not experts in low
11 literacy, so we don't have the funds to do a full
12 expert analysis, but it was designed by a low
13 literacy expert, who then taught us how we can
14 assess our site to make sure that it continues to
15 function at that level.

16 Q. Has an expert reviewed either or both of
17 the websites after the fall 2024 imputation
18 methodology change?

19 MS. BLAIR: I'm just going to object to
20 form. If you're asking about the expert in this
21 litigation or just any --

22 MR. CHUNG: Any expert.

1 MS. BLAIR: Oh.

2 BY MR. CHUNG:

3 Q. A literacy or a digital -- low literacy
4 or digital literacy expert.

5 A. Well, for this litigation, we did have a
6 digital literacy expert --

7 Q. Apart from this litigation, sorry.

8 MR. CHUNG: Thank you.

9 THE WITNESS: Apart from when we founded
10 it in 2014?

11 BY MR. CHUNG:

12 Q. Correct.

13 A. No.

14 Q. Okay.

15 MR. CHUNG: Let's get the next couple of
16 exhibits.

17 (Binder Deposition Exhibits 24 and 25
18 marked for identification and attached to
19 the transcript.)

20 BY MR. CHUNG:

21 Q. All right. So Ms. Binder, the next
22 couple of exhibits, which are Exhibits 24 and 25,

1 are just -- they're printouts from the
2 leapfroggroup.org website.

3 Do they look familiar to you?

4 A. Yes.

5 Q. Okay. Terrific.

6 Now, on the Leapfrog -- just looking at
7 Exhibit 24 first -- all right?

8 A. Okay.

9 Q. And that's a screenshot of Delray Medical
10 Center's entry, right, or page from the
11 leapfroggroup.org website.

12 Do you see that?

13 A. It's a pop-up.

14 Q. Pop-up. Yes. Exactly.

15 And so on The Leapfrog Group website,
16 Leapfrog immediately shows a pop-up box, right,
17 notifying a user when a hospital has declined to
18 respond to the survey; is that right?

19 A. Yes.

20 Q. And when it says, Declined to respond,
21 what does that mean?

22 A. They declined to respond to the survey.

1 Q. Okay. And then you have to close out of
2 that pop-up box to view the information behind
3 it. Is that kind of the function --
4 functionality of the website?

5 A. I believe so.

6 Q. Okay. Now, turning to the next exhibit,
7 25, the next one in front of you.

8 A. Oh.

9 Q. And this is what the page on
10 leapfroggroup.org looks like for Delray Medical
11 Center after you've closed out the pop-up box; is
12 that right?

13 A. Yes.

14 Q. Okay. And then it shows -- this
15 page shows that Leapfrog does not have enough
16 information to rate the hospital, correct, on
17 each of the metrics; is that right?

18 A. It shows they declined to respond.

19 Q. Right. Are there any footnotes or
20 asterisks next to any of the metrics?

21 A. No.

22 Q. Okay. And then the webpage says that the

1 hospital, like you said, declined to respond next
2 to each and every one of those metrics, correct?

3 A. Right.

4 Q. And then -- but there's no safety grade
5 A, B, C, D, or F presented on the page, correct?

6 A. For the survey, we rate the
7 performance --

8 Q. The question is, is there a safety
9 grade --

10 A. No --

11 Q. -- present on the page?

12 A. -- because we don't grade on the survey.

13 Q. Okay. So let's turn to the next couple
14 of exhibits.

15 MR. CHUNG: This will be 26.

16 (Binder Deposition Exhibit 26 marked for
17 identification and attached to the
18 transcript.)

19 BY MR. CHUNG:

20 Q. Now we're going to turn to pages from the
21 other website, hospitalsafetygrade.org website.

22 A. Yes.

1 Q. Do you recognize that kind of snapshot?

2 A. Yes.

3 Q. Okay. Unlike on the leapfroggroup.org
4 website, this website does not immediately show a
5 pop-up box indicating that a hospital did not
6 provide data, right, to Leapfrog, correct?

7 A. Yes. Because we have data for this
8 hospital for the safety grade.

9 Q. All right. But for the -- but it doesn't
10 show -- well, it doesn't the same pop-up that we
11 see -- that we saw with the leapfroggroup.org
12 website, correct?

13 A. Right. Because no one responds to the
14 survey, so -- I mean, to the grade. So -- and we
15 have lots of measures to grade the hospital.

16 Q. Okay. So you chose not to do a pop-up
17 for the hospitalsafetygrade.org website?

18 MS. BLAIR: Objection to form.

19 THE WITNESS: A pop-up to say what?

20 BY MR. CHUNG:

21 Q. That the hospital did not respond to the
22 hospital survey.

1 A. Right. So we're not going to do a pop-up
2 since we have lots of measures on how this
3 hospital has done on patient safety.

4 Q. Okay.

5 A. So we don't need to say they declined
6 on --

7 Q. This webpage, though, shows a safety
8 grade for the hospital, right?

9 A. Yes.

10 Q. And in this case, an F for Delray; is
11 that right?

12 A. Yes.

13 Q. And then it shows a score for each of the
14 imputed metrics, correct? The four out of the
15 30 --

16 A. Uh-huh.

17 Q. -- imputed metrics? All right. Is that
18 a yes or no?

19 A. Yes. I'm sorry. Yes.

20 Q. And then there are these gas gauge scores
21 on --

22 A. Yes.

1 Q. -- this website.

2 And for the imputed metrics, like
3 handwashing, for example, they're set to the
4 lowest possible value, correct?

5 A. Yes.

6 Q. But they're not -- what you don't see
7 there is any sort of question mark with a decline
8 to report icon; is that right?

9 A. That's right.

10 Q. All right. But in fact, for those
11 imputed metrics, Delray, for example, declined to
12 report, right, those -- the metrics that normally
13 would be scored there, correct?

14 A. That's correct. And it's reported here
15 on the website.

16 Q. All right. And in fact, it's at the
17 bottom of the page, kind of below the fold, and
18 in footnotes, where Leapfrog discloses that the
19 hospital did not provide data to Leapfrog,
20 correct?

21 A. It's referenced through an asterisk
22 that's very large, and it's in red, so it's

1 pretty prominently displayed.

2 Q. Okay. So bottom of the page, correct?

3 A. Well, the asterisk is on the top of the
4 page, and the worst hospital score is also on the
5 top of the page.

6 Then the bottom of the page, which is
7 also fully on display on this page --

8 Q. Yes.

9 A. -- is in bright red type.

10 Q. Okay. And that footnote says, The
11 hospital declined to report their performance on
12 this measure, so a score was assigned to reflect
13 the lack of information available; is that right?

14 A. Yes.

15 Q. Okay. It doesn't say how that score was
16 assigned, does it?

17 A. That is how it was -- that's how it was
18 done. It was assigned.

19 Q. But my question is, it doesn't say how --
20 it says a score was assigned, correct?

21 A. That's how we got their score.

22 Q. But it doesn't say how the score was

1 assigned, correct?

2 MS. BLAIR: Objection to form.

3 THE WITNESS: That is how it was
4 assigned. That is how we got to the 15. It was
5 assigned. The hospital declined to report, so a
6 score was assigned to reflect the lack of
7 information available. That's how we got to 15.

8 BY MR. CHUNG:

9 Q. Okay. Let me put it another way.

10 That footnote does not explain or in any
11 way try to summarize, right, or distill the
12 imputation methodology by which the limited
13 achievement score was assigned for that metric,
14 correct?

15 MS. BLAIR: Objection to form.

16 THE WITNESS: That line does not describe
17 the imputation methodology, but it's certainly
18 well reported on the website.

19 BY MR. CHUNG:

20 Q. Is there a link to the survey methodology
21 next to this footnote anywhere?

22 A. I can't see below there, but no, not on

1 this page.

2 Q. Okay.

3 A. But there -- it's in plenty of other
4 places.

5 Q. So just kind of as an example for the
6 hand hygiene score, Delray here, for that imputed
7 metric, is it correct that they received a score
8 of 15? Is that right?

9 A. For --

10 Q. Actually --

11 A. It doesn't say --

12 Q. Actually, a -- doctors order medications
13 through a computer.

14 A. Yeah.

15 Q. That one, they were scored a 15, correct?

16 A. Yes.

17 Q. And that's the limited achievement score,
18 right?

19 A. Yes.

20 Q. Okay. And is that the CPOE score?

21 A. Yes.

22 Q. All right. And 15 is the worst possible

1 score; is that right?

2 MS. BLAIR: Objection to form.

3 THE WITNESS: It's the worst hospital
4 score.

5 BY MR. CHUNG:

6 Q. Yeah.

7 A. Those that report to the survey would get
8 a 15 if they did not meet the standard. It's an
9 extremely high standard.

10 Q. Does Leapfrog know that 15, this score,
11 is an actual reflection of Delray's CPOE score?

12 MS. BLAIR: Objection to form.

13 THE WITNESS: We imputed it based on
14 advice from the expert panel and our own
15 experience and knowledge of reporting on the
16 survey.

17 BY MR. CHUNG:

18 Q. Okay. Did Leapfrog or any of its
19 representatives visit Delray prior to issuing
20 this spring 2025 score?

21 A. No.

22 Q. And just --

1 A. We don't visit hospitals.

2 Q. And just -- you do not visit hospitals,
3 correct?

4 A. I don't personally visit hospitals
5 routinely.

6 Q. Okay.

7 A. Nor do most -- except to verify data, as
8 we described earlier. In our verification
9 process, we don't do routine visits. I actually
10 do a lot of visits in general with some of our
11 regional leaders to see hospitals.

12 Q. But for purposes of verifying data, no,
13 correct?

14 A. Right. No.

15 Q. All right. And then Leapfrog has not
16 received data from Delray on the CPOE metric,
17 correct?

18 A. Well, in the past we did.

19 Q. For purposes of this round.

20 A. No, we have not received data, nor have
21 they taken the test that we give hospitals that
22 report to the survey to determine if their CPOE

1 system is safe for their patients. That is an
2 intensive test that most hospitals, when they
3 first go in, don't pass. So we haven't had --
4 they haven't taken that test either.

5 Q. So does Leapfrog -- just standing here
6 today, does Leapfrog believe 15 is an accurate
7 score for Delray's CPOE?

8 MS. BLAIR: Objection to form.

9 THE WITNESS: We believe in the -- we
10 believe the imputation -- the imputation is the
11 most accurate information available on this
12 hospital's performance on this measure.

13 BY MR. CHUNG:

14 Q. So the question is, does Leapfrog believe
15 15 is an accurate score for Delray's CPOE?

16 MS. BLAIR: Objection to form.

17 THE WITNESS: We believe it is the most
18 accurate possible.

19 MR. CHUNG: Okay. This will be
20 Exhibit 27, Ms. Binder.
21
22

1 (Binder Deposition Exhibit 27 marked for
2 identification and attached to the
3 transcript.)

4 BY MR. CHUNG:

5 Q. Now, is -- this is an e-mail thread from
6 June of 2024.

7 Is this a discussion about the appearance
8 of the footnote on the Hospital Safety Grade
9 website?

10 A. I believe that's what it is. Yes.

11 Q. Okay. I'm going to direct your to
12 attention to page 3 of the document. It's Bates
13 ending 7865. It's an e-mail from Paulina Litter
14 to Ms. Campione.

15 And she asked about this language and she
16 writes, Maybe we can change it to say, so a score
17 was calculated using imputation for the measure.

18 Do you see that?

19 A. Yes.

20 Q. All right. And then in the preceding
21 page, Bates ending 7864, Ms. Campione responds,
22 That was the language Missy wanted, but Leah

1 wants something else that makes it sound like the
2 data we imputed wasn't random.

3 Is Ms. Campione correct that this is what
4 you wanted --

5 MS. BLAIR: Object to form.

6 BY MR. CHUNG:

7 Q. -- that you wanted something else that
8 makes it sound like the data we imputed wasn't
9 random?

10 A. The wording is off, but she was going in
11 the right direction in terms of what I expect in
12 terms of all public reporting efforts.

13 Q. So --

14 A. I don't believe the data is random, and I
15 wouldn't have used that word, but I do want
16 absolute clarity and bluntness for the public so
17 they understand that this data was not
18 calculated. I think that was what Paulina was
19 suggesting. And I didn't want that because that
20 would be an inaccurate assessment of what the
21 imputation was.

22 Q. Okay. Now I'm going to direct your

1 attention to page 1 of the document, Bates ending
2 7863.

3 And you see that Ms. Campione is
4 responding to suggestions for language from
5 Ms. Litter by explaining that we can't say
6 external data sources because we're arbitrarily
7 assigning them points associated with the bottom
8 scoring category.

9 And then she continues: Leah wants us to
10 make it sound like the expert panel approved it
11 and the assigning of these points was legitimate.

12 Do you agree with Ms. Campione that
13 Leapfrog's imputed metrics in this new
14 methodology did, in fact, assign the lowest
15 available score?

16 A. As step 2 we did.

17 Q. Right. Step 2.

18 A. And -- but it's not arbitrary. I don't
19 agree with the word "arbitrarily."

20 Q. She -- well, she used the word
21 "arbitrary," so --

22 A. I disagree with her use of the word

1 "arbitrary."

2 Q. Okay. Why do you disagree with her use
3 of the word "arbitrary"?

4 A. It wasn't arbitrary. It was very
5 well-thought-through.

6 Q. Right, but it is --

7 A. And very carefully vetted with experts
8 and 20 years of experience with hospital surveys
9 and hospitals.

10 So we put a lot of thought into how this
11 was done. It wasn't arbitrarily assigned.

12 Q. But it is a score, the limited
13 achievement score, that is automatically assigned
14 to --

15 A. No.

16 Q. -- non-participating hospitals, correct?

17 A. Yes.

18 Q. Okay.

19 A. Well, non-participating hospitals that
20 don't have any data to give us from the year
21 prior.

22 Q. Yeah. Always got to remember step 1.

1 A. Yes.

2 Q. And do you agree with Ms. Campione that
3 you wanted to make it sound like the expert panel
4 approved this methodology? Right?

5 A. Well, the wording on this is also
6 something -- you know, I wouldn't have -- it
7 isn't ideal, but it's what happens when people
8 are just quickly e-mailing each other. Because
9 it is, in fact, the case that the expert panel
10 approved this, and assigning these points was
11 completely valid.

12 So I -- but I also want our communication
13 of this to be clear to the lay public.

14 Q. Okay.

15 A. So I don't -- the wording here makes it
16 sound like I'm trying to fake something. I'm
17 not. I don't -- it's the opposite. I want us to
18 be very upfront and very clear with the public on
19 what we're doing and why we're doing it.

20 Q. Were your employees, like Ms. Campione,
21 concerned that Leapfrog was not being transparent
22 using this methodology?

1 A. Well, she's doing a very good job of
2 editing the language that would ultimately appear
3 on our website. I think she did a great job here
4 in working with Paulina to try to get at this
5 rather difficult-to-word statement to make
6 certain that it's clear and precise and that the
7 public can understand it. So she did a good job
8 with that.

9 Q. So putting the discussion aside, why
10 doesn't Leapfrog use the same disclosures related
11 to non-participating hospitals on both of the
12 websites, Hospital Safety Grade and Leapfrog
13 Group?

14 MS. BLAIR: Object to form.

15 THE WITNESS: The same which disclosures?

16 BY MR. CHUNG:

17 Q. Relating to non-participating hospitals.

18 A. So -- we do. We say declined to -- for
19 the measures that hospitals declined to respond
20 to, we put that on the safety grade website for
21 those measures. But those are a subset of the
22 many more measures that we are grading.

1 On the Leapfrog survey, it's everything,
2 because they don't respond to the entire survey.
3 So therefore, it's a different way of portraying
4 that message. But it is -- "declined to report"
5 is on both websites.

6 Q. Let me kind of slice it a little finer.

7 A. Okay.

8 Q. So given that the leapfroggroup.org
9 website doesn't have the grades for the
10 hospitals, the health safety grades for the
11 hospitals, nor does it show any imputation of
12 scores for those non-participating hospitals --
13 that's one, right? But on the other hand, the
14 hospitalsafetygrade.org website shows a hospital
15 safety grade for a hospital and, for a
16 non-participating hospital, shows the limited
17 achievement score -- right? -- for the imputed
18 metrics, isn't Leapfrog confusing visitors to
19 both websites about how it scores hospitals that
20 did not participate in the hospital survey?

21 MS. BLAIR: Objection to form.

22 THE WITNESS: We're doing the opposite.

1 We're being extremely blunt and extremely
2 transparent. We are showing all of the measures
3 that are used and -- to calculate the hospital
4 safety grade, of which the vast majority we do
5 have data from CMS for. And for those that we
6 impute, we're very blunt about that. You can see
7 it immediately.

8 Most -- in fact, I don't know of any
9 other public reporting ratings in healthcare that
10 offers that level of transparency of giving you
11 every single measure and how the hospital did on
12 every single measure.

13 So we are -- we go out of our way to be
14 extremely transparent.

15 BY MR. CHUNG:

16 Q. Okay. I'm not sure that's responsive to
17 the question.

18 Do you acknowledge that there are those
19 differences, however, for a non-participating
20 hospital, how they're presented between the
21 Hospital Safety Grade dot [sic] website and the
22 Leapfrog Group website?

1 MS. BLAIR: Objection to form.

2 THE WITNESS: Well, they're two different
3 things, so they're -- but the words "declined to
4 report" are applied appropriately.

5 BY MR. CHUNG:

6 Q. Okay. They're two different things.

7 A. Well, the survey is a voluntary survey
8 that they can choose not to participate in or to
9 participate in. If they decline, then we are
10 just saying, overall, they declined.

11 Whereas the hospital safety grade is 32
12 measures and, for most of them, we have data and
13 we are grading them.

14 Q. Has Leapfrog ever considered
15 standardizing the disclosures or the presentation
16 of information regarding non-participation --
17 non-participating hospitals between the two
18 websites?

19 MS. BLAIR: Objection to form.

20 THE WITNESS: I'm not really clear on
21 that. Can you --

22

1 BY MR. CHUNG:

2 Q. Yeah. Has Leapfrog ever considered
3 standardizing or harmonizing the disclosures
4 relating to non-participating hospitals between
5 the two websites?

6 MS. BLAIR: Objection to form.

7 THE WITNESS: So can you give me an
8 example of what you might mean by that?

9 BY MR. CHUNG:

10 Q. Do you -- let me put it this way. Do you
11 see any inconsistency between the two websites
12 with regard to how non-participating hospitals
13 are presented?

14 A. They are two different programs, so we
15 communicate performance of hospitals two
16 different ways. But we use the same term,
17 "declined to participate," as it applies to the
18 measures that we ask for in the survey. We do
19 that on the website for the survey and we do that
20 for the measures, applicable measures, on the
21 hospital safety grade.

22 Q. Okay. And is that clear -- are you -- is

1 that distinction made clear to the consumer?

2 A. It's clear on the website -- on the
3 Hospital Safety Grade website, it's very clear.

4 Q. Okay. How about on the leapfroggroup.org
5 website?

6 MS. BLAIR: Objection to form.

7 THE WITNESS: So --

8 BY MR. CHUNG:

9 Q. Let me put it this way: Is it your
10 expectation that a low literacy consumer --
11 right? -- visitor to the websites will understand
12 that distinction?

13 MS. BLAIR: Objection to form.

14 THE WITNESS: They will understand
15 "declined to report" and they will understand,
16 for each of the measures, how we got them.

17 BY MR. CHUNG:

18 Q. Okay. But that would require -- that
19 would require this -- the low literacy consumer
20 to visit both websites, correct?

21 MS. BLAIR: Objection to form.

22 THE WITNESS: No. They can visit just

1 the Hospital Safety Grade website? Is that the
2 one you're focused on right now? Or which one do
3 you want me to answer to?

4 BY MR. CHUNG:

5 Q. Well, if they visited both websites --
6 right? -- is the expectation that they would --
7 they would not be confused -- right? -- by the
8 different information covered between the two
9 websites?

10 A. It's not different information, for one
11 thing. But the second thing is most -- the
12 Hospital Safety Grade website was designed for
13 the purpose of consumers doing their own personal
14 research. The hospital -- the leapfroggroup.org
15 has not been designed for consumers primarily.
16 It's designed for -- particularly for purchasers.

17 Q. But --

18 A. So they're designed for different
19 purposes. But that said, I think it's very clear
20 to anyone who visits those sites exactly where we
21 got the data, or didn't.

22 Q. Okay. I'm going to move on to another

1 topic. Leapfrog's revenue sources is topic 8
2 among the 30(b)(6) topics.

3 I think you testified earlier -- and you
4 can correct me if I'm wrong -- but the most
5 significant sources of data today, and for some
6 period of time, have been the accolade licensing
7 program and the data licensing program; is that
8 correct?

9 A. Not sources of data.

10 Q. Source -- I'm sorry, revenues.

11 A. Revenues.

12 Q. Revenue sources.

13 A. The largest source -- well, I testified
14 about -- you asked me about the first year of --
15 that I was at Leapfrog? I think.

16 Q. Yes. Well, let me just ask it another
17 way.

18 So are accolades licensing -- are the
19 accolades licensing and the data licensing
20 programs the two most significant sources of
21 revenue for the organization today?

22 A. Right now, those are the two largest

1 sources of revenue. Yes.

2 Q. Okay. Let's turn to -- and what,
3 generally speaking, has been the total revenue
4 for Leapfrog this past year?

5 A. It was around -- I think around
6 8 million.

7 Q. Okay. And has that -- has there been,
8 like, an increase over time since you've been
9 CEO? What's been the trend in terms of total
10 revenue?

11 A. The average increase in revenue has been
12 11.5 percent.

13 Q. So that's year over year, there's been an
14 increase of about 11.5 percent.

15 A. On average, yes.

16 Q. To what revenue sources do you attribute
17 that kind of year-over-year increase?

18 A. Really, all of them. We've had a major
19 increase in every single category of revenue.
20 But the largest bump came when we launched the
21 hospital safety grade and we began selling the
22 accolade license. So when hospitals get an A,

1 they can purchase -- for their own commercial
2 purposes, they're allowed to use the -- under
3 strict rules, they're allowed to use the A logo.

4 Q. Okay.

5 MR. CHUNG: Let's go to 27 and 27a.

6 Exhibit 28 and Exhibit 29.

7 (Binder Deposition Exhibits 28 and 29
8 marked for identification and attached to
9 the transcript.)

10 BY MR. CHUNG:

11 Q. So Ms. Binder, Exhibit 28 is an e-mail
12 chain from about April of 2024, and then there's
13 an attachment with some tables in it.

14 I'm going to be asking questions, really,
15 mainly about the e-mail, so if you want to take a
16 look at that.

17 A. Okay.

18 Oh, yeah. Okay. Yeah, I remember this.

19 Q. Okay. So who is Ben Choi?

20 A. He was an advisor on finance for Leapfrog
21 for about a year.

22 Q. Okay. Am I right that he was the interim

1 CFO for a period of time?

2 A. That was not his title, but he functioned
3 in some ways as a -- almost like a CFO. Maybe
4 not quite that significant a role, but he was --
5 he was the key finance person.

6 Q. Okay. And Josh Berlin, who is that?

7 A. Josh is the president of the consulting
8 firm that Ben came from. And Josh also has
9 consulted with us and advised us on sort of
10 different projects and strategies.

11 Q. Okay. Now, just turning to the second
12 page of the document, Bates ending 8279. Just
13 looking at Mr. Choi's e-mail to you, under
14 recommendation -- under realistic views, Mr. Choi
15 writes that they are forecasting to fall short on
16 top-line revenue by \$540,000.

17 Do you see that?

18 A. Yes.

19 Q. Okay. Then directing your attention to
20 the recommendations section toward the bottom of
21 the page --

22 A. Yes.

1 Q. -- he writes, Push really hard on
2 high-yield revenue opportunities.

3 And he lists membership, accolades,
4 annual meeting sponsorships.

5 Do you see that?

6 A. Yes.

7 Q. What does membership refer to here? Is
8 that the partners advisory committee?

9 A. Yes.

10 Q. Okay. And then accolades here refers to
11 what you testified to, the accolades licensing
12 program --

13 A. Yes.

14 Q. -- is that right?

15 All right. And then directing your
16 attention to the first page, you respond, If we
17 move toward cost reduction as the primary
18 strategy, it will be much more severe than this,
19 but I'm not going there for now. We can address
20 incremental spending issues, but let's not lose
21 focus on what managers should be thinking about
22 24/7, which is revenues.

1 Why do you want managers focused on
2 revenues 24/7? What is that comment?

3 A. So the survey and the hospital safety
4 grade are extremely expensive. They are -- and
5 from my perspective as the CEO of the
6 organization, I see them on the expense
7 line entirely. They are -- they're very, very
8 expensive to do them the way we do them, which is
9 first class.

10 So in order to maintain -- when you have
11 ups and downs and the exigencies of life, we will
12 not compromise on the integrity and the
13 excellence of our surveys and our hospital safety
14 grade. So my job is to make sure that we have
15 the funding to do that.

16 He talks about how we could cut staff
17 lunches or something like that. And I was like,
18 no, no, we've got to look at how we raise the
19 money that we need to maintain and sustain the
20 survey in a year when we had a contract that was
21 delayed that -- and another one that we canceled.

22 So there were just a couple of things

1 that were blips in the road. In the end, we
2 broke even at the end of the year. But I will
3 say that, for me, it was just we've got to raise
4 the money because we're not going to compromise
5 on the survey or the safety grade, which are
6 costs to us.

7 Q. All right. So the focus, just given the
8 expenses that you outline here, is that the
9 managers should be focusing on how to generate
10 revenues, correct?

11 A. They should -- everyone in the
12 organization, everyone in any nonprofit
13 organization, as to be thinking about fundraising
14 and revenue generating because that's how we
15 survive.

16 Q. Okay. And then you continue by saying
17 that you want managers focused on where they can
18 generate bookable revenues, and then you list a
19 number of bullet points, I think, are your ideas.

20 Do you see that?

21 A. Oh, yeah. Yeah.

22 Q. Okay. What do you mean by bookable

1 revenue?

2 A. Revenues that we -- that we can
3 incorporate into our statement at -- statements.

4 Q. Okay.

5 A. Bookable meaning, like, from an
6 accounting point of view, they are -- they meet
7 accounting principles for what we can -- what we
8 can recognize.

9 Q. Okay. And then you see there is a second
10 bullet point here: I have a nuclear strategy for
11 the CPOE report sales, which I will tell you
12 about tomorrow.

13 Are the CPOE reports part of the kind of
14 data licensing program?

15 A. They didn't exist then and they still
16 don't but -- well, not really. My thought had
17 been we have a lot of information on how
18 hospitals do on the CPOE test. We talked about
19 earlier where we test hospitals on how good a job
20 their systems do in alerting physicians to errors
21 that they may be making in their prescribing.
22 These are errors that would result in death or

1 really harm to the patient. It's a great test.

2 And my nuclear strategy, it turns out we
3 were already doing it. So actually, when I look
4 at it, I'm, like, oh, geez --

5 Q. Okay.

6 A. -- embarrassed because we already were
7 doing it. Which is -- I said, let's just give
8 the hospitals -- let's give them their own
9 results for free. Just give it out.

10 Q. So a few bullet points down, We should
11 plan for special discounts or sales, pushes
12 around accolade sales to get more in late May and
13 June.

14 What did you mean there?

15 A. Well, we issue safety grades twice a
16 year. So we issued -- when was this dated? So
17 we issued the update to the safety grade probably
18 right around the time -- probably after this,
19 somewhere around when this e-mail was written.

20 And when we're issuing the safety grade
21 update, that's when we sell to hospitals that get
22 an A. We offer them an opportunity to buy and

1 use their grade in their own, you know,
2 advertising or other commercial purposes.

3 So what I was suggesting is, let's have a
4 sale and discount -- let's try to really improve
5 the sales of the accolades for that particular
6 time period, given this is a challenging year.

7 Q. Okay. So it's through the use of
8 discounts and sales that you'll be pushing more
9 accolade sales during this time period; is that
10 right?

11 A. We would be -- I'm not sure what you mean
12 by pushing, but we would be offering discounts
13 to --

14 Q. I'm just using your language here.

15 A. I don't say pushing, do I?

16 Q. Pushes. Yeah.

17 A. Oh, okay --

18 Q. Special discounts.

19 A. Okay. Discounts and sales. Yeah,
20 discounts and sales strategy to try and improve
21 our sales on accolades.

22 Q. Okay. There is a -- expand marketing

1 around the certified coach program.

2 A. Uh-huh.

3 Q. Can you describe -- tell us what you were
4 referring to there?

5 A. Just do additional marketing to encourage
6 enrollment in the certified coach program.

7 Q. Okay. And this was another revenue
8 generator?

9 A. It was a strategy that we could think
10 about for generating more revenue.

11 Q. Okay. And can you -- how much -- what
12 are the fees or the charges associated with the
13 certified coach program?

14 A. I think it's, like, \$900 or something per
15 participant.

16 Q. Okay. And then the last bullet point,
17 There's a lot of attention to us around the
18 hospital safety grade release. How do we harness
19 that? More for marketing.

20 What did you mean there?

21 A. We get a lot of exposure and attention,
22 so we -- this would give us an opportunity -- for

1 instance, when we get a lot of exposure and
2 attention on anything we do, we'll get interest
3 in all of our programs. We'll suddenly start to
4 get interest in our partnership programs or our
5 annual meeting enrollments or registrations. It
6 just gins up a lot more interest. And we should
7 make sure we're strategic about that.

8 Q. And does that include more interest
9 around the hospital safety grade -- the accolade
10 licensing program as well?

11 A. Oh, yeah.

12 Q. Okay. And for the data licensing
13 programs as well?

14 A. Yeah, we usually get inquiries to the
15 data licensing program if we get a lot of
16 attention.

17 Q. Okay. And as part of that -- the -- part
18 of the marketing strategy that -- with the
19 release of hospital safety -- hospital safety
20 grades, is part of the marketing strategy to --
21 to let the public know how many hospitals have
22 received hospital survey grades -- hospital

1 safety grades, I'm sorry?

2 A. We don't market the hospital safety grade
3 to the public.

4 Q. Okay. Do you --

5 A. We publi- --

6 Q. How is that?

7 A. Well, we publicize it.

8 Q. What's the --

9 A. That's different.

10 Q. -- difference between marketing and
11 publicizing?

12 A. Well, marketing is when you run an ad or
13 you send out an e-mail that's from you saying,
14 you know, buy this, or something like that.

15 PR is when you go to the press and you
16 say, here's a great story, and they cover it on
17 their own. So it's different.

18 Q. Am I right that you have a vendor -- a
19 marketing or a telemarketing vendor called
20 TelAffects?

21 A. Yes.

22 Q. That assists you on various marketing; is

1 that right?

2 A. Yes.

3 Q. Right? And --

4 A. Well, no, on accolade sales.

5 Q. Right. And so TelAffects does market the
6 hospital safety grade program, correct?

7 A. Yes. Yes.

8 Q. Right. So it's not just publicizing the
9 hospital safety grade program; they actually do
10 market the hospital safety grade program; is
11 that --

12 A. They don't publicize it. They market.
13 And they're kept at arm's lengths from us for
14 that very reason. We on the Leapfrog side, and
15 with our PR firm, we publicize it; we try to get
16 conversations going about patient safety and
17 awareness around patient safety and the
18 importance of it. That is -- and that's central
19 to our mission as well.

20 Q. But TelAffects works for Leapfrog,
21 correct?

22 A. Yes.

1 Q. You pay TelAffects to market it, the
2 accolade licensing program.

3 A. Yes. We're really proud of that program.
4 It's very successful. And it's accomplished --
5 what's great about it is that it raises money for
6 us, which is very important, because we don't
7 survive without that. No money, no mission, if
8 you've ever heard that phrase.

9 But at the same time, even as it's
10 raising money for us, it's serving the mission
11 directly. Because when hospitals advertise an A
12 and tout their record on patient safety, both
13 externally to their community and internally to
14 their staff and their -- often they'll use it,
15 for instance, for nurses week. When they do
16 that, we are calling attention to the importance
17 of patient safety in brand new ways, and it's, I
18 think, it's very powerful and something that
19 we're proud to see happening.

20 Q. And when the hospitals tout their
21 grades -- typically it's an A grade that they
22 tout, right?

1 A. Yeah. Usually.

2 Q. And that's actually -- when hospitals do
3 that, that's actually good for Leapfrog's brand
4 as well.

5 Would you agree with that?

6 A. Yeah.

7 Q. Okay.

8 A. Well, it's mostly good for our mission.

9 Q. Right. Well -- okay.

10 And would it be fair to say that the more
11 hospitals that -- tout their grades, the better
12 it is for Leapfrog's brand?

13 A. I've never thought of it that way, but
14 maybe.

15 Q. Okay. I mean, that goes hand in hand
16 with -- you've testified to this at least a few
17 times already, that it's -- Leapfrog wants as
18 many hospitals to participate in the survey as
19 possible, correct?

20 A. Well, that's a different -- that's a
21 different issue.

22 Q. Right.

1 A. Because the hospital safety grade is
2 different. We give a grade to every hospital
3 that's qualified, for one, regardless of whether
4 they report to the survey. So it's a separate
5 issue.

6 Q. Right. But hospitals -- for those that
7 choose to respond, hospitals that respond to the
8 hospital survey, that data is used -- it's not
9 the only source of data -- is used to generate a
10 hospital safety grade for that hospital, correct?

11 A. It's certainly part of their grade. Yes.

12 Q. Okay.

13 A. And that's good or bad. So if they don't
14 do well on the survey -- which is a high bar, so
15 a lot of hospitals don't do well -- it could have
16 caused them to have a lower grade.

17 Q. Okay.

18 MR. CHUNG: Let's go to tab 28b.

19 Exhibit 30.

20 (Binder Deposition Exhibit 30 marked for
21 identification and attached to the
22 transcript.)

1 BY MR. CHUNG:

2 Q. So Ms. Binder, Exhibit 30 is a document
3 entitled, Leapfrog long-range strategic intent
4 for fiscal year 2026 to '32.

5 A. Yes.

6 Q. Board approved, September 2024.
7 Have you seen this document before?

8 A. Yes, I have.

9 Q. Okay.

10 A. The part that's board approved is the
11 first page.

12 Q. All right. Were you involved in putting
13 together this document?

14 A. Yes.

15 Q. All right. Now, if you turn to the
16 second page, Bates ending in 7794, you'll see
17 that, up top, objective 1 is to scale resources
18 to the capacity needed to make giant leaps for
19 patient safety and stop avoidable death and
20 suffering.

21 Do you see that?

22 A. Yes.

1 Q. And then, within that first objective,
2 there are a series of goals underneath, correct?

3 A. Yes.

4 Q. In the left-hand column. It says goal up
5 top.

6 A. Right, right.

7 Q. Yeah. And then the first, quote/unquote,
8 goal is to expand revenue from existing sources,
9 and then it goes through a series of revenue
10 sources, correct? Is that right?

11 A. Yes.

12 Q. Okay. So increasing Leapfrog's revenue
13 is at least the first mentioned goal behind this
14 objective, right?

15 A. Yes.

16 Q. All right. So under that, there are a
17 number of benchmark indicators there. Just
18 looking through, are those still accurate in
19 terms of the revenue?

20 A. These -- the benchmark indicators were
21 not actually finalized, so -- but they're
22 relatively accurate.

1 Q. Okay. How are they determined?

2 A. They were proposed by the management
3 team. We asked them to look at this, and then we
4 had an iterative process to consider at the
5 senior management team.

6 But as I said, I don't believe they're
7 final. In fact, I know that they're not final.

8 Q. Okay. Are these goals, the benchmark
9 indicators, are they communicated to Leapfrog
10 staff? Are they communicated to Leapfrog staff
11 generally?

12 A. We shared -- again, I don't know if this
13 is the final benchmark indicator as I look at it,
14 but we share whatever the board approves or the
15 board determines, yes.

16 Q. Okay. They may not be final, but I think
17 your testimony is that they're generally what you
18 understand the relevant benchmarks to be,
19 correct?

20 A. Relatively, yes.

21 Q. All right. So we've got September 2025,
22 \$9 million in revenue. And then, three years

1 later, a benchmark of 12 million. And then,
2 three years later for 2031, a benchmark of
3 \$18 million.

4 Do you see that?

5 A. Yes.

6 Q. Okay. How do these goals, the benchmark
7 indicators, influence -- you know, going up
8 3 million -- roughly 3 million per year, how do
9 they influence how you approach changes to the
10 hospital safety grade program?

11 MS. BLAIR: Objection to form.

12 THE WITNESS: I don't think of those in
13 the same way. So as I said, the hospital safety
14 grade program is expensive. So what -- the
15 influence I see is raising money to be able to
16 sustain it and do it in better and better ways.

17 BY MR. CHUNG:

18 Q. Right. And the safety -- if the hospital
19 safety grade program is -- actually, let me put
20 it another way.

21 How do these -- how do these goals
22 influence how you approach the accolade licensing

1 program, given that it's, you know, the most
2 significant revenue source?

3 A. Well, I think if you look at the goal
4 itself, we've talked about having less dependence
5 on accolade revenue as a percent of overall
6 revenue.

7 Q. Right.

8 A. Our board believes strongly in the
9 program and that it is serving our mission to
10 have the accolade program, that it's very
11 successful in terms of raising money. But they
12 want us to have other -- just diversify our
13 revenue sources over time so that we are less
14 dependent on that one source.

15 Q. Okay. Let's move on to -- if you look at
16 objective 3. So this goes to page -- the Bates
17 ending 7797.

18 A. Okay.

19 Q. Okay. And then you'll see, under the
20 goal here, the general public create
21 communication strategies that make the hospital
22 safety grade and Leapfrog itself household names.

1 Do you see that?

2 A. Yes.

3 Q. Okay. And so that's -- is another way of
4 putting that coming up with strategies with the
5 general public that increase or elevate the brand
6 of Leapfrog in the hospital safety grade?

7 A. We're just trying to make people aware of
8 the hospital safety grade.

9 Q. To the point where they're household
10 names; is that right?

11 A. Yes.

12 Q. Okay. And then one way to do that, or at
13 least one of the metrics, is just the number of
14 annual visits to the websites; is that right?

15 A. Right.

16 Q. Okay. And the goals here, the proposed
17 metrics, are to increase by 30 percent by 2028
18 and then by 100 percent for 2031.

19 Do you see that?

20 A. Yes.

21 Q. And how did you arrive at those goals?

22 A. As I said, I think this is an earlier

1 draft which kind of says X number, so that tells
2 me it's a draft --

3 Q. Yeah.

4 A. But -- and so there's -- it's just --
5 we're trying to set a six-year target for the
6 organization and then monitor that progress over
7 time. That's the purpose of the intent.

8 Q. Okay. Now, if you go down a few more
9 cells, under goal, it says, Purchasers/employers:
10 Enable purchasers and their contractors to tie
11 Leapfrog ratings to payment decisions.

12 A. Yes.

13 Q. Do you see that?

14 A. Uh-huh.

15 Q. All right. Now, in order to accomplish
16 this particular goal, isn't it correct that
17 Leapfrog has to convince purchasers and employers
18 that the Leapfrog ratings have value?

19 A. We have hundreds, if not thousands, of
20 employers and purchasers that are part of this
21 movement, so they are already -- not only do they
22 see value, they feel like they're part of

1 creating it.

2 So certainly we've got to engage as many
3 employers and purchasers as we can, but we have a
4 lot of them involved, which is what has been a
5 key success factor for the organization.

6 Q. But Ms. Binder, this is not -- this is
7 enumerated as a goal, not as the status quo,
8 right? The goal is to enable purchasers and
9 their contractors to tie Leapfrog ratings to
10 payment decisions, right?

11 A. Right. It's a long-term strategic
12 intent, and we want to always expand on how
13 purchasers and influencers use Leapfrog data.

14 We have purchasers -- we don't need to
15 convince them that Leapfrog is important. That
16 is -- I mean, there's always going to be
17 additional purchasers, I'm sure, we could bring
18 into the fold. But we have a lot of them already
19 engaged. They are the ones asking hospitals to
20 please report to the survey. They are very
21 actively involved with Leapfrog. They founded
22 Leapfrog.

1 So we have the engagement. But one of
2 the things that we always want to encourage more
3 employers to do is to think about how they are
4 contracting and paying for care in such a way
5 that they are incentivizing patient safety and
6 quality.

7 Q. Right. So in order -- so in order for
8 purchasers and employers to continue to be
9 engaged, is it fair to say that it's important
10 for Leapfrog to maintain or increase the value of
11 its ratings programs?

12 MS. BLAIR: Objection to form.

13 THE WITNESS: In what way do you mean
14 increase value?

15 BY MR. CHUNG:

16 Q. Convince -- basically convince --
17 increase value by at least maintaining or even
18 increasing the number of hospitals that
19 participate in the survey.

20 MS. BLAIR: Objection to form.

21 THE WITNESS: That has -- that has not
22 been something we've tied to the

1 purchaser/employer strategy.

2 BY MR. CHUNG:

3 Q. Okay. So under health plans, if you go
4 down a couple more cells, it reads, Pressure
5 plans to tie Leapfrog ratings to payment
6 decisions.

7 What does that mean?

8 A. Employers in particular have been vocal
9 with us on the need for them to come together
10 through Leapfrog to get health plans to tie
11 Leapfrog ratings, such as on patient safety and
12 quality, to its payment decisions. And one
13 employer will have a very difficult time having
14 any influence at all on a health plan, so they
15 look to Leapfrog as part of our core mission to
16 be able to be the voice for health plans getting
17 pressure from their own clients on the importance
18 of not just paying fee for service but actually
19 paying for excellence that you're looking for.

20 Q. So how does Leapfrog pressure plans to
21 tie Leapfrog ratings to payment decisions?

22 A. We bring employers together to say, we

1 want to see this and, what are you doing for it?

2 Q. Okay. Is the goal here to steer health
3 plans away from hospitals that do not participate
4 in the hospital survey?

5 A. No. That's not the goal, no.

6 Q. Has Leapfrog been successful in
7 pressuring these health plans to tie Leapfrog
8 ratings to payment decisions?

9 A. In some cases, but not -- not in an
10 overwhelming way.

11 Q. Okay.

12 MR. CHUNG: Let's go to tab 29b.

13 This will be Exhibit 31.

14 (Binder Deposition Exhibit 31 marked for
15 identification and attached to the
16 transcript.)

17 BY MR. CHUNG:

18 Q. All right. Ms. Binder, Exhibit 31 is a
19 memorandum to the board of directors' executive
20 committee dated February 25 of 2024.

21 A. Okay.

22 Q. Okay.

1 A. Let me just refresh my memory reading
2 through this.

3 Q. Sure.

4 A. Okay.

5 Q. Okay. Did you write this document?

6 A. Yes.

7 Q. All right. And in the second
8 paragraph you write that revenues were lower than
9 what we originally budgeted; they exceeded
10 expenses.

11 A. Yeah.

12 Q. And you cite, Ending the Money contract,
13 continuing delays in the Defense Health Agency
14 contract and struggles with Cigna.

15 A. Uh-huh.

16 Q. What is the Money contract referring to?

17 A. We had a contract with the -- it's like a
18 website called Money. It used to be Money
19 Magazine in the old days. And they asked us to
20 help them to issue an accolades program. So in
21 other words, Money top hospitals and things like
22 that.

1 Q. Okay.

2 A. We were not satisfied with the way they
3 were portraying those hospitals and how they were
4 doing it, so we ended up -- we ended the
5 contract.

6 We are extremely picky about how those
7 things get done.

8 Q. Okay.

9 A. And so we ended that contract.

10 And then the other --

11 Q. Actually, I was going to --

12 A. Oh.

13 Q. We don't need to go over the other ones.

14 But going down a couple of paragraphs
15 starting with -- the paragraph starting, We have
16 areas of challenge ahead with regard to licensure
17 of our data and continuing growth of development
18 revenues.

19 Do you see that?

20 A. Yes.

21 Q. And why were you facing challenges along
22 these lines?

1 A. Raising money is always a challenge in
2 any nonprofit. So in particular, in our case,
3 licensure of the data -- I think we'd had -- we
4 had a contract drop. We usually -- for licensure
5 contracts, we have very, very little churn. We
6 have very little dropouts. And Cigna had dropped
7 out. It was very disappointing to us. So I
8 think I was probably referring to that.

9 And in addition, we would really like to
10 see the growth in our licensure program. We're
11 really proud of that program too. That one is
12 extremely important to our mission because it
13 gets -- all of the data that we're collecting
14 through the survey, it gets -- when it's licensed
15 by other entities, we're able to put it in front
16 of millions, if not tens of millions, more
17 people. So it is very important to us to try to
18 get that program moving. It's also a very good
19 way for us to raise money.

20 And then -- you asked about the other --
21 what was the other one?

22 Q. Growth of development revenues.

1 A. Yeah. We have a development program
2 which is to ask for donations from individuals.
3 And that has just -- that's a fairly new program,
4 and it's been slowly growing.

5 Q. Okay. Now, almost to the end of this
6 document, at the bottom it says, So despite my
7 impatience to accelerate the pace of growth
8 strategies, I remain optimistic we're poised for
9 expansion that will impact patient safety if we
10 play our cards strategically.

11 A. Yeah.

12 Q. So the pace of growth -- this language
13 here, pace of growth strategies, that's focused
14 on the pace of -- growth -- the growth of
15 revenue; is that correct?

16 A. Well, it's everything.

17 Q. What do you --

18 A. If you have more --

19 Q. -- what are you really --

20 A. Because revenue --

21 Q. What are you really focusing on here
22 with -- what do you really --

1 A. Growth of --

2 Q. -- mean by --

3 A. -- the organization overall. So when we
4 are able to get more revenue through development
5 or all those other sources -- they talk about
6 several of them here -- when we're able to get
7 more revenue in, we then can invest that revenue
8 in expanding our programs which have been so
9 successful, such as the hospital safety grade,
10 the surveys, and then other surveys that we
11 are -- we've considered, such as nursing home
12 surveys or something like that.

13 There's other ways that we can impact
14 patient safety in places other than hospitals.
15 There's just a lot of things we could be doing if
16 we had more revenue.

17 Q. So more programs --

18 A. You could also --

19 Q. So more programs is part of the pace of
20 growth?

21 A. Maybe a low literacy expert to go over
22 our website. You just said that. I would love

1 that. And --

2 Q. More staff --

3 A. Well, it would require --

4 Q. -- would that be part of pace of growth
5 or kind of the aspirational pace of growth here?

6 A. To accomplish particular goals.

7 Q. Okay.

8 A. Yes.

9 Q. All right. And then does the pace of
10 growth here also involve getting more hospitals
11 involved with Leapfrog?

12 A. That has not --

13 MS. BLAIR: Objection to form.

14 THE WITNESS: That has not been on the
15 list. It's not here that --

16 BY MR. CHUNG:

17 Q. Why not?

18 A. Well, we want hospitals to report to the
19 survey. So that's always been on the list for
20 that. But as I said, that's a cost that we have
21 to pay for. More hospitals means more cost.

22 Q. All right. But --

1 A. So I see it as a cost. Raising money as
2 a separate issue so that we can afford to run
3 this first-class survey.

4 Q. Okay.

5 A. And if I can add one thing in terms of
6 revenue. If our goal was just revenue for the
7 sake of revenue, we would have a lot more money
8 and we probably would only focus on accolades.
9 We've been very successful with accolades. We'd
10 probably give every hospital an A if that was our
11 goal. That's not our goal.

12 Our goal is to improve patient safety --

13 Q. Well, you are a 501(c)(3) organization,
14 correct?

15 A. Yes. Our goal -- that's our goal; it's
16 our mission to improve patient safety.

17 Q. So if you were to focus just giving out
18 all A's in the accolades licensing program, that
19 would be a problem for --

20 A. Yes.

21 Q. Your 501(c)(3) registration, correct?

22 A. -- that would not be -- that's why we

1 don't do it --

2 Q. Okay.

3 A. -- and we wouldn't do it. But that's --
4 what I'm trying to say is that's why we focus on
5 revenue, is because we want to afford to pay for
6 the extremely important work we are doing, which
7 is making enormous progress on patient safety and
8 saving lives.

9 Q. Okay.

10 MR. CHUNG: Why don't we take a short
11 break here. We're on to the next topic in a
12 little bit.

13 THE WITNESS: Okay.

14 VIDEO TECHNICIAN: The time is 3:20 p.m.
15 This ends unit 3. We're off the record.

16 (A recess was taken.)

17 VIDEO TECHNICIAN: The time is 3:47 p.m.
18 This begins unit number 4. We're on the record.

19 BY MR. CHUNG:

20 Q. Ms. Binder, before the break we were
21 discussing how Leapfrog is a 501(c)(3)
22 organization, right?

1 And has Leapfrog ever been audited to
2 determine whether its activities comply with its
3 501(c)(3) status?

4 A. We have an annual audit by an independent
5 firm. And I believe they look at all aspects of
6 compliance with key legal requirements and
7 accounting principles, and that would be included
8 in that.

9 Q. Okay. Other than the annual audit, have
10 there been any other audits or investigations of
11 Leapfrog as it relates to whether its activities
12 comply with its 501(c)(3) status?

13 A. Well, other than the annual audit? No.

14 Q. Okay. Has anyone within Leapfrog ever
15 complained that its revenue-generating activities
16 do not further its charitable purpose?

17 A. No.

18 Q. Any complaints from the outside --
19 outside of Leapfrog in that vein?

20 A. No. Not to my knowledge.

21 Q. Topics 9 and 14 on the 30(b)(6) notice
22 have to do principally with Leapfrog's

1 compensation structure, so I wanted to ask: How
2 does Leapfrog set compensation for its executive
3 staff?

4 A. We do research on form 990s, which is the
5 tax form that is completed by nonprofit -- by
6 501(c)(3)s, typically, nonprofit organizations.
7 They're all required to disclose the annual
8 compensation of their highest paid employees and
9 I believe employees who earn over \$100,000 a
10 year.

11 So that gives us a very strong set of
12 competitive and comparative data that we can use
13 to figure out if we're -- if we're competitive in
14 terms of paying our executives.

15 Q. Who is the "we"? Who is getting and
16 reviewing this data and making decisions?

17 A. So -- well, I do it in partnership with
18 the manager who is -- when we're setting
19 compensation for the manager who has direct
20 reports. So for instance, for Missy Danforth,
21 Katie Stewart's compensation, we review her
22 compensation. We do this every year. We review

1 the compensation to ensure that it remains
2 competitive. And I'll do that with Missy.

3 We also call on Engage PEO. I think I
4 mentioned that they are the HR services firm that
5 we work with. And they give us benchmarking data
6 as well for our executives, and for all levels,
7 really, of employee so that we can gauge from
8 that as well.

9 And then -- I think that's the -- and
10 then we have a recruiter also who gives us -- who
11 does give us insights as well.

12 Q. Okay. Is compensation for any of the
13 executive staff tied to any performance goals?

14 A. So increases in compensation on the
15 annual review period is -- two things. One is
16 the performance of the organization against its
17 key benchmarks; and two is their own personal
18 performance towards their own job description.

19 Q. Okay. And who sets those goals, the
20 personal goals?

21 A. They're based on the job description, so
22 the supervisor of the person. So in my case, for

1 example, Missy Danforth has a job description.
2 We review the job description prior to the review
3 each year to make sure it's still accurate. And
4 then the employee self-reports how they believe
5 they are doing on these goals for their -- which
6 are in their job description. And then the
7 supervisor responds to those comments.

8 Q. Are the goals for any of these executive
9 staff for purpose of compensation, are there any
10 revenue goals among those goals?

11 A. In some cases, yes.

12 Q. Okay. Can you -- how about for you?

13 A. For my -- well, for my goals, not so
14 much. They want to know that the organization is
15 growing, so they will look at overall growth of
16 the organization in all forms.

17 I think in the earlier exhibit I touched
18 on a lot of the metrics that they're looking at.
19 So they certainly do want to know that I'm
20 raising money.

21 They also want to know that we're getting
22 the kind of traction we want in the market around

1 improving patient safety. So they want to know
2 both the revenue generation and the effectiveness
3 of our mission.

4 Q. So just to be clear, for your
5 compensation, there are no revenue-based
6 performance goals that you have to meet?

7 A. Well --

8 Q. Yes or no?

9 A. No.

10 Q. No? Okay.

11 A. But --

12 Q. But you mentioned that there are examples
13 of revenue-based performance goals.

14 Is this for other members of the
15 executive staff?

16 A. No. I'm primarily evaluated on the basis
17 of the organization's performance.

18 Q. I'm asking -- the question I just asked:
19 Are there other members of the executive staff
20 who do have revenue-based performance goals for
21 their compensation?

22 A. Yes. Yes.

1 Q. Okay. And who are those?

2 A. Karen. She's our development director.
3 So she -- so we are looking -- as part of her job
4 description, we are looking at, are you raising
5 money in the development campaign and are you
6 raising money in generating additional
7 sponsorships for the annual meeting?

8 And some of the revenue goals we've set
9 for her in terms of fundraising.

10 Q. This is Karen Jupiter?

11 A. Yes. Karen Jupiter.

12 Q. Okay. And who else?

13 A. I'm not sure.

14 Q. Melissa Danforth? Given that she
15 oversees the licensing programs, is she one?

16 A. Yeah, that was more of a temporary thing,
17 though, that she took on, because she had so much
18 turnover in trying to get the marketing
19 leadership correct and haven't been able to do
20 that.

21 Q. So the question is, are her -- is her
22 compensation tied to any revenue-based

1 performance goals?

2 A. Only inso- -- it's not in her specific
3 personal job description, so no, it is not, on a
4 personal level. But as I said, for the executive
5 team, their bonus levels are determined also, in
6 part, in consideration of the organization's
7 overall performance on our metrics, and those
8 include revenue.

9 Q. Okay. So not personal, but
10 organization-wide, their bonus depends on how the
11 overall organization does in terms of revenue; is
12 that right?

13 A. How --

14 MS. BLAIR: Objection to form.

15 THE WITNESS: Not in terms of revenue.
16 Just how the overall organization does. That
17 includes revenue, but it's not only revenue.
18 BY MR. CHUNG:

19 Q. Okay. How about Mr. Banerjee? Does
20 his --

21 A. No, his is not --

22 Q. Is his compensation, any part of it tied

1 to revenue-based performance goals?

2 A. No, it's not.

3 Q. Okay. So it's just Ms. Jupiter or is
4 there anyone else?

5 A. Well, all of the senior team is
6 compensated based on the performance of the
7 organization and -- in terms of their bonus, is
8 compensated in terms of the performance of the
9 organization and their performance on their
10 particular job description.

11 So the entire senior team, then, would be
12 compensated on the performance of the overall
13 organization, so that would include revenue in
14 that respect.

15 But you asked me about specifically on
16 the job descriptions. That's where I immediately
17 think of Karen Jupiter, since that is
18 fundamentally her job, to raise money for the
19 organization.

20 Q. Okay. Your -- am I right that your
21 compensation, at least for 2024, was about
22 \$760,000? Is that right?

1 A. I don't believe that's exactly right.
2 But the base is 575. And two years ago I believe
3 I had a bonus of \$100,000.

4 And then I think on the 990s, they also
5 account for benefits, so, like, health benefits,
6 all that value. So that's where it gets to 760.

7 Q. Okay.

8 A. Last year I made much less. And that's
9 not -- I don't believe it's out on the 990s yet,
10 but --

11 Q. Last year meaning -- what's the year?

12 A. So the fiscal year that's ending as of
13 June 30th, which would be fiscal year 2025.

14 Q. Okay.

15 A. My compensation last year was 575, and I
16 asked the board to not give me a bonus because I
17 wanted to preserve the bonus pool for my
18 executive team. They had done an incredible job,
19 and I wanted to maintain it for them.

20 So that, plus what's going to be on the
21 990 for that, is the 575 plus -- plus the value
22 of the health benefits and retirement benefits.

1 Q. But is it fair to say that your
2 compensation over time since you started as CEO
3 in about 2012 has increased?

4 A. Yes.

5 Q. Okay.

6 (Binder Deposition Exhibit 32 marked for
7 identification and attached to the
8 transcript.)

9 BY MR. CHUNG:

10 Q. Exhibit 32. Key elements of requested
11 changes to the CEO employment contract.

12 Do you see that?

13 A. Yes.

14 Q. Okay. And this is for a date of July 12,
15 2024.

16 Did you author this document?

17 A. Yes.

18 Q. Okay. And this is addressed to The
19 Leapfrog Group executive committee, correct?

20 A. Yes.

21 Q. All right. You write here -- what's the
22 purpose of this document?

1 A. My contract is renewing as of this '25
2 fiscal year, which this is the beginning of
3 that '25 fiscal year. I wanted to give them time
4 to think through what to do about my
5 compensation.

6 Q. Okay.

7 A. And I made the case -- I looked at the
8 comparables in the nonprofit world to give them
9 an assessment of how competitive my compensation
10 is and also some of the history of my
11 compensation.

12 Q. So you write toward the top there, second
13 sentence under the CEO position of my value,
14 Recruitment for this position, as well as other
15 senior positions, will include talent from
16 larger, better financed organizations, given the
17 need for experienced leadership and the level of
18 scrutiny Leapfrog is under.

19 What did you mean about the level of
20 scrutiny that Leapfrog was under? And this is --

21 A. Well, we're very --

22 Q. -- July 2024.

1 A. I mean, we get tens of thousands of press
2 citations and public attention. I'm on the
3 speaking circuits, speaking to thousands of
4 people every year. We are a very high-profile --
5 exceptionally high-profile organization for our
6 financial size.

7 Q. Okay. And then you write your
8 performance -- My performance in this position
9 has been a significant asset to the organization,
10 and over the past decade we have grown Leapfrog's
11 visibility and influence while also growing our
12 revenues by an average of 10 percent per year.

13 So you're including here, as part of
14 the -- kind of the pitch here, that you've been
15 responsible for growing Leapfrog's brand as well
16 as the revenues, correct?

17 A. Yeah. The next sentence talks about the
18 low staff turnover and expansion --

19 Q. I'm just focusing on what I just read.

20 Is that correct, that --

21 MS. BLAIR: Objection to form.

22

1 BY MR. CHUNG:

2 Q. -- your -- all right. I'll move on --

3 A. Which sentence? Over the past decade, we
4 have grown --

5 Q. Yeah.

6 A. -- Leapfrog's visibility and influence
7 while also growing our revenues by an -- yes,
8 that's true.

9 Q. Yes -- okay.

10 So I'm going to direct your attention to
11 the second page.

12 And under compensation request, you ask
13 for a bonus target of 15 to 25 percent of the
14 base.

15 Do you see that?

16 A. Yes.

17 Q. And then the dollar amount is set forth
18 there, 101,250 to 168,750.

19 What was the previous bonus target?

20 A. The previous bonus target was anywhere
21 from zero to \$100,000.

22 Q. Okay. And when was this new bonus target

1 meant to go into effect?

2 A. When we conclude the renewal of my
3 contract.

4 Q. Okay. And then in the next paragraph on
5 the same page you write that your base and bonus
6 request would get your compensation above the
7 median for similarly sized organizations.

8 Do you see that?

9 A. Depending on bonus, yeah.

10 Q. Yeah, depending on bonus.

11 So why did you think your compensation
12 should be above the median for similarly sized
13 organizations?

14 A. Because I've been at Leapfrog for
15 18 years and we are considered by many one of the
16 most successful nonprofit organizations in the
17 country.

18 Q. Okay. And part of that -- would you say
19 part of -- at least in light of your kind of --
20 your contributions here, part of that would be
21 the revenue generation as well, correct?

22 MS. BLAIR: Objection to form.

1 THE WITNESS: It's both revenue and
2 accomplishment of mission, but mostly mission.

3 BY MR. CHUNG:

4 Q. Okay. But you --

5 A. The whole purpose of revenue is mission.

6 Q. Right. But you do underscore that
7 revenue has grown while you've been CEO, correct?

8 A. Yes.

9 Q. All right. And that's a reason -- that's
10 one of the reasons for this request and the
11 increased compensation, correct?

12 A. Well, mainly it's the factors that I lay
13 out here on --

14 Q. I'm asking, is it one of the reasons
15 that's the grounds for your request for increase
16 in compensation?

17 A. Sure, it's one of the reasons.

18 Q. Okay. Would you say that Leapfrog's
19 success depends on participation by hospitals?

20 MS. BLAIR: Objection to form.

21 THE WITNESS: No.
22

1 BY MR. CHUNG:

2 Q. How is that?

3 A. Well, we -- there are many factors that
4 would determine success, but the most important
5 one is that we see improvement in patient safety.

6 Q. What would happen to Leapfrog if all
7 hospitals decided to stop responding to the
8 hospital survey?

9 MS. BLAIR: Objection to form.

10 THE WITNESS: I guess we'd be -- we'd try
11 another strategy to improve patient safety.

12 BY MR. CHUNG:

13 Q. Okay. But what would happen to Leapfrog
14 if all hospitals decided to stop responding to
15 the hospital survey?

16 A. We'd pursue --

17 MS. BLAIR: Objection.

18 THE WITNESS: -- a different strategy to
19 improve patient safety.

20 BY MR. CHUNG:

21 Q. Would you be concerned -- I mean, isn't
22 the foundation -- the foundational program of

1 Leapfrog the hospital survey?

2 A. It was the first program we launched, and
3 it's certainly key to our strategy of
4 transparency in an open marketplace, an open and
5 transparent marketplace in healthcare. We
6 certainly want that.

7 Q. Okay. Would you say it is -- the
8 hospital survey is necessary for Leapfrog's
9 survival?

10 MS. BLAIR: Objection to form.

11 THE WITNESS: No. We'd find some other
12 way to do it. But -- it's not going to go away.
13 But we would try another strategy. We've been
14 successful at pursuing various strategies over
15 our 25-year history. And we would do that
16 because patient safety is not going to wait.
17 People are -- it's third leading cause of death
18 in this country.

19 BY MR. CHUNG:

20 Q. The hospital survey, however -- we talked
21 about the hospital safety grade program
22 starting -- I think it was 2012, right?

1 A. Yes.

2 Q. But the hospital survey preceded your
3 time as CEO, correct?

4 A. Yes.

5 Q. So the hospital survey has been part of
6 Leapfrog -- has it been since the founding?

7 A. Yes.

8 Q. Okay. So I'm just going to ask the
9 question again: Does Leapfrog's success depend
10 on -- as it's currently put together, depend on
11 participation by hospitals?

12 MS. BLAIR: Objection to form.

13 THE WITNESS: Our current -- in our
14 current strategic design --

15 BY MR. CHUNG:

16 Q. Yeah.

17 A. -- we rely on hospital transparency to
18 drive a market for improved patient safety. That
19 is our strategy right now. Yes.

20 Q. Okay. Does Leapfrog provide any form of
21 public recognition such as awards or distinctions
22 to hospitals that participate in the survey?

1 A. Yes, we do.

2 Q. All right. And what are the criteria for
3 that type of -- for those recognitions?

4 A. So we have a top hospitals program and we
5 award based on a variety of factors such as they
6 have to have achieved a certain level of
7 performance in each one of the categories within
8 the Leapfrog hospital survey.

9 Q. Okay.

10 A. So they have to be among the top in
11 those -- it's a whole methodology, and we
12 publicly report that as always.

13 Q. Does Leapfrog ever engage with hospital
14 leadership or hospital administrative staff to
15 encourage participation in the survey?

16 A. Yes.

17 Q. Okay. How does it go about doing that?

18 A. Well, a whole variety of ways, but one is
19 that we work with our regional leaders and we
20 support them, and they are really the main voice
21 for Leapfrog in their communities, meeting with
22 hospitals, talking with hospitals, engaging

1 hospitals on behalf of their employer members.
2 That's one way.

3 The other way is what I would just call
4 sort of -- it's not informal, but it's anecdotal,
5 so to speak, is when myself and other leaders at
6 Leapfrog travel across the country and meet with
7 various hospitals and -- as well as our regional
8 leaders and others in conferences, et cetera.

9 So we have a number of general
10 strategies. I make it a point myself to visit at
11 least three to five hospitals every year, get a
12 tour, find out where the real challenges are.
13 There's really nothing like being on site and
14 really talking to these leaders personally.

15 So we do that, and a number of
16 Leapfrog -- the Leapfrog team does it. Sometimes
17 our board members as well go for tours and
18 conversations with hospital leaders.

19 Q. Are there any partnerships with employers
20 or insurers that use Leapfrog participation --
21 hospital participation in Leapfrog survey as a
22 criterion for contracting or inclusion in the

1 network?

2 A. I don't know. I know that some health
3 plans have put Leapfrog participation in their
4 initial -- in the initial contracts that they
5 present to hospitals, but my understanding is
6 often those are negotiated out before they
7 actually take place.

8 So I don't think there are any that have
9 stayed in place, but I don't know entirely.

10 Q. Okay. Does Leapfrog track hospital
11 participation rates over time?

12 A. Yes.

13 Q. Okay. And what trends has Leapfrog
14 identified in the participation rates?

15 A. They've been growing every year.

16 Q. Okay. And that's as part of kind of the
17 efforts that you just described; is that right?

18 A. Which efforts?

19 Q. The efforts that you just described about
20 the engagement with hospitals.

21 A. Oh. Well, there's a whole variety of
22 reasons besides direct engagement with

1 hospitals --

2 Q. Okay.

3 A. -- that cause -- that cause participation
4 rates to increase.

5 Q. Including changing the imputation
6 methodology last year; is that right?

7 MS. BLAIR: Objection to form.

8 THE WITNESS: That was not the purpose of
9 the change in the imputation.

10 BY MR. CHUNG:

11 Q. Okay. But it had the impact?

12 A. I don't know. Honestly don't know.

13 Q. Okay. You were hoping for that impact,
14 correct?

15 MS. BLAIR: Objection to form.

16 THE WITNESS: No. That was not the
17 purpose of the -- the imputation had a purpose:
18 Was for consumers so that they would not -- we
19 were not overstating the performance on safety of
20 any hospital. That is not -- we'd never want to
21 be doing that. It's not safe for consumers.

22

1 BY MR. CHUNG:

2 Q. Has Leapfrog ever analyzed whether survey
3 participation improves a hospital's safety grade?

4 A. Not the way you described it.

5 Q. I'm sorry?

6 A. Not the way you just described it.

7 Q. Okay. Well, how have -- how has Leapfrog
8 analyzed or studied --

9 A. We've looked at patterns on survey
10 participants versus non-participants in a whole
11 variety of areas, including their safety grades,
12 but also their particular performance on certain
13 CMS metrics.

14 Q. Well, what have you observed in terms of
15 the analysis of survey participants and
16 non-participants as it relates to their safety
17 grades?

18 A. Non-participants tend to not have as high
19 a grade.

20 Q. Okay. And is that -- is that recent data
21 after the imputation methodology change in 2024
22 or just more -- over a longer time period?

1 A. That's been consistent.

2 Q. Okay.

3 A. But let me just add that they --
4 non-participants have also consistently been able
5 to do well. So it isn't -- but in terms of
6 correlating or looking at the patterns between
7 the two kinds of hospitals, like the participants
8 and non-participants, there is generally, on
9 average, higher grades by participating
10 hospitals.

11 Q. Okay. So we're going to move on to
12 Leapfrog's marketing, which is another 30(b)(6)
13 topic.

14 How large is Leapfrog's marketing team?

15 A. We don't have anyone dedicated to just
16 marketing. We have -- I mean, Kush does mostly
17 contracting and responding to inquiries, so
18 that's partly marketing.

19 We have a lot of people who partly work
20 on marketing.

21 Q. And who are those people?

22 A. Kush, Missy, myself.

1 I'm trying to think. I think some of our
2 communications team will help with some, so Karen
3 Jupiter and Lauren Bailey do particularly
4 marketing around our partners program to try to
5 attract more partners and sponsorships.

6 Q. Okay. So you have communications
7 personnel working on marketing as well; is that
8 right?

9 A. For the partners program. And for the
10 annual meeting in particular. Actually, she
11 works a lot on attracting sponsors and interest
12 and registrations for the annual meeting.

13 Q. Do you know how much Leapfrog spends
14 on -- do you also use outside marketing firms to
15 help with marketing?

16 We mentioned TelAffects earlier, correct?

17 A. Yes. TelAffects is the main one that we
18 use for marketing purposes.

19 Q. Any others?

20 A. We have a design -- a designer, graphic
21 designer. We have a videographer that does some
22 video for our annual meeting that we then can use

1 in marketing.

2 So smaller contracts like that. But the
3 main one is TelAffects.

4 Q. Okay. And I'm aware that Leapfrog also
5 uses an outside service, CURA Strategies.

6 A. Yes.

7 Q. What do they do?

8 A. They're our public relations firm. So
9 they handle -- they handle informing the media
10 when Leapfrog has news and making sure that -- or
11 trying to get it covered.

12 Q. Okay. In terms of Leapfrog's marketing
13 strategy, how does the -- how do the hospital
14 safety grades fit into Leapfrog's marketing
15 strategy?

16 A. Well, for the accolades program, we -- we
17 have a number of strategies to -- aimed entirely
18 at hospitals for each round of the grade that
19 earn an A, which is a subset of them. We have a
20 number of strategies to try and engage them and
21 interest them in purchasing that logo and touting
22 their A. So those would be e-mails that are

1 directed at those A-hospitals. We do --
2 actually, it's mainly e-mails. We do some other
3 kinds of mailings, I guess, but that's mainly it.

4 Q. Okay. Does Leapfrog pay for search
5 engine optimization for any of its websites as
6 part of the marketing program?

7 A. We've dabbled in that with -- we got a
8 grant from -- a grant from Google that they give
9 to some non-profits to allow them to dabble in
10 search engine optimization, paying for some --
11 paying to be on the top of a search. And so
12 we -- it's a very small amount, but we've done
13 that.

14 And that's just dabbling. We don't have
15 the funds to really do that kind of SEO, really
16 sophisticated strategy.

17 Q. Okay. So just some specific questions
18 about how Leapfrog markets the hospital safety
19 grades to consumers.

20 How does Leapfrog decide how to describe
21 and explain the hospital safety grades in its
22 marketing?

1 A. We don't really market the hospital
2 safety grades except we market the accolade for
3 hospital safety grades.

4 Q. So how does it go about doing that?
5 What -- how do you decide -- how do you describe
6 the hospital safety grades when you're marketing
7 the accolades program?

8 A. We send e-mails that say, you got an A,
9 you know, you should be proud.

10 And some of the ways that hospitals that
11 earn an A, how they've been able to tout it in
12 their communities, with their boards, with
13 their -- just internally, externally.

14 We try to give them ideas. And -- that's
15 how we do it.

16 Q. And in fact, it's the licensing team
17 that's the first -- they're the first folks from
18 Leapfrog that notify a hospital of an A grade; is
19 that right?

20 A. No. We send a letter to the CEO signed
21 by me, and it's sent FedEx, so it's a hard copy,
22 sent to the CEOs that congratulate them on their

1 A.

2 Q. Is that the very first correspondence?

3 A. That they got an A? Yes.

4 Q. Okay. Isn't it -- doesn't the licensing
5 team send an e-mail, electronic communication, to
6 the hospital notifying them of the A first?

7 A. They also send a note. But the first
8 thing is the letter to the CEO, the hard copy
9 FedEx letter to the CEO.

10 Q. Okay.

11 A. But, I mean, CEOs don't always, you know,
12 let everyone know in five seconds, so we also
13 communicate with others at the hospital to make
14 sure they're aware and have time to consider how
15 they want to promote their A, which they can do
16 for free. And we make that clear in all of our
17 correspondence as well.

18 Q. Okay. Does Leapfrog try to convince
19 consumers that its grading methodology is
20 objective?

21 A. I don't know that we've used the
22 word "objective." Independent.

1 Q. Okay. Does Leapfrog try to convince
2 consumers that its grading methodology is
3 unbiased?

4 A. Yes.

5 Q. Okay. And you said independent?

6 A. Yes.

7 Q. All right. Why not objective?

8 A. I don't know --

9 Q. Is it because there are elements of the
10 scoring methodology that are subjective?

11 MS. BLAIR: Objection to form.

12 THE WITNESS: No, it's just -- it's just
13 not a great word.

14 BY MR. CHUNG:

15 Q. Why not?

16 A. Because in the scientific method, we're
17 always evolving and updating it, and it's not
18 commonly used in even scientific discussions to
19 say, well, this is objective, so this is it.
20 You -- it's just not a word that's used in an
21 evidence-based scientific environment, so we
22 tended to not use the word "objective."

1 Q. Okay. Is that a word that your expert
2 panelists have cautioned against using?

3 A. I don't think they've ever brought it up,
4 but it's just not a word that's commonly used in
5 any kind of scientific discourse.

6 Q. Okay. Does Leapfrog try to convince
7 consumers that the hospital safety grades are not
8 influenced by a hospital's participation or lack
9 of participation in the survey?

10 A. Do we try to convince people that it is
11 not influenced by the survey?

12 Q. Right.

13 A. No.

14 Q. All right. Is it true that a hospital's
15 lack of participation does not affect the
16 hospital's safety grade?

17 A. No. That's not true. And we don't say
18 that. That I know of, anyway.

19 Q. Okay. So it is true that a hospital's
20 lack of participation does affect its safety
21 grade?

22 MS. BLAIR: Objection to form.

1 THE WITNESS: It can affect their safety
2 grade for sure, up or down.

3 BY MR. CHUNG:

4 Q. Okay. Isn't it true that Leapfrog's
5 published hospital safety grades could cause
6 members of the public or patients to delay
7 necessary medical care?

8 MS. BLAIR: Objection to form.

9 THE WITNESS: Highly doubtful.

10 BY MR. CHUNG:

11 Q. Is it possible?

12 A. I don't know.

13 Q. You don't know? Is that your testimony,
14 you don't know whether it's possible?

15 A. I don't know if people would delay needed
16 medical care because of the hospital safety
17 grade. I've never heard of that ever happening.

18 Q. Okay. Well, take a member of the public
19 with Leapfrog grades, you know, in their mind.

20 Is it possible that they might drive past
21 a D- or an F-hospital and make a much longer
22 drive to an A-, B-, or C-hospital?

1 A. Is that --

2 MS. BLAIR: Objection to form.

3 THE WITNESS: Sure.

4 BY MR. CHUNG:

5 Q. Is there a risk there, is what I'm
6 asking?

7 A. The risk is if they go to a hospital
8 that's not safe. That's the risk.

9 Q. I'm asking you, is there a risk --
10 right? -- is a -- let's say a particular member
11 of the public, a consumer, with Leapfrog grades
12 in mind, might drive past a D- or F-hospital and
13 just drive further to an A-, B-, C- -- A-, B-, or
14 C-hospital based on their viewing of the grades?

15 MS. BLAIR: Objection to form.

16 THE WITNESS: Sorry, are you saying in an
17 emergency or are you just saying in general?

18 BY MR. CHUNG:

19 Q. In general.

20 A. I would think that they might not want to
21 go to a -- they'd want to -- prefer an
22 A-hospital. Sure.

1 Q. Okay. And they might do so even if the
2 D- or F-hospital has a type of unit or specialty
3 that the further-away hospital does not?

4 MS. BLAIR: Objection to form.

5 THE WITNESS: Well, it's not what we
6 advise, so we're very clear about advising that
7 you should take a look at the safety grade first,
8 because safety comes first. But then there are
9 other sources of information for other kinds of
10 quality metrics that you should also look at
11 regarding a hospital.

12 We're pretty clear about the fact that
13 you need to look at a variety of sources to
14 really evaluate where you want to seek care.

15 BY MR. CHUNG:

16 Q. Where is that made clear, what you just
17 articulated?

18 A. It's in our talking points. I believe
19 it's on our website. It's various places.
20 We're --

21 Q. What are the talking points? Where are
22 the talking points located?

1 A. I'm not sure exactly how to get there on
2 the website, but they're -- we -- it's a talking
3 point that we've used repeatedly.

4 Q. Okay. And what specifically is the
5 talking point that's on the website?

6 A. That you should consider -- it's probably
7 on the safety grade website, too.

8 That you should consider the safety of a
9 hospital first, because safety comes first, and
10 then you should be looking at other sources of
11 information. This is a common point that I've
12 made many times myself as well.

13 Q. Okay. But do the talking points on this
14 website go into these circumstances where, if a
15 hospital with a lower grade has a type of unit or
16 specialty that a further-away hospital with a
17 higher grade does not, that they should consider
18 the distance when deciding -- or consider whether
19 the hospital has the type of unit or specialty
20 that they need?

21 A. We don't talk about the distance, per se.
22 We do talk about looking at a variety of ratings

1 to understand how a hospital is doing on the
2 services that they provide.

3 Q. Okay. Are you aware of instances of
4 patients avoiding a D- or F-hospital only to be
5 sent back to that hospital because the A- or the
6 B-hospital they went to originally didn't have
7 the proper specialty for them?

8 MS. BLAIR: Objection to form.

9 BY MR. CHUNG:

10 Q. Have you heard of those instances?

11 A. I haven't.

12 Q. You have not?

13 A. I have not heard of them.

14 Q. Okay. Would it concern you if you heard
15 of those instances?

16 A. I mean, there's a lot of -- people go
17 from one hospital to another all the time for all
18 kinds of reasons --

19 Q. So you're not?

20 A. -- so I guess I wouldn't see that as a
21 particular red flag. The red flag is if they're
22 going to a hospital and they get harmed. That's

1 the stories I hear every day.

2 Q. Okay. Is it fair to say that Leapfrog
3 wants to influence where patients choose to
4 receive care?

5 MS. BLAIR: Objection to form.

6 THE WITNESS: We want to give consumers
7 information so they can make a good choice for
8 themselves and their families. Period. We're
9 not trying to do anything to or for hospitals.
10 We are about consumers.

11 BY MR. CHUNG:

12 Q. No, I'm not asking whether you're
13 influencing a patient to go to a specific
14 hospital -- right? But isn't it fair to say that
15 Leapfrog -- part of its mission is to influence
16 where patients choose to receive their care?

17 MS. BLAIR: Objection to form.

18 THE WITNESS: We're trying to influence
19 them to seek care at the safest, highest-quality
20 cases.

21 BY MR. CHUNG:

22 Q. Okay. So it's important -- so it's

1 important, based on that, that Leapfrog's
2 hospital safety grades are accurate; is that
3 right?

4 MS. BLAIR: Objection to form.

5 THE WITNESS: It's always been important
6 for all kinds of reasons.

7 BY MR. CHUNG:

8 Q. Okay. Because if the hospital safety
9 grades are not accurate, Leapfrog could be
10 running the risk of influencing a patient or a
11 family member to go to an unsafe hospital; is
12 that right?

13 A. But that's --

14 MS. BLAIR: Objection to form.

15 THE WITNESS: That's why we don't want to
16 inflate the performance of hospitals. We try not
17 to inflate their performance, and that's why we
18 err on the side of not inflating their
19 performance.

20 BY MR. CHUNG:

21 Q. Okay. Similar question: If the grades
22 are not -- if the hospital grades are not

1 accurate, then there's the risk of steering
2 patients away from safe hospitals, correct?

3 A. They are accurate, so I can't answer
4 that.

5 Q. All right. But if they're not accurate,
6 if the hospital safety grade is not accurate,
7 then there's a risk of steering them away from
8 actually safe hospitals, correct?

9 MS. BLAIR: Objection to form.

10 THE WITNESS: If we overstate the safety
11 of a particular hospital, there is the risk they
12 will go to a hospital that is less safe than they
13 thought.

14 BY MR. CHUNG:

15 Q. Okay.

16 A. That's the biggest risk.

17 Q. And if the hospital safety grade -- if a
18 hospital safety grade for a particular hospital
19 is not accurate, there's a risk that Leapfrog
20 could be influencing consumers to make decisions
21 about their healthcare that are actually
22 detrimental to their health; is that right?

1 MS. BLAIR: Objection to form.

2 THE WITNESS: No.

3 BY MR. CHUNG:

4 Q. That's not right?

5 A. No. As I said, the biggest risk is if we
6 were to inflate the performance of a hospital and
7 they go and it's not as safe as they hoped or
8 deserve. That's a risk.

9 Q. Okay.

10 A. To the consumer, that's the biggest risk.

11 Q. So it's not a risk if -- if a hospital
12 safety grade for a particular hospital is not
13 accurate, it's not a risk that Leapfrog could be
14 steering a consumer or influencing a consumer to
15 make a decision that's actually detrimental to
16 their health?

17 MS. BLAIR: Objection to form. Double
18 negative.

19 You can answer it if you know.

20 THE WITNESS: Can you restate it or say
21 it again?

22

1 BY MR. CHUNG:

2 Q. Right. If a hospital safety grade is not
3 accurate -- right? -- for a particular hospital,
4 isn't there a risk that Leapfrog could be
5 influencing a patient to make a decision about
6 their health that's detrimental to their health?

7 MS. BLAIR: Objection to form.

8 THE WITNESS: If it's not accurate --
9 you're saying if it's not accurate, which I
10 contend, of course, that it is accurate. But if
11 it's not accurate, could they be making a
12 decision that's detrimental to their health?

13 BY MR. CHUNG:

14 Q. Yes.

15 A. The risk is that it would be inaccurate
16 to the extent of overstating the hospital's level
17 of safety. That would -- and then -- then the
18 consumer goes to that hospital thinking that they
19 should -- that they feel safe there and they are
20 too complacent about the safety, and that is a
21 major, major risk to consumers.

22 Q. Okay. Has Leapfrog ever issued a

1 correction or a retraction of a hospital safety
2 grade after learning that the grades may have
3 misrepresented a hospital's actual safety or
4 quality of care? Has that ever happened?

5 A. We have pulled down grades when -- very
6 rarely, but we have pulled down a hospital's
7 grade entirely if we are given evidence that
8 form -- some part of the data was inaccurate.

9 This typically is brought to our
10 attention by a hospital, and they will say that
11 there was some inaccuracy which we get confirmed
12 from the data source, i.e., CMS. In that case,
13 we will bring down the grade entirely. We will
14 never change a grade.

15 Q. What do you mean by bring down the grade?

16 A. We'll take it down from public reporting.

17 Q. Okay. So that -- so essentially the
18 hospital does not get a grade; is that right?

19 A. Right.

20 Q. Okay.

21 A. But again, it's very rare, but it's when
22 there's evidence that something is wrong from the

1 data source.

2 Q. When is the last time that that happened?

3 A. I can't remember. Maybe a year ago.

4 Q. Okay. And which hospital?

5 A. I don't remember the hospital.

6 Q. Okay. Approximately how many times has
7 it happened during your time at Leapfrog?

8 A. Eight to ten times in my time at
9 Leapfrog. I worked -- since the safety grade
10 launch.

11 Q. Can you think of a particular hospital --
12 maybe not the most recent one -- where this
13 actually happened?

14 A. Well, it happened a lot when we had AHA
15 data. Not a lot. I mean, obviously, only eight
16 to ten times in 13 years, so it's not a lot. But
17 it was a particular issue with AHA data because
18 the hospitals would say, oh, that's wrong, AHA
19 reported the data to you, it was incorrect. And
20 we'd go back to AHA and they wouldn't -- AHA
21 would need to correct it. We would not correct
22 it unless AHA, the data source, corrected it.

1 And so AHA, if they didn't correct it
2 or -- then AHA would come back late in the
3 process and try to correct it. And in that case,
4 when we have, from the data source, information
5 that this was -- this particular measure was
6 incorrect, we would -- that's when we would pull
7 down the grade.

8 Q. Okay. Has Leapfrog ever considered the
9 potential public health risks associated with
10 publishing safety grades for hospitals where it
11 just doesn't have data?

12 A. We don't publish safety grades for
13 hospitals for which we do not have data.

14 Q. Okay. Has Leapfrog ever considered the
15 potential public health risks associated with
16 publishing safety grades for hospitals where it
17 doesn't have data for a number of metrics?

18 MS. BLAIR: Objection to form. Asked and
19 answered.

20 THE WITNESS: We don't publish safety
21 grades that we don't stand behind. Our criteria
22 for publishing the --

1 BY MR. CHUNG:

2 Q. That's not my question, Ms. Binder. Let
3 me put it another --

4 A. Well, I'm answering your question the way
5 I've interpreted it.

6 Q. Has Leapfrog ever considered the
7 potential public health risks associated with
8 publishing hospital safety grades for hospitals
9 where it doesn't have data for a number of
10 metrics?

11 MS. BLAIR: Objection to form.

12 BY MR. CHUNG:

13 Q. Have you ever -- has Leapfrog ever
14 considered the risks associated with that?

15 A. We look at the public health risks of
16 patient safety itself, which is, no matter what
17 the grade of the hospital, is a very significant
18 risk. It's the third leading cause of death, and
19 one in four patients admitted to a hospital
20 suffers an adverse event.

21 That is a major public health risk that
22 every one of us in this room and every American

1 faces at any hospital.

2 Q. So the answer is --

3 A. So that's what -- that's the public
4 health risk that we are most concerned with and
5 we believe people deserve to know. They deserve
6 to know about the risks that they face and where
7 we believe the risks are highest.

8 Q. So the answer is no.

9 MS. BLAIR: Objection to form. Asked and
10 answered.

11 MR. CHUNG: Hasn't answered the question.

12 MS. BLAIR: I think she's answered it
13 four times.

14 MR. CHUNG: Hasn't answer the question.

15 MS. BLAIR: That's the answer.

16 BY MR. CHUNG:

17 Q. So is the answer no?

18 A. No, we have not considered the public
19 health risks of going to a hospital that gets a
20 poor grade and -- or -- what is your question,
21 actually? Better say it again because I don't
22 understand it.

1 Q. Has Leapfrog ever considered the
2 potential public health risks associated with
3 publishing a safety grade for a hospital where it
4 just lacks data for a number of metrics?

5 MS. BLAIR: Objection. Asked and
6 answered.

7 THE WITNESS: We don't do that, so...

8 MR. CHUNG: Okay. We got an answer
9 finally.

10 MS. BLAIR: Yeah, I think she said that
11 originally, they don't grade hospitals without
12 data.

13 MR. CHUNG: No. Okay.

14 All right. Let's go to tab 9. This will
15 be Exhibit 33.

16 (Binder Deposition Exhibit 33 marked for
17 identification and attached to the
18 transcript.)

19 BY MR. CHUNG:

20 Q. So Ms. Binder, this is -- we looked at a
21 couple of documents earlier about HCA. This is,
22 I think, another one.

1 A. Yeah.

2 Q. But a different topic.

3 So it's an e-mail chain from 2023.

4 And I first want to direct your attention
5 to the second page, Bates ending in 1650. And
6 then Ms. Harmon writes that Leapfrog has received
7 a media request from a small local watchdog
8 investigative news outlet.

9 A. Wait, I don't have 1650. I have -- oh,
10 I'm sorry. I'm looking at the wrong number.

11 Q. It's the top one.

12 A. The top one. Okay. Yeah. Okay.

13 Q. And you'll see here that -- just at the
14 top of that second page, Ms. Harmon writes that
15 Leapfrog has received a media request from a
16 small local watchdog investigative news outlet
17 about Mission Hospital, which is purchased by
18 HCA.

19 A. Uh-huh.

20 Q. First of all, who is Elizabeth Harmon?

21 A. She was -- she is -- she's left Leapfrog
22 now, but she was the senior communications

1 specialist.

2 Q. Okay. And then if you go further down to
3 the middle of the -- further down the page,
4 you'll see that the request from the reporter
5 notes that Mission gets only two stars from CMS
6 for patient experience but that Leapfrog
7 regularly gives them an A safety grade.

8 Do you see that?

9 A. No --

10 Q. In the penultimate --

11 A. Oh, I see it now. Yeah.

12 Q. Yeah, the penultimate paragraph.

13 So my question is, do you know why
14 Leapfrog assigned an A grade to Mission Hospital
15 regularly while CMS rated the hospital with two
16 stars?

17 A. We follow the methodology, and the
18 methodology looks at their CMS -- their CMS
19 measures that are related to patient safety. CMS
20 Star program is a variety of measures, including,
21 but not only, patient safety. In fact, patient
22 safety is a smaller portion of the Star rating.

1 So they are not exactly the same.

2 So that's why I -- I believe Mission
3 Hospital, subsequent to this, but I'm not
4 positive, but I believe, subsequent to this,
5 their grade declined.

6 But this is exactly what I mean by risk
7 to consumers that we see. The biggest risk is
8 inflating or overstating the performance of a
9 hospital. So this is a case in point of where,
10 given the data that we had and the methodology
11 that we have, which we do stand behind, there's
12 going to be problems every now and then where
13 somebody -- we've had to overstate because we're
14 using data that's, you know, six months to a year
15 old or we're -- just various reasons. The data
16 is not perfect --

17 Q. Okay.

18 A. -- the methodology is not perfect, so we
19 end up with a situation like this which we really
20 don't like, but --

21 Q. So --

22 A. And that's what I've said in this e-mail.

1 Q. So moving further down the page, the
2 reporter requests to know how much of Leapfrog's
3 annual revenue is earned from fees that hospitals
4 pay for using its rating in their marketing. I'd
5 also like to learn if there are other ways in
6 which Leapfrog earns fees from the hospital that
7 it rates.

8 Is there any connection between
9 Leapfrog's revenue sources and the way it grades
10 hospitals?

11 A. No.

12 Q. Okay. I want to --

13 A. Those are kept separate. But the --
14 there's no -- this reporter, we would have given
15 them the answer. We would also have pointed to
16 it on the website.

17 We are open about how much we charge for
18 the accolades.

19 Q. You said you would have or did you?

20 A. Well, I don't recall it precisely, but --

21 Q. So let's go to the first page, your
22 response here.

1 A. Because we already make public what we
2 charge for accolades. So it would have been
3 there.

4 Q. Okay. But in your reply to Ms. Harmon's
5 e-mail, you state that this is officially a
6 serious PR issue; do you --

7 A. It is --

8 Q. -- do you see that?

9 A. -- yes.

10 Q. Okay. Is this a serious PR issue because
11 you've heard from other sources that Leapfrog is
12 pay to play and that these information requests
13 bear on that?

14 A. No, absolutely not.

15 Q. Okay. Why was it a -- was this not a
16 serious issue --

17 A. Because we --

18 Q. -- with the hospital survey?

19 A. No.

20 Q. How about with the hospital safety grade?

21 A. This is a serious issue of us overstating
22 the performance of a hospital through the

1 hospital safety grade --

2 Q. Right.

3 A. -- but that is what's going to happen in
4 imperfect rating systems of all sorts. And that
5 is what we feared. That's the public health
6 problem.

7 Q. Okay.

8 MR. CHUNG: Let's go to tabs 10 and 10a.
9 (Binder Deposition Exhibit 34 marked for
10 identification and attached to the
11 transcript.)

12 BY MR. CHUNG:

13 Q. All right. This is Exhibit 34. It's an
14 e-mail thread discussing what looks like a media
15 story about St. Luke's Hospital, Ms. Binder.

16 Do you see that?

17 A. Yes.

18 Q. All right. And it received an A safety
19 grade in the spring 2023, but then there's a
20 report of a former employee describing rusty and
21 damaged equipment being used on patients.

22 Do you see that?

1 A. Yes.

2 Q. Okay. So if you look at the bottom of
3 page 3 of the document Bates ending 9322, the --
4 Lula Hailesilassie, I think from CURA, writes
5 that an ex-employee exposed St. Luke's Hospital's
6 rusty and damaged equipment that is being used on
7 patients, and that St. Luke received an A grade
8 in the spring 2023 safety grade cycle.

9 Does Leapfrog take into account feedback
10 or stories like this when it computes the
11 hospital safety grade?

12 A. We don't look at this particular kind of
13 whistleblowing story. We can't -- there's no
14 reliable way to do that. There's no reliable way
15 to compare hospitals against each other on the
16 number of whistleblowers who come forward.
17 Pretty much every hospital will have some pretty
18 awful stories to tell from whistleblowers that we
19 do see --

20 Q. Every hospital? What's your basis for
21 that?

22 A. Oh, just general -- just my general

1 knowledge from 18 years at Leapfrog. We see it
2 all the time, that there's problems at every
3 hospital.

4 So, you know, our methodology is -- we're
5 using the best publicly available data that's
6 fair to compare hospitals against each other on.
7 And -- so that does not always include what a
8 whistleblower might -- might bring up.

9 Q. But -- so do you not consider or factor
10 in these reports at all in determining the
11 hospital safety grade for a particular hospital?

12 A. We have to use reliable, risk-adjusted
13 measurement. We have to use a measurement
14 process to offer a reliable grade that compares
15 hospitals against each other. Hospitals, I
16 think, would not respond well if we said, well,
17 this one had three whistleblowers, this one had
18 two, so this one gets a higher grade or
19 something.

20 That -- it's not justifiable and we
21 can't -- it doesn't have an evidence base for
22 grading.

1 Q. Okay. So none of that figures into the
2 hospital safety grade, is your testimony?

3 A. Well, it figures into Leapfrog. I mean,
4 we care deeply about these reports, and we --
5 it's very upsetting.

6 Q. Okay. Are you aware of any evidence that
7 Leapfrog's hospital safety grades have caused
8 reputational harm to hospitals?

9 A. We don't track that, so I don't know.

10 Q. Okay. Now, would you agree that before
11 Leapfrog issues a hospital safety grade to a
12 particular hospital, that hospital has a
13 preexisting reputation? Would you agree with
14 that kind of basic proposition?

15 A. Yes.

16 Q. Okay. And that reputation could be good
17 or bad or somewhere in the middle, right?

18 A. Yeah.

19 Q. Okay. For example, a hospital could have
20 a five-star CMS rating. And would you agree that
21 that's likely to positively impact a hospital's
22 reputation?

1 MS. BLAIR: Objection to form.

2 THE WITNESS: It depends. I mean, if
3 there's other ratings or other kinds of things
4 that make them look bad or they have 12
5 whistleblowers who have just come forward and are
6 on the front page of the paper, it's not going to
7 help that much.

8 BY MR. CHUNG:

9 Q. Okay. Receiving an A Leapfrog grade for
10 that same hospital would, would you say, help
11 that five-star CMS hospital's reputation?

12 MS. BLAIR: Objection to form.

13 THE WITNESS: Again, I would think so.
14 Maybe. But in the context of a variety of other
15 kinds of reputational issues, it would -- I'm not
16 sure which would -- could be pointed to as the
17 key thing.

18 MR. CHUNG: Okay. Let's go to tab 88.

19 This will be Exhibit 35.

20 (Binder Deposition Exhibit 35 marked for
21 identification and attached to the
22 transcript.)

1 BY MR. CHUNG:

2 Q. Okay. Exhibit 35, Ms. Binder, it's an
3 e-mail chain, I think principally between you and
4 Ms. Danforth. And you'll see that it has to do
5 with the Keck Medical Center.

6 Do you see that?

7 A. Yes.

8 Q. Okay.

9 A. But I don't recall this e-mail chain, so
10 I will need to read it.

11 Q. Yeah, please take a look.

12 I first want to direct your attention --
13 it's really the sixth page --

14 A. I'm not finished.

15 Okay.

16 Q. All right. So in Bates ending 861, Ling
17 Zheng from Keck writes to Ms. Danforth basically
18 requesting that Leapfrog suppress its PSI 90
19 score based on a change in how CMS evaluates
20 certain metrics. Is that what she's kind of
21 getting at?

22 A. Uh-huh, yes.

1 Q. And if you look at page 3 of the
2 document, Bates ending 858, there's a follow-on
3 from a Ms. Hall where she writes, We feel that
4 this seriously misrepresents to the public the
5 safety at Keck Hospital of USC when, in fact,
6 there's been no clinical or outcome changes,
7 merely the application of a new AHRQ methodology
8 to historical data. We remain concerned that
9 this unfairly harms our reputation.

10 So is it fair to say that Keck was
11 concerned that a lower safety grade here would
12 negatively impact its reputation in its market?

13 MS. BLAIR: Object to form.

14 THE WITNESS: I don't know. They don't
15 talk about that particular issue.

16 BY MR. CHUNG:

17 Q. Well, she says -- we just read it here:
18 We remain concerned that this unfairly harms our
19 reputation.

20 How do you read that statement?

21 A. Oh, so they're concerned about -- yeah,
22 then they are concerned about their --

1 Q. Okay.

2 A. -- grade as a result of this one measure.

3 Q. So looking at the next page, Bates ending
4 857, you write, just to Ms. Danforth, as a follow
5 on, I don't like their language about reputation.
6 How did this change affect their letter grade?

7 Why didn't you like their -- Ms. Hall's
8 language about reputation?

9 A. I don't recall why I said that, but...

10 Q. Okay. What did this -- what about the
11 language stood out to you, if you remember?

12 A. I don't recall.

13 Q. Okay. Did you disagree with the
14 connection that Ms. Hall was drawing between a
15 lower safety grade and the institution's
16 reputation?

17 A. I don't recall why I said it that way. I
18 think -- I can see that they might feel that
19 their reputation is at stake with any kind of
20 scoring system. So I can see that. But I think
21 what is clear --

22 Q. Well, they're focusing specifically on

1 the Leapfrog hospital safety grade here.

2 Are they talking about other scoring
3 systems?

4 A. No. They're talking about Leapfrog --

5 Q. Right.

6 A. -- and they're talking -- this is not a
7 marketing person who's writing to Leapfrog. This
8 is -- it looks like their quality -- their chief
9 medical officer.

10 Q. Right.

11 A. So their chief medical officer is
12 concerned about the risk adjustment on this one
13 measure, which further -- it seems like further
14 analysis was done. And it seems like that was --
15 that happened throughout a bunch of large
16 teaching hospitals and their PSI rate.

17 So compared to others, they were not
18 unduly harmed, so to speak. Their grade -- their
19 particular performance on this one measure was
20 not particularly harmed, it looks like.

21 But I'm not the expert on this. I would
22 definitely talk to Missy because I can't remember

1 exactly -- this was, like, two years ago.

2 Q. Has Leapfrog received any feedback from
3 hospitals regarding the accuracy or fairness of
4 their assigned safety grades?

5 A. Sure.

6 Q. Okay. From who?

7 A. We value that -- we ask for them --

8 Q. So the --

9 A. -- to come to us with --

10 Q. -- question is, from who?

11 A. From hundreds of hospitals, both positive
12 feedback and negative feedback. We get lots of
13 both. We ask for it. That's why we have a
14 public comment period. That's why we have a
15 whole variety of mechanisms that we use all the
16 time to encourage feedback.

17 Q. In terms of the negative feedback --

18 A. Yes.

19 Q. -- regarding the fairness and the
20 accuracy of an assigned safety grade, what's the
21 most prevalent feedback you hear?

22 VIDEO TECHNICIAN: Ms. Binder.

1 THE WITNESS: Oh, sorry.

2 Well, they don't like the low grade.

3 That's the -- they don't -- hospitals that get
4 lower grades will say it's not -- we don't agree
5 with the methodology.

6 BY MR. CHUNG:

7 Q. Okay. And how does Leapfrog respond to
8 that type of feedback?

9 A. We spend a lot of time, actually,
10 talking -- personally talking with hospitals that
11 get a low grade and going through the measures
12 that led to it and how it applied to the
13 methodology, et cetera, and helping them to set
14 goals to -- for their improvement. We don't tell
15 them how to improve, but we definitely can say,
16 here's an area where you have some shortcomings
17 that if you put a focus on -- for instance, you
18 have a very low -- a very high rate of central
19 line infections; here -- you know, you should
20 really focus on that. And -- among other things.
21 And we'll just take them through it.

22 We spend a lot of time with hospital CEOs

1 in particular that are unhappy with the grade
2 and, you know, that's -- we always do that for
3 free. We do it all the time. We spend more time
4 on -- with hospitals that have lower grades
5 typically because they -- it's -- you know, it's
6 upsetting to them, and we understand that.

7 I will tell you that we do see
8 improvement in those hospitals, and it's
9 incredibly gratifying. It's one of the best
10 parts of my job, frankly, is when I see a
11 hospital that's gone from, you know, an F or a D
12 to an A. And I see it all the time, and it's
13 really, really impressive.

14 Q. Are you --

15 A. Hospitals can do this.

16 Q. Are you aware of any cases where
17 Leapfrog's safety grades have conflicted with
18 other hospital quality ratings?

19 A. Yes.

20 Q. Okay. And how has Leapfrog addressed
21 those types of conflicts?

22 MS. BLAIR: Objection to form.

1 THE WITNESS: We point out how -- well,
2 it depends, actually. It just sort of depends on
3 what context.

4 So if a reporter is asking me about it,
5 they're saying, like, your example, they got five
6 stars from CMS but you gave them a C. Why? I
7 will say, because we are focused on patient
8 safety, and the five stars from CMS has less of a
9 focus on safety.

10 BY MR. CHUNG:

11 Q. Okay. So in those -- I'm glad that you
12 raised that example.

13 In response to a reporter who identifies
14 that sort of discrepancy or conflict --

15 A. Uh-huh.

16 Q. -- what you underscore for the reporter
17 is that CMS and Leapfrog are measuring different
18 things; is that right?

19 A. Well, some of the same things. There is
20 overlap.

21 Q. Right.

22 A. They do look at the same patient safety

1 measures we do, but they put less of a weight on
2 those. Of course, for us, it's a heavy weight.
3 For them, it's a much smaller weight. So
4 therefore, they will sometimes have a
5 different -- they're often correlated, but
6 sometimes, for a particular hospital, there may
7 be some difference.

8 Q. Okay. And we're looking in particular at
9 the CMS Star --

10 A. Yes.

11 Q. -- rating system, correct?

12 So that just given the different factors
13 and the weightings and the focus for one
14 particular hospital, what you're saying is that
15 the ratings can be very different between the
16 two, between Leapfrog and CMS; is that --

17 A. On occasion that will happen because CMS
18 is looking at a -- they're not looking at safety
19 measures the same way we are.

20 Q. Okay.

21 A. But we are looking at the same safety
22 measure -- many of the same safety measures.

1 Q. Okay.

2 MR. CHUNG: Why don't we take a break
3 here. We in the next topic.

4 MS. BLAIR: Sure.

5 VIDEO TECHNICIAN: The time is 4:52 p.m.
6 This ends unit 4. We're off the record.

7 (A recess was taken.)

8 VIDEO TECHNICIAN: The time is 5:22 p.m.
9 This begins unit number 5. We're on the record.

10 (Binder Deposition Exhibit 36 marked for
11 identification and attached to the
12 transcript.)

13 BY MR. CHUNG:

14 Q. All right. We're now going to put
15 Exhibit 36 in front of you, which is Leapfrog's
16 answer to the plaintiffs' amended complaint, and
17 this is topic 15 among the 30(b)(6) topics that
18 you've been designated for, Ms. Binder.

19 A. Yes.

20 Q. And you're familiar with Leapfrog's
21 answer here?

22 A. Yes.

1 Q. Okay. So we're going to look first --
2 we're going to go through a number of, basically,
3 Leapfrog's denials of various allegations here,
4 and then I'll ask you questions about those.

5 So, first, paragraph 2. So if you look
6 at page 3, paragraph 2, in Leapfrog's answer, it
7 denies the allegations that until last year TLG
8 continued to assign grades to plaintiffs based on
9 how similarly situated participating hospitals
10 performed on standard metrics.

11 But isn't it true that, until the fall of
12 2024, Leapfrog did grade the plaintiff hospitals
13 using an imputation method that assigned the mean
14 score of similarly situated hospitals?

15 A. Okay. I'm -- your question is kind of a
16 long one, so I got lost in the middle of it.
17 Sorry.

18 Q. Okay. So I'm just asking for the basis
19 for this denial here.

20 A. Well, the line Leapfrog continued to
21 assign grades to plaintiffs based on how
22 similarly situated participating hospitals

1 performed on standard metrics.

2 Q. Yes. So why deny that?

3 A. I'm just going to re-read this
4 paragraph to be clear on this.

5 Because we -- we are arguing about
6 similarly situated participating hospitals, what
7 that definition would be. And that's not a
8 good -- good characterization of our methodology,
9 as it was in that time period.

10 Q. Okay. So that's just incorrect, is what
11 you're testifying?

12 A. We're denying it, yes.

13 Q. Okay. So it's not correct that, until
14 the fall of 2024, Leapfrog graded plaintiff
15 hospitals using an imputation method that
16 assigned the mean score of similarly situated
17 hospitals?

18 MS. BLAIR: Objection to form. I think
19 you misread that sentence.

20 THE WITNESS: It says --

21 BY MR. CHUNG:

22 Q. I'm just reading it back to you.

1 MS. BLAIR: I think you misread it.

2 MR. CHUNG: Okay.

3 THE WITNESS: It says --

4 MS. BLAIR: -- we assigned grades.

5 MR. CHUNG: I'm not reading it --

6 MS. BLAIR: Oh, I'm sorry.

7 THE WITNESS: We assign -- until last --
8 it says -- this is what we denied: Until last
9 year, Leapfrog continued to assign grades to
10 plaintiffs based on how similarly situated
11 participating hospitals performed on standard
12 metrics.

13 BY MR. CHUNG:

14 Q. Okay. So why are --

15 A. I'm saying similarly situated
16 participating hospitals is not well defined. And
17 that's not -- that's not referring to imputation
18 or anything else in that particular sentence.
19 It's just a very questionable way of describing
20 our methodology.

21 Q. Okay. Let's move on to paragraph 22.

22 So direct -- I specifically wanted to ask

1 you about the last sentence in the paragraph: It
2 specifically explained its 2024 change was
3 designed to prevent non-participating hospitals
4 from inadvertently benefitting, compared to
5 hospitals that self-report, even though TLG has
6 no data to show how non-participation could
7 benefit a hospital.

8 Do you see that?

9 A. I don't, actually. That's paragraph --

10 Q. 22.

11 A. -- 22? I've got page 13?

12 Q. Yes. Going on to the next page. So the
13 last sentence.

14 It specifically explained...

15 A. Oh, yeah.

16 Q. Do you see that? If you can read that
17 sentence.

18 A. We deny that the purpose of the change in
19 2024 was to prevent non-participating
20 hospitals --

21 Q. Okay.

22 A. -- from anything. That was not the

1 purpose of the change.

2 Q. Well, I'm going to show you a document
3 titled, Final Updates to the Leapfrog Hospital
4 Safety Grade Methodology.

5 MR. CHUNG: This will be Exhibit 37.

6 (Binder Deposition Exhibit 37 marked for
7 identification and attached to the
8 transcript.)

9 BY MR. CHUNG:

10 Q. Okay. And if you look at the second
11 page, Ms. Binder, under responses to public
12 comments -- do you see that?

13 A. Yes.

14 Q. Okay. Under 4, comment or supported the
15 change to the imputation methodology, the second
16 sentence reads, Hospitals that choose not to
17 complete the survey should not inadvertently
18 benefit from hospitals that continue to strive to
19 make improvements and maintain Leapfrog
20 standards.

21 So given what this document says
22 regarding the change in the imputation

1 methodology, what's your basis for denying the
2 sentence -- the last sentence of paragraph 22?

3 A. It says --

4 MS. BLAIR: Objection to form.

5 THE WITNESS: It says it was
6 specifically -- it was designed to prevent. This
7 is a response to a comment that we agree that
8 there should not be an inadvertent benefit from
9 not reporting. That said, it is not -- it was
10 not the design -- it was not the centerpiece or
11 the purpose or the design of and the reason
12 for -- the fundamental reason for us to pursue
13 this methodology.

14 BY MR. CHUNG:

15 Q. Okay.

16 A. Fundamental reason --

17 Q. That's the basis --

18 A. -- is consumers --

19 Q. -- for your denial here; is that correct?

20 A. I believe so.

21 Q. Okay. Going to paragraph 24 in the
22 answer.

1 The plaintiffs' allegation here is that,
2 for the four imputed measures -- CPOE, BCMA, IPS,
3 and hand hygiene -- if a hospital does not
4 participate in TLG's survey, TLG assigns a point
5 value that is equivalent to receiving limited
6 achievement for this measure, its lowest possible
7 score, without any factual basis.

8 Do you see that?

9 A. Yes.

10 Q. All right. And the next sentence is, The
11 result is that hospitals who elect not to
12 participate in TLG's survey receive only 60 out
13 of 400 possible points in these four categories.

14 What's the basis for denying this
15 allegation?

16 A. The last sentence in this -- in
17 paragraph 24, it says, TLG has no basis to assign
18 that low value.

19 We have a basis to assign the low value.

20 Q. Okay. Paragraph 25, the next one:
21 Leapfrog denies that TLG's imputation model for
22 ranking non-participating hospitals directly

1 conflicts with TLG's own national expert panel's
2 guidance.

3 Do you see that?

4 A. Yes.

5 Q. All right. And then as TLG explains, not
6 all hospitals have enough data publicly available
7 to be eligible for a grade.

8 Why deny that?

9 A. We didn't deny that not all hospitals
10 have enough publicly available data to be
11 eligible for a grade.

12 Q. Okay. You're just denying the previous
13 sentence; is that right?

14 A. We deny -- let's see.

15 MS. BLAIR: I'll just object to form,
16 that it mischaracterizes the answer on page 16.

17 THE WITNESS: We admit to the allegations
18 that state, TLG explains not all hospitals have
19 enough data publicly available to be eligible for
20 a grade.

21 And we also admit to this allegation: As
22 per the national expert guidance, Leapfrog has

1 requirements for the minimum amount of data it
2 needs to issue an accurate grade.

3 So we admit to those.

4 BY MR. CHUNG:

5 Q. Okay.

6 A. And then we also admit to, you know,
7 hospitals missing more than six process measures
8 are not graded.

9 Q. Okay.

10 A. So the issue is imputed data, and we
11 count imputed data as data.

12 Q. Okay. Let's go to paragraph 26.

13 And Leapfrog denies the sentence: In
14 response, TLG falsely states the hospital safety
15 grade reflects how well a hospital does on
16 safety, not whether they complete the hospital
17 survey.

18 Does Leapfrog admit that it made that
19 statement?

20 MS. BLAIR: Objection to form.

21 THE WITNESS: The statement the -- which
22 statement?

1 BY MR. CHUNG:

2 Q. Exactly: The hospital safety grade
3 reflects how well a hospital does on safety, not
4 whether they complete the hospital survey.

5 Does Leapfrog stand by that statement?

6 A. I don't recall ever seeing that statement
7 made the way it's written here. Because -- but
8 that said, our focus is how well a hospital does
9 on safety, not whether they -- right? And
10 completing the survey is not what it's about.
11 It's doing well on the survey would be what we
12 would be looking at.

13 Q. Right. But this statement, the hospital
14 safety grade reflects how well a hospital does on
15 safety, not whether they complete the hospital --

16 A. That --

17 Q. -- survey, does -- is that -- does
18 Leapfrog stand by that statement?

19 A. Yes.

20 Q. Okay. Going to paragraph 57. Okay?
21 It's on page 29.

22 A. Okay.

1 Q. Okay. So it looks like Leapfrog admits
2 the first part of the allegation, which is
3 plaintiffs are among the many hundreds of
4 hospitals across the country who choose not to
5 participate in the survey.

6 But then Leapfrog denies the rest: Given
7 that non-participation, TLG could easily have
8 told consumers, as it does on the
9 leapfroggroup.org, it lacks sufficient data to
10 provide safety grades for plaintiffs. Instead,
11 it imputed scores to plaintiffs and gave them
12 failing or near failing grades on the
13 hospitalsafetygrade.org website.

14 What's the basis for this denial?

15 A. Well, there's a lot of basis in this
16 particular paragraph, which is very recklessly
17 written given what we know about, and what we
18 have clearly stated on our website, about our
19 methodology.

20 So we don't -- instead, it imputed scores
21 to plaintiffs and gave -- the grades come from
22 all of the measures within the grade methodology,

1 which is 32 measures, not just the imputed
2 measures.

3 Q. But is it incorrect that they were given
4 failing or near failing grades?

5 MS. BLAIR: Objection to form. Misstates
6 the context of the next sentence.

7 THE WITNESS: They were -- right.

8 BY MR. CHUNG:

9 Q. Well, that's -- my question is, is it
10 incorrect that they were given failing or near
11 failing grades?

12 A. They were given Ds and Fs.

13 Q. Okay. Is it correct that, for at least
14 some of the metrics -- right? -- I'm not --
15 again, I'm not reading from the answer here.

16 Is it correct that, at least for certain
17 of the metrics, they were -- the hospitals here
18 were given imputed scores?

19 A. That's not what this says.

20 Q. Yeah. But I'm --

21 A. There were four metrics that are subject
22 to imputation in a well-described and

1 well-thought-through process, and it is not only
2 the reason why they get Ds and Fs. And that's
3 how this is recklessly written. It is not an
4 accurate characterization at all of what happened
5 with the hospital safety grade and why these
6 hospitals did poorly on it.

7 Q. Okay. So paragraph 59, just a couple
8 down, about Delray Medical Center.

9 You would -- I think -- Leapfrog admits
10 that Leapfrog assigned Delray Medical Center the
11 F grade, right?

12 A. Yes.

13 Q. But the denial is, under its flawed
14 technology [sic], TLG assigned Delray Medical
15 Center the lowest possible score on multiple
16 criteria for which TLG had no information,
17 including handwashing -- these are the imputed
18 metrics, right?

19 A. Right.

20 Q. All right. So what is -- is it incorrect
21 that TLG assigned Delray Medical Center the
22 lowest possible score on these four imputed

1 metrics?

2 MS. BLAIR: Object to form.

3 THE WITNESS: The objection -- or the
4 denial would be around the line "to which TLG had
5 no information" and --

6 BY MR. CHUNG:

7 Q. Well, isn't it true -- Ms. Binder, isn't
8 it true that, for those four metrics -- right? --
9 the imputed metrics, TLG did not have data with
10 respect to those four imputed metrics? Isn't
11 that correct?

12 A. We have imputed data. And our imputed
13 data we stand behind.

14 Q. What is the imputed data? Is it the
15 score --

16 A. The score. The imputed score is based on
17 our experience and knowledge and the expert panel
18 recommendation. So it's based on that.

19 And -- so we would say that it is not
20 based on nothing, which is what this --

21 Q. Okay. But --

22 A. -- is sort of claiming.

1 Q. All right. So you're calling the scores
2 themselves data; is that right?

3 A. It's information. This says we had no
4 information. Imputed scores are information, and
5 they're based on -- they're based on thoughtful
6 consideration.

7 Q. In other words, are you saying that the
8 scores, the imputed scores here, the lowest
9 available scores, are based on the scores?

10 MS. BLAIR: I'll object to form.

11 BY MR. CHUNG:

12 Q. Is that what you're saying?

13 A. They're -- no. Scores are -- well, that
14 would be sort of circular reasoning to say the
15 scores are based on scores.

16 Q. That's what I take you to mean. So what
17 do you mean? You said that --

18 A. That imputed scores are information, and
19 that we came to those scores through a process
20 that is fundamentally thoughtful and informed.

21 Q. Okay. But are those scores based on any
22 data that TLG received from the hospital or from

1 any secondary sources?

2 A. It's not based on data we got from the
3 hospital, but it's not based on no information,
4 which is what this states.

5 Q. Okay. Paragraph 88. It reads that this
6 has directly caused -- that Leapfrog's messaging
7 around the safety grades has directly caused
8 plaintiffs harm to their reputation and good
9 will.

10 Do you deny that the D and F grades that
11 were assigned to the plaintiff hospitals have
12 damaged the reputation of the hospitals?

13 A. Those hospitals performed so poorly in so
14 many ways that I could never isolate it to just
15 Leapfrog.

16 Q. So are you denying it?

17 MS. BLAIR: Objection.

18 THE WITNESS: We've denied it.

19 BY MR. CHUNG:

20 Q. Okay. And that's the basis for your
21 denial; is that correct?

22 A. That it's impossible to know whether it's

1 Leapfrog or just other elements of the poor
2 performance of these hospitals --

3 Q. Okay.

4 A. -- that would cause them harm to their
5 reputation and good will which -- I haven't seen
6 evidence, but if there is evidence of that, which
7 there could be, that there's harm to their
8 reputation, it would be impossible -- or at least
9 I haven't seen any evidence or any way of
10 isolating that to Leapfrog.

11 Q. Okay. But would it be fair to say that,
12 just standing alone, that an F grade to a
13 hospital could negatively impact the reputation
14 of that hospital?

15 A. Yeah. It could, if it -- but it would
16 especially harm their reputation if they also had
17 one star or they had a bad press report --

18 Q. I'm just talking about a Leapfrog
19 F grade. I'm not talking about other measures.

20 A. It -- yeah, it could. I guess it could.

21 Q. Okay.

22 A. But it would be very hard to point that

1 out in a hospital that has other problems with
2 their safety performance and their quality.

3 Q. Let's go to -- has Leapfrog communicated
4 with any federal or state government agencies in
5 relation to this litigation?

6 A. We are in -- we are in communication with
7 CMS frequently on various topics. There is a
8 liaison to our board who is --

9 Q. My question is --

10 A. So --

11 Q. So with CMS, any communications with CMS
12 relating to this litigation, is my question.

13 A. I was trying to answer it.

14 Q. Right. I'm trying to get to the point.

15 So any questions --

16 A. I was right at that point, and then you
17 interrupted me. So --

18 Q. Okay.

19 A. All right? We have a liaison to our
20 board. Her name is Michelle Schreiber. She is
21 the director of quality programs at CMS. And so
22 she's been to the board meetings and she's fully

1 briefed on the lawsuit.

2 Q. Okay. Any -- and what's been the purpose
3 of those briefings?

4 A. To brief the board. As I said earlier,
5 I've briefed the board on -- well, with counsel
6 present, we have briefed the board on this
7 lawsuit.

8 Q. Okay. Has Leapfrog paid to lobby any
9 federal or state or local governments in relation
10 to this litigation?

11 A. No.

12 Q. No? Okay. Have you been involved in the
13 public relations aspect of Leapfrog's response to
14 this lawsuit?

15 A. Yes.

16 Q. All right. And in what capacity have you
17 been involved in the response?

18 A. I've been on the team within Leapfrog
19 that has worked with -- has worked on the
20 response to the lawsuit, starting when it was
21 filed.

22 Q. Okay.

1 MR. CHUNG: Let's go to tab 57. This
2 will be Exhibit 38.

3 (Binder Deposition Exhibit 38 marked for
4 identification and attached to the
5 transcript.)

6 BY MR. CHUNG:

7 Q. And you'll see here it's an e-mail thread
8 forwarded from Lauren Bailey to Karen Jupiter
9 sharing a thread she had with you.

10 Do you see that?

11 A. Yes.

12 Q. And you wrote, Let's make a goal to have
13 one story at a minimum every three days about
14 Tenet or one of the hospitals.

15 Do you see that?

16 A. Yes.

17 Q. All right. And why did you make that a
18 goal?

19 A. Because the plaintiff hospitals'
20 representative, who's one of your attorneys at
21 Gibson Dunn, had been all over the media in that
22 particular community telling falsehoods about

1 Leapfrog, and it was necessary for us to become
2 involved in having a voice in the media in that
3 local community, given that these falsehoods were
4 being thrown about in a very reckless way.

5 Q. And was part of that -- part of that
6 strategy of having one story at minimum every
7 three days about Tenet or one of the hospitals,
8 what were those stories going to be about?

9 A. Patient safety.

10 Q. Well, about Tenet or one of the
11 hospitals. Right? You specifically said that
12 you want to have one story at a minimum every
13 three days about Tenet or one of the plaintiff
14 hospitals. Right?

15 A. Uh-huh.

16 Q. So what about Tenet or the plaintiff
17 hospitals were you directing these stories to be
18 about?

19 A. Well, I wasn't saying what they
20 necessarily should be about, but with regard to
21 the hospitals, it would be about their
22 performance on different parts of their safety

1 grade or patient safety.

2 Q. Right. So the idea here was to have one
3 story at minimum every three days, a negative
4 story about Tenet or one of the plaintiff
5 hospitals; is that correct?

6 A. A story that would point out the record
7 on patient safety and/or respond to the
8 continuous series of lies, frankly, coming out
9 from the plaintiff hospitals and the
10 representative -- the lawyer representing them.

11 Q. But, here, it's specific to Tenet or --
12 or the hospitals, correct?

13 MS. BLAIR: Objection to form. Asked and
14 answered.

15 THE WITNESS: Yeah.

16 BY MR. CHUNG:

17 Q. Okay.

18 A. I mean, that's who's telling the lies, so
19 yes.

20 Q. Okay.

21 MR. CHUNG: So let's turn to
22 Exhibit 84 -- or tab 4, I'm sorry.

1 Okay. So we are going to mark this
2 Exhibit 39.

3 (Binder Deposition Exhibit 39 marked for
4 identification and attached to the
5 transcript.)

6 BY MR. CHUNG:

7 Q. So Ms. Binder, this relatively thick
8 exhibit, I'm going to represent to you that this
9 is a Slack conversation that was produced by
10 CURA Strategies in response to a subpoena that
11 was sent to them.

12 And I want to direct your page -- direct
13 your attention to the page ending Bates 467.
14 Okay.

15 And do you see toward the middle of the
16 page -- Sarah Farinelli, is she at CURA
17 Strategies?

18 A. Yes.

19 Q. Okay. Someone that's working on the
20 public relations for you relating to this -- the
21 lawsuit; is that right?

22 A. She's working -- yes, but also public

1 relations in general for Leapfrog.

2 Q. Okay. And then she sends an article from
3 Bloomberg Law about Leapfrog's motion to dismiss
4 being denied.

5 Do you see that?

6 A. Yes.

7 Q. Okay.

8 MR. CHUNG: And just so you have it,
9 we're going to mark this Exhibit 36, I think.

10 MS. BLAIR: 40.

11 MR. CHUNG: 40, sorry. The article
12 itself.

13 (Binder Deposition Exhibit 40 marked for
14 identification and attached to the
15 transcript.)

16 BY MR. CHUNG:

17 Q. And do you recognize this article? Is
18 this the article that's linked by Ms. Farinelli
19 in the chat?

20 A. I believe so.

21 Q. Okay.

22 A. Looks a little different, but...

1 MS. BLAIR: And for the record, Daniel,
2 this doesn't have a Bates number, but it comes
3 from...

4 MR. CHUNG: It comes from Bloomberg Law.

5 MS. BLAIR: Oh.

6 MR. CHUNG: It's what we printed out.

7 BY MR. CHUNG:

8 Q. So on -- if we continue, Stephanie Wight
9 is another CURA Strategies member; is that right?

10 A. Yes.

11 Q. Okay. And at 7:50, she writes that -- On
12 Leah's e-mail, I agree about having talking
13 points ready, but I don't know about complaining
14 to Bloomberg.

15 Do you see that?

16 A. Yes. I -- I always say to the PR firm
17 that we will not complain or try to get
18 retractions unless it's an extremely serious
19 problem.

20 Q. So what e-mail is -- do you know what
21 e-mail that Stephanie Wight is referring to here?

22 A. No.

1 Q. Okay. Did you want to complain to
2 Bloomberg Law about this article?

3 A. I very much doubt it. My usual statement
4 is only when it's a serious problem.

5 Q. Okay. But you don't remember this
6 specific instance whether you wanted to complain
7 to Bloomberg Law about this article?

8 A. I don't recall, but I don't believe I
9 wanted to.

10 Q. Okay.

11 A. Because it wouldn't be -- I almost never
12 want to.

13 Q. So moving to the next page ending in
14 Bates 468, at the top of the page, Ann writes,
15 The fact that it is Bloomberg, too, I think is
16 influencing her. She wants to hurt Tenet, and to
17 do that, she has to hit them financially.

18 Do you see that?

19 A. Yeah, but I don't know what she's talking
20 about.

21 Q. This doesn't reflect a conversation, any
22 sort of conversations, that you had with

1 CURA Strategies about the public relations
2 strategy?

3 A. No.

4 Q. You didn't want to hurt Tenet?

5 A. I want to make sure that coverage of this
6 is aggressive in defending our integrity and our
7 reputation, but that's not necessarily hurting
8 Tenet.

9 And also --

10 Q. Well, she's specifically calling out
11 Tenet here, right?

12 A. Right. Yeah.

13 Q. And she specifically says she wants to
14 hurt Tenet, and to do that, she has to hit them
15 financially.

16 Do you see that?

17 A. Right. Yeah. I don't --

18 Q. And so do you -- does this reflect
19 discussions you had with CURA about a PR campaign
20 to hurt Tenet financially?

21 A. No. I don't even know how we would do
22 that. So...

1 Q. So where is this coming from?

2 MS. BLAIR: Objection to form.

3 BY MR. CHUNG:

4 Q. These are --

5 A. I don't know where it's coming from. I
6 don't --

7 Q. This --

8 A. This is the first I've seen it. So...

9 Q. These are the public relations
10 professionals that you've hired, correct?

11 A. These are -- this is our PR firm that
12 works with us on variety of news items --

13 Q. Okay.

14 A. -- including when this lawsuit became an
15 issue for us.

16 Q. Did you ask CURA to come up with a plan
17 to hurt Tenet financially as part of the public
18 relations campaign?

19 A. No, that's why I'm puzzled by that line.
20 We certainly did want coverage to be, especially
21 in the South Florida area, to highlight the
22 performance of these hospitals and to defend our

1 reputation against the very --

2 Q. Okay.

3 A. -- very alarming lies that were being
4 told by counsel.

5 Q. Did the decision -- did the judge's
6 decision denying Leapfrog's motion to dismiss
7 somehow influence your public relations strategy
8 at this point?

9 A. No. I mean, other than it's news, so
10 that would influence it.

11 Q. Okay.

12 A. We would be responding to questions from
13 reporters, so we would be announcing it
14 ourselves.

15 Q. All right. How, if at all -- how, if at
16 all, did it change or impact the public relations
17 strategy? I'm talking about the denial of the
18 motion to dismiss.

19 A. We would respond -- I think we probably
20 had inquiries from reporters that we would
21 respond to.

22 Q. Okay. Let's go to tab 67.

1 MR. CHUNG: This will be Exhibit 41.
2 (Binder Deposition Exhibit 41 marked for
3 identification and attached to the
4 transcript.)

5 BY MR. CHUNG:

6 Q. And this is an e-mail from April 29,
7 2025, from a Robert Galvin at Blackstone Group to
8 you, or an e-mail exchange.

9 And in the e-mail exchange you ask
10 Mr. Galvin for Saum Sutaria's e-mail address.

11 Who is -- is Saum Sutaria the CEO of
12 Tenet?

13 A. Yes.

14 Q. All right. And you ask him to provide
15 you with direct contact info for Mr. Sutaria; is
16 that right?

17 A. Yes.

18 Q. And why did you want his direct contact
19 information?

20 A. To reach out to him.

21 Q. About what?

22 A. About -- talking about what can be done

1 to not have this ridiculous, frivolous lawsuit
2 and be more constructive.

3 Q. What did you want to write to him?

4 A. What I just said.

5 Q. That's what you were going -- did you
6 write that to him?

7 A. I believe I did, actually.

8 Q. Okay. What do you recall specifically?
9 I mean, I think you used the word "ridiculous"
10 and "frivolous lawsuit." But what do you recall
11 communicating to Mr. Sutaria?

12 A. I'd have to pull out -- it was a short
13 note that said, I've heard that you contacted
14 Johns Hopkins and -- I was glad to hear that he's
15 working on some patient safety programs at Tenet.
16 And that was it.

17 Q. Okay. So -- you can put that down.

18 I just wanted to ask some just questions
19 going back to -- kind of basic questions about
20 the methodology and the hospital safety grade.
21 So, earlier, when we were going through kind of
22 the chronology of expert panel meetings regarding

1 the methodology, there was discussion among the
2 expert panelists or notes about a bias in favor
3 of non-participating hospitals.

4 Do you recall that type of discussion?

5 MS. BLAIR: Objection to form.

6 THE WITNESS: No.

7 BY MR. CHUNG:

8 Q. Or from the previous -- from the previous
9 versions of the methodology. There was
10 discussion about how, under the previous versions
11 of the methodology, hospitals may be
12 disincentivized from responding to the survey.

13 Do you recall that?

14 A. I think there's discussion of that.

15 Yeah.

16 Q. Right. So would you say that -- so
17 that's -- would you say that another way of
18 putting that is that there was a bias in favor --
19 in those previous methodologies, bias in favor of
20 hospitals that didn't respond to the survey?

21 A. I think that was some of the commentary
22 that we heard when we had --

1 Q. Right.

2 A. -- it for public comment, we heard from
3 hospitals that felt that they were -- we were
4 inflating the score for those four measures for
5 hospitals that -- for no reason, for hospitals
6 that we -- that weren't reporting to the survey.
7 And reporting to the survey is a very high bar
8 and a very hard thing to do so that we should not
9 be inflating their scores.

10 Q. Okay. Doesn't the current methodology,
11 though, the current imputation methodology, raise
12 a bias against non-reporting hospitals?

13 MS. BLAIR: Objection to form.

14 THE WITNESS: I don't believe it does,
15 and neither does our expert panel.

16 BY MR. CHUNG:

17 Q. Okay. Why grade non-participating
18 hospitals at all?

19 A. Because those hospitals -- all hospitals,
20 but those hospitals are caring for thousands,
21 tens of thousands, hundreds of thousands of
22 Americans every day who are entrusting their

1 lives every single -- 24/7 to these hospitals.
2 And people deserve to know how they're doing. So
3 we don't think that we should just exempt some
4 hospitals because they are not transparent.

5 Q. Okay. So transparency is the key here;
6 is that right?

7 MS. BLAIR: Objection to form.

8 THE WITNESS: Consumers having
9 information they need to protect their lives and
10 their families' lives when they are needing
11 hospital care, that's the foremost issue. And
12 transparency allows for that.

13 BY MR. CHUNG:

14 Q. Okay. But is -- just going back to
15 transparency, are Leapfrog's hospital safety
16 grades for these hospitals that didn't
17 participate, are they transparent?

18 A. Extremely so.

19 Q. All right. Well, is there any
20 information on Leapfrog's websites, other than
21 the link to the imputation -- other than the link
22 to the scoring methodology, about what the

1 limited achievement score means?

2 MS. BLAIR: Objection to form.

3 THE WITNESS: Well, the -- I'm -- yeah, I
4 don't understand limited -- limited achievement
5 is not discussed on the hospital safety grade.
6 It is -- it's -- the hospitals are scored on each
7 one of the measures, including those four imputed
8 measures.

9 BY MR. CHUNG:

10 Q. Okay. Didn't --

11 A. Limited achievement is from the survey.

12 Q. Didn't Leapfrog receive public comment in
13 connection with the change in methodology in 2024
14 that the public will not understand nor dig into
15 the methodology of the grades? Are you aware of
16 that public comment?

17 A. Some -- some commenters expressed that.
18 Yes.

19 Q. Okay. And Leapfrog doesn't provide the
20 information necessary to completely --
21 comprehensively understand the methodology,
22 correct? Other than linking to the -- to the

1 scoring methodology; is that right?

2 A. We link --

3 MS. BLAIR: Objection to form.

4 THE WITNESS: No. We link to the scoring
5 methodology in several different places on the
6 Hospital Safety Grade website and we explain in
7 layman's terms to anyone who is looking at any
8 particular hospital how they do on each measure,
9 and that we assign -- we assigned scores when we
10 don't have the data.

11 BY MR. CHUNG:

12 Q. Okay. Do you think the scoring
13 methodology is easy to understand for the layman?

14 A. I think the document on scoring
15 methodology is not that accessible to the average
16 layman, which is why we have translated it
17 into -- or translated the different measures and
18 explaining what they're about and why they matter
19 and how we scored hospitals -- we put that in
20 more layman's language throughout our website.
21 And we give consumers several different ways to
22 comprehend how each hospital did on each one of

1 the measures so the -- you know, the gas gauge,
2 the image, as well as the explanation, which is
3 written in layman's language, et cetera.

4 We have a number of techniques that we've
5 applied, which were originally developed in
6 consultation with a low literacy expert and
7 haven't changed much since then, actually. And
8 those are really aiming to give that high level
9 of transparency and comprehension by the lay --
10 by laypeople.

11 Q. Okay. Is at least one of the reasons
12 Leapfrog grades non-participating hospitals
13 because it affects Leapfrog's revenue; is that
14 right?

15 MS. BLAIR: Objection to form.

16 THE WITNESS: No. The non-participant --
17 non-participating hospitals come in, it costs us
18 money. It's very -- as I said, the survey is
19 expensive. And adding these five plaintiff
20 hospitals would just add to our expenses.

21 BY MR. CHUNG:

22 Q. Okay. Let me put it another way.

1 The accolades licensing program is
2 responsible for -- it is the most significant
3 source of revenue for Leapfrog. We've -- I've
4 asked it a bajillion times. Is that correct?

5 A. That is the highest --

6 Q. Yes.

7 A. That is the highest source of revenue --

8 Q. Okay.

9 A. -- for us right now.

10 Q. Okay. And are you worried that, if you
11 don't give -- if you do not give
12 non-participating hospitals a grade, if you allow
13 them to, say, opt out -- right? -- fewer
14 hospitals will participate in the survey; isn't
15 that correct?

16 MS. BLAIR: Objection to form.

17 THE WITNESS: Non-participating -- to opt
18 out of what?

19 BY MR. CHUNG:

20 Q. Opt out of the survey and therefore not
21 get a grade.

22 MS. BLAIR: Objection to form.

1 THE WITNESS: They get a grade.

2 BY MR. CHUNG:

3 Q. Well, if you do not give -- let's put it
4 another way.

5 If you do not give non-participating
6 hospitals a grade, aren't you concerned that
7 fewer hospitals will participate in the survey?

8 A. At -- that's not the primary concern.
9 The primary concern is we're not meeting our
10 mission, which is to give people information --

11 Q. I --

12 A. -- they deserve to know.

13 Q. But I'm asking, is it as -- let's say, is
14 it a concern that fewer hospitals will
15 participate in the survey if you do not give
16 non-participating hospitals a grade?

17 MS. BLAIR: Objection to form.

18 THE WITNESS: That's not the primary
19 concern. I don't even think that is a concern.

20 BY MR. CHUNG:

21 Q. You're testifying that it's not a concern
22 at all?

1 A. That non-participating hospitals, if we
2 didn't give them a grade, that would reduce --
3 you're saying we're supposed to be worried that
4 would -- the --

5 Q. Fewer hospitals will respond to the
6 survey; isn't that a concern?

7 MS. BLAIR: Objection to form. Asked and
8 answered.

9 THE WITNESS: I don't know. I hadn't
10 thought of it that way, so I don't know.

11 BY MR. CHUNG:

12 Q. Okay. Well, at the very least, are you
13 concerned that, if you do not give
14 non-participating hospitals a grade, the number
15 of hospitals that respond to the survey won't
16 increase?

17 A. This is not what keeps me up at night.
18 That's not what I'm --

19 Q. I'm just asking you --

20 A. -- worried about.

21 Q. If you could just answer the question.
22 I'm not asking you what keeps you up at night.

1 I'm asking --

2 MS. BLAIR: Well, you're asking what
3 she's concerned about, so I think that's an
4 answer.

5 THE WITNESS: It's not a prevailing
6 concern.

7 BY MR. CHUNG:

8 Q. Is it a concern at all?

9 A. Anything that impacts full transparency
10 for every hospital in the country is a great
11 concern to me.

12 Q. All right. If there is -- Ms. Binder, if
13 there is a significant drop, a decrease in the
14 number of hospitals that participate in the
15 survey, would that negatively impact Leapfrog's
16 brand?

17 A. I don't know. We've -- before we had the
18 safety grade at all, we had 1300, 1400 hospitals
19 participating. So -- and we had a pretty
20 significant brand reputation then.

21 So that's not something I've worried
22 about.

1 Q. But I think you testified earlier, and we
2 saw some of the -- kind of the self-evaluation
3 documents that, during your time as CEO, that
4 your -- through your efforts as CEO, that the
5 brand -- right? -- and the reputation of Leapfrog
6 has increased over time, correct?

7 A. I don't recall the precise wording I
8 used --

9 Q. Right.

10 A. -- but the impact and influence of
11 Leapfrog to advance patient safety has shown --
12 has grown significantly, and that has resulted in
13 some improvements in some national statistics on
14 patient safety incidents.

15 Q. Okay. So if you had much fewer -- let's
16 say that the number of hospitals that respond to
17 the survey went from -- right now I think it's
18 close to 3,000, right, or thereabouts?

19 A. No. 2400.

20 Q. 2400. Right. Let's say it went down to
21 1,000 hospitals.

22 Does that -- would that impact kind of

1 the breadth and the brand of Leapfrog?

2 MS. BLAIR: Objection to form.

3 THE WITNESS: I don't know. It would
4 certainly impact patient safety and it would
5 undermine transparency. It would be a major step
6 backward for the country.

7 BY MR. CHUNG:

8 Q. If fewer hospitals were responding to the
9 survey, would that decrease or impair the
10 relevance of Leapfrog as an institution?

11 MS. BLAIR: Objection to form. Asked and
12 answered.

13 MR. CHUNG: That's a different question.

14 MS. BLAIR: Oh -- that is what reputation
15 is, isn't it?

16 MR. CHUNG: Please.

17 THE WITNESS: Leapfrog's relevance is
18 very, very high, and we are a high-profile
19 organization, extremely high profile. So I don't
20 see that participation in the survey, per se, is
21 the source of that. We are -- our influence is
22 broad and it's not just on the survey.

1 BY MR. CHUNG:

2 Q. If Leapfrog becomes less relevant because
3 of fewer hospitals responding to the survey,
4 would it be fair to say that fewer hospitals
5 would be willing to pay for accolade licensing?

6 MS. BLAIR: Objection to form.

7 THE WITNESS: I -- I don't know.

8 BY MR. CHUNG:

9 Q. Okay. If Leapfrog's brand goes down or
10 if it becomes less relevant, is it fair to say
11 that fewer hospitals would pay to -- pay to
12 license the survey data from Leapfrog?

13 MS. BLAIR: Objection to form.

14 THE WITNESS: We have not seen a --
15 licensure revenues tied to the number of
16 hospitals reporting to the survey.

17 BY MR. CHUNG:

18 Q. Okay. Would you say that if fewer
19 hospitals -- if fewer hospitals responded to the
20 survey -- if there was a dramatic drop in the
21 number of hospitals that responded to the survey,
22 would you say that donations might go down?

1 Donations to Leapfrog.

2 A. No, no. Those could potentially go up
3 because people would be so outraged.

4 Q. If it becomes -- if Leapfrog becomes less
5 relevant if its brands go down, would you expect
6 donations to go down or up?

7 A. If Leapfrog becomes less relevant?

8 Q. Yeah.

9 A. I don't know how that would happen, so
10 it's hard for me to answer that question.

11 Q. Okay. Now, in terms of -- we read some
12 e-mails involving Dr. Romano where he was
13 discussing the -- kind of the aim or the
14 possibility of the new imputation methodology
15 penalizing hospitals.

16 Do you remember that discussion in the
17 e-mails?

18 A. Uh-huh. Yes.

19 Q. Are you -- it's -- would you say -- kind
20 of basic question: Is keeping -- is increasing
21 or at least maintaining Leapfrog's brand and
22 reputation an important part of your role as CEO?

1 A. It's very important that we maintain the
2 reputation and the trustworthiness of Leapfrog.

3 Q. Right.

4 A. Very, very critical.

5 Q. Okay. And part of that reputation and
6 the brand is having as many hospitals participate
7 in the survey as possible, correct?

8 MS. BLAIR: Objection to form. Asked and
9 answered.

10 THE WITNESS: That's really not the
11 centerpiece of our reputation. Our reputation is
12 wide -- has a wide breadth.

13 BY MR. CHUNG:

14 Q. But -- actually, I think one of the first
15 things that we discussed in the deposition is
16 that it's your wish, or the organization's wish,
17 to have as many, ideally all hospitals,
18 participate in the survey, correct?

19 A. Oh, sure. Yes, that would be great. But
20 that's -- you asked me if it's tied to our
21 reputation or our trustworthiness. And what I'm
22 saying is our reputation and trustworthiness are

1 tied to a lot more factors than just the number
2 of hospitals that participate in the survey.

3 Q. Okay.

4 A. Far beyond that.

5 Q. Is Leapfrog willing to penalize hospitals
6 in order to encourage them to participate in the
7 survey?

8 A. No.

9 Q. Okay. So your testimony is that that was
10 not at least one of the purposes of the change in
11 imputation methodology?

12 A. No, we don't set out to penalize
13 hospitals. Our goal is to get them to improve.

14 Q. Okay. And that's notwithstanding one --
15 a member of your expert safety panel, Patrick
16 Romano, saying in an e-mail that a goal or a
17 purpose of the change in the imputation
18 methodology was to penalize non-participants,
19 correct?

20 MS. BLAIR: Objection to form.

21 THE WITNESS: I believe the wording was
22 something like, if you want to do this, blah,

1 blah, blah. And it's also his opinion, whatever
2 his opinion is. He said if you want to do that.

3 That is not our goal.

4 BY MR. CHUNG:

5 Q. Okay. So you disagree with what
6 Dr. Romano was writing in that e-mail?

7 A. I disagree with -- well, he said, if you
8 believe -- blah, blah, blah, so he didn't
9 actually express an opinion about what we do
10 believe. He just said, if you believe that.

11 We don't.

12 Q. Okay.

13 A. Our goal is not to penalize hospitals,
14 though. Our goal is to create a marketplace
15 where everybody can succeed and do better.

16 Q. Okay. And the -- let's go to -- in terms
17 of the methodology -- I wanted to go back to a
18 couple questions about the imputation
19 methodology.

20 MR. CHUNG: Let's go to 103. So this is
21 Exhibit 42.

22

1 (Binder Deposition Exhibit 42 marked for
2 identification and attached to the
3 transcript.)

4 BY MR. CHUNG:

5 Q. Okay. So Ms. Binder, you're familiar
6 with -- and we've -- with step 1 and step 2 of
7 Leapfrog's current imputation methodology,
8 correct?

9 A. Yes.

10 Q. Okay. And let's take a look at kind of
11 an example here.

12 I'm showing you -- this doesn't have a
13 Bates stamp. We just took it directly, a
14 screenshot, from hospitalsafetygrade.org.

15 A. Uh-huh.

16 Q. And you'll see that the grade for Hilo
17 Benioff Medical Center here, it's a C grade,
18 right?

19 A. Yes.

20 Q. Okay. And if you look under the
21 practices to prevent errors tab, under notes and
22 definitions, it says, Declined to report.

1 Do you see that?

2 A. Yes.

3 Q. Okay. So is it correct that we know,
4 based on that, that this was a hospital that did
5 not participate in the survey?

6 A. Prob- --

7 MS. BLAIR: Objection to form.

8 THE WITNESS: Probably. But --

9 BY MR. CHUNG:

10 Q. Okay.

11 A. Or it could have been that they just
12 didn't respond to that one question.

13 Q. Can you tell me whether the step 1 or
14 step 2 imputation was used for this particular
15 hospital?

16 A. I don't know that offhand.

17 Q. Okay. So there's no explanation here for
18 whether this particular hospital had the
19 historical data or the lowest achievement score
20 imputed to them, right?

21 A. Well, you've -- you didn't copy the
22 whole -- what parts did you copy?

1 Oh, so you're --

2 Q. Yeah. Can you tell --

3 A. Because --

4 Q. -- from what's on the web --

5 A. -- of the way this is Xeroxed, I'm trying
6 to understand what this -- which screenshot you
7 have.

8 You have the CPOE measure, it looks like,
9 doctors' order. And then we have -- they got a
10 score of 40, and a score was assigned. So that
11 must have been step 1.

12 Q. How do you tell that step 1 was assigned
13 here?

14 A. Because a 40 is a score that would be
15 associated with step 1.

16 Q. Okay. How is that?

17 A. Because it's not -- it wouldn't -- it's
18 not a 15, which would be the -- if we didn't have
19 any step 1 data from the past two cycles.

20 Q. Okay. How can a consumer tell, though,
21 from this webpage that it's 1, step 1?

22 A. They -- it doesn't matter. This is -- it

1 says --

2 Q. The question --

3 A. -- the hospital declined to report their
4 performance on this measure, so a score was
5 assigned to reflect the lack of information
6 available.

7 Q. Okay. So -- Ms. Binder, my question is,
8 how can a consumer tell that Hilo Benioff was
9 assigned the score here based on step 1?

10 A. They don't -- there's no need for them to
11 know which step or whatever. It's -- they can
12 look it up on the methodology, which is linked to
13 in many places. But it --

14 Q. Okay. So -- but you can't --

15 A. We tell them that a score was assigned --

16 Q. Okay. But a consumer --

17 A. -- and it's in bold red.

18 Q. -- cannot tell from this page, again,
19 without linking to the -- looking at the
20 imputation methodology, whether it was step 1 or
21 step 2; is that correct?

22 A. They can tell that a score was assigned

1 to reflect the lack of information available --

2 Q. Okay.

3 A. -- which is true.

4 Q. Let's go to the next exhibit.

5 MR. CHUNG: This is 43.

6 (Binder Deposition Exhibit 43 marked for
7 identification and attached to the
8 transcript.)

9 BY MR. CHUNG:

10 Q. Again, this is from the webpage for the
11 Hilo Benioff Medical Center, the survey measures.
12 So let's take a look at the breakdown of the
13 sources used to calculate Hilo's safety grade.

14 I'm showing you a screenshot from, again,
15 hospitalsafetygrade.org that shows the measures
16 used to calculate Hilo's safety grade.

17 And if you review this document, it says,
18 Imputation model applied for ceratin of the
19 measures.

20 Do you see that?

21 A. Yes.

22 Q. Okay. Is there any way here -- again,

1 for the consumer -- right? -- to know whether
2 step 1 or step 2 was used for those scores?

3 A. This chart is aimed at --

4 Q. So Ms. Binder, I'm just going to bore you
5 to the question.

6 Can a consumer, looking at the webpage
7 here -- again, hospitalsafetygrade.org website,
8 which you testified is intended for consumers --
9 correct? Low literacy consumers, correct?

10 MS. BLAIR: Objection to form. That's
11 not her testimony.

12 BY MR. CHUNG:

13 Q. Yes or no?

14 A. The website is intended to be accessible
15 to laypersons.

16 Q. Yes. Is there -- to that layperson, to
17 the consumer, is there any way, looking at this
18 page, for them to know whether this is -- whether
19 step 1 or step 2 was used for the scores for the
20 Hilo Medical Center?

21 A. I don't think so.

22 Q. Okay. And it's only if you -- if one

1 were to link to and read the methodology document
2 that you might start to be able to parse how the
3 hospital is scored, right?

4 MS. BLAIR: Objection to form.

5 THE WITNESS: They're scored by
6 imputation.

7 BY MR. CHUNG:

8 Q. Right.

9 A. We make it quite clear that it was an
10 imputation model.

11 Q. Right.

12 A. The fact that this chart is not specific
13 about how that was applied, specifically step 1
14 or step 2, is one thing. But you don't need to
15 go into every detail on every single chart.

16 Q. But in order for the consumer to be
17 informed about whether step 1 or step 2 of the
18 imputation methodology was applied, they would
19 then have to go to the scoring methodology,
20 correct?

21 A. Yes.

22 Q. Right. And I think you testified earlier

1 that the scoring methodology is -- and you can
2 correct me on the verbiage here -- is not -- is
3 not the easiest thing to understand, correct?

4 MS. BLAIR: Objection to form.

5 THE WITNESS: It's -- the scoring
6 methodology document is written in a way that is
7 aimed at somewhat knowledgeable hospital people.

8 BY MR. CHUNG:

9 Q. Not meant for kind of the consumers that
10 the hospitalsafetygrade.org website was designed
11 for, correct?

12 A. Right. The hospitalsafetygrade.org
13 was -- that website was designed to inform
14 consumers of when imputation -- well, of
15 everything we use to calculate grades, including
16 imputation, which is --

17 Q. Okay.

18 A. -- plainly and transparently conveyed.

19 Q. Okay.

20 MR. CHUNG: Why don't we take a short
21 break. All right?

22 How much time do we have left?

1 VIDEO TECHNICIAN: The time is 6:19 p.m.
2 We're off the record.

3 (A recess was taken.)

4 VIDEO TECHNICIAN: The time is 6:28 p.m.
5 We're on the record.

6 BY MR. CHUNG:

7 Q. Ms. Binder, during your time as CEO of
8 Leapfrog, did at any point Leapfrog consider not
9 issuing hospital safety grades to hospitals that
10 did not respond to the survey?

11 A. No.

12 Q. So that was never an option that was ever
13 discussed?

14 A. No.

15 Q. All right. Was it ever an agenda item?

16 A. Not to my knowledge.

17 Q. All right. Is it an option or a proposal
18 that any member of the Leapfrog staff, executives
19 or otherwise, ever mentioned?

20 A. Not that I recall. The purpose of the
21 safety grade was specifically to expand
22 transparency.

1 Q. So your testimony is that no one at
2 Leapfrog ever even mentioned the possibility or
3 the option of not issuing hospital safety grades
4 to non-participating hospitals; is that your
5 testimony?

6 A. To my knowledge. That -- to my
7 knowledge, nobody discussed that. The purpose of
8 the grade was to -- was for full transparency.

9 Q. Okay. How about members of the expert
10 panel? Is there any -- anyone ever mention the
11 possibility of not issuing grades to
12 non-participating hospitals?

13 A. Again --

14 MS. BLAIR: Objection to form.

15 THE WITNESS: -- not to my knowledge.

16 BY MR. CHUNG:

17 Q. Not to your knowledge. Okay. How about
18 members --

19 A. I don't go to all their meetings, but --

20 Q. Members of the board?

21 A. No. That was never discussed at the
22 board meetings either, that I can recall, anyway.

1 Q. Okay. If the plaintiff -- the five
2 plaintiff hospitals in this lawsuit were to
3 prevail -- right? -- and Leapfrog had to take
4 down their grades, their hospital safety grades,
5 what would be the harm to Leapfrog?

6 MS. BLAIR: To Leapfrog?

7 MR. CHUNG: To Leapfrog. Yes.

8 THE WITNESS: We would undermine our
9 mission, which is full transparency for
10 hospitals. Other hospitals would also see that
11 we are willing to pull down grades for some
12 hospitals and they'd say, what about us too?

13 BY MR. CHUNG:

14 Q. And so that would be the harm to
15 Leapfrog, correct?

16 MS. BLAIR: Objection to form.

17 THE WITNESS: It's a harm to our mission.

18 BY MR. CHUNG:

19 Q. Right. And if other hospitals asked to
20 pull down their grades -- right? -- from -- their
21 hospital safety grades, that would -- that would
22 harm Leapfrog, correct?

1 MS. BLAIR: Objection to form.

2 THE WITNESS: It would harm the public.

3 BY MR. CHUNG:

4 Q. I'm asking, would it harm Leapfrog? I'm
5 not asking about would it harm the public.

6 A. It would harm our mission. It would harm
7 our ability to achieve our mission. It would be
8 a setback.

9 Q. All right. And it would be a setback
10 because fewer hospitals, then, would be issued
11 hospital safety grades, correct?

12 A. It would be a setback because there would
13 be less transparency, and there would be whole
14 communities in this country that would not have
15 access to information about how their hospital is
16 doing on safety.

17 Q. I'm asking about the impact on
18 Leapfrog -- right? Not the public. All right?

19 So the harm -- the impact here would be
20 fewer hospitals would be participating in the
21 survey, correct?

22 MS. BLAIR: Objection to form.

1 THE WITNESS: I don't know about the
2 survey, per se. That would -- I would have to
3 think about what impact it would have on the
4 survey.

5 BY MR. CHUNG:

6 Q. Okay.

7 A. But in terms of pulling down these five
8 hospitals' grades, it would just be harmful to
9 that community that they serve. And then other
10 hospitals who felt that somehow it was a good
11 idea that Leapfrog would pull down -- would make
12 exceptions and pull down grades for hospitals
13 that don't like them, that would undermine the
14 whole cause of transparency and public reporting
15 and fairness, which we believe in for hospitals.

16 Q. Isn't the concern -- I mean, isn't the
17 concern here is that if -- just hypothetically,
18 if the plaintiff hospitals in this case
19 prevailed, that it would basically create a
20 domino effect where many, many hospitals, maybe
21 all hospitals, would ask to have their grade
22 taken down? Is that your concern?

1 A. I guess so. Yeah, that would be a
2 problem. That would certainly be one concern.

3 Q. Right. And that would be a concern for
4 the mission, correct? Right?

5 A. Right --

6 Q. And --

7 A. -- for the mission of patient safety and
8 transparency.

9 Q. And that would be a problem for the
10 bottom line for Leapfrog, correct?

11 MS. BLAIR: Objection to form.

12 THE WITNESS: No.

13 BY MR. CHUNG:

14 Q. So you would be able to generate revenue?
15 Would you be able to generate revenue if there
16 was a domino effect of hospitals just choosing
17 not to participate in the -- in the survey and
18 taking down their grades?

19 A. From a revenue perspective, the survey is
20 a cost to us. So it would just be less cost if
21 fewer hospitals reported, from a purely financial
22 point of view. It would just be harmful to our

1 mission, and that is the most important thing to
2 us.

3 Q. All right. Well, the accolades licensing
4 program, which is the most significant source of
5 revenue, would suffer, correct?

6 MS. BLAIR: Objection to form.

7 THE WITNESS: No. Unlikely to suffer.
8 The number of A-hospitals has remained fairly
9 steady because we score it on a C-score
10 methodology. And therefore, the sales to
11 A-hospitals could continue.

12 BY MR. CHUNG:

13 Q. Well, would you expect if a hospital, in
14 response to, again, a hypothetical result in this
15 lawsuit, would take their -- would no longer
16 participate in the survey and take their grades
17 down, are you concerned that even the A-grade
18 hospitals would follow suit and not devote
19 resources to completing the survey? Is that a
20 concern?

21 MS. BLAIR: Objection to form.

22 THE WITNESS: No, it's not a concern.

1 MR. CHUNG: Okay. No further questions.
2 Thank you.

3 MS. BLAIR: Excellent. Thank you.

4 THE WITNESS: Thank you.

5 VIDEO TECHNICIAN: The time is 6:34 p.m.
6 We're off the record.

7 (Whereupon at 6:34 p.m., the videotaped
8 deposition of LEAH F. BINDER was
9 concluded.)

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CERTIFICATE OF NOTARY PUBLIC

I, CHRISTINA S. HOTSKO, the officer before whom the foregoing deposition was taken, do hereby certify that the witness whose testimony appears in the foregoing deposition was duly sworn by me; that the testimony of said witness was taken by me in stenotypy and thereafter reduced to typewriting under my direction; that said statement is a true record of the proceedings; that I am neither counsel for, related to, nor employed by any of the parties to the action in which this statement was taken; and, further, that I am not a relative or employee of any counsel or attorney employed by the parties hereto, nor financially or otherwise interested in the outcome of this action.



CHRISTINA S. HOTSKO

Notary Public in and for the
District of Columbia

My commission expires:

1 January 2027

Good Samaritan Medical Center, Et Al v The Leapfrog Group
Leah Binder Job No. 7574666

E R R A T A S H E E T

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Leah Binder

Date

1 Good Samaritan Medical Center, Et Al v The Leapfrog Group
2 Leah Binder 7574666

3 ACKNOWLEDGEMENT OF DEPONENT

4 I, Leah Binder, do hereby declare that I
5 have read the foregoing transcript, I have made any
6 corrections, additions, or changes I deemed necessary as
7 noted above to be appended hereto, and that the same is
8 a true, correct and complete transcript of the testimony
9 given by me.

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12 Leah Binder

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Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

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THE ABOVE RULES ARE CURRENT AS OF APRIL 1, 2019. PLEASE REFER TO THE APPLICABLE FEDERAL RULES OF CIVIL PROCEDURE FOR UP-TO-DATE INFORMATION.

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Exhibit 88

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA
WEST PALM BEACH DIVISION

- - - - - x
GOOD SAMARITAN MEDICAL :
CENTER, INC., et al., :
Plaintiffs, : Case No.
v. : 9:25-CV-80526-DMM
THE LEAPFROG GROUP, :
Defendant. :

- - - - - x

Wednesday, September 12, 2025

Washington, D.C.

Videotaped Deposition of:

ALEXANDRA CAMPIONE,
called for oral examination by counsel for the
Plaintiffs, pursuant to notice, at the law offices of
Gibson Dunn & Crutcher, LLP, 1700 M Street,
Northwest, Washington, D.C. 20036-4504, before
Christina S. Hotsko, RPR, CRR, CA CSR, of Veritext
Legal Solutions, a Notary Public in and for the
District of Columbia, beginning at 9:09 a.m., when
were present on behalf of the respective parties:

A P P E A R A N C E S

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Chicago, Illinois 60601

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Also Present:

Orson Braithwaite, Video Technician

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* (Exhibits attached to transcript.)

P R O C E E D I N G S

VIDEO TECHNICIAN: Good morning. We are going on the record at 9:09 a.m. on September 12th, 2025.

Please note that the microphones are sensitive and may pick up whispering and private conversations.

Please mute your phones at this time. Audio and video recording will continue to take place unless all parties agree to go off the record.

This is media unit 1 of the video-recorded deposition of Ms. Alexandra Campione, in the matter of Good Samaritan Medical Center, Inc., et al., versus The Leapfrog Group, filed in the United States District Court for the Southern District of Florida, West Palm Division, case number 9:25-CV-80526-DMM.

My name is Orson Braithwaite representing Veritext Legal Solutions, and I am the videographer. The court reporter is Christina Hotsko from the firm Veritext Legal Solutions.

1 Counsel will now state their appearances
2 and affiliations for the record, beginning with
3 the noticing attorney.

4 MR. CRAIN: Good morning. Lee Crain,
5 Gibson Dunn & Crutcher, for the plaintiffs. I'm
6 here with my colleague Iason Toggias.

7 MS. BLAIR: Kim Blair, Wilson Elser, on
8 behalf of Leapfrog, the defendant.

9 MS. WOOD: Courtney Wood, Wilson Elser,
10 on behalf of the defendant, Leapfrog.

11 VIDEO TECHNICIAN: Thank you. Will the
12 court reporter please swear in the witness.
13 Whereupon,

14 ALEXANDRA CAMPIONE,
15 being first duly sworn or affirmed to testify to
16 the truth, the whole truth, and nothing but the
17 truth, was examined and testified as follows:

18 EXAMINATION BY COUNSEL FOR PLAINTIFFS

19 BY MR. CRAIN:

20 Q. Good morning.

21 A. Good morning.

22 Q. Can you state your name for the record.

1 A. Alexandra Campione.

2 Q. Have you ever gone by any other names?

3 A. My marriage certificate has Russo, but I
4 have not officially changed things.

5 Q. Have you been deposed before?

6 A. No, I have not.

7 Q. So I'd like to go over just some ground
8 rules so we're on the same page throughout the
9 day.

10 You understand that there's a court
11 reporter transcribing every question I ask and
12 answer you give, correct?

13 A. Yes.

14 Q. And because the court reporter can't
15 transcribe us at the same time, we have to go
16 slightly slower in our conversation, pause. And
17 so I'd ask that you wait for me to finish the
18 question, I'll wait for you to finish the answer
19 so the court reporter can take down what we're
20 saying.

21 Does that make sense?

22 A. Yeah.

1 Q. You'll need to answer audibly. So
2 nodding -- it will need to be a yes or no type
3 answer. Does that make sense to you? Fair
4 enough?

5 A. Yes.

6 Q. You understand that you're testifying
7 under oath today as if you were in a court?

8 A. Yes.

9 Q. And are you taking any medications or are
10 you under the influence of any substance which
11 might make it difficult for you to understand or
12 answer my questions today?

13 A. No.

14 Q. Is there any reason why you can't give
15 truthful testimony today?

16 A. No.

17 Q. If you don't understand one of my
18 questions, if something is confusing to you, feel
19 free to let me know. But otherwise, I'm going to
20 assume that you understand the question. Is that
21 fair to you?

22 A. Okay.

1 Q. And then from time to time, your attorney
2 may object. I assume she has talked to you about
3 that. If she objects, unless she instructs you
4 to [sic] answer my question, you'll proceed to
5 answer my question. Fair enough?

6 A. Yes.

7 Q. We can take breaks anytime that's
8 comfortable for you. Just let us all know. The
9 only thing we'd ask is that we don't take a break
10 while a question is pending.

11 Fair enough?

12 A. Yes.

13 Q. So Ms. Campione, you've never been
14 deposed before?

15 A. No.

16 Q. Okay. Have you ever testified at all?

17 A. Yes. One time at a criminal case in
18 Boston. Unrelated to me. I was a witness.

19 Q. Can you just tell me generally the nature
20 of your testimony?

21 A. I just testified that I saw someone
22 running away from someplace.

1 Q. So you were a witness to the scene?

2 A. Yes.

3 Q. Did you prepare for your deposition
4 today?

5 A. Yes.

6 Q. What did you do to prepare, without
7 getting into any substance of your discussions
8 with counsel?

9 A. Sure. I reviewed some e-mails and our
10 scoring methodology for the hospital safety grade
11 program.

12 I also met with our attorneys, Ms. Blair
13 and Ms. Wood, twice before today.

14 Q. When did you meet with your attorneys?

15 A. Yesterday and about two weeks ago.

16 Q. And approximately how long were those
17 meetings?

18 A. Maybe like half the day to the day.

19 Q. And did anybody else besides counsel
20 attend those meetings?

21 A. In our first meeting, we had some other
22 staff at Leapfrog.

1 Q. Can you tell me who it was?

2 A. Leah Binder, Missy Danforth. And I
3 can't -- Karen Jupiter. And I can't remember
4 who -- Katie Stewart.

5 Yes. Those are the Leapfrog staff.

6 Q. And the subject of that meeting -- again,
7 without getting into any discussion with your
8 counsel what was said -- the subject was
9 preparation for your deposition?

10 A. Yes.

11 Q. Okay. Was the subject of that meeting
12 also preparation for other folks' depositions?

13 A. For -- sorry, for other people?

14 Q. Correct.

15 A. Yes.

16 Q. Okay. Did you review any documents
17 outside the presence of counsel to prepare for
18 this deposition?

19 A. A few.

20 Q. Can you tell me which documents you
21 reviewed?

22 A. Yes. That was the scoring methodology

1 and some e-mails.

2 Q. And when you say the scoring methodology,
3 what document are you referring to? Just so it's
4 clear.

5 A. The scoring methodology for the hospital
6 safety grade program.

7 Q. Is that the PDF available on the website?

8 A. Yes.

9 Q. So about --

10 A. It's -- it's one PDF, and it's available
11 publicly.

12 Q. And it's about 26, 28 pages?

13 A. That sounds right.

14 Q. Okay. We'll come to it a little later.
15 I just wanted to make sure I understood.

16 Did you speak to anybody about your
17 deposition?

18 A. No.

19 Q. Not a colleague? A family member?

20 A. Well, family members in passing. But
21 Missy Danforth told me maybe a month ago, you're
22 going to be deposed, you'll receive additional

1 information from our attorneys. And that was
2 about it. And then we met on those two
3 occasions.

4 Q. And the first meeting with the other
5 Leapfrog colleagues was about half the day, you
6 said?

7 A. Yes.

8 Q. I'd like to talk a little bit about your
9 professional history.

10 Can you sort of walk me through your jobs
11 after you graduated from whatever your last
12 degree was?

13 A. Sorry --

14 Q. Maybe --

15 A. -- my job --

16 Q. -- let's --

17 A. Further back? Okay.

18 Q. So start with -- did you go to college?

19 A. Yes. I went to the University of
20 Florida, and I double majored in medical
21 geography and biology. I worked in a lab there
22 at the University of Florida. And -- it was kind

1 of medical geography, but it was in the academic
2 setting.

3 So I worked there for a year after
4 college. And then I started my master's program
5 here in D.C. I have a master's in public health
6 from George Washington. That was specialized in
7 epidemiology.

8 During that time, during my master's
9 program here, I worked at D.C. Health in their
10 HIV, infectious disease kind of department.

11 I also did an internship at the NIH in
12 NIAID, which is Institute of Infectious Disease.
13 And I worked on a paper that was later published
14 by me and some of my colleagues there, and at
15 CDC.

16 After graduating, I moved to Boston,
17 where I now live, and I worked for the
18 Massachusetts Department of Public Health as a
19 COVID epidemiologist.

20 And then I moved to Leapfrog in 2023.

21 Q. And so you live in Boston but work for
22 Leapfrog remotely?

1 A. Yes. 2022, sorry, that I started working
2 at Leapfrog.

3 Q. Got it.

4 And just going back to something you
5 said, what is medical geography?

6 A. It's an interesting blend of geography --
7 so using geographic systems with -- like -- it
8 has different applications, but combining that
9 with, like, the medical field.

10 Q. So going back to Leapfrog, you said you
11 started in 2022.

12 A. Yes.

13 Q. How did you hear about the job?

14 A. A recruitment -- sorry, a recruiter
15 reached out to me.

16 Q. Had you heard of Leapfrog before?

17 A. No.

18 Q. And can you tell me, generally, the
19 nature of the application process?

20 A. So I wasn't really looking for a new job,
21 but this recruiter reached out to me. And it was
22 actually a somewhat rigorous process where they

1 had me complete SAS programs and I had to -- they
2 had sort of like a rubric I think they graded me
3 on to make sure that my programming skills were
4 up to their standard.

5 I also had to produce some writing
6 samples and went through a few rounds of
7 interviews.

8 Q. And approximately what time was this?
9 Like, when was this?

10 A. I believe it was early 2023 -- sorry, I
11 keep saying that. 2022, sorry.

12 Q. And did you meet with Ms. Binder during
13 that time?

14 A. No, I did not.

15 Q. Okay. And when you said SAS, that refers
16 to coding?

17 A. Yes. It's a type of program.

18 Q. Can you tell me generally the nature of
19 the job that you were applying for? What were
20 the responsibilities, the job description?

21 A. Sure. So we have some analyst positions
22 at Leapfrog in the ratings team. These analysts

1 are responsible for scoring the data that's taken
2 from hospitals and producing files that are
3 published publicly.

4 It was expressed to us that we would be
5 helping out on their help desk to work with
6 hospitals and would have kind of a -- we would be
7 working in a couple of different capacities.

8 Q. Were you involved in communications?

9 A. No. I don't have any background in
10 communication.

11 Q. You mentioned the ratings team. Who's on
12 that team?

13 A. It's about ten people. It's the largest
14 part of our company. And they are responsible
15 for developing the content of the survey,
16 developing the questions, working with expert
17 panels to ensure that our survey is to the
18 highest quality. And then we also do the scoring
19 as well, and work with hospitals.

20 Q. Is everybody on the team at the same
21 level?

22 A. No. There's some -- some people have had

1 promotions over the years and they're perhaps at
2 the manager level or senior level.

3 Q. Where do you fall in that today?

4 A. It's -- for the analysts, it's a little
5 bit of a different situation. We no longer have
6 a senior analyst, but I was promoted last year to
7 program manager just to -- because I had taken on
8 more responsibilities with the hospital safety
9 grade program, so my title changed slightly.

10 Q. And that was approximately when last
11 year?

12 A. Perhaps April of last year.

13 Q. And last year, 2024, just to be clear?

14 A. Yes.

15 Q. Who do you report to?

16 A. I report directly to Missy Danforth.

17 Q. Has that been the same throughout your
18 time at Leapfrog?

19 A. Yes.

20 Q. Do you have any direct reports to you?

21 A. No.

22 Q. Okay. Going back to your education, do

1 you have any certifications beyond your MPH and
2 your undergrad?

3 A. No.

4 Q. Are you -- would you think of yourself as
5 specialized in any particular way?

6 A. I would say, before this, epidemiology
7 and SAS programming.

8 Q. And just so there's a clear record, what
9 is epidemiology?

10 A. Epidemiology is the spread of -- or the
11 study of disease within the community.

12 Q. When you joined Leapfrog initially, what
13 was your impression of the organization at the
14 start?

15 A. At the time when I first started, I
16 didn't know very much about patient safety in the
17 field. But it was an exciting company to be a
18 part of because it seemed like there was a high
19 retention, where people had been there a really
20 long time, and they enjoyed what they did. So I
21 was excited to be joining.

22 Q. And what did you understand Leapfrog's

1 purpose to be?

2 A. To increase awareness around patient
3 safety and to improve patient safety in hospitals
4 and surgery centers.

5 Q. So I want to shift gears a little bit.
6 Let's talk about the hospital safety grade.

7 Do you understand what I mean when I say
8 the hospital safety grade?

9 A. I do.

10 Q. What is the hospital safety grade?

11 A. The hospital safety grade is a program of
12 Leapfrog's where we assign most short-term acute
13 care hospitals in the country an A, B, C, D, or F
14 letter grade.

15 Q. And do you know how Leapfrog came up with
16 the original idea for the hospital safety grade?

17 A. I am not sure exactly who came up with
18 it. I know that it was kind of based on the New
19 York City restaurant grading system.

20 Q. And --

21 A. That was kind of the idea for it.

22 Q. How did you learn that?

1 A. I think I've heard Missy Danforth talk
2 about it.

3 Q. And Ms. Danforth has been at Leapfrog
4 since the grade was developed?

5 A. I believe so. I'm not sure.

6 Q. Okay. What sort of issues, what problem,
7 was the safety grade designed to address?

8 A. Well, I guess patients being harmed in
9 the hospital setting and deaths.

10 Q. And then -- let's see. Do you know how
11 the different cutoffs of the different letter
12 grades are assigned?

13 A. Yes.

14 Q. Can you walk me through how that works?

15 A. Yes. From the very beginning?

16 Q. Just from -- how do you decide what an
17 A-hospital, B-hospital, C, D, F -- just in
18 general?

19 A. We look at the numerical scores.

20 Q. And how do you decide the cutoffs for
21 those scores?

22 A. They are based on the distribution of

1 data in a particular year, and then we freeze
2 them until a major methodology change happens,
3 and we reassess them.

4 Q. So are the letters curved?

5 A. I would not describe it as a curve.

6 Q. How would you describe it?

7 A. I think -- I would have to look exactly
8 at what the code is, but it's based on the
9 standard errors from the mean.

10 Q. Okay. And does it -- I think you said --
11 does it change year to year?

12 A. Some years it changes but not every year.

13 Q. Not every year. Okay.

14 And just -- so you mentioned the original
15 design was around the New York City restaurant
16 safety [sic] guide, right?

17 A. Yes.

18 Q. Is there any other reason why Leapfrog
19 decided to go with a letter grading system that
20 you're aware of?

21 A. Yes. I think the goal was to create
22 something that was easy to understand as a

1 consumer that summarized a hospital's record on
2 patient safety.

3 Q. Does Leapfrog intend for consumers to
4 rely on the safety grade?

5 MS. BLAIR: Objection to form.

6 THE WITNESS: No. I think -- "rely" is a
7 strong word. I think that it's one piece of
8 information that they can consider when choosing
9 a hospital.

10 BY MR. CRAIN:

11 Q. Are you aware that it says on the
12 Leapfrog website that patients should always
13 decide on where to receive care based on a
14 hospital's current safety grade?

15 MS. BLAIR: Objection to form.

16 THE WITNESS: Can you repeat your
17 question?

18 BY MR. CRAIN:

19 Q. Sure.

20 Are you aware that it says on Leapfrog's
21 website, quote, patients should always decide on
22 where to receive care based on a hospital's

1 current safety grade?

2 MS. BLAIR: Objection to form.

3 THE WITNESS: I haven't seen that on the
4 website.

5 BY MR. CRAIN:

6 Q. Okay.

7 MR. CRAIN: Let's grab tab...

8 We're going to start the documents.

9 (Campione Deposition Exhibit 1 marked for
10 identification and attached to the
11 transcript.)

12 MS. BLAIR: So this is going to be 1,
13 correct?

14 MR. CRAIN: This will be 1. So this will
15 be Campione 1.

16 So for the record, this document has an
17 18 on it. I think that is Jupiter Exhibit 18.
18 And this will be Campione Exhibit 1.

19 BY MR. CRAIN:

20 Q. Ms. Campione, do you recognize this
21 document?

22 A. Let me take a moment to look through it.

1 Q. Of course.

2 MS. BLAIR: And for the record, Lee --
3 and I made this same denotation at Jupiter's
4 deposition -- this does not have a Bates number
5 on it, so you can represent it was just printed
6 on 9/3/25 per the upper left-hand corner from the
7 website?

8 MR. CRAIN: Correct.

9 MS. BLAIR: Okay.

10 THE WITNESS: Okay. I guess this looks
11 like one of the pages -- one of the tabs on the
12 hospitalsafetygrade.org website.

13 BY MR. CRAIN:

14 Q. Have you seen this page before?

15 A. Yes.

16 Q. And what is it generally?

17 A. Under the tab -- a tab that's used for
18 patients -- or to be used by patients.

19 Q. Is it available to the public?

20 A. Yes.

21 Q. And it's directed towards consumers?

22 A. Yes.

1 Q. Okay. I want to take you down this
2 document a little bit.

3 If you can go to page 4. Tell me when
4 you're there.

5 A. Yes.

6 Q. Great. If you can go to the second full
7 paragraph, starting with "displaying." And it
8 says, Displaying past grades makes it clear which
9 hospitals consistently achieve high standards of
10 patient safety and which have demonstrated a
11 steady path of improvement. Patients should
12 always decide on where to receive care based on a
13 hospital's current safety grade.

14 Do you see that language?

15 A. Yes.

16 Q. Is that inconsistent with your view of
17 whether consumers should rely on the safety
18 grade?

19 MS. BLAIR: Objection to form.

20 BY MR. CRAIN:

21 Q. Do you agree with that language,
22 Ms. Campione?

1 A. I do, but I don't think that it's saying
2 the same thing that you stated earlier, that they
3 should rely only on the safety grade.

4 Q. Fair enough.

5 It is saying, though, that they should
6 always rely on the safety grade, correct?

7 MS. BLAIR: Objection to form.
8 Mischaracterizes the document.

9 BY MR. CRAIN:

10 Q. It says, Patients should always decide on
11 where to receive care based on a hospital's
12 current safety --

13 MS. BLAIR: Current. You keep skipping
14 that one.

15 MR. CRAIN: Which one? Sorry.

16 MS. BLAIR: Current. You didn't --

17 MR. CRAIN: Current.

18 MS. BLAIR: -- say the word "current"
19 before.

20 MR. CRAIN: Oh, sorry.

21 BY MR. CRAIN:

22 Q. Patients should always decide on where to

1 receive care based on a hospital's current safety
2 grade.

3 A. I think the language doesn't exclude
4 using other sources as well.

5 Q. But they do -- it does say that patients
6 should always rely on the safety -- the current
7 safety grade.

8 A. I -- yeah, I think that they should
9 consider it.

10 Q. And is that consistent with your view?

11 A. Yes. I think they should consider it.

12 Q. Always?

13 A. Yes.

14 Q. And this is consistent with Leapfrog's
15 view of how consumers should rely on the safety
16 grade, correct?

17 MS. BLAIR: Objection to form.

18 THE WITNESS: I think they should. I
19 think it's a useful tool.

20 BY MR. CRAIN:

21 Q. Always?

22 A. Sure.

1 Q. Okay. So I want to talk a little bit
2 about which hospitals are assigned a safety
3 grade.

4 Is every hospital assigned a safety
5 grade?

6 A. Only acute care hospitals. So that
7 excludes critical care access hospitals, rural
8 emergency hospitals, pediatric hospitals,
9 surgery -- or surgical hospitals where they
10 primarily perform surgeries, and several others,
11 like veterans hospitals.

12 It's all listed in the scoring
13 methodology.

14 Q. And does Leapfrog also have minimum data
15 requirements for scoring?

16 A. Yes.

17 Q. Talk to me about your understanding of
18 those minimum data requirements.

19 A. Okay. You must have PSI 90. It's an
20 important measure that is composed of ten
21 measures. You must always have at least five
22 outcome measures. And you must always have at

1 least six process and structural measures.

2 Q. And this is communicated clearly to the
3 public, right?

4 A. Very much so.

5 Q. And if those metrics -- the six process
6 measures, the five outcome measures, the PSI --
7 are missing, does Leapfrog grade a hospital?

8 A. If they are missing too much data, no.

9 Q. Okay. Who sets the minimum data
10 requirements?

11 A. I believe our expert panel.

12 Q. Can you tell me a little bit about the
13 expert panel? Who's on the panel?

14 A. Sure. The names are listed publicly on
15 our web page, but it's experts from across the
16 country that are leaders in their field of
17 measurement, of patient safety and quality.

18 Q. And how does one become a member of the
19 Leapfrog expert panel?

20 A. Well, it would seem that you have to go
21 to an elite school. You have to have, you know,
22 tremendous research that -- all of them are very

1 well published and have many studies in the
2 field. I would consider them experts. And I
3 don't think anyone would ever dispute that,
4 really.

5 Q. I'm asking a slightly different question.
6 Just mechanically, how does somebody get
7 on the panel?

8 A. I am not familiar with that process. I
9 just know that all of them are really great.

10 Q. Do you know if the panel picks their own
11 members? Or does Ms. Binder pick them?

12 A. I can't speak to that.

13 Q. Okay. How often does the expert panel
14 meet?

15 A. The expert panel meets about once a year.
16 But if there are -- if something is unresolved at
17 the end of one meeting, we would of course
18 schedule another meeting.

19 Q. And who decides when they meet?

20 A. We -- so at Leapfrog, it would be Missy
21 Danforth and I, whenever we are -- we know that
22 there's a change coming up or it's needed, we

1 would request that Matt Austin convenes the
2 meeting. So he would official schedule the
3 meeting and put together the agenda for it.

4 Q. And who is Matt Austin?

5 A. Dr. Matt Austin is at John Hop- -- sorry,
6 Johns Hopkins -- always a mouthful -- and he
7 works at the Armstrong Institute. He is
8 Ph.D.-level scientist, and we've been working
9 with him for a number of years.

10 Q. Is he a medical doctor?

11 A. He is not.

12 Q. Is he the chair of the expert panel?

13 A. No. I -- he's not the chair.

14 Q. Is there any formal chair?

15 A. I am not sure. I don't think so for the
16 safety grade. There might be one person. Again,
17 I believe it's on the website.

18 Q. And throughout your time at Leapfrog,
19 have you consistently attended the expert panel
20 meetings?

21 A. Yes.

22 Q. Can you -- are you aware of any you've

1 missed?

2 A. No.

3 Q. And if you started at Leapfrog in 2022,
4 that means approximately you've attended three or
5 four?

6 A. Yes. At least four.

7 Q. At least four you said?

8 A. Uh-huh.

9 Q. And what types of decisions does the
10 panel weigh in on?

11 A. Any methodology change, really.

12 Q. And does the panel -- is the panel a
13 decisionmaking body?

14 A. Yes.

15 Q. So the panel makes a determination?

16 A. Yes.

17 Q. And Leapfrog always follows what the
18 panel says, or sometimes?

19 A. Always. I have never seen an incident
20 where they made a recommendation and we didn't
21 follow it.

22 Again, each one of the members are

1 entitled to their own opinion, and they express
2 that freely in the meetings and it's open
3 discourse. And -- but by the end, there's --
4 I've always seen a consensus among them.

5 Q. Is there, like, a vote they take at the
6 end?

7 A. No, but it's -- that's not really how
8 science works.

9 Q. How does science work?

10 A. Well, I think it's open to debate. And
11 if anyone sees a need for additional analysis, we
12 will always complete that and reconvene.

13 Q. Who's ultimately responsible for sort of
14 bringing together what the group consensus was?

15 A. Matt Austin.

16 Q. Okay. And has that been consistent
17 throughout your time at Leapfrog?

18 A. Yes.

19 Q. And how long has Dr. Austin been involved
20 with Leapfrog, to your knowledge?

21 A. A very long time. At least ten years.

22 Q. Okay. In your time at Leapfrog, has

1 there ever been an instance where the folks who
2 work at Leapfrog, like yourself, have disagreed
3 with the panel?

4 A. So we also, I would say, are experts in
5 our particular subject. So, I mean, there
6 definitely has to have been times where we think,
7 oh, I would have gone this direction it with it
8 or I would have done that, but ultimately, it's
9 their decision. And we always follow that.

10 Q. You always follow what the expert panel
11 consensus is?

12 A. Yes.

13 Q. As -- and that consensus is collated, so
14 to speak, by Dr. Austin?

15 A. Yes.

16 Q. Okay. Do you agree that if Leapfrog
17 lacks enough data to assess a hospital, it should
18 not grade the hospital?

19 A. Not necessarily.

20 Q. Can you say -- can you explain why?

21 A. I think that it's -- you need enough data
22 to assign a grade. But just because a measure is

1 missing doesn't mean that you shouldn't grade
2 them because there's lots of reasons that a
3 measure could be missing.

4 Q. So my question was, do you agree that if
5 Leapfrog lacks enough data, the hospital should
6 not be graded?

7 A. Define "enough."

8 Q. Well, I'm asking you to define it.

9 Assuming you agree there's not enough --

10 A. I think that our cut points are
11 appropriate.

12 Q. Okay. So if the cut points are not
13 reached, Leapfrog should not grade the hospital,
14 correct?

15 A. Yes.

16 Q. Okay. And the cut points go back to the
17 six process measures, the five outcome measures,
18 or the PSI 90?

19 A. Yes.

20 Q. And what is PSI 90?

21 A. It's a measure that's developed by CMS,
22 and it's a composite of ten PSI measures; they're

1 patient safety indicators. Each of the patient
2 safety indicators are a rate of a very harmful
3 event that can occur in the hospital setting.

4 Q. Can you give us some examples?

5 A. Sure. Like -- I mean, what we put on the
6 website is kind of, like, a consumer friendly
7 thing. So, I mean, off the top head -- I mean, I
8 can't off the top of my head right now. But...

9 Q. Is that like CAUTI?

10 A. No. That would be a healthcare -- that
11 would be an infection.

12 Q. Got it. Okay. So infections are
13 different?

14 A. Yeah.

15 Q. Okay. Can you tell me just -- again, so
16 we're on the same page, what is a process
17 measure?

18 A. Okay. A process measure -- so process
19 and structural measures make up half of our
20 grade. And they're things that a hospital can
21 have in place that we know, through research,
22 know and -- increase the safety of a patient and

1 prevent harmful errors from occurring.

2 Q. And also, what is an outcome measure?

3 A. An outcome measure is like an actual
4 measurement of events that have happened.

5 Q. "Events" meaning?

6 A. Infections or dangerous patient safety
7 events.

8 Q. How often does Leapfrog release its
9 safety grades?

10 A. Twice per year.

11 Q. And why does Leapfrog do it twice per
12 year?

13 A. To ensure that we have more up-to-date
14 data.

15 Q. I want to talk a little bit about the
16 scoring methodology for the safety grades.

17 Are you familiar with the scoring
18 methodology?

19 A. Yes.

20 Q. How familiar are you with it?

21 A. Very familiar with it. I work with it
22 almost every day.

1 Q. Did you have a role in designing the
2 current methodology?

3 A. I would say no. Not much has changed
4 since I've been here.

5 Q. Okay. Have there been any changes since
6 you've been at Leapfrog?

7 A. Yes.

8 Q. Can you describe generally what the
9 changes have been?

10 A. Let's see. Trying to -- I mean, there's
11 minor changes throughout. Obviously, the reason
12 we're all here today is the imputation model
13 changed in fall 2023. Well -- no. There was an
14 imputation change in fall -- sorry, now I'm
15 mixing it up. I struggle with my year.

16 Q. Take your time.

17 A. Okay. Let's see. In fall 2024 -- so,
18 yes, imputation changes.

19 Q. So the only changes during your 2022 to
20 the present tenure are have been to the
21 imputation?

22 MS. BLAIR: Objection to form.

1 THE WITNESS: Yeah, I wouldn't say that's
2 the only change.

3 BY MR. CRAIN:

4 Q. Okay. So what are the other changes that
5 you recall?

6 A. I don't remember off the top of my head.

7 Q. That's fine.

8 A. We publish them whenever we do have a
9 change, so it was all publicly available.

10 Q. And when you say imputation, what do you
11 mean by imputation?

12 A. So the imputation of data when there is
13 none and -- for the process and structural
14 measures.

15 Q. And going back to the changes that have
16 occurred, I want to focus on the 2024 change to
17 imputation.

18 Is it your testimony that you had no role
19 in designing that methodology?

20 A. So, I mean, when I came to Leapfrog,
21 there was already imputation being used. So no,
22 I wasn't part of the introduction of imputation

1 into the methodology.

2 Q. Were you part of the change to the
3 methodology in 2024?

4 A. Yes. I was part of the analysis that
5 brought it to our attention. There was a problem
6 that was happening where the data was clearly not
7 accurate anymore. And -- yes. Yeah, I mean, I
8 was part of bringing that to their attention,
9 brought it to the expert panel. But ultimately,
10 the expert panel was the deciding factor.

11 Q. So you did have a role in the change?

12 A. Yes. I guess, yeah.

13 Q. Okay. Who else had a role in that
14 change?

15 A. Missy Danforth.

16 Q. Okay.

17 A. And Matt Austin.

18 Q. Anybody else?

19 A. No.

20 Q. Has your role changed during your time at
21 Leapfrog vis-à-vis your interaction with the
22 methodology?

1 A. No. I was brought on -- or almost right
2 away when I joined, I was assigned to the safety
3 grade program. So those core duties that I
4 started doing in the beginning, I still do, where
5 I score the data and update some of the documents
6 that we post for hospitals and for consumers.

7 Those core duties have not changed. I
8 think the -- I've been -- have had the
9 opportunity to do additional analyses since then.
10 And yeah, I would say it's evolved over time.

11 Q. And you said earlier that you interact
12 with the methodology almost daily.

13 Has that been true throughout your time
14 at Leapfrog?

15 A. Yes.

16 Q. I want to talk about a few of the
17 measures that Leapfrog uses and -- just to get
18 your understanding. Not a memory test, so if you
19 don't remember, that's okay.

20 So going back to process and outcome
21 measures, who decides or decided which measures
22 to use in the grading methodology?

1 A. Who decided what measures? So again, a
2 lot of those were decided before my time.

3 Since I've been there, I think only total
4 nursing care hours has been added. So that's
5 only one measure.

6 And how that works is, if it's a survey
7 measure, obviously Missy Danforth and me or my
8 colleagues at Leapfrog are most familiar with the
9 measures that are included in the survey, so we
10 might make a recommendation for those measures to
11 be added. We make that recommendation to the
12 expert panel, and then they ultimately decide.

13 As far as the CMS measures that are
14 used -- so that's publicly available data -- they
15 are familiar with CMS and those measures that are
16 -- those new measures that CMS will introduce.
17 So the expert panel actually -- typically --
18 they're typically the ones that are selecting
19 additional outcome measures to add.

20 Q. So the expert panel, you're saying, is
21 the one that decides which measures to add or
22 subtract in theory?

1 A. Yes. They would have the final say.

2 Q. I want to talk about the four imputed
3 measures.

4 A. Okay.

5 Q. Do you know what I'm talking about when I
6 say that?

7 A. Yes.

8 Q. And the four imputed measures, just to
9 get us on the same page, are CPOE, BCMA, IPS, and
10 hand hygiene; is that right?

11 A. Yes.

12 Q. Talk to me about CPOE. What is CPOE?

13 A. Computerized physician order entry. And
14 that one is -- that was developed a long time ago
15 and that is essentially testing CPOE systems
16 within the hospital. So hospitals must complete
17 a test through our survey, and it evaluates how
18 safe that their CPOE system is.

19 Hospitals can have settings in their CPOE
20 system to, like, override things. So something
21 like prescribing someone penicillin when they
22 have an allergy, it should flag things like that.

1 So it's just ensuring that their CPOE
2 system is fine-tuned to catch potential patient
3 safety events.

4 Q. And the "order" in CPOE, does that refer
5 predominantly to medication or other types of
6 orders, too?

7 A. I believe it's medication, but I'm not
8 the subject matter expert on that one.

9 Q. Fair enough.

10 How does a hospital score well on CPOE,
11 to your understanding?

12 A. Well, they have to do well on that test.
13 I believe that they need to be putting a high
14 percentage of their medications through the CPOE
15 system.

16 Q. And going back to the test, can you tell
17 me what is -- how does the test work?

18 A. Again, I'm not the best person to ask
19 about that. It's been a while since I worked on
20 that.

21 But basically, the test is given -- or,
22 sorry, hospitals are given a certain amount of

1 time, and they put in these, like, test patients
2 into their system that have certain
3 characteristics, and then they go to prescribe,
4 and we see if any alerts are given for their --

5 Q. So is --

6 A. -- prescriptions.

7 Q. I'm sorry.

8 A. It's okay.

9 Q. So it's like a software that the
10 hospitals upload to their own system as a test?

11 A. No. It's external.

12 Q. Okay.

13 A. It's -- yeah.

14 Q. And you said you're not the best person
15 to ask about this.

16 Who is the best person to ask?

17 A. Missy Danforth.

18 Q. Okay. Does CMS measure CPOE?

19 A. No, they do not. They wouldn't have the
20 ability.

21 Q. And can you explain how CPOE reflects the
22 safety of a hospital?

1 A. Sure. I mean, if I was allergic to
2 penicillin and you prescribed it to me and
3 administer that, that would be pretty bad.

4 Q. And to your point earlier, so the system
5 should, in theory, almost put a bar on that
6 penicillin for you in your hypothetical; is that
7 right?

8 A. Produce an alert at least.

9 Q. Okay. If a hospital doesn't participate
10 in Leapfrog's hospital survey, Leapfrog has no
11 data about that hospital's CPOE; is that correct?

12 A. Yes.

13 Q. Let's talk about -- I don't know if
14 it's -- BCMA?

15 A. BCMA.

16 Q. Okay. That's barcode medication
17 administration, right?

18 A. Yes.

19 Q. Tell me about what that means.

20 A. Sure. It's basically ensuring that
21 hospitals have systems in place to scan barcodes
22 when they administer a medication to a patient.

1 Q. So it's like -- it's for the nurse at the
2 bedside that's going to give the medication; is
3 that right?

4 A. Yes.

5 Q. And can you explain how BCMA reflects the
6 safety of a hospital?

7 A. Again, I'm not most familiar with the ins
8 and outs of that and the literature behind it.
9 But you need to make sure that the right patient
10 is getting the right medication.

11 Q. Okay. And the right person would, again,
12 be Ms. Danforth?

13 A. Sorry. What?

14 Q. You said you're not the right person
15 to --

16 A. Oh, yes.

17 Q. Okay. And just so it's clear, the right
18 person to ask about BCMA and the ins and outs, as
19 you said, would be Ms. Danforth?

20 A. Yes.

21 Q. Does CMS measure BCMA?

22 A. No. Again, they wouldn't really have the

1 capability.

2 Q. And why is that?

3 A. They don't administer a survey like this.

4 Q. So the only way to get BCMA information
5 is through a survey?

6 A. I -- I'm not that -- as familiar, but I
7 assume it would be very difficult any other way.

8 Q. So CMS -- does CMS collect data from
9 hospitals?

10 A. I mean, that's a very nuanced question.
11 Like, there's a lot of different ways that they
12 do. And they're a payor. Like, they have --
13 it's a different setup.

14 Q. They collect at least some data, right?

15 A. Yes. So that they can pay hospitals for
16 their admissions.

17 Q. Okay. And in theory, they could ask for
18 data on BCMA, right?

19 A. I think it would be difficult.

20 Q. Why?

21 A. I am not a CMS expert, but I think it
22 would be difficult.

1 Q. But why, though? Why couldn't they just
2 say, give me BCMA data?

3 A. Because they're not, like, a -- they're
4 not Congress. Like, I'm not a politics -- or a
5 policy person.

6 Q. Well, I mean, couldn't the folks that
7 dictate what data CMS wants say, give us BCMA
8 information?

9 A. I -- so, first of all, they do the HCAHPS
10 survey, and that is, like, a much disputed or at
11 least -- you know, hospitals are resistant to do
12 it. But it's been a really powerful and
13 illuminating endeavor for CMS to collect patient
14 experience data.

15 So, I mean, every time they do a program
16 like this, it's -- it's difficult to roll it out.

17 Q. You mean difficult not in terms of
18 collecting the data, but difficult in terms of
19 getting the hospitals to be willing to do it?

20 A. Yes. Yeah.

21 Q. Okay. And you said HCAHPS state -- that
22 folks were resistant to do it.

1 Can you explain what you mean by that?

2 A. I'm not the most -- I'm not super
3 familiar with it, but...

4 Q. But what did you mean?

5 A. I meant that it's -- like, it's a lot of
6 work to do these sorts of things.

7 Q. Is the HCAHPS -- is it a survey?

8 A. It is.

9 Q. Is the HCAHPS survey more or less work
10 than the Leapfrog survey?

11 A. You would have to ask hospitals that.

12 Q. You don't have a view?

13 A. I would say that administering a survey
14 to every single -- or to a proportion of your
15 patients is difficult and costly.

16 Q. Okay. Would you --

17 A. But it's important.

18 Q. Would you say that conducting the
19 Leapfrog survey is difficult and costly?

20 A. In the scheme of things, no.

21 Q. What's the scheme of things?

22 A. I think that it takes about -- so what

1 I've heard is that it takes about 80 to 100
2 hours. And I think that it is a meanwhile [sic]
3 endeavor.

4 Q. And where did you hear that it takes 80
5 to 100 hours?

6 A. From -- I guess from hospitals, but
7 it's -- we've discussed it before internally. So
8 perhaps from Missy Danforth.

9 Q. In your role at Leapfrog, what kind of
10 interaction do you have with hospitals?

11 A. I work on the help desk, which is -- we
12 work on it through ZenDesk. And we all -- all of
13 us on the ratings team help out on help desk and
14 we answer hospitals' questions and surgery --
15 ambulatory surgery centers' questions about our
16 survey or about the safety grade.

17 It's completely free. They submit their
18 questions and, regardless of whether they
19 participate or not, we are willing to help them.

20 Q. And how do you respond? Do you get on
21 the phone with them or do you just write comments
22 back?

1 A. We -- it's -- I mean, it's like writing
2 e-mails back and forth. But if they want to meet
3 for a phone call or a Zoom call, we are always
4 more than willing to do that.

5 Q. And can you give a ballpark about how
6 many outreaches from a hospital come in
7 through -- it's just ZenDesk?

8 A. Yes.

9 Q. How many come in per month?

10 A. I don't know the exact numbers, but it's
11 a lot.

12 Q. More than 50?

13 A. Definitely more than 50.

14 Q. More than 100?

15 A. Definitely more than 100.

16 Q. More than 500?

17 A. I am not sure.

18 Q. Okay. So --

19 A. It depends on the month, really.

20 Q. Is it fair to say that during survey time
21 the questions go up?

22 A. I mean, survey time takes up a lot of the

1 year, actually, because the survey is open from
2 April 1st until January 31st.

3 But yes, there are certain times around
4 deadlines that we have more tickets.

5 Q. Great. Fair enough. That was a bad
6 question.

7 Can we go back to the imputed measures?
8 We took a side road.

9 BCMA. So just going back to BCMA, if a
10 hospital does not participate in Leapfrog's
11 survey, does Leapfrog have any data about the
12 hospital's BCMA?

13 A. No.

14 Q. I want to talk next about the third
15 imputed measure, which I have as ICU physician
16 staffing --

17 A. Yes.

18 Q. -- or IPS.

19 What is IPS?

20 A. Physician staffing. So it's ensuring
21 that your ICU is staffed with individuals that
22 are trained to work in an ICU.

1 Q. And ICU is intensive care unit?

2 A. Yes.

3 Q. And that's different from the ER, right?

4 A. Yes.

5 Q. I just watched The Pitt, so -- very
6 germane to this case.

7 Does CMS measure IPS?

8 A. I am not sure.

9 Q. Okay. And again, if a hospital doesn't
10 participate in Leapfrog's survey, does Leapfrog
11 have any data about IPS about that hospital?

12 A. No.

13 Q. The fourth one is hand hygiene.

14 A. Uh-huh.

15 Q. Is that right?

16 A. Yes.

17 Q. What is the hand hygiene metric?

18 A. So -- and one thing I do want to add on
19 to your past questions --

20 Q. Sure.

21 A. -- about the other measures, is that
22 these are standards that were developed by

1 Leapfrog expert panelists, so they really are
2 unique to Leapfrog. They were developed by the
3 respective expert panels. So it's not really
4 something that CMS could measure.

5 So I would like to, like, amend my
6 previous responses or -- and state that they are
7 exclusively Leapfrog measures, that there
8 wouldn't be something comparable that CMS could
9 do.

10 Q. Could --

11 A. Yeah.

12 Q. You're done?

13 A. Uh-huh.

14 Q. Could Leapfrog just copy the survey and
15 measure the same thing?

16 A. Could Leapfrog --

17 Q. I'm sorry, strike that. Bad question.

18 Could CMS just copy the survey and ask
19 for the same thing?

20 A. I can't speak for CMS.

21 Q. Well, couldn't they just take the
22 questions and ask the same questions?

1 A. Yeah, I guess they could.

2 Q. But they don't?

3 A. No. Why would they?

4 Q. You tell me.

5 A. They have other things they're measuring.

6 Q. What are the other things they're
7 measuring?

8 A. Okay. Do you want me to go back to the
9 hand hygiene or continue?

10 Q. We'll come back to it. I just want to
11 get --

12 A. Okay.

13 Q. Just to your comment that they have other
14 things they're measuring, what are the other
15 things that CMS is measuring?

16 A. Okay. Patient experience. So that's all
17 of the H-comp 1 through 6 that we use in our
18 survey. Those are patient experience surveys
19 that hospitals are required to send out to their
20 patients to see if they had a good experience
21 with the staff and other parts -- cleanliness of
22 their stay, that sort of thing, discharge

1 instructions, medication instructions.

2 Other things they measure are through
3 claims. So this is, like, through Medicare
4 claims. And they will measure the rates of
5 certain events. They look at ICD codes to
6 determine that -- whether a harmful event
7 occurred. And they have their own calculations
8 that they use and that are developed by experts
9 in the field.

10 Q. And what, overall, is -- what is your
11 understanding of what CMS is trying to measure?

12 MS. BLAIR: Objection to form.

13 BY MR. CRAIN:

14 Q. What is your understanding of what CMS is
15 collecting data for?

16 A. I believe essentially to improve
17 healthcare quality, mainly, and safety.

18 Q. And safety?

19 A. Safety and quality, yes. They have a
20 different perspective than us. We're focused
21 solely on patient safety for the most part; and
22 they're focused a lot more, I would say, on

1 quality.

2 Q. And what does "quality" mean?

3 A. Well, again, I'm not super familiar with
4 that field because we're focused on patient
5 safety.

6 Q. Well -- you have no opinion on what
7 quality means?

8 A. Well, I mean, I guess, like, I would want
9 to have -- I mean, like, good care. Good care in
10 the hospital setting. To not be charged too
11 much. Things like that.

12 Q. Noise?

13 A. I don't know.

14 Q. Okay.

15 A. I mean, I wouldn't want a noisy hospital.

16 Q. Fair enough.

17 And just to be clear, I think you
18 testified almost a page about the different
19 things that CMS measured.

20 A. Uh-huh.

21 Q. What is your understanding of what CMS is
22 evaluating with respect to quality?

1 A. My understanding of what they're -- like,
2 how to summarize all of these things?

3 Q. What is quality, to your understanding?
4 Let me -- terrible question. Let's strike that.

5 When you say CMS is evaluating quality,
6 is it fair to say that that's what you're saying?
7 CMS is evaluating -- one of the things CMS is
8 evaluating is quality, right?

9 A. Sure. Yes.

10 Q. What is your understanding of what
11 quality means in that -- in that phrase?

12 A. Well, it definitely includes -- safety is
13 kind of in there as well, but it also includes
14 other things, like patient readmissions. Like,
15 that can be very costly. So they have other
16 measures that look at that.

17 They have -- which wouldn't necessarily
18 fall into patient safety. And I know that
19 because they didn't include that in the safety
20 grade.

21 Yeah, I mean -- yeah, I'm not the expert
22 on this.

1 Q. Okay. Now back to hand hygiene.

2 So tell me -- I don't think we got to
3 it -- what is the hand hygiene measure --
4 metric -- measure -- strike that.

5 What does the hand hygiene measure
6 evaluate?

7 A. So it looks at a couple of different
8 things. The hand hygiene measure ensures that
9 hospitals are measuring, so they're using hand
10 hygiene observations every month to make sure
11 that staff are washing their hands. So there's,
12 like, an observation component.

13 There's also training, whether they're
14 providing training, adequate training, to their
15 staff.

16 There's also culture, so whether they're
17 creating a culture of hand hygiene.

18 Q. And am I right that there's a question
19 that asks whether there's a culture sort of at
20 the top in favor of handwashing?

21 A. I believe so. I know there's a culture
22 component.

1 Q. And how do hospitals measure that?

2 A. I'm not the person to ask. Missy
3 Danforth is.

4 Q. Okay. What is your understanding of how
5 hospitals might measure that?

6 A. How they measure? I mean, I would assume
7 that you would want to make sure that there's
8 signs posted, that leadership has showed a
9 commitment to hand hygiene.

10 Q. Through words?

11 A. I'm -- again, I'm not the expert on that.

12 Q. Okay. And does CMS measure hand hygiene?

13 A. I'm not sure.

14 Q. Okay. And if a hospital doesn't
15 participate in Leapfrog's surgery -- excuse me.

16 If a hospital doesn't participate in
17 Leapfrog's survey, does Leapfrog have any data
18 about hand hygiene?

19 A. No.

20 Q. In your opinion, is handwashing among the
21 most important measures that Leapfrog grades on?

22 A. I think they're all important.

1 Q. There's no hierarchy?

2 A. I think that -- no. I mean, I think
3 that, like, our weighting system takes that into
4 consideration, and that was -- that has existed
5 since the inception of safety grade.

6 Q. Are you aware that Leapfrog, on its
7 website, makes hand hygiene one of the most
8 important metrics?

9 A. Again, you're going to have to show me.

10 Q. Yeah, yeah. It's right in front of you.

11 A. Oh, it's on this page? I think that also
12 can be up to an opinion.

13 Q. If you go to 3. Page 3.

14 A. Uh-huh.

15 Q. To your point, it says, Every person will
16 have different ideas about what is most important
17 to them, but we suggest checking whether your
18 hospital scores well on handwashing.

19 A. Oh.

20 Q. And if you look at the top, the
21 question -- and again, this is in a website
22 called, How to use the grade.

1 But the question is, What measures are
2 most important?

3 Do you see that?

4 A. Okay.

5 Q. And the first one is handwashing, right?

6 A. Yeah.

7 MS. BLAIR: Objection to form.

8 BY MR. CRAIN:

9 Q. Is the first one handwashing?

10 A. It is.

11 Q. And there are how many others?

12 A. Two other bullet points.

13 Q. And are you -- do you agree that
14 handwashing is most important?

15 MS. BLAIR: Objection to form.

16 THE WITNESS: I'm not a communications
17 person, and I don't -- I'm not familiar with how
18 to word things for the general public to a lay
19 audience, so I don't think I'm the person to ask
20 about this.

21 BY MR. CRAIN:

22 Q. When you read this page, which metrics

1 does it say are the most important?

2 A. I mean, I guess if you skim past the
3 first sentence, then you would say handwashing.

4 Q. Skim past the first sentence meaning
5 what?

6 A. Every person will have different ideas
7 about what is most important to them.

8 Q. Okay. But if you skip past that
9 sentence -- say again what you said, I'm sorry.
10 I'm confused.

11 A. Then handwashing is the first bullet
12 point.

13 Q. Okay. So is it -- this is Leapfrog's
14 website, right?

15 A. Yes.

16 Q. And do you disagree with this
17 communication?

18 A. I would say no. Because if I think about
19 it, I don't -- I really think it's important that
20 my surgeon washes his hands before -- or her
21 hands before operating on me.

22 Q. So you agree that handwashing is one of

1 the most important metrics.

2 MS. BLAIR: Objection to form.

3 THE WITNESS: It's subjective.

4 BY MR. CRAIN:

5 Q. What is your opinion?

6 A. My opinion? I think they're all
7 important.

8 Q. And -- okay. You can set that aside.

9 So I want to talk about three other
10 measures, and I'm going to call them the
11 discarded measures. Or we can have another name
12 if you prefer. But I'm referring to the three
13 measures that Leapfrog does not include for a
14 non-participating hospital.

15 Do you know what I mean by that?

16 A. No.

17 Q. Okay. So when a hospital doesn't
18 participate in Leapfrog's survey, are there any
19 measures that are excluded from the score
20 calculation?

21 A. I wouldn't use the word "excluded."

22 Q. What word would you use?

1 A. They're not available.

2 Q. Okay. Is that different from
3 handwashing -- hand hygiene?

4 A. Yes. If you're asking why we don't
5 impute for those measures, then --

6 Q. Well, I'm starting -- I want to get us on
7 the same page, what those measures are.

8 A. Okay.

9 Q. Do you understand what I'm talking about
10 with those measures? There are three, right?

11 A. Yes.

12 Q. Okay. And just so we're on the same
13 page, is one of them, safe practice 1, culture of
14 leadership, structures and systems measure?

15 A. Yes.

16 Q. And another is safe practice 2, culture
17 measurement, feedback and intervention measure --

18 A. Yes.

19 Q. -- correct?

20 Sorry, let's pause.

21 And then is the third one total nursing
22 care?

1 A. Yes.

2 Q. Can you tell me, just generally, what do
3 those three measures evaluate?

4 A. Okay. I'm not as familiar, but I know
5 they come from NQF. And they're processes that a
6 hospital can have in place.

7 Q. So culture of leadership structures and
8 systems, what does that measure?

9 A. That's one of the safe practices. And
10 those were added -- they're very old measures
11 that we've actually included in the survey I
12 think since the survey was first developed.

13 Q. So you have no involvement in developing
14 those?

15 A. No. Those are NQF.

16 Q. Is that -- did Ms. Danforth -- was she
17 involved in developing those?

18 A. Well, they're not really developed --
19 yes, she can answer your questions about them.

20 Q. Okay. And when you say NQF, that's the
21 National Quality -- what's the F?

22 A. Forum, I think.

1 Q. Forum. Okay. Thank you.

2 Does CMS measure any of those three
3 measures?

4 A. I actually believe that they have just
5 put out a measure that is considering these
6 process and structural things because they know
7 that they're important.

8 Q. All three?

9 A. I mean, these can take different forms.
10 And when you say all three, what do you mean?

11 Q. Safety practice 1, safety practice 2, and
12 total nursing care hours.

13 A. Total nursing care hours is an totally
14 separate type of measure.

15 Q. Okay. So maybe we should go through them
16 one by one. I was trying to save us some time.

17 Culture of leadership, structures, and
18 systems. Does CMS measure that?

19 A. I don't know.

20 Q. Okay. And if a hospital doesn't
21 participate in Leapfrog's survey, does Leapfrog
22 have any data about the culture of leadership,

1 structures, and systems measure?

2 A. No.

3 Q. Safe practice 2, culture measurement,
4 feedback, and intervention measure.

5 What is that describing?

6 A. I'm not familiar with it, but it's also
7 NQF.

8 Q. And does CMS measure that, to your
9 knowledge?

10 A. I don't know.

11 Q. Okay. And if a hospital doesn't
12 participate in Leapfrog's survey, is Leapfrog
13 missing data for culture measurement, feedback,
14 and intervention?

15 A. Yes.

16 Q. And then the last one is total nursing
17 care hours per patient day, correct?

18 A. Yes.

19 Q. What does that measure?

20 A. So that measure is different. It's
21 the -- the total nursing care hours per patient
22 day, that is more about nurse staffing and your

1 nursing workforce.

2 Q. You said it's different from the other
3 two.

4 Can you explain how?

5 A. It's a measurement. It's the total
6 nursing care hours per patient day.

7 Q. Are you saying it's more objective?

8 A. No.

9 Q. Okay. Why not?

10 A. It's a measurement.

11 Q. But the other two are not measurements?

12 A. Well, one is numerical and the other one
13 is more -- it's have you met -- do you have these
14 processes in place? Then it's converted to a
15 numerical score.

16 Q. So is it fair -- and I'm just trying to
17 understand. Is it fair to say that the first
18 two, safety practice 1 and 2, are more binary,
19 yes or no?

20 A. Yes. Yeah. It's, do you do these
21 processes? Yes or no, literally.

22 Q. Got it. And nursing care is -- what's

1 the numbers?

2 A. Yes.

3 Q. Okay. Thank you.

4 And then the same question: If a
5 hospital doesn't participate in Leapfrog's
6 survey, does Leapfrog have any data on total
7 nursing care?

8 A. No.

9 Q. Okay. You were starting to testify about
10 the difference between those three -- I'll call
11 them discarded measures, but if you want to call
12 them something else, just let me know -- but the
13 three discarded measures and the four imputed
14 measures.

15 You told me that Leapfrog has no data for
16 any of those seven measures if a hospital does
17 not participate in the survey; is that right?

18 MS. BLAIR: Objection. Form.

19 THE WITNESS: Yes, and I disagree with
20 your characterization of them being discarded.

21 (Discussion off the record.)

22

1 BY MR. CRAIN:

2 Q. You said you disagreed with my
3 characterization of discarded.

4 A. Yes.

5 Q. What would you like to call them?

6 A. There's different reasons that they're
7 not included on the survey. The expert panel
8 could speak to why they made that decision.

9 The two safe practices, those were
10 decided a long time ago that they shouldn't be
11 imputed because they're more process measures;
12 they're less structural. Kind of like that
13 nursing measure we were just talking about, where
14 it's a question of how are you staffing your
15 hospital, that sort of thing.

16 So they're process measures. So it was
17 decided by the expert panel not to impute them
18 ever.

19 Q. When was that decision made?

20 A. I don't know. I wasn't there.

21 Q. Was that decision made before you came to
22 Leapfrog?

1 A. Yes.

2 Q. Okay.

3 A. But the total nursing hours, that's a
4 relatively new measure. So that hasn't come up
5 for imputation yet.

6 Q. Okay. And -- so I'm just going to call
7 them the three. So I don't have to call them the
8 discarded measures, but just the three.

9 What is your understanding of why
10 Leapfrog imputes for the four and does not impute
11 for the three? What's the difference?

12 A. The two safe practices are process
13 measures. And the expert panel decided it wasn't
14 appropriate to impute for those measures.

15 And the total nursing care hours measure
16 is relatively new, and it hasn't been brought
17 to -- for consideration yet of whether to be
18 imputed or not.

19 Q. Is CPOE a process measure?

20 A. It is a structural measure.

21 Q. Okay. Is BCMA a process measure?

22 A. No. It's a structural measure.

1 Q. Okay. So all of the four imputed are not
2 process measures?

3 A. No. They are all structural.

4 Q. Okay. So the difference is Leapfrog has
5 imputed for structural measures but not process
6 measures?

7 A. Yes. I believe that was the expert
8 panel's thinking. But again, I wasn't there at
9 that time.

10 Q. Okay. And I had understood that Leapfrog
11 divided its measures into -- I think it was
12 process and outcome, right? We talked about that
13 earlier today.

14 A. It's -- process and structural is half of
15 the grade, and outcome is the other half.

16 Q. So when Leapfrog says structural on its
17 website, it's referring to -- sorry. When
18 Leapfrog says process on its website, it's
19 referring to process and structural?

20 MS. BLAIR: Objection to form.

21 THE WITNESS: Yeah, I'm -- I don't know
22 exactly where you're referencing.

1 BY MR. CRAIN:

2 Q. So we talked earlier today there were two
3 types of measures, right?

4 A. Well, I think that there's two
5 categories, one being process and structural
6 measures composed of some process measures and
7 some structural measures; then the other half is
8 outcome measures.

9 Q. And what's the difference between process
10 and structural?

11 A. I'm not super familiar with the
12 difference. The -- I'm sure other people can
13 speak better to that.

14 Q. Well, you seem to have very facile
15 understanding of which ones fall into which
16 buckets.

17 So how do you put them into those
18 buckets?

19 A. I mean, structural, it's kind of
20 self-explanatory in the name. But it's a
21 structure you have in your place, like
22 infrastructure, whereas a process is just

1 something you have in -- it's a process you have
2 in place or you don't.

3 Q. Okay. So going to hand hygiene, do some
4 of the questions on hand hygiene pertain to
5 sanitizers?

6 A. Yes. I believe. But you have the option
7 always to wash your hands or use hand sanitizer,
8 so hospitals can still achieve similar points
9 with or without having hand sanitizing stations.

10 Q. But the survey -- is it correct that the
11 survey asks hospitals questions about whether and
12 where they have sanitizers?

13 A. It also -- yes, but it also has questions
14 about whether you have a sink, and so -- and that
15 sort of thing.

16 So I think it's -- you can have either.

17 Q. And is that structural or process?

18 A. I think that -- I would actually -- maybe
19 that measure kind of falls in process and
20 structural. But I would say that's structural.
21 I mean, that is literal, like, where do you have
22 a sink and how far is it from a bed?

1 Q. I mean, that makes sense to me, too.

2 So my question is, your original
3 distinction between the four imputed and three --
4 not discarded, but discarded -- was that one was
5 structural and one was process, right?

6 A. That's my understanding of it, but again,
7 I wasn't there when the expert panel made the
8 decisions.

9 Q. But certain of the -- at least
10 handwashing has structural components, right?

11 A. Yes.

12 Q. So is it -- where did you get the
13 understanding that the three discarded, I'll call
14 them, were discarded because they're structural?

15 A. Because --

16 MS. BLAIR: Oh --

17 BY MR. CRAIN:

18 Q. Because they're structural, right?

19 MS. BLAIR: Objection to form.

20 BY MR. CRAIN:

21 Q. Or processed, excuse me. Now I am all
22 tied up in knots. Strike that.

1 Where did you get the understanding that
2 the three discarded metrics were discarded
3 because they were process?

4 A. I've asked Missy Danforth before and
5 she's explained this to me.

6 Q. Okay.

7 A. And she can do a better job explaining
8 than I can.

9 Q. Fair enough. Okay.

10 MR. CRAIN: Is now a good time for a
11 break?

12 THE WITNESS: Sure. No, we can --

13 MR. CRAIN: Maybe let's go off and --

14 THE WITNESS: Oh, yeah.

15 MR. CRAIN: Let's go off the record.

16 VIDEO TECHNICIAN: The time is 10:18 a.m.
17 This ends unit 1. We're going off the record.

18 (A recess was taken.)

19 VIDEO TECHNICIAN: The time is 10:31 a.m.
20 This begins unit number 2. We're on the record.

21 BY MR. CRAIN:

22 Q. Ms. Campione, I'd like to talk about the

1 survey methodology, if that's okay with you.

2 A. Sure.

3 Q. And I'm going to give you a copy so
4 you're not -- it's not from memory.

5 A. Okay.

6 MR. CRAIN: So this was, I believe,
7 Jupiter Exhibit 1, and we'll mark as Campione
8 Exhibit 1 as well.

9 MS. BLAIR: This is Exhibit 2.

10 MR. CRAIN: It says 1. Oh, this is
11 Exhibit 2, I'm sorry.

12 THE WITNESS: You said survey
13 methodology.

14 MS. BLAIR: Yeah. And for the record,
15 this is --

16 MR. CRAIN: Scoring methodology --

17 MS. BLAIR: -- the scoring methodology.

18 MR. CRAIN: -- excuse me. Scoring
19 methodology.

20 THE WITNESS: Well, there's scoring
21 methodology for the survey as well. This would
22 be the safety grade methodology.

1 MR. CRAIN: Yeah, that's what I mean.
2 Safety grade methodology. Whatever this document
3 is, I want to talk about it.

4 THE WITNESS: Just want to make it clear
5 there's a difference.

6 MR. CRAIN: That's all right. That's
7 good.

8 (Campione Deposition Exhibit 2 marked for
9 identification and attached to the
10 transcript.)

11 BY MR. CRAIN:

12 Q. So we're all on the same page, what is
13 this document?

14 A. This is the spring 2025 safety grade
15 scoring methodology.

16 Q. And was this changed from the methodology
17 that was operative in 2024?

18 MS. BLAIR: Objection to form.

19 THE WITNESS: I'm sorry, which safety
20 grade?

21 BY MR. CRAIN:

22 Q. Was --

1 A. Spring or fall 2024?

2 Q. Either.

3 A. I'm not familiar if we did proposed
4 changes for this.

5 Q. Okay. This reflects the proposed
6 changes -- when you say -- strike that.

7 When you say proposed changes, are you
8 talking about the changes to the imputation
9 model?

10 A. Yes. So every round will have -- we'll
11 put out -- or not every round. If we're making a
12 change, we'll put out proposed changes, and
13 hospitals have the opportunity to comment on
14 those changes.

15 I don't -- as far as the spring 2025
16 safety grade goes, I don't think there are any
17 changes from fall 2024 safety grade.

18 Q. And the spring 2025 safety grade document
19 that we have in front of us --

20 A. Yes.

21 Q. -- would that have taken -- would that
22 have -- would the revisions to the imputation

1 model be reflected in this document?

2 A. Yes.

3 Q. So I want to talk -- you mentioned -- so
4 what is this document? Just tell us generally.

5 A. So this document summarizes what is the
6 hospital safety grade, what hospitals are
7 eligible, what measures are included in the
8 safety grade, the points that are assigned to
9 each measure, or how their rates work.

10 Then it goes into the actual scoring
11 methodology. So it describes how weights are
12 assigned to the measures.

13 Then it describes how we calculate
14 Z scores and what we do with missing data.

15 The next step is calculating the
16 numerical scores, which are then used to make the
17 grades.

18 Q. And just tell me, what are Z scores and
19 numerical scores?

20 A. Okay. So --

21 Q. Yeah.

22 A. Okay. So let me flip to that section.

1 Q. Great. Tell me where.

2 A. Okay. So starting on page 18 is the
3 scoring methodology.

4 The first thing that we discuss are the
5 weighting of each measure. We look at four
6 different components -- well, I should use the
7 word -- we look at four different parts for
8 weighting. We look at the evidence, the
9 opportunity, the impact, and the number of
10 component measures.

11 These numbers that are used in the
12 weighting were determined by our safety grade
13 expert panel. They don't typically change from
14 year to year.

15 The evidence, if it was determined by our
16 expert panel that the measure is supported by
17 either suggestive clinical or epidemiological
18 studies or theoretical rationale, they will
19 assign them 1. If they feel that it is -- or
20 have determined -- because these are scientific
21 studies, if they've determined that they're
22 supported by experimental, clinical or

1 epidemiological studies and strong theoretical
2 rationale, they'll assign 2.

3 Then the opportunity score is about how
4 much opportunity there is for the hospital to
5 improve. So it's kind of a measure of variation
6 from the mean for each individual hospital, their
7 score.

8 The next one is impact. And so that
9 looks at the number of patients impacted, or the
10 severity of harm. So a measure like foreign
11 object retained, that's obviously pretty severe,
12 and so that would be assigned a higher score for
13 severity of harm. However, fewer patients
14 undergo a surgery where this is possible, so
15 they're assigned a lower score.

16 The number of patients affected -- so
17 this is whether it's, like, a hospital-wide
18 measure or it's just limited to surgical
19 patients, so they'll be assigned a 1, 2, or 3.

20 The severity of harm -- like I said,
21 foreign object retained, that would be -- that's
22 at a 2. So it's pretty -- I would describe that

1 as very much an adverse event. But something
2 like patient experience doesn't directly harm the
3 patient, so it's assigned 1.

4 Then they're all added together.

5 PSI 90 is the only measure to have the
6 number of component measures used.

7 So that is multiplied by 10. And those
8 all go into the actual weight of the individual
9 measures.

10 So moving on --

11 Q. Well, before you move on --

12 A. Yes.

13 Q. -- can I ask you to break it down a
14 little bit? I appreciate it.

15 Going back to evidence, evidence of --
16 what is the evidence supposed to be geared
17 towards?

18 A. So evidence is focused on the amount of
19 academic research that was used -- or -- for the
20 measures.

21 Q. Used to develop them or to -- like, what
22 is the -- used for what, I think, is the

1 question?

2 A. I mean, it would be, like, any study out
3 there. So they'll do a literature review and
4 find studies that back up each measure. And
5 it's -- like, its usefulness in patient safety.

6 Q. So back up how accurate it measures a
7 metric? I'm just trying to get at the what
8 it's -- what the evidence is measuring.

9 A. So it's the measure's connection to
10 patient safety. So we define patient safety as
11 freedom from harm. So if -- obviously if
12 there's, like, an experimental study, that would
13 be, like, the strongest study to point towards
14 causation. And then, as you move down the scale,
15 it could be, like, observational. So basically,
16 like, it's strongly suspected by experts that
17 it's related but, for whatever reason, they
18 are -- a lot of times it's just impossible to,
19 like, absolutely prove. So then it would be
20 assigned a lower or higher score based on that.

21 Q. So the evidence weighting measure -- is
22 that what you call it? A weighting -- what do I

1 call these --

2 A. Yes. These are weights.

3 Q. The evidence weight is assessing the
4 strength of the evidence connecting the measure
5 to patient safety; is that right?

6 A. Yes.

7 Q. Okay. And then opportunity is
8 measuring -- I'm still a little confused on that.

9 Can you explain what opportunity is
10 measuring?

11 A. Sure. So it's kind of the spread of
12 data. So like, for a measure like -- I'll use
13 patient experience as an example. But something
14 like patient experience, it's really difficult
15 for hospitals to change that from year to year.
16 Typically, like, if they perform poorly in those
17 measures, it's hard for them to improve from
18 there.

19 So that -- in, like, lay terms, it's kind
20 of what it's looking at, like opportunity. But
21 from a mathematical standpoint, this is looking
22 at the standard deviation divided by the mean.

1 Q. Okay.

2 A. So if there's a lot of spread in the
3 data, then that's going to be higher, I believe.
4 Yeah.

5 Q. And then going towards something you said
6 at the end. You said for PSI, the number -- it
7 includes a number of components.

8 What did you mean by that?

9 A. So PSI is --

10 Q. PSI 90.

11 A. PSI 90, yeah. PSI 90 is a -- it's
12 composed of ten components, PSI 3, 6, 8, 9, 10,
13 11, 12, 13, 14, and 15. And all those go into
14 developing PSI 90. This is a measure that was
15 developed by CMS. And I believe -- actually,
16 Patrick Romano on our expert panel was involved
17 in its development. And it's a highly adjusted
18 measure. It's composed of these ten really
19 important rates, and it goes into developing the
20 score that's centered on 1.

21 Q. And just to take something you said, who
22 is Dr. Romano?

1 A. Dr. Romano is on our expert panel, and
2 he -- I forget which university he's affiliated
3 with now, but he works on these measurements.

4 Q. And this document that we're going
5 through, is this the document that you testified
6 to earlier that you look at almost every day, or
7 you work with almost every day?

8 A. Yes. Yeah, I mean, I wouldn't say I look
9 at it every single day, but...

10 Q. Do you work with it -- what -- what did
11 you say before? You work with it every day?

12 A. I -- in some form or another, I'm
13 applying our methodology or answering questions
14 related to this document.

15 Q. Can you go to page 20? And there's a
16 table here.

17 Do you see that?

18 A. Yes.

19 Q. And it says -- standard measure weight is
20 the right-most column; is that right?

21 A. Yes.

22 Q. And does this add -- this adds to -- this

1 adds up to 100, correct?

2 A. Yes.

3 Q. And can you just do a rough
4 back-of-the-envelope calculation? What does
5 CPOE, BCMA, IPS, and hand hygiene amount to?

6 A. Let's see. Like, 24 percent.

7 Q. Let's see. Yeah, looks about right. So
8 about a quarter?

9 A. Yes.

10 Q. And has Leapfrog always weighed the
11 measures this way or has it changed?

12 A. Can you define or explain more what you
13 mean "this way"?

14 Q. Sure.

15 The percentages in the right-most
16 column --

17 A. Uh-huh.

18 Q. -- does that change?

19 A. The percentages do change from round to
20 round because that opportunity score is based on
21 the mean and standard deviation, and that's
22 changing every round.

1 Q. Okay. So every cycle of the grading
2 period, it changes?

3 A. Yes. These can change. Usually
4 slightly. And then, also, if a measure is added
5 or removed, these will adjust accordingly.

6 Q. And have measures been added or removed
7 in your time at Leapfrog?

8 A. Total nursing care hours per patient day
9 was added while I've been here.

10 Q. Anything removed?

11 A. No.

12 Q. Okay. All right. You can set that aside
13 for the moment.

14 I want to talk a little bit about the
15 hospital survey --

16 A. Okay.

17 Q. -- which I think we've talked less about
18 today, but let's get into it.

19 What is the Leapfrog hospital survey?

20 A. So the Leapfrog hospital survey is a
21 voluntary survey that is administered annually.

22 Q. Do you have any role in designing the

1 survey?

2 A. I manage two subsections of the survey.
3 They are not involved in the safety grade.

4 Q. Which subsections?

5 A. OAS CAHPS and pediatric CAHPS.

6 Q. And who is responsible for managing the
7 sections that are involved in the -- related to
8 the safety grade?

9 A. We have a team of about ten people, and
10 so -- I don't know exactly who is -- works on
11 each of those sections, but there is a person
12 assigned to each of those.

13 Q. Would Ms. Danforth know?

14 A. She oversees all of them. Yeah, she's
15 involved in all of them.

16 Q. Okay. So do you have any role in
17 reviewing responses to the survey?

18 A. Responses? There is another analyst that
19 downloads the data that surveys submit through
20 our online survey tool, scores them much in the
21 same way that I score safety grade. And if they
22 were out for some reason, I could fill in for

1 them and do this process.

2 Q. You said -- you distinguished between
3 scoring the survey responses and scoring the
4 safety grade.

5 Did I understand that right?

6 A. Yes.

7 Q. Can you --

8 A. Totally separate.

9 Q. Explain to me the difference.

10 A. Yes. Absolutely.

11 The survey is graded several times
12 throughout the year, monthly actually, from
13 July until January. Every month the data is
14 taken down that hospitals have submitted at the
15 beginning of the month, and they score it based
16 on the algorithms for the survey. So those are
17 based on -- those assign hospitals to different
18 categories based on their responses to the
19 survey.

20 They also engage in a data verification
21 process where they make sure that they kind of
22 cross-reference the questions across the survey

1 to make sure that they all align and make sense.

2 They -- the scoring process produces a
3 final scored file and a file that is uploaded to
4 the ratings website.

5 Q. Okay. And then -- so you said the data
6 is submitted every month.

7 Is that in -- the hospitals submit what
8 data every month?

9 A. So the way that the survey works is that
10 it opens on April 1st. And the official deadline
11 is June 30th. That's when we ask hospitals to
12 submit by. But the tool stays open throughout
13 the year -- or until November 30th. That's the
14 final deadline.

15 But during that time, during our data
16 verification process, oftentimes hospitals need
17 to go back in, fix their data, and -- because
18 it's not -- there's things that either don't make
19 sense, we've looked into them, we've done
20 document requests, so we're constantly verifying
21 that data. And they have to go in, update their
22 responses.

1 And the August 31st deadline is the
2 snapshot for the safety grade. So if they want
3 that data used in the fall safety grade, they
4 have to have it completely finalized by that
5 date.

6 Q. In your experience, do hospitals
7 typically submit data every month?

8 A. No, they don't.

9 Q. Okay.

10 A. You can submit the survey one time at the
11 beginning of the year and it can be done.

12 Q. Is it one survey per year?

13 A. It's one survey per year, and the
14 questions do not change during the year.

15 Q. And that's used to do both safety grades
16 that year?

17 A. Well, yes. It depends on the snapshots.
18 But that would be for -- it would then be used in
19 the fall grade, then in the spring grade. But
20 the safety grade is really -- it's a separate
21 program, and it's a downstream use of the data.

22 Q. What do you mean downstream use of the

1 data?

2 A. Well, they're scored in the survey.
3 They're placed into scoring categories based on
4 our scoring algorithm that was reviewed by the
5 respective expert panel. Then that file --
6 they're placed into these categories for various
7 measures. And then I get that file and I recode
8 that into the scoring methodology for the safety
9 grade.

10 Q. Can you walk through how that works for,
11 like, hand hygiene for a participating hospital?

12 A. For the survey or safety grade?

13 Q. The whole process you just laid out.
14 They submit a survey response. You said it's
15 scored. So how is that scored?

16 A. So you can look up the safety grade
17 scoring algorithm. It's posted on our website.

18 Q. Well, how is it scored for the survey
19 first?

20 A. So according to that scoring algorithm,
21 the code is set up in a way that it takes the
22 survey responses and, in accordance with the

1 scoring algorithm, assigns them to one of these
2 categories. And the categories are achieved the
3 standard, considerable achievement, some
4 achievement, and limited achievement or did not
5 measure or does not apply.

6 Q. So that's six.

7 A. It depends on the measure.

8 Q. Okay. So to take hand hygiene, ballpark,
9 there are about -- maybe a little under two dozen
10 questions.

11 Does that sound right?

12 A. I am not sure.

13 Q. Okay. There are a certain number of
14 questions on hand hygiene.

15 A. Uh-huh.

16 Q. Is it right that an algorithm takes the
17 answers to those questions and, in the survey
18 scoring, yields an output of the type you just
19 mentioned, high achievement, limited achievement?

20 A. Yes.

21 Q. Okay. And then you take that output and
22 you import it into the safety grade algorithm?

1 A. Yes.

2 Q. Okay. And that yields the grade?

3 A. Well, I mean, I also have lots of other
4 data sources to include, CMS namely --

5 Q. Sure.

6 A. -- and they have multiple data sets, and
7 that has to be combined with this data.

8 Q. Okay. So the two steps are taking the
9 answers to the questions to yield an output,
10 taking that output and putting it into the safety
11 grade with other things?

12 A. Yes. I wouldn't consider them -- I would
13 never consider them as, like, one process where
14 that's a step 1 and step 2. It's completely
15 separate. They're in -- he's scoring in a
16 different folder everything. This code is
17 completely separate. And the final file is final
18 at that point. Then I pull it into the program,
19 much like I do with the CMS data.

20 Q. Are the outputs of the scoring -- of the
21 survey scoring process used for anything other
22 than grading?

1 A. Than safety grade?

2 Q. Correct.

3 A. Yes.

4 Q. What are thaw used for?

5 A. They are used for our VBP program.

6 They're posted on the ratings website. They are
7 given to data licensees.

8 I'm trying to think if there's any other
9 programs. There might be another program in
10 there that we use the data for.

11 Q. What is VBP?

12 A. VBP? It's our value-based purchasing
13 program.

14 Q. Can you explain what that is?

15 A. Yes. That's -- I'm not as familiar with
16 that. It's kind of -- it's somewhat of a safety
17 grade in that it's assigning -- it's creating
18 numerical scores for a hospital, but it considers
19 other measures beyond what's included in the
20 safety grade.

21 The safety grade is -- its scope is
22 narrow -- narrower in that it only includes

1 measures that are strictly related to patient
2 safety and adult care.

3 Q. And you mentioned it's put on the
4 website.

5 Which website are you talking about?

6 A. Ratings.org.

7 Q. Is it hospitalsafetygrade.org?

8 A. No. That's the safety grade website.

9 Q. Okay. So what is ratings.org?

10 A. That's where our -- the results from the
11 survey are posted.

12 Q. Okay. Is that different from
13 leapfrog.org?

14 A. Yes. I believe -- leapfrog.org is just
15 giving information about our organization.

16 Q. How many websites does Leapfrog have?
17 Not sub, but --

18 A. I would say thee's three that are the
19 most important.

20 Q. Okay. So can you just name the three?

21 A. The ratings.org, hospitalsafetygrade.org,
22 and then that leapfrog.org.

1 Q. Okay.

2 A. There might be some other -- like "the"
3 or something in there.

4 Q. And, obviously, sub websites?

5 A. Yes.

6 Q. You mentioned also data licensees.
7 Tell me what you were talking about
8 there.

9 A. I really don't know much about who
10 actually is licensing the data. I just know that
11 I produce one file that is essentially everything
12 that's -- it is everything that's posted publicly
13 in an Excel file that goes to someone else.

14 Q. And licensees purchase that; is that
15 right?

16 A. Yes.

17 Q. Okay. Do you have any sense of how much
18 they pay?

19 A. No, I don't.

20 Q. And you do not know the types of folks
21 who are the licensees?

22 A. No.

1 Q. Researchers, hospitals, anything like
2 that?

3 A. No. I've heard, you know, here and
4 there, like, health plans as well, employers,
5 purchasers, but I don't know any of, like, the
6 actual companies.

7 Q. Health plans meaning, like, insurers?

8 A. Yes.

9 Q. Okay. So I want to go back to the
10 survey. And -- I don't think we need to put it
11 in front of you right now.

12 But presumably you've seen the whole
13 survey, right?

14 A. Yes.

15 Q. It's a thick document, right?

16 A. Yes. I think it's over 100 pages.

17 Q. Well, I think it's over 350 pages.

18 Does that sound right?

19 A. It's comprehensive.

20 Q. It is comprehensive.

21 And I want to just ask you, how -- you
22 said earlier today it takes, I think you said, 80

1 to 100 hours to complete?

2 MS. BLAIR: Objection to form.

3 BY MR. CRAIN:

4 Q. How many hours do you think -- did you
5 say it takes to complete?

6 A. I believe somewhere between 80 to 100.

7 Q. Yeah.

8 A. It depends on whether it's your first
9 time completing the survey.

10 Q. And do you think completing that survey
11 is a significant amount of work or not?

12 MS. BLAIR: Objection to form.

13 THE WITNESS: I mean, how many hours do
14 you work a week?

15 BY MR. CRAIN:

16 Q. Way too many, as I'm sure we all do.

17 Let me ask you this: So you gave an
18 interview to the Philadelphia Inquirer.

19 Do you recall that interview?

20 A. Maybe. I don't know.

21 Q. Okay. We can put it in front of you.

22 MR. CRAIN: Let's grab tab 142. This

1 will be Exhibit 3.

2 (Campione Deposition Exhibit 3 marked for
3 identification and attached to the
4 transcript.)

5 MS. BLAIR: And for the record, I believe
6 this also does not have a Bates stamp on it.

7 Have you produced it in this litigation?
8 Or have we produced it in this litigation?

9 MR. CRAIN: I am not sure. It is a
10 publicly available document.

11 MS. BLAIR: Okay.

12 MR. CRAIN: The website I think is at the
13 bottom, and the date pulled down is August 29th.

14 MS. BLAIR: So you've had it since
15 August 29th and not produced it for the record.

16 MR. CRAIN: The public document, yes.

17 BY MR. CRAIN:

18 Q. Ms. Campione, do you see the document in
19 front of you?

20 A. Yes.

21 Q. Okay. Do you recognize this document?

22 A. I may have seen it once, but I'm not

1 familiar.

2 Q. It's an article from the Philadelphia
3 Inquirer from November 2024.

4 Do you see that?

5 A. Yes, I do.

6 Q. And you -- if you go to page 6, sort of
7 midway down the page, you say -- tell me when
8 you're there --

9 A. Yes.

10 Q. -- The hospitals that do complete the
11 survey put in a tremendous amount of resources.
12 It wasn't fair to let hospitals that weren't
13 transparent actually do better in some cases than
14 those hospitals that were trying to be
15 transparent.

16 Do you see that language?

17 A. Yes.

18 MS. BLAIR: I'm going to object to form
19 because it says, Russo said, and this is
20 Ms. Campione.

21 BY MR. CRAIN:

22 Q. Are you Ms. Russo in this article?

1 A. Yes.

2 Q. You mentioned earlier in your testimony
3 that --

4 A. That's my married name.

5 Q. So when it says, Russo said, that's
6 referring to you, correct?

7 A. Yes.

8 Q. Okay. Do you disagree today that
9 hospitals that do complete the survey put in a
10 tremendous amount of resources?

11 A. I mean, I think they would consider them
12 notable and -- yeah.

13 Q. I'm not sure I understand your answer.

14 Who would consider what --

15 A. The hospital would consider them notable.
16 I mean, they're hours they could be spending
17 doing something else.

18 Q. But what is -- what do you think?

19 A. I don't work in a hospital. So...

20 Q. Okay. Do you stand by this quote?

21 A. I do.

22 Q. Okay. So you agree that the hospitals

1 that do complete the survey put in a tremendous
2 amount of resources?

3 A. Yes.

4 Q. Okay. All right. I want to also go back
5 to something you said earlier today.

6 You said you're not that involved in
7 communications; is that right?

8 A. I answer -- so sometimes I'll meet with
9 reporters, like it looks like I did in this case,
10 to answer their questions related to the scoring
11 methodology.

12 Q. How often do you meet with reporters?

13 A. Well, it's usually over the phone. I
14 mean, I probably take, like, five or six during a
15 safety grade round.

16 Q. Okay. So is that five or six every six
17 months?

18 A. Yes.

19 Q. And you work with -- does Leapfrog have a
20 PR firm?

21 A. Yes.

22 Q. Who is that firm?

1 A. CURA.

2 Q. And do you work with them?

3 A. Yes.

4 Q. Tell me about your nature of work with
5 them.

6 A. I guess -- so they'll send me questions
7 from reporters. I provide them with the data
8 from our safety grade. I make sure that it's,
9 like, in a way that they can understand. I make
10 sure that CURA has everything they need to answer
11 reporters' questions. But when it gets a little
12 more detailed, they'll have to come to me and ask
13 for specifics. Or a special data request,
14 something more specific, so I will take care of
15 those for them.

16 And then, also, I will meet with
17 reporters occasionally, and they'll set up those
18 meetings.

19 Q. And that's the five or so times every six
20 months you mentioned?

21 A. Yes.

22 Q. Fair to say CURA sort of thinks of you

1 as, like, a subject matter expert?

2 A. Yes.

3 Q. And they go to you with questions about
4 the grades, the methodology, those sorts of
5 topics?

6 A. Yes.

7 Q. Any others?

8 A. I can't recall everything they've ever
9 asked me about. But mainly it pertains to the
10 safety grade.

11 Q. Okay. Has Leapfrog conducted any studies
12 or collected any data about how long it takes for
13 hospitals to complete the survey?

14 A. I don't know.

15 Q. So your knowledge, the 80 to 100 hours
16 you mentioned, that's primarily anecdotal?

17 A. Yes. I said earlier that Missy Danforth
18 has told me that after asking her --

19 Q. Okay.

20 A. -- at some point.

21 Q. Do you know whether -- like, the amount
22 of people hospitals need to complete the survey?

1 A. No.

2 Q. Do you know the types of people that
3 complete the survey?

4 A. I know that it varies. It depends on the
5 hospital. And sometimes, within a system,
6 they'll have a single person doing it. But
7 typically they're in, you know, like, a patient
8 safety and quality role.

9 Q. Okay. Have hospitals -- going back to
10 what you talked about with the ZenDesk help
11 desk --

12 A. Yes.

13 Q. -- have hospitals complained or expressed
14 concerns about the time it takes to complete the
15 survey?

16 A. Sure. Of course.

17 Q. Have you received those complaints?

18 A. Yes.

19 Q. Tell me about them. Which ones do you
20 recall?

21 A. I don't recall any off the top of my
22 head, but I think anyone who -- everyone wants

1 less work. So it's not a surprise. I wouldn't
2 say that it's every day and I wouldn't say it's
3 even every month. There really -- you would
4 think there would be more complaints, and there
5 really aren't that many, but they do exist.

6 Q. How many, ballpark, do you get per cycle?

7 A. Which cycle?

8 Q. Let's say the six-month safety grade
9 cycle.

10 A. In regards to safety grade, it's really
11 not that often. We, of course, put out proposed
12 changes, which I mention whenever we're doing a
13 methodology change. And of course, at that
14 point, hospitals will -- may complain about
15 adding a measure because they don't want to do
16 more work.

17 Q. Okay.

18 A. So it's usually at that time that we
19 would hear it. I don't think I usually -- I've
20 ever seen them, like, outside of a proposed
21 changes time. But like I said, that's a time
22 that we are looking to solicit feedback and we

1 ask for it and -- so we hear that sometimes.

2 Q. Okay. Have hospitals ever expressed
3 concerns about the fairness of the hospital
4 survey?

5 A. Of course. Like, it's a scoring
6 algorithm, so they're going to have opinions
7 about how they -- they want points for the things
8 that they do implement. But again, our expert
9 panel has made a decision about what's most
10 important and what qualifies, and our team is
11 trained and understand in their respective
12 section what should qualify and what they should
13 receive credit for.

14 Q. Where -- you mentioned the expert panel's
15 decision.

16 Where are those memorialized?

17 A. I believe that everyone maintains their
18 own records of when their expert panel met and
19 notes from that.

20 Q. Sorry, I'm confused.

21 Who is everyone? When you say everyone
22 maintains their own records.

1 A. Sorry. Everyone on the ratings team,
2 most people -- I should say most people on the
3 ratings team manage a section of the survey, or a
4 subsection, a particular measure. And the person
5 on the ratings team is responsible for
6 convening -- or ensuring that their expert panel
7 meets when appropriate; if there's a change, that
8 things are run by them. And they are responsible
9 for documenting when they met and documents from
10 that time.

11 Q. And just to make sure I understand, there
12 are multiple expert panels, correct?

13 A. Oh, yes.

14 Q. And what types of panels do they exist
15 for?

16 A. What types of panels? So it depends on
17 the measure and the section and the subsection
18 and when it was brought forth.

19 Q. Is there one panel per measure?

20 A. Not for all measures.

21 Q. Sometimes there are buckets?

22 A. Yes.

1 Q. And the panel that we were talking about
2 earlier today on the imputation measure, what is
3 that panel?

4 A. The safety grade expert panel.

5 Q. Okay. So when Leapfrog refers to the
6 national expert panel approved the imputation
7 model, it's referring to that panel?

8 MS. BLAIR: Objection to form.

9 THE WITNESS: If it were in the context
10 of a safety grade page or document, yes.

11 BY MR. CRAIN:

12 Q. Yeah. Okay. And when it's talking about
13 other contexts, they're -- let me rephrase.

14 There are other expert panels that review
15 other things for Leapfrog, right?

16 MS. BLAIR: Objection to form.

17 BY MR. CRAIN:

18 Q. To the extent you can answer.

19 A. Yes. For a particular measure.

20 Q. Yeah. Okay.

21 You talked a little bit about response
22 verification. Do you remember talking about

1 that? And you mentioned document requests.

2 Does Leapfrog verify the accuracy of
3 information hospitals submit in the survey?

4 A. Yes.

5 Q. And tell me how.

6 A. There's several forms of data
7 verification. The first is the -- is the survey
8 tool itself. It is programmed in a way that, if
9 you answer on one section that you don't have a
10 pediatric ICU, and then you report later on that
11 you have pediatric ICU patients, then it's going
12 to cross-check those and produce a warning. And
13 those warnings have to be resolved. Either the
14 hospital has to work it out with us -- depending
15 on the category of the issue. So we put it into
16 buckets of how important it is. And they have to
17 work it out, fix their survey, or -- or give us
18 an explanation for why they need a special
19 exception. So that's the first step, is the
20 survey tool.

21 The next step is the data verification
22 that we do on the -- within our ratings team. So

1 we externally take the code and we have far more
2 complicated algorithms for cross-checking their
3 survey responses. These are developed by each
4 person in their respective section, as I
5 mentioned earlier, the ratings team. They are
6 responsible for coming up with things that would
7 be alarming, a rate that's too low, a rate that's
8 too high, a rate that doesn't really match this
9 type of hospital, it's out of the norm.

10 And they develop these -- we call them
11 data messages, or, like, verification messages.
12 And then we send out e-mails to every hospital.
13 And this is done every month. This is why
14 scoring is done every month. So if you submitted
15 a survey in April or whatever, you would probably
16 just get those data verifications in June -- in
17 July, and then you would work them out with us on
18 our staff. But if you go in and make changes to
19 your survey, now you're going to be
20 cross-referenced again, and we'll send another
21 round of data verification messages to you.

22 Q. And you mentioned earlier document

1 requests.

2 Can you tell me what that meant?

3 A. Yes. Well, so then the next one is
4 document requests. And that is -- that can be
5 random. Like, you can be randomly assigned to
6 that. They'll randomly select hospitals, the
7 ratings team.

8 So the -- we have another -- about half
9 of our members of our rating team are
10 coordinators, and they're responsible for this
11 part of data verification.

12 They, the coordinators, will choose
13 random hospitals, or it will be a hospital that
14 has raised some flags previously, and they're put
15 into this bucket of doc requests.

16 And this is a way more in-depth
17 evaluation of the hospital where they're required
18 to send documents that back up how they've
19 reported to the survey.

20 It's definitely way more in-depth and
21 oftentimes results in the hospital needing to
22 update their survey responses.

1 Q. How many hospitals undergo this document
2 request process?

3 A. I don't know.

4 Q. Do you have a ballpark?

5 A. No.

6 Q. Who would know?

7 A. Missy Danforth.

8 Q. Okay. And how many -- do you know how
9 many requests go into this, like, how many
10 document requests?

11 A. It depends on the measure. It's very
12 specific to each measure.

13 Q. Can you give a couple of examples?

14 A. Like, for hand hygiene, it would be
15 producing a document that shows that you've
16 observed how many -- a historical document that
17 shows your observations, that hospitals are
18 actually observing observations of handwashing
19 events. It could be, like, the training that
20 you're giving to your employees on handwashing
21 and whether it includes certain elements. So
22 that's handwashing.

1 Q. Is it one document per question?

2 A. It really depends on the subject matter.

3 Q. Okay. Fair enough.

4 And are there any site visits?

5 A. Yes. That's the last layer, I would say,
6 of document veri- -- or of data verification.

7 And that is an external company that we contract
8 to do that.

9 Q. What's the name of the company?

10 A. I'm not sure. I think it's called
11 Metastar or something.

12 Q. Madistar?

13 A. Something like that. You'll have to ask
14 Missy Danforth.

15 Q. Okay. Like Medistar maybe?

16 A. Maybe.

17 Q. I don't want you to -- no need to guess.

18 And then do you know how many site visits
19 are conducted?

20 A. No.

21 Q. Even a ballpark?

22 A. No.

1 Q. Okay. Do you know how many hospitals
2 participate in the survey?

3 A. Yes. Somewhere around 2,200.

4 Q. Do you know how many don't participate?

5 A. Well, it depends on what the cohort is.
6 Are you looking at all hospitals that are
7 eligible for the safety grade or all hospitals
8 that are eligible for the survey?

9 Q. Fair enough.

10 How about all hospitals eligible for the
11 safety grade?

12 A. Eligible for the safety grade? It's
13 about 80 percent. I mean, so that's a smaller
14 group of hospitals. It's about 80 percent
15 complete the survey.

16 Q. So the 2,000 reflects the 80 percent and
17 the -- whatever that number that I can't do in my
18 head now would be the other 20 percent?

19 A. Yes. I think -- yeah, about 2800
20 hospitals are graded for the safety grade, and
21 80 percent of those are completing our survey.

22 Q. Okay. Got it. So about 800 don't

1 participate.

2 A. It's less than that, yeah.

3 Q. Okay. Let's see.

4 So if a hospital has to change their
5 survey responses as a result of this process, is
6 there any consequence?

7 A. Well, if they're -- we have data snapshot
8 dates for safety grade. And after those dates,
9 they can't just go in and change their survey.
10 And yes, there are consequences.

11 Q. What if the result is too high? Strike
12 that.

13 So if the change they need to make is
14 lowering a score, will the data snapshot then
15 reflect that higher score?

16 A. No. It's pretty -- it's frozen when it
17 goes into the safety grade.

18 Q. Okay.

19 A. It's one data source. Just like the CMS
20 data is frozen and if they say, oh, there's a
21 discrepancy, they've missed the window of time to
22 dispute that with CMS.

1 Q. Whether it inures to the hospital's
2 benefit or not?

3 A. Right. It doesn't matter if it benefits
4 or not. Sometimes in doc requests, they're going
5 down a grade. Sometimes they're -- you know,
6 they're saying, we should have gotten more points
7 here or there.

8 But we ask hospitals to submit by
9 June 30th, and so they have about a month or two
10 of -- two months of data verification that they
11 go through.

12 Q. You said sometimes hospitals go down a
13 grade or two.

14 Any estimate as to how many hospitals --

15 A. Not a grade -- sorry.

16 Q. Go ahead.

17 A. No. Scoring category.

18 Q. Okay. Got it.

19 You said sometimes go down a scoring
20 category or two, right?

21 A. Based on their survey -- you know,
22 corrections they have to make to their survey.

1 Q. How many hospitals have that downgrade,
2 typically?

3 A. I mean, some of those we don't -- like --
4 you mean in relation to data verification?

5 Q. Yeah. Well, you said that some hospitals
6 have their scoring downgraded as a product of
7 data verification; is that right?

8 A. Sure. Yes.

9 Q. How often does that happen?

10 A. Well, it depends on the time. Like if
11 it's between July and August, it's a good number.
12 Definitely -- I mean, it has to happen before the
13 data snapshot date. So, I mean, it happens.
14 It's a good number.

15 Q. Is that dozens? Hundreds?

16 A. Dozens.

17 Q. Okay. And then going back to -- you said
18 every month -- they're reporting data in every
19 month.

20 Is it -- are there months where, like,
21 the critical mass of hospitals are reporting? I
22 just want to understand the cycle.

1 A. Yes. Our deadline is June 30th.

2 Q. So what -- can you give me a ballpark of
3 approximately what percentage of survey results
4 come in each month?

5 A. Like new surveys?

6 Q. Yeah.

7 A. So I would say, like, by that June 30th
8 deadline, most hospitals have submitted, around
9 2,000, upwards of that. And then maybe perhaps
10 we have, like, 100 the next month and 100 the
11 next month. Then it's pretty stable -- it's very
12 stable at that point.

13 Q. And what about, like, April, May?

14 A. No. The survey is closed during that
15 time.

16 Q. Got it. Okay.

17 A. The last time you can actually submit a
18 brand new survey is November 30th.

19 Q. Okay. Got it. So the bulk come in in
20 June, you said, and then they trickle out 100 or
21 so every month through November?

22 A. Yes. So naturally, the number of

1 hospitals that we're verifying goes down every
2 time.

3 Q. Okay. I want to shift gears and go
4 back -- go back to CMS a little bit.

5 Can you tell me about the CMS star
6 rating? What is that?

7 A. Sure. I mean, again, I'm not the expert
8 in this particular set of measures -- or,
9 actually, program. But the star rating
10 considers -- it includes a lot of the measures
11 that we have in our safety grade, but it also
12 includes other measures. And they have a very
13 technical algorithm, you could say, for how those
14 star ratings are calculated.

15 Q. And are CMS star ratings a measure of
16 hospital safety?

17 A. It includes quality as well. A lot of
18 measures that we -- our expert panel decided a
19 long time ago not to include in the safety grade
20 because they wanted the safety grade to be
21 focused purely on safety.

22 Q. So you're saying the CMS star rating

1 reflects quality and safety?

2 A. Yes.

3 Q. So can you compare the difference between
4 a CMS one-star rating and a Leapfrog F rating?

5 MS. BLAIR: Objection to form.

6 BY MR. CRAIN:

7 Q. What does -- what does a one-star rating
8 convey, in your understanding, to the market?

9 MS. BLAIR: Objection to form.

10 THE WITNESS: I mean, I wouldn't go to a
11 one-star hotel. Like, it's not as good as a
12 five-star.

13 BY MR. CRAIN:

14 Q. So it's measuring -- it's good, in
15 general? Just generally, like, how good
16 something is?

17 A. I think that it's performing worse than a
18 five-star hospital in patient safety and quality.

19 Q. And how does that compare from an F -- to
20 an F?

21 A. They're not apples-to-apples comparison,
22 the safety grades and these star ratings, but I

1 would say that an A-hospital is definitely safer
2 than an F-hospital.

3 Q. Is a five-star hospital safer than a
4 one-star hospital?

5 A. Most likely, yes.

6 Q. Necessarily?

7 A. I mean, this is getting technical.
8 Like -- I mean, I would say yes, it is.

9 Q. Okay.

10 A. Those rates are -- I mean, they're very
11 serious measures that they're including in these
12 things.

13 Q. Based on -- so what's that based on, the
14 "necessarily" -- your response to my
15 "necessarily" question?

16 A. Well, I think that both are a composite
17 of lots of different measures. And you could do
18 really bad in one part and do really well in
19 another part, and you end up with somewhere in
20 the middle; or you can actually do so well in one
21 part component of these measures that are a
22 composite that you actually end up with a

1 five-star rating, for example.

2 Q. Okay. I want to go back to Leapfrog's
3 imputation model.

4 Can you tell me, just stepping back so
5 we're on the same page, what is an imputation
6 model, generally?

7 A. Generally, if you're missing data for a
8 hospital -- sorry, for -- like in a mathematical
9 model, if you're missing data, but you still need
10 to include the observation in your model, you
11 would assign it data.

12 Q. And so -- do you have experience from
13 imputation models prior -- with imputation models
14 prior to your time at Leapfrog?

15 A. I've read about them in studies. I've
16 never personally used one.

17 Q. In what types of studies?

18 A. I mean, they're used in all sorts of
19 epidemiological studies and generally in
20 mathematical models.

21 Q. And when you say imputation, what -- in
22 those mathematical models and studies, what's

1 being imputed?

2 MS. BLAIR: Objection to form.

3 THE WITNESS: Sometimes it can just be a
4 random assignment of, like, a -- kind of like a
5 dummy variable, for example. Or -- there's
6 various ways that you could impute data.

7 BY MR. CRAIN:

8 Q. Does it require secondary data?

9 A. No, not always.

10 Q. And what's the difference between
11 secondary data and primary data?

12 A. Well, if -- are you asking in terms of
13 the safety grade program?

14 Q. In general first.

15 A. Well, I mean, I think the terminology is
16 specific to the safety grade methodology, so I
17 don't understand the question in --

18 Q. Got it.

19 A. -- that context.

20 Q. So secondary data is purely a Leapfrog
21 context?

22 MS. BLAIR: Objection to form.

1 THE WITNESS: No, I would say using that
2 term --

3 BY MR. CRAIN:

4 Q. Okay.

5 A. -- and how it applies. I don't
6 understand what you mean in the previous
7 question.

8 Q. Okay. So tell me what your understanding
9 of the term "secondary data" is.

10 A. As far as the Leapfrog program goes?

11 Q. Your understanding. But if it comes from
12 that, that's fine.

13 A. Like, if someone just walking down the
14 street asks me --

15 Q. Yes.

16 A. -- about secondary data?

17 Q. I'm walking down.

18 A. It comes after primary.

19 Q. Okay. And what's primary data?

20 A. The first data.

21 Q. Okay. And what is it in context of the
22 Leapfrog study -- safety grade?

1 A. If we have primary data, then we will use
2 primary data. If we don't, we will use secondary
3 data.

4 Q. And what is primary data --

5 A. Primary --

6 Q. -- in that context?

7 A. -- data is preferred data.

8 Q. What is preferred data?

9 A. It is the most up-to-date data, most
10 descriptive, and -- yeah. That's why it's
11 primary.

12 Q. Who decides what's primary or preferred?

13 A. Our expert panel.

14 Q. And in the context of the safety grade,
15 was that decided before you came to Leapfrog?

16 A. Yes.

17 Q. Okay. And then what is secondary data in
18 that context?

19 A. Secondary data is what you use when you
20 don't have primary data.

21 Q. And what are the types of secondary datas
22 that Leapfrog use?

1 A. It's changed over time, and it's been
2 used in the safety grade methodology since its
3 inception. And it is -- sometimes it's CMS data,
4 sometimes it's data from other sources like AHA.
5 And now it includes the imputation model.

6 Q. Okay. For how long has Leapfrog used an
7 imputation model?

8 A. I am not sure.

9 Q. There was an imputation model before you
10 started?

11 A. Yes.

12 Q. Tell me -- what did that model look at
13 the time?

14 A. I'm not intimately familiar with how it
15 was used originally. I know what it was like
16 when I got there.

17 Q. That's I mean. When you got to
18 Leapfrog --

19 A. Oh, okay.

20 Q. -- what did the imputation model look
21 like?

22 A. Sorry. So when I got to Leapfrog, there

1 was a step 1 and step 2 imputation.

2 In step 1 imputation, we would go back
3 four rounds, see if the hospital had data
4 previously. That's the previous four rounds of
5 the safety grade.

6 And step 2 would include assigning the
7 hospital to a cohort. This was based on
8 characteristics of the hospital. We got this
9 data from CMS. It's included in this impact
10 file. And it's available for all hospitals in
11 the country. And it includes things like
12 teaching status, bed size, urban/rural status.

13 But we would end up with eight cohorts of
14 hospitals, and then we would calculate how they
15 performed on the Leapfrog survey.

16 Q. Do you know why Leapfrog has an
17 imputation model?

18 A. We have an imputation model because we
19 believe that those four measures are really
20 important, and the safety grade would not be the
21 same without them.

22 Q. Does Leapfrog -- does the imputation

1 model permit Leapfrog to grade more hospitals?

2 MS. BLAIR: Objection to form.

3 THE WITNESS: I mean, I don't agree with
4 that --

5 BY MR. CRAIN:

6 Q. Tell me why.

7 A. -- root of it.

8 I mean, I think that we use secondary
9 sources when available, and the expert panel
10 deemed that these measures were very important
11 and needed a secondary data source. And
12 imputation is how they decided to go about it.

13 Q. The Leapfrog website we looked at earlier
14 says that if six process measures are missing,
15 the hospital should not be graded, correct?

16 A. Correct.

17 Q. If the -- if Leapfrog did not have an
18 imputation model, would six processes be missing
19 for hospitals that do not participate?

20 MS. BLAIR: Objection to form.

21 THE WITNESS: If -- so I think it would
22 be -- you have to look at the methodology as a

1 whole, and I think it would -- other adjustments
2 would have been made.

3 BY MR. CRAIN:

4 Q. Okay.

5 A. It's a hypothetical that doesn't exist.

6 Q. Sure.

7 Without the imputation model, could
8 Leapfrog assign a score to non-participating
9 hospitals for hand hygiene?

10 A. Without --

11 MS. BLAIR: Objection to form.

12 THE WITNESS: Sorry, I don't understand
13 the question.

14 BY MR. CRAIN:

15 Q. If Leapfrog did not deploy an imputation
16 model, could Leapfrog assign a score for hand
17 hygiene for hospitals that do not participate in
18 the survey?

19 A. No, because the imputation model is
20 designed to -- to be a secondary data source.

21 Q. To fill that gap?

22 A. Yes. Because the Leapfrog hand hygiene

1 standard was developed by Leapfrog and is -- and
2 the respective expert panel, and it's deemed
3 extremely important. And there's really no one
4 out there doing -- measuring this.

5 Q. So if the imputation model did not exist,
6 those four measures would not have any result in
7 the scoring methodology, correct?

8 MS. BLAIR: Objection to form.

9 THE WITNESS: I mean, I think that they
10 would have to come -- the expert panel would have
11 to come up with another way of scoring if they --
12 if this was just null.

13 BY MR. CRAIN:

14 Q. Could they have excluded those measures?

15 A. No. I think that it would -- it would
16 not -- the safety grade would not really exist
17 without it. That's not how the safety grade
18 works. The safety grade is designed to grade all
19 hospitals across the country.

20 Q. Why?

21 A. Because that's important. If you look at
22 the scoring methodology, the mean and standard

1 deviation is based on all hospitals. And I would
2 like to know -- I wouldn't want, you know, one
3 hospital in my community not getting graded -- or
4 not being compared to this overall group. It's
5 like -- it's part of the mathematical model of
6 the safety grade, that all hospitals be included
7 and there be a national mean.

8 Q. Is that because it creates an even
9 playing field, for all hospitals to be included?

10 MS. BLAIR: Objection to form.

11 THE WITNESS: I don't understand what
12 that...

13 BY MR. CRAIN:

14 Q. Is grading all hospitals important to
15 make sure hospitals are being compared to every
16 other hospital?

17 MS. BLAIR: Objection to form.

18 THE WITNESS: Yes. I think that it's
19 important to grade all hospitals.

20 BY MR. CRAIN:

21 Q. Is it important to grade all hospitals to
22 the -- sort of the market impact of the safety

1 grade?

2 MS. BLAIR: Objection to form.

3 THE WITNESS: No, not to the market
4 impact --

5 BY MR. CRAIN:

6 Q. Why not?

7 A. -- of the safety grade? I think that
8 it's important -- that the safety grades are
9 valid and I think that it increases their
10 validity by grading all hospitals in the country,
11 not just a select group of hospitals.

12 Q. So if Leapfrog only graded 80 percent of
13 eligible hospitals, the safety grades would be
14 less valid?

15 MS. BLAIR: Objection to form.

16 THE WITNESS: They would be something
17 different.

18 BY MR. CRAIN:

19 Q. Would they be less valid?

20 A. They would be something different.

21 Q. How different?

22 A. They would be -- it would be a subset of

1 hospitals that have shown that they're interested
2 in transparency and patient safety.

3 Q. You said a moment ago that grading all
4 hospitals make the safety grades more valid; is
5 that right?

6 A. For our goals.

7 Q. What are your goals?

8 A. Well, the creators of the safety grade,
9 that group that wrote that original paper of its
10 inception, has written extensively about it and
11 what the goal of the safety grades were.

12 Q. What is your understanding when you said
13 for your goals?

14 A. To create an easy-to-use method for
15 consumers, to see -- to compare hospitals in
16 their area and find one that's the safest.

17 Q. And going back to what you said before
18 when you said the grades are more valid if they
19 grade all hospitals, does that mean if Leapfrog
20 only graded 80 percent of hospitals, the grades
21 would be less valid?

22 MS. BLAIR: Objection to form.

1 THE WITNESS: I think "valid" should only
2 be used, like, in a mathematical context, and I
3 think it's kind of being misused here.

4 BY MR. CRAIN:

5 Q. How?

6 A. I think that it just means something
7 different.

8 Q. Well, 80 percent is a number.

9 A. Do you want to repeat your question?

10 Q. Yeah. You said grading 100 percent of
11 hospitals makes them more valid.

12 If you're only grading 80 percent of
13 hospitals, does that mean they are less valid?

14 MS. BLAIR: Objection to form.

15 THE WITNESS: I think that it would mean
16 something different to consumers.

17 BY MR. CRAIN:

18 Q. What would it mean different to
19 consumers?

20 A. I think it would mean that 20 percent of
21 all hospitals are off the hook. And -- yeah.

22 Q. What do you mean by off the hook?

1 A. That they can -- that they're not being
2 graded by the safety grade.

3 Q. If Leapfrog was only grading 80 percent
4 of hospitals, would it be more or less valid than
5 grading 100 percent of hospitals?

6 MS. BLAIR: Objection to form. Asked and
7 answered.

8 THE WITNESS: Do I have to answer that,
9 then?

10 MS. BLAIR: Yes, you have to answer.

11 THE WITNESS: No.

12 BY MR. CRAIN:

13 Q. It wasn't a yes or no question.

14 MS. BLAIR: I think it was.

15 THE WITNESS: I mean, I just don't think
16 the word "valid" should be used in this
17 situation.

18 BY MR. CRAIN:

19 Q. Then why did you use it with
20 100 percent?

21 A. Because, from a mathematical standpoint,
22 you can use the word "valid."

1 But does something have face validity to
2 a patient? I think that's a different question.

3 Q. Okay. Let's see.

4 THE WITNESS: Oh. Can I --

5 MR. CRAIN: Do you need a break?

6 THE WITNESS: Yes.

7 MR. CRAIN: Okay. We're about an hour.

8 VIDEO TECHNICIAN: The time is 11:28 a.m.

9 This ends unit 2. We're off the record.

10 (A recess was taken.)

11 VIDEO TECHNICIAN: The time is 11:39 a.m.

12 This begins unit number 3. We're on the record.

13 MR. CRAIN: Thank you.

14 BY MR. CRAIN:

15 Q. Ms. Campione, before we go to a new
16 topic, I want to come back and just make sure --
17 we talked a little bit about hand hygiene
18 vis-à-vis the imputation model.

19 If Leapfrog did not have an imputation
20 model, could Leapfrog assign a score for BCMA?

21 MS. BLAIR: Objection to form.

22 THE WITNESS: Are you asking about hand

1 hygiene or BCMA?

2 BY MR. CRAIN:

3 Q. I'm asking now about the other imputed
4 measures.

5 A. Okay.

6 Q. So I'll say it again just to make sure.

7 If Leapfrog did not have an imputation
8 model, could Leapfrog assign a score for BCMA for
9 hospitals that do not participate in the survey?

10 A. Yes, if the expert panel wanted that or
11 decided that.

12 Q. Well, you said before that Leapfrog could
13 not assign a score for hand hygiene in that
14 context.

15 Why could they assign for one for BCMA?

16 A. I -- thinking about this a little bit
17 more, I -- it's the same answer for all four,
18 that, yes, I guess they could do anything, but
19 ultimately, the expert panel would have to sign
20 off on it and whether think it's valid and fair.

21 Q. So I want to make sure I understand your
22 testimony.

1 My question is: If Leapfrog did not have
2 an imputation model, could it assign any of the
3 four imputed metrics a score for
4 non-participating hospitals? And your testimony
5 is Leapfrog could do anything?

6 MS. BLAIR: Objection to form.

7 THE WITNESS: That's -- no.

8 BY MR. CRAIN:

9 Q. I just want to understand. That's what
10 you said.

11 A. No. That's not including everything I
12 just said.

13 Q. True. I focused on the "anything."

14 So tell me, if Leapfrog did not have an
15 imputation model, how could it assign a score for
16 the four imputed measures for non-participating
17 hospitals?

18 A. There's many things that they -- how they
19 could impute. But ultimately, the expert panel
20 chose the way that -- the current imputation
21 model.

22 Q. You just said impute again, though.

1 If Leapfrog was not imputing, how could
2 they assign a score?

3 A. I mean, I guess they could look for
4 another secondary source. So...

5 Q. Are you aware of another secondary
6 source?

7 A. I'm not aware.

8 Q. Okay. Are you aware of another way to
9 assign a score beyond imputation model or other
10 secondary datas?

11 A. No.

12 Q. Okay. And if Leapfrog could not assign a
13 score for those four imputed metrics, isn't it
14 correct that Leapfrog would be missing scores for
15 seven process measures?

16 MS. BLAIR: Objection to form.

17 THE WITNESS: For seven -- yes.

18 BY MR. CRAIN:

19 Q. Okay. And Leapfrog's own expert panel
20 says you can't grade a hospital if you're missing
21 six process measures, correct?

22 A. Yes.

1 Q. So the imputation model allows Leapfrog
2 to score for non-participating hospitals,
3 correct?

4 A. Yes. That's the purpose of an
5 imputation --

6 Q. Because --

7 A. -- methodology.

8 Q. Sorry.

9 Because without the model, your own
10 expert panel would tell you you cannot score
11 these hospitals, correct?

12 MS. BLAIR: Objection to form.

13 THE WITNESS: I mean, I think it depends
14 on a lot of factors. I think that the expert
15 panel is -- would revisit what the purpose of the
16 safety grade is and how, holistically, the
17 methodology fits together, if that -- if somehow
18 it was decided not to go about this imputation
19 method. But they decided the imputation method
20 was fair and accurate.

21 BY MR. CRAIN:

22 Q. Did they decide the imputation method was

1 fair and accurate when they decided that
2 hospitals shouldn't be graded if they're missing
3 more than six process measures?

4 MS. BLAIR: Objection to form.

5 THE WITNESS: Can you repeat that?

6 BY MR. CRAIN:

7 Q. Sure.

8 There was one decision that you're saying
9 the expert panel made to use an imputation method
10 for the four measures, right?

11 A. Yes.

12 Q. And there was another decision you're
13 saying that the expert panel made to say, if you
14 don't have six process measures or more, you
15 shouldn't or can't grade a hospital, correct?

16 A. Yes.

17 Q. And is it shouldn't or can't? We can
18 look at the language, too. Yes, I'm just going
19 to find the language and we'll look at it.

20 A. That I said previously or --

21 Q. It's on the website.

22 A. Oh, okay.

1 Q. We'll find the website language.

2 MS. BLAIR: I think it's in the scoring
3 methodology.

4 THE WITNESS: Yeah.

5 BY MR. CRAIN:

6 Q. Yeah. It's the first exhibit, page 4.

7 Is this it? No, this isn't it.

8 A. Oh, no, it would be the eligibility page.

9 Q. Yeah.

10 A. Page 3.

11 Q. Page 3. See, you do know these documents
12 better than I do.

13 Which document are you on? Oh, you're
14 looking at the methodology.

15 A. Scoring methodology.

16 Q. Got it. Okay.

17 A. Or the hospital safety grade.

18 Q. Page 3. And what's the language?

19 A. Hospitals that are missing scores for
20 more than six process structural measures or more
21 than five outcome measures or missing PSI 90.

22 Q. Let's see. And it says Leapfrog is not

1 able to calculate a safety grade, correct?

2 A. Yes.

3 Q. Okay. So it can't calculate a safety
4 grade if you're missing six process measures,
5 right?

6 A. Correct. But you have to keep in mind
7 that when they created these cutoffs for the
8 amount of measures, they were looking at what
9 measures were available at the time and their
10 sources.

11 So that's what I mean when I say that the
12 expert panel -- you have to look at it
13 holistically. I don't think that these are
14 cutoffs that are live and die for. They're
15 looking at the methodology holistically.

16 Q. So you're saying the question of what the
17 cutoff is is decided in the context of what is
18 available?

19 A. Yes. Of what measures.

20 Q. Okay. So if other measures were not
21 available, they could lower those cutoffs?

22 A. I -- you would have to ask them.

1 Q. Okay. Okay.

2 Just one question before we move on on
3 the imputation model. Are you aware of any plans
4 that Leapfrog has to change the imputation model
5 in the future?

6 A. Right now we're meeting with a
7 subcommittee of the expert panel to look at the
8 weighting scheme. But no, there are no planned
9 changes related to the imputation.

10 Q. Who's on the subcommittee?

11 A. Dr. Romano. And I forget the name of the
12 other woman.

13 Q. Okay. Are they members of the same
14 committee that worked on the imputation model in
15 2024?

16 A. They are members of the safety grade
17 expert panel.

18 Q. And that's the panel that met in April of
19 2024 about the imputation model --

20 A. Yes.

21 Q. -- correct? Okay.

22 So I want to shift gears to that

1 imputation model change.

2 Do you know what I'm talking about when I
3 refer to the 2024 change in methodology?

4 A. Yes.

5 Q. And can you -- just so we're on the same
6 page, in 2024, how did Leapfrog change the
7 imputation methodology?

8 A. So in -- was it fall 2024? -- Leapfrog
9 moved to no longer use the old step 2 methodology
10 where hospitals were assigned to cohorts and
11 means were calculated for each of the measures.

12 They also changed step 1 methodology to
13 impute only two past scores instead of the four
14 past scores.

15 Q. So the prior methodology imputed four
16 rounds of scores back -- strike that. Sorry.

17 In the prior methodology, the hospital
18 would receive whatever its score was on those
19 measures for any of the four past measures?

20 A. Yes.

21 Q. Okay.

22 A. Four -- yeah.

1 Q. The --

2 A. Four past rounds.

3 Q. And in the new methodology, that would
4 only go to two past rounds?

5 A. Yes.

6 Q. In the step 2, the prior methodology
7 assigned them the mean of their cohort, right?

8 A. Yes.

9 Q. Okay. And the new methodology
10 automatically assigns them limited achievement?

11 A. Yes. And I will clarify that the mean of
12 their cohort -- there were two separate means
13 calculated. One was the first score that the
14 hospitals received after, like, 2018, for the
15 measure, and the other was just the current mean.

16 Q. Okay. And do you know -- it was the
17 lower of the two scores?

18 A. The lower of the two scores. Yes.

19 Q. And do you know why it was constructed
20 that way?

21 A. Well, it was realized that hospitals,
22 when they were completing the survey for the

1 first time, hadn't done it previously. Their
2 performance is not the same as a hospital that
3 has continually been benchmarking themselves and
4 completing our survey.

5 Q. And why does that result in the
6 imputation model that was -- the old imputation
7 model? How does that connect?

8 A. So essentially, if a hospital is not
9 completing our survey, it's presumed that they
10 would perform similarly to those hospitals the
11 first time they went to take the survey.

12 Q. Even if the hospital had performed it in
13 the past?

14 A. I would say, on average, yeah. They did
15 some sort of analysis at that time -- it was
16 before my time there -- that looked at that
17 performance, and it was very clear.

18 And I do see it in our data now.
19 Hospitals completing it for the first time,
20 they -- it takes them time to get to the
21 standards that we set.

22 Q. And when you say they completed an

1 analysis, who is that?

2 A. It would have been Matt Austin.

3 Q. And Ms. Danforth?

4 A. She doesn't actually complete the
5 analysis. She would have been present for
6 receiving the results.

7 Q. Okay. And when you say an analysis, what
8 form does that take?

9 A. Well, an analysis includes looking at the
10 scored file, looking at past scored files from
11 the hospital safety grade, putting the hospitals
12 into categories, creating, you know, percentages
13 and -- of how their performance is.

14 Q. Sorry --

15 A. Yeah.

16 Q. -- it was an unclear question. I just --

17 A. Some graphs.

18 Q. Thinking.

19 My question was: Is that analysis
20 written down somewhere?

21 A. I would assume that it's somewhere.

22 Q. Like a white paper? An e-mail? Like

1 what form?

2 A. Not a white paper. It was just an
3 internal analysis.

4 Q. Okay.

5 A. We do those a lot to make sure that --
6 you know, to understand trends in the data.

7 Q. Is that, like, a memorandum or an e-mail?

8 A. It might be in the form of an e-mail. It
9 might be in the form of an attachment on an
10 e-mail.

11 Q. Okay. Like an Excel spreadsheet?

12 A. Sure, it could be an Excel spreadsheet.
13 It could be a paper drawing. I don't know.

14 Q. Okay. No one size fits all.

15 A. Yeah.

16 Q. Okay. And there's no custom or practice
17 within Leapfrog as to what this looks like?

18 A. No.

19 Q. So going back to the change to the
20 imputation methodology, what was your role in the
21 process through which the methodology was
22 changed?

1 A. Okay. So -- let me think back. So since
2 I joined, I was producing a stats document every
3 time I scored that keeps track of those cohort
4 means. It was also in the scoring methodology,
5 so it was publicly available what those final
6 means were for each cohort.

7 And what I noticed was that the mean was
8 consistently going up over time, and that just
9 didn't seem right. It just -- it didn't really
10 make sense.

11 So I brought this concern up to Missy,
12 and Missy was aware that this was happening. She
13 had been monitoring it as well and noticed that.

14 We brought up this concern to Matt
15 Austin, and he slated it to be on the agenda in
16 the expert panel meeting.

17 At that time, we presented to them the
18 current methodology for scoring, and we also
19 presented -- part of being an analyst like I am
20 is just analyzing options with our data, what to
21 do. And we presented some options that we could
22 take.

1 We presented to the expert panel a lot of
2 the -- a lot of them actually thought that we
3 should be giving zero points to hospitals at this
4 point. They decided that the best course was the
5 one that we ended up going with, which is
6 reducing the number of past scores that are
7 imputed through step 1, and with step 2 assigning
8 hospitals to the lowest scoring category of
9 limited achievement.

10 Q. So you said -- you were talking about
11 conversations with the expert panel about this
12 topic, right?

13 A. Yes.

14 Q. Was -- were those happening only in the
15 meeting that happened?

16 A. Yes.

17 Q. Were there any other discussions?

18 A. We -- so I believe that Dr. Romano
19 couldn't be there for the actual expert panel
20 meeting, so we met with him beforehand because it
21 was important that we include everyone from the
22 expert panel in this decision.

1 And it was -- there was a consensus, as I
2 recall, by the end of that expert panel meeting.

3 Q. Okay. And your testimony was a lot of
4 them -- meaning the expert panel -- actually
5 thought that we should be giving zero points to
6 hospitals at this point.

7 Do you recall that testimony a minute
8 ago?

9 A. Yes.

10 Q. Several minutes ago.

11 Who is "them"?

12 A. The expert panelists.

13 Q. Can you name any names?

14 A. No. I can't remember exactly the names.

15 Q. Peter Pronovost?

16 A. That sounds right.

17 Q. Arjun Srinivasan?

18 A. That sounds right, too.

19 Q. Let's see. I think -- there are a few
20 others, but we'll come to them later.

21 Your testimony is that, on that call,
22 those folks expressed that Leapfrog should be

1 giving zero points to hospitals at this point?

2 A. I think -- I mean, they're all recorded.
3 You can watch the meetings.

4 My takeaway -- and it's not my job to
5 summarize what they thought or they felt. That
6 would be more Matt Austin is facilitating this
7 along.

8 They -- their reception was positive.
9 They felt that they -- at this point, our
10 Leapfrog hospital survey has existed since 2002.
11 80 percent of hospitals are completing our survey
12 that are -- go on to be graded.

13 They thought that hospitals that were
14 committed to being transparent with the public
15 and completing our survey and benchmarking
16 themselves, that that was worth something.

17 And I think that was expressed in the
18 meeting.

19 Q. And you said the meeting was recorded?

20 A. Yes.

21 Q. Have you watched that recording since the
22 meeting?

1 A. No, I haven't.

2 Q. Are you aware of whether that recording
3 has been produced in this case?

4 A. No, I don't know.

5 Q. Okay. You said that their reception was
6 positive at the meeting.

7 Can you tell me, what was their reception
8 positive to?

9 A. Doing away with a calculation of a mean
10 for the cohorts. The means were very high.
11 They -- in many cases, hospitals that didn't do
12 the survey at all could receive more points than
13 hospitals that had done the survey and were
14 trying to score better.

15 Q. At the meeting, did you or anyone else
16 present the option of automatically assigning,
17 for non-participating hospitals, the limited
18 achievement metric?

19 A. Yes. That was one of the options we put
20 forward.

21 Q. During the meeting?

22 A. During the meeting, yes, I believe.

1 Q. Who presented that option?

2 A. I think -- I mean, I would have presented
3 the analysis. It was either Matt Austin or me.

4 Q. Okay.

5 A. Or Missy. I mean, it's a collaborative
6 setting.

7 Q. All three of you were on the call?

8 A. Yes.

9 Q. I want to just talk about that meeting a
10 little bit, and then we'll come back in time.

11 Was the meeting in person or virtual?

12 A. Virtual.

13 Q. On Zoom or Teams?

14 A. Zoom.

15 Q. Okay. Can you tell me everyone you
16 remember who attended?

17 A. No, I can't.

18 Q. Can --

19 A. I mean, like, I don't remember.

20 Q. Who do you remember attending?

21 A. The names you said earlier: Arjun,
22 Peter, Matt, Missy, me. Of course I said

1 Dr. Romano was in there.

2 I believe her name is Sara.

3 I would have thought at least the
4 majority were there of the expert panelists.

5 Q. And you recall that Dr. Romano did not
6 attend?

7 A. No. I think that he couldn't meet at
8 that time.

9 Q. Okay. How long was the meeting?

10 A. They're typically an hour, maybe more.

11 Q. Are they always on Zoom?

12 A. I -- since I've been here, yes.

13 Q. Does Leapfrog generally meet virtually?

14 A. Yes --

15 Q. That --

16 A. I was in Boston, and --

17 Q. That was a bad question. Strike that.

18 When Leapfrog has an internal meeting,
19 are they typically virtual?

20 A. Has -- sorry. Has, like, an expert panel
21 meeting?

22 Q. No, no, internal to --

1 A. Internal. Oh. Zoom.

2 Q. It's over Zoom?

3 A. Yes.

4 Q. Are those recorded?

5 A. No.

6 Q. Okay. So the only meetings -- what
7 meetings are recorded?

8 A. Expert panelist meetings.

9 Q. Are expert panels or just the safety
10 grade panels?

11 A. I think all expert panels.

12 Q. And are the recordings available to the
13 public?

14 A. We've never been -- request that.

15 Q. Okay.

16 A. Or had that requested of us.

17 Q. And to your knowledge, they're not
18 publicly available?

19 A. I wouldn't say that's because we're
20 trying to hide anything. They just aren't.

21 Q. I'm just trying to get at whether they
22 are.

1 A. No.

2 Q. Whether you're trying to hide something
3 is a different question. We can come back to
4 that later.

5 Do you remember who was on camera on the
6 Zoom?

7 A. No.

8 Q. Okay. How did the meeting -- so can you
9 tell me everything you remember about the
10 meeting? Just walk me through soup to nuts. If
11 you remember nothing, that's fine. But I want
12 every memory you have about it.

13 A. We presented the PowerPoint. And I
14 just -- I remember Peter perhaps saying something
15 about how he has knowledge of specific hospitals
16 that have decided not to complete the survey
17 because they actually -- they realize, oh, we can
18 get a higher grade -- or, sorry, a higher score
19 for these imputed measures if we just don't do
20 the survey rather than try.

21 And they decided that transparency is key
22 and that those hospitals that do complete the

1 survey and are committed to transparency should
2 not be penalized.

3 Q. Did you present the methodology that
4 ultimately took effect at that meeting?

5 A. I think so. Some form of it perhaps.

6 Q. And the feedback was -- they approved of
7 it?

8 A. Yes. I believe so.

9 Yeah, I don't remember any dissent at the
10 meeting. It was, like I said before, positive.

11 Q. And there were no further meetings?

12 A. I don't think so.

13 Q. Okay. Do you remember anything that
14 Arjun Srinivasan said?

15 A. No.

16 Q. Anything that Sara Singer said?

17 A. No. But I believe that she was -- I
18 remember, overall, she was positive about it.

19 Q. Anything that Kathy McDonald said?

20 A. No.

21 Q. Anything that Peter Pronovost said
22 besides what you've testified to?

1 A. No.

2 Q. Doris Peter?

3 A. No.

4 Q. Arnold Milstein?

5 A. No.

6 Q. And the last one I have is Tim Vogus.

7 A. I remember Tim was wearing a T-shirt.

8 Q. Fair enough. Visual memory.

9 Did Ms. Binder attend?

10 A. No.

11 Q. Does she typically attend the expert
12 panel --

13 A. No, she has no involvement.

14 Q. Okay. Had no involvement?

15 A. With expert panels, no.

16 Q. Okay. And then who attended for
17 Leapfrog?

18 A. Missy and I attended.

19 Q. And then Dr. Austin's role, is he on the
20 panel or is he at Leapfrog?

21 What is his position?

22 A. He's not on the panel. He's kind of

1 responsible for organizing the meetings,
2 facilitating them, ensuring that a consensus is
3 reached, then summarizing afterwards what was
4 said at the meeting.

5 Q. Does he, like, work for Leapfrog?

6 A. You know, like, I -- no, he's not an
7 employee.

8 Q. Yeah. Okay. But he -- what role does he
9 serve then?

10 A. I mean, I see him more as, like, an
11 advisor, like, an academic-type advisor. He's
12 kind of like a consultant.

13 Q. Got it. So he is not on the expert
14 panel?

15 A. No.

16 Q. And he's a little bit more, like you
17 said, a facilitator?

18 A. Uh-huh.

19 Q. Okay. I want to just go back in time --
20 sorry. Before we leave this meeting -- and this
21 is the April 12, 2024, meeting, correct?

22 A. Yes, that sounds right.

1 Q. And we can show you some documents to
2 refresh you if you need it.

3 But do you have any recollection about
4 whether someone -- whether anyone talked about
5 hospitals being disincentivized to participate in
6 the survey?

7 A. Yes. I mean, I kind of -- I think that
8 goes hand in hand with everything else that was
9 said.

10 Q. And what was the disincentive being
11 discussed?

12 A. I think that's kind of what I was
13 referring to earlier with Peter saying that if a
14 hospital realizes that they could just not do the
15 survey and get a score that's higher than they
16 would have otherwise, why wouldn't they take that
17 opportunity?

18 Q. Was the root of that problem step 1 or
19 step 2?

20 A. Step 2. Step 1 -- so basically -- well,
21 the issue with step 1 is, if we're going back
22 four rounds, that would include two past surveys.

1 And the concern was if you're going back two
2 surveys, that data might not be accurate anymore.
3 Every year a hospital can change how they operate
4 and the processes they have in place. So it's
5 not -- it could possibly not be accurate to
6 impute data that far back.

7 So that was the concern with step 1.

8 And the concern with step 2 was that the
9 mean was too high and not an accurate portrayal
10 of how hospitals are actually performing.

11 Q. Okay. Did anyone on the expert panel
12 address any concerns in adopting the approach
13 that you or Dr. Austin or Ms. Danforth were
14 presenting?

15 A. Yes. I think, like, Dr. Romano had some
16 concerns with it --

17 Q. Sorry. Just -- I don't want to
18 interrupt, but I'm going to do it anyway.

19 Dr. Romano was not at the meeting, so I'm
20 talking about --

21 A. No --

22 Q. -- what happened --

1 A. Oh, okay. But we did meet with him the
2 same day --

3 Q. Oh, you met with him the same --

4 A. -- if I remember correctly.

5 THE REPORTER: Can I just ask you to --

6 MR. CRAIN: Sorry, my fault. I'm getting
7 excited.

8 BY MR. CRAIN:

9 Q. You met with him the same day, you said?

10 A. Yes.

11 Q. Okay.

12 A. I think so.

13 Q. Got it.

14 So maybe step back. Tell me about that
15 meeting.

16 A. I think his concern was with a particular
17 hospital that he works with -- I think it's,
18 like, UC Davis -- where they were coming to him
19 and saying, oh, this survey is a lot of work; we
20 don't want to do it every year.

21 And so he was just worried about the
22 burden of the survey every year. And that's, you

1 know, anecdotal information that he had.

2 And so he was expressing those concerns
3 to us. And that really had to do with doing -- I
4 believe we originally proposed -- we were just
5 putting everything on the table -- phasing out
6 step 1 imputation altogether. And his -- I think
7 he just had reservations about that.

8 Q. Who attended the meeting with Dr. Romano?

9 A. Missy Danforth and Matt Austin.

10 Q. Were you there as well?

11 A. Yes.

12 Q. Was that over Zoom?

13 A. Yes.

14 Q. Was that recorded?

15 A. No.

16 Q. How long was that meeting?

17 A. 30 minutes to an hour.

18 Q. Was the only subject discussed the
19 imputation model?

20 A. We would have shown him the PowerPoint
21 that we showed all expert panelists. And I think
22 we had, like, one other -- we showed -- we

1 started grading MTF hospitals that year -- that's
2 military treatment facilities. We shared that
3 with him.

4 But the primary topic was the imputation
5 model.

6 Q. And there was another topic about
7 hypoglycemia?

8 A. Yes.

9 Q. Did you share that with him, too?

10 A. Yes, we did.

11 Q. Okay. So in that 30 minutes, you covered
12 the military treatment hospitals, the imputation
13 method, and the hypoglycemia?

14 A. Yes.

15 Q. Okay. What was the conclusion of that
16 meeting, if any?

17 A. He wanted to see how the other expert
18 panelists felt.

19 Q. And after the other expert panel --
20 panel -- after -- strike that, sorry. A little
21 tongue tied today.

22 After the end of the April 12th meeting,

1 did you tell him that the other expert
2 panels [sic] had voted in favor of the new
3 change?

4 A. I don't know what happened after that. I
5 mean, that's really Matt Austin's job.

6 Q. Got it. Okay.

7 Do you communicate with Dr. Romano
8 separately from Dr. Austin?

9 A. Sometimes, like, we'll -- it's a very
10 collaborative environment where -- like
11 especially on these expert panels -- where people
12 will just -- I mean, it's good to express
13 concerns, and I think that we all do that, just
14 to make sure that we're getting to something that
15 is fair. And, I mean, that's just kind of how
16 science works.

17 Q. How science works. That's the mantra.
18 That's the slide on the case.

19 Okay. And was -- at any time was there
20 any vote taken with or without Dr. Romano?

21 A. We don't really do votes. If someone
22 felt strongly that they disagreed, they -- I

1 would assume it would be their responsibility to
2 bring that up, put it in writing if they really
3 felt -- if they felt strongly against something.

4 That definitely didn't happen on the
5 meeting, and I think Matt summed it nicely in his
6 takeaways, and I assume that he communicated that
7 to Patrick Romano.

8 Q. Let me ask this question: Kathy McDonald
9 was at the meeting, right?

10 A. Probably.

11 Q. Okay. If you don't remember, I'll try
12 someone else.

13 Sara Singer was at the meeting?

14 A. Probably.

15 Q. Okay. How did you know that Sara Singer
16 was -- had approved the methodology that Leapfrog
17 instituted?

18 A. It's not my job to see if they approve or
19 not.

20 Q. Whose job is it?

21 A. Matt Austin's.

22 Q. Who is not a Leapfrog employee?

1 A. No. But he -- I would say it's his job
2 to just make sure that everyone is comfortable
3 with it, hear everyone's opinions, and ensure
4 that they're expressed fairly and, like, the
5 takeaways.

6 Q. So --

7 A. Recommendation, I should say.

8 Q. Recommendation. What do you mean
9 recommendation?

10 A. From the expert panel.

11 Q. Is it a recommendation or a decision?

12 A. I mean, it's a decision and, you know,
13 ultimately, I guess, Leapfrog could do whatever
14 they want, but they don't. They always listen to
15 what the expert panel decides.

16 Q. So you have no understanding of how
17 Dr. Austin confirms that Sara Singer approves?

18 A. No, I'm not involved in that.

19 Q. Would Ms. Danforth know?

20 A. She might. Her and Matt probably
21 communicate more than I do with Matt [sic].

22 Q. I want to go back a little bit in time.

1 So we were talking about the April 12th meeting,
2 2024. I want to start a little bit earlier.

3 So you said maybe 20 minutes ago that you
4 raised a concern in the data.

5 Do you recall that testimony?

6 A. Yes.

7 Q. Approximately when do you recall raising
8 that?

9 A. I don't know. Maybe -- definitely -- it
10 was a growing concern, so maybe in the spring of
11 the -- so if we were doing this in spring 2024,
12 so maybe spring 2023 into fall 2023. And this
13 would have been just verbal in my meetings with
14 Missy and Matt.

15 Q. So sometime spring or fall 2023 was the
16 first time --

17 A. Yes.

18 Q. -- you --

19 A. I mean, it's something that --

20 THE REPORTER: Sorry. I just -- I
21 can't --

22 MR. CRAIN: No worries. No worries.

1 THE WITNESS: It's something that was
2 ongoing. It was in the back of our minds.

3 BY MR. CRAIN:

4 Q. And just to help you triangulate, do you
5 remember if it was hot or cold outside?

6 A. No.

7 Q. Had the leaves turned?

8 A. No, I don't recall.

9 Q. Worth a try.

10 What is HCA?

11 A. It's a hospital system.

12 Q. And did there come a time that -- did HCA
13 participate in Leapfrog's survey?

14 A. I believe so.

15 Q. And did there come a time where HCA
16 decided not to participate?

17 A. There was a time when they were, at the
18 initial submission of, like, June 30th -- after
19 that, I believe it came to -- came up in a
20 meeting that they hadn't submitted yet. Like,
21 all of their hospitals.

22 Q. And how many hospitals was that,

1 approximately?

2 A. I don't know how many HCA hospitals there
3 are. I don't grade the survey.

4 Q. Do you think -- was it a meaningful
5 number?

6 A. Define "meaningful."

7 Q. Was it more than a dozen?

8 A. Yes.

9 Q. More than 50?

10 A. Yes.

11 Q. Okay. More than 100?

12 A. I don't know.

13 Q. Okay. So somewhere between maybe 50 and
14 100?

15 A. Sure.

16 Q. Okay. How did Leapfrog react to HCA's
17 decision to not participate?

18 A. I don't know.

19 Q. You had no involvement in that?

20 A. No.

21 Q. Did HCA ultimately end up coming back to
22 participate?

1 A. I believe that they do.

2 Q. Do you know why they --

3 A. The survey.

4 Q. -- came back?

5 A. No.

6 Q. Okay.

7 A. I don't.

8 Q. Would Ms. Danforth know?

9 A. Yes.

10 Q. Would Ms. Binder know?

11 A. Yes.

12 Q. Around that time period -- do you --
13 sorry, strike that.

14 Do you remember approximately when HCA
15 stopped participating?

16 A. If that's -- it was either last year or
17 the year before, around August or September --
18 or -- sorry, hold on.

19 Around -- I'm thinking of when we first
20 score -- is in July. So it would have been,
21 like, late July, early August.

22 Q. 2023?

1 A. Yes. Wait -- yes.

2 Q. Okay. Final answer?

3 A. I'm not good with dates.

4 Q. That's okay.

5 Last year was the imputation methodology
6 change. The year before was HCA.

7 Does that sound right?

8 A. Yes. Yes.

9 Q. Just to triangulate us all.

10 Now, around that same time, do you recall
11 whether Leapfrog was seeing a decline in the
12 number of hospitals that were participating in
13 the survey?

14 A. Well, I mean, if 100 aren't doing it,
15 then that would be a decline.

16 Q. Fair enough.

17 What about a decline beyond HCA?

18 A. No. I have looked at survey
19 participation since 2002, and it's always been an
20 upward trajectory.

21 Q. Okay.

22 A. Except for COVID, I will say.

1 Q. Okay. And participation is some -- is
2 participation something that Leapfrog wants?

3 A. Yes. We want hospitals to be
4 transparent.

5 Q. And you sort of answered it, but just to
6 be clear, why does Leapfrog want hospitals to
7 participate?

8 A. Because ultimately it benefits the public
9 to have this information.

10 Q. And does it benefit Leapfrog?

11 A. I mean --

12 MS. BLAIR: Objection to form. Sorry --

13 THE WITNESS: Yeah.

14 MS. BLAIR: -- I'm just --

15 THE WITNESS: If our mission is for the
16 public to have more transparent information, then
17 yes.

18 BY MR. CRAIN:

19 Q. Does it benefit Leapfrog economically?

20 A. No.

21 Q. Not at all?

22 A. No.

1 Q. Increased participation does not yield
2 any additional revenue?

3 A. It's a free survey.

4 Q. Okay. Let's take a look at a document.

5 MR. CRAIN: I'm going to go to tab 11.

6 (Campione Deposition Exhibit 4 marked for
7 identification and attached to the
8 transcript.)

9 BY MR. CRAIN:

10 Q. Okay. So Ms. Campione, do you recognize
11 this document?

12 A. No. I can see that I sent it.

13 Q. You sent, I think, the second e-mail on
14 the first page ending in Bates number 2604.

15 Do you see that?

16 A. Yes.

17 Q. And it's dated November 2023?

18 A. Uh-huh.

19 Q. Okay. I want to --

20 A. I'm sorry, yes.

21 Q. I'm sorry. Go ahead.

22 A. Yes.

1 Q. I want to go to the second page that's
2 Bates number 2605.

3 And do you see this is an e-mail from
4 Ms. Danforth to Mr. Banerjee and you?

5 A. Uh-huh.

6 VIDEO TECHNICIAN: Counsel.

7 MR. CRAIN: Oh, I'm sorry. Am I
8 blocking? I'm sorry.

9 BY MR. CRAIN:

10 Q. And she says, Hi Kush and Alex, I'd like
11 to get a sense of the number of licenses that
12 don't submit a survey and the percentage of
13 accolades/revenue those facilities represent for,
14 say, the past two years, last four rounds. Can
15 the two of you work together on this?

16 Can you tell me what your understanding
17 of that request is?

18 A. I'm going to need some more time to read
19 through this.

20 Q. Take your time.

21 A. Okay. Thank you.

22 Okay. What's the question related to

1 this?

2 Q. So the first e-mail -- it goes from
3 bottom to top the way this was produced: I'd
4 like to get a sense of the number of licensees
5 that don't submit a survey and the percent of
6 accolades/revenue those facilities represent for,
7 say, the last two years.

8 What is she referring to, in your
9 understanding, when she says the number of
10 licensees that don't submit a survey?

11 A. I'm not really sure. I know how to get
12 her the data and -- to which I see I reply in
13 that regard.

14 I'm not totally certain what -- why she
15 needs this.

16 Q. I'm asking a more basic question.

17 A. Uh-huh.

18 Q. What are the licensees that she's talking
19 about?

20 A. So she's -- she would be referring to the
21 accolades program.

22 Q. Okay. Tell me about the accolades

1 program.

2 A. So that is when an A-hospital wants to
3 advertise their A grade. Whether they're trying
4 to share it with the community or celebrate it
5 internally, they have to license it.

6 And that's definitely the licensee she's
7 referring to here. I can tell that.

8 Q. And so she's asking you to find the
9 percentage of accolades/revenue that the number
10 of licensees who don't submit a survey encompass?

11 A. Yes.

12 Q. Okay. And then the second
13 paragraph says, Due to step 1 imputation and as
14 the means for step 2 imputed data increase over
15 time, there's a risk of reducing incentive to
16 submit a survey every year -- all caps -- and I'm
17 starting to see this come through in some of the
18 questions we are getting on the help desk.

19 So a few questions on this one.

20 Do you know what questions she's
21 referring to for the help desk?

22 A. So -- okay. So what she's getting at

1 here is exactly what we talked about earlier.
2 It's what was discussed with Dr. Romano. It's
3 what was discussed by Peter in the expert panel
4 meeting. There's just -- sometimes you can get a
5 sense on the help desk what the hospital is
6 asking. And it's just a sense that hospitals
7 sometimes skip survey years because they know
8 that the data can get imputed through step 1
9 imputation.

10 Q. Okay. So they skip the survey year
11 because they can use a prior score?

12 A. Yes.

13 Q. So it's a little bit of a shortcut for
14 them?

15 A. Yes.

16 Q. Okay. And then she says, I'd like to
17 understand how [sic] financial risk if we make
18 changes to how we display grades for hospitals
19 that don't submit.

20 Do you see that?

21 A. Yes.

22 Q. And you testified a minute ago that

1 participation has no effect on revenue.

2 Is that -- do you want to change that
3 testimony? Is that --

4 A. No, I don't. I stand by that.

5 Q. Okay. How do you make your testimony
6 consistent with her sentence here?

7 A. They're two totally separate programs.

8 Q. Okay. So what is the financial risk that
9 you understand her to be talking about here?

10 A. The -- I honest -- I don't know what she
11 means by the last sentence.

12 Q. You have no understanding of the
13 financial risk?

14 A. I'd like to understand how financial
15 risk -- well, first of all, it's not phrased
16 correctly.

17 Q. I think there's a typo.

18 A. If we make changes to how we display --
19 see, I don't even know what she means by "how we
20 display grades for hospitals that don't submit."

21 Q. Okay. So I just want to be very clear:
22 You are aware of no financial risk that would

1 exist if Leapfrog made changes to how they
2 display grades for hospitals that don't submit
3 surveys?

4 A. I don't understand the connection, to be
5 honest.

6 Q. Are you aware of any financial risk that
7 exists if participation goes down?

8 A. No, I am not.

9 Q. Okay. Just taking a look at this.

10 Now, going up to your e-mail, you said
11 you have the data.

12 Do you recall sending that data over to
13 her subsequently?

14 A. Sure. Yes.

15 Q. Okay. And then Mr. Banerjee responds,
16 Could that be why HCA suddenly stopped
17 submitting?

18 Do you have an understanding of what he
19 meant there?

20 A. Yes. I mean, this would just be putting
21 HCA in that category of hospitals that take a
22 shortcut and complete the survey every other

1 year, for instance.

2 Q. He was surmising that they were not
3 responding because of step 1, right?

4 A. Yes.

5 Q. And he says, I think we looked at this
6 trend many years ago and I believe there was
7 correlation to survey participation and As, as
8 well as participation and licensing.

9 Do you see that?

10 A. Yes.

11 Q. Are you aware of Leapfrog having looked
12 at that trend many years ago?

13 A. Yes.

14 Q. Tell me --

15 A. I've looked at it. Like, you can look at
16 the profile, for instance, of a hospital that
17 licenses.

18 Q. Okay. And licensing is a revenue stream,
19 right?

20 A. Yes.

21 Q. Are hospitals that -- strike that.

22 Do hospitals that participate in the

1 survey -- no, let me strike it again.

2 Are hospitals that participate in the
3 survey more likely to license than hospitals that
4 do not?

5 A. Yes.

6 Q. So again, I want to ask you, are you
7 aware of any financial risk if participation goes
8 down?

9 A. That -- I mean, that's not to say that
10 the hospitals that stop submitting -- say it's
11 10 percent of those hospitals that stop
12 submitting. I don't know that they are hospitals
13 that license.

14 So no, I can't say that there's a direct
15 correlation there.

16 Q. A direct correlation between what?

17 A. I would have to do a separate type of
18 analysis and see, oh, if -- you know, the
19 hospitals that we see not completing it in
20 previous years, were they -- are they the
21 hospitals that license? I don't...

22 But I can say that, yes, the majority of

1 hospitals that license, accolades, are hospitals
2 that participate in Leapfrog. They care about
3 Leapfrog, they have devoted resources to
4 Leapfrog, and they're familiar with Leapfrog.

5 So yes, obviously, they're the hospitals
6 that license as well.

7 Q. Okay. And accolades is a revenue stream,
8 correct?

9 A. Yes.

10 Q. Okay. Do you recall completing an
11 analysis of the correlation between participation
12 and licensing?

13 A. Yes, I do.

14 Q. Okay. Let's look at what I think is that
15 analysis. You'll tell me.

16 MR. CRAIN: This will be Exhibit 5.

17 (Campione Deposition Exhibit 5 marked for
18 identification and attached to the
19 transcript.)

20 (Discussion off the record.)

21 BY MR. CRAIN:

22 Q. Okay. Do you recognize this document?

1 A. Let me get to the attachment --

2 Q. I want to start with the invite first.

3 A. Okay. So this is -- oh, I see. Okay.

4 Q. Yeah, so I'll walk you through it.

5 A. Okay.

6 Q. This is -- tell me if you -- so is this a
7 calendar invite from Kush Banerjee?

8 A. Yes.

9 Q. Do you see on the top left it says,
10 Appointment?

11 A. I see that.

12 Q. And it's sent to you, Ms. Danforth, and a
13 bunch of others.

14 Do you see that?

15 A. Yes.

16 Q. What is LeapfrogLeaders@Teleflex.com? Do
17 you know who that is?

18 A. So I believe Lindsay Belville, who's
19 listed as an attendee, she devotes the majority
20 of her time, or did -- just one person there --
21 to Leapfrog, to Leapfrog activities.

22 Q. And --

1 A. So I think she has an e-mail with
2 Leapfrog.

3 I'm not sure exactly. I know that she
4 accesses that account --

5 Q. And what --

6 A. That e-mail.

7 Q. Oh, I'm sorry.

8 A. Sorry.

9 Q. Yeah, it's hard.

10 What is TelAffects, though?

11 A. I believe they're telemarketers. That's
12 the Tel in TelAffects.

13 Q. Everyone's favorite.

14 And the subject says, TelAffects Leapfrog
15 system communication group.

16 Do you see that?

17 A. Yeah -- the subject? Yes.

18 Q. Yeah, the subject.

19 And what type of telemarketing are the
20 TelAffects folks engaged in?

21 A. So they do -- I don't know if they do the
22 data licensee sales. That might just be Kush.

1 I'm really not familiar with what they do. They
2 sell the accolades programs, definitely. And I
3 see a PowerPoint, like, once -- around -- with
4 what they did --

5 Q. Do they, like, cold call hospitals?

6 A. I think -- yeah, I think they call, they
7 e-mail, they have contacts there. They do their
8 whole thing.

9 Q. Got it. Relationship management type.

10 A. Yes.

11 Q. And then there's an attachment, you see,
12 it says 2023 safety grade media coverage
13 accolades V3.pptx.

14 Do you see that?

15 A. I'm sorry, I don't. Where --

16 Q. Right under subject.

17 A. Oh, okay. Yes.

18 Q. And then the attendees, it's the same
19 group of folks: You, Ms. Danforth, and then the
20 TelAffects folks.

21 Do you see that?

22 A. Yes.

1 Q. Okay. Can you tell me what you remember
2 about this meeting?

3 A. January 2024.

4 Q. And feel free to read their notes in the
5 box.

6 A. Okay. So this is something -- so it was
7 a project that Missy had me do. It was probably,
8 like, the first time that I actually analyzed the
9 accolades data.

10 Previously, I would just send them the
11 data, like, every round. They have to know what
12 hospitals -- or what grades hospitals got. And
13 they have their own records or they load it in.

14 And this was the first time I was doing
15 a -- analyzing the data to help Missy, Kush, and
16 the folks at TelAffects better understand what
17 types of hospitals we're licensing.

18 Q. You said this was the first time you did
19 this.

20 Was this outside of your job duties,
21 technically?

22 A. Well, we've talked about how my job has

1 changed over time. And I have more duties. I
2 don't think it's outside of it. It's just
3 something that was added on later once Missy
4 realized I was good at my job.

5 Q. Fair enough.

6 And when you say added on, what was added
7 on? How would you characterize it?

8 A. This is, like, a one-off analysis.

9 Q. Okay. So you haven't done analyses like
10 these -- this since?

11 A. No.

12 Q. Okay. So let's go to the next page to
13 the deck you were mentioning.

14 A. Uh-huh.

15 Q. And it says -- your name is on the front,
16 Alexandra Campione.

17 Do you see that?

18 A. Yes.

19 Q. And dated January 2024.

20 And then if you go to the Bates ending
21 73570.

22 Do you see that?

1 A. 570?

2 Q. Uh-huh.

3 A. Yes.

4 Q. Now, you authored this deck, right?

5 A. Yes.

6 Q. And you did it at Ms. Danforth's request?

7 A. Yes.

8 Q. Okay. Did you present this deck at the
9 meeting?

10 A. Yes.

11 Q. Tell me what you recall about what you
12 presented. What did you say?

13 A. Sure.

14 Q. If you want to walk me through it, that's
15 fine too.

16 A. Present to you?

17 Q. Yeah.

18 A. So here we have the fall -- the total
19 revenue from hospital safety grade accolades
20 program in fall '17, spring '18, going through to
21 fall 2023 --

22 Q. Sorry, what slide are you on?

1 A. Oh.

2 MS. BLAIR: If you could tell him the
3 Bates number at the bottom.

4 THE WITNESS: Yeah. I thought we were on
5 3570.

6 BY MR. CRAIN:

7 Q. 35 -- oh, 73570?

8 A. 35 -- oh. Yeah, yeah.

9 Q. Oh, Okay. Sorry. So I'm -- I was just a
10 little confused.

11 What does this line depict?

12 A. That would be the total.

13 Q. The total of what?

14 A. Revenue for that fiscal year.

15 Q. Got it. And what do the different bars
16 indicate?

17 A. So each of them represent a round. And
18 if you add those together, then it's the total
19 that's shown in the line.

20 Q. The total -- so just to make sure I
21 understand, the line is the total revenue from
22 accolade sales?

1 A. For that fiscal year.

2 Q. For that fiscal year.

3 A. Uh-huh.

4 Q. And it's just tracked over time?

5 A. Yes, and they're just grouped together by
6 fiscal year.

7 Q. Okay.

8 A. Because sometimes it gets confusing
9 because fiscal year 2018 has fall '17 grades in
10 it.

11 Q. I see. So, like, the bar that says
12 FY 2019 --

13 A. Uh-huh.

14 Q. -- that has data from F -- fall '18 and
15 spring '19?

16 A. Yes.

17 Q. And that gets aggregated into a number
18 that's then populated in the line?

19 A. Yes.

20 Q. Thank you. Okay. I didn't quite
21 understand.

22 Sorry, I didn't mean to interrupt.

1 A. No, I think that there was a table that
2 has the actual numbers.

3 Q. Okay. And then -- unless you have more
4 to say on that --

5 A. No, I remember -- I thought there was a
6 table.

7 Q. Maybe it was behind the scenes.

8 Can we go to 73573?

9 And there's a slide that says, Estimating
10 the likelihood of licensing, modeled using fall
11 2023 licensing data.

12 Do you see that?

13 A. Yes.

14 Q. What was the purpose of this slide?

15 A. To, like I said before, create a profile
16 of those hospitals that do license.

17 Q. And why were you creating a profile of
18 hospitals that license?

19 A. Sure. So that they could target
20 additional hospitals for sales.

21 Q. For --

22 A. And if you know what -- the survey

1 participants are more likely, if you know that --
2 if they're a renewal, they're more likely to
3 renew. That's just common knowledge. If they've
4 done a survey recently so they're engaged. If
5 they're not in the system, they actually more
6 likely to license.

7 I don't know the ins and outs of, like,
8 what you do with the licensing, but I can run the
9 data and see that the majority of licensees
10 follow these characteristics.

11 Q. Okay. So you were creating the deck just
12 to -- I want to just make sure this is clear --
13 so that Leapfrog could target certain hospitals
14 for sales.

15 A. So TelAffects could reach out to those
16 hospitals probably more, like if -- I don't know.
17 I'm just imagining that you could call them a few
18 more times if you know that they're more likely
19 to license.

20 Q. Got it. To optimize the opportunity, so
21 to speak.

22 A. Sure.

1 Q. Okay. And TelAffects, just to make sure,
2 worked for Leapfrog?

3 A. Yes.

4 Q. Not an employee, but a contractor.

5 A. Yes.

6 Q. And here in the slide you say, Survey
7 participants are ten times more likely to
8 license.

9 Do you see that?

10 A. Yes.

11 Q. And renewals are ten times more likely to
12 license?

13 A. Uh-huh.

14 Q. And what does that -- what does that
15 mean?

16 A. So looking at A-hospitals, they're more
17 likely to license if they have done a survey
18 and...

19 Q. How do you get that from renewals?

20 A. Oh, sorry. For renewals --

21 Q. Yeah.

22 A. -- that means that they licensed, like, a

1 years ago.

2 Q. Got it. So if they licensed in the past,
3 they're more likely to license in the future.

4 A. Right.

5 Q. Got it. So if they participate in the
6 survey, they're ten times more likely to license.
7 If they've purchased in the past, more likely to
8 purchase in the future, right?

9 A. Uh-huh.

10 Q. And then hospitals that have licensed in
11 the past two years are five times more likely to
12 license.

13 Do you see that as well?

14 A. Yes.

15 Q. Okay. And -- so going back to
16 participation, if participants are ten times more
17 likely to license, isn't it financially
18 beneficial to increase participation?

19 MS. BLAIR: Objection to form.

20 THE WITNESS: It's not what we do. This
21 is a separate analysis and category, and
22 TelAffects doesn't advise us on our methodology.

1 Our expert panel does.

2 BY MR. CRAIN:

3 Q. Okay. I'm just trying to understand if
4 there's a logical connection here.

5 A. I just don't look at it that way.

6 Q. Okay.

7 A. And no one at Leapfrog does.

8 Q. No one at Leapfrog thinks about
9 participation in economic terms?

10 A. I would say that they don't -- they would
11 look at this analysis with the goal of TelAffects
12 getting more accolades licenses. That was the
13 sole goal of this.

14 Q. Did you --

15 A. This is not to inform methodology
16 changes.

17 Q. Did you create this deck in response to
18 Ms. Danforth's e-mail asking you for the
19 licensing data and accolades that we looked at a
20 few moments ago?

21 A. Yes. Of course.

22 Q. Did you create this deck -- strike that.

1 She said in that e-mail she wanted to
2 understand the financial risks.

3 A. Uh-huh.

4 Q. Is it your testimony that this deck
5 doesn't inform at all on those financial risks?

6 A. I don't know what she meant by that, and
7 I testified to that earlier. So I can't really
8 speak to that.

9 Q. Okay.

10 A. But I know the intent of this deck --

11 Q. And --

12 A. -- and this one -- and actually, if we
13 do -- this was November, and you said this
14 meeting was in January?

15 Q. Uh-huh.

16 A. So I can't even say that this deck was
17 related to that, actually, at all. I know that
18 around that time in November, we were just
19 starting to -- that was actually the first data
20 request, I think, I've ever had from her. And
21 then this is something separate.

22 Q. But I think you told me you had -- this

1 was the first time she had asked you to conduct
2 this type of analysis.

3 A. This -- yes. Definitely this analysis.
4 This is asking for data (indicating).

5 But this is the first time that I ever
6 was even looking at the data.

7 Q. Does that data have anything to do with
8 this deck?

9 A. I don't know. You would have to ask her.
10 I mean, this took place in November, and this
11 took place in January.

12 Q. No, I'm asking you. I want to
13 understand --

14 A. I mean, it's the same data. It's the
15 same underlying data, yeah.

16 Q. So just to make sure, because we're
17 talking over each other, the data that you pulled
18 in response to that e-mail is the same data that
19 informed this deck.

20 A. It's the same data that used -- that was
21 used in this deck.

22 Q. Used and/or to create this deck?

1 A. Yes.

2 Q. Okay. And your testimony is that this
3 deck has nothing to do with the financial
4 opportunity or risk to Leapfrog?

5 A. It has to do with the financial
6 opportunity to sell more accolades.

7 Q. Okay.

8 A. It has nothing to do with the scoring
9 methodology.

10 Q. I'm -- yeah, I'm not asking that
11 question.

12 A. Okay. Sorry.

13 Q. I'm asking the question of whether
14 increasing survey participation adds a financial
15 opportunity to Leapfrog.

16 A. If increasing survey -- can you word
17 that --

18 Q. Sure.

19 A. -- in a different way.

20 Q. Let me try it this way: You say in this
21 deck, Survey participants are ten times more
22 likely to license.

1 Do you see that?

2 A. Yes.

3 Q. If they are ten times more likely to
4 license, doesn't that mean Leapfrog is ten times
5 more likely to get revenue?

6 MS. BLAIR: Objection to form.

7 THE WITNESS: I just -- I don't -- this
8 is looking at the current, like, landscape.
9 Like, this is looking at, okay, we've already
10 given these As; they've already completed the
11 survey. Now, how can we get them to buy the
12 accolades.

13 It's not looking at how should we do
14 survey participation in the future, how should we
15 increase survey participation. That's just a
16 totally separate thing.

17 BY MR. CRAIN:

18 Q. Do you disagree, though, that increased
19 participation is good for accolade sales?

20 A. No, because it doesn't mean that they're
21 automatically going to get an A grade. This is
22 talking about grades, safety grades. Survey

1 participation is separate. And just because you
2 do the survey doesn't mean that you're going to
3 be an A grade.

4 Q. But --

5 A. These are hospitals that already have
6 A grades.

7 Q. But this says survey participants are ten
8 times more likely.

9 A. Of the A grades. So say there's -- I
10 don't know -- 900. Only, you know, a percentages
11 of those do the survey and a percentage of them
12 don't. And the ones that do the survey are more
13 likely to license.

14 Q. Okay. Got it. Because the only
15 license -- the only people who purchase the
16 accolades are the A-grade hospitals.

17 A. Yes.

18 Q. Got it. Okay. I was trying to
19 understand where in this deck it said you're
20 talking only about the A grades.

21 A. Yes. The whole thing in context is
22 accolade sales, which are focused on A grades.

1 Q. Only A grades. Got it. Okay. That was
2 the disconnect.

3 MR. CRAIN: Okay. I think that might be
4 a good place to break, if you're okay, for lunch.

5 MS. BLAIR: Yes.

6 VIDEO TECHNICIAN: The time is 12:39 p.m.
7 This ends unit 3. We're off the record.

8 (A recess was taken.)

9 VIDEO TECHNICIAN: The time is 1:44.
10 This begins unit number 4. We're on the record.

11 (Campione Deposition Exhibit 6 marked for
12 identification and attached to the
13 transcript.)

14 BY MR. CRAIN:

15 Q. Good afternoon, Ms. Campione.

16 A. Good afternoon.

17 Q. I'm going to give you a document that's
18 been marked Campione Exhibit 6.

19 Do you recognize this document?

20 A. Yes.

21 Q. What is it?

22 A. This is the meeting invite and attach- --

1 with attachments from the expert panel meeting
2 that took place on April 12th, 2024.

3 Q. And that's the meeting we discussed at
4 length this morning?

5 A. Yes.

6 Q. And the meeting invite comes from
7 Dr. Austin?

8 A. Yes.

9 Q. And includes a number of the folks we
10 talked about earlier today, right?

11 A. The --

12 Q. It was sent to the folks we talked about
13 today?

14 A. Yes. That are on the safety grade expert
15 panel.

16 Q. Great.

17 And when the expert panel meets, is this
18 typically how a deck is distributed, through a
19 calendar invite?

20 A. I can't say that it always is, but it
21 appears to have been this time.

22 Q. Was this deck presented at the meeting?

1 A. Yes.

2 Q. Okay. And I want to just flip through.
3 If we could go to slide 5.

4 Do you recall whether you -- so did you
5 draft this deck?

6 A. I might have. I might have sent some
7 slides to Matt Austin to include. I can't
8 remember, though.

9 Q. Okay. Do you recall whether you drafted
10 this slide?

11 A. This slide? I don't know. I kind of
12 think that maybe I did an outline for it, maybe
13 Matt added on to it. But either way, we both
14 reviewed it beforehand.

15 Q. Okay. So just walking through this
16 slide, the title is, The problem that we're
17 working to solve.

18 Do you see that?

19 A. Yes.

20 Q. And just -- can you just articulate what
21 is the problem?

22 A. That --

1 Q. Feel free to use the slide, too.

2 A. Yeah, no, that's exactly the point of
3 this slide. We are working to deal with how the
4 imputed scores, the -- and really, this should
5 say the mean scores from step 2 -- are creeping
6 up. And they're higher than a lot of the scoring
7 categories from on the -- in the methodology.

8 So -- then there is this other issue,
9 which we talked about earlier, of hospitals
10 skipping doing the survey, which obviously is not
11 desirable because we talked about how current
12 data is the best representation of a hospital's
13 performance at this time. So obviously it's not
14 great if hospitals are not giving us the most
15 up-to-date data.

16 So these are the two issues that we had,
17 and we were trying to find a solution to them.

18 Q. And when it says, Imputed scores have
19 crept up, is that under the prior mean
20 calculation?

21 A. Yes.

22 Q. And what was -- what was the working

1 theory as to why means were creeping up?

2 A. That essentially hospitals that were
3 doing the survey were doing better and better.

4 Q. Did you ever consider whether hospitals
5 were inflating their own grades?

6 A. No, because I think we have a rigorous
7 data verification process. And that's also not
8 my concern in this scope.

9 Q. Okay. In your opinion, is there any
10 chance that hospitals were inflating any part of
11 their survey responses?

12 MS. BLAIR: Objection to form.

13 THE WITNESS: If they were, then they
14 would be doing it in violation to their
15 affirmation of accuracy that they complete when
16 they submit the survey and for every section of
17 the survey.

18 BY MR. CRAIN:

19 Q. And in assessing the problem of
20 whether -- of how imputed scores crept up, did
21 you -- you didn't rule out the possibility that
22 hospitals that were participating were inflating

1 their scores.

2 A. What I would say to that is that the goal
3 is for all hospitals to eventually reach our
4 standard. These are, like, a guideline, and
5 these are telling hospitals how they -- or
6 helping them get to a place where they're safer.
7 That's the purpose of the process and structural
8 measures.

9 So, I mean, while that could be
10 happening, I don't think that's the sole
11 reason -- I absolutely don't think it's the sole
12 reason that the mean was increasing. I think
13 it's because these hospitals that are completing
14 our survey were doing better over time.

15 Q. On the Leapfrog metrics?

16 A. Yes.

17 Q. Did you conduct any analysis to verify
18 whether they were actually doing better?

19 A. I don't know how you would design --
20 you'd have to do a whole study or something.
21 Maybe a sample. I don't -- as an epidemiologist,
22 I mean, you'd have to come up with some method

1 of, like, say a plan. And essentially I guess
2 that's what our onsite data verification is
3 doing, and our document requests are doing.

4 Q. So is that a yes or no?

5 A. Can you repeat the question?

6 Q. Yes.

7 Did you conduct any analysis to verify
8 whether they were actually doing better?

9 A. Whether they were actually doing better?
10 I mean, they were doing better. It was clear.

11 Q. The scores were better.

12 A. Yes. They were improving over time.

13 Q. And you're -- okay.

14 I want to push forward to slide -- let's
15 see. We talked about -- if you go to slide 7, do
16 you see it says, The current imputational model?

17 A. Yes.

18 Q. Is this a true depiction of the model
19 that existed prior to 2024?

20 A. Prior to fall 2024. Yes.

21 Q. It's what we talked about this morning,
22 correct?

1 A. Yes. So this is the spring 2024
2 methodology that we're looking at.

3 Q. Yes.

4 A. The current imputation model.

5 Q. And to your knowledge, that had been in
6 place since when?

7 A. Well, it depends. You know, some rounds,
8 this is modified and always announced in the
9 proposed changes. So as it is, I think it had
10 been this way for at least a round or two --

11 Q. Okay.

12 A. -- in this form.

13 Q. Okay. Let's flip now to slide 9.

14 And this is a slide that says, Step 2,
15 imputation for IPS.

16 Do you see that?

17 A. Yes.

18 Q. Can you explain to me what the step 2
19 imputation for IPS was?

20 A. So the step 2 imputation for IPS -- so
21 this was the current one in place for spring
22 2024.

1 The -- how step 2 imputation worked for
2 ICU was that we -- if they had ICU beds reported
3 in the worksheet S-3 part 1 of a CMS cost report,
4 they were determined to have an ICU and they
5 were, therefore, assigned to the lowest scoring
6 category of limited achievement, or five points.

7 Q. Okay. Got it. Okay.

8 I want you to flip next to slide 11. And
9 this is a slide that says, Spring 2024 measure
10 scores.

11 Do you see that?

12 A. Yes.

13 Q. Can you explain for me what the bottom
14 two rows are, average step 1 imputed score and
15 average step 2 imputed score?

16 A. So these are the mean scores for the
17 measures. If step 1 was used for the hospital, I
18 included that score and then took the mean; if
19 step 2 was used, then I took the mean of those
20 scores for each measure.

21 Q. And the 5 for ICU physician staffing
22 reflects that limited achievement?

1 A. Yes.

2 Q. Okay. For step 1 imputed score, just to
3 be sure I understand, that's the mean of
4 participating hospitals in prior surveys.

5 A. Well, that's the mean of the most recent
6 safety grade score --

7 Q. Okay.

8 A. -- for that measure.

9 Q. Would that be for some hospitals like the
10 last survey and for others hospitals two surveys
11 back?

12 A. In this case, yes.

13 Q. Okay. So anybody imputed through step 1?

14 A. Yes.

15 Q. Okay. And then step 2 is lower, right?

16 A. Yes.

17 Q. Why is step 2 lower compared to step 1?

18 A. Because a lot of these are using that
19 first mean score. So the average score for a
20 hospital in their co- -- in each respective
21 cohort, the first time they ever completed the
22 survey. So if that was, like, a hospital that

1 completed it for the first time in 2018, whatever
2 their score was for CPOE, and a hospital that
3 completed it for the first time in 2019, whatever
4 their score was for CPOE, and then averaged
5 together.

6 Q. Got it. So I had thought that step 2 was
7 the lower of two possible means. Is that wrong?

8 A. That is. But at this point, I think we
9 had moved to -- or not moved to; it just was the
10 case that the majority of those for every -- for,
11 I think, all cohorts at that point was that first
12 mean score.

13 Q. The lower score was always the first mean
14 score?

15 A. Yes.

16 Q. Okay. Got it. Okay.

17 Okay. If we could go to slide 12.

18 Now, this shows hospitals eligible for
19 imputation.

20 Do you see that?

21 A. Yes.

22 Q. And what does eligible for imputation

1 mean?

2 A. They didn't complete the most recent
3 Leapfrog survey.

4 Q. Got it. So it just means they didn't
5 participate in the last round?

6 A. Yes.

7 Q. Okay. And it says, The proportion of
8 hospitals that complete the Leapfrog survey has
9 increased since 2012 from 31 percent to
10 61 percent.

11 Do you see that?

12 A. Yes.

13 Q. And then there was a slight dip in survey
14 participation this past year.

15 Do you see that?

16 A. Yes.

17 Q. And that's from 2022 to 2023.

18 Do you see?

19 A. Yes.

20 Q. Okay. And does that -- we talked earlier
21 today about the HCA declination to participate.

22 Do you remember that?

1 A. Yes.

2 Q. Do you -- are you aware of other
3 hospitals that result -- that were factored into
4 that dip, or your view is it's only HCA?

5 A. It may be HCA. There's definitely
6 hospitals that could have stopped for any other
7 number of reasons.

8 Q. And can you tell approximately how many
9 hospitals fewer participated from 2022 to 2023?

10 A. I can't give you an exact number here.
11 Let's see.

12 Q. Best estimate?

13 A. Maybe like 100.

14 Q. Okay. And then I want to go to slide 13.

15 And do you see at the top it says,

16 Proposed future imputation methodology?

17 A. Yes.

18 Q. Was this the methodology presented at the
19 meeting?

20 A. Yes.

21 Q. Okay. You recall it being presented?

22 A. Yes.

1 Q. Who discussed it?

2 A. Discussed or presented?

3 Q. Who presented it? Fair.

4 A. It was either me -- I might have started
5 and Matt finished or -- because I kind of -- I
6 would have made those graphs before. So I'm not
7 sure. I haven't -- it's been a year.

8 Q. Okay. Is this the methodology that was
9 ultimately instituted?

10 A. No, it is not.

11 Q. Okay. Can you tell me the differences?

12 A. Here, we're suggesting retiring step 1
13 imputation altogether where we use the most
14 recent scores for the measures.

15 Obviously we didn't go on to do that
16 because of the expert panel's advice and decision
17 there.

18 I believe -- so this -- using step 2B
19 imputation for all hospitals, I think that's
20 referring to that previous slide that we were
21 just looking at that was currently being used for
22 ICU physician staffing.

1 So it's suggesting using that form and
2 that -- oh, wait, sorry. Did I -- proposed
3 future imputation methodology. Use step 2B --
4 sorry, I'm a little bit confused here.

5 Q. Take your time.

6 A. Wait. This is -- this doesn't seem
7 right.

8 Q. What seems wrong?

9 A. So this -- hmm. It says, Proposed future
10 imputation methodology.

11 Q. Yes.

12 A. But I feel like this is not -- I mean,
13 this is not what we ended up doing.

14 Q. Well, that's my question. Right?

15 A. Yeah. I'm a little bit --

16 Q. Why are you confused?

17 A. Because I don't think this is what we
18 presented that day.

19 Q. You don't think it's what you presented
20 that day?

21 A. I don't know.

22 Q. Okay. Earlier you testified -- well,

1 strike that.

2 You testified a moment ago that Leapfrog
3 did not undergo this proposal here because of the
4 advice and decision of the expert panel.

5 Do you recall that testimony?

6 MS. BLAIR: Objection to form.

7 THE WITNESS: I mean, I guess -- I mean,
8 I would have to, like, listen to that past
9 meeting to see exactly how it went down. But it
10 looks like we were actually presenting that there
11 be really no change.

12 I guess I'm -- I don't -- these are my
13 tables, so I must have presented this. But it
14 looks like we're -- the expert panel went a
15 different direction, which is perfectly okay for
16 them to do. And they went with the one that we
17 currently use, not this one proposed here in this
18 slide.

19 BY MR. CRAIN:

20 Q. So that's my question.

21 A. Uh-huh.

22 Q. You testified earlier that the expert

1 panel made a decision or made a recommendation.

2 Where did they do that?

3 A. You'll have to read the transcript from
4 the expert panel and ask them.

5 Q. Is it -- you know there's a transcript?

6 A. Yes.

7 Q. Are you aware whether it's been produced
8 in this case?

9 A. No, I don't know.

10 Q. Okay.

11 A. Or -- transcript, Zoom. You know, it's
12 the Zoom transcript.

13 Q. Yeah, yeah, I understand.

14 So I just -- I want your best memory
15 today. That's all I'm asking for.

16 A. Uh-huh.

17 Q. Is it your memory that the model that
18 Leapfrog ultimately adopted was presented at this
19 April 12th meeting?

20 A. It was definitely discussed and agreed
21 upon to some extent. But, if anything, I mean,
22 it shows they weren't -- they came up with

1 something different. And, like, this is what we
2 were suggesting, I guess, and -- yeah.

3 Q. Okay.

4 A. They do their own thing.

5 Q. They do their own thing. Okay.

6 So just to be clear, you said this is not
7 different from the prior methodology. I just
8 want to direct your attention to the first part.

9 It says, Retire step 1 imputation for all
10 measures.

11 Was that the change you were proposing in
12 this slide?

13 A. Yes. That's how it looks. It looks like
14 we were proposing -- and this would have been,
15 like, you know, Matt, Missy, and I met previously
16 and we must have decided, okay, let's retire
17 step 1 and just use the mean of the cohort.
18 And -- yeah, they can do what they want as the
19 expert panel.

20 Q. And in this 2B, is there any difference
21 from the prior model, this proposal here on the
22 slide?

1 A. Is there any -- well, I mean, we're
2 phasing out using the mean of the current scores.

3 Q. Okay.

4 A. Yeah.

5 Q. So just to make sure I have it right, the
6 pri- -- there were two changes here from the
7 prior methodology.

8 Change 1 was retiring step 1 altogether.

9 A. Uh-huh.

10 Q. Correct?

11 A. Yes.

12 Q. And change 2 was to get rid of the
13 two-tiered step 2 and, instead, you would just
14 use the mean of the first time a hospital has
15 reported, correct?

16 A. Yes.

17 Q. Okay. And then on this slide it says
18 that -- it gives you the splits of hospitals for
19 imputation versus the Leapfrog survey.

20 Do you see that at the bottom?

21 A. Yes.

22 Q. Is that, to the best of your

1 recollection, accurate numbers?

2 A. Well, let me -- it looks like it's just
3 the two numbers added together.

4 Q. Yeah.

5 A. So yes.

6 Q. And then just flipping through the slide,
7 the last piece is that hyperglycemia [sic]
8 portion.

9 Do you see that in the next few slides?

10 A. Yes.

11 Q. Okay. And I understand there to be no
12 relevance to this case, but if there is some, let
13 me know.

14 A. I think they decided not to.

15 Q. Not to adopt that. Okay.

16 You can set that aside for now.

17 A. Okay.

18 Q. And I just wanted to go back to something
19 you said. You said the expert panel can do what
20 they want. Is it your understanding of how this
21 works that the expert panel decides the
22 methodology?

1 A. Yes. Major methodology changes, all of
2 them, are set by them and need to be approved by
3 them.

4 Q. But you're not aware of any vote that
5 they take?

6 A. No.

7 Q. And you're not aware of any mechanism by
8 which they communicate their approval?

9 A. Like, verbally and in writing, and if
10 they felt strongly about how they -- if they
11 didn't agree with something that was reached at
12 the conclusion of the meeting or the notes
13 that Matt sent, I would expect that -- they're
14 adults and they can reach out and send an e-mail
15 saying, I strongly disagree.

16 But at the end of the day, they know that
17 their stamp is going on it for approval.

18 Q. So they're presumed to consent unless
19 they object?

20 A. I -- you would have to ask Matt Austin.

21 Q. But I want your opinion and
22 understanding.

1 A. Clearly I wasn't paying attention during
2 this meeting.

3 Q. Okay.

4 A. But I don't have any -- it's not my job
5 to sway them either way. It's their job to be
6 familiar with the literature out there and the
7 studies and the measures themselves and make sure
8 that they're recommending the best measures be
9 included in the safety grade.

10 Q. And is it your understanding that they
11 propose the course of action or Leapfrog proposes
12 the course of action?

13 A. Well, it looks like we made some
14 suggestions, because we're most familiar with
15 these measures day to day. They have full-time
16 jobs and are working on other stuff too. So we
17 will make suggestions, but as you see here, they
18 don't have to go with them.

19 Q. I want to go -- you mentioned there were
20 notes right after the meeting.

21 Do you recall that?

22 A. Yes. I mean, Matt definitely sends,

1 like, a synopsis.

2 MR. CRAIN: So we're going to mark our
3 next exhibit. This is 7.

4 (Campione Deposition Exhibit 7 marked for
5 identification and attached to the
6 transcript.)

7 BY MR. CRAIN:

8 Q. Okay. Do you recognize this document,
9 Ms. Campione?

10 A. Yes.

11 Q. And the top is as e-mail from
12 Ms. Danforth to you in May of 2024.

13 Do you see that?

14 A. Yes.

15 Q. And she says, Can you save in expert
16 panel folder?

17 Do you see that?

18 A. Yes.

19 Q. And what is the expert panel folder?

20 A. So for every section of the survey and/or
21 measure, there's an expert panel, of course, as I
22 testified earlier. And each of them we put

1 information from the meeting in a respective
2 expert panel folder.

3 Q. Okay. Now, go further down. There's an
4 e-mail from -- it looks like Preeti Joshi.

5 Do you see that?

6 A. Yes.

7 Q. Who is Preeti Joshi?

8 A. She is, like, a research assistant to
9 Matt Austin.

10 Q. Okay. And did she attend the meeting?
11 Do you recall?

12 A. I'm not sure. You would have to...

13 Q. Actually --

14 A. We could reference --

15 Q. Yeah, the notes, I think, say she did.

16 A. -- Exhibit 6.

17 Q. If you look, actually, a few pages back
18 in the notes, it says attendees.

19 A. Yes.

20 Q. Do you see that?

21 And then, just before we get there,
22 Ms. Campione, if you go back to her e-mail, she

1 says, Apologies for the delay in sharing the
2 meeting notes from the Leapfrog hospital safety
3 grade expert panel call.

4 Do you see that?

5 A. Yes.

6 Q. If you notice any glaring errors or
7 omissions with the attached notes, please let us
8 know.

9 Do you see that as well?

10 A. Yes.

11 Q. To your best recollection and
12 understanding, were the notes attached to this
13 e-mail the final notes from the meeting?

14 A. It would appear so.

15 Q. So let's go take a look at the notes.

16 And just to start, is this a typical
17 document that follows an expert panel meeting?

18 A. Yes.

19 Q. And it says at the top these are the
20 notes from Friday, April 12th, 2024.

21 Do you see that?

22 A. Yes.

1 Q. Okay. And just taking a look, starting
2 with "on the call," it lists expert panelists,
3 Leapfrog, and Johns Hopkins -- that is hard to
4 say -- Johns Hopkins Armstrong Institute.

5 Do you have any -- do you remember all
6 these people being on the call?

7 A. Yes. I mean, that looks right.

8 Q. Okay. And then going down the line -- I
9 think we can skip over the military treatment
10 facilities. And I just want to work through
11 number 2 on the agenda.

12 It says, Proposed changes to the
13 imputation model.

14 Do you see that?

15 A. Yes.

16 Q. Okay. And it says, Matt provided the
17 expert panel with a quick overview of the current
18 imputation model approaches Leapfrog has been
19 using and some of the challenges those approaches
20 have created for issuing accurate grades.

21 Do you see that?

22 A. Yes.

1 Q. Does that, to your recollection, reflect
2 those first slides we looked at, the problem
3 we're solving for?

4 A. Yes. So I guess he presented those, so
5 yes.

6 Q. And then it says, The current imputation
7 model is two steps when data are missing.

8 Do you see that as well?

9 A. Yes.

10 Q. And that reflects the slide we saw about
11 the current model, right?

12 A. Uh-huh. Yes.

13 Q. And then it says, Leapfrog's proposal was
14 to retire step 1 of the model and use only
15 step 2, assigning hospitals the mean score for
16 their cohort.

17 Do you see that?

18 A. Yes.

19 Q. So does this reflect that Leapfrog was
20 making a proposal to the expert panel?

21 A. Yes.

22 Q. And is that consistent with or

1 inconsistent with your memory?

2 A. That's consistent. I just testified to
3 that.

4 Q. Okay. The next bullet mentions someone
5 named Arjun, who I take it is Arjun Srinivasan?

6 A. Yes.

7 Q. And he's a member of the panel?

8 A. Yes.

9 Q. Okay. And Arjun mentioned one of the
10 concerns with the current step 2 imputation
11 method is if a hospital is performing very
12 poorly, they could choose not to submit a survey
13 and get a better score than their actual
14 performance by just being part of a certain
15 cohort.

16 Do you recall that?

17 A. Yes.

18 Q. And Peter -- who is Peter?

19 A. Pronovost.

20 Q. Peter Pronovost, who I understand was on
21 Time --

22 A. Pronovost.

1 Q. Pronovost? It says it at the top?

2 A. Yes.

3 Q. I understand he was on Time Magazine; is
4 that right?

5 A. Yes.

6 Q. I've heard stories.

7 Peter asks whether Leapfrog has a way to
8 keep the low-performing hospitals in the lowest
9 quartile using the step 2 imputation model.

10 Do you recall that?

11 A. Lowest -- no, not really. I don't really
12 understand.

13 Q. What is the lowest quartile? Do you have
14 any understanding as to what that means?

15 A. I think he's suggesting something
16 different than our current methodology here.

17 Q. What's your understanding of the
18 difference?

19 A. I don't understand what he's suggesting
20 here, at least in these notes.

21 Q. Yeah.

22 A. I'd have to listen to his statement

1 and -- yeah, his full statement to understand.

2 Q. When -- does Leapfrog use the
3 phrase "lowest quartile"?

4 A. No. But it is a method of -- that you
5 can use in scoring in general.

6 Q. How would that work? It's --

7 A. It's the lowest --

8 Q. -- could you --

9 A. -- 25 percent --

10 Q. Okay.

11 A. -- performing, yeah.

12 Q. So it's --

13 A. It could -- sorry.

14 Q. Yeah.

15 THE REPORTER: I can't get you both.

16 MR. CRAIN: No, I know. I'm sorry.

17 BY MR. CRAIN:

18 Q. Go ahead.

19 A. So if we were -- you could perhaps, like,
20 look at the numerical score and say the lowest --
21 the bottom 25 percent. That might have been what
22 he's suggesting.

1 Q. Is it different from the lowest possible
2 score?

3 A. From the lowest? What lowest possible
4 score?

5 Q. Well, if the lowest score is a zero,
6 say --

7 A. Oh.

8 Q. -- would the lowest quartile be
9 25 percent?

10 A. Not necessarily.

11 Q. So you're not quite sure what this means?

12 A. No, I don't -- I think -- yeah, he's
13 suggesting, like, a different alternative that is
14 kind of not like we've used previously. But it
15 is definitely, like, a way that you can score
16 hospitals. Like -- yeah.

17 Q. And I'm still not understanding. And it
18 may be me.

19 When you say it's a different way, how
20 would you understand that way works? And if you
21 have no --

22 A. Yeah, I don't understand. I think that

1 maybe that was just a poor way of phrasing --
2 rephrasing what he said.

3 Q. Okay.

4 A. I would advise that we go to the actual
5 meeting to see.

6 Q. So go to the tape?

7 A. Yes.

8 Q. Okay. So is it -- so let's keep going.

9 The expert panel were in support of
10 having hospitals share their current performance,
11 so like the idea of imputing the equivalent of
12 willing to report to hospitals that do not submit
13 a survey.

14 Do you know what willing to report means?

15 A. Willing to report is actually an old
16 phrase that we used to use instead of limited
17 achievement.

18 Q. Okay. When was that phrase last used?
19 Do you know?

20 A. More than five years ago.

21 Q. Okay. Do you recall anybody saying that
22 phrase on the call?

1 A. No.

2 Q. Do you recall --

3 A. But it's very possible that they could
4 have. Some of these panelists have been a
5 panelist for a long time, so they could have just
6 been using old phrasing from the survey.

7 Q. And then going back, Peter noted that
8 Leapfrog's message on this change will be
9 critical because, if done correctly, it can help
10 enhance focus on safety; otherwise, it has the
11 potential to backfire.

12 Can -- do you know what he meant there?

13 A. I would really go to the actual
14 transcript because this is putting it through
15 someone else's words, and I don't know the...

16 Q. I'm just asking for your best
17 understanding. If you don't have one --

18 A. Like, when I read this sentence, what I
19 think or what I remember from that time?

20 Q. Let's take both. What do you remember?

21 A. I think I stated it earlier. I mean --
22 and I said that it was generally very positive.

1 The focus was on increasing transparency and this
2 focus on safety. He wanted to make sure -- he
3 thought that this had the opportunity to, like,
4 refocus on safety. I'm using Preeti's words
5 here.

6 And then it has the potential to
7 backfire. I assume he meant some hospitals being
8 upset with this change.

9 Q. Which may have transpired. Okay.

10 Then -- you said reading the words on the
11 page. Do you have a different understanding from
12 what you remember?

13 A. Yes. I mean, these are -- well, I would
14 say this isn't -- these are Preeti's words.
15 So...

16 Q. Do you have an independent understanding
17 of what the words mean?

18 A. I mean, I think it's fine, actually, the
19 statement. I mean, she's just saying it's
20 positive, that this could enhance focus on
21 safety, and hospitals could be upset about it.

22 Q. Okay. And then -- let's see. Just

1 reading the last two bullets for completion:
2 Missy asked the expert panel to what extent the
3 health systems that wanted to partner with
4 Leapfrog could help deliver this message.

5 Any recollection of what "this message"
6 might mean?

7 A. I'm not sure what this is referring to,
8 actually. I'm wondering if -- I think -- we
9 should definitely go back to the tape to
10 understand this more, but I think Peter was
11 offering to help with the messaging to understand
12 or form this in a way that, like -- make sure it
13 made sense to hospitals and whatnot.

14 And that's all I can -- that's all I
15 think I can ascertain from these.

16 Q. So after looking at the deck and looking
17 at the notes, was the methodology that Leapfrog
18 ultimately adopted presented in this meeting?

19 A. It was certainly discussed because --
20 because it's, like, what they decided. But it
21 wasn't presented in those slides, no.

22 Q. And does it appear in these notes?

1 A. No, it doesn't appear in these notes.

2 Q. Okay. So you're basing your recollection
3 that it was discussed on a memory you have today?

4 A. No. I think I'm basing it on the fact
5 that this is Matt Austin's job to, like, figure
6 out what they want, the expert panel wants, and
7 to communicate that.

8 Q. He's the facilitator?

9 A. Yes.

10 Q. Okay. Let's go to the next exhibit.

11 MR. CRAIN: 24, please. So we're going
12 to mark this as Exhibit 8.

13 (Campione Deposition Exhibit 8 marked for
14 identification and attached to the
15 transcript.)

16 BY MR. CRAIN:

17 Q. Okay. Do you have it, Ms. Campione?

18 A. Yes.

19 Q. Do you recognize this document?

20 A. Sure. They're Slack messages.

21 Q. I want to go through, first starting at
22 the top, if you look on page 1. The first

1 page -- if you flip it back.

2 A. Oh, yeah. Sorry.

3 Q. If you need a moment to look at it,
4 that's fine.

5 A. Yes. Can I review?

6 Q. Yes. Of course.

7 A. Okay.

8 Q. Okay. Just starting on page 1, it says
9 the date range for this -- the first page.

10 A. Sorry.

11 Q. The date range is April 12th, 2024.

12 Do you see that?

13 A. Yes.

14 Q. And it says there are three participants,
15 but if you look, I think it's you, Ms. Danforth
16 and the Slack Bot.

17 Do you see that?

18 A. Yes.

19 Q. I assume a Slack Bot is AI and not a
20 person.

21 A. Yeah, I -- there is something weird going
22 on.

1 Q. Okay. There is no employee at Leapfrog
2 named Slack Bot.

3 A. No. I wish.

4 Q. Perhaps it was Wilson Elser.

5 MS. BLAIR: Yeah, I was just --

6 MR. CRAIN: Do you want privilege on
7 this?

8 MS. BLAIR: No.

9 BY MR. CRAIN:

10 Q. So if you look -- just -- starting with
11 the first time stamp on the next page --

12 A. Yes.

13 Q. -- starts at 11:02. And if you look at
14 the end, it ends at 5:08.

15 Do you see that?

16 A. Yes.

17 Q. Now, the meeting held that day we saw in
18 the notes was 4:00 to 5:00 p.m.

19 Do you recall that?

20 A. Yes.

21 Q. And if you want to look at the notes,
22 obviously, feel free.

1 A. Uh-huh.

2 Q. So I want to march through some of these
3 chats, and feel free to stop me at any time.

4 So I want to go down to your chat at
5 2:26 -- or maybe 2:24. Let's start with
6 Ms. Danforth.

7 And it says, Missy, I can only be on the
8 phone during the SG panel call. Do you think
9 that will be an issue?

10 SG panel call is safety grade panel?

11 A. Yes, it is.

12 Q. You respond, I don't think so. Matt will
13 be leading and is making the case for the
14 imputation change. I'm assuming he brushed up on
15 the new measures.

16 Do you see that?

17 A. Yes.

18 Q. She says, Okay.

19 And you say, And I know the slides.

20 Right?

21 A. She said, And I know the slides.

22 Q. Oh, I'm sorry. She said that. My

1 mistake.

2 Now, making the case for the imputation
3 change. When you said that, you were referring
4 to the slides?

5 A. Yes.

6 Q. Now, going down, the meeting starts,
7 again, at 4:00, right? We saw that?

8 A. Oh, yes. Yes.

9 Q. Right. So you have no chats from 3:23 to
10 4:42. And then you start chatting.

11 A. Yes. Towards the end of the expert panel
12 call.

13 Q. Yes. And Ms. Danforth says, Sara
14 ons [sic] Peter sold this for us.

15 Do you have any idea what that means?

16 A. Yes. I speak Missy. She's saying Sara
17 and Peter sold this for us.

18 Q. Got it.

19 And do you know what "this" refers to?

20 A. Yes. Yes. It is definitely coming back
21 more now, especially having read this.

22 So we were presenting exactly that

1 proposal, one that was in the slides. And it
2 did -- I kind of remember now, like, Sara was
3 saying -- was just very positive -- or at least
4 felt very strongly that these hospitals shouldn't
5 be getting extra points and being deterred from
6 doing the survey. And that was not helping us to
7 get to -- the ultimate goal of the safety grade
8 is to improve safety within the hospitals. And
9 Peter was very positive as well.

10 And we -- honestly, what they ended up
11 going with, obviously, was a lot -- it was more
12 intense than what we were suggesting or, you
13 know, a bigger change. We were suggesting
14 something that was a small tweak to the old
15 imputation methodology, and they were -- had a
16 different position.

17 Q. "They" meaning the expert panel?

18 A. Here, if we're talking about Sara and
19 Peter, this is -- she's -- I assume at 4:42 Sara
20 and Peter had just spoken and were very positive
21 about moving towards something more like what we
22 ended up implementing.

1 Q. And is it your memory today that they
2 were advocating for what you implemented today?

3 A. Yes. I didn't remember if it was Sara
4 earlier, but I have always said -- it was
5 definitely Peter. I remember that very much so.

6 Q. Peter wanted the option that you
7 ultimately adopted; that's what you're saying?

8 A. Yes. I mean, he was -- he felt strongly
9 that it wasn't accurate, what we were doing
10 before --

11 Q. Okay.

12 A. -- that mean that we were assigning from
13 the first scores.

14 Q. And the next chat says, I wish Patrick
15 was on this call.

16 That's from Missy, so -- Ms. Danforth.

17 A. Yes.

18 Q. Do you have an understanding of why she
19 wanted Patrick on that call?

20 A. I think, because earlier when we
21 discussed with him, he was very hesitant because
22 he really didn't like the step 1 imputation being

1 removed completely, you know, where we're
2 imputing last -- the last survey, or two scores
3 from that survey.

4 And so I think she felt that if he was on
5 that call, he would have been convinced
6 immediately by this interaction.

7 Q. Convinced to remove step 1?

8 A. I think so. Yeah.

9 Q. Okay. And then she says, Arjun too
10 pushing the bottom 25 percent idea.

11 That's the next page.

12 A recollections of what that means?

13 A. Yes. That references the earlier notes,
14 where he's -- someone --

15 Q. Peter.

16 A. It says Peter here, but she's saying it's
17 Arjun, it looks like -- oh, no. Okay. Sorry, I
18 misread.

19 So Peter must have been pushing, yes, the
20 bottom 25 percent idea, lower quartile. And I
21 think they had strong reactions.

22 Q. Is that where you say, Very, very

1 different reactions?

2 A. Yes. And I don't know what I'm referring
3 there -- you would have to be -- like, line this
4 up second to second.

5 But you can see that we are -- the expert
6 panelists are having a discussion, and we're not
7 involved in it.

8 Q. Who is "we" being --

9 A. Missy and I are not involved in these --
10 the expert panel is debating, clearly, and we're
11 not involved in this debate.

12 Q. You're observing.

13 A. We're observing.

14 Q. Then you respond, I think you convinced
15 Patrick at the end, though.

16 Do you know what you convinced him of?

17 A. She --

18 Q. Or she. I'm sorry. She convinced him
19 of --

20 A. Yes. So what I'm referring to -- okay.
21 So what I'm referring to is that call that we had
22 earlier with Patrick. And there was debate going

1 on in that meeting about what's the best one,
2 throwing different ideas out there.

3 And I think Missy was presented to him --
4 she made a case for the one that we were
5 proposing that was presented. And I -- clearly I
6 had the impression that I thought Patrick was
7 actually open to the idea.

8 Q. The one you were proposing, meaning the
9 one we saw in the slides?

10 A. Yes.

11 Q. Then you go down two. Missy says, He
12 said 1,000 hours.

13 Do you know what that's referring to?

14 A. Yes. So as I said earlier, he has --
15 he's affiliated with a hospital, and the hospital
16 must have told him something about how the survey
17 takes them a thousand hours.

18 Q. Got it.

19 And then Missy says, I hope he keeps that
20 to himself.

21 Do you see that?

22 A. Yes.

1 Q. Do you know if that was ever shared with
2 the panel?

3 A. I mean, I think 1,000 hours is an extreme
4 exaggeration. And I think that, you know, to run
5 around and say anecdotally 1,000 hours, I think
6 that's what she's -- but again, you'll have to
7 ask Missy.

8 Q. Okay. And then you say back to back --
9 this is at 4:43 and 4:44 --

10 A. Uh-huh.

11 Q. -- Honestly, this meeting has me
12 second-guessing the step 2 imputation at all.
13 The mean is so high for CPOE and BCMA.

14 Can you tell me what you remember
15 prompted that thought?

16 A. Yes. This is referring to the fact that
17 the expert panel started going that different
18 direction. And again, we're not engaging in
19 this. This is their own discussion. And they're
20 making a case to not use that first score mean at
21 all. And they kind of clearly had me convinced
22 that maybe it doesn't make sense.

1 Q. So is this the first time you recall
2 thinking about -- well, strike that. Let's see.

3 Do you recall -- the mean is so high for
4 CPOE and BCMA -- is that the slide we were
5 looking at that had the numbers?

6 A. Yes.

7 Q. Okay. And maybe --

8 A. Oh, yes.

9 Q. -- just for the record, get the number.
10 I think it's slide 11.

11 A. Yes. I would be referring to that 93 and
12 92 for CPOE and BCMA respectively.

13 Q. Okay. And then a few lines down, at
14 4:45, you say, If we make step 1 just the
15 previous survey, it would at least make the lapse
16 in survey participation short-term, and they
17 can't fall back on step 2.

18 Do you see that?

19 A. Yes.

20 Q. Is that consistent with the proposal
21 being made?

22 A. Yes. I mean, that is exactly what we

1 ended up doing, so it sounds like that's the
2 conclusion the expert panel was coming to.

3 Q. You're drawing that your chat reflects
4 the expert panel's conclusion?

5 A. Yes.

6 Q. Do you remember that conclusion?

7 A. Yes. I -- yes, I guess -- yeah. I mean,
8 I don't remember it in like the strictest term
9 who said it, how it was agreed. I can't -- I'm
10 not the Zoom recording. But clearly -- yeah.

11 Q. Now --

12 A. I was following that, and that's where
13 they landed.

14 Q. Sorry.

15 And "they" again being the expert panel?

16 A. Yes.

17 Q. So at 5:03 you say, The step 2 means are
18 so high. What if we use step 1, limit it to
19 only, say, two round, then assigned them to the
20 bottom performance category.

21 Do you see that?

22 A. Yes.

1 Q. And then Ms. Danforth said, That would be
2 drastic, but let's talk about it. LOL.

3 Do you see that?

4 A. Yes.

5 Q. Do you know what she meant by "drastic"?

6 And actually, if you look at the next
7 chat down, you said, It would be drastic.

8 So maybe I'll fix the question.

9 Why did you think it was drastic?

10 A. Okay. What is the question?

11 Q. Why did you think the proposal that you
12 made at 5:03 p.m. would be drastic?

13 A. Missy said it would be drastic.

14 Q. Correct. And then you responded, It
15 would be drastic.

16 A. Yes. Compared to what we originally
17 proposed.

18 Q. And so what did you mean by drastic?

19 A. Well, I guess going from whatever those
20 means were, 93 and 92, which are obviously really
21 inaccurate of those hospitals' performance, to 5
22 or 15, that would be -- it is a big change.

1 Q. And what you're -- so going back to 5:03,
2 you say, What if we use step 1, limit it to only,
3 say, two round, then assigned them to the bottom
4 performance category.

5 Do you see that?

6 A. Yes.

7 Q. Is that the methodology you adopted?

8 A. Yes.

9 Q. And you say, What if.

10 Do you see that?

11 A. Yes.

12 Q. Did you come up with that idea?

13 A. I mean, unless they started talking about
14 it later on -- a few minutes later and -- I don't
15 know what was discussed in the meeting.

16 Q. Well --

17 A. Like at that point, after that, they
18 could have brought it up. Missy could have
19 chimed in and suggested it.

20 Q. Well, the meeting was over at 5:00.

21 A. Oh, true. Okay. I don't know. I can't
22 tell you.

1 Q. To the best of your recollection, did you
2 come up with this idea after the meeting?

3 A. It does -- yes, I guess so, based on
4 what's in front of me. But I would like to see
5 the actual meeting and what happened and what we
6 landed on. Because someone did bring up during
7 the meeting assigning zero points.

8 Q. Your memory is zero points?

9 A. Yes. I remember -- someone did suggest
10 that in the meeting.

11 Q. Okay. And then the idea that you raise
12 at 5:03, both you and Ms. Danforth agree it would
13 be drastic, right?

14 A. Yes. Because it's different than what we
15 proposed that day.

16 Q. And is it -- strike that.

17 Do you recall that idea -- specifically
18 recall that idea being discussed in the meeting?

19 A. I don't recall. I really don't.

20 Q. Given that it was such a drastic change,
21 would you have expected to have remembered it on
22 the meeting?

1 A. Not necessarily. I mean, this was
2 obviously a very collaborative meeting with --
3 you know, honestly, we might not have even gotten
4 to that last slide of looking at hypoglycemia.
5 It's a lot of back and forth, a lot of ideas
6 thrown out there, like pushing the bottom
7 25 percent idea. It's a lot being thrown around.
8 And it's Matt Austin's job to distill all of that
9 and get us somewhere.

10 Q. And --

11 A. But at the end of the day, we produced
12 our proposed changes document and that -- that is
13 reviewed by the expert panel. And they have to
14 look at whatever our final conclusion is, so --
15 but I would say in this meeting, clearly, a lot
16 was happening and a lot of ideas were being
17 thrown around.

18 Q. But you can't recall whether this one at
19 5:03 was?

20 A. No, I don't know if that...

21 Q. If you go to the last page, it says 5:06.
22 You say, So to Peter's point, we would have to

1 be -- sorry, let me fix that.

2 So to Peter's point, we would just have
3 to very carefully push our justification and
4 messaging.

5 Do you see that?

6 A. Yes.

7 Q. Can you tell me what you meant when you
8 wrote that?

9 A. We were discussing how the messaging
10 around patient safety -- you know, what is our
11 reason for doing this -- justification. What is
12 our reason for doing this?

13 And I think it -- you know, we needed to
14 be delicate with it.

15 Q. Why delicate?

16 A. Well, I think that it can get
17 misinterpreted, and that's why we're here today.
18 But that is not what the expert panel was after.
19 So that's why you needed to handle it delicately.

20 Q. What do you think was a
21 misinterpretation?

22 A. That it was done, like, punitively or

1 vengefully, and it wasn't.

2 Q. You think there was no punitive intent
3 behind it?

4 A. No.

5 Q. Proceeding down, at 5:07, Ms. Danforth
6 says, Well, let's think about it. I'm open.

7 And then you say, Sounds good. Overall,
8 everyone was so amenable in the last meeting.

9 Do you recall what you meant by "last
10 meeting"?

11 A. I probably had other meetings that day,
12 so I'm just talking about our last meeting.

13 Q. Do you think -- is that referring to the
14 expert panel meeting or a different meeting?

15 A. Well, it's 5:07 and that ended at 5:00.
16 So -- I said everyone was really open to the idea
17 in the last meeting.

18 Q. Well, you said, Everyone was so amenable
19 in the last meeting.

20 So you're saying that refers to the
21 expert panel meeting that just ended?

22 A. Yes.

1 Q. Okay. And amenable to what?

2 A. To a change.

3 Q. To a change? Okay.

4 MR. CRAIN: I'm going to mark a new
5 document. This is Exhibit 9.

6 (Campione Deposition Exhibit 9 marked for
7 identification and attached to the
8 transcript.)

9 BY MR. CRAIN:

10 Q. So Ms. Campione, this is an e-mail that
11 ends with a -- it's a thread that ends with an
12 e-mail from Matt Austin to you and Ms. Danforth.

13 Do you see that?

14 A. Yes.

15 Q. And the subject is, Imputation changes.
16 Do you see that as well?

17 A. Yes.

18 Q. And we'll walk through it. If you want
19 to start with the bottom e-mail, please. And it
20 starts with an e-mail from you to Ms. Danforth,
21 Dr. Austin and -- is it Dr. Joshi or --

22 A. I don't know.

1 Q. Okay. It says, Hi all. Please find the
2 table we discussed below.

3 Do you recall -- first of all, do you
4 recall this table?

5 A. Yes.

6 Q. And do you recall the discussion about
7 it?

8 A. So we met -- we must have met with
9 Leah -- can we get through it and then I can see
10 if --

11 Q. Sure.

12 A. But I'm assuming that, like, we me with
13 Leah and I showed it. And then in this context
14 I'm saying, Here is the e-mail that we showed you
15 on the call.

16 Q. Okay. Let's walk through the e-mail
17 because I don't want to confuse you.

18 So it says, Please find the table we
19 discussed below. I also included the underlying
20 issues. Please feel free to edit respond to my
21 e-mail.

22 Do you see that?

1 A. Uh-huh.

2 Q. And then if you go -- so you have
3 underlying issues.

4 The first bullet says, Hospitals are
5 disincentivized from completing the survey.

6 Does that refer to what was discussed at
7 the expert panel?

8 A. Yes. I believe that was in one of the
9 slides.

10 Q. And that was the step 1 shortcut?

11 A. I mean, no. Actually, I think that would
12 be in reference to the step 2.

13 Q. Why do you think that?

14 A. I mean, either one, really.

15 Q. Okay.

16 A. Like, that's -- if the survey -- if the
17 goal of that is the more hospitals that complete
18 the survey, the more data that the public has.

19 Q. So you're saying either step 1 or step 2
20 could have incentivized the hospital to not
21 participate?

22 A. Yes.

1 Q. Okay. And then I think you have two
2 sub-bullets there, actually.

3 Do you see that?

4 A. Yes.

5 Q. And the first sub-bullet is step 1 and
6 the second is step 2?

7 A. Yes.

8 Q. Okay.

9 A. Exactly.

10 Q. Yeah. Okay. And then it further lays
11 out those concerns.

12 So this is basically the problem you're
13 trying to solve for, right, these top bullets?

14 A. Yes.

15 Q. And then, if you look at the table, these
16 are options, right?

17 A. Yes. Oh, we're looking at the table?

18 Q. Yeah.

19 A. But also, there's the concerns, which --

20 Q. Yeah, I'm happy --

21 A. -- are fair. I just want to emphasize.

22 Okay. And the table --

1 Q. Yeah.

2 A. -- is -- what are we looking at?

3 Q. So what is the table layout?

4 A. Okay. So this puts -- and to use this
5 term "drastic" from our Slack messages, it
6 presents options for step 1 and step 2 that range
7 from either no change at all to the drastic
8 change.

9 Q. And which of these options were discussed
10 on the meeting on April 12th?

11 A. So if I had to, like, put it into a
12 category, it would be --

13 Q. If any.

14 A. Yeah, so we were actually saying -- we
15 proposed eliminating step 1 imputation, so the
16 most drastic change for step 1.

17 And then we proposed -- I guess now it's
18 a no change to impute the mean, because that's
19 essentially where we were at every time. We were
20 imputing the first time the scores -- the mean of
21 the first time they completed the survey.

22 Q. So the proposal on the slide we saw for

1 the April 12th meeting is reflexive in the no
2 change and the small change boxes?

3 A. Yes. For step 1 it would be the most
4 drastic. For step 2 it would be the least
5 drastic.

6 Q. Got it.

7 Were any other of these options discussed
8 on the call, to your memory?

9 MS. BLAIR: Objection to form. Asked and
10 answered.

11 BY MR. CRAIN:

12 Q. And I'm asking for the first time about
13 this chart.

14 A. I mean, I guess it would be some
15 variation of this.

16 Q. Can you tell me which one of these boxes
17 were discussed on the call?

18 A. Okay. So moderate change, assign
19 hospitals to the bottom quartile. That was
20 Peter's suggestion, and that's referenced
21 earlier.

22 And -- or several standard deviations

1 below the mean. And then -- okay. So then it
2 looks like then the next thing is that idea that
3 I had at the end of the Slack, impute with
4 limited achievement scores.

5 Q. And those two ideas -- the bottom
6 quartile and the limited achievement -- are
7 different, correct?

8 A. I don't -- we don't know yet because we
9 haven't performed an analysis of what the bottom
10 scores are.

11 Q. I don't mean the output is different.
12 They may or may not be. But I'm saying the
13 proposals here are different.

14 A. It would be -- the methodology would
15 technically be different. That scoring
16 methodology would have different descriptions.

17 Q. Different descriptions or different --

18 A. But it could arrive at the same score.

19 Q. I understand it could arrive at the same
20 score.

21 The inputs would be different, right?

22 A. Yeah.

1 Q. Okay. So going back to the e-mail, if
2 you go to April 22nd at 12:27 p.m., there's an
3 e-mail from Matt Austin to you and Ms. Danforth.

4 And is it Ms. Joshi?

5 A. Yes.

6 Q. Okay. And he says, Alex, this looks
7 great. I'm wondering, do we, one, want to
8 reflect that we're already using drastic for
9 step 2 for IPS; and two, do we want to use a
10 different term for drastic charge, like large
11 change?

12 Any idea why he wants to change the
13 language there?

14 A. Look, I'm not a communications person,
15 and so --

16 Q. Is he?

17 A. No, he's not, but he realizes "drastic"
18 seems extreme, the word in itself. But -- it's
19 semantics.

20 Q. Okay.

21 A. What is the question?

22 Q. You answered it. All set.

1 Go next to the other two tables on pages
2 ending 8329 and 8330.

3 Can you tell me just narratively what's
4 going on with these two? What were the changes
5 here?

6 A. Okay. So it looks like I edited the
7 table so the IPS stood out, to point out that it
8 already is in that category.

9 Q. And then --

10 A. So that's 8330.

11 And then, for 8329 -- let's see the
12 difference. Oh, we also have to point out that
13 BCMA needs to be broken out. And that's -- we
14 haven't talked about that.

15 BCMA had a major change on the survey in
16 whatever survey cycle that would have been used
17 in step 1. So it wasn't fair to compare past
18 scores to current scores, to have that be imputed
19 from a previous survey.

20 Q. Got it. Okay. So the way of measuring
21 BCMA changed so you weren't going to use the
22 step 1 for BCMA?

1 A. Yes. They wouldn't be apples to apples.

2 Q. Got it. Understood. Okay.

3 A. For just a short time, until we had
4 another survey worth of data. Now it's -- this
5 upcoming fall it's going to use step 1
6 imputation.

7 Q. Okay. If you go to the first page.

8 And do you recall a few minutes ago you
9 mentioned this may have been shown to Leah?

10 Do you see the e-mail from you at 4:27?
11 It says, Matt and Preeti, are you free this
12 Thursday at 4:30 to meet with Leah, by any
13 chance?

14 A. Yes.

15 Q. Is that the meeting you were recalling?

16 A. Yes. Yeah, that makes sense. So at this
17 point, we hadn't met with Leah, and now we're
18 presenting these to her.

19 Q. And do you recall whether you presented
20 the last chart at 8329 to her?

21 A. I assume that's -- since that's the final
22 one --

1 Q. Okay.

2 A. -- that would have been.

3 Q. And tell me, what do you recall at that
4 meeting?

5 A. I'm not sure.

6 Q. Let me show you another document, which
7 may help.

8 MR. CRAIN: So we're going to mark this
9 Exhibit 10.

10 (Campione Deposition Exhibit 10 marked
11 for identification and attached to the
12 transcript.)

13 BY MR. CRAIN:

14 Q. So you can see, Ms. Campione, this is
15 another invite with an agenda in the chart.

16 Do you see the calendar invite?

17 A. Yes.

18 Q. And it looks like you sent it?

19 A. Yes.

20 Q. And the meeting was to be April 25th at
21 4:30, as you suggested in the prior e-mail,
22 right?

1 A. Yes.

2 Q. And required attendees include
3 Ms. Danforth, Dr. Austin, Ms. Joshi, and
4 Ms. Binder. Do you see that?

5 A. Uh-huh.

6 Q. And it look like -- am I right that the
7 chart was the last version we had looked through
8 on 8320?

9 A. Yes.

10 Q. Okay. Does this e-mail refresh your
11 recollection about the meeting that you sent the
12 invite for?

13 A. Yes.

14 Q. Tell me what you remember.

15 A. Oh, does it -- no, I don't remember the
16 meeting anymore, no. This is the same
17 information basically in the last one.

18 Q. Yeah -- okay. And it was on Zoom?

19 A. Yes.

20 Q. Do you know if this one was recorded?

21 A. No.

22 Q. You don't know or it was not?

1 A. It was not recorded.

2 Q. Sorry, bad question.

3 Okay. And you don't remember anything
4 Ms. Binder said on that call?

5 A. No.

6 Q. Okay. Was she favorable to the change?
7 Unfavorable?

8 A. I mean, I -- we're -- I think she met it
9 with a good amount of skepticism and trying to
10 weigh the changes and just -- I don't remember,
11 like, a strong takeaway from the meeting, but
12 I -- I don't know.

13 Q. And do you presently remember that the
14 meeting happened?

15 A. Yes. It definitely happened.

16 Q. Okay. You just don't remember the
17 content.

18 A. No.

19 Q. You can't remember what you don't
20 remember?

21 MR. CRAIN: Let's go to tab 37. So this
22 will be Exhibit 11.

1 (Campione Deposition Exhibit 11 marked
2 for identification and attached to the
3 transcript.)

4 BY MR. CRAIN:

5 Q. And this is another e-mail thread between
6 or among you, Dr. Austin, Ms. Danforth, and
7 Ms. Joshi.

8 Do you see that?

9 A. Yes.

10 Q. And it starts -- if you want to go to the
11 bottom, you send out an e-mail at 5:41 p.m. You
12 say, Hi, all -- tell me when you're there.

13 A. Okay.

14 Q. Good? Okay.

15 Hi, all. I have some bad/good news. The
16 step 2 scores aren't what we would like. Turns
17 out the hospitals that do the survey perform very
18 well. The BCMA scores below will likely drop
19 with the methodology changes, though.

20 What's the context of this e-mail?

21 A. So it would have been looking for those
22 quartiles, I'm assuming. Yes, using this

1 quartile suggestion.

2 Q. I see. So this is what we saw --
3 Dr. Pronovost's suggestion?

4 A. Yes.

5 Q. Okay. And what's the bad/good news?
6 What does that mean?

7 A. So it turns out that the hospitals -- a
8 lot of the hospitals doing the survey are doing a
9 really good job with these standards.

10 Q. And so -- oh, so that's the good news;
11 they're doing well?

12 A. Yes.

13 Q. And what's the bad news?

14 A. Bad news is it wouldn't work. It
15 wouldn't be, like, a valid way to assign scores.

16 Q. Why is that?

17 A. Well, if we're trying to represent what
18 performance is like for hospitals not completing
19 the survey, I think it's fair to say they
20 wouldn't be performing like that.

21 Q. Okay. So just so I understand, the chart
22 below -- right? It says CPO -- it says, Measure

1 25thpercentile, mean of bottom quartile, two
2 standard deviations below mean, three standard
3 deviations below mean.

4 Do you see that?

5 A. Yes.

6 Q. And on CPOE it says -- I'm not sure I'm
7 understanding this -- 25th percentile is 100.

8 What is -- is that right? Or am I
9 misunderstanding that? It's pretty high.

10 A. Yeah, maybe there's an error in this.

11 Q. Okay.

12 A. Let me see. I might have used the
13 wrong...

14 Let's see. Mean of bottom quartile --

15 Q. Is that what really -- is it mean of
16 bottom quartile that's the significant number?

17 A. 25th percentile? Yeah, I mean, there's
18 not enough information here to know.

19 Q. To quite tell? Okay.

20 A. Yeah. But the other columns are pretty
21 self-explanatory.

22 Q. Yeah. So the mean of bottom quartile,

1 just to put it in lawyer terms that I can
2 understand, that's taking the bottom quartile of
3 hospitals and finding the mean score, right?

4 A. Yes.

5 Q. Okay. So the mean score for CPOE is 77,
6 right?

7 A. Yes.

8 Q. Do you know what the lowest achievement
9 score is?

10 A. For CPOE? I'd have to look at the
11 scoring methodology.

12 Q. You can take a second and look.

13 A. Yes. It's 15.

14 Q. 15. Okay. So under Dr. Pronovost's
15 proposal, a non-participating hospital would
16 score 77, correct?

17 A. Yes.

18 Q. And under the ultimate methodology, they
19 scored a 15, right?

20 A. Yes. I think he didn't know -- he wasn't
21 familiar with what our data would actually yield.

22 Q. Would you say that difference is drastic?

1 A. Yes. It definitely was not his intent
2 when he made this suggestion.

3 Q. You're saying he wanted it to be lower?

4 A. I think he assumed that it was lower.
5 And judging from the overall attitude of the
6 call, yes.

7 Q. Okay. And on hand hygiene, the mean was
8 49 percent, right? Of the bottom quartile?

9 A. Can you repeat that question?

10 Q. Yeah. For hand hygiene, where you say
11 mean of bottom quartile, under Dr. Pronovost's
12 proposal in the meeting, as you testified to, on
13 the bottom quartile, a non-participating hospital
14 would be assigned a 49, right?

15 A. Yes.

16 Q. And do you know what they were ultimately
17 assigned under limited achievement? It's okay to
18 flip back.

19 A. 15.

20 Q. And for BCMA, the mean of the bottom
21 quartile under Dr. Pronovost's proposal was 87,
22 right?

1 A. Yes. But again --

2 Q. What --

3 A. -- he didn't have these numbers when he
4 made the suggestion.

5 Q. Sure. And what was the ultimate score
6 that was assigned under the methodology adopted?

7 A. 25.

8 Q. Okay. And IPS isn't on here, right?

9 A. No, because it's already being assigned
10 at that point.

11 Q. Going up the e-mail, Dr. Austin responds
12 to you, Alex, would it be easy to look at the
13 same for first-time reporters?

14 Do you have an understanding of why he's
15 asking you that question?

16 A. I think he's saying so you would have to
17 have historical data as well. So if I looked at
18 this past survey and saw -- and limited it to
19 hospitals that were reporting to the survey for
20 the first time, he's asking what would that mean
21 look like.

22 Q. Let me refine the question if I can.

1 This may help.

2 Is he asking you if the numbers using the
3 first-time reporters' means would be lower?

4 A. I think he's curious what they would look
5 like.

6 Q. Does he --

7 A. Because clearly this is not what Peter
8 was after.

9 Q. This is too high?

10 A. Yes.

11 Q. And he's thinking maybe the first-time
12 reporters will be lower, right?

13 A. I -- yeah. They probably would be.

14 Q. And --

15 A. As I testified to earlier.

16 Q. And then he says, We may have to consider
17 the option of just assigning the score for
18 limited achievement, which is actually consistent
19 with how we're approaching IPS.

20 Do you see that?

21 A. Yes.

22 Q. So he's thinking we've got to take it

1 down to the basement, right?

2 A. Yes. So like in that Slack message
3 earlier, I wasn't the mastermind of this. I
4 think these other people were coming to the same
5 conclusions.

6 Q. Everybody is coalescing, in your
7 testimony?

8 A. I would say -- and this is the process
9 I've spoken of before, that it's a collaborative
10 process --

11 Q. Mastermind --

12 A. -- as we look at the different data
13 sources and data.

14 Q. I was going to say mastermind is kind of
15 a loaded word, isn't it?

16 A. Yeah, it is.

17 Q. And then you respond, Not too difficult.
18 I would predict they're just slightly lower.

19 Right? Go to the prior page.

20 A. Uh-huh.

21 Q. And you're responding, you know, it's --
22 tell me what you mean in that sentence.

1 A. Just judging from what the mean was of
2 the first time. It would be similar to that.

3 Q. Okay. And then he responds, Then maybe
4 not worth the effort, right?

5 And why was it not worth the effort?

6 A. Because it would have yielded similar
7 means, and that was not what Peter's intent was.

8 Q. So even though the data was yielding
9 those means, Peter wanted the number to be a lot
10 lower.

11 A. I think that they don't deal with this
12 data day in and day out, and so they don't know
13 what the means really look like. They're just
14 looking at summary statistics.

15 Q. So do you think Dr. Pronovost, Mr. Time
16 Magazine, was looking for data that would fit his
17 assumption about how hospitals were performing,
18 or was he actually trying to assess what the data
19 showed?

20 MS. BLAIR: Objection to form.

21 THE WITNESS: It's -- you know, I don't
22 think it matters what his intent was because at

1 the end of the day, it would go before the expert
2 panel and they could decide if it was fair and if
3 it was valid or not.

4 BY MR. CRAIN:

5 Q. Would it be fair, to use your words, to
6 grade a hospital at 15 if all the data showed
7 that the mean of similar cohorts in the bottom
8 quartile, not even the mean overall but in the
9 bottom quartile, was actually 77, 49, or 87? Is
10 that a fair result?

11 A. Can you repeat the question --

12 Q. Yeah. You said --

13 A. -- but shorter?

14 Q. I'll go back -- oh, sorry.

15 You said the expert panel would decide if
16 it's fair.

17 And just to start, do you have an opinion
18 on what's fair and what's not fair?

19 MS. BLAIR: Objection to form.

20 THE WITNESS: It's up to them.

21 BY MR. CRAIN:

22 Q. Okay. But do you have a view on

1 fairness?

2 A. Yes. I'm a human being.

3 Q. Fair enough.

4 Is it fair to grade hospitals at 15 if
5 the data before you says that the mean of the
6 bottom quartile of hospitals in a similar cohort
7 is 77, 49, or 87?

8 MS. BLAIR: Objection to form.

9 THE WITNESS: I think that this data
10 speaks to the fact that there's, like, two sets
11 of hospitals here, the ones that are completing
12 and the ones that are not.

13 And the ones that are completing, I think
14 the numbers speak for themselves here, that
15 they're performing really well.

16 BY MR. CRAIN:

17 Q. So your expectation is that if the
18 hospitals that were not completing actually
19 completed, their mean would be 15?

20 MS. BLAIR: Objection to form.

21 THE WITNESS: I don't think it would --

22 MS. BLAIR: -- mischaracterizes

1 testimony.

2 THE WITNESS: Not necessarily. I don't
3 think it would be 77, 49, and 87, the numbers
4 that we referenced earlier.

5 BY MR. CRAIN:

6 Q. It would be an order of magnitude lower?

7 A. I think it would be. Yeah.

8 Q. What's the basis of that opinion?

9 A. Just -- I don't know.

10 Q. Okay.

11 A. I just know that's not valid. And I
12 think that was originally addressed to the expert
13 panel, and they clearly had the same opinion.

14 Q. Let's take hand hygiene. Right? So the
15 mean of the bottom quartile was about 50, right?

16 A. Uh-huh.

17 Q. And the ultimate lowest achievement was
18 15?

19 A. Yes.

20 Q. Or was it 25? Let's --

21 A. 15.

22 Q. 15. So it's less than half.

1 Hand hygiene assesses what?

2 A. What I testified to earlier: culture,
3 feedback, so -- observations. And -- what's the
4 other one?

5 Q. Training.

6 A. Training.

7 Q. So is it your view that -- strike that.
8 I'll move on. Bad question.

9 Okay. Let's go back to the e-mail.

10 So I want to go to the top to
11 Ms. Danforth.

12 She said, This is sort of what I was
13 afraid of, but somehow more stark in seeing the
14 actual numbers -- stark seeing the actual
15 numbers. I do think we need to at least
16 consider [sic] --

17 A. Consider.

18 Q. I assume that means consider.

19 -- going to limited achievement.

20 What's she afraid of?

21 A. That the numbers are not -- they're very
22 high --

1 Q. But the --

2 A. -- and inaccurate. And this is the idea
3 that you can't use hospitals that complete the
4 survey as some sort of benchmark or
5 representation of hospitals that don't do the
6 survey.

7 Q. And I just want to be clear: The 15
8 scores that we were talking about, the lowest
9 achievement, are those accurate depictions of
10 performance under the metrics?

11 MS. BLAIR: Objection to form.

12 THE WITNESS: If you don't have data, you
13 don't have data. Those hospitals chose not to be
14 transparent --

15 BY MR. CRAIN:

16 Q. So you don't know --

17 A. -- and provide data.

18 Q. Sorry.

19 So you don't know either way?

20 MS. BLAIR: Objection to form.

21 THE WITNESS: Right. Yeah.

22

1 BY MR. CRAIN:

2 Q. So those hospitals could have just as
3 well been performing on these metrics in the 60s,
4 the 50s, the 30s, the 90s; you have no idea?

5 MS. BLAIR: Objection to form.

6 THE WITNESS: If I leave a section of my
7 test blank in an exam, like, yeah, I could have
8 gotten all of them right, I guess.

9 BY MR. CRAIN:

10 Q. So --

11 A. But if I don't fill them out, then why
12 should I get points for those?

13 Q. So Leapfrog is like an exam?

14 A. It's -- yeah, I guess. It's a survey.

15 Q. But it's voluntary.

16 A. Sure. It's voluntary for me to go to
17 college.

18 Q. That's fair. But if you're in college,
19 it's not voluntary for you to not take the test.

20 A. It is.

21 Q. How is it voluntary if -- I guess you're
22 saying you could just fail.

1 A. Right. I mean, you could leave a section
2 of a survey or a test blank if you wanted to.

3 Q. And --

4 A. You could run out of time.

5 Q. Okay. And does that F communicate that
6 you don't know anything about the subject matter?

7 MS. BLAIR: Objection. Form.

8 MR. CRAIN: You liked that question, Kim.

9 MS. BLAIR: Maybe -- maybe it does.

10 THE WITNESS: I don't -- if I leave a
11 section of the survey empty -- or, sorry, of a
12 test empty, if I do really well on the rest of
13 the test, there's a possibility I could still get
14 an A.

15 MR. CRAIN: Okay. Let's -- are you guys
16 okay on break?

17 MS. BLAIR: I'm fine.

18 MR. CRAIN: Good.

19 MS. BLAIR: You good?

20 MR. CRAIN: We've been going about an
21 hour and 15.

22 MS. BLAIR: Do you want to take a break?

1 THE WITNESS: No, I'm good.

2 MR. CRAIN: Good.

3 MS. BLAIR: It's up to you if you want to
4 take a break. You're in charge.

5 MR. CRAIN: Yeah, you are. I'm not.
6 Okay.

7 THE WITNESS: Maybe in a little bit.

8 MR. CRAIN: So let's go to the next tab.
9 Tab 42. This is Exhibit 12.

10 (Campione Deposition Exhibit 12 marked
11 for identification and attached to the
12 transcript.)

13 (Discussion off the record.)

14 BY MR. CRAIN:

15 Q. Tab 42. So -- do you have that,
16 Ms. Campione?

17 A. Yes, I do.

18 Q. Okay. So I want to go to the bottom of
19 this. And there's an e-mail from -- sorry, not
20 the bottom. The bottom of the first page shows
21 the e-mail. And do you see -- it's an e-mail
22 from Dr. Austin to Dr. Pronovost, cc'ing

1 Ms. Danforth and you.

2 Do you see that?

3 A. Yes.

4 Q. And Dr. Pronovost responds subsequently,
5 I think -- Dr. Austin has to follow up, right?

6 Do you see that?

7 A. Wait. Sorry. What --

8 Q. Do you see Dr. Austin follows up on the
9 7th seeking comments --

10 A. Okay.

11 Q. -- and then, on the 14th, Dr. Pronovost
12 responds?

13 Do you see that?

14 A. Yes.

15 Q. Okay. Now, do you recognize the document
16 that's on page 3? It's Bates ending 202260.

17 A. Yes.

18 Q. Okay. What is the document?

19 A. So this looks like perhaps the text that
20 will end up going in the proposed changes.

21 Q. And does this reflect ultimately the
22 methodology that Leapfrog adopted?

1 A. I will read it.

2 Q. Take a second.

3 A. Okay.

4 Q. And the question I had: Does this
5 reflect ultimately the methodology that Leapfrog
6 adopted?

7 A. No.

8 Q. What's different?

9 A. IPS should have been included in at least
10 the step 1, unless there's some -- yeah. So IPS
11 had a reduction from four rounds to two rounds,
12 and BCMA wasn't going to have step 1 imputation
13 in the first -- for fall 2024 and spring 2025.

14 Q. Got it.

15 A. So there's just some technical things
16 that are incorrect. But generally, yes.

17 Q. Big picture, it's the same.

18 A. Yes.

19 Q. Okay. And this was Dr. Austin sending
20 this to Dr. Pronovost for his review?

21 A. It would appear that way.

22 Q. Do you know whether Dr. Austin sent this

1 to any other members of the expert panel?

2 A. I don't know.

3 Q. Okay. We'll show you one other.

4 To your understanding, if he had sent it
5 to others, would you have been left off those
6 communications?

7 A. I mean, he may or may not have included
8 me. I mean -- but eventually, it has to find its
9 way into the proposed changes, which I'm
10 drafting. So either way --

11 Q. Got it.

12 A. -- however he goes about it is fine.

13 Q. So eventually, if folks had comments,
14 they would come back to you?

15 A. Yes.

16 Q. Okay. I want to go now to tab 48. Okay.
17 (Campione Deposition Exhibit 13 marked
18 for identification and attached to the
19 transcript.)

20 BY MR. CRAIN:

21 Q. And this is Exhibit 13.

22 So I want to start with the bottom

1 e-mail. This is another thread. This one, just
2 like the last one, is Dr. Austin to, this time,
3 Dr. Romano, cc'ing you and Ms. Danforth.

4 Do you see that?

5 A. Yes.

6 Q. And he says, Patrick, since our
7 conversation with you a couple of weeks ago about
8 changing the imputation approach used in
9 Leapfrog's hospital safety grade, we met with the
10 broader expert panel to hear their input and I've
11 drafted the attached language to share with the
12 hospitals about the proposed changes.

13 Just triangulating ourselves, the meeting
14 a couple of weeks ago, was that -- are you with
15 me?

16 A. Well, this is May 7th and that was
17 May 14th. So...

18 Q. Look at the bottom e-mail. The middle
19 e-mail from Dr. Austin to --

20 A. Oh, okay. I see.

21 Q. Do you see that?

22 A. Peter offers -- okay. I see now. Okay.

1 Q. Yeah. Peter responds on the 14th.

2 A. Okay.

3 Q. But Dr. Austin follows up on the 7th.

4 So he also e-mails Dr. Romano on the 7th,
5 right?

6 A. Okay.

7 Q. And he says, Since our conversation with
8 you a couple of weeks ago.

9 Is that referring to the 30-minute
10 meeting we talked about from April 12th?

11 A. It could.

12 Q. Are you aware of any other meeting it
13 could be?

14 A. I'm not aware.

15 Q. Did you have any other meetings with
16 Dr. Romano?

17 A. No, I did not.

18 Q. Okay.

19 A. No.

20 Q. We met with the broader expert panel.

21 And again, that's the April 12th meeting?

22 A. Yes.

1 Q. To hear their input and I've drafted the
2 attached language to share with the hospitals
3 about the proposed changes. In the attached, I
4 believe you will see that we have found a path
5 forward that still uses a hospital's unique
6 historical data, when available, although for
7 shortened time, and, when historical data are not
8 available, creates an incentive for hospitals to
9 share information about their patient safety
10 practices.

11 There's no third clause. He's missing
12 an "and."

13 Do you see that as well?

14 A. Yes.

15 Q. Okay. So we have on May 7th Dr. Austin
16 sending this document to Dr. Romano and
17 Dr. Pronovost.

18 A. Right.

19 Q. Are you aware of him sending it to
20 anybody else?

21 A. No. I mean, like I said before, I
22 wouldn't -- he could do it and I wouldn't know.

1 Q. Okay. So then on the 14th, if you go
2 back to the prior document, Dr. Pronovost
3 responds and gives his comments, right?

4 A. Okay.

5 Q. And then Matt Austin follows up with
6 Patrick -- go back to the -- Exhibit 13. I'm
7 sorry for the toggling.

8 And he says, Patrick, if helpful to your
9 review, Peter offered some suggested edits to
10 clarify the concept of imputation. Thanks for
11 any feedback you may have on this communication
12 to hospitals.

13 Do you see that?

14 A. Yes.

15 Q. And then Patrick responds and he says,
16 Thank you for sharing. I like the simpler and
17 more direct approach here. If the goal is to
18 penalize non-participants, you might as well do
19 so in a clear and unmistakable manner while
20 allowing for hospitals to manage their burden and
21 jump back on the wagon after a year. This
22 approach is certainly much easier to implement

1 and more straightforward that -- presumably
2 "than" -- the step 2 imputation that you folks
3 originally proposed in that the consequences of
4 non-response will become readily apparent.

5 Now, the step 2 imputation that you folks
6 originally proposed, is he referring to what you
7 discussed with him on April 12th?

8 A. Yes. This makes a lot of sense.

9 Q. Tell me why.

10 A. Because -- so when we met with him, we
11 were proposing to get rid of step 1 altogether.
12 And like your e-mail showed before, step 1, that
13 was, like, a concern of ours. We presented
14 step 2B where we're using the mean of the first
15 score.

16 We presented that to him, and he thought
17 it was a little too complicated if the goal here
18 is just to ensure that these hospitals aren't
19 assigned -- these non-participants aren't
20 assigned a, like, inaccurate score.

21 Q. Just to be clear, he says the goal is to
22 penalize non-participants.

1 A. Uh-huh.

2 Q. Right? You said a different goal there.

3 A. I mean, I don't agree with his
4 characterization of this, the goal is to penalize
5 non-participants. I absolutely don't agree with
6 it.

7 But I think that the heart of what he's
8 saying here is you need a simpler, more direct
9 approach that's easy for hospitals to understand
10 and the public to understand.

11 Q. I just want to stop you before we go down
12 the rest of the document. Let's look at the top
13 e-mail.

14 A. Uh-huh.

15 Q. Because you said I absolutely don't
16 agree? Is that what you said?

17 At the top, you said, I completely agree.

18 A. Yeah. I completely agree with a simpler
19 and more direct approach here.

20 Q. Okay. So you completely agree with part
21 of his e-mail?

22 A. I completely agree with the first

1 statement. I like the simpler and more direct
2 approach here.

3 Q. Okay. So which statements in here do you
4 disagree with now?

5 A. I don't agree that we're doing this for
6 the goal to penalize non-participants. I don't
7 agree with that characterization. But then
8 everything else after that I think is clear. I
9 mean, we want to be transparent about what we're
10 doing, and taking the mean of the bottom quartile
11 and trying to find what we're after is not clear.
12 And taking the mean of the first scores, it's not
13 accurate.

14 So I -- at the end of the day, I think
15 it's just better that we do something in a clear
16 way.

17 Q. Okay. So you completely agreed with his
18 e-mail before, but now you partially agree?

19 MS. BLAIR: Objection to form.

20 THE WITNESS: I mean...

21 BY MR. CRAIN:

22 Q. It's a yes or no question.

1 A. I didn't say there I completely agree
2 with your entire e-mail, did I? I said I
3 completely agree.

4 Q. Period.

5 A. Period.

6 Q. Okay. I'll take that.

7 A. I completely agree with the gist of his
8 e-mail.

9 Q. The gist of his e-mail? And what is the
10 gist of his e-mail?

11 MS. BLAIR: Objection to form. Asked and
12 answered.

13 THE WITNESS: I like the simpler and --

14 MR. CRAIN: She said it.

15 THE WITNESS: -- more direct approach
16 here.

17 BY MR. CRAIN:

18 Q. The gist of his e-mail is not the goal
19 should penalize non-participants?

20 A. I don't think so. If you read the rest
21 of the e-mail, it --

22 Q. Let's go through it.

1 A. -- it's getting into other stuff.

2 Q. Yeah. Okay. I corrected a couple of
3 typos and peers' edits and suggested rephrasing
4 of one sentence.

5 Presumably you don't disagree with that.

6 As I mentioned earlier, your step 2B
7 proposal would have led to lower imputed
8 estimates, but not more accurate imputation.

9 A. Right.

10 Q. Okay. You agree with that?

11 A. Yes.

12 Q. Okay.

13 I find no reason to believe, and you
14 didn't present any evidence to suggest, that a
15 hospital's unreported data from the current year
16 is better approximated by its cohort mean from
17 the first year of reporting than by its current
18 cohort mean.

19 Do you agree with that?

20 A. Yes, I do. And after reading that, I
21 was, like, yeah, I do. And I've always felt that
22 way. If you have data from the hospital, it's

1 best to use it. But at a certain point, it
2 expires.

3 Q. Okay.

4 The underlying hypothesis behind your
5 proposed step 2B approach was that hospitals stop
6 reporting because their true performance
7 deteriorated.

8 Do you agree that's your hypothesis?

9 A. I think it's part of it.

10 Q. What's the other part?

11 A. Well, I mean, there's a number of reasons
12 that you could stop reporting.

13 Q. Give me some.

14 A. Your true performance deteriorated. You
15 didn't like what your scores were. You'd rather
16 use those step 2 means.

17 Q. I noted you didn't -- well, let's keep
18 reading. You didn't say his hypothesis.

19 My hypothesis -- this is Dr. Romano -- by
20 comparison was that most hospitals stop reporting
21 because it is too burdensome and because they
22 only find market value in an A grade, which

1 proves impossible to attain or maintain.

2 Do you see that?

3 A. I.

4 Q. And do you --

5 A. I don't agree with that, his hypothesis.

6 Q. You disagree with his hypothesis?

7 A. Yeah. No, I don't really agree with that
8 part.

9 Q. Okay. Even though you wrote back, "I
10 completely agree."

11 A. Right. I didn't.

12 Q. You didn't call him afterwards and say,
13 Dr. Romano, you got this wrong?

14 MS. BLAIR: Objection to form.

15 THE WITNESS: Yeah, I don't think that
16 that is what that means. But...

17 BY MR. CRAIN:

18 Q. What means?

19 A. I don't think that when you say, oh, I
20 completely agree with you, like, you're saying
21 every example you gave, every, you know,
22 description -- like that's not what that e-mail

1 was meant --

2 Q. Okay.

3 A. -- to do.

4 Q. If my hypothesis is correct, then the
5 current step 2 approach (current cohort mean)
6 would yield more accurate imputations, but it
7 doesn't achieve your strategic objective of
8 penalizing non-participants.

9 Agree or disagree?

10 A. I disagree with that.

11 Q. All --

12 A. Because he's saying, again, that it's
13 kind of -- going back to the goal is. He's
14 making the assumption that the goal is to -- and
15 I don't think that's the goal.

16 Q. Okay. So you don't think that's the
17 goal. So you disagree --

18 A. I think the goal is to not assign these
19 scores that -- give them points that they don't
20 deserve.

21 Q. How do you know they don't deserve them?

22 MR. CRAIN: You like that question.

1 THE WITNESS: We don't have data that we
2 don't have.

3 BY MR. CRAIN:

4 Q. So you don't know whether they deserve
5 them.

6 MS. BLAIR: I'm just going to object to
7 form.

8 THE WITNESS: Right.

9 BY MR. CRAIN:

10 Q. Okay. In other words, I wasn't keen on a
11 back-door approach to penalizing
12 non-participation. If you want to penalize
13 non-participants, then don't pretend you are
14 imputing missing values in a statistically
15 optimal way. Just be honest about your goal.

16 A. Oh -- see, I agree with that. I probably
17 ended this -- the e-mail, read that sentence, and
18 was, like, yeah.

19 Q. We love honesty. Okay.

20 You don't agree now with the prior
21 sentence, correct?

22 A. No, I don't agree -- just be honest about

1 your goal. I think we perfectly were in our
2 proposed changes of -- it's all laid out there.
3 In other words, don't keep -- back-door approach
4 to penalizing -- like, I -- it just if you want
5 to penalize non-participants, the last part, then
6 don't pretend that you're imputing missing values
7 in a statistically optimal way. Because it
8 wasn't a statistically optimal way anymore.

9 Q. What wasn't --

10 A. That mean value was not representative.

11 Q. And the new value was?

12 A. I don't think there's a perfect way to do
13 it. You don't have data that you don't have.
14 And at the end of the day, 80 percent of
15 hospitals are doing our survey and are committed
16 to that, and it's not fair to them to just be
17 giving points out willy-nilly for hospitals that
18 are choosing not to do the survey because they
19 want to get a different score.

20 Q. Because to your point in the Philadelphia
21 Inquirer, it's a tremendous effort to do the
22 survey, right?

1 MS. BLAIR: Objection to form.

2 THE WITNESS: Define "tremendous."

3 BY MR. CRAIN:

4 Q. Well, it's your words from the article.

5 A. Can I define "tremendous"?

6 Q. Absolutely.

7 A. Okay. I think reasonable and it's not
8 something that you can just, like, flip through
9 and fill out in an hour. I think 80 hours is
10 tremendous effort.

11 Q. Okay. I want to go back to something you
12 said about this e-mail.

13 You said that you were agreeing with the
14 gist, right? Do you recall that testimony?

15 A. Yes.

16 Q. He, I think four times, says that the
17 goal is to penalize non-participants.

18 Why is that not the gist of this e-mail?

19 A. That's not the gist I took.

20 Q. What is the gist you took?

21 A. A simpler and more direct approach here.

22 The -- imputing missing values is not

1 statistically optimal.

2 There's really -- it's a tough situation
3 here where -- and I can relate to how he's a data
4 guy and you want to come up with, like, the most
5 accurate and everything. But the safety grade
6 is, like, a living, breathing thing that is being
7 assigned twice a year, so it's just not possible.

8 Q. And were you surprised that he thought
9 that the goal was to penalize non-participants?

10 A. Again, I wasn't agreeing with that.

11 Q. But were you surprised?

12 A. To hear that he was saying -- I wouldn't
13 say in that meeting, that 30-minute meeting we
14 had with him the other day, that's not what was
15 being said. I think he's just saying -- he's
16 talking -- he's trying to get to the point -- or
17 something. I don't know.

18 Q. Do you have any understanding of why he
19 thought that?

20 A. He is an independent person and he's very
21 smart, and he's just doing his own analysis and
22 his own conclusions.

1 Q. But you don't have an understanding of
2 why he came to that conclusion?

3 A. No. That's not the language we were --
4 that was even being used at all in that meeting
5 that we had with him. And the expert panel
6 meeting, that wasn't -- no one said that's the
7 goal. If you look at the slides, that doesn't
8 say that was the goal of this thing.

9 Q. No one talked about penalizing
10 non-participants during the meeting?

11 A. I mean, it's how you define "penalizing."
12 I think -- the goal is to not give them data that
13 is not deserved. Points that are not deserved.

14 Q. You know what I'm going to ask now,
15 though. How do you know whether it's deserved?

16 A. Hmm. Asked and answered.

17 Q. Withdrawn. I'll go with your prior
18 answer.

19 MR. CRAIN: Should we take five?

20 MS. BLAIR: Yes.

21 VIDEO TECHNICIAN: The time is 3:21 p.m.
22 This ends unit 4. We're off the record.

1 (A recess was taken.)

2 VIDEO TECHNICIAN: The time is 3:37 p.m.
3 This begins unit number 5. We're on the record.

4 MR. CRAIN: Thank you.

5 (Campione Deposition Exhibit 14 marked
6 for identification and attached to the
7 transcript.)

8 BY MR. CRAIN:

9 Q. So we're going to look at what's been
10 marked as Exhibit 14.

11 Ms. Campione, do you have in front of you
12 an e-mail from Ms. Binder?

13 A. Yes.

14 Q. Okay. And who is Leah Binder?

15 A. She is the CEO of The Leapfrog Group.

16 Q. When did you first meet Ms. Binder?

17 A. I don't know, maybe a month after joining
18 Leapfrog.

19 Q. And you didn't interview with her, you
20 said.

21 A. No.

22 Q. What's your view of her personality?

1 A. She is a strong independent woman.

2 Q. Okay. That sounds good.

3 Let's go to the back of this document.

4 If you look at page 3 -- it's 9813.

5 So this is an attachment to the e-mail?

6 A. Yes.

7 Q. And what is this document?

8 A. So this document is the proposed changes
9 that were eventually published publicly. And
10 she's just providing some edits.

11 Q. Is this the same document that Dr. Austin
12 asked Dr. Pronovost and Dr. Romano to edit?

13 A. They were working on the actual -- it
14 was, like, the excerpt that actually includes the
15 actual methodology changes.

16 Actually, maybe it has some other stuff
17 in there, too. But they kind of created the
18 bones of it. And I'm not sure -- I would --

19 Q. So it's different --

20 A. I haven't, like, compared it sentence to
21 sentence.

22 Q. Okay. Fair enough. Fair enough.

1 And -- so if we go back to Ms. Binder's
2 e-mail -- or let's start with yours.

3 You say, Hi, Leah. We have finalized the
4 changes to the imputation methodology. Both
5 Peter and Patrick have reviewed and signed off on
6 the messaging.

7 Does that refresh your recollection as to
8 whether they had edited at least some part of
9 this document?

10 A. Yes.

11 Q. Okay.

12 Can you review and send back with any
13 feedback by COB Tuesday, 5/21? We want to
14 publish it ASAP so hospitals can be prepared to
15 take the survey if they are considering skipping.

16 Do you see that?

17 A. Yes.

18 Q. So you want to publish it quickly because
19 the deadline is coming up?

20 A. Yes. And we want to give them adequate
21 time to prepare to actually take the survey.

22 Q. And you're anticipating that these

1 changes will prompt additional people to
2 participate?

3 A. Well, I mean, if I'm a hospital that
4 takes it every three years, because of the
5 current step 1 imputation, we want to give them
6 the opportunity to report other data and not
7 spring this on them. So if they would like to
8 complete the survey as they have in the past, we
9 want to give them sufficient time to prepare.

10 Q. And so, to use your hypothetical, if
11 you're a hospital that takes off every three
12 years, under the new methodology, you just get
13 limited achievement, right?

14 A. Well, you might change to do it every two
15 years.

16 Q. Okay.

17 A. If that's your -- the game you play.

18 Q. Got it. Okay. But if they do nothing in
19 response, in your hypothetical, then they'll just
20 get limited achievement?

21 A. Right.

22 Q. And so going back to the top, Ms. Binder

1 writes back to you, cc'ing Ms. Danforth and
2 Dr. Austin, and says, Hi, Alex. Here it is with
3 some tweaks, mostly moving a few things around
4 for clarity. And a document of two pages doesn't
5 need an appendix, so just call it table 2.

6 I think we've all gotten edits like that.

7 I don't think we need the sentence about
8 influencing survey participating and giving
9 people confidence in validity.

10 Do you recall what she's referring to
11 there? And feel free to look back at the
12 document. I think it's at the end of
13 paragraph 2.

14 A. Okay. Yes. I included that because I
15 like it. It gives context to how hospitals that
16 were, you know, doing certain things with the
17 survey, playing this game or whatever, were
18 biasing the results.

19 Q. So you disagreed with her edit?

20 A. No. I mean, she's just -- it's the
21 overall messaging. She had a different goal.

22 Q. Let me --

1 A. There's a hundred different ways to say
2 the same thing.

3 Q. Yeah. Let me adapt the question.

4 You liked what you had proposed but you
5 were fine with her edit.

6 A. Yeah.

7 Q. She says, then, It sounds defensive.
8 Do you agree with that?

9 A. I mean, it's -- I don't speak for
10 Leapfrog. Ultimately, this document is going to
11 be an official Leapfrog document. It doesn't
12 matter how I feel about it and, you know, if I
13 was a hospital, how I'd like to hear it versus
14 her. I think it's all opinion.

15 Q. But just to be clear, you're an employee
16 of Leapfrog.

17 A. Yes. And I'm not a comms person. So...

18 Q. Okay. But you have spoken about Leapfrog
19 to reporters at least five times every six
20 months, right?

21 A. Yes.

22 Q. Okay. So she says, It sounds defensive,

1 like nobody participates in the survey, and our
2 own TEP questions our validity.

3 What is the TEP? It is expert panel,
4 with some T?

5 A. I'm not going to speculate on what she
6 meant there.

7 Q. Okay. That's not an acronym you're
8 familiar with?

9 A. No.

10 Q. Okay. Do you agree that it sounds like
11 nobody participates in the survey and our own --
12 something -- questions the validity?

13 MS. BLAIR: Objection to form.

14 THE WITNESS: Can you repeat the
15 question?

16 BY MR. CRAIN:

17 Q. Yeah. Do you agree with her -- she says,
18 It sounds defensive -- and referring to that
19 sentence she struck -- like nobody participants
20 in the survey, and our own TEP questions our
21 validity.

22 A. I mean, that's, like, her opinion.

1 Q. Okay. Do you share --

2 A. No, I thought the sentence didn't do
3 that. But...

4 Q. Okay. And to be clear, she does not want
5 to convey that message, right?

6 MS. BLAIR: Objection to form.

7 BY MR. CRAIN:

8 Q. To your understanding.

9 A. Well, it's not true, so --

10 Q. Okay.

11 A. -- no, she wouldn't want to.

12 Q. And why do you think it's not true?

13 A. Because we just had Peter sign off on it
14 and Patrick sign off on it.

15 Q. So two members on the panel.

16 A. And everyone else on the panel was
17 agreeing with it in that general direction.

18 I don't know what Matt did after that
19 point, but it's not true.

20 And if Patrick was the most -- was
21 against it, as we saw from the last e-mail, or
22 initially, and was open for debate, he's now come

1 around, and so that wouldn't be fair.

2 Q. Okay. And just to be clear, though,
3 you're aware of no document by which the other
4 members of the panel besides Romano and Pronovost
5 expressly agreed to this change.

6 A. No. But I do know that they will receive
7 the proposed changes later. And once again, I'll
8 remind you, it's not final. They're proposed.

9 Q. Okay. Because you're seeking comment,
10 right?

11 A. Yes.

12 Q. Okay. And she says, Anyway, it's not
13 necessary to get into the why. It's enough that
14 the expert panel advised us to do the imputation
15 in a different way and not treat older, better
16 data in an equivalent way to new data.

17 Is this sentence accurate?

18 A. The expert panel advised us to do the
19 imputation in a different way?

20 Yes.

21 Q. Who on the expert panel advised you to do
22 imputation in a different way?

1 A. Well, you'll have to watch the meeting.
2 I don't know.

3 Q. Okay. You don't know.

4 A. I don't know exact names. But...

5 Q. Okay. But your only knowledge of where
6 somebody may have advised Leapfrog to do
7 imputation in a different way is that meeting?

8 A. Yes. And any commun- -- or I guess --
9 you're saying to my knowledge. I mean, I guess
10 there's --

11 Q. Yeah, there's the --

12 A. -- the additional communications that
13 were...

14 Q. Yeah, let me fix the question.

15 A. Okay.

16 Q. It was confusing.

17 Are you aware of any other meeting or
18 communication through which the expert panel may
19 have advised you to do the imputation in a
20 different way?

21 A. No.

22 Q. Okay. Then she says, I think when we

1 respond to the public comments, we can be more
2 pointed and specific about the survey and
3 imputation reasoning if necessary. The comments
4 will give us a good gauge on the extent to which
5 we need to reveal all our reasoning and whether
6 the expert panelists will truly stand up for it
7 when push comes to shove.

8 Do you see that?

9 A. Yes.

10 Q. What does she mean there when she says --
11 to your understanding, when she says, We need to
12 assess whether we will reveal all our reasoning?

13 A. I mean, it really doesn't matter what I
14 think. She sent back the edits and I'm going to
15 go -- we're going to go publish them. I mean,
16 it's -- I don't know.

17 Q. You've said earlier today that one of
18 Leapfrog's -- and correct me if I'm wrong, but
19 one of Leapfrog's goals or missions is
20 transparency, right?

21 A. Uh-huh.

22 Q. Is this consistent with transparency?

1 A. She's saying that when the public
2 comments come in, we can with be more pointed and
3 expound.

4 But I think that what she's trying to do
5 is not give a whole preamble. She wants to make
6 sure the proposed changes really contain proposed
7 changes and keep that to a minimum. I don't
8 think that's trying to not be transparent.
9 That's trying to make sure that we're not
10 influencing people's opinions. We're going to
11 let them see the proposed changes.

12 Q. So she wants them to comment on the
13 proposed changes without the underlying
14 rationale, right?

15 A. That's what it sounds like. She feels
16 that there's enough there.

17 Q. And do you have any understanding -- the
18 last clause -- The comments will give us good
19 gauge on the extent to which we need to reveal
20 all our reasoning and -- this is the part I want
21 you to focus on -- whether the expert panelists
22 will truly stand up for it when push comes to

1 shove?

2 A. I mean, I don't know what she means
3 there. You'll have to ask her.

4 Q. Okay. You have no independent
5 understanding?

6 A. No.

7 Q. Okay.

8 A. It doesn't have anything to do with how I
9 do my job.

10 Q. Okay. If you can go to her edits on
11 page 9814. And predominantly, she makes changes
12 to paragraphs -- it looks like 2 and 3 are the
13 biggest.

14 Do you see that?

15 A. Yes.

16 Q. And her edits say, To ensure the hospital
17 safety grade methodology continues to support
18 these goals -- and we can go back and look at the
19 goals in a second -- Leapfrog's blue ribbon
20 expert panel and researchers at John Hopkins
21 Medicine annually review the scoring methodology.
22 The panel -- she changed "recognized" to

1 "advised" -- that Leapfrog modify the current
2 imputation method.

3 What's your understanding of that change
4 there?

5 A. Are you asking me what her intent was
6 with making those changes? Because you would
7 have to ask her.

8 Q. I'm asking you which word is more
9 accurate, "recognized" or "advised"?

10 A. Well, actually, the two words -- the
11 three words that she adds to that sentence kind
12 of make it a different sentence.

13 Q. How so?

14 A. Well, it's just -- it's a different
15 statement. It's not wrong, but it's a different
16 statement. So I don't think that you can look at
17 it in a vacuum of changing "recognized" to
18 "advised."

19 Q. So the first sentence was, The panel
20 recognized that the current imputation method,
21 which is used to fill in missing data among
22 hospitals that did not complete the most recent

1 survey -- is that sentence --

2 MS. BLAIR: Objection to form. You
3 didn't read the whole sentence.

4 MR. CRAIN: Yeah, yeah, fair enough.
5 I'll keep going.

6 BY MR. CRAIN:

7 Q. Let me start at the beginning.

8 The panel recognized that the current
9 imputation method, which is used to fill in
10 missing data among hospitals that did not
11 complete the most recent survey, have influenced
12 hospital survey participation and may no longer
13 be valid.

14 A. Yes. That is reflective of what was said
15 in the expert panel meeting.

16 Q. So that's accurate?

17 A. Uh-huh.

18 Q. Okay. The revision is, The panel advised
19 that Leapfrog modify the current imputation
20 method which is used to fill in missing data
21 among hospitals that did not complete the most
22 recent Leapfrog survey.

1 Is that accurate?

2 A. I think that's a more concise way of not
3 going into details. And her e-mail says the
4 reason why she did it; she didn't feel like we
5 needed to be giving background on why we did it.

6 Q. So you don't think there's any difference
7 between the panel recognizing something and the
8 panel proactively advising something?

9 A. Well, they're just saying something
10 different. Like, if this -- I could write the
11 same thing that she did in that one sentence by
12 using my whole sentence, expounding, and then add
13 in another sentence later on. But you can see
14 she cut out other places in the next paragraph.

15 So I think that someone would have to
16 read the entire section or the entire proposed
17 changes with her edits then after, then they can
18 come to their own conclusions, but I don't think
19 that what you're implying is what's happening
20 here.

21 Q. What am I implying?

22 A. You're implying that it's, like, she

1 changed it from "recognized" to "advised."

2 Q. Well, she did change it from "recognized"
3 to "advised."

4 A. And that's it.

5 Q. What's the implication?

6 A. Well, it just becomes a different
7 sentence that we've said elsewhere. I mean,
8 like, one would be saying, like, oh, they -- I
9 mean, but at the end of the day, it's true, so
10 what does it matter?

11 Q. When did the panel advise Leapfrog to
12 change the methodology?

13 A. When did the panel advise Leapfrog? In
14 the expert panel meeting where everyone said,
15 yeah, this isn't fair that these hospitals are
16 getting assigned this mean.

17 Q. Okay.

18 MR. CRAIN: Let's go to tab 55.

19 Okay. We're going to go to another
20 exhibit.

21

22

1 (Campione Deposition Exhibit 15 marked
2 for identification and attached to the
3 transcript.)

4 BY MR. CRAIN:

5 Q. So this is an e-mail thread between you,
6 Dr. Austin, and Ms. Danforth.

7 Do you see that?

8 A. Yes.

9 Q. And if you go to the bottom, it's the
10 same e-mail that we saw before where you were
11 sending Ms. Binder the finalized changes to the
12 imputation methodology both Peter and Patrick
13 have reviewed.

14 Do you see that?

15 A. Yes.

16 Q. And then -- it's the e-mail where
17 Ms. Binder conveys her comments above that on
18 May 17th.

19 Do you see that?

20 A. Yes.

21 Q. And then Ms. Danforth forwards it to
22 Dr. Austin, right?

1 A. No. He was cc'd on the e-mail before.

2 Q. Oh, sorry, you're right. Yes.

3 So she sends it back to him and drops
4 Ms. Binder, right?

5 A. Yes.

6 Q. Okay. Sorry, I didn't -- I missed that
7 it wasn't a forward.

8 And she says, Hi, Matt. Since she mostly
9 updated the parts Peter and Patrick helped with,
10 you can take a look and let us know if you have
11 any concerns. We'd love to get this out Monday
12 or Tuesday next week.

13 Do you see that?

14 A. Yes.

15 Q. In what capacity is she asking him to
16 weigh in on his concerns?

17 A. Well, I think that she is -- she's
18 saying, do you think that this -- even with her
19 taking out those sentences, do you think that
20 this is still representative of how Peter and
21 Patrick felt?

22 And, you know, we've talked about earlier

1 about how Matt really is the go-to between us and
2 the expert panel. We meet with him occasionally,
3 tell him our input, you know, make suggestions.
4 But at the end of the day, Matt really is the
5 in-between, and he kind of represents them and
6 makes sure their opinions are heard.

7 So she's just making sure that the
8 document as a whole is still representative of
9 their -- what they wanted to convey.

10 Q. So then he responds, My only note is the
11 "why" has been edited out of the explanation, so
12 you don't really explain why this change is being
13 done, but it reads fine. No concerns.

14 Do you see that?

15 A. Yeah. And that's what Leah said she was
16 doing. She said that we didn't need to explain
17 anymore. So...

18 Q. So my question on no concerns --

19 A. Uh-huh.

20 Q. -- is it your testimony that him
21 conveying no concerns is a statement from the
22 expert panel, essentially?

1 A. No, I wouldn't say that's literally what
2 that means.

3 Q. Is he speaking for the expert panel in
4 his capacity here?

5 A. No. Missy asked him if this was --
6 what's the word? If this was still -- if this
7 was in contrast to the original e-mail that he
8 had with them, two e-mails. And he said he has
9 no concerns.

10 Q. Well, she asked -- she didn't ask if it's
11 in contrast. She said, Let us know if you have
12 any concerns.

13 Right?

14 MS. BLAIR: Objection to form.

15 THE WITNESS: Yeah, I think that's
16 implied there.

17 BY MR. CRAIN:

18 Q. How do you know that's implied?

19 A. She said, since you took out these parts,
20 can you take a look and let us know if that's of
21 concern.

22 Q. Okay. So you think she's not asking him

1 for his independent view; she's asking him for
2 his views of what Patrick and Peter might think?

3 A. She's asking if it conflicts and -- in my
4 opinion. And so I think you should ask her what
5 she meant.

6 Q. Okay. Now, he also says, My only note is
7 the "why" has been edited out of the explanation,
8 so you don't really explain why this change is
9 being done.

10 Do you see that?

11 A. Yes. So the explanation has been
12 removed.

13 Q. Yeah. And is that ultimately what was
14 published?

15 A. Yes.

16 Q. So there was no "why" in the published
17 version?

18 A. Yes. She -- her opinion was that the
19 "why" should come later, but she didn't say the
20 "why" shouldn't come.

21 Q. When did the "why" come?

22 A. When we responded to public comments.

1 Q. Got it. Well, let's go to those.

2 MR. CRAIN: Tab 77. So this is
3 Exhibit 16.

4 (Campione Deposition Exhibit 16 marked
5 for identification and attached to the
6 transcript.)

7 BY MR. CRAIN:

8 Q. Okay. So this is a document Bates ending
9 8623. And the top e-mail is from you.

10 Do you see that?

11 A. Yes.

12 Q. Do you recognize this document?

13 A. Yes. It looks like I've summarized
14 public comments that came in from our help desk,
15 and I've provided them here for Missy if she
16 wants to review them. I've color-coded it to
17 pull out themes. And then I addressed them in
18 responses in another attachment in the proposed
19 changes, and she's going to review them.

20 Q. Great. So let's go through a few of
21 these. And I think we only have this
22 black-and-white version. So it's a little

1 tricky.

2 MR. CRAIN: We may ask for a color
3 version.

4 MS. BLAIR: Sorry.

5 BY MR. CRAIN.

6 Q. So the -- against themes color coding,
7 can you -- the top two I can see. Can you try to
8 decipher the bottom two?

9 A. They've been redacted.

10 Misrepresents performance. More time.
11 Do not penalize hospitals for -- they're saying,
12 please don't penalize hospitals for not
13 completing a resource-intensive survey. Keep
14 them separate or allow hospitals to opt out.

15 And then, of course, I can't read the
16 last one.

17 Q. Yeah. I actually think it's highlighted,
18 not redacted. I think it's the --

19 A. I know, I know. It's not redacted, for
20 the record. Just joking.

21 Q. Transparency, transparency.

22 A. Yes.

1 Q. So these -- the first three, and then
2 whatever the fourth says, are your sort of
3 synthesis of the comments you saw?

4 A. Yes.

5 Q. Okay. And if you look later in the
6 document -- we can maybe look at some of the
7 documents later -- some of the comments in a
8 separate document where it will be more visible.

9 But if you go to 78628. And -- actually
10 go to 29.

11 Do you see where it says, Responses to
12 public comments?

13 A. Yes.

14 Q. Did you write this document?

15 A. I drafted this. Yes.

16 Q. Okay. And just walking through, I have a
17 couple of questions.

18 If you go -- so you have four
19 commentators supported the change to the
20 imputation methodology.

21 Then you have two commentators -- I'm
22 just looking at the bold -- two commentators

1 expressed concerns about step 2 imputation
2 misrepresenting the current procedures or
3 infrastructures -- infrastructure of the hospital
4 to the public.

5 Do you see that?

6 A. Yes.

7 Q. Did you disagree with those comments?

8 A. Do I disagree with those comments? What
9 is -- like, generally? This day? Then?

10 Q. So let's -- fair enough.

11 At the time, did you disagree that the
12 step 2 imputation could misrepresent the current
13 procedures or infrastructure at the hospital to
14 the public?

15 A. I mean, this is kind of the same question
16 we've been getting here. And I think -- I mean,
17 it's really tough to say. I mean, I would -- I
18 think that the other way grossly misrepresented
19 more. I think there's always going to be some,
20 you know, situation where it isn't perhaps how
21 they're performing but -- or what structures they
22 have in place.

1 But at the end of the day -- and I think
2 we address that here -- is they should complete
3 the survey if they want to get points for the
4 processes they have in place.

5 Q. And you said the other way. Is that the
6 bottom quartile or the prior imputation method?

7 A. Sorry. Now I'm confused.

8 Q. Yeah. You said -- let's see.

9 You said, oh, I think that the other way
10 grossly misrepresented more.

11 Which was the other way you're referring
12 to there?

13 A. In my opinion, both.

14 Q. Okay. The quartile also misrepresents?

15 A. Yes.

16 Q. Okay. So the only thing that properly
17 represents the structure and procedures -- the
18 infrastructure or procedures of a hospital to the
19 public is limited achievement for
20 non-participating hospitals?

21 A. I think there's no perfect way, and
22 that's what we've landed on here.

1 Q. Is there any risk that limited
2 achievement misrepresents the current procedures
3 or infrastructures of a hospital to the public?

4 A. I think misrep- -- I mean, I think, at
5 the end of the day, it's all publicly available
6 methodology, and anyone could look at it,
7 consumers or hospitals. And so as long as we're
8 publishing it publicly, we're not
9 misrepresenting.

10 Q. Where on the website is it published?

11 A. Beneath -- anytime imputation is used
12 it's shown.

13 Q. What is shown?

14 A. A statement.

15 Q. A statement that says a score has been
16 imputed?

17 MS. BLAIR: Objection to form.

18 THE WITNESS: No, it doesn't say that.

19 It says --

20 MR. CRAIN: We can look at it.

21 Let's go to tab 137. Exhibit 17.

22

1 (Campione Deposition Exhibit 17 marked
2 for identification and attached to the
3 transcript.)

4 BY MR. CRAIN:

5 Q. So this is the West Boca Medical Center
6 hospital safety grade page; is that right?

7 A. Yes.

8 Q. And West Boca Medical Center you
9 understand is one of the plaintiffs in this case?

10 A. Yes.

11 Q. So was this the page you're referring to
12 where you said it's showing what the methodology
13 is?

14 A. Well, not this particular page because
15 it's a web page, and on a web page you can scroll
16 down.

17 Q. Yes. So let's go -- let's go through the
18 document.

19 Where on this document, which I will
20 represent to you is a PDF printout of that web
21 page --

22 A. Uh-huh.

1 Q. -- where does it disclose the
2 methodology?

3 A. Well, if I look at this hospital score of
4 15*, I would wonder why the asterisk is not [sic]
5 there, and I would use my eyes to go down to 4
6 and see that it says, The hospital declined to
7 report their performance on this measure, so a
8 score was assigned to reflect the lack of
9 information available.

10 Q. Where does it say how the score was
11 assigned?

12 A. I mean, you can't put everything on one
13 page. That would be very overwhelming to a
14 consumer.

15 Q. I get that --

16 A. But I think it's an accurate statement.

17 Q. My question is different.

18 Where does it say how the score was
19 assigned?

20 A. I don't understand what that means.

21 Q. This says a score was assigned, right?

22 MS. BLAIR: Uh-huh.

1 MR. CRAIN: Your counsel says yes.

2 MS. BLAIR: I'm sorry. Did I say that
3 out loud?

4 THE WITNESS: Yes. It does say that. It
5 says a score was assigned to reflect the lack of
6 information available. And their score is 15.

7 BY MR. CRAIN:

8 Q. And their score is 15.

9 Where does it say how you came to that
10 15?

11 A. I don't think it matters that it says how
12 we came to that.

13 Q. You don't think the "how" matters?

14 A. I mean, we don't -- I don't think that is
15 necessary here. I can see that they're 15. I
16 can see that the worst hospital score is 15. So
17 I can -- I know that the lowest score was
18 assigned here.

19 Q. So we're on this page because I asked
20 you, where does Leapfrog publish the methodology?
21 And you --

22 A. Uh-huh.

1 Q. -- came to this page.

2 Where on this page -- you said this page.
3 You mentioned there was a footnote below. Right?

4 A. You didn't ask where is the methodology.

5 Q. Yeah, we can go back. Let's see.

6 I said, where on the website is it
7 published?

8 You said, beneath anytime imputation is
9 used, it's shown.

10 What is shown?

11 A statement.

12 A statement that says a score has been
13 disputed [sic]?

14 And that's where -- we're here. Right?

15 A. Well, the first statement that you just
16 read had "it," so that already isn't --

17 Q. Do I have to go back?

18 A. If you're saying I said something, then I
19 think you do.

20 Q. Okay. Well, then I'll go back. Let's
21 see. Now I've lost it.

22 Well, I'll just ask the same question

1 again.

2 A. Okay.

3 Q. Where on this page is Leapfrog's
4 methodology published?

5 MS. BLAIR: On this page?

6 MR. CRAIN: Correct.

7 BY MR. CRAIN:

8 Q. Not -- this document, let's --

9 A. Okay. But --

10 Q. Any of these --

11 A. -- to be clear, I don't think that's what
12 I said before, that it was.

13 Q. What do you think you said?

14 A. Well, now I don't remember. We've kind
15 of gone -- we've diverged.

16 Q. I don't want to confuse you, so I'm going
17 to go back and look.

18 Okay. I said, Is there any risk that
19 limited achievement misrepresents the current
20 procedures or infrastructures of a hospital to
21 the public from that comment. Right?

22 A. Okay.

1 Q. Right. Then you said, I think misrep- --
2 I mean, I think, at the end of the day, it's all
3 publicly available methodology and anyone could
4 look at it, consumers or hospitals. And so as
5 long as we're publishing it publicly, we're not
6 misrepresenting.

7 And I said --

8 A. Okay.

9 Q. -- Where on the website is it published?

10 A. Okay. Thank you for repeating that.

11 Q. Yes. Clear?

12 A. Yes. 3it is clear.

13 To which response I would say this
14 screenshot doesn't include the tabs, and that's
15 where the methodology is posted. On a different
16 page. And I would assume -- there has to be --
17 there's definitely a link somewhere -- and this
18 is a paper. So there's definitely a link
19 somewhere about -- where it does link on these
20 pages to the methodology.

21 Q. So I agree with you there's a link
22 somewhere. You don't see it on this page, right?

1 MS. BLAIR: Objection to form.

2 THE WITNESS: Because it doesn't include
3 the tabs on this page. So I don't --

4 BY MR. CRAIN:

5 Q. Okay. So you think it might be in one of
6 the tabs.

7 A. I know that it's in one of the tabs.

8 Q. Okay. We'll come back to that.

9 A. Okay.

10 Q. So my other question is, what does the
11 link go to?

12 A. So this link? Okay. So if I was here
13 looking at this, it says, Hospitals can earn up
14 to 100 points for using a well-functioning CPOE
15 system in most areas in the hospital. For
16 details on sources, click here.

17 Q. Yes.

18 A. So if I was a consumer and wanted to know
19 more information, without overwhelming them with
20 too much information -- because there's a good
21 amount to read on here already -- I could click
22 on "for details" on sources. Click here.

1 Q. Okay.

2 A. Do you have that page available?

3 Q. I do have it; I've just got to find it
4 here.

5 So my question is -- Iason is going to
6 find it.

7 MR. CRAIN: Oh, he has it already. Okay.
8 Let's do it. Okay.

9 BY MR. CRAIN:

10 Q. So when you click on --

11 MR. CRAIN: This is for Delray, but it's
12 the page. So this is Exhibit 18.

13 (Campione Deposition Exhibit 18 marked
14 for identification and attached to the
15 transcript.)

16 BY MR. CRAIN:

17 Q. So I'll represent to you -- I'm sorry.
18 So do you know what this page is?

19 A. Yes. So this is the detailed table view.

20 Q. And that's where the link goes to on the
21 prior document, right?

22 A. Yes.

1 Q. Where on this page does it explain
2 Leapfrog's methodology?

3 A. I know there's a link somewhere. It --

4 MS. BLAIR: I'm going to object to form
5 only because this does not properly -- I'm
6 looking at the actual web page, and this is not
7 correct. Because the actual web page says, For a
8 full description of methodology, click here.

9 And for whatever reason, what you printed
10 out does not --

11 MR. CRAIN: Where does it say that?

12 MS. BLAIR: If you look at the actual
13 website. So right here --

14 MR. CRAIN: At the bottom.

15 MS. BLAIR: And your printout does not
16 say that. So I'm just going to object to form.

17 VIDEO TECHNICIAN: Counsel.

18 MS. BLAIR: Oh, I'm sorry. I'm objecting
19 to form, Orson.

20 MR. CRAIN: Okay. Let's come back,
21 because we've printed this one out.

22 MS. BLAIR: That's fine.

1 BY MR. CRAIN:

2 Q. The methodology -- is the methodology
3 published anywhere but the survey methodology
4 document that we talked about earlier?

5 A. No. For ease, we have everything in the
6 scoring methodology document.

7 Q. Okay. That's the only place where it's
8 all laid out, right?

9 A. Yes.

10 Q. Do you have any idea how many visitors to
11 Leapfrog's website actually download that
12 document?

13 A. No, I don't.

14 Q. Do you have a guess?

15 A. No. But if they don't have a need,
16 then...

17 Q. Why would they not have a need?

18 A. Maybe because the average person doesn't
19 feel like searching through this. But they got
20 all the information they needed on that first
21 page.

22 Q. On that first page --

1 A. Yeah.

2 Q. -- right.

3 A. And the line said that a sign has been --
4 a score has been assigned to this hospital --

5 Q. Do you think --

6 A. -- based on the lack of information.

7 Q. Apologies. Do you think it's likely that
8 more than half of visitors to the website
9 download that document?

10 MS. BLAIR: Objection to form --

11 THE WITNESS: I don't -- and I don't
12 think --

13 MS. BLAIR: -- lacks foundation.

14 THE WITNESS: -- they need to. I think
15 that was enough information.

16 BY MR. CRAIN:

17 Q. It's enough information? So going back
18 to Exhibit 16, the one where it says West Boca --

19 A. Oh, 17.

20 Q. Or that's 17? Sorry.

21 Going back to 17, the West Boca, it
22 says -- on page 2, it says, Hospitals can earn up

1 to 100 points for using a well-functioning CPOE
2 system in most areas of the hospital.

3 Do you see that?

4 A. Yes.

5 Q. This hospital gets a 15, right?

6 A. Yes. Then it says there's a lack of
7 information.

8 Q. It says, The hospital declined to report
9 their performance on this measure so a score was
10 assigned to reflect the lack of information
11 available.

12 A. Yes.

13 Q. Is it your view that someone looking at
14 this page would come away thinking that the 15 is
15 an arbitrary number or that somebody coming away
16 from this page would think it actually reflects
17 whether the hospital was using a well-functioning
18 CPOE system?

19 A. I think -- I mean, if it was me before I
20 worked here, I would think they didn't -- they
21 declined to report and they didn't have
22 information and they might have one. But there's

1 also 32 measures here that I'm seeing here every
2 time I open a tab and they don't have that.
3 So -- and they're all in the red.

4 Q. For hospitals that participate, what does
5 a limited achievement score convey?

6 A. That -- and the old category was willing
7 to report, both of which I think portray that
8 they're trying.

9 Q. Trying? Okay.

10 And what does limited achievement convey
11 for a hospital that did not participate?

12 A. Well, I mean, that was probably why some
13 of our expert panelists advised that we give zero
14 points.

15 Q. They advised that you give zero points?

16 A. Yes. I testified to that earlier.

17 Q. Based on what?

18 A. When I was in the expert panel, they
19 decided that maybe these hospitals don't deserve
20 anything.

21 Q. Got it. Let's go --

22 A. But limited achievement means they're

1 trying.

2 Q. Limited achievement means they're trying?

3 A. They're reporting to us.

4 Q. Is anybody not trying?

5 A. That's a good question.

6 Q. I'll take --

7 A. One we can't answer.

8 Q. That's right. I'll take that.

9 I want to go back to the response to
10 public comment, if you have that there.

11 MS. BLAIR: And for the record, is that
12 16?

13 MR. CRAIN: I think that --

14 MS. BLAIR: Is that the Alex to Missy --

15 MR. CRAIN: Yes.

16 MS. BLAIR: -- June 4th --

17 MR. CRAIN: Yes, 16.

18 BY MR. CRAIN:

19 Q. Okay. So we're back on the same page.

20 If you can go to the page where it says, Two
21 commentators express concerns.

22 I think it's page ending --

1 A. The summary.

2 Q. -- 629.

3 And it says -- I'm just going down to the
4 next text -- We recognize that hospitals eligible
5 for step 2 imputation may score higher if they
6 complete a Leapfrog hospital survey. However, we
7 cannot ensure that this is the case if we do not
8 have the data. And our analyses have shown that
9 performance among hospitals that intermittently
10 complete the annual survey is lower than those
11 hospitals that completed the most recent survey.

12 What analysis -- analyses is this talking
13 about?

14 A. They were done before my time.

15 Q. So this is referring to an analysis
16 before the imputation method?

17 A. Just a while back, that when they were --
18 I believe it would have been when they -- I mean,
19 I only joined in 2023 -- no --

20 Q. 2022.

21 A. 2022. Thank you.

22 They -- when they were looking at doing

1 the imputation, they looked into, more
2 extensively, that first score mean that we talked
3 about earlier. So they looked at -- if hospitals
4 are, like, doing the survey for the first time or
5 intermittently or whatever, they did it -- my
6 understanding is that they did an analysis at
7 that time.

8 Q. And the output of that analysis was to
9 give non-performing [sic] hospitals in step 2 the
10 mean of their cohort, right?

11 A. The mean -- or to allow this first score
12 mean to be calculated.

13 Q. What do you mean by first score mean?
14 Oh, first -- got it.

15 A. The first time that they completed the
16 survey.

17 Q. The lowest of the two.

18 A. Well, I mean, I think that it was -- they
19 introduced that as well.

20 Q. Okay. How does that analysis support the
21 change here?

22 A. Well, because of what it says.

1 Q. So the analyses from before 2022 have
2 shown that performance among hospitals that
3 intermittently complete the annual survey is
4 lower than those hospitals that completed the
5 most recent survey?

6 A. I mean, yes. But I don't think that that
7 analysis or takeaway -- these arguments are not
8 the reason why this imputation model was approved
9 and used.

10 Q. But --

11 A. And you can ask the expert panel why they
12 went that way and why they finally approved this
13 at the end.

14 Q. But just to be clear, you -- you drafted
15 this document, right?

16 A. Yeah, and I'm just creating points,
17 arguments. Yeah.

18 Q. Arguments are good. We do arguments with
19 law.

20 I'm trying to understand. You're telling
21 commentators that this is not misleading or
22 misrepresenting because of an analysis that

1 happened before your time.

2 Did you even see the analysis?

3 MS. BLAIR: Objection to form.

4 MR. CRAIN: Fair enough.

5 BY MR. CRAIN:

6 Q. The analysis you're referring to in this
7 sentence, have you ever looked at it?

8 A. No, I haven't. But, ultimately, Missy
9 and Matt are going to review this.

10 Q. Did you --

11 A. And they did, so they can decide if it
12 represents. But I'm just drafting something for
13 them to look at.

14 Q. So how did you draft it if you hadn't
15 seen it?

16 A. Well, I've heard them talk about it. We
17 talked about it in these meetings.

18 Q. Got it.

19 So this analysis was talked about also in
20 the April 12th meeting?

21 A. I don't -- I don't think it was brought
22 up in the meeting, the expert panel meeting. But

1 we've obviously met with Missy, Matt, me. You
2 know, one time Leah was there. We meet a lot.

3 Q. Okay. So you wrote this based on what
4 they told you.

5 A. Yes. A lot of what I do is listen to
6 everyone, distill it, and then just draft
7 something for them to make sure that they agree
8 with it and then also, ultimately, I try to make
9 sure that it's accurate with what the actual
10 methodology change that we're putting forth is.

11 Q. But you couldn't verify the accuracy of
12 this sentence, right?

13 A. No, I can't testify today that that
14 sentence -- that I've seen an analysis that backs
15 up that sentence, no.

16 Q. And just to be clear, you have never seen
17 an analysis that backs up that sentence, right?

18 A. No. I'm not saying it's not out there.
19 I trust Missy and Matt.

20 Q. I just think there's a double negative.
21 Let me fix that.

22 Have you ever seen an analysis that backs

1 up this sentence?

2 A. No, I haven't.

3 Q. Thank you. Okay.

4 I want to keep going down: We do
5 acknowledge the commentator's point that the
6 public may misinterpret the assigned measure
7 scores. In response, we will add a new denotion
8 to the hospital safety grade's website for scores
9 that have been imputed.

10 Do you see that language?

11 A. Yes.

12 Q. What does that refer to?

13 A. The note that is on the -- on Exhibit 17
14 that we discussed earlier.

15 Q. The asterisk?

16 A. Yes.

17 Q. Okay. And so that footnote, your
18 testimony, was added directly in response to the
19 comments?

20 A. Yes.

21 Q. Okay.

22 MR. CRAIN: Could we take five, Kim?

1 MS. BLAIR: Sure.

2 MR. CRAIN: Let's take five.

3 VIDEO TECHNICIAN: The time is 4:20 p.m.

4 This ends unit 5. We're off the record.

5 (A recess was taken.)

6 VIDEO TECHNICIAN: The time is 4:42 p.m.

7 This begins unit number 6. We're on the record.

8 MR. CRAIN: Thank you.

9 Exhibit 19.

10 (Campione Deposition Exhibit 19 marked
11 for identification and attached to the
12 transcript.)

13 BY MR. CRAIN:

14 Q. So Ms. Campione, do you recognize this
15 document?

16 A. Yes.

17 Q. Okay. And what is it?

18 A. It's a screenshot or a page from the
19 hospitalsafetygrade.org website.

20 Q. I'll represent it's a PDF printout of the
21 page, and you'll see the date, September 11th, so
22 yesterday.

1 And so -- this is for Delray Medical
2 Center.

3 Do you see that?

4 A. Yes.

5 Q. And you understand that's one of the
6 plaintiffs in this case?

7 A. Yes.

8 Q. Yeah. And this shows the Leapfrog has
9 labeled Delray an F, right?

10 A. Yes.

11 Q. Okay. If we go to page 2 of the
12 printout, it's -- do you see it's clicked on to
13 the handwashing tab?

14 A. Okay.

15 Q. Okay? And first of all, it shows that
16 this hospital's score is 15, right?

17 A. Yes.

18 Q. And then -- one, two -- three down from
19 that it says the worst hospital score is 15,
20 correct?

21 A. Yes.

22 Q. And on the right for handwashing it says,

1 Healthcare workers can stop infection and illness
2 by carefully cleaning their hands. When hospital
3 staff does not carefully wash their hands, they
4 can spread germs from one patient to another and
5 cause someone to become seriously ill.

6 Do you see that?

7 A. Yes.

8 Q. And it says, Hospitals can earn up to 100
9 points for having a handwashing policy and
10 evaluating how hospital workers follow that
11 policy.

12 Do you see that?

13 A. Yes.

14 Q. Now, Delray gets the worst possible
15 score, right?

16 A. Uh-huh.

17 Q. Do you have any idea whether Delray has a
18 handwashing policy?

19 A. No.

20 Q. Okay. And do you have any idea whether
21 Delray evaluates how hospital workers follow that
22 policy?

1 A. No.

2 Q. Have you ever been to Delray?

3 A. I haven't, but their infections are not
4 very good. So...

5 Q. So you don't want to go?

6 A. No.

7 Q. But you don't know whether they wash
8 hands.

9 A. No, I don't.

10 Q. Okay. Are you aware that Ms. Binder
11 published an op-ed about Delray?

12 A. No.

13 Q. Okay. In your view, does this
14 page communicate to consumers that Delray doesn't
15 wash hands?

16 A. I think it conveys that Delray declined
17 to report their performance on this measure, so a
18 score was assigned to reflect the lack of
19 information available.

20 Q. So your view is that a patient
21 considering whether to go to Delray would look at
22 this and say, I don't know whether they wash

1 hands?

2 MS. BLAIR: Objection to form.

3 Mischaracterizes testimony.

4 BY MR. CRAIN:

5 Q. I'm asking. You can say no.

6 A. They would say -- say that again.

7 Q. Yeah, let me fix the question.

8 Would a consumer, looking at this page,
9 come away thinking I don't know whether Delray
10 washes hands well or not, or would they think
11 they must do a really bad job at handwashing?

12 MS. BLAIR: Objection to form.

13 THE WITNESS: Former.

14 BY MR. CRAIN:

15 Q. The former?

16 A. Yes.

17 Q. Why do you say that?

18 A. I would say we don't know -- a lack of
19 information -- or there's a lack of information
20 because they did not report their performance on
21 this measure.

22 MR. CRAIN: Okay. I want to mark this as

1 Exhibit 20.

2 (Campione Deposition Exhibit 20 marked
3 for identification and attached to the
4 transcript.)

5 BY MR. CRAIN:

6 Q. Do you recognize this document?

7 A. Yes. I think I've seen it before.

8 Q. Okay. What is it?

9 A. An op-ed, as you said, in the Palm Beach
10 Post.

11 Q. And who's it by?

12 A. Leah Binder.

13 Q. And I want to go to page 2. And it says,
14 My grandmother -- and again, this is Ms. Binder
15 writing, correct?

16 A. Yes.

17 Q. My grandmother said Delray Medical Center
18 was very clean. High praise from a woman whose
19 nearsightedness never prevented her from spotting
20 a speck of dust 1,000 feet away. Her only
21 complaint was that they served dinner at
22 7:00 p.m., which is very late for south Florida

1 retirees.

2 Do you see that?

3 A. Yes.

4 Q. Okay. And then it says, a little further
5 down -- I'll just find it. Where is it?

6 Actually, it's up. Go to the first page, please.

7 A. Okay.

8 Q. She said at the time her grandmother went
9 to Delray Medical, which was in 2014, it was
10 clear everyone working there paid attention to
11 the simple work habits that can mean life or
12 death for vulnerable patients, like frequent
13 handwashing and double-checking medication
14 orders. The staff was friendly and kind.

15 Do you see that?

16 A. Yes.

17 Q. And then let's skip down two paragraphs.
18 Sorry I went out of order.

19 She says, Sadly, hospital ratings show
20 that today's patients are unlikely to view Delray
21 Medical Center as my grandmother and I once did.

22 Do you see that?

1 A. Yes.

2 Q. Ms. Binder is telling the public in
3 Florida that Delray is dirty, isn't she?

4 MS. BLAIR: Objection to form.

5 THE WITNESS: I haven't read the rest of
6 the paragraphs.

7 BY MR. CRAIN:

8 Q. Do you want to take a minute?

9 A. Well, I thought you were reading it.

10 Q. No, you're welcome to read it.

11 A. Okay.

12 Q. We've got time.

13 A. Okay.

14 Q. Is Ms. Binder telling the readers of this
15 op-ed that Delray today is dirty?

16 A. No.

17 Q. Is she telling the readers that Delray
18 does not adequately wash hands?

19 A. No.

20 Q. She's saying it's different from when her
21 grandmother was there, right?

22 A. She's saying patients are not happy with

1 the care that they're receiving at the facility.

2 Q. She says that -- where do you get that?

3 A. It says, According to CMS, the agency
4 that runs Medicare, patients tend to rate their
5 experience at Delray Medical and the other Tenet
6 hospitals in the lawsuit poorly, with scores on
7 patient-reported experience far below the
8 national average.

9 Q. You read the first and second page,
10 right?

11 A. I don't know what --

12 Q. Did you read the whole article?

13 A. Okay. No, I haven't.

14 Q. Oh.

15 A. Would you...

16 Q. She starts the article by saying, Delray
17 used to have an A from Leapfrog, right?

18 It's in paragraph 3.

19 A. Okay.

20 Q. And she says the A -- at that time, it
21 was super clean -- or very clean, excuse me.

22 Do you see that?

1 A. Yes.

2 Q. And she says, Now patients are unlikely
3 to view Delray Medical Center as my grandmother
4 and I once did.

5 Do you see that?

6 A. Uh-huh.

7 Q. So grandma viewed Delray as very clean.

8 A. Okay.

9 Q. Do you disagree that she's saying Delray
10 is dirty?

11 MS. BLAIR: Objection to form. Asked and
12 answered.

13 THE WITNESS: I don't think she's saying
14 that at all.

15 BY MR. CRAIN:

16 Q. Okay. And you don't think the
17 handwashing page communicates that Delray doesn't
18 adequately wash their hands?

19 A. No. I think --

20 MS. BLAIR: Objection.

21 THE WITNESS: -- that this says that
22 patients are really unhappy with their care at

1 this hospital.

2 BY MR. CRAIN:

3 Q. Okay. And you don't see the contrast
4 she's drawing --

5 A. Yes, that her --

6 Q. -- between her --

7 A. -- grandmother had a good experience and
8 now patients are having bad experiences.

9 Q. Had a good experience at a clean
10 hospital.

11 MS. BLAIR: Objection to form.

12 THE WITNESS: One of the patient
13 experience measures is about cleanliness. And I
14 would assume it's probably not reported well in
15 CMS' measures.

16 BY MR. CRAIN:

17 Q. But she's talking about the Leapfrog A,
18 right?

19 A. She said they were A, and her grandmother
20 also said it was very clean and had a good
21 experience, so that's good. And now they have
22 really poor scores from CMS for patient

1 experience.

2 Q. But they're not dirty?

3 MS. BLAIR: Objection to form.

4 THE WITNESS: I don't -- look at the CMS
5 scores. See what patients are saying about the
6 cleanliness of the hospital.

7 BY MR. CRAIN:

8 Q. Back to this website.

9 You're saying, just looking at how
10 handwashing is described here, that someone
11 reading this -- well, I'm not going to put words
12 in your mouth.

13 MS. BLAIR: Please don't.

14 BY MR. CRAIN:

15 Q. What does the 15 on this page convey
16 about the hospital's performance in handwashing?

17 A. The 15 and the asterisk next to it convey
18 that the hospital declined to report their
19 performance on this measure, so a score was
20 assigned to reflect the lack of information
21 available.

22 Q. So it displays nothing about the

1 hospital's performance?

2 A. Do you want me to read it again?

3 Q. No. I want your answer to my question.

4 A. I think that's what it portrays.

5 Q. So you said, in response to my question,
6 that the 15 portrays that there was a lack of
7 information, yes?

8 A. Yes. And they were assigned the worst
9 possible score.

10 Q. And lack of information has no
11 correlation with performance; is that right?

12 MS. BLAIR: Objection to form. Asked and
13 answered.

14 THE WITNESS: Sorry. Lack of
15 information --

16 BY MR. CRAIN:

17 Q. Does lack of information have any
18 correlation to performance?

19 A. Yes, it does.

20 Q. What are you basing that on?

21 A. If you leave your test answers not
22 complete, then you're going to get a bad score.

1 Q. So we're back to the test.

2 A. Yes. If you don't fill in a section of
3 the test or you don't show up that day...

4 Q. So --

5 A. It's not a good thing.

6 Q. -- absence of information you're saying
7 is evidence of poor performance?

8 A. I think that it shows that there's a lack
9 of commitment to transparency by the hospital.

10 Q. That's a different issue, transparency,
11 right?

12 A. No, I think --

13 MS. BLAIR: Objection to form.

14 THE WITNESS: -- it's the same issue.

15 BY MR. CRAIN:

16 Q. Transparency and performance are the
17 same?

18 A. If the goal is to improve patient safety,
19 then yes.

20 Q. Okay. So let me ask you this: What does
21 this page say about whether Delray has a
22 handwashing policy?

1 A. It doesn't.

2 Q. It says nothing?

3 A. Yes.

4 Q. Okay. And what does it say about whether
5 Delray has -- whether Delray evaluates how
6 hospital workers follow the policy?

7 A. Well, it doesn't.

8 Q. Doesn't? Okay.

9 I want to talk a little bit about the
10 language in the footnote. Footnote 4.

11 Did you have a role in drafting that
12 language?

13 A. Yes.

14 Q. Tell me about your role in drafting it.

15 A. Sure. I believe someone in -- not on the
16 ratings team was responsible for writing -- they
17 were responsible for writing it, and then I -- my
18 role here would be to review that said statement
19 and make sure that it aligns with what our
20 methodology says.

21 Q. Okay. Do --

22 A. And the output of that was this sentence

1 here.

2 Q. Okay. Do you recall who wrote it?

3 A. I do not. Well --

4 Q. I'll refresh your recollection.

5 A. Yeah, when was the timing on it?

6 Q. I'll give you a document.

7 MR. CRAIN: This is going to be 21.

8 (Campione Deposition Exhibit 21 marked
9 for identification and attached to the
10 transcript.)

11 BY MR. CRAIN:

12 Q. Okay. So Exhibit 21 is a document that
13 starts with the Bates number 427863 on page 1.

14 Do you see that?

15 A. Yes.

16 Q. Okay. And I want to go -- just starting
17 at the top, do you see the subject says, Re: New
18 imputation denotation?

19 A. Are we starting at the --

20 Q. Yeah, just --

21 A. -- top of the page?

22 Q. -- to orient you. Do you see the subject

1 says, Re: New imputation denotation?

2 A. Yes.

3 Q. Is that the footnote?

4 A. Yes.

5 Q. Okay. And this is an e-mail between you
6 and Paulina Litter.

7 Do you see that?

8 A. Yes.

9 Q. Who is Paulina?

10 A. So she -- she's not at Leapfrog anymore,
11 but she was working on -- I don't know exactly
12 what her role was at -- senior specialist,
13 operations and special projects. And she's not
14 on the ratings team.

15 Q. She -- she was on the ratings team?

16 A. She is not on -- or was not on the
17 ratings team.

18 Q. Got it. Okay. So let's go to the last
19 page and work our way up.

20 A. Okay.

21 Q. So the first e-mail starts on May 29th.

22 Do you see that?

1 A. Yes.

2 Q. And it's from you to Ms. Litter, right?

3 A. Yes.

4 Q. And you say, Here's the final mockup and
5 description. Thanks again.

6 Do you see that?

7 A. Yes.

8 Q. And you say, We would like to add a third
9 item in the notes and definitions at the bottom
10 and an optional asterisk to the four measures'
11 score: CPOE, BCMA, IPS, and hand hygiene. The
12 data file would denote whether the asterisk
13 should be present either with four additional
14 columns or include the asterisk in the original
15 data columns. The latter would be similar to the
16 data review website, but I am guessing it
17 wouldn't work since the numeric values are used
18 to determine the gas gauge direction.

19 Can you break that down for me?

20 A. It's not really important; it's just how
21 I would give this data to this person who does --
22 I guess it's -- well, it's to Paulina, but I know

1 that she's going to share it with Devon, who is
2 actually the software engineer.

3 So it's information that he needs to know
4 as to how I'm going to denote in the data file
5 how it's going to be shown on the website.

6 Q. Okay. And the gas gauge denotation I think
7 is on Exhibit 20 -- or sorry, Exhibit 19. It's
8 this part at the bottom?

9 A. Yes.

10 Q. Okay. And that's page 1 of Exhibit 19.

11 Now, you say, Here's the final mockup and
12 description.

13 Was there a process before it got to
14 Paulina?

15 A. I don't remember.

16 Q. Okay. Let's go up. I'm going to jump
17 up --

18 A. Well, actually -- sorry.

19 Q. Yes.

20 A. Actually -- okay. So it looks like the
21 first thing that I would have written, if this
22 was -- because this was my screenshot -- my first

1 thing says, This hospital declined to report data
2 for this measure so a score was imputed for the
3 measure.

4 You can see there's an arrow at the
5 bottom. So that was originally my text but,
6 again, I'm not a comms person.

7 Q. You're saying that was the language you
8 originally drafted?

9 A. Yes. That's the language I would use if
10 I had to put this into a single sentence for a
11 consumer. That was just what I came up with
12 initially.

13 Q. And how does that differ from what the
14 website landed on?

15 A. Well, I think we landed on something that
16 was a true representation of the scoring
17 methodology.

18 Q. So there it says the hospital declined to
19 report their performance on this measure so a
20 score was designed [sic] to reflect the lack of
21 information available.

22 So is the difference just the lack of

1 information available?

2 A. Yeah, I guess so. And I used the term
3 "imputed," and there's concern that "imputed"
4 isn't understood by the general public.

5 Q. "Imputed" is unclear?

6 A. Well, yeah, I mean, it's --

7 Q. To --

8 A. -- a mathematical term.

9 Q. Okay. So just to make sure our record is
10 clear, you're saying "imputed" came out of here
11 because it's unclear to a lay public that doesn't
12 know the mathematical terms?

13 A. Sure.

14 Q. Okay. Going up this e-mail -- so let's
15 see.

16 Paulina writes back to you -- so there's
17 some e-mail exchange with Atlas Works. Who is
18 Atlas Works?

19 A. So that would be the software engineer.

20 Q. Okay. And who is Raven Creative? And
21 just --

22 A. Yes. Like, it's -- Raven Creative. I

1 don't know -- I don't know Atlas -- maybe they're
2 Atlas -- maybe it's, like, two software
3 engineers. I'm not sure.

4 Q. Okay. Some sort of vendor, you think?

5 A. Well, I know he's the software engineer
6 that works on this website.

7 Q. Got it. Okay.

8 Now, I want to go to Paulina's e-mail on
9 page 427865.

10 And she says -- she's forwarding an
11 e-mail from Devon Weller and she says, Does this
12 work for you? My only callout is the language
13 seems a bit off to me as a layperson to know what
14 "imputed" means. Maybe we can say -- change it
15 to say, so a score was calculated using
16 imputation for the measure. Would that work?

17 A. Yes.

18 Q. So that goes to your point before about
19 imputation being unclear to a lay public, right?

20 A. Yes.

21 Q. Okay. And then you respond, Yes, but are
22 you able to see the change on his link? I

1 followed all the instructions and I'm going to
2 try again later today. I've just been out and
3 I'm catching up on stuff.

4 Then you say, This was the language Missy
5 wanted, but Leah wants something else that makes
6 it sound like the data we imputed wasn't random.
7 So LMK -- or let me know -- if you have any
8 ideas.

9 A. Okay.

10 Q. Do you see that?

11 A. Yes.

12 Q. Okay. So the original language at the
13 bottom of the e-mail with the arrow that you
14 pointed to --

15 A. Yes.

16 Q. -- that was Missy's language that she
17 wrote?

18 A. Well, I mean, if I originally -- I don't
19 know if I originally wrote it. I assume I wrote
20 and I said, Does this look good? And she's,
21 like, yes. Something along those lines.

22 Q. Okay.

1 A. But she had approved it. And all I'm
2 doing here is making sure that everyone signs off
3 on it and is happy with what it says.

4 Q. And what do you mean, Leah wants
5 something else that makes it sound like the data
6 we imputed wasn't random?

7 A. I feel like -- I mean, now -- this can be
8 taken out of context, how I use the word "sound"
9 but I wanted to -- I should have said "emphasize"
10 there. I wasn't really thinking about which --
11 my word choice here. And -- I'm saying -- yeah,
12 so Leah wants something else that emphasizes the
13 data we imputed wasn't random.

14 So I'm just trying to get her to -- she's
15 asking -- it really was kind of her job to work
16 on this and do something from, like -- you know,
17 make it sound great. That's not what I do. I'm
18 a data person. So I'm just making sure that it's
19 accurate.

20 Q. Did she control the messaging?

21 A. Control?

22 MS. BLAIR: Objection to form as to who

1 "she" is.

2 MR. CRAIN: Pardon. Fair enough.

3 BY MR. CRAIN:

4 Q. Did Ms. Binder control the messaging?

5 A. I wouldn't say she controlled it. She
6 gives her -- she gives input on it.

7 Q. Was Ms. Binder ultimately responsible for
8 the messaging?

9 A. I mean, everyone has to approve it. Her
10 expert panel -- I mean, if someone wasn't happy
11 with it...

12 Q. Who gets the last word?

13 A. Missy and Leah.

14 Q. Now, do you remember what she told you
15 that made you write, Leah wants something else?

16 A. Yeah. I think we met, and this was --
17 maybe I had shown that or something. It was
18 really in this, like, workshop phase. And I'm
19 guessing she just said, I want to make sure --
20 this just sounds like she just -- she wanted a
21 little bit of a different direction with it. I
22 don't know how to -- it's a hard position to be

1 in to take other people's opinions and what they
2 want and then try to distill it and give it to
3 someone else. It's -- it's hard. But eventually
4 we arrived at what we did.

5 Q. A lot of cooks in the kitchen.

6 A. Yes.

7 Q. And in your view, just going back to the
8 language you wrote side by side with this e-mail,
9 is there anything about the language you had here
10 that Missy approved that made it sound like the
11 data imputed was random?

12 A. Maybe to a person that doesn't work with
13 data. And I think that's kind of what it comes
14 down -- and Missy is on the ratings team and is
15 intimately involved with -- or familiar, I should
16 say, with the scoring methodology. And Leah is
17 thinking about what the general public knows,
18 and -- she just has a different perspective.
19 That's all.

20 Q. Is it the "imputed" that suggests that?

21 A. Again, I can't speak for her. She can
22 explain why what we originally wrote she wanted

1 to -- I think she just wanted to give more
2 information so that -- like, I don't know. I'm
3 not -- I'm too involved in this. I can't give
4 you, like, an objective look at it.

5 Q. Fair enough.

6 Let's scroll up a little bit,
7 proverbially at least.

8 And Paulina writes you back and says,
9 Yeah, I just did it and got the stage version, so
10 everything is working on my end.

11 And then she gives you a bunch of
12 proposals. Do you see that? A few thoughts --

13 A. Yes.

14 Q. -- on that language.

15 And I won't read them all, because there
16 are quite a few. But just as an example, the
17 first one says, The hospital declined to report
18 data for this measure so a score was calculated
19 with external data sources using an imputation
20 model.

21 Do you see that?

22 A. Yes.

1 Q. And fair to say that the other iterations
2 are similar to that?

3 A. Yes. Just some of them have links after
4 them.

5 Q. And what do the links go to? Do you
6 know?

7 A. The scoring methodology.

8 Q. Got it. Is that that 26-page --

9 A. Yes.

10 Q. -- approximately -- yeah.

11 Okay. And then you respond, Okay.

12 Great. It's working for me too. Thanks for
13 doing this, but we can't say external data
14 sources because we're arbitrarily assigning them
15 the points associated with the bottom scoring
16 category, limited achievement, or old data from
17 the previous survey (internal data source). Leah
18 wanted us to make it sound like the expert panel
19 approved it and the assigning of these points was
20 legitimate.

21 And then you propose language. So --

22 A. Okay.

1 Q. Do you see that?

2 A. Yes.

3 Q. And I just want to be clear: You wrote
4 here that Leapfrog was going to be arbitrarily
5 assigning points associated with the bottom
6 scoring category --

7 A. Uh-huh.

8 Q. -- is that right?

9 A. Well, from a mathematical standpoint, it
10 is a little bit arbitrary. These are numerical
11 scores that we're assigning to categories. So in
12 the way that it's not -- it's 15 points, not 16
13 points and not 14 points, that's a little
14 arbitrary.

15 But from the standpoint of whether
16 they're being assigned to that category, that's
17 not what I'm saying at all. They were assigned
18 to the limited achievement category because they
19 didn't provide data.

20 Q. Okay. And is it arbitrary compared to
21 the mean of the lowest quartile we saw before?

22 MS. BLAIR: Objection to form.

1 THE WITNESS: Sorry, what does that mean?

2 BY MR. CRAIN:

3 Q. Yeah. Is it arbitrary to assign the
4 limited achievement score as compared to the mean
5 of the lowest quartile that we saw previously?

6 A. I think in my previous question [sic] I
7 didn't say it was -- I said the exact opposite.
8 It's not arbitrary to assign them to the limited
9 achievement category. I said the points
10 themselves, from a mathematical standpoint, are
11 arbitrary.

12 Q. So what makes it not arbitrary -- strike
13 that.

14 What -- so you've talked about how it's
15 arbitrary in a mathematical sense, right?

16 A. Yes.

17 Q. What is the other sense in which it is
18 not arbitrary?

19 MS. BLAIR: Objection to form.

20 THE WITNESS: Sense in which assigning
21 to -- the categories?

22

1 BY MR. CRAIN:

2 Q. Well, you write here, We can't say
3 external data sources because we're arbitrarily
4 assigning them points associated with the bottom
5 scoring category.

6 And you've testified that the "arbitrary"
7 is related to mathematics; it's arbitrary
8 mathematically.

9 Is it not arbitrary in other contexts?

10 MS. BLAIR: Objection to form.

11 THE WITNESS: No, I don't think so. And
12 I think I've explained earlier why we chose to
13 put them in the limited achievement category
14 versus others. We looked at other options, and
15 they just didn't make sense and they
16 misrepresented grossly what was actually going on
17 at these hospitals, in our opinion.

18 BY MR. CRAIN:

19 Q. Well, how did you know what was going on
20 at these hospitals?

21 A. Well, we don't, and they're not being
22 transparent about it. And the expert panel

1 decided that transparency was important at this
2 point.

3 BY MR. CRAIN:

4 Q. So let me just be clear. You said
5 that -- let me -- let's see.

6 You said the other options just didn't
7 make sense and they misrepresented grossly what
8 actually is going -- what was actually going on
9 at these hospitals, in our opinion.

10 How did you know that they misrepresented
11 grossly what actually was going on at these
12 hospitals, in your opinion?

13 MS. BLAIR: Objection. Asked and
14 answered.

15 THE WITNESS: It was our opinion.

16 MR. CRAIN: It's a different question.
17 Grossly misrepresented this time.

18 BY MR. CRAIN:

19 Q. How did you know that the higher scores
20 grossly misrepresented?

21 A. That -- I mean -- and, honestly, that
22 could be my opinion. There could be someone

1 else's opinion that they really just should be
2 assigned limited achievement because, at this
3 point, 80 percent of hospitals are doing the
4 survey and putting resources towards doing it and
5 giving this data, and these hospitals are
6 choosing not to. They're familiar with Leapfrog
7 and the survey, and they're blatantly choosing
8 not to, showing that they don't have a strong
9 commitment to transparency.

10 Q. Why did Leapfrog impute lowest [sic]
11 achievement for the four imputed measures?

12 MS. BLAIR: Objection. Asked and
13 answered.

14 MR. CRAIN: Like five different ways.

15 MS. BLAIR: Disagree.

16 MR. CRAIN: I'll withdraw it for now.
17 I'll save it for the court.

18 BY MR. CRAIN:

19 Q. No, I'm keeping --

20 MS. BLAIR: You have to answer.

21 MR. CRAIN: I'm withdrawing the
22 commentary, not the question.

1 THE WITNESS: So why did the -- I mean --
2 I mean, you should ask the expert panel.

3 BY MR. CRAIN:

4 Q. Okay. Let me do it this way: You have
5 said today that the limited achievement scores
6 represents what was going on on the ground at
7 this hospital; is that correct?

8 A. No.

9 MS. BLAIR: Objection to form.

10 THE WITNESS: Yeah, I --

11 BY MR. CRAIN:

12 Q. Why is it not correct?

13 A. No, I have not answered that.

14 Q. Okay. Do you agree with that statement?

15 A. That it doesn't -- sorry, can you repeat
16 the statement?

17 Q. Yes.

18 Do you agree with the statement that
19 limited achievement scores reflects what actually
20 is going on at these hospitals?

21 A. I think it reflects the lack of
22 information.

1 Q. Okay. Do you agree it reflects what's
2 actually going on at these hospitals with respect
3 to the performance measures?

4 MS. BLAIR: Objection to form.

5 THE WITNESS: In regard to the
6 performance -- well --

7 BY MR. CRAIN:

8 Q. If you don't understand, that's fine. I
9 can rephrase it.

10 A. Yeah, I don't really understand.

11 Q. I'm not trying to trip you up. I'm just
12 really trying to understand what you think.

13 Is it your view that a limited
14 achievement score for handwashing, hand hygiene,
15 is reflecting what's actually happening at these
16 hospitals?

17 A. I mean, I don't know how to answer it.

18 Q. You don't know --

19 A. I --

20 Q. -- or you don't know how to answer the
21 question?

22 A. I think that I've answered this already,

1 and I think that we've been very clear about, at
2 this point, hospitals should be completing the
3 survey. And it's -- and if they're not, it seems
4 like they have something to hide, and I don't
5 think that's fair to the public.

6 Q. Why do you think they have something to
7 hide, as opposed to Dr. Romano's hypothesis that
8 it's just too burdensome?

9 A. That's just a hypothesis. It hasn't been
10 proven.

11 Q. Has yours been proven?

12 A. No.

13 Q. So why pick the most punitive measure?

14 MS. BLAIR: Objection to form.

15 MR. CRAIN: Okay. Let me -- fair enough.

16 THE WITNESS: Sorry. Should we give them
17 the most points because they didn't give us
18 information?

19 BY MR. CRAIN:

20 Q. That's -- should we give them the most
21 points because they didn't give us information?

22 Did at any time Leapfrog suggest that

1 non-participating hospitals should get the most
2 points?

3 A. No.

4 Q. Was that option ever on the table?

5 A. No, because it doesn't make any sense.

6 Q. Great. There were other options on the
7 table.

8 A. Yes.

9 Q. And -- there were four options. We
10 looked at them, right?

11 A. Right. And the original proposal was the
12 mean of the cohort. And the expert panel said
13 that's not fair and they were not happy about
14 that and they went a different direction.

15 Q. They went a different direction. Right.

16 A. They did. And it's our job to provide
17 the data and analysis or anything they want to
18 see. And if at any point they didn't agree with
19 us -- and Patrick Romano was given the
20 opportunity to express, if he felt strongly, that
21 he didn't like this direction. He could have
22 said it.

1 Same thing with Peter. In fact, Peter
2 was enthusiastic about it.

3 So I don't really see the point here.

4 Q. Dr. Romano was also enthusiastic, right?

5 A. I would say -- I mean, you have shown the
6 e-mails. He wasn't enthusiastic about it, but he
7 is a numbers person. And in a perfect world,
8 he's always looking for the best measurement and
9 the best way to score these hospitals. And in
10 real life, we just, like, don't have access to
11 that information.

12 Q. That's not what his e-mail said, right?
13 He said this was the most honest way, right?

14 MS. BLAIR: Objection to form.

15 BY MR. CRAIN:

16 Q. He said he liked the honesty of the
17 approach, right? Wasn't that how the last
18 sentence of his e-mail ended?

19 A. Yes. Yeah.

20 Q. Okay.

21 A. Okay.

22 Q. And what he liked about it -- tell me why

1 I'm wrong -- is that if the goal was to punish or
2 penalize non-responsive hospitals, this did so in
3 a very clear way, right?

4 A. I think it was clear about how we felt
5 about transparency.

6 Q. Okay. Was it clear about Leapfrog's
7 desire to punish non-participating hospitals?

8 A. No. I think that it was clear that we
9 don't think that you should be getting extra
10 credit if you are choosing to not give
11 information.

12 Q. And how do you decide whether a hospital
13 is getting extra credit or just appropriate
14 credit if it's not participating?

15 A. How do you know if I know a subject if I
16 don't complete that section of the test?

17 Q. How do you know --

18 A. In an exam -- if I took a test, how do
19 you know what I know if I don't complete the
20 test? It doesn't mean I should get 100.

21 Q. I think I just figured out the analogy.

22 Why are you grading students that aren't

1 in the class?

2 A. Why aren't they showing up to the test?
3 I assume they're enrolled by virtue of just being
4 a student.

5 Q. By virtue of being a student, they're
6 enrolled in every case?

7 MS. BLAIR: Objection to form.

8 MR. CRAIN: Okay. We'll move on from
9 this. We're going to have fun with this analogy
10 later.

11 Okay. Let's keep going.

12 BY MR. CRAIN:

13 Q. Okay. I want to talk about the website,
14 the Leapfrog website, in a little more detail.
15 And I want to look at tab 127a, which will be
16 Exhibit 22. It's also Jupiter Exhibit 20.

17 (Campione Deposition Exhibit 22 marked
18 for identification and attached to the
19 transcript.)

20 BY MR. CRAIN:

21 Q. Do you see that, Ms. Campione?

22 A. Yes.

1 Q. Okay. What is this document?

2 A. It is a page from the
3 hospitalsafetygrade.org website.

4 Q. And what page?

5 A. The frequently asked questions about the
6 Leapfrog hospital safety grade.

7 Q. And what's the purpose of this page?

8 A. To answer questions.

9 Q. To answer questions. Questions from
10 whom?

11 A. Well, I don't have context for which tab
12 it came -- it was under.

13 Q. Okay. Fair enough. It doesn't say.
14 Okay.

15 I want to move to page 3. And there's
16 language in here -- do you see, Does a hospital
17 get a better safety grade if it reports to the
18 Leapfrog hospital survey?

19 Do you see that?

20 A. Yes.

21 Q. And then it says, The hospital safety
22 grade reflects how well a hospital does on

1 safety, not whether they complete the Leapfrog
2 hospital survey.

3 I want to break down that sentence.

4 The first clause there, The hospital
5 safety grade reflects how well a hospital does on
6 safety -- do you see that?

7 A. Yes.

8 Q. Do you agree that is always true?

9 A. Yes.

10 Q. Is that true for non-participating
11 hospitals?

12 A. Yes.

13 Q. Why do you say that?

14 A. Because there are 22 measures that get
15 put into the safety grade. A good amount of them
16 come from CMS.

17 Are we disputing that data today? I
18 don't think so. I'll answer that.

19 Q. Asked and answered.

20 A. The -- we have the patient experience
21 data. We have the Leapfrog hospital survey. And
22 a big part of safety is being transparent.

1 And -- and so if you don't answer the survey and
2 you get assigned an imputed score, I think you're
3 not doing great in patient safety.

4 Q. Okay. So this is true as to
5 non-participating hospitals?

6 A. Well, yes.

7 Q. Is it true as to each metric that goes
8 into the safety grade?

9 MS. BLAIR: Objection to form.

10 BY MR. CRAIN:

11 Q. So the hospital safety grade reflects how
12 well a hospital does -- I'm going to bracket
13 that -- say, on hand hygiene?

14 MS. BLAIR: Objection to form.

15 BY MR. CRAIN:

16 Q. Is that accurate?

17 A. The safety grade reflects how well a
18 hospital does on hand hygiene? No, that's not
19 true because it's a holistic composite.

20 Q. Okay. Got it.

21 Let's go back up a little bit.

22 Do you see language that says, If a

1 hospital does not report to the Leapfrog hospital
2 survey -- do you see that there?

3 A. Uh-huh.

4 Q. -- other sources of data are used to
5 calculate a grade. The majority of data used to
6 calculate the safety grade comes from the Centers
7 for Medicare and Medicaid Services (CMS).

8 Is that accurate?

9 A. Yes.

10 Q. Okay. I want to show you a document.

11 MR. CRAIN: Let's go to tab 39. That's
12 going to be Exhibit 23.

13 (Campione Deposition Exhibit 23 marked
14 for identification and attached to the
15 transcript.)

16 BY MR. CRAIN:

17 Q. Okay. We talked -- you have it?

18 A. Yes.

19 Q. Okay. We talked earlier today about
20 CURA Strategies.

21 Do you see the bottom e-mail from CURA?

22 A. Yes.

1 Q. And it looks like it's -- the subject
2 says, A question from Miami Herald.

3 Do you see that?

4 A. Yes.

5 Q. Is this an example of one of the times
6 CURA wrote you to get your feedback on something?

7 A. Yes.

8 Q. Okay. And it says, Hi, Alex. Technical
9 question for you. Miami Herald has a follow-up
10 question, and I wanted to make sure I answered
11 appropriately. See below. The language that
12 concerns me is "most of the data comes from CMS."
13 Do we have a better phrasing? So on and so
14 forth.

15 And you respond -- this is on May 1,
16 2024. And you say, I agree the phrasing is not
17 great and actually a bit misleading. It was
18 probably written before we had imputation.

19 And then you propose a change.

20 Do you see that?

21 A. Yes. I do.

22 Q. Okay. Now, if you look at the bottom,

1 again, do you see it says, In the FAQ it states?

2 MS. BLAIR: In the fact it states?

3 MR. CRAIN: In the FAQ.

4 MS. BLAIR: Oh.

5 MR. CRAIN: Sorry.

6 BY MR. CRAIN:

7 Q. Do you see that?

8 A. Yes. I just don't understand -- what I
9 rewrote just expounds on it.

10 Q. Okay.

11 A. I don't think that it is contrary to that
12 original statement.

13 Q. So the language here in the sentence, In
14 the FAQ it states -- and I'll just read it to
15 make sure we're all on the same page.

16 In the FAQ it states that Leapfrog gives
17 a grade to hospitals regardless if they
18 voluntarily report data or not.

19 A. Uh-huh.

20 Q. If a hospital does not report to the
21 Leapfrog hospital survey, other sources of data
22 are used to calculate a grade. The majority of

1 data used to calculate the safety grade comes
2 from the Centers for Medicare and Medicaid
3 Services (CMS).

4 Do you see that?

5 A. Yes.

6 Q. Okay. That's the same language that's
7 still on the website, right? You can use the
8 other exhibit you have.

9 A. Yes.

10 Q. Okay.

11 A. Yeah, I think that my first sentence is
12 being taken out of context here. It looks like I
13 was just being really technical that day and was
14 adding a lot of additional information.

15 Q. Are you --

16 A. Because I then say, It primarily consists
17 of measures from CMS.

18 Q. What's the difference?

19 A. I don't know. You have to -- I was
20 feeling sassy that day. I don't know.

21 Q. Okay.

22 A. I just wanted to rewrite it and give a

1 lot more information.

2 Q. Okay.

3 A. But I don't think that it contradicts it.

4 Q. Okay.

5 A. And I don't really know what I meant on
6 that day because --

7 Q. Okay.

8 A. -- the majority of data does come from
9 CMS. There's 22 measures and...

10 Q. So you don't recall specifically what you
11 thought was misleading.

12 A. No, I -- most of the data comes from --
13 yeah, no, I don't really -- I actually don't know
14 what I meant that day.

15 Q. Okay.

16 A. Because it's kind of a simple fact that
17 22 measures are used in the safety grade and only
18 7 of them come from the survey.

19 Q. Is that accurate as to the weighting?

20 A. No, because it's referring to the data.
21 Most of the data comes from CMS.

22 Q. Okay. As opposed to how the grade is

1 computed?

2 A. Even if it was, you were saying earlier,
3 a quarter of the grade, that's still less than
4 half. So that would be the majority being CMS.

5 Q. Is that right? Because I thought there
6 were other metrics that go into -- beyond the
7 quarter.

8 A. Beyond the?

9 Q. The quarter.

10 A. The quarter? Well, it depends on whether
11 they do the survey or not. So if they don't,
12 then they would be treated as not available for
13 the other three measures.

14 Q. Okay. Let's go back to the FAQ.

15 So I just want to take a look at page 5.

16 And you see at the top -- the question is
17 actually on page 4. It says, Why don't I see my
18 hospital?

19 And at the bottom it says, The absence of
20 a safety grade does not mean a hospital is
21 unsafe. It means that Leapfrog does not have
22 enough data to assign a grade.

1 Do you see that?

2 A. Uh-huh.

3 Q. Okay. If non-participating hospitals
4 have a grade, does that mean the hospital is
5 unsafe?

6 MS. BLAIR: Objection to form.

7 MR. CRAIN: Yeah, let me rephrase that.

8 BY MR. CRAIN:

9 Q. If hospitals have an F grade, does that
10 mean the hospital is unsafe?

11 A. Yes.

12 Q. If hospitals have a D grade, does that
13 mean the hospital is unsafe?

14 A. Relative to a C or A or B? Yes.

15 Q. Okay. And if hospitals have a C grade,
16 unsafe or safe?

17 A. They are more safe than a D- or
18 F-hospital.

19 Q. Okay. So it's all relative?

20 A. Yes.

21 Q. Okay. And for a non-participating
22 hospital that gets an F -- strike that.

1 Let's keep going down the next paragraph.

2 So you say, Leapfrog experts and advisors
3 at the John Hopkins Armstrong Institute for
4 Patient Safety and Quality regularly review all
5 publicly available measures of safety and their
6 methodology to determine a hospital's letter
7 grade. The national expert panel regularly
8 convenes to review the methodology for validity
9 and reliability.

10 Do you see that? It's the second
11 paragraph on the page.

12 A. Why don't I see my hospital? Is that --

13 Q. It's under --

14 MS. BLAIR: Page 5 of 8.

15 THE WITNESS: Oh.

16 MS. BLAIR: Second paragraph.

17 THE WITNESS: Okay. What is the
18 question?

19 BY MR. CRAIN:

20 Q. Do you see that there --

21 A. Yes.

22 Q. -- the national expert panel regularly

1 convenes to review the methodology for validity
2 and reliability?

3 A. Yes.

4 Q. Does the "regularly convene" refer to the
5 annual meeting?

6 A. Yes.

7 Q. Okay. So it's once a year they convene?

8 A. Yes.

9 Q. Okay. I'm trying to see if there's
10 anything else on this document.

11 I think you can set this one aside.

12 MR. CRAIN: I'd like to go to 133. This
13 will be Exhibit 24.

14 (Campione Deposition Exhibit 24 marked
15 for identification and attached to the
16 transcript.)

17 BY MR. CRAIN:

18 Q. All right. Do you have this document,
19 Ms. Campione?

20 A. Yes.

21 Q. Do you recognize it?

22 A. Yes.

1 Q. What is the lives lost and lives saved?

2 A. It is -- the page shows that -- it's a
3 white paper that was published by Matt -- well, I
4 mean, you'd have to click on the white paper.
5 But it was a study that Matt did, Matt Austin
6 did, at John Hopkins.

7 Q. Do you know when it was published?

8 A. Sometime after 2016.

9 Q. 2016?

10 A. I said after 2016 because this says, A
11 significant improvement from 2016.

12 Q. Fair enough.

13 I'll represent to you that, when you
14 click on it, it goes to -- 2019 it's dated.

15 Now, this says, The analysis -- I'm
16 looking at the bottom of this paragraph.

17 A. Okay.

18 Q. It says, The -- okay. So -- The analysis
19 also found that D- and F-hospitals carried nearly
20 twice the risk of mortality of A-hospitals.

21 Do you see that?

22 A. Yes.

1 Q. And again, that's based on the white
2 paper, right?

3 A. Yes.

4 Q. This is a copy of the website from after
5 the imputation was changed, correct?

6 A. Yes.

7 Q. Okay. And --

8 MS. BLAIR: Well -- I'm sorry, I'll
9 object to form. There's no date on this.

10 THE WITNESS: Yeah.

11 BY MR. CRAIN:

12 Q. Yeah, I'll represent to you that this was
13 pulled after 2024.

14 A. Okay.

15 Q. In 2025.

16 So my question is, this website is
17 telling consumers that if you go to a D and F,
18 that you have nearly twice the risk of mortality
19 of an A-hospital, right? That's what they read.

20 MS. BLAIR: Objection to form.

21 THE WITNESS: I don't think that it's
22 saying the analysis also found that D- and

1 F-hospitals carry nearly twice the risk.

2 So whenever the analysis was conducted
3 and the data it used, that was the conclusion
4 that they drew from the data.

5 BY MR. CRAIN:

6 Q. Back then.

7 A. Yeah. Whenever this analysis was done.
8 I don't think it says, if you go to a D- and
9 F-hospital, you will experience this. It doesn't
10 say that.

11 Q. Is it accurate, in 2024, to say that D-
12 and F-hospitals carry nearly twice the risk of
13 mortality of A-hospitals?

14 A. Well, we don't know that because an
15 analysis wasn't done then.

16 Q. Okay. We don't know; that's what
17 you're --

18 A. On the current data.

19 Q. Okay. And yet this is what Leapfrog puts
20 out to consumers, correct?

21 A. I don't understand the implication
22 because this says the analysis also found that D

1 and F -- and you can click on the paper and see
2 when it was conducted.

3 Q. Okay. Let's go two pages down -- three
4 pages down to Bates 3007.

5 And it says -- this is on Leapfrog's
6 website as well.

7 A. Uh-huh.

8 Q. Do you recognize this graphic?

9 A. Yes.

10 Q. You've seen it before?

11 A. Yes. It's on the page.

12 Q. Okay. And it says, Fewer avoidable
13 patient deaths in America's hospitals. And it
14 says, But your risk of dying depends on the
15 hospital you choose. The Leapfrog hospital
16 safety grade is a letter grade that scores
17 hospitals on how well they protect patients from
18 errors, injuries, accidents and
19 inspections [sic]. Compared to an A-hospital,
20 your risk of dying increases ... 91.8 percent for
21 D and F-hospitals.

22 Do you see that?

1 A. Yes.

2 Q. Okay. What's the support for that?

3 A. Well, the paper that's above it. But you
4 can see that it says 2015 to 2018, so I'm
5 assuming that's when the paper was published.
6 That's where they got the statistic of 160,000.

7 Q. Okay. So in your view, Leapfrog does not
8 tell consumers today that they have a
9 91.8 percent chance of dying if they go to a D-
10 and F-hospital as compared to an A-hospital?

11 MS. BLAIR: Objection to form.

12 THE WITNESS: I mean, as an
13 epidemiologist, I probably would phrase this
14 differently and I'd prefer that everyone reads
15 scientific journals, but the fact is they don't.

16 So yes, this is a watered-down version of
17 it or put in basic terms. But I wouldn't say
18 that this is the messaging everywhere on all the
19 pages. In fact, this is kind of, like, a random
20 rabbit hole you would have to go down to find
21 this page. I don't even know where it's
22 location.

1 BY MR. CRAIN:

2 Q. We can find that information for you.

3 A. Yeah.

4 Q. Back to Iason.

5 A. They don't have it next to the D and
6 F grades being advertised for your five
7 hospitals.

8 Q. We'll double-check that.

9 So my question, going back to -- we
10 talked earlier in the day about the safety grade
11 being easily digestible for a lay audience.

12 Do you remember that?

13 A. Yes.

14 Q. And I take your point, you're an
15 epidemiologist -- right? -- so you may look at
16 things differently from the lay person, right?

17 A. Yes.

18 Q. You said that -- I think -- you said you
19 would probably phrase this differently.

20 In what way?

21 A. I would have to look at the journal -- or
22 at the paper.

1 Q. Do you think it's responsible for
2 Leapfrog to leave this on its website when it
3 suggests -- do you think it's responsible for
4 Leapfrog to leave this on its website when the
5 only support for the proposition that it's
6 stating here is a paper from six years ago, two
7 methodologies behind?

8 A. Do I think it's responsible?

9 Q. Let's start over. Let me take you back
10 to 2019.

11 Was there even any imputation at the
12 time?

13 A. I'm not sure. I wasn't there.

14 Q. Okay. Have you ever heard of the AHA?

15 A. Yes. I -- yes. But also, I will add --
16 actually, I think if you look at the study, none
17 of the Leapfrog measures are used in this.

18 Q. None of the Leapfrog measures are used in
19 the study?

20 A. In this study.

21 Q. Okay.

22 A. They are not. So no, there's no -- like,

1 if there was, maybe -- well, I guess ICU
2 physician staffing, but the other ones were not.
3 And ICU physician staffing used the AHA data.

4 Q. So I'm not sure I understand that.
5 Because isn't the study comparing the final
6 grades?

7 A. Well -- yes, it is. But it's looking at
8 the correlation between the final grades that
9 were assigned and these measures. So it's
10 looking at predicting how many deaths were -- you
11 know, could have happened from these sets of
12 measures. And granted, there could be lots more
13 deaths happening. We're just limited to the data
14 that we have, so looking at infections, looking
15 at these patient safety events, they calculated
16 the number of deaths that could be occurring.

17 And that's all based on articles and
18 things that state, like, oh, you know, the
19 mortality rate for this infection is X, Y, Z.
20 And I believe that they -- the researchers used
21 that to estimate the amount of deaths that could
22 have occurred from those infections.

1 Q. Back in 2019?

2 A. Yes.

3 Q. Okay. And back in 2019, the current
4 imputation method was not operative, right?

5 A. I don't believe that it was. Because
6 only ICU physician staffing was used in this, and
7 it had a different secondary data source.

8 Q. Okay. As an epidemiologist, would it be
9 fair to extrapolate from the results of that
10 study the conclusion that they reached on
11 mortality between the A- and D- and F-hospitals
12 to A- and D- and F-hospitals today?

13 MS. BLAIR: Objection to form.

14 THE WITNESS: Can you repeat that,
15 please?

16 BY MR. CRAIN:

17 Q. Yeah. Bad question.

18 You're an epidemiologist, right?

19 A. Yes.

20 Q. The white paper has a set of conclusions
21 that compare mortality of A-hospitals and D- and
22 F-hospitals, correct?

1 A. Yes.

2 Q. The way that you -- that Leapfrog has
3 identified what is an A- and a D- or F- hospital
4 has changed over these past six years, right?

5 A. Okay. Yes.

6 Q. Many times, right?

7 A. Yes.

8 Q. Is it fair to extrapolate the conclusions
9 of that study on different models of assessing
10 the hospital grades to the current model today?

11 A. No, it wouldn't be. But I don't see the
12 word "today" on here.

13 Q. Okay. But it would not be fair to do so
14 today. You're just saying that's not what this
15 website says?

16 A. I'm saying it doesn't say "today," but
17 yes, that's true, that it would not be fair to
18 extrapolate them today.

19 Q. Okay. Okay. You can set that one aside.

20 And just for the record, the lives lost
21 and lives saved is on the front of the website.

22 I don't know if you --

1 A. The front of the website?

2 Q. Yeah.

3 MR. CRAIN: Why don't we bring it up.

4 So for the record, we are giving

5 Ms. Campione a laptop.

6 MS. BLAIR: Can you tell us what page
7 you're at so I can follow along?

8 MR. CRAIN: Yes. The page is
9 www.hospitalsafetygrade.org. So it's just the
10 home page --

11 THE WITNESS: Okay.

12 MR. CRAIN: -- the landing page.

13 MS. BLAIR: And it's on the front
14 page there? Is that what you're saying?

15 MR. CRAIN: Yeah.

16 MS. BLAIR: Got it.

17 BY MR. CRAIN:

18 Q. So Ms. Campione, can you read the website
19 that you're looking at now? The URL.

20 A. Ww.hospitalsafetygrade.org [sic].

21 Q. And can you describe where on the page
22 the lives lost and lives saved link is?

1 A. Yes. It's under "your hospital safety
2 grade." And there are -- one, two, three, four,
3 five -- six tabs you can click on. And this is
4 the fifth tab.

5 Q. Okay. And why don't you go ahead and
6 click on it. It might be a touchscreen.

7 A. Fancy.

8 Q. Are you there?

9 A. It's not -- yes, I'm there.

10 Q. And does it go to the same page we were
11 looking at, entitled, Lives Lost and Lives Saved?

12 A. Yes.

13 Q. And that is Exhibit -- let's see -- 24?

14 A. Yes.

15 MS. BLAIR: And for the record, Lee,
16 that's two clicks, then. You have to click on
17 "Your hospital safety grade" and then you click
18 on "Lives Lost and Lives Saved," correct?

19 MR. CRAIN: Let me see. Is that right?

20 MS. BLAIR: That's how I'm seeing it.

21 THE WITNESS: You have to go to the
22 main --

1 MR. CRAIN: You go to the main website --

2 THE WITNESS: You have to toggle over,
3 then you have to toggle over.

4 MR. CRAIN: And there's a dropdown.

5 THE WITNESS: Yup.

6 BY MR. CRAIN:

7 Q. Okay. Just for the record, Ms. Campione,
8 can you describe what you have done to get there?

9 A. I have hovered over four [sic] hospitals,
10 and then I've read through five different tabs --
11 oh, wait, I'm in the wrong one, sorry.

12 What -- "your hospitals." So one of --
13 two, three, four, five -- there are six tabs at
14 the top. I've hovered over the second one. Now
15 I've hovered over -- one, two, three, four,
16 five -- or four different tabs I could click on.
17 I've clicked on this one.

18 In my opinion, that's not on the front
19 page of our website.

20 Q. The link is on the front page, yes?

21 MS. BLAIR: Objection to form. It is
22 not.

1 THE WITNESS: With a lot of hovering.

2 MR. CRAIN: Okay. I'll take it.

3 BY MR. CRAIN:

4 Q. While you're there, can you go back to
5 hospitalsafetygrade.org?

6 A. There.

7 Q. I'd like you to go to the search
8 function. And can you search by hospital?

9 A. Yes.

10 Q. And type in Delray, please.

11 What do you see?

12 A. Hospital match. One hospital matching,
13 hospital name: Delray Medical Center.

14 Q. And what's on the left side of the page?

15 A. The F grade, and it says, Delray Medical
16 Center, and their address.

17 Q. What's the biggest letter on the page?

18 A. The F.

19 Q. Can you click into Delray? Can you
20 please navigate to the 26-page methodology and
21 narrate as you're clicking through?

22 A. Okay. To the meth- -- wait. Do you want

1 me to -- like, I know where it is.

2 Q. Yeah. Take us through how to get there.

3 A. Okay. I would go to perhaps the -- I
4 mean, there's multiple -- it's posted multiple
5 places on the website, so there's a number of
6 ways I could go to it.

7 Q. If you're a patient looking at Delray's
8 score, how would you go to find it? That's what
9 I you to show me.

10 MS. BLAIR: Objection to form.

11 THE WITNESS: Well, if I wanted to know
12 the methodology, I would go to "your hospital,"
13 "about the grade," maybe scroll down, and I see
14 "How is the Leapfrog hospital safety grade
15 produced?"

16 And there's a lot of information here
17 about the measures that are used, process
18 outcome; it explains it. And I see a link right
19 to the right that says, Quick links, scoring
20 methodology used in the spring's 2025 release of
21 the hospital safety grades.

22

1 BY MR. CRAIN:

2 Q. And that takes you to the 2- -- is it 26
3 or 28-page PDF?

4 A. The spring 2025 safety grade scoring
5 methodology.

6 Q. Which I think was our Exhibit 1, right?

7 A. Yes.

8 Q. Great. Okay.

9 MR. CRAIN: Can we take five?

10 MS. BLAIR: Sure. Yes.

11 VIDEO TECHNICIAN: The time is 5:42 p.m.
12 This ends unit 6. We're off the record.

13 (A recess was taken.)

14 VIDEO TECHNICIAN: The time is 6:00 p.m.
15 This begins unit number 7. We're on the record.

16 BY MR. CRAIN:

17 Q. We're in the home stretch, Ms. Campione.
18 We talked a little bit about the 2019
19 white paper, the lives saved, lives lost.

20 Do you remember that discussion?

21 A. Yes.

22 Q. Is Leapfrog working on an update to that

1 analysis?

2 A. I believe they're in the process of
3 working on something with them --

4 Q. Do you have any role --

5 A. -- with Matt Austin.

6 Q. With Matt -- I just want to make sure.
7 With Matt Austin?

8 A. Yes.

9 Q. Do you have any role in that revised
10 white paper?

11 A. No, I don't, personally, really. I mean,
12 I've communicated a few times. As far as -- I'm
13 trying to remember. I'm not remembering at the
14 moment, but he does the analysis. I think I
15 provided -- or pointed them towards the data
16 sets, and -- but the analysis is actually done by
17 Preeti Joshi that we referenced earlier, his
18 research assistant, and Matt himself.

19 Q. Okay. Is there anybody else at Leapfrog
20 that works on the white paper with them?

21 A. I wouldn't say work on it. Like,
22 ultimately, he's going to write it, and he does

1 the analysis. I think -- but -- who would have
2 been involved? I don't remember who would
3 exactly have been facilitating that.

4 Q. And we had seen that you maybe
5 co-authored some prior papers with him; is that
6 right?

7 A. There might be, like, one paper. I don't
8 think anything has been, like, published in a
9 scientific journal, but I think there was
10 something with Urban Institute, perhaps.

11 Q. Racial disparities in care?

12 A. Yes.

13 Q. Do you know if you'll be an author on the
14 new white paper?

15 A. No, I wouldn't -- that was under -- it
16 was a different role that I was filling in that.

17 Q. Do you know why they're updating the
18 analysis?

19 A. To get more up-to-date data.

20 Q. To the point we were talking about
21 before?

22 A. Sure. Yes.

1 Q. Okay. Do you know when the revised
2 analysis is expected to come out?

3 A. I think they're planning for the fall,
4 but you never know. Sometimes we do analyses and
5 nothing ever happens. I think we're due to
6 probably update that page.

7 Q. Okay. And why do you say we're due to
8 upgrade that page?

9 A. Like you said --

10 Q. Update that page, excuse me.

11 A. It came out in 2019, so it's probably
12 reached the end of its relevancy.

13 Q. It's no longer accurate?

14 A. I wouldn't say --

15 MS. BLAIR: Objection to form.

16 THE WITNESS: I wouldn't say no longer
17 accurate. I think it's an accurate portrayal of
18 where hospitals were at that time.

19 BY MR. CRAIN:

20 Q. Got it. Okay. But it would not be an
21 accurate portrayal of hospitals at this time?

22 A. Well --

1 MS. BLAIR: Objection to form.

2 THE WITNESS: It doesn't mean that it
3 wouldn't be applicable in any way. We use --
4 people reference studies all the time that
5 happened many years ago.

6 BY MR. CRAIN:

7 Q. Okay. I want to shift gears. Can we go
8 to Exhibit 1 again, the survey methodology.

9 MS. BLAIR: So I have Exhibit 1 as this.

10 MR. CRAIN: I'm sorry. Is it Exhibit 2?

11 MS. BLAIR: Yeah, but we can do this
12 one --

13 MR. CRAIN: You know what --

14 THE WITNESS: I have it as 2.

15 MR. CRAIN: -- it's Jupiter Exhibit 1.

16 MS. BLAIR: Yeah.

17 MR. CRAIN: It's Campione Exhibit 2.

18 MS. BLAIR: Correct. Just making sure.

19 MR. CRAIN: We're going to be in trouble
20 down the line. It's going to be Binder
21 Exhibit 3 --

22 MS. BLAIR: Hey, I asked if we could just

1 keep going, but...

2 MR. CRAIN: I just work here.

3 MS. BLAIR: Same.

4 BY MR. CRAIN:

5 Q. So Ms. Campione, I want to go in to look
6 at some of the way things are described here.

7 Can you go to page -- let's see -- 10.
8 Actually, 11, please. I'm sorry. And it's Bates
9 17511. Actually, there are two Bates. We'll
10 just use the internal.

11 MS. BLAIR: For the record, I'm not
12 sure -- some of the documents look like this, and
13 the larger number is the first page of the
14 document itself, and then the smaller number is
15 the subsequent pages.

16 I have no idea how or why that happened,
17 but --

18 MR. CRAIN: I've never seen that.

19 MS. BLAIR: So it's the smaller number.
20 So it's 17522 you're referring to.

21 MR. CRAIN: Okay. That's helpful to
22 know.

1 MS. BLAIR: Yeah.

2 BY MR. CRAIN:

3 Q. All right. So do you see at the top,
4 Ms. Campione, it says, National Quality Forum:
5 Safe practices?

6 A. Yes.

7 Q. That's one of the three what I called
8 discarded measures at the beginning of the day --

9 A. Okay.

10 Q. -- is that right?

11 A. Yes. You did call them that.

12 Q. And I know you call them something
13 different, but -- we didn't settle on a
14 nomenclature, so I'm just going to call them the
15 discarded measures.

16 Now, when you scroll down -- not scroll
17 down.

18 When you look down to the paragraph There
19 is no secondary data -- do you see that?

20 A. Yes.

21 Q. So it says, There is no secondary data
22 source for the NQF safe practices. Therefore,

1 hospitals that did not submit a 2024 Leapfrog
2 hospital survey by November 30 will not have
3 those measures included in their safety grade and
4 the measure will be reported as "declined to
5 report." See dealing with missing data for more
6 information.

7 Do you see that?

8 A. Yes.

9 Q. And that's an accurate depiction of how
10 the methodology works?

11 A. Yes.

12 Q. Now, is it right that there's no
13 secondary data if a hospital participated in a
14 prior survey?

15 A. Are you asking me if I think that's right
16 or do you [sic] think that's accurate?

17 Q. Let me fix the question. I'm doing a lot
18 of that today.

19 If a hospital participated on a prior
20 survey, there would be secondary data for safe
21 practice 1 and safe practice 2, correct?

22 MS. BLAIR: Objection to form.

1 THE WITNESS: If there was an imputation
2 model used on these measures, then yes.

3 BY MR. CRAIN:

4 Q. So setting aside whether there's an
5 imputation model, if the hospital -- for
6 hospitals that complete a survey, they get a
7 score on safe practice 1, right?

8 A. Okay. Yes.

9 Q. Yes?

10 A. Wait. They get a score, yes, when they
11 complete the survey. It's -- the only data
12 source is the Leapfrog hospital survey.

13 Q. Yes. If the hospital the next year does
14 not participate, there's no current score, right?

15 MS. BLAIR: I'll object to form, the use
16 of "score."

17 BY MR. CRAIN:

18 Q. What should I call it?

19 A. Sorry, I just don't know where --

20 Q. Okay.

21 A. No current score where?

22 Q. Safe practice 1. If a hospital

1 participates in the survey, it gets a score for
2 safe practice 1?

3 A. Right. They're given the score, yeah,
4 based on how they responded to the survey.

5 Q. Okay. And if a hospital does not respond
6 the next year, takes the shortcut we've talked
7 about --

8 A. They would be reported as declined to
9 report.

10 Q. Okay. Why are they reported as declined
11 to report instead of taking the prior year's
12 survey score?

13 A. Because there's no imputation model used
14 on these measures.

15 Q. Okay. Why is there no imputation model?

16 A. Because the safety grade expert panel
17 decided a long time ago that these measures won't
18 have imputation used.

19 Q. What is the rationale for that decision?

20 A. I believe because -- I wasn't there when
21 this happened, but it's because these are process
22 measures and they believe that at any time a

1 hospital could change their practices, I guess,
2 because it's a process measure, and they didn't
3 feel it was appropriate to impute for these
4 measures, but they did feel it was appropriate to
5 impute for those other measures.

6 Q. Okay. Do you believe it's appropriate to
7 draw that distinction?

8 A. Yes.

9 Q. Why?

10 A. Because I think that makes sense.

11 Q. Why?

12 A. Because of the reasons I said.

13 Q. So you just agree with the reasons that
14 you imputed to the expert panel, right?

15 A. Yeah, but -- and it's also -- I mean,
16 it's not what -- my opinion doesn't really
17 matter. It's the expert panel, ultimately.

18 Q. Well, it does today.

19 A. It does today.

20 MS. BLAIR: Object to form.

21 BY MR. CRAIN:

22 Q. Okay. So I want to go back up, just --

1 if you go to page 10. And it says -- this is the
2 IPS measure.

3 Do you see that?

4 A. Yes.

5 Q. It says, at the bottom, under the chart,
6 For hospitals that did not submit a 2024 Leapfrog
7 hospital survey by November 30th, see "using
8 secondary data sources" for detailed information
9 on Leapfrog's imputation methodology.

10 Do you see that?

11 A. Yes.

12 Q. And just so I'm clear, do you know what
13 the secondary data source we're talking about is
14 here?

15 A. Well, it's imputation. So if you go to
16 that section, then you would learn more.

17 Q. So it's step 1 or step 2?

18 A. Yes.

19 Q. And step 1, the secondary data source is
20 the historical score, right?

21 A. Yes.

22 Q. And step 2, what is the secondary data

1 source?

2 A. Is step 2 imputation.

3 Q. It's just lowest achievement?

4 A. Right. They're assigned a score of
5 limited achievement.

6 Q. Is that a secondary data source, or is
7 that just an assignment?

8 A. That -- well, I mean, I guess imputation
9 is the source.

10 Q. Imputation is the secondary data source?

11 A. It's up to -- I mean --

12 Q. Isn't that --

13 A. The expert panel approved it, and they
14 believe that that can be used as a secondary data
15 source.

16 Q. Do you think the expert panel really
17 grappled with all these distinctions?

18 MS. BLAIR: Objection to form.

19 THE WITNESS: It's within their purview
20 to do so.

21 BY MR. CRAIN:

22 Q. Do you think they did?

1 A. I don't know.

2 Q. You were on the meeting, right?

3 A. I would hope that they would. They're
4 putting their stamp of approval on it and their
5 name is associated with it, so I would hope that
6 they would.

7 Q. Okay.

8 A. I can't verify it. I wasn't there. I'm
9 not in their home every night.

10 Q. Fair enough.

11 Now, do you think it's clear to the
12 layperson -- going back to what we've discussed
13 earlier today -- the difference between dealing
14 with missing data and secondary data sources,
15 that Leapfrog has no data for the IPS metric for
16 non-participating hospitals?

17 A. Sorry?

18 Q. Yeah, I can clarify.

19 A. Clarify.

20 Q. When you read this, is it clear just from
21 these two pages that Leapfrog does not have any
22 data to support a limited achievement score for

1 non-participating hospitals?

2 MS. BLAIR: Objection to form.

3 THE WITNESS: Well, I mean, I think they
4 usually look at the scoring methodology
5 holistically. And if you're sent to a different
6 page, you should go to a different page, and it
7 provides more context.

8 BY MR. CRAIN:

9 Q. So let's go to that page. Can you help
10 me find it?

11 A. Secondary data sources?

12 Q. Yeah.

13 A. 15.

14 Q. 15? Thank you.

15 Is this just the imputation methodology?

16 A. No. There's also CMS data which is
17 another secondary data source.

18 Q. Got it. Okay. So it covers multiple
19 forms of secondary data, not just imputation.

20 A. Right.

21 Q. Okay. And again, for non-participating
22 hospitals without a historical score, the only

1 secondary data source is the imputation.

2 A. Yes.

3 Q. Okay. Okay. I want to just take a
4 look --

5 MR. CRAIN: Tab 9. This will be
6 Exhibit 25.

7 MS. BLAIR: 25?

8 MR. CRAIN: Yes. 25.

9 (Campione Deposition Exhibit 25 marked
10 for identification and attached to the
11 transcript.)

12 BY MR. CRAIN:

13 Q. Do you have it, Ms. Campione?

14 A. Yes.

15 Q. So this is, if you look at the first
16 page, another Slack chat.

17 Do you see that?

18 A. Yes.

19 Q. And the date range is from October 4th,
20 2023?

21 A. Yes.

22 Q. And the folks on the thread include you,

1 Paige, and Slack Bot. Do you see that?

2 A. Yes.

3 Q. And who is Paige?

4 A. Paige Lipscomb.

5 Q. Okay. Who is Paige -- Lipscomb, you
6 said?

7 A. Lipscomb.

8 Q. Lipscomb. Who is she?

9 A. She's a former employee at Leapfrog.

10 Q. Okay. I want to -- do you remember we
11 were talking about the HCA participation earlier
12 today?

13 A. Yes. Yes.

14 Q. That HCA at some point declined to
15 participate in the survey?

16 A. Yes.

17 Q. Okay. I want to go down to October 4th
18 at 11:31.

19 A. Yes.

20 Q. Okay. And it actually starts -- let's
21 start at 11:30.

22 So Paige says, Are they a D for the

1 grades? What else would she be referring to?

2 Do you have any recollection who "she"
3 is?

4 A. I don't know, no.

5 Q. Okay. And she says, Why are convos
6 always so bizarre?

7 And then you say, This was the last
8 meeting in a nutshell.

9 Any recollection of what you're referring
10 to?

11 A. So going down, it looks like we're
12 talking about a regional leader meeting.

13 Q. What is that?

14 A. That would be a meeting with the regional
15 leaders.

16 Q. Who are the regional leaders?

17 A. The regional leaders are individuals
18 across the country that are -- they're not
19 representatives of hospitals. They're usually
20 representatives of, like, business coalitions and
21 purchasers -- or they're part of, like,
22 organizations that represent them.

1 I don't -- I'm not totally clear on who
2 they are --

3 Q. Okay.

4 A. -- I just know that they're people across
5 the country that care about our programs.

6 Q. Can I ask you, to that point, are you
7 aware that Leapfrog was founded by employers?

8 A. Yes. And purchasers.

9 Q. And purchasers. Do you know anything
10 about how that came to be?

11 A. No, not really. I wasn't around then.

12 Q. Do you know what employers?

13 A. I know probably some big names I think
14 I've seen. But I was -- I believe I was seven
15 years old at the time.

16 Q. Fair enough. Okay.

17 And what are the big names you're
18 referring to?

19 A. Maybe Boeing, I think I've heard, or
20 Marriott.

21 Q. Ms. Danforth would know more?

22 A. Yes, she definitely would. And Leah

1 Binder would definitely know more.

2 Q. Got it. Okay. So you -- keep going
3 down. So you say, This was the last meeting in a
4 nutshell. We were talking about changing scoring
5 methodology to penalize HCA.

6 Do you see that?

7 A. Yes.

8 Q. Do you remember what you're referring to
9 there?

10 A. Not really. I mean, I guess in
11 October 2023, it would have been perhaps when we
12 added total nursing care hours, but I'm not sure.

13 2024 was -- yeah, I don't remember off
14 the top of my head any methodology changes that
15 we made during that time. But we didn't make
16 it -- I don't think we made any in the following
17 spring. I'm not sure.

18 Q. Okay. And do you remember any effort
19 whatsoever to penalize HCA?

20 A. You know, I remember -- this -- this was,
21 like, my extrapolation. I was probably reading
22 into it because, like you said, there was --

1 right around that same time, they hadn't done the
2 survey by that point; we're in October now and
3 they hadn't done the survey. And I think Leah
4 was definitely upset about that.

5 And they were just throwing around
6 making -- these regional leader meetings are kind
7 of -- they're just -- they don't -- the regional
8 leaders don't day in/day out look at the scoring
9 methodology and know things. They're not --
10 they're just meeting and talking, essentially.
11 Leah starts a meeting by talking about what's
12 going on at Leapfrog, and I'm only ever on them
13 if I just have to give them an update about when
14 the safety grade is going to start again and all
15 that sort of thing.

16 So it's basically just a bunch of random
17 people giving their opinions and their insights
18 into, like, what they've seen hospitals in their
19 area doing or what they're saying because
20 they're, like, meeting with hospitals.

21 Q. Who is talking about changing the scoring
22 methodology to penalize HCA?

1 A. I don't think anyone was talking about
2 that explicitly. I was just, like, that was my
3 reading into this. Because, again, I'm kind
4 of -- especially at this point, I've only been
5 there -- what would that be? -- like half a year.
6 And so --

7 Q. I thought you started --

8 A. Oh, my gosh. I keep thinking I started
9 in 2023.

10 Okay. Well, I'm not on the inside of
11 these meetings, and so I'm just making
12 assumptions.

13 Q. Okay. And then Paige says, What in the
14 world?

15 And she says, I hate that we don't just
16 do our thing; like, we manipulate everything.

17 And then you respond -- maybe I'll ask
18 you to read it.

19 A. Bananaland.

20 Q. What did you mean by bananaland?

21 A. What does bananaland mean to you?

22 Like, honestly, I don't even know what

1 the context is for this.

2 Q. And then you say, Leah keeps grudges.

3 Do you see that?

4 A. Yes. So I don't know what she -- who she
5 was talking about exactly. I really don't -- I
6 don't know what was going on in this --

7 Q. Is this your --

8 A. What they were saying.

9 Q. Is that still your opinion?

10 A. That she keeps grudges? I think that she
11 cares about patient safety. And she has a lot of
12 relationships at this point with people and she's
13 disappointed if a hospital decides to -- or a
14 system, or something like that, does something
15 she doesn't think is fair. And I think that's
16 fine.

17 I keep grudges. Is that okay?

18 Q. I'm afraid of that.

19 MR. CRAIN: And I think, with that, with
20 a little bananaland, I will pass the witness.

21 MS. BLAIR: And I have no questions.

22 So...

1 MR. CRAIN: Ms. Campione, you're free to
2 go.

3 MS. BLAIR: You're free to go.

4 VIDEO TECHNICIAN: The time is 6:20 p.m.
5 This concludes today's deposition. We're off the
6 record.

7 (Whereupon at 6:20 p.m., the videotaped
8 deposition of ALEXANDRA CAMPIONE was
9 concluded.)

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CERTIFICATE OF NOTARY PUBLIC

I, CHRISTINA S. HOTSKO, the officer before whom the foregoing deposition was taken, do hereby certify that the witness whose testimony appears in the foregoing deposition was duly sworn by me; that the testimony of said witness was taken by me in stenotypy and thereafter reduced to typewriting under my direction; that said statement is a true record of the proceedings; that I am neither counsel for, related to, nor employed by any of the parties to the action in which this statement was taken; and, further, that I am not a relative or employee of any counsel or attorney employed by the parties hereto, nor financially or otherwise interested in the outcome of this action.



CHRISTINA S. HOTSKO

Notary Public in and for the
District of Columbia

My commission expires:

1 January 2027

Good Samaritan Medical Center, Et Al v The Leapfrog Group
Alexandra Campione Job No. 7574640

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Alexandra Campione

Date

1 Good Samaritan Medical Center, Et Al v The Leapfrog Group
2 Alexandra Campione 7574640

3 ACKNOWLEDGEMENT OF DEPONENT

4 I, Alexandra Campione, do hereby declare that I
5 have read the foregoing transcript, I have made any
6 corrections, additions, or changes I deemed necessary as
7 noted above to be appended hereto, and that the same is
8 a true, correct and complete transcript of the testimony
9 given by me.

10
11 _____
12 Alexandra Campione

Date

13 *If notary is required

14 SUBSCRIBED AND SWORN TO BEFORE ME THIS
15 _____ DAY OF _____, 20____.

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[worked - yeah]

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[yeah - à]

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Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

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Exhibit 89

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA
WEST PALM BEACH DIVISION
CASE NO.: 9:25-CV-80526-DMM

GOOD SAMARITAN MEDICAL
CENTER, INC., et al.,
Plaintiffs,

vs.

THE LEAPFROG GROUP,
Defendants.

CONFIDENTIAL

VIDEO-RECORDED

DEPOSITION OF: KAREN VAN CAULIL

DATE: September 25, 2025

TIME: COMMENCED: 9:03 a.m.

CONCLUDED: 12:31 p.m.

TAKEN BY: Plaintiffs

PLACE: Wilson Elser Moskowitz Edelman & Dicker,
LLP

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REPORTED BY: Mae Fisher, RMR, CRR

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P R O C E E D I N G S

THE VIDEOGRAPHER: Good morning. We are on the record at 9:03 a.m. on September 25, 2025.

Please note that the microphones are sensitive and may pick up whispering and private conversations. Please mute your phones at this time. Audio and video recording will continue to take place unless all parties agree to go off the record.

This is media unit number 1 of the video-recorded deposition of Karen van Caulil taken by counsel for plaintiff in the matter of Good Samaritan Medical Center, Inc., et al., versus The LeapFrog Group.

My name is Anthony Giagnacova and the court reporter is Mae Fisher, both representing Veritext Legal Solutions.

Counsel will now state their appearances and affiliations for the record beginning with the noticing attorney, after which the court reporter will swear in the witness.

MR. HVIDT: This is Scott Hvidt with Gibson Dunn for the plaintiffs.

MS. DABANKA: Elizabeth Dabanka with Gibson Dunn for the plaintiffs.

MR. BILLEK: Max Billek from Wilson Elser on

1 behalf of LeapFrog Group and I'm representing the
2 witness as well.

3 THE WITNESS: Hi, I'm Karen van Caulil with the
4 Florida Alliance for Healthcare Value.

5 THE COURT REPORTER: Can you raise your right
6 hand, please.

7 Do you solemnly swear or affirm that the
8 testimony you are about to give in this cause will be
9 the truth, the whole truth, and nothing but the truth?

10 THE WITNESS: Yes.

11 KAREN VAN CAULIL,
12 a witness herein, having been first duly sworn, was
13 examined, and testified as follows:

14 DIRECT EXAMINATION

15 BY MR. HVIDT:

16 Q. Good morning, Ms. Van Caulil.

17 A. It's Dr. van Caulil.

18 Q. Dr. van Caulil. Thank you.

19 A. It's okay.

20 Q. I was about to ask if that's how I should refer
21 to you.

22 A. Karen is fine.

23 Q. Karen is fine.

24 A. Yes.

25 Q. Okay. Could you please state your full name for

1 the record again?

2 A. Sure. It's Karen van Caulil.

3 Q. And do you understand that the court reporter is
4 taking down all the questions I ask and the answers that
5 you will be providing?

6 A. Yes.

7 Q. Have you been deposed before?

8 A. Yes. It's many years ago, I was trying to
9 remember how long, probably 30 years ago.

10 Q. And is that the only time you've been deposed?

11 A. Yes.

12 Q. And what type of matter was that?

13 A. It was in North Carolina. It was a certificate
14 of need-related matter.

15 Q. And I know it's been 30 years. But I'm just
16 going to go over a few ground rules for the deposition
17 to make her life easier today.

18 A. Okay.

19 Q. So because she's taking down a record, let's try
20 not to talk at the same time. I will try to allow you
21 to finish your answers completely before asking the next
22 question. I ask that you allow me to finish my question
23 before you begin your answer.

24 Do you understand that?

25 A. Yes, I do.

1 Q. And all the answers will need to be audible. So
2 no nodding of the heads or shaking heads so that she's
3 able to take down the actual words that you're answering
4 with.

5 A. Okay.

6 Q. And do you understand that you are testifying
7 under oath today?

8 A. Yes.

9 Q. And are you taking any medications or any
10 influence that would make it difficult for you to
11 understand questions or provide accurate answer?

12 A. No.

13 Q. If you don't understand one of my questions, and
14 that's very likely, please -- please ask to -- for me to
15 rephrase it and so -- because if you do not do so, we'll
16 assume -- the record will assume that you knew what I
17 was talking about.

18 A. Okay.

19 Q. From time to time, your counsel might object to a
20 question and so we will get into a cadence back and
21 forth, but please allow for a pregnant pause to allow
22 him to assert an objection if there's one that's needed.

23 A. I understand.

24 Q. And then please do speak up if you'd like a
25 break, need to go to the bathroom, need food, need

1 anything. But I'd just ask that we not take a break
2 during -- while a question is pending.

3 A. Okay.

4 Q. Thank you.

5 Dr. van Caulil, do you work?

6 A. Yes.

7 Q. Where do you work?

8 A. I work at the Florida Alliance for Healthcare
9 Value.

10 Q. And what do you do for them?

11 A. I'm the president and CEO.

12 Q. And what is included in your job responsibilities
13 as the president and CEO?

14 A. So we are a small nonprofit. We're a business
15 coalition on health. We're a 501(c)(3) research and
16 education organization.

17 We -- if you're familiar with business coalitions
18 on health, it's public and private sector employers who
19 come together in a learning community. The employers we
20 work with are typically self-funded, which means they're
21 paying the bills for healthcare and they have the
22 ability to flex their benefit design, do variations on
23 their network, their outreach, et cetera.

24 And so in my capacity as president and CEO, I'm
25 leading the organization in terms of, you know, the

1 projects and initiatives and the research that we
2 undertake. I have a board of directors and that's
3 composed of nine public and private sector employers.
4 So as far as, you know, board-related matters, that's in
5 my purview to work with the board.

6 I -- we work in policy as well, to make sure that
7 the employer voice is heard in Tallahassee and in D.C.
8 around health matters. Typically they haven't
9 participated on the healthcare policy and the employers
10 we work with are not healthcare businesses. They are
11 school districts and manufacturing companies and many
12 other industries. And so when they have worked in the
13 policy space, it's been around their core business. So
14 this is an area where if we see something that might
15 impact them favorably or not, we would be involved in
16 policy there.

17 I oversee my staff. I have a vice president. I
18 have a project and a program coordinator and an
19 administrative coordinator.

20 I'll stop there, if you have any further
21 questions.

22 Q. That's very helpful. So one item today, so if I
23 called it the Florida Alliance for Healthcare Values
24 today The Alliance?

25 A. Florida Alliance.

1 Q. Florida Alliance. Would that be what you'd
2 prefer for just --

3 A. Yeah, because there actually is a sister
4 organization called The Alliance in Wisconsin, so not to
5 confuse with them.

6 Q. Wonderful. Yeah, I want to just make sure that
7 we can come up with a terminology.

8 A. Florida Alliance works.

9 Q. Florida Alliance will be how we refer to it
10 today. Thank you for that.

11 A. Um-hmm.

12 Q. So as the name might suggest, for the Florida
13 Alliance, are all the employer members Florida
14 employers?

15 A. They -- it's a mix because there are some, like a
16 public school district. You know, all of their
17 employees, their plan members are in the state of
18 Florida. But there are companies that are members that
19 may have lives in other states or even globally. So
20 it's a mix.

21 Q. But do all --

22 A. But they all have at least -- I'm sorry, to
23 finish the thought -- they all have to have lives in
24 Florida.

25 Q. Wonderful. So like a company might have

1 employees in Florida and in California and they can be a
2 member of the Florida Alliance?

3 A. Yes. As long as they have lives in Florida.

4 Q. Understood. And so if the company only has
5 live -- only has employees or lives in California but
6 not any in Florida, they cannot be a member of the
7 Florida Alliance?

8 A. That's correct. Actually, I'd like to clarify
9 that. Not an employer member. So we have affiliate
10 members. And affiliate members are a mix of -- it's
11 hospitals and healthcare systems. It's solution
12 providers in healthcare, benefits consultants and they
13 typically are not headquartered in Florida. They may
14 have employees, but that's not a factor in that level of
15 membership. Sorry I wasn't clear on that.

16 Two -- two different levels. We also have a
17 healthcare advisory council and that's some hospitals
18 and healthcare systems, only a handful of those. We are
19 moving that category into affiliate so we only have the
20 two.

21 Q. And as a nonprofit with these multiple types of
22 members, is the organization focused on the benefit of
23 the employer members and then the affiliate members are
24 also in service of that mission? Is that a fair way to
25 refer to it?

1 A. Yes. I would say so. We're led by the
2 employers. It is a business coalition on health and the
3 affiliate members and the healthcare advisory council
4 members work with us on projects and initiatives. We
5 work in as multi-stakeholder way as possible. They
6 provide a lot of resources. They're also very
7 interested in what employers are doing and thinking and
8 challenged by, so it's an opportunity for them as well
9 to interact and to learn.

10 Q. And you mentioned that these employers are in a
11 variety of industries and they're not in the healthcare
12 industry, per se. Is there interest in healthcare
13 values related to their provision of health plans to
14 their employees?

15 A. I'm not understanding your question. This is the
16 employer members you're speaking about? Would you mind
17 repeating the question?

18 Q. Yeah. So your employer members are in a variety
19 of industries.

20 A. Right.

21 Q. Correct?

22 A. Correct.

23 Q. And they are members of the Florida Alliance for
24 Healthcare Values?

25 A. Yes.

1 Q. And their interest in healthcare values, is that
2 connected to their provision of health plans to their
3 employees?

4 A. Yes. I just want to clarify. You're saying
5 values, plural, it's not. You had that on the
6 deposition that way. It's Florida Alliance for
7 Healthcare Value. It's the cost and the quality
8 equation for value. So just want to clarify that.

9 Q. Thank you. And so --

10 A. So --

11 Q. So to go back to the question --

12 A. Yes.

13 Q. -- to make that clear.

14 A. Sorry.

15 Q. So the member -- the employer members of the
16 Florida Alliance for Healthcare Value, their interest in
17 healthcare, is that related to their provision of health
18 plans to their employees?

19 A. Yes. It is also related to educating their
20 workforce in the healthcare space. So it's not limited
21 to the provision of coverage. It is that culture of
22 health and well-being is also part of that.

23 Q. And that is -- what they're trying to do -- what
24 they're interested in there is not just providing a
25 health plan to their employees, but helping give their

1 employees information about the options they see in the
2 medical area to make the right healthcare decisions for
3 themselves; is that a fair way of saying it?

4 A. Some of the employers do that. I don't have
5 sight on all 80 of the employers and what they're
6 providing to their -- to their workforce, to their
7 employees. But some do that. And they do that through
8 different ways. They might have a vendor who works with
9 them in a -- you know, sort of a narrow network sort of
10 way. They might have direct contracts. You know,
11 there's different vendors who the employee can go in and
12 search on a provider and look at, you know, their
13 ratings from all different organizations. But they
14 don't all do that.

15 Q. I am handing you what's been marked as Exhibit 1
16 in your deposition.

17 (Exhibit No. 1 was marked for identification.)

18 BY MR. HVIDT:

19 Q. Have you seen this document before?

20 A. Yes.

21 Q. And what is this document?

22 A. This is the notice given to me that I'm having
23 this deposition today.

24 Q. You see this is the notice of the subpoena for a
25 non-party Karen van Caulil here at Wilson Elser --

1 A. Yes.

2 Q. -- in Orlando, Florida --

3 A. Yes.

4 Q. -- on September 25th?

5 A. Yes.

6 Q. I'd ask, just a reminder to let me finish --

7 A. Sorry.

8 Q. -- my question before answering. I know that I
9 can be foreshadowing sometimes of where I'm going but
10 just for the ease of the court reporter.

11 A. I apologize.

12 Q. No worries. Thank you.

13 And do you see what's called the case caption up
14 above, where it says Good Samaritan Medical Center, et
15 al., versus The LeapFrog Group?

16 A. Yes.

17 Q. Do you understand that you are being deposed in
18 that litigation?

19 A. Yes.

20 Q. And is Florida Alliance a party to that
21 litigation?

22 A. I don't believe that Florida Alliance is party.

23 Q. And are you a party to the litigation?

24 A. I don't believe I am.

25 Q. And do you have an understanding of what the

1 lawsuit is about?

2 A. Yes.

3 Q. And in your own words, what do you understand the
4 lawsuit to be about?

5 A. My understanding is that the five hospitals in
6 Palm Beach County that are part of Tenet Healthcare
7 wanted The LeapFrog Group to suppress their grades from
8 the spring hospital grade reporting. That the hospital
9 system has issue with the way the methodology generates
10 the grade. That's basic understanding.

11 Q. And do you have an understanding of what your
12 role may or may not be in the litigation?

13 A. I believe that my role is because the Florida
14 Alliance for Healthcare Value is the regional leader
15 organization, that there may be some interest by the
16 hospitals in that role that we serve.

17 Q. Did you prepare for your deposition today?

18 A. Yes.

19 Q. How did you prepare for your deposition?

20 A. I had a couple of meetings with my attorneys,
21 two. I looked at some of the e-mails that I knew that I
22 was involved with regarding LeapFrog in recent times. I
23 scanned our weekly bulletins, which is our major
24 communication with our employer members every week, just
25 to remind myself of what information we shared with them

1 over time. I thought about what questions you might be
2 asking me and thought about my responses.

3 So I will say that the regional leader
4 responsibilities in our organization fall to my vice
5 president, Ashley Tait-Dinger, so I don't attend
6 regional leader meetings. If I have over the years,
7 it's been minimal when she's unable to attend. So she
8 is the absolute main contact for regional leader
9 activities. So just to clarify that, that I don't have
10 -- you know, I don't sit in on regional leader meetings.
11 I don't review what they're -- what they're doing.
12 That's Ashley's role in the organization.

13 Q. Did you speak with Ashley before your deposition
14 today to prepare for it?

15 A. She had major surgery last Wednesday and is out
16 on medical leave so I did talk to her before she went
17 out. Just to, you know, clarify a few things that, you
18 know, I figured I should probably, you know, know. I
19 asked if anyone had reached out, you know, for example,
20 about the lawsuit that she may not have mentioned to me
21 and nobody had. Questions like that.

22 Q. And in preparing for your deposition, did you
23 review any documents outside the presence of counsel?

24 A. Are you asking did I look at documents on my own?

25 So I looked at -- well, I'm also trying to think

1 about the timing of getting the deposition, versus what
2 I might have seen prior to that time. So I -- I read
3 what was in the media, different articles that were
4 published in the spring. I read the LeapFrog response
5 to that. So those are things that I had done
6 previously.

7 Q. And in meeting -- you mentioned meeting with your
8 counsel in preparation for today's deposition. How long
9 were the meetings that you had with counsel?

10 A. I would say probably each of them was an hour,
11 hour and a half.

12 Q. And is -- are you or Florida Alliance paying for
13 your counsel's time in this matter?

14 A. No. LeapFrog is paying, as I understand.

15 Q. You could set that aside. We don't need that.

16 A. Where do I put it?

17 MR. BILLEK: You just turn it upside down.

18 BY MR. HVIDT:

19 Q. You can just turn it upside down.

20 MR. BILLEK: So it's not distracting.

21 THE WITNESS: Okay.

22 BY MR. HVIDT:

23 Q. I understand we don't have that much space.

24 Dr. van Caulil, did you attend college?

25 A. Yes.

1 Q. And where did you attend college?

2 A. My undergrad was at Duke University.

3 Q. And what was your degree in?

4 A. Bachelor of science in biology.

5 Q. And do you have any professional degrees?

6 A. I have a master's and I have a doctorate. But
7 when you say a professional degree, what would be an
8 example of a professional degree?

9 Q. Those would both be examples of professional
10 degrees.

11 A. Okay.

12 Q. What is your master's in?

13 A. Master of science in public health and health
14 policy and administration.

15 Q. And where did you earn that degree?

16 A. University of North Carolina at Chapel Hill.

17 Q. And you mentioned you had a doctorate. What is
18 your doctorate in?

19 A. I have a PhD in public affairs from the
20 University of Central Florida.

21 Q. And following receiving your degree, can you --
22 degrees, could you walk me through at a high level your
23 employment history?

24 A. Sure. So following graduation from college, I
25 was employed in Durham, North Carolina, with a company

1 called Medical Personnel Pool. And they were a home
2 health agency and supplemental staffing and I was a
3 coordinator. So that was for a couple years. And then
4 I worked at Duke hospital in the department of surgery
5 in between my undergrad and master's also, and then
6 while I was working on my master's, I was a research
7 assistant in the department of surgery.

8 After my master's, I did an administrative
9 residency at North Carolina Baptist Hospital, which is
10 in Winston-Salem. And from there, they hired me to work
11 in the department of clinical strategic planning, which
12 was a joint department between the hospital and the
13 school of medicine.

14 We moved from North Carolina to Florida and I
15 telecommuted, which was unusual back then, and stayed
16 with them for a couple of years and then worked on a
17 contract basis. I -- when I had my kids, I was a
18 consultant doing a lot of certificate of need work,
19 still for Baptist and some other clients.

20 Then I was hired in -- here in Orange County in
21 Orlando to develop and implement the system of care for
22 the uninsured here in Orange County. And -- so that
23 involved securing a federal grant to be able to bring
24 all the different stakeholders together to create that
25 system.

1 Then I was hired to be the executive director of
2 the Health Council of East Central Florida, which is a
3 regional health planning agency. So that's four
4 counties of Orange, Osceola, Seminole and Brevard, so
5 sort of Greater Orlando. And the University of Central
6 Florida College of Medicine recruited me away to be the
7 director of health planning to help build the medical
8 city here in Lake Nona.

9 And also in that position, I managed a big
10 federal grant to bring -- I think it was 1400 primary
11 care docs from paper charts to electronic health
12 records. And since then, I've been at the Florida
13 Alliance. Our legal name is actually Central Florida
14 Healthcare Coalition and the d/b/a is Florida Alliance.
15 We did a name change with the d/b/a probably six years
16 ago. It was Florida Healthcare Coalition and changed
17 the name in 2019.

18 I have been adjunct faculty at UCF, you know, in
19 that time period as well.

20 Q. Thank you. Impressive career.

21 Did you start the Florida Alliance when you
22 joined or did it exist before you got there?

23 A. The Central Florida Healthcare Coalition, the
24 legal name organization, started in 1984. So no, I did
25 not start it. I was in my senior year of college then.

1 So well before I got to Florida.

2 Q. And does the -- does Florida Alliance -- does it
3 have a relationship with any governmental entities?

4 A. So we have in our membership municipalities and
5 county governments. So in that capacity, yes.

6 Q. And is there any relationship between Florida
7 Alliance and our state regulator of hospitals?

8 A. The only relationship I think that would fit in
9 that category would be that I chair the Agency for
10 Healthcare Administration's -- it's a long name --
11 Advisory Council. State Consumer Health Information and
12 Policy Advisory Council. So that advisory council is in
13 statute to, you know, ensure that the state-reported
14 data, the regulator data is transparent and available to
15 consumers in a way that they can understand it.

16 Q. And is that -- you mentioned that you chair that
17 agency.

18 A. I currently, yeah.

19 Q. Is that a -- that sounds like it is a
20 relationship that you have. Is that correct?

21 A. Correct. That's why I was saying, the only thing
22 that really comes to mind, there's no contractual
23 relationship that we have with the state. So I don't
24 believe that there is anything beyond disclosing that I
25 have that role that I play on a volunteer basis.

1 Q. And does the Florida Alliance have any
2 relationship with any of the plaintiff hospitals in this
3 litigation?

4 A. No.

5 Q. Has the Florida Alliance ever communicated with
6 the plaintiff hospitals?

7 A. Ashley has sent letters requesting all of the
8 hospitals, including those, to fully participate,
9 encourage them to fully participate in the LeapFrog
10 hospital survey. She has signed off on those letters in
11 recent years. I signed off on them in the past. So I
12 think that's probably the only correspondence that we
13 ever had, and that is to basically say, we encourage you
14 to participate; we are all about transparency of
15 healthcare quality and costs and hope that you will
16 consider doing so and direct them to LeapFrog to take it
17 from there.

18 Q. And you mentioned LeapFrog. Do you understand
19 The LeapFrog Group is the defendant in this litigation?

20 A. Yes.

21 Q. And does the Florida Alliance have a relationship
22 with the defendant, LeapFrog Group?

23 A. The Florida Alliance is the regional leader
24 organization for the -- for Florida, for LeapFrog.

25 Q. And what is a regional leader organization for

1 LeapFrog?

2 A. So that's the vehicle that The LeapFrog Group
3 uses in, you know, in the markets, if you will. And I
4 don't know if they're -- they're not all necessarily at
5 a state level. It depends on the regional leader
6 organization that they work with. Some are, you know,
7 municipality level. Some might even be multistate.

8 And the regional leaders are the organizations
9 that, using the influence of employers and other
10 purchasers to encourage hospitals to be transparent
11 about patient safety and quality. So sending those
12 letters that I mentioned a few minutes ago is really
13 probably the most major aspect. I think -- I certainly
14 couldn't respond for what every regional leader
15 organization does. I think there's, you know, some
16 differentiation on the level of activity that they --
17 that they do.

18 For us, as regional leader, we make sure that our
19 employer members receive the reports that are generated
20 by The LeapFrog Group, that they're aware of the
21 websites for the survey and the grades, so they can go
22 there and use the information and the resources there.
23 We will also conduct meetings with hospitals with our
24 employers to talk about all different issues and
25 LeapFrog will often come up in those. So it's kind of

1 high level.

2 Q. You mentioned that part of being a regional
3 leader, the Florida Alliance makes sure that its
4 employer members are aware of the grades that LeapFrog
5 Group releases; is that correct?

6 A. Yes. Make them aware that they've been released
7 and then they can go and look for themselves in their
8 respective markets. What we'll do is, we have a weekly
9 bulletin that goes out almost every week of the year.
10 There are a couple weeks in the year that we don't do
11 it. And when the spring release and the fall release
12 comes out, we will do a synopsis that says, you know, we
13 had, you know, this many hospitals graded, this many
14 were A, B, C, D, F, have the link so that they can go to
15 the website. We will generate a press release that's
16 sort of high level, too. There were this many -- excuse
17 me -- hospitals in each of those grade levels. And,
18 also, if there were top hospitals -- and this is also
19 for ASCs. I shouldn't say it's just hospitals; it's
20 also the ambulatory surgery centers but direct them, you
21 know, for more information to go directly to LeapFrog to
22 get that information.

23 Q. And as part of the Florida Alliance's
24 relationship with The LeapFrog Group, you mentioned this
25 regional leader component, is part of the regional

1 leader component; is there a contract that governs that
2 relationship?

3 A. No.

4 Q. It's a volunteer relationship?

5 A. Yes.

6 Q. No money is exchanged, either direction, as part
7 of that relationship?

8 A. No money is exchanged. I do get reimbursed for
9 travel expenses if -- and so does Ashley, if we need to
10 leave Florida to go, you know, to a meeting. But that's
11 the only -- only exchange.

12 Q. And is there any other relationship between
13 Florida Alliance and The LeapFrog Group, other than the
14 regional leader relationship?

15 A. I serve on the board as an individual. No other
16 relationship beyond regional leader for the
17 organization. There is a data use agreement between
18 LeapFrog and the Florida Alliance, at least in the past,
19 we don't have a current data use agreement. So the last
20 year or so, LeapFrog has a new platform and a different
21 agreement came through and we've been back and forth
22 just trying to get clarification on the wording so we
23 don't have an active agreement. So right now, there's
24 nothing in force.

25 Q. To break that down a little bit, so you are

1 currently a member of the LeapFrog board of directors;
2 is that correct?

3 A. Yes.

4 Q. And your membership on the LeapFrog board of
5 directors is in the capacity -- in your individual
6 capacity; is that correct?

7 A. Yes.

8 Q. Your membership on the LeapFrog board of
9 directors is not something that's like the Florida
10 Alliance gets an automatic member on the LeapFrog board
11 of directors?

12 A. That's correct. It's because of my individual
13 experience and expertise and relationships with other
14 organizations. It's not -- it's not a Florida Alliance
15 board seat.

16 Q. Thank you. And then you mentioned the data use
17 agreement. What is the data that is at issue in that
18 agreement?

19 A. Well, Ashley knows all the details of that. I
20 would say at a kind of basic level, it would be the
21 hospital and ambulatory surgery grade data, survey data.
22 You know, I don't think there's anything else in there,
23 if you have the data use agreement and have access to
24 that data.

25 Q. And is there any fee that the Florida Alliance

1 pays The LeapFrog Group to get access to that data
2 pursuant to the data use agreements?

3 A. No.

4 MR. HVIDT: I am handing the witness what has
5 been marked as Exhibit 2.

6 (Exhibit No. 2 was marked for identification.)

7 MR. HVIDT: And Exhibit 2 was produced in this
8 litigation as FHA000045. The plaintiffs received this
9 production from the Florida Alliance on Tuesday night
10 and when we received it, the documents were identified
11 by code, like this Bates number, but they were not
12 Bates stamped.

13 Our vendor in uploading them yesterday did not
14 have time to apply the Bates stamping consistent with
15 the coding that Florida Alliance applied in the
16 document ID before we needed to print them for the
17 deposition today. So we are proceeding without Bates
18 stamped versions today for the Florida Alliance
19 productions.

20 And on the record, want to ask counsel for the
21 witness, who's also counsel for the defendant,
22 LeapFrog Group, if it's okay that we apply, insert a
23 Bates-copied version of the same document as soon as
24 one is available for purposes of the documents used
25 today that were produced by Florida Alliance?

1 MR. BILLEK: Of course.

2 THE WITNESS: May I ask what a Bates stamp is?

3 BY MR. HVIDT:

4 Q. Yes. A Bates stamp is a -- so you will see one
5 from a document produced by LeapFrog Group later. And
6 it is at the bottom right-hand corner of the document
7 and it simply is a coding where it's -- the code I read
8 in FHA0045, it would simply say that on that first page
9 and then the next page would go to 46.

10 A. Okay.

11 Q. And it's meant for evidentiary purposes so that
12 when we're talking about a document, we know that we're
13 all talking about the same thing.

14 MR. BILLEK: So it's like a page number that we
15 stamp on when we give it over.

16 THE WITNESS: Okay. Thank you.

17 BY MR. HVIDT:

18 Q. You're welcome.

19 A. So Bates must have been an important person, I
20 guess.

21 MR. BILLEK: Exactly.

22 THE WITNESS: At some point.

23 MR. HVIDT: I have handed the witness
24 Exhibit 2.

25 BY MR. HVIDT:

1 Q. Dr. van Caulil, have you seen this document
2 before?

3 A. Yes.

4 Q. And what is this document?

5 A. So this is the slide deck that was used for our
6 annual meeting of the board of directors in March. That
7 was our 41st annual board of directors meeting.

8 Q. And does the Florida Alliance have a process for
9 saving documents in the ordinary course of business?

10 A. Yes.

11 Q. And as far as you're aware, was this document
12 pulled from that process, that computer server that
13 saved this document in the ordinary course?

14 A. I was not involved in pulling the documents at
15 the request. So I don't know whether this came off of
16 our server or whether that was something that was just
17 directly turned over. Sorry, I don't. I don't know.

18 Q. Do you have any reason to doubt that this
19 document is an accurate reflection of the document that
20 was presented to the board of directors on March 4 of
21 2025?

22 A. Well, if I could just flip through quickly, I
23 could answer that question.

24 Q. Please go ahead.

25 A. Thank you.

1 THE VIDEOGRAPHER: The microphone.

2 THE WITNESS: I'm sorry. Didn't mean to do
3 that.

4 I don't have any reason to doubt that this
5 document is an accurate reflection of what was
6 presented.

7 BY MR. HVIDT:

8 Q. And was this document prepared in the ordinary
9 course of business?

10 A. Yes.

11 Q. And did you have a role in creating this
12 document?

13 A. Yes.

14 Q. And if you flip to page 2, do you see where it
15 says, Today's agenda?

16 A. Yes.

17 Q. And you see the first item on the agenda is a
18 call to order, welcome and overview?

19 A. Yes.

20 Q. And do you see your name there listed as the
21 president and CEO?

22 A. Yes.

23 Q. If we could flip to page 4 where the -- where the
24 title of the page is Florida Alliance Staff. Do you see
25 that?

1 A. Yes.

2 Q. And it lists your name there at the top.

3 Correct?

4 A. Yes.

5 Q. And then earlier today, you mentioned Ashley
6 Tait-Dinger. Do you recall that?

7 A. Yes.

8 Q. And is her name listed there as the vice
9 president?

10 A. Yes.

11 Q. And what is her role for Florida Alliance?

12 A. So as you can see, we're a small staff. In fact,
13 Jack Mahoney has subsequently retired, so it's just the
14 four of us. So if you're familiar with running a
15 nonprofit organization, everybody wears multiple hats to
16 be able to execute on the mission and actually be a
17 viable, sustainable organization.

18 Ashley's responsibilities are regional leader
19 responsibilities. She does our financial work and
20 compliance and insurance and sort of the business of
21 running the business, I would say. She is a very
22 technical person, so she does IT and data. So those are
23 her primary responsibilities. But if I'm unable to
24 attend a meeting or run a meeting, she could get called
25 on to do that.

1 I could say those are her primary
2 responsibilities. But -- and, as I said, as a small
3 organization, it's -- you know, other duties as
4 assigned. Happens pretty frequently, so...

5 Q. You mentioned one of Ashley's responsibilities is
6 as regional leader responsibilities. When you were
7 referring to regional leader responsibilities, those are
8 The LeapFrog Group regional leader responsibilities; is
9 that correct?

10 A. Yes.

11 Q. And looking at this list of the Florida Alliance
12 staff, below Ashley's name is Lisa Hain. Is that how
13 you pronounce it?

14 A. Yes.

15 Q. And what is Lisa Hain's role?

16 A. So she provides support to all of our team in
17 terms of scheduling meetings. She -- so she keeps my
18 calendar in particular. She facilitates the
19 correspondence between the board and the Florida
20 Alliance and with our members. She maintains the
21 website. She may, you know, at times work on the weekly
22 bulletin if I need her to look something up or find a
23 link. So she is administrative only. She's not project
24 management at all.

25 Q. And one of her roles you mentioned was

1 facilitating correspondence. Does she initiate
2 correspondence on behalf of Florida Alliance on her own
3 with members?

4 A. No.

5 Q. And so if she's sending a correspondence to a
6 Florida Alliance member, is that either because you or
7 Ashley directed her to do so?

8 A. Yes. Or on my behalf. So I should clarify to
9 say, you know, a lot of the letters that we do only need
10 to be updated or, you know, slightly amended. She'll
11 pull up out of the records the most recent version of a
12 document and do a preliminary updating or I'll direct
13 her or Ashley will direct her. Well, that same
14 correspondence needs to go to this party, you know, to
15 do that. So she doesn't do content-related generation
16 of a document.

17 Q. Understood. So she might send a document on --
18 an e-mail on your behalf; is that correct?

19 A. Yes. She will do that.

20 Q. Do -- consistent with that, does Lisa Hain -- or
21 Hain report to you?

22 A. Yes, she does.

23 Q. Does Ashley Tait-Dinger report to you?

24 A. Yes.

25 Q. If we could flip now to page 8. The title of the

1 page is Board of Directors 2025 to 2026.

2 A. Um-hmm.

3 Q. Please let me know when you're at that page.

4 A. I am.

5 Q. Is this the current Florida Alliance board of
6 directors?

7 A. Yes.

8 Q. And other than you listed there, are these
9 individuals all representatives from Florida employers?

10 A. Yes.

11 Q. And if you could, who is Kenneth Aldridge?

12 A. So he is the director of health services at Rosen
13 Hotels & Resorts. He also serves as our secretary and
14 treasurer on the board.

15 Q. And do you know -- do you know how many Florida
16 employees Rosen Hotels & Resorts has?

17 A. I don't have the actual number of employees, but
18 I think it's in the four to 5,000 range.

19 Q. And then can you tell me a little bit about Beth
20 Curran?

21 A. Yes. So she is the senior director of risk
22 management for Orange County Public Schools. She's also
23 the compliance officer on the board.

24 Q. And do you know how many employees approximately
25 Orange County Public Schools has?

1 A. Again, I don't have the number of employees. And
2 the reason that I don't, there's a couple reasons. We
3 have 80 employer members, so I don't have those numbers,
4 and they fluctuate. But sometimes that gets conflated
5 with covered lives in this world that we work in of
6 benefits. So I do know that Orange County Public
7 Schools probably has 32,000 covered lives. I think that
8 employee number is in the twenties. But that's just
9 ballpark.

10 Q. And the reason that covered lives might exceed
11 the number of employees is because some -- an employee
12 might have dependents that are included in the health
13 plan; is that correct?

14 A. Yes. And sometimes they have retirees.

15 Q. And so let's continue to use the phrase covered
16 lives moving forward as I try to communicate about this.
17 So going back to Rosen Hotels, do you have an
18 understanding of -- an estimate of how many covered
19 lives Rosen Hotels & Resorts has?

20 A. No. Let me explain why it would be better to
21 stick with an employee ballpark because our dues that
22 the members pay are on a sliding fee scale based on
23 their number of Florida employees.

24 I do know about Orange County Public Schools
25 covered lives because I've been in meetings where that

1 has come up. So I -- you know, again, I don't have
2 specifics on any of them, so I'm going to be giving you
3 my best guess as we go down -- down the line here.

4 Q. I appreciate that. Thank you. And it's possible
5 that the number of covered lives under Rosen
6 Hotels & Resorts exceeds the four to 5,000 estimate of
7 number of employees that it has; is that correct?

8 A. It's possible. I don't know if all of their --
9 they call them associates, their employees are eligible
10 for benefits in the hotel industry. There might be
11 part-time people not eligible. So I wouldn't say it's a
12 definite that -- it varies from industry to industry.
13 So I don't know the answer to that.

14 Q. Thank you.

15 And then can you tell me about Jair Espinosa?

16 A. Jair.

17 Q. Thank you.

18 A. Jair Espinosa is -- I don't know whether it's
19 benefits director or benefits manager at the City of
20 Miami. I honestly couldn't guess at this point how many
21 employees they have. They're not a very, very large
22 organization. So it's probably 2,000 if I were to
23 guess, but I don't feel comfortable guessing, so...

24 Q. And can you tell me about Sara Holtzman DeMarino?

25 A. Yes. So LYNX is Central Florida transit

1 authority. She is in a wellness, well-being position
2 there. I don't -- off the top of my head, I don't
3 know -- anticipating your next question on lives or
4 employees -- I don't -- I don't know.

5 Q. Appreciate that. Just for purposes of creating a
6 record, if we could -- I know that it's clear where I'm
7 going with my next question. But if -- just with your
8 counsel's permission, if we could stick with the
9 question asked and then to establish the record, that
10 would be helpful. I'll try to be as efficient as
11 possible.

12 A. Okay.

13 Q. And so to be clear, you do not know how many
14 employees or covered lives LYNX has; is that correct?

15 A. That's correct. I'm not comfortable guessing.

16 Q. And can you tell me a little bit about Dawn Hunt?

17 A. Sure. She leads benefits for MarineMax. They're
18 a national, if not global, company. But they are
19 headquartered here in Florida.

20 Q. And do you know how many Florida covered lives or
21 employees MarineMax has?

22 A. It's right around the 2,000 employee mark.

23 Q. And can you tell me about Stephanie Koch, Koch
24 (pronouncing)?

25 A. Koch.

1 Q. Koch. Third try.

2 A. Stephanie is the director of HR, human resources
3 for Hendry Marine Industries. She is the vice chair of
4 our board. And Hendry Marine has 400 employees.

5 Q. Can you tell me a little bit about Susan McBroom?

6 A. Susan is also the head of human resources in her
7 position at Patriot Rail. They are also a smaller
8 employer within Florida, probably three to 400 or a
9 couple -- I'll just say 300, ballpark, employees.

10 Q. And can you tell me about Rosa Novo and any
11 understanding of how many Florida employees or covered
12 lives Miami-Dade County Public Schools has?

13 A. Sure. So Rosa is our board chair. And her title
14 is administrative benefits director for the district.
15 They are the largest school district in the state of
16 Florida, third largest in the country. As far as
17 covered lives, it's in the 50,000 mark.

18 I don't have an updated number for the school
19 districts because this year there's been a loss of the
20 number of students and staff for a variety of reasons
21 across the state. So that's the most recent number that
22 I've heard.

23 Q. Thank you. And then lastly, can you tell me a
24 little bit about Mark Weinstein and any understanding of
25 how many Florida covered lives or employees ICUBA has?

1 A. Um-hmm. So Mark Weinstein is the CEO of ICUBA
2 and that is Independent Colleges and Universities
3 Benefits Association. They're a little bit different
4 than the other employer representatives on the board in
5 that they're a multiple-employer welfare arrangement.
6 And the short version of that is called a MEWA. So they
7 have, I believe, 25 private educational institutions
8 that come together in this MEWA to purchase healthcare
9 services. And they do that through ICUBA. I believe
10 there's about 15,000 employees in all of these different
11 private schools.

12 Q. And for the private educational institutions
13 within ICUBA, are those all Florida private
14 universities?

15 A. Yes. They're all located in Florida.

16 Q. Do you know if any of them are located in the
17 Palm Beach County area?

18 A. No. I don't know for sure. But it's possible.
19 They have schools in South Florida, Orlando and Tampa
20 predominantly. But I can't think of any that are
21 specifically in Palm Beach County. Nova Southeastern
22 University is one of their members, and I don't know
23 that they have a campus there.

24 Q. Thank you. Understanding that these were
25 estimates that you were able to provide here today, I've

1 been adding that all up, and so between Rosen
2 Hotels & Resorts, four to 5,000 employees; Orange County
3 Public Schools, 32,000 covered lives, the City of
4 Miami's estimated 2,000 employees; not knowing the
5 number with LYNX; the 2,000 MarineMax; the 400 employees
6 with Hendry Marine Industries; the three to 400 with
7 Patriot Rail; the approximately 50,000 with Miami-Dade
8 County schools, understanding that there's been some
9 changes within that; and the approximately 15,000 among
10 the 25 private educational institutions within ICUBA,
11 that adds up to just over 100,000 Florida employees
12 covered by the -- represented by the employers on your
13 board of directors; is that fair to say?

14 MR. BILLEK: Object to form.

15 You can answer. You can answer.

16 THE WITNESS: I -- we have a mix of employees
17 and covered lives in that calculation, so it's not all
18 apples and apples.

19 BY MR. HVIDT:

20 Q. Understanding that to be the case, do you --
21 understanding that there are some of those numbers that
22 are employees and some of those numbers that are covered
23 lives, if you add up the employees and the covered lives
24 as you've testified today where you've known those
25 numbers or estimated those numbers, do you -- is that

1 a -- adding those numbers all up, is that -- does that
2 sound right to you?

3 MR. BILLEK: Object to form.

4 You can answer.

5 THE WITNESS: Well, I didn't add them up. If
6 you added them up and that's the total that you got,
7 that sounds about right. I did not -- I don't have a
8 calculator in front of me and I didn't do a running
9 tally. It doesn't sound out of line.

10 BY MR. HVIDT:

11 Q. Flipping to page 13, where it says at the top,
12 2024 by the numbers, do you see that?

13 A. Yes.

14 Q. Do you see where it says that you have 87
15 employer members?

16 A. Yes. This was 20 -- from the 2024 annual report.
17 Yes.

18 Q. Do you know how many employer members you have
19 sitting here today?

20 A. It's just over 80. The difference between the 87
21 and the 82 is largely because there were banks that also
22 are another MEWA under the Florida Bankers Health
23 Consortium that merged or were taken over by other
24 banks, so it's attributed primarily to that.

25 Q. Do you know approximately how many Florida

1 covered lives are under that -- under your employer
2 membership?

3 A. We haven't done an update of that in a while and
4 need to. Over the years, it's been, you know, about
5 300,000, 400,000. What has complicated that calculation
6 is that sometimes the employers will send all of the
7 lives in all of their markets and all of their states
8 and will have to go back and forth on that. So I have
9 held back on publishing any number because I don't want
10 to have apples and oranges. And we've actually had
11 discussions about, well, should we -- should we ask
12 covered lives, rather than employees? Should we say
13 anywhere, not just Florida? So we haven't landed on a
14 final decision on that. But it is a significant number
15 of employees/lives that are represented by the 80-plus
16 employer members.

17 Q. And for your 80-plus employer members, do you
18 know how many employees are included within that?

19 A. No, that would be part of that update.

20 Q. So the answer as it relates to employees would be
21 similar to the -- the same as the answer you gave to the
22 question about how many covered lives there are within
23 the employer members; is that correct?

24 A. That's correct. I wish I had the specifics, but
25 it has -- seems like it should be a pretty

1 straightforward ask and answer, but it doesn't always
2 come back that way. So -- and as I mentioned
3 previously, some employers, based on the industry, not
4 every employee is eligible for benefits. Some have
5 dependents. Some have retirees. So that also
6 unfortunately complicates the calculation. So we -- we
7 try.

8 Q. Understanding that the number is difficult to
9 calculate, you mentioned earlier that the last estimate
10 you were aware of was around 300 to 400,000 Florida
11 covered lives; is that correct?

12 A. That's correct. But that's probably four or five
13 years ago.

14 Q. Do you think that that number has increased?

15 A. I think it's probably not vastly different for a
16 few reasons. I mean, we've had additional employer
17 members but also workforce size has also gone down in
18 some instances. So, you know, there are gains and
19 losses in different -- different members. So I feel
20 comfortable with that as a ballpark.

21 Q. If you could flip to the next page, do you see
22 where it says, Employer Members?

23 A. Yes.

24 Q. And then if you flip to the next page, does this
25 page represent the logos of the employer members that

1 granted you permission to use their logos on the page?

2 A. Yes.

3 Q. And then I believe that this page number I'm
4 going to flip to is towards the back of the document.
5 And so we'll take time to get there. But if you could
6 flip to the page that is 2025 Plan of Work.

7 A. Okay.

8 Q. It's page 38 of the PDF.

9 A. Oh, must have just passed it.

10 I have it.

11 Q. Thank you. Do you see where the top of the slide
12 reads, 2025 Plan of Work?

13 A. Yes.

14 Q. And is the plan of work a high-level summary of
15 the things that Florida Alliance is going to be doing in
16 the year 2025?

17 A. Yes. It's a high-level list of what we hope to
18 be able to work on. It is a mix of what we've secured,
19 if there's a grant, perhaps, project funding that we
20 might be seeking. So it basically covers the high-level
21 description of the projects.

22 Q. And if you look at the second bullet there, do
23 you see where it says, LeapFrog regional leader
24 activities/employer action reports?

25 A. Yes.

1 Q. And are the LeapFrog regional leader activities
2 consistent with those that we talked about earlier?

3 A. Yes.

4 Q. And what are employer action reports?

5 A. So we haven't been able to work on those yet
6 because we do not have a data use agreement. And that
7 is in LeapFrog's court right now and they've been busy
8 of late. And that would give us permission to create,
9 for the employers at their request, reports that could
10 use some of the LeapFrog survey and grade data alongside
11 other data. Fair price-related activities that you
12 could see later on the list.

13 And so in the back and forth on the data use
14 agreement, we're trying to get permission to show
15 LeapFrog results and, also, other -- other sources of
16 data. And that hasn't -- process has not been
17 completed. So we haven't done -- we haven't done that.
18 But that would be for the employers as they're figuring
19 out their changes they might have in networks and their
20 benefit design. A lot of them have been looking at
21 direct contracting. For example, you can see that also
22 on the list. They would ask us for information and we
23 haven't -- we haven't done an employer action report in
24 several -- several years. But the board members had
25 suggested that that would be useful.

1 Q. When was the last year that you did an employer
2 action report, if you can recall?

3 A. Well, that was one of the questions that I asked
4 Ashley because I couldn't recall and she said it's
5 probably January of 2020, she said, preCOVID.

6 Q. When you say that employers are looking into
7 direct contracting, what is direct contracting?

8 A. So they -- there's a bunch of different ways to
9 do direct contracting. But they could work with the
10 health plan, the carrier, the TPA, whatever phrase they
11 use who administers their health plan to carve out a
12 particular center of excellence as an example. Or they
13 may hire a separate third-party administrator to have a
14 relationship, not just with a hospital, it could be with
15 independent physicians for specific services.

16 Oftentimes it is to, you know, get a better deal
17 on the cost that they're paying, but they want to make
18 sure that these are providers who are doing a good job,
19 have good outcomes. So they do their due diligence to
20 determine that that's an appropriate strategy for
21 driving value in their health plan.

22 We have members who might direct contract for
23 home health services, for infusion services. It's such
24 a variety.

25 Q. And one example of direct contracting that you

1 mentioned is if an employee wants to carve out a
2 particular center of excellence, did I get that right?

3 A. They may have a direct contract with a center of
4 excellence, yeah. It could be carved in, it could be
5 carved out.

6 Q. And does a center for excellence there refer to a
7 particular hospital or health system?

8 A. It could. But it could also be an outpatient.
9 It could be community oncologists. The term center of
10 excellence is used pretty -- pretty broadly. A lot of
11 health -- you know, healthcare systems say they're a
12 center of excellence for oncology or cardiac, so it
13 really does depend on what the organization is referring
14 to for themselves. But what the employers, when they
15 say a center of excellence, this is a provider who, from
16 their due diligence, has been able to have good
17 outcomes, has -- if applicable to LeapFrog in
18 particular, you know, they have done well in terms of
19 achieving, you know, in the survey results or the grade
20 results, but they certainly look at a lot of other --
21 other data.

22 So excellence has a lot wrapped into it. It's
23 price, it's quality, it's patient safety, it's equity.
24 So...

25 Q. And so it's possible -- some of them -- some of

1 your employer members are looking into direct
2 contracting; is that correct?

3 A. Yes.

4 Q. And one mechanism you can build into a direct
5 contract, if you're an employer, is you might get a
6 better deal by directing from a particular provider by
7 directing your employees to that provider; is that fair?

8 A. Yes. It usually has an element of a volume
9 expectation.

10 Q. And Florida Alliance is looking to create
11 employer action reports that use LeapFrog survey and
12 grading data to help facilitate its Florida members'
13 efforts into potentially direct contracting with
14 providers; is that correct?

15 A. Yes. That's one of the reasons that an employer
16 member would want that information.

17 Q. Thank you.

18 MR. HVIDT: We've been going about an hour.
19 Would you like to take a break, go off the record for
20 a minute?

21 THE WITNESS: I'm fine to keep going. It's up
22 to you.

23 MR. HVIDT: Are you okay?

24 THE COURT REPORTER: I'm fine, thanks.

25 MR. HVIDT: I'm happy to keep going if you're

1 okay. I just wanted to be mindful of that.

2 THE WITNESS: Thank you.

3 BY MR. HVIDT:

4 Q. You can set that document to the side.

5 A. Thank you.

6 Q. Earlier, we were talking about how Florida
7 Alliance is LeapFrog's regional leader; is that correct?

8 A. Yes.

9 Q. And do you understand what LeapFrog's goal is in
10 having regional leaders?

11 A. Yes. I think that the goal is to have boots on
12 the ground in the various states and regions of the
13 state who have relationships with employers and
14 healthcare purchasers to be able to reach out to the
15 hospitals they have relationships with and ambulatory
16 surgery centers, and they would be -- the regional
17 leader organizations would presumably be more familiar
18 with the market. And that helps LeapFrog with their
19 mission.

20 Q. Is one of the goals of LeapFrog's relationship
21 with the regional leaders to increase hospital
22 participation in the LeapFrog hospital survey?

23 A. Yes. Because, you know, our mission certainly
24 syncs with LeapFrog's mission to promote transparency.
25 And so having all of the hospitals, all of the

1 ambulatory surgery centers in the state fully respond to
2 their respective surveys would be the ultimate goal.

3 Q. You say that part of Florida Alliance's goal --
4 mission is to promote transparency. Is that correct?

5 A. Yes.

6 Q. Do you also ask for transparency from LeapFrog?

7 A. I don't know that we've explicitly had to ask
8 LeapFrog because they've been transparent about, you
9 know, how the -- you know, the hospitals and the
10 ambulatory surgery centers are asked to participate, the
11 process for submitting the data. They publish their
12 methodology. I won't speak for Ashley Tait-Dinger but
13 she's very active, I know from hearing from others on
14 the regional leader calls. If she has questions about
15 anything, she has never said that there was any pushback
16 or refusal to answer any questions she might have.

17 So I would say that, you know, our relationship
18 with LeapFrog has been, you know, very clear and any
19 questions, if we did have them, were always answered.
20 But, you know, methodology specifics would have to go to
21 the website and look at them specifically. I could not
22 tell you off the top of my head about the complexity of
23 that.

24 Q. I am handing you what's been marked as Exhibit 3
25 to your deposition.

1 (Exhibit No. 3 was marked for identification.)

2 BY MR. HVIDT:

3 Q. The -- Exhibit 3 has been produced in this
4 litigation as LEAPFROG00401485. And it is the 2025
5 regional leader communications toolkit launching
6 LeapFrog surveys.

7 Do you see that?

8 A. I do.

9 Q. Have you seen this document before?

10 A. I have not. If I could just flip through it,
11 there may be pieces of it I have seen. This would be a
12 document that would go to Ashley.

13 Yeah, this is not a document that would have been
14 sent to me personally. This would be the toolkit that
15 the representatives at the regional leader organizations
16 would use to -- I assume to guide the process. And
17 we've been involved with LeapFrog since 2002 as an
18 organization, and Ashley's worked on LeapFrog as her
19 responsibility -- she's probably been with the
20 organization 12 years, so I have full confidence in her,
21 in carrying out those duties.

22 Q. And Florida Alliance is one of LeapFrog's
23 regional leaders; is that correct?

24 A. Florida Alliance is the regional leader for
25 Florida for LeapFrog.

1 Q. And Ashley works for Florida Alliance; is that
2 correct?

3 A. That's correct. She's the vice president, as we
4 discussed earlier.

5 Q. And looking at this cover page to this document,
6 it is described as the communications toolkit for
7 regional leaders. Do you see that?

8 A. Yes.

9 Q. And if we go to the next page, you look down at
10 the last paragraph, see that the first sentence there,
11 do you see where it says, The 2025 communications
12 toolkit offers you instructions for launching the
13 LeapFrog Hospital survey and the LeapFrog ASC survey in
14 your region, focusing on the critical initial
15 communication you carry out, to encourage hospital and
16 ASC participation.

17 Do you see that?

18 A. Yes.

19 Q. Do you have any understanding whether Ashley and
20 Florida Alliance follows the communications toolkit that
21 LeapFrog provides?

22 A. I don't know if every item that's in here is
23 something that she does. I -- I don't know the answer.

24 Q. Do you know if she follows it generally?

25 A. I would have to assume, yes. There isn't -- as

1 we talked about earlier, there isn't a contract or an
2 agreement that says you will do this at this time in
3 this way. There's nothing like that. This is a
4 volunteer activity. And I believe I also said earlier
5 that my understanding is the regional leader
6 organizations do different levels of activity. I'm sure
7 it's a bandwidth issue with different organizations.
8 We're small, some are smaller than we are.

9 So I don't think this is a -- my best guess would
10 be that this is not a document that there's an
11 expectation that everybody is doing every single thing
12 in here. It's a guide.

13 Q. And would you agree that LeapFrog is providing
14 its regional leaders with this guide in hopes that they
15 follow it?

16 A. I'm sure they would like the regional leaders to
17 follow the guide.

18 MR. BILLEK: Just note my belated objection to
19 the form of the question.

20 BY MR. HVIDT:

21 Q. If you could flip to page 4 of this document,
22 which ends in 488 on the Bates stamp. Do you see where
23 it says, Step by step how to launch the LeapFrog
24 hospital survey and LeapFrog ASC survey in your market?

25 A. Yes.

1 Q. And then do you see that this slide, this page
2 and the next, provide a numerical list of recommended
3 action items to encourage participation in the survey?

4 A. From a quick scan, yes. But I haven't read all
5 of these to know what all those steps are.

6 Q. Understand. And then if you look at item 1, it
7 says, To get members and hospitals and ACSs excited
8 about the 2025 surveys.

9 Do you see that?

10 A. Yes.

11 Q. And then step 2 references, Personalizing
12 template letters asking hospitals to participate.

13 Do you see that?

14 A. Oh, down 2 -- yes. I see it now.

15 Q. And then if you look down to 4, it says, Send
16 hospitals letters by mail or e-mail no earlier than
17 March 30th but no later than April 30th.

18 A. Yes.

19 Q. And then if you go over to step 5, it says,
20 Follow up with those who have not responded.

21 Do you see that?

22 A. Yes.

23 Q. Is it fair to say that LeapFrog is encouraging
24 that regional leaders take multiple -- communicate
25 multiple times with hospitals or ACSs to encourage them

1 to participate in a given year?

2 A. Yes.

3 Q. Do you have any understanding from your role on
4 the LeapFrog board of directors that participation in
5 the surveys, the more there is, the better it is for
6 LeapFrog's finances?

7 MR. BILLEK: Object to form. You can answer.

8 THE WITNESS: The hospitals and ACSs do not pay
9 to participate in the survey. So answering it from my
10 role on the board, that's not a correct -- that's not
11 a correct question. There is not a financial line
12 item related to survey participation.

13 BY MR. HVIDT:

14 Q. So while the hospitals don't pay to participate
15 in the survey, does the increase in the number of
16 hospitals that participate in the survey impact the
17 licensing revenue that LeapFrog is able to achieve?

18 A. So I really don't know much about the licensing
19 revenue. I believe that's to be able to use the data.
20 Is that -- is that what the licensing revenue is that
21 you're referring to?

22 Q. The licensing that I was referring to there is
23 the licensing of the survey responses that hospitals
24 provide LeapFrog in participating in the survey.

25 But then moving on, do you have any understanding

1 whether the number of hospitals that participate in this
2 survey, if it increases, leads to a directional increase
3 in the number of accolades, subscriptions that LeapFrog
4 is able to get from hospitals?

5 A. So it would follow that the pool of potential
6 hospitals that could -- going back to your other
7 question -- pay to receive the results and/or pay the
8 accolade fee -- and I don't know how much either of
9 those are -- if that pool is greater, then I would agree
10 that that, you know, stands to be advantageous for
11 LeapFrog. That's not a discussion that I've been a
12 party to at any time. I wouldn't -- you know, I would
13 assume that makes sense. If there's more -- more
14 hospitals participating, then there's more hospitals who
15 might be interested in the data and might be interested
16 in participating in that accolade program.

17 Q. Flipping to slide -- page 7 of Exhibit 3, ending
18 in Bates number 491, do you see where it says, Best
19 practices used by regional leaders?

20 A. Yes.

21 Q. And the first item there bulleted under,
22 Launching the LeapFrog surveys in your community, do you
23 see where it says, Engage employers with purchasing
24 power to influence hospital decision-making based on
25 hospital survey participation?

1 A. Yes.

2 Q. Do you have an understanding why LeapFrog is
3 recommending that regional leaders engage employers with
4 purchasing power?

5 A. So all employers have purchasing power. It's
6 their second largest line item, healthcare is, and
7 hospital services are a significant portion of that.

8 So do I have an understanding why LeapFrog is
9 recommending engaging employers with purchasing power?
10 Well, my understanding, notwithstanding LeapFrog's
11 recommendation, is that all employers should be engaged,
12 you know, in speaking to, you know, the hospitals and
13 other providers in their markets about being transparent
14 with their price and their quality and their patient
15 safety.

16 And so I don't know how to answer the question on
17 any understanding why LeapFrog is recommending it. I
18 think it's broader than that. I think it's engage
19 employers across the board to be able to be more active
20 purchasers of healthcare, to insist upon transparency,
21 to be able to get their own data. This is not just an
22 issue that's with LeapFrog and the employers. They're
23 challenged by getting data from the PBMs, from the
24 health plans, their own data, if you will, their claims.

25 So one of the things that we do, not just as a

1 regional leader, but, you know, for our members, is to
2 get them to be more active. They do wield influence in
3 the market, especially, you know, if they're a
4 significant size. But collectively, through the Florida
5 Alliance, and you saw that we have smaller employer
6 members, can all sit down together and have a respectful
7 conversation with a hospital or a health plan or a PBM
8 and lay out expectations and hopes.

9 So, sorry I'm not answering directly, but I think
10 the premise of LeapFrog is to engage employers.
11 Employers started LeapFrog.

12 THE VIDEOGRAPHER: Counsel, can we take a small
13 break for the video change?

14 MR. HVIDT: Yeah.

15 MR. BILLEK: Absolutely.

16 THE VIDEOGRAPHER: We are off the record at
17 10:36 a.m.

18 (A brief recess was taken.)

19 THE VIDEOGRAPHER: We are on the record at
20 10:44 a.m.

21 BY MR. HVIDT:

22 Q. Counsel, are employers purchasers of healthcare?

23 A. You said counsel, so --

24 Q. Sorry. Strike that. Thank you.

25 MR. BILLEK: I'm happy to answer.

1 MR. HVIDT: Thank you, Counsel.

2 BY MR. HVIDT:

3 Q. Dr. van Caulil, are employers purchasers of
4 healthcare?

5 A. Yes.

6 Q. And do they purchase -- can they purchase that
7 healthcare from hospitals?

8 A. Yes.

9 Q. And so are employers directly and indirectly
10 customers of hospitals?

11 A. I've never heard the term customers used in that
12 exchange. They are paying the bill on behalf of their
13 plan members. So I guess -- I guess you could call that
14 a customer. Not familiar with using that term in our
15 world here.

16 Q. Looking down at the third bullet here back on
17 Exhibit 3 on page 7, do you see where it says, Meet with
18 local media?

19 A. Yes.

20 Q. And in that bullet, do you see the last sentence
21 there where it says, Encourage them to call attention to
22 the hospitals and ACSs that decline to respond to your
23 request for survey participation?

24 Do you see that?

25 A. Yes.

1 Q. What do you interpret that sentence to mean?

2 A. That the regional leaders, I guess, should
3 consider engaging with media to encourage full
4 participation in the survey. We don't do this. We
5 don't -- we don't work with the media on any kind of
6 issues on a regular basis.

7 Q. Can you flip to the next page, please. Do you
8 see where it says on page 8, on Bates number ending in
9 1492, Ideas for encouraging nonrespondents to the
10 LeapFrog surveys?

11 A. I see it.

12 Q. And do you see in the bolded underlined section
13 where it references, Common objections?

14 A. Yes.

15 Q. Have you ever encouraged hospitals -- you in your
16 individual capacity, encouraged hospitals to participate
17 in the LeapFrog hospital survey?

18 A. Me individually? No, not -- not as a rule. I
19 have been in meetings with hospitals that haven't --
20 well, let me rephrase. I'm sorry, I guess I have to
21 think this through, so strike what I said. So --

22 Q. Would you like me to reask the question?

23 A. Yeah. Please reask it. I thought of a couple of
24 instances that could probably be applicable.

25 Q. In your individual capacity, have you ever

1 encouraged hospitals to participate in the LeapFrog
2 hospital survey?

3 A. Yes. There was a period of time where the HCA
4 hospitals in Florida declined to respond. I think it
5 was in two -- two cycles. And there are 47 HCA
6 hospitals in the state, so that was a significant gap in
7 transparency for us because they had fully participated
8 for years and years and been very active in terms of
9 working with LeapFrog. And they declined to respond
10 because there were some new measures that were added a
11 few years ago, couple years ago.

12 And I did send letters to the CEOs of those
13 hospitals and asked them to please consider responding
14 to the survey again, that it was very important for the
15 Florida Alliance employer members for them to do so, and
16 if they needed to skip those questions, that would be up
17 to them. But please not to completely, you know,
18 nonrespond.

19 So in that individual capacity, yes. We had --
20 we had a meeting, I don't know, a year or more ago with
21 one of the hospitals in South Florida that either they
22 weren't responding at all or perhaps not fully. And in
23 that meeting, I said basically the same thing that I
24 just mentioned with HCA and that was that, you know, we
25 would encourage them -- you know, we -- we, on behalf of

1 the employer members, really want to promote
2 transparency.

3 So because I've not read this regional leader
4 book, you know, our encouraging in Florida as regional
5 leader is pretty much limited to issuing those letters
6 that I mentioned a while ago, you know, please respond,
7 and sending them to LeapFrog. I don't believe we do any
8 kind of follow-up if they haven't responded. We
9 certainly don't engage the media to call anybody out.
10 But we do have conversations in meetings with the
11 hospitals around LeapFrog participation.

12 Q. For the conversation with the hospital in South
13 Florida where they weren't responding to the survey, did
14 they provide to you a reason why they don't participate
15 in the survey?

16 A. Yes. And I think it was for certain questions.
17 I don't think it was for the entire survey. But I don't
18 recall exactly. But it boiled down to not enough
19 bandwidth in the staff, that it was a heavy lift for
20 them.

21 Q. And aside from the HCA dynamic and that one
22 Florida -- South Florida hospital, do you have any other
23 recollection sitting here today of your individual
24 encouragement of hospitals to participate in the survey?

25 A. Well, I signed the letters, you know, for many

1 years that would go to them. I haven't signed them in
2 the last couple of years. Nothing -- nothing else comes
3 to mind that would be me, Karen van Caulil, you know,
4 having a discussion or a letter.

5 Q. Does the Florida Alliance receive objections from
6 nonrespondents to the survey as to why they're not
7 responding? Now I'm asking the question not as to you
8 individually but the Florida Alliance in its reach-outs
9 to hospitals to encourage them to participate.

10 A. I'm rereading your question. Does the Florida
11 Alliance receive objections from nonrespondents to the
12 survey as to why they're not responding? I don't
13 understand the question.

14 Q. Does Florida Alliance when it reaches out to
15 hospitals to encourage them to participate, does the
16 Florida Alliance receive reasons from those hospitals as
17 to why they're not responding to the survey?

18 A. You know, I think that Ashley sends something
19 that's like your intention to participate or not. I --
20 I -- we don't ever talk about whether she gets anything
21 back because I think that the form says, you know, and
22 why not, if you're not. But I don't have direct
23 knowledge of that. But I think there is a vehicle for
24 receiving that information.

25 I can tell you that one instance comes to mind

1 when she had sent a letter to one of the hospitals that
2 was really obliterated in a hurricane up in the
3 Panhandle and somebody got back and said, we're closed,
4 you know, until we can get back up and running, so take
5 us off the list. So I think that's an extreme example,
6 but that one comes to mind. So that tells me there's a
7 vehicle for that communication.

8 Q. You can set that document to the side for now.

9 How did you first hear of the LeapFrog Group?

10 A. I think that I probably first heard about it when
11 I was interviewing for the position and wasn't familiar
12 with it. So that would have been 14-plus years ago,
13 probably during the interview process. That would be in
14 2011.

15 Q. And when you say you first heard about it when
16 you were interviewing for the position, that's the
17 position as the CEO and president of the Florida
18 Alliance; is that correct?

19 A. Correct. At the time called the Florida
20 Healthcare Coalition, yes.

21 Q. And --

22 MR. BILLEK: Central Florida.

23 THE WITNESS: Well, let me --

24 MR. BILLEK: Oh, no. I didn't mean to open up
25 a can of worms.

1 THE WITNESS: No, no, no. So just to clarify,
2 because it is confusing. So the legal name is Central
3 Florida Healthcare Coalition. We have the d/b/a of
4 Florida Healthcare Coalition and a d/b/a Florida
5 Alliance for Healthcare Value. When I joined the
6 organization, it was called the Florida Healthcare
7 Coalition.

8 MR. BILLEK: My apologies.

9 BY MR. HVIDT:

10 Q. Thank you.

11 You -- we talked earlier about how you are a
12 member of the board of directors of LeapFrog; is that
13 correct?

14 A. Correct.

15 Q. And when did you join the board?

16 A. September 2023.

17 Q. Were you invited to join the board?

18 A. Yes.

19 Q. Who were you invited by?

20 A. The nominating committee chair, and I can't
21 remember who it was at the time. And Leah.

22 Q. And who's Leah?

23 A. Leah Binder is the CEO of LeapFrog.

24 Q. Before you were invited in part by her to the
25 LeapFrog board, did you have a preexisting relationship

1 with her?

2 A. Yes. I've known Leah for probably the majority
3 of the time that I've been with the Florida Alliance.
4 We've served on committees and other boards together and
5 certainly knew of her from our work as a regional
6 leader. So I -- so I guess the shorter answer is, I
7 knew Leah. We have worked together.

8 Q. Were you aware whether there are any requirements
9 to be a board member of LeapFrog?

10 A. I serve on the nominating committee now. And the
11 way that board members are identified or potential board
12 members are identified is by looking at skill sets and
13 experience and expertise that would be helpful in having
14 strategic discussions about LeapFrog. So I'm not aware
15 of any specific requirements or qualifications, but I do
16 know that I was looked to as somebody who could
17 represent the employer healthcare purchaser voice.

18 Q. Are there any conflict of interest requirements?

19 A. I believe we sign a conflict of interest
20 disclosure form, yeah.

21 Q. Is there any requirement that the board donate to
22 The LeapFrog Group?

23 A. They have asked that we each contribute whatever
24 level, especially this year because of the 25th
25 anniversary, and they wanted to create like a board

1 match for donations.

2 Q. How often does the board of LeapFrog meet?

3 A. We have quarterly meetings.

4 Q. Are they all in person?

5 A. They have been two in person and two virtual, in
6 my two years.

7 Q. And what do you understand to be the duties and
8 responsibilities of a LeapFrog board member?

9 A. Well, certainly to attend the meetings and to
10 participate on a committee. I serve on the nominating
11 committee, as I mentioned. We -- you know, any board
12 member of any nonprofit, you know, has a fiduciary duty,
13 so certainly when the audited financial statements are
14 presented to us, we, you know, are seeking a clean audit
15 and can ask questions and have to vote to approve that
16 or not.

17 But primarily, it is the strategic direction of
18 LeapFrog and participating in those -- those
19 discussions.

20 Q. Does the LeapFrog board have any responsibilities
21 as it relates to the operations or management of
22 LeapFrog?

23 A. No. The operations and management people will
24 give updates. Leah will give an update on some of the
25 other staff on the status of operations, but they're not

1 action items.

2 Q. Has -- in your time on the LeapFrog board, since
3 September 2023, has the LeapFrog board ever disagreed
4 with the decisions of the LeapFrog executive team?

5 A. I don't think that we've, in the two years -- and
6 I haven't been at every board meeting. I missed one of
7 them because I had surgery like a day or so before. But
8 I don't think that there's ever been any kind of
9 disagreement with the team when they've brought things
10 forward. I would say that the members of the LeapFrog
11 board are all very smart, insightful people and they
12 might provide an alternate view or something to
13 consider. But I'm not aware of any disagreement with a
14 decision. People ask questions to, you know, understand
15 more deeply decisions that the LeapFrog staff have made
16 or the expert panel or whatever's being presented.

17 Q. In your time since you joined the board, what
18 kind of strategic decisions have been put forward to the
19 LeapFrog board for vote?

20 A. The only vote that I can think of in the two
21 years on a strategic decision has been how to conduct a
22 strategic planning process. Would it be to create a
23 committee, and that was a vote, and then they brought it
24 back recently to vote on it being a part of longer board
25 meetings. But an example of a strategy is to start

1 thinking about artificial intelligence and how that
2 might relate to the work that The LeapFrog Group does
3 and to bring in some experts to help navigate through
4 that because there wasn't anybody on the board that, you
5 know, would be really strong in that area.

6 Q. And so other than the vote on how to conduct a
7 strategic planning process, in your time on the LeapFrog
8 board of directors since September 2023, you can't
9 recall another time where the board was asked to vote on
10 a strategic decision as it relates to LeapFrog's
11 operations; is that correct?

12 A. I'm thinking right at the moment. I think we --
13 we don't really vote on operational matters. So I'm
14 going to say, to the best of my recollection, I can't
15 think of another time where we voted. The voting, vote
16 on minutes, as I said, vote on the audit, vote on having
17 a committee, those have been the primary votes that I
18 can recall.

19 Q. And would you consider LeapFrog's methodology for
20 how it grades hospitals to be part of those operational
21 matters that the LeapFrog board hasn't had a vote
22 regarding in your time on the LeapFrog board since
23 September 2023?

24 A. I -- I don't think we've voted on methodology in
25 that time. We've been informed about the methodology.

1 I can't recall a vote. We don't have that detail. In
2 fact, the last board meeting we had in June or somewhere
3 around that time, they did a 101 with the board to
4 educate anyone who is available to educate about
5 high-level methodology for the grade and the survey.
6 Because it's just not something that the board
7 deliberates.

8 MR. HVIDT: I'm handing the witness what's been
9 marked as Exhibit 4 in this deposition, which has been
10 produced in this litigation as LEAPFROG00378234.

11 (Exhibit No. 4 was marked for identification.)

12 BY MR. HVIDT:

13 Q. And it's a document titled, Final Draft LeapFrog
14 Long Range Strategic Intent, Fiscal Year 2026 to 2032,
15 December 2024.

16 Do you see that, Dr. van Caulil?

17 A. Yes, I do.

18 Q. And have you seen this document before?

19 A. I don't think I have. If it was presented to the
20 board on December 2024, that's the meeting that I
21 missed. I had surgery on December 13th and I think the
22 board meeting was the 16th up in Baltimore. I couldn't
23 travel for it.

24 Q. Understood. Thank you for clarifying that.

25 The item that I just want to point to,

1 understanding that you weren't there, when you're --
2 even if you aren't able to attend a board meeting, are
3 you e-mailed the packet of materials that are displayed
4 at the board meeting?

5 A. They send us materials in advance to review.
6 Sometimes they send things that weren't in the board
7 packet after. I don't -- I don't actually recall seeing
8 this. That doesn't --

9 Q. It's possible you may have received it but you
10 just haven't read it. Is that --

11 A. It's possible. It's possible that I received it.
12 I don't -- I don't remember seeing this.

13 I do know that the strategic planning committee
14 was working on something to react to.

15 Q. And looking there at objective 1, do you see
16 where it says, Scale of resources to the capacity needed
17 to make giant leaps for patient safety and stop
18 avoidable death and suffering?

19 A. Yes.

20 Q. Understanding that there has been, as you've
21 described earlier, movement in the strategic planning,
22 is scaling LeapFrog's resources one of the objectives in
23 LeapFrog's current strategic plan?

24 A. So there have been discussions about adding
25 additional staff because of workload, if that's what

1 scale resources to the capacity needed means. So that's
2 certainly been a discussion or at least an information
3 sharing to the board.

4 Q. And if you could flip to the next page where it
5 carries over to 235. Is it fair to say that this page
6 has about five bullets that are under that objective 1
7 that we just talked about?

8 A. Yes, I see it.

9 Q. And is the first bullet, Expand and diversify
10 revenue sources including funding through grants,
11 development, industry partnerships, data licensure?

12 A. Yes. That's the first bullet. Yes.

13 Q. You can set that document to the side for now.

14 We talked earlier about -- we mentioned
15 LeapFrog's hospital safety grade before. Can you tell
16 me in your own words what LeapFrog's hospital safety
17 grade is?

18 A. So two times a year, The LeapFrog Group publishes
19 A, B, C, D, F grades for hospitals and ambulatory
20 surgery centers also. I know you just asked about
21 hospital, but they're published at the same time. And
22 those are patient safety specific measures. It is, to
23 my understanding, a combination of publicly reported
24 data to CMS and, also, if the hospital responds to the
25 survey, there are some elements that get pulled into the

1 calculation of that grade.

2 Q. Do you have an understanding of how a hospital
3 who is -- who does not participate in the LeapFrog
4 hospital survey is grading?

5 A. They use publicly available data to generate a
6 grade.

7 Q. What is the publicly available data that they use
8 to generate a grade?

9 A. It's primarily CMS data.

10 Q. Do they use any other data to fill in for the
11 measures that are only -- that are not CMS-related data?

12 MR. BILLEK: Object to form.

13 You can answer.

14 THE WITNESS: Would you mind repeating the
15 question?

16 BY MR. HVIDT:

17 Q. Yes. So you mentioned that the LeapFrog Hospital
18 Safety Grade includes measures that are pulled from the
19 survey results that a hospital completes for the
20 LeapFrog Hospital Survey; is that correct?

21 A. Yes. I think there's a -- some subset of
22 questions that are from the survey.

23 Q. And if a hospital doesn't respond to the survey,
24 LeapFrog doesn't have data from that hospital for
25 those -- that subset of measures; is that correct?

1 A. That's correct.

2 Q. And do you have any understanding as to how
3 LeapFrog treats that subset of measures where the -- for
4 the hospitals that don't participate in the survey?

5 A. Yes. Certainly. That was something that was
6 explained to the board since I've been on the board
7 because that methodology changed last year, how they
8 imputed a score. And my understanding is that up until
9 the fall, if you didn't respond to the survey, you would
10 get the average or median score. And then for four
11 measures now, it's not that any longer. It's the lowest
12 possible score. So limited achievement for that
13 measure.

14 Q. You used the word impute -- imputed a score.
15 What does that mean?

16 A. That's the terminology that LeapFrog uses. So to
17 your earlier question, when they don't have it
18 available, this is how they fill that in.

19 Q. What does the word impute mean?

20 A. To calculate, to identify. I don't know the
21 dictionary definition. I would say in context it is how
22 they generate a score for that.

23 Q. How they generate a score for missing data; is
24 that correct?

25 A. Yes.

1 Q. And you mentioned that up until the fall, if you
2 didn't respond to the survey, you'd get an average or
3 median score. When you say the fall, are you referring
4 to up until fall of 2024?

5 A. I don't know specifics on this. I'm not involved
6 with the methodology. I've given you my understanding.
7 I don't know the exact time in 2024. I don't know when
8 it took effect.

9 Q. And you were a board member when the change took
10 effect; is that correct?

11 A. I was a board member when it was discussed. I
12 don't recall when it would take effect.

13 Q. And you mentioned that there are hospitals that
14 don't respond to the survey are now assigned the lowest
15 possible score; is that correct?

16 A. Limited achievement, I believe is what it's
17 actually called.

18 Q. And do you know on what basis LeapFrog assigns
19 nonparticipating hospitals the lowest possible score?

20 A. So they work with an expert panel to determine
21 the methodology and the basis for that change would have
22 been result of their deliberation and study of the issue
23 as to what the most appropriate proxy for nonresponse
24 would be.

25 Q. So is it your understanding that the LeapFrog

1 expert panel, in coming up with the lowest possible
2 score, was trying to identify the most approximate
3 estimate for what that score would have been had the
4 nonrespondent participated in the survey?

5 A. No. I don't think that's what they were trying
6 to do. They are assigning limited achievement of that
7 measure because they don't have data or information to
8 tell them what that hospital response would have been
9 should they have responded.

10 Q. So is it your understanding that the methodology
11 is not trying to estimate what the -- an accurate
12 estimate of what the nonresponding hospital would have
13 answered had it answered the survey?

14 A. I don't think that's the intent of the
15 methodology to try to come up with what the hospital
16 would have responded. They're asking the hospital to
17 respond to the question so that they can have accurate
18 information.

19 My recollection of conversations around this
20 change was that there were participating hospitals who
21 raised the issue of why would you give an average score
22 to somebody who's not responding, that might be a higher
23 score than somebody who is responding, that you need to
24 go back and come up with a different way.

25 And I can also tell you that over the years, I've

1 been in meetings, whether that's with the Florida
2 Hospital Association or some of these hospital meetings
3 where comments have been made, you know that hospitals
4 are gaming this with the survey by not responding to the
5 question because they'll get a better score if they
6 don't respond than if they provided their experience.

7 So I had heard that a few times. So I think that
8 probably was a factor in determining that providing an
9 average score was probably not fair to the hospitals
10 that do participate.

11 Q. And do -- strike that.

12 And so you -- the intent of the methodology is
13 not -- of the imputation methodology is not to assign
14 the nonresponding hospitals an accurate estimate of what
15 they would have answered had they answered the survey?
16 Is that correct?

17 MR. BILLEK: Object to form.

18 You can answer.

19 THE WITNESS: I want to say that I am not
20 involved in the methodology determination. And I
21 don't know what the intent was of the methodology
22 change. I -- I can't really answer that question
23 because it doesn't seem like it would even be possible
24 for those who work at LeapFrog to come up with an
25 answer that the hospital should be providing

1 themselves. They wouldn't have the data. They
2 wouldn't have the ability to come up with what they
3 could have provided themselves.

4 BY MR. HVIDT:

5 Q. So from your perspective as a LeapFrog board
6 member, you don't think it's possible for LeapFrog to
7 come up with an answer that would estimate what the
8 nonresponding hospitals would have achieved had they
9 participated in the LeapFrog survey; is that correct?

10 MR. BILLEK: Object to form.

11 THE WITNESS: I -- I don't know how they would
12 come up with an estimate when the simplest thing would
13 be for the hospital to answer that question for
14 themselves.

15 BY MR. HVIDT:

16 Q. So let me ask it again, because it's a yes-or-no
17 question.

18 So from your perspective as a LeapFrog board
19 member, you don't think it's possible for LeapFrog to
20 come up with an answer that would estimate what the
21 nonresponding hospitals would have achieved had they
22 participated in the LeapFrog survey; is that correct?

23 MR. BILLEK: Object to form.

24 THE WITNESS: I don't think this is a LeapFrog
25 board of directors' role since we don't talk about the

1 methodology and we don't hear about all of the
2 investigation and research and thinking and
3 deliberation on that. I would say as an individual, I
4 can't answer this as a LeapFrog board member. I would
5 say as an individual, I think it would be very
6 difficult to estimate what the nonresponding hospital
7 would have achieved on a measure and we'll say again,
8 the best way to come up with the most correct response
9 is for the hospital to provide that information
10 themselves.

11 BY MR. HVIDT:

12 Q. And isn't it the case that the -- by assigning
13 the hospital the lowest possible score, LeapFrog is not
14 trying to estimate what that hospital would have
15 achieved had it participated in the LeapFrog Hospital
16 Survey?

17 MR. BILLEK: Same objection.

18 THE WITNESS: I don't know what LeapFrog is
19 trying to achieve with the methodology because I
20 wasn't part of the discussions or have I heard about
21 the discussions to know what they were trying to
22 achieve.

23 BY MR. HVIDT:

24 Q. Is LeapFrog, by assigning the non -- by assigning
25 nonparticipating hospitals the lowest possible score for

1 the measures that LeapFrog does not have data on those
2 hospitals, is LeapFrog trying to encourage those
3 nonparticipating hospitals to participate in its survey?

4 A. I would think that as a hospital, if you know
5 you're performing better than that limited achievement
6 score, you would want to respond to that question so
7 that the public can see that you do care about patients'
8 safety and you are doing well on that measure.

9 So to answer your question, it could be that in
10 their deliberations about the change in the methodology,
11 that they hoped that nonparticipating hospitals would
12 answer for themselves. But I am not privy to that
13 discussion or whether that was part of their rationale
14 for this change.

15 Q. So as a LeapFrog board member, you are not privy
16 to whether the change in methodology as it relates to
17 nonparticipating hospitals, what the rationale was for
18 that change; is that correct?

19 A. I don't remember the exact discussion at the
20 meeting because it was a while ago and I think I was a
21 new board member trying to get my bearings, if you will,
22 on LeapFrog board responsibilities.

23 My recollection would be that the change was made
24 so that hospitals that are participating in the survey
25 who might be performing with limited achievement weren't

1 upset that hospitals that are not participating were
2 getting a higher score. That's my recollection of the
3 rationale. But I do know that when it was presented, it
4 was said to us that it was an extensive evaluation and
5 assessment and determination by the experts who were
6 convened to do that. And for us on the board,
7 collectively, we trust their expertise and their charge
8 to do that work.

9 So it wasn't a lengthy discussion. It was
10 information that was provided. But again, it's, you
11 know, easily a year ago.

12 Q. So when LeapFrog was updating the board about the
13 methodology change, it was said to the board that this
14 change followed a determination by the expert panel; is
15 that correct?

16 A. Yes.

17 Q. And did they discuss whether the expert panel
18 voted on this methodology change?

19 A. I don't recall that being part of the discussion.

20 Q. Did they discuss whether the expert panel
21 convened in a quorum regarding the proposed methodology
22 change that was actually implemented?

23 A. I don't know whether it was in a quorum. I don't
24 know that.

25 Q. So the LeapFrog executives didn't communicate to

1 you that the methodology change that they were going to
2 implement was not discussed with the full board at an
3 expert panel meeting?

4 A. No, I didn't say that. I said that I don't -- I
5 don't recall -- you know, I don't know whether it was a
6 quorum because I don't recall whether it was presented
7 that way.

8 Q. Understand and --

9 MR. BILLEK: And just note my objection to the
10 double negative you used. It made it confusing.

11 THE WITNESS: Yeah.

12 BY MR. HVIDT:

13 Q. Understand. I'm going to go back to that --

14 A. Okay. Sorry.

15 Q. -- because I was not trying to suggest that you
16 said that.

17 What I wanted to get an understanding of is when
18 the LeapFrog executives communicated about the
19 methodology change with the board, did they share with
20 the board that the methodology change that they were
21 proposing was not discussed with the full expert panel
22 at the April expert panel -- April 2024 expert panel
23 meeting?

24 A. I don't recall hearing that.

25 Q. So when --

1 A. I'm reading. I'm sorry. Let me read your
2 question again. Did they share with the board that the
3 methodology change that they were proposing was not
4 discussed with the full expert panel at the April expert
5 panel meeting?

6 I don't recall that level of specificity. It
7 could have been said. I don't -- I don't recall that.

8 Q. As a board member, would you have appreciated
9 knowing that the methodology proposal that was discussed
10 with the expert panel in April 2024 was different than
11 the methodology that the LeapFrog -- that LeapFrog ended
12 up implementing in the fall of 2024?

13 MR. BILLEK: Object to form.

14 THE WITNESS: I think that I would have wanted
15 to know what the difference was between the
16 recommendation and what was being implemented.

17 BY MR. HVIDT:

18 Q. Sitting here today, do you have any awareness
19 that the methodology change that was discussed at the
20 April 2024 expert panel meeting is different than the
21 LeapFrog methodology that it has had in place since the
22 fall of 2024?

23 A. I don't recall hearing that.

24 MR. HVIDT: Can we go off the record for a
25 moment? Thank you.

1 THE VIDEOGRAPHER: We are off the record at
2 11:33 a.m.

3 (A brief recess was taken.)

4 THE VIDEOGRAPHER: We are on the record at
5 11:37 a.m.

6 MR. HVIDT: Thank you.

7 BY MR. HVIDT:

8 Q. I'm handing you what's been marked as Exhibit 5.

9 (Exhibit No. 5 was marked for identification.)

10 BY MR. HVIDT:

11 Q. And Exhibit 5 has been produced in this
12 litigation by Florida Alliance as FHA0002072.

13 Do you see that, Dr. van Caulil?

14 A. Yes.

15 Q. And earlier today, we were talking about how the
16 LeapFrog staff presented to the LeapFrog board of
17 directors a LeapFrog 101. Do you remember that?

18 A. Yes. It wasn't part of a board meeting. It was
19 a separate meeting if people were available, and then
20 they sent the slides if you were unable to attend.

21 Q. And did you receive the slides?

22 A. Yes.

23 Q. Have you looked through them?

24 A. Yes.

25 Q. And the date of this set of slides is April 28,

1 2025. Do you see that?

2 A. Yes.

3 Q. And were you able to attend the meeting where
4 Leah Binder and Missy Danforth presented these?

5 A. No.

6 Q. And so is that why you were sent the slides
7 separately?

8 A. Yes. But they may have sent them to everybody,
9 whether you attended or not. I don't recall the e-mail
10 specifically.

11 Q. But you did not hear Leah Binder and Missy
12 Danforth walk through --

13 A. No, I --

14 Q. -- the slides in any way?

15 A. No, and I don't believe -- I'm sorry, I
16 interrupted -- no, and I don't believe they sent a
17 recording.

18 Q. Thank you. That was going to be my next
19 question.

20 And if -- you mentioned that you have read these
21 slides; is that correct?

22 A. I looked at them when I received them, yes.

23 Q. Okay. And if we can flip to slide 10. Do you
24 see where it says, Improving voluntary transparency?

25 A. Yes.

1 Q. Okay. And do you see where it says that
2 80 percent of hospitals voluntarily respond to
3 LeapFrog's annual survey?

4 A. Well, the wording is 80 -- Hospitals that
5 voluntarily respond to the annual LeapFrog survey
6 represent 80 percent of all acute care beds in the U.S.,
7 so that's specific to acute care beds.

8 Q. And so do you -- is that consistent with your
9 understanding that participation in LeapFrog's survey is
10 voluntary?

11 A. Yes.

12 Q. And if 80 percent of all acute care beds in the
13 United States are represented through hospitals that
14 participate, does that imply that there are 20 percent
15 of acute care beds in the U.S. that do not -- are in
16 hospitals who do not participate in the LeapFrog survey?

17 MR. BILLEK: Note my objection to form of the
18 question.

19 You can answer.

20 THE WITNESS: I don't know that you can say
21 20 percent of acute care beds. There are some
22 hospitals that don't qualify, if they're a specialty
23 hospital in some other determination. So if you
24 wouldn't mind repeating the question.

25 BY MR. HVIDT:

1 Q. Essentially the question is if -- 100 percent
2 minus 80 percent equals 20 percent; is that correct?

3 A. Yes, it is correct.

4 Q. Thank you.

5 A. So -- there's always caveats to everything, I'm
6 afraid.

7 Q. And you do not know whether or not the hospitals
8 that are excluded from that -- the hospital safety grade
9 are included in that calculation of 80 percent; is that
10 correct?

11 A. So this is a question about the survey. Can you
12 ask your question again, because I heard you say the
13 grade. So I just want to make sure I heard it
14 correctly.

15 Q. Yes. So you can strike that. It's not
16 significant.

17 A. Okay.

18 Q. We can -- let's flip over to the next slide,
19 please.

20 A. Okay.

21 Q. Do you see where it says at the top of slide 11,
22 Levers LeapFrog uses to gain survey participation?

23 A. Yes.

24 Q. And is this slide consistent with your
25 understanding that LeapFrog is trying to increase survey

1 participation?

2 A. LeapFrog -- yes. LeapFrog is trying to increase
3 survey participation because they'd like to see all the
4 hospitals in the country be transparent about their
5 quality and patient safety.

6 Q. And on this slide, does LeapFrog reference that a
7 lever that it can use to gain survey participation is
8 assigning nonparticipating hospitals the lowest score
9 for the imputed scores?

10 A. I'm waiting for the question to fully type out so
11 I can review it here. Does LeapFrog reference that a
12 lever that it can -- it's not showing on my screen.

13 Q. If you can -- if you can't understand my
14 question, then just ask me to repeat it again, because
15 looking back at the transcript, she's doing her best to
16 type it up but --

17 A. Yeah -- no, I --

18 Q. If we can just --

19 A. Please repeat the question.

20 Q. Yeah. On this slide, does LeapFrog reference
21 that one of the levers it uses to gain survey
22 participation is assigning nonparticipating hospitals
23 the lowest possible score for the imputing measures?

24 A. No, it doesn't include the limited achievement
25 score.

1 Q. And is this -- this is a slide deck that was sent
2 by LeapFrog staff to its board of directors to give it a
3 101 on the LeapFrog -- on LeapFrog's business; is that
4 correct?

5 A. Yes.

6 Q. And as the board, would you have appreciated that
7 LeapFrog staff be fully transparent of all the levers it
8 uses to gain survey participation in this slide?

9 A. I don't know that by leaving out the limited
10 achievement score for nonresponses would be something
11 that would be on a slide like this as a strategy.
12 Because I don't know, based on all the questions you
13 asked earlier and my responses, I don't know if that was
14 the intent of the expert panel or the staff in making
15 that decision to change the methodology.

16 So LeapFrog is transparent and I don't think by
17 leaving that out, they are not being transparent. It
18 says some measures included in the hospital safety
19 grade, so...

20 Q. And some measures being included in the hospital
21 safety grade is referencing to the notion that if you
22 participate in the LeapFrog survey, those answers get
23 used in the hospital safety grade; is that correct?

24 A. You're going to have to repeat that. I'm sorry.

25 Q. The reference to some measures included in the

1 hospital safety grade as a lever, LeapFrog uses to gain
2 survey participation, likely references the notion that
3 if you participate in the survey, those survey answers
4 go to measures that are included in your hospital safety
5 grade?

6 A. Survey participation in and of itself does not
7 mean you're going to get a better hospital safety grade,
8 but there are measures, yes, in the hospital survey that
9 are used in calculating the hospital safety grade if
10 you've responded to the survey.

11 Q. If you could flip to slide 25. I understand...

12 MR. BILLEK: Am I missing where these are
13 numbered or do you just mean the 25th page?

14 MR. HVIDT: 25th page on the PDF.
15 Unfortunately, it was produced to us without page
16 numbers.

17 MR. BILLEK: No, that's okay. When you said
18 slide 25, I thought you meant there was a number on
19 this slide somewhere that I couldn't see.

20 MR. HVIDT: The slide that is 25 is,
21 Differences Between LeapFrog Hospital Survey and
22 Safety Grade.

23 BY MR. HVIDT:

24 Q. Are you on that page?

25 A. I am now.

1 Q. Do you see where under LeapFrog Hospital Safety
2 Grade, it says, Grades are assigned via many sources?

3 A. Yes.

4 Q. The grades are assigned from LeapFrog from CMS
5 scores; is that part of the sources?

6 A. I don't know all the sources but I know CMS is
7 one of the sources.

8 Q. And do you know that LeapFrog Hospital Survey
9 answers are a source that goes into the grades?

10 A. Yes.

11 Q. Is there another source?

12 A. I don't know all the sources.

13 Q. Sitting here today, you can't think of another
14 source; is that correct?

15 A. That's correct.

16 Q. And if you could flip now to page 27, which is --
17 says, New safety grade imputation model.

18 Do you see that?

19 A. Yes.

20 Q. And then if you flip to the next page, slide 28,
21 it says, How LeapFrog calculates a grade for hospitals
22 that don't report to the survey, imputation.

23 Do you see that?

24 A. Yes.

25 Q. And in the first bullet on the left-hand side, it

1 reads, There's been a shift over time toward imputing
2 lowest level of performance when we don't have LeapFrog
3 Hospital Survey data.

4 Do you see that?

5 A. Yes.

6 Q. Does this slide explain why there's been a shift
7 toward imputing the lowest level of performance?

8 A. Only in that it's in line with the second bullet,
9 they're in line with recommendations from the national
10 expert panel and Johns Hopkins advisors. It doesn't --
11 I believe that's the answer.

12 Q. And that second bullet just references that the
13 change was made in line with recommendations. And that
14 bullet doesn't say why those recommendations were made;
15 is that correct?

16 A. That's correct. And again, I wasn't there for
17 the presentation for any additional, you know,
18 explanation or if anybody asked. And I don't have a
19 recording, so I don't know if it was addressed at the
20 time.

21 Q. And here, it says that the -- under that second
22 bullet that LeapFrog changed, quote, the way it
23 estimates performance.

24 Do you see that?

25 A. Yes.

1 Q. And so do you interpret this slide to mean that
2 LeapFrog was saying that the imputation process is
3 trying to estimate the performance of the nonperforming
4 hospitals?

5 MR. BILLEK: Object to form.

6 THE WITNESS: It says LeapFrog changed the way
7 it estimates performance for hospitals.

8 BY MR. HVIDT:

9 Q. So is that a yes?

10 A. Yes.

11 Q. You could flip to the next slide. Do you see
12 where it says, Common objections to LeapFrog?

13 A. Yes.

14 Q. And then if you flip again to the slide 31, the
15 slide after that, kind of banner change, says, Common
16 objections to LeapFrog concerns with the data.

17 Do you see that on slide 31?

18 A. There's two slides with that, so which one in
19 particular?

20 Q. We'll start with the first slide.

21 A. Okay. All right. Yes, I see it.

22 Q. The one where the first item on the left says,
23 LeapFrog data is self-reported. How can it be trusted?

24 Do you see that?

25 A. I do.

1 Q. And is it your understanding that this slide and
2 the next slide, LeapFrog is communicating common
3 objections that hospitals have provided for not
4 participating -- for reasons why they're not
5 participating in LeapFrog's hospital survey?

6 A. I don't know that if it's limited to not
7 participating. It could be that it's raised by a
8 hospital that has participated. So I wouldn't come to
9 the conclusion that it's just from those who have not.

10 Q. That's fair. These are objections to the
11 LeapFrog hospital safety grade that could be from
12 nonparticipating hospitals or could be from anyone. Is
13 that correct?

14 A. It doesn't say specifically, but I -- I would
15 have to guess it could be from anyone.

16 Q. Do you see there on slide 31 where the third box
17 says -- the blue box says, We have a poor safety grade
18 only because we do not participate in the LeapFrog
19 Hospital Survey.

20 Do you see that?

21 A. Yes.

22 Q. And so the inclusion of that quote on the slide
23 implies that that's a common objection that has been
24 raised to LeapFrog; would you agree with that?

25 A. Yes.

1 Q. And you see how in response, the last sentence
2 that's response below that says, Many hospitals that do
3 not report to LeapFrog earn As.

4 A. I see that.

5 Q. Do you have any understanding of the truth of
6 that statement?

7 A. I have seen but couldn't quote it directly a
8 number that LeapFrog has provided in recent months of
9 the number of hospitals who have As, Bs, Cs, Ds, Fs, who
10 don't participate in the survey.

11 Q. Would it surprise you to know that there's about
12 550 nonparticipating hospitals in this last grading
13 cycle that were given the lowest score through the
14 imputation methodology?

15 A. I would not be surprised or surprised. I don't
16 have a sense of how many. I don't know. I don't know
17 if that number is surprising or not.

18 Q. And of those 550 nonparticipating hospitals, do
19 you know that there are zero nonparticipating hospitals
20 in Florida who were given an A by LeapFrog in the spring
21 2025 cycle? Would that surprise you?

22 A. I don't have a reaction that's surprise or not
23 surprise. It's -- I didn't know that information,
24 though.

25 Q. And if the number of nonparticipating hospitals

1 that were given imputed lowest score for the four
2 measures, of the 550 across the country was only two,
3 would that, in your mind, be many hospitals?

4 MR. BILLEK: Object to form.

5 You can answer.

6 THE WITNESS: Could you repeat the question?

7 BY MR. HVIDT:

8 Q. Yeah. So in this document, the LeapFrog staff is
9 communicating to the board that many hospitals that do
10 not report to LeapFrog earn As. Do you see that?

11 A. I see that, yes.

12 Q. And in spring of 2025, the nonresponding
13 hospitals who were given a step 2 imputation that earned
14 an A was two of 550. Does that -- is two out of 550
15 many hospitals in your mind?

16 MR. BILLEK: Object to form.

17 THE WITNESS: I don't know that this response
18 here is limited to just one grade cycle. So could be
19 many hospitals over time that have not reported to
20 LeapFrog earn As.

21 BY MR. HVIDT:

22 Q. And did you know that in the fall of 2024, the
23 only other grading cycle that had this imputation
24 methodology, the numbers were the same?

25 MR. BILLEK: Object to form.

1 THE WITNESS: I hadn't heard that data.

2 BY MR. HVIDT:

3 Q. If that data is accurate, would you characterize
4 that data as being many hospitals?

5 A. Two hospitals in two hospitals is not many for
6 just those two cycles. I would assume that what they're
7 trying to say is that many hospitals over time have
8 received As.

9 Q. Before the methodology change, there could have
10 been nonresponding hospitals that got As, and that
11 statement could have been correct prior to the
12 methodology change; is that correct?

13 A. I think that's possible. I don't know the answer
14 to that, though.

15 Q. You can set that document to the side.

16 MR. BILLEK: That was 5?

17 MR. HVIDT: Yes. Thank you. And before I hand
18 the witness what has been marked as Exhibit 6, I want
19 to, on the record, note that there's a set of
20 documents that LeapFrog provided to plaintiff's
21 counsel on Sunday without Bates stamps. And when they
22 communicated that, they said that they would be
23 producing them later with Bates stamps. And we have
24 not yet received those versions.

25 And so there are a few documents we're going to

1 have to use today that do not yet have Bates stamps
2 but will have Bates stamps soon, consistent with how
3 we treated the Florida Alliance documents that were
4 produced, approximately 30 hours ago. Counsel, can we
5 get an agreement that we can insert the Bates-copied
6 version of this document in place of the
7 nonBates-copied version of this document when that's
8 provided by you?

9 MR. BILLEK: Of course.

10 MR. HVIDT: Thank you.

11 (Exhibit No. 6 was marked for identification.)

12 BY MR. HVIDT:

13 Q. I'm handing you what we've marked as Exhibit 6 to
14 your deposition. And I'll represent that Exhibit 6
15 appears to be LeapFrog group board of director minutes
16 from the June 11, 2024, board of directors meeting at
17 the Darcy Hotel, Washington, D.C. and Zoom.

18 Do you see that, Dr. van Caulil?

19 A. Yes.

20 Q. And do you see under the attendees your name
21 listed there on the third line?

22 A. I do.

23 Q. And is that correct? Did you attend this board
24 of directors meeting?

25 A. Yes. I can't recall whether it was in person or

1 Zoom, though.

2 Q. And is it part of LeapFrog's practices to prepare
3 minutes for board of directors meetings?

4 A. Yes.

5 Q. And when LeapFrog Group prepares minutes for
6 board of directors meetings, do they try to be truthful
7 and accurate as to the events that occurred during the
8 LeapFrog board of directors meetings?

9 A. Yes.

10 Q. And looking here at this document, do you have
11 any reason to doubt the authenticity or accuracy of the
12 minutes provided here?

13 A. No.

14 Q. And looking through this document, at this
15 meeting, was -- was the LeapFrog Group board of
16 directors asked to vote on whether the LeapFrog Group
17 should change its grading methodology for its hospital
18 safety grades?

19 A. I don't think that was an action taken. May I
20 look through the minutes?

21 Q. You may. Please look through the minutes and let
22 me know if that was an action taken at this meeting.

23 A. I don't see any actions taken on the grading
24 methodology.

25 Q. Do you see any reference in these minutes to

1 LeapFrog changing its imputation methodology to, instead
2 of trying to estimate the performance of
3 nonparticipating hospitals, to instead assign them the
4 lowest possible score for those measures that were
5 previously imputed?

6 A. I don't see an agenda item on the topic at all.

7 Q. Do you recall receiving a -- you can set that to
8 the side -- do you recall receiving a report from the
9 LeapFrog CEO at that June 2024 board of directors
10 meeting?

11 A. Leah typically does a verbal and written report.
12 I don't recall what was said.

13 Q. When you say written report, would she provide a
14 report in writing to the board of directors?

15 A. Yes. She does that. I don't know if that's
16 every time, but she'll write out her talking points.

17 MR. HVIDT: I'm handing the witness what has
18 been marked as Exhibit 7 in the Karen van Caulil
19 deposition which has been produced in this litigation
20 as LEAPFROG00326021. The cover page is an e-mail from
21 Leah Binder dated June 6, 2024, to Angela Hopkins re:
22 CEO report June 2024.

23 (Exhibit No. 7 was marked for identification.)

24 BY MR. HVIDT:

25 Q. Do you see that, Dr. van Caulil?

1 A. Yes.

2 Q. Do you see how there's an attachment there, CEO
3 report-June 2024?

4 A. I see -- it doesn't have a dash. It says
5 LeapFrog Group board of directors, CEO report, Leah
6 Binder, June 2024.

7 Q. In looking at the e-mail, do you see where Leah
8 says, Attached is the final?

9 A. Yes.

10 Q. And I also put it in the board packet. Little
11 correction there, I to in.

12 A. Okay.

13 Q. Do you see that?

14 A. Yes.

15 Q. So flipping to the attachment now, do you see in
16 that first section there where it says, The hospital
17 safety grade successful spring update?

18 A. Yes.

19 Q. Looking down to that second paragraph, can you
20 read that paragraph into the record for me, please?

21 A. We also published our planned updates to the
22 safety grade methodology slated for this fall. The
23 update dramatically lowers imputed scores for certain
24 measures for hospitals that decline to report to the
25 LeapFrog Hospital Survey. This follows a strong

1 recommendation from the expert panel. This should have
2 some impact on hospital reporting to the survey and will
3 strengthen the grade overall.

4 Q. Thank you.

5 And seeing that document in that line, does that
6 refresh your recollection of whether there was
7 discussion -- whether it was reported to the board that
8 there would be a methodology change at that June 2024
9 meeting?

10 A. Yes. I knew that it had been reported to us that
11 there was a change, but there wasn't board discussion or
12 a presentation of the methodology. So when Leah does a
13 report like this, this is essentially her talking points
14 during the meeting.

15 Q. Understood. So Leah may have said this or
16 something like this at the meeting. But you don't
17 recall there being any discussion after that was
18 referenced; is that correct?

19 A. I don't recall if there was discussion. There
20 could have been comments, but it wasn't a significant
21 discussion.

22 Q. And do you see where she says that, This follows
23 a strong recommendation from the expert panel?

24 A. I see that.

25 Q. Is that consistent with what you testified to

1 earlier that when The LeapFrog Group communicated this
2 change to you, they said that this came from a
3 recommendation from the expert panel?

4 A. Yes.

5 Q. And do you see where following that, she says,
6 This should have some impact on hospital reporting to
7 the survey?

8 A. Yes, I see that.

9 Q. And with that sentence, when she says, should
10 have some impact, do you think she is suggesting that
11 this change should increase hospital participation in
12 the LeapFrog Hospital Survey?

13 MR. BILLEK: Object to the form.

14 You can answer.

15 THE WITNESS: I -- I don't know what impact
16 that implies in that statement.

17 BY MR. HVIDT:

18 Q. And just to confirm, there was no board vote in
19 June 2024 on whether LeapFrog should change its safety
20 grade methodology in this regard; is that correct?

21 A. That's correct. We don't vote on the
22 methodology.

23 MR. HVIDT: Consistent with the last exhibit,
24 this is a document that was produced to us on Sunday
25 without Bates numbers with an indication that Bates

1 numbers versions would be following but haven't
2 followed yet. Are we in agreement that we can use
3 this document in the same regards?

4 MR. BILLEK: Of course.

5 MR. HVIDT: Thank you.

6 (Exhibit No. 8 was marked for identification.)

7 MR. HVIDT: I have handed the witness what will
8 be marked as Exhibit 8.

9 I'm so sorry.

10 MR. BILLEK: That's all right.

11 BY MR. HVIDT:

12 Q. Did I hand you two?

13 A. Oh, yes, actually. I'm sorry.

14 Q. Thank you.

15 MR. HVIDT: That may have been why I thought
16 that you already had one.

17 MR. BILLEK: That's all right. I don't want
18 anybody at Gibson Dunn to get fired over that
19 photocopying issue.

20 MR. HVIDT: We have handed the witness what is
21 titled at the top, Minutes, The LeapFrog Group Board
22 of Directors September 25, 2024, Zoom.

23 BY MR. HVIDT:

24 Q. Do you see that?

25 A. Yes.

1 Q. And do you see under attendees, your name is
2 listed?

3 A. Yes.

4 Q. And consistent with the exhibit two exhibits ago,
5 are minutes for LeapFrog Group board of directors
6 meetings prepared in the ordinary course of business?

7 A. Yes.

8 Q. Do you have any understanding to doubt or reason
9 to doubt the accuracy of the information in this
10 document?

11 A. No.

12 Q. And do you have an understanding of the time of
13 the year where LeapFrog's methodology is locked in for
14 how it's going to report for when -- how it's going to
15 report grades for the upcoming cycle?

16 A. No, I don't.

17 Q. And you're sitting there September 25, 2024, and
18 there's a grade cycle that's in the late fall and fourth
19 quarter of 2024; is that correct?

20 A. I don't know when they publish the fall scores,
21 but the last quarter sounds correct.

22 Q. And do you think that the LeapFrog methodology
23 that it was using for the fall of '24 would have been
24 locked in by this meeting?

25 A. I don't know.

1 Q. At this meeting, was there a vote on whether
2 LeapFrog should change its methodology for how it grades
3 nonparticipating hospitals?

4 A. No. We don't vote on methodology changes.

5 Q. And if you flip to the second-to-last page of the
6 minutes, the very bottom, do you see where it says,
7 Safety grade methodology change underlined?

8 A. Yes.

9 Q. And then carrying forward onto the last page, do
10 you see a description of the LeapFrog's safety grade
11 methodology change?

12 A. Yes.

13 Q. And do you see in that first sentence where it
14 says, LeapFrog uses an imputation model to be able to
15 grade hospitals even if they do not submit a LeapFrog
16 Hospital Survey?

17 A. Yes.

18 Q. Is it your understanding that if LeapFrog didn't
19 use an imputation model, it would not be able to grade
20 hospitals that do not submit a LeapFrog Hospital Survey?

21 MR. BILLEK: Object to form.

22 You can answer.

23 THE WITNESS: I -- I don't know if it would be
24 appropriate to have a different methodology for
25 nonresponding hospitals. So I think that using the

1 imputation model is so that they can use the same
2 approach for all hospitals. I'm not sure I'm
3 answering your question.

4 BY MR. HVIDT:

5 Q. Understanding, yeah, yeah --

6 A. Yeah.

7 Q. -- so I'll have a couple follow-ups on that.

8 A. Okay.

9 Q. The first question is, using the words in the
10 document?

11 A. Right.

12 Q. And so I'm just trying to get an understanding of
13 how that -- that sentence is structured. In there, it
14 says that LeapFrog uses an imputation model to be able
15 to grade hospitals even if they do not submit a LeapFrog
16 Hospital Survey.

17 Do you see that?

18 A. I do.

19 Q. And so would you take that sentence to mean that
20 if LeapFrog didn't use an imputation model, it would not
21 be able to grade hospitals if they did not submit the
22 LeapFrog Hospital Survey?

23 A. I read the sentence to say that's how -- the
24 imputation model is how they are able to grade
25 hospitals. I don't know that it says that without it,

1 they could not. I wouldn't take it that far in my
2 reading of that sentence.

3 Q. Okay. And you mentioned that you don't think it
4 would be appropriate to have a different methodology for
5 nonresponding hospitals. Is that correct?

6 A. That is not a fully formed thought. I was trying
7 to think as I was speaking how you would do that. So
8 I -- I probably should retract my comment because it's
9 not a fully formed thought. I'm trying to think out
10 loud in response to your question.

11 Q. Do you think that all hospitals should be graded
12 on the same methodology?

13 A. I think that it's complicated to answer that
14 question because if the hospitals don't participate and
15 you're missing a couple of items, you have to find
16 another way to put a value in.

17 Q. But if you're putting a value in, are you not --
18 are you grading them in a different methodology because
19 you don't have the data for those missing measures?

20 A. No. If your methodology states and it's publicly
21 available and the hospitals know that ahead of time,
22 this is the methodology, if you choose not to respond,
23 we're still grading you and this is how it will be
24 calculated. So it is the same methodology. It's not a
25 different methodology.

1 Q. Are nonresponding hospitals and responding
2 hospitals graded in the same manner?

3 A. I don't know how to interpret that question.
4 I -- I don't know what happens behind the development of
5 the grade. So I can't answer that question.

6 Q. Setting LeapFrog aside for the minute, if you are
7 grading hospitals, shouldn't you try to grade the
8 hospitals on the same measures?

9 MR. BILLEK: Object to form.
10 You can answer.

11 THE WITNESS: LeapFrog gives the opportunity
12 for every hospital to respond to the questions. And
13 they have in the methodology, we're doing this grade.
14 You should respond to the survey to ensure that your
15 achievement of that measure is reflected. In the
16 absence of that, here is the methodology that we use.

17 BY MR. HVIDT:

18 Q. And in that approach, is that approach clear to
19 those who use the LeapFrog grades to make their
20 decisions about where to receive healthcare?

21 MR. BILLEK: Object to form.

22 THE WITNESS: I can tell you that the Florida
23 Alliance in our role as regional leader makes sure
24 that the employers who are in our membership
25 understand that. LeapFrog has always been very

1 transparent on their website for the hospitals on the
2 methodology or the materials that are sent to them.

3 BY MR. HVIDT:

4 Q. Do you think that LeapFrog is clear that it is
5 penalizing nonresponding hospitals for not participating
6 in the survey?

7 A. I think LeapFrog is very clear that they'll give
8 limited achievement for that measure in the absence of
9 having any other information.

10 Q. And do you agree that giving limited achievement
11 to a hospital that doesn't participate in the LeapFrog
12 Hospital Survey is a penalty for not participating in
13 the LeapFrog Hospital Survey as it relates to the grade?

14 A. No. I don't see it has a penalty.

15 Q. What do you see it as?

16 A. I see it as the best possible guess, estimate,
17 proxy for that measure in the absence of having any
18 other information. Why would you say that there's been
19 a higher level of achievement when there's no evidence
20 to support that?

21 Q. And why would you say that there's a lower level
22 of achievement when there's no evidence to support that?

23 A. Because -- well, it says in the previous,
24 LeapFrog would look at their most recent scores from
25 four rounds, they're looking at the last two rounds. So

1 I don't know if there's some level of analysis. Again,
2 I've said it so many times, I don't know how the
3 methodology works. I don't know what happens behind the
4 scenes and why they came up with, after deliberation on
5 the expert panel, that putting limited achievement as
6 the appropriate way to fill in that gap, I had -- I've
7 not thought of that as a penalty. I've thought of that
8 as an opportunity for the hospital to provide the
9 information we want to see. We're about transparency
10 and if you know ahead of time what that methodology is
11 in fact, then that gives you every opportunity to put
12 the answer in that reflects your achievement.

13 Q. Again, why would you say that a lower level
14 achievement score is appropriate for a nonresponding
15 hospital when there's no evidence to support that?

16 MR. BILLEK: Object to form.

17 THE WITNESS: I think it's more appropriate to
18 give that level than it is to assume that they've had
19 a higher level of achievement.

20 BY MR. HVIDT:

21 Q. But when you're giving a lower -- lowest level of
22 achievement, aren't you also -- are you assuming that
23 they wouldn't -- that they would get the lowest level?

24 A. I'm not making any assumptions. I don't
25 understand your question.

1 Q. By assigning the lowest level of achievement to
2 nonparticipating hospitals, for the imputed measures,
3 LeapFrog is not trying to estimate their performance had
4 they responded to the survey; is that correct?

5 A. You showed me a document that had wording that
6 said this is how LeapFrog is estimating their
7 performance, a few minutes ago -- a few documents ago.

8 Q. I showed you a document that showed that the
9 LeapFrog staff communicated to the board that they're
10 trying to estimate --

11 A. Correct.

12 Q. -- the -- that they're trying to estimate the --
13 what the nonparticipating hospital would have achieved
14 by assigning them a lowest score; is that correct?

15 A. The document that we looked at said that they're
16 trying to estimate what the nonparticipating hospital
17 would have achieved, but I don't remember it saying by
18 assigning the lowest score. I don't remember seeing
19 that tag on to the statement.

20 Q. And when the LeapFrog staff communicated to the
21 board of directors that they were trying to estimate how
22 the hospital would have performed had it participated in
23 the LeapFrog survey by assigning the lowest possible
24 score, did you take them as being truthful in that?

25 A. I don't remember the specific discussion. I know

1 it's written like this. I didn't have any reason to
2 think that I wasn't being told the truth.

3 Q. Looking back at the minutes, if we go down -- I
4 think it's probably like eight lines down, do you see
5 where it says, This means hospitals?

6 A. I see that.

7 Q. Sentence reads, This means hospitals that have
8 not reported their performance to LeapFrog will have a
9 lower score for the imputed measures.

10 Do you see that?

11 A. Yes.

12 Q. And so by that sentence, LeapFrog staff was
13 updating the LeapFrog board that nonparticipating
14 hospitals would automatically have a lower score for the
15 imputed measures.

16 Is that correct?

17 A. Yes.

18 Q. And then it goes on to say that, These measures
19 are CPOE, BCMA, IPS and hand hygiene.

20 Do you see that?

21 A. Yes.

22 Q. The next sentence says, Hospitals can still get
23 an A if they fall into this category but it does make it
24 harder.

25 Do you see that?

1 A. Yes.

2 Q. And so is the LeapFrog staff communicating to the
3 board that it will be harder for a nonparticipating
4 hospital to receive an A simply by virtue of not
5 participating in the LeapFrog Hospital Survey?

6 MR. BILLEK: Object to form.

7 You can answer.

8 THE WITNESS: I don't know that that full
9 sentence that you said, by -- simply by virtue of not
10 participating, is -- is accurate. They're saying that
11 hospitals can still get an A if they do extremely well
12 in the publicly reported data. They're not going to
13 get that mid-level response without providing their
14 own -- their own data.

15 BY MR. HVIDT:

16 Q. And here, the LeapFrog staff is communicating to
17 the board that it will be harder for nonparticipating
18 hospitals to get an A if they don't participate in the
19 LeapFrog survey and are given an imputed limited
20 achievement score; is that correct?

21 MR. BILLEK: Object to form.

22 You can answer.

23 THE WITNESS: Yes.

24 BY MR. HVIDT:

25 Q. And as I mentioned earlier, it would be harder to

1 get an A -- it has proven to be harder to be getting an
2 A if you're a nonparticipating hospital in the LeapFrog
3 survey. Only two of 550 such hospitals got one in the
4 spring of 2025; is that fair to say that that's harder?

5 MR. BILLEK: Object to form.

6 You can answer.

7 THE WITNESS: What were the numbers prior to
8 that time? I don't know the answer.

9 BY MR. HVIDT:

10 Q. Over 100.

11 MR. BILLEK: Object to form.

12 You can answer.

13 THE WITNESS: So over 100 in the cycles before
14 got As who were a nonrespondent and it went down to
15 two? Okay. And the question was?

16 BY MR. HVIDT:

17 Q. Does that show that it has proven to be harder
18 for nonparticipating hospitals to get an A?

19 A. Yes. I don't know that -- with a caveat. I
20 don't know the detail of the 98 or however, you know,
21 100, whatever number you said. Now I don't remember.
22 200, 100. Hospitals, whether they performed poorly on a
23 CMS measures. I don't know that it's because of those
24 four measures that were imputed. So I would have to
25 revise my answer to say, certainly going from 100 to two

1 shows that there's something happening to reduce the
2 number of As. It could be a combination. It could be a
3 combination of issues.

4 Q. So assigning them the lowest score is likely a
5 contributing factor in --

6 A. I would -- I would say it could be a contributing
7 factor. I don't know that it is the only factor.

8 Q. And again, it is proven harder for a
9 nonparticipating hospital to get an A as there's no
10 Florida nonparticipating hospitals who got an A in the
11 spring of 2025 grading cycle; is that correct?

12 A. Is the question -- the question is it harder for
13 Florida than anyone else, you're saying, or you're just
14 saying has it proven that it's harder?

15 Q. Does the fact that there are no Florida
16 nonparticipating hospitals who got an A in the spring
17 2025 grading cycle confirm that the LeapFrog staff was
18 communicating to the board that this methodology change
19 will make it harder for nonparticipating hospitals to
20 get an A?

21 A. Yes.

22 MR. HVIDT: I have a subject change and it's
23 12:30. Do we want to go off the record?

24 THE WITNESS: Whatever you want to do.

25 MR. BILLEK: Do you want to take a break for

1 lunch or something?

2 MR. HVIDT: Yeah, I'm happy for it to be a
3 brief lunch but I do think we have around two hours
4 remaining.

5 THE COURT REPORTER: Do you want to go off the
6 record?

7 MR. HVIDT: Yeah. Sorry.

8 THE VIDEOGRAPHER: We are off the record at
9 12:31 p.m.

10 (Luncheon recess was taken.)

11 THE VIDEOGRAPHER: We are on the record at
12 12:59 p.m.

13 MR. HVIDT: Thank you.

14 BY MR. HVIDT:

15 Q. Earlier this morning, we talked about Florida
16 Alliance's role as a regional leader for The LeapFrog
17 Group; is that correct?

18 A. Yes.

19 Q. And you talked about how as part of that role,
20 Florida Alliance will send letters to hospitals to
21 encourage their participation in the LeapFrog Hospital
22 Survey; is that correct?

23 A. Yes.

24 Q. And has Florida Alliance sent letters to the
25 plaintiff hospitals in 2025 encouraging them to

1 participate in the LeapFrog Hospital Survey?

2 A. I don't know for sure.

3 Q. Does Florida Alliance have a practice of sending
4 letters to all hospitals in its region to encourage them
5 to participate in the LeapFrog Hospital Survey?

6 A. So Ashley, who I've mentioned, our VP, is in
7 charge of making that determination. I mentioned that
8 sort of extreme answer -- excuse me -- example of a
9 hospital that might be damaged and, you know, not
10 operational or not fully operational. So she does go
11 through, you know, who would be eligible. And the goal
12 is to send, you know, to every -- every eligible acute
13 hospital. So in general, you know, and the different --
14 the different categories.

15 So the shorter answer is, the practice is to send
16 to all applicable hospitals because there are some that
17 are not applicable.

18 Q. Thank you.

19 MR. HVIDT: I'm handing the witness what has
20 been marked as Exhibit 9 in this deposition.

21 (Exhibit No. 9 was marked for identification.)

22 THE WITNESS: Okay.

23 MR. HVIDT: Which has been produced in this
24 litigation as PBHN000018124. It is dated
25 April 23, 2025.

1 Counsel, do you see that date? I'm sorry.

2 Strike that.

3 BY MR. HVIDT:

4 Q. Dr. van Caulil, do you see that date?

5 A. I do.

6 Q. And what is Exhibit 9?

7 A. So this is a letter to -- I don't know if I'm
8 pronouncing his first name correctly -- Jerad Hanlon at
9 West Boca Medical Center and it has that item on the
10 intent to submit. Looks like it's a partial letter. It
11 looks like it's missing the signature page on it. So it
12 doesn't look like a full letter, actually, because if we
13 were to send it, it would be signed. So it's a letter
14 that looks like it's not complete. So I don't know
15 whether -- do you have the remainder of it? Okay.

16 Q. This is the document that was received by --

17 A. Okay.

18 Q. -- Jerad Hanlon at West Boca Medical Center.

19 A. Okay.

20 Q. And produced in the way that he sent it to us or
21 was kept in ordinary course of business. And so looking
22 at the top of the letter, do you see the Florida
23 Alliance for Healthcare Value logo?

24 A. Yes.

25 Q. Do you have any reason to doubt that Florida

1 Alliance sent a letter to West Boca Medical Center?

2 A. I don't have any doubts, but I -- I would say the
3 letter is not -- it's not complete. It's not -- it's
4 missing at least one page.

5 Q. And aside from lacking a signature --

6 A. I don't know the reason why. I'm sorry. I can't
7 speculate as to why. But I know that, you know --

8 Q. Aside from the fact that you're not seeing a
9 signature on this document, do you have any other reason
10 to question that the -- that the substance of the
11 document is inaccurate in any way?

12 A. No, I don't.

13 Q. And is this letter consistent with the letters
14 that Florida Alliance sends to hospitals in Florida to
15 encourage them to participate in the LeapFrog Hospital
16 Survey?

17 A. So I have already mentioned that it is not a
18 complete letter, I don't think. I -- when I've seen
19 copies of the letters, Ashley is signing them and
20 there's more specific information that would be included
21 from my quick perusal of it. So it is not consistent,
22 then, in that somewhere along the way, part of it is
23 missing, I think.

24 Q. Looking at the first page, is the first page of
25 the letter consistent with the first page of the letters

1 that Florida Alliance typically sends to Florida
2 Hospitals to encourage them to participate in the
3 LeapFrog Hospital Survey?

4 A. Yes. I believe so. But the letters come from
5 Ashley Tait-Dinger, so I don't have, you know, exact
6 wording known for the letter. But it looks consistent
7 with what I've seen in the past.

8 Q. Does Ashley Tait-Dinger report to you?

9 A. Yes, she does.

10 Q. Would you -- do you review the templates of the
11 letters before you approve of the template being
12 personalized for the Florida Hospitals?

13 A. No. If she's signing the letter, I may or may
14 not have seen -- seen it. The template comes from
15 LeapFrog and is updated with, I guess, local information
16 if -- if needed.

17 Q. And -- but the nature of this was produced by
18 West Boca Medical Center, do you have any reason to
19 dispute that they received this document?

20 A. No.

21 Q. And in looking at this first page of the letter,
22 do you -- is it fair to say that the letter is trying to
23 encourage West Boca to participate in the LeapFrog
24 Hospital Survey?

25 A. Yes.

1 Q. And it includes a form on the next page asking
2 for its intent to participate or not. Do you see that?

3 A. Yes. And that's what I had mentioned earlier
4 this morning, trying to recall what that looked like,
5 yeah.

6 Q. Absolutely. And there's a comment box where we
7 talked about how there's --

8 A. Correct.

9 Q. -- you might explain why you do not wish to
10 participate?

11 A. Yes.

12 Q. And in looking at this letter, and that's
13 represented in Exhibit 9, do you see any reference to
14 how LeapFrog will assign a low score to the hospital for
15 imputed measures if it doesn't participate in the
16 LeapFrog Hospital Survey?

17 A. No. And again, for the record, wherever along
18 the way there -- there is an aspect of this letter that
19 I'm pretty sure is missing, which would direct the
20 recipient with any questions to LeapFrog to their
21 website for reporting. That's what I believe is missing
22 from this letter.

23 Q. Are you aware whether Florida Alliance produced a
24 copy of this letter in its production?

25 A. I am not.

1 Q. Are you aware whether this document would have
2 been responsive to the subpoena sent to Florida
3 Alliance?

4 A. It should have been. At the time period, yes, it
5 should have been.

6 Q. And do you have any understanding as to why it
7 wasn't produced?

8 A. No. I don't know that it wasn't produced.

9 Q. When did you become aware of the lawsuit that was
10 filed by plaintiff hospitals for the -- that the
11 deposition that you're taking is within?

12 A. I was at our annual conference on May 1st and I
13 think I got an e-mail from Leah that day. I remember
14 seeing -- seeing it then. I think that there were some
15 conversations maybe earlier than that that it might
16 happen. Yeah. Late April or so.

17 Q. So you were informed in late April or so that
18 there might be a litigation; is that correct?

19 A. I think that sounds like the time period. Yes.

20 Q. And how were you informed?

21 A. I don't remember specifically whether it was in a
22 meeting or reading something that said that there had
23 been conversations between the hospitals and LeapFrog
24 about not displaying the grade and when LeapFrog said
25 we're going to display the grade, the information that I

1 got was we could expect a lawsuit as a result.

2 Q. And would that have come in the capacity as a
3 board member?

4 A. I don't recall.

5 Q. Were -- when you had that communication, were you
6 asked to do anything before the lawsuit was filed by
7 LeapFrog?

8 A. Only if any calls or e-mails or letters were
9 directed to us, to send them to Leah or Karen, whoever
10 at LeapFrog, and also not to speak to the media.

11 MR. HVIDT: I am handing the witness what's
12 been marked as Exhibit 10 in this deposition.

13 (Exhibit No. 10 was marked for identification.)

14 MR. BILLEK: Thanks.

15 MR. HVIDT: Exhibit 10's Bates number will be
16 FHA0002804. It was produced in this litigation by
17 Florida Alliance.

18 BY MR. HVIDT:

19 Q. Dr. van Caulil, do you see the document that I've
20 handed you?

21 A. Yes.

22 Q. Do you see that the top e-mail is an e-mail from
23 Chris Skisak to Leah Binder, regional leaders of
24 LeapFrog, board members of LeapFrog, with copy to Missy
25 Danforth, Karen Jupiter and Lauren Bailey regarding

1 spring safety grade lawsuit?

2 A. Yes.

3 Q. And you mentioned earlier that you received an
4 e-mail from Leah Binder on May 1, 2025, regarding the
5 lawsuit. Is that correct?

6 A. Yes. As I said, we had our annual conference
7 that day and I looked at my phone and saw the e-mail.

8 Q. And looking down at the e-mail from Leah Binder,
9 do you see where she cites the hospitals involved in the
10 lawsuit?

11 A. Yes.

12 Q. Do you see next to the hospitals involved in the
13 lawsuit, she puts their spring grade. Do you see that?

14 A. I do.

15 Q. And in your own words, how would you characterize
16 Leah Binder's e-mail to the regional leaders and the
17 board members here?

18 A. So she's certainly alerting the board and the
19 regional leaders to the fact that there's a lawsuit
20 that's been filed. And that they're going to do what it
21 takes to defend LeapFrog's position. She -- I'm just
22 looking down -- yes, she did attach the statement that
23 she had put together. That was the other document that
24 I had seen at or around that same time. And also to
25 please, you know, let people know that if they had any

1 questions, who to refer to.

2 Q. And do you see Chris Skisak's response above?

3 A. Chris Skisak, yes. He's my counterpart at the
4 Houston Business Coalition on Health, yes, I see it.

5 Q. So is he a regional leader?

6 A. The Houston Business Coalition on Health is a
7 regional leader, yes.

8 Q. Is he a member of the board of LeapFrog?

9 A. No.

10 Q. Do you see the second sentence of his e-mail, he
11 writes, In this case, the grades are doing what we all
12 hope - steer patients away from unsafe hospitals to more
13 safe ones, close quote.

14 A. Yes, I see that.

15 Q. Do you agree with him?

16 A. I wouldn't characterize the situation that way.

17 Q. Do you agree that a low LeapFrog grade steers
18 patients away from those hospitals?

19 A. I think it can. I think that patients take in a
20 lot of information in seeking hospital care. Oftentimes
21 they're going at the request -- at the recommendation of
22 their physician. I don't know that they're looking at
23 the -- at the grades. But it certainly could, if
24 somebody was aware of the hospital safety grades, give
25 them pause and to investigate further.

1 Q. And is one of the reasons why LeapFrog publishes
2 safety grades to influence consumer decisions about what
3 hospitals they should get their care at?

4 A. I wouldn't use the word influence. LeapFrog does
5 this to promote transparency so that consumers and
6 employers, purchasers of health services, have
7 information about patient safety performance. And they
8 are free to look at the methodology and the approach and
9 make their own decision about whether they agree with it
10 and should take that grade under consideration.

11 Q. Do you understand that LeapFrog's own documents
12 notes that one of the reasons for their hospital safety
13 grades is to influence consumer hospital decisions?

14 A. I haven't seen that written.

15 Q. In going back to Chris's e-mail, he references
16 steering patients away from unsafe hospitals.

17 Do you see that?

18 A. I do.

19 Q. And so is he connecting unsafe hospitals with the
20 letter grades D and F?

21 A. I don't know what Chris is doing.

22 Q. Would you characterize an F and D grade to be an
23 unsafe hospital?

24 A. I always look at the whole picture: The hospital
25 survey information, the safety grade information, when

1 we're -- when I'm personally seeking care, elderly
2 mother, and look at the history. So I'm a different
3 person than the general community, I will give that.
4 But I think it's part of a story and should be looked
5 at, you know, alongside other -- other sources.

6 Q. And that part of the story can impact decisions
7 made about where to receive healthcare --

8 A. Yes.

9 Q. -- is that correct?

10 A. Yes.

11 Q. And when you say that it's always good to look at
12 the whole picture, would you consider part of the whole
13 picture to include whether or not that hospital
14 participated in the LeapFrog survey?

15 A. For me personally, yes.

16 Q. Do you think that that's something that the
17 general consumer of the LeapFrog grade understands?

18 A. I don't know.

19 Q. You can set that to the side for the moment.

20 After receiving notice from Leah Binder of the
21 lawsuit, did you then notify your board at Florida
22 Alliance?

23 A. Yes.

24 Q. And going back to our discussion this morning,
25 your board, other than yourself, are representatives

1 from Florida employers; is that correct?

2 A. Yes, that's correct.

3 MR. HVIDT: I'm handing the witness what's been
4 marked as Exhibit 11 in the van Caulil deposition. It
5 was produced by the Florida Alliance as FHA0001995.

6 (Exhibit No. 11 was marked for identification.)

7 MR. HVIDT: Momentarily going back to
8 Exhibit 10. Exhibit 10 was produced by the Florida
9 Alliance as FHA0001739.

10 BY MR. HVIDT:

11 Q. Dr. van Caulil, do you see Exhibit 11 as an
12 e-mail chain regarding lawsuit against LeapFrog from
13 hospitals in Palm Beach County by and among you and your
14 board and Ashley Tait-Dinger in May of 2025?

15 A. Yes.

16 Q. And if you could go down to your original e-mail
17 dated May 6, 2025, on the third-to-last page.

18 A. Okay.

19 Q. Do you see your e-mail there to your board with
20 copy to Ashley that initiates this chain?

21 A. Yes.

22 Q. And included in your e-mail to your board of
23 Florida employers, you included the same lists of the
24 plaintiff hospitals that Leah Binder included in her
25 e-mail, along with the LeapFrog spring 2025 grade for

1 the hospitals.

2 Do you see that?

3 A. Yes.

4 Q. And so when you send an e-mail to your board, you
5 expect them to hopefully read the e-mail; is that
6 correct?

7 A. Yes.

8 Q. And your board, as we walked through in a
9 back-of-the-napkin manner, might have an employee or
10 covered lives number in Florida around 100,000; is that
11 fair?

12 A. Yes. We came to that earlier.

13 Q. And here in this e-mail, you are alerting them to
14 the plaintiff hospitals with their LeapFrog spring 2025
15 grade next to them; do you see that?

16 A. Yes.

17 Q. And if you flip to the next page, do you see the
18 paragraph beginning, I asked what protection?

19 A. Yes.

20 Q. Farther down, you write in that paragraph, We
21 have not sent these hospital CEOs the requests to
22 complete this survey as it would likely fan the flames.

23 Do you see that?

24 A. Yes, I do see that.

25 Q. What do you mean by that?

1 A. So as it says also earlier in the letter, I did
2 have a call with the LeapFrog attorney a few days before
3 that and felt that it would upset the CEOs to receive
4 those letters. And now Leah had wanted us to go ahead
5 and to send those letters and -- after this time of
6 this -- after this was sent. And we waited and I had
7 forgotten -- I had forgotten there was a period of time
8 in there where we didn't want to do that. So then the
9 letters were eventually sent, because of the later
10 sentence there, Business as usual, not to change course.

11 Q. Understood. And so there was a decision
12 initially to not send the hospital CEOs a request to
13 complete the LeapFrog Hospital Survey?

14 A. Yes.

15 Q. And later, there was a change?

16 A. Yes.

17 Q. And LeapFrog -- and Florida Alliance did send
18 letters to the plaintiff hospitals asking them to
19 participate in the LeapFrog survey?

20 A. Yes.

21 MR. BILLEK: Scott, when you have a second, I
22 just need a two-second break for an urgent matter I
23 have to deal with. I'm sorry to interrupt you and I'm
24 not trying to jam up your -- so whenever you get a
25 minute.

1 MR. HVIDT: Totally understand. Mind if we
2 quickly finish this document? We're pretty close.

3 MR. BILLEK: Of course. Finish your topic.

4 Thank you.

5 BY MR. HVIDT:

6 Q. At the time of this e-mail, it wasn't yet clear
7 whether LeapFrog's counsel would be your counsel; is
8 that correct?

9 A. That's correct.

10 MR. HVIDT: I can pause there for you to go
11 deal with your matter.

12 MR. BILLEK: Thank you.

13 MR. HVIDT: We can go off the record.

14 THE VIDEOGRAPHER: We're off the record at 1:25
15 p.m.

16 (A brief recess was taken.)

17 THE VIDEOGRAPHER: We are on the record at 1:31
18 p.m.

19 BY MR. HVIDT:

20 Q. Looking back at the page in Exhibit 12 that we're
21 looking at --

22 A. I think we're looking at 11.

23 Q. We're looking at Exhibit 11, the page we're still
24 at, in the following paragraph that begins, We also
25 decided.

1 Do you see that?

2 A. Yes.

3 Q. In this paragraph, is it fair to say that you are
4 contemplating whether to include reference to this
5 lawsuit in the weekly bulletin sent to the Florida
6 employer members that you have? And if so, what amount
7 of information?

8 A. Yes. I was asking the board if we should alert
9 the employer members because you showed earlier, you
10 know, our members are displayed, you know, publicly, in
11 case they were contacted by the media or anyone so they
12 would know ahead of time and they would know who to
13 direct their questions to. I wasn't sure what to do. I
14 was asking for board guidance on that.

15 Q. And ultimately, you -- the decision was made to
16 include a reference in the weekly bulletin to the
17 lawsuit; is that correct?

18 A. Yes. The board members wanted us to do that.

19 Q. Handing you what's been marked as Exhibit 12 in
20 the van Caulil deposition.

21 (Exhibit No. 12 was marked for identification.)

22 BY MR. HVIDT:

23 Q. Which was produced in this litigation by Florida
24 Alliance as FHA0000001.

25 Do you see Exhibit 12 before you, Dr. van Caulil?

1 A. Yes.

2 Q. And what is Exhibit 12?

3 A. So I mentioned earlier in the deposition that we
4 communicate with our employer members via a weekly
5 bulletin. And this is the one that went out on May 9th.

6 Q. And so this weekly bulletin that went out on
7 May 9th was distributed to all of the Florida employer
8 members of the Florida Alliance for Healthcare Value; is
9 that correct?

10 A. Yes. Each of the employer members would have
11 received this via e-mail on that day.

12 Q. And earlier, we discussed that the employer
13 members of the Florida Alliance for Healthcare Value
14 represented approximately three to 400,000 Florida
15 employees or covered lives a few years ago and that
16 might be a fair approximation of where it sits today; is
17 that correct?

18 A. Yes.

19 Q. And if you flip through this document, which
20 hopefully has page numbers, to page 7. Do you see where
21 there's a blue banner that says, The LeapFrog Group?

22 A. Yes.

23 Q. And if you scroll down to the bottom of that
24 section, do you see where it says, As you may have
25 heard, a lawsuit has been filed against The LeapFrog

1 Group on behalf of five hospitals in Palm Beach County,
2 requesting that The LeapFrog Group suppress their grades
3 on the safety score website.

4 A. Yes.

5 Q. And then you go on to say if they have questions
6 or inquiries, to direct them to Karen Jupiter at The
7 LeapFrog Group; do you see that?

8 A. Yes.

9 Q. Are weekly bulletins prepared in the ordinary
10 course of Florida Alliance business?

11 A. Yes.

12 Q. You can set that to the side.

13 MR. HVIDT: Can we go off the record
14 momentarily?

15 THE VIDEOGRAPHER: We are off the record at
16 1:37 p.m.

17 (A brief recess was taken.)

18 THE VIDEOGRAPHER: We are back on the record at
19 1:39 p.m.

20 MR. HVIDT: Thank you.

21 BY MR. HVIDT:

22 Q. Dr. van Caulil, did you attend a board meeting in
23 June of this year for The LeapFrog Group?

24 A. Yes. I wasn't able to attend for the full time,
25 but I was there for a good portion of the meeting.

1 Q. And during that board meeting, was there a report
2 on the lawsuit?

3 A. I don't recall. I assume you're looking for the
4 minutes or agenda from it, so if I could refresh my
5 memory. Sorry the jump to conclusions, but --

6 Q. That one was helpful.

7 A. Yeah.

8 MR. HVIDT: And so I'm handing the witness
9 what's been marked as Exhibit 13 in the van Caulil
10 deposition, which is a document that was produced by
11 The LeapFrog Group on Sunday without Bates numbers and
12 we haven't yet received the Bates-copied version.

13 I'll note on the record an item for all the
14 documents produced by LeapFrog Group on Sunday that
15 don't have Bates numbers, that LeapFrog Group asks
16 that they be confidential, and so we'll have the
17 transcript be confidential while those portions are
18 designated as confidential moving forward.

19 Is that okay with you, Counsel?

20 (Exhibit No. 13 was marked for identification.)

21 MR. BILLEK: Yes.

22 BY MR. HVIDT:

23 Q. And, Dr. van Caulil, do you see that the top of
24 this document says, LeapFrog Group board meeting agenda?

25 A. Yes.

1 Q. And do you see the date of it is June 25, 2025?

2 A. Yes.

3 Q. And there's a location in person and a board
4 meeting Zoom link. Do you see that?

5 A. Yes.

6 Q. And is it the practice of The LeapFrog Group to
7 not memorialize and approve minutes at the subsequent
8 board meeting?

9 A. Yes. The practice is you would receive the
10 minutes from this June meeting at the September meeting.

11 Q. So it is the case that here, before the September
12 board meeting occurred, there would not have been
13 minutes at this meeting yet approved; is that correct?

14 A. That's correct. We have not received a draft
15 minutes or a board packet yet.

16 Q. And looking down at the agenda items, do you see
17 where it says five rows down, Executive session?

18 A. Yes.

19 Q. And then it says the -- in the discussion, The
20 board will meet in the executive session with counsel
21 and Leah and three members of the management team to be
22 briefed on a confidential legal matter.

23 Do you see that?

24 A. I do.

25 Q. As part of that discussion, do you recall there

1 being a PR message delivered to the board?

2 A. No, I don't recall. Public relations PR you're
3 saying?

4 Q. Correct.

5 A. No.

6 Q. Do you recall Lauren Bailey communicating --

7 A. Oh, Lauren did a presentation. Okay. I guess I
8 wouldn't have called that PR. But yes. Lauren did a
9 presentation.

10 Q. What would you call that presentation that Lauren
11 did?

12 A. Communications.

13 Q. Do you recall when Lauren gave that presentation
14 that there was a slide deck accompanying that
15 presentation?

16 A. Yes. There were slides, yes.

17 Q. And did the slides follow along with oral
18 communication that she gave to the board?

19 A. Yes.

20 Q. You can set that one to the side.

21 MR. HVIDT: I'm handing Dr. van Caulil a
22 document that's been marked as Exhibit 14, which was
23 produced in this litigation by LeapFrog as
24 LEAPFROG00402156, as previously marked as Bailey
25 Exhibit 42.

1 (Exhibit No. 14 was marked for identification.)

2 BY MR. HVIDT:

3 Q. Do you see that, Dr. van Caulil?

4 A. Yes, I do.

5 Q. And flipping through the document, and please
6 take your time, could you let us know if the message on
7 the page is consistent with what you recall being orally
8 communicated by Lauren Bailey at the board meeting?

9 A. Yes.

10 Q. Looking in the document, Exhibit 14, do you see
11 under slide 2 where it says, Slide 2?

12 A. Yes.

13 Q. Do you see where Lauren says, quote, We will make
14 it painful for Tenet by drawing further attention to
15 their very poor performance with strategic media
16 coverage and local and national press?

17 A. Yes.

18 Q. Is that consistent with the message that Lauren
19 gave to the board at the June 2025 board meeting?

20 A. To the best of my recollection, yes.

21 Q. Do you see down in that first page where it says,
22 Slide 7, and then there's three sub-bullets there?

23 A. Yes.

24 Q. And there's a bold part where he says, They say
25 we are weaponizing fear, distorting facts and misleading

1 the public.

2 Do you see that?

3 A. I do.

4 Q. And her response is, Our methodology is
5 100 percent transparent and completely unbiased.

6 Do you see that?

7 A. I do.

8 Q. Do you believe that the LeapFrog methodology is
9 completely unbiased?

10 A. I do.

11 Q. Do you have an understanding that the LeapFrog
12 safety grade expert panel does not agree that it's
13 completely unbiased?

14 A. No.

15 Q. Flipping over to the next page, do you see where
16 there's a reference to Slide 9?

17 A. Yes.

18 Q. And then three sub-bullets down, it says quote,
19 We also like to focus on the poor performance of these
20 hospitals earning a D and F.

21 Do you see that?

22 A. Yes.

23 Q. And so in this communication, is LeapFrog
24 equating a D and F to the poor performance of the
25 hospitals?

1 A. Is that a question?

2 Q. Yes. The question was, in this communication, is
3 LeapFrog staff equating to the board poor performance to
4 the hospitals receiving a D and an F?

5 A. Yes.

6 Q. And so when someone is communicating that the
7 hospitals received a D and an F, that's consistent with
8 trying to communicate that they are poor-performing
9 hospitals; is that correct?

10 A. Poor performing on the hospital safety grade,
11 yes.

12 Q. Looking at slides 10 and 11, Lauren references
13 how they've garnered 18 original stories about the
14 lawsuit.

15 Do you see that?

16 A. I do.

17 Q. When you heard the word -- or garnered, a similar
18 message, did you interpret that to mean that The
19 LeapFrog Group was taking efforts to put the lawsuit
20 into the press?

21 MR. BILLEK: Object to form.

22 You can answer.

23 THE WITNESS: I -- when I was hearing the
24 presentation, my interpretation was that both sides
25 were engaging the media heavily to get their story

1 across.

2 BY MR. HVIDT:

3 Q. You also mentioned earlier today that you had
4 read some references about the lawsuit in the press
5 before; is that correct?

6 A. Yes.

7 Q. And had you read about the Palm Beach Post
8 articles?

9 A. I -- I couldn't say specifically.

10 Q. Okay.

11 A. Sorry.

12 Q. Is it fair to say that there was local Florida
13 press about the lawsuit that highlighted the hospital's
14 D and F grades?

15 A. So it's an interesting question because I had to
16 look for it, you know, to Google, if you will, to be
17 able to pull up the articles. I didn't see anything in
18 the normal course of my engaging with the news media,
19 and I had board members and other people who knew about
20 this say, I haven't heard a thing. I haven't heard
21 anything. I haven't seen anything. I have a board
22 member who lives in Palm Beach County, I have other
23 employer members down there that said, I haven't seen
24 anything.

25 So while there was local Florida press about the

1 lawsuit, I don't know that it was pervasive. And I
2 don't know that it all had the grades in it, depending
3 on which side of the issue, plaintiff or the defendant,
4 were telling the story. So I just thought that was
5 interesting that most people in my circle hadn't seen or
6 heard anything about it. And that surprised me.

7 Q. In today's news cycles, there's a lot of news
8 happening. Is that fair to say?

9 A. Yes, there's a lot of news happening.

10 Q. And often when you -- we're no longer in the days
11 where we got a morning paper and that's a primary way
12 where we got the morning -- got the news; is that right?

13 A. Yes.

14 Q. And we're no longer in a day where there's three,
15 four nightly news stations that you tune into to get the
16 news for the day --

17 A. Yes.

18 Q. -- is that correct?

19 A. Yes, unfortunately that's the case.

20 Q. I agree that's unfortunate.

21 And so the fact that you need to search for news
22 that you're looking for doesn't mean that people aren't
23 consuming it?

24 A. Correct. But my point is that the people who I
25 thought would have heard about it hadn't, quote, seen

1 anything, their words, on it. If you go back to the
2 discussion we had about the board and what should we do
3 and say, I was concerned that, you know, they would read
4 about it in the media before hearing it from us and they
5 know we're a regional leader, we'd be associated in some
6 way.

7 Q. And I'll come back to that momentarily.

8 When you have those conversations with them, did
9 you fill them in about the lawsuit?

10 A. No.

11 Q. Flipping to the last page of this document before
12 we set it aside. Do you see in the second-to-last
13 paragraph, Lauren mentions your name. Do you see that?

14 A. I do.

15 Q. And what is Lauren referring to there?

16 A. So in July, I'm going to say mid July, the Bruce
17 Bradley fellows, are you familiar with that program in
18 LeapFrog? It's a fellowship that they have. They were
19 coming down to Florida, specifically to Orlando,
20 specifically to AdventHealth, to have their educational
21 session and such. And Leah had asked -- well, actually,
22 Joe Berger, who runs the regional leader program, asked
23 Ashley, my vice president, if she would attend that
24 meeting, Leah would be there, Jill would be there, the
25 fellows would be there, AdventHealth was going to do a

1 big presentation on their patient safety.

2 Ashley was unable to come for medical reasons.
3 She lives in the state of Washington right now. So I
4 was to attend. And so Leah said to me, or somebody on
5 her staff said Leah has had a conversation with the CEO
6 of Jupiter Medical Center. She was thanking them for
7 their straight As. And in the course of the
8 conversation mentioned the Florida Alliance and the CEO
9 is not familiar with your organization. And Leah
10 thought it might be a good opportunity when she's in
11 Florida to go down to Jupiter Medical Center, learn from
12 them what they've done to be able to achieve straight As
13 and have me and an employer member or two come along to
14 talk about the Florida Alliance.

15 And so I said that, you know, I would -- I would
16 be able to do that. And I had a couple of employer
17 members who are willing to attend. I -- my intent in
18 the meeting for us was to be able to educate about the
19 Florida Alliance. We do a lot, a lot more than
20 LeapFrog. It's a very small percent of the work that we
21 do. And hospital CEOs like to meet with employers in an
22 area and use it as that opportunity, not to, you know,
23 really get into any kind of LeapFrog discussion.

24 The meeting was subsequently canceled. Leah did
25 not come to Florida at all. She had -- I believe it was

1 her brother having surgery and so she reached out to me
2 and said that the meeting was canceled. I could go
3 ahead if I wanted to and meet with them. But as this
4 lawsuit was progressing, I was not really feeling
5 comfortable with going down to Palm Beach and having my
6 employers brought into the mix in case anything had come
7 up about the lawsuit.

8 So I was fine with the meeting being canceled.
9 We had no prep calls. I never rescheduled and there's
10 been nothing further.

11 Q. You mentioned that your intent behind the meeting
12 was to connect your employer members to a CEO who wasn't
13 aware of the Florida Alliance.

14 A. That's correct.

15 Q. What -- thank you.

16 A. Sorry.

17 Q. What was -- what was communicated to you from
18 LeapFrog as to what their intent was for the meeting?

19 MR. BILLEK: Just note my objection.

20 You can answer.

21 THE WITNESS: Leah told me and then also in
22 this meeting, the board meeting, that it was to
23 highlight and spotlight and congratulate Jupiter
24 Medical Center on their achievement. I learned that
25 they were setting up media interviews, and I did say

1 that we would not be participating in anything like
2 that.

3 BY MR. HVIDT:

4 Q. Did LeapFrog communicate to you that they were
5 trying to keep LeapFrog in the news in Palm Beach
6 County?

7 A. I don't remember them saying it that way and that
8 that would be a way to do that, so no.

9 Q. Did LeapFrog communicate to you that they were
10 trying to portray Jupiter in contrast to plaintiff
11 hospitals in the media and with employers?

12 A. I would say yes.

13 Q. And in one of the -- and in trying to contrast
14 Jupiter Medical Center with the plaintiff hospitals, did
15 LeapFrog want to contrast Jupiter's A LeapFrog grade
16 with plaintiff hospital's D and F LeapFrog grades?

17 MR. BILLEK: Object to form.

18 You can answer.

19 THE WITNESS: I don't know what their plan was
20 for that. The gist of the message was, here's a
21 straight A hospital in an area where we have several
22 hospitals who haven't achieved that level of success
23 with our grading. So what are you doing differently
24 and innovatively around patient safety and quality
25 that we can learn from and perhaps share?

1 BY MR. HVIDT:

2 Q. You can set that document to the side.

3 A. The pile's getting a little smaller.

4 Q. That, it is.

5 A. It's getting higher over here.

6 Q. Did the Florida Alliance reach out to its -- some
7 of its members to see if they would be willing to
8 participate in the meeting with Jupiter Medical Center?

9 A. Yes, I did.

10 MR. HVIDT: I've handed the witness what has
11 been produced in this litigation by Florida Alliance
12 as FHA0000907.

13 (Exhibit No. 15 was marked for identification.)

14 THE WITNESS: Yes.

15 BY MR. HVIDT:

16 Q. Do you see Exhibit 15 in front of you?

17 A. I do.

18 Q. And what is Exhibit 15?

19 A. So this is an e-mail that Lisa Hain sent to check
20 in with Nancy Bolton, who is the benefits person at Palm
21 Beach schools, to see if she's available to attend that
22 meeting at Jupiter Medical Center. We already had Susan
23 McBroom, who we talked about earlier today, at Patriot
24 Rail, who had said that she would attend. And she sent
25 that on July 1st. I was in Europe at the time.

1 Q. And earlier today, we talked about Lisa Hain's
2 role with Florida Alliance. Do you recall that?

3 A. Yes.

4 Q. And you said that she performs an administrative
5 role and will coordinate communication. Is that fair?

6 A. I wouldn't say she coordinates communication.
7 She supports us in our communication effort.

8 Q. And so when -- before we presented you with
9 Exhibit 15, you mentioned that you sent a message to
10 some of your Florida employer members about
11 participating in the meeting with Jupiter Medical
12 Center. Do you recall that?

13 A. Yes.

14 Q. And so when Lisa is the actual sender of this
15 e-mail, did you direct her to send this e-mail?

16 A. So I don't recall that. As I said, I was on
17 vacation. I was in Scandinavia at the time. And I
18 think that I sent e-mails before I left, which would
19 have been -- I think I left June 28th for vacation. And
20 then when either I wasn't hearing from people or they
21 couldn't respond, it could be that Ashley worked with
22 her on this. I don't recall whether I would have
23 e-mailed while I was away. So, I'm sorry, I don't
24 recall. But it was due to the fact that I was -- I was
25 out of pocket.

1 Q. Would either you or Ashley have been the one
2 to -- directed the communication that Lisa Hain sent
3 here?

4 A. Yes.

5 Q. And the substance of the message from Lisa Hain,
6 is that a substance that would have been communicated
7 for her to send by either you or Ashley?

8 A. Yes.

9 Q. And in the message, you're reaching out to Palm
10 Beach schools and Nancy Bolton specifically. Why are
11 you reaching out to Palm Beach schools?

12 A. Because the meeting was going to be in Palm Beach
13 County.

14 Q. And would the meeting being in Palm Beach County
15 also relate to the notion that Jupiter is in Palm Beach
16 County?

17 A. Yes.

18 Q. And would the nature of the meeting in Palm Beach
19 County relate to that the five plaintiff hospitals are
20 in Palm Beach County?

21 A. I would say much less than -- than the issue that
22 Jupiter Medical Center is in Palm Beach County. As I
23 said a few minutes ago, my intent for the meeting was to
24 get to know the CEO, and I presume other team members,
25 who would come so that we could educate them about the

1 Florida Alliance and see where there were opportunities
2 to collaborate.

3 Q. You didn't initiate the meeting request, it
4 wasn't your idea --

5 A. No.

6 Q. -- to come up with the idea for the meeting; is
7 that correct?

8 A. That's correct.

9 Q. Was it LeapFrog's idea to have that meeting?

10 A. I don't know whose idea it was. I don't know
11 whether it came from Jupiter Medical Center or
12 originated from LeapFrog. I don't know.

13 Q. And in this message that was sent, do you see --
14 can you read into the record the last sentence of that
15 main paragraph of the e-mail?

16 A. The purpose of the meeting is to recognize and
17 thank Jupiter Medical Center for the straight As they
18 received as part of the spring LeapFrog Hospital Safety
19 Grades when there are five other hospitals in the county
20 with Ds and Fs.

21 Q. Thank you.

22 And when it references that there are five other
23 counties -- five other hospitals in the county with Ds
24 and Fs, is that a reference to the plaintiff hospitals?

25 A. Yes.

1 Q. Why did Florida Alliance feel a need to include
2 reference to the notion that there are five other
3 hospitals in the county with Ds and Fs?

4 A. I don't recall.

5 Q. And is Palm Beach schools an employer of a decent
6 amount of covered lives in Palm Beach County?

7 A. Yes.

8 Q. And in connecting Palm Beach schools with Jupiter
9 Medical Center, is there a goal to direct Palm Beach
10 schools to have their employees go to Jupiter Medical
11 Center over the five plaintiff hospitals?

12 A. No.

13 Q. Is it a possibility that upon being informed that
14 Jupiter Medical Center gets straight As, in comparison
15 to five hospitals in Palm Beach County that get Ds and
16 Fs from LeapFrog, that Nancy Bolton might direct her
17 employees to go to Jupiter Medical Center instead of the
18 five plaintiff hospitals?

19 A. I don't know whether Nancy Bolton or her
20 leadership would do that.

21 Q. Is it a possibility that upon being informed that
22 Jupiter Medical Center gets straight As, in comparison
23 to five hospitals in Palm Beach County that gets Ds and
24 Fs from LeapFrog, that Nancy Bolton might direct her
25 employees to go to Jupiter Medical Center instead of

1 five plaintiff hospitals?

2 MR. BILLEK: Object to the form of the
3 question.

4 You can answer.

5 THE WITNESS: I don't know if it's a
6 possibility. I don't know if it's a possibility
7 because I don't know what their plan states or their
8 benefit design or their contracts. So I don't know if
9 it's a possibility.

10 BY MR. HVIDT:

11 Q. Is that the intent that LeapFrog had behind this
12 meeting, in juxtaposing Jupiter with plaintiff
13 hospitals?

14 MR. BILLEK: Object to form.

15 You can answer.

16 THE WITNESS: I don't know what the intent was
17 of LeapFrog beyond what I said which was to highlight
18 their -- Jupiter Medical Center's straight As and to
19 give us an opportunity to introduce ourselves.

20 BY MR. HVIDT:

21 Q. But when you were at a board meeting in June of
22 2025, did Lauren Bailey communicate to the board and
23 yourself that LeapFrog wanted to make it painful for
24 Tenet?

25 A. Yes. That was stated.

1 Q. So is it possible that the effort to set up a
2 meeting with Jupiter Medical Center and Florida
3 employers highlighting Jupiter Medical Center's LeapFrog
4 straight As with plaintiff hospitals' Ds and Fs, that
5 that was one of the ways that LeapFrog was trying to
6 make it painful for Tenet?

7 MR. BILLEK: Object to form.

8 THE WITNESS: I don't recall that I make that
9 connection. If LeapFrog wants to highlight a
10 high-performing hospital and give us an opportunity to
11 create a relationship with a hospital, a health system
12 or whoever, who we haven't had the opportunity to work
13 with, I don't translate that to being pain for the
14 other hospitals.

15 BY MR. HVIDT:

16 Q. But LeapFrog's communicated to you that that was
17 their intent behind this meeting; is that correct?

18 A. That was not my intent for the meeting.

19 Q. But did LeapFrog communicate to you that that was
20 their intent for the meeting?

21 MR. BILLEK: Just note my objection to the
22 form.

23 THE WITNESS: No, they did not communicate to
24 me that the intent for the Jupiter meeting was to
25 cause any harm or pain to the five hospitals. It was

1 to spotlight, thank Jupiter Medical Center because
2 you're in a county where not everybody is able to
3 achieve that high level of grade consistently. What
4 is it that you are doing that is innovative and
5 effective that we can learn from? I mean, they're
6 also a 501(c)(3) organization just like the Florida
7 Alliance. And these types of meetings can put a
8 spotlight on things that can be shared broadly.

9 So to me, when it was posed as an opportunity,
10 that's what I saw could happen at the meeting.

11 However, we never had the meeting.

12 BY MR. HVIDT:

13 Q. You never had the meeting but you did have
14 reach-outs to Florida employers, correct?

15 A. I reached out. My staff reached out to Florida
16 employers who live or work in Palm Beach County to see
17 if they were interested in meeting at the hospital.

18 Q. And in those correspondences, you noted that five
19 of the hospitals in Palm Beach County have Ds and Fs, in
20 comparison to Jupiter Medical Center's As; is that
21 correct?

22 A. Yes. That's correct.

23 Q. And -- let's look at another one of those
24 correspondence.

25 Did Nancy Bolton respond to this outreach, do you

1 recall?

2 A. I don't recall. She -- if she did respond, she
3 couldn't make it.

4 MR. HVIDT: I'm handing the witness what's been
5 marked as Exhibit 16, which was produced by Florida
6 Alliance as --

7 THE WITNESS: Oh, okay.

8 (Exhibit No. 16 was marked for identification.)

9 MR. HVIDT: -- FHA0000913, which is the e-mail
10 chain, Re: Join Karen at Jupiter Medical Center
11 July 16th between Lisa Hain and Karen van Caulil at
12 the top.

13 BY MR. HVIDT:

14 Q. Do you see that?

15 A. Yes.

16 Q. And if you flip down to the second page, do you
17 see the response from Nancy Bolton there in the middle?

18 A. Yes, I see it now that she was unable to make the
19 meeting.

20 Q. But in responding to the e-mail, is it fair to
21 say that she had received and consumed the e-mail that
22 was sent to her?

23 MR. BILLEK: Object to form.

24 THE WITNESS: Nancy responded to Lisa's e-mail
25 on July 1st saying she had a school board meeting that

1 day and unable to attend. So I would interpret that
2 as her having read Lisa's e-mail.

3 MR. HVIDT: Thank you.

4 And I'm now handing the witness what's been
5 marked as Exhibit 17, which was produced in this
6 litigation by Florida Alliance as FHA0002804.

7 (Exhibit No. 17 was marked for identification.)

8 MR. HVIDT: Exhibit 17 at the top is an e-mail
9 chain between Ashley Tait-Dinger, Karen van Caulil
10 regarding, Join Karen at Jupiter Medical Center July
11 16, 1:00 p.m. to 3:00 p.m.

12 BY MR. HVIDT:

13 Q. Do you see that?

14 A. Yes.

15 Q. If you flip back to your -- origin of this
16 e-mail, do you see on July 1, 2025, Lisa Hain e-mailed
17 Rosa Novo? Do you see that?

18 A. Yes.

19 Q. And Rosa Novo is the chair of the Florida
20 Alliance board; is that correct?

21 A. Yes.

22 Q. And in this message that was sent, does this
23 message mirror what we looked at in Exhibit 15?

24 A. Yes.

25 Q. And there in that sentence, at the end of that

1 main paragraph, Florida Alliance references Jupiter
2 Medical Center's straight As and then says, When there
3 are five hospitals in a county with Ds and Fs.

4 Do you see that?

5 A. Yes.

6 Q. And Rosa Novo works with Miami-Dade schools; is
7 that correct?

8 A. Correct.

9 Q. And how many covered lives or employees do you
10 recall they had?

11 A. Yeah. That was like 45 or 50,000, I believe I
12 said at the time.

13 Q. And in this message, Florida Alliance is
14 communicating to Rosa that plaintiff hospitals have Ds
15 and Fs and is contrasting that with Jupiter Medical
16 Center's straight As; is that correct?

17 A. I'm sorry? Could you say that again? I was --

18 Q. Yeah. Going back to the original e-mail. In
19 this message, Florida Alliance is communicating to Rosa
20 Novo that plaintiff hospitals have Ds and Fs and is
21 contrasting that with Jupiter Medical Center's straight
22 As.

23 Is that correct?

24 A. So the e-mail does not say it's the plaintiff
25 hospitals. It just says there are five other hospitals

1 in the county with Ds and Fs. That doesn't make any
2 reference to the five hospitals or that they are the
3 ones that are -- that have filed a lawsuit.

4 Q. It doesn't refer to them by name; is that
5 correct?

6 A. That's correct.

7 Q. But are the five -- is the intent here behind
8 Florida Alliance's communication to five other hospitals
9 in the county with Ds and Fs are the five plaintiff
10 hospitals?

11 A. It is referencing the five -- that there are five
12 other hospitals in the county with Ds and Fs. That's
13 what it says. But it does not call them out and it does
14 not point out that it's those five that happen to be in
15 the lawsuit.

16 Q. And -- but it does reference that there are five
17 other hospitals in the county with Ds and Fs?

18 A. Yes, it does.

19 Q. And is LeapFrog's intent in setting up this
20 meeting to contrast an A grade hospital with D and F
21 grade hospitals?

22 A. I don't know if it's LeapFrog's intent at the
23 time to do that.

24 Q. And Rosa responds saying she can't attend; is
25 that correct?

1 A. Correct.

2 Q. And then Lisa updates you that Rosa is not able
3 to attend; is that right?

4 A. That's correct. Which I felt was unfortunate
5 because of her being board chair.

6 Q. And you ask -- excuse me, strike that.

7 Lisa then references to you on July 4th that
8 there's no word from MAPEI. Do you see that?

9 A. Yes.

10 Q. What is MAPEI?

11 A. So that's another employer member down in the
12 same area. I can't remember what language it's an
13 acronym for but maybe Italian, the different letters.
14 They're like a manufacturing industrial glues and
15 adhesives and such, so...

16 Q. Do you have any -- are they in the Palm Beach
17 County area?

18 A. Yes.

19 Q. Do you have any understanding of how many covered
20 lives or employees they have?

21 A. I would say less than 1,000.

22 Q. And then moving forward, you write to Ashley on
23 July 4th, I hate to even suggest this but should I see
24 if FPL would like to attend?

25 You see that?

1 A. Yes.

2 Q. What's FPL?

3 A. Florida Power & Light. They're not a member of
4 the Florida Alliance.

5 Q. Okay. And then --

6 A. I wanted to keep it to employer members, but knew
7 that they were located in the county as their
8 headquarters.

9 Q. And after discussion of that idea, you suggest
10 maybe Melissa Miller; do you see that on the first page?

11 A. Yes.

12 Q. Who's Melissa Miller?

13 A. So she is with -- or had been with Florida
14 Power & Light. I was just clarifying to Ashley that I
15 was not thinking of this other person, Michael, who we
16 had been working with. Melissa had served as our board
17 vice chair and was in a different position at FPL. I
18 didn't take it further than that.

19 Q. There was no reach-out to --

20 A. No.

21 Q. -- Melissa Miller?

22 A. No. Stopped right there, yes.

23 Q. How many -- do you recall how many employer
24 members you reached out to about attending this meeting?

25 A. Rosa and Nancy, Elissa from MAPEI, Marcia from

1 Lennar, Susan McBroom from Patriot Rail. I think that's
2 it.

3 Q. I'm handing you what's been marked as Exhibit 18
4 to this deposition. And Exhibit 18 was produced by
5 Florida Alliance as FHA0000921.

6 (Exhibit No. 18 was marked for identification.)

7 BY MR. HVIDT:

8 Q. And it is an e-mail from Lisa Hain to Elissa
9 Cadovius?

10 A. Cadovius.

11 Q. And Barbara Ramos regarding, Join Karen at
12 Jupiter Medical Center July 16, 1:00 p.m. to 3:00 p.m.

13 Do you see that?

14 A. Yes.

15 Q. And is the substance of this message to Elissa
16 and Barbara consistent with the message that was
17 conveyed to Rosa Novo and Nancy Bolton in Exhibit 17 and
18 15 respectively?

19 A. Yes.

20 Q. And in this message, again, it references Jupiter
21 Medical Center's straight As from the LeapFrog Hospital
22 Safety Grade when there are five other hospitals in the
23 county with Ds and Fs.

24 Do you see that?

25 A. Yes.

1 Q. You can set that to the side. Thank you.

2 You mentioned Lennar. Did I say it right?

3 A. Lennar Homes, yes.

4 Q. Lennar Homes?

5 A. Yes.

6 Q. Do you have an understanding of how many covered
7 lives Lennar Homes has?

8 A. That's one of the employer members who gives like
9 national, international numbers. And I don't know that
10 I have offhand Florida, I would say it's maybe 2,000 in
11 Florida.

12 Q. You also mentioned Patriot Rail, and a
13 representative of Patriot Rail sits on your board; is
14 that correct?

15 A. Yes.

16 Q. And earlier we talked about how they might have a
17 few hundred Florida employees or covered lives; is that
18 correct?

19 A. Correct.

20 Q. And why -- why, again, were you targeting -- or
21 do all those Florida employers you were talking about
22 have a presence in Palm Beach County?

23 A. All of them except for Patriot Rail. Susan
24 McBroom lives in Palm Beach County. If they have lives
25 in Palm Beach County, it's a very small number.

1 Q. Patriot Rail might be a little bit further south
2 in Florida?

3 A. No, out of Jacksonville predominantly.

4 Q. Oh, Jacksonville.

5 A. Its short rail, railroad, I don't really know
6 what that really means, but that's what I've been told.

7 Q. Don't they connect to the big ones?

8 A. I think so.

9 Q. And did you ever reach out to Florida bankers
10 regarding the meeting as well?

11 A. I guess I might have, yeah. I -- I don't
12 remember if we did or not. They do have banks in South
13 Florida. As I mentioned, there are multiple employer
14 welfare arrangements as well with many, many banks.

15 MR. HVIDT: And I've handed the witness what's
16 been marked as Exhibit 19 to this deposition, which
17 was produced by Florida Alliance as FHA0001749 and is
18 a May 8, 2025, e-mail from Ashley Tait-Dinger to Lisa
19 Hain regarding contacts.

20 (Exhibit No. 19 was marked for identification.)

21 BY MR. HVIDT:

22 Q. Do you see that?

23 A. Yes.

24 Q. And then Ashley Tait-Dinger writes, Can you send
25 me the main contacts' e-mails for the following?

1 Do you see that?

2 A. Yes.

3 Q. And then lists Palm Beach - Nancy Bolton. Do you
4 see that?

5 A. Yes.

6 Q. And then it notes Lennar - not sure who this is?

7 A. Yes.

8 Q. And then it says MAPEI - not sure who this is?

9 And then it says Banker - Adella.

10 Do you see that?

11 A. Yes.

12 Q. And then do you see where she writes, I need to
13 contact them about the LeapFrog lawsuit?

14 A. Yes, I see that.

15 Q. Do you have an understanding of whether Florida
16 Alliance contacted each of those Florida employer
17 members of Florida Alliance about the LeapFrog lawsuit?

18 A. No, I don't.

19 Q. And are these communications that we've been
20 looking at the contacts' e-mails that Ashley Tait-Dinger
21 was looking for those contact information for?

22 A. Are you asking about for the Jupiter meeting?

23 Q. Yes.

24 A. No, I don't think so. I don't think that the
25 invitation to the Jupiter meeting was till weeks after

1 that, probably in -- probably in June.

2 Q. Did you ask Ashley Tait-Dinger to reach out to
3 those Florida employer members about the lawsuit?

4 A. I don't recall doing that. We talked earlier
5 about the dialogue with the board on how to inform the
6 members and it could be that this didn't happen and it
7 deferred to the weekly bulletin correspondence. I'm not
8 familiar with this e-mail.

9 Q. I'm handing you what's been marked as Exhibit 20
10 to the van Caulil deposition, which is produced in this
11 litigation as LEAPFROG00792177.

12 At the top of the document is an e-mail chain
13 between Lauren Bailey, Karen van Caulil, Leah Binder,
14 Angela Hopkins, Karen Jupiter, regarding Jupiter Medical
15 Center.

16 Do you see that, Dr. van Caulil?

17 (Exhibit No. 20 was marked for identification.)

18 THE WITNESS: Yes.

19 BY MR. HVIDT:

20 Q. If we could walk this back to the original e-mail
21 in this chain on Bates number ending 2180.

22 A. Yes.

23 Q. The e-mail on this chain that started it was from
24 Leah Binder; is that correct?

25 A. Yes.

1 Q. And it's dated May 28th. Do you see that?

2 A. Yes.

3 Q. And she writes, You may recall we spoke about
4 planning a visit of you and some of your members and me
5 to Jupiter Medical Center, one of the straight A
6 hospitals.

7 Do you see that?

8 A. Yes.

9 Q. Do you recall when you spoke with Leah Binder
10 about planning a visit between you and her and some of
11 the Florida Alliance members to Jupiter Medical Center
12 that predated May 28, 2025?

13 A. I think that we spoke just before that, only
14 maybe days before. I don't recall the exact date. She
15 called me and asked me if I would be interested. It was
16 a very short conversation.

17 Q. And she writes that the CEO of Jupiter Medical
18 Center is excited about the visit and is interested in
19 setting up this meeting; is that correct?

20 A. That's what it says.

21 Q. And forwarding along in this e-mail to the page
22 number ending 2178, do you see your e-mail dated
23 June 16, 2025?

24 A. Yes.

25 Q. And you wrote that you have an enthusiastic yes

1 from Susan McBroom, the director of human resources at
2 Patriot Rail.

3 Do you see that?

4 A. Yes.

5 Q. And you also referenced the -- you're waiting to
6 hear back from Nancy Bolton at Palm Beach schools.

7 Do you see that?

8 A. Correct. Yes.

9 Q. And then carrying forward, you respond that
10 Shannon Chamberlain from Lennar Homes is also attending.
11 Do you see that, on June 19th?

12 A. Yes.

13 Q. And so is it correct that before the meeting was
14 canceled, you had a commitment to attend the meeting
15 from two of your Florida employer members; is that
16 correct?

17 A. That's correct.

18 Q. And those were Lennar Homes and Patriot Rail?

19 A. Correct.

20 Q. And in response to your e-mail, Lauren Bailey
21 responds the next day, I'm going to reach out to their
22 PR team today to kick off planning.

23 Do you see that?

24 A. Yes.

25 Q. Did you interpret the their PR team to be Jupiter

1 Medical Center's PR team?

2 A. Yes.

3 Q. And you had mentioned that you did not intend to
4 participate in the PR component; is that correct?

5 A. That's correct.

6 Q. Did your intention of not participating in the PR
7 component stop -- was that communicated before June 20,
8 2025?

9 A. I communicated that from the outset. As soon as
10 I heard that there was going to be any level of media,
11 it might have been at the board meeting the first time I
12 heard that. I said that I would not participate nor put
13 my employers in a position like that. And Leah said she
14 understood.

15 Q. And LeapFrog intended to continue with the PR
16 effort, even if it didn't include the Florida members in
17 that PR component?

18 A. I don't know if they were going to continue
19 without us. I just made it clear that we were not
20 participating.

21 Q. If you had communicated to Leah at the board
22 meeting earlier in June that you had intended not to
23 have your members participate in the LeapFrog -- in the
24 PR effort regarding the meeting and on June 20, 2025,
25 Lauren Bailey's communicating a plan to reach out to

1 Jupiter Medical Center's PR team today to kick off
2 planning, does that indicate that LeapFrog was --
3 continued to go ahead with PR planning for the meeting
4 with Jupiter Medical Center even after you communicated
5 your intent not to participate in such PR planning?

6 A. It looks like that was Lauren's plan. I don't
7 know if she went ahead and did that, but it looks like
8 that's her plan.

9 MR. HVIDT: I'm handing the witness what's been
10 marked as Exhibit 21 to the van Caulil deposition.
11 The exhibit was produced in this litigation as
12 FHA0002195. And the top e-mail is from Karen van
13 Caulil to Ashley Tait-Dinger regarding Jupiter Medical
14 Center dated May 28, 2025.

15 (Exhibit No. 21 was marked for identification.)

16 BY MR. HVIDT:

17 Q. Do you see that?

18 A. Yes.

19 Q. Was this e-mail sent in the ordinary course of
20 business?

21 A. Yes.

22 Q. And if you flip to the e-mail that originated
23 this chain, do you see the e-mail that was in a prior
24 exhibit that we looked at from Leah Binder to you
25 regarding this Jupiter Medical Center meeting?

1 A. Yes.

2 Q. And again, she references a conversation that she
3 had with you predating this May 28, 2025, e-mail; is
4 that correct?

5 A. Yes.

6 Q. And you forwarded that e-mail to Ashley
7 Tait-Dinger on May 28, 2025, on the second page.

8 Do you see that?

9 A. Yes.

10 Q. And then Ashley Tait-Dinger replies, I thought
11 the meeting was with AdventHealth in June.

12 Do you see that?

13 A. Yes.

14 Q. And you write back on May 28, 2025. Can you read
15 in the record your e-mail?

16 A. Yes. This is something different. Leah wants to
17 highlight Jupiter Medical Center's A safety grade
18 because of the lawsuit and poor performing hospitals in
19 Palm Beach County.

20 Q. Does reading this e-mail refresh your
21 recollection that Leah communicated to you that she
22 wants to highlight Jupiter Medical Center's A safety
23 grade because of the lawsuit and poor performing
24 hospitals in Palm Beach?

25 A. Well, I hadn't recalled that I had said that in

1 an e-mail, so obviously my statements earlier, I need to
2 amend. She must have said at some point to me that that
3 was her intent. And I hadn't remembered that. Because
4 subsequent discussions were about when we had the
5 follow-up call was to really highlight their straight A
6 performance.

7 Q. And so before your e-mail on May 28, 2025, you're
8 communicating that when Leah spoke with you, she
9 communicated to you that she wanted to highlight Jupiter
10 Medical Center's A safety grade because of the lawsuit
11 and poor performing hospitals in Palm Beach County; is
12 that correct?

13 A. I don't recall the exact conversation, but I
14 don't see myself writing that sentence if I didn't feel
15 that at the time.

16 Q. And you mentioned earlier that you recalled that
17 the conversation you had with her was shortly before the
18 May 28th e-mail from her to you that starts this chain;
19 is that correct?

20 A. Yes. I don't remember the exact date. It was a
21 brief conversation and it was supposed to have a more
22 detailed follow-up which never happened. There was a
23 planning meeting set, and I think on the Jupiter end
24 they had to reschedule it so it never was rescheduled.

25 Q. And you didn't think that the meeting was a good

1 idea from the outset; is that correct?

2 A. No. It's not entirely correct. Initially, I
3 thought it would be a good opportunity to be able to
4 meet the Jupiter Medical Center CEO and his leadership
5 team and as the days and weeks progressed and I
6 discussed this with Ashley, we thought that it probably
7 would be best not to do it while the lawsuit was going
8 on, that it probably made more sense to wait until a
9 later date and hope that we could reengage.

10 Q. And why would having a meeting with Jupiter
11 Medical Center highlighting its A LeapFrog grade not be
12 a good idea while the lawsuit was pending?

13 MR. BILLEK: Object to form.

14 You can answer that again.

15 THE WITNESS: So, you know, you can't control
16 where a conversation is going to go before you have
17 it. And as Ashley and I continued to talk about it,
18 it just made sense to stick with what we were saying
19 to everybody else, which was to, you know, kind of
20 stay out of any kind of discussions about the matters
21 of the lawsuit. And in case it came up, didn't want
22 to put my employers in that position.

23 BY MR. HVIDT:

24 Q. I'm handing you what's been marked as Exhibit 22
25 in the van Caulil deposition, which was produced in this

1 litigation as FHA0002516.

2 (Exhibit No. 22 was marked for identification.)

3 BY MR. HVIDT:

4 Q. It is an e-mail chain between -- at the top
5 between Ashley Tait-Dinger and Karen van Caulil dated
6 July 7, 2025, Re: Visit to Jupiter Medical Center.

7 Do you see that?

8 A. Yes.

9 Q. And if you'd go to the original e-mail in this
10 chain on the last page, let me know when you're there.

11 A. I'm here.

12 Q. And so did you get an e-mail from Leah Binder on
13 July 7, 2025, Re: Visit to Jupiter Medical Center?

14 A. Yes.

15 Q. And in the second sentence of the e-mail, does
16 Leah Binder tell you -- or strike that.

17 The first sentence of the e-mail, Leah Binder
18 informs you that she's not going to be able to make the
19 trip to Florida. Do you see that?

20 A. Yes.

21 Q. And the second sentence references what we talked
22 about earlier as relates to her brother needing surgery.
23 Do you see that?

24 A. Yes.

25 Q. And then what's the third sentence say, if you

1 could read that into the record, please?

2 A. In addition, the timing is not right for me to be
3 in Florida in terms of some legal issues.

4 Q. Do you have an understanding of what she was
5 referencing there?

6 A. No, not specifically.

7 Q. Were you aware that as of July 7th, LeapFrog was
8 maintaining that the court that is housing this
9 litigation didn't have jurisdiction over the LeapFrog
10 Group?

11 A. No, I'm not aware.

12 Q. Were you aware that at this time, the LeapFrog
13 Group was claiming that it didn't direct business into
14 Florida?

15 A. I'm not understanding directing business into
16 Florida. No, I'm not aware of that.

17 Q. And then forwarding on in the e-mail chain,
18 there's an e-mail from Ashley Tait-Dinger to you and
19 potentially to Lisa Hain, but it's not clear whether
20 she's on it or not, on July 7th at 9:35 p.m., that
21 begins on the first page and then goes on to the second.

22 Do you see that?

23 A. Yes.

24 Q. She says, Just to you. So this has actually
25 removed Lisa Hain. Does that make sense?

1 A. Yes.

2 Q. And she writes, Leah e-mailed me too. Shocking
3 counsel did not think this was good timing...but let us
4 do it...oh, I thought we were covered under your
5 insurance...if you were told not to, why would we be
6 allowed?

7 Do you see that?

8 A. Yes.

9 Q. What did you interpret her to mean?

10 A. I didn't understand her e-mail. I was still out
11 of the country at the time. And Ashley will send
12 e-mails that are a little hard to follow with stream of
13 consciousness. My interpretation of it was we all came
14 to the same conclusion, that the meeting should not
15 proceed.

16 Q. And you responded, quote, I am relieved it is
17 canceled.

18 Do you see that?

19 A. Yes.

20 Q. And can you explain why you were relieved it is
21 canceled?

22 A. I think I've already answered that. I didn't
23 want to put my employer members in a difficult position
24 when I was also hearing about media and what might
25 happen at the meeting. I just thought it would be best.

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1 And Leah offered. She said if you want to go
2 ahead with the meeting without me, you can do that. But
3 I, as I said, was like, let's reschedule for a later
4 time.

5 Q. And Ashley Tait-Dinger replied, Yes, me too, I
6 thought the whole thing was a bad idea.

7 Do you see that?

8 A. I do see that.

9 Q. Do you agree with her?

10 MR. BILLEK: Object to form.

11 You can answer.

12 THE WITNESS: I had already said I was fine
13 with it being canceled.

14 MR. HVIDT: If we could go off record for a
15 minute.

16 MR. BILLEK: Sure.

17 THE VIDEOGRAPHER: We are off the record at
18 2:46 p.m.

19 (A brief recess was taken.)

20 THE VIDEOGRAPHER: We are on the record at 2:55
21 p.m.

22 MR. HVIDT: Counsel for plaintiffs rest and
23 reserve.

24 MR. BILLEK: I have nothing further. I don't
25 have anything at all.

1 THE VIDEOGRAPHER: This concludes the
2 deposition. We are off the video record at 2:55 p.m.

3 MR. BILLEK: We will order in the same speed
4 and information that plaintiff orders.

5 (The deposition was concluded at 2:55 p.m.)
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CERTIFICATE OF OATH

STATE OF FLORIDA)

COUNTY OF ORANGE)

I, MAE FISHER, Registered Merit Reporter,
Certified Realtime Reporter and Notary Public, State of
Florida, certify that KAREN VAN CAULIL personally
appeared before me on September 25, 2025, and was duly
sworn/affirmed.

WITNESS my hand and official seal this 29th day
of September, 2025.



MAE FISHER, RMR, CRR

Notary Public - State of Florida

Commission HH 443649

Expires: January 8, 2028

Personally known _____

OR Produced Identification X _____

Type of Identification Produced Driver's license

1 TRANSCRIPT CERTIFICATE
2 STATE OF FLORIDA)
 COUNTY OF ORANGE)
3
4 I, MAE FISHER, Registered Merit Reporter,
 Certified Realtime Reporter and Notary Public, State of
5 Florida, certify that I was authorized to and did
 stenographically report the deposition of Karen van
6 Caulil; that a review of the transcript was not
 requested; and the foregoing transcript, pages 5 through
7 180, is a true record of my stenographic notes.
8 I FURTHER CERTIFY that I am not a relative,
 employee, attorney, or counsel of any of the parties,
9 nor am I a relative or employee of any of the parties'
 attorney or counsel connected with the action, nor am I
10 financially interested in the action.

11
12 DATED this 29th day of September, 2025, at
13 Orlando, Orange County, Florida.

14
15
16 

17
18 _____
19 MAE FISHER, Notary Public
20 State of Florida
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Good Samaritan Medical Center Inc, Et Al. v. The Leapfrog Group
Karen Van Caulil (#7586376)

E R R A T A S H E E T

PAGE_____ LINE_____ CHANGE_____

REASON_____

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REASON_____

Karen Van Caulil

Date

1 Good Samaritan Medical Center Inc, Et Al. v. The Leapfrog Group
2 Karen Van Caulil (#7586376)

3 ACKNOWLEDGEMENT OF DEPONENT

4 I, Karen Van Caulil, do hereby declare that I
5 have read the foregoing transcript, I have made any
6 corrections, additions, or changes I deemed necessary as
7 noted above to be appended hereto, and that the same is
8 a true, correct and complete transcript of the testimony
9 given by me.

10
11 _____
12 Karen Van Caulil

_____ Date

13 *If notary is required

14 SUBSCRIBED AND SWORN TO BEFORE ME THIS

15 _____ DAY OF _____, 20____.

16
17
18 _____
19 NOTARY PUBLIC
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Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

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Exhibit 90

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UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA
WEST PALM BEACH DIVISION

CASE NO.: 9:25-CV-80526-DMM

GOOD SAMARITAN MEDICAL
CENTER, INC., et al.,

Plaintiffs,

-vs-

THE LEAPFROG GROUP,

Defendant.

_____ /

VIDEO-RECORDED DEPOSITION OF ERIK CAZARES
PURSUANT TO RULES 30 AND 30(b)(6)
Volume 1 (Pages 1 - 101)

DATE: Wednesday, September 24, 2025
TIME: 10:34 a.m. - 1:01 p.m.
LOCATION: ASC Advisors LLC
550 South Andrews Avenue
Suite 700
Fort Lauderdale, Florida 33394

Stenographically Reported By:
Theresa Rust, RPR

Job No.: 422124

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11

12 ALSO PRESENT:

Alex Rampone, Videographer

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1 Thereupon,
2 the following proceedings began at 10:34 a.m.:

3 THE VIDEOGRAPHER: We are now on the
4 record. My name is Alex Rampone. I'm the
10:35 5 videographer with Lexitas. Today's date is
6 September 24, 2025, and the time is 10:34 a.m.
7 eastern time.

8 This deposition is being held at 550 South
9 Andrews Avenue, Suite 700, Fort Lauderdale,
10:35 10 Florida 33301 in the matter of Good Samaritan
11 Medical Center, Inc. versus Leapfrog Group. The
12 deponent is Erik Cazares.

13 Would counsel and all present please
14 introduce themselves, and after, the court
10:36 15 reporter, Theresa Rust, will swear in the
16 witness.

17 MS. ZIBAS: My name is Jura Zibas. I'm
18 with the law firm of Wilson Elser on behalf of
19 the defendant, The Leapfrog Group.

10:36 20 MR. CHUNG: Daniel Chung of Gibson Dunn &
21 Crutcher for plaintiffs.

22 MR. FISCHER: Alexander Fischer from Gibson
23 Dunn.

24 THE STENOGRAPHER: Raise your right hand,
25 please.

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1 Do you swear that the testimony you are
2 about to give will be the truth, the whole
3 truth, and nothing but the truth?

4 THE WITNESS: Yes.

10:36 5 THE STENOGRAPHER: Thank you.

6 THEREUPON:

7 ERIK CAZARES

8 Was called as a witness and, having been first duly
9 sworn and responding "I do," was examined and
10 testified as follows:

11 DIRECT EXAMINATION

12 BY MS. ZIBAS:

13 Q. Good morning, Mr. Cazares. As I indicated,
14 my name is Jura Zibas. I represent the defendants,
10:36 15 and we're here today to take your deposition as it
16 relates to the lawsuit filed in the Southern District
17 of Florida, U.S. District Court.

18 Have you been deposed before in the past?

19 A. Yes.

10:37 20 Q. How many times?

21 A. Twice.

22 Q. And what were the cases, if you recall?

23 A. One was an employment and the other one a
24 union matter.

10:37 25 Q. And were the lawsuits related to your work,

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1 meaning under your former employer or your current
2 employer?

3 A. Yes.

4 Q. All right. And the reason I ask is just in
10:37 5 terms of having to explain to you the process. So
6 you understand that we're going to be videotaping you
7 answering questions. Please wait until I finish
8 asking the question. If your attorney has an
9 objection, let your attorney object. Unless he
10:37 10 directs you not to answer, you answer the question
11 after the objection is on the record. If there's a
12 question that you don't understand, just let me know.
13 And we will do every -- I'll make every effort to
14 then rephrase it or explain the question.

10:38 15 If you need to take a break, please let us know.
16 You can take a break. This isn't an endurance test.
17 Just have to do it in between questions.

18 Does that all make sense to you?

19 A. Yes.

10:38 20 Q. All right. When did you first learn about
21 -- let's set up the foundation. You are aware that
22 there is a lawsuit filed by Palm Beach Community
23 Hospital against the Leapfrog Group; is that correct?

24 A. Yes.

10:38 25 Q. When did you first learn that a lawsuit

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1 would be filed against the Leapfrog Group by Palm
2 Beach Gardens Community Hospital?

3 MR. CHUNG: I'm going to object based on
4 privilege. If your answer involves any
10:38 5 communications with lawyers, either in-house
6 lawyers or outside lawyers, avoid those
7 conversations.

8 MS. ZIBAS: Yes. I'm not interested in
9 your conversation. Just if you -- when you
10:39 10 learned about it.

11 A. It was earlier this year. I don't have the
12 exact date.

13 (Exhibit 1 was marked.)

14 BY MS. ZIBAS:

10:39 15 Q. Okay. I have marked what is Cazares Number
16 1. It's an exhibit I want you to take a look at that
17 we're just going to identify and flip the pages.

18 A. Okay.

19 Q. Have you seen this document that is Cazares
10:40 20 Number 1 before?

21 A. This specific document, I have not.

22 Q. This is a deposition notice, and on the
23 front, it indicates that we are here for your
24 deposition as an individual and also as a
10:41 25 representative of Palm Beach Gardens Community

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1 Hospital. Is that your understanding of the purpose
2 of today?

3 A. Yes.

4 Q. What is your current job title?

10:41 5 A. I'm the CEO of Palm Beach Gardens Medical
6 Center.

7 Q. And when did you start in that role?

8 A. July of 2024.

9 Q. And before we go into your education or
10:41 10 employment background, going back to the two times
11 you were previously deposed. Were those in state or
12 Federal Court cases, do you know?

13 A. I don't recall. No, I don't recall. Long
14 time ago.

10:41 15 Q. Okay. So we want to go through some of
16 your back -- your history and background first. So
17 why don't you tell me your -- where did you earn your
18 college degree or nursing degree?

19 A. Sure. I graduated from the University of
10:42 20 Texas El Paso with a Bachelor of Science in nursing
21 in 2000. That was the first degree that I earned.
22 And I started practicing as a registered nurse in
23 January of 2001. Received a Master's in science and
24 nursing administration from Texas Tech University and
10:42 25 that was in 2013.

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1 Q. So while you were earning your Master's in
2 nursing administration, were -- did -- were you
3 employed?

4 A. Yes.

10:42 5 Q. And where was your -- what was your first
6 job after you graduated from nursing school?

7 A. It was in a hospital called Sierra Medical
8 Center.

9 Q. And how long did you work at Sierra Medical
10:43 10 Center?

11 A. I worked there until 2008.

12 Q. And after Sierra Medical Center, did you
13 work somewhere else?

14 A. Yes. I went to Sierra Providence East
10:43 15 Medical Center.

16 Q. And what was your title there?

17 A. Well, I had different titles. My initial
18 title was director of the telemetry floor, and then I
19 took over several other departments and eventually
10:43 20 became the assistant chief nurse officer for that
21 particular hospital.

22 Q. That was Sierra Providence East?

23 A. Correct.

24 Q. How long did you work at Sierra Providence
10:43 25 East in your various roles?

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1 A. Until 2015.

2 Q. And then where did you go in 2015?

3 A. Then I went back to Sierra Medical Center
4 as the chief nursing officer.

10:44 5 Q. And when you're a chief nursing officer,
6 what are your duties, in general?

7 A. Oversight of all of nursing operations,
8 staffing, safety, quality, patient experience.

9 Q. And how long were you the chief nursing
10:44 10 officer at Sierra Medical Center?

11 A. I was there for approximately three years.

12 Q. And that's around 2018; is that correct?

13 A. Correct.

14 Q. And then where did you go?

10:44 15 A. Then I went back to Sierra Providence East.
16 By that time, it was called the Hospitals of
17 Providence East Campus and as a role of a chief
18 operating officer.

19 Q. So you went back to Sierra Providence East,
10:45 20 but it was then the Hospitals of Providence East
21 Campus?

22 A. The Hospitals of Providence East Campus.

23 Q. And you were the COO?

24 A. Correct.

10:45 25 Q. And then how long were you the COO?

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1 A. I was there until 2022 as the COO.

2 Q. Okay. And then what did you do in 2022?

3 A. And then I transitioned back to the -- what
4 used to be Sierra Medical Center. Now, it's called
10:45 5 the Hospitals of Providence Sierra Campus as the
6 chief executive officer.

7 Q. And when you were the chief executive
8 officer of Hospitals of Providence Sierra Campus,
9 what would you call -- how would you describe your
10:45 10 overall duties?

11 A. I was responsible for oversight of all
12 hospital operations, financial, quality, safety,
13 contracts, physician relations.

14 Q. Did you report to a board of directors or
10:46 15 governing board?

16 A. There was a -- yes. There was a local
17 hospital governing board.

18 Q. And who owns The Hospitals of Providence
19 Sierra?

10:46 20 A. Tenet.

21 Q. When did Tenet buy The Hospitals of
22 Providence Sierra Campus?

23 A. I don't know.

24 Q. Did Tenet buy The Hospital of Providence
10:46 25 East Campus at some point, as well?

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1 A. They built that hospital in 2008.

2 Q. Okay. So when you were at Hospitals of
3 Providence Sierra, were you considered a Tenet
4 employee or a hospital employee?

10:47 5 A. I was under the Tenet payroll.

6 Q. Did you ever -- when you were at Hospitals
7 of Providence Sierra, did you ever interact with
8 people at Tenet headquarters office regarding
9 quality, safety, or any of those -- any of those
10:47 10 principles?

11 A. Yes.

12 Q. And who did you interact with at Tenet
13 headquarters about quality and safety?

14 A. Different individuals depending on what we
10:47 15 were addressing, but they have leads. They have a
16 safety lead. They have a quality lead and so forth.

17 Q. And do you still interact with the safety
18 and quality lead today at your current role?

19 A. Yes.

10:47 20 Q. Who is the safety lead?

21 A. Well, we interact with like the chief
22 medical officer for the company, Ernest Franklin.
23 Dr. Franklin. And the chief nursing officer. That's
24 who I now interact with the most. Judy Chabot.

10:48 25 Q. Did you eventually start working at Palm

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1 Beach Gardens Community Hospital?

2 A. I'm sorry. Repeat the question.

3 Q. I said at some point, did you begin your
4 role as a chief executive officer at Palm Beach

10:48 5 Gardens Community Hospital?

6 A. Yes. In July of 2024.

7 Q. So what made you go from -- decide to go
8 from Texas, the Hospitals of Providence Sierra
9 campus, to Palm Beach Gardens?

10:48 10 A. Sure. I was approached with the
11 opportunity for the position at Gardens, and I was
12 open to relocate, so then that brought me here to
13 Florida. Explored the opportunity and it was
14 something that grabbed my attention, and I thought it
10:49 15 would be a good fit.

16 Q. Who approached you?

17 A. This was Maggie.

18 Q. Is that Maggie Gill?

19 A. Maggie Gill.

10:49 20 Q. And do you know what Maggie Gill's role is?

21 A. She is the regional leader for our
22 hospitals.

23 Q. And is she a Tenet employee?

24 A. I believe so.

10:49 25 Q. And what region does she lead?

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1 A. Well, she's got multiple regions, but she's
2 over the Florida region, and I believe she has a few
3 more areas.

4 Q. So when you came to the Palm Beach Gardens
10:50 5 Community Hospital, did you have a transition period
6 where the prior CEO worked with you or you just
7 started sort of on your own?

8 A. I was -- on day one, I was by myself.

9 Q. And how many people report to you directly?

10:50 10 A. Oh, I have about six direct reports.

11 Q. And what are their titles? And if you
12 don't remember, that's fine.

13 A. Sure. I've got my executive assistant,
14 chief nursing officer, chief operating officer, chief
10:50 15 financial officer, chief human resource officer, and
16 there's one more. Who else? That's it because the
17 other ones -- so it's five.

18 Q. Is there a chief strategy officer at Palm
19 Beach Gardens?

10:51 20 A. There is.

21 Q. And does that person -- who does that
22 person report to?

23 A. To the market chief strategy lead.

24 Q. And who does the market chief -- is the
10:51 25 market chief strategy lead at Palm Beach Gardens or

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1 is that a Tenet person?

2 A. No. He's a sister facility.

3 Q. What facility is that?

4 A. I believe he's Hospital Delray.

10:51 5 Q. And when you talk about a sister property,
6 is this part of the Palm Beach Health Network?

7 A. Correct.

8 Q. And you refer to them at sister properties?

9 A. Yeah.

10:51 10 Q. Do you have any direct or specific role at
11 Palm Beach Network yourself?

12 A. No, just my hospital.

13 Q. And how many beds do you have at Palm Beach
14 Gardens?

10:52 15 A. 199 licensed beds.

16 Q. And what do you mean by licensed beds?

17 A. That those are the amount of beds that
18 we're licensed through the State of Florida.

19 Q. And do you have a trauma center?

10:52 20 A. No.

21 Q. What services are offered at Palm Beach
22 Gardens?

23 A. The main service line is cardiac. We also
24 do orthopedics, neurology, general surgery, emergency
10:52 25 services. I would consider those the main service

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1 lines.

2 Q. And where is Palm Beach Gardens Community
3 Hospital physically located?

4 A. In Palm Beach Gardens.

10:52 5 Q. And what's the address there?

6 A. I don't know the exact address. It's on
7 Birds Road.

8 Q. Is it in a part of Palm Beach with a
9 population that is a little -- that is older?

10:53 10 A. Yes.

11 Q. So what is the -- what -- and this is
12 sometimes hard to figure out. What's the median age
13 of your patient population?

14 A. Yeah. When we last looked at it, it was 62
10:53 15 and a half years old.

16 Q. And when did you last look at it?

17 A. Several months ago.

18 Q. And why did you look at the median age of
19 the population? Were you doing a market study or --

10:53 20 A. We do that from time to time, look at the
21 age of the population that we're serving.

22 Q. And is there a certain time of year that
23 Palm Beach Gardens Community Hospital is busier than
24 others, such as snowbird season?

10:53 25 A. Yes.

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1 Q. And what is the Palm Beach snowbird season,
2 what months?

3 A. Well, I'm just beginning to learn it
4 because I've only been here one year. So last year
10:54 5 we were, I'd say, it was December through April.

6 Q. And do you see a large drop-off in
7 admissions and visits to the hospital after April?

8 A. There's a drop.

9 Q. Historically, and based on the information
10:54 10 that you've reviewed to date, has there always been a
11 drop after April?

12 A. Yes.

13 Q. Now, as CEO of Palm Beach Gardens, how much
14 oversight is there by Tenet Healthcare of your
10:54 15 everyday daily role? How much do they oversee you?

16 MR. CHUNG: Objection to form.

17 A. I mean, it's hard to quantify the amount of
18 oversight, but we get direction on different
19 initiatives, projects.

10:55 20 BY MS. ZIBAS:

21 Q. When you get direction from Tenet, does it
22 come through Maggie?

23 A. Not always. Sometimes through Maggie,
24 sometimes directly from corporate leaders.

10:55 25 Q. And in comparison to when you were the CEO

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1 at Hospitals of Providence Sierra Campus, is it about
2 the same direction from corporate Tenet there as what
3 you see now at Palm Beach Gardens?

4 MR. CHUNG: Objection to form.

10:55 5 A. Yes. Yes, it's fairly similar.

6 BY MS. ZIBAS:

7 Q. The Leapfrog Group is the defendant in this
8 case filed by Palm Beach Gardens. Can you just give
9 me both in your personal capacity, what do you know
10:56 10 about The Leapfrog Group, in terms of what they do,
11 who they are, et cetera?

12 MR. CHUNG: Objection to form.

13 A. Well, the Leapfrog Group assigns hospitals
14 a patient safety letter grading using a methodology
10:56 15 that they've used for some time. But that
16 methodology recently changed. So my most recent
17 experience is that that methodology is now negatively
18 affecting hospitals that do not participate in
19 leapfrog, that they don't submit data.

10:56 20 A perfect example is Palm Beach Gardens Medical
21 Center. Palm Beach Gardens Medical Center hadn't
22 submitted data or participated in Leapfrog since 2022
23 and recently received a letter F grade for patient
24 safety. And that was based on incomplete data since
10:57 25 we didn't participate, deceptive, what we consider

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1 deceptive grading methodology, and it has had a
2 significant impact on the reputation of the hospital,
3 the way that the hospital is viewed by physicians,
4 patients, community stakeholders, employees.

10:57 5 BY MS. ZIBAS:

6 Q. When you say we, when you refer to we, the
7 deceptive grading methodology, who is the we you're
8 referring to when you just testified?

9 A. Repeat that. What did I say?

10:57 10 Q. You referred to we. So when you say we,
11 are you referring to Palm Beach Gardens as a we or
12 Tenet and Palm Beach Gardens?

13 A. Correct. Palm Beach Gardens.

14 Q. Now, how did you find out about the
10:58 15 background of not submitting data from Palm Beach
16 Gardens since 2022? Who provided you that background
17 information?

18 A. That was my quality director.

19 Q. And who is your quality director?

10:58 20 A. Kathleen McDonald.

21 Q. And how long has Kathleen McDonald worked
22 at Palm Beach Gardens?

23 A. I don't know off the top of my head.

24 Q. Has she been there more than five years?

10:58 25 A. I don't know for a fact.

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1 Q. And when you were at Hospitals of
2 Providence Sierra, did Hospitals of Providence Sierra
3 participate in taking Leapfrog survey?

4 A. Not while I was the CEO.

10:58 5 Q. And what was their grade when they did not
6 participate?

7 A. I believe it was a C.

8 Q. And did it continue to be a C through 2023
9 and 2024?

10:58 10 A. I believe so.

11 Q. And do you know if in 2025 that it was a C?

12 A. I don't know. I don't know.

13 MS. ZIBAS: I'm handing you a document that
14 is labeled Cazares 2.

10:59 15 (Exhibit 2 was marked.)

16 BY MS. ZIBAS:

17 Q. And it says Leapfrog hospital safety grade.

18 And if you look at the URL, it was taken off the

19 hospitalsafetygrade.org site. For the Hospital of

10:59 20 Providence Sierra Campus and in spring 2025, do you
21 see the hospital grade says C?

22 A. Yes.

23 Q. And as far as you know, was -- are they
24 participating in taking a survey?

10:59 25 A. I don't know. I cannot speak to what

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1 Sierra is doing now.

2 MS. ZIBAS: I'll give you Cazares 3.

3 (Exhibit 3 was marked.)

4 BY MS. ZIBAS:

11:00 5 Q. And this is another page from that same
6 Leapfrog hospital safety grade, but as you can see at
7 the bottom, it has infections, problems with surgery,
8 different tabs that you would click on.

9 A. Uh-huh.

11:00 10 Q. And if you go to the second page, under
11 notes and definitions, it said declined to report.
12 The hospital was asked to provide this information to
13 the public but did not. Does this help you determine
14 if they are participating in the survey?

11:00 15 MR. CHUNG: Objection to form.

16 A. Yeah. I cannot tell if they're
17 participating, and I can't speak to what -- what data
18 they're submitting or not submitting.

19 BY MS. ZIBAS:

11:00 20 Q. And why -- so if Palm Beach Gardens is not
21 submitting data and the Hospital of Providence Sierra
22 Campus is not submitting data, why do you think one
23 receives an F and one receives a C?

24 MR. CHUNG: Objection to form,
11:01 25 mischaracterizes prior testimony.

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1 A. As I mentioned earlier, I cannot speak to
2 whether Sierra is participating or not participating
3 at this moment.

4 BY MS. ZIBAS:

11:01 5 Q. Do you know if any Tenet Healthcare
6 hospitals participate in the Leapfrog survey?

7 MR. CHUNG: Objection to form.

8 A. I'm not aware of that information.

9 BY MS. ZIBAS:

11:01 10 Q. Who would know that?

11 MR. CHUNG: Objection to form.

12 MS. ZIBAS: At Tenet, based on your
13 experience of working under Tenet.

14 A. I don't know.

11:01 15 BY MS. ZIBAS:

16 Q. Would the chief medical officer know?

17 MR. CHUNG: Objection to form.

18 A. I don't know if he would know, has
19 participated or not.

11:01 20 BY MS. ZIBAS:

21 Q. Does Palm Beach Gardens have a safety plan?

22 A. Yes.

23 Q. And do they have a safety plan in 2023?

24 A. My understanding is they did.

11:02 25 Q. What about 2024?

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1 A. Yes.

2 Q. What about 2025?

3 A. Yes.

4 Q. What did you do to prepare for your
11:02 5 deposition today, outside of speaking with your
6 lawyers? I'm not interested in the sum and substance
7 of the conversation. Just in general, what did you
8 do to prepare?

9 A. Reviewed my declaration, reviewed the
11:02 10 complaint.

11 Q. During the course of this litigation, have
12 you gathered documents to respond to discovery
13 requests?

14 A. Yes.

11:02 15 Q. And did you -- anybody else, as far as you
16 know, at Palm Beach Gardens gather documents?

17 A. Yes.

18 Q. And were all documents you gathered
19 provided to your counsel?

11:03 20 A. Yes.

21 Q. Do you know when Palm Beach Gardens
22 Hospital -- Community Hospital was formed?

23 A. 1968.

24 Q. And do you -- are they owned by Tenet now?

11:03 25 A. Yes.

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1 Q. And do you know when Tenet purchased them?

2 A. I don't.

3 Q. Did you read any expert reports in
4 preparation for your deposition today?

11:03 5 A. No.

6 Q. Do you have anybody at Palm Beach Gardens
7 who manages marketing?

8 A. We have a marketing manager.

9 Q. Just one person?

11:03 10 A. Yes.

11 Q. And who is that?

12 A. Her name is Amanda Blanchard.

13 Q. And does Amanda Blanchard have a staff?

14 A. No.

11:04 15 Q. And is there anybody that does social media
16 management?

17 A. She handles some of it.

18 Q. Does she have an outside vendor or does she
19 handle it all herself?

11:04 20 A. I'm not quite sure how she handles it.

21 Q. Do you have a marketing budget at Palm
22 Beach Gardens?

23 A. We do.

24 Q. And is it based on revenue share, or is it
11:04 25 just a certain sum of money that's allocated?

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1 A. It's an allocation.

2 Q. And who determines the annual budget for
3 the hospital?

4 A. It's the hospital leadership, myself, with
11:04 5 my chief financial officer, with approval from our
6 corporate office.

7 Q. Does your corporate -- and when you say
8 corporate office, I assume you mean Tenet; correct?

9 A. Correct.

11:05 10 Q. Have you found that Tenet reduces the
11 budget after you submit it, or is it pretty much a
12 rubber stamp?

13 MR. CHUNG: Objection to form.

14 A. It's neither.

11:05 15 BY MS. ZIBAS:

16 Q. Describe to me what you mean by neither.

17 A. They don't rubber stamp it, and they don't
18 necessarily reduce it.

19 Q. Do they move funds from one allocation to
11:05 20 another?

21 MR. CHUNG: Objection to form.

22 A. No.

23 BY MS. ZIBAS:

24 Q. So how do they -- how do they change the
11:05 25 budget, if they don't accept the budget that you

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1 submit?

2 MR. CHUNG: Objection to form,
3 mischaracterizes testimony.

4 A. When we submit the budget, it's a
11:05 5 conversation regarding whether the dollars are needed
6 and what they're needed for, and then we come to an
7 agreement.

8 BY MS. ZIBAS:

9 Q. Has the budget for 2026 been completed?

11:06 10 A. For 2026?

11 Q. Yes.

12 A. No.

13 Q. What are the role -- what's the role or the
14 tasks that are accomplished by Amanda Blanchard as
11:06 15 the marketing manager?

16 A. What are the -- can you repeat the
17 question?

18 Q. Yes. What are the tasks or the job duties
19 of Amanda Blanchard?

11:06 20 A. Basically everything that involves
21 marketing, whether it's social media, coordinating
22 community events, coordinating statements out to the
23 media or the organization. She works with
24 communications to do that, as well.

11:07 25 Q. And is that the Palm Beach Gardens

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1 communications?

2 A. Correct.

3 Q. And is that a separate department?

4 A. I don't know if they're completely separate
11:07 5 or if they're linked.

6 Q. And are they -- would the communications
7 potentially be linked to a marketing manager, as far
8 as -- is that who reports to?

9 MR. CHUNG: Objection to form.

11:07 10 A. No.

11 BY MS. ZIBAS:

12 Q. Who does the communications person report
13 to?

14 A. There is a -- there's a communications
11:07 15 director and marketing.

16 Q. And do you meet with the communications
17 director?

18 A. No.

19 Q. Have you ever discussed The Leapfrog Group
11:07 20 with the communications director?

21 A. No.

22 Q. Have you ever given any -- you personally
23 given any statements to the press about The Leapfrog
24 Group?

11:08 25 A. No.

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1 Q. Did you ever review any statements prepared
2 by the Palm Beach Health Network about The Leapfrog
3 Group?

4 A. No. I got copied on communications after
11:08 5 it went out.

6 Q. Do you know why the Palm Beach Gardens
7 Community Hospital stopped participating in The
8 Leapfrog Group survey?

9 A. I don't. I don't know why.

11:08 10 Q. Do you know what year that was?

11 A. I believe it was back in 2022 they stopped
12 participating.

13 Q. You referenced earlier that you described
14 the -- that The Leapfrog Group has a methodology, had
11:09 15 a methodology and then it changed. Can you describe
16 to me your understanding of The Leapfrog Group
17 methodology before the change?

18 A. Sure. So the way that I understand it is
19 that before the change, nonparticipating hospitals,
11:09 20 when they didn't submit data in certain metrics, they
21 were awarded a score or given a score based on the
22 average of similar hospitals' performance, and that
23 changed to where the fall of 2024, on four particular
24 metrics, Leapfrog automatically scores them at the
11:09 25 lowest level for those four particular metrics:

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1 handwashing, computerized physician order entry, bar
2 code medication scanning, and ICU staffing. And by
3 doing that, the score -- they got the lowest score
4 possible in those metrics, and the letter grade is
11:10 5 then affected. Drops either to a D or F. In the
6 case of Gardens, it dropped to an F. Before that, it
7 had been a C, even when the hospital was not
8 participating.

9 Q. So when it -- when they received a C
11:10 10 because of the scoring that you described by the
11 nonparticipating hospitals, did you think that was,
12 in your personal opinion, was that fair for not
13 participating that they received a high score and
14 then now it's a lower score?

11:10 15 MR. CHUNG: Objection to form.

16 A. I don't -- I'm not ready to comment whether
17 it was fair or not. What I do know is the letter
18 grade F is detrimental to the organization. And when
19 the hospital had a letter score of C, we did not
11:11 20 experience the negative reputation that we're
21 experiencing now that we have in awarding an F, from
22 physicians, from patients, community members,
23 governing board members. As soon as that F came out,
24 we started getting complaints and concerns from all
11:11 25 these individuals, which didn't exist when the

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1 hospital was rated a C.

2 BY MS. ZIBAS:

3 Q. How did the information get out, you said,
4 about the F? Was a press release put out by Palm
11:11 5 Beach Health Network? Who put the press release out?

6 MR. CHUNG: Objection to form.

7 A. I don't recall where the initial release
8 came out. But the grades came out and then it was
9 brought to our attention that patients were
11:11 10 significantly concerned about going to Gardens
11 because of the F grade. We even know our competitor
12 was publishing their letter grade of an A and ours of
13 an F, so they also had input into getting some of
14 that in the community, as well.

11:12 15 BY MS. ZIBAS:

16 Q. Who is your competitor that was publishing?

17 A. Jupiter.

18 Q. So did Jupiter Medical Center publish their
19 grade versus your grade into the -- I guess the news
11:12 20 media?

21 A. I don't know if they published it into the
22 news media, but they definitely public -- made it
23 public to their physician group, which is also the
24 same physicians in our organization.

11:12 25 Q. Do you know if Jupiter Medical Center

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1 received an A?

2 A. Yes.

3 Q. Have you talked to anyone at Jupiter
4 Medical Center about their A grade?

11:12 5 A. No.

6 Q. Do you know the CEO of Jupiter Medical
7 Center?

8 A. I know who he is, but I don't talk to him.

9 Q. So as you sit here today, you still do not
11:13 10 know who initially published the score, The Leapfrog
11 Group score about Palm Beach Gardens hospital; is
12 that correct?

13 MR. CHUNG: Objection to form.

14 A. That's correct.

11:13 15 BY MS. ZIBAS:

16 Q. Did you ever investigate further as to who
17 initially published the grades?

18 A. No.

19 Q. Did Tenet ever publish the grades?

11:13 20 A. I don't know.

21 Q. Now, you talked about physician -- it was
22 detrimental because physicians talked about it. How
23 many physicians talked to you about it?

24 A. I can't recall the amount of physicians.

11:13 25 It's -- they continue to talk to me about it,

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1 especially after a Tik Tok video was created and was
2 out there broadcasting Gardens as the worst hospital
3 in Florida, specifically referencing handwashing.
4 After that Tik Tok video, I started receiving more
11:14 5 and more complaints from physicians, that they were
6 talking to patients in their offices, and especially
7 patients that needed to have procedures done. They
8 didn't want to go to Gardens because of the F letter
9 grade that had been awarded by Leapfrog for patient
11:14 10 safety.

11 One particular patient is a cardiac patient that
12 needed to have a cardiac procedure and did not want
13 to go to Palm Beach Gardens. I received a phone call
14 from the surgeon. This particular patient, when I
11:14 15 talked to him, said that the main reason was because
16 of Leapfrog. So he was looking at other facilities
17 to have his cardiac procedure.

18 Our hospital is well known for our cardiac care
19 and infrastructure experience, so these patients are
11:15 20 making decisions to go to other facilities where the
21 care may not be to the quality or caliber and have
22 the outcomes that we have, specifically for cardiac
23 care in this instance.

24 Q. Do you have a CCU unit at Palm Beach
11:15 25 Gardens?

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1 A. We have a CVICU.
2 Q. And how many beds?
3 A. 12 bids.
4 Q. Do you have ICU?
11:15 5 A. We do.
6 Q. And how many beds?
7 A. 16.
8 Q. How many operatories?
9 A. How many what?
11:15 10 Q. Operatories?
11 A. What is that?
12 Q. An operating room?
13 A. Operating rooms?
14 Q. Operating rooms for cardiac.
11:15 15 A. We have two.
16 Q. And how many -- is that total operating
17 rooms or just for cardiac?
18 A. No, that's just for cardiac.
19 Q. And how many total?
11:15 20 A. 12.
21 Q. So you can do maximum -- you can schedule
22 maximum of two a day in the cardiac or just one?
23 A. No, you can do multiple.
24 Q. What's the maximum number you can do in a
11:16 25 day?

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1 A. Depends how long the physician is willing
2 to work. Sometimes they can do up to three, four,
3 surgeries a day.

4 Q. So when you say this patient needed cardiac
11:16 5 procedure and the surgeon called you, when was that?

6 A. This was approximately three to four weeks
7 ago.

8 Q. And who was the surgeon?

9 A. Dr. Patel.

11:16 10 Q. Did Dr. Patel tell you there was only one
11 patient concerned about the handwashing?

12 A. No. He's told me about multiple patients,
13 and I asked them that if those patients, whenever he
14 gets those patients, if he could give me their
11:16 15 information so I can talk to them and reassure them
16 of the care that we deliver at Palm Beach Gardens
17 Medical Center. So this is a particular patient that
18 I talked to, and he expressed his concerns about our
19 Leapfrog score and that being the driving decision
11:17 20 for not wanting to have surgery at Gardens.

21 But he's -- Dr. Patel said he's had multiple
22 patients, and I can give you a list of other
23 physicians who have also received similar concerns.

24 Q. Okay. Give me a list of those physicians.

11:17 25 A. Sure. There's Dr. Mostel; he's another

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1 cardiologist. I believe there's a few more that I
2 had shared with my legal team, with the legal team.

3 Q. You provided that information to your legal
4 team?

11:17 5 A. Yes.

6 Q. Did you put it in your responses to your
7 interrogatories?

8 A. No. I don't think so.

9 Q. Is there a reason you didn't put it in the
11:17 10 interrogatories?

11 A. It was just too many to list.

12 Q. But based on your understanding of this
13 lawsuit, there's a claim of reputational harm;
14 correct?

11:17 15 A. Correct. That's correct.

16 Q. But yet you didn't want to list --

17 A. Well, no, because --

18 Q. -- harm?

19 A. -- up until this day, I continue to get
11:18 20 calls from physicians. And as a matter of fact,
21 after the video, the viral video, it's only been
22 escalating, and it's three to four times a week I'm
23 getting either calls from physicians or patients
24 voicing their concerns about patients not wanting to
11:18 25 go to Palm Beach Gardens Medical Center, specifically

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1 citing the F grade.

2 Q. And who put up the -- who created the Tik
3 Tok video?

4 A. I don't know.

11:18 5 Q. And who posted it?

6 A. I don't know.

7 Q. Did you view it on Tik Tok?

8 A. I viewed it on -- I don't have Tik Tok, but
9 I viewed it online.

11:18 10 Q. On what?

11 A. Online. I mean, click on the link and it
12 pops up.

13 Q. And now you said the governing board also
14 complained to you. Who on the governing board?

11:18 15 A. There's a physician on the governing board
16 whose name is Dr. Suarez. We also have a community
17 member, Michael Mitrone. Those are two that come to
18 mind.

19 Q. And what did Dr. Suarez say to you?

11:19 20 A. He immediately complained about why Gardens
21 received an F on patient safety and Jupiter has an A,
22 when he considers -- he practices at both hospitals,
23 and he considers the quality at Gardens to be
24 superior in many aspects to Jupiter. So he was very
11:19 25 concerned, to which I responded to him that we did

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1 not participate in Leapfrog at that time, and that
2 had -- we had been granted a low rating because of
3 those four metrics that I mentioned earlier. We
4 received the lowest possible score for not submitting
11:19 5 the data. So that was my explanation to him.

6 Q. And what about Michael Mitrone? What did
7 he say?

8 A. Same thing. He wanted -- he didn't think
9 it was fair, and he wanted to know what we were going
11:20 10 to do about the bad reputation that the letter, that
11 the F grade had created for the organization.

12 Q. And what did you tell him that Palm Beach
13 Gardens is going to do about the reputation that you
14 believe it's created?

11:20 15 A. I told him we were looking into that and to
16 see what is it we could potentially do about it. I
17 didn't give him any specific details.

18 Q. Did you ever tell the board that one of the
19 solutions was filing this lawsuit?

11:20 20 A. No. What I did tell Mike Mitrone and the
21 rest of the governing board is that part of our goal
22 to minimize or mitigate the negative reputation is
23 for us to go out there and promote the quality of
24 Gardens, which is what I've been doing. I've been
11:20 25 out in the community. I've been talking to people.

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1 I've been highlighting our different awards and
2 accolades that highlight our outcomes for the
3 organization.

4 Q. Does Palm Beach Gardens participate in
11:21 5 Healthgrades?

6 A. We do.

7 Q. And how are Healthgrades determined?

8 A. Healthgrades is based on patient outcomes,
9 and where the hospital excels compared to the rest of
11:21 10 the nation, then Healthgrades will award in that
11 specific area a recognition for the hospital.

12 Q. How do they get their data at Healthgrades?

13 A. I believe they pull the data.

14 Q. And does Palm Beach Gardens --

11:21 15 A. Publicly-reported data.

16 Q. Does Palm Beach Gardens purchase the
17 license for using the logo to promote the accolade?

18 A. I'm not sure exactly what Gardens pays. I
19 know that we do buy like the trophy or plaque from
11:21 20 them there's a -- when there's an area that we excel
21 in.

22 Q. In the advertising, do you use the
23 Healthgrades logo?

24 A. Yes.

11:22 25 Q. So do you pay a license for that?

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1 A. I don't know.

2 Q. Is that something -- who handles the
3 advertising for Palm Beach Gardens?

4 A. Amanda.

11:22 5 Q. And what about Joint Commission? Does Palm
6 Beach Gardens go through The Joint Commission
7 process?

8 A. Absolutely. Joint Commission is our main
9 credentialing body. They're one of the approved CMS
11:22 10 vendors to go in into our facility and basically look
11 at everything. So we -- we are Joint Commission
12 accredited. They were in our hospital last year at a
13 group surveyors that went in and did an intense,
14 rigorous survey of our organizations. They spent
11:23 15 three days looking at our processes, talking to
16 patients, talking to family members, employees,
17 physicians, observing procedures in the operating
18 room, looking at our facility infrastructure, looking
19 at handwashing, infection control practices. They
11:23 20 followed a very rigorous process, and we had
21 successful accreditation. No conditional findings
22 for the organization.

23 Q. Does Palm Beach Gardens pay for consulting
24 services with Joint Commission?

11:23 25 MR. CHUNG: Objection to form.

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1 A. I don't know if it's considered consulting
2 services because that is a regulatory and mandatory
3 survey that we need to have in order to continue
4 receiving payment from Centers for Medicare and
11:23 5 Medicaid services, but there is a fee associated.

6 BY MS. ZIBAS:

7 Q. But do you pay -- there is an additional
8 option to pay for consulting services to provide
9 guidance --

11:24 10 A. Oh, not that I'm aware of. Not that I'm
11 aware of.

12 Q. Do you know what CMS star ratings are?

13 A. We're a one star.

14 Q. And what does that mean?

11:24 15 A. It's a one star on a scale of five. That's
16 what I understand.

17 Q. And what does -- is one the worst?

18 A. Yes.

19 Q. And are you aware that the CMS data is
11:24 20 public?

21 A. Yes.

22 Q. And are you aware that the CMS data is used
23 as part of the Leapfrog hospital grade?

24 A. Some of it, yeah, is used.

11:24 25 Q. And what is -- what is Palm Beach Gardens

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1 Community Hospital doing, if anything, to try to
2 improve its CMS star rating?

3 A. Yeah. Well, we're not specifically
4 addressing CMS star rating. In general, the very
11:24 5 nature of what we do in hospitals is to take care of
6 patients. We continuously are looking at our
7 practices to improve patient safety and improve
8 quality, improve the patient experience, and that's
9 whether -- we're not doing it with a specific effort
11:25 10 of improving CMS star ratings or any particular
11 agency's rating or -- that's just what we do. As a
12 clinician, as a nurse, that's my priority, as well,
13 regardless of the ratings.

14 Q. So when people -- when you -- you mentioned
11:25 15 briefly about the detrimental reputation because The
16 Leapfrog grade. How would the fact that there's a
17 CMS one-star rating not impact Palm Beach Gardens
18 Community Hospital?

19 MR. CHUNG: Objection to form.

11:25 20 A. The CMS star rating is not being publicly
21 promoted in the community. It is not something that
22 has been brought to my attention by any physicians,
23 family members, community members, and even when --
24 even before this, it was never something that
11:26 25 negatively affected the reputation of the hospital

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1 the way that the Leapfrog F score has affected the
2 reputation of the facility.

3 BY MS. ZIBAS:

4 Q. Are you aware if Palm Beach Health Network
11:26 5 has been out promoting the low grades as part of this
6 lawsuit?

7 MR. CHUNG: Objection to form.

8 A. I'm not aware of that.

9 BY MS. ZIBAS:

11:26 10 Q. Do you regularly read the media in the
11 local Palm Beach papers related to the hospital and
12 the Palm Beach Health Network?

13 MR. CHUNG: Objection to form.

14 A. I've not -- I don't regularly read
11:26 15 newspapers. I'm aware there's been articles.

16 BY MS. ZIBAS:

17 Q. Have you read any of the articles?

18 A. No.

19 Q. So do you -- at Palm Beach Gardens
11:27 20 Community Hospital, do you consider hand hygiene to
21 be important for patient care?

22 A. Absolutely.

23 Q. And is there a plan or a metric that is
24 used to track the hand hygiene of the employees?

11:27 25 A. Yes.

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1 Q. And what is that metric or system?

2 A. It's a surveillance methodology that the
3 hospital uses where they have trained staff to go out
4 there and observe employees, physicians, interacting
11:27 5 with patients to make sure they're following proper
6 protocol for handwashing, and then they report that
7 back to the infection control committee.

8 Q. And who is on the infection control
9 committee?

11:27 10 A. There are -- it's our infection control
11 nurse. There's an infectious disease doctor. There
12 are nursing leaders, chief nursing officer.

13 Q. Is there also a medical executive
14 committee?

11:28 15 A. Yes.

16 Q. And does the medical exec -- is the medical
17 executive committee informed about the outcomes of
18 the hand hygiene surveillance method?

19 A. Yes.

11:28 20 Q. What about safety, safety plan, is that
21 important to patient care?

22 A. Absolutely.

23 Q. And what metric, if any, is used at Palm
24 Beach Gardens hospital to monitor the safety plan and
11:28 25 adherence to the safety plan?

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1 A. Well, there are many. Hospital patient
2 safety involves many components. For example,
3 there's prevention of wounds, prevention of
4 infections with central lines, catheters, follies,
11:29 5 what we call follies, other infections, such as have
6 Clostridium difficile, MRSA, that's one thing.
7 There's fall prevention protocols, as well. That
8 goes into a patient safety, quality. Medication
9 errors.

11:29 10 Q. And when -- what is done with the patient
11 safety data that's gathered regarding all of these
12 points? Is it given to a committee or reviewed by
13 you?

14 MR. CHUNG: Objection to form.

11:29 15 A. Sure. The findings are discussed in the --
16 in the quality and safety committee. Where there's
17 opportunities for improvement, the hospital follows a
18 climb to steady act cycle for improvement where we
19 target those specific areas that need improvement and
11:30 20 we reevaluate and assess. That information is --
21 does go up to the medical executive committee and the
22 governing.

23 BY MS. ZIBAS:

24 Q. And does any of it go further up to Tenet
11:30 25 corporate?

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1 A. Tenet has the ability to assemble that
2 data, as well.

3 Q. And what about ICU staffing? Obviously, if
4 it's staffing, you probably monitor it. Is this
11:30 5 something that also is a metric that is shared with
6 the quality safety committee or is it shared with
7 medical executive committee or both?

8 MR. CHUNG: Objection to form.

9 A. Are you referring to ICU staffing from the
11:30 10 physician side --

11 MS. ZIBAS: Physician side.

12 A. -- or the nursing side.

13 Okay. So from the physician side, we contract
14 with a group that staffs our ICU with intensivists,
11:31 15 physicians, and midlevel providers, and they staff
16 the ICU around the clock, 24/7, with providers. And
17 that plan is shared with the medical executive
18 committee and the governing board.

19 BY MS. ZIBAS:

11:31 20 Q. Do you also contract services for the
21 emergency room for staffing physicians?

22 A. Yes.

23 Q. And what about your generalist, your
24 internists, do you also staff those with contract
11:31 25 physicians?

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1 A. No. We have independent hospitalists.

2 Q. What about the computerized physician order
3 entry system, do you regularly track that with a
4 metric and report?

11:32 5 A. We do.

6 Q. And where is that data reported?

7 A. Similar committees, through the quality and
8 safety committees.

9 Q. Are you on the quality and safety
11:32 10 committee?

11 A. I attend. I don't attend all of them, but
12 I do attend from time to time.

13 Q. How many people are on that committee?

14 A. I can't tell you off the top of my head,
11:32 15 but it's -- it's well attended by different
16 specialties in the organization, including
17 physicians.

18 Q. And what about bar code medication
19 administration, is that tracked, as well?

11:32 20 A. Yes.

21 Q. And does that go to the same committees,
22 the quality safety committee?

23 A. I believe it does.

24 Q. Do you have a pharmacy on site?

11:32 25 A. Yes.

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1 Q. And are the pharmacists staffed through
2 contract or are they hospital employees?

3 A. They're hospital employees.

4 Q. So do you agree that the measures that we
11:33 5 just walked through, the safety, the CPOE, the
6 medication administration, the ICU staffing, and hand
7 hygiene are all important factors for patient care?

8 A. Repeat that again.

9 Q. I said just going through the factors that
11:33 10 we just went through, the ICU staffing, the hand
11 hygiene, the safety plan, the CPOE, and the BCMA, are
12 these all factors that you think are important for
13 patient care at Palm Beach Gardens?

14 MR. CHUNG: Objection.

11:33 15 A. They are part of a -- they are part of
16 factors that do affect quality and safety, I would
17 agree with that, but they're not the only ones.

18 BY MS. ZIBAS:

19 Q. When we were discussing the Leapfrog
11:33 20 methodology before, do you know how many total
21 measures are evaluated to come to the grade?

22 MR. CHUNG: Objection to form.

23 A. I believe it's 22.

24 MS. ZIBAS: Excuse me. Off the record. My
11:34 25 mom is in the hospital with a clot, so just

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1 trying to make sure.

2 THE VIDEOGRAPHER: We're off the record at
3 11:33 a.m.

4 (Brief recess was taken at 11:33 a.m.)

11:47 5 (Back on the record at 11:46 a.m.)

6 THE VIDEOGRAPHER: Back on the record at
7 11:46 a.m.

8 BY MS. ZIBAS:

9 Q. All right. Mr. Cazares, in our last
11:47 10 question, you explained or you testified that there
11 are 22 measures that you're aware of that Leapfrog
12 evaluates as part of their safety grade. Is that
13 Leapfrog evaluates or CMS? As far as you know, is it
14 22 for CMS or Leapfrog?

11:47 15 A. Leapfrog as far as I'm aware.

16 Q. Now, do you believe that through patient --
17 do you -- let me cross that off.

18 Do you, at Palm Beach Gardens, conduct patient
19 experience surveys?

11:47 20 A. Yes.

21 Q. And who oversees the patient experience
22 surveys?

23 A. The chief nursing officer.

24 Q. And does someone assemble the data?

11:48 25 A. Yes.

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1 Q. And is that shared with you or with anybody
2 else?

3 A. Yes.

4 Q. And did you produce that data as part of
11:48 5 the discovery in this case?

6 A. Not me personally.

7 Q. Do you know if somebody else did?

8 A. I don't know.

9 Q. And is the patient experience data
11:48 10 assembled monthly, quarterly, annually?

11 A. I believe it's reported quarterly, but we
12 have the ability to pull it at any time.

13 Q. And what do you do with that data once you
14 review it? Do you create a plan to address people,
11:48 15 their negative experiences? What do you do?

16 A. Sure. The information that we gather from
17 the surveys, we use it to align our operations to
18 better meet the needs of our patients.

19 Q. Do you believe that -- do you agree that
11:49 20 patients should have transparency regarding the
21 patient care at Palm Beach Gardens?

22 MR. CHUNG: Objection to form.

23 A. Could you repeat the question?

24 BY MS. ZIBAS:

11:49 25 Q. Yes. Do you believe that patients are

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1 entitled to transparency into their patient care at
2 Palm Beach Gardens?

3 MR. CHUNG: Objection to form.

4 A. I believe in transparency, yes.

11:49 5 BY MS. ZIBAS:

6 Q. And are there any systems in place at Palm
7 Beach Gardens to give a patient transparency into
8 their medical care?

9 MR. CHUNG: Objection to form.

11:49 10 A. Yes. I don't understand the question.

11 BY MS. ZIBAS:

12 Q. Well, for instance, do you have medical
13 records and information about the hospital ratings
14 available for patients to review when they become
11:50 15 inpatients or outpatients?

16 MR. CHUNG: Objection to form.

17 A. We don't have ratings. We don't share
18 ratings with our patients.

19 BY MS. ZIBAS:

11:50 20 Q. What about their medical records, are they
21 entitled to review their medical records?

22 A. They are.

23 Q. While a patient?

24 A. Well, while a patient, there's a process
11:50 25 that has to be followed for them to be able to access

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1 the records.

2 Q. Did you ever calculate the BCMA error rate
3 in 2024 at Palm Beach Gardens? You or somebody else
4 on your behalf ever calculate the error rate?

11:50 5 A. I didn't. I don't know if someone else
6 did.

7 Q. And do you know what the error rate was?

8 A. No. What do you mean by error rate?

9 Q. Well, any -- if they found that people did
11:51 10 not follow the policies or procedures for bar code
11 medication administration?

12 A. You're talking about the compliance?

13 Q. Correct.

14 A. Compliance rate or error rate?

11:51 15 Q. Both. Separately error rate and compliance
16 rate.

17 A. Yeah. For what year?

18 Q. 2024.

19 A. Oh, I'm not familiar for 2024. I don't
11:51 20 remember what that was.

21 Q. What about for 2025?

22 A. For 2025, I know the last time I looked at
23 the compliance rate was 95, close to 95 percent.

24 Q. And do you also track the compliance rate
11:51 25 of the computerized physician ordering entry?

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1 A. That is tracked, as well.

2 Q. And do you know what the compliance rate
3 was in 2025 for that?

4 A. The last time I looked at that compliance
11:52 5 rate was approximately 80 percent.

6 Q. Do you know if as part of the CMS star
7 ratings, that if CMS looks at hand hygiene or the
8 CPOE?

9 A. I can't think -- I can't recall exactly all
11:52 10 the things that CMS looks at.

11 Q. Do you recall anything that CMS looks at?

12 A. Yes. They look at patient safety
13 indicators, infection rates.

14 Q. And --

11:52 15 A. Patient experience.

16 Q. And what did you find in the CMS star
17 ratings in terms of the outcomes of infection rates
18 at Palm Beach Gardens?

19 MR. CHUNG: Objection to form.

11:52 20 A. That's -- repeat the question, again.

21 BY MS. ZIBAS:

22 Q. What did you find in CMS star ratings in
23 terms of the outcomes and infection rates at Palm
24 Beach Gardens?

11:53 25 MR. CHUNG: Objection to form.

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1 A. Last time that I looked at the CMS ratings,
2 on most metrics, our hospital, when it comes to
3 infection and outcomes on most metrics, we are in par
4 with the national average.

11:53 5 BY MS. ZIBAS:

6 Q. And what does that mean, being on par with
7 the national average?

8 A. That means that we are in the same range as
9 similar hospitals across the nation.

11:53 10 Q. Have you ever asked Maggie Gill or anyone
11 at Tenet if Palm Beach Gardens could participate in
12 the Leapfrog survey?

13 A. I have not.

14 Q. Have you ever reviewed the Leapfrog survey?

11:53 15 A. In its entirety?

16 Q. Yes.

17 A. No.

18 Q. Have you -- since you've been a CEO or COO
19 of any hospital, have any of the hospitals where
11:54 20 you've worked participated in the Leapfrog survey?

21 A. Repeat, since when?

22 Q. Since you were a COO or CEO?

23 A. When I was a COO, I believe our hospital
24 did participate.

11:54 25 Q. And when you were C -- and was that a

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1 decision made by whom to participate when you were
2 COO?

3 A. I don't remember.

4 Q. Are you permitted as the CEO of Palm Beach
11:54 5 Gardens for your hospital to participate?

6 A. Right now, we've -- we have a directive,
7 and directed not to participate in Leapfrog.

8 Q. And what about in 2024, was there a
9 directive when you first started not to participate
11:54 10 in Leapfrog?

11 A. Wasn't questioned in 2024. I didn't
12 question it. It wasn't an issue.

13 Q. And who was the directive from that you not
14 participate in the Leapfrog survey?

11:55 15 A. My immediate boss, Maggie.

16 Q. As part of Amanda's duties as marketing
17 manager or another person at Palm Beach Gardens, does
18 anybody participate or hire anyone to do market share
19 studies against your competitor, Jupiter Medical
11:55 20 Center?

21 A. No, I'm not aware.

22 Q. Is that something that's been considered?

23 A. Not that I'm aware of.

24 Q. Now, of your patient population, would you
11:55 25 say that over 50 percent of them obtain information

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1 about what hospital to go to on the Internet?

2 A. I don't know.

3 MR. CHUNG: Objection to form.

4 BY MS. ZIBAS:

11:55 5 Q. Has there ever been a study done or survey
6 done at Palm Beach Gardens as to what patients rely
7 on for their source of selecting the hospital to go
8 to?

9 A. None that I'm aware of.

11:56 10 Q. Is it something that's been discussed to
11 survey?

12 A. Not that I'm aware of.

13 Q. Do you think it would be helpful to know
14 what the sources of information are for your patient
11:56 15 population?

16 MR. CHUNG: Objection to form.

17 MS. ZIBAS: To select a hospital.

18 MR. CHUNG: Objection to form.

19 A. I don't know if it would be helpful or not.

11:56 20 BY MS. ZIBAS:

21 Q. Is your compensation tied to the revenue
22 outcomes at Palm Beach Gardens?

23 A. To the revenue?

24 Q. Yes. Is there any compensation tied to the
11:56 25 revenues of the hospital?

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1 A. Amongst other things, yes.

2 Q. And has the revenue increased or decreased
3 since 2024?

4 A. It's increased slightly.

11:56 5 Q. And going back to the reputational harm you
6 described, why don't you explain to me outside of the
7 complaints from some of the physicians and patients,
8 can you tell me how many patients you or somebody
9 else at the hospital have talked to about the
11:57 10 Leapfrog grades that were complained about?

11 MR. CHUNG: Objection to form.

12 A. I can't quantify the amount of patients.
13 Like I mentioned earlier, the amount of complaints
14 has been increasing, especially after the Tik Tok
11:57 15 video. That seemed to have really gotten out there
16 in the community, and more and more patients have
17 been complaining to the physicians, who then complain
18 to me, and I've also received direct complaints from
19 patients. They've left Google reviews referencing
11:57 20 the Tik Tok video. There's been different complaints
21 voiced, and we're seeing more and more of them as
22 time goes by.

23 BY MS. ZIBAS:

24 Q. And when you say more and more, how many do
11:58 25 you receive in a week?

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1 A. Between patients and physicians, between
2 four and five.

3 Q. And do you track those in a log or do you
4 have a journal or somewhere in the computer?

11:58 5 A. I do not.

6 Q. Does anybody track these complaints?

7 A. Some complaints are tracked. We have a
8 general grievance log, but it's not specifically for
9 Leapfrog letter grades or complaints.

11:58 10 Q. So what is the general grievance log?

11 A. That's -- it's a log that is maintained by
12 our patient safety officer and it's -- that's one of
13 the regulatory mandates by CMS. And this is mostly
14 for patients that have received services in our
11:58 15 facility.

16 Q. Why is there no log of the complaints
17 related to Leapfrog being maintained?

18 MR. CHUNG: Objection to form.

19 A. Yeah. I'm -- the hospital has -- that
11:59 20 would require additional resources, more time, you
21 know, dedicated to keeping track of all these
22 patients and complaints, and that is not something
23 that we can afford to do right now. Our staff is
24 committed to improving patient safety in the
11:59 25 hospital, and that's where we're redirecting our

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1 resources.

2 BY MS. ZIBAS:

3 Q. Has the complaints about this Tik Tok
4 video, did they come from patients or from
11:59 5 physicians?

6 A. Patients, physicians, staff, governing
7 board members.

8 Q. And have you had any physicians resign
9 because of the Leapfrog grades?

11:59 10 A. No.

11 Q. How is the nursing recruiting and
12 retention? Is it difficult?

13 MR. CHUNG: Objection to form.

14 A. What do you mean by difficult?

12:00 15 BY MS. ZIBAS:

16 Q. I mean, in general, is it difficult for
17 Palm Beach Gardens to attract nurses, and I'd say if
18 you compared 2025 to 2024?

19 MR. CHUNG: Objection to form.

12:00 20 A. I would not say that it's any different
21 than most hospitals.

22 BY MS. ZIBAS:

23 Q. Would you say that most hospitals have
24 difficulty attracting nurses or there's as nursing
12:00 25 shortage essentially?

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1 A. I think, in general, there's a nursing
2 shortage.

3 Q. Have there been any contracts signed with
4 any outside vendors to provide services related to
12:00 5 patient safety, to provide any services or consulting
6 related to patient safety?

7 A. Not that I'm aware of.

8 Q. Do you have any contract signed with
9 outside vendors that would provide advice or
12:01 10 consulting for quality improvement?

11 A. None that I'm aware of.

12 Q. Have -- since you've taken on your role as
13 CEO, have you made any changes, you yourself, to the
14 quality improvement plan?

12:01 15 A. The actual written plan, no.

16 Q. Okay. Have you provided guidance or
17 suggestions to make changes to the quality
18 improvement plan?

19 A. I have. I've directed my teams to enforce
12:01 20 the patient safety plan and to make sure that we
21 increase compliance with the patient safety plan
22 across the organization.

23 Q. What was the compliance prior to you
24 providing the guidance to increase the compliance?

12:02 25 A. Well, that's a broad question because like

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1 I mentioned earlier, the patient safety plan involves
2 many different things, but particularly, in patient
3 experience, which is an area that the hospital has
4 struggled for some time, we have directed our teams
12:02 5 to increase compliance with our patient experience
6 initiatives.

7 Q. Is patient experience one of the measures
8 that CMS looks at in their star rating?

9 A. Yes.

12:02 10 Q. Are there any other rating systems that you
11 haven't talked about yet today that Palm Beach
12 Gardens participates in? We talked about
13 Healthgrades, basically. Are there any others that
14 the hospital participates in?

12:03 15 A. That rate the hospital?

16 Q. Yes. Or grade the hospital. One of the
17 two.

18 A. Grade the hospital. Well, we said Joint
19 Commission, Healthgrades. There may be a couple
12:03 20 others that are listed on awards. American Heart
21 Association, we have a designation for stroke. And
22 then we have one for cardiac rehab, American
23 Association of Cardio and Pulmonary Rehab. We also
24 have a certification, and that's based on actual
12:03 25 audits of the facility in person.

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1 Q. And does Palm Beach Gardens pay for using
2 the -- pay a license fee or pay any fee to be able to
3 use the logos from like American Heart?

4 A. I'm not sure if we're paying. I really
12:03 5 don't know if we're actually paying to use their
6 logo.

7 Q. Do you know if Palm Beach Gardens and the
8 Palm Beach Health Network have been monitoring the
9 Leapfrog grades every grading period?

12:04 10 MR. CHUNG: Objection to form.

11 A. My understanding is that our quality
12 director keeps track of the Leapfrog grades.

13 BY MS. ZIBAS:

14 Q. And why does the quality director track the
12:04 15 Leapfrog grades?

16 A. I believe she's the one that has access to
17 the website. So that's how it's been set up.

18 Q. And is that a directive from the Tenet
19 Healthcare home office, or is this just something of
12:04 20 interest of the quality director?

21 A. I don't -- I don't know if it's -- there's
22 guidance from home office that it should be the
23 quality director or not. That's the way it's been,
24 and the quality director is the one that pulls those
12:05 25 scores or tracks them.

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1 Q. Has the quality director ever discussed
2 with you that they -- that Palm Beach Gardens would
3 like to participate in the Leapfrog survey?

4 MR. CHUNG: Objection to form.

12:05 5 A. No. She has not.

6 BY MS. ZIBAS:

7 Q. Do you have any -- do you have any evidence
8 or do you have any documents that would prove that
9 Leapfrog takes any money from hospitals to give them
12:05 10 better grades?

11 A. It is my understanding that when a
12 hospitals participates in Leapfrog, they submit data,
13 valuable data from their organization, and that
14 Leapfrog owns the rights to that data, which they can
12:06 15 then use for commercial purposes. Commercial gains
16 is what they actually have on their application when
17 the data is submitted, so we're technically having to
18 sign this form saying that Leapfrog now owns this
19 data and they can do with it as they please for
12:06 20 commercial gains. So we consider that a form of
21 compensation.

22 Once the hospital participates in Leapfrog, they
23 also have to pay Leapfrog to be able to market the
24 letter grade that they receive, so that's another
12:06 25 form of compensation. The opposite of that is if a

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1 hospital does not participate, they are then
2 penalized with a lower score in those four metrics
3 that we talked about earlier, which results in a
4 lower letter grade, as was the case in Palm Beach
12:06 5 Gardens Medical Center, and it ultimately resulted
6 with the public perception and reputation being
7 damaged, as I mentioned earlier, with physicians and
8 patients and community members complaining about
9 patients not wanting to go to Gardens because of the
12:07 10 low safety rating.

11 Q. So is it free -- is there a fee for the
12 hospital to complete the Leapfrog survey?

13 A. Not that I'm aware of. What I consider the
14 payment is what I mentioned earlier, which is we're
12:07 15 turning in the data, and we're handing it off, the
16 rights to that data, for Leapfrog to use and
17 monetize. And the CEO actually has to sign a
18 document that allows them to do that before
19 participating on that, as well as once the hospital
12:07 20 participates and they receive a letter grade, then
21 they're expected -- then they're expected to pay if
22 they want to market their letter grade, which is
23 another form of compensation there.

24 Q. But doesn't Healthgrades require you to pay
12:08 25 to market with their letter grade?

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1 A. They require -- from what I know, is that
2 you have to buy the trophy from them or the award, if
3 you want the award. You don't have to buy it. But
4 the big difference is that Healthgrades is not
12:08 5 penalizing us for not participating. If we don't
6 participate in Healthgrades or if we don't get an
7 award in Healthgrades, there is no public damage.
8 They don't go out there and automatically fail a
9 hospital in a particular area, as Leapfrog is doing.

12:08 10 Q. So these documents you talk about that you
11 have to sign, have you seen the documents that you
12 have to sign that Leapfrog requires you to sign?

13 A. Yes.

14 Q. When did you see them?

12:09 15 A. It's -- there's a document included in our
16 complaint that shows an example.

17 Q. Okay. And is that the first time you saw
18 the document in the complaint?

19 A. Yes, because I've never -- I've never
12:09 20 signed one before.

21 Q. And where is the information coming from
22 that indicates that you turned in the data and you --
23 and the rights belong to Leapfrog? Where is that
24 information coming from?

12:09 25 A. From that document.

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1 Q. Is that also from the complaint?

2 A. From -- yes.

3 Q. Okay. So the first time that you saw this
4 information is in the complaint that's filed in the
12:09 5 lawsuit; correct?

6 A. Yes. I had already heard of it from my
7 colleagues.

8 Q. And who told you about it?

9 A. Other colleagues.

12:09 10 Q. Who, which colleagues?

11 A. Other CEOs.

12 Q. And which CEOs talked about it?

13 A. This is years, years ago.

14 Q. How many years ago?

12:09 15 A. Four, five, six years ago. Throughout my
16 long tenure, I've known about that.

17 Q. And were they all Tenet hospital CEOs,
18 Tenet-owned hospital CEOs?

19 A. Not necessarily.

12:10 20 Q. How many CEOs talked about Leapfrog that
21 you recall that were not Tenet owned?

22 A. I don't -- I don't remember.

23 Q. Do you have any meetings with CEOs of
24 hospitals, say, quarterly or even annually that are
12:10 25 not Tenet-owned hospital CEOs?

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1 A. No, I don't have any formal meetings.

2 Q. Do you ever participate in any conferences
3 or any educational sessions with other CEOs of
4 hospitals that aren't Tenet owned?

12:10 5 A. I used to.

6 Q. And when did you stop?

7 A. I don't recall exactly.

8 Q. And why did you stop participating in
9 conferences?

12:10 10 A. Mostly time.

11 Q. So going back to this public perception.
12 Why don't you describe to me, quantify to me, what is
13 this public perception you keep describing in a very
14 negative way? How many people are impacted, et

12:11 15 cetera? Why don't you give me an idea, quantify
16 it --

17 A. I cannot --

18 MR. CHUNG: Objection to form. Asked and
19 answered, argumentative.

12:11 20 A. I cannot give you a specific number. Like
21 I mentioned, I'm currently receiving anywhere from
22 four to five complaints a week, combination of
23 physicians, patients, community stakeholders, and
24 those complaints have been increasing ever since that
12:11 25 Tik Tok video was released.

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1 BY MS. ZIBAS:

2 Q. Do you plan on tracking some of the
3 complaints now going forward, or are you still going
4 to continue to just not track --

12:12 5 A. I don't have any plans to track. Like I
6 mentioned, we have many things that we're doing in
7 the organization to run a hospital 24/7, to drive
8 quality. It's just another activity that it's not --
9 it's not a priority for us to be tracking all the
12:12 10 complaints that are coming in.

11 MS. ZIBAS: I'll mark this next Exhibit 4.

12 (Exhibit 4 was marked.)

13 BY MS. ZIBAS:

14 Q. I've put in front of you what we marked as
12:12 15 Exhibit 4, and it's a declaration that appears that
16 you drafted; is that correct?

17 A. Correct.

18 Q. And did you independently draft this?

19 A. This was drafted with the assistance of
12:13 20 lawyers.

21 Q. Did you ever discuss your declaration in
22 Exhibit 4 with Jared Hanlon?

23 A. No.

24 Q. Have you ever seen the declarations of the
12:13 25 other CEOs who are plaintiffs in this lawsuit?

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1 A. I have not.

2 Q. Have you discussed this lawsuit with any of
3 the other CEOs of the five plaintiff hospitals?

4 A. No.

12:13 5 Q. Would you know why some of the sentences in
6 the declarations of yours and Jared Hanlon are
7 exactly the same?

8 MR. CHUNG: Objection to form.

9 A. I don't know why.

12:13 10 BY MS. ZIBAS:

11 Q. All right. So in looking at -- starting
12 with page 2.

13 A. Okay.

14 Q. So starting -- actually, go to page 6. And
12:14 15 looking at paragraphs 13 and 14, where did you obtain
16 this background information if you were not CEO at
17 the time for -- to draft these two paragraphs?

18 A. Once again, we don't participate in
19 Leapfrog, is that what you're --

12:14 20 Q. No. I asked you where did you get this
21 information in 13 and 14 because you weren't CEO? So
22 I'm trying to understand where you got this
23 information.

24 A. Let me read it. I mean, this information
12:15 25 mimics the same sentiment I had at our previous

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1 facilities, as well, on why we don't participate in
2 Leapfrog.

3 Q. Okay. But the previous facility still gets
4 Cs; correct?

12:15 5 MR. CHUNG: Objection to form.

6 A. I don't know. I don't know what the
7 previous facility is doing right now.

8 BY MS. ZIBAS:

9 Q. Based on the exhibits I gave you, and I
12:15 10 guess you can always check the website, that they are
11 getting Cs now.

12 A. This is only two pages. I'm pretty sure
13 there's more to the assessment. So I can't tell by
14 this if they participated or not.

12:16 15 MS. ZIBAS: All right. There's a -- so if
16 you look at the -- and we'll mark this as
17 Exhibit 5, so you can compare.

18 (Exhibit 5 was marked.)

19 BY MS. ZIBAS:

12:16 20 Q. If you look at Exhibit 5 that's been put in
21 front of you, the Leapfrog hospital safety grade for
22 Palm Beach Gardens Medical Center, and it says F on
23 it; correct? And if you go to the second page in
24 red, it says declined to report. The hospital was
12:16 25 asked to provide this information to the public but

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1 did not, under notes and definitions. Is that an
2 accurate statement?

3 A. This is showing specifically -- I just
4 don't know what this is referring to specifically.

12:17 5 Q. Have you ever looked at the Leapfrog
6 hospital grade website?

7 A. I've gone in there.

8 Q. And was there anywhere on the website, did
9 you notice on the website that there is that language
12:17 10 that says the hospital did not participate or was
11 asked to provide information but did not? Have you
12 ever seen that on the website?

13 A. There are some metrics where it states
14 that, but then we're still graded on some of them and
12:17 15 on some we're not, which is part of the confusion
16 here, why we're not okay with that methodology.

17 Q. Who is we?

18 A. We, the hospital, myself.

19 Q. Now, looking at -- so paragraphs 13 and 14,
12:17 20 did you draft these, at all, these two paragraphs?
21 Did you draft any of this language yourself?

22 A. This was drafted with the assistance of
23 lawyers.

24 Q. And are you aware it's identical to their
12:18 25 language used by the other CEOs?

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1 A. That I did not know. I have not seen their
2 declarations.

3 Q. In paragraph 17 on the next page, it
4 references spring 2022 hospital safety grades and we
12:18 5 were surprised. Since you were not the CEO and you
6 were still working in Texas, where did the
7 information come from to draft paragraph 17?

8 A. This was -- this is on behalf of the
9 organization.

12:18 10 Q. And who provided you the information at the
11 organization to draft that paragraph?

12 A. This was in consultation with our lawyers.

13 Q. And paragraph 18 says in fall of 2024, TLG
14 adjusting it's grading methodology as noted below and
12:19 15 continued to grade the community hospital. How were
16 you notified about the adjustment to the grading
17 methodology?

18 MR. CHUNG: Objection to form.

19 In this line, continuing objection based on
12:19 20 privilege and just asking you based on privilege
21 not to -- if your responses involves
22 communications with counsel, not to -- not to go
23 into those communications.

24 A. Okay. Repeat the question.

12:19 25 BY MS. ZIBAS:

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1 Q. How did you learn about -- you have a
2 statement in paragraph 18, in fall of 2024, TLG
3 adjusted it's grading methodology as noted below and
4 continued to grade community hospital. How did you
12:19 5 learn about the adjusted grading methodology that you
6 reference in this sentence?

7 A. I learned about it after we received an F,
8 and I learned of it from our quality director.

9 Q. Now, in paragraph 19, you state in your
12:20 10 declaration, it shows that if you participate in its
11 pay-to-play, time consuming hospital survey, TLG
12 assigns you a better grade. What do you mean by
13 pay-to-play?

14 A. Well, as I mentioned earlier, if the
12:20 15 hospital participates, part of the participation is
16 that they have to submit the data, hand over the data
17 to Leapfrog. Leapfrog then can use that data as they
18 wish, including for commercial gains, and that's part
19 of the earlier comment that I made. And then once
12:20 20 the hospital receives a letter grade, they have to
21 pay Leapfrog to be able to promote that score or
22 publish that score or use their logo. So that's one.

23 The other one is the hospital is pressured to do
24 so, almost coercion, if you -- could be a word to
12:21 25 describe that because if you don't participate, if

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1 the hospital does not participate, the hospital gets
2 scored at the lowest possible score on those four
3 metrics that we discussed earlier, which the
4 hospital, Palm Beach Gardens Medical Center, is
12:21 5 performing well; yet, they scored at the very lowest
6 level.

7 So there is pressure for the hospital to
8 participate, pressure for the hospital to submit the
9 data, to hand it over to Leapfrog, and that's
12:21 10 basically where this pay for play comes from.

11 Q. What are the commercial gains that Leapfrog
12 gets that you described? Where are you getting your
13 information about the commercial gains?

14 A. That's not my information.

12:21 15 Q. Where is it?

16 A. That's what Leapfrog puts in their
17 statement. In their statement, Leapfrog says that
18 the data can be used for commercial gains.

19 Q. Okay. And again, that is -- you first read
12:21 20 that based on the complaint filed in this case;
21 correct? That's where you first read that
22 information?

23 A. That's where I first read it, but I've
24 already had -- like I mentioned earlier, I had
12:22 25 already known about it.

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1 Q. Why doesn't Palm Beach Gardens merely
2 participate in the survey, rather than spend the time
3 having to address all of the reputational damage?

4 MR. CHUNG: Objection to form.

12:22 5 A. Gardens does not participate because it is
6 a very time consuming activity that the hospital does
7 not feel participating in the survey is improving
8 patient safety or quality, and that time and
9 resources could be better spent addressing real
12:22 10 initiatives in the organization to improve safety and
11 quality.

12 BY MS. ZIBAS:

13 Q. How much time would be spent filling out
14 the Leapfrog survey based on your estimate that it's
12:23 15 time consuming?

16 A. I wouldn't be able to give you a time
17 estimate. But the individuals that put this work
18 together, they have many other things to do in the
19 hospital, and this is not an additional burden that
12:23 20 we would want to provide them with.

21 Q. And since the hospital is already
22 completing the CMS data, isn't most of the data
23 that's submitted to Leapfrog similar?

24 MR. CHUNG: Objection to form.

12:23 25 A. Some of the data is similar, but there's

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1 still a lot of work and additional work that is
2 required to submit the Leapfrog survey, and that is
3 not time or resources that the hospital is going to
4 commit when those could be better spent elsewhere in
12:23 5 the organization.

6 BY MS. ZIBAS:

7 Q. And you referenced that the organization
8 would rather spend it on improvements. What
9 improvements is the Palm Beach Gardens working on in
12:23 10 lieu of spending time and resources on the survey?

11 MR. CHUNG: Objection to form.

12 Mischaracterizes prior testimony.

13 A. Going back to my earlier comments about the
14 hospital's overall goals, our goal is to continuously
12:24 15 improve patient safety, quality, patient experience
16 in the organization, and we have many initiatives
17 that are geared towards that. And that's where our
18 resources will continue to be funneled to.

19 BY MS. ZIBAS:

12:24 20 Q. So going to page 13 of your declaration,
21 you have as the top line, TLG safety grades harm the
22 community, hospital, its patients, and its community.
23 You drafted this paragraph or with the guidance of
24 counsel drafted the paragraph, and today you came in
12:25 25 here and you're testifying about a number of

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1 physicians and other patients. Why did you not list
2 them in this paragraph?

3 MR. CHUNG: Objection to form.

4 A. I think I answered that earlier. We
12:25 5 continue to get complaints. Like I said, every week,
6 we get more and more complaints in there, as well.
7 And here it's broadly stated that we've been
8 receiving complaints from physicians and patients in
9 the community, and we continue to do so to this day.

12:25 10 BY MS. ZIBAS:

11 Q. How many complaints has medical executive
12 committee told you that they received?

13 A. I can't quantify that.

14 Q. Why can't you quantify it?

12:25 15 A. Because I'm not keeping track of how many
16 complaints are being brought to my attention from
17 every individual. I can tell you, in general, four
18 to five complaints a week is what I can tell you at
19 this point.

12:25 20 Q. Do you consider any of the complaints from
21 patients or the governing board legitimate complaints
22 about the patient care at Palm Beach Gardens?

23 MR. CHUNG: Objection to form.

24 A. I don't understand your question.

12:26 25 BY MS. ZIBAS:

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1 Q. So you said that everyone that you're
2 receiving complaints, is that correct, complaints
3 about the Leapfrog grades?

4 A. Complaints about patients not wanting to go
12:26 5 to Gardens because of the letter F grade.

6 Q. And do you think that some of the concerns
7 of the patients are legitimate --

8 MR. CHUNG: Objection to form.

9 MS. ZIBAS: -- regarding the patient care
12:26 10 at Palm Beach Gardens?

11 MR. CHUNG: Objection to form.

12 Mischaracterizes witness' testimony.

13 A. The concerns that the patients have are
14 that the hospital has received an F grade for patient
12:26 15 safety, and therefore, choosing not to come to the
16 hospital. That's the reputational harm that we're
17 referring to.

18 BY MS. ZIBAS:

19 Q. But you haven't been able to quantify, at
12:26 20 this point, that reputational harm?

21 MR. CHUNG: Objection to form.

22 Mischaracterizes the witness's testimony.

23 BY MS. ZIBAS:

24 Q. Because you state in your declaration,
12:27 25 there's reputational harm.

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1 A. There's reputational harm.

2 Q. Have you not been able to quantify it?

3 A. There's reputational harm, patient

4 complaints, patients are leaving to our sister

12:27 5 facility -- to our competing facility, which is

6 Jupiter Medical Center. They've communicated that to

7 our physicians. And these are the complaints that I

8 receive on a weekly basis.

9 Q. How -- What's your percentage of decrease

12:27 10 in admissions between 2024 and 2025?

11 A. I don't have it in front of me. There's a

12 document that, I believe, we address that, but I

13 can't think of it right off the top of my head.

14 Q. Is there a decrease in inpatient

12:27 15 admissions?

16 A. There's a slight increase.

17 Q. And is there a decrease in ER visits?

18 A. There is.

19 Q. What's the percentage?

12:27 20 A. Roughly, 5, 6 percent. Somewhere around

21 that range.

22 Q. And is there a decrease in the outpatient

23 services?

24 A. Yes.

12:28 25 Q. What's the percentage decrease?

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1 A. I believe it's similar, maybe a little
2 over.

3 Q. And have any -- has the hospital taken on
4 any survey or research as to what is causing the
12:28 5 decrease in the ER visits and the outpatient
6 services?

7 A. No.

8 Q. So in paragraph 25 of your declaration, you
9 indicate in the last sentence that resources that
12:28 10 could have otherwise been spent continuing to improve
11 patient care. So why don't you describe to me what
12 the resources -- what the patient care improvements
13 have been where you're spending the resources?

14 A. I mentioned that earlier. There's
12:29 15 different activities that the hospital targets when
16 it comes to patient experience, decreasing patient
17 falls, making sure we have compliance with different
18 quality metrics across the organization. For
19 example, handwashing, fall prevention, that's where
12:29 20 the resources are going.

21 MS. ZIBAS: I'll give you Exhibit 6.

22 (Exhibit 6 was marked.)

23 BY MS. ZIBAS:

24 Q. This is an e-mail from Maggie Gill dated
12:29 25 December 11, 2024. It's Exhibit 6. And you were one

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1 of the recipients of this e-mail. Do you see that in
2 the top of this e-mail?

3 A. I do.

4 Q. And the body of the e-mail and the subject
12:30 5 says FYI, and at the bottom, it says, please send me
6 request reintroduce Leapfrog reporting, include
7 rationale, imputed score, and clippings of negative
8 press/community and MD feedback. I will request an
9 exception for PBHN and PMC to start next reporting
12:30 10 period. Thanks, Maggie.

11 Do you recall that e-mail, receiving that
12 e-mail?

13 A. I do.

14 Q. And was this topic discussed with Maggie or
12:30 15 among the CEOs, at all, about reintroducing Leapfrog
16 reporting?

17 A. I don't recall having a conversation with
18 them. I do recall this e-mail.

19 Q. And was a request made to reintroduce
12:30 20 Leapfrog reporting?

21 A. No, not that I'm aware of.

22 Q. Did you hear anything further about this
23 e-mail?

24 A. No.

12:31 25 Q. Do you know why Maggie made that request?

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1 A. I can't speak for Maggie so -- but I'm --
2 no. I can't speak for why Maggie made that request.
3 As far as my hospital is concerned, I had voiced to
4 Maggie that we were starting to get complaints from
12:31 5 physicians about our F grading in Leapfrog.

6 Q. Do you agree with the -- with Maggie's
7 e-mail to re -- to request to reintroduce Leapfrog
8 reporting?

9 MR. CHUNG: Objection to form.

12:31 10 A. I don't agree or disagree. I mean, that's
11 her statement.

12 BY MS. ZIBAS:

13 Q. Do you want -- did -- did Palm Beach
14 Gardens want to start participating in Leapfrog,
12:32 15 again, in the survey?

16 A. You mean, did I want to?

17 Q. Yes.

18 A. No.

19 MS. ZIBAS: Here's Number 7.

12:32 20 (Exhibit 7 was marked.)

21 BY MS. ZIBAS:

22 Q. I'm handing you an e-mail from Naomi
23 Seymour to you dated December 11, 2024. Do you see
24 that?

12:32 25 A. Yes.

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1 Q. Do you recall receiving this e-mail?

2 A. Yes.

3 Q. It says, Ricky shared that we will probably
4 start submitting to Leapfrog, again. So their tactic
12:32 5 worked. What does that mean, in your opinion, when
6 you received that e-mail? Did you understand that to
7 mean?

8 A. Which specific part?

9 Q. The whole sentence or two sentences.

12:33 10 A. The one that Naomi sent?

11 Q. Yes. First, who is Naomi?

12 A. She is my chief nursing officer.

13 Q. Okay.

14 A. Basically, she's saying that Ricky, who is
12:33 15 the group chief nursing officer, alluded to that we
16 may start submitting to Leapfrog, again, is what it
17 says there. And then she makes a reference so that
18 their tactic worked. She's referring to Leapfrog's
19 pressure on the hospitals to participate by handing
12:33 20 out F grades is what -- that's the way I interpret
21 the e-mail.

22 Q. Are you aware there are nonparticipating
23 hospitals that earn As and Bs?

24 MR. CHUNG: Objection, form.

12:34 25 A. No. I'm not aware of what other hospitals.

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1 BY MS. ZIBAS:

2 Q. Have you ever looked at that factor, that
3 there are hospitals who do not participate that
4 receive high letter grades?

12:34 5 MR. CHUNG: Objection, form.

6 A. I have not looked into that.

7 BY MS. ZIBAS:

8 Q. Would it surprise you to learn that because
9 they had these other nonparticipating Leapfrog
12:34 10 hospitals that had high CMS scores ended up with high
11 letter grades?

12 MR. CHUNG: Objection.

13 A. What was your question?

14 BY MS. ZIBAS:

12:34 15 Q. I said would it surprise you to learn the
16 nonparticipating Leapfrog hospitals had high CMS
17 scores and, thus, they had high letter grades?

18 MR. CHUNG: Objection to form.

19 A. Yeah. I'm not concerned about other
12:34 20 hospitals. I'm concerned about my hospital.

21 BY MS. ZIBAS:

22 Q. If you're not concerned about other
23 hospitals, why does the reputational harm, why is
24 that an issue?

12:34 25 MR. CHUNG: Objection to form.

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1 A. Because my hospital is being -- is the one
2 receiving reputational harm as a result of the F
3 grade.

4 BY MS. ZIBAS:

12:34 5 Q. And how has that impacted the hospital?

6 MR. CHUNG: Objection to form, asked and
7 answered.

8 BY MS. ZIBAS:

9 Q. You don't have to repeat what you already
12:35 10 answered. If there's anything you want to add about
11 the reputational harm or goodwill damage that you've
12 put in your declaration.

13 A. As I mentioned earlier, we've lost patients
14 to other hospitals as a direct result of the F grade
12:35 15 that was handed to Palm Beach Gardens Medical Center,
16 and it continues to be a problem as physicians
17 continue to voice concerns about patients not wanting
18 to go to Palm Beach Gardens Medical Center to receive
19 care, and we're getting four to five complaints a
12:35 20 week on this.

21 Q. How many actual patients have you lost to
22 Jupiter Medical Center? Because you've only
23 mentioned two, specifically, during this deposition.

24 MR. CHUNG: Objection to form.

12:35 25 Mischaracterizes prior testimony.

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1 BY MS. ZIBAS:

2 Q. How many are there that you can name?

3 A. I've mentioned that we -- that I receive
4 four to five complaints a week.

12:36 5 BY MS. ZIBAS:

6 Q. But of those complaints, how many of those
7 patients actually did come to Palm Beach Gardens?

8 A. That is not a question that I can directly
9 answer for you.

12:36 10 Q. Now, was the fact that there was -- would
11 be a lawsuit filed on behalf of Palm Beach Gardens
12 ever discussed with the governing board?

13 MR. CHUNG: Objection.

14 Based on privilege, I'm instructing the
12:36 15 witness not to answer that question.

16 MS. ZIBAS: These are governing board
17 minutes. There's nothing to do with lawyers.
18 This has to do with the governing board minutes
19 of a board that's public under Sunshine.

12:36 20 MR. CHUNG: You're referencing minutes that
21 we have not seen and have not been put in front
22 of the witness.

23 MS. ZIBAS: Well, I'm asking if he
24 discussed it with the board, which I'm allowed
12:36 25 to do.

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1 BY MS. ZIBAS:

2 Q. Did you discuss with the board, unrelated
3 to lawyers, the filing of this lawsuit?

4 MR. CHUNG: I'm objecting based on
12:37 5 privilege, if any of those discussions with the
6 governing board involved consultation with
7 counsel, either inside counsel or outside
8 counsel --

9 MS. ZIBAS: And I'm not asking about that.
12:37 10 Just any discussions --

11 MR. CHUNG: Let me finish the objection.
12 I'm asking you not to get into those
13 discussions, those communications.

14 BY MS. ZIBAS:

12:37 15 Q. So did you have any discussions with the
16 board members outside of the presence of counsel
17 about filing this lawsuit?

18 A. I don't recall.

19 Q. And who is paying the legal fees? Because
12:37 20 there's a request for attorney's fees made in this
21 lawsuit. Who is paying the legal fees on behalf of
22 Palm Beach Gardens?

23 A. I'm not sure.

24 Q. So you're not aware if the hospital is
12:37 25 paying? If the hospital is not paying, who is

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1 paying?

2 MR. CHUNG: Objection to form.

3 A. I said I'm not sure. That would be a
4 question for my CFO.

12:38 5 BY MS. ZIBAS:

6 Q. Have you ever discussed with your CFO the
7 legal fees for this lawsuit?

8 A. No.

9 Q. Have -- do you ever review the financials
12:38 10 on a monthly basis of expenditures?

11 A. High level.

12 Q. Do you ever look at the legal spent for the
13 hospital?

14 A. It's a line item.

12:38 15 Q. Have you looked at it in the last three
16 months?

17 A. I'm pretty sure I've looked at it, but I
18 don't recall what it was.

19 Q. You don't recall any numbers in the last
12:38 20 three months?

21 A. No.

22 MS. ZIBAS: This is Number 8.

23 (Exhibit 8 was marked.)

24 BY MS. ZIBAS:

12:39 25 Q. And if you take a look, what I'm giving you

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1 is Exhibit 8, are the governing board minutes dated
2 December 17, 2024. Do you see those?

3 A. Uh-huh.

4 Q. And if you review these minutes, is there
12:39 5 any reference to Leapfrog in the minutes?

6 A. There's a reference on here.

7 Q. Is that Bates number 17883 on the bottom
8 right-hand corner.

9 A. Yes.

12:40 10 Q. Okay. In that reference, was that reported
11 by you during the meeting or somebody else? Was it
12 reported by Kathleen McDonald, it looks like, under
13 quality report?

14 A. Well, it's got my name on there.

12:40 15 Q. And do you recall making the statement, it
16 says, Mr. Cazares noted that the hospital will likely
17 begin participation with Leapfrog moving forward in
18 efforts to mitigate the potential for disparaging
19 publications. Do you see that?

12:41 20 A. I do see that.

21 Q. And do you recall why you made that
22 statement in December 17, 2024?

23 A. Well, that must have been around the time
24 that the market was alluding to potentially begin
12:41 25 participating again.

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1 Q. And did you agree with your statement in
2 moving forward in efforts to mitigate the potential
3 for disparaging publications?

4 MR. CHUNG: Objection to form.

12:41 5 A. Repeat the question.

6 BY MS. ZIBAS:

7 Q. I mean, did you agree with your statement
8 about participating with Leapfrog moving forward in
9 efforts to mitigate the potential for disparaging
12:41 10 publications?

11 A. Yeah. It was a notification that the
12 market might move forward with participating in
13 Leapfrog again.

14 Q. In litigation, there's a statement that the
12:42 15 goodwill of Palm Beach Gardens Community Hospital has
16 been harmed. How has the goodwill been harmed?

17 MR. CHUNG: Objection to form.

18 A. Well, this goes back to my earlier
19 statements about patients, community members,
12:42 20 governing board members voicing complaints about the
21 hospital's low safety score.

22 BY MS. ZIBAS:

23 Q. What's your understanding of the term
24 goodwill, as used in the complaint and your
12:42 25 declaration?

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1 A. Well, the hospital's ability to do right by
2 their patients, by the community.

3 MS. ZIBAS: I'm going to take, like, maybe
4 five or ten minutes and see what other things I
12:43 5 want to ask, if anything.

6 THE VIDEOGRAPHER: We're off the record at
7 12:43 p.m.

8 (Brief recess was taken at 12:43 p.m.)

9 (Back on the record at 12:51 p.m.)

12:52 10 THE VIDEOGRAPHER: We're back on the
11 record. Time is 12:51 p.m.

12 BY MS. ZIBAS:

13 Q. Are there any plans currently at Palm Beach
14 Gardens on how to improve the CMS star rating?

12:52 15 A. As I mentioned earlier, our goals are
16 ongoing to improving patient safety quality and
17 patient experience for the hospital, for our
18 patients, that's a part of our goal, not necessarily
19 to improve the specific grading of any organization.

12:53 20 Q. Do you have any documents that you
21 submitted in this case or that you know that your
22 staff may have submitted that directly links the
23 decrease in the ER visits and outpatient visits to
24 the Leapfrog grade?

12:53 25 MR. CHUNG: Objection to form.

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1 A. I don't. I'm not aware of any.

2 BY MS. ZIBAS:

3 Q. What about linking the admission, number of
4 admissions to the Leapfrog grading? Are there any
12:53 5 documentation to support such a statement?

6 MR. CHUNG: Objection to form.

7 A. I don't have any. I'm not aware of any
8 document that was submitted specific for that.

9 BY MS. ZIBAS:

12:54 10 Q. And was the governing board involved in
11 deciding whether to file this lawsuit creating more
12 publicity in litigating this case about the Leapfrog
13 grade?

14 MR. CHUNG: Objection to form.

12:54 15 A. The governing board was not involved in the
16 decision.

17 BY MS. ZIBAS:

18 Q. Who was involved in the decision?

19 MR. CHUNG: Objection to form.

12:54 20 MS. ZIBAS: To file the lawsuit and
21 increase the publicity about the Leapfrog grade.

22 MR. CHUNG: Objection to form.

23 A. The decision was made to file the lawsuit.
24 That's -- that was above my pay grade. From Maggie,
12:55 25 Maggie Gill. I don't know if above her, I don't

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1 know. I don't know who made the final decision.

2 BY MS. ZIBAS:

3 Q. And is the governing board kept up-to-date
4 on the cost of the legal fees for the litigation?

12:55 5 A. No. The cost of the litigation are not
6 clear to us right now, so they haven't been updated
7 on what the cost of that.

8 Q. Will the governing board be updated?

9 A. I don't know.

12:55 10 Q. How -- when will you know if you need to
11 update them?

12 MR. CHUNG: Objection to form.

13 A. I think the decision will be made if --
14 depending on where the funds come from, come from.

12:56 15 BY MS. ZIBAS:

16 Q. Where would the funds come from, if not
17 from the hospital?

18 A. I don't know.

19 Q. Does Palm Beach Gardens use a company
12:56 20 called Trulliant [sic.]?

21 A. Trulliant?

22 Q. Yes.

23 A. Or Trilliant?

24 Q. Trilliant. You may not. It's for data
12:56 25 gathering, not all hospitals use it.

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1 A. Trilliant.

2 Q. Maybe I'm mispronouncing --

3 A. I'm familiar with Trilliant. I do believe
4 some people in the market may use that for data
12:56 5 gathering.

6 Q. Does Palm Beach Gardens use it, as far as
7 you know?

8 A. Specifically, I don't -- I don't have
9 access to Trilliant, but I don't know if some of the
12:57 10 other employees have access to it.

11 Q. Does Palm Beach Gardens have a contract
12 with Vizient as a consulting firm?

13 A. I'm not aware of that?

14 MS. ZIBAS: I don't believe I have any
12:57 15 other questions at this time. Obviously, if new
16 documents are produced later on in this
17 litigation that involve this witness, we would
18 reserve the right to submit questions for that
19 purpose only. Not saying that's going to
12:57 20 happen, but if it does.

21 MR. CHUNG: I will have very brief
22 redirect. Let me ask you, Counsel, if you are
23 -- have a copy of the amended complaint? Do you
24 have a copy of the amended complaint that we can
12:58 25 use?

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1 MS. ZIBAS: No. Mine is marked up. Can't
2 use mine.

3 MR. CHUNG: That's fine. I think what we
4 will do is just a couple of questions coming off
12:58 5 the amended complaint. We have it on laptop and
6 I think what we can do is get approved visually
7 and designate the complaint as I think
8 Exhibit 9, and we can deal with the logistics
9 later of getting it formally marked.

12:58 10 I'm going to ask Mr. Fischer to put an
11 electronic version of the amended complaint,
12 which we'll designate and later mark as
13 Exhibit 9.

14 (Exhibit 9 was marked.)

12:58 15 CROSS-EXAMINATION

16 BY MR. CHUNG:

17 Q. Mr. Cazares, do you recognize the document
18 that's in front of you as the amended complaint in
19 this action?

12:58 20 A. Yes.

21 Q. And are you familiar with the amended
22 complaint?

23 A. Yes.

24 Q. And I'm going to direct your attention to
12:59 25 page 17 and paragraph 42 of the amended complaint, if

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1 you can just toggle down to it. And just let us know
2 when you're there.

3 A. 17?

4 Q. Yes. Page 17. It's paragraph 42.

12:59 5 A. Yes.

6 Q. Do you see that?

7 A. Yes.

8 Q. Earlier in the day, you were asked
9 questions by counsel about a document, a Leapfrog
12:59 10 document in the complaint that referenced commercial
11 purpose or commercial -- commercial gains in the
12 context of questions you were asked about the
13 pay-to-play allegation.

14 A. Correct.

12:59 15 Q. Do you remember those questions?

16 A. Yes, I do.

17 Q. Okay. Is the document that's kind of blown
18 up in paragraph 2, the document that you were
19 referencing?

12:59 20 A. Yes.

21 Q. And are you aware that that is -- or are
22 you familiar with the -- are you aware that document
23 is an excerpt from Leapfrog's hospital survey?

24 A. Correct.

01:00 25 Q. And can you just read the -- and what is it

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1 exactly? What is it an excerpt of?

2 A. It's part of the patient rights and ethics
3 section, basically an attestation by the CEO that is
4 being made here.

01:00 5 Q. All right. And what does that attestation
6 cover?

7 A. Basically that the information has been
8 reviewed. It's accurate. Reflects the most
9 up-to-date information. And then it talks about the
01:00 10 Leapfrog Group will retain exclusive ownership of the
11 data, intellectual property rights, and that the
12 hospital acknowledges that the group, that the
13 Leapfrog Group may use the information in a
14 commercial manner for profit.

01:01 15 Q. This is the document you were referring to
16 earlier?

17 A. Yes.

18 Q. When you were referencing --

19 A. Commercial gains.

01:01 20 Q. -- the commercial gains that Leapfrog is
21 asking the hospital, the reporting hospital to sign
22 over as a condition of participating in the survey;
23 correct?

24 A. That's correct. That's the document that I
01:01 25 was referring to.

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1 MR. CHUNG: Okay. No further questions.

2 Thank you.

3 MS. ZIBAS: Looks like we're done.

4 THE STENOGRAPHER: Would you like to read

01:01 5 of waive?

6 MR. CHUNG: I'm sorry?

7 THE STENOGRAPHER: Would you like to read

8 or waive?

9 MR. CHUNG: We can -- we'll read.

01:01 10 MS. ZIBAS: And you're going to gather all

11 of the exhibits, right, and take them with you

12 and attach them. Thank you. Appreciate it.

13 THE VIDEOGRAPHER: Off the record at 1:01

14 p.m.

15 (Thereupon, the proceedings concluded at

16 1:01 p.m.)

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1 CERTIFICATE OF OATH

2

3 THE STATE OF FLORIDA)

4 COUNTY OF MIAMI-DADE)

5

6

7

8

9 I, THERESA RUST, the undersigned authority,
10 certify that ERIK CAZARES, appeared before me and was
11 duly sworn on the 24th day of September 2025.

12 Signed this 24th day of September 2025.

13

14

15

16

17 THERESA RUST, RPR
18 Notary Public - State of Florida
Commission No. #GG145788
Expires: October 25, 2025

19

20

21

22

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24

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1 CERTIFICATE OF REPORTER

2

3 THE STATE OF FLORIDA)

4 COUNTY OF MIAMI-DADE)

5

6 I, Theresa Rust, Florida Professional
7 Reporter, certify that I was authorized to and did
8 stenographically report the video-recorded deposition
9 of ERIK CAZARES, pages 1 through 97, that a review of
10 the transcript was requested, and that the transcript
11 is a true and complete record of my stenographic
12 notes.

13 I further certify that I am not a relative,
14 employee, attorney, or counsel of any of the parties,
15 nor am I a relative or employee of any of the
16 parties' attorney or counsel connected with the
17 action, nor am I financially interested in the
18 action.

19

20 DATED this 24th day of September 2025.

21

22

23

Theresa Rust, RPR, FCRR

24

25

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September 24, 2025

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1 October 9, 2025

2 DANIEL CHUNG, ESQUIRE
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3

ERIK CAZARES

4 IN RE: GOOD SAMARITAN VS. THE LEAPFROG GROUP
CASE NO.: 9:25-CV-80526-DMM

5 TYPE OF PROCEEDING: DEPOSITION

DATE: 9.24.25

6

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19

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23

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ERIK CAZARES

25 Job No. 422124

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CASE NO. 9:25-CV-80526-DMM
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22 _____
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Exhibit 91

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA
WEST PALM BEACH DIVISION

-----X
GOOD SAMARITAN MEDICAL)
CENTER, INC., et al.,)
)
Plaintiffs,) CASE NO.
)
v.) 9:25-CV-80526-DMM
)
THE LEAPFROG GROUP,)
)
Defendant.)
-----X

VIDEOTAPED 30(B)(6) DEPOSITION OF
THE LEAPFROG GROUP,
BY AND THROUGH ITS CORPORATE REPRESENTATIVE,
MELISSA AMEE DANFORTH,
AND IN HER PERSONAL CAPACITY
Thursday, September 18, 2025; 9:11 a.m. EST

Reported by: Cindy L. Sebo, RMR, CRR, CLR, RPR,
CCR, CSR, RSA, CA CSR 14409, NJ Certified CR
30XI0024460, NJ Certified RT 30XR00019500, NM CSR
589, NY Realtime Court Reporter, NY Association
Certified Reporter, OR CSR 230105, TN CSR 998, TX
CSR 12778, WA CSR 23005926, Remote Counsel
Reporter, LiveLitigation Authorized Reporter,
Notary Public
Job No. 7574666

Videotaped 30(b)(6) Deposition of THE LEAPFROG GROUP, By and Through its Corporate Representative, MELISSA AMEE DANFORTH, and in her personal capacity, held at the law offices of Gibson, Dunn & Crutcher LLP, 1700 M Street, Northwest, Washington, D.C. 20036-4504, before Cindy L. Sebo, Registered Merit Court Reporter, Certified Real-Time Reporter, Certified LiveNote Reporter, Registered Professional Reporter, Certified Court Reporter, Certified Shorthand Reporter, Real-Time Systems Administrator, California Shorthand Reporter 14409, New Jersey Certified Court Reporter 30XI00244600, New Jersey Certified Realtime Reporter 30XR00019500, New Mexico CSR 589, New York Realtime Certified Reporter, New York Association Certified Reporter, Oregon CSR 230105, Tennessee CSR 998, Texas CSR 12778, Washington CSR 23005926, Remote Counsel Reporter, LiveLitigation Authorized Reporter and Notary Public, beginning at approximately 9:11 a.m. EST, when were present on behalf of the respective parties:

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ALSO PRESENT:

GLEN FORTNER, Videographer

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Attorney Crain

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(Exhibits Provided to Reporter.)

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DEPOSITION

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P R O C E E D I N G S

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Washington, D.C.

Thursday, September 18, 2025; 9:11 a.m. EST

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(Danforth Deposition Exhibit Number
1, Notice of 30(b)(6) Deposition
of The Leapfrog Group, marked for
identification, as of this date.)

--oOo--

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(Danforth Deposition Exhibit Number
2, Leapfrog's Designations and
Objections to Plaintiffs' Notice
of 30(B)(6) Deposition of The
Leapfrog Group, marked for
identification, as of this date.)

--oOo--

THE VIDEOGRAPHER: Good

1 morning. We are going on the record
2 at 9:11 on September 18th, 2025.

3 Please note the microphones
4 are sensitive and may pick up
5 whispering and private conversations.

6 Please mute your phones at
7 this time.

8 Audio and video recording
9 will continue to take place unless
10 all parties agree to go off the
11 record.

12 This is Media Unit 1 of the
13 videorecorded deposition of
14 Melissa Danforth, both in her
15 personal capacity and as a 30(b)(6)
16 representative for Leapfrog, taken by
17 counsel for Plaintiff in the matter
18 of Good Samaritan Medical Center,
19 Inc., et al. v. The Leapfrog Group
20 filed in the United States District
21 Court for the Southern District of
22 Florida, Number 9:25-CV-80526.

1 The location of the
2 deposition is Gibson Dunn.

3 My name is Glen Fortner,
4 representing Veritext, and I'm the
5 videographer. The court reporter is
6 Cindy Sebo from the firm Veritext.

7 I'm not related to any party
8 in this action nor am I financially
9 interested in the outcome.

10 Counsel will be noted on the
11 stenographic record.

12 Will the court reporter
13 please swear in the witness? And
14 then counsel may proceed.

15 --oOo--

16 MELISSA AMEE DANFORTH,
17 after having been first duly sworn under
18 penalty of perjury by the certified
19 stenographer to tell the truth, the whole
20 truth and nothing but the truth, testified
21 herein as follows:

22 --oOo--

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CERTIFIED STENOGRAPHER:

Thank you.

The witness is sworn,
Counsel.

--oOo--

EXAMINATION BY COUNSEL FOR PLAINTIFFS

--oOo--

BY ATTORNEY CRAIN:

Q. Good morning, Ms. Damforth.

A. Good morning. Danforth.

Q. Danforth. I'm sorry.

A. Yes. I'm sorry. I know.

As soon as he said it, I was like,
it's going to last all day.

Danforth.

Q. Like go forth?

A. Yeah.

Q. Got it.

Well, welcome to Gibson Dunn.

A. Thank you.

Q. My name is Lee Crain. I am counsel
for the Plaintiffs in this lawsuit.

1 Can you please state your full
2 name for the record?

3 A. Melissa Danforth.

4 Q. And have you ever gone by any other
5 names?

6 A. Everyone calls me Missy.

7 Q. Great.

8 Have you ever been deposed
9 before?

10 A. No.

11 Q. Okay. So I want to go through some
12 just ground rules so we're on the same page.

13 A. Okay.

14 Q. You understand that the court
15 reporter is taking a transcription?

16 A. Yes.

17 Q. And you understand that all our
18 questions and answers need to be oral?

19 A. Yes.

20 Q. So no nodding heads, that sort of
21 thing. Just make sure when you're responding to
22 a question, it's all oral.

1 A. Understood.

2 Q. We're going to need to make sure we
3 slow down our conversation, a little bit
4 differently from normal talk. Try not to talk
5 over me. I will try not to talk over you to
6 make sure she has a clean record.

7 Sound fair?

8 A. Yes.

9 Q. If you have any need for a break --
10 I understand you may need to stand up at certain
11 times because of a medical condition -- don't
12 hesitate to say if you need a break.

13 The only thing I will ask is I
14 -- we -- we will not be taking a break while a
15 question is pending.

16 A. Understood.

17 Q. Okay. You understand today you're
18 under oath --

19 A. Yes.

20 Q. -- as if you were testifying in a
21 court?

22 A. Yes.

1 Q. Great.

2 And are you taking any
3 medication or under the influence of anything
4 that might impair your ability to give truthful
5 testimony today?

6 A. No.

7 Q. You understand that you have the
8 obligation to testify truthfully today?

9 A. Yes.

10 Q. Okay. You understand from time to
11 time, your attorney may object?

12 A. Yes.

13 Q. And if she objects, unless she
14 instructs you not to answer, you're -- you still
15 are required to answer the question.

16 Do you understand that?

17 A. Yes.

18 Q. Great.

19 Okay. So let's jump in. I
20 want to start -- first, you have two documents
21 in front of you that we have premarked as
22 Exhibits 1 and 2.

1 A. Yes.

2 Q. Do you recognize those documents?

3 A. Yes, I do.

4 Q. Have you seen them before?

5 A. I have.

6 Q. And Exhibit 1 is the Notice of
7 Deposition -- 30(b)(6) Deposition of The
8 Leapfrog Group.

9 Do you see that?

10 A. Yes.

11 Q. And then Exhibit 2 is Leapfrog's
12 Designations and Objections to Plaintiffs'
13 Notice of 30(b)(6) Deposition.

14 Do you see that?

15 A. Yes.

16 Q. You understand today you are
17 testifying both in your personal capacity and on
18 behalf of The Leapfrog Group, the Defendant in
19 this case?

20 A. That's correct.

21 ATTORNEY BLAIR: Objection to
22 form.

1 BY ATTORNEY CRAIN:

2 Q. Do you understand that you're
3 testifying today on behalf of The
4 Leapfrog Group?

5 A. Yes.

6 Q. Do you understand that you're also
7 here to testify in your personal capacity?

8 A. I do.

9 Q. Great.

10 And Leapfrog has designated you
11 as its corporate representative for certain of
12 the designated topics.

13 Do you see that?

14 A. I do.

15 Q. Are you -- have you reviewed these
16 topics before?

17 A. I have.

18 Q. Great.

19 Okay. So I won't go through
20 all of them now. We'll go through all of them
21 throughout the day.

22 You can set those aside for

1 now.

2 So you said you were never --
3 you have never been deposed, correct?

4 A. Correct.

5 Q. Have you ever testified in court?

6 A. No.

7 Q. Testified in any other context?

8 A. No.

9 Q. Okay. And did you prepare for your
10 deposition today?

11 A. I did.

12 Q. What generally did you do to
13 prepare?

14 A. I met with Ms. Blair and Ms. Wood
15 three to four times --

16 Q. Okay.

17 A. -- I believe.

18 Q. Approximately when?

19 A. I would say over the past several
20 weeks since the notice of deposition. I know --
21 I apologize.

22 Can I look at the timing?

1 Q. Of course.

2 A. This was since -- three or four
3 times since the notice of deposition --

4 Q. All right.

5 A. -- yeah.

6 Q. And did you meet with other Leapfrog
7 employees?

8 A. The first time we prepared for
9 depositions, which none of us had taken before,
10 we initially met as a small group of those on
11 the deposition list briefly probably for three
12 or four hours just to have Ms. Blair explain
13 what a deposition is.

14 And then --

15 Q. I just -- I do not want you to share
16 anything that your counsel conveyed to you. And
17 I assume Ms. Blair agrees.

18 ATTORNEY BLAIR: Yes, I
19 agree, but --

20 THE WITNESS: But then after
21 that, I did all of my preparation just
22 with Ms. Blair and Ms. Wood alone.

1 BY ATTORNEY CRAIN:

2 Q. Okay. And approximately how long
3 were your meetings?

4 A. I would say between a few hours and
5 a full day.

6 Q. Did you review any documents to
7 prepare for this deposition?

8 A. I did.

9 Q. Can you tell me generally what you
10 looked at?

11 A. I looked at PowerPoints, e-mails,
12 financial documents -- a lot of documents.

13 Q. Any -- any ballpark estimate?

14 A. Probably a couple dozen.

15 Q. Did you watch any videos in
16 preparation for this deposition?

17 A. No.

18 Q. Listen to any audio recordings?

19 A. No.

20 Q. Did you review any deposition
21 transcripts from this case?

22 A. I reviewed the drafts of those

1 deposed prior to me.

2 Q. The rough transcripts?

3 A. Yes.

4 Q. Okay. That includes Ms. Campion?

5 A. Yes.

6 Q. Mr. Banerjee?

7 A. Yes.

8 Q. Ms. Jupiter?

9 A. Yes.

10 Q. And I forget the last one.

11 A. Bailey.

12 Q. Ms. Bailey?

13 A. Yes.

14 Q. Okay. You remember better than I
15 do.

16 Okay. And approximately when
17 did you review those? Like, in the last week or
18 so?

19 A. Yes --

20 Q. Okay.

21 A. -- last two weeks.

22 Q. And did you read them top to --

1 like, cover to cover?

2 A. No.

3 Q. Okay. Scanned them. Got it.

4 A. A scan.

5 Q. Okay. Did you speak to anybody at
6 The Leapfrog Group about your deposition?

7 A. Besides my attorneys?

8 Q. Correct.

9 A. No, I did not.

10 Q. Okay. Did you speak to anybody else
11 about it?

12 A. No, I did not.

13 Q. Okay. Let's talk -- these are the
14 easy questions.

15 A. Sure.

16 Q. Can you tell me a little bit about
17 your employment history, starting with where you
18 went to college and -- and sort of subsequently?

19 So where did you go to college?

20 A. Sure. I went to the University of
21 Maine in Farmington, Maine. And following
22 graduation, I was a stay-at-home mom for five

1 years.

2 My first job was at the Franklin
3 County -- oh, I'm sorry -- yes, Franklin County
4 Children's Task Force, which is the child abuse
5 and neglect agency for Franklin County, Maine.
6 I did grant writing there. I taught parenting
7 classes for parents who had been
8 court-mandated, and I also led a bullying
9 prevention program in local elementary and
10 middle schools.

11 My next job was with a community
12 health organization called Healthy Community
13 Coalition. At the time, Leah Binder, the
14 president and CEO of The Leapfrog Group, was
15 the executive director of that community
16 organization.

17 There, I did a lot of grant writing
18 for things like bringing breast cancer
19 screenings to our area, smoking cessation
20 programs.

21 I then moved on to Franklin
22 Community Health Network, which, at the time,

1 was a hospital and trying to grow into an
2 integrated health network that included Healthy
3 Community Coalition.

4 And so I became a special projects
5 manager there. And then when Leah Binder came
6 to Leapfrog in 2008, she recruited me in 2009.
7 And I've been at Leapfrog ever since.

8 Q. Okay. Just breaking down some of
9 that --

10 A. Sure.

11 Q. -- what did you study at Farmington?

12 A. English and women's studies.

13 Q. And women's studies.

14 Okay. And how did you decide
15 to get into healthcare?

16 A. I didn't. I decided to get into
17 service work. And so I had been a stay-at-home
18 mom for five years. I was trying to decide what
19 to do. Had a very close friend that was working
20 for the child abuse and neglect agency. She was
21 talking to me about her work. It sounded
22 amazing.

1 I had just had two small children,
2 so the idea of working at an agency that
3 protects children really appealed to me.

4 Once I started at that first
5 non-profit, I found it incredibly engaging and
6 rewarding and basically made the decision at
7 that point that I would have my whole career in
8 a place where I could do public good and help
9 take care of people.

10 Q. And -- and can you tell me -- remind
11 me, when did you first meet Ms. Binder?

12 A. So I went back to work when my son
13 went to kindergarten. So that would have
14 been -- '97 plus five -- 2002 -- maybe 2004 --
15 '5 -- 2005.

16 Q. Okay. And what was her position at
17 the time?

18 A. She was executive director of
19 Healthy Community Coalition, which was that
20 community-based -- so they had a mobile health
21 van, for example, and they did community health,
22 not acute care.

1 Q. Did you report to her there,
2 or . . .

3 A. I did. So I started as a
4 consultant, actually just -- just doing grants.
5 And when I moved to Franklin Community Health
6 Network as a special projects manager, I also
7 reported to her there as well.

8 Q. Okay. And talk to me about -- how
9 did she join The Leapfrog Group?

10 A. When we were working together at
11 Franklin Community Health Network, we just heard
12 one day that Leah was moving to Washington, D.C.

13 I'm not exactly sure. I know that the board at
14 The Leapfrog Group did a national search, and
15 she was one of the candidates interviewed and
16 then ultimately selected, but I don't have much
17 more detail than that.

18 Q. Okay. What were your initial
19 impressions of her in those early days?

20 A. Exceptional grant writer. I had
21 been writing to that point mostly smaller
22 grants, focused on things like domestic violence

1 prevention.

2 She really taught me a great deal
3 about the process of writing Federal grants.
4 And with that mentorship, I was able to
5 actually bring hundreds of thousands of dollars
6 into that rural community from SAMHSA, from the
7 Kellogg Foundation.

8 And so it was actually, like, a
9 very good working experience.

10 Q. And then can you talk to me a little
11 bit about how you got the Leapfrog job?

12 A. Like I said, Leah Binder came to
13 Leapfrog in 2008. After about a year, I would
14 say, she gave me a call and said, you know, I
15 miss working with you. I think we worked really
16 well together. I think there is a position here
17 that could work out for you -- similar kinds of
18 special projects like I was doing at the health
19 network.

20 It was a big move for me and my
21 family. My husband is from Farmington, Maine.
22 Our children had the same teachers that he had,

1 which is, like, good and bad. They were
2 getting older. And we thought maybe it would
3 be a good change for our family and just give
4 them a little bit more opportunity but also
5 access to slightly better education.

6 Q. And then before we get to Leapfrog
7 Group --

8 A. Sure.

9 Q. -- I saw in your LinkedIn you are --
10 you have -- you own a jujitsu studio?

11 A. My husband and I own and operate a
12 Brazilian jujitsu gym in Mont --
13 Montgomery County, Maryland.

14 Q. So we've got to watch out on this
15 side of the table?

16 A. I -- I've had this back injury for
17 two years, so if I can --

18 Q. So we're safe?

19 A. -- get back and forth to the
20 restroom today, we'll be -- we'll be happy --

21 Q. Okay --

22 A. -- but --

1 Q. -- if you need any breaks --

2 A. Yeah. But, again, like, I've --

3 I've been really committed, like I said, to
4 trying to do service things. And so, like,
5 there, I had been teaching just one class, which
6 is a women's-only class, that had a lot of
7 mothers and daughters, young women, older women.
8 So it was more fun than career.

9 Q. Okay. Can you tell me -- we saw you
10 had multiple positions at Leapfrog --

11 A. Yes.

12 Q. -- can you tell me about your
13 gradual, it seems like, ascendance?

14 A. Yes. So when I first came to
15 Leapfrog in 2009, I was the director of
16 communications and membership. The work I had
17 been doing at Franklin Community Health Network
18 was really focused on things like putting out an
19 annual report. I was working with some
20 practices. I was doing some EHR-based projects.
21 It really was special projects.

22 When I came to Leapfrog,

1 originally, it was more focused, specifically
2 on working with some of our employer and
3 purchaser groups. When I say "purchaser
4 groups," I'm talking about people who purchase
5 healthcare, sort of a term of art.

6 It confused me at first, but
7 employers and purchasers can be thought of in
8 the same way. They're people that purchase
9 employee benefits.

10 It was, at that time, a really
11 small organization. There was only of a
12 handful of us. I was doing a number of things
13 because of that, as I had done previously in my
14 non-profit work.

15 After a couple of years -- we had
16 been working with a team at the University of
17 Wisconsin in Madison, and they were providing
18 the scientific oversight over our Leapfrog
19 Hospital Survey.

20 Q. Can I ask you, is that, like, the
21 role that Armstrong ultimately --

22 A. Yes. I was going to describe that.

1 So just by way of background so
2 it's not confusing, we were founded in -- in
3 2000 immediately after this very famous report
4 came out from the Institute of Medicine, Call
5 to Earth Human. It was the first time that
6 anyone had ever quantified, put a number on,
7 the number of people that die every year in
8 hospitals from preventable medical errors.

9 And employers, purchasers -- and
10 these are large, self-insured employers: GM,
11 GE, Marriott, FedEx -- got their hands on this
12 report through the Business Roundtable, which
13 is a association of Fortune 100 CEOs, and they
14 were really shocked that they had been spending
15 millions if not billions of dollars to provide
16 these benefits and there were all of these
17 preventable harms occurring in hospitals.

18 And they said, We need more
19 information. Like, we should not have been
20 blindsided by this report. And they literally
21 founded our organization to go out and get that
22 information for them about the safety and

1 quality of hospitals.

2 And so immediately after we were
3 founded, we built this relationship with the
4 University of Wisconsin in Madison to help us
5 ultimately design what would become the
6 Leapfrog Hospital Survey.

7 I say that as background because
8 after I had been at Leapfrog for a couple of
9 years -- and tell me if I'm going too fast --

10 Q. Yeah.

11 A. -- I know you said to speak
12 slowly -- after I had been at Leapfrog for a
13 couple of years, those scientists that were
14 working with us at the University of Madison in
15 Wisconsin [sic] both, within a couple of months
16 of each other, took other jobs.

17 One was our senior scientist. Her
18 name was Dr. Barbara Rudolph. She was the
19 first senior scientist ever involved in the
20 survey. And so that had been, you know, up to
21 that point, Leapfrog's history. She had worked
22 with them.

1 Q. Approximately what time period?

2 A. That would be 2000- -- probably
3 around 2011, 2010, maybe.

4 Her Ph.D. candidate research
5 assistant at that time was Dr. Matt Austin --
6 or who had become Dr. Matt Austin. So
7 Ms. Rudolph was recruited by the Robert Wood
8 Johnson Foundation to lead the largest
9 community health survey in the country. Hard
10 to say no to that job.

11 I always refer to it as her
12 Devil-Wears-Prada moment. It was a dream job
13 that every girl wanted. And so she took it. I
14 don't blame her.

15 But at that same time, Matt Austin
16 was recruited to Johns Hopkins to Armstrong
17 Institute for Patient Safety and Quality by
18 Dr. Peter Pronovost, who had been working with
19 us in an expert capacity on the survey.

20 To your point, we were able to
21 basically -- almost have continuous scientific
22 leadership over the content of the survey by

1 ending that agreement with the University of
2 Wisconsin and starting an agreement with the
3 Armstrong Institute for Patient Safety.

4 Q. Can I ask you a question? So you --
5 you mentioned the employers that -- that helped,
6 I guess, start Leapfrog.

7 A. Yeah.

8 Q. Are they still involved?

9 A. Yes -- not necessarily the same
10 exact ones, but yes. We continue to be governed
11 by employers and purchasers. Our governing
12 board has grown to also include some patient
13 safety advocates, but we have no healthcare
14 represented on our board or governance
15 whatsoever.

16 Q. Which employers are represented?

17 A. We -- I'm going to give you a
18 handful. This will not be an exhaustive list.
19 And to be clear, Leah Binder, I think, is
20 assigned that particular topic.

21 But, for example, Sally Welborn
22 serves on our board of directors. She was head

1 of benefits for Walmart for many, many years.
2 She now has a private consulting firm where she
3 basically consults on the same topics.

4 Linda Schwimmer, who is our current
5 chair of our board -- she is the president or
6 executive director of the New Jersey healthcare
7 Quality Institute that represents purchasers,
8 employers in the State of New Jersey.

9 Previously, Michelle Martin --
10 Martin, A- -- M-A-R-T-I-N -- was on our board
11 for many years, and she was a head of benefits
12 for Paramount, which is, like, a television --
13 the television station, not the movie station,
14 and others.

15 And, again, Leah would be the --
16 have the full complete list.

17 Q. Understood --

18 A. Yeah.

19 Q. -- I understand.

20 Let's shift gears a little bit.

21 A. Okay.

22 Q. So you -- you started -- I think

1 your first title was senior -- was it vice
2 president of communications?

3 A. Yes. Should I go back and talk to
4 you about my trajectory at Leapfrog?

5 Q. What's your second title? It was, I
6 think --

7 A. My second title was probably
8 director of the Leapfrog Hospital Survey.

9 Q. I have vice president of hospital
10 ratings.

11 Does that sound right?

12 A. There would have been one in
13 between.

14 Q. Okay. Got it.

15 A. Sorry.

16 Q. Okay. So just tell me a little bit
17 about the --

18 (Simultaneous unreportable crosstalk.)

19 THE WITNESS: My LinkedIn
20 probably is not the most up-to-date.

21 So -- so when

22 Barbara Rudolph and Matt Austin --

1 they sort of took these separate
2 jobs, Leah and I had a long
3 conversation about how that could
4 have been more disruptive to our
5 operations than it ended up being
6 because we were so reliant on
7 external resources to do the
8 administration of our Hospital
9 Survey.

10 We were using a company
11 first called Thomson and then
12 Thomson Reuters, and -- and they
13 became something else. They were
14 primarily responsible for
15 administering the survey via an
16 online data collection tool, scoring
17 the survey responses, preparing the
18 scored survey results files.

19 So just -- I don't know how
20 familiar you are with our survey
21 operations, but we collect individual
22 responses. Those individual

1 responses get processed through
2 scoring algorithms, and the result is
3 a result that we publicly report.

4 And so in the simplest
5 terms -- for C-sections, we may be --
6 get a numerator and denominator, we
7 calculate a rate, it's the rate
8 that's published -- it's the rate
9 that Thomson Reuters was putting into
10 these files for us.

11 They were also doing all of
12 the technical assistance. The
13 hospitals participating in the survey
14 said they had questions about the
15 measure of specifications of the
16 reporting period. Thomson Reuters
17 did all of that.

18 And then --

19 BY ATTORNEY CRAIN:

20 Q. So --

21 A. -- with --

22 Q. -- a lot of --

1 A. Okay.

2 Q. -- what Leapfrog does today is --
3 was outsourced back then?

4 A. Was outsource --
5 (Whereupon, as the certified
6 stenographer seeks clarification,
7 colloquy will not be captured on
8 the written record.)

9 BY ATTORNEY CRAIN:

10 Q. Outsourced back then?

11 CERTIFIED STENOGRAPHER: Just
12 let him finish the question.

13 THE WITNESS: Oh, I was
14 trying to finish my answer, but I
15 understand.

16 CERTIFIED STENOGRAPHER:
17 Well, then finish your answer.

18 (Laughter.)

19 THE WITNESS: So with that
20 big transition of our scientific team,
21 we decided we would move some
22 functions in-house, mostly just so we

1 had more expertise in-house and
2 weren't so reliant. It's very common
3 at small nonprofits that you have a
4 small staff and you rely on external
5 expertise to do a lot so you're not
6 carrying those costs yourself.

7 But we had been around at
8 that point for a decade, and we
9 thought it was time to really bring
10 some of that work in-house. So I
11 became the director of the Leapfrog
12 Hospital Survey and then eventually
13 the vice president for healthcare
14 ratings, as we've expanded beyond
15 hospitals to include ambulatory
16 surgery centers.

17 BY ATTORNEY CRAIN:

18 Q. Got it.

19 And what's your position today?

20 A. Senior vice president for healthcare
21 ratings.

22 Q. And -- and what feeds into that?

1 What -- how many people report
2 to you?

3	A. Ten.
---	---------

4 Q. And can you -- does that include
5 Ms. Champion?

6 A. I -- I can list them.

7	Q.	Sure.
---	----	-------

8	A. Okay.
---	----------

9 So I have a director of healthcare
10 ratings, Kathryn Stewart.

11 I have a director of the Leapfrog
12 Ambulatory Surgery Center Survey,
13 Jean-Luc Tilly, J-E-A-N-L-U-C Tilly.

14 I have a director of licensure
15 programs, Kush Banerjee.

16 I have a program manager for the
17 Hospital Safety Grade, Alex Champion.

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18             I have a program manager for data,
19     Dylan Eller, and two data analysts: Leo Rule
20     and Austin Edwards.  He has, like, two first
21     names --
```

22 0. Yeah?

1 A. -- Austin Edwards.

2 And then I have a senior program
3 coordinator, Robyn Nabi.

4 Another senior program coordinator,
5 Leah Kaufman.

6 A program coordinator Heather Scott
7 and a program associate, Mallory Fries.

8 Q. And who do you report to?

9 A. I report directly to Leah Binder.

10 Q. And what are the topics that you're
11 responsible for?

12 A. Many.

13 Q. Just give me a sense.

14 A. Stop me if I'm going on.

15 I mean, first and foremost,
16 responsible for working with the rest of our
17 senior executive team to provide overall input
18 on the general strategic direction of the
19 organization and making sure we're being
20 responsive to the board and the goals that they
21 set out for us.

22 Specifically, I oversee all of our

1 healthcare ratings programs, including the
2 Leapfrog Hospital Survey, Hospital Grade,
3 Ambulatory Surgery Center Survey and our
4 value-based purchasing program, and that
5 includes managing our contract with the John --
6 Johns Hopkins Armstrong Institute for patient
7 safety and quality.

8 I also recently, since about
9 halfway through 2023, have responsibility over
10 data licensure and Accolade sales. I also
11 actually do quite a bit around education.
12 Leapfrog offers a number of free and some paid
13 educational opportunities for various
14 stakeholders. I develop and deliver, I would
15 say, three-quarters of that content.

16 Q. Got it. Okay.

17 A. Oh -- I'm sorry.

18 Q. No, please.

19 A. I also in my capacity -- I serve on
20 several different national technical expert
21 panels, and so I am, myself, a subject-matter
22 expert in the areas of patient safety,

1 performance measurement, healthcare equity and
2 diagnostic excellence.

3 So I participate on several
4 different CMS, the Centers for Medicaid &
5 Medicare Services -- CMS technical expert
6 panels, and I currently serve on Patel's
7 partnership for quality governing board and
8 other of their committees.

9 Q. You said you're an expert, I think,
10 in patient safety and performance measurement
11 and healthcare equity.

12 Did you develop that over time,
13 or was there education that you -- that went
14 into that?

15 A. I developed it over time. As I
16 said, we have a long-standing relationship at
17 this point with Johns Hopkins. They are the
18 scientific experts. But I'm able to advise more
19 on things like feasibility, mostly because of
20 the work that I do directly with hospitals at
21 Leapfrog.

22 So I might not be able to be the

1 expert on if we're developing every admissions
2 measure or should heart attack or pneumonia
3 patients be included or excluded, but in terms
4 of feasibility of data collection, I can be
5 helpful in that way.

6 Q. Got it. Okay.

7 And then one other -- I just
8 want to make sure you -- the -- the Safety Grade
9 itself is under your supervision; is that right?

10 A. The Hospital Safety Grade is one of
11 our programs, correct, that I oversee.

12 Q. Great. Okay.

13 Stepping back just a little
14 bit, can you tell me, like, generally what is
15 Leapfrog's mission?

16 A. I can tell you specifically what is
17 Leapfrog's mission.

18 Q. Wherever you want to go.

19 A. Sure. So our mission is to reduce
20 preventable harm and specifically death from
21 medical errors.

22 Q. Does Leapfrog advise hospitals how

1 to improve their quality?

2 A. We do not --

3 Q. Okay.

4 A. -- in any capacity, and we never
5 have.

6 Q. Okay. And what is Leapfrog sort of
7 an expert in?

8 A. So we are an expert in -- what I
9 would say is elevating topics within patient
10 safety.

11 Could I give two examples --

12 Q. Sure.

13 A. -- in case that's not clear?

14 So patient safety, thankfully, is
15 an area within health services research that
16 has got -- health services research which has
17 gotten, thankfully, a lot of attention
18 recently. And so through our work with about
19 13 different independent voluntary technical
20 expert panels --

21 (Whereupon, as the certified
22 stenographer seeks clarification,

1 colloquy will not be captured on
2 the written record.)

3 ATTORNEY CRAIN: Voluntary.

4 THE WITNESS: -- voluntary
5 technical expert panels and our
6 relationships with other aligned
7 national organizations, like the
8 Agency for Healthcare Research and
9 Quality -- AHRQ -- the Centers for
10 Disease Control and Prevention, CMS,
11 the Institute for healthcare
12 Improvement. We're able to take some
13 of that evidence-based research and
14 sort of bring it to the public.

15 And what I mean by that is
16 there's been a particular issue that
17 we've been focused on in the past
18 couple of years called "hospital
19 boarding" in the emergency
20 department. It's basically when you
21 go to the emergency department, the
22 doctor sees you and they say, Man,

1 you're really sick. We have to admit
2 you.

3 Unfortunately, for a lot of
4 different reasons, sometimes once
5 that order has been sent in, you can
6 wait in that emergency department or
7 in a hallway or a -- back in the
8 waiting room for hours, for days, for
9 over a week.

10 When that happens, what we
11 know, because of published literature
12 that comes from that health
13 science -- health services research
14 community, is you're less likely to
15 get medications, so your condition
16 can be exasperated. You're less
17 likely to be taken for the tests or
18 treatments that have been ordered for
19 you, sometimes literally because
20 people can't find you.

21 So when that becomes
22 identified as this is a critical

1 patient safety issue that has
2 reasonable interventions that could
3 make it better for patients, we have
4 the opportunity at Leapfrog, through
5 our annual Hospital Survey, to pull
6 together a national expert panel to
7 help us develop a series of questions
8 or to implement measures that have
9 already been developed by others.

10 So we can collect
11 information on hospital performance,
12 score that and ultimately publicly
13 report performance on that measure.

14 And if any of that is
15 confusing, let me know and I can give
16 a different example.

17 BY ATTORNEY CRAIN:

18 Q. No, that's helpful.

19 A. Okay.

20 Q. Thank you.

21 Can we talk a little bit about
22 the Safety Grade, going back to that issue?

1 A. Yes.

2 Q. So just starting at a benchmark --

3 A. Sure.

4 Q. -- what is Leapfrog's Hospital
5 Safety Grade?

6 A. So the Hospital Safety Grade is a
7 composite, so it's a letter grade of an A, B, C,
8 D or F that represents their performance on 22
9 national measures of patient safety, and I'm
10 sure at some point today this will come up. So
11 when we talk about patient safety, we're talking
12 about, again, that preventable harm. Other
13 aspects of hospital performance that we measure
14 on our Leapfrog Hospital Survey are more
15 comprehensive to include things like quality.
16 And quality might be a readmission measure where
17 it's best if you're not being readmitted too
18 often, but sometimes it's necessary.

19 The preventable errors that we
20 focus on in the Hospital Safety Grade are
21 things that largely the scientific community --
22 including doctors, nurses, et cetera -- have

1 said, There are known evidence-based
2 interventions in place to make sure that these
3 things either rarely happen or never happen.

4 Q. And then can you tell me when was
5 the Safety Grade developed originally?

6 A. So the Safety Grade was developed --
7 started being developed around 2012. I think we
8 launched it for the first time in 2013.

9 Q. And who came up with the idea?

10 A. It -- I couldn't identify a single
11 individual. It was a number of things happening
12 at the same time, or my recollection is that it
13 was a number of things happening at the same
14 time.

15 So first and foremost, Leapfrog had
16 been around at that point about 10 years. I
17 think we were sort of getting ready to
18 celebrate or just celebrated our 10-year
19 anniversary, and we had some board members and
20 others who worked with us at that time who had
21 been working with us since our founding or
22 almost since our founding, and the -- again,

1 purchasers and employers, and they were
2 somewhat frustrated that since the IOM report
3 had come out, there didn't actually seem to be
4 this drastic reduction in preventable harm to
5 patients in hospitals. I think everyone
6 thought, you know, this will be the match that
7 lights the fuse that ignites this change, and
8 we'll make sure that people aren't harmed as
9 much. And actually, the opposite was happening
10 because of advances in medical coding and
11 research science. It was basically suggested
12 that actually the IOM report was like a gross
13 underestimate of the number of people that was
14 actually being harmed and dying in hospitals
15 from medical errors, and that number was much
16 higher.

17 So the discussion as I remember it
18 was really focused around how can we at
19 Leapfrog, who have been focused on a lot of
20 important things, like I said, maternity care,
21 so C-section rates, readmissions, surgical
22 volume; but, again, largely quality measures,

1 where you don't want to see too much of it or
2 not enough of it, but sometimes it's necessary,
3 how can we get back to really focusing on these
4 deaths from preventable harm, this -- this
5 really narrow concept of patient safety.

6 About that same time, two things
7 happened: One is in New York, and one is in
8 Los Angeles, I believe. The state health
9 departments or local health departments started
10 having restaurants put the sanitation grades on
11 their windows, and I -- I think I remember
12 someone saying, No one's going to go to a C
13 restaurant in New York. You know, like, I've
14 been to New York. No one's going to go to a C
15 restaurant in New York.

16 And there was something about that
17 level of transparency driving that C sushi
18 restaurant to be in a -- you know, to -- to get
19 better, to get cleaner, whatever it was.

20 Additionally, what was happening is
21 that these letter grades didn't only include
22 you're an A, you're a B, you know, God forbid,

1 you're a C sushi restaurant, but it sort of,
2 like, listed, like, why they were an A or a B
3 or a C. And there was this education happening
4 to -- like, the general public about, like,
5 what New York cares about when they're looking
6 at the sanitation or the hygiene of
7 restaurants. And we thought that's what we
8 have the opportunity to do around patient
9 safety. What is patient safety? Who is
10 involved in patient safety? And frankly, it
11 includes patients themselves. We all have a
12 role in keeping ourselves safe. If we're in a
13 hospital or a doctor's office, or an ambulatory
14 surgery center.

15 And so it was just really, I think,
16 some things happening at the same time,
17 frustration over the slow pace of change.
18 These novel restaurant grades and this idea
19 that we could and should do more, specifically
20 to educate patients -- so to be clear, when
21 Leapfrog was founded, and I say we were founded
22 by employers and purchasers, and we were

1 working directly with purchasers -- employers
2 and purchasers, I mean that quite literally.

3 Over time, however, they expressed
4 to us, you know, This is great, but maybe it
5 would be great if we can make something a
6 little bit more consumer friendly. They didn't
7 use that term. They're talking about, like,
8 more understandable, easier to consume for our
9 covered lives.

10 And so the idea of a composite, I
11 think, is one that appealed to us in sort of
12 meeting the requests we were getting from
13 employers and purchasers to be more
14 understandable, if we could, to their covered
15 lives. So it would be hard to say whose idea
16 was it. It really felt, to me, at the time
17 just a lot of different things sort of
18 coalescing around a single concept.

19 We also had been working at that
20 point with some extremely prominent globally
21 known subject-matter experts, including folks
22 like Dr. David Bates from Brigham and Women's

1 Hospital; Dr. Peter Pronovost from John -- at
2 the time, Johns Hopkins -- now he's in Ohio --
3 Lucian Leape who was considered literally the
4 father of patient safety and just passed this
5 year.

6 And they also, I think, had a lot
7 of energy around bringing the focus to patient
8 safety, and they, themselves, as researchers, I
9 think, were frustrated with how many people
10 were still getting hurt from things that
11 shouldn't happen.

12 Q. And -- and the grade you mentioned
13 was designed to be consumer focused?

14 A. It was designed to be consumer
15 friendly, so the idea that, like, these
16 restaurant grades -- people understand a -- a C
17 sushi restaurant is not where you probably want
18 to eat. It was designed just to be something
19 more commonplace than maybe what we had been
20 using for the Hospital Survey results.

21 Q. Okay. So just going back to the
22 hospital analo- -- sorry -- the restaurant

1 analogy.

2 A. Yes.

3 Q. Fair to say we're talking about
4 market forces, like putting out letter grades
5 that SV effect change in the marketplace?

6 A. So these were regulatory in nature
7 in New York and -- and Los Angeles, and I
8 couldn't say if they effected change. I would
9 often hear people bragging, My pizza -- my
10 favorite pizza place in New York has a C, and
11 I'll never stop going, and they'll never change.

12 And that just might be, like, the
13 New York/L.A., like, rebel attitude, but I -- I
14 couldn't speak to whether or not it did or
15 didn't.

16 I think that whether or not it did,
17 it at least increased transparency around those
18 things, and then people could make a decision.
19 It's just pizza; I don't care. I'll go if
20 they're a C.

21 Q. Yeah. For -- for hospitals,
22 though --

1 A. Yes.

2 Q. -- was it designed to -- to
3 encourage change and improvement through those
4 market forces?

5 A. It was designed to help us meet our
6 mission in reducing preventable harm and death
7 to patients, correct.

8 Q. Okay.

9 So I want to take a look at a
10 document. So let's step back for a second.

11 A. Sure.

12 Q. I want to talk a little bit about
13 the excerpt -- the Safety Grade expert panel.

14 A. Okay.

15 Q. When was that established? Was it
16 around the same time?

17 A. It would have been almost
18 immediately. Like, as we started at the board
19 level to talk about this idea of doing something
20 around patient safety, we would have -- I can't
21 honestly remember those conversations exactly,
22 but just knowing how we work at Leapfrog, we

1 would probably almost immediately start
2 consulting with subject-matter experts in the
3 field, correct. And we had existing ongoing
4 relationships with many of them.

5 Q. Like Dr. Pronovost?

6 A. Like -- Pronovost.

7 Q. Pronovost?

8 A. Yes.

9 Q. Sorry. I read that wrong.

10 A. That's okay.

11 Q. So tell me a little bit about the
12 expert panel, how it developed.

13 How often do they meet?

14 A. So I -- at Leapfrog, one of my roles
15 is not convening technical expert panels, so
16 just if I could talk about that for a second --

17 Q. Please.

18 A. -- is that okay?

19 So I do -- like I said, I do
20 oversee these programs but not every aspect of
21 those programs. And so part of the contract
22 that we have with Armstrong Institute for

1 patient safety and quality, they're responsible
2 for convening our technical expert panels. And
3 so Matt Austin, as I've talked about, was --
4 would have been with us at this time, so we
5 would have asked him to help us convene this
6 panel.

7 And probably -- because, again,
8 we -- we're already working with folks like
9 Peter Pronovost and David Bates, we would have
10 asked them out of courtesy -- they are
11 literally giants in the field of patient
12 safety, not just in the United States but
13 around the world -- if they would like to be
14 included. Lucian -- Lucian Leape had had an
15 association with Leapfrog. I'm sure we would
16 have asked him if -- Matt would have asked him
17 if he wanted to be included, and then I'm not
18 exactly sure how Matt identified the others.

19 Q. Okay.

20 A. Probably -- to be frank, probably
21 going to David and Peter saying, Who else is
22 giant in this space that you think would bring

1 some value? And Matt independently reviews
2 their published literature, their CVs,
3 et cetera.

4 Q. So Dr. Austin makes the decision of
5 who to invite to join the panel?

6 A. He helps recognize and identify
7 them. For this particular panel, again, in my
8 memory, Peter and David Bates were probably
9 involved early on, would also have had some
10 input, like, Yes, like, he or she is really an
11 expert in that area. We should definitely bring
12 them on.

13 Q. So, like, just to put a concrete
14 example --

15 A. Sure.

16 Q. -- do you know how Dr. Romano joined
17 the panel?

18 A. I don't.

19 Q. Okay. Dr. Austin presumably would
20 know?

21 A. Yes.

22 Q. Okay. And then just going back to

1 my question --

2 A. I don't know how he was --

3 Q. Yeah.

4 A. -- identified or joined the panel or
5 when; however, I do know at that time we were
6 interested in the specific patient safety
7 measures called Patient Safety Indicators. The
8 acronym is PSIs. They were developed by the
9 Agency for Healthcare Quality and Research
10 [sic], AHRQ, and they're an interesting type of
11 measure.

12 So basically they're a
13 software-based measurement tool, where you can
14 read in hospital claims, and it picks up
15 procedure and diagnosis codes from those claims
16 to identify a pool of patients that are
17 eligible to be measured and then the things
18 that we're looking for that shouldn't have
19 happened to them; maybe it's postoperative
20 sepsis or postoperative wound adhesions,
21 meaning the wound came out, right.

22 So all of these things that

1 happened also happened to be recorded and
2 documented on claims, and so these are called
3 claims-based measures. And Patrick Romano was
4 leading the team that was developing and
5 refining these patient safety indicator
6 measures that we were very interested. And so
7 my sense is that's how he was identified and
8 then invited.

9 Q. And Dr. Romano would have -- or
10 sorry -- Dr. Austin would have invited him?

11 A. Correct.

12 And Dr. Romano continues to be
13 involved in that project through AHRQ as they
14 continue to refine those measures.

15 Q. And then just going back to my
16 question, how often, generally, does the -- does
17 the Safety Grade expert panel meet?

18 A. My recollection is that in the
19 beginning, we met more frequently because we're
20 trying to work everything out and identify
21 measures and make decisions about the
22 methodology and how narrowly we were defining

1 patient safety. And then over time, we
2 typically meet once or twice a year.

3 Q. And do you typically join those
4 meetings?

5 A. I do. I attend most all of our
6 technical expert panel meetings for the Survey
7 and the Safety Grade.

8 Q. And does the -- the expert panel --
9 does it have a chair?

10 A. No, it does not.

11 Q. Dr. Austin plays the role of sort of
12 a facilitator; is that right?

13 A. Correct. So his -- it's his actual
14 contractual responsibility to develop an agenda,
15 meeting materials, meeting notes.

16 Q. Got it.

17 And then how does the -- does
18 the expert panel make decisions, or does it just
19 make recommendations?

20 A. They provide guidance.

21 Q. Okay.

22 A. So they are, as I've described,

1 whether it's our maternity care expert panel or
2 the Safety Grade, across the board, the foremost
3 experts in these areas. And so the criteria
4 that we look for is that you've been widely
5 published, not that you've published a handful
6 of articles, you've published decades of
7 articles on these particular topics. Many of
8 them also serve on other technical expert panels
9 or otherwise subject-matter experts outside of
10 Leapfrog in a number of different capacities.

11 I also, I think I described, serve
12 on several technical expert panels, and my role
13 as an expert panelist and their role as an
14 expert panelist for Leapfrog really mirror each
15 other, and that I'm often asked to provide
16 guidance based on my personal expertise.
17 They're asked to provide guidance based on
18 their research and their own personal
19 expertise.

20 Q. Who makes the ultimate decision if
21 there's a disagreement?

22 A. To be quite frank, I can't think of

1 a disagreement among expert panelists. The
2 panels are quite collegial, as are the ones I've
3 been on. If there's -- if someone voices a
4 concern during a discussion, which is often
5 quite open and frank -- again, these individuals
6 haven't met for the first time on our panel.
7 They've likely known each other longer than
8 we've known them, and no one is afraid to speak
9 up. There are no shrinking violets on any of --
10 any of our panels, and so there's always a
11 lively discussion; sometimes, I'm sure, debate.

12 But they ultimately themselves will
13 typically come to guidance at the -- like, This
14 is -- you know, this is what we think. That
15 sounds right. That sounds good to me. David,
16 does that sound right to you? You know, that
17 kind of thing.

18 Ultimately, though, if they did
19 have a disagreement, Matt would let us know
20 that the panel couldn't come to consen- -- and
21 this is theoretical, the panel couldn't come to
22 consensus. I would let Leah know if it was

1 something very serious. Leah would go to the
2 board of directors.

3 But, again, I -- I really can't
4 think of a single instance across any of our
5 technical expert panels where that's occurred,
6 and we operate about 13 of them.

7 Q. Who -- who decides sort of what the
8 consensus is? Is that Dr. Austin?

9 A. I don't understand the question.
10 I'm sorry.

11 Q. Like, who -- who -- who speaks for
12 the panel at the end of the day and says, This
13 is the group's consensus?

14 A. So I guess, technically, it would be
15 Dr. Austin, but it's not really necessary to
16 have that specific function. I'm on the calls.
17 I'm part of the conversation. So there's not
18 really a necessary formality for Matt to be,
19 like, this is what the panel decided. I heard
20 the conversation.

21 Does that makes sense and --

22 (Interruption by cellular

1 telephone.)

2 (Sotto voce discussion between the
3 witness and counsel.)

4 BY ATTORNEY CRAIN:

5 Q. So there's no, like, vote, right?

6 A. No. I've never taken a vote as an
7 expert panelist. And we don't ask our panelists
8 to vote either.

9 Q. And then -- so there -- there's --
10 at these meetings, there's a topic of
11 discussion --

12 A. An agenda, yes.

13 Q. -- an agenda. There's a dec- -- a
14 decision point, for instance, whether to
15 include --

16 A. Not necessarily. Sometimes --

17 Q. If I can finish my question.

18 A. Oh, sorry.

19 Q. -- for instance, whether to include
20 something on the Hospital Survey or in the
21 Safety Grade.

22 Like, there's a do we want to

1 include this metric, for instance, right? That
2 could come up, yes?

3 A. It could.

4 Can I give one caveat? And
5 apologize for --

6 Q. Sure --

7 A. -- interrupting you --

8 Q. -- no.

9 A. -- so across all of our programs --
10 you know, the Hospital Survey, as I described,
11 has been around for -- this is our 25-year
12 anniversary. We have over 2,400 hospitals a
13 year voluntarily participating in that survey.
14 And many of them have been doing it for many
15 years even for our newer program, the Ambulatory
16 Surgery Center Survey. It's been around for --
17 just since 2019, but we still have ASCs that are
18 doing it every year.

19 And so it's often our
20 responsibility to actually bring topics to
21 these panels sometimes years ahead of when the
22 change might actually go into place. So I just

1 want to be clear.

2 So it's not like I'm taking to
3 them -- or we're taking to them can you please
4 make a decision about this measure because
5 we're going to include it in six months. It's
6 really on us, myself and Dr. Austin, to make
7 sure that we are staying ahead of things. You
8 know, this measure is going to be publicly
9 reported by CMS in 2027. We would like to talk
10 to the panel about it now so we can give
11 hospitals one-year notice, two-year notice,
12 three years.

13 So it's oftentimes for discussion.
14 It may not be for immediate decision or
15 implementation. I -- if that --

16 Q. That's helpful --

17 A. -- makes sense. Okay.

18 Q. -- it does.

19 And I guess my follow-up
20 question is -- you said "immediate decision."

21 Who's making the decision?

22 A. If it's to add or remove a mother --

1 measure, it's the Panel saying, I think this is
2 a good measure to add. And usually people will
3 say, I agree, I agree, I agree.

4 But, again, it's not a verbal vote;
5 it's -- it's a verbal consensus.

6 Q. So the -- the expert panel makes the
7 decision or Leapfrog makes the decision?

8 A. The expert panel provides us with
9 some guidance that this would be a good measure
10 to add. Ultimately, it's our decision whether
11 or not we add it, but we tend to always follow
12 the expert panel's guidance.

13 Q. And when you say "our," just so it's
14 clear, that's Leapfrog, correct?

15 A. Correct.

16 Q. And anybody particular internally at
17 Leapfrog?

18 A. Anything related to any of the
19 measures on any of our ratings programs would be
20 Matt Austin, myself, Leah Binder. And like I
21 said, if it was something controversial, it
22 would go to our board.

1 And when I say "controversial," for
2 example, following the decision on Roe versus
3 Wade, we had a lot of employers and purchasers
4 very concerned about the impact that would have
5 on the safety of women and really said, This is
6 a patient safety issue. Why isn't Leapfrog
7 speaking out about this? Why isn't Leapfrog
8 doing something about this?

9 Given the political nature of that
10 particular topic, if one of our expert panels
11 had theoretically said, I -- if our maternity
12 care expert panel had said, I think we need to
13 do something around this from a measurement and
14 public reporting perspective, that likely would
15 have gone to our board of directors, if that's
16 a helpful example.

17 Q. It is.

18 So when you say
19 "controversial" --

20 A. Yes.

21 Q. -- that's helpful --

22 A. Yeah.

1 Q. -- and -- and I remember that
2 decision well.

3 A. Yeah.

4 Q. Going back to the Safety Grade,
5 are -- are -- what are the types of hospitals
6 that are not assigned a Safety Grade?

7 A. So for the Hospital Safety Grade --
8 is it okay if I start a little bit at the
9 beginning so it's not confusing --

10 Q. Sure.

11 A. -- and if it -- if you're like, oh,
12 I already know this, then just tell me, because
13 I'm not, you know --

14 Q. Go ahead. Yeah.

15 A. -- so for the Hospital Safety Grade,
16 again, we're just using these measures of
17 patient safety as our expert panel has defined
18 "patient safety," which is freedom from harm,
19 right.

20 And so the Safety Grade includes
21 two domains of measures. You can sort of think
22 of them as, like, two buckets. Okay. And I'm

1 going to use my hands, but I'm going to use my
2 words, too.

3 Two buckets. One of the buckets
4 includes what we call "process and structural
5 measures." So these are processes and
6 structures that researchers, scientists have
7 said and have evidence -- so they actually are
8 things that would prevent harm to patients.

9 An example would be the use of
10 computerized prescriber order entry to order
11 inpatient medication orders can prevent adverse
12 drug events, which is basically someone giving
13 you a medication that they shouldn't for any
14 number of reasons and it kills you. Right. So
15 that's an adverse drug event.

16 So that's a structural measure.
17 It's, in this case, a piece of technology
18 including some systematic implementation.

19 The other bucket of measures are
20 called "outcome measures." And this is
21 actually rates or incidences of harm occurring.
22 So catheter-associated urinary tract

1 infections -- no one wants one of those, right?

2 Q. Pass.

3 A. Yeah. One of those --

4 (Laughter.)

5 THE WITNESS: We all pass.

6 Pass around the table.

7 ATTORNEY CRAIN: See, Kim.

8 You like -- you like coming to a
9 deposition with me.

10 ATTORNEY BLAIR: You got me.

11 THE WITNESS: We -- one of
12 the founding principles that our
13 technical expert panel came up with at
14 the very beginning and has since
15 affirmed continuously is that
16 hospitals should basically get equal
17 credit or equal consideration -- let's
18 say equal consideration for the
19 processes and structures they're
20 having in place. You can kind of
21 think of it as, like, their effort to
22 reduce harm and then, like, the actual

1 harm, right.

2 There were some concerns
3 early on that if we just looked at
4 outcomes, that could be frustrating
5 to hospitals because it can take a
6 long time to change some of those
7 rates, or maybe -- there are just
8 various complexities related.

9 So they really just wanted
10 to basically say try really hard, and
11 we'll consider that. And also, like,
12 we're going to look at how that
13 worked out and -- and we're going to
14 consider -- we're going to consider
15 that.

16 Does that make sense?

17 BY ATTORNEY CRAIN:

18 Q. Yes --

19 A. Okay.

20 Q. -- no; it does.

21 A. Okay. So -- so in thinking about
22 the types of hospitals that don't get graded,

1 it's related to the fact that in that outcomes
2 bucket, that outcomes domain I talked about,
3 virtually all of the measures come from the
4 Centers for Medicare & Medicaid Services, or
5 CMS.

6 And those measures are only
7 available for hospitals that participate in
8 something called the IPPS program. It's the
9 Introspective [sic] Payment -- there's another
10 P. But, basically, it's the agreement that CMS
11 enters into with hospitals in order to get
12 reimbursed for the care and services provided
13 to traditional Medicare patients, right, so
14 Medicare fee-for-service patients.

15 Because of that, critical access
16 hospitals, for example -- they'll participate
17 in the traditional Medicare payment structure,
18 so they wouldn't be required by Medicare to
19 report on those measures, and we wouldn't have
20 data.

21 Pediatric hospitals only care for
22 pediatric patients. They would typically have

1 Medicaid, not Medicare, so they're not included
2 in that IPPS program -- Veterans Administration
3 hospitals, Indian Health Services hospitals,
4 et cetera.

5 Additionally, though, there's other
6 general acute care hospitals that otherwise are
7 participating in the program, but because they
8 may be specialized -- like, we mostly or always
9 care for cancer patients, or we mostly or
10 always care for surgical patients -- because of
11 the nature of the patients who are included in
12 these measures, they would never have
13 information available, right. And this is,
14 like, oncology hospitals, certain types of
15 orthopedic surgery hospitals where, like,
16 the -- their scope of service is quite narrow.

17 So that generally describes the
18 type of hospitals that aren't assigned Safety
19 Grades, and it's due specifically to CMS'
20 policy on who they mandate to report on these
21 measures.

22 Does --

1 Q. Got it.

2 A. -- that make sense?

3 Q. No; it's helpful.

4 I --

5 A. Okay.

6 Q. -- so is it -- am I understanding
7 this right that those buckets of hospitals --
8 there just isn't enough data to reliably --
9 reliably grade?

10 A. There isn't outcomes data -- so
11 there isn't outcomes data. Again -- so going
12 back to the two buckets, because each bucket is
13 worth 50 percent of the overall grade, the panel
14 would not -- would not be supportive of not
15 having any outcomes measures, right.

16 Not to say the processes and
17 structures aren't important, but, really,
18 they -- they really want those outcomes. And
19 those outcome measures would not be available.

20 Q. So you're missing half, essentially,
21 of the equation?

22 A. Yeah. Yes.

1 Q. There are other minimum data
2 requirements, too, right?

3 A. Correct.

4 Q. Can you walk us through that?

5 A. Sure.

6 One of the measures that we use to
7 calculate the Safety Grade in that outcome
8 measures bucket is called PSI 90. It's a
9 patient safety composite also developed by
10 AHRQ, however, calculated by CMS. It, in and
11 of itself, includes 10 individual PSIs.

12 So we call them -- there's 10 child
13 PSIs. Each of those 10 child PSIs has a rate
14 calculated. There's a weight --

15 (Sotto voce discussion between the
16 certified stenographer and the
17 witness.)

18 (As the certified stenographer
19 seeks clarification, colloquy will
20 not be captured on the written
21 record.)

22 THE WITNESS: This is a

1 Dr. Seuss.

2 For each of those individual
3 child PSIs, a rate, R-A-T-E, is
4 calculated, then a weight,
5 W-E-I-G-H-T, is assigned for an
6 overall composite.

7 Because that one CMS measure
8 includes these 10 component measures,
9 in the Hospital Safety Grade
10 weighting formula, it receives about
11 15 percent as the standard weight.
12 So hospitals that are missing a score
13 for PSI 90 don't receive a Hospital
14 Safety Grade.

15 Do you want me to keep
16 going, or did you have a question?

17 BY ATTORNEY CRAIN:

18 Q. There -- there are two more, right?

19 A. Yes. I was going to keep going, but
20 it looks like you had a question -- okay.

21 Q. Yeah. I was going to go to those
22 next, so feel free.

1 A. Okay. I'm good at reading nonverbal
2 cues.

3 Q. I'm good at making them.

4 (Laughter.)

5 THE WITNESS: In addition to
6 that, hospitals missing measure scores
7 for more than six process and
8 structural measures, hospitals missing
9 measure scores for more than five
10 outcome measures are also not graded.

11 And this typically will
12 include, like, very small, rural
13 hospitals that aren't critical access
14 hospitals but could be a critical
15 access hospital where their volumes
16 are so low they typically are missing
17 too many outcome measures in order to
18 receive a Hospital Safety Grade.

19 BY ATTORNEY CRAIN:

20 Q. And what about the process measures?

21 A. There are not many hospitals in the
22 U.S., frankly, who are missing too many process

1 measures, I will say, with one exception. In
2 that process and structural measure bucket,
3 right, we include five patient experience
4 measures that come from CMS. It comes from a
5 survey instrument for patients called HCAHPS.
6 It's, like, the healthcare Consumer Attitudes
7 [sic] -- don't ask me the rest of it, but it's
8 basically why you were at the hospital. You get
9 discharged. When you get home, they send you a
10 survey.

11 There are some hospitals, due to
12 small volume, where enough patients don't
13 return the survey. You can't make patients do
14 the survey. Enough patients don't do the
15 survey.

16 So in those instances, if they're
17 missing patient experience scores for those
18 five measures and then, say, they don't operate
19 an ICU and maybe they're missing data for one
20 other measure -- but it's very rare. Very
21 rare.

22 Q. Those aren't, though, the process

1 measures, are they?

2 A. The five --

3 Q. HCAHPS.

4 A. -- HCAHPS patient experience
5 measures are included in the process and
6 structural measure domain --

7 Q. Okay --

8 A. -- in that bucket --

9 Q. -- got it.

10 Okay.

11 A. -- yes, correct. They're five of
12 the 12 measures included in that bucket.

13 Q. So there are 12 process and
14 structural measures, correct?

15 A. Correct. And 10 outcome measures.

16 Q. And 10 outcome measures?

17 A. Yes.

18 Q. If a hospital does not respond to
19 Leapfrog's survey --

20 A. Yes.

21 Q. -- how many process and structure
22 measures does Leapfrog not have survey data for?

1 A. Measures or measure scores?

2 Q. Process -- tell me the difference.

3 A. Sure.

4 So for -- for determining the
5 Hospital Safety Grades, since its inception
6 back in 2013, we've always used the term
7 "measure scores." And the reason is because
8 when we first started doing the Hospital Safety
9 Grade and the expert panel were setting out
10 some guidelines for us to follow, they wanted
11 to be able to include -- again, because we're a
12 national not-for-profit, we're trying to do a
13 public service -- as many hospitals as
14 possible. And so they urged us to identify as
15 often as we could both primary and secondary
16 data sources that may be available.

17 And so while the primary and
18 secondary data sources have varied over the
19 years, we look for scores among -- or across
20 those things.

21 Q. So to that point --

22 A. Sure.

1 Q. -- can we talk generally about what
2 that means?

3 A. Yes.

4 Q. So can you give us just a clean --
5 like, you -- what is your view of what "primary
6 data source" means?

7 A. So the primary data source is
8 actually not a view I have; it's something that
9 we define.

10 So I don't want to be presumptuous,
11 but I assume you have the Safety Grade
12 methodology document in your pile.

13 Q. Is that helpful to you?

14 A. Could pull out a table?

15 Q. Absolutely.

16 A. I'm sorry.

17 Q. No, no, no. Please.

18 ATTORNEY CRAIN: You know
19 what --

20 THE WITNESS: I just think it
21 will --

22 ATTORNEY CRAIN: -- we've

1 been going an hour.

2 Should we take a break --

3 (Simultaneous unreportable

4 crosstalk.)

5 (Whereupon, as the certified

6 stenographer seeks clarification,

7 colloquy will not be captured on

8 the written record.)

9 THE WITNESS: If I'm not
10 allowed to ask for documents, just
11 tell me, and --

12 ATTORNEY CRAIN: You are
13 absolutely allowed to ask. Whether I
14 give it is a different question.

15 (Laughter.)

16 ATTORNEY CRAIN: But we will
17 give you that one --

18 THE WITNESS: Okay.

19 ATTORNEY CRAIN: -- let's --
20 we've been going about an hour --

21 THE WITNESS: Yes.

22 ATTORNEY CRAIN: -- let's

1 take a break. We'll tee that up and
2 come back --

3 THE WITNESS: Okay.

4 ATTORNEY CRAIN: -- after the
5 break. Yeah.

6 THE VIDEOGRAPHER: Going off
7 the record. The time is 10:10.

8 --oOo--

9 (Whereupon, a recess was taken from
10 10:10 a.m. EDT to 10:30 a.m. EDT.)

11 --oOo--

12 --oOo--

13 (Danforth Deposition Exhibit Number
14 3, Leapfrog Hospital Safety
15 Grade, Scoring Methodology, Spring
16 2025, Bates stamped
17 LEAPFROG00217511 through
18 LEAPFROG00217537, marked for
19 identification, as of this date.)

20 --oOo--

21 THE VIDEOGRAPHER: Going back
22 on the record. The time is 10:30.

1 BY ATTORNEY CRAIN:

2 Q. Good?

3 Okay. Great.

4 Ms. Danforth, welcome back.

5 Before the break, we were
6 starting to talk about the methodology of the
7 Safety Grade --

8 A. Yes.

9 Q. -- correct?

10 And just, again, wait for me to
11 finish the question before you say yes or no.

12 Just to -- to start -- so we
13 premarked this Exhibit 3. And on the front
14 page, you'll see it says, Leapfrog Hospital
15 Safety Grade, Scoring Methodology, Spring 2025
16 Safety Grade.

17 Do you see that?

18 A. Yes.

19 Q. Was this the document you were
20 asking to see before the break?

21 A. Yes.

22 Q. Okay. And I had asked you for your

1 view of what primary data is, and I think you
2 were going to tell me the definition from this
3 document, right?

4 A. Yes. I just thought it would be
5 helpful.

6 Q. Absolutely.

7 So tell me -- which page would
8 you like to go to?

9 A. We're going to go to Page 4 --

10 Q. Okay.

11 A. -- of this document. And it looks
12 like this is printed front to back --

13 Q. Yep.

14 A. -- so just going back one step, I
15 described those two buckets --

16 Q. Yes.

17 A. -- those six process and structural
18 measures. That's the table that you see on
19 Page 4 and 5.

20 And then I described that there are
21 10 outcome measures, and that's the table you
22 see on Pages 6 and 7.

1 And then I described that one of
2 the measures we use in the outcome measures
3 bucket is called that CMS PSI 90 and that it
4 included those 10 child measures. And that --
5 those 10 child measures are listed on Page 8.

6 Q. Um-hum --

7 A. Okay.

8 Q. -- yep.

9 So where's the definition of
10 what primary data is?

11 A. Sure.

12 Q. Just to focus on my question.

13 A. There is no definition. These
14 primary and secondary data sources in this
15 table -- so moving left to right, the second
16 column, Primary, the third -- fourth column
17 labeled Secondary Data Sources -- this is how
18 the data has always been represented.

19 I couldn't speak exactly to when
20 this table first got created --

21 Q. So I -- I want to just cut you off
22 there just before we go to a different direction

1 for my question.

2 A. Sure.

3 Q. My question is -- I just want a
4 definition so we're on the same page --

5 A. Sure.

6 Q. -- what is primary data?

7 A. So a primary data would indicate if
8 this is available, we'll use it; otherwise,
9 we'll go to the next column --

10 Q. Okay.

11 A. -- labeled Secondary Data --

12 Q. So I --

13 A. -- chronologically.

14 Q. -- I had understood that primary
15 data, as defined at least scientifically, as the
16 data that a researcher collects themselves for a
17 specific purpose.

18 Is that a fair definition?

19 A. I am not myself a researcher. I
20 honestly couldn't speak to whether or not that's
21 the case or not. The way I'm using it and
22 describing it in this context doesn't

1 necessarily come from how someone doing a random
2 control trial study might describe it.

3 I believe these original terms,
4 again, came from our original expert panel,
5 indicating that if this was available, we'd use
6 it; otherwise, we'd move on to see if a
7 secondary data source was available.

8 Theoretically, there could be a
9 third, or a tertiary, data source.

10 Q. So -- then let's -- do you have a
11 definition of what a secondary source is?

12 ATTORNEY BLAIR: Objection --

13 THE WITNESS: In the context
14 -- I'm sorry.

15 ATTORNEY BLAIR: -- objection
16 to form.

17 THE WITNESS: I can speak to
18 it in the context of my programs.

19 Again, I'm not a researcher.

20 BY ATTORNEY CRAIN:

21 Q. What does it mean to you -- what
22 does secondary data mean to you?

1 A. Yeah. Specifically in this context,
2 it means if what's in the primary data source
3 column is not available, we would move to the
4 second column, that literally.

5 Q. So Leapfrog, over the 13 years since
6 it started issuing the Hospital Safety Grades,
7 has used different types of secondary data
8 sources; is that correct?

9 A. Yes.

10 Q. And I just want to go through a
11 couple of them to see if we're on the same page
12 about what -- what they are.

13 A. Okay.

14 Q. Is CMS data a secondary data source?

15 A. Not always. Oftentimes -- then
16 that's why I thought it would be helpful to
17 look --

18 Q. Yeah.

19 A. -- at the chart. It's a primary
20 data source. And in some cases, like with these
21 HCAHPS measures, it's the sole data source.

22 Q. But CMS data is not collected by

1 Leapfrog, right?

2 A. Correct.

3 Q. Okay. It's collected by CMS,
4 correct?

5 A. Correct.

6 Q. And it's not collected to inform
7 Leapfrog's grading process, correct?

8 A. Can you repeat the question?

9 Q. I'm asking about the purpose of why
10 CMS collects its data.

11 CMS does not collect its data
12 to help Leapfrog grade hospitals, correct?

13 A. Correct.

14 Q. It -- it collects its data for a
15 different purpose, right?

16 A. Correct. It makes it publicly
17 available --

18 Q. Yes.

19 A. -- yeah.

20 Q. Then other forms of secondary data
21 that Leapfrog has used in the past -- and,
22 again, I just want to get on the same page --

1 A. Yes.

2 Q. -- the American Hospital Association
3 data that Leapfrog used to use, right?

4 A. Correct.

5 Q. And tell me just a little bit -- so
6 that's AHA, right? The
7 American Hospital Association?

8 A. Yes.

9 (Laughter.)

10 BY ATTORNEY CRAIN:

11 Q. Yeah. Sorry. We're going to have a
12 lot of aha moments today.

13 A. I was like, the '80s band?

14 (Laughter.)

15 BY ATTORNEY CRAIN:

16 Q. So Leapfrog, for a time, used
17 American Hospital Association data to inform its
18 methodology, correct?

19 A. We did.

20 Q. And that was a form of secondary
21 data, right?

22 A. Correct.

1 Q. Leapfrog also used certain averages
2 or means to -- to inform its methodology at
3 times, right?

4 ATTORNEY BLAIR: Objection to
5 form.

6 THE WITNESS: At times, our
7 imputation methodology has included
8 the use of averages or means, correct.

9 BY ATTORNEY CRAIN:

10 Q. And that's the secondary data in
11 that context, right?

12 A. Correct.

13 Q. Okay. Leapfrog has also used
14 historical scores as secondary data, right?

15 A. As part of our imputation
16 methodology --

17 Q. Yes.

18 A. -- only, correct.

19 Q. And I just want to make sure we're
20 not crossing wires here.

21 Is it fair to say that -- the
22 imputation methodology is the process by which

1 secondary data is imputed into the score,
2 correct?

3 ATTORNEY BLAIR: Objection to
4 form.

5 BY ATTORNEY CRAIN:

6 Q. If you don't understand, I can
7 clarify that.

8 A. If you can ask the question again.
9 I --

10 Q. Yeah.

11 A. -- I apologize. It's not that I
12 don't necessarily understand what you're asking,
13 but you're describing something in terms that
14 I've never heard it described before. Using
15 words that I know, I just want to make sure I
16 answer you correctly.

17 Q. For sure.

18 A. Okay.

19 Q. I'm trying to figure out the
20 relationship between the imputation
21 methodology --

22 A. Yes.

1 Q. -- or model --

2 A. Yeah.

3 Q. -- and secondary data.

4 A. Sure.

5 Q. The imputation model is like a
6 structure, right?

7 A. Yes.

8 Q. And it's a structure by which
9 Leapfrog takes secondary data and imputes it
10 into the Safety Grade --

11 ATTORNEY BLAIR: Object --

12 BY ATTORNEY CRAIN:

13 Q. -- methodology; is that right?

14 ATTORNEY BLAIR: -- objection
15 to form.

16 THE WITNESS: It's a
17 structure by which Leapfrog imputes it
18 into the Safety Grade . . .

19 I would say that we use our
20 imputation model developed by our
21 national expert panel to assign
22 measure scores when primary data is

1 not available. I'm not clear enough
2 on your question to know if we're
3 saying the same thing or not, but
4 what I just described is accurate.

5 BY ATTORNEY CRAIN:

6 Q. Fair enough. Okay.

7 I'm just trying to think if
8 we're on the same page or not.

9 A. Can I give an example?

10 Q. A short one. A slow one to Cindy's
11 point.

12 ATTORNEY BLAIR: Slow and
13 short.

14 THE WITNESS: Okay.

15 If we're missing a measure
16 score for one of these measures that
17 has a -- in this -- in the column
18 saying Secondary Data Source
19 Imputation Model Applied, then we are
20 imputing a measure score for that
21 measure.

22 Is that what you're saying?

1 BY ATTORNEY CRAIN:

2 Q. I think that's right.

3 A. Okay.

4 Q. I guess what I'm saying is it --
5 this column has confused me, candidly --

6 A. Understood.

7 Q. -- because it says "secondary data
8 source" --

9 A. Yes.

10 Q. -- and -- and really what, like, the
11 source would be is the mean or the AHA or the
12 historical data, right?

13 ATTORNEY BLAIR: Objection to
14 form.

15 THE WITNESS: No, that's not
16 correct.

17 BY ATTORNEY CRAIN:

18 Q. Okay. So tell me why that's not
19 right.

20 A. The source has historically been
21 since the inception of the Safety Grade -- or I
22 guess I would call it a source for the second

1 score. So it can include American Hospital
2 Association and data. It can include imputed
3 data. It does include data from the CMS Cost
4 Report. It's really any source where a
5 secondary -- where a measure score can be
6 determined, located, made available.

7 So it's not limited to those
8 examples you gave but definitely does include
9 those examples you gave as well as others. The
10 methodology for this program has been evolving
11 constantly. That's why we have a technical
12 expert panel --

13 Q. Sure.

14 A. -- so it may include other things in
15 the future that they deem necessary and
16 appropriate, but it certainly would also include
17 what you just described.

18 Q. Yeah.

19 A. Okay.

20 Q. So over the history -- so I guess
21 let me ask this question, just a year.

22 A. Yes.

1 Q. Approximately when did Leapfrog
2 start using an imputation methodology for at
3 least certain measures?

4 A. Years ago, I would estimate, but we
5 need to look through the detailed methodology --

6 Q. Yeah.

7 A. -- document.

8 Q. Just your best understanding.

9 Let me -- let me triangulate
10 you --

11 A. I think -- oh.

12 Q. -- if this might help, let me
13 triangulate you.

14 In, I think, approximately --
15 we'll get to documents, but 2020 or 2021, the
16 AHA stopped licensing data; is that right?

17 A. Yes.

18 And that's what I was trying to
19 remember, that date.

20 Q. Was that the first time that an
21 imputation methodology was used, or was one
22 before?

1 A. That's what I'm trying to remember.

2 Q. Yeah.

3 A. So, again, not to overexplain, but
4 the American Hospital Association actually
5 administers a handful of different surveys at
6 different times of the year. We weren't using
7 data points from a single American Hospital
8 Association --

9 Q. Okay.

10 A. -- survey. We were using data
11 points across various American Hospital
12 Association surveys, including a HIT, or health
13 information technology, supplement that they
14 administer -- administered to hospitals as well.

15 I believe we stopped using all
16 American Hospital Association data. The last
17 time we got it, I think, was 2021. I was just
18 trying to remember.

19 Q. Yeah, and I --

20 A. It -- it would be accurate it's
21 around that time, yes.

22 Q. We'll come to documents. So I

1 wanna --

2 A. Yeah.

3 Q. -- it's either 2020 or 2021?

4 A. Yes.

5 Q. Just to triangulate with that

6 marker --

7 A. Yes.

8 Q. -- was there an imputed -- was there
9 an imputation model prior to that date that you
10 recall?

11 A. Not that I can remember --

12 Q. Okay.

13 A. -- no.

14 Q. Since 2021 --

15 A. Yes.

16 Q. -- can you identify any other
17 secondary data sources that we have not
18 discussed that Leapfrog had used in its scoring
19 methodology?

20 A. Since 2021, are there any additional
21 data sources . . .

22 We have used in the past something

1 called the CMS IMPACT, all caps, I-M-P-A-C-T,
2 file, which is different than what we use now,
3 called the CMS cost report. That would be the
4 only other source I can remember right now.

5 Q. Can I ask this question?

6 A. Um-hum.

7 Q. So on the chart, you saw down -- it
8 lists CMS in Primary.

9 A. Yes.

10 Q. And I know CMS, you just mentioned,
11 has been used as a secondary data source.

12 A. Correct.

13 Q. Why the -- why both?

14 A. Sure.

15 Can I refer to a page number?

16 Q. Of course.

17 A. So if you turn to Page 6.

18 So this is the table that includes
19 those 10 outcome measures: The only instance
20 where CMS is used as a secondary data source
21 are for these five -- what we call --
22 "healthcare-associated infections," so it's

1 CLABSI, or central line-associated bloodstream
2 infections, CAUTI, catheter-associated
3 bloodstream infections, surgical site
4 infections following colon surgery, MRSA, which
5 is --

6 Q. Don't want that?

7 A. -- an antibiotic resistant, and a
8 C. difficile, which is antibiotic -- and,
9 actually, that's the one you don't want.

10 Q. I don't want any.

11 A. Yes.

12 Through its annual Hospital Survey,
13 Leapfrog administers one of the largest
14 national NHSN groups in the country -- so NHSN
15 stands for the National Healthcare Safety
16 Network. It's currently administered through
17 the CDC, and it is a place where CDC does
18 national infection surveillance for these
19 healthcare infections healthcare things like
20 pneumonia, previously COVID.

21 Through participation in CMS' IPPS
22 program, which we talked about earlier,

1 hospitals that participate in that IPPS program
2 are required to report their infections into
3 NHSN, so you can't choose to do it or not. And
4 CMS gets the data directly from NHSN and
5 publicly reports it on its Care Compare
6 website.

7 As we were learning about this at
8 Leapfrog, we learned that we as a national not
9 for-profit could also administer an NHSN
10 hospital group similar to CMS, where instead of
11 waiting for CMS to publish the data on their
12 Care Compare website, hospitals would give us
13 rights to the same reports that CMS publishes,
14 which include no patient data, no patient
15 identifiers, thereby allowing us to report
16 those data alongside our other Leapfrog
17 Hospital Survey results.

18 Q. So I want to go back to my
19 definition of primary data, which -- which you
20 said was not yours, so I -- I take that, but --

21 A. Yes.

22 Q. -- recall that my definition was

1 data that a researcher seeks for a specific --
2 collects for specific purpose --

3 A. Okay.

4 Q. -- right?

5 In -- in these two columns, the
6 2024 Leapfor- -- Leapfrog Hospital Survey for
7 C. diff fits that definition, right?

8 ATTORNEY BLAIR: Objection to
9 form.

10 THE WITNESS: I'm sorry. Can
11 you repeat that?

12 BY ATTORNEY CRAIN:

13 Q. Yeah.

14 So Leapfrog collects this
15 information on -- itself, right?

16 A. No, and I'm not trying to be too
17 too --

18 Q. Okay.

19 A. -- technical --

20 Q. Yeah.

21 A. -- but, again, hospitals submit this
22 information to NHSN. They choose or choose not

1 to give us the right to access this data through
2 NHSN. We don't go out and collect it directly
3 from hospitals.

4 It literally is a downloadable
5 report from -- directly from NHSN that only
6 includes those hospitals that have completed
7 NHSN's data rights template.

8 Q. So why does this say 2024 Leapfrog
9 Hospital Survey, then?

10 A. Because for the purposes of the
11 Hospital Safety Grade, an important component of
12 the measures that we use in calculating the
13 grade is whether or not it's publicly available.
14 Leapfrog Hospital Survey results are publicly
15 available, and that's important because we like
16 to have hospitals be able to see their
17 performance on these measures prior to them
18 being used to calculate the Hospital Safety
19 Grade.

20 So hospitals have an opportunity
21 through the Leapfrog Hospital Survey to preview
22 their scored survey results before we publicly

1 report them on leapfroggroup.org. Hospitals
2 have an opportunity -- actually, an obligation
3 through CMS to review their CMS performance
4 measures 30 days before CMS makes it available
5 on their Care Compare website.

6 So the technical, I guess, place
7 where hospitals would know, Hey, where did
8 Leapfrog get this -- is through the Leapfrog
9 Hospital Survey and the corresponding website,
10 which is leapfroggroup.org.

11 Q. Okay. So I -- I guess I'm a little
12 confused.

13 The -- the data for CAUTI --

14 A. Um-hum.

15 Q. -- that's collected not by Leapfrog?

16 A. No; it's directly collected into
17 NHSN. We have a heavily password-protected
18 website that we log into following a very
19 arduous, called SAMS, S-A-M-S, process for the
20 Federal Government --

21 Q. Yeah.

22 A. -- we get a report four times a year

1 only from hospitals who have completed our rates
2 template and said, We give NHSN permission to
3 give this data to Leapfrog.

4 Q. So then why does this say 2024
5 Leapfrog Hospital Survey? That's what I --
6 that's the disconnect. I'm still not
7 understanding.

8 A. Because the mechanism that we have
9 to go through the process of administering the
10 group and obtaining the -- the rights from
11 hospitals is described in the Leapfrog Hospital
12 Survey --

13 Q. Okay.

14 A. -- I believe it's Section 7B of the
15 hard copy of the Survey --

16 Q. Yeah.

17 A. -- and it includes step-by-step
18 instructions of exactly how that process is
19 done.

20 Q. Okay. But just -- just to make
21 sure, again, that I'm understanding it right, on
22 CAUTI --

1 A. Yes.

2 Q. -- the -- the source of data that
3 Leapfrog uses is not the Leapfrog -- the
4 Hospital Survey?

5 ATTORNEY BLAIR: Objection to
6 form.

7 THE WITNESS: Technically for
8 both Leapfrog and CMS for these five
9 healthcare infection measures, the
10 source of data could be considered
11 NHSN.

12 BY ATTORNEY CRAIN:

13 Q. Okay.

14 A. It's the identical report for both.

15 Q. Got it. Okay.

16 A. And I'm not trying to be confusing.
17 I'm just trying to understand the question.
18 Sorry.

19 Q. No, no, I -- I'm learning live on
20 this question --

21 A. Yeah.

22 Q. -- so that's what I'm trying to

1 understand.

2 So why doesn't Leapfrog put
3 "NHSN" here?

4 A. We could put "NHSN," and CMS could
5 also put "NHSN" --

6 Q. Okay.

7 A. -- yeah.

8 Q. Okay. Okay.

9 A. That would -- that would be accurate
10 and correct as well.

11 Q. Is this inaccurate?

12 A. No.

13 Again, maybe 4,000 hospitals submit
14 data to NHSN. We don't have access to all
15 4,000 hospitals. So this is really meant to
16 convey that for those hospitals that have given
17 us permission -- and, again, the hospitals know
18 they have because they've gone through our
19 survey. That is how we're going to be getting
20 that data from them --

21 Q. Okay.

22 A. -- we can't just get data from NHSN

1 from every -- any hospital in the country.

2 It's -- that's just not how it works.

3 Q. Can I -- can we just go back to the
4 top of this document for a second?

5 A. Yes.

6 Q. And I have some questions about it.

7 Who crafted this originally, if
8 you know?

9 A. I don't know --

10 Q. Okay.

11 A. -- it's not been redesigned, only
12 updated over the years.

13 Q. No worries.

14 Did you have a role in the
15 revisions?

16 A. I review it every round.

17 Q. Every round.

18 And how often is it updated?

19 A. Twice a year --

20 Q. Okay.

21 A. -- I'm sorry. Four times a year.

22 Q. Why four times?

1 A. So through the Hospital Safety
2 Grade -- we have a process that's described in
3 painful details on the Hospital Safety Grade
4 website, where we first announce years in
5 advance what we call data snapshot dates so
6 hospitals know, These are the days we're going
7 to pull down your Leapfrog Hospital Survey
8 results, your CMS data, whatever the -- data is
9 available.

10 We then take that data inside,
11 Alex Campion -- who you met, my Safety Grade
12 program manager -- processes the data, runs it
13 through our scoring algorithm, we do a round of
14 QA and then we hold what we call a courtesy
15 data review period. It's usually a two- to
16 three-week period twice a year where we provide
17 a version of this document that includes some
18 extra pages I'm not seeing here called data
19 review instructions. And it basically tells
20 hospitals, You will go to this
21 password-protected website using a username and
22 password. You get to review all of the data,

1 so the measure scores for each of the measures
2 used to calculate your Hospital Safety Grade.
3 We provide hyperlinks directly back to the
4 source.

5 So in the case of these infection
6 measures where it says "Leapfrog Hospital
7 Survey," it would actually go back to
8 leapfroggroup.org --

9 Q. Got it.

10 A. -- so they could verify, I see a
11 standardized infection ratio for CLABSI of
12 0.118. Yes, that's correct. Leapfrog made
13 that.

14 So they have three weeks to
15 basically review the data, click the links. We
16 make an Excel-based calculator available so
17 they can re-create our calculations. And they
18 get what's called a preliminary numerical
19 score, a preliminary numerical score. But
20 there's no letter grade associated with that.

21 During the review period -- and
22 that is described in this document in the

1 latter pages -- if hospitals have closed, we
2 have to remove them from our data set. If
3 hospitals have what's called a CMS,
4 certification number change, or CCN, which is
5 how we match hospitals to that data that CMS
6 publishes, we would have to record that change,
7 and that may mean updating their measure scores
8 for those CMS measures.

9 Therefore, the data means, standard
10 deviations, et cetera, used for the overall
11 calculation are not finalized until after the
12 two- to three-week data review period. So this
13 document -- may I take you to a different page?

14 Q. I -- well, I -- I kind of want to go
15 just back to my question, if I could.

16 A. Right.

17 But that's why I'm saying I do this
18 four times a year --

19 Q. Four times --

20 A. -- not twice.

21 Q. -- a year. Okay.

22 A. Yeah.

1 So there's a preliminary version --

2 Q. Yeah.

3 A. -- and then a final version --

4 Q. Okay.

5 A. -- okay.

6 Q. Great.

7 A. Do you want me to show what changed?

8 Q. No --

9 A. Okay.

10 Q. -- I'm -- I'm good now.

11 A. Okay.

12 Q. A couple other questions on this.

13 A. Yes.

14 Q. So who is this written for?

15 A. Hospitals who are receiving a

16 Hospital Safety Grade --

17 Q. Okay.

18 A. -- as well as people, like the
19 public, who have questions about the Hospital
20 Safety Grade methodology as well as researchers
21 who use the Hospital Safety Grade data in
22 research, and others who are using or

1 referencing the Leapfrog Hospital Safety Grades.

2 Q. Is there any other place publicly
3 available that describes Leapfrog scoring
4 methodology?

5 A. I would not know the answer to that
6 question. There very -- there very well may be.
7 I -- I'm not sure.

8 Q. You're -- you're not the corporate
9 rep for websites, so I take that.

10 A. Okay.

11 Q. Are you aware of any --

12 A. No, I'm not.

13 Q. Okay. Let -- let me finish the
14 question --

15 A. Okay.

16 Q. -- if I could.

17 Are you aware of any other
18 location on Leapfrog's website -- strike that.
19 Let me -- let me start back.

20 This document, I'll represent
21 to you, we pulled off Leapfrog's website --

22 A. Yes.

1 Q. -- okay?

2 You're aware that it's
3 available on the website?

4 A. Yes.

5 Q. Are you aware of any other document
6 or website where the scoring methodology is laid
7 out for the public?

8 ATTORNEY BLAIR: Objection to
9 form.

10 THE WITNESS: On the Hospital
11 Safety Grade Web site, there's one to
12 two places where the methodology is
13 described in more of a summary
14 format --

15 BY ATTORNEY CRAIN:

16 Q. Okay.

17 A. -- and is not a PDF. So I don't
18 know if there are other PDF documents available,
19 but there are two Web pages that generally
20 describe -- and the process of describing the
21 Safety Grade to the public in a more summary
22 way, and then we linked the more detailed

1 document.

2 So if that's what your question is,
3 then the answer is yes.

4 Q. The answer is yes. Okay. So let --
5 let me just -- because it was a long question.

6 When you -- do you -- when you
7 say there are other websites that summarize at a
8 high level, what are those websites?

9 A. Other Web pages --

10 Q. Web pages, yeah.

11 Which ones?

12 A. -- on the Hospital Safety Grade
13 website.

14 Q. Do you remember their title at all?

15 A. If you showed me a screenshot of the
16 home page, I would be able to immediately locate
17 it. I can't verbatim recite it off the top of
18 my head.

19 Q. Okay. Do you recall whether it
20 describes how the imputation methodology works?

21 A. It describes that we use imputation.
22 Probably not in the detail we have here --

1 Q. Okay.

2 A. -- correct.

3 Q. So is it fair to say that for a
4 patient to understand how a hospital imputes --
5 how Leapfrog -- strike that. Let me fix that.
6 Boy, just all over the place.

7 Is it fair to say that for a
8 patient to understand how Leapfrog imputes
9 scores to non-participating hospitals, they need
10 to read this document, Exhibit 3?

11 ATTORNEY BLAIR: Objection to
12 form.

13 THE WITNESS: No.

14 BY ATTORNEY CRAIN:

15 Q. Where else can they get that
16 information?

17 A. I'm going to describe the Web
18 page -- again, please -- this is not verbatim.

19 Q. Okay. Fine.

20 A. -- whenever you are looking at a
21 Hospital Safety Grade, you will see their
22 performance on each of the measures represented

1 both numerically as well as using gas gauge
2 icons. Anytime a score has been imputed, it's
3 marked by an asterisk using the exact same size
4 font as the score itself.

5 And there's a note, I believe, in
6 red font; but, again, please -- without it in
7 front of me --

8 Q. Let me -- let me stop you there. I
9 don't mean to cut you off, but we have a
10 document that I think will help you.

11 A. Okay.

12 ATTORNEY CRAIN: So let's
13 mark this as Exhibit 4.

14 Thank you.

15 --oOo--

16 (Danforth Deposition Exhibit Number
17 4, Leapfrog Web page, Delray
18 Medical Center, marked for
19 identification, as of this date.)

20 --oOo--

21 THE WITNESS: Thank you.
22

1 BY ATTORNEY CRAIN:

2 Q. It's not a memory test. Kim and I
3 have discussed.

4 A. Yes.

5 ATTORNEY CRAIN: So this is
6 Exhibit 4.

7 CERTIFIED STENOGRAPHER: Let
8 me mark it.

9 ATTORNEY CRAIN: No worries.
10 Thank you.

11 (Sotto voce discussion.)

12 BY ATTORNEY CRAIN:

13 Q. So I've given you Exhibit 4.
14 I assume you recognize this
15 document?

16 A. Yes. Thank you.

17 Q. Yeah. So let me just go back to my
18 question, and I wanted to understand -- is there
19 another website where a patient can understand
20 how the imputation model imputes a grade?

21 ATTORNEY BLAIR: I'm just
22 going to -- you keep saying "website,"

1 and -- are you asking her if there are
2 other people somewhere in the world
3 that put their scoring methodology on
4 it and not Leapfrog --

5 ATTORNEY CRAIN: No, I --

6 ATTORNEY BLAIR: -- or you
7 mean a Web page? That's what I'm
8 getting confused at.

9 ATTORNEY CRAIN: Fair enough.

10 ATTORNEY BLAIR: Sorry. And
11 I -- I would have just objected to
12 form, but I just wanted to make --

13 ATTORNEY CRAIN: No, no, no.
14 It's -- I --

15 ATTORNEY BLAIR: Okay.

16 ATTORNEY CRAIN: -- I
17 appreciate it. I very much appreciate
18 it.

19 BY ATTORNEY CRAIN:

20 Q. Let me -- let me establish some
21 ground rules on this discussion so we're on the
22 same page.

1 A. Okay.

2 Q. When I'm talking about the Web page
3 here --

4 A. Okay.

5 Q. -- or the website, interchangeably,
6 I'm referring to hospitalsafetygrades.org
7 [sic] --

8 Do you know what that website
9 is?

10 A. Yes.

11 Q. -- and any of its subpages.

12 A. Perfect.

13 Q. I'm also referring to hospital --
14 to -- leapfroggroup.org, I think, is Leapfrog's
15 other website?

16 A. Yes.

17 Q. And is there a third?

18 A. No.

19 Q. Okay. So those are the two websites
20 I'm talking about --

21 A. Okay.

22 Q. -- as the top and any page that

1 falls underneath that.

2 We're all on the same page?

3 A. Yeah.

4 Q. Okay. So my question is, With that
5 as our universe --

6 A. Yes.

7 Q. -- is there any other page besides
8 Exhibit 3, the scoring methodology document --

9 A. Yes.

10 Q. -- that describes how Leapfrog
11 imputes a score for nonparticipating hospitals?

12 Do you understand my question?

13 A. I did --

14 Q. Okay.

15 A. -- and I was desc- -- I was
16 describing --

17 Q. Yeah. Let me -- let me take you
18 there. Just -- we'll get there.

19 A. Yes.

20 Okay.

21 Q. You were describing what I think is
22 Exhibit 4; is that right?

1 A. Yes.

2 Q. And Exhibit 4 is the
3 Delray Medical Center's Safety Grade page.

4 Is that fair to say?

5 A. Yes.

6 Q. Okay. And on the Safety Grade page,
7 I think you were going to Page 2, where it talks
8 about the hospital score.

9 Do you see that? It's 15.

10 A. Yes.

11 Q. And there's a little asterisk,
12 correct?

13 A. Yes.

14 Q. And the asterisk says, The hospital
15 declined to report their performance on this
16 measure, so a score was assigned to reflect the
17 lack of information available.

18 A. Correct.

19 Q. Was that what you were referring to?

20 A. Yes.

21 Q. So now we're on the same page?

22 A. Yes.

1 Q. So my follow-up question --

2 A. Yes.

3 Q. -- is, How will a patient know how a
4 score was assigned?

5 A. I'm not following your question.

6 Q. So this page says a score was
7 assigned, correct?

8 A. Yes.

9 Q. If a patient wants to understand how
10 Leapfrog assigned that score --

11 A. Right.

12 Q. -- where do you get that
13 information?

14 A. Sure.

15 Let me answer the question and also
16 just reframe the page, if I could.

17 So --

18 Q. Well, can you start with answering
19 the question? And then we can reframe.

20 A. If a patient wants to know how we
21 assigned this specific score, that information
22 is available in the PDF that you have produced

1 for me, which is hyperlinked immediately in the
2 measure description. You can see the -- I think
3 it's a green --

4 Q. So I'll -- so I'll tell you that is
5 --

6 A. -- hyperlink.

7 Q. -- that is not correct. The -- that
8 -- that link goes to -- I can give you
9 Exhibit -- we can do Exhibit 5 -- goes to the
10 longer table, right?

11 A. Where the methodology lives,
12 correct.

13 Q. So let's do Exhibit 5. I just want
14 to be on the same page. I don't --

15 A. Sure --

16 Q. -- want to confuse you.

17 A. -- and I'll come back to my
18 response, if I could --

19 Q. Sure.

20 A. -- because I wasn't able to finish
21 it.

22

--o0o--

(Danforth Deposition Exhibit Number 5, Leapfrog Web page, Hospital Details, Delray Medical Center, marked for identification, as of this date.)

--o0o--

ATTORNEY CRAIN: And I'm
going to ask --

ATTORNEY BLAIR: This is 5?

ATTORNEY CRAIN: This is 5.

ATTORNEY BLAIR: Okay. Thank
you.

BY ATTORNEY CRAIN:

Q. We'll get there.

So Exhibit 5 --

A. Yes.

Q. -- you were -- going back to Exhibit 4, you were referencing For details on sources, click here --

A. Yes.

Q. -- right?

1 I will represent to you,
2 because I'm not showing it to you on a
3 computer --

4 A. Okay.

5 Q. -- that Exhibit -- that link goes
6 here (indicating), to --

7 A. Yes --

8 Q. -- Exhibit 5?

9 Okay --

10 A. -- that's correct.

11 Q. -- are you saying that this page,
12 Exhibit 5, says how a score was imputed?

13 A. No. I'm saying that's where the
14 link to the full PDF document that you showed me
15 is located.

16 Q. Okay. So the link to Exhibit 3,
17 the -- the longer scoring methodology --

18 A. Yes.

19 Q. -- is on Exhibit 5?

20 A. Yes, and other pages as well, but
21 yes.

22 Q. Okay. On Exhibit 5 and Exhibit 4 --

1 A. Yes.

2 Q. -- does it say anywhere how the
3 score was imputed?

4 ATTORNEY BLAIR: I'm going to
5 object to form. We had this before,
6 but for --

7 ATTORNEY CRAIN: Yeah.

8 ATTORNEY BLAIR: -- whatever
9 reason, the link is not showing.

10 ATTORNEY CRAIN: So -- so I
11 will -- I will represent to counsel
12 this is how it prints to us every
13 time --

14 ATTORNEY BLAIR: Okay.

15 ATTORNEY CRAIN: -- but I
16 agree with you; there --

17 ATTORNEY BLAIR: Thank you --

18 ATTORNEY CRAIN: -- is a link
19 to the survey.

20 ATTORNEY BLAIR: -- so we can
21 say for the record there is --

22 ATTORNEY CRAIN: Yes --

1 ATTORNEY BLAIR: -- a link --
2 there is --

3 ATTORNEY CRAIN: -- for --
4 for --

5 ATTORNEY BLAIR: -- she is
6 not wrong?

7 ATTORNEY CRAIN: -- for the
8 record -- yeah, I'm agreeing --

9 ATTORNEY BLAIR: Okay.

10 ATTORNEY CRAIN: -- for the
11 record, on Exhibit 5, when you look
12 under a website, under Communication
13 about discharge -- you see that came
14 at the bottom on Page 3?

15 ATTORNEY BLAIR: Yeah.

16 ATTORNEY CRAIN: There's a
17 link to the survey methodology, the
18 28-pager.

19 For some reason -- we've
20 tried --

21 ATTORNEY BLAIR: It's fine.

22 ATTORNEY CRAIN: -- Control

1 P, we tried to say down.

2 It doesn't print that way,
3 but we agree with you; it's on the
4 website --

5 ATTORNEY BLAIR: Excellent.
6 Thank you.

7 ATTORNEY CRAIN: -- so no
8 dispute there.

9 ATTORNEY BLAIR: Okay.

10 BY ATTORNEY CRAIN:

11 Q. My question, though, is, On the --
12 In the --

13 A. Yes --

14 Q. -- four corners of this page --

15 A. -- I understand your question.

16 Q. -- where does it say how a score was
17 imputed?

18 A. We don't on that page --

19 Q. Okay. That's my question.

20 I just want to answer my -- we
21 have limited time --

22 A. Absolutely.

1 Q. -- today, so I want to focus you.

2 A. Sure.

3 Q. On Exhibit 4 -- is your back okay?

4 A. Yeah --

5 Q. Okay.

6 A. -- I'm going to stand for a little
7 while.

8 Q. If you need a break, any time.

9 A. I'm okay.

10 Q. Okay. On Exhibit 4 --

11 A. Yeah.

12 Q. -- same question --

13 A. Yeah.

14 Q. -- on Exhibit 4, does it say how a
15 score was imputed?

16 A. No.

17 Q. Okay. On Exhibit 3 --

18 A. Yes.

19 Q. -- the 28-page methodology --

20 A. Yeah.

21 Q. -- it does say how a score was
22 imputed, correct?

1 A. Correct. On the website, we only
2 represent that it's the worst possible score.

3 Q. Correct.

4 Now -- now -- now I'm answering
5 correct.

6 Is there any other Web page in
7 our universe -- Leapfrog's .org,
8 hospitalsafetygrade.org -- that says how a score
9 imputed?

10 A. There very well may be. I would not
11 be responsible for those other Web pages.

12 Q. I understand you're not the
13 corporate rep for that. I get that. And it's
14 not a memory test, but I'm asking for your best
15 memory today. And if the answer is I don't
16 know, I don't have -- that's fine.

17 But my question is, Are you
18 presently aware of any other page, besides the
19 28-page PDF that's Exhibit 3, where it explains
20 how a score is imputed?

21 (Whereupon, the witness reviews the
22 material provided.)

1 THE WITNESS: If I'm being
2 very technical, yes.

3 BY ATTORNEY CRAIN:

4 Q. What page?

5 A. So Leapfrog -- I think I described
6 earlier today we hold several -- what we call
7 "town hall calls," so basically free webinars.
8 We actually explain the scoring methodology for
9 the Safety Grade in detail.

10 Any webinar that we hold, we
11 record. So both an audio description as well
12 as the slides would have all of those details.
13 Those would live probably on both
14 leapfroggroup.org as well as
15 hospitalsafetygrade.org.

16 Additionally, I do presentations
17 for employer groups, consumer groups all the
18 time. And any time I talk about the Safety
19 Grade, I talk about imputation to a level of
20 detail. And all of those materials would also,
21 theoretically, be public on our website --

22 Q. Okay.

1 A. -- I'm just trying to be as thorough
2 as possible.

3 Q. And I appreciate that --

4 A. Okay.

5 Q. -- it's helpful to know the
6 universe.

7 My other question is, On
8 Exhibit 4 and 5, the Delray F page --

9 A. Yes.

10 Q. -- and the more detailed Delray F
11 page --

12 A. Yes.

13 Q. -- are any of those other materials
14 linked to those pages?

15 A. They're not.

16 Q. Okay.

17 If I'm -- strike that.

18 Okay. Let's see.

19 ATTORNEY CRAIN: Sorry. Give
20 me one second.

21 BY ATTORNEY CRAIN:

22 Q. Okay. So are you doing okay?

1 A. Yes.

2 Q. Okay. I'm mindful of your back.

3 A. That's okay.

4 Q. Okay. Let's talk a little bit about
5 the methodology. And you're more than welcome
6 to refer to Exhibit 3, if it's helpful.

7 A. Yes.

8 Q. So just to get the nomenclature
9 on -- and, again, I just want to just focus you
10 on my questions because we have limited time.

11 A. Yes.

12 Q. Can you tell me what "achieve the
13 standard" means?

14 A. Yes. For the purposes of the
15 Leapfrog Hospital Survey, we publicly report
16 hospitals' performance on those measures that
17 come from the survey in four performance
18 categories where achieve the standard is
19 represented as four cell phone bars;
20 considerable achievement is represented as
21 three; some achievement is two; limited
22 achievement is one.

1 Additionally, we use scoring terms,
2 such as "unable to calculate score," "does not
3 apply," "did not measure."

4 Q. And -- and just in lay terms, like,
5 what are they supposed to mean?

6 A. They're meant to denote progress
7 towards achieving Leapfrog's overall standard
8 for that measure, which is established by one of
9 those 12 independent technical expert panels.

10 So, for example, for C-sections, if
11 a hospital's C-section score on the Leapfrog
12 Hospital Survey website is represented as four
13 filled bars, or achieve the standard, it
14 literally means that their C-section rate was
15 23.6 percent or less.

16 So it's a way to visually and
17 descriptively denote progress towards achieving
18 our standard in a way that we hoped would be
19 motivating for hospitals to improve over time.
20 And that's why we have, like, some achievement
21 and then considerable achievement.

22 So it's a way to try to describe a

1 performance scale.

2 Q. And -- and what does limited
3 achievement convey?

4 A. It means that they did not achieve
5 the standard. So it's almost like a -- it can
6 be used as a catchall to mean they're working on
7 it; they're starting, but they're not there yet.

8 Q. Anything else?

9 A. It's basically, in a four-point
10 scale, I guess, the lowest performance.

11 Q. Okay.

12 A. Um-hum.

13 Q. I want to talk through -- I'm not
14 going to go through every one of the 22 because
15 we have limited time but a couple just to get us
16 on the same page.

17 A. Sure.

18 Q. Let's start with BCMA.

19 A. Yes, barcode medication
20 administration.

21 Q. You got it.

22 Just in lay terms for the

1 Court, what is BCMA?

2 A. Barcode medication administration is
3 both a technology and a process by which people
4 in hospitals, usually nurses, are supposed to
5 make sure they're scanning both your patient ID
6 band as well as a barcode on the medication that
7 you're about to receive to make sure they're
8 giving the right medication to the right patient
9 in the right dose at the right time.

10 It's a way to try to avoid the
11 wrong patient getting the wrong medicine or at
12 the wrong time or the wrong dose.

13 Q. The prover- -- tell me if this is
14 fair. The proverbial example I have is, like,
15 the patient with the penicillin allergy, not
16 giving them that.

17 Is that right?

18 A. No.

19 Q. No. Okay.

20 A. So for barcode medication
21 administration, it may catch that, but ideally,
22 it's computerized prescriber [sic]/add [sic] on

1 p. 48 order entry, which is an electronic system
2 that physicians can use to prescribe medications
3 where, hopefully, their clinical decision
4 support is advanced enough to actually stop that
5 medication even from being ordered.

6 BCMA can be seen as a second line
7 of defense if it gets through, but frankly, if
8 the CPOE isn't catching it, it's not likely the
9 BCMA would --

10 Q. Okay.

11 A. -- catch it either.

12 Q. So they work together --

13 A. They do --

14 Q. -- okay.

15 A. -- one is ordering medications and
16 one is administering medications, like,
17 literally before they put the -- the IV in your
18 arm.

19 Q. That's very helpful --

20 A. Yes.

21 Q. -- and just to -- so it's clear --

22 A. Yeah.

1 Q. -- the ordering is CPOE --

2 A. Correct.

3 Q. -- and the administration is BCMA?

4 A. Yes.

5 Q. That's very helpful.

6 So almost two sides of the same
7 coin?

8 A. Yes.

9 Q. Okay. Great.

10 You must have been a great
11 teacher.

12 So a couple questions about
13 BCMA --

14 A. Yes.

15 Q. -- does CMS register -- does CMS
16 measure BCMA?

17 A. Not today.

18 Q. Okay. Has it ever?

19 A. So CMS has what is called "safer
20 guides," S-A-F-E-R guides. They have some
21 requirements through the IPPS program that
22 hospitals attest to their use of the safer

1 guides.

2 The safer guides include guidelines
3 for the safe use of technology, quite
4 literally. It may include things like the use
5 of CPOE or the use of BCMA or the use of
6 infusion pumps. I would not be the
7 subject-matter expert on that, so I couldn't
8 say definitively.

9 Q. Okay. No. Fair enough.

10 And then we're going to talk a
11 little bit in a bit about nonparticipating
12 hospitals.

13 Do you understand what I
14 mean --

15 A. Yeah --

16 Q. -- when I say -- okay.

17 A. -- you mean that they're not
18 participating in a Leapfrog Hospital Survey --

19 Q. Exactly --

20 A. -- I'm with you.

21 Q. -- and just let -- let me finish,
22 and I'll let you finish for the -- for poor

1 Cindy.

2 ATTORNEY CRAIN: Sorry,

3 Cindy.

4 BY ATTORNEY CRAIN:

5 Q. Is it --

6 ATTORNEY CRAIN: You all

7 right?

8 CERTIFIED STENOGRAPHER: Yes.

9 ATTORNEY CRAIN: We'll get

10 there.

11 CERTIFIED STENOGRAPHER: Okay

12 .

13 BY ATTORNEY CRAIN:

14 Q. Is it accurate to say that for
15 nonparticipating hospitals, as we just defined
16 it, Leapfrog has no data on their actual BCMA
17 performance?

18 A. Correct.

19 Q. Okay. I want to go back to CPOE.

20 A. Yes.

21 Q. Does CMS register CPOE beyond the
22 safer guidelines that you mentioned?

1 A. Not that I'm aware of.

2 Q. Okay. Same question --

3 A. When you say "register," do you mean
4 measure?

5 Q. I do mean measure --

6 A. Okay.

7 Q. -- thank you. That's fair enough.
8 And if -- if you have questions anytime, ask.

9 A. Okay.

10 Q. So same question for CPOE: For a
11 nonparticipating hospital, does Leapfrog have
12 any data measuring the actual performance of a
13 hospital's CPOE?

14 A. No.

15 Q. Okay. IPS -- tell me what IPS is.

16 A. ICU physician staffing. So,
17 basically, it measures how hospitals are
18 staffing their adult medical-surgical ICUs and
19 pediatric medical-surgical ICUs, specifically
20 whether or not they're using board-certified
21 intensivists to care for those patients, because
22 it can reduce mortality in those units by

1 40 percent. It's really significant.

2 Q. Yeah.

3 And ICU -- I just -- I just --
4 I told Kim last week I just watched The Pitt.
5 So IC- --

6 A. Oh.

7 Q. -- that's the IC- -- ICU?

8 A. Yes --

9 Q. Yeah. Okay.

10 A. -- no, no; that's the emergency
11 department.

12 Q. I always confuse -- the -- the ICU
13 is where The Pitt sends folks?

14 A. Yes, yes.

15 ATTORNEY BLAIR: Several.

16 ATTORNEY CRAIN: Kim says
17 yes.

18 ATTORNEY BLAIR: Several
19 folks get sent there, I think.

20 ATTORNEY CRAIN: Fair. Not
21 all.

22 THE WITNESS: I think the

1 emergency department would send
2 patients to the ICU --

3 BY ATTORNEY CRAIN:

4 Q. Okay.

5 A. -- it actually can't work the other
6 way.

7 ATTORNEY BLAIR: No. That's
8 what I think, too.

9 ATTORNEY CRAIN: Yeah. Okay.
10 Great. We're on the same page.

11 BY ATTORNEY CRAIN:

12 Q. So back to IPS --

13 A. Yes.

14 Q. -- and we should -- we should kibitz
15 about The -- The Pitt afterwards, fabulous show
16 --

17 ATTORNEY BLAIR: Agreed.

18 BY ATTORNEY CRAIN:

19 Q. -- same question for IPS --

20 A. Yes.

21 Q. -- for a nonparticipating hospital
22 in the Leapfrog Hospital Survey, does Leapfrog

1 have any data for the IPS measure?

2 A. We do.

3 ATTORNEY BLAIR: Objection --
4 objection: form.

5 BY ATTORNEY CRAIN:

6 Q. Okay. What is the data?

7 A. The CMS cost report, which is the
8 data source I referred to earlier, includes some
9 information that hospitals are required to
10 provide regarding operating adult and/or
11 pediatric intensive care units and charges from
12 those units.

13 Q. Is it -- are the CMS cost reports
14 one-to-one with what Leapfrog collects in the
15 survey?

16 A. They are not.

17 Q. Okay. How do they differ, just
18 generally?

19 A. We get more information on our
20 survey.

21 Q. Okay. So there are at least some
22 pieces of information that you -- that Leapfrog

1 is missing for nonparticipating hospitals for
2 IPS.

3 Is there --

4 A. Correct.

5 Q. Okay. Hand hygiene -- everyone's
6 favorite.

7 Tell me about what "hand
8 hygiene" means.

9 A. On the survey?

10 Q. On the survey.

11 A. Leapfrog's hand hygiene standards
12 include several different elements. Again, this
13 is a structural measure, so assessing whether or
14 not have these things in place.

15 There are two core components of
16 the standard focused on what we call
17 "monitoring," so whether or not hospitals are
18 observing whether clinicians and others who
19 touch patients or touch things that will touch
20 patients, like surgical instruments, are
21 appropriately sanitizing their hands -- it's
22 not always washing. That's why I say

1 "sanitizing" -- based on World Health
2 Organization guidelines.

3 Additionally, the other core
4 component of five is something called
5 "feedback." And so not only are you actually
6 making sure people are doing the right thing at
7 the right time using the right substance,
8 whether it's soap and water or alcohol-based
9 hand sanitizer, but are you then taking those
10 data and getting them back to the right people
11 so they can see if improvement -- quality
12 improvement activities are needed or any kind
13 of training or remediation are needed.

14 The standard includes three other
15 elements focused on things like infrastructure
16 as well as culture and -- feedback, culture --
17 and there's another one --

18 Q. That's all right. Not a memory
19 test.

20 A. There are five. Oh, my gosh. I'm
21 so disappointed in myself.

22 Q. You studied up, I can tell.

1 A. Demote me -- no. I look at it every
2 day.

3 Q. You live this, yeah.

4 When you say "infrastructure,"
5 does that mean, like, sanitizers?

6 A. It means several things. It means,
7 like, are people making sure there's batteries
8 when they -- when they run out. It also means
9 sanitizers, yes. It's a number of things.

10 Q. And then same question: With
11 respect to hand hygiene --

12 A. Yes.

13 Q. -- for nonparticipating hospitals --

14 A. Yes.

15 Q. -- let me finish.

16 A. Oh.

17 Q. It's just hard for Cindy.

18 For -- for nonparticipating
19 hospital, for hand hygiene, does Leapfrog have
20 any data measuring their performance for hand
21 sanitizer?

22 A. No.

1 Q. Okay. I want to talk -- talk about
2 a couple more, safe -- the safe practices.

3 Do you know what I refer to
4 when I say "Safe Practice 1"?

5 A. Yes.

6 Q. Safe Practice 1, I have, is Culture
7 of leadership structures and systems measure --

8 A. Correct.

9 Q. -- does that sound right?

10 Okay. And if you need help, we
11 can go to document, but you got it.

12 Tell me again for the Court,
13 who is a layperson -- or a -- a lawyer -- an
14 imminent lawyer but not a doctor, I think, what
15 is Safe Practice Number 1, Culture of leadership
16 structures and systems.

17 A. There is an organization called the
18 National Quality Forum, and it is a organization
19 that, in the past, has convened subject-matter
20 experts. And in this case, they convened a very
21 large group to publish a report called Safe
22 Practices for Better Healthcare.

1 It includes 30 or 33 evidence-based
2 practices that not only hospitals but other
3 healthcare facilities should use specifically
4 to prevent adverse events, so without
5 preventable harm to patients.

6 Of those 30, 33 safe practices --
7 and that report has been updated with the
8 latest science at least two or three times --
9 long ago, Leapfrog included all of them, I
10 think, on the Leapfrog Hospital Survey at one
11 point.

12 Over time, because of advancements
13 in measurement, changes in evidence, we now, in
14 2025, only include two of the original National
15 Quality Forum-endorsed safe practices: Safe
16 Practice 1, which you just read: And another
17 called Safe Practice 2, which is culture,
18 measurement, feedback and intervention.

19 Q. Okay. And what do those two
20 measure?

21 A. Sure. The first one measures
22 whether or not hospitals have their leadership

1 engaged, specifically in patient safety
2 practices. So it's things like making sure
3 patient safety gets on the board agenda, making
4 sure that the board has resourced a patient
5 safety officer, someone whose job it is to
6 monitor patient safety.

7 Culture of safety refers to
8 something fairly specific in the healthcare
9 industry. It measures, in essence, whether or
10 not staff feel safe to speak up if they see
11 something going on. And it's most often talked
12 about -- if you're a nurse in the operating
13 room and you see the surgeon skip a step, do
14 you feel safe to speak up or if you basically
15 told leave him alone, let him do his job.

16 So it requires the hospitals every
17 two years, they're administering an
18 evidence-based culture of safety survey.
19 HRQ -- we've talked about them a lot today.
20 They put out one. And there are other tested
21 evidence-based tools specifically to measure
22 this.

1 The safe practice assesses whether
2 or not hospitals are doing this every two
3 years, presenting the results back to units and
4 different levels of leadership throughout the
5 organization, investing and making sure that
6 the survey can be done every two years and then
7 using the results to try to improve safety.

8 And sometimes that can be done in a
9 number of different ways, again, using --

10 Q. Yeah.

11 A. -- tool kits from ARC.

12 Q. So I'm going to boil it down. Just
13 tell me if this is fair.

14 A. Yes.

15 Q. Is this the -- like, the "see
16 something, say something" metric?

17 Fair?

18 A. It measures the -- the extent to
19 which -- yes --

20 Q. Yeah.

21 A. -- you feel safe if you see
22 something to say something.

1 Yes, that's actually very good,
2 yeah.

3 Q. I take the subway a lot.

4 A. Oh, okay. I take -- go by a lot of
5 airports.

6 Q. So when you say "AHRQ measure," does
7 it measure everything that's in this practice or
8 just certain parts of it?

9 A. HRQ has developed a survey tool that
10 measures culture of safety --

11 Q. Okay.

12 A. -- so earlier we talked about that
13 HCAHPS survey --

14 Q. Yeah.

15 A. -- I think I confused people -- that
16 patient experience survey.

17 HRQ has developed a culture of
18 safety survey. So a hospital would give it to
19 their staff --

20 Q. Yeah.

21 A. -- and they anonymously report.

22 Press Ganey does this, for example, on behalf of

1 hospitals, and then they give the results back.
2 Like, the nurses in the maternity care say that
3 teamwork is high and communication is great, but
4 in the emergency department, like on The Pitt,
5 maybe teamwork is bad and communication is poor.

6 Q. Yeah. Depends on the -- you know,
7 where in The Pitt.

8 So on -- so for this one --

9 A. Yes.

10 Q. -- Leapfrog does not use the AHRQ
11 Survey for its measures, right?

12 A. I don't think I explained this well.

13 Q. Okay. So, yeah, tell --

14 A. So --

15 Q. -- me where -- how I'm not
16 understanding.

17 A. -- in the hard copy of the survey,
18 this particular safe practice has maybe six
19 questions associated with it. The first
20 question is, Has your hospital in the last
21 24 months administered a standardized
22 evidence-based culture of safety survey to at

1 least 50 percent of its staff?

2 Q. I see.

3 A. HRQ has developed a survey that can
4 be used to say yes to Question 1.

5 Q. Got it --

6 A. Okay.

7 Q. -- that's my confusion.

8 A. I'm sorry.

9 Q. Okay. So the HRQ survey can be used
10 to inform a hospital's answers to the Leapfrog
11 survey?

12 A. To the first question -- exactly.
13 And then they get results back, and then -- yes.

14 Q. Got it. Okay. That's helpful.
15 Okay.

16 And then does Leapfrog -- is
17 Leapfrog able to get access to the HRQ surveys
18 or no?

19 A. So HRQ has developed a survey you
20 can download free on its website. It does not
21 administer the survey.

22 Q. Got it.

1 A. Other organizations like
2 Press Ganey --

3 Q. I see.

4 A. -- because it's basically a free
5 public recourse, Press Ganey can administer the
6 survey if the hospital asks them to do so.

7 Q. I see.

8 So there's no, like, central
9 repository where Leap- --

10 A. No, unfortunately.

11 Q. Just -- just -- I know it's
12 unnatural because of the deposition format, but
13 just make sure we're helping Cindy out. Sorry.

14 So there's no central
15 repository where Leapfrog can go to get this
16 type of AHRQ information?

17 A. No.

18 Q. Okay. Now, for Safe Practice 1 and
19 Safe Practice 2, the same question I've asked
20 before: For a nonparticipating hospital, does
21 Leapfrog have any data informing those measures?

22 A. No.

1 Q. Okay. And then the last one I want
2 to talk about is the Total Nursing Care Per --
3 Per Patient Day Measure.

4 A. Yes.

5 Q. Sound familiar?

6 Can you tell me again just at a
7 30,000-foot level what that measures?

8 A. It was developed by the American
9 Nurses Association, or the ANA. It includes a
10 set of specifications to allow hospitals to
11 report in a standard way on the total number of
12 patient days in specific units, not
13 hospital-wide -- a medical unit, a surgical
14 unit, a med-surg unit -- as well as specific
15 instructions to allow hospitals to report in a
16 standardized way the total number of nursing
17 hours in those units. It defines nursing hours,
18 inclusions and exclusions, direct patient care,
19 inconclusions and exclusions in the different
20 roles that are included in the measure.

21 So it's not just registered nurses.
22 It can also include nursing assistants and

1 something called LPNs, which are licensed
2 practical nurses.

3 Q. That was not quite the 30,000-foot,
4 but I appreciate the effort.

5 So -- so in terms of -- this is
6 measuring, essentially, how -- how -- nursing
7 staffing, more or less, right?

8 A. Yes.

9 Q. Okay. That's my 30,000-foot.

10 A. Sorry.

11 Q. That's okay. I just want us all to
12 be on the same page.

13 A. Yes.

14 Q. Then I'll ask again just for --
15 for --

16 A. Yes.

17 Q. -- completion.

18 For this measure, for the Total
19 Nursing Care Hours Per Patient Day Measure, if a
20 hospital does not participate in the survey,
21 does Leapfrog have any data to inform that
22 measure?

1 A. No.

2 Q. Okay. So we've gone through seven,
3 right? They -- they're the four im- -- what we
4 will ultimately call, I think, the "imputed
5 measures."

6 Does that mean -- we're on the
7 same page about that?

8 A. I understand that to --

9 Q. That --

10 A. -- mean CPOE, BCMA, hand hygiene and
11 ICU physician staffing.

12 Q. We're definitely on the same page.

13 And then the other three are
14 measures for which Leapfrog ultimately excludes
15 from the calculation of the Safety Grade for
16 nonparticipating hospitals?

17 A. Correct. There's no imputation.

18 Q. What's the difference? Why is that?

19 A. Thirty-foot level?

20 Q. Well, start at 30,000, and I'll --
21 I'll direct you down.

22 A. Oh, 30,000?

1 ATTORNEY BLAIR: Not 30.

2 BY ATTORNEY CRAIN:

3 Q. Not 30, no.

4 A. No. Now I'm paranoid. I'm, like,
5 Aah. Usually hospitals want, like, more
6 information, more detail, and that's who I'm
7 always talking to --

8 Q. Yeah.

9 A. -- so no one ever says --

10 Q. Give me the 30,000-foot level.

11 Yeah.

12 A. -- give me less.

13 A little while ago, I described the
14 Safety Grade of having those two buckets,
15 processes and structures, plainly, I hope.

16 Structures are things like do you
17 have a CPOE system? Do you have a barcode
18 medication system? And those are things where
19 because of the structure of the questions and
20 our hard copy of the survey, we can generally
21 assume today, and actually probably for the
22 past decade, that most hospitals in the

1 country -- and, actually, we know this from
2 getting the data previously from AHA -- would
3 at least say yes to the first question: Yes,
4 we have CPOE. Yes, we have BCMA. Yes, we're
5 doing something related to hand -- you know,
6 hand hygiene. Yes -- or, No, we have an ICU.

7 We don't need to infer that.
8 Again, we get that from the CMS cost report.
9 So I just want to make that separate from the
10 other three for a minute. But still, it's a
11 structural measure, either you have an ICU or
12 you don't. Either you have barcode medication
13 technology or you don't.

14 The other three measures, which we
15 don't have imputation method for -- Safe
16 Practice 1, Safe Practice 2 and Total Nursing
17 Hours Per Patient Day -- hopefully, the way I
18 described them to you implied they're not
19 structures. They're processes. One is
20 culture, right.

21 So to try to infer culture or Total
22 Nursing Hours Per Patient Day -- hospital unit

1 types vary so dramatically -- for example, the
2 Kaiser hospitals in California, all of their
3 patient care units are what's called mixed
4 acuity, so it's a mix of some general medical
5 patients, maybe some ICU patients. And there's
6 no way for us to know that in advance, right.

7 And, again, for the first three
8 measures I just described, we do have some
9 indication at least whether or not they were in
10 place because we used to get that information
11 from the American Hospital Association.

12 For the other three measures, I
13 don't feel that the expert panel ever felt like
14 there was a good other source or that those
15 would be measures that could reasonably be
16 imputed because they're not structures.
17 They're processes or culture.

18 Q. Couldn't you, though, for
19 nonparticipating hospitals just impose limited
20 achievement for those three?

21 A. If our expert panel gave us that
22 guidance, it's certainly something theoretically

1 we could do. They've just not given us that
2 guidance.

3 Q. And -- and why?

4 ATTORNEY BLAIR: Objection to
5 form.

6 THE WITNESS: For the reasons
7 I just described. I think in their
8 discussions, they've said that
9 structures are different than
10 processes.

11 BY ATTORNEY CRAIN:

12 Q. Do you recall a specific discussion
13 in any of those expert panel meetings where the
14 three measures -- Safety Practice 1, Safe
15 Practice 2 and Total Nursing Care -- were
16 discussed in assessing whether to include them
17 in an imputation model?

18 A. Only Safe Practice 2. Many, many
19 years ago, one of the experts on our Safety
20 Grade expert panel -- her name is Sara Singer.
21 She used to be at Harvard. She's now at
22 Stanford. She is a culture of safety

1 subject-matter expert. That's her area of
2 expertise.

3 In the very beginning of the
4 development of the Hospital Safety Grade, at
5 that time, I believe, to my recollection, she
6 had indicated culture of safety is not
7 something that could be inferred or imputed.

8 Q. At the very beginning?

9 A. Yes.

10 Q. So 2012ish?

11 A. I could -- I could not say exactly
12 when.

13 Q. Do you see where I'm -- that I'm a
14 little confused about? Because imputation, I
15 thought we had discussed, came into being after
16 the AHA decided not to license data in around
17 2021.

18 Are you saying Sara Singer
19 brought up this topic before?

20 A. Imputation is a common technique in
21 scoring methodologies and healthcare ratings.
22 Though it may not have been used in the actual

1 scoring methodology, it's a topic that was
2 always discussed.

3 Q. Yeah.

4 A. Do you want me to repeat that?

5 Q. Let me take one look-see.

6 Yeah. So it was -- your
7 recollection is it was discussed over several
8 years?

9 A. It can be discussed before it's
10 used. I've been talking --

11 Q. Yeah.

12 A. -- to my husband about taking a
13 vacation for years. We have yet to go.

14 Q. We have the same discussion. I -- I
15 hear you.

16 Okay. So let's -- let's take a
17 look -- just before we leave the methodology --

18 A. Yes.

19 Q. -- can you describe, let's say
20 15,000-foot, how are the different measures that
21 inform the Safety Grade weighted?

22 And you have the document if

1 you need it. Feel free.

2 A. The trick is keeping it at
3 15,000 feet.

4 There's a weighting calculation
5 also developed by the national expert panel
6 that includes four components. The first
7 component, I believe, is severity of harm,
8 so --

9 Q. Yeah. I --

10 A. -- some of these things could kill
11 you; some of them could just hurt you. The
12 second component -- and at this point, I am
13 actually going to --

14 Q. Page 18?

15 A. -- just to keep it short -- yes,
16 exactly.

17 The second -- so that's impact,
18 which includes the number of patients affected
19 and the severity of harm.

20 The other criteria is evidence, and
21 so either it's supported by suggestive or
22 clinical experience or experimental. It's

1 meant to differentiate between, like, maybe
2 measures that -- like a -- a -- like a closed
3 control group was used, which is hard in
4 medicine.

5 Opportunity is actually a
6 calculation, so it's like the actual -- it's
7 called standard deviation, but it basically
8 means across all hospitals' performance on,
9 say, central line-associated bloodstream
10 infections. Are the scores relatively in a
11 tight range or actually are they spread out in
12 a large range? If they're in a small range,
13 there's not that much room for movement, or, in
14 this case, we're calling it "improvement"
15 because they're already grouped or clustered
16 around a particular area. That would have a
17 low opportunity rating.

18 If it's a big range, then that
19 suggests that there is more opportunity for
20 improvement.

21 So like PSI 90, which we've talked
22 about a lot today, that measure is so heavily

1 risk adjusted for patient characteristics that
2 the range of scores are typically between just
3 under 1.0 and maybe 3.0. There's not that much
4 opportunity, right, within that very tight
5 range of scores, so that -- I'm just trying to
6 convey that concept.

7 The final criteria is what's called
8 the number of component measures. That fourth
9 criteria was only adopted when we added PSI 90
10 because the panel did not think that a measure
11 that included 10 separately endorsefully
12 specified measure should be treated as a single
13 measure.

14 Q. Got it. Okay. Yeah.

15 So then if you go to the next
16 page, 20 --

17 A. Yes.

18 Q. -- it has -- the standard measure
19 weights are the different percentages that each
20 of these measures are weighed at the last --

21 (Simultaneous unreportable crosstalk.)

22 THE WITNESS: That's correct.

1 BY ATTORNEY CRAIN:

2 Q. Okay. This has changed over time;
3 is that right?

4 A. So because of the nature of that
5 opportunity score I just described, which is
6 calculated, it changes between the preliminary
7 -- or it can change between the preliminary --
8 that courtesy Safety Grade review period I
9 described -- and then the final, and that's why
10 every round we do two versions of this. These
11 opportunity scores change even if we remove one
12 hospital because they closed --

13 Q. Got it.

14 A. -- two hospitals because they
15 closed.

16 And so that can impact very, very
17 slight changes in the overall weight, so,
18 again, that's why we produced the two
19 documents.

20 Q. Okay. And -- and going back to the
21 seven measures we've talked about.

22 A. Yes.

1 Q. So you see SP 1, SP 2 and Total
2 Nursing Care?

3 A. Yeah.

4 Q. For nonparticipating hospitals, am
5 I -- am I right in understanding that the weight
6 -- those weights are effectively redistributed?

7 A. They're reapportioned across other
8 measures within that specific domain for which
9 there is a measured score available, and that's
10 described in here.

11 Should I go to the page reference?

12 Q. Yeah. Let's go to that page.

13 Where -- where are you looking?

14 A. Page -- bottom of Page 23, top of
15 Page 24.

16 So, basically, how I described --
17 the expert panel really thought it was
18 important that the process and structural
19 measure domain stay at 50 percent, the outcome
20 measure domain stay at 50 percent. So if
21 you're missing a measure score on a process and
22 structural measure, none of that weight can

1 flow to the outcome measures.

2 Q. Got it.

3 A. It's constrained to that process and
4 structural domain bucket.

5 Q. Can -- can I just rearticulate to
6 make sure I understand?

7 A. Yes.

8 Q. You're saying that if you pull
9 something out of one bucket, the weight can't go
10 to the other?

11 A. Correct.

12 Q. Got it. That's helpful. Okay.

13 So -- so for -- now, but can it
14 go -- so SP 1 is a structural or process, right?

15 A. Process and structural measure,
16 correct.

17 Q. Its weight could then be
18 redistributed to handwashing?

19 A. Anything within that domain.

20 Q. Okay.

21 A. And we can go back to that table, if
22 that's helpful, but anything within that domain.

1 Q. Yeah. Okay. And do you know -- is
2 it in here what it's distributed --
3 redistributed to for nonparticipating hospitals?

4 A. Yes. That's what's described on
5 Page 23 and 24.

6 Can I -- can I read from the
7 document or not?

8 Q. Please, yeah, tell me where.

9 A. If you go to the bottom of Page 23,
10 you should see a subheader called Dealing with
11 Missing Data: Due to a variety of reasons, a
12 hospital may not have a measure score for all 22
13 measures. If a hospital is missing a measure
14 score for any measure (except for PSI 90;
15 hospitals missing PSI 90 are not graded), the
16 standard weight for that measure is
17 redistributed to the other measures in the same
18 measure domain.

19 The new measures -- I'm sorry --
20 the new weight for each measure within the
21 domain is calculated by reapportioning the
22 standard weight assigned to the measure with

1 the missing score to other measures with the
2 same domain.

3 For example, a hospital missing a
4 measure score for ICU physician staffing
5 because the hospital does not operate in adult
6 or pediatric IC- --

7 (Whereupon, as the certified
8 stenographer seeks clarification,
9 colloquy will not be captured on
10 the written record.)

11 THE WITNESS: ICU.

12 CERTIFIED STENOGRAPHER: Or
13 pediatric?

14 THE WITNESS: Yeah.

15 ATTORNEY CRAIN: In adult or
16 pediatric, yeah.

17 THE WITNESS: -- the standard
18 weight of 6.9 percent will be
19 reapportioned to the remaining 11
20 measures within the process and
21 structural measure domain --
22

1 BY ATTORNEY CRAIN:

2 Q. Okay.

3 A. -- and because this is -- I'm not a
4 mathematician, so, to me, complicated to read,
5 mathematically -- we don't make hospitals figure
6 it out. I described a calculator that's
7 available on that website. When you enter data,
8 all of the calculations happen very
9 transparently, and so they can see exactly how
10 those weights are redistributed.

11 Q. Yeah, it is -- it is -- agreed.
12 Okay.

13 ATTORNEY CRAIN: Let's set
14 this aside for a moment. We will come
15 back to it, so hang on to it. Sorry.

16 BY ATTORNEY CRAIN:

17 Q. Can we shift -- are you okay?

18 A. Yeah.

19 Q. Okay. If you need -- we're -- we've
20 been going an hour. Are you -- okay.

21 You're still good to go?

22 A. Um-hum.

1 ATTORNEY CRAIN: I was
2 thinking maybe we drive towards lunch,
3 okay, if that's good with everybody.

4 ATTORNEY BLAIR: That's fine.

5 THE WITNESS: Yeah.

6 ATTORNEY CRAIN: Okay.

7 BY ATTORNEY CRAIN:

8 Q. I want to talk a little bit about
9 the Hospital Survey --

10 A. Yes.

11 Q. -- and just -- because I think
12 you're the corporate representative for
13 Hospital Survey?

14 A. Correct.

15 Q. So start, again, 30,000-foot --

16 A. Yeah.

17 Q. -- what is the Hospital Survey?

18 A. Just so I'm clear, do I -- would I
19 answer these questions any differently as the
20 corporate representative? Because this is, I
21 think, the first time that you've prefaced a
22 question with that. I just want to make sure

1 I'm giving you the right answer.

2 Q. I -- so that's up to you. It's up
3 to you whether your own personal knowledge
4 differs from the corporation's --

5 A. Okay.

6 Q. -- I -- I don't know, I think, is
7 the answer.

8 A. Okay.

9 Q. You -- if you want to take a break
10 and consult with your counsel, I'm happy to --
11 to do that, but I -- I've been proceeding along
12 the topics -- like, for in -- we talked about
13 the survey methodology --

14 A. Right.

15 Q. -- and you were the corporate
16 representative for those topics. My -- my
17 expectation is you were talking, unless you told
18 me otherwise, as the corporate rep and in your
19 personal capacity, unless there's a divergence.

20 A. No.

21 And so I just wanted to make sure
22 that's appropriate for this as well.

1 So . . .

2 Q. Yeah. Let's -- let's just make sure
3 it's really clear because I probably should have
4 laid that out at the start.

5 A. Okay.

6 Q. My -- my working assumption is
7 because this is a combo deposition --

8 A. Yes.

9 Q. -- that unless you tell me
10 otherwise, and I'll give you an example to help,
11 that you're giving testimony for Leapfrog and
12 yourself.

13 Fair enough?

14 A. Yes.

15 ATTORNEY BLAIR: With one
16 caveat --

17 ATTORNEY CRAIN: Yes.

18 ATTORNEY BLAIR: -- to the
19 extent you're going to ask her about a
20 topic that is not laid out in the
21 30(b)(6) --

22 ATTORNEY CRAIN: For sure.

1 ATTORNEY BLAIR: -- she will
2 only be testifying to that.

3 ATTORNEY CRAIN: Absolutely.

4 BY ATTORNEY CRAIN:

5 Q. So I will give you an example just
6 so we're, again, on the same page --

7 ATTORNEY BLAIR: No, yeah, I
8 get it.

9 BY ATTORNEY CRAIN:

10 Q. -- when I asked you about the
11 website, Ms. Binder is the corporate rep for
12 that.

13 So you are -- from my
14 understanding, that is not the topic for which
15 you are the corporate rep, so I was asking in
16 your personal capacity. And I will try to be
17 clear as well, but if you have any questions,
18 just ask.

19 A. Understood. Thank you.

20 Q. And we can always take a break and
21 talk -- you can talk to your counsel, too.

22 Okay?

1 So with that understanding,
2 just tell me -- 30,000-foot, what is the
3 Hospital Survey?

4 A. The Leapfrog Hospital Survey is a
5 free annual voluntary survey where we collect
6 data on nationally standardized measures,
7 including patient safety measures, quality
8 measures, like maternity care and pediatric
9 care. And in the past, we also include measures
10 that are in a bucket called efficiency, and it's
11 things like readmissions. Today, no efficiency
12 measures are included on the Leapfrog Hospital
13 Survey.

14 Q. Okay. Did you have any role in
15 designing the survey originally?

16 A. I did not.

17 Q. Okay. It was already -- by the time
18 you came to Leapfrog, it had already been
19 created?

20 A. That's correct. Leapfrog was
21 founded in 2000, the first survey was mini --
22 administered in 2001 and then I came to Leapfrog

1 in 2009.

2 Q. At -- at -- generally, has it
3 changed significantly since your first
4 experience in 2009 with the survey?

5 A. It has.

6 Q. Can you tell me again, just
7 generally, how has it changed over time?

8 A. We have expanded the content of the
9 survey to include other important areas of
10 hospital care, mostly based on one of two
11 things: interests and stated importance from our
12 employer/purchaser members and our board of
13 directors. For example, we have now more
14 maternity care measures because employers and
15 purchasers pay for about a third of the births
16 in the United States, but also emerging patient
17 safety topics.

18 As I described earlier, an example
19 would include hospital boarding in the
20 emergency department, which no one talked about
21 10 years ago, and today is even represented on
22 television.

1 Q. Yeah. In The Pitt. It's just -- I
2 have to bring it up at the time.

3 ATTORNEY BLAIR: We have to
4 show it to the Judge.

5 ATTORNEY CRAIN: It has to be
6 there.

7 ATTORNEY BLAIR: Yeah.

8 ATTORNEY CRAIN: It was just
9 so good.

10 (Laughter.)

11 ATTORNEY CRAIN: So -- see,
12 we're just having fun.

13 ATTORNEY BLAIR: That's
14 right.

15 BY ATTORNEY CRAIN:

16 Q. So the Hospital Survey, is that
17 under your authority?

18 A. It is.

19 Q. And who is the person responsible
20 for -- like, who owns that under you?

21 A. I own that.

22 Q. Oh, you own it. Okay.

1 A. Yes.

2 Q. You don't have a direct report that
3 runs the survey?

4 A. I have various people who help out
5 with various aspects of the Hospital Survey,
6 including Matt Austin and our 12 expert panels;
7 however, at the end of the day, I review every
8 word in that survey before it goes out. The
9 same is true for the Leapfrog Ambulatory Surgery
10 Center Survey, the same is true for Exhibit 3 --

11 Q. Yeah.

12 A. -- that's been marked and the same
13 is true for the value-based purchasing program
14 methodology.

15 Q. So you review every page of the
16 Hospital Survey, each iteration?

17 A. Yes.

18 Q. Wow. How long does that take?

19 A. A long time. That's why I was so
20 disappointed in myself for not knowing that hand
21 hygiene system, right? I'll never forgive
22 myself. I may demote my own self on my way

1 home.

2 Q. I was pretty impressed before when
3 you cited the -- I think it was 6B. That was --
4 that was very impressive.

5 Okay. So just breaking down
6 who -- who owns it, I -- are you, yourself,
7 drafting the revisions, or you're reviewing the
8 work of others as they draft?

9 A. I'm reviewing the work of others as
10 they draft it, though I do draft some revisions
11 personally myself.

12 Q. Okay. And just in -- in the last
13 year or two, have you drafted any -- any
14 revisions personally?

15 A. In the last year or two, I have
16 drafted revisions personally, yes.

17 Q. About which topics?

18 A. Three of the more complex measures
19 on our survey are those American Nurses
20 Association measures. People think doctors are
21 tough. Nurses are tough.

22 The measures are so specific in

1 their definition of what direct patient care
2 is, what is included and excluded, that we've
3 had to go through several iterations of
4 clarifying the specifications in order to
5 ensure that we're collecting standardized,
6 high-quality data.

7 I have worked directly with
8 individuals at one of the leading nurses'
9 qualities registries to do that. I felt it was
10 so important and that the information was,
11 frankly, so complex that I should take a bigger
12 role in actually doing that myself, just for
13 integrity.

14 Q. And presumably, efficiency if you --

15 A. Yes.

16 Q. For the four imputed measures --

17 A. Yes.

18 Q. -- is there any particular person at
19 Leapfrog that's responsible for owning those
20 sections under you?

21 A. There are. For computerized
22 physician -- let me take a step back --

1 Q. Okay.

2 A. -- for every section of the Leapfrog
3 Hospital Survey and every section of the
4 Leapfrog Ambulatory Surgery Centers Survey,
5 because we have 12 different national expert
6 panels, someone on my team is assigned as a
7 liaison between Matt Austin, the panel and me.

8 The role of those individuals is
9 limited and specific. We are the ones
10 answering questions about measure
11 specifications and reporting periods. They are
12 responsible for identifying themes, suggesting
13 frequently asked questions, suggesting
14 revisions for the purposes of clarity. So
15 we're collecting standardized, accurate,
16 high-quality data.

17 If the expert panel makes a
18 decision, like we're going to change the
19 reporting period from 12 months to 18 months,
20 those individuals physically mark up the Word
21 document and track changes.

22 So for CPOE, it's Robyn Nabi. I

1 introduced her as one of my senior program
2 coordinators. For barcode medication
3 administration, it's Kathryn Stewart. I
4 introduced her as my director of healthcare
5 ratings. For hand hygiene, it's
6 Kathryn Stewart again, my director of
7 healthcare ratings. And for Total Nursing
8 Staff -- the nursing measure, it's Robyn Nabi,
9 who also oversees CPOE.

10 For these particular measures and,
11 frankly, many, many others on the survey,
12 however, even though we have assigned liaisons,
13 I tend to be extremely involved.

14 Q. Why is that?

15 A. It's important to me, as my role has
16 changed and evolved at Leapfrog, that I not lose
17 touch with getting feedback from the hospitals
18 and the ambulatory surgery centers. So I am on
19 help desk every day. Like, I want to hear what
20 people have to say. It's very important to me.

21 We want this to be as
22 straightforward as possible. And I put a high

1 value on data accuracy and integrity. And I
2 feel like if I move too far away -- not that my
3 team isn't excellent, that they do a good job,
4 but I need to be able to stand in front of a
5 hospital CEO at the end of the day and defend
6 all of these measures, not some of these
7 measures.

8 And so I guess I've made it just a
9 personal responsibility. It's certainly not
10 outlined in my job description.

11 Q. Extra credit.

12 (Laughter.)

13 THE WITNESS: Less sleep.

14 BY ATTORNEY CRAIN:

15 Q. Less sleep, yeah. I hear that.

16 Just talking about some of the
17 things you just mentioned -- so help desk --
18 what does that mean? What is the process? Can
19 you just tell me more what the help desk is?

20 A. Sure.

21 At Leapfrog, I think I described
22 when I was talking about some of my early work

1 there -- we used to use Thomson Reuters to
2 provide all of the technical assistance. When
3 I say "technical assistance," I specifically
4 mean questions, like should this be included in
5 the numerator and denominator or not, right.
6 So it's technical assistance specifically
7 related to answering the questions in the hard
8 copy of the survey.

9 When we brought that in-house, we
10 needed some kind of a tool or a software to
11 manage, like, a ticketing system. So we used
12 something called Zendesk. It's actually, I
13 think, one of the most popular electronic
14 ticketing systems across industries where
15 hospitals, ambulatory surgery centers, you --
16 anyone, basically come to our website; you put
17 in some contact information; you ask us
18 questions; we send you quest -- answers back in
19 writing.

20 If we need to have a call, we have
21 a call, usually a Zoom. But it's our mechanism
22 for providing technical assistance around any

1 of our four ratings programs that I've
2 described.

3 Q. Can -- can you just give me a
4 ballpark so I know what we're thinking about?
5 Like, how many Zendesk -- is tickets -- is that
6 the metric?

7 A. Correct.

8 Q. How many tickets come in per week?
9 Per month? Just your best ed- -- educated
10 guess.

11 A. There's a lot of variation weekly
12 and monthly. Annually, it's over 6,000.

13 Q. Wow. Okay. That's a lot.

14 A. Yeah. I'm very busy.

15 Q. Sure. Well, thank you for spending
16 the day with us.

17 So -- so how many of those do
18 you process per month?

19 A. I try to put my hand on at least
20 probably 3 to 10 tickets a week.

21 Q. Okay. And does your -- your
22 in-house team handles the rest of the 6,000?

1 A. Absolutely. It's the expectation of
2 every single member of the ratings team with the
3 exception of Kush Banerjee, who's the director
4 of licensure, that people are able to provide
5 technical assistance to hospitals.

6 And to be frank, the majority of
7 the questions are just showing them where in
8 the hard copy of the survey they can find that
9 response. So it's things like on Page 55,
10 you've indicated that actually IV bags that
11 can't have a barcode on it can be excluded from
12 the BCMA measure.

13 Q. Okay. And -- and so to that point,
14 the questions that are coming in -- are they
15 typically about how to answer the survey?

16 A. They're typically about ensuring
17 that hospitals are accurately doing their data
18 collection.

19 So in this instance, for example,
20 we ask about compliance, so how many drug
21 administrations that you've had. In some
22 hospitals, they may put a barcode on an Ensure

1 shake to give to a geriatric patient.

2 Should we consider this a
3 medication? Well, it has a barcode, but it's
4 not treating a condition or disease. So those
5 are the majority of the questions.

6 And, again, it's actually almost
7 all laid out in the hard copy of the survey,
8 but sometimes they just need to be directed to
9 the page of where that information lives.

10 Q. Okay. And the survey is about 350
11 pages, if I'm right.

12 A. It is.

13 Q. Yeah.

14 Do you have an understanding of
15 how long it takes hospitals to accurately
16 complete the survey?

17 A. So it varies. Since I've been at
18 Leapfrog, one of the things that I've been
19 responsible for is developing and helping to --
20 and oversee and administer what's called our
21 "on-site data verification program."

22 The year that we developed and

1 piloted our on-site data verification program,
2 which was originally designed for hospitals and
3 it now also includes ambulatory surgery
4 centers. I was fortunate to be able to
5 participate on a handful of the site visits to
6 hospitals that were helping us refine the
7 protocols --

8 Q. Yeah.

9 A. -- to make sure that they weren't
10 wasting our time, we weren't wasting their time,
11 et cetera.

12 Through that process, I was able to
13 learn a lot about data collection and survey
14 administration, and the estimate of 40 to 80
15 hours came from those conversations --

16 Q. Okay.

17 A. -- but it varies significantly.

18 In a small rural hospital that's
19 only offering a limited number of services, it
20 could take 10 or 15 hours because they're not
21 delivering babies. They don't have an ICU.
22 They're not doing pediatric CT scans.

1 In a large university medical
2 center, where there's thousands of patient
3 beds, it could be more.

4 But frankly, what we've learned
5 over time -- and, again, I'm directly talking
6 to a lot of hospitals around the country -- is
7 the first year, it takes longer because maybe
8 you've never collated your hand hygiene
9 observation data. Maybe you're not even doing
10 hand hygiene observations in all of the units.
11 Maybe you don't have quarterly audit processes
12 in place. But year over year, that time
13 commitment really gets reduced.

14 One thing I didn't mention about
15 the survey that I'd like to is that we have a
16 commitment -- an unspoken commitment but a
17 spoken commitment to try to maintain questions,
18 measure specifications and the scoring
19 algorithms we use to get to those four
20 performance categories we talked about --
21 achieve the standard, et cetera -- for about
22 three years.

1 And that way, if you do the work to
2 actually put the things in place, it doesn't,
3 like, change the next year and you're starting
4 again, and then change the next year and you're
5 starting again.

6 We also really want hospitals to
7 work towards a similar thing for a certain
8 amount of time so they can see their
9 improvements, if they have them, presented in
10 those publicly reported results that I talked
11 about.

12 So maybe the first year you get
13 started, based on what you have in place or
14 what you're able to do or what you know how to
15 do for a certain measure, you're only at
16 limited achievement. But because we're keeping
17 everything relatively stable for you, now
18 you're working on it all year. And now, the
19 next year, your considerable achievement --

20 Q. Yeah.

21 A. -- and, in some cases, achieve the
22 standard.

1 So, again, we don't always do it.
2 We try to do it, and it's a real commitment.

3 Q. Are you aware there was a study, I
4 think, conducted by Oklahoma State University
5 about how long the Hospital Survey takes to
6 achieve?

7 A. I am.

8 Q. Can you tell me a little bit about
9 that study?

10 A. Sure.

11 So my understanding is it wasn't a
12 study, but I don't want to sort of parse words.
13 But I think I told you in the beginning that we
14 were founded by purchasers and employers.
15 Today, we've maintained that commitment and we
16 work with about 35 business health coalitions
17 or purchasing groups around the country.
18 They're generally state-based.

19 In Oklahoma, the purchasing group
20 that we work with there is called WellOK, where
21 the "OK" stands for Oklahoma.

22 Q. I figured.

1 A. They have a relationship with one of
2 the universities there, and they wanted to use
3 an intern that they got from the university to
4 basically shadow a first-time participating
5 hospital in doing the Leapfrog Hospital Survey.
6 And they wrote up her observations --

7 Q. Okay.

8 A. -- I actually didn't know that they
9 published it. I just know that I've seen it.

10 Q. Got it.

11 Okay. Yeah. I mean, we're
12 happy to show you a document if it's helpful,
13 but I -- does it sound right that the conclusion
14 was it could take nearly 80 hours to complete
15 the survey?

16 A. Yes. I think I gave the range of 40
17 to 80 --

18 Q. Forty to 80.

19 A. -- and -- and this is -- again, I
20 think it was a -- please correct me, but I think
21 it was, like, the large academic medical center
22 associated with the University of Oklahoma.

1 Q. That may be right, yeah.

2 A. Yes --

3 Q. Okay.

4 A. -- yes, that --

5 Q. Great.

6 Okay. One other thing -- you
7 mentioned that you -- you spend, it sounds like,
8 a lot of time talking to hospitals.

9 A. Yes.

10 Q. Can you tell me 30,000-foot --

11 A. Yes.

12 Q. -- what types of things are you
13 talking about? What -- what are the contexts?
14 Like, I'm just trying to explore how -- how --
15 what's -- what does that look like?

16 A. I describe that sometimes when
17 hospitals have questions on help desk, they need
18 a call. Somehow, something is getting lost in
19 writing. I jump at the opportunities to take
20 those calls. I love talking to hospitals and
21 ambulatory surgery centers about our measures.
22 I love talking about why they're important. I

1 love answering their questions.

2 I learn a lot about how the
3 instructions are written to understand do we
4 need to clarify something, refine something.
5 So that's some portion of the calls.

6 Related to the Hospital Safety
7 Grade, if hospitals -- and it's usually maybe a
8 chief medical officer or a quality director.
9 Sometimes it's the CEO; sometimes it's a board
10 member -- if they have questions about the
11 Safety Grade methodology or why we're using CMS
12 data or any of the measures whatsoever, I take
13 a lot of those calls.

14 I do, like I said, a lot of
15 education, and I try to make that education as
16 interactive as possible. And so when I'm doing
17 webinars, whether it's with 10 hospitals or 700
18 hospitals, I'm always the one or often the one
19 actually on the other line of the Zoom
20 answering their questions.

21 So it really varies depending on
22 what people are interested in, but I try to

1 make myself really available. Pre-COVID, I
2 traveled to hospitals to meet with them
3 in-person, if they requested it, free of charge
4 because we really do want to engage with them,
5 hear from them. We're always trying to do
6 better, make it better.

7 And while, yes, I could send other
8 people -- and obviously, I don't like germs, so
9 I probably should -- but it's something that I
10 try to do --

11 Q. Yeah.

12 A. -- I can't always do it as much as I
13 want, but --

14 Q. No wonder you don't have a vacation.

15 A. I'm doing Alabama Hospital
16 Association next week, so . . .

17 Q. Good luck.

18 So a couple other questions --

19 A. Yeah.

20 Q. -- just on -- and then I think we
21 may be getting close to a break -- oh, yeah.

22 So talking about the types of

1 comments, you know, that -- your conversation --

2 A. Yes.

3 Q. -- with hospitals, has the burden of
4 completing the survey ever come up before?

5 A. I would say early on, like,
6 2009/2010, that something was discussed a lot.
7 Today, no --

8 Q. Okay.

9 A. -- and, in fact, what we've seen is
10 -- and most hospitals now are part of health
11 systems, which I'm sure you know. Most health
12 systems consolidate around the tasks related to
13 quality measurement and data reporting. And
14 that includes patient safety measurement in data
15 reporting.

16 And so we're seeing in some small
17 systems, large systems it's somebody's job to
18 do this, and Leapfrog is just one other thing
19 that they do.

20 We're also seeing that because our
21 measures are meaningful to hospitals in a way
22 that sometimes the CMS measures are not,

1 because some of it comes from claims only,
2 because the data can be a little bit older,
3 hospitals and health systems have adopted our
4 measures on their board's quality scorecards,
5 which is, I think, a fairly common thing.

6 And so they've made the choice to
7 focus on any one or number of measures on the
8 Leapfrog Hospital Survey, and so it's not
9 necessarily a burden to them; it's -- it's part
10 of their culture.

11 Q. They were already doing it?

12 A. Yes.

13 Q. Yeah.

14 Do you -- are the hospitals
15 you're talking to -- what percentage of them are
16 participating versus nonparticipating?

17 A. At this point, I think we have about
18 80 percent of inpatient hospital beds
19 represented in the Leapfrog Hospital Survey
20 results, millions of admissions. So just by
21 nature of that fact, the majority of hospitals I
22 talk to are participating in the survey, but I

1 also talk to hospitals that are not
2 participating in the survey --

3 Q. Yeah.

4 A. -- so just, like --

5 Q. Fair enough.

6 A. -- participation's around 80/20 --
7 I'm sorry --

8 Q. No, no. It's -- it's a fair point.

9 A. Okay.

10 Q. So I -- I guess the -- the follow-up
11 question is, Can you tell me a little bit about
12 what are the conversations you have with
13 nonparticipating hospitals?

14 A. They vary. Sometimes they want to
15 talk about what it would take to participate in
16 the survey. Sometimes they want to get
17 introduced to a hospital of like size, teaching
18 status, patient acuity -- who's doing the
19 Hospital Survey, because they want to do it, but
20 they don't want to start from scratch.

21 A lot of times, it's questions
22 about the Hospital Safety Grade, the way the

1 methodology works. I do a lot of
2 demonstrations using Zoom with that Hospital
3 Safety Grade calculator that I showed you -- I
4 could probably do it in my sleep, I've done so
5 many -- and then me answering questions about
6 that.

7 Sometimes, like in the case of the
8 Alabama Hospital Association, it's a place
9 where we only recently got a -- a regional
10 purchasing group to work with. And so there's
11 not been, really, a -- a strong -- what I would
12 call "Leapfrog presence" in that state.

13 And so the Hospital Association
14 just wants to hear directly from the source
15 more information about the survey versus the
16 Safety Grade, the survey and the Safety
17 Grade --

18 Q. Yeah.

19 A. -- how many dogs I have. I don't
20 know.

21 Q. How many -- how many?

22 A. Two.

1 Q. Two.

2 (Laughter.)

3 BY ATTORNEY CRAIN:

4 Q. That's under oath.

5 (Laughter.)

6 BY ATTORNEY CRAIN:

7 Q. So the other question I have -- so
8 we'll come to this a little bit more later --

9 A. Okay.

10 Q. -- but the imputation methodology we
11 talked about a little earlier -- your
12 conversation -- how many -- do you have
13 conversations with nonparticipating hospitals
14 about the imputation methodology?

15 A. I'm sure I do --

16 Q. Can you --

17 A. -- I can't think of one in the past
18 six months, but it's my job to do that, yes.

19 Q. Do you recall any -- like, the
20 general tenor of those discussions?

21 A. I'm trying to recall the last one I
22 had.

1 Talking to -- I -- I can't recall
2 specific ones, so I want to be very clear about
3 that --

4 Q. Yeah.

5 A. -- typically, it's related to what
6 we have -- the -- you know -- I'm sorry.

7 Typically, it's something like we
8 aren't going to do the survey this year, for
9 example, and we want to understand that's
10 going -- how that's going to impact our
11 Hospital Safety Grade.

12 And then I would explain to them if
13 you don't do the survey for one year, this is
14 the numerical scores that will be imputed for
15 these four measures. These are how the weights
16 will be redistributed, et cetera. If you don't
17 do the survey for two years, et cetera, if you
18 don't -- so it's typically just a very
19 informational call --

20 Q. Got it.

21 A. -- I honestly don't try to talk them
22 back into doing the survey or advise them in any

1 way. I'm simply relaying the information as I
2 know it.

3 They get very frustrated.

4 Q. Okay. Tell me what -- what do you
5 mean?

6 A. Because they want me to give them
7 guidance.

8 Well, what would you do? Well,
9 what do you think?

10 It's not really appropriate for me
11 to do that. I give them the information and
12 tell them it's best to call in a larger team
13 and have those discussions, but it's not a
14 decision I can make for them.

15 Q. So this is the decision they are
16 going to make, and these are the repercussions
17 of that decision?

18 A. These are -- this is how that
19 decision would play out, correct --

20 Q. Okay.

21 A. -- I've never used the word
22 "repercussions," but --

1 Q. Consequence, repercussion -- the
2 "result" --

3 A. Yes.

4 Q. -- may be a more neutral word.

5 A. Sure.

6 Q. Yeah.

7 And do you know -- in those
8 conversations, do you have a sense of why the
9 hospitals stopped reporting for those years?

10 A. It varies. I will tell you a very
11 common one right now, which I'm sure won't come
12 as a surprise to you. It's cybersecurity
13 events.

14 Q. Huh. Interesting.

15 A. We've been hearing an increase in
16 cybersecurity events specifically targeting
17 health systems --

18 Q. Yeah.

19 A. -- insurance companies, et cetera.
20 And so that can be a reason why they have
21 limited access to data or limited staff --

22 Q. Oh, I see --

1 A. -- additionally --

2 Q. -- can I -- can I just follow up on
3 that --

4 A. Yeah.

5 Q. -- because when you say -- it was
6 surprising to me, actually --

7 A. Oh.

8 Q. -- it's not surprising to me that
9 they have these, but the connection is unclear
10 to me --

11 A. Yeah.

12 Q. -- you're saying the cybersecurity
13 incident -- they, like, lock down the data so
14 they can't participate?

15 A. No. They can't record data. So
16 then --

17 Q. I see.

18 A. -- because our survey sometimes asks
19 for, like, them to do something, they're like,
20 We're off-line right now --

21 Q. Got it.

22 A. -- because everything got shut down.

1 Q. Okay. So, like, a sys- -- a system
2 shutdown --

3 A. So we're working off paper,
4 correct --

5 Q. Got it --

6 A. -- correct --

7 Q. -- okay.

8 A. -- another really common reason,
9 actually, is every hospital right now is on
10 electronic health records. There's really
11 actually only a handful of major electronic
12 health record vendors in the space: Epic,
13 Cerner, Meditech, et cetera.

14 If hospitals decide to go from,
15 like, Epic to Cerner, it is apparently a very
16 big deal, and they take everything down.
17 There's a process to move over and train. And
18 that can be a reason that hospitals tell us
19 they're going to pause participation in the
20 survey for one year or more, because they're
21 going through a major -- what they call
22 "transformation."

1 Q. Process, yeah.

2 And then just thinking about,
3 like, during COVID --

4 A. Yes.

5 Q. -- did hospitals ever tell you, We
6 just can't do it this year; we're overwhelmed?

7 A. Yes.

8 Q. Okay. Tell me a little more about
9 that.

10 A. Sure.

11 COVID was scary --

12 Q. Say that again.

13 A. -- yeah -- for a lot of different
14 reasons if you worked in a hospital because you
15 were seeing things you had never seen before;
16 you were afraid to get sick and take it home.

17 So Leapfrog actually -- in
18 discussions with hospitals, our board of
19 directors and others, we actually did something
20 we had never done before. In 2020, our survey
21 launches -- I said it's rolling submissions --
22 April 1st. They have until November 30th to

1 participate in this two-month data collection
2 period -- or data correction, with a C --
3 correction period.

4 For the 2020 Leapfrog Hospital
5 Survey, we said that hospitals who wanted to
6 could do the Leapfrog Hospital Survey.
7 Otherwise, if they had done a 2019 Leapfrog
8 Hospital Survey, we would maintain those data.
9 And we just distinguished between the two on
10 our public reporting website,
11 leapfroggroup.org.

12 So if you were a consumer looking
13 at a C-section rate, you knew it was from the
14 2019 survey versus the 2020 survey.

15 Q. Do you recall how you denoted that?

16 A. I don't -- oh. We added a field in
17 the website file that we import. And I believe
18 we just displayed it --

19 Q. Okay.

20 A. -- I don't exactly recall, though,
21 to be frank --

22 Q. Okay.

1 A. -- it was a wild time.

2 Q. And did that -- so that was sort of
3 like an imputation?

4 A. No. I would say it was -- we froze
5 the results for some hospitals and -- and -- we
6 thought about just freezing the survey. And as
7 we talked to different hospital groups about
8 that, there actually wasn't consensus around
9 that.

10 Some hospitals said No. We've been
11 working on improving this for two years. We're
12 ready to report. I want to report now --

13 Q. Got it.

14 A. -- you know, other hospitals said,
15 We did a survey last year. We're getting
16 slammed right now. We just can't do it.

17 So we tried to find a solution that
18 worked and represented what both groups of
19 hospitals were telling us.

20 Q. So just -- just to make sure I
21 understand, for the hospitals that said we're
22 working on it, we want to report, you gave them

1 their 2020 grade, right?

2 A. No. You asked me about the Leapfrog
3 Hospital Survey.

4 Q. Oh, I'm sorry. So you -- I -- I --
5 I thought we were talking about the grade, too.

6 A. No. The Hospital Survey and the
7 Safety Grade are two completely different
8 programs, and --

9 Q. Got it --

10 A. -- our roles --

11 Q. -- okay.

12 A. -- and protocols around those things
13 during COVID were not --

14 Q. Okay.

15 A. -- the same.

16 Q. So tell me -- yeah, that -- fair
17 enough. I think --

18 A. Yeah --

19 Q. -- I conflated --

20 A. -- okay.

21 Q. -- the two. Yeah, yeah. Let me --
22 okay.

1 So you froze the survey.

2 Did you freeze --

3 A. I'm sorry.

4 Can we just go back on the record,
5 and I can confirm we've been talking about the
6 Leapfrog Hospital Survey, correct?

7 Q. Yes, we've been -- yes. I think I
8 conflated the two.

9 A. Okay.

10 Q. Yeah. I think we're okay.

11 So why -- why don't -- just to
12 be clear, what -- what did you do during COVID
13 for the Safety Grade?

14 A. We calculated Hospital Safety Grades
15 based on the data that was publicly available on
16 those snapshot dates that I described --

17 Q. Okay.

18 A. -- to you earlier. So if it was
19 2020 results, it was 2020 results. If it was
20 2019 results, it was 2019 results --

21 Q. Okay.

22 A. -- and we represented those

1 reporting periods accurately, and I think on the
2 version of Exhibit 4 that you showed me, you can
3 see how those reporting periods are displayed on
4 that Hospital Safety Grade website.

5 Q. Yeah.

6 A. Okay.

7 Q. Okay. And then back to the survey
8 now.

9 A. Yes.

10 Q. I don't want -- I don't want to
11 confuse you, but I think I confused myself.

12 Back to the survey.

13 A. Yes.

14 Q. During COVID, certain hospitals told
15 you they were overwhelmed --

16 A. Yes.

17 Q. -- and wouldn't be completing the
18 survey?

19 A. Yes.

20 Q. You reported their survey results,
21 said, basically, These are the 2019 results of
22 the survey --

1 A. Yes.

2 Q. -- for the hospitals not
3 completing --

4 A. Yes.

5 Q. -- and for the --

6 CERTIFIED STENOGRAPHER: Just
7 let him finish.

8 BY ATTORNEY CRAIN:

9 Q. -- for the ones that did complete
10 the survey, you reported their 2020 results?

11 A. Yes.

12 Q. Okay. Thank you.

13 I think we're on the same page.

14 It's --

15 CERTIFIED STENOGRAPHER: Can
16 we take a bio break soon?

17 ATTORNEY CRAIN: Yes. Yes,
18 of course. Give me five more minutes.

19 Is that okay?

20 CERTIFIED STENOGRAPHER: Yes.

21 ATTORNEY CRAIN: Okay.

22

1 BY ATTORNEY CRAIN:

2 Q. So one other question.

3 On -- on the discussions with
4 hospitals --

5 A. Yes.

6 Q. -- can you recall today any instance
7 in which a hospital said, We don't want to do
8 the survey because our performance has declined?

9 A. I can't recall a hospital admitting
10 that exact thing to me.

11 Q. Okay. I can follow --

12 A. On a phone call.

13 Q. Otherwise?

14 A. Sometimes we get tickets to our help
15 desk, and it won't be someone necessarily a --
16 the leadership of the hospital, but, basically,
17 like, someone may be lower level doing data
18 collection that would just ask because they
19 don't know or they were told to ask.

20 Like, a lot of times, this can
21 happen when there's, like, a switch to the CPOE
22 system, for example. We haven't finished

1 setting up our clinical decision support yet.
2 We don't want to retake the CPOE test right now
3 because we know the alerts aren't working, so
4 we're not going to take the test.

5 What does that mean?

6 Q. Okay.

7 A. So we do hear testimony -- not
8 testimonials. We do get questions from
9 hospitals and through them asking the question
10 about, What's going to happen? Because we can't
11 do this right now. They're telling us it's
12 because, We got worse. We stopped doing it. We
13 have a change in leadership, and we're not going
14 to do this anymore.

15 I'm trying to convince them it's
16 still worth it, that kind of thing.

17 Q. So you -- you -- just to make sure I
18 understand --

19 A. But not on a phone call.

20 Q. Okay. And -- and so let me break
21 this down a little bit.

22 ATTORNEY CRAIN: And then I

1 promise, Cindy, we will break.

2 BY ATTORNEY CRAIN:

3 Q. So you get questions from which you
4 infer that there's declined performance?

5 A. No. I get questions, and in the
6 process of them answering the question, they add
7 that piece, which maybe they meant to or were
8 not meant to do.

9 Q. Okay.

10 A. So in the process of saying, What
11 happens if we don't take the CPOE test? they
12 will have described, Because we switched our
13 CPOE system, the new alerts aren't working.
14 Management doesn't want me to take the CPOE
15 test.

16 Q. Okay.

17 A. So, no, I would never infer
18 something like that.

19 Q. Okay.

20 A. I see it as maybe them accidentally
21 putting too much information in the ticket when
22 they were just supposed to ask a single

1 question.

2 Q. Okay. And then you -- you
3 emphasized "not on a phone call."

4 A. That I could remember.

5 Q. What about a Zoom?

6 A. I would consider that a phone call.

7 Q. Got it. Okay.

8 So any oral video you're
9 talking about?

10 A. (No audible response.)

11 Q. Okay. And -- okay.

12 ATTORNEY CRAIN: I think for
13 Cindy, let's take a break, if you're
14 good, Kim?

15 ATTORNEY BLAIR: Yeah, good.

16 ATTORNEY CRAIN: Okay.
17 Should we just do lunch now?

18 ATTORNEY BLAIR: Yeah.

19 ATTORNEY CRAIN: Okay.

20 THE VIDEOGRAPHER: Going off
21 the record. The time is 12:07.

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--oOo--

(Whereupon, at 12:07 p.m. EDT, a
luncheon recess was taken.)

--oOo--

1 A F T E R N O O N

S E S S I O N

2 (1:15 p.m. EDT)

3 --oOo--

4 MELISSA AMEE DANFORTH,
5 was called for continued examination and, after
6 having been previously duly sworn under penalty of
7 perjury by the certified stenographer to tell the
8 truth, the whole truth and nothing but the truth,
9 was examined and testified further as follows:

10 --oOo--

11 THE VIDEOGRAPHER: Going back
12 on the record. The time is 1315.

13 --oOo--

14 EXAMINATION (CONTINUED) BY COUNSEL FOR PLAINTIFFS

15 --oOo--

16 BY ATTORNEY CRAIN:

17 Q. Welcome back.

18 A. Thank you.

19 Q. Okay.

20 ATTORNEY CRAIN: Oh, is my
21 mic on?

22 Okay. Good.

1 BY ATTORNEY CRAIN:

2 Q. I want to shift gears and talk about
3 the imputation model.

4 A. Yes.

5 Q. Do you prefer "model" or
6 "methodology"?

7 A. Either is fine.

8 Q. Okay. You're okay. You're good.
9 Why did Leapfrog establish an
10 imputation model?

11 A. So going back again when I was
12 referencing the New York and California
13 restaurant letters, there's this idea that
14 obviously, yes, transparency is important, but
15 we also felt that we could use this as an
16 opportunity to really educate patients,
17 families, employers, purchasers, others on what
18 are the asp -- what are some aspects of patient
19 safety, right. So some people may or may not
20 know that it includes things like pressure
21 ulcers, falls, medication errors, hand hygiene,
22 right. These are what we consider aspects of

1 patient safety.

2 And as we examined a host -- when I
3 say "we," again, this would be our national
4 expert panel of which I was an observer, not a
5 participant. When the expert panel was
6 examining all of the various publicly reported
7 patient safety measures that were out there, my
8 recollection is that the idea of having a
9 Safety Grade that included as many available
10 patient safety measures as possible would be
11 the ideal situation.

12 Some of those measures ended up
13 coming from our own Leapfrog Hospital Survey.
14 I don't think that was ever a foregone
15 conclusion, but through deliberation and
16 processes, the expert panelists said,
17 Medication safety is actually the most common
18 medication -- medical error that happens to any
19 patient in a hospital; it's number one.

20 We have to have medication safety
21 represented in the Hospital Safety Grade. What
22 are the available measures that are publicly

1 available? And it just so happened at that
2 time there was only one, actually, CPOE. We
3 didn't even have BCMA on the survey.

4 So the original Safety Grade
5 included slightly different measures on both
6 the process and structural measure side as well
7 as on the outcome measure side. And when we
8 first started calculating Hospital Safety
9 Grades, identifying measures, looking for data
10 sources, we had secondary data sources for
11 some of the measures from the
12 American Hospital Association through their
13 various surveys.

14 So we had had the Safety Grade
15 around now 2013 to 2021. It was
16 well-established, particularly among hospitals.
17 They really understood it by that point.

18 When AHA decided they weren't going
19 to calculate Hospital Safety Grades anymore --
20 or they weren't going to license as their data
21 to calculate Hospital Safety Grades anymore, a
22 discussion was, What are the other available

1 resources? And at that point, there was
2 discussion around imputation for certain of the
3 measures.

4 But to be clear, as I described
5 earlier, going back even to the inception of
6 the Hospital Safety Grade, the idea of
7 imputation was always discussed, and it was
8 discussed from my earliest recollection related
9 to cultural of safety. So this idea of
10 imputation related to methodologies,
11 particularly composites, is not new. It's not
12 groundbreaking. It's not unique to this expert
13 panel. Their thinking and the evolution of the
14 model really did evolve almost organically over
15 time due to various factors.

16 Q. And -- and just, again, to what we
17 talked about earlier this morning, imputation
18 wasn't actually instituted, so to speak, until
19 2021, right?

20 A. Correct.

21 Q. Okay. So to my question of why
22 Leap- --

1 A. I'm sorry. It might have been 2022.
2 I think the last time we used the data was 2021,
3 so it may have been one of the 2022 Grades, but
4 we've agreed it's around that time frame.

5 Q. Yeah. Okay.

6 And that's a helpful
7 clarification. I -- I take the point.

8 The decision to start
9 imputation presumably was '21, and the first
10 time you did it was '22?

11 A. I believe that's correct without
12 having the documents in front of me.

13 Q. Yeah, fair enough.

14 Going back to my question.

15 So I asked why did Leapfrog --
16 why is Leapfrog, you know -- what's the purpose
17 of imputation? You talked about education,
18 right? That was how you started your answer.

19 A. Um-hum.

20 Q. Why do you need an imputation
21 module -- model to educate the public?

22 A. We don't need an education -- we

1 don't need an imputation model to educate the
2 public; however, again, even very early on when
3 we start -- first started calculating Hospital
4 Safety Grades, there were discussions about,
5 Well, if we use measures from a Leapfrog
6 Hospital Survey and we don't have them for every
7 hospital, are we sure we want to use them, or
8 would we still want to use them?

9 And that's why, again, early
10 discussions around even imputing then -- for
11 example, the safe practices, the culture of
12 safety -- safe practice -- those discussions
13 took place. There was always an awareness that
14 because the expert decision -- made a decision
15 to include some measures that were from the
16 Leapfrog Hospital Survey, there was going to be
17 some hospitals that likely would not have those
18 data because it's a voluntary survey --

19 Q. Yeah.

20 A. -- so concepts like imputation,
21 secondary data sources, et cetera, came to be.

22 And I apologize. I realize I

1 wasn't clear.

2 The idea of education is that they
3 didn't want to leave out those important
4 concepts of patient safety just because they
5 may not be available for hospitals that didn't
6 do the Leapfrog Hospital Survey. And that came
7 about specifically because medication errors
8 are the number one error in hospitals. And at
9 the time, we were the only source of any
10 measures related to medication safety.

11 Q. So that's very helpful. I guess
12 the -- my follow-up question to that is, You
13 said you didn't want measures in -- in the --
14 let me just make sure I -- you said, "We don't
15 have them for every hospital where we --
16 where -- sure we want to use them, or would we
17 still want to use them?" Meaning the -- you
18 know, the measures, right, going in? Why isn't
19 a different option to just not grade every
20 hospital?

21 A. From the very beginning of
22 conversations with the expert panel related to

1 the Hospital Safety Grade, they had a commitment
2 to calculating Safety Grades for as many
3 hospitals as possible because unlike things like
4 delivering babies where maybe every hospital
5 doesn't do it or having a complicated cancer
6 surgery where maybe every hospital doesn't do
7 it, these patient safety measures are really
8 fundamental to pretty much any hospital that's
9 providing acute care, and so they thought it was
10 important to include as many as possible, but we
11 don't. I mean, clearly there's over 4,000-plus
12 hospitals in the United States, and we only
13 grade around 2,800 to 3,000 every round.

14 Q. Well, you -- you said earlier today
15 that you grade 80 percent of hospitals, right?

16 ATTORNEY BLAIR: Objection to
17 form.

18 BY ATTORNEY CRAIN:

19 Q. Explain to me --

20 A. No.

21 Q. -- do you remember that number,
22 80 percent?

1 A. No, I said -- again, so that's when
2 we were talking about the
3 Leapfrog Hospital Survey --

4 Q. Okay.

5 A. -- and I said we have about
6 80 percent of inpatient hospital beds
7 represented from hospitals who are participating
8 in a Leapfrog Hospital Survey, meaning that we
9 have the majority of hospitals --

10 Q. Okay.

11 A. -- doing the
12 Leapfrog Hospital Survey.

13 Q. And so 20 percent are -- of
14 inpatient beds are at hospitals that do not
15 participate in the survey?

16 A. Yes.

17 Q. Why does Leapfrog need to grade
18 those hospitals?

19 ATTORNEY BLAIR: Objection to
20 form.

21 THE WITNESS: Again, the
22 expert panel's intention was because

1 this is a patient Safety Grade, to
2 grade as many hospitals as possible.

3 BY ATTORNEY CRAIN:

4 Q. What is -- is it to grade as many
5 hospitals as possible or to also grade them
6 accurately?

7 A. It's both.

8 Q. Okay.

9 A. Which we do.

10 Q. So -- and just to be clear, you're
11 saying the imputation model Leapfrog has
12 presents an accurate portrait -- depiction of a
13 hospital's performance?

14 A. I have confidence in our entire
15 methodology, including the imputation
16 methodology, yes.

17 Q. Okay. What's the basis for that?
18 Why do you have confidence in it?

19 A. I trust our expert panel. I have
20 said before I'm not a health science researcher,
21 a health services researcher. I'm not a
22 mathematician, but I believe that the

1 individuals providing us with guidance and
2 expertise -- which over the years, has been
3 beyond the expert panel.

4 Over time, we've consulted with
5 Mathematica -- they're a leading analytics firm
6 in the U.S. -- and others, and because -- you
7 know, those are the folks that -- not just
8 Leapfrog, CMS, Joint Commission, other national
9 organizations -- are also trusting to provide
10 them guidance on performance, measurement,
11 et cetera. I feel confident in the panel
12 and -- and their guidance.

13 Q. Is it accurate that the expert panel
14 approved the imputation methodology Leapfrog
15 deploys today?

16 A. So as I've described, there's not a
17 voting process, there's a discussion and there
18 was agreement, correct.

19 Q. Are you referring to the April 12th,
20 2024 meeting?

21 A. We did meet on April 12th, 2024.

22 Q. Was that the discussion you were

1 just referring to?

2 A. There were discussions both before
3 and after that meeting, and I would say
4 throughout the process of finalizing the fall
5 2024 methodology, there was agreement among the
6 expert panelists, yes.

7 Q. Okay. We'll come up to that.

8 Let's start -- so you had
9 mentioned there was a discussion over time
10 involving imputation; is that right?

11 A. Yes.

12 Q. I want to take you back to some of
13 those discussions and sort of get your
14 documents.

15 So I want -- excited. All
16 right.

17 ATTORNEY CRAIN: So this is
18 going to be Exhibit 6.

19 --oOo--

20 (Danforth Deposition Exhibit Number
21 6, Leapfrog Hospital Safety Grade
22 Expert Panel In-Person Meeting

1 Agenda, June 14, 2017, Bates
2 stamped ARMSTRONG_0003576 through
3 ARMSTRONG_0003579, marked for
4 identification, as of this date.)

5 --oOo--

6 THE WITNESS: Oh, thank you.

7 Sorry.

8 ATTORNEY CRAIN: Six, right?

9 CERTIFIED STENOGRAPHER: Yes.

10 ATTORNEY CRAIN: Good. Six.

11 (Sotto voce between cocounsel.)

12 BY ATTORNEY CRAIN:

13 Q. Okay. Ready?

14 A. Yes.

15 Q. Okay. Ms. Danforth -- Danforth,
16 Exhibit 6, if you see at the top, it is a
17 Leapfrog Hospital Safety Grade Expert Panel
18 In-Person Meeting Agenda.

19 Do you see that?

20 A. I do.

21 Q. And it's dated Wednesday, June 14th,
22 2017.

1 Do you see that?

2 A. I do.

3 Q. And I'm just going to tick down to
4 the meeting attendees.

5 Do you see it labels expert
6 panelists and board/staff?

7 A. I do.

8 Q. And among the folks who attended are
9 Ms. Binder, yourself and Dr. Austin.

10 Do you see that?

11 A. I do.

12 Q. And I -- just a question. I noted
13 Ms. Binder stops at some point attending these
14 meetings.

15 Do you recall when that
16 happened?

17 A. I remember that this was an
18 in-person meeting, which was unique. We don't
19 often meet in person with our technical expert
20 panels even prior to COVID because they live
21 around the country. It's very expensive. So I
22 know she would have attended this in-person

1 meeting. I couldn't recall if she attended
2 previous to this or after this any virtual
3 meetings that we would have.

4 Q. Okay.

5 A. But I would say that an in-person
6 meeting for sure she would be present.

7 Q. Do you have a best estimate of when
8 the last ex -- Hospital Safety Grade expert
9 panel she attended was?

10 A. I wouldn't.

11 Q. Okay. So if you go down a little
12 bit, specifically to the Unintentional
13 Consequences of How We Currently Treat Missing
14 Data.

15 Do you see that?

16 A. I do.

17 Q. And it says, Matt discussed some of
18 the unintentional consequences of how we
19 currently treat missing data, some of which are
20 driven by the Z-score methodology, and also
21 assigning grades to hospitals that may have more
22 or less data than others.

1 Do you remember the context of
2 that -- that note?

3 A. Unfortunately, I don't --

4 Q. Okay.

5 A. -- this is from 2017 --

6 Q. Okay.

7 A. -- eight years ago. I apologize.

8 Q. No, no. Don't -- no need to
9 apologize.

10 Do you have any present
11 understanding of what this could mean?

12 A. I don't. Only because in 2017, the
13 methodology was so different, including the
14 measures that we use both on the process and
15 structural measure side and outcome measure
16 side. I would need to read through the full
17 thing and any other meeting materials if I was
18 really going to speak to anything.

19 Q. Okay. Okay.

20 Let's go to Page 2. If -- you
21 see there's, at the top, a Number 2.

22 Do you see that in the bullets?

1 A. I do.

2 Q. And it says, Imputation of the score
3 when we have missing data.

4 Do you see that?

5 A. Correct.

6 Q. Is this one of the instances we've
7 been talking about where imputation has come up
8 before 2021 in these meetings?

9 A. I don't remember the specific
10 meeting.

11 Q. Okay.

12 A. As I've described, my most vivid
13 memory was specifically from Sara Singer related
14 to culture of safety. I don't remember this
15 specific incident.

16 Q. And you don't remember when the --
17 when Ms. Singer made that comment?

18 A. I don't.

19 Q. Okay. And just walking through --
20 you know, I understand if you don't remember,
21 but just to see if it refreshes your
22 recollection, it says, Matt mentioned that

1 expert panel discussed this in the past and did
2 not feel it supported the goal of the Safety
3 Grade.

4 Do you know what he means by
5 that?

6 A. I don't.

7 Q. Okay. Could he -- do you remember
8 any -- you know, do you have any sense of what
9 type of imputation did not support the goal of
10 the Safety Grade?

11 A. Again, my only recollection of
12 talking about imputation very early on was
13 specific took -- to the culture of safety
14 concept, which we've talked about extensively,
15 but I -- beyond that, I couldn't speak to this.

16 Q. Is that reflected in the next
17 bullet, Imputing scores for individual measures,
18 like Safe Practices?

19 A. I'm honestly not sure what that's
20 referring to, but my reference to Sara Singer
21 indicating that it would not be appropriate to
22 impute for something like a culture of safety

1 is -- is specifically what I'm referencing.

2 Q. Okay. Okay.

3 And culture of safety was
4 Safe Practices 2 or 1?

5 A. Safe Practice 2, correct.

6 Q. Okay. And then it says, Imputing
7 scores for individual measures like safe
8 practices would incentivize them to report on
9 the survey.

10 Do you see that?

11 A. I do.

12 Q. Do you know what that means?

13 A. Again, I -- I don't have a good
14 recollection of this meeting, and we've never
15 imputed scores for the safe practices since the
16 inception of the Safety Grade. I only remember
17 a single discussion even involving the safe
18 practices and imputation, so I only know the
19 outcome of what this discussion must have been,
20 which is what -- that we've never imputed safe
21 practice scores.

22 Q. And so just looking at this sentence

1 again --

2 A. Yes.

3 Q. -- is it correct to say that
4 imputing scores for individual measures would
5 incentivize hospitals to report on the survey?
6 And I purposefully tweaked the sentence in my
7 question. So I'm asking a very precise
8 question.

9 ATTORNEY BLAIR: Objection to
10 form.

11 THE WITNESS: And I don't
12 know if it would incentivize hospitals
13 to report to the survey or not. Like
14 I said, we've been doing imputation
15 for the Hospital Safety Grade
16 perform -- participation in a
17 Leapfrog Hospital Survey has remained
18 relatively steady. Whether I,
19 personally, believe it's an incentive
20 is irrespective of the reality of what
21 the participation looks like, so I --
22 I can't really speak to this.

1 BY ATTORNEY CRAIN:

2 Q. What do you personally believe?

3 A. That it depends.

4 Q. Depends on what?

5 A. I think if hospitals are generally
6 doing those elements already included in the
7 safe practices, it may incentivize them to say,
8 Oh, well, we're already doing this. Let's
9 report it to Leapfrog and have that included in
10 the Hospital Safety Grade. If hospitals are not
11 already doing those things or don't want to do
12 those things or don't agree with some of those
13 things, then it could disincentivize them.

14 I think an important thing to
15 remember is that hospitals that submit surveys
16 and get Safety Grades get Ds, get Fs. And so
17 participation in the survey isn't a straight
18 line to an A grade, a B grade, et cetera.

19 You know, in fact, we've seen time
20 and time again hospitals reporting to the
21 survey across all of the grades. So to speak
22 about a hospital's incentive or disincentive, I

1 think there's a lot of variation.

2 Q. Okay. The panel is -- two bullets
3 down, The panel discussed whether or not we
4 should assume the worst score if hospitals are
5 not transparent.

6 Do you recall that discussion?

7 A. I don't.

8 Q. Okay. Do you -- do you have an
9 understanding of what that could mean?

10 A. I wouldn't be able to speak
11 definitively. It could mean imputing a 0 --
12 unfortunately, I don't. I actually don't
13 remember this meeting at all, so I don't --

14 Q. Okay. Is -- is --

15 A. -- to be -- to be honest. I -- I'm
16 sure I was there. 2017 feels like a long time
17 ago. I don't remember this meeting at all.

18 Q. Anything pre-COVID is a blur.

19 A. It is a pre-COVID thing.

20 Q. Yeah. Yeah.

21 Then let me ask this question.

22 A. Yes.

1 Q. Let's see.

2 Is it fair to assume the worst
3 scores if hospitals are not transparent?

4 ATTORNEY BLAIR: Objection to
5 form.

6 THE WITNESS: Is this me,
7 personally, answering the question?
8 Is this me --

9 BY ATTORNEY CRAIN:

10 Q. Personal --

11 A. -- on behalf of Leapfrog?

12 Q. -- personal capacity.

13 A. I think, today, as we stand here in
14 2025, specific to the four measures that we
15 impute scores for in the Hospital Safety Grade,
16 given that actually we're imputing the same
17 score a reporting hospital gets if we know that
18 they have those structures in place but nothing
19 more and that we could actually impute 0, which
20 one expert panel has recommended, I wouldn't
21 even describe what we're doing now as being the
22 worst score we can impute. It is the worst

1 score in the data set for these measures, as
2 we've indicated clearly on our public reporting
3 website.

4 But, frankly, there has been
5 discussion about imputing 0s, which probably
6 would be the real worst score.

7 Q. I thought, though -- so tell me if
8 I'm misunderstanding.

9 I thought, like, say, a 15 for
10 handwashing was the lowest score.

11 A. So today, that is the lowest score,
12 but it's specifically associated with that
13 performance category, as we discussed, that's
14 from the Leapfrog Hospital Survey.

15 So in some ways, we're still giving
16 a hospital that's not done anything related to
17 the survey the same credit that we're giving a
18 hospital that's done a Leapfrog Hospital Survey
19 and basically said, Yes, we have this but we
20 don't have these other things in place.

21 The scores that you see assigned to
22 those performance categories for each of those

1 four measures were not determined by this
2 Hospital Safety Grade expert panel. They
3 actually come from another program, and they
4 were determined by a separate independent
5 national expert panel.

6 So, for example, the lowest score
7 for CPOE, I believe, is 15. So let me check.

8 Q. I won't hold you to it. The
9 document says what it says.

10 A. I don't trust myself now after that
11 hand hygiene -- hand hygiene domain mishap.
12 It's shaken my confidence.

13 The lowest score associated with
14 CPOE is 15. However, the lowest score
15 associated with --

16 Q. IC.

17 A. -- IC position staffing is --

18 Q. Five.

19 A. -- 5.

20 So those were not arbitrarily
21 assigned. There are differences for a reason.
22 And that's because those numerical values

1 associated with those four performance
2 categories were decided by another separate,
3 independent national technical expert panel for
4 the purposes of Leapfrog's value-based
5 purchasing program.

6 I've talked about that a few times,
7 when we take those performance categories and
8 assign these scores.

9 So the difference in the scores
10 represent relative importance that panel
11 thought, relative harm for having the highest
12 versus lowest achievement. And that's why IC
13 staffing has the lowest low score, because it's
14 the greatest harm because it can result in --
15 in -- results in death.

16 And so -- though, today, we're
17 imputing the lowest score from a Leapfrog
18 reporting hospital, we could, theoretically,
19 given guidance from the expert panel, report a
20 lower score that could not be attained by a
21 Leapfrog reporting hospital.

22 Q. Got it. I think I understand.

1 And then just to make it
2 concrete, when you say "the lowest score," for
3 handwashing, for instance, what is that,
4 presuming exists for the lowest reporting
5 hospital?

6 A. So in order to achieve limited -- in
7 order to earn limited achievement on the hand
8 hygiene standard, it is a structural measure,
9 and so there's a series of components. And
10 based on the yeses or noes -- you might refer to
11 it as, like, a scoring rubric.

12 So based on that scoring rubric,
13 the components that would equal limited
14 achievement are laid out.

15 Unfortunately, given the detail of
16 that, I would just need to have it in front of
17 me to reference it. And we can certainly
18 discuss it.

19 Q. Okay. And -- and just to be clear,
20 though, under the current structure, there is no
21 lower score than limited achievement for any
22 hospital; is that right?

1 ATTORNEY BLAIR: Objection to
2 form.

3 THE WITNESS: For these four
4 measures?

5 BY ATTORNEY CRAIN:

6 Q. For these four measures.

7 A. Currently, correct --

8 Q. Okay.

9 A. -- correct, yeah --

10 Q. Okay.

11 A. -- so even nonreporting hospitals
12 still get a score associated with a Leapfrog
13 reporting hospital --

14 Q. Okay.

15 A. -- that's correct. We have --
16 there's no score beneath that.

17 Q. Okay. And the -- just before we
18 leave this document --

19 A. Yeah.

20 Q. -- I just want to make sure.

21 None of these -- particularly
22 Bullet 2 -- none of these bullets refresh your

1 recollection as to what was discussed?

2 (Whereupon, the witness reviews the
3 material provided.)

4 THE WITNESS: They don't.

5 BY ATTORNEY CRAIN:

6 Q. Okay.

7 Okay --

8 A. And --

9 Q. -- you can set that aside.

10 A. -- and -- yes --

11 Q. Oh. Do you have something?

12 A. -- typically, we would only have,
13 like, an in-person expert panel meeting for a
14 specific reason, but there's nothing at this --
15 you know, that -- on this agenda that jumps out
16 at me.

17 So I'm wondering -- and if it was
18 the panel hadn't met in-person in a long time
19 and we brought them all together -- but no.

20 And -- I mean, I see my name on the
21 agenda, certainly, particularly at the end,
22 Page 4, Discussion of the Landscape Ahead.

1 So I can see Missy shared
2 information on surgeon volumes and pediatric CT
3 dose, but I have no recollection of doing that.

4 If the notes said I did, I'm sure I
5 did.

6 Q. Okay.

7 Okay. You can set this one
8 aside.

9 Thanks for indulging the memory
10 lane. We're not off it yet.

11 ATTORNEY CRAIN: Let's go to
12 Tab 6.

13 So let's see. This will be
14 Exhibit 7.

15 --oOo--

16 (Danforth Deposition Exhibit Number
17 7, E-mail with attachment,
18 LEAPFROG01918816 through
19 LEAPFROG01918821, marked for
20 identification, as of this date.)

21 --oOo--

22 ATTORNEY BLAIR: Thank you.

1 ATTORNEY CRAIN: You're
2 welcome.

3 BY ATTORNEY CRAIN:

4 Q. Okay. Ms. Danforth, this is an
5 e-mail from Andrew Card, who looks to be a
6 Leapfrog employee.

7 A. Yes.

8 Q. Was he -- was he, by chance,
9 Ms. Campione's predecessor?

10 A. So he was a program analyst on my
11 ratings team. He wasn't -- it ended up -- after
12 we hired Alex, she did some of his work but not
13 all of it.

14 Q. Not one-to-one?

15 A. No, it's not a one-to-one. Thank
16 you.

17 Q. So he -- he attaches what he says
18 are notes from a Safety Grade expert panel.

19 If you look at the next page,
20 Bates ending 5729 --

21 A. Yes.

22 Q. -- and I'm going to refer -- do you

1 know what a Bates number is?

2 A. Yes.

3 Q. Okay. You've been educated. All
4 right.

5 A. Yes.

6 Q. So if you look at Notes from Safety
7 Grade Expert Panel Call, June 8th, 2020 --

8 A. Yes.

9 Q. -- by chance, do you remember this
10 meeting?

11 A. May I read this for a minute?

12 Q. Of course.

13 A. Okay.

14 (Whereupon, the witness reviews the
15 material provided.)

16 THE WITNESS: So I'm familiar
17 with some of these topics, and we
18 spoke extensively particularly about
19 the addition to PSI 90 and having to
20 update are we waiting methodology.

21 I don't remember being in
22 this specific meeting; but, again, I

1 am familiar with these topics.

2 BY ATTORNEY CRAIN:

3 Q. Okay. So let's walk through -- I
4 just want to get your understanding of these
5 terms to the extent you remember.

6 A. Yes.

7 Q. So focusing on imputation --

8 A. Yes.

9 Q. -- and it says, Matt reviewed the
10 models that Mathematica put together for
11 Leapfrog that imputes scores for CPOE, BCMA and
12 IPS. The model that make the both -- the --
13 sorry -- the model that make the most sense both
14 for minimizing miscalculation/bias and for
15 having face validity is as follows: Use the
16 most recent historic year if data was submitted
17 within the last three years; otherwise use the
18 most frequent value of the health system;
19 otherwise impute a score based on similar
20 hospitals (number of beds, region and
21 urbanicity).

22 Do you see those -- that --

1 that --

2 A. I do.

3 Q. This model -- the -- the three
4 bullets with -- with the white bullet -- was
5 that ever instituted?

6 A. I would need to reference the
7 specific scoring algorithm documents, like the
8 one you gave me today for spring 2025.

9 I can tell you as early as -- or as
10 recent as 2023, we were imputing recent
11 historical data within the last two years.

12 Q. Do you recall -- so my -- my
13 recollection -- and you tell me if it's wrong --
14 is that you -- you did not institute the second
15 one; you used the most frequent value of the
16 health system.

17 Is that right or --

18 A. I don't recall --

19 Q. Okay. That's fine.

20 A. -- ever implementing that as part of
21 the Safety Grade.

22 Q. Got it.

1 And then -- so he says -- if
2 you go to the top bullet, he's saying, The model
3 that may make -- he's saying, The model that
4 make the most sense both for minimizing
5 miscalculations and bias.

6 Do you have an understanding
7 what "miscalculations and bias" means in this
8 context?

9 A. I have an understanding that he's
10 speaking specifically to some work that
11 Mathematica did. I think I referenced it
12 actually right before you showed me this. I'm
13 prophetic.

14 I have an understanding that he's
15 referencing specifically the models that
16 Mathematica tested and put before the group.

17 Q. And -- and what does
18 "miscalculations and bias" mean in this context?

19 A. I don't remember the specific models
20 that Mathematica tested except to say that they
21 were many that were trialed and reviewed. I
22 would need to go back to those notes.

1 But Mathematica would have used
2 those phrases. Most common -- likely, it was
3 them describing --

4 Q. Yeah.

5 A. -- the analysis they had done and
6 then Matt reiterating back as accurately as he
7 could, I guess, what Mathematica had presented
8 to us.

9 Q. You've spent many years going to
10 these expert panel meetings, correct?

11 A. Yes.

12 Q. And they discussed imputation many
13 times, right?

14 A. They've discussed imputation over
15 the years, yes.

16 Q. Over the years.

17 Is -- is it fair to state that
18 as they have been discussing imputation, they
19 have been trying to avoid miscalculations of --
20 of the Safety Grade through imputation?

21 A. It's fair to say that as they've
22 discussed imputation, they're thinking around

1 the use of imputation has evolved. And they do
2 have a concern about making sure that the Safety
3 Grades are accurate and reliable.

4 Q. And -- and what sort of bias are
5 they talking about in those discussions?

6 A. In these discussions, again, the
7 expert panel is not talking about bias.

8 My read and understanding of the
9 first bullet is that Matt is communicating to
10 this panel work that Mathematica had done on
11 our behalf. And that's what he's sharing.

12 In terms of conversations related
13 to bias in imputation that the current expert
14 panel has had -- and, again, I don't see a
15 attendance document here; so I don't know who
16 was present or not present.

17 But I think that over time, there
18 have been increasing concerns that the bias
19 actually exists in another way, which is that
20 hospitals are getting too much credit.

21 And, again, during this time, 2013
22 to 2025, the emphasis that I talked about early

1 on about really focusing on patient safety and
2 reducing harm to patients, since that time, I
3 think only two or three additional papers
4 quantifying harm -- so deaths or harm to
5 patients in hospitals -- are really considered
6 definitive that have come out since the IOM.
7 And all of them are estimating things like one
8 in four CMS patients are being harmed by
9 preventable events in hospitals, that if we
10 were to do autopsies on every death in a
11 hospital, medicals errors would be the third
12 leading cause of death.

13 And Marty Makary said that, the
14 head of the FDA.

15 So I think as the science has
16 changed, the understanding of preventable harm
17 has changed. Our expert panel's thoughts
18 around imputation have changed, and their
19 concern about biasing in such a way that
20 hospitals would appear safer than they might be
21 is a concern.

22 And, again, that's my conjecture,

1 my -- my read of -- of the discussions. That's
2 not verbatim any discussion I've been a part
3 of.

4 But so -- and I'm sure you have
5 transcripts of many of those meetings, and we
6 could revisit them if you have them
7 available --

8 Q. Yeah.

9 A. -- so I'm giving my impression of --
10 as a colleague, not as a member of the expert
11 panel.

12 Q. Yeah. Yeah.

13 So let me -- let me ask you
14 to -- specifically a corporate representative
15 question.

16 A. Yeah.

17 Q. Why does Leapfrog believe that they
18 were giving hospitals too much credit, as you
19 said?

20 A. Because we --

21 Q. And -- and specifically
22 nonparticipating hospitals.

1 A. Yes.

2 Do you want to ask the question

3 again --

4 Q. Sure.

5 A. -- so she has it and I can -- okay.

6 Q. Yeah.

7 In your corporate

8 representative topic -- thank you --

9 A. Yes.

10 Q. -- for your help -- why does

11 Leapfrog believe that it is giving

12 nonparticipating hospitals too much credit?

13 A. We had done some analysis -- and

14 when I say "we," not me. So let me actually

15 first clarify that I do no analysis.

16 I believe Hopkins -- Matt Austin or

17 one of his research assistants at Hopkins had

18 done some analysis which was shared with one of

19 our expert panel meetings -- so it may be in

20 the notes -- indicating -- looking at

21 performance over time, hospitals that had

22 dropped out of the survey coming back. So

1 there was a data analysis that I don't have
2 memorized or in front of me that helped inform
3 that particular opinion.

4 Q. Do you remember when that was
5 presented?

6 A. I don't. So I -- again, I do
7 oversee these programs. I don't do these
8 analysis. I am on the -- the meetings, clearly,
9 but I am doing that for all four of the Leapfrog
10 programs.

11 And I know the Hospital Safety
12 Grade is a big focus of this case, but in my
13 day-to-day work, all the programs are
14 important. And so I don't remember something
15 that specific about this one program.

16 Q. Yeah. And -- and, again, I'm not
17 trying to trick you, or anything to that effect.
18 I'm actually asking because I've never seen
19 it --

20 A. Yeah.

21 Q. -- and I've looked at many documents
22 in this case. And it seems fairly material

1 to -- to Leapfrog's -- I mean, it was where you
2 went in your answer.

3 So I'm trying to triangulate
4 where it might be if it actually -- you know, I
5 don't mean --

6 A. Yeah.

7 Q. -- discussed, but if it was
8 presented, I'm trying to understand where to
9 find it --

10 A. Yeah.

11 Q. -- so any help -- help you can give
12 us in that regard?

13 A. I would have to consult or have you
14 consult with Matt Austin.

15 Q. Okay. So the -- so -- so the answer
16 is we have to ask Dr. Austin?

17 A. Yes.

18 Q. Okay. So we -- we'll ask him.

19 A. Okay.

20 Q. But, again, I'm not -- I'm not
21 trying to ask for a memory test. I'm just
22 trying to figure out, like --

1 A. No. I did prepare significantly to
2 be sure I could answer these questions; but,
3 again, like, something as specific as a meeting
4 where there's no attendance and I can only see
5 the notes, I'm not going to be able to recall
6 anything beyond that.

7 Q. Tot- -- totally get it. And I'm --
8 I'm not asking you to do more.

9 And if -- if it's not in the
10 record, so to speak, it's just not in the
11 record --

12 A. Okay.

13 Q. -- but to the extent we can find it,
14 I think it --

15 A. Yeah --

16 Q. -- it would be helpful --

17 A. -- yeah, I know.

18 Q. -- so that's -- that's why I ask.

19 Okay. So keep going -- I
20 think -- is there anything else on that document
21 to ask?

22 Oh. So just going back to

1 that -- so -- one, two, three -- four bullets
2 down from imputation, do you see There was?

3 A. Yes.

4 Q. There was an open question of how
5 punitive Leapfrog should be for hospitals that
6 do not submit data.

7 And just first question
8 might -- fair to say you don't remember the
9 actual discussion referenced here?

10 A. I don't --

11 Q. Okay --

12 A. -- and --

13 Q. -- do -- please.

14 A. -- I don't. And actually, I'm
15 trying to just recall even the particulars of
16 the methodology in 2020, and nothing stands out
17 at me as being punitive.

18 So, again, if something was
19 discussed, it's not clear, to me, that any
20 action was taken in terms of any changes to the
21 actual methodology.

22 Q. Yeah. So I -- I -- I --

1 A. Okay.

2 Q. -- take your point.

3 Prior to this period, there's
4 no imputation at all, right?

5 A. Okay. Yeah.

6 Q. Agreed?

7 A. Yeah.

8 Q. Okay. And then this appears to be
9 the period in which Leapfrog has retained
10 Mathematica to try to assess how it might
11 impute, correct?

12 A. Yes.

13 Q. Okay. And so it seems, to me, that
14 there's a discussion in -- in assessing the
15 right imputation model --

16 A. Yes.

17 Q. -- of how punitive Leapfrog should
18 be for hospitals that do not submit data.

19 Is that a fair reading of this?

20 ATTORNEY BLAIR: Objection to
21 form.

22 (Whereupon, the witness reviews the

1 material provided.)

2 THE WITNESS: Again, I didn't
3 write these notes. I don't remember
4 the discussion, so I don't know if
5 that word, "punitive," is accurate or
6 not.

7 BY ATTORNEY CRAIN:

8 Q. Do you have a personal view as to
9 whether imputation is related to punitiveness or
10 not?

11 A. I have a personal view that
12 imputation in the context of a discussion at the
13 expert panel -- that term could have been
14 used --

15 Q. Okay.

16 A. -- to -- in the course of a
17 conversation casually or haphazardly --

18 Q. Is --

19 A. -- I don't think -- and I know that
20 no one was suggesting that Leapfrog is punitive
21 or anything we're considering would be punitive.

22 Q. Is it your view that at no time,

1 Leapfrog has imposed an imputation methodology
2 to be punitive?

3 A. Yes, absolutely. Leapfrog has never
4 imposed a methodology to be punitive.

5 Q. Even though there have obviously
6 been discussions about whether to be punitive?

7 A. I, personally, have never used that
8 term in my discussion of any of the Leapfrog's
9 rating programs.

10 I did not make these notes. I
11 don't know what the actual discussion was.

12 I guess, to me, that has a negative
13 connotation. It's not a term I use. It's not
14 a term people on my team use. I can't reflect
15 its accuracy here.

16 ATTORNEY CRAIN: Okay. Let's
17 look at Tab 10.

18 Okay. This will be Exhibit
19 -- oh, man. I lost it already.

20 ATTORNEY BLAIR: Eight.

21 THE WITNESS: Eight.

22 ATTORNEY CRAIN: See, Kim,

1 you're always there for me.

2 ATTORNEY BLAIR: Eight.

3 ATTORNEY CRAIN: Eight.

4 BY ATTORNEY CRAIN:

5 Q. Don't write that.

6 A. Don't write that.

7 --oOo--

8 (Danforth Deposition Exhibit Number
9 8, E-mail string, Bates stamped
10 LEAPFROG01918816 through
11 LEAPFROG01918821, marked for
12 identification, as of this date.)

13 --oOo--

14 ATTORNEY CRAIN: I saw you
15 with the pen. I got nervous.

16 THE WITNESS: Thank you.

17 ATTORNEY CRAIN: This is

18 Tab 10.

19 BY ATTORNEY CRAIN:

20 Q. Okay. So this is fast-forwarding a
21 year to 2021.

22 Do you see that?

1 A. Yes.

2 Q. And it's an e-mail thread between
3 you, Dr. Austin and someone named Emma Domico?

4 A. Yes.

5 Q. Was he -- was she Dr. Austin's
6 assistant or --

7 A. So Matt has students as assistants
8 throughout the years. Jourdan Dirk is one.
9 You've seen his name --

10 Q. Yeah.

11 A. -- Preeti Joshi, now you see her
12 name.

13 Emma Dirk was in between.

14 Q. In between. Got it.

15 So if you go to the back page,
16 it starts -- and these e-mails run -- the last
17 one is the first one, the way it's produced.

18 So it starts from Dr. Austin to
19 you, Mr. Card, cc'ing Ms. Domi- -- Domico,
20 April 25th, 2021 at 4- -- 4:59 p.m?

21 Do you see that?

22 A. I do.

1 Q. And he says, Missy, Andrew, Next
2 Friday is the HSG expert panel call.

3 "HSG" meaning hospital safety
4 group -- grade?

5 A. Yes.

6 Q. As Emma and I were walking through
7 the agenda items, we would benefit from your
8 input and expertise. Best, Matt.

9 Do you see that?

10 A. Yes.

11 Q. And then he puts a list of six
12 items.

13 Do you see that?

14 A. Yes.

15 Q. And there's different colors, black
16 and gray?

17 A. Yes.

18 Q. Now, if you go just -- we'll come to
19 them in a second.

20 If you go up one --

21 A. May I read them, or no?

22 Q. Yeah. I just wanted to --

1 A. Oh, sorry --

2 Q. -- orient you first --

3 A. -- yes.

4 Q. -- you absolutely may read them.

5 But if you look at your e-mail,
6 the next one at 10:09 a.m. -- you see that? You
7 say, See below?

8 A. Yes.

9 Q. And I just want to make sure we're
10 on the same page.

11 My read of this e-mail is that
12 the black text is Dr. Austin's and the gray is
13 your responses; is that right?

14 A. I don't know.

15 Can I take a second --

16 Q. Yeah, read it --

17 A. -- just to read it?

18 Q. -- but I -- I wanted to make sure
19 you saw the See below.

20 A. Yeah. I understand what your
21 question is asking.

22 (Whereupon, the witness reviews the

1 material provided.)

2 THE WITNESS: Yes. I believe
3 that Matt asked for input on those six
4 items. I replied back and added my
5 responses underneath. Yes --

6 BY ATTORNEY CRAIN:

7 Q. In the lighter --

8 A. -- I think that's correct.

9 Q. -- in the lighter text?

10 A. Yes.

11 Q. Great.

12 Okay. So just now that
13 we're oriented, I want to focus on Bullets 2 and
14 4.

15 He says in 2 --

16 This is -- these are agenda
17 items, right?

18 A. Um-hum.

19 Q. -- How to score hospital missing
20 process/structural measures. Are we looking for
21 suggestions on imputation methods?

22 A. Um-hum.

1 Q. And you say, Yes. And the idea to
2 impute for all missing, including Safe Practices
3 and HH â€” I will send a follow-up to the e-mail
4 Andrew sent.

5 Do you see that?

6 A. Yes.

7 Q. And so does this reflect that you're
8 still working together as a group to try and
9 figure out what the right imputation methodology
10 is going to be?

11 A. So I'm going to have to jog my
12 memory, but we have the Hospital Safety Grade
13 expert panel. For this particular subset of
14 that work where we were just working on
15 imputation, we asked for volunteers to form a
16 small subcommittee that would help us work on
17 the imputation with Mathematica and then report
18 back out to the group, and that's because these
19 people have regular jobs. They serve on a
20 voluntary basis. We don't pay them. They
21 receive no honorariums, and so we can't assume
22 they're all going to want to.

1 My memory is that it was
2 Patrick Romano, Sara Singer and maybe a third
3 who participated in that smaller group, but I
4 don't -- I want to say Tim Vogus, but I can't
5 remember.

6 So on the record, I know it was
7 Sara Singer and Patrick Romano.

8 And so they -- I don't know at what
9 point we were talking to Sara and Patrick and
10 Mathematica versus the larger group, so I don't
11 -- so if this is the full agenda -- I'm just
12 trying to put all that in my brain the right
13 way.

14 Q. Do -- do you refer to "HSG expert
15 panel" to mean something else ever?

16 A. No. I think that's the full panel.

17 Q. Okay.

18 A. But where I say on Number 2 -- it
19 says, How does -- Matt's saying, like, Should
20 this be an agenda item? And on Number 2, it
21 says, Yes. And the idea to impute all
22 missing -- I'm not responding to him as if to

1 say, like, Matt, that's what I think the agenda
2 is. I might be reflecting back to him, That's
3 what we talked about with the smaller workgroup,
4 so, like, Patrick and Sara. Like, yes, that is
5 the agenda item. Specifically they wanted to
6 talk about this -- I believe is probably what's
7 happening here.

8 I wouldn't necessarily be the one
9 to decide what goes on in the agenda. It may
10 have been part of a smaller subgroup meeting.
11 And based on that discussion, my impression is
12 this is what they wanted to talk about at this
13 meeting.

14 Q. Okay.

15 A. That's all I was saying.

16 Q. Okay. No, I understand.

17 A. Okay.

18 Q. And "HH," is that hand hygiene?

19 A. Yes.

20 Q. Okay.

21 So I want to look at 4 now.

22 A. Yes.

1 Q. And the agenda item he proposes is
2 Penalizing hospitals if they don't report, and
3 then he says, in brackets, [is this part of
4 Agenda Item Number 2? And is Leapfrog really
5 open to this idea? If not, I don't want to keep
6 asking their opinions].

7 So you -- do you see that?

8 A. Yes, and I say, Remove " this is
9 really covered in Number 2.

10 Q. What did you mean by that?

11 A. That we were focusing on imputation.

12 Q. So focusing on imputation.

13 So he is asking is Leapfrog
14 really open to penalization, right?

15 A. I am -- can read the paper what he's
16 asking, yes.

17 Q. Do you agree with me? Is that a
18 fair read of it?

19 A. I'm going to read verbatim what he
20 said, yes.

21 Q. Yeah. Okay.

22 Is Leapfrog really open --

1 okay. Got it.

2 And you say, We don't --
3 remove. We don't --

4 A. Correct.

5 Q. -- need this agenda item.

6 Right?

7 A. I'm saying, Remove this. We're
8 going to focus on -- remove "this is really
9 covered in Number 2, ideas for imputing.

10 I choked on water. I'm not getting
11 choked up.

12 Q. No, that's okay. I'm getting choked
13 up.

14 A. No, sorry. Wait. Let me clear it
15 up.

16 Q. Yeah, take a second. Take a second.
17 (Pause.)

18 THE WITNESS: Yeah, and I'm
19 saying, Remove this; we're going to
20 focus on imputation.

21 BY ATTORNEY CRAIN:

22 Q. When you say "this is really covered

1 in Number 2" -- so I'm trying to understand is
2 it --

3 A. I'm trying to explain. What I would
4 have meant is, We're going to focus on
5 imputation. Let's get the agenda probably just
6 to focus on imputation.

7 Q. But you didn't say to him, We're not
8 penalizing anybody.

9 Right?

10 ATTORNEY BLAIR: Objection to
11 form: asked and answered.

12 THE WITNESS: I didn't write
13 in a full sentence that, no.

14 BY ATTORNEY CRAIN:

15 Q. Okay. And you're saying that the
16 question of How to score hospitals' missing
17 process/structural measures, are we looking for
18 suggestions on imputation methods?

19 That's his Agenda Item Number
20 2, right?

21 A. Correct.

22 Q. You're saying that penalizing

1 hospitals if they don't report is really covered
2 in Number 2, correct?

3 ATTORNEY BLAIR: Object --
4 objection to form: mischaracterizes
5 the testimony.

6 THE WITNESS: Not correct.

7 BY ATTORNEY CRAIN:

8 Q. Okay. Why --

9 A. I'm saying that -- I'm telling him
10 for the purposes of the agenda it looks like I
11 want to focus on imputation and weighing it on
12 PSI 4, and that's it. So two out of the six
13 agenda items is where I wanted to focus.

14 Q. Okay.

15 A. I don't always write my e-mails in
16 full sentences, particularly with someone I've
17 been working with as long as Matt. So your read
18 and my read may be different, but my intention
19 is to say, I don't want six agenda items. I'd
20 like two.

21 Q. So just to be clear, your testimony
22 is that impu- -- the question of whether to

1 penalize hospitals if they don't report is not
2 covered by the question of how to score
3 hospital's missing process/structural measures?

4 ATTORNEY BLAIR: Objection to
5 form.

6 THE WITNESS: I'm testifying
7 that I don't think I really answered
8 or addressed anything related to
9 penalizing hospitals, but I'm telling
10 him to finalize the agenda with these
11 two items.

12 BY ATTORNEY CRAIN:

13 Q. And not penalization?

14 A. I don't address that topic.

15 Q. Well, you said, "This is really
16 covered in Number 2."

17 ATTORNEY BLAIR: Objection to
18 form: asked and answered.

19 BY ATTORNEY CRAIN:

20 Q. You can answer.

21 ATTORNEY BLAIR: You have to
22 answer it again.

1 THE WITNESS: I'm testifying
2 that I really didn't address his
3 question of penalizing hospitals. I'm
4 telling him to focus in on an agenda
5 that includes two items --

6 BY ATTORNEY CRAIN:

7 Q. Okay.

8 A. -- imputation and PSI 4.

9 Q. Okay. And --

10 A. And do you have the agenda?

11 Q. I don't know.

12 ATTORNEY CRAIN: Do we have
13 the agenda?

14 BY ATTORNEY CRAIN:

15 Q. I'm not sure. We didn't get every
16 agenda, so I don't know if it's because they
17 didn't exist or they weren't produced, but we
18 don't have every agenda.

19 ATTORNEY BLAIR: Lord knows
20 we produced everything.

21 ATTORNEY CRAIN: Okay. Let's
22 go back in time a little bit. I just

1 want to jump there.

2 Let's go to Tab 7 -- 7(a).

3 BY ATTORNEY CRAIN:

4 Q. Now, this, Ms. Danforth, is one of
5 your performance reviews you're going to see.

6 ATTORNEY CRAIN: This is
7 Exhibit 9.

8 ATTORNEY BLAIR: Thank you.

9 ATTORNEY CRAIN: Did I get
10 it?

11 ATTORNEY BLAIR: Yeah.

12 CERTIFIED STENOGRAPHER: Yes.

13 ATTORNEY CRAIN: Okay. I'm
14 not good with the exhibit numbers.

15 THE WITNESS: Oh, I was going
16 to keep one open so I could tell.

17 ATTORNEY CRAIN: Don't write.

18 THE WITNESS: Okay. I'm not.

19 ATTORNEY BLAIR: You can
20 write on it.

21 THE WITNESS: I'll put the
22 cap on the pen so everyone can relax.

1 ATTORNEY CRAIN: All the
2 lawyers are going to have a heart
3 attack.

4 CERTIFIED STENOGRAPHER: One
5 second.

6 --oOo--

7 (Danforth Deposition Exhibit Number
8 9, E-mail with attachment, Bates
9 stamped LEAPFROG02383511 through
10 LEAPFROG02383517, marked for
11 identification, as of this date.)

12 --oOo--

13 THE WITNESS: Thank you.
14 (Sotto voce between cocounsel.)

15 BY ATTORNEY CRAIN:

16 Q. Do you have this, Ms. Danforth?

17 A. Yes.

18 Q. So this is a -- it looks like a
19 performance review from Ms. Binder to
20 Shira Kavanagh.

21 Do you see that?

22 A. Yes.

1 Q. And you'll see in the document it
2 shows your self-analysis, right?

3 A. Correct.

4 Q. If you look at the second page, the
5 Self-Assessment in Relation to Position
6 Description?

7 A. Yes.

8 Q. And this is dated December 16th,
9 2020?

10 A. Yes.

11 Q. And I want to -- I actually just
12 have one inquiry I want to focus you on.

13 If you go to Page 83514.

14 Do you see that?

15 A. Yes.

16 Q. And there's a Roman III --

17 A. Yes.

18 Q. -- and it says, Professional Goals
19 for FY2021 Based On Board-Approved FY2021 Goals.

20 Do you see that?

21 A. Yes.

22 Q. And it says -- now, this is you

1 writing, correct?

2 A. Um-hum.

3 Q. It says, My professional goals over
4 the next year will include the following:
5 Number 1, Implement and refine the new
6 mathematical imputation model for the Hospital
7 Safety Grade to ensure we are well-positioned
8 not just now, but five years from now.

9 Do you see that?

10 A. I do.

11 Q. What -- what does the "five years
12 from now" refer to?

13 A. I have been on a mission to find
14 other sources of data for the Hospital Safety
15 Grade, who could expand the scope of those data
16 sources. What I said right now, it includes two
17 columns, primary, secondary; it could include
18 tertiary.

19 I was being hypothetical, but also
20 it's been something that I've been interested
21 in.

22 It's been disappointing that there

1 have, to date, been a limited number of
2 national data sources available for Hospital
3 Safety Grade measures. With the recent
4 discontinuation of the AHA data -- by this
5 point, we probably knew about it -- I had a
6 focus on identifying other ways to get data on
7 hospitals.

8 One, I'm sure, is probably talked
9 to in here, and if it's not, it's what -- I
10 talk about all the time, is around this time
11 there was the rise of something called
12 all-payer claims databases, all-payer claims
13 databases. It was an initiative at the state
14 level for basically all of the healthcare
15 providers to put all of their claims into a
16 single statewide database so researchers and
17 others could mine a full, complete claims data
18 set.

19 When I was talking to you about the
20 CMS claims measures, one thing about those is
21 it only includes claims from Medicare
22 fee-for-service patients. Today, a lot of

1 Medicare patients have Medicare Advantage
2 plans. Those patients aren't calculated when
3 CMS calculates the rates for those claims being
4 its measures. These state-based all-payer
5 claim databases were theoretically an
6 opportunity for us to generate other sources of
7 data that would be available for all hospitals
8 that had not really been available previously.

9 So it's really a specific focus on
10 making sure that we're constantly not just
11 relying on the data that we have today, but
12 thinking ahead to the data that we might need
13 in five years if other data went away.

14 Q. And, again, why do you need that
15 data?

16 A. So we can continue to advance and
17 refine the work that we do. I think I told you
18 the Safety Grade right now includes things like
19 falls, pressure ulcers, medication safety. Of
20 course, that's important, but there are many,
21 many other aspects of patient safety for which
22 we don't have any data because we don't have any

1 measures.

2 We're constantly on the lookout for
3 new data and new measures, not just for the
4 Safety Grade but also for the Leapfrog Hospital
5 and ASC surveys.

6 It, again, goes back to our
7 mission: If we're going to reduce harm to
8 patients from preventable medical errors, we
9 need more information about the different kinds
10 of preventable medical errors that occur in
11 hospitals.

12 I haven't even talked about some
13 surgical complications that are very common,
14 other kinds of medical --

15 Q. Yeah.

16 A. -- complications that are very
17 common: Transfusion of the wrong blood. There
18 are so many harms that take place. We don't
19 have measures or sources of data, and it's my
20 literal job to constantly be on the lookout for
21 those, and actually our expert panel, but I do
22 have it reflected here.

1 Q. Okay. No, I -- I think I get it.

2 Okay. Let's keep going.

3 ATTORNEY CRAIN: Give me 7 --

4 no, let's not do 7.

5 BY ATTORNEY CRAIN:

6 Q. Okay.

7 Okay.

8 All right.

9 Okay. I'm going to skip to
10 another topic.

11 A. Okay.

12 Q. I want to talk about 2023 and 2024.

13 Okay?

14 A. Yes.

15 Q. I want to start with -- first, are
16 you familiar with a -- a system called HCA?

17 A. Yes.

18 Q. Okay. In 2023, am I right that HCA
19 stopped participating in the Leapfrog Survey?

20 A. I believe that they did not submit
21 2023 Leapfrog Hospital Surveys, correct. They
22 paused participation for one year.

1 Q. Do you know why?

2 A. Yes.

3 Q. Why?

4 A. They had indicated, not to me
5 directly, that they did not want to report on
6 those -- I told you about those nurse staffing
7 and skill mix measures. We had actually only
8 recently added those to the survey probably
9 around 2020, 2023, and they communicated they
10 didn't want to or weren't ready -- I -- this is
11 not verbatim -- want to report on those nurse
12 staffing and skill mix measures.

13 It was not ever shared with me or
14 told to me, but my impression or some
15 assumptions were it had something to do with
16 nursing unions, but I know it was specifically
17 related to those nursing measures.

18 Q. You said "paused for a year."

19 Was -- did you understand their
20 intent was just to take a break and come back?

21 A. I didn't understand that it was
22 their intent. They communicated that. I

1 believe they were asked publicly and said, We're
2 not stopping participation in the survey
3 forever. We're pausing for a year.

4 Q. Got it.

5 A. But I don't think that was something
6 that I inferred. I believe that was something
7 I've seen in writing.

8 Q. Okay. Do you remember where or --

9 A. I don't.

10 Q. Okay. If not, that's okay.

11 A. Okay.

12 Q. Again, just trying -- trying to,
13 like --

14 A. I know.
15 And I have a good visual memory,
16 but --

17 Q. I can tell.

18 A. Yes.

19 ATTORNEY CRAIN: Tab 13.

20 BY ATTORNEY CRAIN:

21 Q. Let's see.

22 So I want to go back to this

1 period, and there's a --

2 ATTORNEY CRAIN: This will be
3 Exhibit 10, right?

4 ATTORNEY BLAIR: Yep.

5 THE WITNESS: Yes.

6 ATTORNEY CRAIN: Okay.

7 ATTORNEY BLAIR: By my count.
8 What do I know?

9 THE WITNESS: I'm keeping the
10 last one open now so I always know.

11 ATTORNEY CRAIN: You can
12 help.

13 THE WITNESS: Yeah. With my
14 capped pen.

15 CERTIFIED STENOGRAPHER: One
16 second.

17 --oOo--

18 (Danforth Deposition Exhibit Number
19 10, E-mail string, Bates stamped
20 LEAPFROG00602604 through
21 LEAPFROG00602605, marked for
22 identification, as of this date.)

--o0o--

THE WITNESS: Thank you.

CERTIFIED STENOGRAPHER: You'

re welcome.

BY ATTORNEY CRAIN:

Q. Okay.

So do you have this in front of
you?

A. Yes.

Q. So this is a document Bates stamped ending 602604, and it's an e-mail thread between and among you, Ms. Campione and Mr. Banerjee.

Do you see that?

A. I do.

Q. And it's, I believe, from -- it's all in November 2023.

Do you see that?

A. Yes.

Q. Okay. And you start the thread. You write to Mr. Banerjee and Ms. Campione.

Do you see that?

A. Yes.

1 Q. And you say, Hi, Kush and Alex, I'd
2 like to get a sense of the number of licensees
3 that don't submit a survey and the percentage of
4 Accolades revenue those facilities represent
5 for, say, the past two years (last four rounds)
6 â€” can the two of you work together on this?

7 Do you see that?

8 A. Yes.

9 Q. Do you recall what your -- do you
10 know what you're asking them to do here?

11 A. I was asking them to do an analysis
12 of our Accolades sales. So an Accolade is --
13 oh.

14 Q. Yeah. What's an Accolade?

15 A. Okay.

16 Q. You got it.

17 A. An Accolade is what --

18 Q. You do your own follow-ups..

19 (Laughter.)

20 THE WITNESS: I paused at
21 least.

22 (Sotto voce discussion.)

1 THE WITNESS: Well, I get
2 asked questions all the time. I'm
3 just used to, like, jumping right into
4 it. So I'm sorry.

5 An Accolade is sort of a
6 term of art. Basically it's a --
7 it's a -- it's a specific copyrighted
8 logo that Leapfrog licenses to
9 hospitals or ambulatory surgery
10 centers who wish to use one of our
11 specific copyrighted logos only in
12 advertising or marketing.

13 So, for example, we do a top
14 ambulatory surgery center award
15 annually. If an ambulatory surgery
16 center, for example, wanted to put up
17 a billboard to say, We're a Leapfrog
18 top ASC -- they purchase or license
19 the -- we call it a "designated logo"
20 from us.

21 And we do have copyrights
22 protecting those logos, so we do have

1 to show, obviously, that we are --
2 we're protecting them.

3 Up until this time of
4 August, you would not have seen me
5 asking these questions because my job
6 was a little bit different. So
7 around this time, what's not in this
8 e-mail is we had had a -- I don't
9 know if she was a director -- I don't
10 know her exact title.

11 I apologize -- but either
12 director or vice president of finance
13 and operations. Around this time of
14 August, she had been let go from
15 Leapfrog. She was actually
16 responsible for this Accolade program
17 and also data licensure through
18 supervision of Kush. So Kush
19 reported to her, and her and Kush
20 reported on all of these things.

21 This was not my area of work
22 at Leapfrog at this time in 2023, and

1 with -- her name was Patrice Brown --
2 with Patrice's departure, I had a
3 conversation with Leah where
4 basically I volunteered to take on
5 Kush's supervision, not just because
6 I thought it was meaningful to the
7 organization, which obviously I do.
8 But, frankly, Kush and I had been
9 working together at this point for,
10 like, eight years.

11 For a number of different
12 reasons, he had reported to, like,
13 four different people in that amount
14 of time, and I personally knew it was
15 very difficult for him to have career
16 growth within our organization. He
17 kept switching bosses, and then they
18 would want to see what he was working
19 on, and, Well, let's wait a year and
20 see where you're at.

21 Then you switch bosses and,
22 like, Oh, well, I'm just getting to

1 know what you're working on. Let's
2 wait a year and see where you're at.

3 And I really felt an
4 obligation and a desire to mentor
5 Kush and make sure that he really had
6 someone stable. I had been at
7 Leapfrog at this point --

8 (Whereupon, as the certified
9 stenographer seeks clarification,
10 colloquy will not be captured on
11 the written record.)

12 THE WITNESS: Yes.

13 I had felt an obligation and
14 a desire to really mentor Kush. I
15 had been at Leapfrog at this point
16 for 13, 14 years. He had been here
17 for eight years. So I said to Leah,
18 I will -- you know, if it's okay with
19 you, I'll start supervising Kush.

20 I didn't know very much
21 about this part of the organization,
22 and I spent probably four to

1 six months asking questions like
2 this, and many, many others, just me
3 trying to learn. Again, for the
4 organization, but also because part
5 of what I was trying to do was assess
6 what our capabilities were and
7 whether or not this is work he could
8 really do on his own, if maybe we
9 needed more staff or more people.

10 So my terminology may or may
11 not be correct in some of these
12 things. And I'm not exactly sure
13 however many other requests like this
14 I have. But during this time -- and
15 it would be reflected in his
16 performance reviews in the future as
17 well -- this was me getting up to
18 speed on this part of our business
19 trying to assess both the actual
20 business requirements of the
21 organization but also thinking that
22 he might need extra staff and just

1 trying to really get a sense.

2 So Alex Campione is the
3 other person on this e-mail, and
4 that's because Kush historically had
5 not had other staff to help him do
6 analyses or projects. Alex wasn't
7 assigned this as part of her regular
8 role or job description, so this was
9 new to her as well, and it's me
10 trying to just figure out what my new
11 job is going to be, basically.

12 BY ATTORNEY CRAIN:

13 Q. So let -- so let's keep going
14 down --

15 A. Yes.

16 Q. -- because I -- so a couple of
17 questions there.

18 A. Sure.

19 Yeah.

20 Q. So you want to get the sense -- so
21 why are you focused on the number of licensees
22 that don't submit a survey as opposed to the

1 number of licensees that do submit a survey?

2 A. I guess I could have asked it the
3 other way as well.

4 Q. Okay.

5 A. I'm just trying to get a sense of --
6 of those that license the Accolade, what's the
7 breakdown of those that do and don't submit a
8 survey. And interestingly, I think no one had
9 ever looked at that before. Maybe I asked for
10 some data, or something. Like, I don't know,
11 and I'm like, Oh, well, I'm going to go ask and
12 find out, but it was just something I was
13 curious about.

14 Q. Okay.

15 A. We watch, obviously, you know, the
16 sales data that comes in, but it's, like,
17 numbers. Like -- and I was just trying to get
18 more information. I come from the ratings team.
19 We look at a lot of data. I was just looking
20 for some data.

21 I could have asked the question in
22 a different way and gotten the same answer.

1 Q. Okay. And you say, Due to Step 1
2 imputation and as the means for the Step 2
3 imputed data increase over time, there is the
4 risk of reducing incentive to submit a survey
5 every year " and I'm starting to see this come
6 through in some of the questions we are getting
7 on help desk.

8 Do you see that?

9 A. Yes.

10 Q. What are you referring to there?

11 A. We were getting questions on help
12 desk --

13 Q. About --

14 A. -- from hospitals basically saying
15 could they skip a year submitting a survey. I
16 think I referred to some of those earlier.

17 Also we were starting to get
18 complaints from hospitals, that they felt that
19 the current imputation we were using at this
20 time in 2023, which was more reflective of the
21 means of hospitals that were reporting to the
22 survey, that they weren't fair or accurate

1 because hospitals were benefiting from the work
2 and resources and investments they were doing.
3 So it was a reflection of those things we were
4 seeing on our help desk.

5 Q. When -- when you say "skip every
6 year," though, doesn't that refer to Step 1 at
7 the time?

8 A. I'm just answering the question 1
9 what questions we are getting.

10 Q. Okay. So you don't think hospitals
11 were saying can we skip a year because our
12 historical score will be imputed?

13 A. Oh. There -- may have been saying
14 both.

15 Q. Okay. Got it.

16 Okay. And then you say,
17 There's the -- there's the risk of reducing
18 incentive to submit a survey every year.

19 Do you see that?

20 A. Yes.

21 Q. Is that referring to Step 1 or
22 Step 2?

1 A. I don't know if I was being that
2 purposeful --

3 Q. Yeah.

4 A. -- in this particular e-mail, but,
5 technically, it would have only referred to
6 Step 1. But to be honest, in this e-mail, I'm
7 not sure I'm focused on the methodology. It was
8 more really a data request.

9 Q. Yeah.

10 Just -- and just to be clear --

11 A. Yeah.

12 Q. -- Step 1 is the one through which
13 Leapfrog imputes a historical score?

14 A. Correct.

15 Q. So there would be some incentive, if
16 you liked your score the last year, to simply
17 rest on --

18 A. Potentially, yes --

19 Q. -- let --

20 A. -- that would --

21 Q. -- let's finish -- to simply rest on
22 that score?

1 A. Yes.

2 Q. Okay. And then you say, I'd like to
3 understand how financial risk if we make changes
4 to how we display grades for hospitals that
5 don't submit.

6 I think there's a missing word
7 there, but --

8 A. Okay.

9 Q. -- just looking at that, what --
10 what is the -- we -- we've learned -- I think
11 Ms. Campione called it "Missy speak," I recall.

12 What is the financial risk
13 you're referring to here?

14 A. I don't know.

15 I do remember the first part very
16 clearly because I had seen no data on Accolade
17 licensure.

18 I don't recall specifically --
19 well, we've made no updates the way that we
20 display Hospital Safety Grades since I've been
21 at Leapfrog.

22 Q. Okay. You don't know what financial

1 risk it could theoretically be?

2 A. I don't because we've never made any
3 changes to the --

4 Q. Okay --

5 A. -- display, so I apologize.

6 Q. -- let's go up through the e-mail
7 and see --

8 A. Yes --

9 Q. -- if it refreshes your memory.

10 A. -- yeah.

11 Q. Alex says, Not a problem. I already
12 have previous licensing data, but if we want to
13 include this round's licensing, I'll need that
14 data. Kush â€” Do you have the licensing so far?
15 We could wait a week -- a few weeks so it's more
16 accurate.

17 Do you see that?

18 A. Um-hum.

19 Q. And that reflects what you had said
20 before, that she generally didn't work on
21 licensing?

22 A. Never until then.

1 Q. And then Mr. Banerjee responds,
2 Could that be why H- -- HCA suddenly stopped
3 submitting?

4 Do you see that?

5 A. Yes, I do.

6 Q. And that refers to the HCA we
7 discussed a little while -- a few moments ago?

8 A. Yes.

9 Q. Okay.

10 And is -- is it right -- am I
11 understanding that he's theorizing that HCA took
12 a -- took a break, much like some of the other
13 hospitals that you were seeing?

14 A. Correct. And the information I
15 shared with you about HCA taking a pause due to
16 not wanting to report on the nursing measures is
17 not information that would have been shared with
18 him if it hadn't been public. It was likely a
19 conversation in a senior management team
20 meeting.

21 Q. But -- well, you said something was
22 public, right, that HCA said?

1 A. I read something --

2 Q. Okay.

3 A. -- I said that I read something.

4 Q. And do you again remember what you
5 had read?

6 A. Just that they were taking a pause
7 and coming back.

8 Q. Okay. But didn't say why?

9 A. No.

10 Q. Okay. And when you say a senior
11 management meeting, who would that include?

12 A. Leah Binder.

13 Q. Okay. So you heard something from
14 Leah Binder about why HCA had stopped
15 participating?

16 A. Yes, specific to the nursing
17 measures.

18 Q. Got it.

19 Okay. So we have to ask her
20 how she heard that?

21 A. Yes.

22 Q. Okay. And then he says, I think we

1 looked at this trend many years ago, and I
2 believe there was correlation to survey
3 participation and A's, as well as participation
4 on licensing. It will be interesting to see
5 where it is now -- where it is at now.

6 Do you see that?

7 A. I do.

8 Q. So could that be the financial risk
9 that you're referring to, if participation goes
10 down, that revenue will go down?

11 A. It might have been.

12 And I guess at this point when I
13 was asking the question, I didn't know what I
14 didn't know.

15 Some months after this in a
16 different type of a request like this, I
17 learned that actually of all of the A's that --
18 all of the hospitals that earned an A Safety
19 Grade -- I think about 22 percent were actually
20 licensing those grades.

21 If I had known at the time that our
22 licensure rate for the A designated logo was

1 that low, I likely would not have asked this
2 question as well. But, again, I'd only seen
3 total numbers, not, like, percentages.

4 So, clearly, there's low uptake of
5 licensing the Hospital Safety Grade A, so I
6 would not have been focused on financial risk,
7 since it was already so low.

8 Q. I see.

9 Okay. Well, I take it -- so
10 are you referring to the deck that Ms. Campione
11 prepared?

12 A. I don't know what deck that is.

13 Q. Okay. When you say "22 percent,"
14 where are you getting that number?

15 A. We have a third-party licensure team
16 that we work with called TelAffects.

17 Q. Okay. Telemarketers?

18 Is TelAffect- --

19 A. They're like telemarketers --

20 Q. Yeah.

21 A. -- yes, but they're called
22 TelAffects --

1 Q. Yeah.

2 A. -- like, T-E-L-A-F-F-E-C-T-S.

3 They produce a summary for us. And
4 I believe 22 percent was on the summary deck
5 that I just saw from the spring cycle, so it's
6 fresh in my mind.

7 Q. Got it.

8 Okay. So let me --

9 A. I -- I -- it would be TelAffects,
10 though, not Ms. Campione.

11 Q. Yeah. So let --

12 A. Okay.

13 Q. -- let me show you Ms. Campione's
14 deck --

15 A. Oh, okay.

16 Q. -- that's -- that's where I was
17 going next.

18 ATTORNEY CRAIN: This will be
19 Exhibit 11.

20 --oOo--

21 (Danforth Deposition Exhibit Number
22 11, Calendar invite, Bates

1 stamped LEAPFROG01073566 through
2 LEAPFROG01073581, marked for
3 identification, as of this date.)

4 --oOo--

5 ATTORNEY CRAIN: And,
6 Ms. Blair.

7 ATTORNEY BLAIR: Thank you.

8 ATTORNEY CRAIN: You're
9 welcome.

10 BY ATTORNEY CRAIN:

11 Q. Okay. This is a document -- I don't
12 know why it's portrait -- or landscape, but do
13 you see it's an e-mail -- or it's a calendar
14 invite from Mr. Banerjee?

15 A. Yes.

16 Q. And it's to you, Ms. Campione and
17 folks from TelAffects, to your point?

18 A. Yes.

19 Q. And attached to this is a slide show
20 deck that Ms. Campione -- I believe it has her
21 name on it.

22 Do you see that?

1 A. Yes.

2 Q. Do you -- does this refresh your
3 recollection as to this -- this document? Do
4 you recall this?

5 A. Yes.

6 Q. What do -- what do you remember
7 about why she created this?

8 A. Because I didn't want to have to go
9 to the third party to get information. I wanted
10 to be able to generate that quest -- answers to
11 my questions in real time using people who
12 worked at Leapfrog --

13 Q. Okay.

14 A. -- so I asked her to pull this
15 together herself instead of relying on
16 TelAffects.

17 Q. And then -- and you joined -- you --
18 you presented it at a meeting with TelAffects,
19 or someone --

20 A. No, no. I -- I had Alex do this as
21 an alternative to waiting for TelAffects to
22 provide something to us. So Alex would have

1 done this.

2 Q. Okay. Do you recall if Ms. Campione
3 presented this on this meeting?

4 A. I know I've seen this slide deck. I
5 don't know if it was on the meeting that's
6 attached to this meeting invite, but I -- I know
7 I've seen this --

8 Q. Yeah. Okay.

9 A. -- slide deck, yes.

10 Q. So just walking through the deck, I
11 want to just focus on -- you mentioned
12 22 percent, and I think that number is on
13 Slide -- there's no numbers, but it's
14 Bates 73575.

15 Do you see that?

16 A. Oh. That's not the -- I do see
17 22 percent, but that's not the 22 percent I was
18 referring to --

19 Q. Oh, okay.

20 A. -- I was saying that overall,
21 only -- of all of the hospitals that have earned
22 an A Hospital Safety Grade, whatever that number

1 is, only about 22 percent of them actually
2 license and use that licensed logo --

3 Q. Okay.

4 A. -- it had not been my understanding
5 previously that it was that low, frankly. I
6 just didn't know. I had only seen, like, a
7 total number --

8 Q. Yeah.

9 A. -- and I'm saying that if I had
10 known then that it was only 22 percent out of
11 whatever the total was, I might not have been so
12 concerned with asking about financial risk
13 because the number was so low --

14 Q. I see.

15 A. -- but this also -- I do see it
16 says, 22 percent licensed that are survey
17 participants and nonsurvey participants, which
18 makes sense.

19 Because, like I said, the majority
20 of hospitals submit surveys, so the majority of
21 hospitals receiving Safety Grades submit
22 surveys. The majority of hospitals -- pretty

1 much every single letter grade is likely also
2 going to be a survey participant just --

3 Q. Yeah.

4 A. -- by virtue of that.

5 Q. Yeah.

6 Yeah. So can you go two slides
7 back, 73573?

8 A. Yes.

9 Q. And it says, Survey -- you see
10 that -- yes -- bunch of --

11 A. Yes --

12 Q. -- little icons?

13 A. -- yes.

14 Q. Survey participants are 10 times
15 more likely to license.

16 A. Yes.

17 Q. And so could that be the financial
18 risk you've been referring to? Participants
19 lead to --

20 A. No. I'm sorry. At this point, I
21 had no idea the number was this low.

22 This would not have rep --

1 22 percent to 2 percent would not have
2 represented -- 2 percent would not have
3 represented a financial risk to me at all.

4 Q. But you didn't know that when you
5 sent the e-mail?

6 A. I had no idea what was -- when these
7 stats -- any stats were related to Accolade
8 licensure when I sent the e-mail, which is why I
9 was asking the question.

10 Q. So what -- what financial risk were
11 you referring to, then?

12 A. I was probably just, again, asking
13 the question. I had not been involved in the
14 finance side of our operations prior to 2023. I
15 may not have been using those terms correctly.

16 I was just asking to see what the
17 breakdown was for my own information.

18 I don't know precisely what
19 financial risk I was referring to at the time.
20 I -- I don't see any financial risk in these
21 numbers as I look at this deck right now.

22 Q. Is -- can financial risk mean

1 something else than loss of revenue?

2 A. I'm -- I don't -- I mean, at the
3 moment, it could have been, like, potential loss
4 of revenue or potential change, or something
5 like that, probably.

6 Q. Okay.

7 Okay.

8 A. Yes.

9 Q. Okay.

10 A. Predeck, postdeck, yes.

11 Q. Okay.

12 All right. Oh, one other quick
13 thing on this deck -- let me just go back to it.
14 Sorry.

15 At this time, was it your
16 recollection that participating was increasing,
17 decreasing or staying the same?

18 A. It's been incrementally, I would
19 say, increasing over time, very incrementally.

20 I think that, you know, the goal is
21 to have as much transparent safety and quality
22 information in this -- coming from the survey

1 again -- we're talking about the survey -- as
2 possible. So that can grow so far, but it's
3 been incrementally increasing over time.

4 But we've been around 2300, 2400
5 now for several years. It might fluctuate a
6 little bit, but it's -- it's been steady at
7 23-, 2400 for several years.

8 Q. Okay. So still at about that
9 80 percent of inpatient beds over time?

10 A. Yes --

11 Q. Okay.

12 A. -- yeah, 75 to 80 percent --

13 Q. Okay.

14 A. -- yes.

15 ATTORNEY CRAIN: We've been
16 going for about an hour --

17 THE WITNESS: Can I just say
18 one thing?

19 BY ATTORNEY CRAIN:

20 Q. Yeah, sure.

21 A. Sorry.

22 So one of the reasons for that,

1 just so it sort of makes sense, is because we
2 do have a lot of health systems that have
3 100 percent participation in the survey. And a
4 lot of those health systems have large
5 hospitals, and so they -- they are large
6 hospitals.

7 Q. So, in other words, a large system
8 could account for a large number of beds, and
9 they stay in and they're stable?

10 A. Yes, yes. And so we don't -- we
11 just don't see a lot of fluctuation, correct.

12 Q. Okay.

13 ATTORNEY CRAIN: Take a
14 little break?

15 ATTORNEY BLAIR: Sure.

16 THE WITNESS: Yeah.

17 ATTORNEY CRAIN: Okay.

18 THE VIDEOGRAPHER: Going off
19 the record. The time is 1429.

20 --oOo--

21 (Whereupon, a recess was taken from
22 2:29 p.m. EDT to 2:47 p.m. EDT.)

1 --oOo--

2 --oOo--

3 (Danforth Deposition Exhibit Number
4 12, E-mail string, Bates stamped
5 LEAPFROG00297580 through
6 LEAPFROG00297581, marked for
7 identification, as of this date.)

8 --oOo--

9 THE VIDEOGRAPHER: Going back
10 on the record. The time is 1447.

11 BY ATTORNEY CRAIN:

12 Q. Okay. So I have given you what I
13 think has been marked Exhibit 12.

14 A. Yes.

15 Q. And it's an e-mail. The
16 Bates Number is ending 297580.

17 Do you see that?

18 A. Yes.

19 Q. Do you recognize this e-mail?

20 A. I know that I wrote it. I'm not
21 going to have a recollection on e-mails. I do,
22 like, 500 e-mails a day. But I wrote this

1 e-mail.

2 Q. Fair enough. Fair enough.

3 Okay. I'll take that.

4 So you see it's February 26th,
5 2024?

6 A. Yes.

7 Q. And you sent to the ratings team?

8 A. Yeah.

9 Q. And is that all of the 10 folks who
10 report to you or a subset?

11 A. This particular e-mail group would
12 not include Kush.

13 Q. Got it.

14 So 9 of the 10?

15 A. Yes.

16 Q. Okay. And so you say, Hi, Everyone.
17 I wanted to let you know that we will be
18 convening the Safety Grade expert panel this
19 spring to discuss updates to the two-step
20 imputation model used to calculate SGs for
21 hospitals that don't submit a survey.

22 Do you see that?

1 A. Yes.

2 Q. And now just so we're on the same
3 page, to the extent you remember --

4 A. Yes.

5 Q. -- the -- the methodology at that
6 point had a Step 1 and a Step 2, right?

7 A. Correct.

8 Q. Let's slow down just a -- let me
9 finish.

10 Step 1 was an imputation of
11 historical store -- scores, correct?

12 A. I'm sorry. Are you talking about
13 the spring 2024 Safety Grade methodology?

14 Q. At that time.

15 A. Do you have that document?

16 Q. I think -- we'll -- we'll come to
17 it. If you don't remember, I can -- I can wait,
18 but --

19 A. Okay. I would prefer to have it in
20 front of me --

21 Q. Okay.

22 A. -- just so I can be as accurate as

1 possible.

2 Q. We'll come to it.

3 Okay --

4 A. Okay.

5 Q. -- so -- so going down -- so you --
6 you then say -- back to the e-mail -- you're
7 going to discuss updates to the two-step
8 imputation model.

9 And then in the next paragraph,
10 you say, Specifically due to the update to the
11 BCMA measure (i.e., the addition of preop and
12 postanesthesia care units), we will propose to
13 retire Step 1 of the imputation method --
14 methodology (i.e., use of the most of the
15 current score from the past four rounds of
16 grades) and move entirely to only using Step 2
17 of the imputation methodology (i.e., mean score
18 of hospital's cohort based on first-year
19 performance).

20 Do you see that?

21 A. Yes.

22 Q. Does that refresh your recollection

1 of what the methodology was at that time?

2 A. So at that time, the methodology
3 would have been --

4 Q. Don't write -- sorry. I thought you
5 were writing.

6 A. Oh, no.

7 Q. Okay. You're good. You're good.

8 A. I was just following --

9 Q. Sorry. We're all on edge.

10 ATTORNEY BLAIR: We're all on
11 edge.

12 THE WITNESS: I capped this
13 last section. We have to have trust.

14 No. I --

15 (Laughter.)

16 THE WITNESS: Yes, we had a
17 two-step methodology previously, if
18 that's the question. Yes.

19 BY ATTORNEY CRAIN:

20 Q. And -- and Step 1 here, it says, Use
21 of the most current score from the past four
22 rounds of grades --

1 A. That's correct.

2 Q. Okay. And Step 2, at that time, was
3 the mean score of hospital's cohort based on
4 first-year performance?

5 A. Yes.

6 Q. Okay. And do you recall why
7 first-year performance?

8 A. We had done some analysis in
9 previous rounds, and because, again, of those
10 concerns that hospitals who were benefiting from
11 these means, and the means were quite high. So
12 I think we looked to see if we could calculate
13 the means of the first years the hospitals
14 reported on these measures as a potential
15 solution.

16 In my recollection, however, I
17 don't know exactly the details of how that came
18 to be.

19 Q. And when you say "we" there, is that
20 Dr. Austin again?

21 A. It would have been myself,
22 Matt Austin. And Alex Campione would have

1 been -- at least had knowledge of those
2 conversations as well by this point.

3 Q. And -- and just to put a fine point
4 on it, when you say "analysis," does that come
5 in a certain documentary form?

6 A. It would probably be in Excel.

7 Q. Okay. And do you recall
8 specifically when that -- you know, do you
9 recall a specific Excel today?

10 A. No.

11 Q. Okay.

12 A. And to be frank, I often don't see
13 the original Excels. They tend to put it in a
14 easier-to-read table format to put in a Word
15 document for me --

16 Q. Or --

17 A. -- I'm not an Excel master.

18 Q. -- or an e-mail?

19 A. Maybe a table in an e-mail, yeah, or
20 a table in a Word document or a table in a
21 PowerPoint slide. I don't typically always see
22 the full Excel document.

1 Q. Okay. But that analysis would have
2 come to you?

3 A. It would have come to me, or they
4 would have told me if there was a difference. I
5 would have known that it occurred.

6 I don't specifically remember
7 physically looking at it, no.

8 Q. Okay. Do you remember when you were
9 told?

10 A. In terms of, like, the mean score of
11 the cohort based on the first-year performance?

12 Q. Yeah. Well, you said there was some
13 analysis done, and I'm trying to figure out if
14 it's documented anywhere.

15 A. It would have been -- so whenever we
16 do things like this, it's going to be documented
17 in a public document called "Proposed Changes to
18 the" -- whatever round hospital scoring
19 methodology, which I know we produced.

20 So it would be, like, fall 2022 in
21 preparation for spring 2023 or spring 2023 in
22 preparation for fall 2022 [sic] a description

1 that -- actual tables themselves. All of that
2 made it usually in those documents, which we
3 publish on our website.

4 Q. Okay. Got it.

5 Okay. And -- and just sitting
6 here today, you have no present memory of
7 looking at that type of document for this
8 analysis that you're referring to?

9 A. No.

10 Q. Okay. And then you say, If you
11 receive questions about the impact of not
12 submitting a 2024 survey on the fall 2024
13 grades, please note to folks that we are
14 reviewing updates to the methodology, including
15 the imputation methodology, with the expert
16 panel and to announce updates later this spring.

17 A. Correct.

18 Q. Okay. Tell me more what -- like,
19 are those the questions where -- we were talking
20 about before on the Zendesk.

21 A. The review to the methodology?

22 Q. If -- if -- you say, If you receive

1 questions about the impacts of not submitting a
2 2024 survey --

3 A. Yes. Yes --

4 Q. Okay.

5 A. -- we would have received those
6 through Zendesk, correct.

7 Q. Okay. One of the ones we talked
8 about before?

9 A. Yes. A's I said, like, we really
10 like to give hospitals advance -- as much
11 advance notice as possible. So I wouldn't want
12 my staff, if we are about to have the expert
13 panel meet, which they do end up meeting in
14 April, say something and then have to find the
15 ticket and say, I know I told you that in
16 February, but now that it's April, the answer's
17 changed.

18 So I always err around the caution
19 and ask them to just tell them to hold up, and
20 we'll be publishing proposed changes soon.

21 Q. Okay.

22 Okay. So you can set that one

1 aside.

2 We're going to move forward.

3 Okay. So I want to talk about
4 -- you said the -- the expert panel met in
5 April?

6 A. Yes.

7 Q. And so are -- do you -- I want to
8 ask you first for your memories about that
9 meeting, and then we can go to some documents.
10 And we'll take it as it comes.

11 Fair enough?

12 A. Yes.

13 Q. So is it -- so the expert panel met
14 on April 12th, 2024.

15 Do you recall that date?

16 A. Only because, as part of this
17 preparation, I had to look at my calendar.
18 Otherwise, I would not have re- -- recalled that
19 date.

20 Q. So you would look back at your
21 calendar to -- to see when the expert panel met?

22 A. Correct.

1 Q. Okay. And did you -- you reviewed
2 Ms. Campione's transcript?

3 A. I scanned Ms. Campione's
4 transcript --

5 Q. Okay.

6 A. -- which was quite lengthy.

7 Q. It was quite lengthy. We had a long
8 day. I think the one I saw was 500 pages.

9 Did you review her testimony
10 about the April 12th meeting?

11 A. Not word for word.

12 Q. Okay. But to some degree?

13 A. I know that she was asked questions
14 about that paragraph.

15 Q. Okay. So I -- I want to ask you
16 some of the same questions.

17 First, let's start high,
18 30,000-foot.

19 A. Got it.

20 Q. What do you remember about the
21 April 12th meeting?

22 A. Can I tell you what I remember?

1 Because it's based on what I had to look up to
2 remember.

3 Q. Whatever you remember today --

4 A. Okay.

5 Q. -- that's what I'm asking for. Your
6 best memory.

7 A. Okay.

8 Q. If it's -- if there aren't memories,
9 that's fine, but your best memory.

10 A. No. So when I looked back at my
11 calendar, I saw that I had -- we had met -- and
12 when I say "we," myself, Matt Austin, Alex
13 Campione had met with one member of the expert
14 panel, Patrick Romano, before the larger expert
15 panel meeting had met.

16 I don't remember it precisely, but
17 my guess is that it was hard to find a date,
18 and the majority of people were available at a
19 certain date and time. And Patrick was
20 available at a different time, so we said we
21 would meet with him on -- one-on-one, but on my
22 calendar, that's how it's notated.

1 Q. And that meeting was about
2 30 minutes?

3 A. The meeting with Patrick Romano was
4 scheduled for 30 minutes.

5 Q. And the -- the larger expert panel
6 meeting was later that day; is that right?

7 A. Yes. That same day for one hour.

8 Q. Between 4:00 o'clock and 5:00
9 o'clock?

10 A. That's how it's scheduled. I don't
11 know that either of them actually ended right on
12 time, both or none could have run over.

13 Q. Fair enough.

14 Now, you -- do you recall who
15 attended the larger meeting?

16 A. I looked at meeting minutes that
17 showed attendance. I could not recite their
18 names off the top of my head right now.

19 Q. Dr. Austin attended?

20 A. Yes.

21 Q. Ms. Campione attended?

22 A. Yes.

1 Q. And then any --

2 A. I was in attendance.

3 Q. Okay. Fair. Yeah.

4 A. Peter Pronovost would have been in
5 attendance, Arjun Srinivasan was in attendance.
6 I know other people were as well. Again, I
7 couldn't recite them, but I did see the list --

8 Q. Great.

9 A. -- in preparation for today.

10 Q. Okay. And we'll come -- we'll look
11 at that list together.

12 So . . .

13 A. Okay.

14 Q. And then it was over Zoom?

15 A. Yes.

16 Q. And do you know if it was recorded?

17 A. Yes.

18 Q. Okay. Have you watched the
19 recording since?

20 A. No.

21 Q. Have you resumed -- reviewed a Zoom
22 transcript?

1 A. No.

2 Q. Okay. I want to know -- during that
3 meeting, do you recall whether imputation -- the
4 imputation model was discussed?

5 A. Yes.

6 Q. Okay. Do you remember -- did
7 Leapfrog present possible changes to the
8 imputation methodology to the expert panel in
9 that meeting?

10 A. I believe so, yes.

11 Q. Okay. Do you remember the nature of
12 those changes?

13 A. I don't, but I know they would have
14 been presented in a PowerPoint format.

15 Q. Okay.

16 A. Matt and Alex would have --
17 Matt Austin and Alex Campione would have
18 prepared them together. I would have reviewed
19 them before the meeting.

20 Q. Yeah.

21 A. But I don't present them, so I
22 wouldn't be able to tell you verbatim what was

1 on the slide.

2 ATTORNEY CRAIN: Okay. Let's
3 go to the slides. That may be the
4 easiest thing. And -- oh, Emily has
5 the slides. She knew what I was going
6 to go to.

7 So this is Exhibit 13.

8 --oOo--

9 (Danforth Deposition Exhibit Number
10 13, Calendar invite with
11 attachment, Bates stamped
12 LEAPFROG00437361 through
13 LEAPFROG00437379, marked for
14 identification, as of this date.)

15 --oOo--

16 ATTORNEY CRAIN: Cindy's
17 nodding.

18 ATTORNEY BLAIR: Thirteen.

19 THE WITNESS: Thank you.

20 CERTIFIED STENOGRAPHER: Sure

21 .

22 ATTORNEY CRAIN: Okay.

1 Tell me when.

2 I'm waiting for Cindy.

3 CERTIFIED STENOGRAPHER: Than
4 k you.

5 ATTORNEY CRAIN: Of course.
6 Of course.

7 BY ATTORNEY CRAIN:

8 Q. Okay. So this is a meeting invite
9 from Dr. Austin.

10 Do you see that?

11 A. Yes.

12 Q. And this is -- this is the meeting
13 we've been talking about, the one-hour,
14 approximately, meeting for the Safety Grade
15 panel?

16 A. Yes.

17 Q. Okay. And you can see the names of
18 the attendees at the top?

19 A. So those are the people who are
20 invited. I don't know, except for the ones I
21 named, if every single one of those attended,
22 but it would be in the meeting minutes, and I

1 believe that you have a copy of those.

2 Q. We'll get there next.

3 A. Okay.

4 Q. Yeah.

5 A. So these were the invitees --

6 Q. Correct.

7 A. -- not the attendees.

8 Q. Fair enough.

9 A. Okay.

10 Q. And Dr. Romano is not an invitee,
11 correct?

12 A. Correct, because he was on the
13 meeting invite prior --

14 Q. Correct.

15 A. -- yes.

16 Q. Okay. So going back, do you see the
17 slide deck?

18 A. Yes.

19 Q. Okay. Was this the slide deck you
20 were talking about a moment ago?

21 A. Yes.

22 Q. Okay. And you'll see there's an

1 agenda on Slide 2?

2 A. Yes.

3 Q. And there are two -- there are three
4 points. I really just want to focus on Point 2.

5 Do you see it says, Feedback on
6 reevaluating imputational model?

7 A. Yes.

8 Q. Okay. And this has been a topic we
9 had seen in other expert notes or agendas from
10 earlier periods, correct?

11 A. Correct.

12 Q. Okay.

13 ATTORNEY CRAIN: So let's
14 skip military treatment facilities,
15 that we value them and appreciate
16 their service.

17 Let's go to Slide 4,
18 Reevaluate Imputation Model.

19 BY ATTORNEY CRAIN:

20 Q. Do you see that?

21 A. Yes.

22 Q. Okay. So this slide, I'll represent

1 to you, Dr. Austin drafted, at least from the
2 documents we've seen. And it says, The problem
3 we are working to solve.

4 Do you see that?

5 A. Yes.

6 Q. And it says Leapfrog -- History:
7 Leapfrog moved to its current imputation
8 approach in 2021 when the
9 American Hospital Association discontinued its
10 survey data license with Leapfrog. (AHA survey
11 had been a longtime secondary data source).

12 Do you see that?

13 A. Yes.

14 Q. Okay. And that was one of the
15 secondary data sources we talked about at the
16 start, right?

17 A. It was.

18 Q. Yeah. And it says, Leapfrog was
19 also seeking ways to grade additional hospitals.

20 Do you see that as well?

21 A. Yes.

22 Q. And -- and, again, why does Leapfrog

1 want to grade additional hospitals?

2 A. Again, because our goal is to
3 provide a public good, a public service, and
4 what's most helpful is for most patients to be
5 able to find information on their hospital.

6 Q. Okay.

7 Now, it says, We are currently
8 facing these challenges, and it has two
9 subbullets.

10 Do you see that?

11 A. I do.

12 Q. So Imputed scores have crept up,
13 making imputation a more favorable choice for
14 lots of hospitals, and has de incentivized true
15 transparency performance.

16 Do you see that?

17 A. I do.

18 Q. Okay. Do you know sitting here
19 today what that conclusion and that bullet is
20 based on?

21 A. That the imputed scores have crept
22 up?

1 Q. Not that. The more favorable choice
2 for lots of hospitals and has de incentivized
3 true transparency performance.

4 A. Likely to anecdotal feedback and
5 stories we're hearing -- hearing, including from
6 some members of the expert panel, that they were
7 hearing that as well.

8 Q. Okay. So not -- not a specific
9 analysis?

10 A. I'm sorry. The part about making
11 imputation a more favorable choice for lots of
12 hospitals?

13 Q. Let me -- let me phrase it this
14 way --

15 A. Okay.

16 Q. -- for nonparticipating hospitals,
17 you don't actually have the data to assess what
18 their performance is, correct?

19 ATTORNEY BLAIR: Objection to
20 form.

21 THE WITNESS: That wasn't the
22 point I was trying to clarify, so I --

1 I'm just trying to take us back to the
2 question.

3 BY ATTORNEY CRAIN:

4 Q. I'm -- I'm shifting questions.

5 A. Oh, you're -- okay. Now we're off
6 this question. Okay.

7 Q. We're -- yeah. We're going -- I'm
8 trying to get at it a different way --

9 A. Okay.

10 Q. -- which, hopefully, will arrive at
11 a clear answer.

12 A. Okay.

13 Yeah.

14 Q. So -- so for nonparticipating
15 hospitals, you don't actually have the data to
16 assess their performance on every metric,
17 correct?

18 A. On those four measures and then the
19 three we talked about, yes.

20 Q. Okay. So is it possible to conduct
21 an empirical analysis to see whether imputation
22 is actually more favorable to them than

1 completing the survey and getting a report that
2 way -- a grade that way?

3 ATTORNEY BLAIR: Objection to
4 form.

5 THE WITNESS: Is it possible
6 to conduct an empirical analysis . . .

7 I'm not sure I understand
8 the question, so I'm hesitant.

9 BY ATTORNEY CRAIN:

10 Q. No, no. Yeah, always ask.

11 A. Yes, I thought you were asking about
12 the imputed scores have crept up.

13 Q. No. I'm asking about the second
14 part.

15 A. Right. And --

16 Q. The more favorable choice part. I'm
17 trying to understand how did you all know.

18 A. And I just said it was anecdotal
19 feedback. I -- we hadn't done an empirical
20 analysis --

21 Q. Okay.

22 A. -- and then you asked if we could

1 have done an empirical analysis, and I was
2 thinking about how we could have done that
3 and . . .

4 Q. Could you have?

5 A. I'm not sure. I wouldn't have been
6 the one to do it or think of how to do it. That
7 would have been Matt and the expert panel.

8 Q. Okay. Fair enough. Fair enough.
9 Thank you. And I appreciate -- the -- the recap
10 was helpful.

11 A. Okay.

12 Q. And then de incentivized true
13 transparency of performance, is that based,
14 again, on anecdotal evidence?

15 A. Yes.

16 Q. Okay. Then it says, Hospitals are
17 using Step 1 imputation (using their individual
18 hospital's historical data) as a reason to not
19 report on the current year's survey.

20 Do you see that?

21 A. Yes.

22 Q. And was that, to your recollection,

1 the core problem being raised at this meeting?

2 A. No.

3 Q. Okay. Tell me what you think the
4 core problem was, then?

5 A. The first bullet point, the imputed
6 scores have crept up.

7 Q. Okay. And why is that a problem?

8 A. Because they were getting so high,
9 as I've described before, that we are hearing
10 from other hospitals, members of the expert
11 panel, that they were so high there was concern
12 that they did not reflect performance.

13 And one way to think of it, or how
14 I think about it, is if you say "average score"
15 to someone or "mean score," if it's a 0 to 100
16 scale or a A, B, C, D, F, people think a 50 is
17 the mean or the average, a C is -- is the
18 average. But because these mean scores were
19 being calculated based on hospitals that were
20 actually doing the things that we're asking
21 them to do on the survey, the mean scores in
22 some cases were 90 to 87 --

1 Q. Sure.

2 A. -- we were really getting away, I
3 think, from the intent -- what we would call
4 "the intent" of using the mean score, which is
5 really looking for an average score, average
6 performance, and we were imputing a near perfect
7 score.

8 And as these means started to creep
9 up -- again, because we're so transparent,
10 every hospital could see it, whether they're
11 doing a survey or not, because we publish the
12 mean scores in our public methodology
13 documents -- and so you can look back at them.
14 I know you have them all -- and see, Oh, it
15 started at a 79, and then it went to an 88, and
16 then it went to a 92. Isn't the highest score
17 a hundred?

18 Is this really a mean score? In
19 fact, anyone even looking at a table called
20 "mean scores" that see scores like 92 would
21 wonder, Hmm, that's kind of high.

22 And so as -- again, as I've

1 expressed earlier, we were hearing from
2 hospitals, you know, This is concerning. This
3 isn't fair. Phrases like, These other
4 hospitals are riding our coattails. We were
5 hearing from our subject-matter experts, that
6 they had concerns, Is this really
7 representative?

8 And as a reminder, just why
9 Leapfrog was founded -- I talk about our
10 mission a lot, but that's why I'm standing here
11 today, frankly. Our mission is to, you know,
12 on behalf of purchasers and employers, make
13 transparent information that's available for
14 patients. I think we really started to have
15 concerns that we weren't doing what was best
16 for patients by imputing these scores that were
17 near a hundred.

18 Q. So -- so just to follow up on that.
19 Let's take handwashing, right.

20 So the hand -- you're saying
21 the mean for handwashing for participating
22 hospitals had crept up, correct?

1 A. So, again, I'm not trying to be
2 nitpicky, but our hand hygiene standard, one
3 element is handwashing, but there are several
4 elements, yes, on our hand hygiene standard.
5 That mean had crept up, correct.

6 Q. Okay. How did you know that
7 nonparticipating hospitals' performance was not
8 also improving?

9 A. It would be difficult for me as
10 someone who's worked at Leapfrog for 16 years
11 talking to hospitals all the time, including
12 hospitals participating in the survey for the
13 first time, that they were doing all of the
14 things it takes to earn -- achieve the standard
15 on our survey.

16 Q. Why would it be difficult?

17 A. Because there was nothing like this
18 before Leapfrog came out with a standard that
19 emphasized these various evidence-based
20 practices.

21 So the WHO, which stands for the
22 World Health Organization, had put out some

1 guidelines about one thing. The association
2 for infection prevention list had put out some
3 information about another component. Another
4 evidence-based group maybe had put out -- what
5 our expert -- expert panel did is actually look
6 across all of these different peer-reviewed
7 sources and said, In the creation of an
8 evidence-based hand hygiene standard that will
9 reduce incidences of healthcare-associated
10 infections and pneumonia and COVID, and those
11 kinds of things, what are across all of these
12 sources, all the things that should be in
13 place, and brought those elements together.
14 And that's why it includes those five domains
15 even though I can only remember four.

16 So maybe someone had been focusing
17 on education; maybe someone had been focusing
18 on observations. But no one that we know had
19 actually brought all of these components
20 together in the structured evidence-based way.

21 In the first year that we put the
22 standard out, hospitals told us -- and we

1 published those comments -- that it was very
2 hard for them to do because they had never been
3 asked to do these things before. So I had a
4 good feeling that a hospital that had never
5 done them, that wouldn't be in place.

6 And I haven't had a chance to talk
7 about this, but whenever we publish changes to
8 the Leapfrog Hospital Survey -- we have a very
9 extensive public comment period, just like we
10 do when I publish changes to the
11 Leapfrog Hospital Safety Grade where publicly
12 we talk about, in this case, the new hand
13 hygiene standard.

14 I think that first year we got 600
15 comments from hospitals saying the standard was
16 really hard. We publish responses to those
17 comments, and you can see that process playing
18 out in a very public way in discourse.

19 So I would say just based on that
20 and those 600 comments, it would be difficult
21 for me to assume that a hospital that had never
22 done these things before through the survey was

1 voluntarily doing them without telling us.

2 Q. So -- so let's -- let's take Delray
3 as an example --

4 A. Okay.

5 Q. -- right, because Ms. Binder
6 published an op-ed on Delray, which I know
7 you've seen.

8 A. I have not read.

9 Q. Oh, okay. It was sent to you?

10 A. Yeah, I'm sure it was.

11 Q. Okay. You don't know --

12 A. I may not have -- I'm sure it was
13 sent to me. I did not read it --

14 Q. Okay.

15 A. -- I don't read everything that gets
16 sent to me.

17 Q. Ms. -- fair enough. That's true of
18 us all.

19 Ms. Binder says that Delray had
20 been an A, right?

21 A. I'm sorry. Do you have --

22 Q. Sure. We can get you the op-ed.

1 ATTORNEY CRAIN: Do you want
2 to grab the op-ed?

3 THE WITNESS: I'll -- I'll
4 keep this -- I just -- I don't want
5 to --

6 BY ATTORNEY CRAIN:

7 Q. No, no. Yeah.

8 A. Okay.

9 Q. Ms. Binder says in her op-ed -- and
10 we'll get you a copy in a second -- that Delray
11 had been an A and that her grandmother had
12 gotten care at Delray and had thought it was
13 very clean and that people were taking the
14 requisite handwashing -- you know, they were
15 doing the right handwashing habits.

16 And we will get you the copy
17 right now.

18 ATTORNEY CRAIN: This will be
19 Exhibit 14.

20 ATTORNEY BLAIR: I'll just
21 object to form: I'm not sure it says
22 that.

1 ATTORNEY CRAIN: Well, we'll
2 read it.

3 ATTORNEY BLAIR: Fourteen.

4 ATTORNEY CRAIN: Fourteen.
5 Okay.

6 --oOo--

7 (Danforth Deposition Exhibit Number
8 14, Article, marked for
9 identification, as of this date.)

10 --oOo--

11 ATTORNEY CRAIN: Okay.

12 That's simple work habits.

13 (Laughter.)

14 BY ATTORNEY CRAIN:

15 Q. So this is Ms. Binder's op-ed in
16 The Palm Beach Post.

17 Do you see that?

18 A. Yes.

19 Q. And it says -- if you look at the --
20 the third full para- -- the last full paragraph
21 on the page, it says, I remember people who
22 worked at one of the hospitals â€œ

1 Delray Medical Center â€” from 2014.

2 Do you see -- are you with me?

3 A. Mine says, I don't relish this
4 fight, even if --

5 Q. Yeah. I'm going a couple sentences
6 down.

7 A. Oh, I'm sorry. Yes.

8 Q. No, you're -- you're on the right
9 paragraph.

10 Do you see -- do you see "I --
11 I remember"?

12 A. Yes.

13 Q. Okay. I remember people who worked
14 at one of the hospitals â€” Delray Medical Center
15 â€” from 2014 when I spent three days there
16 visiting my grandmother, now a blessed memory.
17 At that time -- at the time, the hospital earned
18 an A Safety Grade from Leapfrog, and it showed.
19 It was clear everyone working there paid
20 attention to the simple work habits that can
21 mean life or death for vulnerable patients, like
22 frequent handwashing and double-checking

1 medication orders. The staff was friendly and
2 kind.

3 Now, do you see that language?

4 A. I do.

5 Q. Delray subsequently stopped
6 participating in this survey, right?

7 How is it that -- so is your --
8 you just gave me an assumption that hospitals
9 that were not working to achieve Leapfrog's
10 standards could be assumed that they are low --
11 that their performance is lower than the mean,
12 right?

13 A. Can I correct one thing?

14 Q. Something I said, or something in
15 the op-ed?

16 A. Something related to both.

17 Q. Sure. Go ahead.

18 A. Okay. Because my -- my answer to
19 your questions aren't going to make sense if I
20 don't. I'm sorry.

21 Q. I want your answers to make sense.

22 A. So this says "Delray Medical Center

1 in 2014."

2 Q. Yeah.

3 A. Leapfrog didn't have a national hand
4 hygiene standard in 2014. Our hand hygiene
5 standard wasn't developed until -- oh, my
6 goodness -- later.

7 Q. Okay.

8 A. I would say -- not exactly sure, but
9 within the past five or six years. So I just
10 want to be clear that in 2014, Leapfrog didn't
11 have the hand hygiene standards we have in our
12 survey now. That's now included in the Hospital
13 Safety Grade.

14 So I can't answer any of your
15 questions related to hand hygiene specific to
16 our standard.

17 Q. I hear you.

18 A. And that's why I wanted to clarify
19 that because we've been talking about so much
20 about that standard, and I just gave you a long
21 response related to that standard. That
22 standard was not even a thought in anyone's

1 brain in 2014.

2 Q. And yet Ms. Binder's kind of drawing
3 that connection, isn't she?

4 A. I don't --

5 ATTORNEY BLAIR: Objection to
6 form.

7 BY ATTORNEY CRAIN:

8 Q. You can answer.

9 ATTORNEY BLAIR: Yeah, you
10 can answer.

11 THE WITNESS: Oh, I don't see
12 her referencing our hand hygiene
13 standard.

14 BY ATTORNEY CRAIN:

15 Q. Well, she says, The hospital earned
16 an A Safety Grade from Leapfrog and it showed.
17 It was clear with -- clear everyone working
18 there paid attention to the simple work habits
19 that can mean life or death for vulnerable
20 patients, like frequent handwashing.

21 So --

22 A. I don't think she's trying to make a

1 connection to Leapfrog's hand hygiene standard,
2 which didn't exist. I think she's trying to
3 reference something that she personally might
4 have visibly seen.

5 But, again, I -- I'm just reading
6 this now for the first time. I just wanted to
7 be clear that --

8 Q. Yeah.

9 A. -- we did not have a hand hygiene
10 standard in 2014. That couldn't be what's being
11 referenced here because it did not exist, and I
12 don't want any comments that I might make
13 related to handwashing to be confused that I'm
14 talking about our hand hygiene standard.

15 Q. Okay. You don't think at all
16 reading this that she's connecting the A Safety
17 Grade with the frequent handwashing and
18 double-checking medication orders?

19 ATTORNEY BLAIR: Objection to
20 form.

21 THE WITNESS: So one
22 important aspect that's been a thread

1 throughout the entirety of the
2 Hospital Safety Grade from 2013 to
3 now -- and, in fact, many of our press
4 releases have actually highlighted
5 this specific set of measures -- are
6 those five healthcare-associated
7 infection measures that we talked at
8 length about from NHSN.

9 At that time in 2014, those
10 infection measures would have been
11 included in here. During that time
12 throughout history, people have
13 associated handwashing with
14 healthcare-associated infections. So
15 it's not unreasonable to think that
16 if a hospital had an A Safety Grade,
17 it may have been related that they
18 had a lower infection rate, which you
19 can't see infection rates, but she
20 may have seen handwashing. But I'm
21 saying there's -- there can be no
22 reference to our hand hygiene

1 standard because it just simply
2 doesn't exist.

3 BY ATTORNEY CRAIN:

4 Q. So is it unreasonable to think that
5 an A hospital has frequent handwashing and
6 double-checking medication orders?

7 A. Is it unreasonable to think that an
8 A hospital frequently washes --

9 Q. Has frequent handwashing -- I'm just
10 using her language -- and double-checking of
11 medication orders?

12 ATTORNEY BLAIR: Objection to
13 form.

14 What year?

15 BY ATTORNEY CRAIN:

16 Q. In the present.

17 A. In general?

18 Q. In general.

19 A. I don't think that's unreasonable.

20 Q. Okay. Is it reasonable to think
21 that an F hospital does not have frequent
22 handwashing and does not double-check medication

1 orders?

2 ATTORNEY BLAIR: Objection to

3 form.

4 BY ATTORNEY CRAIN:

5 Q. In general.

6 A. I'm sorry. Is -- is that statement
7 in here as well?

8 Q. I'm -- I'm contrasting with --

9 A. Oh, I'm sorry.

10 Q. -- yeah -- F hospital is no.

11 I'm just trying to understand.

12 Is it -- is it reasonable to
13 think that an F hospital does not have frequent
14 handwashing and double-checking of medication
15 orders, in general?

16 A. I -- it's really difficult -- can I
17 just read the whole thing? I just want to make
18 sure I understand the context of these things.

19 Q. It's not really a question about her
20 article --

21 A. Oh, okay.

22 Q. -- it's just a general question.

1 A. Is it reasonable to think that an F
2 hospital doesn't have those things in place?

3 Not necessarily. I mean, again,
4 the Safety Grade is made up of 22 measures, so,
5 theoretically, a hospital could not have
6 things -- those things in place and be doing
7 well in the other areas.

8 I've seen all combinations on
9 performance across these 22 measures --

10 Q. Yeah.

11 A. -- and there's so much variation. I
12 just -- an A hospital might not have it, and an
13 F hospital might not have it because there are
14 so many other things that go into calculating
15 hospital safety.

16 Q. Okay. Let's keep going on this
17 deck.

18 Do you have it up? This was
19 Exhibit --

20 A. I'm sorry. Are we going back to --

21 Q. Back to April 12th --

22 ATTORNEY BLAIR: Thirteen.

1 BY ATTORNEY CRAIN:

2 Q. -- Exhibit 13 on April 12th.

3 A. Yes.

4 Q. Yeah. That's going to get
5 confusing.

6 Okay. So I want to take you to
7 Slide 7.

8 A. Yes.

9 Q. And we had talked -- you wanted to
10 see what the current imputation model was.

11 Is this an accurate reflection
12 of what the imputation model was at the time?

13 A. Yes, I'm sure it is if it's on this
14 slide.

15 Q. Okay. Do you want to take a second
16 to look at it, or are you confident of that?

17 A. If you're going to ask me detailed
18 questions about it, I will -- I will scan it.

19 Q. Okay.

20 (Whereupon, the witness reviews the
21 material provided.)

22 THE WITNESS: Yes, this is

1 correct.

2 BY ATTORNEY CRAIN:

3 Q. Okay. That's all I wanted to know,
4 if it was accurate.

5 So let's go to Slide -- I'm
6 going to skip to -- let's see -- Slide 13.

7 A. Yes.

8 Q. And this slide says, Proposed Future
9 Imputation Methodology.

10 Do you see that?

11 A. Yes.

12 Q. And so I'm going to walk you through
13 this slide.

14 Here is -- to your
15 recollection, is this slide the methodology that
16 Leapfrog proposed to the safe -- to the Safety
17 Grade expert panel?

18 A. By virtue of it being in this deck
19 and attached to this -- attached to this e-mail
20 notice, yes.

21 Q. Okay. Do you have any reason to
22 believe any other proposal was put forward to

1 the panel in the meeting?

2 A. On these slides or through
3 discussion?

4 Q. Either/or.

5 A. Through discussion, many other
6 options --

7 Q. Okay.

8 A. -- were discussed, which is my
9 recollection --

10 Q. Okay.

11 A. -- but we brought Proposed Future
12 Impu- -- Imputation Methodology, Slide 13, to
13 the panel. Through their discussion, other
14 ideas surfaced, but this is the only one that we
15 proposed.

16 Q. Got it. That's helpful.

17 Do you remember, sitting here
18 today, what the other ideas were at the meeting?

19 A. Through discussion, yes. And that's
20 why I remember Arjun Srinivasan being at the
21 meeting. My recollection is that he suggested
22 rather than imputing means, we should impute 0.

1 Arjun Srinivasan is a military
2 doctor. He's one of the highest ranking
3 military physicians at the CDC. He is a
4 lifelong epidemiologist.

5 One of his many roles is to oversee
6 that NHSN program, that healthcare-associated
7 infections program. He's one of the foremost
8 scientists in the world related to patient
9 safety and, particularly, infection
10 prevention -- just his criterion --

11 Q. Get it --

12 A. -- in case you don't know him --

13 Q. -- yep.

14 A. -- I remember him suggesting that we
15 impute 0.

16 I believe Dr. Peter Pronovost had
17 suggested that we take a look at maybe
18 imputing, like, the lowest quartile -- instead
19 of the mean, the lowest quartile performance.

20 There may have been other
21 recommendations as well. The 0 stuck out the
22 most to me.

1 Q. Let me ask you, on -- on the lowest
2 quartile proposal, was he propose -- what --
3 what does that mean? How does that -- is that a
4 mean of the lowest quartile?

5 A. So we had been imputing these means,
6 which, again, in my mind, weren't really
7 reflecting what we meant by mean or average
8 score. They were in the 90s, 80s, et cetera.

9 I think in proposing quartiles and
10 the lowest quartile, the bottom quartile -- I
11 don't remember exactly -- he was thinking we
12 need to impute a number that's less than this,
13 right. Like, these are clearly too high.

14 He had been one actually to share
15 that he was hearing from hospitals why would we
16 do the survey when I can get this phenomenal
17 score imputed? And so he was brainstorming
18 verbally, how about the lowest quartile.

19 I don't remember if it was the mean
20 or the lowest quartile -- or the lowest
21 quartile. And I would not have been the one to
22 calculate it, so I may not have been zeroed in

1 on that exact wording.

2 Q. Let -- let me ask just the question.

3 If it wasn't the mean of the
4 lowest quartile, do you know how it would
5 otherwise have been calculated?

6 A. It would just be the lowest quartile
7 scores. He would just array, I believe, all of
8 the scores. And I think there's a formula that
9 you can --

10 Q. Fair enough.

11 It's beyond my pay grade, too.

12 Okay. Now, going back to this

13 Slide 13 --

14 A. Yes.

15 Q. -- just walking through briefly, it
16 says, Retire Step 1 Imputation for all measures.

17 Do you see that?

18 A. Yeah.

19 Q. That was what -- one of the things
20 you proposed, right?

21 A. Yes.

22 Q. And that was not ultimately conduct

1 -- done, right?

2 A. Correct.

3 Q. Instead, you narrowed Step 1 from
4 four surveys to, I think, two; is that right?

5 A. No. It's close.

6 Q. How did -- how did I get -- confuse
7 that?

8 A. Okay. So it's not four surveys
9 because the surveys are annual --

10 Q. Got it.

11 A. -- and so they're used in two --

12 Q. Got it.

13 A. -- different safety scores --

14 Q. Okay.

15 A. -- two different Safety Grades --

16 Q. Yep.

17 A. -- so we narrowed it from the past
18 four rounds of the Safety Grade to the past two
19 rounds of the Safety Grade --

20 Q. I'm always conflating. Yeah. Got
21 it.

22 Okay. So just to restate it --

1 A. Yes.

2 Q. -- so you took it -- Step 1 you took
3 from the past four Safety Grades to two rounds
4 of Safety Grades?

5 A. Correct.

6 Q. Okay. Then Step B here says, An
7 imputation for all hospitals of CPOE, BCMA and
8 hand hygiene.

9 Do you see that?

10 A. Yes.

11 Q. And it looks like there are a few
12 options here.

13 Assign hospitals that do not
14 complete the most recently Leapfrog survey to
15 cohorts; Calculate the mean of scores obtained
16 in each hospital's first year of reporting on
17 the current standard by the Leapfrog Hospital
18 Survey --

19 A. Yes.

20 Q. -- and then Hospital is assigned the
21 mean for their cohort.

22 Do you see that?

1 A. Yes.

2 Q. And that was ultimately not adopted
3 either, right?

4 A. Correct.

5 Q. Okay. And instead, for Step 2,
6 Leapfrog imposed the limited achievement score,
7 correct?

8 A. Leapfrog imputes the numerical score
9 associated with the performance category for
10 each individual measure as limited achievement,
11 yes.

12 Q. In Step 2?

13 A. Yes.

14 Q. And Step 1 is still historical,
15 correct?

16 A. Correct.

17 Q. Yeah. Okay.

18 Okay. And that is the end of
19 this slide deck in this topic.

20 Do you see that on the next
21 slide, New Measures Under Consideration --

22 A. Yes.

1 Q. -- talking about hypo- --
2 hyperglycemia?

3 Do you see that?

4 A. Yes.

5 Q. Okay. Let's see.

6 So I think -- does this refresh
7 your recollection as to what was discussed at
8 the meeting? It sounds like it may, given what
9 you remembered about Arjun.

10 A. So I remembered the comments from
11 Arjun and Peter because I was surprised to hear
12 0 --

13 Q. Yeah.

14 A. -- that felt interest -- that felt
15 extremely -- like, you -- you kept saying, Isn't
16 that the lowest number, and I was like, No,
17 that's not the lowest number.

18 So that -- and I remember Peter
19 specifically talking about hearing from
20 colleagues why do the survey because they could
21 have this other -- there are other details of
22 the particular meeting, though, that I

1 refreshed in preparing for today.

2 Q. Okay.

3 Tell me -- tell me what you
4 remember -- what you refreshed on.

5 A. I just reviewed other documents
6 related to the meeting because I couldn't
7 remember the --

8 Q. You mean the meeting minutes?

9 A. Yeah -- yeah --

10 Q. Okay. Let's -- let's go to that --

11 A. -- there are meeting minutes, yes.

12 Q. -- yeah, we have that next.

13 ATTORNEY CRAIN: Let's -- is
14 that 30A?

15 Yeah.

16 Okay.

17 All right. Oh, boy. This
18 is Exhibit 14 --

19 THE WITNESS: Fifteen.

20 ATTORNEY CRAIN: Fifteen.

21 Okay.

22 ATTORNEY BLAIR: Oh, man. I

1 had them out of order.

2 THE WITNESS: Because we went
3 out of order. And the article is 14.

4 ATTORNEY BLAIR: Yeah.

5 ATTORNEY CRAIN: Okay.

6 --oOo--

7 (Danforth Deposition Exhibit Number
8 15, E-mail string, Bates stamped
9 LEAPFROG00205986 through
10 LEAPFROG00205990, marked for
11 identification, as of this date.)

12 --oOo--

13 THE WITNESS: Thank you.

14 BY ATTORNEY CRAIN:

15 Q. Okay. You ready?

16 A. Yes.

17 Q. Okay. These are the -- the --
18 you've -- this is one of the documents you
19 prepared for today -- looking at?

20 A. Yes, because I couldn't remember who
21 attended the meeting, and this has them all
22 listed.

1 Q. I see you got excited there.

2 Okay. So let's start at the

3 top --

4 A. Yes.

5 Q. -- this is Exhibit 15. It's

6 Bates Number 205986 --

7 A. Yes.

8 Q. -- and it -- the last e-mail is from
9 you to Ms. Campione: Can you save in expert
10 panel folder?

11 Do you see that?

12 A. Yes.

13 Q. And what is the expert panel folder?

14 A. When Matt or Preeti send out the
15 materials we have on our shared drive, where
16 my -- the staff is supposed to save the document
17 so I don't have to search for them in e-mail --

18 Q. Fair enough.

19 A. -- it happens about 50 percent of
20 the time. I want to be on the record for that.

21 Q. Documents started helping.

22 Yeah, I got it.

1 A. Problem.

2 Q. All right. Let's -- let's go to
3 the -- the notes.

4 Now just -- just some -- some
5 table setting --

6 A. Yeah.

7 Q. -- is there a process by which the
8 notes are created?

9 A. I don't create the notes --

10 Q. Okay.

11 A. -- Matt's research -- Matthew
12 Austin -- Matt Austin's research assistant has
13 always sent out the notes.

14 I think Matt and his research
15 assistant take the notes, and then they
16 consolidate them and then they send them out.

17 No one at Leapfrog -- none of my
18 staff take any notes during any expert panel
19 meetings --

20 Q. Okay.

21 A. -- that are used for the record.

22 Q. Got it. Okay.

1 Okay. Now, this -- so let's
2 just walk down this -- this document together.

3 It says, Meeting Notes, at the
4 top.

5 Do you see that?

6 A. Yes.

7 Q. And Friday, April 12th, 2024, from
8 4:00 to 5:00 p.m. --

9 A. Yes.

10 Q. -- you see that?

11 Wow. Late Friday meeting.

12 And do you -- just looking at
13 these attendees, do you have any reason to think
14 that this is incorrect?

15 A. No.

16 Q. Then it looks -- if you look just at
17 the document from the 30,000-foot level --

18 A. Yes.

19 Q. -- you see it's three agenda points,
20 right?

21 A. Yes.

22 Q. And those correspond to the three we

1 saw in the deck, right?

2 A. Yes.

3 Q. Okay.

4 Slow down. Yeah. You've got
5 to not interrupt for -- for Cindy.

6 So I want to focus on Number 2.
7 And it says, Proposed changes to the imputation
8 model.

9 Now, it starts with Matt
10 provided the expert panel with a quick overview
11 of the current imputation model approaches
12 Leapfrog has been using and some of the
13 challenges those approaches have created for
14 issuing accurate grades.

15 Do you see that?

16 A. Yes.

17 Q. And then the next bullet lays out
18 the current model at that time, right?

19 A. Yes.

20 Q. Analogous to the slide we looked at,
21 right?

22 A. Yes.

1 Q. Yes.

2 And then it says, Leapfrog's
3 proposal was to retire Step 1 of the model and
4 use only Step 2, assigning hospitals the mean
5 score for their cohort.

6 Do you see that?

7 A. Yes.

8 Q. And that -- that -- to the best of
9 your recollection, that's what happened?

10 A. Yes.

11 Q. Arjun mentioned one of the concerns
12 with the current Step 2 imputation method is if
13 a hospital is performing very poorly, they could
14 choose to not submit a survey and get a better
15 score than their actual performance by just
16 being part of a certain cohort.

17 Do you see that?

18 A. Yes.

19 Q. And is that the -- the -- one of the
20 problems we saw on that first slide?

21 A. Yes.

22 Q. Okay. Peter asked whether Leapfrog

1 has a way to keep the low-performing hospitals
2 in the lowest quartile using this Step 2
3 imputation model.

4 Correct?

5 A. Peter did -- that's noted here, yes.

6 Q. Yeah.

7 And -- and that -- that's
8 consistent with the memory that you talked about
9 earlier today?

10 A. Yes.

11 Q. Did you -- did you have that memory
12 before you refreshed yourself with this
13 document?

14 A. I didn't remember anything from this
15 meeting before I refreshed myself with this
16 document.

17 Q. Got it. Just to be clear. Okay.
18 Understood. Many years ago -- or actually, one
19 year ago.

20 The expert panel were in
21 support of having hospitals share their current
22 performance, so liked the idea of imputing the

1 equivalent of Willing to Report to hospitals
2 that do not submit a survey.

3 Do you see that?

4 A. Yes.

5 Q. And what -- what does "willing to
6 report" mean?

7 A. So "willing to report" is the old
8 term we used to use instead of "limited
9 achievement" that was associated with one filled
10 cell phone bar.

11 So Leapfrog's public reporting
12 website has gone through some evolutions, and
13 those four descriptive performance categories
14 that we described have gone through some
15 evolution.

16 So if you looked at a survey from
17 probably 2020, 2021, 2022, instead of "limited
18 achievement," you would see "willing to
19 report."

20 Q. Got it.

21 Okay.

22 A. Um-hum.

1 Q. Do you have an independent
2 recollection of whether anybody specifically
3 raised the phrase "willing to report"?

4 A. I don't.

5 Q. Okay. So you're not -- you don't
6 recall today whether this bullet is accurate?

7 A. I don't.

8 Q. Okay. Then, Peter noted that
9 Leapfrog's message on this change will be
10 critical because, if done correctly, it can help
11 enhance focus on safety; otherwise, it has the
12 potential to backfire.

13 Do you see that?

14 A. Yes.

15 Q. Okay. Do you recall what he meant
16 by that?

17 A. Probably that hospitals would be
18 angry. And he knows that I take those calls,
19 and he likes me and cares about my health and
20 well-being.

21 Q. Fair enough.

22 And -- and to the -- and to

1 that point, you said, Missy asked the expert
2 panel to what extent the health systems that
3 wanted to partner with Leapfrog could help
4 deliver this message.

5 A. Yes.

6 Q. Do you recall raising that?

7 A. Yes. Probably when Peter said his
8 part, I said, Oh, Peter, you're volunteering to
9 help --

10 Q. Okay.

11 A. -- I'll take your help and find
12 friends. Yeah.

13 Q. Do you -- do you recall thinking
14 that hospitals would be upset with this change?

15 A. I recall thinking that hospi- --
16 hospitals are going to be upset with any change
17 that we make to the methodology. So -- and I --
18 I think I told you a lot of the calls I take are
19 with hospitals, explaining changes.

20 And in this particular regard, we
21 had gotten some strongly worded e-mails from
22 hospitals on the other side saying how can

1 Leapfrog do this. I assumed we would be
2 getting strongly worded e-mails saying how can
3 Leapfrog do this now.

4 Q. Got it.

5 Okay. Is there anything else
6 you remember from the meeting besides the things
7 noted on this document?

8 A. No, except as I -- as I think I've
9 already described, there would be, like, a video
10 and a Zoom transcript. I just haven't rewatched
11 the video and haven't read the Zoom transcript.

12 Q. Okay.

13 Okay. Let's see.

14 ATTORNEY CRAIN: Sorry. Just
15 give me one minute.

16 BY ATTORNEY CRAIN:

17 Q. Okay. So I want to just go through
18 one other thing.

19 A. Okay.

20 ATTORNEY CRAIN: Let's go to
21 Tab 17. This is a Slack chat.
22 Sixteen.

1 --oOo--

2 (Danforth Deposition Exhibit Number
3 16, Text string, Bates stamped
4 LEAPFROG00139558 through
5 LEAPFROG00139561, marked for
6 identification, as of this date.)

7 --oOo--

8 THE WITNESS: Thank you.

9 BY ATTORNEY CRAIN:

10 Q. Okay. Are we ready?

11 A. Yes.

12 Q. Okay. So, Ms. Danforth, this is
13 Exhibit 16. It's a Slack chat between you and
14 Ms. Campione and a Slackbot.

15 Do you see that?

16 A. Yes.

17 Q. And it's dated April 12th.

18 You see that?

19 A. Yes.

20 Q. Okay. And it -- it's -- that's the
21 date of the meeting, right?

22 A. Yes.

1 Q. And I'm just going to focus you on,
2 first, 2:24.

3 Do you see that time stamp?

4 A. Yes.

5 Q. And it says, Missy, I can only be on
6 the phone during the SG panel call. Do you
7 think that will be an issue?

8 And Ms. Campione says, I don't
9 think so. Matt will be leading and is making
10 the case for the imputation change. I'm
11 assuming he brushed up on the new measures.

12 You say Okay, and then you say,
13 And I know the slides.

14 Do you see all that?

15 A. Yes.

16 Q. Okay. And then several hours pass
17 by and -- I want to focus you on 4:42.

18 Do you see that?

19 A. Yes.

20 Q. And you say, Sara ans Peter sold
21 this for us.

22 A. I think that's a typo.

1 Q. Yeah. I just wanted to read it
2 accurately before Kim objects.

3 So I assume you meant "and"?

4 A. Yes.

5 Q. Yeah.

6 Do you -- do you have a present
7 recollection of what you meant, "Sara and Peter
8 sold this for us"?

9 A. Yes, because I had to -- I reviewed
10 this --

11 Q. Okay.

12 A. -- I had to review all of these
13 things to remember. And I think I was
14 indicating that they were strongly supporting
15 whatever our idea was.

16 Q. Okay. The idea on the deck or the
17 idea that ultimately became the model?

18 A. I don't know. Just that we were
19 going to make a change.

20 Q. Okay. And then you say, I wish
21 Patrick was on this call.

22 Any --

1 A. Yes.

2 Q. -- recollection as to why?

3 A. Because he wasn't, one --

4 Q. Fair.

5 A. -- but I -- probably because -- so I
6 didn't remember this, but I -- again, in my
7 preparation and review to make sure I was
8 prepared, in reviewing e-mails, I did see
9 e-mails from Patrick.

10 I am making the assumption that
11 when we had our call with Patrick, he was not
12 as enthusiastic about changes as Sara and
13 Peter. But I honestly don't remember the call
14 -- remember the call with Patrick. It is on my
15 calendar. I'm sure I was there. I just don't
16 have a recollection of the call.

17 And on this call, again, because I
18 said -- I was only on the phone, so I know -- I
19 do remember being on the phone. I'm sure I
20 reviewed the slides before they were presented,
21 but I must have been, like, on my phone
22 Slacking Alex.

1 So I did have to refresh my memory.

2 I did --

3 Q. Yeah.

4 A. -- not have a strong memory of this.

5 Q. Okay. So -- so you say, 4:42,
6 pushing the bottom 25 percent idea --

7 A. Yes.

8 Q. -- is that Dr. Pro- -- Pronovost's
9 quartile thought?

10 A. I think so --

11 Q. Okay.

12 A. -- I mean, again, I -- I can't -- I
13 don't know what slide was up at the time or
14 where we were in the transcript, but that makes
15 sense based on the notes.

16 Q. Yeah.

17 And then you say, I secretly
18 love that.

19 Any idea -- with lots of
20 exclamation points.

21 Any idea why?

22 A. I thought it might help the idea of

1 using quartiles as something that is commonly
2 used. Everyone typically -- though
3 three minutes ago we said no one knew, but most
4 hospitals would know what quartiles were. So if
5 we said "the bottom of quartile," they would
6 understand this.

7 At this time, too, I think that we
8 all thought it would solve this creeping-up
9 problem and that the bottom quartile score
10 would be lower than the mean.

11 Q. And do you -- it sounds like you --
12 you recall whether that was true?

13 A. When we -- my -- my recollection is
14 that when we looked at it, the bottom quartile
15 was not much lower than the mean --

16 Q. Okay.

17 A. -- so, actually, it wouldn't have
18 solved this problem, and Peter would not have
19 supported that.

20 Q. Why do you think Peter would not
21 have supported that?

22 A. Because his -- the context of this

1 is they're getting scores that are too high. So
2 if the -- the mean is too high and the -- the
3 bottom quartile is just slightly lower, I don't
4 think he would have supported that.

5 Q. So -- but, again, how do you know
6 that they're too high?

7 A. Feedback from my -- the expert
8 panel. They were, like -- they -- they gave us
9 feedback that these scores -- these can't be
10 means. How can a mean be a 72 or -- we can read
11 off the chart, but . . .

12 Q. Okay.

13 But I guess the means are too
14 high for the nonparticipating hospitals, too?
15 Am I not understanding that right?

16 A. The means are too high to be imputed
17 for nonparticipating hospitals because there was
18 not face validity that nonparticipating
19 hospitals were even performing at this level.
20 And, again, I'll go back to hand hygiene.

21 I remember when we put out the
22 nurse staffing and skill mix measure, which we

1 knew would be hard because hospitals don't
2 necessarily want to tell people what their
3 nurse-to-patient ratio is -- and we knew that,
4 you know, unions can be a tricky issue, right.
5 We're funded by employers. We get that. But
6 they have some of the strongest evidence of
7 being tied to patient outcomes.

8 When this hand hygiene measure came
9 out, we got inundated with comments from
10 hospitals saying, This is impossible. No one
11 can do this. Like, these requirements are too
12 strenuous. And, again, these were all
13 published in that Leapfrog Hospital Survey
14 public comment document where we responded.

15 So to think again that a hospital
16 that had never done our survey might not even
17 be familiar with the elements of our
18 standard -- I'm going back to the document
19 where -- that includes the -- the PowerPoint
20 that we shared with the expert panel.

21 If you can go to Page 10 where we
22 have the spring 2024 cohort means for Step 2

1 imputation.

2 Q. Sorry. Which document -- you're
3 looking at the deck from the meeting?

4 ATTORNEY BLAIR: Exhibit 13.

5 THE WITNESS: Yes. That you
6 produced to me as Exhibit 13.

7 BY ATTORNEY CRAIN:

8 Q. Um-hum. All right. Let's see.
9 Sorry. I had set it aside.

10 Got it. Yep.

11 A. And can you go to Page 10?

12 Q. Um-hum.

13 A. And if you look in the right-hand
14 side --

15 Q. Yep.

16 A. -- these scores were just extreme --
17 extremely high. I mean, I think people were
18 just very concerned. And, again, this wasn't me
19 saying like, Wow. I bet the hospitals are doing
20 this or not doing this. It is so fresh in my
21 memory because I, personally, reviewed the 600
22 comments from hospitals saying, This is very,

1 very difficult. It's very, very hard to do.

2 Q. This is -- so just to make sure I'm
3 on the same page, this -- the line -- it says,
4 Step 2 Hand Hygiene Score (Mean of Cohort)?

5 A. Yes.

6 Q. And they're mostly in the 50s and
7 60s?

8 A. Yes.

9 Q. Okay. And, ultimately, what's
10 imposed is 15, right?

11 A. Correct.

12 Q. Why such a big difference?

13 A. So, again, we had already -- oh, no,
14 we haven't talked about this.

15 In previous rounds of the Hospital
16 Safety Grade, we had identified this new data
17 source for ICU physician staffing called the
18 CMS cost report. We did talk about this.

19 Q. Yes.

20 A. Through that CMS cost report, we
21 could tell whether or not hospitals operated in
22 an adult or pediatric ICU. A's I said, that

1 response, if I was making a comparison to the
2 questions on the Leapfrog Hospital Survey and
3 you said, Yes, you operate in ICU, and then we
4 didn't know about the other things, would have
5 yielded a score of -- based on our public
6 scoring algorithms, those rubrics I keep
7 referring to -- of limited achievement, which
8 then has that numeric value assigned to it.

9 We had done that change, I think, a
10 full year, two rounds, before spring 2024 and
11 did two rounds of announcements and public
12 comments to give hospitals adequate time to
13 review the change so we can understand if there
14 would be any challenges or problems using the
15 CMS car -- or cost report. Maybe there's
16 something we didn't know.

17 And because previously using the
18 AHA data, hospitals had much higher scores.
19 Imputed from AHA are calculated based on AHA,
20 and we're going to get the score of 5. And,
21 actually, for all of the imputed measures, the
22 ICU physician staffing has the lowest numerical

1 score associated with limited achievement. In
2 other cases, it's -- it's 25, and got no
3 comments whatsoever about that change.

4 So that change of aligning the
5 point value imputed with limited achievement,
6 for that one measure, had been in effect for
7 two rounds of the Hospital Safety Grade. We
8 had not received comments from hospitals who
9 had that imputation used to calculate their
10 grade.

11 And so I think that when we were
12 looking at this particular change that ended up
13 coming about, I believe I said, Well, actually,
14 we have been doing this for ICU physician
15 staffing, and we've gotten no feedback --
16 negative feedback whatsoever, and naively maybe
17 thought there would be acceptability around it
18 because we had been doing it for a year for
19 another measure already.

20 Q. Okay.

21 A. Because one thing to remember is
22 that that document that we keep looking at

1 together, that Spring 2025 Safety Grade
2 Methodology document --

3 Yeah.

4 -- can we bring that up again?

5 Q. Uh-huh.

6 A. Exhibit 3.

7 Q. Uh-huh.

8 A. So these tables that we've been
9 looking at --

10 Q. Yep.

11 A. -- that show the Leapfrog measures
12 and the four performance categories and the
13 scores associated, these tables have not changed
14 since the inception of the Hospital Safety
15 Grade. So these tables and these values are
16 very, very familiar to hospitals. So even if
17 you're not theoretically doing a
18 Leapfrog Hospital Survey, you've seen these
19 tables four times a year for as long as you've
20 been getting a Hospital Safety Grade.

21 So the familiarity aspect of it,
22 for me, was a positive.

1 Q. But how does that justify taking
2 means that were in the 50s and 60s and imputing
3 a score of 15? I just don't --

4 A. We didn't think that the means in
5 the 50s and 60s were accurate.

6 Q. A's to -- as to nonparticipating
7 hospitals?

8 A. Correct.

9 Q. And why was that? Why is that?

10 A. A's I've described, we were
11 receiving feedback from participating hospitals
12 that these things were very difficult to do, and
13 the panel did not have strong beliefs that
14 nonparticipating hospitals would do these
15 things.

16 I can use another example, if that
17 would be helpful.

18 Q. No, I -- I'd like to focus back on
19 my questions, if I can.

20 A. Yes. Um-hum.

21 Q. Let's go back to this document with
22 the Slack Chat.

1 A. Yes.

2 Q. Okay. So you see Ms. Campione goes
3 back -- and I want to go to -- okay. 4:45,
4 Ms. Campione says, If we made Step 1 just the
5 previous survey, it would at least make the
6 lapse in survey participation short term, and
7 they can't fall back on Step 2.

8 You say, Oh, so, like, Step 1
9 or 0?

10 And then she says, The Step 2
11 means are so high, what if we used Step 1,
12 (limited to only, say, two round), then assigned
13 them to the bottom performance category?

14 Do you see that, 5:03?

15 A. Yes.

16 Q. And then you say, That would be
17 drastic, but let's talk about it, LOL.

18 Do you see that?

19 A. Yes.

20 Q. Okay. Is Ms. Campione's Chat at
21 5:03 the same as the model that was ultimately
22 imposed?

1 A. Yes.

2 Q. Why did you think it was drastic?

3 A. It was different from what we were
4 proposing.

5 Q. But you didn't say it would be
6 different.

7 Everything is different, right?

8 A. I really don't know why I used that
9 choice of word. I just -- it was very different
10 than what we were proposing.

11 Q. Okay. It was a significant change,
12 right?

13 A. It was a big change.

14 Q. And it was a change that as the
15 notes noted from Dr. Pronovost, could be taken
16 poorly, right?

17 A. Correct.

18 ATTORNEY BLAIR: Objection to
19 form: mischaracterizes the document.

20 BY ATTORNEY CRAIN:

21 Q. I just had one other question.

22 Oh, no -- let's see.

1 You can set this aside. Okay.

2 A. Set this aside?

3 Q. Yep.

4 A. Okay.

5 Q. Okay.

6 ATTORNEY CRAIN: Can we go
7 off? We've been going about an hour.

8 ATTORNEY BLAIR: Sure.

9 ATTORNEY CRAIN: Yeah? Okay.

10 THE VIDEOGRAPHER: Going off
11 the record. The time is 1545.

12 --oOo--

13 (Whereupon, a recess was taken from
14 3:45 p.m. EDT to 4:06 p.m. EDT.)

15 --oOo--

16 THE VIDEOGRAPHER: Going back
17 on the record. The time is 1606.

18 BY ATTORNEY CRAIN:

19 Q. Okay.

20 All right. So we're going to
21 look at a new document. I just want to talk it
22 through a little bit.

1 A. Okay.

2 Q. I want to talk a little bit about
3 Dr. Pronovost's quartile model.

4 A. Yes.

5 Q. So I just want to -- so do you --
6 we'll have Cindy mark this as Exhibit 16.

7 ATTORNEY CRAIN: Right?

8 CERTIFIED STENOGRAPHER: Corr
9 ect -- no, 17.

10 ATTORNEY CRAIN: Seventeen.

11 ATTORNEY BLAIR: Yeah, I
12 didn't even know.

13 Thank you.

14 --oOo--

15 (Danforth Deposition Exhibit Number
16 17, E-mail string, Bates stamped
17 LEAPFROG00220682 through
18 LEAPFROG00220686, marked for
19 identification, as of this date.)

20 --oOo--

21 BY ATTORNEY CRAIN:

22 Q. Okay. So this is an e-mail,

1 Ms. Danforth.

2 A. Yes.

3 Q. The last one is from you.

4 Do you see that?

5 A. Yes.

6 Q. And I want to go to Ms. Campione's
7 e-mail, which I think leads off the discussion
8 at 5:41 p.m. on April 25th, 2024.

9 Do you see that?

10 A. Yeah.

11 Q. And that's that two -- almost two
12 weeks after the April 12th meeting, a little
13 under?

14 A. Yes.

15 Q. Okay. And she says, I have some
16 bad/good news. The Step 2 scores aren't what we
17 would like. Turns out the hospitals that do the
18 survey perform very well. The BCMA scores below
19 will likely drop with the methodology changes,
20 though.

21 Do you see that?

22 A. Yes.

1 Q. Okay. And -- and what it says here
2 is -- she -- she has a chart where it lays out
3 CPOE, hand hygiene and BCMA, right?

4 A. Yes.

5 Q. Yes. Sorry. We need verbal
6 answers, yeah.

7 And then the -- so do you have
8 any understanding of what 20 -- we have this 100
9 on 25th percentile column.

10 Do you know what that means?

11 A. Yes.

12 At the top 25th percentile, the
13 cutoff score would have been 100. So the top
14 25 percent of hospitals, their score is 100.

15 Q. Okay. Got it.

16 So that's -- so 25th percentile
17 basically means top 25th percentile?

18 A. Just based on the numbers being 100,
19 I'm interpreting it that way.

20 Q. Okay. Should be the first quartile,
21 basically?

22 A. Yes.

1 Q. Okay. So then we have Mean of
2 bottom quartile.

3 A. Correct.

4 Q. Do you see that? Okay.

5 A. I do.

6 Q. And that is reflexive of
7 Dr. Pronovost's idea that we -- we look to
8 impute the bottom quartile in some capacity,
9 right?

10 A. Yes.

11 And, again, I don't recall if he
12 asked for the mean of the bottom quartile or
13 the bottom quartile, but I believe -- I
14 believe, as I just spoke to this, what I had
15 said is actually described here. So the mean
16 of the bottom quartile is 77 for CPOE. That's
17 very near the mean.

18 So the bottom quartile and the mean
19 are virtually identical.

20 Q. Yes.

21 A. When he made the suggestion, what I
22 was implying, and I believe what he was

1 implying, is that he was expecting it to be
2 lower because in true regular distribution
3 quartiles, the top quartile would be, say, 75 to
4 a hundred and then 50 to 75 --

5 Q. Sure.

6 A. -- and then 25 -- and the bottom
7 quartile would be somewhere between 0 and 25 --

8 Q. Yeah.

9 A. -- not 77 --

10 Q. Yeah.

11 A. -- so I didn't have this in front of
12 me earlier, but this is what I was trying to
13 describe in the previous questioning.

14 Q. Yes.

15 And then if you get to the top,
16 you say, This is sort of what I was afraid of,
17 but somehow more stark seeing the actual
18 numbers. I do think we at least need to
19 cowider --

20 Which I think means "consider";
21 is that right?

22 A. I bet that is right.

1 Q. -- going to limited achievement.

2 Do you see that?

3 A. Yes.

4 Q. Okay. And, again, limited
5 achievement for some of these scores is orders
6 of magnitudes less, right?

7 A. It's less.

8 Q. It's significantly less, right?

9 A. It's less.

10 Q. Well, a lot less or a little less?

11 A. It's less. Again, it depends.

12 There's a range. We're talking about 5, which
13 had already been in place for a year; in some
14 cases, it's going to be 25. A's you pointed
15 out, some of the hand hygiene scores were around
16 49 or 50. So it depends on the measure; it
17 depends on the cohort. It's less.

18 Q. Okay. And then what -- just to --
19 just to be clear about it, when you say "this
20 was sort of what I was afraid of," what do you
21 mean there?

22 A. I thought the bottom quartile would

1 resemble or be identical to those mean scores.

2 Q. Okay.

3 A. I thought they would be very
4 similar. I didn't think they would be that
5 similar, but I thought they would be very
6 similar --

7 Q. Yeah.

8 A. -- and so that's exactly what I
9 meant.

10 Q. And why did you want them to
11 ultimately not be similar?

12 A. So, again, to go back, what we were
13 trying to do is address a problem that both
14 hospitals and the expert panel had communicated,
15 which is these imputed scores for these -- and,
16 again, I want to actually start calling it three
17 measures because by this point, we're already
18 computing a different score for IC physician
19 staffing.

20 Is that okay?

21 Q. IPS. Sure.

22 A. So for these three measures, is too

1 high, and we are afraid that it's not reflecting
2 what's actually happening in these hospitals.
3 And at Leapfrog, our actual mission on our
4 website, on our stationery. But in our life and
5 all the days and all the work that we do every
6 day, again, is to reduce harm to patients from
7 preventable medical errors. If we're
8 overassessing hospitals' performance on these
9 measures, we're not reducing harm to patients
10 from preventable medical errors.

11 And I realize it probably sounds
12 very simplistic when I describe it that way,
13 but that is really our intention. And the
14 intention of our expert panel as to our
15 researchers, specifically in patient safety,
16 who have been doing this work in some cases 30,
17 40 years, long before I've been to Leapfrog, is
18 also to reduce harm to patients from
19 preventable medical errors.

20 And so it was a genuine -- not just
21 as an expert panelist, right, but as
22 Dr. Pronovost and Arjun Srinivasan, I think a

1 genuine concern that we weren't doing what was
2 best for patients in this methodology, if we
3 were overestimating what they thought was
4 realistic for hospitals that weren't submitting
5 a Leapfrog Hospital Survey.

6 And I realize I've said that in a
7 few different ways, but it's important because
8 our intentions are really aligned around this
9 mission.

10 And whether or not we're saying
11 every other sentence what's best for the
12 patient, what's best for the patient, what's
13 best for the patient, all of this dialogue is
14 focused on what we think, in our opinions, is
15 best for the patient.

16 Q. Is it -- is it best for the patient
17 to convey accurate information?

18 A. In this particular situation, I
19 personally felt that it was going to be
20 challenging to keep having the expert panelist
21 support these high means, and you -- you sort of
22 see that in this. They really didn't feel like

1 it was accurate.

2 A previous alternative imputation
3 methodology, which had been in place for a
4 year, reflected what ended up happening for
5 these three measures later, right. We're
6 imputing that numerical score associated with
7 limited achievement for IPS for a year, then we
8 end up doing this for these three.

9 At that time, based on the
10 discussion and based on the analyses and based
11 on what you've just showed me, I agreed with
12 the expert panel, that I thought this was the
13 right decision to make in terms of a next step
14 for the -- the methodology --

15 Q. So I want to break that --

16 A. -- and -- and to be clear, I have
17 confidence in this methodology. I -- I'm the
18 one that ultimately have -- has to talk to the
19 hospitals, be on the phone talking about the
20 methodology.

21 Q. So I want to break that down --

22 A. Sure.

1 Q. -- there's a lot in that answer.

2 A. Yeah.

3 Q. You said you have confidence in the
4 methodology.

5 A. Yes.

6 Q. Does that mean you believed that the
7 methodology conveys accurate information --

8 A. I do, Melissa Danforth.

9 Q. Let me finish. Let me finish.

10 A. Sorry.

11 Q. Do you believe that the methodology
12 conveys accurate information about the
13 hospitals?

14 A. I do.

15 Q. Okay. And you said, "I do,
16 Melissa Danforth."

17 A. Yes.

18 Q. Does Leapfrog believe, in your
19 corporate representative capacity, that the
20 Hospital Safety Grade for nonparticipating
21 hospitals conveys accurate information about
22 those nonparticipating hospitals' performance?

1 A. We do.

2 Q. Okay. And that's what you
3 communicate to consumers, right?

4 A. We communicate to consumers all of
5 the information on the Web page that we looked
6 at.

7 Should we bring that up again and
8 look at it?

9 Q. No. I want to ask you --

10 A. Okay.

11 Q. -- my questions because I'm just --
12 I'm mindful of our time.

13 A. Yeah, we communicate to consumers
14 all of the information that we've talked about
15 today, including the fact that if we don't have
16 information from a hospital because they've
17 declined to provide it, that we have assigned
18 them --

19 Q. Yes.

20 A. -- the worst possible score. We
21 indicate that with an asterisk, and we call out
22 in 18-point font that is associated with the

1 worst possible score, that's correct.

2 Q. So a consumer going to the website
3 that says an F at Delray, is it Leapfrog's view
4 that what Leapfrog is communicating --

5 A. I can't speak to the website.

6 Q. Fair enough.

7 You can speak to the Safety
8 Grade, correct?

9 A. Yes.

10 Q. Okay. When a consumer sees the
11 Safety Grade and they see it's an F, does that
12 communicate that the hospital has poor
13 performance, or does it communicate that the
14 hospital has not participated?

15 ATTORNEY BLAIR: Objection to
16 form.

17 BY ATTORNEY CRAIN:

18 Q. Nonparticipating hospital?

19 A. Neither.

20 Again, the Hospital Safety Grade is
21 a composite measure. It's made up of 22
22 different measures. There's a lot of measures

1 within the Hospital Safety Grade where we do
2 have lots of information. For example -- I
3 think you used Delray Hospital.

4 Q. Yes.

5 A. I believe at that particular
6 hospital, for example, we have all of their
7 patient experience measure scores for those five
8 patient experience measures.

9 We have scores for three -- what's
10 called hospital-acquired conditions: foreign
11 objects retained, falls and trauma, air
12 embolism. We have scores for all five
13 healthcare-associated infections. We have
14 scores for patient safety indicator 04, which
15 looks at death from treatable complications
16 following surgery, and also PSI 90, which,
17 again, is that 10.

18 So the Hospital Safety Grade, I
19 don't think, communicates a hospital does or
20 does not have one or two or three things.
21 That's why it's a composite. And that's why my
22 understanding is -- we make all those gas

1 gauges available so consumers can go through
2 each one and look at performance on an
3 individual thing.

4 So, for example, if you're not
5 having surgery, you may not care about the
6 surgical measures or --

7 Q. So, I -- I want to ask you about
8 those gas gauges now that you bring them up.

9 A. Sure.

10 Q. The gas gauge for handwashing has a
11 limited achievement, right, for Delray?

12 A. The gas gauges are a -- a graphical
13 depiction of a hospital's performance in
14 relation to the average score for that measure.
15 So the way you just described it is not correct.

16 Q. Okay.

17 A. Can we look at it --

18 Q. Absolutely --

19 A. -- together so I can show you?

20 Q. -- yes.

21 A. Okay.

22 So I believe that was one of the

1 earlier exhibits.

2 Q. Exhibit 3, I want to say.

3 ATTORNEY CARDONE: Exhibit 4.

4 ATTORNEY CRAIN: Four?

5 Oops.

6 THE WITNESS: And to be

7 clear, this is me speaking as

8 Missy Danforth about --

9 BY ATTORNEY CRAIN:

10 Q. Yeah.

11 A. -- the gas gauges, which are on the
12 website.

13 Is it 4?

14 ATTORNEY CARDONE: Yes.

15 THE WITNESS: Oh.

16 ATTORNEY CRAIN: Are you sure
17 it's not 3?

18 BY ATTORNEY CRAIN:

19 Q. Yes. That one (indicating).

20 A. Okay.

21 Q. Okay. So I'm on this page, and I
22 see on Page 2, handwashing, right?

1 A. So this isn't what it looks on the
2 website the way this printed, but can you go to
3 the second page of the printout?

4 Q. Yeah.

5 A. Okay.

6 So the gas gauges have three colors
7 that are displayed on them and then, like, a
8 little needle.

9 Q. Yes.

10 A. Okay. So this is meant to be, like,
11 the key, I think is the correct -- kind of like
12 the --

13 Q. Sure.

14 A. -- key to say what the -- okay.

15 ATTORNEY BLAIR: For the
16 record, can she say what she's
17 pointing to?

18 THE WITNESS: Sure.

19 ATTORNEY BLAIR: Because I
20 can't see what --

21 THE WITNESS: So this is
22 the --

1 BY ATTORNEY CRAIN:

2 Q. Oh.

3 A. -- hospital performance key that
4 goes under the gas gauges, where, reading left
5 to right, worse than average is the color red,
6 and then average is the color yellow, and then
7 green is the color better than average --

8 Q. Sure.

9 A. -- so what the gas gauges
10 communicate are: green, better than average;
11 yellow, average; or red, worse than average.

12 And then to provide context to
13 that, the scores are then listed on the side
14 here, on the left, where it says, This hospital
15 scores a 15 -- again, with that asterisk -- the
16 best hospital score is 100; the average
17 hospital score is 74.40.

18 So 15 is less than 74.40 because 15
19 is associated with the worst score. I'm not
20 looking at it, but the gas gauge should be red.

21 Q. So is Leapfrog confident that 15 is
22 an accurate reflection of Delray's handwashing

1 score?

2 ATTORNEY BLAIR: Objection to
3 form.

4 THE WITNESS: We've assigned
5 that numerical score --

6 BY ATTORNEY CRAIN:

7 Q. No. Ms. Danforth, I'm sorry --

8 A. -- to reflect the lack --

9 Q. -- Ms. Danforth --

10 A. -- of information available.

11 Q. -- I'm -- I'm sorry. I really would
12 like for you to answer my question.

13 ATTORNEY BLAIR: She is.

14 ATTORNEY CRAIN: She's not,
15 consistently.

16 BY ATTORNEY CRAIN:

17 Q. So is Leapfrog confident -- is -- is
18 the score of 15 an accurate reflection of the
19 hospital's performance on handwashing?

20 ATTORNEY BLAIR: Objection to
21 form.

22 THE WITNESS: The score of

1 15 -- and I can't say it clearer than
2 it's written -- was assigned to
3 reflect the last of it -- lack of
4 information available based on
5 guidance from our national expert
6 panel.

7 BY ATTORNEY CRAIN:

8 Q. So why give a score?

9 A. Based on guidance from our national
10 expert panel.

11 Q. Okay. So you're -- you're --
12 Leapfrog -- your speaking for Leapfrog because
13 we're talking about the scoring methodology,
14 right?

15 A. I am.

16 Q. And so Leapfrog gives this limited
17 achievement score because of guidance from the
18 national expert panel, right?

19 A. Yes.

20 Q. And where did that guidance come
21 from?

22 A. Discussions with the national expert

1 panel that we've been talking about.

2 Q. Okay. Was it ever conveyed to
3 Leapfrog that the panel approved of limited
4 achievement for this type of a metric for
5 handwashing?

6 A. I'm not sure that we've ever used
7 the word "approved" or "disapproved." We
8 typically use things like "support" -- the panel
9 "supports," the panel "agrees."

10 We can go back to the notes.

11 Can we do that?

12 Q. No, we can't --

13 A. Oh, okay.

14 Q. -- because I'm -- I -- I'm on a
15 limited time and I want to focus you.

16 A. Okay. Then I can't say that it's --
17 it would be supports or agrees.

18 Q. Okay. Supports or agrees.

19 A. Um-hum.

20 Q. Who made the decision to impose the
21 limited achievement score for handwashing for
22 nonparticipating hospitals?

1 A. A's I've described earlier today in
2 my testimony, it is a process with all of the
3 people involved that I've previously testified:
4 the expert panel, including Patrick Romano on an
5 individual call; myself; Matt Austin. And that
6 would have been discussed with Leah Binder as
7 well.

8 Q. Okay. Let's go to Dr. Romano.

9 Let's --

10 ATTORNEY CRAIN: This is 18?

11 CERTIFIED STENOGRAPHER: Yes.

12 ATTORNEY CRAIN: Okay.

13 THE WITNESS: I'm out of
14 order now.

15 ATTORNEY CRAIN: I'm getting
16 it.

17 Thank you.

18 ATTORNEY BLAIR: Oh, thank
19 you.

20 --oOo--

21 (Danforth Deposition Exhibit Number
22 18, E-mail string, Bates stamped

1 LEAPFROG01081490 through
2 LEAPFROG01081491, marked for
3 identification, as of this date.)

4 --oOo--

5 ATTORNEY CRAIN: Are we on?

6 THE WITNESS: Yes.

7 BY ATTORNEY CRAIN:

8 Q. Okay. I mean Cindy's on.

9 CERTIFIED STENOGRAPHER: I

10 am.

11 ATTORNEY CRAIN: You're the

12 most important person.

13 BY ATTORNEY CRAIN:

14 Q. Okay. So this is an e-mail. If you
15 look -- go to the bottom, it's -- it's an e-mail
16 from Matt Austin to Dr. Romano, cc'ing you and
17 Ms. Campione.

18 Do you see that?

19 A. Yes.

20 Q. And he's proposing -- he's saying,
21 Since our conversation with you a couple of
22 weeks ago -- this is May 7th -- about changing

1 the imputation approach used in Leapfrog's
2 Hospital Safety Grade, we met with the broader
3 safety expert panel to hear their input and have
4 drafted the attached language to share with
5 hospitals about the proposed changes.

6 Do you see that?

7 A. I do.

8 Q. Okay. Then he goes on. He --
9 he's -- he's asking for Dr. Romano's expertise
10 and perspective, correct?

11 You see that on the last
12 sentence?

13 A. Yes.

14 Q. Okay. So he follows up -- if you go
15 up the chain, on May 14th, he had got no
16 response, so he -- he pings Dr. Romano again.

17 And then Dr. Romano writes
18 back.

19 Do you see that?

20 A. Yes.

21 Q. Now, have you reviewed this e-mail
22 in your preparation today?

1 A. Yes.

2 Q. Okay. So you're aware and,
3 presumably, you have memorized this document, as
4 you have many others, that Dr. Romano lays out
5 two hypotheses for why hospitals are not
6 participating in the survey.

7 Do you see that?

8 ATTORNEY BLAIR: Objection to
9 form.

10 THE WITNESS: So, first, I
11 haven't memorized it. And so, no, now
12 I don't see that.

13 BY ATTORNEY CRAIN:

14 Q. Okay.

15 Okay. So he says -- if you
16 look in the middle, he says, The underlying
17 hypothesis --

18 A. Yes --

19 Q. -- do you see that?

20 A. -- I do.

21 Q. The underlying hypothesis behind
22 your proposed Step 2B approach was that

1 hospitals start -- stop reporting because their
2 true performance deteriorated relevant --
3 relative to their cohort.

4 Is that an accurate view of
5 your hypothesis at the time?

6 ATTORNEY BLAIR: Objection to
7 form.

8 THE WITNESS: A's we've
9 discussed, it was not that hospitals
10 just stopped reporting, but some
11 hospitals had never reported.

12 I'm not exactly sure what
13 this is referring to, but, no, that's
14 not how I would've described this at
15 all, and that's not how we've been
16 talking about it.

17 BY ATTORNEY CRAIN:

18 Q. Okay. Is it -- is it inconsistent
19 with your view that hospitals were not
20 reporting -- responding to Leapfrog's survey
21 because their true performance had deteriorated
22 relative to their cohort?

1 ATTORNEY BLAIR: Objection to
2 form.

3 THE WITNESS: So, again, the
4 means are assigned to hospitals who
5 maybe have never done the Leapfrog
6 Hospital Survey.

7 So it's not like I did a
8 survey; I got bad; I stopped
9 reporting; they're assigning these
10 means. It's also I've never done a
11 survey in 20 years.

12 And so, no, this is not
13 correct.

14 BY ATTORNEY CRAIN:

15 Q. Okay. Fair enough.

16 Is it consistent with your view
17 that the hospitals who have never done a survey
18 are necessarily lower performances than the mean
19 of their cohort?

20 A. It is not necessarily my personal
21 view. I believe there have been public papers
22 indicating that transparency can be a driver to

1 performance --

2 Q. Okay.

3 A. -- and I have been influenced by
4 those papers.

5 Q. Can you identify any of those papers
6 today?

7 A. I couldn't, but -- off the top of my
8 head, no.

9 Q. Okay. He says, My hypothesis, by
10 comparison, was that most hospitals stop
11 reporting because it is too burdensome and
12 because the -- they only find market value in an
13 A grade, which proves impossible to attain or
14 maintain.

15 Do you see that?

16 A. I do.

17 Q. Okay. So his -- his theory, at
18 least for hospitals who stopped reporting -- I
19 take your point -- are -- is that it's too
20 burdensome, right?

21 A. That is his theory, yes.

22 Q. And did you disagree with that

1 hypothesis?

2 A. I don't see a response from me, but
3 I likely would not have agreed with that
4 hypothesis, correct.

5 Q. I -- I'm asking today.

6 Do you --

7 A. Yes. No, I don't agree with that.

8 Q. And Leapfrog does not agree with
9 that hypothesis?

10 A. I don't think Leapfrog would agree
11 with that hypothesis.

12 Q. Okay. And then what he says, if you
13 -- if you look throughout the e-mail -- I want
14 to start at the top now. He -- he says, I like
15 the simpler, more direct approach here "if the
16 goal is to penalize nonparticipants, you might
17 as well do so in a clear and unmistakable manner
18 while allowing for hospitals to manage their
19 burden and jump back on the wagon after a year.

20 Do you see that?

21 A. I do.

22 Q. What is your response to

1 Dr. Romano's view that the goal is to penalize
2 nonparticipants?

3 A. Complete disagreement.

4 Q. Okay. Tell me why.

5 A. Because we've never talked about
6 penalizing hospitals. We've talked about
7 incentivizing hospitals. We don't talk in terms
8 of penalizing hospitals.

9 And that's why I think I took
10 exception to the couple documents where you're
11 showing me it used the word "punitive." That's
12 not in the vernacular of how we speak at
13 Leapfrog.

14 We, again, are not in the business
15 of -- of penalizing hospitals. We're in the
16 business of making information available, in
17 this case, about patient safety to patients.

18 Q. And -- and who is "we" when you say
19 that?

20 A. The Leapfrog Group.

21 Q. Okay. So you're excluding the
22 expert panel in that -- in that "we"?

1 A. I, personally, have no recollection
2 of any individual expert panelist talking about
3 penalizing hospitals through the Hospital Safety
4 Grade methodology.

5 Q. Besides Dr. Romano?

6 A. I think he's reflecting on his --
7 he -- I think he's -- he's projecting. He says,
8 If the goal is to.

9 I don't think he's trying to. I
10 actually don't know where that statement came
11 from. We've never had that conversation with
12 him.

13 Q. That was not discussed, to your
14 recollection at the --

15 A. No.

16 Q. -- let me finish.

17 That was -- just for Cindy.

18 That was not discussed, to your
19 recollection, at the April 12th meeting?

20 A. No.

21 Q. No one mentioned penalizing
22 hospitals --

1 A. Not to my recollection.

2 Q. Okay.

3 Okay. So your perspective is
4 to the extent Dr. Romano thought the new
5 imputation model was designed to penalize
6 hospitals, he's just wrong?

7 ATTORNEY BLAIR: Objection to
8 form.

9 THE WITNESS: To the extent
10 Dr. Romano -- I'm sorry. Can you
11 repeat the question? I don't want to
12 represent his opinion.

13 BY ATTORNEY CRAIN:

14 Q. That's why I said "to the extent" --

15 A. Okay.

16 Q. -- so you can -- you can fight the
17 premise in the next question.

18 A. Okay.

19 Q. In this one, take my premise.

20 A. Okay.

21 Q. To the extent he thought that the
22 new imputation methodology --

1 A. Yes.

2 Q. -- was designed to penalize
3 nonparticipants, he was wrong?

4 A. Yes.

5 Q. Okay. And you -- you're free to
6 fight me on the premise, although he says it
7 four times, that the goal is to penalize.

8 But do you see -- I mean, we
9 can go to it if you want to take a look, but --

10 A. No --

11 Q. -- okay.

12 A. -- so, actually, when I was shown
13 this e-mail as part of preparation, I didn't
14 remember this e-mail --

15 Q. Okay.

16 A. -- and, again, like, I don't have a
17 lot of one-on-one interaction with the expert
18 panelists, but I actually didn't remember this
19 e-mail.

20 But I do know that there was
21 another e-mail from Dr. Romano that you
22 probably have, where he made sort of a

1 tongue-in-cheek joke about I guess it doesn't
2 do your hospital any favors if someone sits on
3 the expert panel, because his hospital had
4 actually had the imputation methodology
5 applied, Step 2, which is University of
6 California, Davis --

7 Q. Yeah.

8 A. -- I think if he felt strongly and
9 disagreed with the methodology, we have a
10 collegial relationship enough and he has a
11 collegial relationship enough with Matt and
12 others to speak up at that time and say, I want
13 to reconvene the expert panel and talk about
14 this. I really strongly disagree with it. And
15 he did not.

16 Q. I agree with you. He did not.

17 And I -- so isn't it fair to
18 say he agreed with the proposal because he
19 thought the goal was to penalize
20 nonparticipants?

21 ATTORNEY BLAIR: Objection to
22 form.

1 THE WITNESS: I can't
2 interpret that question. I'm sorry.

3 BY ATTORNEY CRAIN:

4 Q. Okay.

5 A. Sorry.

6 Q. Well, you're saying that -- you're
7 interpreting his intent with respect to the
8 approval of the methodology, right?

9 A. Are we going back to this e-mail
10 now?

11 Q. Well, you said a few minutes ago if
12 he felt strongly and disagreed with the
13 methodology, we have a colle- -- collegial
14 relationship enough, and he -- I think --

15 A. I was -- with that statement, I was
16 implying that if he truly believed we are
17 penalizing hospitals, and particularly his own
18 hospital, my -- my belief is that he would bring
19 that up to us and ask to have a conversation.

20 So I was using that as an example
21 that I don't believe when he says "penalizing
22 hospitals" here, he really meant it, and he

1 doesn't believe it today, and he didn't believe
2 it when he saw the imputation methodology
3 applied to his hospital --

4 Q. He --

5 A. -- that's what I mean by that
6 statement.

7 Q. He doesn't believe that the
8 imputation -- he doesn't believe --

9 A. Is -- is penalizing hospitals,
10 correct.

11 Q. How do you know that?

12 A. In the -- in the subsequent e-mail,
13 he doesn't say, See, you're penalizing --

14 Q. Well, you said he doesn't think
15 it -- think it today.

16 Do you have conversations with
17 him about this topic?

18 A. I haven't.

19 Q. Okay.

20 A. My -- we've been working with
21 Dr. Romano for many, many years. It's not been
22 my experience that he waits for me to ask him if

1 he needs to bring something up to Matt.

2 So I'm inferring -- I'm only
3 inferring that --

4 Q. So --

5 A. -- if something was wrong, he would
6 bring it up.

7 Q. -- so you're inferring that he
8 approves of it today and it's not penalizing
9 even though, in this e-mail, he says four times
10 --

11 A. Yes, that's correct.

12 Q. Hold on. I want -- I want to
13 finish. I'm sorry --

14 A. I thought you were done. I'm sorry.

15 Q. No, no. I was in the middle of a
16 word.

17 A. Oh.

18 Q. So you are inferring that he is
19 agreeing that this is not a penalizing
20 methodology today even though his e-mail from
21 last year says four times he's okay with this
22 because the goal is to penalize

1 nonparticipants?

2 ATTORNEY BLAIR: And I'm
3 going to object to form in that it's
4 missing the attachment.

5 ATTORNEY CRAIN: That's fine.

6 THE WITNESS: Can I --

7 ATTORNEY BLAIR: Yeah.

8 BY ATTORNEY CRAIN:

9 Q. You may answer.

10 A. That is what I'm saying.

11 Q. Okay.

12 Okay. So you're inferring his
13 intent is to approval but not as to nonpen- --
14 that it's a penalizing methodology?

15 A. I'm inferring that when he wrote
16 this e-mail, regardless of how it reads, I don't
17 believe that, today, he thinks that we are using
18 a penalizing methodology.

19 Q. Why?

20 ATTORNEY BLAIR: Objection:
21 asked and answered.

22 ATTORNEY CRAIN: Not

1 answered, but I'll give you maybe
2 asked.

3 THE WITNESS: Because based
4 on my knowledge and relationship with
5 Patrick Romano, if he believed that we
6 were using a penalizing methodology,
7 he would bring it up to us and/or with
8 the rest of the expert panel.

9 Since this e-mail has -- was
10 sent, he has never made any comments
11 like that. And, in fact, I forgot he
12 even said it in this instance.

13 BY ATTORNEY CRAIN:

14 Q. But that's because he was okay with
15 the approach, right?

16 ATTORNEY BLAIR: Objection to
17 form.

18 THE WITNESS: I don't think
19 I'm understanding your question.

20 BY ATTORNEY CRAIN:

21 Q. Okay. We agree that he's saying
22 this -- this new approach is fine, right?

1 A. Yes.

2 Q. Okay. But he's specifically writing
3 in this e-mail he thinks it's fine because --

4 A. And that's what we disagree on, that
5 it's penalizing.

6 Q. You disagree that he thinks that, or
7 you disagree that it is penalizing?

8 A. I disagree that he thinks that
9 today, and I disagree that it is.

10 Q. And you disagree that he thought
11 that when he wrote this?

12 ATTORNEY BLAIR: Objection to
13 form: mischaracterizes the document.

14 ATTORNEY CRAIN: No; I'm
15 asking.

16 THE WITNESS: I can't infer
17 what he might have thought when he
18 wrote this. I --

19 BY ATTORNEY CRAIN:

20 Q. I just --

21 A. -- don't know what his state of mind
22 was.

1 Q. I want to be superclear.

2 A. Yes.

3 Q. You are inferring what his state of
4 mind is today without a document and without a
5 discussion, but you can't infer what his state
6 of mind is when you read this e-mail?

7 ATTORNEY BLAIR: Objection --

8 THE WITNESS: If --

9 ATTORNEY BLAIR: -- to form.

10 THE WITNESS: -- if I read
11 the e-mail as plain that he -- he
12 believed it was penalizing, I don't
13 believe it's penalizing. And I am
14 saying that I don't believe
15 Patrick Romano believes it's a
16 penalizing methodology today.

17 BY ATTORNEY CRAIN:

18 Q. And -- and what does "penalizing"
19 mean to you?

20 A. However he's used it here.

21 "Punitive," I think, is what we were using -- I
22 think what we were using before.

1 Q. So "punitive" means punish, right?

2 A. Yes. Because as a reminder -- and I
3 know I've said this lot, but I feel like maybe
4 I'm not saying it clearly -- whether or not you
5 participate in a Leapfrog Hospital Survey, you
6 can get an A, B, C, D, F. Whether you
7 participate in a Leapfrog Hospital -- you can
8 still get an A, B, C -- we have hospitals that
9 have never done a survey that have the Step 2
10 imputation model applied that have A's.

11 We have hospitals that have never
12 done a survey that have the same Step 2
13 imputation model applied that have B's.

14 The fact of that leads me to say to
15 you, I don't think the methodology is
16 penalizing; I don't think the methodology is
17 punitive. And I don't have to just think it.
18 I see it because I see hospitals that have
19 never done a survey and have the same
20 methodology applied and have A's, B's, Cs,
21 et cetera.

22 So it's not a conjecture. You see

1 it on our publicly reported website. That's
2 what I'm basing my statement on.

3 Q. So let me -- how many
4 nonparticipating hospitals have A's?

5 A. I would have to look. I don't --
6 I'm not going to know that information off the
7 top of my head.

8 Q. Ballpark.
9 Is it 100? Is it 5?

10 A. It's . . .

11 Q. Best estimate.

12 A. I would estimate the majority of
13 hospitals at any grade level is a C. And so the
14 majority of hospitals, whether they submit a
15 survey or not, are going to be at a C.

16 I wouldn't want to make an estimate
17 on the other letter grades. I'm sorry.

18 I'm not -- I know that for the
19 purposes of this case, if there's other
20 documents where you have lists of hospitals, I
21 -- I'd be happy to look at them. I just don't
22 want to say something incorrect.

1 Q. The documents speak for
2 themselves --

3 A. Okay.

4 Q. -- I'll -- I'll come back --

5 A. No. I mean with the -- with the
6 counts. I just -- I don't want to speak from
7 memory.

8 Q. No. I know. Those documents speak
9 for themselves --

10 A. Okay.

11 Q. -- I will -- I -- my recollection is
12 the number is quite, quite small, but set that
13 aside.

14 A. Yeah.

15 Q. Is it your view that the
16 nonparticipating hospitals, if they started
17 participating, would not see their scores rise?

18 A. It is my view. And, in fact, I've
19 had many calls with very distraught directors of
20 quality because they participated in the survey
21 and their score went down. So it's not
22 necessarily true that when you start

1 participating in the survey, your grade goes up.
2 Sometimes your grade goes down. Sometimes it
3 stays exactly the same.

4 Like I said, this is a 22-measure
5 composite, and so there's a lot of factors
6 going into it. So I could never say to you or
7 anyone definitively by virtue of answering the
8 questions on the survey, your grade's going to
9 go up, down or stay the same. I've seen all
10 three things happen.

11 Q. Because you don't actually know how
12 nonparticipating hospitals are performing,
13 right?

14 A. That's correct.

15 ATTORNEY BLAIR: Objection to
16 form.

17 ATTORNEY CRAIN: Okay. Did
18 we get it?

19 Okay.

20 THE WITNESS: And that's why
21 we're so clear that the score we're
22 assigning is based on that lack of

1 information.

2 BY ATTORNEY CRAIN:

3 Q. But -- but you're not clear, are
4 you? I mean, where are you clear in that?
5 Let's go back to Exhibit 3 --

6 A. I, personally, don't I think I could
7 be more clear than the bold red sentence on our
8 website --

9 Q. Well, let's --

10 A. -- that accompanies the asterisk
11 that accompanies the measure score.

12 Q. I will show you how you can be
13 clear.

14 ATTORNEY CRAIN: Where --
15 where's the document? Sorry. What
16 tab?

17 ATTORNEY CARDONE: Tab 64.

18 ATTORNEY CRAIN: Okay.

19 Tab 64, Exhibit 4.

20 There we go.

21 THE WITNESS: And, again,
22 website, Missy Danforth.

1 BY ATTORNEY CRAIN:

2 Q. Yes.

3 But you, Missy Danforth, has
4 been at Leapfrog for 16 years and know this like
5 the back of your hand, right?

6 A. Yeah --

7 Q. Okay.

8 A. -- not the website so much, but,
9 yes, everything else.

10 Q. But -- you have it.

11 ATTORNEY CARDONE: No.

12 You're -- it's Exhibit --

13 BY ATTORNEY CRAIN:

14 Q. You have it.

15 A. Oh. So --

16 Q. You have it. I'm going back to the
17 Delray website.

18 A. Yes -- oh, 4. Yes.

19 Q. Right. So -- so you can see it
20 says -- within the gas gauge, it says, Declined
21 to Report?

22 A. I'm sorry.

1 I'm sorry. Which gas gauge am I
2 looking at?

3 Q. The gas gauge on the right side --

4 A. Yes.

5 Q. -- which is under Staff work
6 together to prevent errors.

7 A. Yes.

8 Q. Do you see that?

9 A. I do.

10 Q. So why isn't that clearer than a gas
11 gauge that says "red"?

12 ATTORNEY BLAIR: Objection to
13 form.

14 THE WITNESS: I'm sorry. I
15 don't understand that question.

16 BY ATTORNEY CRAIN:

17 Q. Okay. So you said you weren't sure
18 how it could be clearer on the website, that
19 you're -- you're --

20 A. Correct. Web design is not my area
21 of expertise.

22 Q. Okay. But you -- you are an English

1 major, so words are your area of expertise.

2 A. Free websites.

3 Q. Fair. Fair. I won't tell --

4 A. I'm just saying --

5 Q. -- I won't tell anybody.

6 So my -- my question is, How is
7 someone looking at this supposed to understand
8 that the handwashing gas gauge, the 15 score,
9 is -- is a reflexive of lack of data and not
10 performance?

11 A. The asterisk.

12 Q. But the asterisk says a score was
13 imputed. We -- we went through this six hours
14 ago.

15 ATTORNEY BLAIR: Objection to
16 form. That's not what it says.

17 BY ATTORNEY CRAIN:

18 Q. It says, So a score was assigned --
19 excuse me -- to reflect the lack of information
20 available.

21 Right?

22 A. Correct.

1 Q. But it doesn't say how?

2 A. I guess I would argue that the
3 sentence, The hospital declined to report their
4 performance on this measure, so a score was
5 assigned to reflect the lack of information,
6 both tells them how -- and, again, because it's
7 directly associated with that specific asterisk,
8 for me reading this, I can easily make that
9 connection. I think even in
10 nonhealthcare-related things, people know when
11 they see an asterisk, it's likely associated
12 with a measure -- or I'm sorry -- a message, a
13 message.

14 Q. Is it Leapfrog's view that the
15 handwashing score for nonparticipating
16 hospital --

17 A. Hand hygiene.

18 Q. Hand hygiene. Excuse me.
19 -- for nonparticipating
20 hospitals conveys a lack of information or lack
21 of performance?

22 A. It literally says exactly how we --

1 what we are trying to convey. What we're trying
2 to convey with this asterisk is that the
3 hospital declined to report their performance on
4 this measure, so a score was assigned to reflect
5 the lack of information available. That's
6 exactly what we're trying to convey.

7 Q. But it also says worst hospital
8 score is 15, right?

9 A. Correct.

10 Q. So why doesn't it convey that this
11 is the worst hospital in that metric?

12 ATTORNEY BLAIR: It does.

13 (Sotto voce comments by counsel.)

14 THE WITNESS: My read of
15 this --

16 ATTORNEY BLAIR: Objection to
17 form.

18 THE WITNESS: -- that is
19 conveyed.

20 Because the two scores are
21 equivalent, I -- that is conveyed to
22 me by the equivalence of the numbers.

1 I don't know how else to communicate
2 it.

3 BY ATTORNEY CRAIN:

4 Q. Okay. All right. I guess.

5 (Sotto voce discussion.)

6 ATTORNEY CRAIN: Emily has a
7 good question.

8 THE WITNESS: Yes.

9 BY ATTORNEY CRAIN:

10 Q. Couldn't you convey lack of
11 information by just not scoring?

12 A. Not scoring the measure?

13 Q. Yeah.

14 A. Based on the guidance of our expert
15 panel, they have suggested that for this
16 particular measure, and we're talking about hand
17 hygiene, we impute a score.

18 Q. And is the guidance from the
19 April 12th meeting?

20 ATTORNEY BLAIR: Objection to
21 form: asked and answered.

22 THE WITNESS: I'm sorry, but

1 the actual guidance on imputing scores
2 on hand hygiene happened years before.
3 In fact, these five hospitals have had
4 imputed scores for these measures, I
5 think, since 2023 or 2024. So, again,
6 the imputation for these measures did
7 not happen in April 2024, and we've
8 talked about that extensively today.

9 BY ATTORNEY CRAIN:

10 Q. Sure. But not for limited
11 achievement.

12 That's the new -- that's the
13 change, right?

14 A. Correct.

15 Q. Yeah. Okay.

16 Okay. Let me just make the
17 question.

18 Okay. Okay. Let's keep going.

19 Okay.

20 ATTORNEY CRAIN: Let's go to

21 Tab 34.

22 Okay. This will be

1 Exhibit 17?

2 CERTIFIED STENOGRAPHER: Nine
3 teen.

4 ATTORNEY CRAIN: Nineteen, oh
5 my goodness.

6 THE WITNESS: I'm out of
7 order now. I didn't want to take the
8 time to fix it.

9 ATTORNEY CRAIN: No, it's all
10 right. We'll deal with it later.

11 THE WITNESS: Okay.

12 CERTIFIED STENOGRAPHER: One
13 second.

14 --oOo--

15 (Danforth Deposition Exhibit Number
16 19, E-mail string with
17 attachments, marked for
18 identification, as of this date.)

19 --oOo--

20 THE WITNESS: Thank you.

21 BY ATTORNEY CRAIN:

22 Q. Okay. So do you recognize this

1 document, Ms. Danforth?

2 A. Only because I reviewed it as part
3 of preparation for today.

4 Q. Part of preparation.

5 So you have no preexisting
6 memory of this document?

7 A. Not this specific --

8 Q. Okay.

9 A. -- document, no, but I'm -- I'm sure
10 it's as represented.

11 ATTORNEY CRAIN: Yeah, I
12 just -- I'll just note for the record
13 this was produced originally at
14 LEAPFROG00178623, and then counsel
15 sent over the native version with the
16 colors. So that's -- that's why this
17 one doesn't have a Bates.

18 Remember this one?

19 ATTORNEY BLAIR: Yeah.

20 ATTORNEY CRAIN: Yeah. Okay.
21 So stipulated?

22 ATTORNEY BLAIR: So

1 stipulated. We couldn't read it
2 before.

3 ATTORNEY CRAIN: We could
4 not. So thank you for sharing that.

5 BY ATTORNEY CRAIN:

6 Q. And so, Ms. Danforth, these are
7 responses to comments on the -- the imputational
8 model that you proposed in 2024.

9 Do you see that?

10 A. These are comments and responses to
11 comments.

12 Q. Correct. Exactly, correct.

13 A. Yes, correct, yes.

14 Q. And Ms. Campione drafted these,
15 right?

16 A. Yes.

17 Q. Okay. Now, she color-coded them
18 helpfully, and she sort of lays out the
19 different topics.

20 Do you see that?

21 A. Yes. Blue, green, pink, red.

22 Q. Exactly.

1 So blue, there's a -- a --

2 Misrepresents Performance?

3 A. Yes.

4 Q. Green says, More time?

5 A. Yes.

6 Q. Pink says, Do not penalize hospitals
7 for not completing a resource-intensive survey.
8 Keep them separate or allow hospitals to opt
9 out?

10 A. Yes.

11 Q. And red says, Hospital performance
12 does not change that much in two years
13 (addressed in response to theme above).

14 Do you see that?

15 A. Yes.

16 Q. Okay. Does this refresh your
17 recollection at all as to the type of comments
18 Leapfrog received after proposing the
19 imputational model?

20 A. Yes. I'm -- I'm sure I reviewed
21 these at the time.

22 Q. Okay. Now, I just want to talk with

1 you a little bit about the responses to those
2 comments.

3 A. Sure. I just want to see how many
4 there are. Give me one second.

5 Q. Yeah, that's -- that's a great
6 point.

7 A. Five, yes.
8 So we did receive six comments,
9 but --

10 Q. Yes.

11 A. -- as a reminder, over 800 hospitals
12 would have had this imputation applied --

13 Q. Yes.

14 A. -- so 6 out of 800. So this is a
15 fairly small sample size. But, yes, I -- I'm
16 sure I would have reviewed these comments when
17 we received them, and I'm sure we would have
18 reviewed this e-mail.

19 Q. Yes.

20 A. I have no doubt, yes.

21 Q. Now, just going to the number point.

22 In prior changes to the Safety

1 Grade Methodology, is this a representative
2 number of comments, more or less?

3 A. So this is 6 comments and then 4
4 additional comments, so 10 total. When we --
5 not to harp on this nursing thing, when we first
6 proposed back in 2022, 2023 to include the Total
7 Nursing Hours Per Patient Day Measure in the
8 Hospital Safety Grade, the original proposal, to
9 my recollection, was that we were actually going
10 to include two measures: One was called total
11 Nursing Hours Per Patient Day, and that is the
12 one that got added to the program. One was
13 called RN Hours Per Patient Day, which we've
14 talked about, and that didn't get added to the
15 program.

16 My recollection is that the
17 proposed changes to add those nursing measures
18 received more comments than this.

19 Q. Okay. Just by an order of
20 magnitude, any sense?

21 A. Many more --

22 Q. Okay.

1 A. -- two times -- probably two times
2 as many, three times as many.

3 Q. Okay. So I just want to look at the
4 responses here, and if you go to Page -- or
5 actually it's not a page number, but it's a
6 green bar.

7 Do you see that where it says
8 Responses to Public Comments?

9 A. Can you tell me just the hospital
10 name?

11 Q. No. Responses -- keep going.
12 There's no page numbers.

13 Do you see the green bar down
14 there?

15 A. Oh, yes.

16 Q. So just for -- for the record,
17 because there's no Bates number or page number,
18 it says, Responses to Public Comments.

19 A. Yes --

20 Q. -- do you see that?

21 So it says, Four commentator --
22 commenters supported the change to the

1 imputation methodology it said.

2 Do you see that?

3 A. Yes.

4 Q. Okay. Two commentators expressed
5 concern about Step 2 imputation misrepresenting
6 the current procedures or infrastructure of the
7 hospital to the public.

8 Do you see that?

9 A. Yes.

10 Q. Okay. Now, if we look at that -- so
11 the -- the nonbolded text under there, is that
12 Leapfrog's response to that comment?

13 A. Yes.

14 Q. Okay. So it says, We recognize that
15 hospitals eligible for Step 2 imputation may
16 score higher if they complete a
17 Leapfrog Hospital Survey.

18 Is that -- is that consistent
19 with your current view?

20 A. My current view -- I think I just
21 described it -- let me see it again in this
22 specific context.

1 They may overall on the Hospital
2 Safety Grade, because it includes a lot of
3 things, score higher or lower or stay the same.

4 Q. Okay. So I -- I'm just a little
5 unclear to my question.

6 This says, We recognize that
7 hospitals eligible for Step 2 imputation may
8 score higher.

9 Is that correct or not correct?

10 A. It's partially correct.

11 Q. Okay.

12 A. I -- actually, I don't think I wrote
13 this. I'm not sure that's how I would have
14 stated it, but I agree that's what it says, and
15 I believe it's partially correct. Just like I
16 said, they may; they may not; they may be
17 exactly the same.

18 Q. Okay. However, we cannot ensure if
19 this is the case if we do not have the data.
20 Our analyses have shown that performance among
21 hospitals that intermittently complete the
22 annual survey is lower than those hospitals that

1 completed the most recent survey.

2 Do you see that?

3 A. I do.

4 Q. Okay. What is the analysis that
5 this refers to?

6 A. That's what we've spoken about
7 earlier today where I suggested that you might
8 want to ask Matt Austin because I wouldn't have
9 done that analysis.

10 Q. Okay. Would -- and -- and, again,
11 I'm going to ask the same question because I'm
12 still not sure where to find it.

13 Do you have any recollection of
14 whether it was sent to you in any written form?

15 A. It would have been probably, like, a
16 table, like, in this other e-mail that Alex sent
17 where she had a table that included that
18 information that we were looking at together,
19 something like that.

20 Q. You say "probably."

21 Do you have a memory of it?

22 A. I don't have a memory of it --

1 Q. Okay.

2 A. -- but . . .

3 Q. But if it exists, it would have been
4 something like that?

5 A. Yes.

6 Q. Okay. The expert panel recognized
7 that hospitals with a drop in performance may be
8 incentivized not to report via the
9 Leapfrog Hospital Survey, and scores calculated
10 using participating hospitals would misrepresent
11 their true performance.

12 Do you see that?

13 A. Yes.

14 Q. Okay. Where did the expert panel
15 recognize that?

16 A. That was the discussion of the
17 meeting we had on April 12th.

18 Q. Okay. Any other place that it was
19 discussed?

20 A. I -- I don't know. I apologize.
21 Again, to refresh my memory on the April 12th
22 meeting, I had to read the minutes, so I -- I

1 can't say for sure either way.

2 Q. All I'm asking for is your best
3 memory today.

4 A. Yes, I know for sure it was
5 discussed on that meeting.

6 Q. Okay. And you don't have any other
7 recollection of it discussed elsewhere?

8 A. Not right now.

9 Q. Okay. And then it says at the
10 bottom, We do acknowledge the commenter's point
11 that the public may misrepresent the assigned
12 measure scores. In response, we will add a new
13 denotation to the Hospital Safety Grade website
14 for scores that have been imputed.

15 Do you see that?

16 A. Yes.

17 Q. Okay. And is that referring to the
18 asterisk?

19 A. Yes.

20 Q. Okay. Anything else it's referring
21 to?

22 A. I do not believe so.

1 Q. Okay. I want to keep going down.
2 We -- see four commentators towards the bottom?

3 A. I do, yes.

4 Q. Four commenters opposed penalizing
5 hospitals that choose not to devote resources to
6 completing a voluntary survey each year and be
7 allowed to opt out to the -- of the Hospital
8 Safety Grade.

9 Do you see that?

10 A. I do.

11 Q. Okay. Why doesn't Leapfrog permit
12 nonparticipating hospitals to opt out?

13 A. To opt out of what?

14 Q. Of being graded.

15 A. Because as I've expressed, from a
16 mission perspective, both Leapfrog and our
17 expert panel believe that in order for this to
18 be of good public use, we should grade as many
19 hospitals as possible because, again, so much
20 good safety data is available on the -- through
21 CMS, through Leapfrog, through this imputation
22 methodology. It's been a focus of ours to try

1 to make as much information available publicly
2 as possible. It's literally why we were
3 founded.

4 Q. And -- and you say to "grade as many
5 possible -- hospitals as possible."

6 Is it also to grade as many
7 hospitals as possible in an accurate way?

8 A. I believe that's literally embedded
9 in this -- in everything I -- in everything I
10 say. We're trying to do the best we could
11 possibly do, yes.

12 Q. So -- so the answer is yes?

13 A. Yes.

14 Q. Okay.

15 Okay. So then the response is,
16 The Leapfrog Hospital Survey is designed to help
17 hospitals benchmark their progress in quality
18 and safety.

19 Do you see that?

20 A. Yes.

21 Q. Okay. And then I'm just going to
22 keep reading down. Let's see.

1 And it says, The choice to not
2 participate should not excuse a hospital from
3 being graded, nor should they be given a score
4 that unfairly awards them points.

5 Do you see that?

6 A. I do.

7 Q. Okay. And, again, what is unfair?

8 A. Again, to reiterate, it was the idea
9 that these hospitals were being given near
10 perfect points based on the performance of other
11 hospitals.

12 Q. And -- and why is that unfair?

13 A. Because we have no information to
14 indicate -- and just going back to the hand
15 hygiene example, we have no reason to believe
16 that hospitals that aren't participating in a
17 Leapfrog Hospital Survey are doing those things.
18 So to give them credit for doing them was a
19 concern of Leapfrog's and the expert panel.

20 Q. Okay. I'm still not understanding
21 why -- why is that unfair?

22 ATTORNEY BLAIR: Objection to

1 form.

2 THE WITNESS: I unfortunately
3 don't have a better way to describe it
4 than to reflect the intentions in our
5 actual conversations.

6 BY ATTORNEY CRAIN:

7 Q. Okay. Okay.

8 All right. Let's keep going.
9 I want to talk about that asterisk a little bit.

10 Let's see . . .

11 Let's see . . .

12 ATTORNEY CRAIN: Actually,
13 let's go to Tab 62.

14 BY ATTORNEY CRAIN:

15 Q. Are you aware, Ms. Danforth, of a
16 document called Leapfrog's Guiding Principles.

17 A. I'm not off the top of my head.

18 Q. I'll show it to you. I'm just -- I
19 was curious if you knew of it.

20 ATTORNEY CRAIN: So this will
21 be Exhibit 20.

22

--o0o--

(Danforth Deposition Exhibit Number 20, Expert Panel's Guiding Principles on the Development of the Composite Leapfrog Hospital Safety Grade for U.S. Hospitals, marked for identification, as of this date.)

--o0o--

ATTORNEY BLAIR: And for the record, this is the expert panel's guide.

ATTORNEY CRAIN: Expert
panel's, yeah.

THE WITNESS: I'm sorry.
This doesn't have a Bates number
either.

Who produced this?

BY ATTORNEY CRAIN:

Q. It is pulled off the website, the public website. Your public website.

A. I am not aware of this document.

1 Is it leapfroggroup.org or
2 hospitalsafetygrade.org?

3 Q. I don't recall. One of the two.

4 Let me see.

5 Yeah.

6 Hospitalsafetygrade.org.

7 A. Um-hum. Can you just tell me what
8 heading it's under?

9 (Sotto voce comments by counsel.)

10 ATTORNEY CRAIN: Yeah, we
11 just got to it.

12 Okay. Are we -- we're good,
13 Cindy?

14 Okay. Great.

15 BY ATTORNEY CRAIN:

16 Q. So this -- so you don't recognize
17 this document, you're saying?

18 A. No.

19 Q. Okay.

20 ATTORNEY CRAIN: This -- for
21 the record, this is a document titled
22 Expert Panel's Guiding Principles on

1 the Development of the Composite
2 Leapfrog Hospital Safety Grade for
3 U.S. Hospitals.

4 THE WITNESS: So early on
5 when we were developing the Hospital
6 Safety Grade, we were, as I said,
7 working with Johns Hopkins Institute
8 for Patient Safety and Quality, and
9 Matt Austin -- we were also working
10 with another healthcare consulting
11 firm called Discern Consulting.

12 They had a convening role, I
13 believe, early on in bringing
14 together patient safety experts
15 because the review of existing
16 patient safety measures and
17 literature was quite extensive.

18 I cannot say for sure, but
19 this doesn't look like a,
20 quote/unquote, Leapfrog document.
21 This may have come from Discern
22 Consulting in their role of convening

1 and/or facilitating very, very early
2 meetings of the development of the
3 Hospital Safety Grade.

4 Is that clear?

5 BY ATTORNEY CRAIN:

6 Q. Sort of.

7 A. Okay.

8 Q. I guess I'm just wondering why it's
9 on Leap -- Leapfrog's public website.

10 A. I've never -- I was not aware this
11 was on our public website. That's why I asked
12 you which website you saw it on.

13 Q. Yeah.

14 A. I -- I --

15 Q. Okay.

16 A. -- was not aware that it was on our
17 public website.

18 Q. So I want to walk through this a
19 little bit.

20 A. May I read it just quickly? Just
21 so -- this is --

22 Q. Sure.

1 A. -- the first time I'm seeing this.

2 Thank you.

3 Q. Yeah.

4 (Whereupon, the witness reviews the
5 material provided.)

6 THE WITNESS: Okay.

7 BY ATTORNEY CRAIN:

8 Q. You're a fast reader.

9 A. I scanned it. I'm not.

10 Q. Okay. Let's -- let's start at the
11 top.

12 So The expert panel guiding The
13 Leapfrog Group on the development of the
14 Leapfrog Hospital Safety Grade has reached
15 consensus that the following principles will
16 guide their recommendations to Leapfrog for
17 calculating the grade.

18 Now, you are the Leapfrog
19 representative for the expert panel, correct?

20 A. Yes.

21 Q. Okay. But you don't -- you're not
22 aware of this document?

1 A. As I said, I think it may have come
2 from before -- when we first were developing the
3 Hospital Safety Grade, we did briefly work with
4 Discern Health in a convening way before we got
5 the expert panel up and running and turned
6 everything over to Matt Austin at the Armstrong
7 Institute for Patient Safety and Quality.

8 (Whereupon, as the certified
9 stenographer seeks clarification,
10 colloquy will not be captured on
11 the written record.)

12 ATTORNEY CRAIN: Institute.

13 THE WITNESS: Institute for
14 Patient Safety and Quality.

15 So my best guess is -- and,
16 again, it would have been 2012, 2013
17 that this is a product of
18 Discern Health in their convening
19 capacity.

20 BY ATTORNEY CRAIN:

21 Q. So are you saying that you don't
22 think the expert panel adopted this?

1 A. I'm saying that in my many meetings
2 of meeting with the expert panel and the
3 materials you've shown me today, I've not seen
4 this as a meeting material.

5 Q. And are you certain of that?
6 Because there have been times where you -- you
7 couldn't remember all the meetings.

8 A. I'm not.

9 Q. Okay.

10 A. But the use of the term "construct"
11 really stands out to me. Again, like, it's
12 something that we would have used, like, very,
13 very early on as we were constructing the
14 methodology for the Hospital Safety Grade, and
15 that's why I believe it could have been
16 Discern Health. And I'm not questioning that
17 the document exists. I'm just orienting myself
18 to it.

19 And I don't have an immediate
20 recollection of it, but I'm sure that if you
21 found it on our website, it is from our
22 website.

1 Q. Give me one second.

2 A. And under Construct, I see where it
3 says, The focus of the composite score is
4 patient safety, which is being defined as
5 freedom from harm, and that reflects other of
6 our materials.

7 So . . .

8 Q. Okay. So I want to -- I want to
9 talk through some of these points, the purpose
10 of a composite score, right.

11 It says, The purpose of the
12 composite score is to create a simple metric
13 that will improve consumer and purchaser
14 engagement around patient safety in U.S.
15 hospitals. Ideally, this increased engagement
16 will create additional market forces for
17 hospitals to improve the safety of care of
18 delivery.

19 Do you see that?

20 A. I do.

21 Q. Do you know what "the market forces"
22 are referring to there?

1 A. I don't.

2 (Whereupon, Attorney Blair, exited
3 the proceedings.)

4 THE WITNESS: I can say in
5 general one thing that we talk about a
6 lot at Leapfrog is that we really want
7 hospitals competing on patient safety.
8 So instead of saying we have the
9 fanciest birthing suites, we want them
10 to say we have the best patient safety
11 track record.

12 So given those
13 conversations, I can assume that when
14 we say create additional market
15 forces for hospitals to improve
16 patient safety of care, we mean we
17 wants hospitals competing on things
18 like low infection rates, low falls
19 rates and not just, you know, steak
20 dinners if you have a baby there, to
21 put it simply and concisely.

1 BY ATTORNEY CRAIN:

2 Q. I've been to different hospitals in
3 New York for that purpose, so I get it.

4 So --

5 A. It's a big thing.

6 Q. -- I -- I hear you.

7 So it -- it -- I want to harken
8 back to what we talked about this morning about
9 the restaurant grades --

10 A. Yeah.

11 Q. -- right.

12 Nobody goes to a C except for
13 the person when who wants the C pizza place,
14 right?

15 Is that the point of the
16 grades: the market forces of competition on
17 safety? People walk -- voting with their feet,
18 so to speak on safety, right?

19 A. So our experience is people don't
20 actually vote with their feet. I think we
21 really have seen that more than any other
22 affective way to drive hospitals to improve on

1 safety is for the hospitals to make safety
2 itself a priority, which why Safe Practice 1,
3 that leadership structure is -- again, it's
4 leadership engaged in safety -- is one of the
5 only measures that has stayed on our survey
6 almost since its inception and also in the
7 Hospital Safety Grade.

8 And so, you know, I think one of
9 the best and most effective, I guess, ways
10 we've seen hospitals really improve in this way
11 is to make that decision to improve.

12 I don't know that I have any
13 examples of what you just described, which is
14 patients --

15 Q. Voting with --

16 A. -- I think you said voting with
17 their feet.

18 Q. Yes.

19 Okay. So -- all right.

20 So let's keep going down this
21 document. And before -- I just -- well, I'll
22 come back to it.

1 Let's go to Imputing missing
2 data on Page 2.

3 Do you see that?

4 A. Yes.

5 Q. It says, When a hospital is missing
6 data for a particular performance measure, we
7 recommend ignoring the measure and recalibrating
8 the weights within the domain so that hospitals
9 are scored only on the measures for which their
10 performance data are available.

11 Do you see that?

12 A. I do.

13 Q. Now, that is not what Leapfrog does
14 today, right?

15 A. It is not what we do today.

16 Q. Okay. Leapfrog could do that with
17 respect to the four imputed measures, right?

18 A. Leapfrog's methodology has evolved
19 over the past 13 years. We haven't been doing
20 this for a number of years.

21 Q. Okay. But you could exclude hand
22 hygiene, for instance, right?

1 A. If the expert panel provided us with
2 some guidance and rationale on why we might
3 exclude hand hygiene, we would certainly have
4 that discussion with them.

5 Q. Okay. And the guidance and
6 rationale, for instance, could be that you have
7 no data on hand hygiene for nonparticipating
8 hospitals, right?

9 A. The expert panel can bring to us any
10 guidance or rationale they have for any change.

11 Q. Can I go back to something we talked
12 about earlier today? We talked about primary
13 and secondary data.

14 A. Yes.

15 Q. What is the secondary data source
16 for hand hygiene for nonparticipating hospital?

17 A. The imputed measure score we've been
18 talking about today.

19 Q. But that's not data, right?

20 A. And, again, we'll have to go back to
21 the transcript, but I believe what we talked
22 about and what I described, hopefully in not in

1 too much painful detail, is that those headings
2 are really meant to communicate that, first,
3 we'll look to see if there's a measure of score
4 available here and, if not, we'll go to this
5 other column or other category or other place to
6 look for a measure score.

7 We consider and the expert panel
8 considers imputed data data. And so that is
9 the secondary data source for those measures.

10 Q. So I -- I just want to make sure I'm
11 understanding this.

12 The -- the 15 score --

13 A. Yes.

14 Q. -- right, the limited achievement --
15 you're saying that is data?

16 A. Correct.

17 Q. Even though it's -- it could be 12,
18 it could be 20, it's still data?

19 A. An imputed score is a data point we
20 can use, correct.

21 Q. Well, I thought imputed -- im- --
22 imputation was -- was the process of taking the

1 data -- the score and put -- imputing it, right?

2 A. I'm sorry. I don't understand your
3 question.

4 Q. Yeah. Fair enough. It was a bad
5 question.

6 That was my first one today. I
7 admitted it was a bad question.

8 A. You looked confused too, so I was
9 like --

10 Q. Fair question.

11 So you -- you have -- we talked
12 about lots of different secondary sources this
13 morning, right?

14 A. Yes.

15 Q. The aha data -- we had our aha
16 moment, right? We had the historical data,
17 right?

18 The imputation model takes
19 those data and puts it into the score, right?

20 A. So --

21 Q. I just want an answer to my
22 question.

1 Yes or no?

2 A. I'm sorry, but I don't think the way
3 that you've explained that is correct --

4 Q. Okay. So if --

5 A. -- because --

6 Q. -- you can't answer it, that's fine.

7 A. -- I think you're confounding the --
8 the -- the term "imputation model" with imputed
9 data, which isn't -- and some other things. And
10 I'm sorry, but the way you're describing it and
11 the terms that you're using -- I don't believe
12 that that is correct, but, certainly, you can
13 ask again and --

14 Q. We'll try.

15 A. -- I'll try.

16 Q. So imputed data is -- is -- is the
17 -- the historical score for Step 1 is imputed
18 data, right?

19 A. So Leapfrog has a two-step
20 imputation --

21 Q. Yeah.

22 A. -- methodology, where Step 1, we

1 impute the historical past score from the last
2 two rounds of the Safety Grade --

3 Q. Yeah.

4 A. -- so based on the way I just
5 described it, yes, that's correct.

6 Q. Okay. Yes, it's correct, but the --
7 in that context, the historical score is the
8 imputed data?

9 A. Yes.

10 Q. Okay. In this Step 2, what is the
11 imputed data?

12 A. The numerical score assigned by
13 Leapfrog associated with the performance
14 category of limited achievement.

15 Q. And -- but that doesn't have an
16 external data source, right?

17 A. It is a reference to a point value
18 already assigned in other parts of Safety Grade
19 Methodology.

20 Q. Leapfrog just picked that number,
21 right?

22 A. It is associate -- Leapfrog did not

1 pick that number. As I described, a separate
2 national technical expert panel assigned those
3 values to each of the four performance
4 categories for each of those four measures, and
5 we aligned with those values for the purposes of
6 the Hospital Safety Grade.

7 Q. Okay. So let me -- let me go
8 passive voice.

9 The number was picked by
10 someone, right?

11 A. Yes.

12 Q. It didn't derive from an objective
13 calculation of data, right?

14 A. It was derived from a -- a separate
15 expert panel; that's correct.

16 Q. Okay. That's not my question,
17 though.

18 Is there any objective data
19 source where that number was derived from?

20 A. I'm sorry. Can --

21 Q. You're telling me who picked it,
22 right?

1 A. Right.

2 Q. The expert panel -- the separate
3 expert panel picked it.

4 I'm asking, Could that number
5 have been 20? Could it have been 5? Could it
6 have been 12?

7 A. Right. And what -- what I'm saying
8 is that when that panel went through that
9 process of assigning those values to each of the
10 four performance categories, my recollection --
11 and actually, we worked with Discern Health on
12 this as well because they helped us develop the
13 methodology for a value-based purchasing
14 program.

15 But my methodology is they used, I
16 think, something called maybe a Delphi process,
17 where there's sort of a process of looking at,
18 like, evidence, peer-reviewed literature and
19 other things.

20 So no, it's not just a simple
21 random assignment of a number. It was based on
22 a literature review and a scientific process to

1 assign those numbers to those performance
2 categories.

3 I just wasn't at Leapfrog when it
4 occurred. It actually predated even
5 Leah Binder. This would have happened probably
6 in 2006 or 2007 when these values were assigned
7 to these performance categories, but my
8 recollection and hearing how it was done is no,
9 it wasn't just someone saying how about 40; no,
10 35. It was a more scientific process than
11 that. I just can't speak to it.

12 So the way you worded your
13 question -- I'm not sure how to answer it based
14 on the fact that I know it wasn't a random
15 assignment of a number. It was a scientific
16 process that took into account peer-reviewed
17 literature, subject-matter expertise and other
18 components that I couldn't speak to.

19 Q. Okay. So for the imputed scores,
20 right, for hand hygiene again --

21 A. Yeah.

22 Q. -- which I got right this time --

1 A. Yeah.

2 Q. -- I'm learning -- you said it could
3 have been zero, right?

4 A. I said the imputed score could have
5 been zero. I did say that.

6 Q. So what's the objective basis of a
7 zero number?

8 A. I don't know because we -- we really
9 didn't have a long discussion about imputing
10 zero. One expert panelist, I think I mentioned,
11 made that recommendation. I don't remember any
12 discussion about the basis of imputing zero, and
13 we've never imputed zero.

14 Q. And I just want to make sure --

15 A. Sure.

16 Q. -- you've not reviewed a transcript
17 of the meeting, right?

18 A. I have not.

19 Q. But your recollection is that one
20 panelist made a specific recommendation of zero?

21 A. Yes, because it surprised me. So it
22 -- that's why I remember. And I believe it was

1 Arjun Srinivasan, but I -- we would have to
2 check the transcript.

3 Q. And was your recollection something
4 you recently were refreshed on or it's something
5 you remember?

6 A. No; it's something I remember.
7 Because it actually wasn't the first time that
8 someone had recommended that; it was the most
9 recent time.

10 On previous expert panel calls when
11 the expert panel makeup was slightly different,
12 we had a representative from the Agency for
13 Healthcare Quality and Research [sic]. I
14 talked to them -- I've talked about them a lot
15 today, AHRQ.

16 The representative's name was
17 Andrew Bindman, B-I-N-D-M-A-N. And I remember
18 during his conversations on the expert panel,
19 at one point, he threw out -- you know, we're
20 doing all of this work maybe with Mathematica
21 at that time, and he's like, We need hospitals
22 focused on patient safety. Let's -- I would

1 give them zeros, or something to that effect --

2 Q. Yeah.

3 A. -- and obviously, we didn't do that.
4 We kept on working our process with Mathematica.

5 But since Andy Bindman had said
6 that, I hadn't heard that really come up again.
7 And to me, it really represented, I think, a
8 shift in the focus of the expert panel to be,
9 you know, really locked in and zeroed in on --
10 on patient safety.

11 Q. On patient safety or on
12 participation?

13 A. On patient safety and wanting
14 information about patient safety.

15 Q. Are those two concepts separate to
16 Leapfrog, participation and patient safety?

17 A. I would argue that without Leapfrog
18 or CMS, it would just be difficult to know
19 anything about patient safety. As I mentioned,
20 when we were looking at my performance review,
21 I've looked high and low to find other patient
22 safety data available that's not from Leapfrog

1 or not from CMS. I'd love for someone else to
2 take on some of our measures so I can do more
3 with, say, hospital board and the emergency
4 department, but today, in 2025, if we're talking
5 about publicly available sources of information
6 about patient safety, it's Leapfrog; it's CMS.

7 The CDC publishes aggregated data,
8 but, certainly, you know, we are one of those
9 sources.

10 Q. Okay. Can we go back to the
11 guidelines document?

12 A. Yes.

13 Q. So I want to go back to the imputed
14 missing data section.

15 A. Yes.

16 Q. Let's look at the second paragraph.

17 In the situations where a
18 hospital does not have data available from the
19 primary data source for a particular performance
20 measure but an alternative data source is
21 available, data from the alternative or
22 secondary data source can be used in composite.

1 If data are used from a secondary data source,
2 attempts should be made to provide a grade that
3 is equitable to what the hospital would have
4 earned had the data been available from the
5 primary data source.

6 Do you see that?

7 A. I do.

8 Q. Is it Leapfrog's view, in the
9 corporate representative time, that that is what
10 the current imputation model does?

11 A. The current imputation model does
12 not do that, and the methodology in general has
13 not followed these principles in some time --

14 Q. Okay.

15 A. -- and that's why, like I said, I
16 think this must have been from the very, very
17 earliest days and, frankly, have not been
18 referenced by the panel, to my recollection or
19 knowledge, in any number of years.

20 Q. Yeah. The thing I -- I know you're
21 not the corporate representative for the
22 website, but I struggle with how a consumer

1 looking at this document would -- would
2 understand what Leapfrog is doing if there are
3 these big inconsistencies between this document
4 --

5 A. I'm --

6 Q. -- and the methodology.

7 A. -- struggling to understand how a
8 consumer could find this on our website.

9 Q. We found it.

10 A. I will -- the first thing I'll do
11 when I get home will be try to find it myself.

12 Q. Okay. So -- so I just want to go
13 back to that last sentence.

14 If data are used from a
15 secondary source, attempts should be made to
16 provide a grade that is equitable to what the
17 hospital will have earned had the data been
18 available from the primary data source.

19 Your view as a corporate
20 representative and personally -- if they
21 diverge, you can tell me -- is that is not what
22 Leapfrog does?

1 A. My view as Missy Danforth and the
2 corporate representative of Leapfrog is that the
3 thinking and guidance of the expert panel has
4 evolved over time, that's not captured in this
5 document. This document would not be considered
6 accurate in terms of expert panels guiding
7 principles.

8 Q. Okay. I just want to -- I'd like an
9 answer to my question. I get you have a
10 different point you want to make, but I -- and
11 so in this sentence, is this what Leapfrog
12 does -- let's see -- attempts should be made to
13 provide a grade that is equitable do what the
14 hospital would have earned had the data been
15 available -- available from the primary data
16 source?

17 A. Is this what Leapfrog does now
18 through our current Hospital Safety Grade
19 Methodology?

20 Q. The imputation method, yeah.

21 A. Yes. We make every attempt to find
22 other available data, which I've talked about

1 exhaustively.

2 If the fact exists that there is
3 not other available data -- but in terms of
4 effort to find other available data,
5 unquestionably, it is a significant focus of
6 all of the work we do, not just the Hospital
7 Safety Grade but also the Leapfrog Hospital
8 Survey.

9 Again, we spend lots of people time
10 and money to administer our free annual
11 Hospital Survey. We publish all of the survey
12 results for free on a free public website. And
13 we know over time, more and more important
14 patient safety and quality topics have emerged,
15 but we have limited room on our survey to ask
16 endless things. I think you pointed out it's,
17 you know, 300 pages long.

18 If CMS or the
19 American Hospital Association or the
20 Joint Commission or the Institute for
21 Healthcare Improvement were to take on any of
22 our measures in collection of that data and

1 publicly report it, we would absolutely use it.
2 We just have not been able to find anything
3 additional.

4 But in terms of effort and intent,
5 yes. Absolutely.

6 Q. So let me ask this question: Does
7 Leapfrog provide a grade that is equitable to
8 what the hospital -- nonparticipating hospital
9 would have earned had the data been available
10 from the primary data source?

11 A. So you're actually taking that out
12 of context --

13 Q. I'm asking --

14 A. -- because --

15 Q. -- a different question. I'm not
16 asking about the sentence --

17 A. Okay.

18 Q. -- I'm asking -- you can even
19 pretend the document doesn't exist.

20 A. Okay.

21 Q. If you want to look at it, because I
22 am reading the language, it may help.

1 A. I think that's why I'm confused.

2 Yes.

3 Q. I'm asking, Does Leapfrog provide a
4 grade for nonparticipating hospitals that is
5 equitable to what the hospital would have earned
6 had the data been available from the primary
7 data source?

8 A. Yes, I think we do.

9 Q. Okay. Let's go to the next page.

10 On top of 3, it says, If a
11 hospital is missing data for a large number of
12 performance measures, then a grade cannot be
13 reliably calculated. In this situation, no
14 grade should be issued for the hospital.

15 Do you see that?

16 A. I do.

17 Q. Does Leapfrog adhere to that
18 guidance?

19 A. Yes. And we've talked about it in
20 some detail --

21 Q. Yes --

22 A. -- hospitals missing measure --

1 Q. -- we have --

2 A. -- scores for more than six process
3 and structural measures, more than five outcome
4 measures are not issued a grade. Imputed
5 measures are not considered missing data. It's
6 considered a measure score that's used in the
7 calculation.

8 Q. So -- so that's what I wanted to get
9 at. That was my question, right.

10 We talked about -- we went
11 through all four imputed method -- method --
12 excuse me -- imputed measures --

13 A. Yeah.

14 Q. -- this morning, right?

15 And we went through the three
16 measures that you don't provide scores on for
17 nonparticipating hospital, right?

18 A. Correct.

19 Q. Okay. Without the imputation
20 methodology, that's seven process measures
21 missing, right?

22 A. Yes.

1 Q. Okay. So if the imputation
2 methodology was not applied, under Leapfrog's
3 guidance, you couldn't grade a nonparticipating
4 hospital?

5 A. No, not necessarily.

6 Q. Okay. Why?

7 A. So the missing data thresholds
8 themselves have actually evolved significantly
9 over the years. When we first started this in
10 2013, as I mentioned, we had slightly different
11 process and structural measures, slightly
12 different outcome measures, and the numbers of
13 the process and structural measures and the
14 numbers of outcome measures were slightly
15 different.

16 At any point, the expert panel can
17 evaluate -- as measures get added and removed,
18 added and removed -- those missing data
19 thresholds and determine if they agree or
20 disagree or recommend or provide guidance on if
21 those things should be changed.

22 So no, it's not necessarily true we

1 couldn't grade hospitals if they had more
2 missing data. Our expert panel could certainly
3 decide at any point they want to expand our
4 missing data threshold. And that's within
5 their role and capacity to do so.

6 They could say hospitals can be
7 missing 10 process and structural measures,
8 nine outcome measures, as long as they have
9 PSI 90.

10 Q. Absolutely. No, I -- so they could
11 -- forgive me. I'm going to say it this way:
12 They could juice the numbers in that way, right?

13 I know you'll say no because
14 I -- I said that that way, but that's what it
15 sounds like to me.

16 The question I have, then, is,
17 They -- they didn't do that, right? So
18 hospitals that don't participate are missing
19 seven process measures, right?

20 A. The expert panel does not view --

21 Q. I -- I just want an answer to my
22 question. I'm running low on time. If we can

1 just focus in.

2 A. No, they're not.

3 Q. The -- they're not what? Sorry.

4 A. They're not missing measure
5 scores --

6 Q. Okay.

7 A. -- for seven process and structural
8 measures --

9 Q. Okay.

10 A. -- they're missing measure scores
11 for three process and --

12 Q. Okay --

13 A. -- structural measures.

14 Q. -- fair enough. And you got me.

15 They're missing -- you are
16 missing data for seven of those measures from
17 the hospitals, correct?

18 A. Imputed scores are data points. Not
19 correct.

20 Q. Okay. You are -- I will go again.

21 You are missing any performance
22 data from the hospitals themselves for those

1 seven, right?

2 A. We're missing data from the
3 hospitals themselves.

4 Q. Okay. And so the only way to put
5 that data into Leapfrog's grading system is to
6 impute, right?

7 Let me -- let me revise it.
8 It's a long day for us all.

9 A. Yes -- no -- I know. I just want to
10 make sure I'm answering your question
11 accurately. So that one was long. I just need
12 to process it.

13 Q. Yeah, yeah. No. I get it.

14 If the imputation model was not
15 applied, there would be no way for Leapfrog to
16 have data for six process measures, correct?

17 A. If no imputation model existed,
18 theoretically, Leapfrog would not have measure
19 scores for those six process measures.

20 Q. Correct.

21 Okay. And then under
22 Leapfrog's guidance, which is publicly put on

1 its website, it could not grade the
2 nonparticipating hospitals, right?

3 A. No. The missing data thresholds
4 that you just described weren't established. I
5 don't see those numbers in this document.

6 Do you?

7 Q. No. I'm talking about the ones that
8 you just mentioned before, the six process
9 measures.

10 Right?

11 A. But I'm saying that number has
12 evolved over time. When this document was
13 written --

14 Q. Yes.

15 A. -- it would not have been that.

16 Q. I -- I -- I --

17 A. Oh, okay. I'm sorry --

18 Q. -- I'm setting that aside --

19 A. -- okay. I'm not following.

20 Q. -- I'm saying patients today looking
21 at Leapfrog's website -- which I know you're not
22 a corporate representative for. We don't need

1 to rehash that -- patients today looking at the
2 website will see that the Leapfrog did not grade
3 hospitals that lack information for the six
4 outcome measures, right -- process measures?

5 A. We don't specify which of the 22
6 measures need to be missing in order not to get
7 graded. So the way that you just asked that
8 question is not true.

9 As I described earlier, a very
10 small hospital, for example, that didn't have
11 enough patients to return those patient
12 experience surveys would be missing those five
13 patient experience measures. Maybe they don't
14 have an ICU, so it does not apply for ICU
15 staffing. And theoretically, they're, you
16 know, missing one other thing that takes them
17 to seven.

18 Hospitals that are not graded
19 can -- we don't say this hospital can't be
20 graded because they're missing this specific
21 measure and this specific measure and this
22 specific measure and this specific measure.

1 Q. So the Leapfrog's website says,
2 Hospitals missing more than six process measures
3 . . . are not graded.

4 A. Right.

5 But it's any six process measures.
6 You keep saying "these" six process measures,
7 and it's not correct. It's any six process and
8 structural measures. And as I've said, those
9 five patient experience measures are process
10 and structural measures, so they could be
11 missing those measures.

12 Q. Totally with you.

13 A. Oh, okay.

14 Q. I did not say "these" in that
15 question.

16 A. Oh, okay. I think --

17 Q. Because it does not say that on the
18 website.

19 A. Okay.

20 Q. And I'm -- you can see it's
21 highlighted.

22 A. Okay. I can't -- but I'll take your

1 word for it.

2 Q. Hospitals missing more than six
3 process measures . . . are not graded.

4 ATTORNEY WOOD: Objection to
5 form.

6 BY ATTORNEY CRAIN:

7 Q. Okay. I'll read it all for
8 Courtney.

9 Hospitals missing more than six
10 process measures, more than five outcome
11 measures, or PSI 90 are not graded.

12 Do you see that?

13 A. I don't see that. I --

14 Q. I'm sorry. Are you aware of it?

15 A. I -- I believe that that's wherever
16 you say it is because you're reading from a
17 document.

18 Q. That's consistent with what you
19 testified today about what -- about the missing
20 numbers that are not graded, right? We talked
21 about the -- exactly those numbers earlier
22 today, right?

1 A. The six process -- yes. In terms of
2 the number of missing measure scores, yes.

3 Q. Okay.

4 A. Yes.

5 Q. So --

6 A. Based on the 2025 -- Spring 2025
7 scoring methodology that we've been looking
8 at --

9 Q. -- you don't think it's a little --

10 A. -- yes.

11 Q. -- bit confusing that Leapfrog is
12 actually missing hospital performance data for
13 seven outcome measures -- process measures -- I
14 always say that wrong -- process measures but is
15 telling people on its website that they don't
16 grade when six are missing?

17 A. I don't think that's confusing
18 because they're not missing. If you look on,
19 like, the Delray, they don't have seven blanks,
20 process and structural measure scores. So I
21 don't -- I guess I don't think that's confusing.

22 Q. So what does "missing" mean?

1 A. Not available from the primary or
2 secondary or other sources. Again, like, I wish
3 I had a better way to describe this, but --

4 Q. I do, too.

5 A. -- we're looking at the existence of
6 a measure score, and the existence of a measure
7 score includes imputed data, and I -- I
8 described with, say, CMS imputing that patient
9 racial and ethnicity data, that is real data.
10 That is real data they make calculations on --

11 Q. For sure.

12 A. -- and they represent to hospitals.

13 When we impute data, it is also
14 real data that we make calculations on. We
15 don't consider imputed data missing data. It
16 is a data point that is used in a mathematical
17 calculation.

18 Q. And I'm totally with you for
19 historical data for the means. That is -- those
20 are real numbers. What I'm still not
21 understanding is -- limited achievement just
22 seems to be -- and I'll use Ms. Campione's word

1 the other day -- an arbitrary number.

2 A. I understand that Ms. Campione used
3 that word. Ms. Campione didn't know the
4 historical background of how those numbers were
5 assigned, and, in fact, they're anything but
6 arbitrary. As I said, they were scientifically
7 assigned, and that's why there's variation among
8 them, by a technical expert panel that was
9 administered by Discern Health before I got
10 here. They're not arbitrary. They were done in
11 a -- a scientific way and in a scientific
12 process.

13 Q. And before Ms. Binder got there,
14 right?

15 A. Yes. I believe it would have been
16 2006 or 2007.

17 Q. Okay.

18 A. And the reason I know that is
19 because the original CEO of The Leapfrog Group,
20 Suzanne Delbanco, passed very young due to
21 cancer. And during her memorial, people were
22 sort of retelling stories --

1 Q. Got it.

2 A. -- and one of those people was from
3 Discern Health and said, Actually, I've been
4 working with Leapfrog for even longer, and I
5 actually was the one working on this value-based
6 purchasing program.

7 And so it's very fresh in my mind.

8 Q. So -- and I -- I don't mean to be
9 glib, and I'm -- I'm very sorry for her early
10 passing, but your understanding of how the
11 limited achievement numbers came to be is from a
12 memorial service, or is it from another source?

13 A. No; it's from -- I administer that
14 program now, and so I have some historical
15 background. I just don't have the physical
16 documents showing --

17 Q. Okay.

18 A. -- the meeting minutes and all of
19 that because it happened before my time, and
20 those weren't necessarily passed on to me. But
21 I was made aware by Discern Health that that was
22 the process because I asked that same question

1 early on.

2 Long before we did the Safety
3 Grade -- again, those values are used in our
4 value-based purchasing program, and so, you
5 know, as we've added measures to the
6 value-based purchasing program, over time,
7 we've had to assign numerical scores to those
8 performance categories. And Discern Health did
9 that scientific process for that different
10 technical expert panel. I just don't have
11 access to the exact meeting minutes notes
12 process that they use.

13 Q. Okay. Have you reviewed the expert
14 reports in this case?

15 A. Have I reviewed the expert reports?
16 For our witnesses or your
17 witnesses?

18 Q. Any.

19 A. Yes.

20 Q. Which -- which ones?

21 A. Both.

22 Q. Okay.

1 A. And I would call it a thorough scan.
2 I'm not going to be able to word-for-word
3 recite, but I have seen expert witness
4 testimony.

5 Q. Okay. Just reports, not test -- or
6 there is some testimony.

7 Have you --

8 A. PDFs.

9 Q. PDFs. Okay.

10 Is it a transcript that you've
11 reviewed, or it's like a written report?

12 A. No; it's -- it's a written report.

13 Q. Okay. And are you aware of any
14 explanation in those expert reports of how the
15 limited achievement number was assigned?

16 A. Am I aware of any explanation of
17 those expert reports of how the . . .

18 I'm not.

19 Q. Okay.

20 A. I don't know how they would have had
21 that information.

22 Q. Yes.

1 I just want to go to one last
2 thing. If you go back to Exhibit 6 -- just so
3 you know I'm not making it up. You'll see when
4 you get there.

5 A. Yeah.

6 Q. Exhibit 6 is the June 14th, 2017
7 meeting.

8 I don't think you have the
9 right document, do you?

10 A. No.

11 Oh, mine has two numbers. I'm
12 sorry.

13 Q. Oh, yeah, there may be --

14 A. Each document has --

15 Q. It's the pink 6.

16 A. Okay. Give me a minute.

17 Q. It's going to be hard for trial.

18 A. I said I put them out of order and
19 didn't want to --

20 Q. No worries.

21 A. -- spend time putting them back in
22 order, but now I can't find it.

1 Six?

2 Q. Got it?

3 Oh, 6, yeah.

4 A. No.

5 Q. Oh, all the way at the bottom.

6 It's the last one. I think it
7 is.

8 Six?

9 A. No. This is 20, so -- I'm sorry.

10 Q. Here, let me just show you what I
11 have as Exhibit 6.

12 A. I did not lose any documents. I
13 want to be very clear.

14 Q. This is what I have as Exhibit 6,
15 and I just wanted to show you that point.

16 Do you see where it says
17 Guiding Principles?

18 A. I do now. I did not when I --

19 Q. Okay.

20 A. -- originally -- oh, from 2017. No,
21 I --

22 Q. 2017.

1 A. Oh, I do now see it --

2 Q. Got it? Okay.

3 A. -- and --

4 Q. Do you have any reason to think that
5 the document we looked at, the Guiding
6 Principles, is not the one referenced in that
7 meeting minutes?

8 A. Only because it's not dated, and --
9 and, again -- so I -- I can't attest. I
10 apologize, but --

11 Q. And you don't recall what was
12 discussed in that regard at the meeting?

13 A. No. And if you remember when I told
14 you about this in-person --

15 Q. Yeah.

16 A. -- meeting, I said I actually didn't
17 remember even having in-person meetings. They
18 were very rare. It said we were in Alexandria,
19 Virginia. The last in-person expert panel
20 meeting I remember was in Baltimore because
21 everyone wanted to be near an airport. So I --

22 Q. No worries.

1 A. -- didn't -- and I apologize. When
2 I scanned this -- I do see it now. So I wasn't
3 --

4 Q. I just wanted to make sure --

5 A. I just -- I just misstated. So I
6 apologize, for the record.

7 Q. No worries. I --

8 A. And I can't confirm whether or not
9 that's what was reviewed because it's not dated,
10 and I don't know what those meeting minutes
11 would be.

12 Q. Great. Okay.

13 A. I have to stop scanning things.

14 Q. Yeah.

15 ATTORNEY CRAIN: Let's go
16 off.

17 ATTORNEY WOOD: Yeah. It's
18 got to be close.

19 THE VIDEOGRAPHER: Going off
20 the record. The time is 1730.

21 --oOo--

22 (Whereupon, a recess was taken from

1 5:30 p.m. EDT to 5:47 p.m. EDT.)

2 --oOo--

3 --oOo--

4 (Danforth Deposition Exhibit Number
5 21, E-mail string, Bates stamped
6 LEAPFROG00244555 through
7 LEAPFROG00244558, marked for
8 identification, as of this date.)

9 --oOo--

10 THE VIDEOGRAPHER: Going back
11 on the record. The time is 1747.

12 ATTORNEY CRAIN: Great.

13 BY ATTORNEY CRAIN:

14 Q. Welcome back, Ms. Danforth.

15 A. Thank you.

16 Q. Glad you're enjoying the -- the
17 sparkling water.

18 A. Oh, my gosh, you're telling me.

19 Q. So I -- I've given you a document
20 from May of 2024.

21 Do you see that?

22 A. Yes.

1 Q. And it's an e-mail -- it's a thread
2 between you, Ms. Campione and Paulina Litter.

3 Do you see that?

4 A. Yes.

5 Q. And I don't think we've -- I don't
6 recall talking about her today.

7 Who is Paulina Litter?

8 A. I believe her last name is
9 pronounced Litter.

10 Q. Litter. Okay.

11 A. But she was a employee at Leapfrog
12 whose position title I don't remember.

13 Q. It says senior specialist,
14 operations and special projects --

15 A. Oh, sorry.

16 Q. -- at the top.

17 A. Yes.

18 Q. Okay.

19 A. Yes. She did not work on my team.

20 Q. Got it.

21 Okay. So I'm going to go to
22 the bottom, which is the first e-mail on

1 Page 244558.

2 Do you see that?

3 A. I do.

4 Q. And am I -- is it fair to say that
5 this is a -- this is the process through which
6 that footnote we've been talking a lot about was
7 ultimately drafted? Is that what this looks
8 like to you?

9 A. Probably, yes.

10 Q. Okay. So it's an e-mail from her to
11 you, and she says, Hi, Missy. Paulina is going
12 to talk to Devon tomorrow. I thought more on
13 it, and I don't think getting four columns to
14 flag imputation for the four measures is a big
15 lift. I think asterisks might create issues for
16 them, and having the imputation text for every
17 hospital will create confusion.

18 Do you see that?

19 A. Yeah.

20 Q. Okay. So I'm just going to take you
21 up where they start drafting what the footnote
22 is.

Page 537

1 A. Yes.

2 Q. And if you go to Page 244556.

3 A. I am there.

4 Q. And Ms. Campione proposes, Is this
5 what you have in mind? And she says, Text.

6 Do you see the asterisk on the
7 bottom?

8 A. Yes.

9 Q. She says, The hospital declined to
10 report data for this measure, so secondary data
11 was imputed using Leapfrog's imputation
12 methodology.

13 Do you see that there?

14 A. Yes.

15 Q. And we've talked a lot today about
16 second data -- secondary data and the imputation
17 methodology, right?

18 A. Yes.

19 Q. Now, you respond as 4:07 p.m.

20 Do you see that?

21 A. Yes.

22 Q. And you say, Yes, maybe . . . -- or

1 colon So a score was imputed for this
2 measure " instead of secondary data.

3 Do you see that?

4 A. Yes.

5 Q. So you took out the language
6 "instead of secondary data"?

7 A. So I was the one who actually
8 received the help desk ticket comment that we
9 reviewed today basically saying, You need to be
10 really up-front about how you're doing this on
11 the website. I took that to heart and really
12 wanted to be up-front that this was a score that
13 was imputed that was assigned, et cetera. I was
14 really trying to stay away from saying it was a
15 score that was calculated or a score that was
16 derived. I was trying to be -- to be frank,
17 just as plain as possible.

18 And so the score was "assigned";
19 the score was "imputed." I think we ended up
20 going with "assigned." We don't use terms like
21 "primary data" versus "secondary data," really,
22 on this particular part of our website that

1 I'm, like, familiar with. It's really to help
2 hospitals understand because, again, like, we
3 have tried to be as transparent as possible
4 with hospitals, so that's typically how we use
5 those terms.

6 And so here I was trying to convey,
7 you know, Let's use "impute." I think I say
8 something like that.

9 Q. Okay. And when you say -- just
10 going back, you said you don't use "primary" and
11 "secondary" data.

12 You use it on the 28-page
13 document we looked at, right?

14 A. Yes.

15 Q. Just not on the -- the website?

16 A. Like, on the gas gauge page --

17 Q. Yeah.

18 A. -- we refer to data sources, and in
19 that table, you can see all those data sources.
20 That's actually where it's referenced.

21 But on these footnotes, I was just
22 trying to be as short and plain and

1 straightforward as possible in making a
2 suggestion or recommendation.

3 Q. Okay. And you said you didn't want
4 to use the word "calculated" --

5 A. Correct.

6 Q. -- why is that?

7 A. As I've described, it wasn't
8 calculated. It was assigned.

9 Q. Okay. And the same thing with
10 "derived."

11 You said you didn't want to use
12 the word "derived"?

13 A. Oh, did I say that? I'm sorry.

14 Q. You did. I can read it back, if
15 it's helpful.

16 A. Okay. I didn't want to use
17 "calculated."

18 Q. Okay. Are you saying you -- you
19 were okay with "derived"?

20 A. I don't usually use that word.

21 Q. Okay.

22 A. I don't know where that just came

1 from, but I didn't want to use "calculated."

2 Q. Okay. Okay.

3 A. Sorry.

4 Q. Okay. And then Ms. Campione
5 responds. She goes, Like this? Text:
6 Asterisk, The hospital declined to report data
7 for this measure, so a score was imputed for the
8 measure.

9 Do you see that?

10 A. Yes.

11 Q. And then you say, Yes, in this
12 e-mail on the next page?

13 A. Yes. But there must have been more
14 e-mails because that's not what we went through.

15 Q. Yeah, subsequently you change it to
16 "assign."

17 A. Okay. Yeah, so this was just
18 spitballing, yeah.

19 Q. Yeah. And -- and you ultimately
20 land on the "assign" language.

21 A. Correct.

22 Q. And why "assigned" versus "imputed"?

1 A. I think someone must have said to
2 us, "Imputed" might not be a consumer friendly
3 word. How about "assigned"?

4 And I said, Yes, it was assigned.
5 I honestly have -- I have no idea.

6 Q. Okay.

7 A. I'm conjecturing.

8 Q. Okay. All right.

9 A. I -- I take it this far, and then
10 it -- all the rest of the e-mails will have
11 other people's names on it.

12 Q. I'm trying to see if we can get that
13 e-mail for you.

14 A. Yeah.

15 Q. Yeah. Okay.

16 ATTORNEY CRAIN: Let me --
17 can you give me that -- the sequence,
18 Emily?

19 ATTORNEY WOOD: The --

20 ATTORNEY CRAIN: Yeah.

21 BY ATTORNEY CRAIN:

22 Q. I want to ask you about something we

1 talked about earlier today.

2 A. Okay.

3 Q. Just go back to something. So on --
4 we talked about -- so we talked about the
5 financial risk e-mail.

6 Do you remember that
7 discussion?

8 A. Yes.

9 Q. You had -- you testified that you
10 had just gone into that role, and so you were
11 asking to figure out the way the licensing
12 system worked, right?

13 A. For accolade specifically, yes.

14 Q. Yes. And just to be clear, were you
15 more knowledgeable about other licensing?

16 A. No. I just --

17 Q. For that e-mail, you're saying?

18 A. For this e-mail, I -- yes.

19 Q. Okay. I just wanted to make sure.

20 So you've been in the role now
21 for almost two years, right?

22 A. Yes.

1 Q. Okay. And now that you are no
2 longer new in the role of overseeing both
3 ratings and licensing --

4 A. Yes.

5 Q. -- what is the financial risk to --
6 to Leapfrog from hospitals not participating in
7 its survey?

8 A. I couldn't quantify any financial
9 risk to Leapfrog for hospitals not participating
10 in its survey.

11 Q. Is -- are you saying there's no
12 financial risk to Leapfrog if participation goes
13 down?

14 A. I could not assess any financial
15 risk to Leapfrog if participation goes down. As
16 I mentioned, participation has fluctuated over
17 the years between 2,300, 2,400, approximately.

18 The way that our data sets are
19 priced -- and, again, it's Leapfrog Hospital
20 Survey results, those score results. So
21 basically instead of four cell phone bars, it
22 says in the Excel file "achieve the standard."

1 The Leapfrog ambulatory surgery center results,
2 same thing, instead of those cell phone bars
3 you see in our public reporting website, it
4 would say "achieve the standard." The Hospital
5 Safety Grades -- I'm sorry.

6 Q. I'm just confused because I don't --
7 I don't see how it's responsive to my question.

8 My -- my question is -- and
9 forgive me for -- you know, my question is, Is
10 there any financial risk to Leapfrog from a
11 decline in participation?

12 Yes or no?

13 A. No, that I can assess.

14 Q. Okay. None at all?

15 A. None that I can assess.

16 Q. And why do you qualify with "I can
17 assess"?

18 A. I have been in this role for two
19 years. I don't necessarily do things like
20 financial modeling or -- I really just make sure
21 that the data is correct. I help coach --
22 oversee contracts. I'm not necessarily doing

1 financial risk analysis in -- in any way.

2 Q. Okay.

3 A. I also haven't had any opportunity
4 to have input on basically what you just
5 described. Basically any kind of modeling,
6 looking at financial risk is not something I've
7 done in the past two years.

8 Q. Okay. And so you are -- you are the
9 corporate representative for licensing, right?

10 A. Correct.

11 Q. Leapfrog has no view as a corporate
12 entity that if participation declined, that
13 could reduce revenue?

14 A. Because of the way our contracts are
15 structured --

16 Q. Hold -- hold on.

17 A. -- it would not necessarily reduce
18 revenue.

19 So I do have an opinion. I guess
20 the answer would be no.

21 Q. Okay.

22 A. Can I talk a little bit about the

1 structure?

2 Q. Yes. I wanted to get the -- get
3 your opinion first.

4 A. Okay.

5 Q. So Leapfrog's view is if
6 participation declined --

7 A. Yes.

8 Q. -- you would not lose revenue?

9 A. Correct.

10 Q. Okay. Why is that?

11 A. So the -- the way that our data
12 licensure contracts are structured now -- so now
13 we're not talking about the Accolades, those
14 designated logos. So the way our data licensure
15 contracts are structured is because they often
16 take a very long time to negotiate those
17 agreements -- it can be upwards of a year --

18 Q. Yes.

19 A. -- or even longer, we often include,
20 like, auto renewal terms. And once we have a
21 data licensee enter into a data licensure
22 agreement with auto renew, we've historically

1 seen that they continue to license those data
2 just empirically as the number of hospitals
3 included in the data sets that have data
4 available has fluctuated over time.

5 I've not known of any feedback that
6 now we don't want to license the data, we've
7 not seen any data licensee stop licensing the
8 data due to survey participation. I've never
9 had a data licensee ask me about survey
10 participation or the number of hospitals
11 participating.

12 So in that way, I -- the answer --
13 my answer would be no.

14 Q. Okay. Let me ask this question,
15 then.

16 See, when I say it that way,
17 I'm buying time to frame the question in my
18 head. We all -- we all have our tricks, right.

19 If Leapfrog stopped grading
20 nonparticipating hospitals, just stopped
21 altogether, do you believe participation would
22 go down in the survey?

1 A. No.

2 Q. Okay.

3 A. No. We have hundreds of hospitals
4 that will never be eligible to receive a
5 Hospital Safety Grade who for years and years
6 have participated in the
7 Leapfrog Hospital Survey. Again, the Safety
8 Grade is really the sort of narrow construct --
9 I think we just saw that word -- focused on
10 patient safety, but a Leapfrog Hospital Survey
11 includes measures about maternity care and
12 pediatric care, inpatient surgery, outpatient
13 surgery. It's used to compare outpatient
14 surgery in hospitals to ambulatory surgery
15 centers.

16 So there's all kinds of hospitals,
17 and I've spoken about this previously, like
18 pediatric hospitals, critical access hospitals,
19 that have and do and continue to do the survey
20 regardless of the Safety Grade and who have
21 never gotten a Safety Grade and still do the
22 surveys, so I wouldn't see that as being a

1 factor.

2 Q. Is there any connection at all
3 between the Safety Grade and hospitals'
4 decisions to participate in the survey?

5 A. I'm sure some hospitals make the
6 decision to participate in the survey because
7 some of those measures are used in the
8 Safety Grade, but before we started doing the
9 Hospital Safety Grade, we had hundreds of, you
10 know, thousands of hospitals.

11 So, yes, the answer is probably
12 yes, some.

13 Q. Okay. So --

14 A. Not all, and, again, hundreds of
15 hospitals do the survey that aren't even
16 eligible for a Safety Grade.

17 Q. Got it. Okay. Understood.

18 A. Okay. Yes.

19 Q. But if -- okay. So if fewer
20 hospitals ended up submitting data in the
21 survey, would that make the data set that
22 Leapfrog collects less complete?

1 A. Would that make the data set that
2 Leapfrog collects less complete?

3 I guess I, personally, have never
4 talked about our data set as being complete or
5 incomplete. The data licensees that we work
6 with are oftentimes, like, state-based or
7 regional in nature. And so complete to them
8 may be hospitals in our network or hospitals in
9 our state, not necessarily hospitals across the
10 country. So I don't know that I've or Leapfrog
11 has made the connection between how many
12 hospitals are in the data file versus a data
13 being complete.

14 I think we talk about the data
15 being complete as these minimum data
16 requirements that we talked about earlier
17 today, meaning that all hospitals submitting a
18 survey are required to report on those
19 Sections 1, 2, 4, 5, 6 and 7. That's how we
20 tend to talk about data completeness, is that
21 we have those minimum requirements.

22 And to be clear, for the Ambulatory

1 Surgery Center Survey, all sections are
2 required. So there's five sections to that
3 survey, and all are required in order for them
4 to submit the survey.

5 Q. If fewer hospitals participate in
6 the survey, Leapfrog has less data, right?

7 A. We would have less data on those
8 hospitals, yes.

9 Q. Think -- think you had to go with me
10 on that one. It's just a numerical --

11 A. Yeah. It just -- it's not a --

12 Q. -- it's just a number?

13 A. -- a -- a value -- right. It's a
14 number. I can't assess a value to it, right.

15 Q. Okay. A data set that is less
16 complete is worth less than a data set that is
17 more complete, right?

18 A. Can you give me an example?

19 Q. If you had a data set of 30
20 hospitals, presumably, that would be less
21 valuable than a data set that included 2,000.

22 A. Right. And that's where I'm saying,

1 no, that's not the case. We have a health plan,
2 I think, in Massachusetts, and I think the data
3 that they request is probably for 30 hospitals.
4 And they've been licensing those data and
5 renewing it for years and years and years. And
6 so, again, it really depends.

7 The -- the uses are so variable by
8 each -- because it's not all these national,
9 you know, health plans or national employers.
10 A lot of times, it might be a small or regional
11 data user. It could be a researcher. And
12 maybe the thing they care about is, you know,
13 C-section rates. So to them, completeness is
14 actually just I need as many C-section rates
15 for as many years as you have.

16 So this question is not -- this
17 answer is not evasive. It is literally what
18 the data licensees tell me -- it's what they
19 tell me. This is first -- this is firsthand
20 what they told me, not what I've heard --

21 CERTIFIED STENOGRAPHER: Excu
22 se me. Sorry. Could you -- could you

1 repeat that?

2 ATTORNEY CRAIN: She said,
3 This is first --

4 THE WITNESS: This is
5 firsthand what they told me, not --
6 not what -- not what I've heard.

7 And so, you know, the value
8 of the data to them is based on who's
9 in it and who they want to use.

10 BY ATTORNEY CRAIN:

11 Q. So you oversee the licenses, right?

12 A. Yes.

13 Q. And you are the corporate
14 representative --

15 A. Yes.

16 Q. -- for licenses?

17 Can you tell me generally what
18 percentage of licensees fall into the different
19 categories you mentioned? So national
20 insurers -- approximate -- ballpark, how many of
21 your licensees are national insurers?

22 A. Two.

1 Q. Out of how many?

2 A. Thirty -- 30 or 35.

3 Q. Okay. So 30 or 35 total licensees?

4 A. Yep.

5 Q. What are the two?

6 A. Elevance and . . .

7 Q. Is one of them Centene?

8 A. No. That's not a national health
9 plan. It -- so it's United, but it's not
10 actually United that licenses the data. They
11 have, like, a subsidiary --

12 Q. Got it.

13 A. -- that licenses the data. But I
14 believe they're technically affiliated with
15 UnitedHealthcare.

16 Q. Okay. And how many employers?

17 A. How many employers licensee the
18 data? One employer group.

19 Q. Okay. Which one?

20 A. Purchaser Business Group on Health.
21 And they're in California. They used to be
22 Pacific Business Group on Health.

1 Q. Okay. And how many, like,
2 individual researchers?

3 A. I didn't include the researchers in
4 that number because they often get the data for
5 free --

6 Q. I see.

7 A. -- so I included, like, the 0 or 35
8 -- these are organizations that we charge --

9 Q. So --

10 A. -- money to --

11 Q. -- okay. Let me fix -- let me make
12 it easier on you --

13 A. Okay.

14 Q. -- of the 35, what -- what are the
15 rough numerical buckets of -- that -- that's in
16 that 35?

17 A. Okay. So there's organizations,
18 like solutions providers, right, so what you
19 might think of as, like, healthcare vendors that
20 may license the data for, like, internal use,
21 like business development, that kind of thing.

22 We have a couple states --

1 California, Massachusetts -- that license the
2 data so they can do some benchmarking just for
3 hospitals in their state. So one is called
4 CHIA, C-H-I-A, and they're, like, a public
5 health organization --

6 Q. Okay.

7 A. -- in Massachusetts.

8 So there's a lot of little buckets.
9 I'm just --

10 Q. Yeah.

11 A. -- I'm going to -- those are little
12 buckets.

13 So health care solutions providers
14 are vendors -- you might think of them --

15 Q. Yeah.

16 A. -- a lot of those are for internal
17 use.

18 These state-based organizations or
19 agencies -- we talked about the national health
20 plan. We have some regional health plans. So
21 Health Net actually licenses the data, but they
22 only administer health insurance products in

1 California and maybe part of Oregon. They're
2 not -- they're not national in scope.

3 Blue Cross Blue Shield,
4 North Carolina, Blue Cross Blue Shield of
5 New Jersey, and then Capital Blue Cross and
6 Blue Shield, which is just this little weird
7 market in Pittsburgh.

8 We also have -- I don't know how
9 you would define them in a way that's easy, but
10 we call them "value-added resellers." It's
11 basically organizations who have data of their
12 own. They license Leapfrog's data and combine
13 it with their own or other data, and they
14 resell it as their own independent product to
15 whoever they want. And we don't necessarily
16 know who that is, but we've given them
17 permission to do that.

18 And one example would be
19 Embold Health. They collect physician data,
20 and they do physician ratings. They pair some
21 of that with our facility-level ratings, and
22 they have a separate and independent product --

1 Q. Okay.

2 A. -- and that would be another
3 category.

4 Q. Any others you can think of?

5 A. Yes. So the other category -- and
6 this is -- I'm not sure -- they are a healthcare
7 -- consultants -- I would call them
8 "consultants," so, like, Premier, which I think
9 is, like, a healthcare consulting organization.
10 So that would be the other group. And it's just
11 Premier.

12 So I would say the consultant,
13 value-added resellers, regional and national
14 health plans, solutions providers, employers
15 and purchasers.

16 Q. Great presentation.

17 My question --

18 A. I had nothing to read off.

19 Q. Very impressive, your buckets.

20 Of those 35 -- and, again, not
21 a memory test, so I'm just asking for your best
22 estimate even though you are passing the memory

1 test -- what -- what portion of those 35 or so
2 license Leapfrog's complete set of data versus a
3 smaller set of data?

4 A. So if the organization or an
5 individual wants a less -- like, not the full --

6 Q. Yeah.

7 A. -- Leapfrog Hospital Survey results
8 but maybe they just want infection rates for
9 Connecticut for 2024, that falls under what we
10 call "data products." And I believe you've seen
11 our financial statements. So data licensure --
12 data products is separate --

13 Q. Okay.

14 A. -- we have very few organizations
15 that are licensing these one-time data products.

16 Q. Okay. So the 35 license the
17 complete set?

18 A. The 35 have an annual license.

19 Can I just describe what that
20 means?

21 Q. In brief.

22 A. Okay. So there's three different

1 data sets, and you can think of it as three
2 separate Excel files: Leapfrog Hospital Survey
3 results, Leapfrog ASC Survey results, Leapfrog
4 Hospital Safety Grades.

5 So 30 to 35 license one of those
6 three data sets I just talked about --

7 Q. Got it.

8 A. -- for the Leapfrog Hospital Survey
9 and the Leapfrog Ambulatory Surgery Center
10 Survey. Because those surveys are on a rolling
11 basis, the data is delivered to them and
12 refreshed on a monthly basis beginning first in
13 July and going all the way to February. So
14 they're getting updates all the time.

15 For the Hospital Safety Grades,
16 because we're issuing grades twice a year --

17 Q. Yeah.

18 A. -- they're getting those files twice
19 a year.

20 Q. Fair -- fair enough. No --

21 A. Okay.

22 Q. -- so my question -- so on those

1 three files --

2 A. Yes.

3 Q. -- let's say it's the survey file --

4 A. Yes.

5 Q. -- to take an example.

6 It's every hospital that
7 participates in the survey?

8 A. No; it's every --

9 Q. Okay.

10 A. -- hospital on our roster. And so
11 whether a hospital participates in our survey or
12 not, they're included in the file.

13 So I believe you've seen --

14 Q. I see.

15 A. -- our public reporting website,
16 leapfroggroup.org --

17 Q. Yeah.

18 A. -- so you can see how you can search
19 for hospitals, and it comes up as Decline to
20 Respond. Any hospital searchable on that
21 website is in that file. You can think of that
22 file as a distillation derived from -- I will

1 use it -- derived from our public reporting
2 website.

3 Q. And calculate -- no.

4 That's very helpful.

5 Okay. So all -- okay.

6 So another question we have --
7 so if fewer hospitals participate in the survey,
8 would that impact Leapfrog's brand?

9 A. Not in the immediate term. I mean,
10 if every hospital in the country stopped
11 participating in the survey, that would impact
12 Leapfrog's brand. But like I said, over the
13 years, we've had fluctuations in survey
14 participation. I've not seen an impact on our
15 brand. I've not heard anyone talk about that
16 impacting our brand, and that's as Leapfrog.

17 Q. So -- so let me -- let me just, like
18 -- if -- if Leapfrog stopped grading
19 nonparticipating hospitals and some certain
20 percentage of hospitals say, Great, we don't
21 have to do the survey anymore because we won't
22 be penalized -- I know that's not your position,

1 but just --

2 A. Yes. I -- I'm following.

3 Q. -- follow me.

4 Let's say a certain
5 decent-sized percentage decided not to
6 participate anymore --

7 A. Yeah.

8 Q. -- would that have any financial
9 implications to Leapfrog?

10 A. I don't believe it would. And,
11 again, that's because, in the past, we've seen
12 those kind of fluctuations. And the way that
13 our licenses are structured and so few of them
14 being national, I -- I honestly can't imagine
15 that would have financial ramifications.

16 We --

17 Q. What -- what if, like, half of
18 hospitals stopped participating?

19 Still no impact?

20 A. Maybe, but I -- I'm not sure.

21 So can I tell you the feedback that
22 I do get about -- so mostly what we hear from

1 people who don't license the data, right -- so
2 people who we talk to about the data are like,
3 No, we're not paying you for this; they don't
4 license the data -- it's not because there's
5 not enough hospitals or it's not because -- I
6 mean, I guess sometimes it might be there's not
7 enough hospitals in my state.

8 The biggest reasons have tended to
9 be you don't have the measures I'm looking for.
10 And I've talked a lot today about I -- I want
11 to -- I'd love to give some measures away and
12 add some more.

13 The hardest topics right now are
14 things like behavioral health safety and
15 quality; oncology care safety and quality; more
16 specific types of orthopedic care, like joint
17 replacement, spine safety and quality.

18 So when people tell us we don't
19 want to license your data, we don't want to pay
20 for the data, the resounding theme has been
21 because you don't have these behavioral health
22 measures, and that's what we're looking for;

1 you don't have this oncology data, and that --
2 and that's what we're looking for.

3 So when I think about sort of
4 growing the data licensure program, I'm looking
5 for opportunities to collect data on different
6 topics that potential data licensees tell us
7 they're interested in, like behavioral health
8 oncology, et cetera. That's how I, in this
9 role, have framed those conversations.

10 Q. Sorry.

11 A. It doesn't make me paranoid at all,
12 so . . .

13 Q. For the record, I was conversing
14 with my cocounsel, just briefly.

15 A. That's how -- and I -- I mean, I've
16 talked a lot about that today, but really,
17 that's -- I'm looking for opportunities. We
18 need the types of information that people are
19 asking us for.

20 We can't keep growing and growing
21 and growing the survey, so, like, how can we
22 start to -- to solve for some of those things?

1 Q. Let me ask this question -- I did
2 again -- If participation increases, does that
3 confer a financial benefit on Leapfrog?

4 A. No.

5 Q. None whatsoever?

6 A. No.

7 Q. There will be no revenue increase?

8 A. Not necessarily, because a lot of
9 our contracts -- because they're auto-renewal,
10 those organizations have also negotiated no
11 increases for some number of years as a
12 condition of auto-renewal.

13 Plus, to be frank, we don't value
14 the data or price the data based on the number
15 of hospitals. We've never done that. We don't
16 have a model to increase the prices based on
17 the number of hospitals.

18 So I could not, as Leapfrog, think
19 of a way that we could do that because we've
20 never done it.

21 Q. I -- I just want to be very clear in
22 my question, too. I'm not limiting my question

1 just to licensing --

2 A. Okay.

3 Q. -- is there any revenue stream that
4 increased participation would confer a financial
5 benefit on?

6 A. So the only revenue stream -- stream
7 associated with participation in the
8 Leapfrog Hospital Survey is the data that we
9 license. We also sell benchmarking reports to
10 hospitals that summarize their
11 Leapfrog Hospital Survey results using that
12 value-based purchasing program methodology I
13 described.

14 We have 23-, 2400 hospitals
15 participating in the survey today. We sell
16 maybe \$40,000 worth of benchmarking reports.
17 Theoretically, if more hospitals came in that
18 cared about benchmarking, maybe I could
19 increase my benchmarking report line, but it's
20 not a direct one-to-one.

21 Q. And you said the only one was
22 licensing, but there's also Accolades, right?

1 A. But that's not necessarily related
2 to participation in the
3 Leapfrog Hospital Survey.

4 Q. But Ms. Campione's deck that we
5 looked at before says there's a 10-times
6 correlation between participation and purchasing
7 Accolades.

8 A. She said that hospitals that part --
9 that license to accolade -- again, just to be
10 back to my 80/20, the majority of hospitals in
11 the country are doing the survey before and
12 after the Safety Grade. The majority of
13 hospitals being graded are participating in the
14 Safety Grade.

15 The fact that the majority of
16 hospitals being graded, which is -- I don't
17 know -- a few hundred hospitals -- like, a few
18 hundred -- 200-and-something hospitals are
19 licensing the Safety Grade.

20 Do I think that would have an
21 increase in Accolade revenue? No, because
22 already hundreds more hospitals participate in

1 the survey and earn an A and have for many
2 years and have never licensed the Hospital
3 Safety Grade.

4 We've empirically seen no growth in
5 our Accolades program related to participation
6 in the survey. And that's why when we talked
7 about this, I was almost embarrassed that you
8 brought that up because I said if I had known
9 that number was 200 hospitals -- I see how
10 silly that question was -- I was just trying to
11 get -- get in the mix with question.

12 Q. So now, having been two years in
13 that mix --

14 A. There's still no relationship
15 between participation in the survey. There's
16 been virtually flat number of sales. In fact, I
17 believe the spring 2025, we had exactly the same
18 or one or two different as spring 2024.

19 So it's -- it's not identical.
20 Fairly, fairly flat.

21 Q. Yeah, okay.

22 I want to ask about a couple

1 more things. I want to talk about the Safety
2 Grades again --

3 A. Yes.

4 Q. -- in that bucket --

5 A. Yes.

6 Q. -- there's a lot of buckets today --
7 topics.

8 Hospitals that get A grades --

9 A. Yes.

10 Q. -- fair to say an A grade helps a
11 hospital's reputation?

12 A. I'm just going to repeat back
13 comments hospitals have said to us, to my face,
14 not hearsay.

15 Many hospitals tell us -- and this
16 is reflected in our low Accolades licensure
17 numbers -- that they don't need to silence the
18 Safety Grade, that they already have a strong
19 reputation in the community. They're known for
20 surgery. They're known for -- so while some
21 hospitals may license a Safety Grade because
22 they think it does improve their reputation in

1 the community, other hospitals tell us
2 something different.

3 And, again, the majority of
4 hospitals, 700 plus, don't license the
5 Safety Grade at all, so I don't know how they
6 feel about the A Safety Grade.

7 Q. I'm asking your view. And let's --
8 let's set aside licensing for a second, right?

9 A. Yeah.

10 Q. When the Leapfrog Safety Grades come
11 out, there's a significant press effort to
12 publicize those grades, right?

13 A. Yes.

14 Q. They're -- separate from licensing,
15 right?

16 A. Correct.

17 Q. Hospitals that get A grades try to
18 -- they or Leapfrog try to get stories about
19 those A grades, right?

20 A. Some of those hospitals do, yes --

21 Q. Okay.

22 A. -- not all and a smaller percentage

1 than I would think.

2 Q. How small a percentage?

3 A. I think there are whole states where
4 I've actually never seen a press announcement.
5 I mean, we have a PR firm called Kyra, and they
6 combine things. But I hear, for example,
7 annually that New Jersey -- hospitals
8 in New Jersey get a lot of coverage. I've never
9 heard, for example, hospitals in Utah get a lot
10 of coverage or hospitals in -- so that's what I
11 mean by -- like, we have A's --

12 Q. Yeah.

13 A. -- theoretically in every state --

14 Q. Yes.

15 A. -- and in some places, I've never
16 heard Kyra or seen a report that hospitals from
17 those places have ever done a press release,
18 ever gotten media coverage.

19 So there does seem to be some
20 variable, is all I'm describing.

21 Q. Sure. But an A grade is a positive
22 thing, right?

1 A. I think so.

2 Q. And if a hospital already has a good
3 reputation in the community, an A grade can
4 solidify that reputation, right?

5 A. I think so. Theoretically, yes.

6 Q. And it could, in theory, improve
7 that reputation, right?

8 A. I've never seen or heard of any
9 stories about an -- a grade improving a
10 reputation.

11 So can I give an example?

12 It's like Brigham and Women's
13 Hospital in Massachusetts. Like, people travel
14 all over the world to go there. They, I do
15 think, maybe advertise and license their A.

16 Do I think -- is it a measurable
17 impact on their brand awareness? I don't -- I
18 don't think so. I don't know. You would have
19 to ask them --

20 Q. Yeah.

21 A. -- and that goes for every hospital.
22 We've tried to collect data from

1 hospitals. We ask them how they're using the
2 grade. And even when they license, it is
3 painfully hard to get -- for them to tell us,
4 so I -- you would think I would have more
5 visibility.

6 It's something TelAffects actively
7 does. They call these hospitals and say, You
8 licensed the grade. How are you using it?

9 I only have a handful of examples
10 of what I can speak to factually of how I know
11 hospitals are using it. And I'm happy to share
12 all of those right now.

13 Q. Sure. So I --

14 A. Okay.

15 Q. -- I don't want you to share all of
16 those right now --

17 A. Oh, okay.

18 Q. -- but I'm happy to talk about it
19 after.

20 A. Okay.

21 Q. Can we talk briefly about CMS STARS
22 scores?

1 A. Yes. STARS -- STARS. Okay.

2 Q. Do you think -- so five stars is the
3 highest, right?

4 A. CMS has a five-star rating -- 1, 2,
5 3, 4, 5 -- correct.

6 Q. Five's the best.

7 Do you think a five-star rating
8 has the same or greater impact on a hospital's
9 reputation as a Leapfrog A?

10 A. Depending on the audience, yes. For
11 example, the majority of health plans around the
12 country -- you might notice I only named five
13 health plans --

14 Q. Sure.

15 A. -- that license Leapfrog data. The
16 majority of regional and national health plans
17 around this country heavily rely on those CMS
18 star ratings over Leapfrog data, over almost any
19 kind of data, for a couple of reasons: One,
20 it's free. Obviously, CMS makes it available,
21 free and downloadable. And also my impression
22 is that they're trying to align with CMS who is

1 a very large national payer. So from a payer
2 perspective, meaning health plans, the CMS
3 five-star ratings probably, from my perspective,
4 have the biggest impact of anything.

5 Q. What about from other perspectives?

6 A. So the CMS five-star ratings are
7 really designed for Medicare bare --
8 beneficiaries, but I know they're used by a lot
9 of other people.

10 I would say for private purchasers
11 and insurers, they're often looking at both.
12 We actually, very disappointingly, have a
13 regional leader in Wisconsin of all places, and
14 when they put out an RFP to have their health
15 plan use quality data in payment and
16 reimbursement, even though they're a Leapfrog
17 regional leader working to get participation in
18 our survey, they chose all CMS measures.

19 And so even employers and
20 purchasers -- there's just something about that
21 alignment with this big federal agency that for
22 the purposes of our constituents, they really

1 tend to gravitate to.

2 Q. Let me ask you -- do you believe the
3 CMS STARS are well known among patients?

4 A. Yes. Very.

5 Q. Okay. Do you believe they are more
6 or less or equally known to the Leapfrog Safety
7 Grade?

8 A. Sadly, probably more.

9 Q. Okay. So I want to --

10 A. We've been asked, Have you thought
11 about moving to STARS? Like, we're told, like,
12 STARS are very easily understandable and -- but
13 they're very well known.

14 Q. Okay.

15 A. It's a touchy subject for me because
16 a lot of times -- now that I am responsible for
17 data licensure --

18 Q. Yeah.

19 A. -- we're just going to use the CMS
20 data.

21 So . . .

22 Q. Got -- oh, got it.

1 A. I have an acute sensitivity.

2 Q. Yeah, yeah. Understood.

3 Understood. Okay.

4 So I want to flip it a little
5 bit --

6 A. Yes.

7 Q. -- talk about F grades.

8 A. Yes.

9 Q. F grades, would you agree, can
10 damage a hospital's reputation?

11 ATTORNEY WOOD: Objection to
12 form.

13 THE WITNESS: Again,
14 potentially.

15 And can I give empirical
16 evidence?

17 BY ATTORNEY CRAIN:

18 Q. No. I'm sorry. I'm just -- I have
19 so little time. I want you to just --

20 A. Okay.

21 Q. -- answer my question, and you are
22 welcome to go on redirect after my time is done.

1 A. If I -- then I would have to say no.

2 Q. Okay.

3 So your -- your answer is that
4 an F grade cannot damage a hospital's
5 reputation?

6 A. Oh, not "cannot."

7 Q. Okay.

8 A. I -- I can't speak definitively.

9 Q. Let me -- let me just say --

10 A. Sure.

11 Q. -- let me go back to my question,
12 and I just want you to answer my question --

13 A. Yeah.

14 Q. -- because I'm trying to get you out
15 of here on time, and I don't want to have to
16 keep you longer.

17 Can an F hospital -- can an F
18 grade damage a hospital's reputation?

19 A. Theoretically.

20 Q. Can an F grade damage a hospital
21 with a bad reputation?

22 A. Theoretically.

1 Q. Can an F grade solidify an already
2 existing bad reputation?

3 A. Theoretically.

4 Q. Can an F grade make it more
5 difficult for a hospital to repair its
6 reputation?

7 A. Theoretically.

8 Q. Okay.

9 A. I could answer more definitively if
10 I'm able to -- to share the examples that I
11 have, so it's totally up to you.

12 Q. If -- if your counsel's willing to
13 give me more time, I'm willing to hear it --

14 A. Oh, okay.

15 Q. -- but if not, then I'm not willing
16 to hear it right now.

17 ATTORNEY CRAIN: Up to you,
18 Courtney.

19 THE WITNESS: No.

20 ATTORNEY CRAIN: Let's --
21 let's go on break.

22 THE WITNESS: Let's keep

1 moving.

2 ATTORNEY CRAIN: Yeah, let me
3 take five.

4 THE WITNESS: Yes.

5 ATTORNEY CRAIN: Let's just
6 take a break.

7 THE WITNESS: Really five?

8 ATTORNEY CRAIN: Really five.
9 I'll do my best.

10 THE VIDEOGRAPHER: Going off
11 the record. The time is 1823.

12 --oOo--

13 (Whereupon, a recess was taken from
14 6:23 p.m. EDT to 6:32 p.m. EDT.)

15 --oOo--

16 THE VIDEOGRAPHER: Going back
17 on the record. The time is 1832.

18 BY ATTORNEY CRAIN:

19 Q. So we're almost done with the first
20 day of your deposition. Just kidding.

21 I have two more topics I want
22 to cover in the brief amount of time we have

1 left: The first is I want to talk about the
2 certified coach program.

3 A. Yes.

4 Q. I understand you're the teacher of
5 that program, right?

6 A. I am the coach --

7 Q. You are the coach.

8 A. -- of the certified coach's program,
9 yes.

10 Q. It's like King of Kings.

11 Coach of coach, right?

12 A. Yes.

13 Q. Yeah, so tell me -- when was the
14 coach program created?

15 A. We developed this program probably
16 two years ago, and we did it for one very
17 specific reason, which is that we wanted other
18 people who worked with hospitals who were
19 consulting with hospitals to not give hospitals
20 inaccurate information about the
21 Leapfrog Hospital Survey.

22 There's only one of me as we've

1 talked a lot about today, and I only have a
2 team of 10. And so the idea was to basically
3 take other healthcare professionals who also
4 work with hospitals, show them the hard copy of
5 the survey, where to find the reporting
6 periods, a lot of what I did with you today, so
7 if a hospital asks them, we have a slightly
8 better chance of saying, I know where to find
9 that in the hard copy of the
10 Leapfrog Hospital Survey, instead of answering
11 it off the cuff and telling them something
12 totally wrong and inaccurate.

13 Q. And -- thank you for that.

14 And can -- can anyone
15 participate in the program?

16 A. So, technically, I guess, yes,
17 anyone could participate in the program. It's a
18 four-hour interactive webinar. I develop all of
19 the content. I deliver the webinar myself.
20 Like a lot of the education I do, there's a lot
21 of, like, polling and the use of something
22 called Slido so I can check as we go along to

1 make sure they're understanding what I'm saying.

2 So when I talk about performance
3 categories, are they following what I mean when
4 I talk about measure specifications.

5 At the end, they actually take an
6 exam. The exam has to be completed within two
7 weeks or 30 days of them finishing the webinar
8 part with me. And they take the exam, and if
9 they get a passing score, which we've
10 considered, I believe, 70 or greater, then they
11 become a certified coach.

12 On our website, it's explained in
13 detail that it means that they understand where
14 to find information about the
15 Leapfrog Hospital Survey, where to find
16 materials and resources on our website, like
17 the scoring algorithms in the binder. It's not
18 meant to replace our help desk.

19 And they aren't taught to, and are
20 actually emphatically advised not to, advise in
21 any way on our measures. I basically spend
22 four hours saying, If a hospital asks you

1 something you're not a hundred percent sure of
2 the answer, please send them to the help desk.
3 So we do a lot training around that.

4 Q. When you say they can't advise new
5 measures, that means, like, what -- how to
6 respond to the measures or -- or what --

7 A. So if there's a question about -- I
8 think earlier we were talking about those Ensure
9 shakes, and -- and they have a barcode. They
10 shouldn't be telling hospitals whether or not
11 those Ensure shakes are a medication based on
12 our definition. If it is not clearly to the
13 letter articulated in our measure
14 specifications, they are coached, trained to
15 have those hospitals come to the
16 Leapfrog Hospital Survey.

17 I really define their role in a
18 very specific way. I talk about it a lot. So
19 a coach's job is not to win the game for the
20 team. That's not what a good coach does. I'm
21 a coach for Brazilian jujitsu. My job is to
22 know the rules, know who to ask and know how

1 the game is scored.

2 And so I teach them the rules, the
3 scoring algorithms and the know-how to ask for
4 help. It's really quite focused around those
5 three components.

6 Q. How do they stay up-to-date as
7 things change?

8 A. If they want to continue to be a
9 Leapfrog certified coach, they would repeat the
10 course the next year with my new presentation.
11 But, again, the content may change, but a lot of
12 what I'm working on them with is, like, the
13 structure of the survey, documentation
14 requirements and how to find that on our
15 website, how to use a paper and pencil in our
16 scoring algorithms to help hospitals understand,
17 Oh, if I say, Yes, Yes, Yes, No, right, we have
18 those scoring algorithms rubrics. There should
19 be no surprises. Let's teach them how to do
20 that. But I still like to have them do a
21 refresher.

22 Q. And does it cost for the program?

1 A. There is.

2 Q. How did Leapfrog decide what the
3 cost would be?

4 A. That's a good question.

5 We wanted it to -- it was designed
6 for healthcare professionals, not individuals
7 from hospitals. And so we wanted it to be more
8 than whatever we charge hospitals because we
9 didn't want hospitals to think we were trying
10 to get them to pay more to learn about the
11 survey. We keep all of their education under
12 \$400. I think it's \$395 for a same similar
13 four-hour educational thing.

14 So I think someone just decided,
15 How about a thousand dollars --

16 Q. Okay.

17 A. -- or \$995?

18 Q. And so the hospitals -- what --
19 what's the name of the hospital education
20 program?

21 A. They're called Leapfrog Deep Dive
22 Series, and I offer them on various topics

1 throughout the year, very similar to what I just
2 talked about, what we deep dive into a
3 particular area. And so if it's someone who is
4 maybe new to doing the survey at that
5 hospital -- it's like a very hands-on sort of
6 coaching experience, again, where I just show
7 them where to find everything, how this works.

8 If someone says, How do we know
9 this is evidence-based? This is where you find
10 our fact sheets. It's a lot of that.

11 Q. And so it's just -- just so I
12 understand, the -- both educational programs are
13 about how to respond to the survey, not change
14 the underlying performance; is that right?

15 A. Correct. We -- we do no guidance or
16 advice on how to actually improve on the
17 measures. What we do do, however, is our
18 communications department does what we call case
19 studies, where they interview hospitals --

20 Q. Yeah.

21 A. -- on various topics, like reducing
22 C-sections or staffing your ICU with

1 intensivists.

2 On my slides, I point them to the
3 resource of the case studies that they can use
4 but make it clear that's not us saying, That's
5 what you should do. It's just a resource that
6 we offer.

7 Q. Okay.

8 A. We do no advising whatsoever on how
9 to improve on the measures or how to do quality
10 improvement in any way.

11 Q. And just ballpark, how many
12 hospitals participate in the Deep Dive program?

13 A. So I usually offer two or three a
14 year, and I have maybe 50 to 60 hospitals on
15 each one. We do cap it because I want to be
16 able to answer all of their questions -- that's
17 why I'm used to these long-form responses --
18 because the goal is that they are getting more
19 personalized attention, if they need it, to
20 answer all of their questions. And when they
21 leave, they should feel like, Okay. I really
22 got this.

1 Q. Yeah.

2 A. And I do a poll at the end. I say,
3 What is your confidence now in leading your
4 hospital's -- Leapfrog Hospital Survey? And
5 most of the time, people say, I feel more
6 comfortable, or, I feel --

7 Q. Sure.

8 A. -- much better. I'm still nervous,
9 but the goal is for them not to be so nervous.

10 Q. And then last question on this line.

11 A. Yes.

12 Q. How many folks have gone through the
13 certified training program -- coach program?

14 A. For the certified coaches, maybe 20.

15 Q. Okay. Since the --

16 A. I can't see the people, so that's a
17 really good question on the coaches, so I don't
18 know how many are joining. I don't check on
19 purpose because I don't want it to psych me out.
20 I would say 20 to 30.

21 Q. Okay. One last topic. I want to
22 talk about the white paper, which is one of your

1 topics.

2 A. Yes.

3 Q. Now, first question, Leapfrog has
4 said that C, D and F, or just D and F hospitals,
5 that you're twice as likely to die if you go to
6 one of those hospitals as opposed to an A
7 hospital.

8 Are you familiar with that?

9 A. I'm familiar with the graphic you're
10 referencing. I don't know that those are
11 exactly the stats -- if you have it to pull
12 up -- but I'm familiar with the graphic,
13 correct.

14 Q. Okay. Is that -- is that Leapfrog's
15 view of the mortality difference in those
16 hospitals today?

17 ATTORNEY WOOD: Objection to
18 form.

19 (The witness mumbles under breath
20 while reviewing the material
21 provided.)
22

1 BY ATTORNEY CRAIN:

2 Q. Let me revise.

3 A. I'm sorry.

4 Q. Is a patient twice as likely to die
5 if they go to a C, D or F hospital today as
6 compared to an A hospital?

7 A. Again, I don't know that the
8 original graphic says that.

9 Does someone just quickly have it
10 so I can look at it?

11 Q. I -- I'm just asking a different
12 question.

13 A. Okay. Okay.

14 Q. Setting aside the graphic --

15 A. Okay.

16 Q. -- is --

17 A. I have not estimated mortality based
18 on Spring 2025 Safety Grades --

19 Q. Okay.

20 A. -- where I could answer that
21 question as of today.

22 Q. Has Leapfrog?

1 A. That's not work we do. We contract
2 with Johns Hopkins to do that work.

3 Q. Has Johns Hopkins?

4 A. Johns Hopkins is -- have they
5 done -- no, they haven't -- they have -- they're
6 not doing that right now.

7 Q. Okay. And -- and they have not --

8 A. They did the last one. Sorry.
9 That's why I was pausing. They've done it
10 twice.

11 So what you see on our website is
12 actually an update to a similar white paper
13 that was developed earlier. The upgrade was
14 really adding costs. Employers/purchasers want
15 to know how much things cost. So they did it
16 once in 2015, 2016. They did it again in 2018,
17 2019. They haven't done it again.

18 ATTORNEY CRAIN: Got it?

19 CERTIFIED STENOGRAPHER: Jeez
20 , Louise.

21 ATTORNEY CRAIN: 2015 and
22 2016, and then they get it -- did it

1 again --

2 CERTIFIED STENOGRAPHER: I

3 got it. I got it.

4 ATTORNEY CRAIN: Okay.

5 BY ATTORNEY CRAIN:

6 Q. And they have not done it, at least
7 publicly, since, right?

8 A. Correct.

9 ATTORNEY CRAIN: Okay. Just
10 give me one second.

11 All right. I will pass the
12 witness.

13 ATTORNEY WOOD: Then we are
14 all set.

15 ATTORNEY CRAIN: Okay.

16 THE VIDEOGRAPHER: This
17 marks --

18 ATTORNEY CRAIN: You're free
19 to go.

20 THE VIDEOGRAPHER: -- this
21 marks the end of the deposition of
22 Melissa Danforth. Going off the

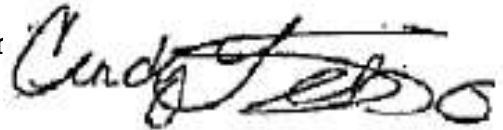
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record at 1841.
(Witness excused.)

(Deposition concluded at 6:42 p.m. EDT.)

C E R T I F I C A T E

1 I, Cindy L. Sebo, Nationally Certified Court
2 Reporter herein, do hereby certify that the
3 foregoing deposition of MELISSA AMEE DANFORTH was
4 taken before me pursuant to notice at the time and
5 place indicated; that said witness duly swore to
6 tell the truth, the whole truth, and nothing but
7 the truth under penalties of perjury; that said
8 testimony of witness was correctly recorded to the
9 best of my abilities in machine shorthand,
10 thereafter transcribed under my supervision with
11 computer-aided transcription; that deposition is a
12 true and accurate record of the testimony given by
13 the witness; that I am neither counsel, nor kin to
14 any party in said action, nor interested in the
15 outcome; and that a copy of this transcript
16 obtained from a source other than the court
17 reporting firm, including an adversary or
18 co-counsel in the matter, is uncertified and may
19 not be used at trial. Septer



20 CINDY L. SEBO, RMR, CRR, CLR, RPR, CCR, CSR, RSA,
CA CSR 14409, NJ Certified CR 30XI0024460,
21 NJ Certified RT 30XR00019500, NM CSR 589,
NY Realtime Court Reporter, NY Association
22 Certified Reporter, OR CSR 230105, TN CSR 998,
TX CSR 12778, WA CSR 23005926, Notary Public

INSTRUCTIONS TO WITNESS

Please read your deposition over carefully and make any necessary corrections. You should state the reason in the appropriate space on the errata sheet for any corrections that are made.

After doing so, please sign the errata sheet and date it.

You are signing same subject to the changes you have noted on the errata sheet, which will be attached to your deposition.

It is imperative that you return the original errata sheet to the deposing attorney within thirty (30) days of receipt of the deposition transcript by you. If you fail to do so, the deposition transcript may be deemed to be accurate and may be used in court.

CAPTION: Good Samaritan, et al. v. The Leapfrog Group

MELISSA AMEE DANFORTH

NO. 7574666

E R R A T A S H E E T

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CAPTION: Good Samaritan, et al. v. The Leapfrog Group

MELISSA AMEE DANFORTH

NO. 7574666

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ACKNOWLEDGMENT OF WITNESS

I, MELISSA AMEE DANFORTH, do hereby
certify that I have read the foregoing pages
herein, and that the same is a correct
transcription of the answers given by me of the
proceedings taken remotely to the questions therein
propounded under penalty of perjury, except for the
corrections or changes in form or substance, if
any, noted in the attached errata sheet.

DATE

SIGNATURE

Subscribed and sworn to before me
this ____ day of _____, 20____.

My Commission expires:

Notary Public

Page 602

1 Kimberly Blair

2 kimberly.blair@wilsonelser.com

3 September 22, 2025

4 RE: Good Samaritan Medical Center Inc, Et Al. v. The Leapfrog
5 9/18/2025, Melissa Amee Danforth (#7574658)

6 The above-referenced transcript is available for
7 review.

8 Within the applicable timeframe, the witness should
9 read the testimony to verify its accuracy. If there are
10 any changes, the witness should note those with the
11 reason, on the attached Errata Sheet.

12 The witness should sign the Acknowledgment of
13 Deponent and Errata and return to the deposing attorney.
14 Copies should be sent to all counsel, and to Veritext at
15 errata-tx@veritext.com.

16 Return completed errata within 30 days from
17 receipt of testimony.

18 If the witness fails to do so within the time
19 allotted, the transcript may be used as if signed.

20
21
22 Yours,

23 Veritext Legal Solutions
24
25

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Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

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THE ABOVE RULES ARE CURRENT AS OF APRIL 1, 2019. PLEASE REFER TO THE APPLICABLE FEDERAL RULES OF CIVIL PROCEDURE FOR UP-TO-DATE INFORMATION.

VERITEXT LEGAL SOLUTIONS

COMPANY CERTIFICATE AND DISCLOSURE STATEMENT

Veritext Legal Solutions represents that the foregoing transcript is a true, correct and complete transcript of the colloquies, questions and answers as submitted by the court reporter. Veritext Legal Solutions further represents that the attached exhibits, if any, are true, correct and complete documents as submitted by the court reporter and/or attorneys in relation to this deposition and that the documents were processed in accordance with our litigation support and production standards.

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Exhibit 92

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September 23, 2025

Page 1

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA
WEST PALM BEACH DIVISION

CASE NO.: 9:25-CV-80526-DMM

GOOD SAMARITAN MEDICAL
CENTER, INC., et al.,

Plaintiffs,

-vs-

THE LEAPFROG GROUP,

Defendant.

_____ /

VIDEO-RECORDED DEPOSITION OF JERAD HANLON
PURSUANT TO RULES 30 AND 30(b)(6)
Volume 1 (Pages 1 - 247)

DATE: Tuesday, September 23, 2025
TIME: 9:03 a.m. - 12:37 p.m.
LOCATION: One Financial Plaza
100 Southeast Third Avenue
Suite 805
Fort Lauderdale, Florida 33394

Stenographically Reported By:
Theresa Rust, RPR

Job No.: 422123

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1 APPEARANCES:

2 On behalf of Plaintiffs:

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11 BY: JURA ZIBAS, ESQUIRE
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12 ALSO PRESENT:

13 Alex Rampone, Videographer

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1 Thereupon,

2 the following proceedings began at 9:03 a.m.:

3 THE VIDEOGRAPHER: We are now on the record
4 and the time is 9:03 a.m. This is the
09:04 5 video-recorded deposition of Jared Hanlon in the
6 matter of Good Samaritan Medical Center, Inc.
7 versus Leapfrog Group.

8 The deposition is being held in Fort
9 Lauderdale, Florida on September 23, 2025. The
09:05 10 videographer is Alex Rampone, and the court
11 reporter is Theresa Rust; both in association
12 with Lexitas Legal Services.

13 Counsel, please announce appearances for
14 the record.

09:05 15 MS. YANG: Betty Yang on behalf of the
16 plaintiffs.

17 MS. DEBANKA: Elizabeth Debanka on behalf
18 of the plaintiffs.

19 MS. ZIBAS: Good morning. I'm Jura Zibas
09:05 20 with the law firm of Wilson Elser, here on
21 behalf of the Leapfrog Group, and I will be
22 taking your deposition today.

23 THE STENOGRAPHER: Raise your right hand,
24 please.

09:05 25 Do you swear that the testimony you are

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1 about to give will be the truth, the whole
2 truth, and nothing but the truth?

3 THE WITNESS: Yes.

4 THE STENOGRAPHER: Thank you.

5 THEREUPON:

6 JERAD HANLON

7 Was called as a witness and, having been first duly
8 sworn and responding "I do," was examined and
9 testified as follows:

09:05 10 DIRECT EXAMINATION

11 BY MS. ZIBAS:

12 Q. Good morning, Mr. Hanlon. As I indicated,
13 I am here on behalf of the Leapfrog Group to ask you
14 questions related to a lawsuit that was brought in
09:05 15 Federal Court by West Boca Medical Center, along with
16 other medical institutions or medical centers,
17 however you want to refer to them, against the
18 Leapfrog Group. I am going to be asking you
19 questions.

09:06 20 If you don't understand the question, I can
21 rephrase it, you can tell me. If your attorneys
22 object, they can object. Wait, don't answer until
23 they put their objection on the record. If there's
24 any response I have to give, I'll give the response;
09:06 25 otherwise, you will answer the question.

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1 We're here to get as much information from your
2 memory and your experience as possible. It's not a
3 test of any kind. If you don't know the answer, you
4 say I don't know or I don't remember, it's okay. No
09:06 5 reason to try to -- you know, there's no mystery
6 here, so I just want to make sure that's clear.

7 Now, have you been deposed before?

8 A. I have not.

9 Q. Okay. So the rules are you can take a
09:06 10 break, as long as there's no question pending. If
11 you need to take a break to go to the restroom, et
12 cetera, speak with your lawyer, like I said, as long
13 as there's no question pending, that's fine.

14 A. Sure.

09:07 15 Q. You can take a break at any time. You
16 know, we'll see how the day goes. I'm hopeful maybe
17 we won't be here all day, but I don't know until we
18 start the dialogue. So that's just kind of where we
19 are at this early juncture.

09:07 20 And I think as you go along through the process,
21 it will make more sense, rather than me sitting here
22 giving you a lot of instructions. Always, you know,
23 listen to your attorneys, if they do direct you, and
24 if they, you know, give you any type of instruction,
09:07 25 make sure that you follow that instruction.

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1 MS. ZIBAS: So in order to start the day, I
2 have marked what we call a notice of deposition
3 as Hanlon 1.

4 (Exhibit 1 was marked.)

09:07 5 BY MS. ZIBAS:

6 Q. I'm putting it in front of you, and I just
7 want to merely ask, have you seen this document
8 before?

9 A. Yes, I have.

09:08 10 Q. So we're here today to take your deposition
11 pursuant to this notice, and it's a notice, if you
12 read at the top, of you, Jared Hanlon, individually,
13 and pursuant to 30(b)(6) to West Boca Medical Center.
14 So you're answering on behalf of yourself and the
09:08 15 medical center.

16 There may come a point in time where your
17 lawyers may ask who I'm asking a question on behalf
18 of. We can clarify it. I'm sure there's no issue.
19 It does get difficult when you're the individual and
09:08 20 the entity because your knowledge is your knowledge.

21 A. Sure.

22 Q. So we'll do our best to make sure it's
23 clear, and if you are ever concerned, you just raise
24 that concern. I don't want you to be confused as to
09:09 25 who you're answering a question on behalf of.

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1 So as we start the day, I'm going to get --
2 start out with your -- a little bit of background
3 about yourself. Where do you currently work?

4 A. West Boca Medical Center.

09:09 5 Q. And do you have a title there?

6 A. I do.

7 Q. And what is your title?

8 A. Chief executive officer.

9 Q. And when did you become the chief executive
09:09 10 officer at West Boca Medical Center?

11 A. October of 2023.

12 Q. Now, going back to your educational
13 background, do you have a college degree?

14 A. I do.

09:09 15 Q. Okay. And where did you receive your
16 college degree, your undergraduate?

17 A. James Madison University.

18 Q. And where did you receive, if you received,
19 a higher level degree?

09:09 20 A. I received my master's in the hospital
21 administration at Virginia Commonwealth University.

22 Q. And what year was that?

23 A. 2006.

24 Q. And after your master's of hospital
09:10 25 administration, did you receive any further

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1 education?

2 A. No, not formal.

3 Q. When you say not formal, are you taking
4 continuing education courses at times?

09:10 5 A. Yes, at times.

6 Q. How often do you take continuing education
7 courses?

8 A. I'm a part of the American College of
9 Healthcare Executives, and there's CEUs that are
09:10 10 available through that.

11 Q. And do you go to a conference to take those
12 courses?

13 A. You can. I typically do them online.

14 Q. Have you ever taken a course that deals
09:10 15 with marketing hospitals?

16 A. I have not.

17 Q. Now, after you finished your education,
18 where is the first -- what's the first job that you
19 had?

09:10 20 A. I was an assistant administrator at Davis
21 Regional in Statesville, North Carolina.

22 Q. Okay. And what years or approximately how
23 long were you there?

24 A. I was there about 18 months, from '06 to
09:11 25 '08.

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1 Q. And after that position, where did you go?

2 A. I went to University Medical Center in
3 Lebanon, Tennessee as an associate administrator.

4 Q. Okay. And how long were you there?

09:11 5 A. Approximately, three years, from 2008 to
6 2011.

7 Q. And in 2011, what was your -- where did you
8 go for your job or your career move?

9 A. Then I left Lebanon, Tennessee and I moved
09:11 10 back home to Petersburg, Virginia and worked for
11 Southside Regional Medical Center as the chief
12 operating officer.

13 Q. And when you were at Southside Regional as
14 chief operating officer, did you have any role in
09:12 15 marketing services?

16 A. No, not directly.

17 Q. And what about indirectly?

18 A. Other than just having a -- we had a
19 marketing director that I worked with to -- I was
09:12 20 responsible for the overall operations at the
21 hospital, so I worked with the director there.

22 Q. And how long were you at Southside
23 Regional?

24 A. About eight years. I left in 2018.

09:12 25 Q. And where did you go in 2018?

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1 A. Start of 2019, I left in December of '18
2 and started in -- at Delray Medical Center as the
3 group chief strategy officer for the Palm Beach
4 network.

09:13 5 Q. So were you employed by Delray Medical
6 Center or the Palm Beach network?

7 A. I was employed by Tenet, is the corporate
8 employee.

9 Q. So what was your role? What were your
09:13 10 duties as group chief strategy officer?

11 A. I was responsible to look at the overall
12 strategy among the five Palm Beach Health Network
13 hospitals, to look at market share, to look at
14 physician recruitment opportunities in order to
09:13 15 direct and organize our strategy going forward for
16 the five hospitals there.

17 Q. And what five hospitals are you referring
18 to?

19 A. West Boca Medical Center, Delray Medical
09:13 20 Center, Good Samaritan Medical Center, St. Mary's
21 Medical Center, and Palm Beach Gardens Medical
22 Center.

23 Q. What made you decide to go work for the
24 Tenet Healthcare Corporation?

09:14 25 A. My group president, Maggie, I had met her

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1 in Virginia and was really impressed with her, and
2 she approached me about an opportunity to come down
3 to Florida. And I as I shared with Betty, once my
4 wife came down here in December, December 7, we
09:14 5 walked out of the hotel and it was beautiful and
6 sunny and she said we're coming.

7 MS. YANG: I won't assert protective order
8 on that.

9 MS. ZIBAS: I assumed wouldn't be an issue.
09:14 10 BY MS. ZIBAS:

11 Q. So why don't you -- let's talk about this
12 Palm Beach Health Network a little bit. When was the
13 Palm Beach Health Network formed, as far as you know?

14 A. It is a branding as a network. I don't
09:15 15 believe it is a formal entity.

16 Q. Now, do all of the Tenet Healthcare
17 corporate employees who work with the Palm Beach
18 Health Network? Are they all at Delray Medical
19 Center?

09:15 20 A. No.

21 Q. How many were at Delray Medical Center when
22 you were there as group chief strategy officer?

23 A. I wouldn't know an exact number. There was
24 several.

09:15 25 Q. And as far as you know, does Tenet

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1 Healthcare Corporation direct the strategy for all
2 those five hospitals?

3 MS. YANG: Objection to form.

4 A. As being owned as part of Tenet, yes. They
09:16 5 are involved in the strategy that we develop at the
6 local level.

7 BY MS. ZIBAS:

8 Q. And when you were group chief a strategy
9 officer, who did you report to directly?

09:16 10 A. Maggie Gill.

11 Q. What was Maggie Gill's title in 2019, if
12 you know?

13 A. She was the CEO of Delray, as well as the
14 Palm Beach market CEO.

09:16 15 Q. Did you have a staff as group chief
16 strategy officer working under you?

17 A. Yes. I had a business analyst, a data
18 analyst. I also worked with the strategy officers at
19 each of the facilities. Each facility had a CSO that
09:17 20 would -- they were employed by the hospital directly.
21 They were not Tenet employees. I was the only Tenet
22 employee. And so they had a direct line to their
23 respective CEO and a dotted line to me as the group
24 CSO.

09:17 25 Q. And what did the data analyst or business

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1 analyst do in their role?

2 A. Helped us to evaluate market share volumes,
3 presence of medical staff and physicians in the area.

4 Q. And were there reports or documents
09:17 5 produced by these analysts that were then shared with
6 all the hospitals about market share?

7 A. Yes. We regularly reviewed market share
8 data.

9 Q. What kind of data did you gather to review
09:18 10 market share?

11 A. Combination of both internal and then we
12 used external sources, such as Trilliant and other
13 payer systems that we could analyze and see what the
14 volume was in the area.

09:18 15 Q. Who is Trilliant?

16 A. They're an independent company that
17 compiles a lot of data from -- from various biller,
18 billing sources and things like that.

19 Q. Now, in order to prepare for your
09:18 20 deposition today, outside of meeting with your
21 attorneys, and I don't want to hear about any
22 conversations you had be your attorney, what else did
23 you do to prepare?

24 A. Just reviewed our policies, reviewed many
09:19 25 of the documents that we submitted to Leapfrog.

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1 Q. And when you said submitted to Leapfrog,
2 are you saying during the course of this litigation
3 or prior to litigation?

4 A. During the course of this litigation.

09:19 5 Q. And did you -- were you part of the group
6 or were you the person who gathered documents at West
7 Boca Medical Center for this litigation?

8 A. I was part of the group.

9 Q. How many people gathered documents?

09:19 10 A. You know, Andrea Nunes is our director of
11 quality, Gina West, our group director. That was
12 pretty much . . .

13 Q. Are you aware that experts were hired to
14 testify on behalf of West Boca Medical Center in this
09:19 15 lawsuit?

16 A. Yes.

17 Q. And did you read any of the expert reports?

18 A. Yes.

19 Q. And which ones did you read?

09:20 20 A. I saw our expert testimony showing what we
21 would have received had we have participated in the
22 Leapfrog survey in terms of the grade.

23 Q. Do you remember the name of that expert?

24 A. I don't off the top of my head.

09:20 25 Q. Any other expert reports?

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1 A. I don't believe so, that I can recall.

2 Q. Now, when is the first -- going back, have
3 you heard of, obviously, the defendant, the Leapfrog
4 Group?

09:20 5 A. Yes.

6 Q. And when did you first hear of the name the
7 Leapfrog Group?

8 A. In my career, I've heard of the Leapfrog
9 Group from even back when I was a COO at Southside
09:21 10 Regional.

11 Q. And when you were at Southside Regional,
12 did Southside Regional participate in the Leapfrog
13 Group survey?

14 A. I don't remember.

09:21 15 Q. Have you -- are you aware that the Leapfrog
16 Group does have a survey that's at issue in this
17 lawsuit?

18 A. Yes.

19 Q. And do you know how many pages the survey
09:21 20 is?

21 A. Not an exact count but it's lengthy.

22 Q. And have you ever personally looked at the
23 survey in the last two years?

24 A. No.

09:21 25 Q. Do you know if anyone at West Boca Medical

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1 Center has looked at the survey in the last two
2 years?

3 A. Yes.

4 Q. And who would that be, as far as you know?

09:22 5 A. Andrea Nunes, our director of quality.

6 Q. Going back to the Palm Beach Health
7 Network. When you were chief strategy officer, who
8 were the other, as you call, C-suite officers in the
9 Palm Beach Health Network?

09:22 10 A. For the group?

11 Q. For the group.

12 A. For the group, okay. Our CEO, group CEO
13 was Maggie Gill. Our group CFO was Sheri Montgomery.
14 Our group chief nursing officer was Libby Flipppo.

09:22 15 And our group chief operating officer was Stephen
16 Garner.

17 Q. Did you have meetings when you were part of
18 the Palm Beach Health Network, meaning the network,
19 the actual group, did you have meetings?

09:22 20 MS. YANG: Object to form.

21 A. Yes.

22 BY MS. ZIBAS:

23 Q. How often did you have meetings?

24 A. Regularly. I mean, there would be several
09:23 25 ad hoc meetings. I would meet with a lot of those

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1 individuals on a daily basis.

2 Q. Did you meet via Zoom, e-mail, phone?

3 A. Combination of all of the above, in person.

4 Q. What were the goals of the Palm Beach

09:23 5 Health Network ultimately, as far as you know?

6 MS. YANG: Object to form.

7 A. In terms of what type of goals are you?

8 BY MS. ZIBAS:

9 Q. Well, you talked about you were -- you have

09:23 10 responsibility for market share. I mean, is this an

11 organization that merely was put together for

12 marketing purposes, recruitment purposes?

13 MS. YANG: Objection to form.

14 A. No. I mean, we started to brand as a group

09:24 15 because of the fact that we were coordinating the

16 care. You know, recruiting staff is challenging,

17 difficult. Capital is very rare to come by, and so

18 we wanted to make sure we were working as

19 collectively as a group to provide efficient

09:24 20 high-quality patient care to our community.

21 BY MS. ZIBAS:

22 Q. You had mentioned earlier that you would

23 also look at physician recruitment opportunity. Was

24 physician recruitment at the Palm Beach Health

09:24 25 Network difficult?

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1 A. I think --

2 MS. YANG: Objection to form.

3 A. I think it's difficult everywhere to
4 recruit physicians. What we do on an annual basis is
09:24 5 an annual physician needs assessment to evaluate how
6 many physicians are in the market, and based off of
7 the patient population, how many physicians we're
8 short, and we look to try to fill that, get that gap,
9 that need.

09:25 10 BY MS. ZIBAS:

11 Q. Were you able to -- when you were chief
12 strategy officer, were you able to achieve success in
13 recruiting physicians or additional physicians?

14 A. Yes. We recruited several.

09:25 15 Q. And in terms of market share, who were the
16 competitors to the Palm Beach Health Network?

17 A. For the Palm Beach Health Network?

18 Q. Correct.

19 A. So I'm going off of my role. This is
09:25 20 personally. I'm not representing West Palm.

21 Q. I understand.

22 A. Okay. When I was the group chief strategy
23 officer, I would say it would be Baptist Health,
24 which includes Boca Regional. They had just been
09:26 25 acquired by Baptist in July of '19. I would say

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1 Baptist also included Bethesda East and Bethesda
2 West, JFK, both main and north, Palms West, Jupiter
3 Medical Center, Wellington Regional, Broward Health,
4 which is Coral Springs, and north, Broward Health
09:27 5 North. I think that covers all of them.

6 Q. All right. Now, you -- you remained in
7 your role as chief strategy officer for the Palm
8 Beach Health Network for how long?

9 A. For a little over a year.

09:27 10 Q. Okay. And then what did you do next?

11 A. In March of 2020, COVID hit and there was a
12 need for -- we had a vacancy for our chief operating
13 officer position at St. Mary's and the Palm Beach
14 Children's Hospital, and so Maggie asked if I could
09:27 15 help out up at West Boca. And our focus shifted from
16 the strategy role to day-to-day operations with
17 dealing with COVID.

18 Q. And how long did you -- did you
19 simultaneously, while you were COO of St. Mary's and
09:28 20 Palm Beach Children's, also remain working as part of
21 the Palm Beach Health Network?

22 A. So I started out in interim basis as chief
23 officer in October of 2019, and was doing dual role
24 from October of '19 until March of 2020. And then I
09:28 25 shifted completely to COO of the Palm Beach Health

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1 Network, and -- I'm sorry, of St. Mary's and the Palm
2 Beach Children's Hospital.

3 Q. Were you also the group chief COO of Palm
4 Beach Health Network?

09:28 5 A. I wasn't until about 2021, I believe, is
6 when Stephen Garner, who was the group chief
7 operating officer, left to go back to Arizona as CEO,
8 and I assumed the role as group COO at that time.

9 Q. So were you both -- you were both the COO
09:29 10 of the group, as well as the COO of St. Mary's and
11 Palm Beach Children's; is that correct?

12 A. Yes.

13 Q. And what were your duties? Sounds like a
14 lot of work to be responsible for the network and two
09:29 15 hospitals.

16 A. Yeah. It was a lot, especially at that
17 time, given everything going on. I was responsible
18 for the day-to-day operations of St. Mary's and the
19 Palm Beach Children's Hospital, and my role as group
09:29 20 was to serve as a liaison and coordinate effective
21 operations from a group-wide perspective, if there
22 were buying opportunities that we could leverage our
23 five hospitals together. So I didn't have direct
24 operational oversight of the other facilities. I had
09:30 25 dotted-line reporting of their COOs to me.

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1 Q. When you were COO of St. Mary's and then
2 obviously the COO of the Palm Beach Health Network,
3 were you aware if these five hospitals were
4 participating in the Leapfrog Group surveys?

09:30 5 A. I was not at the time.

6 Q. When did you first learn about West Boca
7 Medical Center's participation or nonparticipation in
8 the Leapfrog surveys?

9 A. When I moved to -- down to West Boca so
09:30 10 probably 2024.

11 Q. So prior to taking on your role as CEO of
12 West Boca, did you have any interaction with any of
13 the people at Tenet who made decisions about Leapfrog
14 Group and participation?

09:31 15 MS. YANG: Objection to form.

16 A. Can you ask that question, again?

17 MS. ZIBAS: Yes, no. That was a bad
18 question.

19 BY MS. ZIBAS:

09:31 20 Q. Until the time you went to West Boca
21 Medical Center as the CEO, prior to that time, were
22 you involved or did you know about Tenet Healthcare's
23 decision to participate or not participate in the
24 Leapfrog Group surveys?

09:31 25 MS. YANG: Objection to form, assumes

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1 facts.

2 A. I can't speak for Tenet, so I didn't
3 personally have any knowledge of Tenet's decision at
4 the time.

09:31 5 BY MS. ZIBAS:

6 Q. And in 2022, were you ever on any e-mails
7 that you recall from Tenet stating that there's a
8 decision not to participate in the Leapfrog Group?

9 A. I don't recall.

09:31 10 Q. Now, looking just specifically at West Boca
11 Medical Center, do you know when the medical center
12 was originally founded?

13 A. 1986.

14 Q. And was it an independent medical center or
09:32 15 was it owned by a group at that point?

16 A. That I do not know.

17 Q. Did there come a time when West Boca
18 Medical Center was purchased by Tenet Healthcare?

19 A. I'm not exactly sure if Tenet was the owner
09:32 20 when it was first built or if it was subsequently
21 acquired. I don't -- I don't know that.

22 Q. When you took on the role of CEO of West
23 Boca, was West Boca Medical Center owned by Tenet
24 Healthcare?

09:32 25 A. Yes.

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1 Q. And is it today still owned -- is West Boca
2 Medical Center still owned by Tenet Healthcare?

3 A. Yes.

4 Q. And in your day-to-day operations as CEO,
09:33 5 do you report to someone at Tenet Healthcare?

6 A. I report to Maggie Gill.

7 Q. And what is Maggie Gill's current title?

8 A. She has taken on -- she's our group
9 president, but is also over multiple groups. So I
09:33 10 believe it's division or -- I believe it's division
11 president.

12 Q. Are you currently a Tenet Healthcare
13 employee?

14 A. Yes.

09:33 15 Q. And is your compensation based on metrics
16 of success at the hospital?

17 A. Yes.

18 Q. And are the -- do those metrics include
19 revenues of the hospital?

09:33 20 A. I have incentive compensation is based off
21 of revenues.

22 Q. Is there a quality director at West Boca
23 Medical Center currently?

24 A. Yes.

09:34 25 Q. And was there one there when you started as

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1 CEO in October 2023?

2 A. Yes.

3 Q. Do you report at West Boca Medical Center
4 to a board?

09:34 5 A. Yes.

6 Q. And is that board called a governing board,
7 a board of directors, what is the name?

8 A. It's a governing board.

9 Q. And how often does that governing board
09:34 10 meet?

11 A. Monthly, ten times a year.

12 Q. And how many board members are there?

13 A. Nine voting members and three nonvoting
14 members.

09:34 15 Q. And does the governing board have input
16 into your compensation?

17 A. Not directly.

18 Q. Does the governing board have any input
19 into whether a lawsuit is filed?

09:35 20 MS. YANG: Objection to form.

21 Hold on one second.

22 I'll just caution you, Dr. Hanlon, not to
23 discuss any substance of any communications
24 between the board and any attorneys or

09:35 25 reflecting any attorney advice. You can answer

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1 that question yes or no.

2 A. Could you repeat the question, please.

3 BY MS. ZIBAS:

4 Q. Yes. Does the governing board have any
09:35 5 input as to whether a lawsuit is filed? And like
6 your lawyer said, I'm not interested in legal. I
7 just want to know do they have any input, yes or no?

8 A. They can give guidance and feedback into
9 things they feel are important to the hospital.

09:36 10 Q. And in the lawsuit that we're here about
11 today against the Leapfrog Group, did the board
12 provide input, and, again, don't give me any of your
13 attorney's advice or any advice between the board and
14 their attorney, did they provide any guidance or
09:36 15 feedback regarding filing this lawsuit?

16 MS. YANG: That I'm going to instruct you
17 not to answer on the basis of privilege.

18 MS. ZIBAS: And the privilege, I assume,
19 just to expands, assumes that there were
09:36 20 discussions regarding the guidance and feedback
21 between the board and the lawyers; is that
22 correct.

23 MS. YANG: I'm not sure I understand the
24 question.

09:37 25 MS. ZIBAS: I asked him specifically about

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1 -- he testified about guidance and feedback. I
2 didn't ask for advice. And so I just want to
3 verify that the guidance and feedback from the
4 board to Mr. Hanlon or to the hospital included
09:37 5 attorneys, and that's the position that you are
6 taking?

7 MS. YANG: Well, I'm not taking a position
8 on that factual question because I'm not the
9 witness, but you're asking specifically about
09:37 10 the lawsuit that we are already in the middle of
11 today, so we would claim privileged work-product
12 over that.

13 MS. ZIBAS: I disagree, but we will go on.
14 That's not how it works. You have to be more
09:37 15 specific. There's case law on that. But we
16 will hold that for another day because it's not
17 that important.

18 BY MS. ZIBAS:

19 Q. Do you have -- is there a medical executive
09:37 20 committee at West Boca Medical Center, as well?

21 A. Yes.

22 Q. And who is on the medical executive
23 committee?

24 A. The respective chairs for the various
09:37 25 departments of the medical staff, as well as

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1 representatives from several of the contracted
2 groups, such as anesthesia, pathology, emergency
3 department, and pediatric coverage, hospitalists.

4 Q. How many physicians are on the medical
09:38 5 executive committee?

6 A. Approximately, 15.

7 Q. And how many times a year do they meet?

8 A. Monthly.

9 Q. And do you attend those meetings?

09:38 10 A. Yes.

11 Q. Have you discussed the Leapfrog Group with
12 any of the members of the medical executive
13 committee?

14 A. Yes.

09:39 15 Q. How many of the physicians?

16 A. All of them.

17 Q. Was it during a meeting or outside of a
18 meeting?

19 A. Both.

09:39 20 Q. And how many times in 2024 do you recall
21 did -- was the Leapfrog Group discussed with the
22 physicians?

23 A. I couldn't recall an exact number.

24 Q. More than once, as far as you recall?

09:39 25 A. Yes.

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1 Q. And what was the sum and substance of the
2 conversation?

3 A. Questions as to why we were scored so low
4 and why it was different from previous Leapfrog
09:39 5 grades.

6 Q. And did you respond to their questions?

7 A. Yes.

8 Q. And how did you respond?

9 A. That we didn't feel that the grades
09:40 10 reflected by Leapfrog were accurate because it was
11 based off of incomplete information that we hadn't
12 supplied them and an algorithm and formula that
13 didn't support the information that they had or
14 didn't have.

09:40 15 Q. What was the incomplete information?

16 A. We didn't participate in the survey.

17 Q. And do you know what measures are used from
18 the survey to give you a grade?

19 A. Yes.

09:40 20 Q. And what are those measures?

21 A. There's several questions from the survey
22 that are included. There's CMS measures that are
23 publically reported. Some of those we don't have it.
24 We have too small of a sample size, so that data may
09:40 25 not all apply to us, even though it's publicly

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1 reported. It also includes several questions
2 regarding barcode administration, computerized
3 physician order entry, handwashing, and our ICU
4 staffing levels. There's also other questions that
09:41 5 are included in the survey that I don't think are
6 included in the actual grade, but they are reported
7 on Leapfrog's website that come from the survey.

8 Q. Have you ever looked at the Leapfrog's
9 website?

09:41 10 A. Yes.

11 Q. When was the last time you looked at it?

12 A. Within the last week or so.

13 Q. And have you ever looked at a website
14 called hospitalsafetygrade.org?

09:42 15 A. Yes.

16 Q. What is that website?

17 A. It shows gradings of hospitals.

18 Q. And when you refer to not included in the
19 grade, are you referring to a grade that would be
09:42 20 found on the hospitalsafetygrade.org website?

21 A. I don't . . .

22 Q. You referenced grade. You said there were
23 other things in the survey that were not included in
24 the grade. When you refer to grade, I just want to
09:42 25 make sure we're on the same page. Are you referring

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1 to the hospital safety grade that's on the website?

2 A. Which website?

3 Q. The hospitalsafetygrade.org.

4 MS. ZIBAS: Here, I'll mark this. I
09:42 5 already marked 2 so that throws me off.

6 Here, we'll mark this later, but this is
7 what I'm referring to. I haven't marked yet. I
8 went out of order. I already marked 2 for
9 something else, so we'll mark it as 3, and then
09:43 10 we'll go back to two.

11 (Exhibit 3 was marked.)

12 THE WITNESS: And obviously, this
13 particular tab that's highlighted doesn't have
14 -- there's other tabs that have information
09:43 15 that's reported that we don't supply.

16 BY MS. ZIBAS:

17 Q. Okay. But when we -- when you reference
18 grade, are you referring to in this Exhibit 3, this
19 website, Leapfrog Hospital Safety Grade?

09:43 20 A. Correct.

21 Q. Okay. That's what I was just trying to
22 make sure we were on the same page.

23 A. Yeah. Uh-huh.

24 Q. Now, is there anybody at the West Boca
09:43 25 Medical Center that has a role to track hospital

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1 safety?

2 MS. YANG: Objection to form.

3 A. How do you define safety?

4 BY MS. ZIBAS:

09:44 5 Q. Well, let's go back. Is there a hospital
6 safety plan at the West Boca Medical Center?

7 A. Yes.

8 Q. And who designed or wrote that safety plan?

9 A. It's a variety of committees that review
09:44 10 and approve it, draft it, and then it has to be
11 reviewed and approved by our medical executive
12 committee, as well as our governing board.

13 Q. Now, you have -- I think you said that you
14 have a quality officer or quality person?

09:44 15 A. Director.

16 Q. Director. And who is that quality director
17 at West Boca Medical?

18 A. Andrea Nunes.

19 Q. How long has she been there?

09:44 20 A. Approximately, 21 years.

21 Q. And in general, what is her -- what are her
22 job duties?

23 A. She oversees a lot of our data abstraction,
24 our quality reporting, and the various committees
09:45 25 that we need to review or quality satisfaction,

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1 safety data.

2 Q. Now, you mentioned earlier, CMS, that this
3 is publicly-reported data; is that correct that it's
4 public information?

09:45 5 A. There are some measures that are publicly
6 reported via CMS.

7 Q. And is there any one person that oversees
8 the gathering of the information to report to CMS at
9 West Boca Medical Center?

09:45 10 A. There's not just one person. We have data
11 abstractors, quality coordinators, as well as our
12 director of quality, and then all of that information
13 goes to committees for regular review. And as I
14 mentioned, we also report out those committee

09:46 15 findings to our medical executive committee, as well
16 as to our board.

17 Q. And are the -- is the data that's gathered
18 to report to CMS, to the best of your knowledge, is
19 it accurate?

09:46 20 A. Yes.

21 Q. Now, you indicated that some of the sample
22 sizes were too small to report. Can you explain what
23 you mean by that?

24 A. There may be some services that we don't
09:46 25 offer at the hospital that CMS collects data on and

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1 publishes that they list not available for us, either
2 because we don't offer the service or our sample size
3 is too small.

4 Q. How many beds do you have at West Boca?

09:47 5 A. 195.

6 Q. What is your occupancy rate?

7 A. It varies, but anywhere from 50 to 70
8 percent.

9 Q. Is there any certain time of year that it
09:47 10 is a higher occupancy rate?

11 A. That -- that varies. It has varied
12 recently. Usually, we would see a surge around the
13 wintertime because of all the snowbirds, but since
14 COVID, that's really prevented a lot of people from
09:47 15 returning home so it's stabilized out.

16 Q. Have you seen a reduction in the occupancy
17 rate between 2024 and 2025?

18 A. Yes.

19 Q. And do you think that's because people are
09:47 20 starting to return back north after COVID?

21 MS. YANG: Objection to form.

22 A. Comparing it to prior years, you know, it
23 -- it's seasonality and there's going to be different
24 years, but we have seen our volume decrease.

09:48 25 BY MS. ZIBAS:

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1 Q. Do you find when there are a lot of
2 hurricanes in Florida, that less people come to West
3 Boca Medical Center Hospital?

4 A. I don't know if it's hurricane related.

09:48 5 Q. Has anyone ever evaluated whether a
6 hurricane, like last year if there were a number of
7 hurricanes in certain parts of Florida, if that
8 impacts the number of admissions or occupancy?

9 A. I mean, it probably impacts the number of
09:48 10 people that want to come to Florida, which ultimately
11 could impact the volume at the hospital.

12 Q. Has the -- have the number of ER visits
13 decreased between 2024 and 2025?

14 A. Yes.

09:49 15 Q. And do you know how many or what
16 percentage?

17 A. Approximately, 17 percent year over year.

18 Q. And what about between 2023 and 2024, when
19 you first started?

09:49 20 A. I don't recall an exact number. But I do
21 know it also decreased.

22 Q. And prior to you taking on the CEO role,
23 did you look at any data to see if there was a
24 decrease between 2022 and 2023?

09:49 25 A. I did not look at that time.

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1 Q. Okay. Did the number of admissions
2 decrease between 2023 and 2024?

3 A. I would have to look at the statistics to
4 be able to honestly answer that.

09:50 5 Q. Has revenue decreased between 2024 and
6 2025, overall?

7 A. Revenue has gone up.

8 Q. What's the median age of your patient
9 population at West Boca Medical Center?

09:50 10 A. I don't know the exact number. I would
11 suggest it's probably in the 50s.

12 Q. Do you happen to know what percentage of
13 your population, your hospital population, that means
14 both ER, admissions, et cetera, outpatient, that are
09:50 15 on Medicare?

16 A. I mean, that can vary each month. I would
17 say probably close to 60 percent.

18 Q. Are you involved, at all, in reviewing the
19 nursing recruitment and retention at West Boca?

09:51 20 A. I'm involved in all of the recruitment.

21 Q. And in general at West Boca, as I know
22 there is at most hospitals, has there been a
23 difficulty in recruiting and retaining nursing staff?

24 A. Yes.

09:51 25 Q. And what factors have you found impacts

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1 retention and recruitment of nursing staff?

2 MS. YANG: Objection to form.

3 A. What factors impact?

4 BY MS. ZIBAS:

09:51 5 Q. The recruitment and retention.

6 A. The staff?

7 Q. Yes.

8 A. I think the type of nurse that we're
9 looking for. I think compensation, the availability
09:52 10 of that. We struggle with cost of living here in
11 Florida. And just enough staff to fill all of the
12 needs.

13 Q. Between 2023 and 2025, were you able to
14 hire more nurses, or is it still a continuing problem
09:52 15 to hire nurses?

16 A. It --

17 MS. YANG: Objection to form, vague.

18 A. It's still challenging.

19 MS. YANG: Just give me a second to finish
09:52 20 my objection before you answer, Jared.

21 BY MS. ZIBAS:

22 Q. How many -- as you sit here today, do you
23 know how many open positions you have for nurses at
24 West Boca?

09:52 25 A. I wouldn't know the exact number, no.

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1 Q. Looking at the composition, meaning the
2 types of board members that are on your governing
3 board, are there any physicians on the governing
4 board?

09:53 5 A. There are.

6 Q. And how many?

7 A. Three voting and two nonvoting.

8 Q. Are there any nurses on the board,
9 governing board?

09:53 10 A. There are not.

11 Q. Any other type of medical personnel on the
12 governing board?

13 A. We have the chief of fire and EMS,
14 battalion chief, and then we've got the four
09:53 15 physicians, three -- I'm sorry. Five physicians.

16 Q. Does West Boca Medical Center do any type
17 of benchmarking against the other hospitals in the
18 region in Florida, meaning the Palm Beach Health
19 Network, as well as the others that you mentioned
09:54 20 earlier in your deposition?

21 MS. YANG: Objection to form.

22 MS. ZIBAS: Benchmarking them.

23 A. Benchmarking what?

24 BY MS. ZIBAS:

09:54 25 Q. Surveys, monitoring their data to see how

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1 it compares to West Boca in terms of admissions?

2 MS. YANG: Same objection.

3 A. Surveys based off of just admissions?

4 BY MS. ZIBAS:

09:54 5 Q. Admissions, maybe patient satisfaction.

6 MS. YANG: Objection, compound.

7 A. We do look at volume comparisons to other
8 facilities, yes.

9 BY MS. ZIBAS:

09:55 10 Q. What are the services that West Boca
11 Medical Center offers? And when I'm talking about
12 that, I'm talking like hip and knee replacement,
13 cardiac, et cetera? What are the lines of services
14 that are offered at West Boca?

09:55 15 A. Women's and children's services, including
16 labor and delivery, GYN, pediatrics, and there's a
17 whole plethora of subspecialties within those means.
18 We do a lot of surgery, both in-patient and
19 outpatient, including orthopedic, spine, general,
09:55 20 gastroenterology. We offer emergent services both
21 for adult and pediatric. And we offer general
22 medical services for acute care issues requiring
23 either inpatient or outpatient stay. We also offer
24 wide variety of therapies, both on the inpatient and
09:56 25 outpatient perspective.

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1 Q. How many operatories do you have for
2 surgery?

3 A. Six inpatient ORs, four outpatient ORs, two
4 GI suites, and an interventional radiology lab.

09:56 5 Q. Are you a trauma center?

6 A. We are not.

7 Q. Is there a plan for West Boca to become a
8 trauma center?

9 A. Not at this time, no.

09:57 10 Q. When West Boca Medical Center compares
11 itself to the competitors, do you look specifically
12 at just those hospitals that are offering the same
13 lines of service?

14 A. No. We include overall volumes.

09:57 15 Q. Does West Boca have a marketing department
16 or a person responsible for marketing?

17 A. We do.

18 Q. And is it one person or a team?

19 A. There's one person assigned to the
09:57 20 hospital, and then there's a group liaison, as well.

21 Q. And when you say assigned to the hospital,
22 what do you mean?

23 A. There's one marketing. We have a marketing
24 manager that works at West Boca.

09:58 25 Q. And are they paid by West Boca or are they

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1 paid by Tenet?

2 A. They're paid by West Boca.

3 Q. And who is that person?

4 A. Linda-Jean Long.

09:58 5 Q. And what are basically the -- does the
6 marketing person have a budget for marketing?

7 A. Yes.

8 Q. And who determines the budget?

9 A. It -- it's involved -- well, the corporate
09:58 10 office, as well as local leadership.

11 Q. And when you say local leadership, are you
12 referring to the Palm Beach Health Network
13 leadership?

14 A. As well as myself and my 18 med, plus West
09:58 15 Boca Medical Center.

16 Q. And is a marketing plan developed each
17 year?

18 A. Yes.

19 Q. As part of -- tell me some of the things
09:59 20 that -- that's a bad question.

21 What -- describe to me what's in the marketing
22 plan. For instance, is it social media? Is it
23 flyers? Is it, you know, Webinars?

24 A. It's a combination of community events,
09:59 25 education, social media posts, media, regular media,

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1 sponsorships.

2 Q. Do you have a social media manager?

3 A. No. It -- we have an outside company that
4 coordinates a lot of our social media posts, but it's
09:59 5 overseen and managed by our marketing manager.

6 Q. Who is the outside company, if you know?

7 A. I don't know their name.

8 Q. Are you involved, at all, in the strategy
9 on the social media side?

10:00 10 A. Yes.

11 Q. Looking at your patient population and that
12 visits West Boca, would you say most of them are
13 social media savvy?

14 MS. YANG: Objection to form. Calls for
10:00 15 speculation.

16 A. I wouldn't be able to answer that honestly
17 for the community or public.

18 BY MS. ZIBAS:

19 Q. Has your marketing person, Linda Long, ever
10:00 20 taken -- you know, done a survey to determine if your
21 population of patients is social media savvy? You
22 said median age potentially of 50. I know you don't
23 know for sure.

24 MS. YANG: Objection.

10:01 25 BY MS. ZIBAS:

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1 Q. Was any survey ever done or any evaluation
2 ever done?

3 MS. YANG: Objection, form compound.

4 A. I'm not exactly sure what you mean by
10:01 5 survey and what that survey would be measuring.

6 BY MS. ZIBAS:

7 Q. Well, has anybody ever tried to figure out
8 if the population uses social media at West Boca
9 Medical Center?

10:01 10 MS. YANG: Objection to form, lack of
11 foundation.

12 A. I think we want to go all avenues that we
13 can to educate the community, and social media is one
14 of those avenues that we utilize.

10:01 15 BY MS. ZIBAS:

16 Q. Do you utilize Google Analytics for West
17 Boca Medical Center?

18 A. What do you mean by Google Analytics? Is
19 there something specific that you're asking if they
10:01 20 measure?

21 Q. Yes. When you -- you can sign up for
22 Google Analytics, and you can ask for measurements of
23 who was searching for your website, who was searching
24 for statistics on the website, what services they're
10:02 25 looking for. That's what Google Analytics does.

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1 A. Okay.

2 MS. YANG: Objection to form.

3 Is there a question?

4 MS. ZIBAS: Yes. I asked do they use

10:02 5 Google Analytics, and he asked me to explain it.

6 MS. YANG: You can answer that question.

7 A. I know we utilize things such as Google
8 star ratings. I'm not specifically sure if there are

9 -- if they've hired Google Analyst -- Analytics to

10:02 10 specifically report anything.

11 BY MS. ZIBAS:

12 Q. What is Google star rating?

13 A. It's an opportunity for the community to
14 express their thoughts on various businesses,
10:02 15 entities.

16 Q. Do you know how Google star ratings works?

17 A. It's basically a polling of the patient or
18 the population, if they had a good experience,
19 various business or company.

10:03 20 Q. When we talked earlier about your CMS and
21 the reporting that is done, about how many hours are
22 spent in gathering the data for CMS? You said you
23 had a data abstractor, quality coordinator, director
24 of quality involved. Do you know approximately how
10:03 25 many hours are spent gathering that data?

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1 MS. YANG: Objection to form.

2 A. I wouldn't be able to give you an exact
3 number or even ballpark. It's going to be numerous
4 hours.

10:03 5 BY MS. ZIBAS:

6 Q. Have you ever heard of something called
7 Healthgrades?

8 A. I have.

9 Q. And explain to me what is Healthgrades in
10:04 10 your own words.

11 A. Healthgrades is an outside body that
12 utilizes CMS data and analyzes that publicly-reported
13 data to compare hospitals and highlight hospitals
14 that performed well compared to their perspective
10:04 15 counterparts.

16 Q. And does West Boca Medical Center
17 participate in Healthgrades?

18 A. Yes.

19 Q. And does West Boca Medical Center pay any
10:04 20 money to Healthgrades?

21 A. Yes.

22 Q. And what is the money paid for?

23 A. To advertise and license the data that they
24 have compiled and shared with us.

10:05 25 Q. And have you ever looked up the methodology

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1 of Healthgrades?

2 A. I have not looked up the methodology.

3 Q. Have you ever looked at the methodology for
4 the Leapfrog Group?

10:05 5 A. Methodology . . .

6 Q. To determine the safety grade.

7 A. I have looked to try to understand it,
8 but . . .

9 Q. And when did you look to try to understand
10:05 10 it?

11 A. Within this year, 2025.

12 Q. And why did you look it up this year?

13 A. Because of the poor rating that we
14 received.

10:05 15 Q. Does Tenet Healthcare ask West Boca Medical
16 Center to participate in Healthgrades?

17 MS. YANG: Objection to form. Assumes
18 facts.

19 A. They -- Tenet does not ask West Boca to
10:06 20 participate.

21 BY MS. ZIBAS:

22 Q. And is there anyone that has to spend time
23 or resources in providing data to Healthgrades at
24 West Boca?

10:06 25 A. Could you restate the question?

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1 Q. Yes. At West Boca Medical Center, you said
2 that you participate in Healthgrades, correct, or you
3 pay for Healthgrades, licensing data.

4 A. For Healthgrades, yes.

10:06 5 Q. Yes. So is there anyone that's assigned or
6 it's their job, as part of their job duty at West
7 Boca to provide data or information to Healthgrades?

8 A. No. They use publicly-reported data.

9 Q. And do you think it's accurate?

10:07 10 MS. YANG: Objection to form, lack of
11 foundation.

12 A. Do I think that the CMS data --

13 MS. ZIBAS: Healthgrades --

14 A. -- is accurate?

10:07 15 MS. ZIBAS: Yes.

16 A. Yes. I believe the CMS data is accurate.

17 BY MS. ZIBAS:

18 Q. Do you know if West Boca Medical Center
19 used to participate in taking the Leapfrog survey?

10:07 20 A. Yes. I believe they did prior to 2021.

21 Q. And do you know why that West Boca Medical
22 Center stopped participating?

23 A. It took a lot of resources to complete the
24 survey that we felt could be better dedicated towards
10:08 25 improving the overall scores rather than reporting

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1 the survey.

2 Q. And what resources were required that would
3 have been beyond the same people doing the CMS?

4 A. To complete the survey.

10:08 5 Q. And all right. So let's talk about the
6 survey, to the best of your information. So as far
7 as you -- you had testified earlier -- and I know you
8 went through some of this so I'm not going to ask you
9 to repeat it. But there were four very specific
10:08 10 things from the survey that are used in the safety
11 Healthgrades; correct? That was the CPOE, BCMA, hand
12 hygiene, and ICU physician staffing?

13 A. Those are just four of the things that are
14 included in the survey.

10:08 15 Q. Okay. So in the survey, beyond those four
16 things, is there anything else that has to be added
17 that wasn't already provided by CMS data?

18 MS. YANG: Objection to form. Vague and
19 lack of foundation.

10:09 20 A. There are other questions that are reported
21 on the website that come from the survey.

22 BY MS. ZIBAS:

23 Q. I know that you said you haven't read the
24 survey, but based on the information that you have
10:09 25 from your team and talking to them, what is the

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1 percentage of additional information that is required
2 in the survey that isn't already provided through
3 CMS?

4 MS. YANG: Objection to form. Vague and
10:09 5 calls for speculation.

6 A. There -- in terms of an exact number of
7 measures, there's probably 12 measures, I believe,
8 that if I'm recalling correctly, that are provided
9 through the survey.

10:10 10 BY MS. ZIBAS:

11 Q. And are those 12 measures in addition to
12 the four, the CPOE, the --

13 A. That includes the four.

14 Q. Okay. And who provided you the information
10:10 15 that there were 12 measures? Did you learn that on
16 your own or was that provided to you?

17 A. I learned that from our quality director.

18 Q. Now, did you learn in -- at any point in
19 time that the Leapfrog Group was changing their
10:10 20 methodology, their survey and their calculation of
21 the hospital safety grade?

22 A. I learned it when the grades significantly
23 declined.

24 Q. Okay. And who told you about the change?

10:10 25 A. Our director of quality.

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1 Q. And when did the grade significantly
2 decline?

3 A. On or about fall of '24.

4 Q. And do you recall what your director of
10:11 5 quality explained to you about the change?

6 A. She explained that the -- we had not
7 participated in the survey, and that if we had
8 submitted some of the information that they were
9 requesting, it would have improved our score.

10:11 10 Q. Now, in 2022 and 2023, was West Boca -- was
11 West Boca participating in the survey?

12 A. 2022, we stopped completing the survey, I
13 think, in 2021.

14 Q. Okay. So what was the letter grade in,
10:12 15 say, spring of 2023?

16 A. I believe we were a C.

17 Q. And then in fall of 2024, what was the
18 letter grade?

19 A. It dropped to a D.

10:12 20 Q. And then in 2025?

21 A. It was an F.

22 Q. So in -- when you -- when West Boca
23 received the C, was there a discussion or concern
24 about the letter grade then?

10:12 25 A. I think we -- there was not a discussion

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1 about the letter grade at that time. We were
2 focussed on the actual data, not so much the letter
3 grade from Leapfrog.

4 Q. And what data were you focussed on?

10:12 5 A. The CMS data.

6 Q. And after -- and in the new methodology or
7 the fall 2024 methodology, was there any discussion
8 or did you ever look up how it changed, specifically
9 how the scoring was done for those that did not
10:13 10 participate?

11 MS. YANG: Objection to form, vague and
12 compound.

13 A. Yes. There was discussion when we dropped
14 to a D, and Andrea gave me some insight into why we
10:13 15 had dropped.

16 BY MS. ZIBAS:

17 Q. And did -- and what did Andrea tell you?

18 A. That a lot of it was because it was based
19 off of information that was part of the survey that
10:13 20 we hadn't participated in.

21 Q. But as far as you understand it, was a --
22 was there a number given for West Boca Medical Center
23 for hand hygiene and ICU physician staffing, for
24 those four measures, BCMA and CPOE, was there an
10:14 25 actual number given?

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1 MS. YANG: Objection to form.

2 A. A number from whom or from --

3 BY MS. ZIBAS:

4 Q. For in the -- in the calculation for the
10:14 5 Leapfrog score, was there a number in the documents
6 you searched and reviewed?

7 MS. YANG: Objection to form.

8 A. I can't speak to -- to what Leapfrog
9 assigned to us. We were focussed on the data points
10:14 10 themselves, not necessarily the grade or Leapfrog's
11 calculation of that grade.

12 MS. YANG: We've been going a little over
13 an hour. When you get to a good stopping --

14 MS. ZIBAS: Oh, we can stop any time you
10:14 15 want. That's fine.

16 THE VIDEOGRAPHER: Off the record at 10:13
17 a.m.

18 (Brief recess was taken at 10:13 a.m.)

19 (Back on the record at 10:24 a.m.)

10:25 20 THE VIDEOGRAPHER: We're back on the
21 record. Time is 10:24 a.m.

22 MS. ZIBAS: All right. Mr. Hanlon, we're
23 continuing questioning.

24 BY MS. ZIBAS:

10:25 25 Q. So let me ask you, does Tenet Healthcare

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1 ever have meetings with you as CEO of West Boca
2 Medical Center?

3 MS. YANG: Objection to form.

4 A. Tenet Healthcare is a broad term. I guess
10:25 5 is there a specific individual?

6 BY MS. ZIBAS:

7 Q. Well, who do you -- is there anyone that
8 you, as CEO, report to at Tenet Healthcare
9 Corporation?

10:26 10 A. I report to Maggie Gill.

11 Q. And other than Maggie, do you ever have
12 meetings with other people from Tenet Healthcare in
13 your role as CEO?

14 MS. YANG: Objection to form.

10:26 15 A. Yes. I meet with other employees of Tenet
16 Healthcare.

17 BY MS. ZIBAS:

18 Q. Do you ever meet with people in the finance
19 -- well, back up. Is there a finance group or CFO at
10:26 20 Tenet Healthcare?

21 A. There is a CFO at Tenet Healthcare. Yes.

22 Q. Do you ever meet with the CFO of Tenet
23 Healthcare?

24 MS. YANG: Objection to form.

10:26 25 A. I haven't recently. I think the last time

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1 I met with the CFO directly was when I interviewed
2 for the position.

3 BY MS. ZIBAS:

4 Q. Do you have to prepare reports on a monthly
10:26 5 or quarterly basis to submit to Tenet about West Boca
6 Medical Center?

7 MS. YANG: Objection to form.

8 A. Myself personally, I am involved in a lot
9 of our monthly reporting in coordination with several
10:27 10 other individuals at the hospital.

11 BY MS. ZIBAS:

12 Q. And who do you coordinate with at the
13 hospital?

14 A. For the monthly reporting?

10:27 15 Q. Correct.

16 A. Our CFO, our chief nursing officer, our
17 chief operating officer.

18 Q. Does Maggie ever ask you for your input
19 regarding participating in the Leapfrog Group?

10:27 20 MS. YANG: Objection to form, vague.

21 A. Has she ever asked me?

22 BY MS. ZIBAS:

23 Q. Yes.

24 A. Or does she?

10:27 25 Q. Well, has she ever?

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1 A. Has she asked me if I wanted to
2 participate --

3 Q. Correct.

4 A. -- in the Leapfrog Group?

10:28 5 Q. Correct.

6 A. She has not specifically asked me if I
7 wanted to participate in the Leapfrog Group.

8 Q. Have you ever -- have you ever attended
9 meetings with the Palm Beach Health Network in the
10:28 10 last two years, meaning the officers?

11 A. Yes.

12 Q. And during any of those meetings, did the
13 topic of participating in the Leapfrog Group survey
14 ever come up?

10:28 15 A. In those meetings?

16 Q. Yes.

17 A. Yes.

18 Q. And what was discussed, sum and substance?

19 A. Based off of the revised grades, whether or
10:28 20 not it was something that we should consider
21 participating in.

22 Q. And was a decision, to the best of your
23 knowledge, made whether the -- there would be a
24 request to the home office to participate in Leapfrog
10:29 25 Group, again?

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1 MS. YANG: Objection to form. Vague,
2 assumes facts.

3 A. I personally did not make a request to the
4 home office to participate in Leapfrog Group.

10:29 5 BY MS. ZIBAS:

6 Q. Do you know if anyone else in the Palm
7 Beach Health Network officers, of the officers, asked
8 to participate?

9 A. I couldn't speak --

10:29 10 MS. YANG: Objection to form.

11 A. I couldn't speak for them.

12 BY MS. ZIBAS:

13 Q. Do you know -- do you have an understanding
14 of what the CMS star ratings measure?

10:29 15 A. Yes.

16 Q. And what is that, what's your
17 understanding?

18 A. There's a wide variety of data measures,
19 both quality and satisfaction, that are included in
10:29 20 that.

21 Q. And do you know how West Boca Medical
22 Center has -- what star they received from CMS?

23 A. Two.

24 Q. And when did they receive a two?

10:30 25 A. The most recent.

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1 Q. And prior to the most recent, what was the
2 star rating?

3 A. If I recall, I believe we've been a two for
4 -- more recently.

10:30 5 Q. What do you define as more recently?

6 A. As in 2025.

7 Q. What about in 2024, what was the CMS star
8 rating?

9 A. I don't recall off the top of my head.

10:30 10 Q. Did -- did West Boca Medical Center ever
11 receive a one CMS star rating?

12 A. I believe we are anticipating a one star in
13 the data that will be coming out.

14 Q. And why are you anticipating a one?

10:31 15 MS. YANG: Objection to form.

16 A. Just based off the data that has been
17 submitted to us.

18 BY MS. ZIBAS:

19 Q. And what data was submitted to you that
10:31 20 indicates that you would be getting a one?

21 A. The quality data that we report.

22 Q. And what quality data do you report?

23 A. A wide variety, things from CLABSI, central
24 line-acquired bloodstream infections; CAUTIs,
10:31 25 catheter-associated urinary tract infections, MRSA,

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1 C. diff, patient satisfaction. There's a wide
2 variety of measures that come into the CMS star
3 rating.

4 Q. Do you know what the CMS patient experience
10:32 5 score is?

6 A. That's a broad question because there's
7 multiple questions as part of the patient
8 satisfaction survey.

9 Q. Prior to January 2025, was there ever a
10:32 10 quality improvement plan in place at West Boca
11 Medical Center?

12 A. Yes.

13 Q. And was there a quality improvement plan in
14 place in 2024?

10:32 15 A. Yes.

16 Q. What about 2023?

17 A. Yes.

18 Q. And did you participate in the drafting of
19 the quality improvement plan?

10:32 20 A. I didn't participate in the drafting, but
21 in the approval and in subsequent changes and review
22 of the quality improvement plan.

23 Q. And what did West Boca consider to be the
24 top areas of need of improvement in the quality
10:33 25 improvement plan?

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1 MS. YANG: Objection to form, outside the
2 scope.

3 A. There's several items that we pay attention
4 to and focus on and do this on a monthly basis.

10:33 5 BY MS. ZIBAS:

6 Q. So does the quality improvement plan change
7 monthly?

8 A. The plan itself does not. The review of
9 the data and how we're performing to identify any
10:33 10 trends that we need to address and modify our
11 practice or process in order to continue to improve.

12 Q. And does West Boca Medical Center have a
13 patient safety improvement plan in place?

14 MS. YANG: Objection to form, vague.

10:33 15 A. Patient safety improvement plan?

16 BY MS. ZIBAS:

17 Q. Yes.

18 A. We have a patient safety plan that includes
19 ways that we want to improve.

10:33 20 Q. And is the patient safety plan updated
21 every year?

22 A. It's reviewed.

23 Q. Has anyone at Tenet Health -- Tenet
24 Healthcare headquarters ever expressed concern over
10:34 25 the CMS star rating of West Boca Medical Center?

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1 MS. YANG: Objection to form, vague, lack
2 of foundation.

3 A. Has anyone at Tenet Healthcare?

4 BY MS. ZIBAS:

10:34 5 Q. Tenet Healthcare, yeah, headquarters.

6 A. Again, defining headquarters is -- I'm a
7 Tenet employee, Maggie is a Tenet employee, so yes,
8 there's been concern expressed about making sure that
9 we're continuing to improve.

10:34 10 Q. And who has expressed the concern?

11 A. As I just said, myself and Maggie Gill.

12 MS. ZIBAS: I am going to hand you what has
13 been marked as Exhibit 2.

14 (Exhibit 2 was marked.)

10:35 15 BY MS. ZIBAS:

16 Q. It's the declaration that you may be
17 familiar with. It's declaration of Jared Hanlon, and
18 it is executed on May 13, 2025.

19 A. Yes.

10:35 20 Q. Okay. And are you familiar with this
21 declaration?

22 A. I am.

23 Q. Did you draft this declaration?

24 A. I didn't draft it. I reviewed it and
10:36 25 modified.

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1 Q. And do you believe everything in this
2 declaration is accurate to the best of your ability?

3 A. I do.

4 Q. If you turn to page 4, we're looking at the
10:36 5 end of paragraph 9. I'm going to be asking you
6 specific questions regarding some of the statements
7 made in this declaration. And at the top of the
8 page, page 4, it says the entities that award and
9 assign these accreditations visit the healthcare
10:36 10 facility and performed regular periodic in-person
11 reviews, audits, surveys, and assessments of the
12 facility.

13 A. I'm sorry. I'm trying to --

14 Q. It's at the top.

10:36 15 A. Page 4.

16 Q. That top sentence.

17 A. Okay. Got you.

18 Q. That sentence, it starts, you know, it's
19 the end of your paragraph 9.

10:36 20 A. Okay. Okay.

21 Q. When you say the entities that award and
22 assign these accreditations, what entities are you
23 referring to?

24 A. The Joint Commission.

10:37 25 Q. Is The Joint Commission the only entity

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1 that comes in for in-person reviews, audits, surveys,
2 and assessments of the facility?

3 A. It is not the only entity that comes in.
4 There's other entities, such as AHCA and other
10:37 5 regulatory entities.

6 Q. Now, if you go down to paragraph 11, there
7 is a reference to Healthgrades.

8 A. Uh-huh.

9 Q. That we had briefly talked about before.
10:37 10 Do you consider Healthgrades a pay-to-play scheme?

11 MS. YANG: Objection to form, vague.

12 A. Can you explain what you mean by
13 pay-to-play?

14 BY MS. ZIBAS:

10:38 15 Q. You don't know, that's fine. We'll go
16 further along and hopefully we'll be able to figure
17 that out, and we can come back to that based on the
18 language in here.

19 So page -- paragraph 12, page 5, there's a
10:38 20 paragraph about when we decide whether to provide our
21 hospital's data to commentators, my colleagues,
22 leadership, and I consider the fairness and accuracy
23 of each commentator's methodology for processing and
24 compiling data because we know the patients base
10:38 25 important medical decisions on these types of

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1 reports.

2 Are you referring to, in that sentence, to the
3 Leapfrog Group?

4 A. I'm referring to every accreditation that
10:39 5 we consider. Leapfrog is not the only, you know,
6 body out there that evaluates hospitals.

7 Q. And was the Leapfrog Group analyzed --

8 A. Yes.

9 Q. -- as you stated in this paragraph?

10:39 10 Okay. And what was done to analyze the Leapfrog
11 Group methodology?

12 A. In terms of we considered the amount of
13 effort and time that would have to be contributed to
14 participate, as well as any cost that might be
10:39 15 associated with that to determine which ones we feel
16 provide the most accurate and worthwhile presentation
17 to our patient base and community.

18 Q. And what were the costs associated with the
19 Leapfrog survey that were estimated?

10:40 20 A. I think a lot of it is based on the amount
21 of time and effort, and obviously I have to pay the
22 staff members to complete that information.

23 Q. And what was the estimated time that you
24 would have had to pay?

10:40 25 A. It would have been significant in terms of

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1 the number of hours. To give you an exact number, I
2 can't say for certain, but it was a -- it's a pretty
3 involved survey.

4 Q. And would it have been -- would it have
10:40 5 been more time than the time spent submitting data to
6 CMS?

7 MS. YANG: Objection to form. Vague and
8 calls for speculation.

9 A. The data that we submit to CMS is required.
10:40 10 It's mandatory. There are other questions involved
11 in the survey, the Leapfrog survey, that are outside
12 even just the CMS reporting that would have taken
13 time to compile and complete.

14 BY MS. ZIBAS:

10:41 15 Q. If you look at paragraph 13, we're going to
16 sort of dissect some of your statements here. Does
17 Healthgrades -- back up.

18 Do you consider Healthgrades a rating? Is
19 that -- do you consider that a rating for the
10:41 20 hospital, Healthgrades?

21 MS. YANG: Objection to form, vague.

22 A. I feel like it's a grade, yes.

23 BY MS. ZIBAS:

24 Q. Grade. Okay. And would you consider a
10:41 25 Healthgrades' grade the same as the Leapfrog Group

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1 safety grade?

2 MS. YANG: Objection.

3 MS. ZIBAS: Grade.

4 MS. YANG: Objection to form vague.

10:41 5 MS. ZIBAS: Or similar.

6 A. I think they're two different -- they are
7 looking at two different things.

8 BY MS. ZIBAS:

9 Q. And describe the best you can, what are
10:42 10 they looking at that are two different things?

11 A. Well, the Leapfrog survey includes, in
12 addition to CMS information, also the information
13 provided through the survey. Healthgrades purely
14 looks at the CMS data.

10:42 15 Q. And if you go further down in paragraph 13,
16 you say given the serious problems in TLG's
17 methodology -- and I assume TLG refers to Leapfrog
18 Group -- it was clear to our leadership that the
19 hospital, its doctors, its patients, and the
10:42 20 community would benefit far more from us no longer
21 spending time, energy, and funds towards providing
22 TLG the onerous data it sought and instead
23 redirecting those resources towards patient services
24 and providing the highest quality care.

10:42 25 Can you explain to me what are -- what are the

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1 serious problems in the TLG's methodology?

2 A. I think it involves the computation model
3 that they're using to award the grades. It's not --
4 it's not based solely off of publicly-reported data.

10:43 5 There's actual other data that is included that has
6 to be submitted by the facility, requiring them to
7 expend resources to provide that data.

8 Q. Now, are you aware that if you're a
9 nonparticipating hospital in the survey, you still do
10:43 10 get a score?

11 A. Correct.

12 Q. And do you understand that that score is
13 just the lowest achieved score. Do you understand
14 that? For all hospitals?

10:43 15 A. Correct. And that's why we feel its
16 inaccurate.

17 Q. But prior to the change in the survey,
18 prior to 2024, are you aware that the score that was
19 used for nonparticipating survey hospitals was closer
10:44 20 to a perfect score?

21 MS. YANG: Objection to form.

22 A. Again, I don't know enough about the
23 specifics of Leapfrog's methodology and how they're
24 computing these grades.

10:44 25 BY MS. ZIBAS:

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1 Q. Okay. If you go to the next page, page 7.
2 And paragraph 18, you, in that second sentence there,
3 it shows that if you participate in its pay-to-play
4 time-consuming hospital survey, TLG assigns you a
10:45 5 better grade. What do you mean by that in that
6 sentence?

7 MS. YANG: I'm sorry. Can you point me to
8 the sentence one more time, what paragraph?

9 MS. ZIBAS: 18, second sentence.

10:45 10 MS. YANG: Thank you.

11 A. Could you restate the question? I'm sorry.
12 BY MS. ZIBAS:

13 Q. Yes. What does that mean, pay-to-play,
14 time consuming hospital survey that you wrote there
10:45 15 in your declaration?

16 A. So it is a time-consuming survey and if --
17 for the participants who don't submit the survey,
18 they are penalized.

19 Q. Does it cost money to submit the survey?

10:45 20 A. It doesn't cost money to submit the survey,
21 other than the time it takes us and the money that it
22 costs us to pay or employees to compile the
23 information.

24 Q. So what do you mean by pay-to-play?

10:46 25 A. Well, Leapfrog Group uses the data that is

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1 submitted and monetizes that by selling licensure and
2 advertising for the ability to do that. And in order
3 to get that data, they ask participants to --
4 hospitals to submit the survey. That survey costs us
10:46 5 time, money, and resources to complete, so therefore,
6 I'm having to pay to participate in that. And if I
7 don't participate in the survey, I'm inappropriately
8 penalized for information that they don't have.

9 Q. So going back to the question I asked you
10:46 10 about Healthgrades, aren't you paying for the
11 licensing to use their logo after you get their
12 grade?

13 A. I am.

14 Q. And is that -- is Healthgrades then a
10:46 15 pay-to-play, as well?

16 A. The data to play, we don't pay anything to
17 participate, and it doesn't expend resources for us
18 to submit the data anymore than what we're already
19 required to do through CMS.

10:47 20 Q. So it's just the additional data that
21 Leapfrog Group asks you about those four measures and
22 a few other measures. Is that what you're referring
23 to as the time-consuming survey?

24 MS. YANG: Objection to form. Misstates
10:47 25 testimony.

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1 A. It's not only the those -- that data, but
2 it's methodology that they use to award that grade,
3 and the added fact that there is data that's not
4 submitted.

10:47 5 BY MS. ZIBAS:

6 Q. That same sentence refers to see Exhibit 3.
7 If you could take a look at your see Exhibit 3, and
8 apologize for the font being so small, but that's the
9 way it was submitted to us. I tried to make it
10:47 10 bigger but I can't.

11 A. Okay.

12 Q. Now, in the declaration, you reference
13 Exhibit 3 as a true and correct copy of the TLG
14 spring 2025 calculator TLG shared with the medical
10:48 15 center. Do you see that, this Exhibit 3, is this a
16 calculator that you're referring to to figure out the
17 score?

18 A. I'm sorry. Where are you?

19 Q. Exhibit 3, you reference --

10:48 20 A. Okay.

21 Q. Okay. Now, is this, Exhibit 3, the
22 calculator you're referencing when you look at the
23 numbers for the Leapfrog Group score?

24 A. Yes.

10:48 25 Q. And do you see that there are scores in

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1 there for CPOE, BCMA?

2 A. Correct.

3 Q. Physician and hand hygiene.

4 A. Uh-huh.

10:49 5 Q. So it's -- so as far as you know, are these
6 accurate or not, these numbers?

7 MS. YANG: Objection to form.

8 A. That's what Leapfrog is saying they awarded
9 to us.

10:49 10 BY MS. ZIBAS:

11 Q. But there were numbers in the calculator
12 for these measures, these four measures; correct?

13 A. That was populated by Leapfrog Group and
14 not based on any information that we entered in.

10:49 15 Q. And was it based on the fact that it was
16 the lowest achieved score of the participating
17 hospitals?

18 A. I don't know what -- exactly what that's
19 based off of. Again, we didn't submit the data, so
10:49 20 we -- I don't feel we should have been graded on
21 that. It's only information that they didn't have.

22 Q. Okay. Going back to when we were
23 discussing what the methodology is, do you understand
24 that as of fall 2024, for those that aren't
10:50 25 participating, you're receiving a grade of a

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1 participating hospital, but it's the lowest score?

2 MS. YANG: Objection to form, vague.

3 MS. ZIBAS: Is that your understanding?

4 A. Again, we didn't participate.

10:50 5 BY MS. ZIBAS:

6 Q. But for the methodology, I'm just asking
7 about the methodology. I understand you didn't
8 participate. But is that the methodology?

9 A. I can't speak to --

10:50 10 MS. YANG: Objection to form, vague.

11 A. I can't speak to Leapfrog Group's
12 methodology when it wasn't something that we
13 participated in.

14 BY MS. ZIBAS:

10:50 15 Q. When you have reviewed the website, did you
16 ever see anything about how the methodology was
17 determined? How the numbers were determined?

18 A. I did.

19 Q. Now, if you look at page 8 of your
10:50 20 declaration, you talk about this paragraph 19 is
21 entitled TLG deceived our potential and current
22 patients with deceptive safety grades easily reached
23 on Google. What do you mean by that statement in
24 your declaration?

10:51 25 A. We feel that the grade that was awarded to

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1 us is inaccurate and deceptive, and it's available by
2 searching on Google.

3 Q. And who selected the Google search term
4 hospital safety rankings that's listed in your
10:51 5 declaration?

6 MS. YANG: Objection to form.

7 A. Can you point me to where you're --

8 BY MS. ZIBAS:

9 Q. Right there.

10:51 10 A. Repeat.

11 Q. I said, who selected that search term,
12 hospital safety rankings? Because you reference
13 Google hospital safety ranking search term. Who
14 selected them for your --

10:52 15 MS. YANG: Objection above.

16 A. This is for an instance, so that's just one
17 example of what we could Google and what pops up.

18 BY MS. ZIBAS:

19 Q. Have you received any complaints from
10:52 20 patients about your Leapfrog rating?

21 A. Yes.

22 Q. Okay. How many patients?

23 MS. YANG: Objection to form.

24 A. How many patients have --

10:52 25 BY MS. ZIBAS:

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1 Q. Have contacted West Boca Medical Center
2 about the Leapfrog safety grade?

3 MS. YANG: Objection to form, calls for
4 speculation and outside the scope.

10:52 5 You can answer in your individual capacity,
6 to the extent you know.

7 A. Okay. I've had -- I can give some specific
8 examples of patients that have vocalized and
9 verbalized to us. I can't speak for the number of
10:52 10 patients that never even gave us an opportunity or
11 voiced their concern to us directly, but have in the
12 community.

13 But yes. I've got examples of patients. We had
14 a patient in our freestanding emergency department
10:53 15 that came and sought care, emergency care in our ED,
16 and needed surgery and decided to leave, against
17 medical advice, to go to another facility, and she
18 vocalized that that was because the Leapfrog rating
19 that she had seen publicized and wanted to go to a
10:53 20 different facility.

21 BY MS. ZIBAS:

22 Q. Where did she see it publicized? Did she
23 tell you?

24 A. It's been in social media and in the papers
10:53 25 and . . .

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1 Q. Did you ask this patient where specifically
2 they saw the information?

3 A. I did not, no.

4 Q. When you prepared your declaration, I
10:53 5 understand these are for instant search terms, but do
6 you have anyone internally at West Boca that is
7 advising you or assisting you with your Google search
8 terms and rankings and addressing any concerns you
9 may have about your Google search term and rankings?

10:54 10 MS. YANG: Objection to form, compound.

11 A. No. I think that's just an example of one
12 of the search terms that any person could search in
13 Google.

14 BY MS. ZIBAS:

10:54 15 Q. Do you agree that depending on your search
16 term, makes a difference what comes up when you do a
17 Google search?

18 A. I can't speculate to that, no.

19 Q. So this one person that complained in the
10:54 20 emergency department, is there any other one example
21 that you can think of of someone who complained that
22 they did not seek care at West Boca because of the
23 Leapfrog Group score or grade?

24 A. I've had numerous physicians approach me
10:54 25 with patients that have questioned them about it.

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1 I've had board members. We've had Google reviews
2 left that specifically site the Leapfrog rating.

3 Q. Did you provide those Google reviews as
4 part of your discovery, documents that you gathered
10:55 5 for this lawsuit?

6 A. Yes.

7 Q. And which board members or how many board
8 members talked to you about, you know, concerns about
9 the Leapfrog grade?

10:55 10 A. Several. Chief Neil Nemechek posed
11 questions because some of his paramedics and EMTs had
12 been hearing it from patients. Van Williams, Palm
13 Beach State College Provost for the Boca campus.
14 Sheri Scarborough. I've had Dr. Norina Ocampo, who
10:56 15 is on our medical executive committee and former
16 chief of staff, reach out because patients of hers
17 have -- had asked her about the Leapfrog Group.

18 Q. Do you know if these people that made
19 mentioned the Leapfrog Group, was it because of the
10:56 20 newspaper coverage, or did they actually go to the
21 website?

22 MS. YANG: Objection to form, lack of
23 foundation.

24 A. I think it's probably a combination of
10:56 25 both. I can't say with any certainty that they --

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1 whether they went to the website first or saw the
2 newspaper articles and some of the advertising in
3 some of the other hospitals are doing and then went
4 to the site. So I can't speculate.

10:56 5 BY MS. ZIBAS:

6 Q. For all the examples that you just ran
7 through, do you know for sure -- well, I mean, can
8 you confirm that all the patients that raise concerns
9 actually went to the website?

10:57 10 MS. YANG: Objection to form, vague, calls
11 for speculation.

12 A. I can't confirm that, no.

13 BY MS. ZIBAS:

14 Q. Did anyone at West Boca Medical Center ever
10:57 15 go out and contact these individuals and ask them for
16 more information about their -- whether they reviewed
17 the Leapfrog website?

18 MS. YANG: Objection to form, outside the
19 scope. You can answer in your individual
10:57 20 capacity.

21 A. I can tell you we did with some of the
22 board members. With the patients, I didn't reach
23 out.

24 BY MS. ZIBAS:

10:57 25 Q. So if you look at, going back to your

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1 declaration, page 12, paragraph 23. You reference a
2 drop in elective patient encounters after TLG
3 released its fall 2024 grade. What was the
4 percentage drop?

10:57 5 MS. YANG: Objection to form.

6 A. The percentage drop, I can't give you an
7 exact amount because it just depends on the timeframe
8 that you're looking at. I just know overall, we have
9 seen a reduction in our elective patient encounters.

10:58 10 BY MS. ZIBAS:

11 Q. Was there a drop in revenue?

12 A. For those particular, yes.

13 Q. And what are elective patient encounters?

14 A. It's going to be outpatient, elective
10:58 15 surgeries, patients choosing to come to our emergency
16 department and in an emergent condition.

17 Q. Do you think the fact that West Boca
18 Medical Center is not a trauma center deters some of
19 the people coming to your emergency department?

10:59 20 MS. YANG: Objection to form, calls for
21 speculation.

22 A. I think -- I don't think patients know
23 necessarily the differentiation between a trauma and
24 emergency. They're just going to their closest
10:59 25 emergency room.

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1 BY MS. ZIBAS:

2 Q. You further -- you go down in paragraph 24.

3 The sentence says the damage caused by the TLG grades
4 has been significant. Can you please describe to me

10:59 5 what you mean by that sentence? What is the damage?

6 A. I think in terms of our reputation, our --

7 which has ultimately led to the volume decline. I

8 think the goodwill and the things that we're

9 providing to the community has been tarnished because

10:59 10 of this. I think it's required a lot of expense,

11 resources, and time to explain this to not only our

12 board members, medical staff, and staff, but also to

13 try to convey an accurate portrayal to the community,

14 as well.

11:00 15 Q. How much time has been spent trying to

16 counteract the inaccurate, negative picture created

17 in the community? How much time?

18 MS. YANG: Objection to form, vague.

19 A. Numerous hours.

11:00 20 BY MS. ZIBAS:

21 Q. What resources have been used to have to

22 counteract the inaccurate, negative picture created

23 in the community? It says time and resources. What

24 resources?

11:00 25 A. Time and our -- the skill set and abilities

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1 of our individuals and employees at the hospital that
2 could have otherwise been dedicated towards impacting
3 the actual results instead of responding to TLG.

4 Q. So the -- wait a minute. The resources
11:01 5 here is to counteract, is that what you're referring
6 to? I'm asking about the resources spent to
7 counteract the inaccurate, negative picture?

8 A. Correct. We've had to do various community
9 education events to -- whether it be in social media
11:01 10 or through conversations with staff, medical staff,
11 board members, community individuals.

12 Q. Has the time and resources spent, has it
13 been quantified and reported to Maggie and/or others
14 at Tenet Healthcare headquarters?

11:01 15 A. I would say it can't -- it's challenging,
16 if not impossible, to completely quantify this.

17 Q. Okay. Was it -- was more time spent to
18 counteract the inaccurate, negative picture of TLG
19 than would have been spent in completing the survey?

11:02 20 MS. YANG: Objection to form.

21 A. Again, without knowing how many hours it
22 would take to complete the survey, nor understanding
23 an exact amount for how many hours is spent, it's
24 difficult to compare the two.

11:02 25 BY MS. ZIBAS:

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1 Q. So there's -- so the time has not been
2 quantified by West Boca Medical Center; correct?

3 A. What time?

4 Q. The time to counteract or the time to
11:02 5 complete the survey?

6 A. It hasn't. There isn't a specific number.
7 It's just a significant amount of time.

8 Q. What do you mean by loss of goodwill to the
9 hospital?

11:02 10 A. I think the reputation harm that it has
11 portrayed to the community.

12 Q. And what is that harm? How do you quantify
13 that?

14 A. Again, the example I gave, patients
11:02 15 choosing to go elsewhere. We've really done some
16 significant improvements in our patient perception,
17 in our community perception, as indicated by the
18 increase in our Google star rating, and this
19 counteracts a lot of that goodwill that we have built
11:03 20 over the last several years with our community.

21 Q. What's the -- how many people participated
22 to reach the Google star rating?

23 A. There's -- we've received well over 2 --
24 2,000 reviews.

11:03 25 Q. But so far, we don't have anything but one

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1 specific person that actually said that they wouldn't
2 receive services at West Boca because of Leapfrog;
3 right? Correct? You only have the one person you
4 can really specify?

11:03 5 MS. YANG: Objection to form, vague.

6 A. That's just one. There's probably more
7 that you could assume that didn't take the time to go
8 out and complete it online, but just chose to go
9 elsewhere because the negative rating.

11:04 10 BY MS. ZIBAS:

11 Q. Do you think the CMS star rating impacts
12 the reputation of West Boca medical?

13 MS. YANG: Objection to form.

14 A. I do.

11:04 15 BY MS. ZIBAS:

16 Q. And how do you differentiate whether it's
17 the Leapfrog Group grade or the CMS star rating
18 that's impacting the reputation of Boca -- West Boca
19 Medical Center?

11:04 20 MS. YANG: Objection to form, vague.

21 A. I think because they're measuring different
22 things. The CMS star ratings are required mandatory;
23 whereas, the TLG relies upon some additional
24 information, as well as an algorithm or a computation
11:04 25 model that's different.

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1 BY MS. ZIBAS:

2 Q. Now, looking at page 13, paragraph 27.

3 First sentence says the medical center has worked
4 tirelessly to ensure it is providing high-quality
11:05 5 care and improving patient health outcomes. Please
6 describe to me what has been at West Boca to ensure
7 it's providing high-quality care and improving
8 patient health outcomes?

9 A. So this is -- this is a multifaceted
11:05 10 approach. We review our data on a monthly and even
11 weekly basis to see how we are trending to make
12 improvements to adjust the direction that we're
13 moving to ultimately achieve our goals of providing
14 high-quality care in our community.

11:05 15 Q. Have any consultants been hired to help
16 West Boca Medical Center improve its quality care?

17 A. Consultants?

18 Q. Outside consultants.

19 A. I mean, we've -- we've had Press Ganey come
11:06 20 in and help us with our patient satisfaction tactics
21 for doing that. We've hired -- well, we paid The
22 Joint Commission to come in and evaluate our programs
23 and give us feedback. So yes, we've hired
24 consultants.

11:06 25 Q. So what does -- what has Press Ganey done

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1 for West Boca Medical Center?

2 A. Press Ganey is the company that administers
3 or HCAHPS surveys. So the patient satisfaction is
4 required by CMS. And they have come in and shared
11:06 5 best practices from some of the other facilities that
6 they also measure.

7 Q. And what about The Joint Commission? What
8 have they specifically been doing to aid West Boca
9 Medical Center?

11:07 10 A. So we've invited them to come in and
11 evaluate various programs, such as our hip, knee, and
12 spine programs to give us feedback on ways that we
13 can improve. I think the hip, knee, and shoulder
14 survey that we did was extremely impressive. We
11:07 15 didn't have a single recommendation for improvement,
16 and The Joint Commission surveyor highly touted our
17 program there. We're in the process of applying for
18 our spine certification and expect a survey here
19 either later this year or first part of next year.

11:07 20 Q. How many surgeons do you -- are on staff
21 with privileges to perform procedures under hip,
22 knee, and spine?

23 A. I can't give you an exact number.

24 Q. Now, with Press Ganey, did they look at
11:08 25 specific measures when they provided consulting

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1 services, or they just looked at general patient
2 experience?

3 MS. YANG: Objection to form, vague.

4 A. They looked at what would have the greatest
11:08 5 impact in improving our scores.

6 BY MS. ZIBAS:

7 Q. And what did Press Ganey advise you?

8 A. To really focus in on our nurse
9 communication.

11:08 10 Q. Did Press Ganey say there was a lack of
11 nurse communication?

12 MS. YANG: Objection, form.

13 A. No. They just identified that as the -- an
14 area that we could get -- significantly improve our
11:09 15 scores by focussing on that component of the HCAHPS
16 questions.

17 BY MS. ZIBAS:

18 Q. Does West Boca Medical Center evaluate the
19 hand hygiene of its employees?

11:09 20 A. Yes.

21 Q. And is that done as part of CMS or is that
22 done as part of its quality program?

23 A. It's done as part of our quality program.

24 Q. Does West Boca ever look at the physician
11:09 25 ordering entry system as part of its review?

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1 A. Yes.

2 Q. And do they look at staffing of critical
3 care units as part of their review?

4 A. We address our ICU staffing, yes.

11:10 5 Q. And does West Boca Medical Center, as part
6 of its quality review, also look at the Barcode
7 Medication Administration?

8 A. Yes.

9 Q. And is this all done by -- is that Ms.
11:10 10 Nunes as the director of quality, is it under her
11 group?

12 A. It's her team and it's reported up through
13 QUIPSY.

14 Q. And what does West Boca do with this data
11:10 15 that it gathers from these measures?

16 A. We review it and identify any trends, both
17 positive and/or negative to adapt process and
18 improvement, reeducation, those sorts of things, to
19 improve upon those.

11:10 20 Q. And by gathering this data, is this not the
21 same data that you would need for the Leapfrog
22 survey?

23 MS. YANG: Objection to form, lack of
24 foundation.

11:10 25 A. Again, I don't know the exact questions

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1 that they are -- that Leapfrog Group is requesting.

2 BY MS. ZIBAS:

3 Q. So when -- since the quality group or the
4 quality team is reviewing these four measures, you

11:11 5 would -- West Boca Medical Center must consider these
6 four measures important; is that correct?

7 MS. YANG: Objection to form, vague.

8 A. I guess, yes.

9 BY MS. ZIBAS:

11:11 10 Q. Going back to the term goodwill that you
11 had in your declaration, is there any way you can
12 describe how West Boca Medical Center quantifies the
13 loss of goodwill?

14 MS. YANG: Objection to form, vague.

11:12 15 A. I think the decrease in volume is just one
16 example of how we've -- if people have goodwill
17 towards or you're in a good reputation to your
18 facility, they will likely utilize your facility
19 more. If they don't, they will seek their care
11:12 20 elsewhere.

21 BY MS. ZIBAS:

22 Q. When you talk about volume, what
23 specifically are you referring to as volume is
24 decreased? Are you talking about the elective

11:12 25 outcomes, the outpatient treatment?

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1 A. Both elective, and in the example that I
2 gave, the one patient that came to the emergency
3 room, even it's impacting our emergency care.

4 Q. So percentage-wise, are the admissions
11:12 5 down?

6 MS. YANG: Objection to form.

7 A. Overall admissions?

8 BY MS. ZIBAS:

9 Q. Yes.

11:12 10 A. Yes.

11 Q. And you think that's caused by the Leapfrog
12 Group?

13 A. In part, yes.

14 Q. It's not caused by the CMS ratings?

11:13 15 A. That probably has a factor in it, as well.

16 Q. But revenues are up at the hospital
17 overall?

18 A. Revenues for the overall hospital, yes, are
19 up.

11:13 20 Q. And where would you say is the most
21 revenue? Is it driven by emergency room transfers,
22 admissions? Where is the highest dollar volume of
23 revenue generated?

24 MS. YANG: Objection to form, vague, and
11:13 25 outside the scope.

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1 You can answer, if you know in your
2 individual capacity.

3 MS. ZIBAS: If you know. If you don't, I
4 understand that.

11:13 5 A. It's spread across all. I mean, it's going
6 to be a combination of NICU, labor and delivery,
7 surgical volume, and admission.

8 BY MS. ZIBAS:

9 Q. In 2024 and 2025, had you had any
11:13 10 physicians surrender their privileges at the
11 hospital?

12 A. Resign, yes.

13 Q. And how many have resigned?

14 A. Oh, I don't know the exact number off the
11:14 15 top of my head.

16 Q. And do you know why they resigned?

17 A. Some have moved out of the state. Some
18 have retired. It's a wide range of reasons.

19 Q. All right. So now we're going to go back
11:14 20 to this Hanlon Number 3, which I showed you, which we
21 marked previously. And you pointed out that this --
22 I'm going to represent to you this is a page from
23 hospitalsafetygrade.org website. And you pointed out
24 earlier that the only the highlighted section is
11:14 25 safety problems. And if you go to the second page,

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1 you see where number one in red, it says decline to
2 report. The hospital was asked to provide this
3 information to the public but did not. Do you see
4 that sentence?

11:15 5 A. I do.

6 Q. Is that accurate?

7 MS. YANG: Objection to form, lack of
8 foundation.

9 MS. ZIBAS: Foundation is I'm asking based
11:15 10 on looking at this website page.

11 MS. YANG: Same objection.

12 A. What is the note definition referring to?

13 BY MS. ZIBAS:

14 Q. Well, that's from the website. You had
11:15 15 said that you looked at the website at some point.

16 A. Uh-huh.

17 Q. So is that statement, the hospital was
18 asked to provide this information to the public but
19 did not, is that accurate?

11:15 20 MS. YANG: Objection to form, vague, and
21 lack of foundation.

22 A. Again, it states it, but it doesn't
23 reference -- I don't see the one notated on which
24 particular item is included in this.

11:15 25 BY MS. ZIBAS:

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1 Q. Yes. I think we need to --

2 A. Does it technically cover everything?

3 Q. Yes.

4 A. Okay.

11:15 5 Q. But is that an accurate statement that West
6 Boca did not provide this information?

7 MS. YANG: Objection to form.

8 MS. ZIBAS: Related to the safety problems.

9 MS. YANG: Objection to form, vague.

11:16 10 A. We provided the CMS data.

11 BY MS. ZIBAS:

12 Q. Okay.

13 A. We didn't participate in the survey.

14 Q. But the CMS data was taken from the public
11:16 15 information you did provide them; is that correct?

16 A. Correct. That would be correct.

17 Q. Did you ever speak to the press on behalf
18 of West Boca Medical Center or on behalf of Palm
19 Beach Health Network about the Leapfrog grades?

11:16 20 A. Did I personally --

21 Q. You personally.

22 A. -- speak to the press?

23 Q. Yes.

24 A. I have not spoken personally to the press.

11:16 25 MS. ZIBAS: Here's Hanlon Number 4.

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1 (Exhibit 4 was marked.)

2 BY MS. ZIBAS:

3 Q. Take a look at what has been marked as
4 Hanlon Exhibit 4.

11:17 5 A. Okay.

6 Q. Okay. Do you recognize this e-mail that
7 you sent out to A-team?

8 A. Our A-team, yes.

9 Q. And this is dated November 16, 2023. Why
11:17 10 did you send this out as a key message for fall 2023?

11 A. Because I received this from our public
12 relations representative that there were -- the
13 Leapfrog scores were going to be getting announced
14 publicly and to have talking points to be able to
11:18 15 speak to it.

16 Q. And was this a concern in advance of the
17 release?

18 MS. YANG: Objection to form, vague.

19 A. This was something that public relations
11:18 20 wanted us to have in case we were asked about it.

21 BY MS. ZIBAS:

22 Q. So did the public relations team draft the
23 West Boca Leapfrog key messages that are on the third
24 page?

11:18 25 A. Yes.

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1 Q. And did you have any input into these key
2 messages?

3 A. Yes. I could have. If I had concerns or
4 questions, I could reach back out to Shelly to ask
11:18 5 her to review or reconsider.

6 Q. What does Shelly Weiss, does she work for
7 Tenet Health corporate office? Where does she work?

8 A. I don't know if she's on the specific
9 hospital's payroll or if she's direct corporate -- I
11:19 10 believe she's a direct corporate employee.

11 Q. So this -- you had started about a month
12 before you sent this e-mail. You started in October
13 2023; correct?

14 A. Correct.

11:19 15 Q. And was it your understanding that Tenet
16 Healthcare was monitoring the release of the Leapfrog
17 grades and when they would be released?

18 A. I can't speak for Tenet Healthcare. I know
19 that Shelly Weiss knew that the scores would be
11:19 20 coming out, and so she wanted to provide us talking
21 points.

22 Q. Were you at West Boca Medical Center
23 monitoring the timing of the release of the scores?

24 A. Andrea Nunes certainly was.

11:20 25 MS. ZIBAS: This is Hanlon Number 5.

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1 (Exhibit 5 was marked.)

2 BY MS. ZIBAS:

3 Q. If you can take a look at Exhibit 5, do you
4 recognize this e-mail? I know it was sent to you
11:21 5 from Shelly Weiss. Does it jog your memory, at all?

6 A. I don't recall it. But I don't discount
7 that it's not accurate.

8 Q. Did you -- once you reviewed this e-mail
9 with all this attached information, did you do
11:21 10 anything further as a follow-up? Did you call
11 anyone? Did you call Maggie? Did you call any of
12 the other -- did you call Shelly to ask if you needed
13 to do anything further regarding these statements?

14 A. I did not.

11:22 15 MS. ZIBAS: This will be Exhibit 6.

16 (Exhibit 6 was marked.)

17 BY MS. ZIBAS:

18 Q. Going back to the governing board meetings,
19 who prepared the agendas for each of the meetings for
11:22 20 the governing board?

21 A. Our executive assistant actually did the
22 agenda with input from chief of staff, as well as
23 board, governing board chair, Chuck Stout, and
24 myself.

11:22 25 Q. And this document, which we marked

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1 Exhibit 6, says prepared by J. Hanlon. Is that you?

2 A. Document prepared by J. Hanlon.

3 Q. It's at the top.

4 A. Oh, so Alexa, my executive assistant, this
11:23 5 was -- normally she takes the minutes, but I think
6 she might have been on maternity leave at this
7 particular meeting, so I may have been the one taking
8 the minutes at this particular meeting.

9 Q. Okay. So I'm looking specifically at page
11:23 10 7, and there's a Bates number at the bottom, 15751,
11 but if you go to page 7, that's the focus of my
12 questions.

13 A. Okay.

14 Q. Now, it says administrative report, Mr.
11:23 15 Hanlon presented some slides.

16 A. Uh-huh.

17 Q. Okay. Says announced the 2024
18 Healthgrades' awards for West Boca. Leapfrog, Tenet
19 has chosen not to participate in the Leapfrog
11:24 20 program, so the scores that they award will not be
21 reflective since they do not have all the information
22 to apply an accurate grade. Reannounce the TJC Gold
23 Seal certification for hip, knee, and shoulder, and
24 Google rating achieved our goal of getting to 4 in
11:24 25 2024.

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1 Do you see those? Are those accurate statements
2 of the findings?

3 A. Yes.

4 Q. Did you draft those?

11:24 5 A. I believe so.

6 Q. And then there were conclusions and
7 recommendations.

8 A. Uh-huh.

9 Q. And it says Mr. Nobles questioned that WBMC
11:24 10 used to participate in Leapfrog and Mr. Hanlon
11 clarified that over the years, Tenet has made the
12 decision across the company to not participate in
13 Leapfrog because it does not provide the value that
14 it used to.

11:24 15 Can you explain to me what you mean by providing
16 the value that it used to?

17 A. Because we stopped participating in the
18 survey, and so they were basing the grades off
19 inaccurate information?

11:25 20 Q. Was -- maybe I'm misunderstanding this.
21 But it says Tenet has made the decision to not
22 participate because it does not provide the value.
23 So I would assume that Tenet based its decision on
24 the value proposition.

11:25 25 A. It used to.

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1 MS. YANG: Objection to form.

2 BY MS. ZIBAS:

3 Q. And how is it Leapfrog in 2021 provided
4 value, but in 2024, it does not?

11:25 5 A. Because the amount of resources that are
6 needed to submit the survey are not there anymore.

7 Q. And was that a decision that was made
8 solely by Tenet?

9 A. I wouldn't say solely. Tenet, as a
11:25 10 company, decided to stop participating in the
11 Leapfrog survey, and each hospital had the
12 opportunity to justify the need for it to be
13 reinstated in the particular markets.

14 Q. Did West Boca Medical Center ask to
11:26 15 reinstate Leapfrog Group survey in their market?

16 A. Ask who?

17 Q. Ask Tenet.

18 A. Did West Boca, specifically myself?

19 Q. Yes. Correct.

11:26 20 A. I did not ask the corporate office or my
21 supervisor to presume participation in The Leapfrog
22 Group.

23 Q. And do you know if Maggie made the request?

24 A. I don't know if Maggie made the request.

11:26 25 That's -- again, I didn't make the request so . . .

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1 Q. Do you know if Ms. Nunes, in conjunction
2 with Maggie, made the request to home office?

3 MS. YANG: Objection to form.

4 A. I can't speak to what Andrea made to the
11:26 5 corporate office.

6 BY MS. ZIBAS:

7 Q. Did you ever discuss with Maggie and Andrea
8 to request the home office to allow them to
9 participate in the Leapfrog survey again?

11:27 10 A. Andrea had made requests to participate in
11 the survey, and I ultimately made the decision as CEO
12 that it wasn't worth the time or the resources that
13 we would have to dedicate to it to complete it.

14 Q. And when did you make that decision?

11:27 15 A. Well, that's an ongoing decision. This was
16 revisited. It gets revisited whenever the survey or
17 the gradings, grades come out, at those times.

18 Q. And how much time and resources has been
19 spent on gathering documents for this lawsuit at West
11:27 20 Boca?

21 MS. YANG: Objection to form. Outside the
22 scope.

23 You can answer to the extent you know.

24 A. Same. It's difficult to quantify.

11:27 25 BY MS. ZIBAS:

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1 Q. So if it's difficult to quantify the number
2 of hours spent on the survey or the number of hours
3 to gather documents or the number of hours to rectify
4 an inaccurate -- what did you put in your
11:28 5 declaration? Let me get the language. Inaccurate,
6 to counteract the inaccurate negative picture. So if
7 you look at the number of hours -- if you can't
8 quantify how many hours it takes to counteract the
9 negative picture or the number of hours to complete
11:29 10 the survey or the number of hours it took to gather
11 documents for the lawsuit, how do you know -- how do
12 you know the resources were really -- one was worse
13 than the other?

14 MS. YANG: Objection to form. Vague,
11:29 15 argumentative, compound.

16 A. Without -- you can still know it's going to
17 take countless or numerous amounts of hours without
18 having an exact figure.

19 MS. ZIBAS: This is Hanlon 7.

11:29 20 THE WITNESS: Okay.

21 (Exhibit 7 was marked.)

22 BY MS. ZIBAS:

23 Q. Okay. So if we look at, this is meeting
24 minutes from the governing board, January 28, 2024,
11:30 25 is that correct, based on the information at the top?

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1 A. Correct.

2 Q. And if you look at page 8, the meeting
3 minutes, it states Jared provided clarification on
4 awards that WBMC received in terms of Leapfrog. WBMC
11:30 5 does not participate in the survey. Tenet is in the
6 process of pursuing -- pursuing legal action against
7 Leapfrog, as the information provided was an
8 inaccurate reflection of WBMC. Leapfrog does not
9 have the data to support their award.

11:31 10 Do you recall discussing this with the board?

11 A. Yes.

12 Q. And what did you tell them?

13 A. What this states here, that we felt like
14 Leapfrog awarded a grade that was inaccurate, and
11:31 15 that we don't participate in that, and that we're
16 going to have to pursue legal action to get them to
17 stop or to revise the process.

18 Q. And the meeting was January 28, 2024;
19 correct?

11:31 20 A. Correct.

21 Q. When was the lawsuit filed?

22 A. I believe May.

23 Q. Of 2025; correct?

24 A. Correct.

11:31 25 Q. What was the reason for the delay?

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1 MS. YANG: Objection to form.

2 And I'll caution you not to get into any
3 discussions with counsel.

4 A. This is actually -- this is dated
11:32 5 incorrectly. This should have been January 28 of
6 2025. And the reason I know that is because of all
7 of the participants that are here, this was our
8 transition meeting. So this is an error in the date.
9 This is supposed to be January 28 of 2025.

11:32 10 BY MS. ZIBAS:

11 Q. Okay.

12 A. We -- our board members transitioned, and
13 we had several that turned out of the board. And
14 this was a meeting where we had it at a restaurant,
11:33 15 private room in a restaurant because we included all
16 the exiting members and the new members, and that was
17 in January of '25. So that's a mistake on the date.

18 Q. Okay. And you say Jared to follow up with
19 the board once more information is provided. Was
11:33 20 there further information provided, at some point?

21 A. Yes. This has been a topic of discussion
22 at the many of the board meetings this year.

23 Q. And did the board provide their guidance or
24 input into the lawsuit and filing of it?

11:33 25 A. Their guidance or they -- they have given

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1 us feedback in terms of the things that we needed to
2 improve upon from a quality perspective, and weighing
3 in feedback that they've received in the community
4 about the Leapfrog and what they're hearing in the
11:33 5 community from it.

6 Q. And what was the guidance provided by the
7 board to you about the Leapfrog?

8 A. It's they serve as a liaison group to
9 convey what they're hearing in the community.

11:34 10 Q. And what were they hearing in the community
11 as a liaison group?

12 A. The things that we've kind of talked about.
13 You know, there's been some social media videos that
14 have been sent out referencing The Leapfrog Group,
11:34 15 and they were sharing those with me, asking what we
16 need to do to get these taken down. And what they
17 should be telling their neighbors and their patients
18 and their staff about the accuracy of the claims
19 being made by the Leapfrog.

11:34 20 Q. Okay. If you go further down the page, it
21 says Jared touch points. WBMC is working on shifting
22 volume to other locations as WBMC is tapped out with
23 space. Does that mean that the volume was so high
24 that you didn't have space for patients?

11:35 25 MS. YANG: Objection to form. Misstates

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1 the document.

2 A. No. This is related to other locations
3 within the hospital. Our ORs, only have six
4 inpatient ORs, we've seen an increase in number of
11:35 5 inpatient surgeries, and we've seen a decrease in the
6 number of outpatient surgeries and other elective
7 volumes. So it's a matter of shifting the volume
8 within the physical facility based on the type of
9 service that's needed.

11:35 10 Q. How many outpatient ORs did you have,
11 again?

12 A. Four.

13 Q. And so you were converting those to
14 inpatient?

11:35 15 A. No. They're in an outpatient building off
16 campus, which is why we can't do inpatient surgeries
17 in those ORs because they're not in the hospital.
18 They're at an outpatient facility. So even though we
19 have capacity, it's not the right capacity that we
11:35 20 needed to accommodate those patients.

21 Q. And was that being addressed or is it being
22 addressed?

23 A. Yes. We're looking to expand an existing
24 OR, as well as add another OR on the inpatient side,
11:36 25 as well as trying to counteract the negative

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1 perception that the community has gotten to build
2 back up our outpatient OR.

3 Q. What type of outpatient procedures have
4 declined?

11:36 5 A. A lot of pediatric ENT, pediatric general
6 surgery, some GYN, general surgery.

7 Q. How many pediatrics -- how many surgeons do
8 you have on staff doing the pediatric procedures?

9 A. Pediatric ENT, in particular, we have four.
11:37 10 Pediatric general surgery, we have three. I could go
11 down the list. General surgery, I don't -- I can't
12 give you an exact amount. I just -- it's north of
13 20.

14 Q. Going back to the Leapfrog methodology. So
11:37 15 did you ever get into a discussion with patients
16 about the methodology that was posted on the website
17 or that was available for them to review?

18 A. Me specifically?

19 Q. You specifically.

11:37 20 A. No.

21 Q. Do you know if anyone else at West Boca
22 Medical Center did so?

23 A. I can't speak for it, no.

24 Q. Are you aware that there are hospitals who
11:37 25 do not participate in the survey, and they get a

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1 grade higher than a D or an F?

2 MS. YANG: Objection to form, lack of
3 foundation.

4 A. I can't speak to that. I don't know.

11:38 5 BY MS. ZIBAS:

6 Q. Other than Healthgrades, are there any
7 other grades or rating services that West Boca
8 Medical Center participates in?

9 MS. YANG: Objection to form.

11:38 10 A. I don't think -- again, defining ratings
11 are grades, there's other accrediting bodies, other
12 entities that we use to help evaluate and convey the
13 quality of care that we provide in West Boca.

14 BY MS. ZIBAS:

11:38 15 Q. But I'm not referring to accrediting ones,
16 but ratings or grades where you actually then pay to
17 use their logo or you license their logo, like you do
18 with Healthgrades. Are there any others that West
19 Boca uses or participates in?

11:38 20 A. Again, from a grading or rating, there are
21 other entities that we utilize to help convey the
22 quality of care that we provide, such as The Joint
23 Commission, Get with the Guidelines, ACR,
24 Healthgrades. So there are numerous other entities.

11:39 25 Q. What is get with the guidelines?

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1 A. Get with the Guidelines is a demonstration
2 of our stroke care measures, looking at not only
3 quality outcomes, but also processes and things that
4 we've had in place to appropriately care for -- for
11:39 5 strokes.

6 Q. And does anyone at West Boca Medical Center
7 have to provide data in order for -- to get with the
8 guidelines?

9 A. It's the registry data that we already
11:40 10 provide, that we're required to provide.

11 Q. To provide to who?

12 A. The registry. It's state-mandated.

13 Q. Now, does Joint Commission have any -- do
14 they have any accolades that you pay for? Once you
11:40 15 get a good certificate or score from them or pass, do
16 they have anything they sell, like the Healthgrades
17 stuff?

18 A. We do contract with The Joint Commission to
19 come in and evaluate our -- not only just our overall
11:40 20 accreditation that we do on a triannual basis that's
21 required by CMS, but we also work with them to come
22 in and evaluate our hip, knee, and shoulder. And
23 we've recently applied for our spine certification
24 for Joint Commission.

11:41 25 Q. Do you think it helps West Boca, the fact

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1 you're paying for a contract with Joint Commission,
2 does that help with your overall evaluation outcome?

3 MS. YANG: Objection to form, vague, lack
4 of foundation.

11:41 5 MS. ZIBAS: With Joint Commission.

6 A. I think it does help to have Joint
7 Commission come in and have an onsite inspection and
8 a comprehensive review of our program and award us
9 their seal of approval based off of our quality
11:41 10 program that we offer. Yes, I do think it's
11 beneficial.

12 BY MS. ZIBAS:

13 Q. For -- we had previously discussed that
14 your quality department was looking at the
11:41 15 computerized physician ordering entries. Is that
16 information that's gathered solely by the quality
17 department, or do you participate in how that's
18 monitored and the data that's gathered?

19 A. I participate in how it's monitored, as
11:42 20 it's one of the measures that we report through our
21 quality improvement/patient safety committee.

22 Q. Do you gather data on a quarterly basis or
23 monthly basis for CPOE, BCMA, hand hygiene, and ICU
24 staffing?

11:42 25 A. It's a combination of both.

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1 Q. Now, now are you aware that as part of this
2 lawsuit, West Boca Medical Center is seeking legal
3 fees and costs in this matter?

4 MS. YANG: Objection to form.

11:43 5 MS. ZIBAS: Are you aware of that?

6 A. Yes.

7 BY MS. ZIBAS:

8 Q. And who is currently paying the attorney's
9 fees and costs for West Boca?

11:43 10 MS. YANG: Objection to form, outside the
11 scope.

12 To the extent you know.

13 A. Each respective facility is paying legal
14 fees.

11:43 15 BY MS. ZIBAS:

16 Q. And do you know how much has been spent to
17 date by West Boca Medical Center?

18 A. I don't know of a complete total.

19 Q. Do you know what -- well, what number do
11:43 20 you know?

21 MS. YANG: Objection to form, vague,
22 outside the scope.

23 You can answer, if you know.

24 A. I know we reported on it last month, and I
11:43 25 can't remember the exact number off the top of my

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1 head, though.

2 BY MS. ZIBAS:

3 Q. Do you know the total amount to be --
4 that's budgeted?

11:44 5 A. We don't have a budgeted amount.

6 Q. Do you have an anticipated amount that West
7 Boca Medical Center will spend in total?

8 MS. YANG: Objection to form.

9 I'm going to instruct not to answer on
11:44 10 that.

11 MS. ZIBAS: I assume at the time of trial,
12 he'll be able to testify to that amount since
13 it's been sought.

14 MS. YANG: Well, you're welcome to ask him
11:44 15 about any fees that have been incurred, but
16 asking about budgeting gets into attorney
17 work-product information.

18 MS. ZIBAS: Well, he doesn't know what's
19 been incurred.

11:44 20 BY MS. ZIBAS:

21 Q. Who would know any amount incurred to date?

22 A. I could get the information, if I could
23 reference our invoicing system. I just don't know it
24 off the top of my head.

11:44 25 Q. Do you have any records -- you indicate,

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1 you explained the one example of the individual from
2 the emergency department that went to another
3 hospital; and then you referenced a speaking with
4 Sheri Scarborough, several other people on the board.
11:45 5 Can you provide any more specifics about individuals,
6 either physicians or patients, who went -- who didn't
7 want to be treated at West Boca Medical Center,
8 specifically because of the Leapfrog grade?

9 MS. YANG: Objection to form, vague and
11:45 10 compound.

11 A. I can give another example. Shelley Cueto
12 is a practice manager for Dr. Phipps and Dr. Cueto.
13 She reached out to me because of a Tik Tok video that
14 was going around social media claiming that West Boca
11:46 15 was one of the five worst hospitals, referencing in
16 the video the Leapfrog gradings as an F. And she
17 asked me if this was true, and I had to explain to
18 her the reasoning why we didn't feel it was accurate.
19 And she then, in turn, had to convey that to both Dr.
11:46 20 Phipps and Dr. Cueto and patients that they were
21 seeking care from those two physicians in particular.

22 Q. And who posted the Tik Tok video?

23 A. I don't know.

24 Q. Did you obtain a copy of the Tik Tok video?

11:46 25 A. Yes.

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1 Q. And you provided that as part of your
2 documents in discovery?

3 A. It was part of numerous text messages that
4 I've received from board members that included the
11:46 5 video.

6 Q. Did you provide it as part of your
7 discovery to your attorneys?

8 A. Yes.

9 Q. Were you -- as part of what you've been
11:47 10 going through in this lawsuit, were you ever able to
11 -- do you have any evidence that Leapfrog takes --
12 has paid any money to award better grades to
13 hospitals?

14 MS. YANG: Hold on one second.
11:47 15 Without getting into any discussions with
16 the attorneys or legal advice, you can answer
17 the question of what evidence you have.

18 A. Can you restate the question?

19 BY MS. ZIBAS:
11:47 20 Q. Do you have any evidence that Leapfrog has
21 been paid any money to award better grades to other
22 hospitals, safety grades?

23 A. I don't have any indication of Leapfrog,
24 any specific examples of Leapfrog Group being paid to
11:48 25 award a higher grade.

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1 MS. ZIBAS: All right. I need to go
2 through my notes. I really don't have -- I'm
3 not an all-day person here. Don't know where
4 you guys were from. You can go off the record.
11:48 5 We can go through this.

6 THE VIDEOGRAPHER: We're off the record at
7 11:47 a.m.

8 (Recess was taken for lunch at 11:47 a.m.)

9 (Back on the record at 12:28 p.m.)

12:29 10 THE VIDEOGRAPHER: Back on the record.

11 Time is 12:28 p.m.

12 BY MS. ZIBAS:

13 Q. All right. We're back on the record. I'm
14 going to follow up with a few questions, Mr. Hanlon,
12:29 15 just to clarify. First of all, we had been talking
16 about the four measures, the ICU staffing, the hand
17 hygiene, the Barcode Medication Administration, the
18 Computerized Physician Order Entry, and based on my
19 understanding, that these are four measures that your
12:30 20 quality department reports and gathers data and you
21 monitor it, is that correct, when they report, when
22 they gather the data? And this is done in order to
23 give it to your quality improvement patient safety
24 committee? Is that who gets this information?

12:30 25 MS. YANG: Objection to form, vague and

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1 compound.

2 A. So I'm a member of the quality improvement
3 committee, and this data goes through that, that
4 committee.

12:30 5 BY MS. ZIBAS:

6 Q. And the data, when it's put together, is it
7 in a form of a report or is it just hard data? What
8 kind of format is it in?

9 A. It varies. Like for example, the ICU
12:31 10 staffing, that's pretty static. It doesn't change
11 drastically. Handwashing, we do audits monthly, and
12 that data is recorded as to compliance with
13 handwashing. Same thing with CPOE and barcode
14 administration, we pull that information from our
12:31 15 electronic medical record and other electronic
16 sources to report out on a regular basis.

17 Q. So when you pull it from the electronic
18 data, then you then assemble a report and send it to
19 the committee, or Ms. Nunes and her department do
12:31 20 that; is that correct?

21 A. They do that, yes.

22 Q. Okay. Just wanted to clarify.

23 Now, we talked about the legal fee number, and I
24 know you said that you don't have the system in front
12:31 25 of you. Do you recall any of the numbers to date

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1 paid for legal fees, at all?

2 MS. YANG: Objection to form, vague.

3 A. I don't. Not off the top of my head.

4 BY MS. ZIBAS:

12:32 5 Q. Does West Boca Medical Center, do you use
6 an organization or partner with Vizient?

7 A. I don't -- I don't recognize that
8 organization so I'm not sure.

9 Q. Do you -- does West Boca Medical Center
12:32 10 partner or hire any outside company to help them
11 evaluate healthcare performance?

12 MS. YANG: Objection to form, vague.

13 A. What is your definition of performance?

14 BY MS. ZIBAS:

12:32 15 Q. Well, companies such as Vizient, Premier
16 Inc., HealthTrust Purchasing Group, Healthgrades,
17 they all are -- they measure healthcare performance,
18 and do you hire outside companies to assist West Boca
19 Medical Center with gathering data or interacting
12:32 20 with these organizations?

21 MS. YANG: Objection to form.

22 A. I don't have any clarity in terms of what
23 we would be hiring them to do. Are you suggesting
24 providing consulting services or --

12:33 25 BY MS. ZIBAS:

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1 Q. Do you hire consultants? Does West Boca
2 Medical Center hire consultants to work with
3 Healthgrades and to help their grades or to license
4 the logos? I mean, is this done directly with West
12:33 5 Boca?

6 MS. YANG: Objection to form, vague.

7 A. Is the -- and I'm sorry. I'm trying to get
8 clarity on your question. So does --

9 BY MS. ZIBAS:

12:33 10 Q. It's okay.

11 A. So are you saying does Healthgrades
12 contract directly with West Boca?

13 Q. Yes. Do they contract directly or do you
14 use an intermediary third-party?

12:33 15 A. For Healthgrades, I believe we contract
16 directly with Healthgrades.

17 Q. And what -- and I assume for Joint
18 Commission, you do as well, you contract directly;
19 correct?

12:34 20 A. Correct.

21 Q. What about Trilliant?

22 A. That is a database. That's not necessarily
23 a service.

24 Q. Does West Boca Medical Center contract
12:34 25 directly to use that database?

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1 A. I do not know. Our chief strategy officer
2 would have to answer that. I'm not exactly sure --

3 Q. And who --

4 A. -- if it's Tenet or West Boca.

12:34 5 Q. And who is your chief strategy officer,
6 again?

7 A. Derek Collins.

8 Q. And has West Boca Medical Center
9 participated in any consumer perception surveys to
12:34 10 compare the public views of your hospital versus
11 competitors?

12 A. We get a report on, I would say, probably
13 on a quarterly basis that looks at community
14 perception that's sent to us from our marketing
12:35 15 leader.

16 Q. And who compiles this report?

17 A. I'm not sure if it's -- I think it is an
18 outside agency. I don't know what that agency's name
19 is. I just get the quarterly report that looks at
12:35 20 community perception.

21 Q. And in the latest report that you can
22 recall receiving from West Boca, what was -- what was
23 that results of the community perception survey?

24 MS. YANG: Objection to form, vague.

12:35 25 A. How are you evaluating the results?

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1 BY MS. ZIBAS:

2 Q. I haven't seen the report so I would like
3 to know what is in that report. Why don't we start
4 there?

12:36 5 A. Sure. It looks at percentage of positive
6 opinions on like social media and Google reviews and
7 things like that, and kind of gauges community
8 perception of the facility.

9 Q. And you mentioned that Google ratings,
12:36 10 Google star went up; is that correct?

11 A. Yes.

12 Q. And what's the percentage of positive
13 opinions in the last report that you can recall?

14 A. I know it was -- it had improved. I can't
12:36 15 speak to exactly the exact percentage improvement
16 without seeing the report in front of me.

17 Q. And does West Boca Medical Center
18 participate in or retain anyone to do any market
19 research reports comparing West Boca Medical Center
12:37 20 to its competitors?

21 MS. YANG: Objection to form.

22 A. What are you defining as market research?

23 BY MS. ZIBAS:

24 Q. That would be a good question because I am
12:37 25 not sure what market research reports or studies your

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1 marketing department has done. So market research
2 would be same as a survey, asking the public their
3 opinion?

4 MS. YANG: Objection to form.

12:37 5 A. There are -- I mean, we participate in
6 HCAHPS, for example, which are required for CMS that
7 evaluates patient satisfaction levels. And again, we
8 do look at overall perception of the facility through
9 either positive or negative reviews and feedback from
12:37 10 that perspective.

11 MS. ZIBAS: I think that's all the
12 questions I have at this point. Obviously, if
13 there's documents during the meet and confer
14 process that the other attorneys are going
12:38 15 through that -- you know, additional documents
16 arise that are related to West Boca Medical
17 Center, we'll reserve the right to call him back
18 or ask questions in writing, deposition by
19 writing.

12:38 20 MS. YANG: We disagree with that, but of
21 course we're happy to take that up with you
22 after, and we'll reserve for trial.

23 THE VIDEOGRAPHER: No questions.

24 MS. YANG: No. We'll reserve for trial.

12:38 25 MS. ZIBAS: Thank you for your time.

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1 THE WITNESS: Thank you.

2 THE VIDEOGRAPHER: Off at 12:37 p.m.

3 MS. YANG: We'll read.

4 (Thereupon, the proceedings concluded at
5 12:37 p.m.)

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1 CERTIFICATE OF OATH

2

3 THE STATE OF FLORIDA)

4 COUNTY OF MIAMI-DADE)

5

6

7

8

9 I, THERESA RUST, the undersigned authority,
10 certify that JERAD HANLON, appeared before me and was
11 duly sworn on the 23rd day of September 2025.

12 Signed this 23rd day of September 2025.

13

14

15

16

17 THERESA RUST, RPR
18 Notary Public - State of Florida
Commission No. #GG145788
Expires: October 25, 2025

19

20

21

22

23

24

25

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September 23, 2025

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1 CERTIFICATE OF REPORTER

2

3 THE STATE OF FLORIDA)

4 COUNTY OF MIAMI-DADE)

5

6 I, Theresa Rust, Florida Professional
7 Reporter, certify that I was authorized to and did
8 stenographically report the video-recorded deposition
9 of JERAD HANLON, pages 1 through 118, that a review
10 of the transcript was requested, and that the
11 transcript is a true and complete record of my
12 stenographic notes.

13 I further certify that I am not a relative,
14 employee, attorney, or counsel of any of the parties,
15 nor am I a relative or employee of any of the
16 parties' attorney or counsel connected with the
17 action, nor am I financially interested in the
18 action.

19

20 DATED this 23rd day of September 2025.

21

22

23

Theresa Rust, RPR, FCRR

24

25

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1 October 8, 2025

2 BETTY X. YANG, ESQUIRE
byang@gibsondunn.com

3

JERAD HANLON

4 IN RE: GOOD SAMARITAN VS. THE LEAPFROG GROUP
CASE NO.: 9:25-CV-80526-DMM

5 TYPE OF PROCEEDING: DEPOSITION

DATE: 9.23.25

6

The transcript of the above proceeding is now
7 available and requires signature by the witness.

8 Please e-mail fl.production@lexitaslegal.com for
access to a read-only PDF transcript and PDF-fillable
9 errata sheet via computer or use the errata sheet
that is located at the back of the transcript.

10

Once completed, please print, sign, and return to the
11 e-mail address listed below for distribution to all
parties.

12

If you are in need of assistance, please contact
13 Lexitas at 888-811-3408.

14 If the witness does not read and sign the transcript
within a reasonable amount of time, the original
15 transcript may be filed with the Clerk of the court.

16 If the witness wishes to waive his/her signature now,
please have the witness sign in the blank at the
17 bottom of this letter and return to the e-mail
address listed below.

18

Very truly yours,

19

20 Theresa Rust, RPR
Lexitas
21 fl.production@lexitaslegal.com

22 I do hereby waive my signature.

23

24

JERAD HANLON

25 Job No. 422123

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September 23, 2025

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1 ERRATA SHEET
DO NOT WRITE ON TRANSCRIPT - ENTER CHANGES HERE
2 IN RE: GOOD SAMARITAN VS. THE LEAPFROG GROUP
CASE NO. 9:25-CV-80526-DMM
3 WITNESS: JERAD HANLON TAKEN: 9/23/2025

4	PAGE	LINE	CHANGE	REASON FOR CHANGE
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19				

20 Under penalties of perjury, I declare that I
21 have read the foregoing document and that the facts
stated in it are true.

22 _____
Date JERAD HANLON

23 Job No. 422123
24 fl.production@lexitaslegal.com

25

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UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA
WEST PALM BEACH DIVISION
CASE NO.: 9:25-CV-80526-DMM

GOOD SAMARITAN MEDICAL CENTER, INC.,
DELRAY MEDICAL CENTER, INC.,
PALM BEACH GARDENS COMMUNITY
HOSPITAL, INC. d/b/a PALM BEACH
GARDENS MEDICAL CENTER,
ST. MARY'S MEDICAL CENTER, INC.,
AND WEST BOCA MEDICAL CENTER, INC., et al.,

Plaintiffs,

v.

THE LEAPFROG GROUP,

Defendant.

VIDEOTAPED DEPOSITION OF HEATHER HAVERICAK
(CONFIDENTIAL)

DATE TAKEN: Friday, September 19, 2025
TIME: 9:08 a.m. - 3:51 p.m.
PLACE: Quest Workspaces West Palm Beach
515 North Flagler Drive
Suite 350
West Palm Beach, Florida 33401

Stenographically Reported By:
Barbie Gallo, RMR-CRR
www.lexitaslegal.com
888-811-3408

Job No.: 421986

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ALSO PRESENT:

22 DANIEL RAGLAND, videographer
23
24
25

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46		INTERROGATORIES TO DELRAY	
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1 Thereupon,
2 the following proceedings began at 9:08 a.m.:

3 * * *

4 THE VIDEOGRAPHER: We are now on the record.
5 Today's date is September 19th, 2025. The time
6 is 9:08 a.m. This is the video-recorded
7 deposition of Heather Havericak taken in the
8 matter of Good Samaritan Medical Center,
9 Incorporated versus The Leapfrog Group.

10 This deposition is being held at 515 North
11 Flagler Drive, Suite 350, West Palm Beach,
12 Florida 33401.

13 My name is Daniel Ragland. I am the
14 videographer with Lexitas. The stenographer is
15 Barbie Gallo with Lexitas.

16 Will counsel please announce their
17 appearances for the record after which the
18 stenographer will swear in the witness.

19 MS. BLAIR: Kim Blair for The Leapfrog
20 Group.

21 MR. MARCUS: Jeff Marcus on behalf of the
22 plaintiffs. I'm joined by Kevin Simmons of
23 Gibson Dunn.

24 THEREUPON,

25 HEATHER HAVERICAK,

Heather Havericak
September 19, 2025

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1 Being by me first duly sworn to tell the whole truth,
2 as hereinafter certified, testified as follows:

3 DIRECT EXAMINATION

4 BY MS. BLAIR:

5 Q. Ms. Havericak, as you know, I'm Kim Blair.
6 I represent The Leapfrog Group in connection with this
7 matter. I want to just start by showing you what we're
8 going to mark as Exhibit 1.

9 (Defendant's Exhibit Number 1 for i.d.)

10 BY MS. BLAIR:

11 Q. Ms. Havericak, I will submit to you this is
12 the Amended Notice of the Taking In-Person Videotaped
13 Deposition of Heather Havericak Individually and
14 Pursuant to Rule 30(B)(6) to Delray Medical Center,
15 Inc.

16 Have you seen this document before?

17 A. Yes.

18 Q. And so you understand that you've been
19 summoned here today to testify not only as in your
20 individual capacity but also as the corporate
21 representative for Delray Medical Center?

22 A. That's correct.

23 Q. And have you -- if we turn to page 6 of this
24 document, these are the matters, the topics upon which
25 you are to be giving testimony in your capacity as the

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1 corporate representative for Delray Medical Center,
2 correct?

3 A. That's correct.

4 Q. And you've seen this document before, and
5 you're prepared to testify on these topics that we see
6 on page 6, 7 and 8 today?

7 A. That is correct.

8 Q. And to the extent I ask questions today that
9 cover the topics that are on pages 6 through 8, I will
10 assume that your testimony is on behalf of
11 Delray Medical Center if they relate to these topics
12 unless you tell me otherwise.

13 Is that fair?

14 A. That's correct.

15 Q. Have you been deposed before?

16 A. I have.

17 Q. How many times?

18 A. Three.

19 Q. And were they in a personal capacity or in
20 your capacity, your professional capacity?

21 A. In my professional capacity.

22 Q. Were any of those depositions with respect
23 to Delray Medical Center as opposed to Broward where
24 you used to work?

25 A. They were not in connection with

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1 Delray Medical Center.

2 Q. Okay. Were they in connection with Broward?

3 A. They were.

4 Q. And approximately how long ago were those
5 depositions?

6 A. I can't recall the years of those.
7 Somewhere in the early 2020s.

8 Q. Is it fair to say this is the first
9 deposition that you're giving in a corporate capacity
10 for Delray Medical Center?

11 A. Yes.

12 Q. I just want to go over a few ground rules,
13 but you're probably familiar. The court reporter is
14 taking down everything that I say and everything you
15 say, and so I'm going to attempt to not talk over your
16 answers today, and I ask that you try to into the talk
17 over my questions so that Barbie can get down
18 everything that we're saying.

19 Is that fine?

20 A. Yes.

21 Q. She's also taking down words, and so she
22 can't record a shrug of the shoulders, an "uh-huh,"
23 "huh-uh," so all of your answers must be verbal.

24 Is that fair?

25 A. Yes.

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1 Q. At any time -- this is not an endurance
2 test, so if at any time you need to take a break, just
3 let me know, and at that point in time we will take a
4 break. The only caveat being that if there is a
5 question pending, I ask that you answer that question
6 before we steak a break.

7 Is that fine?

8 A. Yes.

9 Q. From time to time your lawyers may lodge an
10 objection to one of my questions. Unless your lawyer
11 instructs you not to answer, you need to answer that
12 question.

13 Is that fair?

14 A. Yes.

15 Q. I will from time to time ask bad questions.
16 If at any time you don't understand a question that
17 I've asked you, please ask me to rephrase it and I will
18 do my best. To the extent you answer that question,
19 we're going to assume you understood it for purposes of
20 the record.

21 Is that fine?

22 A. Yes.

23 Q. What did you do to prepare for your
24 deposition here today?

25 A. I worked with my counsel and reviewed

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1 relevant documents to the case.

2 Q. How many times did you meet with your
3 counsel?

4 A. I would have to pull up my calendar and have
5 that to give an accurate number to quantify.

6 Q. More than five?

7 A. I can't quantify that number.

8 Q. Do you know how many hours approximately you
9 spent preparing for your deposition?

10 A. Again, I would need to look at my calendar.

11 Q. Do you recall any of documents you reviewed
12 in preparation for your deposition?

13 A. There were many documents we reviewed.

14 Q. Can you tell me any general categories of
15 documents that you reviewed?

16 A. We looked at quality documents, patient
17 experience scores. We looked at some of our other
18 regulatory accreditations and previous Leapfrog scores.

19 Q. Did you review any emails?

20 A. We did.

21 Q. Do you recall any specific emails you
22 reviewed in preparation for your deposition?

23 A. I would need the documents in front of me to
24 be able to tell you all the emails we reviewed.

25 Q. Did you review any board meeting minutes?

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1 A. We did.

2 Q. What about med exec meeting minutes?

3 A. Yes.

4 Q. Did you review any quality scorecards?

5 A. Yes.

6 Q. Do you know if you've produced those quality
7 scorecards in this litigation to your counsel?

8 A. I would need the documents in front of me to
9 see which quality documents we've given.

10 Q. But you can't recall as you sit here today
11 what quality documents specifically you reviewed?

12 A. No, because there was multiple documents so
13 I need them in front of me.

14 Q. Did you speak to anybody other than your
15 counsel about your deposition here today?

16 A. I did not.

17 Q. Have you reviewed the deposition transcript
18 of Sheri Montgomery in preparation of your deposition
19 here today?

20 A. I have not.

21 Q. Do you recall when the first -- I don't want
22 to know anything you talked about with your counsel.
23 I'm not allowed to know about that. But do you recall
24 when your first meeting was with your counsel to
25 prepare for your deposition?

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1 A. I need my calendar. I'm a CEO of a hospital
2 so I have so many meetings every day. I can't remember
3 all those off the top of my head.

4 Q. Do you know if it was within the last month?

5 A. We've had meetings in the last month, but I
6 don't know when the first one was. I need the
7 calendar.

8 THE VIDEOGRAPHER: The time is 9:17 a.m.

9 We're going off the record.

10 (A recess was taken from 9:17 a.m. to 9:18 a.m.)

11 THE VIDEOGRAPHER: The time is 9:18 a.m. We
12 are back on the record.

13 BY MS. BLAIR:

14 Q. Ms. Havericak, were you involved in
15 gathering documents to produce in this litigation?

16 A. I saw some of them.

17 Q. And I'm asking specifically about gathering
18 documents to provide to your lawyers to produce to the
19 other side. Were you involved in that process?

20 A. I was involved in some of that process.

21 Q. And what documents do you recall gathering
22 and producing to your lawyers in this litigation?

23 A. Emails that were relevant to the topic, some
24 of our committee minutes which we already talked about
25 which are med exec and governing board.

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1 And then other members of our team gathered
2 some of the quality data, which could be quality
3 scorecards or just quality dashboards and some of the
4 patient experience scores and some of the past Leapfrog
5 data.

6 Q. When you say "emails relevant to the topic,"
7 what do you consider the topic to be?

8 A. Relevant to Leapfrog scoring, relevant to
9 the Leapfrog process.

10 Q. And when you refer to the dashboards, what
11 does that refer to?

12 A. It can be a variety of things. We have
13 multiple quality dashboards that we utilize within the
14 hospital to help us gauge our performance on quality
15 and safety.

16 Q. Do you know do those dashboards have names?

17 A. There's a whole -- there's a variety of
18 dashboards, so you could have dashboards in the
19 cardiovascular space. You could have dashboards for
20 hand hygiene. You could have dashboards for the
21 unit-based measures. I mean, there's a whole variety
22 of them.

23 Q. And your understanding is that those
24 dashboards have been produced in this litigation?

25 A. Correct.

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1 Q. And is there a software that is associated
2 with those dashboards?

3 A. Most dashboards are just in an Excel file.

4 Q. Do you know what Trillient is?

5 A. I'm familiar with it.

6 Q. Does your hospital use Trillient to track
7 patient safety data?

8 A. I'm not certain that they use that to track
9 it.

10 Q. Do you know what your hospital uses
11 Trillient for?

12 A. I'm not familiar with what they use it for.

13 Q. Does your hospital engage in, do you know
14 what Vizient is?

15 A. I do know what Vizient is.

16 Q. Does your hospital engage in Vizient?

17 A. To my knowledge, we do not use Vizient.

18 Q. What about Premier, do you use premiere?

19 A. I'm not familiar that we use Premier.

20 Q. Does your hospital use any third-party
21 source like Vizient to track quality and patient safety
22 data?

23 A. We work with accrediting organizations, so
24 we are accredited by the Joint Commission. We also
25 have other accreditations with Joint Commission outside

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1 of just our regulatory component. So we have hip, knee
2 and shoulder certification, which we voluntarily do, so
3 they come in and do validation visits with us.

4 We are a comprehensive stroke program
5 through DNV so they validate all of our data as well.

6 And then we have registries that we report
7 data to for all of our cardiovascular, so the Society
8 of Thoracic Surgeons, which is STS.

9 We have our TBT registry which is for our
10 TAVR program.

11 We have our PCI dashboards for our
12 cardiovascular programs.

13 We have our left atrial appenditure [sic]
14 closure dashboard, so all of those are through
15 different cardiology bodies.

16 And then we also have our trauma program
17 that's a level I trauma program that has a regulatory
18 component through the Department of Health, so there's
19 data that goes there.

20 And then we also are a Bariatric Center of
21 Excellence so we have data that goes through the
22 bariatric component as well.

23 Q. Okay. And earlier you mentioned a
24 hand hygiene dashboard. How is that kept?

25 A. So we do hand hygiene surveillance in each

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1 unit each month. There's a tool that's used to collect
2 that data. And then those scores are populated on the
3 unit-based quality dashboard. And then that
4 information of that performance is reported out on a
5 monthly basis at our infection control meeting and at
6 our quality monthly meeting.

7 Q. Have you produced the unit-based quality
8 dashboard in this litigation?

9 A. I believe that those have been produced.

10 Q. And so you believe there are documents that
11 have been produced in this litigation that show the
12 surveillance of hand hygiene at Delray Medical Center?

13 A. Yes.

14 Q. And you -- to your -- to the best of your
15 knowledge, you've given those documents to your
16 attorneys to be produced in this litigation?

17 A. Our quality team has produced those
18 documents.

19 Q. Yeah, my apologies. By "you," I meant
20 Delray Medical Center, correct?

21 A. Yes.

22 Q. I'm going to show you what we'll mark as
23 Exhibit 2.

24 (Defendant's Exhibit Number 2 for i.d.)

25 BY MS. BLAIR:

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1 Q. Ms. Havericak, I'm providing you with what
2 we've marked Exhibit 2 in this deposition. I'm trying
3 to short-circuit a long discussion about what your
4 background is.

5 And if you look at paragraphs two, three,
6 four and five of this document which is the declaration
7 of -- you know what? Let me start over.

8 This document is entitled the Declaration of
9 Heather Havericak, correct?

10 A. That's correct.

11 Q. And if we turn to the last page of this
12 document which has a Bates number of PBHN 2127, is that
13 your signature on this document?

14 A. That is my signature.

15 Q. And this was executed on May 14th, 2025,
16 correct?

17 A. That's correct.

18 Q. And if we look back at paragraphs two
19 through five of the Declaration of Heather Havericak,
20 does this accurately reflect both your education and
21 your professional background?

22 MR. MARCUS: Object to form.

23 A. It does.

24 BY MS. BLAIR:

25 Q. And as I note here, it talks about from 2002

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1 to 2005 you worked at the Miami Children's Hospital,
2 correct?

3 A. That's correct.

4 Q. And then sometime in or around 2006 you went
5 to Broward, correct?

6 A. That's correct.

7 Q. And as I read this document, you were at
8 Broward until you took the job as the CEO at
9 Delray Medical Center in 2024?

10 A. That's correct.

11 Q. In terms of your education, you have a
12 master's degree from Indiana State University, correct?

13 A. Correct.

14 Q. Is there any other education or -- well, is
15 there any other education that's not listed in
16 paragraph three of Exhibit 2?

17 A. Well, there's the primary education that you
18 get to before you get a master's degree, yes.

19 Q. Good point. Where did you go to undergrad?

20 A. I went to College of DuPage in Glen Ellyn,
21 Illinois, and then I went to Florida International
22 University for my bachelor's of science in nursing.
23 And I did a couple years at North Central College as
24 well.

25 Q. Do you have any accreditations that are not

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1 listed in this document?

2 A. No. I'm just a fellow of the American
3 College of Healthcare Executives.

4 Q. And what does that mean?

5 A. It's an advanced certification for
6 healthcare leadership that requires you to give back to
7 the community, doing community service hours, serving
8 on boards, passing a board of governors exam and then
9 doing ongoing continuing education.

10 Q. So you still are involved with that today?

11 A. Yes, it's required to be renewed every three
12 years.

13 Q. And so you take continuing education classes
14 to renew that?

15 A. I do.

16 Q. Are any of those continuing education
17 classes in patient safety?

18 A. Yes, I actually just renewed my fellowship,
19 and I did do some patient safety.

20 Q. I want to talk a little bit about your work
21 at Broward. How long -- did you start as a nurse at
22 Broward Health?

23 A. I started as a bedside nurse in pediatric
24 hematology oncology.

25 Q. And you became the permanent CEO starting in

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1 August of 2019, correct?

2 A. That's correct.

3 Q. At any time -- well, and you were the -- you
4 were the acting CEO of Broward Health Medical Center
5 from 2019 to 2024?

6 A. No. I was acting from March of that year
7 until I became permanent in August. And then I was
8 permanent CEO from August until I left Broward actually
9 in July of 2023.

10 Q. And what did you do -- where did you go in
11 July of 2023?

12 A. I just took some time in between going to
13 Delray.

14 Q. Got it. About a year.

15 A. No, no. Just a couple of months.

16 Q. And you -- oh, you started at Delray in
17 January of 2024?

18 A. Yeah.

19 Q. When you were at -- where is Broward Health
20 Medical Center located?

21 A. It's in Fort Lauderdale, Florida.

22 Q. When you were the CEO of Broward, they
23 participated in the Leapfrog survey, correct?

24 A. That's correct.

25 Q. Did you ever in any of your time at Broward

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1 for 17 years have any involvement in the completion of
2 the Leapfrog survey for Broward Medical Center?

3 A. I did.

4 Q. And can you just briefly tell me about what
5 your involvement was in completing the Leapfrog survey
6 while at Broward?

7 A. So we would be -- I would be involved in
8 just looking at the measures, looking at where we
9 potentially needed to have improvement strategies. And
10 then before any data was actually submitted, I would
11 review that.

12 I did have one year where I was coming in as
13 an interim where data had already been submitted, and
14 there was a data error in that submission to Leapfrog.
15 So during that period of verification when we're able
16 to verify and validate data that Leapfrog allows us, we
17 noticed that one of the self-reported measures was not
18 correct.

19 And we mitigate -- we asked them to change
20 that during that embargo period or whatever it's
21 called, but we weren't able -- we were not successful
22 in getting that changed. So, you know, moving forward
23 from there when I was in a permanent role, every time
24 that data was submitted, I sat with our quality
25 director to make sure every single component had

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1 accuracy.

2 Q. Do you recall what the change was that you
3 asked Leapfrog to change during the verification
4 period?

5 A. I don't remember which measure it was. It
6 was either barcode medication scanning or CPOE. I
7 can't recall which one it was, but it did cause us to
8 get a D, as in dog.

9 Q. And do you recall the reason why they would
10 not change it?

11 A. We didn't get any rationale on why it wasn't
12 changed, from what I remember.

13 Q. Did you contact them through the help desk,
14 through the Leapfrog help desk?

15 A. Our -- the team did that was there.

16 Q. And at some point in time while you were the
17 CEO of Broward Health, Broward was an A, correct?

18 A. Broward -- Broward Health North was an A,
19 not Broward Health Medical Center, and I was at Broward
20 Health Medical Center, yes. It's part of a network of
21 hospitals.

22 Q. What is the highest grade Broward Health
23 Medical Center ever received from leapfrog while you
24 were associated with them?

25 A. I believe it was a B.

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1 Q. At any time that you were associated with
2 Broward Health Medical, did Broward ever purposely
3 misrepresent its survey results to Leapfrog?

4 A. Not to my knowledge.

5 Q. To your knowledge, at any time when you were
6 associated with Broward, did Broward manipulate its
7 Leapfrog survey results?

8 A. Not to my knowledge.

9 Q. At any time that you were associated with
10 Broward, do you believe that Broward's score -- that
11 Broward's scores on the Leapfrog survey were
12 overinflated because you were a participating hospital?

13 MR. MARCUS: Object to form.

14 A. I wouldn't say that -- say that, no.

15 BY MS. BLAIR:

16 Q. And as I understand your previous testimony,
17 at some point in time Broward was participating in the
18 Leapfrog survey and received a D?

19 A. That's correct.

20 Q. As a participant in the survey?

21 A. That's correct.

22 Q. And so do you have an understanding that the
23 Leapfrog survey is separate and distinct from the
24 Leapfrog hospital safety grade?

25 MR. MARCUS: Object to form.

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1 A. I wouldn't agree with that.

2 BY MS. BLAIR:

3 Q. Have you seen Leap -- you've seen Leapfrog
4 survey, correct?

5 A. Yes.

6 Q. Would you agree with me that not every
7 measure on the Leapfrog survey is part of the scoring
8 methodology for the hospital safety grade?

9 A. I wouldn't agree with that.

10 Q. So it's your testimony that every answer
11 from the Leapfrog Hospital Survey gets scored into the
12 Leapfrog hospital safety grade?

13 MR. MARCUS: Object to form.

14 A. I would say that every measure in that --
15 that survey matters, especially since 2024 when the
16 imputation model was changed. You're asking me about
17 Leapfrog, what -- and how it was before 2024, so when
18 that imputation model changed, that penalized
19 hospitals, because with us not submitting data, that
20 really takes those four measures and makes them about a
21 30 percent weight, so every measure matters in that
22 survey.

23 BY MS. BLAIR:

24 Q. And we'll talk about it in detail later on
25 today.

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1 At any time that you were associated with
2 Broward Medical Center, did Broward pay Leapfrog for
3 its grades?

4 MR. MARCUS: Object to form.

5 A. Not that I'm aware of.

6 BY MS. BLAIR:

7 Q. At any time that you were associated with
8 Broward Medical Center, did Broward pay to participate
9 in the survey?

10 MR. MARCUS: Object to form.

11 A. Not that I'm aware of.

12 BY MS. BLAIR:

13 Q. At any time that you were associated with
14 Broward, did Broward pay Leapfrog consulting fees to
15 get a better grade?

16 MR. MARCUS: Object to form.

17 A. Not that I'm aware of.

18 BY MS. BLAIR:

19 Q. At any time that you were associated with
20 Broward did you receive any solicitation from Leapfrog
21 to pay for consulting services from Leapfrog?

22 A. Not that I'm aware of.

23 Q. Can you just tell me a little bit about, to
24 the extent you know, the rebranding of the five
25 plaintiff hospitals in this litigation as Palm Beach

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1 Health Network, what the purpose of that was?

2 A. That was really, from my understanding, to
3 just show how our hospitals that are all affiliated
4 with each other come together, so from a community
5 perspective and consumer perspective that all of those
6 hospitals are part of the Palm Beach Health Network.

7 Q. Do you consider any of the other four
8 hospitals that are plaintiffs in this litigation to be
9 competitors of Delray?

10 MR. MARCUS: Object to form.

11 A. No.

12 BY MS. BLAIR:

13 Q. And why not?

14 A. Because we work together as a health network
15 in a system to provide care to our community, and each
16 of us has slightly different services, and we need to
17 come together to provide those services holistically
18 for our community.

19 Q. Do you -- does Delray transfer patients to
20 the other four hospitals and vice versa?

21 A. Typically Delray does not have to transfer
22 patients because Delray typically takes more patients.
23 We're a level I adult and pediatric trauma center. We
24 have tertiary cardiovascular care and advanced
25 neuroscience, so the only thing that we typically need

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1 to transfer out are women having babies or if there's
2 pediatric patients that have come that might need to go
3 to the children's hospital within the Palm Beach Health
4 Network or burn patients because we are not a burn
5 center.

6 Q. Does Delray have -- well, strike that.

7 Do these five hospitals have different or
8 separate budgets and financial statements?

9 A. We do each have separate budgets and
10 financial statements.

11 Q. And do each of these five hospitals keep
12 separate statistics on admissions?

13 A. We do.

14 Q. Do the five plaintiff hospitals share any
15 resources at the Palm Beach Health Network level?

16 A. We do.

17 Q. And what resources do you share?

18 A. Our group chief strategy officer is a
19 resource for the network. Our public relations is a
20 resource for the network. Our marketing is at a
21 network level. Gina West who's one of our quality
22 directors has a primary focus at a hospital but also
23 has network oversight. Our chief nursing officer
24 has -- we have one from one of our facilities that has
25 oversight. Our chief operating officer is at one of

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1 the hospitals but has group oversight. Our chief
2 financial officer is at our center but then has group
3 oversight. There's a variety of positions that have
4 group oversight. We have an infection prevention
5 person for the group.

6 Q. Who's the infection prevention person?

7 A. Her name is Taylor.

8 Q. Taylor Pool?

9 A. Yes.

10 MS. BLAIR: That's P-o-o-l-e [sic].

11 BY MS. BLAIR:

12 Q. How much of the Delray budget goes into the
13 Palm Beach Health Network marketing budget?

14 MR. MARCUS: Object to form.

15 A. I would need -- I would need those numbers
16 in front of me. I can't tell you those.

17 BY MS. BLAIR:

18 Q. Am I right that Delray or all five hospitals
19 contribute money to the group marketing budget?

20 A. That would be correct.

21 Q. And do all five of these hospitals
22 contribute money to the quality budget?

23 A. We each have quality directors and quality
24 departments at our facilities, so I don't believe that
25 they're cost allocated over for the group people

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1 because we have those locally.

2 Q. Okay. So Regina West, for example, she --
3 is she not the group chief quality officer?

4 A. She is the group chief quality officer, but
5 she also is the quality officer for St. Mary's Medical
6 Center.

7 Q. Okay. And so her -- she gets paid through
8 St. Mary's and not through group budget?

9 A. I think so. I'd have to look at it.

10 Q. Do you have any idea how much Delray's
11 marketing budget is?

12 A. I, again, would need the financial statement
13 in front of me to tell you.

14 Q. Is it a percentage of the overall budget?

15 A. Again, I need the numbers in front of me.

16 Q. What about what is Delray's quality budget?

17 A. Again, I need the numbers in front of me. I
18 have 1,600 employees. I can't tell you the number of
19 the budget of each department off the top of my head.

20 Q. I don't have the documents or I'd give them
21 to you.

22 Do you know what percentage of Delray's
23 budget goes to the quality budget for your hospital?

24 A. Not without looking at numbers.

25 Q. What type of document would I need to look

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1 at to know -- strike that.

2 What type of document would you need to look
3 at in order to tell me the answers to what is the
4 marketing budget and what is the quality budget?

5 A. I would need the cost centers associated
6 with those budgets from the financial statements and
7 the FTE counts, the full-time equivalents from each of
8 those departments.

9 Q. Maggie Gill is the chief executive of
10 Palm Beach Health Network, correct?

11 A. She's the group president and chief
12 executive officer of the Palm Beach Health Network.

13 Q. And do the five hospitals that make up the
14 Palm Beach Health Network contribute to pay her salary?

15 A. I have not -- I'm not involved in how her
16 salary is paid.

17 Q. What is her role in the Palm Beach Health
18 Network?

19 A. She's our group president and all the CEOs
20 report directly to her.

21 Q. Do you know what her job duties are as the
22 group president?

23 A. I don't -- no, I'm not familiar with her
24 specific job duties. Those wouldn't necessarily be
25 shared with me.

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1 Q. Does she make decisions for Delray, any
2 decisions for Delray related to quality or patient
3 safety?

4 A. We make decisions together.

5 Q. Does she report directly to Tenet Healthcare
6 home office?

7 A. She reports to one of the members in the
8 home office.

9 Q. Do you know who she reports to?

10 A. Lisa Foo.

11 Q. That's F-o-o?

12 A. Yes.

13 Q. And what is Lisa Foo's title?

14 A. She's the chief operating officer of
15 Tenet Healthcare.

16 Q. What is Regina West's role, not at
17 St. Mary's but for Palm Beach Health Network?

18 A. So Regina is the group quality director, so
19 she will facilitate our monthly quality meetings, which
20 are called QMOR, so we have a balanced scorecard that
21 we meet together with on a monthly basis. She also
22 brokers meetings to facilitate standardization of
23 quality practices among the Palm Beach Health Network
24 with all the DQIs or the directors of quality at each
25 site, so she facilitates leadership within the

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1 directors of quality as well, so they have a dotted
2 line to Regina.

3 Q. And in terms of the balanced scorecard you
4 just talked about, is that a balanced scorecard for
5 each individual hospital, or is it for the Palm Beach
6 Health Network as a whole?

7 A. So the balanced scorecard is for each
8 individual hospital, and then there's a roll-up to the
9 Palm Beach Health Network of how we're doing
10 collectively.

11 Q. And are those physical reports that you
12 receive?

13 A. We receive them, but we also have a software
14 that we can pull them out of and look at them at any
15 time.

16 Q. And what is the name of that software, if
17 you know?

18 A. Kaleidoscope.

19 Q. What is QIPSC?

20 A. QIPSC is our quality monthly meeting where
21 all of our quality data from all the different
22 departments is filtered up into, so we meet on a
23 monthly basis. We have a physician chairing that with
24 our director of quality, and that's where the leaders
25 come together looking at our outcomes and how we're

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1 performing in quality, patient safety.

2 And then that information goes up to the med
3 exec and then up on to the governing board so that that
4 dissemination of information is filtered up.

5 Q. Okay. So QIPSC is at the individual
6 hospital level?

7 A. Yes, yes.

8 Q. And what types of data does Regina West
9 track for the hospitals that make up the Palm Beach
10 Health Network?

11 A. So she -- we all have the same -- we have
12 the same balanced scorecard, so there's a large
13 component in there that's looking at our
14 hospital-acquired infections, which would be
15 catheter-based infections, central-line-based
16 infections, MRSA and then C. diff infections, so she
17 has a large component on that.

18 She also is looking at our mortality rates,
19 and then also looking at readmission rates and things
20 like that.

21 Q. Does she put together a hospital safety plan
22 for the group as a whole?

23 A. She doesn't put the plan together as a
24 whole. We do those individually at each of the
25 hospitals.

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1 Q. How often do you put -- do you do a hospital
2 safety plan?

3 A. Those have to be updated annually.

4 Q. And that's a regulatory requirement,
5 correct?

6 A. Correct.

7 Q. And do you know if the hospital safety plans
8 have been produced in this litigation for '23, '24 and
9 '25?

10 MR. MARCUS: Object to form.

11 A. I would need the documents in front of me to
12 see which years, but I know the safety plan has been
13 submitted.

14 BY MS. BLAIR:

15 Q. Is Regina West in charge of putting together
16 any patient safety improvement plans for any of the
17 individual hospitals?

18 A. She could have an influence on those when
19 we're putting them together because, again, if we have
20 a best practice at one of our hospitals that's working
21 from a patient safety perspective and it's evidence
22 based, we'd want to disseminate that to the other
23 facilities, but those are also worked on at the
24 facility level as well.

25 And I'd have to say that's one area that

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1 Delray Medical Center has improved significantly on.
2 We today, as we sit here, are 270 days in our hospital
3 without a central-line-based infection.

4 We've made huge improvements in C. diff and
5 then also have made huge improvements in catheter-based
6 UTIs.

7 And those were all developed through our
8 quality teams with our physicians because we really put
9 in nurse-driven protocols to get Foleys out, which is a
10 best practice.

11 We were able to do conversions of our not
12 having PIC lines in and going to mid-lines which are
13 going to reduce the incidence of developing central
14 line-associated infections.

15 We identified that C. diff is very prominent
16 in our patient population, so getting testing done
17 early and often when the patients are coming in with
18 loose stool is very important.

19 And then because we serve a very elderly
20 population where the average age is in the 80s and some
21 are coming from skilled nursing facilities, they may be
22 living in, being at acute rehabs, there's a high
23 incidence of MRSA from the community onset, so we
24 developed protocols with our infection control champion
25 physician where we're able to do a Nozin® protocol and

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1 able to get these patients tested appropriately on
2 admission. And it's just driven large improvements for
3 us in our patient safety and our outcomes for our
4 patients.

5 Q. Who is your infection control champion
6 physician?

7 A. Dr. Erritouni.

8 Q. Can you spell that?

9 A. I knew you were going to ask me that.

10 Q. Sorry.

11 A. It's -- I don't think I could spell it off
12 the top of my head. It's e-r-o-u-t-i-n-i [sic], I
13 think.

14 Q. And you talked a little bit about CAUTI,
15 right, that's UTI infections?

16 A. Yes.

17 Q. C. diff, correct?

18 A. Yes.

19 Q. MRSA, right?

20 A. Yes.

21 Q. These -- and CLABSI I think you spoke about,
22 correct?

23 A. Yes.

24 Q. And those are all infections that are
25 monitored by CMS, correct?

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1 A. Those are monitored by CMS, yes.

2 Q. In terms of the -- you mentioned earlier the
3 group chief strategy officer at Palm Beach Health
4 Network. Is that Derek Collins?

5 A. That is Derek Collins.

6 Q. Is he involved in decisions regarding
7 marketing of the hospitals?

8 A. Marketing reports directly to Derek.

9 Q. And is there a marketing director of Delray?

10 A. Our marketing director at Delray is also the
11 group marketing director.

12 Q. And who is that?

13 A. Lisa Cook.

14 Q. Oh, yes. I see.

15 And you talked about a chief nursing officer
16 for Palm Beach Health Network. Is that
17 Ricardo Ramirez?

18 A. That is.

19 Q. What hospital does he work at?

20 A. West Boca Medical Center.

21 Q. What about Shannon Wills, is she the
22 Palm Beach Health Network chief human resource officer?

23 A. She is, and she's also my chief human
24 resource officer at Delray.

25 Q. And as I read your interrogatory answers,

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1 there's no nurse union at Delray, correct?

2 A. We do not have a union.

3 Q. Has Delray, like other hospitals, had
4 trouble recruiting nurses in the last three, four
5 years?

6 A. From what I understand, because I came to
7 Delray in 2024, they did have some significant
8 challenges in years past, but we have done a wonderful
9 job developing a nurse extern program, so we have been
10 able to really build that pool up to 100 plus nurses
11 where we're able to recruit talent right out of that
12 nurse extern program. And we've gotten our retention
13 rates for the year down to below 15 percent. And
14 there's just been really a concerted effort on
15 recruiting the best talent we can. But that nursing
16 extern program has been really important for us.

17 Q. How long has that been in place?

18 A. That's been in place, I believe, for two and
19 a half or three years.

20 Q. There's a -- I think you -- well, I want to
21 go back to the rebranding of Palm Beach Health Network.
22 I understand that occurred in April of 2022. Does that
23 comport with your understanding?

24 MR. MARCUS: Object to form.

25 A. I'm not sure the exact date because I wasn't

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1 in my capacity at the facility.

2 BY MS. BLAIR:

3 Q. Have you ever been told or come to find out
4 what the purpose or whether or not the purpose of the
5 rebranding was to compete with new hospitals or medical
6 facilities that were coming into the Palm Beach area?

7 MR. MARCUS: Object to form.

8 A. That's not my understanding of it.

9 BY MS. BLAIR:

10 Q. You've never read any newspaper articles
11 that have suggested that that was the purpose of the
12 rebranding of Palm Beach Health Network?

13 A. I have not.

14 MR. MARCUS: Object to form.

15 BY MS. BLAIR:

16 Q. You've mentioned the board at Delray. How
17 many members are on your board?

18 A. I believe right now we have seven.

19 Q. How long are their terms?

20 A. Their terms are anywhere from two to three
21 years and they can be renewed.

22 Q. Is there a chair of the board?

23 A. There is.

24 Q. Who is that?

25 A. Dr. Jeffrey Newman.

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1 Q. Is he a practicing physician?

2 A. He is.

3 Q. Where does he practice?

4 A. Delray Medical Center and Palm Beach
5 Gardens.

6 Q. And for the record, Palm --

7 A. And he has privileges at West Boca Medical
8 Center.

9 Q. And all three of those hospitals are
10 hospitals in this litigation, correct?

11 A. Correct.

12 Q. Do you know who Larry Ellison [sic] is?

13 A. Larry Edelson?

14 Q. Larry Edelson. I said that wrong.

15 A. Yes.

16 Q. Is he on the board?

17 A. He was a former board member.

18 Q. When did he stop being a board member?

19 A. He was off the board before I came, so I'm
20 not clear on the date that he rolled off.

21 Q. What about Steve Saltzman, is he a board
22 member?

23 A. No.

24 Q. Do you know who Steve Saltzman is?

25 A. I don't think I'm familiar with

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1 Steve Saltzman.

2 Q. Does Delray Medical Center have any issues
3 recruiting for board membership?

4 A. We do not.

5 Q. Who -- how are board members recruited for
6 Delray?

7 A. We work just with our community stakeholders
8 to look at different people in the community that would
9 have good skill sets that could be of benefit for our
10 board and really just be a good addition to the board.
11 So we want a well-rounded board. We wouldn't want
12 everyone that's in the medical field. We have people
13 that are from the real estate sector, from the business
14 sector, from the government sector, from fire rescue
15 because we just want it to be well rounded.

16 Q. How many members are in your med exec?

17 A. Let me count them. So we have our chief of
18 staff. We have our vice chief of staff. We have our
19 treasurer. We have our department of medicine chair,
20 department of cardiology chair, department of surgery
21 chair. We have our two members at large. And then we
22 have our trauma director, our chief of vascular, our
23 chief of the emergency room and chief of radiology and
24 chief of pathology.

25 Q. Is there a chair of the med exec?

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1 A. There is.

2 Q. And who is that?

3 A. Dr. Lon Sadowsky.

4 Q. I'm from Chicago so these names aren't
5 making sense to me, but could you spell it for her?

6 A. Me, too.

7 S-a-d-o-w-s-k-y.

8 Q. And do the -- does the director -- well, let
9 me ask this.

10 Who is the director of quality for Delray?

11 A. Stephany Johnson.

12 Q. And who is Heather Wehmeyer?

13 A. She was the former director of quality.
14 Stephany started at or around October 3rd, 2024. She
15 transferred to us from St. Mary's.

16 Q. When did Heather Wehmeyer stop working at
17 Delray?

18 A. So she just works in a different capacity
19 now. She works in our cardiac quality team.

20 Q. Was that a demotion for her?

21 A. It was.

22 Q. Why was she demoted?

23 A. She just had been promoted into the wrong
24 role. That role was just a little too large for her.

25 Q. And when was she transitioned to the cardiac

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1 quality team?

2 A. It was sometime around when Stephany was
3 starting. I don't have the exact date.

4 Q. Does the med exec get quality reports from
5 your quality director?

6 A. They do.

7 Q. And how often do they get those?

8 A. They get quality information every month in
9 the meetings which will be given by me or by Stephany.
10 We're both in the meeting.

11 Q. And who do you consider to be executive
12 leadership at Delray?

13 A. Our chief operating officer; our chief
14 nursing officer; our chief financial officer; our CHRO;
15 our ACNO; our ACFO; and our associate administrator.

16 Q. And who is the COO of Delray?

17 A. Aganette Parks.

18 Q. And how long --

19 Is that Mr. or Mrs.?

20 A. Mrs.

21 Q. Mrs. Parks. How long has Mrs. Parks been
22 the COO?

23 A. She was just promoted in December of 2024.

24 Q. Who was the COO before her?

25 A. I was.

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1 Q. Oh.

2 A. For just three months or four months.

3 Q. What about before you?

4 A. Maria Morales who is now the group COO and
5 she's at St. Mary's.

6 Q. Yes.

7 Is it common for executive leadership to go
8 from one of these five hospitals to the other?

9 A. Yeah, I think we've done a really good job
10 building a bench and identifying succession planning
11 where you're able to recruit that talent within and
12 give people opportunities. And that's common in the
13 healthcare overall.

14 Q. Who's the current CNO?

15 A. Jennifer Shoemaker.

16 Q. And when did she become the CNO?

17 A. I don't have her exact date either. It was
18 before I came. I think it was sometime in 2023.

19 Q. Who is the CFO currently?

20 A. Michelle Cartwright, and she's also the
21 group CFO.

22 Q. How long has she been the CFO?

23 A. I don't have her exact dates, but she's been
24 there as long as I've been there in my role.

25 Q. So prior to January '23 she would have been

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1 the CFO?

2 A. I believe so.

3 Q. What about the CHRO for Delray?

4 A. I don't have her time either, but I believe
5 she's been there a long time.

6 Q. What's her name?

7 A. Shannon Wills. I'm sorry.

8 Q. No, that's fine. And is she --

9 A. She's group as well and ours.

10 Q. Perfect.

11 What are the job duties of the director of
12 quality at Delray?

13 A. So that person is directly responsible for
14 just the oversight of our quality and patient safety
15 programming. They also run all of our -- they have
16 oversight for all of our case review conferences, so
17 these teams report. Infection control reports up to
18 them. And really just collaboration with the
19 administrative team to ensure that that patient safety
20 plan is rolled out, adhered to and measured and
21 monitored.

22 Q. Does Delray have various quality committees?

23 A. We do.

24 Q. What quality committees do you have?

25 A. Some of them that I can think of right now,

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1 we have QIPSC. We have cardiac surgery improvement.
2 We have our STEMI work group improvement. We have a
3 monthly neuroscience for our stroke quality
4 improvement. We have monthly trauma quality
5 improvement. We have a patient experience or care
6 experience committee that meets monthly. There's a
7 variety of them. There's an EP quality improvement. I
8 mean, all the departments really have a lot.

9 Q. Well, let's talk about QIPSC. Who's on the
10 QIPSC committee for Delray?

11 A. So it's chaired, again, by our director of
12 quality and our -- one of our med exec members which is
13 Dr. Moussa, M-o-u-s-s-a.

14 Q. So that would be Stephany Johnson, correct?

15 A. Stephany Johnson and Dr. Moussa.

16 Q. Okay.

17 A. I sit on that committee. The CNO sits on
18 that committee. The COO sits on that committee.

19 And then we have our clinical directors that
20 are on that committee as well, so that would be our
21 nursing directors, our imaging director, our ED
22 director, I mean, all of those types of folks. And
23 then our infection prevention nurses are on there.

24 But I would need to give you the sign-in
25 sheet --

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1 Q. No --

2 A. -- to show you, there's a lot of people that
3 are part of that committee.

4 Q. I appreciate it. It's not a memory test. I
5 appreciate that, though.

6 A. Okay.

7 Q. And how often does QIPSC meet?

8 A. Monthly.

9 Q. And what about the --

10 A. Oh, and I'm sorry. Our governing board,
11 Lori Vinikoor, sits on our board, too.

12 Q. Vinegar like --

13 A. No, Vinikoor, V-i-n-n-k-o-r [sic], I think.

14 Q. And what about the patient experience
15 committee, who chairs that?

16 A. I do.

17 Q. And how many members are on that committee?

18 A. Well, I just started -- I kind of
19 reinvigorated that committee in July, so I actually
20 have bedside care providers from many of the units, so
21 there's nurses, there's CNAs who are like patient care
22 techs. So I have about 20 people that sit on that
23 committee.

24 And then there's a grouping of some
25 managers, some clinical directors. And then we're

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1 going to be rolling some physicians into that meeting
2 next month as well.

3 Q. Have you hired a patient experience
4 champion?

5 A. So I have a care experience -- I don't
6 really use "patient experience" as a word anymore, so
7 we use "care experience." And I have a care experience
8 coordinator. And it -- she was already within the
9 health network working at Delray Medical Center so we
10 just put her in a different capacity in a different
11 role.

12 Q. When was the position of care experience
13 coordinator started?

14 A. We put her in that role in April, I believe.

15 Q. April of 2025?

16 A. Yes.

17 Q. And what is her name?

18 A. Angelica, and I'm going to spell her last
19 name, it's L-i-g-a-s, Ligas.

20 Q. What does the patient ex -- do you call it
21 the patient experience committee, or do you call it the
22 care experience committee?

23 A. I call it the care experience committee.

24 Q. What does the care experience committee do?

25 A. So we -- this was a committee, again, that

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1 was reinvigorated in July. But we are evaluating the
2 unit-based scores, the overall scores from the HCAHPS
3 for the hospital.

4 But we also are looking at our Google
5 reviews as well. So really part of that when we
6 started to look at our Google reviews back in September
7 of 2024, we were a 1.8 star-rated Google hospital. And
8 I'm happy to say that with all the process improvement
9 we've put in place we're a 4.5 so we're leading all of
10 Palm Beach County with Google reviews. So that's going
11 to be an early indicator, and then those HCAHPS will
12 start to follow.

13 So that committee is really looking at our
14 hardwired practices, looking at our scores, where we
15 can do things differently from the bedside, you know.

16 So if -- for example, we just had this
17 committee this past week, so we really were looking at
18 the bedside handoff that's happening between
19 practitioners, where we are doing well on it, where we
20 have opportunities.

21 We also developed recognition programs for
22 all the staff members as it relates to patient
23 experience so we've created a champion experience award
24 that's going to be rolled out this month. We have each
25 unit gets a care experience award if they're the

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1 champion of the month, so just developing different
2 awards and recognition programs and that they really
3 are ambassadors that are then going out into their
4 units, talking about scores, talking about best
5 practices in addition to everything that the leadership
6 team is doing to back that up.

7 Q. And those HCAHPS scores, they turn into star
8 ratings at CMS, correct?

9 A. They are a factor in the star rating.

10 Q. And what is the patient experience CMS star
11 rating currently for Delray?

12 A. It's a one-star.

13 Q. And do you anticipate that to go up as the
14 fixes -- my word -- that you put into place?

15 A. I expect them to go up, but that's going to
16 take time, because when you look at star ratings that
17 are reflective today, those -- that's data that's going
18 through, I believe, '21 to '23, so we're going to need
19 some time for those plans to mature and then that data
20 to come off so that we can start to see the fruits of
21 the labor.

22 Q. Right. And that's because the publicly
23 available CMS data lags, correct?

24 A. Correct.

25 Q. And we talked about just very briefly the

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1 nurse retention improvements that you've been doing at
2 Delray.

3 Is it fair to say based on your testimony
4 that currently you don't feel as if Delray has any
5 staffing retention issues?

6 MR. MARCUS: Object to form.

7 A. I think we've made large improvements in
8 staffing and retention. I would say there's probably
9 one or two departments that are more specialty specific
10 that have more challenges that might be above that
11 average, but I think we have a good plan in place where
12 we don't need to be concerned.

13 BY MS. BLAIR:

14 Q. Can you talk to me a little bit about
15 Delray's marketing plans? Do you have a marketing plan
16 for Delray?

17 A. So we have -- we do business planning every
18 year, so really you're building in your marketing plans
19 with that, but I do go over my marketing plan, you
20 know, for the year, and then I meet on a monthly basis
21 with my marketing and then my public relations team to
22 just make sure that we're staying on track with
23 everything. So we'll identify the key service lines
24 that we are going to be promoting. It may be related
25 to new capital equipment or new capital projects or

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1 different innovative technologies that we're going to
2 be launching within that given year, and we have plans
3 that go along with all of that, but it's typically by
4 service line.

5 Q. And is most of the marketing for Delray
6 individual to Delray, or is it in the Palm Beach Health
7 Network group?

8 A. The marketing can -- the marketing can be a
9 combination of both. So, for example, if it's a shared
10 service line where Delray Medical Center, for example,
11 if it's cardiovascular services that we want to
12 promote, Delray Medical Center and Palm Beach Gardens
13 are both large cardiovascular hubs and destinations so
14 there may be something that we do together.

15 Q. Would you agree with me that the brand of
16 Delray has increased under your leadership?

17 A. I would agree.

18 Q. When you came to Delray in 2024 --

19 A. January '24.

20 Q. -- January 2024, what kind of brand
21 recognition did you believe Delray had?

22 MR. MARCUS: Object to form.

23 A. From the feedback, it's not what I believe,
24 but the feedback I received when spending time with
25 important community constituents and physicians was

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1 that the reputation, they didn't know all the key
2 services and the quality outcomes, the superior quality
3 outcomes that we had achieved there. It was kind of a
4 hidden secret.

5 BY MS. BLAIR:

6 Q. And when you say "they," are you referring
7 to the community at large?

8 A. The community constituents and different
9 physicians I went out to talk to.

10 Q. And when you came on as the CEO of Delray,
11 was it one of your goals to improve the brand of
12 Delray?

13 A. That's always, as a CEO, you always want to
14 improve your brand and make sure the community
15 understand the services, the physicians are comfortable
16 with the services.

17 Q. Had there ever been any studies done for
18 Delray specifically comparing its brand, let's just
19 say, in 2023 versus today?

20 A. I don't think I've seen all those studies.

21 Q. I don't...

22 And I'm just trying to figure out is there a
23 way in which -- is there a way in which Delray measures
24 whether or not you're improving your brand within the
25 Palm Beach community?

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1 A. There are these monthly reports. I don't
2 recall exactly what the name of those reports are, but
3 those come out from Lisa Cook that just talks about the
4 consumer awareness as it relates to our various
5 hospitals.

6 Q. And what is your understanding of what those
7 reports are measuring?

8 A. It's just, from what I recall -- I need them
9 in front of me -- it's looking at like consumers'
10 understanding what Delray is or what any of the
11 hospitals are. It has the positive and negatives. It
12 captures, you know, how many times we've been in the
13 media from what I remember.

14 Q. Oh, I think I've seen those. Okay.
15 Other than those types of reports, are there
16 any other reports that you're aware of that would kind
17 of measure?

18 A. Not that I'm aware of.

19 Q. Are you aware of whether Tenet Health
20 systems, like the home office, puts out any -- does any
21 analysis of individual hospitals' brand awareness?

22 MR. MARCUS: Object to form.

23 A. I'm not aware of that.

24 BY MS. BLAIR:

25 Q. Are you aware or have you ever seen any

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1 analyses of the brand of Tenet health systems as a
2 whole?

3 A. No.

4 Q. Are you aware of whether there's any reports
5 of the brand awareness of Palm Beach Health Network as
6 a group?

7 MR. MARCUS: Object to form.

8 A. Just the report I'm telling you about there,
9 but that's more at the local, that's the local level
10 not in the Tenet Healthcare.

11 BY MS. BLAIR:

12 Q. Right. But when you say it's at the local
13 level, is it for Delray individually or is it for Palm
14 Beach Health Network?

15 A. For Palm Beach Health Network. That's the
16 reports I'm explaining.

17 Q. Oh. Is there a report like that, like the
18 one you just described, from Lisa Cook for Delray
19 individually?

20 A. Well, Delray is included. It's just, it's
21 included in that report that Lisa Cook sends.

22 Q. Okay. So it's both on a group level and
23 then kind of breaks out on an individual level?

24 A. Correct.

25 Q. I just couldn't remember.

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1 A. Sorry.

2 Q. No, no.

3 And I assume that as the CEO of a
4 hospital -- well, you tell me.

5 As the CEO of the hospital, what is like the
6 most important thing that you want to achieve for your
7 hospital?

8 A. I want it to be a quality destination that
9 is safe for patients and that consumers feel confident
10 in and physicians.

11 Q. And so would you agree with me that
12 hospitals put a high importance on patient safety?

13 A. Yes.

14 Q. And would you describe patient safety as
15 reducing the risk of preventable harm?

16 MR. MARCUS: Object to form.

17 A. I think that's part of the recipe.

18 BY MS. BLAIR:

19 Q. What are the other parts?

20 A. You want to reduce patient harm. You want
21 to be being forward thinking, making sure you're having
22 evidence-based protocols in place so that you can
23 advance the care as well.

24 Q. And I assume part of what hospitals want to
25 do is make sure that patients leave a hospital in

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1 better shape than they came in; is that fair?

2 A. You always want to strive for that, but
3 depending on the kind of patients you're taking care
4 of -- and remember we are situated as a level I trauma
5 center, a comprehensive stroke center, and we have an
6 elderly population, so sometimes you're not going to be
7 able to fulfill that, but you want to do your best to
8 get them back to the level they were at, but that's
9 sometimes is impossible based on your patient
10 populations.

11 Q. That's a good point.

12 And is it important to you as the CEO of
13 Delray that patients feel cared for while they're in
14 the hospital?

15 A. It's very important to me.

16 Q. And that would be those HCAHPS scores we
17 were talking about, correct?

18 A. That's a portion of it. That's their
19 perception, but we validate that on a daily basis
20 through rounding. So our leaders are rounding. I
21 actually go and round on patients every day. And
22 that's the goal for every staff member that works in
23 our hospital that patients and families are at the
24 center every day. So that's validated through our
25 rounding every day.

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1 Q. And would you agree with me that patients
2 deserve transparency with respect to patient safety in
3 a hospital?

4 A. Yes.

5 Q. Would you agree with me that patients
6 deserve to have information related to patient
7 experiences at a hospital?

8 A. Yes.

9 Q. And that they deserve to have up-to-date
10 information with respect to hospital-acquired
11 infections at any given hospital?

12 A. Yes.

13 Q. And would you agree with me that you strive
14 to provide your board with clear and accurate data with
15 respect to patient safety at Delray Medical Center?

16 A. Yes.

17 Q. And same with the med exec, you want to make
18 sure that they have clear and transparent information
19 related to patient safety at Delray?

20 A. Yes.

21 Q. And you would agree with me that that's the
22 same for your constituents, the patients of the
23 community as well, correct?

24 A. That's correct.

25 Q. In terms of other hospitals in the area who

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1 do you consider the competitors of Delray hospital to
2 be?

3 A. So the Baptist Health system, which is
4 comprised of Boca Regional, Bethesda East and West,
5 JFK, those are going to be some of our more immediate
6 competitors.

7 Q. And how do you determine who your
8 competitors are?

9 A. So we look at our primary service areas that
10 we serve and just looking at where patients are going
11 within that primary service area and then hospitals
12 that are closest to us with some of same services. So
13 that's kind of how we gauge it, through those primary
14 service area maps.

15 Q. And how -- I'm not from Florida, so I
16 apologize.

17 How far is Baptist Health Bethesda east?

18 A. Bethesda East is probably, if I -- I don't
19 know, five, six miles. Bethesda West is maybe the
20 same.

21 Q. And what about Boca Raton?

22 A. Boca is probably about ten or less.

23 Q. What about HCA Florida?

24 A. That one's probably about 14, 15 miles.

25 Q. Do you consider Jupiter Medical Center to be

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1 a competitor of Delray?

2 A. Not really.

3 Q. What about Wellington Regional Medical
4 Center?

5 A. For some services they could be but not
6 really.

7 Q. And then I have had Baptist Health Boca
8 Raton Regional?

9 A. That's Boca Regional that I told you. It's
10 the same.

11 Q. It's the same?

12 A. They're all part of Baptist now. Bethesda
13 East, West and Boca.

14 Q. Sorry. I had it...

15 And what about the Broward hospitals, do you
16 consider them to be competitors?

17 A. I mean, Broward Health North that's situated
18 on Sample Road has some similar services, so we do pull
19 some of theirs, but they're not a major area of concern
20 from competition.

21 Q. Does Baptist Health Bethesda transfer
22 patients to Delray?

23 A. They do.

24 Q. Is that a regular occurrence?

25 A. Yes, especially because we're a level I

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1 trauma center, so those hospitals are not trauma
2 centers so they can't keep the trauma patients there.

3 Q. And have those transfers been relatively
4 consistent since you've been the president of Delray?

5 A. Yes.

6 Q. And what about Baptist Health Bethesda
7 Hospital West, do they transfer patients?

8 A. They do.

9 Q. Is that a regular occurrence?

10 A. It is, mostly for trauma patients, again.

11 Q. And have the transfer levels remained the
12 same since you've been president of Delray?

13 A. Yes.

14 Q. What about Baptist Health Boca Raton, do
15 they regularly transfer patients to you?

16 A. They will send us trauma patients. They
17 have more tertiary services, so trauma is the main
18 thing that they send us.

19 Q. And in terms of the level of transfers from
20 Baptist Health Boca Raton, have those maintained the
21 relatively same level since you've been the CEO?

22 A. Those have.

23 Q. And same questions with respect to
24 HCA Florida JFK, do they regularly transfer patients?

25 A. They do, again, mostly trauma patients

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1 because of the services that they offer and psych
2 patients.

3 Q. Trauma and psych like psychology?

4 A. Psychiatry. We have a behavioral health
5 unit.

6 Q. And have the level of transfers from
7 HCA Florida JFK remained pretty level since you've been
8 the CEO?

9 A. They have.

10 Q. Do you consider -- well, are you aware, for
11 example, that Cleveland Clinic has come into the
12 Palm Beach area?

13 A. Yes.

14 Q. Do you consider them to be a competitor of
15 Delray?

16 A. In some limited services.

17 Q. In which limited services?

18 A. Colorectal surgery and cardiovascular
19 surgery but not to the Palm Beach hospital, like not to
20 those sites. It's pulling them down to the Weston site
21 for those services. I want to clarify that.

22 Q. Okay. And how far is Weston from Delray?

23 A. Oh, probably 30 plus miles. But they have
24 an outpost for Cleveland Clinic on the Coral
25 Springs/Parkland line where they have outpatient

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1 colorectal surgeons going there, so that's where that
2 feeder is.

3 Q. Okay. And do you consider Delray to be
4 losing any patients to Cleveland Clinic Weston?

5 A. Just in those two categories that I
6 described.

7 Q. And for how long have you been competing
8 with Cleveland Clinic Weston in colorectal and
9 cardiovascular?

10 A. That has really come up in 2025 we've seen
11 that.

12 Q. And do you have any understanding of why
13 that's come up in 2025?

14 A. It has to do with the providers that they
15 put out there. They put regular GI providers and the
16 colorectal surgeons in that area and did a lot of
17 marketing around it.

18 Q. What about NYU Langone Health, do you
19 consider them to be a competitor?

20 A. No, we work very closely with them.

21 Q. And how do you work closely with them?

22 A. They have large practices in cardiology and
23 primary care that are located across the street from
24 our campus, and all of their cardiology patients are
25 admitted to Delray Medical Center.

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1 Q. So how long have they been admitting
2 patients -- and they, I mean, how long has NYU Langone
3 been admitting patients to Delray?

4 A. Since I've arrived they've already been
5 doing that, but we've seen a stronger collaboration.

6 Q. So those have been up since you've been a
7 CEO?

8 A. Um-hum.

9 Q. You have to say "yes."

10 A. Oh, yes, yes. Sorry.

11 Q. Do you see a decrease in patient admissions
12 at your hospital in the winter months due to the sort
13 of transient snowbird nature of the population of the
14 area?

15 MR. MARCUS: Object to form.

16 A. In the winter months, that's our season, so
17 we see them come up, so they go back to the colder
18 places in the winter -- in the summer months.

19 BY MS. BLAIR:

20 Q. Sorry.

21 A. But we actually, it's very -- we get a lot
22 more volume during those winters months.

23 Q. Okay. Yeah, I'm from Chicago so it's the
24 opposite. I apologize.

25 A. Yes.

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1 Q. So, for my record, so during the summer
2 months your volume goes down; during winter months, it
3 goes up here?

4 A. That's historically what it looks like.

5 Q. Are you finding that since you've become the
6 CEO of Delray in or around January of 2024, do you see
7 that to be still the case?

8 A. We've leveled it out a lot better, so we're
9 not seeing those ups and downs, but we've been very
10 strategic in what we're doing, so really building in
11 the right physicians. We've done a lot of recruitment.
12 We've done a lot of collaboration alignment with our
13 community physicians. And then we've really worked at
14 understanding where we needed different programs.

15 So, for example, we had never had women's
16 imaging on our campus at our outpatient imaging center,
17 and we understood that women, of course, needed
18 mammograms. And talking to the physician, talking to
19 the community, we put that women's imaging in place in,
20 you know, October of 2024.

21 And then we started breast oncology surgery,
22 which had never been at Delray, in January of '25, and
23 that's just been a success where we've served 2,000
24 women in our community since putting that in place.

25 So everything has been very strategic in

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1 what we've done.

2 Q. And is that part of your strategic planning
3 as the CEO of Delray?

4 A. It is.

5 Q. And have you seen revenues go up since
6 you've become the CEO of Delray?

7 A. We have.

8 Q. Do you -- does Delray -- we just talked
9 about some of your competitors in the area, or maybe
10 all of your competitors in the area. Do you use -- do
11 you know if Delray uses Trilliant to measure your
12 competitive positions versus your competitors in the
13 area?

14 A. Our business development team has access to
15 Trilliant data.

16 Q. "Trilliant." I'm sorry.

17 A. Yes, Trilliant. And they -- they will
18 provide those reports to us. So we will sometimes look
19 at those for different service lines to understand just
20 some of referral patterns and where we need to, you
21 know, enhance our services to meet the community need.

22 Q. But, as I understand our discussion that we
23 just had, you are increasing your patient volume and
24 revenue versus your competitors' based on the strategic
25 planning that you've undertaken?

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1 A. I don't know what the competitors' revenue
2 has looked like. I just know what ours looks like and
3 we are increasing.

4 Q. So the Trilliant platform doesn't,
5 obviously, tell you what their revenue is, correct?

6 A. No, no, it just tells you like patient, how
7 many patients have gone where and for what services.
8 It doesn't give you revenue data.

9 Q. Can you tell your patient volume versus your
10 competitors when you look at Trilliant?

11 A. You can see it to some extent, but, again,
12 it's six -- it's about six months old so it's in the
13 rear.

14 Q. And are those reports produced to you like
15 in hard copy?

16 A. They typically would be something in hard
17 copy or the business development team would just show
18 them on a screen, but they come in -- you see the
19 reports like in an Excel file, the way that it's
20 exported.

21 Q. Do you know if it has a name on the top of
22 it?

23 A. Whatever it -- whoever is running the report
24 will put like a title on it, depending on what the
25 report is.

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1 Q. Do you know if they've been produced in this
2 litigation?

3 MR. MARCUS: Object to form.

4 A. I'm not aware that they were produced.

5 BY MS. BLAIR:

6 Q. Other than that Trilliant report that we
7 just discussed, do you know whether or not there's any
8 other market studies that are done for -- let's start
9 with for Delray at the individual level versus your
10 competitors?

11 MR. MARCUS: Object to form.

12 A. Not that I'm aware of.

13 BY MS. BLAIR:

14 Q. And what about on the Palm Beach Health
15 Network level, do you know whether or not, other than
16 the Trilliant we discussed, do you know whether or not
17 there are any other market studies that are done?

18 A. Not that I'm aware of.

19 Q. Are you aware of whether -- I think I might
20 have asked you this, so I apologize.

21 Are you aware of whether there's been any
22 brand analysis done for your hospital?

23 MR. MARCUS: Object to form.

24 A. Just those reports that I spoke to you
25 about.

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1 MR. MARCUS: Kim, we've been going a while.

2 Do you want to go off the record for a quick
3 break?

4 MS. BLAIR: Oh, yea. Yeah, we can go off
5 the record, absolutely.

6 THE VIDEOGRAPHER: The time is 10:26 a.m.
7 We're going off the record.

8 (A recess was taken from 10:26 a.m. to 10:43 a.m.)

9 THE VIDEOGRAPHER: This is media number two
10 in the deposition of Heather Havericak. The
11 time is 10:43 a.m. We are back on the record.

12 BY MS. BLAIR:

13 Q. Ms. Havericak, before we took a break we
14 were talking a little bit about -- well, you were
15 telling me earlier this morning about a lot of the
16 different accolades that your hospital has, correct?

17 A. Yes.

18 MS. BLAIR: And we can mark this as
19 Exhibit 3.

20 (Defendant's Exhibit Number 3 for i.d.)

21 MS. BLAIR: I have no clue where my copy is,
22 but I'll figure it out.

23 BY MS. BLAIR:

24 Q. Ms. Havericak, I've just handed you what
25 we've marked Exhibit 3 to your deposition. And if you

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1 see on the bottom right hand of these documents, they
2 have what we call a Bates number. This is PBHN 8914
3 through 8917.

4 Have you seen this document before today?

5 A. I have.

6 Q. Do you know the date in which this one, this
7 particular one would have been created?

8 A. I don't have the exact date. This gets
9 updated as we have different things that are added to
10 it.

11 Q. And if I look on the second page, a lot of
12 the awards and distinctions by service line that are
13 listed appear only to go through 2024. Would you have
14 a more up-to-date one that would list 2025 accolades as
15 well?

16 A. We do have an updated one.

17 Q. And just kind of looking at the awards and
18 distinctions on the second page of what we've now
19 marked Exhibit 3, are there any accolades here -- I'm
20 sorry. Are there any accolades that are not listed
21 here that you know of?

22 A. Yes. So our 2025 Healthgrades® awards do
23 not appear to be listed in this document.

24 Q. And do you know off the top of your head
25 what they are?

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1 A. I don't know all of them off the top of the
2 head, but there's a variety of them in cardiovascular,
3 in pulmonary care, in critical care. And then we did
4 receive Healthgrades 250 Best Hospitals™ in 2025.

5 And then we have also recently been
6 accredited through the Joint Commission for our initial
7 accreditation as a certified hip, knee and shoulder
8 replacement center. We also were just accredited
9 through the SRC, which is the Surgical Review
10 Corporation, as a Robotics Center of Excellence.

11 Q. And in terms of Healthgrades®, is that a
12 paid-for service?

13 A. That's not a paid-for service. The data is
14 not an opt in or opt out. It comes from claims data
15 that pulls from both Medicare data and private
16 insurance companies. The only time payment comes into
17 play is when you're using the actual accreditation
18 marks that you have earned through the data that's been
19 verified.

20 Q. Do you pay for the accreditation marks for
21 Healthgrades®?

22 A. We do.

23 Q. And so if I look just on this document, like
24 under cardiac and vascular where it says Healthgrades®,
25 and it is microscopic, and I apologize, it looks like

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1 it says an R and a circle. Do you see that?

2 A. I do.

3 Q. And that's, is that the accreditation mark
4 that you're referring to?

5 A. That's their trade -- trademark that you
6 have to pay to use --

7 Q. Okay.

8 A. -- based on the quality outcomes that we've
9 earned through claims data through Medicare and private
10 payers.

11 Q. And so Healthgrades® comes from CMS data?

12 A. Part of it comes from CMS data. The other
13 part comes from private claims, too, so commercial
14 payers as well.

15 Q. And do you have to provide that for private
16 claims data to Healthgrades®?

17 A. No.

18 Q. From what platform do they receive that?

19 A. I'm not sure what platform they'd get that
20 from.

21 Q. And so if we look at the bottom of this page
22 like that first row of logos that all say
23 Healthgrades®, is that the accreditation marks you are
24 referring to that you pay for?

25 A. On the top row?

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1 Q. Yes.

2 A. Yes, those are some of them. But these are
3 not reflective of what we earned in 2025.

4 Q. Good point.

5 And if we see on that bottom row to the
6 right side there's like these U.S. News trademarks?

7 A. I see those.

8 Q. What accolades do those refer to, if you
9 know?

10 A. Can I take my glasses out for a second?

11 Q. Oh, please, yes.

12 A. Because I don't think I can see that.

13 Actually, I don't think I brought them.

14 MR. MARCUS: You want mine?

15 THE WITNESS: No, that's okay.

16 A. It appears to be from 2020 to 2023 for high
17 performing hospitals for heart attack, heart failure
18 and stroke.

19 BY MS. BLAIR:

20 Q. And to the best of your knowledge, how do
21 hospitals earn these types of awards from U.S. News?

22 A. From the best of my knowledge, and I haven't
23 looked at U.S. News & World Report in quite sometime,
24 there's also data that's pulled from Medicare, CMS data
25 and from claims data from what I remember.

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1 Q. Okay.

2 A. But we haven't been participating with
3 U.S. News & World Re -- U.S. News since I've been at
4 Delray.

5 Q. And going back to the Healthgrades®, do you
6 know whether Delray's participation in Healthgrades® is
7 approved by Tenet home office?

8 MR. MARCUS: Object to form.

9 A. It's, again, it's not an opt in or opt out,
10 so those, the data that they pull and the awards they
11 send to us, those are just there, and then we make the
12 decision to enter into the -- to use the trademark.

13 BY MS. BLAIR:

14 Q. Okay. I see. So you as a hospital don't
15 have to put any resources toward complying -- my
16 word -- complying with Healthgrades® in order to get
17 these awards out?

18 A. Can you rephrase that question?

19 Q. Sure. It was a bad question.

20 Delray hospital doesn't have to expend any
21 internal resources to provide data to Healthgrades® in
22 order for Healthgrades® to rank Delray?

23 A. Correct.

24 Q. And is that the same with respect to
25 U.S. News, to the best of your knowledge?

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1 A. From what I remember from my previous
2 employer, but I can't be certain on that because I
3 haven't looked at that in sometime.

4 Q. What about --

5 Okay. Let's just talk about this bottom row
6 of what I'm going to call -- strike that.

7 With respect to U.S. News, do you know
8 whether you have to pay to use that their logo that we
9 see on the bottom row to the right?

10 A. I'm not sure.

11 Q. Okay. And if we go to the left side of this
12 bottom row, it looks like this says --

13 A. A carotid care champion quality [sic]
14 award.

15 Q. Yeah, what is that?

16 A. So that is based on our -- we participate in
17 submitting data through our vascular program to the
18 Vascular Quality Initiative so we have to actually take
19 our data, we have someone that works in vascular
20 quality, they have to enter all the data, abstract it
21 from the medical records. And based on outcomes of the
22 VQI data we were awarded the Carotid Care Quality
23 Champion because our data is so good and outcomes are
24 so good for our patients. And there's no payment
25 involved in that.

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1 Q. No payment to use that logo?

2 A. Correct.

3 Q. And do you know whether or not -- and is
4 that one, then, the Carotid Care Quality Champion, that
5 is one that you, Delray would use internal resources to
6 pull data to report?

7 A. They're reporting it, they're reporting that
8 monthly, like in the registry, so that is our personnel
9 pulling data.

10 Q. And what is the registry?

11 A. The registry, so in order to participate --
12 we're part of the Vascular Quality Initiative because
13 we want to enhance our patient quality and safety for
14 quality care so we have to ept data into this platform
15 for the VQI so we have a full-time employee that does
16 that.

17 Q. Okay. And so that's like an FTE --

18 A. Correct.

19 Q. -- full time?

20 A. Correct.

21 Q. And his or her only job is doing this?

22 A. Is vascular quality. So they will do this
23 and do other things as well --

24 Q. Got it.

25 A. -- that relate to vascular quality.

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1 Q. And is participating in the Vascular Quality
2 Initiative tied to any contract or payment for the
3 hospital?

4 A. Not that I'm aware of.

5 Q. What is TCAR Center of Excellence?

6 A. That's also part of our vascular program, so
7 that's a procedure that we do where you work with the
8 carotid artery, and it's minimally invasive. And we're
9 the highest -- we've done the most procedures in the
10 country at our center. And that's based on our
11 outcomes, because in order to be part of the TCAR
12 program, you also have to enter your data on the
13 outcomes of those procedures.

14 Q. And would that be same --

15 A. Yes.

16 Q. -- person?

17 A. Yes.

18 Q. So their job is not only with the
19 Vascular Quality Initiative but also with respect to
20 TCAR, correct?

21 A. Yes, because TCAR is part of the vascular
22 program so she's responsible for all vascular items.

23 Q. Okay. And it looks like -- and I apologize.
24 I literally cannot read the next one AACVPR. Is that
25 also carotid or cardiovascular?

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1 A. No, this is cardiovascular, but it's
2 cardiovascular rehab. So we wanted to get our program
3 accredited in cardiopulmonary rehab, so that's one of
4 our outpatient departments in the hospital. So they
5 went through the accreditation process where they have
6 to meet all the standards, and then they had a
7 validation survey to show that they met all the
8 standards, their outcomes are appropriate, all the
9 staff had the appropriate proficiency training,
10 education to be able to validate that.

11 Q. And is that the same person from -- that
12 does the vascular quality?

13 A. No, that's a different -- that's a different
14 group of people.

15 Q. Okay. And then this looks like it's
16 Blue Cross/Blue Shield, the next two, Blue Distinction®
17 Center?

18 A. Yes.

19 Q. And so is -- I assume that's tied to a
20 payment program?

21 A. That's just -- that comes from the Blue
22 Cross/Blue Shield network. So they actually pull data
23 based on our outcomes. And there's a -- and I don't --
24 without having the document in front of me of all the
25 standards, it pulls on some quality outcomes,

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1 readmissions. And there's a price component in there
2 too.

3 Q. Okay.

4 A. From what I remember.

5 Q. And like legitimately I can't even read the
6 next one so I'm not going to ask.

7 A. Yeah, I was just trying. I don't -- I'm
8 sorry.

9 Q. No, no, it's totally fine.

10 And to the best of your knowledge, then, of
11 the ones we talked about --

12 A. Oh, I know what it is. It's a comprehensive
13 stroke center it's saying. It's our DNV Comprehensive
14 Stroke Center.

15 Q. Oh. What is that?

16 A. So DNV is another accrediting organization
17 similar to the Joint Commission. So in the State of
18 Florida you do, in order to call yourself a
19 comprehensive center, you do have to either be
20 accredited through Joint Commission or through DNV. So
21 the organization at Delray before I came started that
22 through DNV.

23 So they come every year for two days to
24 validate. We just had our DNV survey and we're
25 reaccredited. So they bring three surveyors on site

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1 who are experts in stroke care, and they really trace
2 through the whole journey of patients looking at open
3 records, closed records. They'll start in the
4 emergency room. They go to the operating room. They
5 go to the units and really trace everywhere where a
6 patient is.

7 And then they meet with all of the
8 stakeholders. They review all the stakeholders' files,
9 from the physicians and the staff to make sure everyone
10 meets the training and educational levels that are
11 required to be part of that.

12 Q. Okay. Okay. Thank you. I couldn't read it
13 at all.

14 So to the best of your knowledge, we at
15 least know that -- and I'm going to call them like the
16 logos or I forget what you called them, accreditation
17 marks for Healthgrades®, those are paid for, but we --
18 you don't know for sure whether any on the bottom line
19 are paid for to use those logos, correct?

20 A. Correct.

21 Q. How do you track how Delray is doing in
22 terms of patient experience versus your competitors?

23 A. So for patient experience we use a vendor
24 called Press Ganey, so they administer our HCAHPS
25 surveys. And within there you won't be able to see,

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1 per se, the competitors, but it has you ranked in
2 that -- in that program. So all -- I have access to
3 Press Ganey. All the clinical managers have access,
4 the directors, the administrative team. So you can go
5 in and see how you rank at the state level and then at
6 the national level.

7 Q. And when you started at Delray, do you know
8 how Delray ranked at the state level for HCAHPS?

9 A. From what I recall, we were in a lower
10 percentile.

11 Q. And what about from a national average when
12 you started?

13 A. The same.

14 Q. But there are initiatives underway, correct?

15 A. Correct.

16 Q. Do you -- how do you track how Delray is
17 doing in hospital-acquired infections compared to
18 competitors? Is there a way to view that?

19 A. So for hospital-acquired infections we
20 report data into NHSN, so, again, it's not going to
21 tell us exactly how the competitor is doing, but it's
22 going to give us a SIR's rating, so what -- you know,
23 how many patients you have, what your expected
24 infection rate is going to be. And then it doesn't --
25 it doesn't really rank you like that way, the same way

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1 the Press Ganey does.

2 Q. Okay.

3 A. So we really benchmark where we are like to
4 the SIR's rating, like the SIR's, and that's kind of
5 how we measure ourself.

6 Q. Okay. So --

7 A. And then how we did to prior year like
8 continuously looking to how we improve.

9 Q. And for us lay people when you say "SIR's,"
10 how do you spell that and what is it?

11 A. Sure, so it is the -- it's S-i-r-s. And
12 it's just, it is, again, just looking at the expected
13 model of how many patients you have, how many expected,
14 like what your expected infection rate should be based
15 on the patient population and the number of patients
16 you have.

17 Q. And when you started at Delray, do you
18 remember how Delray was doing on these, you know,
19 SIR's, I'm going to say ratings, but I don't know if
20 that's the right term?

21 A. Without -- without the data in front of me
22 from exactly when I started, I wouldn't be able to tell
23 you exactly where we were at. We had some
24 opportunities, but, again, I can't quote you where
25 those are.

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1 Q. Okay. But that data would be available in
2 the NHSN data for that time period, correct?

3 A. Yes.

4 Q. And that would be a report would have been
5 generated in or around that time at Delray advising
6 med exec or quality directors as to what those HAI's
7 were?

8 A. Yes.

9 Q. And is that the best place for me to look at
10 what they were?

11 A. The best place to look would be in that
12 monthly quality meeting.

13 Q. But just based on your recollection when you
14 took over as the CEO of Delray, were the HAIs good?
15 Bad? Average? Do you recall?

16 MR. MARCUS: Object to form.

17 A. They were -- they were average.

18 BY MS. BLAIR:

19 Q. Do you know whether or not Delray has ever
20 participated in the Lown, L-o-w-n, survey?

21 A. I'm not familiar with that.

22 Q. Are you aware that Delray did participate in
23 the Leapfrog Hospital Survey for sometime historically?

24 A. I am.

25 Q. And do you know when they started

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1 participating in Leapfrog Hospital Survey?

2 A. I don't know the date that they actually
3 started, but I do know from some of the documents that
4 I've seen, it looks like they participated in 2018,
5 2019.

6 Q. Do you know what the last year was that they
7 participated?

8 A. I think it was somewhere around 2020.

9 Q. Do you know if when Delray participated in
10 the Leapfrog Hospital Survey it was ever charged to
11 participate in the hospital survey?

12 MR. MARCUS: Object to form.

13 A. I have seen some documents that show that a
14 licensing fee was executed in a contract to use the
15 letter grade.

16 BY MS. BLAIR:

17 Q. Right. And do you understand that that
18 licensing fee was to use logos just like the logo,
19 Healthgrades® logos we looked at in Exhibit 3?

20 MR. MARCUS: Object to form.

21 A. It looks similar.

22 BY MS. BLAIR:

23 Q. And so my earlier question was, do you know
24 if Delray ever paid to complete the survey?

25 A. To my knowledge, no.

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1 Q. Do you know if any hospital has ever paid
2 Leapfrog to participate in a survey?

3 MR. MARCUS: Object to form.

4 A. I'm not aware of any.

5 BY MS. BLAIR:

6 Q. Are you aware of any hospital has ever paid
7 Leapfrog for better grades?

8 MR. MARCUS: Object to form.

9 A. I'm not aware that any have paid Leapfrog
10 for better grades.

11 BY MS. BLAIR:

12 Q. Do you understand that the Leapfrog Hospital
13 Survey is voluntary?

14 A. While I understand it's voluntary, with the
15 change in the imputation model in 2024, it becomes a
16 punitive measure when you don't participate because of
17 a failing grade is assigned for some of those key
18 measures that are self-reported, and those end up
19 taking up about 33 percent when you look at the
20 weighted total and average.

21 Q. Right. And we're going to look at that.

22 But you are not required as a hospital to
23 participate in the Leapfrog Hospital Survey, correct?

24 MR. MARCUS: Object to form.

25 A. We are not required.

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1 BY MS. BLAIR:

2 Q. And Delray does not currently participate in
3 the Leapfrog Hospital Survey, correct?

4 A. We do not.

5 Q. Do you know whether or not Delray has ever
6 been approached by Leapfrog to pay for consulting
7 services?

8 A. Not to my knowledge.

9 Q. Do you know whether Delray was ever forced
10 to license these trademarks that we looked at from
11 Leapfrog in exchange for better grades?

12 MR. MARCUS: Object to form.

13 A. Not to my knowledge.

14 BY MS. BLAIR:

15 Q. What is the basis for the plaintiffs'
16 allegation that Leapfrog is a "brazen pay-to-play
17 scheme"?

18 MR. MARCUS: Object to form.

19 A. We have made the decision not to participate
20 in the Leapfrog survey, and with that, we have been
21 personalized. Because of that imputation model where
22 we did not submit data, rather than giving us a
23 not applicable or not grading us, Leapfrog falsely
24 assigned an F rating, which has shaken the community's
25 confidence in our ability to provide care. It's

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1 reckless; it's dangerous; and it's deceptive because
2 all consumers see is an F rating, and that's not the
3 full picture --

4 BY MS. BLAIR:

5 Q. And what --

6 A. -- of how we are providing care from a
7 patient safety and quality perspective.

8 Q. And we'll get to that.

9 I'm asking specifically the allegation in
10 the Complaint that its "brazen pay-to-play," and your
11 answer didn't have anything about paying in it. And so
12 I'm just asking, with respect -- and we'll get to all
13 of those, and I understand your theory.

14 But what is the basis for the allegations
15 that Leapfrog is a brazen play-to-pay [sic] scheme?

16 MR. MARCUS: Object to form.

17 A. Because if you choose not to participate,
18 this is the downfall of the catastrophic impact it has
19 on our community and patients. It is almost forcing to
20 you participate in Leapfrog. But when you don't
21 participate, it's causing reputational damage and harm,
22 so that's what I mean by "pay to play."

23 BY MS. BLAIR:

24 Q. Okay. So by -- what you mean by "pay to
25 play" doesn't include any actual payment. It's just

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1 participation in the survey?

2 MR. MARCUS: Object to form.

3 A. I, again, can repeat what I said.

4 BY MS. BLAIR:

5 Q. Right. And there was no -- in your answer
6 there was no discussion of money, correct?

7 A. There's no discussion of money.

8 Q. Do you have any reason to believe that
9 Delray's competitors that do participate in the
10 Leapfrog Hospital Survey manipulate their data?

11 A. I have no knowledge of that.

12 Q. Do you understand that's an allegation in
13 the Complaint?

14 MR. MARCUS: Object to form.

15 A. What is in the Complaint is that Leapfrog
16 does not come and do any validation of self-reporting
17 measures. That's different than saying a competitor
18 has manipulated data.

19 BY MS. BLAIR:

20 Q. Well, you say here, "Those hospitals inflate
21 their performance."

22 MR. MARCUS: Object to form.

23 BY MS. BLAIR:

24 Q. It says that in paragraph 55 of your
25 Complaint. And I'm asking do you have any evidence

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1 that your competitors inflate their performance on the
2 Leapfrog Hospital Survey.

3 MR. MARCUS: Object to form.

4 A. I don't have evidence that they inflate, but
5 Leapfrog does not validate or verify any of the
6 self-reported measures that are submitted.

7 BY MS. BLAIR:

8 Q. And we'll get to that later, but my question
9 is about whether or not your competitors inflate their
10 performance on the Leapfrog hospital safety -- or
11 Leapfrog Hospital Survey. And you don't have any
12 evidence of that as you sit here today, correct?

13 A. I do not.

14 Q. Do you have any evidence that your
15 competitors that participate in the Leapfrog survey
16 manipulate their data on the survey?

17 MR. MARCUS: You're asking her personally,
18 right? Who's the "you"?

19 BY MS. BLAIR:

20 Q. Yes, I'm asking you personally.

21 A. I do not.

22 Q. And I think you told me earlier that when
23 Broward participated in the survey, they did not
24 manipulate their data, correct?

25 A. To my knowledge, no.

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1 Q. Do you understand that Delray has produced
2 documents in this litigation sufficient to simulate
3 what their responses would have been to the four
4 imputed measures, BCMA, CPOE, hand hygiene and
5 ICU physicians staffing?

6 A. Yes.

7 Q. And can we trust that the sufficient to
8 simulate data that has been produced by Delray in this
9 litigation was not manipulated, correct?

10 A. It was not manipulated.

11 Q. Do you know whether hospitals, and let's
12 just talk prefall of 2024. Prefall of 2024, so you --
13 well, strike that. Let me lay some foundation.

14 You understand that the Leapfrog methodology
15 was changed for the fall 2024 hospital safety grade,
16 correct?

17 A. Correct.

18 Q. And so I want to talk about prefall 2024 the
19 hospital safety grade. Do you, Ms. Havericak, have any
20 opinion, personal opinion about whether or not there
21 was any benefit in participating in the Leapfrog
22 Hospital Survey prior to fall of 2024?

23 A. I don't think there's a lot of value in
24 participating in that survey.

25 Q. And why not?

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1 A. I mean, just personally, there's other
2 certification and awards of quality and validations
3 that you can do where your data is actually being
4 validated, verified. And I just, I don't think that
5 this is a transparent full way of looking at quality
6 and safety. I think there's other organizations that
7 do that better.

8 Q. And when you use the word "transparent,"
9 what do you mean when you use that word?

10 A. Telling the whole story and being truthful.

11 Q. And, again, I'm talking about prefall of
12 2024. What about the Leapfrog hospital safety grade
13 was not truthful?

14 A. It still was assigning in some of those
15 measures just an average grade, so it's not giving a
16 full picture of validated performance.

17 Q. And do you understand that prefall of 2024
18 for the four imputed measures, nonparticipating
19 hospitals like Delray were receiving 100 percent for
20 the four measures at issue in this litigation?

21 MR. MARCUS: Object to form.

22 A. That's not what I understand it to be.

23 BY MS. BLAIR:

24 Q. You don't understand that prior to fall of
25 2024 Delray received 100 out of 100 points for CPOE,

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1 BCMA, hand hygiene and ICU physician staffing?

2 A. Yeah, I haven't seen a report that shows
3 that.

4 BY MS. BLAIR:

5 Q. Okay. And we'll look at that later.

6 If -- so I'm just making sure. Do you --
7 would you -- is it your position that if Delray in
8 spring of 2024 as a nonparticipating hospital was
9 receiving 100 out of 100 points for the four measures
10 that come from the hospital survey and are used in the
11 hospital safety grade, that would be inaccurate?

12 MR. MARCUS: Object to form.

13 A. I can't say if it would be inaccurate
14 without putting our actual data in it.

15 BY MS. BLAIR:

16 Q. Do you know whether any of the five
17 Palm Beach hospital network's hospitals complained
18 about the Leapfrog hospital safety grade methodology
19 prior to fall of 2024 in that nonparticipating
20 hospitals were being assigned the mean grade of their
21 cohorts for those four measures?

22 MR. MARCUS: Again, you're asking the
23 witness personally?

24 MS. BLAIR: Yeah.

25 A. I'm not aware.

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1 BY MS. BLAIR:

2 Q. Are you aware as the corporate
3 representative for Delray whether that's how the
4 methodology worked prior to fall of 2024?

5 A. Can you repeat that question?

6 Q. Sure.

7 A. That sounds like a different question.

8 Q. Sure. I just, I'm trying to get an
9 understanding of whether you understand the difference
10 between how nonparticipating hospitals were graded
11 prior to the fall 2024 hospital safety grade.

12 So why don't you just tell me, for those
13 four measures, BCMA, CPOE, hand hygiene and what we
14 call IPS or ICU physician staffing, how do you
15 understand nonparticipating hospitals were graded for
16 those four measures prior to fall of 2024?

17 A. From my understanding, they were given an
18 average on -- from the cohort of what was there, not
19 100 percent.

20 Q. Well, do you understand that they were given
21 achievement scores, full achievement scores for those
22 four measures based on the median from their cohorts?

23 MR. MARCUS: Object to form.

24 A. I do understand that.

25 BY MS. BLAIR:

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1 Q. And if you look, it's 100 out of 100 for
2 achievement for those four measures.

3 MR. MARCUS: Object to form.

4 BY MS. BLAIR:

5 Q. Do you understand that to be the case?

6 A. Again, I need to see the data of what our
7 scores were for that time period.

8 Q. Okay. We'll look at that.

9 So do you have an understanding that for ICU
10 physician staffing prior to fall of 2024, a methodology
11 change had already occurred in 2023 that
12 nonparticipating hospitals would be receiving low
13 achievement for ICU physician staffing?

14 MR. MARCUS: Object to form.

15 A. I don't think I was aware of that.

16 BY MS. BLAIR:

17 Q. And what do you understand the change was
18 between spring of 2024 and fall of 2024 with respect to
19 the hospital safety grade methodology?

20 A. From what I understand, the imputation model
21 where we were not submitting data in those four
22 categories being barcode medication scanning,
23 computerized order entry, ICU physician staffing and
24 hand washing, those were now being assigned the lowest
25 possible score from the cohort if we did not submit

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1 data; additionally, that those categories when you look
2 at the weighted side end up representing about
3 30 percent of the total score for the Leapfrog grade
4 being assigned.

5 Q. Do you understand that the lowest possible
6 score is the lowest score assigned to a participating
7 hospital?

8 A. Yes.

9 Q. Okay. So not from the cohort, correct?

10 A. From the lowest, yes.

11 Q. And that is the change that we are all here
12 about in this litigation, to your knowledge, correct?

13 MR. MARCUS: Object to form.

14 A. That is the change that we see issue with.

15 BY MS. BLAIR:

16 Q. Do you know why the five plaintiff hospitals
17 stopped participating in the Leapfrog Hospital Survey
18 in or around 2021?

19 MR. MARCUS: Object to form.

20 A. I wasn't here in those years, but from what
21 I've been told, we wanted to use our resources in other
22 areas. That was during COVID when resources were
23 scarce, and we wanted to put our resources in driving
24 our patient safety and quality and not putting those
25 resources directly towards the Leapfrog efforts.

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1 BY MS. BLAIR:

2 Q. Any other reasons that you can think of?

3 A. Not at this time.

4 Q. Do you know whether or not the decision to
5 stop participating in the Leapfrog Hospital Survey was
6 a directive from Tenet home office?

7 MR. MARCUS: Object to form.

8 A. I'm not aware of it being a directive.

9 MS. BLAIR: What are we on, 4 and 5?

10 THE STENOGRAPHER: This will be 4 and 5,
11 yes.

12 MS. BLAIR: 4 and 5.

13 (Defendant's Exhibit Number 4 for i.d.)

14 (Defendant's Exhibit Number 5 for i.d.)

15 MS. BLAIR: Sorry. Give me one sec.

16 BY MS. BLAIR:

17 Q. I'll start with 5.

18 Ms. Havericak, I have -- I am handing you
19 what we've now marked as Exhibit 5. Do you see this is
20 an email from Satyavani Nukala to Heather Wehmeyer,
21 CC'ing Stephany Johnson on November 4th, 2024?

22 A. Yes, I see that.

23 Q. And if you -- and just for the record if I
24 look at these Bates numbers at the bottom, it's
25 PBHN 11845 through 11849. Is that what you have in

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1 front of you?

2 A. Yes.

3 Q. And you'll see if we go kind of to the first
4 email, all the way back on 11849, it starts on 11848.
5 This is an email from Satyavani Nukala to several
6 people. Do you see that email?

7 A. I do.

8 Q. And it says, "Good afternoon. The fall 2024
9 safety embargo period started today."

10 Who is Satyavani Nukala? "Nukala."

11 A. It appears she's a biostatistician of
12 clinical operations. I haven't worked with her.

13 Q. Okay. And she is in what we're calling the
14 Tenet Healthcare home office; is that correct?

15 A. She appears to be in the Dallas office, yes.

16 Q. Did you have an understanding in or
17 around -- well, do you have an understanding that Tenet
18 home office asked all of the hospitals in its system to
19 report their health -- their Leapfrog hospital safety
20 grades during the embargo period at each grading
21 period?

22 MR. MARCUS: Object to form.

23 A. Can you repeat that? I'm sorry.

24 BY MS. BLAIR:

25 Q. Sure. I've just seen a number of emails in

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1 this litigation, and this is not the only one, where
2 someone from home office is saying, Good afternoon.
3 You know, the safety grade embargo period started
4 today. Please review your score and letter grade and
5 share it with me.

6 Do you see how she's asking that?

7 A. I do.

8 Q. Is that something that Tenet home office
9 does regularly, asks the hospitals to share their
10 Leapfrog score with home office?

11 MR. MARCUS: Object to form.

12 A. I'm not sure because I'm not on this email
13 and would naturally be a thread in this email. I'm not
14 sure. I don't have knowledge of that.

15 BY MS. BLAIR:

16 Q. Do you have knowledge, not with this email
17 specifically but just in your role as the president of
18 Tenet Healthcare that home office asks the hospitals to
19 run their Leapfrog grade every grading period and
20 report it back to them?

21 MR. MARCUS: Object to form.

22 A. I'm not aware that home office does ask them
23 to do that.

24 BY MS. BLAIR:

25 Q. Okay. And you'll see here there's like a

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1 follow-up if we look at page 11847. This Mr. or
2 Mrs. Nukala is asking Stephany for an update. "Please
3 share the Leapfrog fall 2024 score and grade," correct?

4 MR. MARCUS: Object to form.

5 A. So it looks like on 887 -- or I'm sorry --
6 47 and 48, yes, it looks like there's a transition
7 between Heather and Stephany and she's asking her to
8 send the grade.

9 BY MS. BLAIR:

10 Q. And that was going to be my question. Is
11 this the transition in them in the role as quality
12 director for Delray?

13 A. It appears to be during that time frame.

14 Q. And then if we look at 11846, Heather is
15 updating home office that the Delray grade is going to
16 be an F, correct?

17 MR. MARCUS: Object to form.

18 A. It appears she sent an email to Bonnie that
19 the score is going to be an F for Delray.

20 BY MS. BLAIR:

21 Q. Okay. And then the email at the top of
22 11846 is "Thank you, Heather. I wonder why Delray's
23 grade is depriving year by year."

24 Do you see that email?

25 A. I do.

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1 Q. And if we look at 11845, which is where I
2 was trying to get to when I started this, Heather says
3 to Satyavani, "It is because we have not been
4 participating in Leapfrog per Tenet corporate's
5 instruction."

6 Do you see that?

7 A. I see that.

8 Q. Does that refresh your recollection that, in
9 fact, the reason that the hospital stopped
10 participating, at least one of them, was at the
11 direction of corporate?

12 MR. MARCUS: Object to form.

13 A. It doesn't. This is an email from
14 Heather Wehmeyer, and I wouldn't know who gave her that
15 direction because I've never been given that direction
16 personally.

17 BY MS. BLAIR:

18 Q. And we'll look at what we're going to mark
19 as Exhibit 4 or I've already marked as Exhibit 4. And,
20 for the record, this is PBHN 2072 through 2075.

21 A. Yes.

22 Q. And I want to focus on the second email on
23 the first page here, which is from you to
24 Stephany Johnson and Jennifer Shoemaker as well as
25 Nicole Jackson. Do you see that like about in the

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1 middle of the page?

2 A. I do.

3 Q. Who is Nicole Jackson?

4 A. My associate chief nursing officer.

5 Q. Okay. And you say, "This is unfortunate
6 because the public still looks at this. Does the PR
7 team have something prepared that talks about not
8 participating in this?"

9 Do you see that?

10 A. I do.

11 Q. Okay. And that is in response to, if we go
12 to 2073, Stephany Johnson's email to you dated
13 November 4, 2024 where she says, the Leapfrog score for
14 Delray has fallen from a D reported in the spring 2024
15 to an F. All scores across the market have fallen as
16 we were instructed by corporate to not participate in
17 data submission for the rating."

18 Do you see that?

19 A. I do.

20 Q. Does that refresh your recollection that, in
21 fact, the hospitals were instructed by corporate to not
22 participate in data submission for rating?

23 MR. MARCUS: Object to form.

24 A. I mean, I see it here, but, again, I have
25 not been told by corporate not to participate in

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1 Leapfrog. So I get a lot of emails every day. I
2 don't...

3 BY MS. BLAIR:

4 Q. Okay. And you don't recall, and you've not
5 in preparing for your deposition today, you've not come
6 to the conclusion that part of the reason that at least
7 the five hospitals that are plaintiffs in this
8 litigation stopped participating in the Leapfrog survey
9 because it was a directive from corporate?

10 MR. MARCUS: Object to form.

11 A. Again, I haven't been given that directive
12 from corporate.

13 BY MS. BLAIR:

14 Q. Still to this day you have not?

15 A. I have not.

16 Q. Are you aware of any emails from corporate
17 that advised at least the five plaintiff hospitals in
18 this litigation that participation in Leapfrog would
19 not be supported unless it was tied to a local
20 requirement, contract compliance or reimbursement?

21 MR. MARCUS: Object to form.

22 A. I don't recall seeing that email.

23 BY MS. BLAIR:

24 Q. Were you the president of Delray in or
25 around September 27th of 2024?

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1 A. Yes.

2 Q. Who is Anna Gunod?

3 A. She is the infection prevention lead in the
4 home office.

5 Q. I don't have a copy of this, but I'll get
6 one later.

7 So it's your understanding -- is it your
8 understanding that the decision for the five plaintiff
9 hospitals to stop participation in the
10 Leapfrog Hospital Survey was the decision of the five
11 hospitals without any input from Tenet corporate?

12 MR. MARCUS: Object to form.

13 A. Again, I wasn't here when those decisions
14 were made, so I don't know every single person that was
15 involved in that. From what I have been told
16 secondhand is that it was during the time in transition
17 of COVID and that we were going to use our efforts to
18 improve our patient safety and quality and focus on our
19 other accreditations, and that's the information that I
20 have.

21 BY MS. BLAIR:

22 Q. And as the corporate representative of
23 Delray, is it the answer of Delray that the reason
24 Delray stopped participating in the Leapfrog Hospital
25 Survey in 2021 was because Delray itself made the

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1 decision that its resources would be better utilized in
2 patient care and patient safety and not in complying
3 with or participating in, excuse me, the Leapfrog
4 Hospital Survey?

5 MR. MARCUS: Object to form.

6 A. That is correct.

7 BY MS. BLAIR:

8 Q. Do you know whether or not there was any
9 objection by Delray executive staff in or around 2021
10 about staffing participation in the Leapfrog hospital
11 safety grade?

12 MR. MARCUS: Object to form.

13 A. I don't have knowledge of that. You're
14 talking about 2021. I wasn't there.

15 BY MS. BLAIR:

16 Q. Have you had any discussions with your
17 board, your governing board regarding Delray's decision
18 to stop participating in the Leapfrog Hospital Survey?

19 A. I did.

20 Q. And when were those discussions?

21 A. I believe, but without looking at minutes, I
22 can't be certain, I believe they were around the time
23 it would have been, I think, November of '24,
24 December '24 where we talked about those letter grades
25 coming out and that we would not -- we were not

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1 participating.

2 Q. And what was the reaction from the board
3 about the letter grades?

4 A. They were concerned. Again, they asked a
5 lot of questions. And we took time to go through how
6 the scores are calculated, what the measures are and
7 then really talking about what our performance and
8 quality and safety looked like.

9 But they needed to be equipped with the
10 right information so they didn't just have the
11 deceptive information that they were seeing with an F
12 and what went into that F and what it meant because it
13 could be confusing for them when they're seeing, you
14 know, data that's happening right now that looks very
15 different than that.

16 Q. And do you recall what you told the board
17 about what goes into the safety grade?

18 A. Yeah, we went through the self-reported
19 measures; we went through the CMS star rating measures
20 and just kind of talked through all of those pieces.

21 Q. Did your board come to a consensus that the
22 right decision was to for the participate in the
23 hospital -- the Leapfrog Hospital Survey?

24 MR. MARCUS: Object to form.

25 A. I don't know that they came to a consensus.

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1 BY MS. BLAIR:

2 Q. Was there a vote by your board about whether
3 or not Delray should participate in the Leapfrog
4 Hospital Survey?

5 A. There was not a vote.

6 Q. Do you know whether or not you told the
7 board that home office would not allow participation in
8 the Leapfrog Hospital Survey unless it was directly
9 tied to payment --

10 MR. MARCUS: Object to form.

11 BY MS. BLAIR:

12 Q. -- or accreditation?

13 A. I don't remember saying that.

14 Q. Was there any discussion at the board level
15 about attempting to increase the Leapfrog hospital
16 safety grade for Delray by means other than
17 participating in the Leapfrog Hospital Survey?

18 A. We talked about enhancing our ratings, our
19 CMS ratings and some of the safety initiatives that go
20 along with that, so our hospital-acquired infections,
21 our patient experience, those are the things that we
22 talked about.

23 Q. And do you understand that there are
24 hospitals -- well, strike that.

25 Do you understand that Leapfrog grades

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1 approximately 2,800 acute care hospitals across the
2 United States?

3 A. Yes.

4 Q. Do you understand that 80 percent of those
5 hospitals participate in the Leapfrog Hospital Survey?

6 MR. MARCUS: Object to form.

7 A. I don't know the numbers of who participates
8 and who doesn't.

9 BY MS. BLAIR:

10 Q. That's fair.

11 Do you have -- do you know that there are
12 hospitals that do not participate in the Leapfrog
13 Hospital Survey that receive A's?

14 A. I've never seen that.

15 Q. But you are aware that there are hospitals
16 that do participate in the Leapfrog Hospital Survey
17 that, for example, receive D's, like Broward did,
18 correct?

19 A. I'm aware of that before the imputation
20 model changed, yes.

21 Q. Are you aware that there are hospitals after
22 the imputation changed that received D's even though
23 they participate in the Leapfrog Hospital Survey?

24 A. Again, I would have to see all the hospitals
25 and what their scores are and if they participate or

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1 not.

2 Q. You've never undertaken that analysis; is
3 that correct?

4 A. I have not.

5 Q. Do you know if any of the experts that
6 you've hired in this litigation have ever undertaken
7 that analysis?

8 MR. MARCUS: Object to form.

9 A. I don't know what they've done.

10 BY MS. BLAIR:

11 Q. Would you agree with statements that have
12 been made in this case that if you don't participate in
13 post fall of 2024, if you don't participate in the
14 Leapfrog Hospital Survey, you automatically receive a
15 failing grade?

16 A. Yes, I agree with that.

17 Q. So it is your position as the corporate
18 representative of Delray that if a hospital does not
19 participate in the Leapfrog Hospital Survey, they
20 receive an F?

21 MR. MARCUS: Object to form.

22 A. They have the potential to receive an F,
23 yes.

24 BY MS. BLAIR:

25 Q. Would you agree with me that any hospital

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1 whether they participate or not, has the potential to
2 receive an F?

3 A. Not necessarily.

4 Q. What does that mean, "not necessarily"?

5 A. It depends on what the rest of their data
6 looks like.

7 Q. Correct.

8 A. But you are going to receive an F post with
9 that imputation model if 30 percent of your scores are
10 getting assigned to the lowest number that's available
11 from the submitting hospitals. Like there's just
12 mathematically no way to overcome that with 30 to
13 33 percent of the score being a failing grade.

14 So, yes, I think if you do not participate,
15 you are going to get a failing grade. And that is
16 my...

17 BY MS. BLAIR:

18 Q. Okay. Do you know how long it takes to fill
19 out the hospital survey? I'm sorry. The Leapfrog
20 Hospital Survey?

21 A. Yes, it's very laborious because it's not
22 just about filling out the survey, but it's about
23 validating your data and ensuring it's accurate. And
24 then it takes all the time on the units doing all of
25 the hand hygiene surveillance, making sure you're

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1 validating all of those pieces. It can take upwards of
2 probably a good thousand hours to be able to do all of
3 those things appropriately.

4 Q. And so when you were the CEO of Broward, did
5 it take about a thousand hours a year to engage in the
6 Leapfrog survey?

7 A. It's about that.

8 Q. Have you --

9 A. There's teams of people that have to devote
10 time to that.

11 Q. Have you seen studies that suggest it's
12 40 to 80 hours a year to conduct and finalize the
13 Leapfrog hospital survey?

14 MR. MARCUS: Object to form.

15 A. I have not.

16 BY MS. BLAIR:

17 Q. Are you aware that your lawyers have taken
18 the position in this litigation that it takes between
19 40 and 80 hours a year to complete the Leapfrog
20 Hospital Survey?

21 MR. MARCUS: Object to form.

22 A. I am not.

23 BY MS. BLAIR:

24 Q. Do you know how many FTE's need to be
25 assigned to complete the Leapfrog Hospital Survey in a

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1 year?

2 A. Again, it's not just about completing the
3 survey. It's all the things that go along with the
4 survey. So in my judgment, it would be about a half of
5 an FTE.

6 Q. A year?

7 A. Yes.

8 Q. And that's about a thousand hours?

9 A. Um-hum.

10 Q. Do you know how many hours your staff has
11 spent to date in connection with this lawsuit?

12 A. I do not.

13 MR. MARCUS: Object to form.

14 BY MS. BLAIR:

15 Q. Do you know whether or not the cessation of
16 hospitals participating in the Leapfrog Hospital Survey
17 coincided with Saum Sutaria -- if I'm saying his name
18 right -- of becoming the CEO of Tenet Healthcare at
19 large?

20 MR. MARCUS: Object to form.

21 A. I'm not aware of that.

22 BY MS. BLAIR:

23 Q. Do you have any understanding of how
24 compliance with the Leapfrog Hospital Survey was
25 handled by Delray in 2020, which was the last year that

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1 they participated in the Leapfrog Hospital Survey?

2 A. No.

3 Q. Do you have any understanding of what the
4 budget was at Delray in 2020 to comply with the
5 Leapfrog Hospital Survey in 2020?

6 A. I don't. I'm sorry.

7 MR. MARCUS: Could we go off the record for
8 just one second?

9 THE VIDEOGRAPHER: The time is 11:48 a.m.
10 We're going off the record.

11 (A recess was taken from 11:37 a.m. to 11:39 a.m.)

12 THE VIDEOGRAPHER: The time is 11:39 a.m.
13 We're back on the record.

14 BY MS. BLAIR:

15 Q. And my follow-up question, Ms. Havericak,
16 was, do you know in the last year that Delray
17 participated in the Leapfrog Hospital Survey in 2020
18 how many FTE hours they committed to complying with the
19 Leapfrog Hospital Survey?

20 A. I'm not aware.

21 Q. And I want to start -- I want to talk just
22 about 2023 before we get to 2024 when all of the things
23 happened.

24 Do you know whether or not Delray was
25 monitoring CPOE in 2023?

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1 A. Again, I wasn't there in 2023 so I don't
2 know what they were monitoring.

3 Q. And, for the record, do you know what I
4 mean, by CPOE?

5 A. Yes, computerized order entry.

6 Q. Okay. And can you just describe briefly
7 what computerized physician order entry is?

8 A. That's where the physicians are
9 electronically entering their order into our medical
10 records, which Cerner. You want to make sure that
11 they're entering those orders from a patient safety
12 perspective and that you're really limiting telephone
13 orders that are going in where a nurse or allied health
14 professional would be entering those orders for them.

15 Q. And you have a CPOE policy in place at
16 Delray, correct?

17 A. We do.

18 Q. Do you know if there was one in place in
19 2023?

20 A. I wasn't here in '23, but I -- from what I
21 understand in looking at our policy, it looks like it
22 was in place at that time.

23 Q. So that would be a "yes" to 2024 as well?

24 A. Yes. Yes.

25 Q. Okay. Do you know how -- and do you know

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1 how Delray was monitoring CPOE compliance prior to,
2 well, let's just say, in 2023?

3 A. I don't know how they were monitoring it in
4 '23.

5 Q. What about in '24, do you know how they were
6 monitoring CPOE compliance in 2024?

7 A. When I came, we are monitoring it through
8 the monthly meetings with all of our hospitalists.
9 That's the largest group of patients that admits
10 patients into the hospital. So on a monthly basis
11 we're pulling their CPOE compliance by provider. And
12 that's shared with the providers in a monthly meeting
13 just to ensure that they're meeting the thresholds and
14 then understanding if people are below the threshold
15 what we need to do, do they need more training, do they
16 understand how to put in the orders, do they understand
17 the CPOE policy.

18 So that's how that is monitored.

19 Q. Okay. And when you say "provider" for this
20 record, that's a physician?

21 A. Physician, yes.

22 Q. Because sometimes we say "health care
23 providers." So we're talking about physicians,
24 correct?

25 A. Physicians.

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1 Q. Do you know in 2023 whether Delray was
2 monitoring barcode medication compliance?

3 A. Again, I don't know what they were doing in
4 '23.

5 Q. What about in '24, do you know what they
6 were doing in '24?

7 A. Yes, our chief nursing officer in
8 collaboration with the directors in each of the units
9 and the divisions are looking at the barcode medication
10 scanning on a monthly basis. And then, again, if
11 there's fallouts, doing interventions to understand why
12 there's fallouts, were there issues with the computers
13 or the tools and equipment or was there user error,
14 people not following policy and procedure.

15 Q. And prior to fall of 2024 how would you
16 describe Delray's compliance with BCMA procedures?

17 A. It's excellent.

18 Q. And same question with respect to CPOE --
19 how would you describe prior to fall of 2024, how would
20 you describe Delray's compliance with CPOE, compliance
21 with CPOE?

22 A. Correct. We're excellent, too. We're
23 meeting the thresholds.

24 Q. And when you say "we're meeting the
25 thresholds," who puts into place those thresholds?

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1 A. We put those in place at the organization.

2 Q. And is that at the Palm Beach Health Network
3 level?

4 A. We all have the same within our policies.

5 Q. And do you know what the threshold is? Is
6 it a percentage?

7 A. Yeah, it's a percentage. So CPOE
8 compliance, we like the physicians to be 90 percent or
9 greater, and then barcode medication scanning, I
10 believe, is 85 or 90. I don't remember off the top of
11 my head.

12 Q. And in -- let's talk about hand hygiene. In
13 2023, do you know how Delray was monitoring hand
14 hygiene?

15 A. I do not.

16 Q. What about in 2024?

17 A. Yes.

18 Q. How was Delray monitoring hand hygiene in
19 2024?

20 A. So there are -- were unit-based tracers that
21 are done that the managers are responsible for
22 submitting to the infection control department every
23 month, and then those are shared in the infection
24 control committee and then in the quality committee.

25 We have increased those observations just

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1 based on some of the data we were seeing.

2 Nationally you see that hand hygiene when
3 you look at the Journal of the American Medical
4 Association, you see, you know, when you're looking at
5 self-reported measures, we need to make sure people are
6 validating. So there are actually tracers that are
7 going on in all of the units when people don't know
8 they're being watched for hand hygiene, so, you know,
9 we're performing well there and identifying where the
10 gaps are.

11 So, you know, in some trends when we look at
12 the data we see, for example, maybe the food and
13 nutritional services folks that are delivering trays
14 aren't using hand hygiene every time, we're able to go
15 then and do tailored education to them, teach them
16 about hand hygiene and why it's important, and then
17 we'll do extra tracers on those units that aren't
18 meeting the targets.

19 MR. MARCUS: And, Kim, I don't want to
20 interrupt, but just we'll have a standing
21 objection if you -- to the phrasing that, "do
22 you understand your lawyers are taking
23 positions"?

24 MS. BLAIR: Oh, sure.

25 MR. MARCUS: You said that a couple times.

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1 MS. BLAIR: Yeah. Twice. I just said it
2 twice.

3 MR. MARCUS: All right.

4 MS. BLAIR: That's all right.

5 MR. MARCUS: We object to that.

6 BY MS. BLAIR:

7 Q. Ms. Havericak, when you use the word
8 "tracers," what does that mean?

9 A. It's going out and validating in realtime
10 when our clinicians are in practice, you know, what
11 they're doing. So for hand hygiene tracers we have a
12 hand hygiene tool that they look at when they're
13 tracing to see when the -- if it's a physician, if it's
14 a nurse, any bedside care provider that goes into the
15 room, are they washing their hands before they're going
16 in, after they're caring for the patient are they
17 washing their hand. We want to make sure that all of
18 those moments of hand hygiene are met.

19 Q. So is it like -- I'm sorry for --

20 A. It's a form.

21 Q. Oh, it's a form.

22 A. It's a form that they fill out, and then we
23 just calculate the totals and the data from all of
24 those different tracer forms.

25 Q. Okay.

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1 A. Different people are doing them at different
2 times so we can capture an accurate reflection of our
3 practices.

4 Q. Okay. So it's not electronic in some way?

5 A. No, it eventually all goes into an
6 electronic form, but they're paper form so that we can
7 have access for everyone.

8 Q. Okay. And then ICU physician staffing, do
9 you have a -- I know your interrogatory answers say you
10 have 24/7 ICU physician staffing, correct?

11 A. We do.

12 Q. And that is -- is that like pursuant to a
13 contract?

14 A. So we have two different contracts. Our
15 trauma patients are covered under the trauma contract
16 for trauma ICU, and then our cardiac ICU and neuro ICU
17 is under another contract for our intensivists so
18 they're staffed 24/7 on site.

19 Q. Is that both physicians and nurses?

20 A. So they, the trauma contract is all just
21 physicians. The other ICU contract outside of trauma
22 has physicians and then allied health professionals
23 which could be a physician assistant or an advanced
24 registered nurse practitioner.

25 Q. Do you know whether in 2024 Delray was

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1 monitoring the Leapfrog measures for all four of these
2 CPOE, BCMA hand hygiene and ICU physician staffing even
3 though it wasn't participating in the hospital survey?

4 MR. MARCUS: Object to form.

5 A. We were monitoring. You don't need to
6 monitor the ICU staffing because we have a contract in
7 place, so that wouldn't change from month to month, but
8 there are processes to monitor all three of the other
9 self-reported measures, yes.

10 MS. BLAIR: Okay. Can you mark this as
11 Exhibit 6.

12 (Defendant's Exhibit Number 6 for i.d.)

13 BY MS. BLAIR:

14 Q. I marked this as Exhibit 6. And that
15 handwritten 5 at the bottom comes from someone else's
16 deposition.

17 Ms. Havericak, I've now handed you what
18 we've marked as Exhibit 6 to your deposition, which, if
19 you look, it is entitled the Leapfrog Hospital Survey
20 Hard Copy."

21 Do you see that?

22 A. Yes.

23 Q. Have you ever seen this document before?

24 A. Yes.

25 Q. And when is the last time you saw this

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1 document?

2 A. I don't recall exactly what date it was.

3 Q. Was it while you've been a CEO at Delray?

4 A. Yes.

5 Q. And for what purpose did you review this
6 document?

7 MR. MARCUS: Object to form.

8 A. I reviewed it in the case that we would
9 potentially be going back to Leapfrog reporting. I
10 wanted to understand all the measures.

11 MR. MARCUS: Kim, is there a Bates number
12 for this Exhibit?

13 MS. BLAIR: No, you used it as Exhibit 5 to
14 Karen Jupiter's deposition. I just took it from
15 what you used.

16 MR. MARCUS: Okay.

17 MS. BLAIR: I think they printed it from the
18 website, which is why it doesn't have a Bates
19 number.

20 BY MS. BLAIR:

21 Q. And so, Ms. Havericak, when you tell me
22 that --

23 Are you okay? You want to take a break?

24 A. Yeah, I'm okay.

25 Q. I'm sorry.

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1 When you tell me that you looked at it in
2 case the hospital would go back to the Leapfrog
3 hospital's --

4 I'm sorry. Strike all of that.

5 When you tell me that you looked at it
6 because Delray was considering potentially restarting
7 its participation in the Leapfrog Hospital Survey, was
8 that after the fall of 2024 safety grade had been
9 published?

10 A. It was.

11 Q. And did you specifically -- well, strike
12 that.

13 Do you understand that this document which
14 we've now marked as Exhibit 6 is about 350 pages long,
15 I think?

16 A. Yeah, it appears to be 353.

17 Q. And do you understand that this survey
18 contains many different areas of questions, not all of
19 which go into the hospital safety grade?

20 A. Yes, I understand that.

21 Q. And do you understand that a hospital
22 completing this survey can still complete the survey
23 without completing all nine sections of the survey?

24 MR. MARCUS: Object to form.

25 A. Yes, I understand that.

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1 BY MS. BLAIR:

2 Q. And if we look specifically at the four
3 measures that are at issue in this litigation, I would
4 direct your attention to page 57, which is Section 2
5 Medication Safety.

6 Are you there?

7 A. Um-hum.

8 Q. And if we look at page, for example, 59,
9 which is 2A, "Computerized Physician Order Entry,"
10 CPOE, is that the CPOE standard that we've been
11 discussing in this deposition that is one of the
12 measures that you understand to be part of the Leapfrog
13 hospital safety grade?

14 MR. MARCUS: Object to form.

15 A. Yes.

16 BY MS. BLAIR:

17 Q. Okay. And if we go to page 69 of this
18 document, do you see where it says, Section 2,
19 "Medication Safety Reference Information. What's new
20 in the 2025 survey and the CPOE evaluation tool."

21 Do you see that section?

22 A. I see that section.

23 Q. And if we juxtapose of that page 59, I
24 apologize, that we were just on, at the very bottom of
25 page 59, it says, "If yes to question number 2 and you

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1 are an adult or general hospital, use the take CPOE
2 tool button on the survey dashboard to access the CPOE
3 evaluation tool."

4 Do you see that?

5 MR. SIMMONS: Object to form.

6 A. I see that.

7 BY MS. BLAIR:

8 Q. Do you have any understanding what the
9 CPOE evaluation tool is in the Leapfrog Hospital
10 Survey?

11 MR. MARCUS: Object to form.

12 A. I mean, I'm not an expert in the CPOE tool,
13 no.

14 BY MS. BLAIR:

15 Q. Okay. Do you understand that there's there
16 is a specific and proprietary test that Leapfrog has
17 for hospitals to test whether or not their CPOE system
18 is accurate?

19 MR. MARCUS: Object to form.

20 A. I am aware of that.

21 BY MS. BLAIR:

22 Q. And when Delray was providing documents in
23 this litigation sufficient to simulate, do you know
24 whether or not Delray undertook the CPOE evaluation
25 tool to make a determination as to what its score would

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1 have been in the fall of 2024 had it participated in
2 the survey?

3 MR. MARCUS: Object to form.

4 A. I'm not sure if they used that.

5 BY MS. BLAIR:

6 Q. Do you know whether they could have used it?

7 MR. MARCUS: Same objection.

8 A. I'm not sure.

9 BY MS. BLAIR:

10 Q. In putting together documents in this
11 litigation sufficient to simulate -- not my word --
12 sufficient to simulate, did Delray fill out this
13 portion of the Leapfrog survey to make a determination
14 as to what its score would have been for CPOE in the
15 fall of 2024?

16 MR. MARCUS: Object to form.

17 A. From the simulated one at Delray, I do
18 believe they inputted the score that would be there.

19 BY MS. BLAIR:

20 Q. Okay. And do you know how they got to what
21 the score would be?

22 A. I'm not sure how they got there. The
23 quality team did that.

24 Q. Do you know whether there are any documents
25 that were generated from the quality team doing that

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1 sufficient to simulate that were produced in this
2 litigation?

3 MR. MARCUS: Object to form.

4 A. I haven't seen those documents.

5 BY MS. BLAIR:

6 Q. And don't put that away.

7 A. Okay.

8 MS. BLAIR: Can you mark this as 7?

9 (Defendant's Exhibit Number 7 for i.d.)

10 BY MS. BLAIR:

11 Q. Ms. Havericak, I am now handing you what
12 we've marked as Exhibit 7 in this litigation. And this
13 is Bates labeled PBHN 10582 through 10590.

14 Have you seen this document before?

15 A. I have seen this.

16 Q. And can you just briefly describe what this
17 document is?

18 A. This is the medication administration policy
19 for Delray Medical Center.

20 Q. Would this include -- does medication
21 administration include CPOE?

22 A. I'd have to read through it to tell you.

23 Q. Okay.

24 A. Okay. What was your question again? I
25 apologize.

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1 Q. As I read this document that we've marked as
2 Exhibit 7, it appears to include what I would consider,
3 but I want to know your view, both CPOE and BCMA
4 requirements. Is that an accurate reflection of this
5 document?

6 A. It has components of both of those in here.

7 Q. Are there any other documents at Delray that
8 govern the policies and procedures for CPOE at Delray?

9 A. The rules and regs and the bylaws would have
10 information.

11 Q. The Delray bylaws?

12 A. The Delray rules and regs.

13 Q. So the Delray rules and regulations --

14 A. Um-hum.

15 Q. -- have specific information related to
16 CPOE?

17 A. They would have information about order
18 entry for physicians.

19 Q. Do you know whether or not the Delray rules
20 and bylaws have been produced in this litigation?

21 MR. MARCUS: Object to form.

22 A. I don't know if they've been produced.

23 BY MS. BLAIR:

24 Q. Do you know if the Delray rules and bylaws
25 that contain information related to CPOE or BCMA differ

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1 in any way from the document that we've now marked as
2 Exhibit Number 7?

3 A. The rules and regs and bylaws will look
4 different, but they would have the same meaning and the
5 same interpretation --

6 Q. Okay.

7 A. -- as it relates to computerized order
8 entry.

9 Q. So I'm going to ask it just another way so I
10 make sure I understand.

11 There's nothing in these bylaws and rules
12 that would not otherwise be contained in this document
13 that we marked as Exhibit 7 as it relates to CPOE or
14 BCMA?

15 MR. MARCUS: Object to form.

16 A. Well, CPOE would have -- it would be in
17 rules and regs. Like barcode medication scanning is
18 more of a nursing piece in the hospital. That wouldn't
19 be incorporated into rules and regs.

20 BY MS. BLAIR:

21 Q. Okay.

22 A. Just the CPOE part would.

23 Q. Excellent. Thank you.

24 And so, sorry, to ask it a different way, in
25 order to get a full understanding of Delray's CPOE

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1 policies and procedures, I don't need to also look at
2 the bylaws and regulations; is that a fair statement?

3 A. That's a fair statement.

4 Q. Would you --

5 Okay. So I've gotten myself lost.

6 So we agree that this covers both CPOE and
7 BCMA?

8 A. It does.

9 Q. Okay. Are there any other documents I
10 should be aware of that Delray has with respect to BCMA
11 compliance that are not otherwise contained in
12 Exhibit 7?

13 MR. MARCUS: Object to form.

14 A. Yes, this is just the policy, the
15 compliance. If you're looking for the data from the
16 compliance, you would need reports on BC, barcode
17 medication scanning.

18 BY MS. BLAIR:

19 Q. Okay. And those barcode compliance reports
20 exist in what form?

21 A. Our chief nursing officer and the unit
22 directors have those. They pull those on a monthly
23 basis.

24 Q. Is that part of the QIPSC reporting?

25 A. They do report that off their QIPSC.

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1 Q. Is there a compliance -- are there
2 compliance reports with respect to CPOE?

3 A. At those monthly hospitalists meetings. So
4 I have two groups of hospitalists, and we go over those
5 on a monthly basis, and those are embedded in the
6 monthly reports.

7 Q. And what is entailed in a CPOE compliance
8 report?

9 A. So it's just for that it's in a slide deck
10 for those meetings and those presentations, so there's
11 different elements that we look at from a quality and
12 safety perspective for each provider within the
13 hospitalist group.

14 So for CPOE, it's all based on just their
15 name and what their actual compliance is for their
16 overall CPOE for that given month. And we look at it
17 month over month.

18 Q. Okay. Does Delray ever perform any testing
19 on its CPOE system to make sure it's operating in the
20 way in which it should?

21 A. I don't have all that knowledge, but we have
22 teams of people that work on that. We have clinical
23 informatics and our pharmacy teams that may do that
24 that I'm not aware of.

25 Q. So have you ever seen any documents that

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1 show that testing is done on the CPOE system to make
2 sure it's functioning properly?

3 A. I haven't personally seen those documents.

4 Q. And if I wanted to get those documents, I
5 would need to ask clinical informatics?

6 A. Clinical informatics is where I think those
7 would come from, yes.

8 Q. And would you agree with me that both CPOE
9 and BCMA are important to patient safety?

10 A. They are both important to patient safety,
11 yes.

12 Q. In preparing for this litigation, did you
13 have the occasion to compare Exhibit Number 7 against
14 the questions and requirements in the Leapfrog Hospital
15 Survey that we've marked as Exhibit 6?

16 MR. MARCUS: Object to form.

17 Have you produced Exhibit 6 in the
18 litigation?

19 MS. BLAIR: Yes.

20 MR. MARCUS: But you don't know the Bates
21 number?

22 MS. BLAIR: I don't, no. I just use the
23 Exhibits. I'm traveling between places so...

24 MR. MARCUS: No, it's okay. I'm just
25 asking.

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1 A. Can you repeat that question one more time?

2 I'm sorry.

3 BY MS. BLAIR:

4 Q. Sure.

5 Have you ever done a comparison of your --
6 sorry -- of Exhibit 7, which is the policies and
7 procedures for medication administration at Delray with
8 the questions and requirements on the Leapfrog Hospital
9 Survey for CPOE and BCMA?

10 MR. MARCUS: Object to form.

11 A. I have not.

12 BY MS. BLAIR:

13 Q. If we could turn in Exhibit 6 to page 219,
14 do you see that 219 is Section "6C: Hand Hygiene"?

15 A. Yes, that's what I have on 219.

16 Q. Perfect. And when you were describing
17 earlier that in or around November or December of 2024
18 when you were reviewing Exhibit 6, because there might
19 be the possibility that Delray would go back to
20 participating in the Leapfrog hospital survey, did you
21 review the hand hygiene standard in the Leapfrog
22 Hospital Survey?

23 A. I do remember vaguely going over that.

24 Q. And for purposes of my record, it looks like
25 the hand hygiene survey questions go from 219 through

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1 224. Is that your view of this as well?

2 A. Yes.

3 Q. And is it your position as the CEO of Delray
4 that complying with the Leapfrog hand hygiene -- the
5 questions for hand hygiene on the Leapfrog Hospital
6 Survey is onerous?

7 MR. MARCUS: Object to form.

8 A. I do believe the way in which they have it
9 set up looks onerous, but hand hygiene is the most
10 important thing we can do to prevent patient safety
11 issues, so we just developed a tool appropriately for
12 us at Delray.

13 MS. BLAIR: And I'll mark this as Exhibit 8,
14 and it is a group Exhibit.

15 (Defendant's Exhibit Number 8 for i.d.)

16 BY MS. BLAIR:

17 Q. Ms. Havericak, I am now handing you what's
18 been marked as group Exhibit 8. And I'll submit to you
19 that it is PB -- the Bates numbers are PBHN 10530 to
20 10547, and then there is an extra page at the end which
21 is PBHN 10735.

22 Do you have that?

23 A. Um-hum.

24 Q. Can you briefly describe for the record what
25 this document or group Exhibit is?

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1 A. It's the infection prevention and control
2 hand hygiene policy.

3 Q. And that last document in this group
4 Exhibit, what is that?

5 A. That's the hand hygiene tracer observation
6 tool.

7 Q. And I think you testified earlier -- but
8 correct me if I'm wrong -- these are the documents that
9 are filled out regularly by staff with respect to hand
10 hygiene, correct?

11 A. These are the tracer observation tools used
12 by staff and leaders to do hand hygiene observations.

13 Q. So are they like hanging in a room and
14 people just fill them out or how does it work?

15 A. No, we have them in each of the units, so we
16 have them in little binders and folders so they have
17 them. And then they have a certain amount of these
18 that they have to do every month, and they have to be
19 turned in by a certain time.

20 Q. Okay. And so -- I just don't understand how
21 it works so I apologize for these questions.

22 But so is there like, I'm watching Kevin
23 wash his hands and I denote Kevin washed hands? Like
24 who is validating?

25 A. Yeah so, for example, if I was the manager

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1 on the unit, and I'm in the intensive care unit, and I
2 see the doctors rounding and the nurses rounding, I'll
3 go through and just be watching people as they go.

4 So, say, Kevin is a registered nurse, I'd
5 mark that he was a registered nurse and then what he
6 did with hand hygiene, did he do the hand hygiene; did
7 he not do the hand hygiene.

8 And then in addition to that, if there was
9 an opportunity where you didn't see hand hygiene, you
10 would politely stop them and give them realtime
11 education so that they knew to do the hand hygiene, so
12 you stop it in the chain when it's happening.

13 Q. Got it. And so like what would be put into
14 these little boxes on each of these columns?

15 A. So this is just telling you what kind of
16 workforce member is so that you can get data trends on
17 all the different disciplines because we want to look
18 at hand hygiene across the whole spectrum of all the
19 different employees that work in the hospital.

20 So the tracer, you may one day do a lot of
21 tracers on nurses just because that's who's on your
22 unit, but then you want to be able to get some of these
23 other folks, too, because you may have the lab coming
24 in and drawing blood on patients, and we want to make
25 sure they're following the same practices. Physical

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1 therapy and occupational therapy may be coming into the
2 units. We need to make sure they're doing hand
3 hygiene. So that's why you have a legend of all the
4 different specialties that work in the hospital.

5 Q. So do -- thank you for that.

6 A. Um-hum.

7 Q. And so do they write like a "yes" or "no"?

8 A. They write a "yes" or "no," and then they
9 usually have some like additional notes on the side
10 that we're able to then compile because then this all
11 gets turned into the infection prevention manager, and
12 she compiles all the data by department. So these are
13 all turned in by department so we can see the trends
14 throughout the hospital.

15 Q. Okay. So just so I know what it should
16 looked at filled out --

17 A. Yeah.

18 Q. -- if I'm watching and I see a nurse, so
19 let's just take column one, washing their hands, do I
20 put a check mark under nurse in row one and then I
21 write "yes" over --

22 A. That's exactly what you would do.

23 Q. Okay.

24 A. And that would show compliance.

25 Q. Okay. And these get turned into a report

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1 somewhere?

2 A. Yes, they get turned into a report that the
3 infection control team produces every month.

4 Q. Do you know whether or not those reports
5 have been produced in this litigation?

6 MR. MARCUS: Object to form.

7 A. I'm not sure. I think they have. I can't
8 be certain. I haven't seen this.

9 BY MS. BLAIR:

10 Q. And so based on what I -- do you -- strike
11 that.

12 Do you know is this a requirement for all
13 five hospitals in the Palm Beach Health Network?

14 MR. MARCUS: Object to form.

15 A. I can only speak for Delray Medical Center.

16 BY MS. BLAIR:

17 Q. And we talked earlier about, though, there
18 is some quality control that overarches all five
19 hospitals, correct?

20 A. That's correct.

21 Q. And so I'm just asking in your involvement
22 with the Palm Beach Health Network, do you know if this
23 was a tool that's developed for Delray, or is it a tool
24 that was developed by Palm Beach Health Network for all
25 five hospitals?

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1 A. I just know that it's our Delray tool.

2 Q. And so if I've not seen something similar to
3 this for another one of the plaintiffs in this
4 litigation, that could be because this is something
5 that Delray has individually and the other four
6 hospitals don't have?

7 A. That's correct.

8 MR. MARCUS: Object to form.

9 BY MS. BLAIR:

10 Q. Do you know in connection with the
11 sufficient to simulate production that has been made in
12 this litigation, do you know whether documents related
13 to these logs that we just talked about, the hand
14 washing logs, were reviewed in order to make a
15 determination as to how Delray would have scored on
16 hand hygiene in fall of 2024?

17 MR. MARCUS: Object to form.

18 A. I do believe that they inputted the hand
19 hygiene scores into that simulated model.

20 BY MS. BLAIR:

21 Q. And do you know whether there was a document
22 that was created after they inputted the hand hygiene
23 scores into the Leapfrog survey model?

24 MR. MARCUS: Object to form.

25 A. What kind of document are you referencing?

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1 BY MS. BLAIR:

2 Q. Well, so I thought you said that you do
3 believe that they inputted the hand hygiene score into
4 that simulated model, correct?

5 A. That's correct.

6 Q. And so was there like something that was
7 generated from that simulated model so we would know
8 how Delray would have performed on the hand hygiene in
9 the fall of 2024?

10 MR. MARCUS: Object to form.

11 A. So from what I remember there -- it looks
12 like kind of how the Leapfrog score comes out. They
13 created kind of a simulated model that looks like that.
14 I think it's an Excel spreadsheet, though.

15 BY MS. BLAIR:

16 Q. And so if you had to comply with just the
17 hand hygiene section of the Leapfrog survey, based on
18 the work that you're already collecting, how onerous
19 would that be?

20 MR. MARCUS: Object to form.

21 A. The hand hygiene part is already something
22 that's integrated into our daily practice.

23 BY MS. BLAIR:

24 Q. So not onerous for that part?

25 A. Correct.

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1 Q. And you don't know whether any of the other
2 four plaintiff hospitals do hand hygiene in the same
3 way that Delray does, correct?

4 A. Correct.

5 Q. Do you know whether CMS measures CPOE?

6 A. I'm not familiar with CMS measuring CPOE.

7 Q. Do you know if there's any other regulatory
8 agency that governs CPOE?

9 MR. MARCUS: Objection.

10 BY MS. BLAIR:

11 Q. Or I'm sorry. That measures CPOE?

12 MR. MARCUS: Object to form.

13 A. Not that I'm aware of.

14 BY MS. BLAIR:

15 Q. Do you know whether the Joint Commission
16 looks at CPOE?

17 A. They will look at, yeah, they look at it
18 when they come in to make sure that we're working
19 according to our policy and that physicians, where
20 appropriate, are putting in CPOE orders and not using
21 verbal or telephone orders.

22 Q. Does the Joint Commission perform a test on
23 a hospital's CPOE system to make sure it is performing
24 correctly?

25 MR. MARCUS: Object to form.

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1 A. They don't perform testing. They actually
2 come in and validate your practice every three years.

3 BY MS. BLAIR:

4 Q. In terms of BCMA, is that a measure that CMS
5 measures?

6 A. It's not necessarily a measure CMS measures,
7 but, again, Joint Commission does look at our barcode
8 medication scanning as part of our patient, proper
9 patient ID policy and our medication administration
10 policy.

11 Q. Do you know whether Healthgrades® has
12 anything where it comes in and verifies your BCMA data?

13 A. Not that I'm aware of.

14 Q. Does the Florida Department of Health
15 measure BCMA compliance?

16 A. Not that I've seen.

17 Q. Does the Florida Department of Health
18 measure CPOE in any way?

19 A. Not that I've seen.

20 Q. Does -- well, does CMS measure ICU staffing?

21 A. Not that I've seen.

22 Q. What about NHSN?

23 A. No, NHSN just looks as hospital-acquired
24 infections and surgical site infections and preventable
25 harm in hospitals.

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1 Q. What about Joint Commission, do they look at
2 your ICU staffing?

3 A. That is something they look at when they
4 come in for their validation surveys, yes.

5 Q. And what are they looking at, to the best of
6 your knowledge?

7 A. To ensure that the model is there that we
8 have the appropriate coverage and that credentialing
9 files that they have the proper training, board
10 certifications and education and that their DOPs are
11 appropriate and that they're going through ongoing OPPE
12 and FPPE where appropriate.

13 Q. What is OPPE?

14 A. It's Ongoing Professional Practice
15 Evaluation, and then the other is Focused Peer Practice
16 Evaluation.

17 Q. Thank you. Do you know whether CMS measures
18 hand hygiene?

19 A. Not that I've seen.

20 Q. Do you know whether Joint Commission
21 measures hand hygiene?

22 A. Yes, they do.

23 Q. And in what way?

24 A. They -- so when they come in for their
25 validation surveys, they have a whole session where we

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1 go through all of our data for the last three years,
2 all of our infection control committee minutes. They
3 look at our infection prevention plan. And then that's
4 part of what they do when they go out on to the units.

5 In a hospital our size because we're
6 536 beds, typically three to four surveyors come at a
7 time and stay for four days with us, and they'll watch
8 the hand hygiene episodes on every single unit while
9 they're tracing patients.

10 Q. Do you know if the Florida Department of
11 Health reviews your hand hygiene compliance?

12 A. They sure do. So they come in, and they do
13 a site visit. And they do the same thing where they go
14 around and trace in different areas to look at
15 physicians and staff members, how they're taking care
16 of patients and utilizing hand hygiene. Then they look
17 at our hand hygiene data and look at our infection
18 control practices as well.

19 Q. And would you agree with me that none of the
20 data that the Joint Commission collects is publicly
21 available to patients?

22 MR. MARCUS: Object to form.

23 A. Joint Commission only shows whether a
24 hospital is accredited or not.

25 BY MS. BLAIR:

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1 Q. Right. So they, Joint Commission, does not
2 publicly share, for example, how a hospital does on
3 hand hygiene even though they may be evaluating
4 policies, correct?

5 MR. MARCUS: Object to form.

6 A. That's correct.

7 BY MS. BLAIR:

8 Q. And what about the Florida Department of
9 Health, do they share publicly how a hospital does, for
10 example, on hand hygiene?

11 A. They do not.

12 Q. What about does the Joint Commission
13 share -- well, they don't -- they only share publicly
14 that you are accredited, right?

15 A. That's correct.

16 Q. So CPOE information they don't share,
17 correct?

18 MR. MARCUS: Object to form.

19 A. Correct.

20 BY MS. BLAIR:

21 Q. And same question with respect to BCMA, the
22 Joint Commission does not share any BCMA-specific
23 information with the consuming public, correct?

24 MR. MARCUS: Object to form.

25 A. That is correct.

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1 MS. BLAIR: So it's 12:15.

2 MR. MARCUS: I was going to say, is this a
3 good time for a break?

4 MS. BLAIR: How do you feel? Yeah.

5 THE WITNESS: I'm okay. Whatever you want
6 to do.

7 MS. BLAIR: Yeah. It's really up to you.

8 (A discussion was held off the record.)

9 THE VIDEOGRAPHER: This is the end of media
10 two. The time is 12:20 p.m.

11 (A recess was taken from 12:19 p.m. to 1:05 p.m.)

12 THE VIDEOGRAPHER: This is media number
13 three in the deposition of Heather Havericak.
14 The time is 1:06 p.m. We are back on the
15 record.

16 BY MS. BLAIR:

17 Q. Ms. Havericak, I just want to talk a little
18 bit about Delray and the Leapfrog grade for the spring
19 of 2024, so this would have been prior to the
20 methodology change. And I just have a few Exhibits I
21 want to go over somewhat quickly. So we are on 9.

22 (Defendant's Exhibit Number 9 for i.d.)

23 BY MS. BLAIR:

24 Q. This will be Exhibit 9.

25 Ms. Havericak, do you have in front of you

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1 what we've marked as Exhibit 9 which is an email from
2 Heather Wehmeyer to Andrea Nunez dated March 7th, 2024?

3 A. Yes.

4 Q. And this document has -- bears the Bates
5 range of PBHN 13590 through 13593.

6 Did you see this document -- have you seen
7 this document before today?

8 A. No.

9 Q. Okay. And just for purposes of the record,
10 in or around March of 2024, Heather Wehmeyer would have
11 been the director of quality for Delray?

12 A. Yes, she would.

13 Q. So this would have been before
14 Stephany Johnson, correct?

15 A. That is correct.

16 Q. And if you look at the last page of this
17 document, which is 13592. Oh, sorry. No, it's not.

18 15 --

19 13593, again, this is the email or the email
20 from Bonnie to lots of people. And she says, "Hello,
21 everyone. Good morning. Leapfrog has released the
22 hospital's preliminary numerical score for 2024 spring
23 safety grade. Please share your preliminary numerical
24 score."

25 Do you see that?

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1 A. I do.

2 Q. And we saw an Exhibit earlier this morning
3 where Bonnie was asking for this type of information
4 from an earlier period in 2023, correct?

5 A. That's correct.

6 Q. And does this refresh your recollection in
7 any way that someone from Tenet home office asked for
8 the Leapfrog scores on a regular basis?

9 MR. MARCUS: Object to form.

10 A. I can see through these emails that someone
11 has asked for it.

12 BY MS. BLAIR:

13 Q. Okay. But you have no recollection that
14 that's what happens on every grading period?

15 A. No, I do not.

16 Q. Do you know if in spring of 2025 you
17 received, you being Delray, received an email like this
18 from Tenet home office asking for the preliminary
19 Leapfrog scores?

20 A. I don't remember if I did.

21 Q. And if we look at this, then Regina West
22 sends it out, correct, to Andrea Nunez and
23 Heather Wehmeyer, among others?

24 I'm sorry. This is 13592.

25 Do you see that?

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1 A. Yes, it looks like Gina sent it out to
2 Andrea, Heather, Taylor and Kathleen, yes.

3 Q. And she say, "Hi, quality warriors. It's
4 time again."

5 Do you see that?

6 A. I do see that.

7 Q. And she's asking for these quality directors
8 to send preliminary Leapfrog scores to Regina West,
9 correct?

10 A. Yes, that's what the request looks like.

11 Q. Okay. And then if you look at the top of
12 13591, Gina West says to Heather Wehmeyer, "Just a
13 heads-up that you may fall to a D if they use the same
14 calculation methodology."

15 Do you see that?

16 A. I do.

17 Q. And this would have been before the fall
18 2024 methodology change, correct?

19 MR. MARCUS: Object to form.

20 A. Well, based on this email that I'm seeing
21 that I have in front of me, it looks like it would be
22 because it was March of 2024.

23 BY MS. BLAIR:

24 Q. Right. And for the record, and that's
25 probably why I got an objection, do you understand that

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1 the spring -- the spring grades for Leapfrog are
2 released at the end of April each year?

3 A. Yes.

4 Q. Okay. So if we're talking in the March of
5 2024 time frame, this would have been prior to the
6 spring 2024 Leapfrog grades being released, correct?

7 A. Correct.

8 Q. And the methodology change that we're
9 talking about here today did not occur until fall of
10 2024, correct?

11 A. That is correct.

12 Q. And is it your memory that, in fact, for
13 spring of 2024 Delray received a D grade from the
14 Leapfrog hospital safety grade prior to the change in
15 the methodology in the fall of 2024?

16 A. I believe it did based on the score that's
17 in front of me.

18 Q. Okay. And when you say "based on the score
19 that is in front of you," are you referring to the
20 third page of this document, the 2.2946?

21 A. Correct.

22 Q. Okay.

23 MS. BLAIR: I'll mark this one as 10.

24 (Defendant's Exhibit Number 10 for i.d.)

25 BY MS. BLAIR:

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1 Q. Ms. Havericak, I am now handing you what
2 we've marked as Exhibit 10, which is an email from
3 Monica Stillman-Vormittag dated March 26, 2024 to
4 Regina West and CC'ing Heather Wehmeyer.

5 Do you see that?

6 A. I do.

7 Q. And this is talking about SIR benchmarks, do
8 you see that?

9 A. Yes.

10 Q. And I believe earlier you referred to them
11 as SIR's benchmarks, correct?

12 A. Correct.

13 Q. What does SIR's stand for?

14 A. It's your predicted model of what kind of
15 infections you're going to say based on your patient
16 population and your number of patients.

17 Q. Okay. And if we look at the first line --

18 Well, first of all, who is Monica Vormittag
19 in or around March of 2024?

20 A. She was in that time and still is our
21 manager of infection prevention.

22 Q. Okay. So her title at the bottom of this
23 email remains the same?

24 A. Correct.

25 Q. And she says, "Hi, Gina. Please see the

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1 following items to meet Leapfrog SIR benchmarks."

2 Do you see that?

3 A. I do.

4 Q. Why were -- why was Delray benchmarking
5 itself with respect to the Leapfrog benchmarks if it
6 wasn't participating in any way with Leapfrog?

7 MR. MARCUS: Object to form.

8 A. I'm not sure.

9 BY MS. BLAIR:

10 Q. Were you the president of Delray in March of
11 2024?

12 A. I was not.

13 Q. Okay. You became -- were you associated in
14 any way with Delray in March of 2024?

15 A. I was the chief operating officer.

16 Q. And so this type of benchmarking would not
17 have been within your purview in March of 2024?

18 A. It would not.

19 Q. Who was the acting CEO in or around March of
20 2024?

21 A. Daniel Listi, L-i-s-t-i.

22 Q. Did you take over the job from Daniel Listi?

23 A. I did.

24 Q. Did -- during the transition between
25 Mr. Listi and yourself, did he provide you with any

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1 information related to Delray benchmarking itself
2 against the Leapfrog SI -- SIR's as we're calling them?

3 A. He did not.

4 Q. Okay. So have you seen this document before
5 today?

6 A. No.

7 Q. And in looking at these scores, I don't know
8 what they mean, so when you see it says "CLABSI
9 predicted 13, infections eight. SIR equals 6.15," do
10 you see that?

11 A. Yes.

12 Q. Is that an above average score, below
13 average score, do you know?

14 A. I have to see it in relation to the
15 benchmarks. Like this doesn't tell me anything with
16 this information the way it's presented.

17 Q. Okay. And that was going to be my question.
18 Who would have set the benchmarks that you need to look
19 at it against?

20 A. They would pull those benchmarks out of
21 NHSN, like I mentioned earlier.

22 Q. Okay. So this -- is it your
23 understanding -- and if you don't know, I understand --

24 A. Sure.

25 Q. -- but so this .615 refers to an NHSN number

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1 or a Leapfrog number?

2 MR. MARCUS: Object to form.

3 A. I can't make out what it's referencing in
4 this document in the way in which it's presented. Like
5 I need more context to this.

6 BY MS. BLAIR:

7 Q. Okay. Fair enough. And is it surprising to
8 you as you sit here today to know that the infection
9 prevent manager and the director of quality were
10 benchmarking hospital-acquired infections against
11 Leapfrog SIR's benchmarks?

12 MR. MARCUS: Object to form.

13 A. Yes, it's surprising because Leapfrog and
14 SIR's benchmarks are different things.

15 BY MS. BLAIR:

16 Q. Right. I thought so, too, so that's why I'm
17 trying to understand this email. But you don't
18 understand what they're doing here?

19 A. I don't understand what's presented in front
20 of me, no.

21 (Defendant's Exhibit Number 11 for i.d.)

22 BY MS. BLAIR:

23 Q. Ms. Havericak, I've just handed you what
24 we've marked Exhibit 11, which is an email from
25 Heather Wehmeyer. Her title, per her signature block

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1 at that time, was director of clinical quality
2 improvement dated April 17th, 2023 to Regina West,
3 Andrea Nunez, Carola Kuret, K-u-r-e-t, Taylor Pool and
4 Kathleen McDonald.

5 Do you see that?

6 A. I do.

7 Q. And if we turn to the second page of this
8 document, which is Bates labeled PBHN 12146 -- and I
9 specifically want to look at this email, it starts in
10 the middle of the page from Regina West dated
11 April 17th at 3:40 p.m.

12 Do you understand that April 17th, 2023
13 would have been before the Leapfrog spring 2023 grades
14 would have been released, correct?

15 A. Can you repeat that?

16 Q. Sure.

17 A. Sorry.

18 Q. So I showed you Exhibit 9 and 10 were right
19 before the spring 2024 grades were released in April of
20 2024. This document, though, is from April of 2023, a
21 year earlier, correct?

22 A. That's what it appears to be, yes.

23 Q. And so do you have an understanding that the
24 Leapfrog spring hospital safety grade would have been
25 released at the end of April 2023?

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1 A. Yes.

2 Q. Okay. And if we look at Regina's email, she
3 says, "Hello, fellow quality leaders."

4 Do you see that?

5 A. Yes.

6 Q. And she says, "I completed an analysis of
7 our Leapfrog scores for spring 2023."

8 Do you see that?

9 A. Yes.

10 Q. Does this refresh your recollection at all
11 that, in fact, Palm Beach Health Network was monitoring
12 its Leapfrog hospital safety grades in or around 2023?

13 MR. MARCUS: Object to form.

14 A. From the email I'm looking at, it appears
15 they were, but I wasn't with the company then.

16 BY MS. BLAIR:

17 Q. Understood.

18 And if we go down, it says, the second
19 bullet point -- well, the first bullet point says, "All
20 five hospitals scored at a C level."

21 Do you see that?

22 A. Yes.

23 Q. Do you know what Delray's Leapfrog hospital
24 safety grade was in the spring of 2023?

25 A. I do not.

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1 Q. Okay. And it says, the second bullet point,
2 "the largest opportunity continues to lie in patient
3 experience."

4 Do you see that?

5 A. Yes.

6 Q. And patient experience, is that the HCAHPS
7 that we've been discussing today?

8 A. It's measures taken from the HCAHPS, yes.

9 Q. Have you as the president of Delray, had an
10 opportunity to go back and look at Delray's historic
11 performance on patient experience?

12 A. I have.

13 Q. Would you agree that in or around April of
14 2023, there was a large opportunity for Delray to
15 improve in patient experience?

16 A. I would say there's always opportunity to
17 improve in patient experience.

18 Q. And then you see she goes on to say, "West
19 Boca would need to participate in the fall 2023 survey
20 and change their BCMA and IPS performance as well."

21 Do you see that?

22 A. I see that.

23 Q. Do you know how performing in the fall 2023
24 Leapfrog Hospital Survey would have impacted
25 West Boca's BCMA and IPS performance if it was already

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1 being based on the cohort median?

2 MR. MARCUS: Object to form.

3 A. I don't know what would have impacted West
4 Boca.

5 BY MS. BLAIR:

6 Q. Okay. And so we talked a little bit earlier
7 about your understanding of the Leapfrog hospital
8 safety grade methodology prior to 2024. Do you recall
9 that discussion earlier today?

10 A. Yes.

11 Q. And I'm going to bring you back to another
12 Exhibit if I can find it. I think it's either
13 Exhibit 4 or 5. Can you get those out in front of you?

14 A. The 4 and 5 we already looked at?

15 Q. Yes. And it's 4, I believe. That is your
16 Exhibit 4 from Stephany Johnson dated November 4th,
17 2024.

18 A. Yes.

19 Q. Okay. Making sure I have the right number.
20 If we go to Bates number, in that Exhibit if
21 you go to Bates number PBHN 2074, it's a chart.

22 A. Yes.

23 Q. And for the record, I will submit to you
24 that this chart and the scores come from the fall 2024
25 safety grade, but I just want to ask about the measures

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1 themselves.

2 A. Okay.

3 Q. So if we look at the first column of the
4 measures, do you know whether or not these were the
5 same measures that were being evaluated to come up with
6 Delray's spring 2024 hospital safety grade?

7 MR. MARCUS: Object to form.

8 A. Can you repeat that question?

9 BY MS. BLAIR:

10 Q. Sure. So do you understand that there are
11 22 measures that make up the Leapfrog hospital safety
12 grade?

13 A. I do.

14 Q. Do you -- do you believe that the measures,
15 not the scores but the measures were the same in spring
16 of 2024 as they were in fall of 2024?

17 MR. MARCUS: Object to form.

18 A. Yes.

19 BY MS. BLAIR:

20 Q. And looking at this list, and if you look
21 one page before, this is sent to you by
22 Stephany Johnson, correct?

23 A. That is correct.

24 Q. And she's attaching this list for you, is
25 that --

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1 A. It looks like this was an attachment, yes.

2 Q. Okay. And so we look at all these different
3 measures. And of these measures, you'll see the third
4 column here, and, again, this is PBHN 2074, has the
5 data source links. Do you see that?

6 A. The reporting period or, I'm sorry, the
7 second column data source links.

8 Q. Oh it's the third column for me.

9 A. Oh, mine is -- mine is -- oh, yeah, I guess
10 it is --

11 Q. Oh, okay.

12 A. -- the third if you look at the name.

13 Q. Yeah.

14 A. Sorry.

15 Q. No, no, I just want to make sure for the
16 record.

17 And so the computerized physician order
18 entry on the third column, right, data source/links it
19 says, "Assigned score due to missing." "Due to
20 missing," correct? You see that?

21 A. Yes.

22 Q. And we see here that the assigned score, if
23 we go all the way to the last column, is 15 for CPOE,
24 correct?

25 A. That is correct.

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1 Q. And what is your understanding of how CPOE
2 was measured prior to -- well, let's just say how it
3 was measured in spring of 2024?

4 A. Just with that like median score of all the
5 different cohorts, like it was just being assigned that
6 way.

7 Q. And do you understand that this 15, and
8 we'll just stick with CPOE, do you understand that this
9 score of 15 is a limited achievement score --

10 MR. MARCUS: Object to form.

11 BY MS. BLAIR:

12 Q. -- for CPOE?

13 A. I understand it to be the lowest ranked
14 score that can be assigned, yes.

15 Q. Do you have an understanding that whether it
16 be spring 2024 or fall 2024, the numerical score
17 assigned for the measure for CPOE fell into four
18 different categories --

19 MR. MARCUS: Object to form.

20 Q. -- which is achievement, considerable
21 achievement, somewhat achievement and limited
22 achievement?

23 MR. MARCUS: Same objection.

24 BY MS. BLAIR:

25 Q. Did you have any understanding of that prior

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1 to fall of 2024?

2 A. Yes.

3 Q. Okay. And did you have an understanding
4 that any hospital that fell within limited achievement
5 would get a 15 whether they participated in the survey
6 or not?

7 A. No, I didn't realize that that's exactly
8 what the number was.

9 Q. Okay. Did you have an understanding -- do
10 you have an understanding that if a hospital's
11 numerical score fell into the highest category,
12 achievement, that they would get 100 points out of
13 100 points?

14 A. Yes.

15 Q. Do you understand that Delray in the spring
16 of 2024 received 100 points out of 100 points for CPOE
17 because its cohort median fell within highest
18 achieving?

19 MR. MARCUS: Object to form.

20 A. Again, I need to see results of that.

21 BY MS. BLAIR:

22 Q. Okay.

23 A. I don't recall the numbers off the top of my
24 head.

25 Q. And I don't have that Exhibit here today.

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1 A. Okay.

2 Q. But I've seen it. If that were the case,
3 would you have any reason to dispute it?

4 MR. MARCUS: Object to form.

5 A. Again, I have to see the document.

6 BY MS. BLAIR:

7 Q. Sure.

8 Do you know how many points total Delray was
9 getting for the four imputed measures in spring of
10 2024?

11 A. I don't know the total without having it in
12 front of me.

13 Q. So you don't know that it was 100 points out
14 of -- 400 points out of 400 at that time?

15 MR. MARCUS: Object to form.

16 A. I would need the document in front of me. I
17 don't know the numbers.

18 BY MS. BLAIR:

19 Q. Sure. I guess I'll pull it up at a break.

20 All right. And let's look at barcode
21 administration, which is the second row on this chart.

22 You see here that if we look at the third
23 column again, data source/links, it says, "Assigned
24 score due to missing."

25 Do you see that?

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1 A. I do.

2 Q. And do you agree with me that that is what
3 Leapfrog did, they just assigned you a score for that?

4 MR. MARCUS: Same objection.

5 A. Can you repeat that?

6 BY MS. BLAIR:

7 Q. Sure. Would you agree that in -- well, do
8 you agree with the denotion [sic] here in this third
9 column for BCMA for fall of 2024 that Delray was simply
10 assigned a score due to missing information and didn't
11 actually earn that score?

12 MR. MARCUS: Object to form.

13 A. I agree that we were given a score and we
14 didn't submit data.

15 BY MS. BLAIR:

16 Q. Okay. So you agree that that statement for
17 BCMA in that third column assigned score due to missing
18 is accurate?

19 MR. MARCUS: Object to form.

20 A. I don't agree with the score being assigned
21 because there's no data that can be validated to
22 provide that score.

23 BY MS. BLAIR:

24 Q. I understand you disagree with the fact that
25 they assigned you a score, but I'm just asking if you

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1 agree with the fact that that's, in fact, what
2 happened, they just assigned you a score?

3 A. That score --

4 MR. MARCUS: Same objection.

5 A. That appears from this document to be what
6 they did in assigning us that score.

7 BY MS. BLAIR:

8 Q. And the next row on this sheet is
9 ICU physician staffing. And do you see that it says
10 "data source" there, "CMS cost report"?

11 A. I do.

12 Q. Do you know what the CMS cost report is?

13 A. I know about the CMS cost report.

14 Q. Can you just tell me what the CMS cost
15 report is?

16 A. I mean, I'm not involved. The CFO does all
17 the CMS cost report, but that's just taking into
18 account all of the different components from the
19 hospital operations on a yearly basis.

20 Q. Do you have any understanding of whether or
21 not the CMS cost report contains any information
22 regarding ICU physician staffing for Delray?

23 A. I am not aware of that.

24 Q. Did you understand that in 2023 Leapfrog had
25 changed its imputation model such that nonreporting

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1 hospitals were going to get a 5 if they had an ICU but
2 did not report any data?

3 MR. MARCUS: Object to form.

4 A. I did not know that.

5 BY MS. BLAIR:

6 Q. And then if we go down to seventh column,
7 hand hygiene, are you there?

8 A. I am.

9 Q. And you see where it says "assigned" -- oh,
10 sorry -- third column, "Assigned score due to missing"?

11 A. Yes.

12 Q. And do you understand that Delray was
13 assigned a score of 15 because there was no data based
14 on the fact that Delray had not participated in the
15 survey?

16 A. Yes.

17 Q. And if we look at the fourth column for all
18 four of these measures, the first three columns in
19 that -- or, sorry -- the first three rows in the
20 seventh row, it says "reporting period." And do you
21 see where it says "not applicable"?

22 A. Yes.

23 Q. Do you understand that under the prefall
24 2024 methodology if a hospital had an annual survey
25 within the last four rounds, that hospital score would

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1 have been used to calculate this score?

2 MR. MARCUS: Object to form.

3 A. I don't know all the inner workings of the
4 Leapfrog definitions.

5 BY MS. BLAIR:

6 Q. Okay. And then if we look at the three
7 measures that are kind of in the middle of the four we
8 just discussed, so that would be column four, five --
9 I'm sorry -- row four, five and six, if we go, if we
10 follow those rows all the way across to the last
11 column, each one of them say "declined to report."

12 Do you see that?

13 A. I do.

14 Q. Do you have any understanding as to
15 Leapfrog's methodology and why these three measures say
16 "declined to report"?

17 A. I do not.

18 Q. For the remaining measures, so now I'm going
19 to talk about the -- and it is 22 measures,
20 22 additional rows underneath.

21 No, no, I'm sorry. Forget that.

22 So we have this seven, correct, the seven we
23 just talked about?

24 A. Yes.

25 Q. And then below that there are 25 measures

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1 below those rows, correct? It goes on to PBHN 2075.

2 Do you see that?

3 A. Yes.

4 Q. Okay. And for those measures, each one of
5 them it says the data source links for each one of
6 those measures is CMS, correct?

7 MR. MARCUS: Object to form.

8 A. That's correct.

9 BY MS. BLAIR:

10 Q. Do you have any understanding as to whether
11 or not the CMS data that Delray had provided to CMS for
12 the dates that are listed in the reporting period in
13 the second to last column was accurate?

14 MR. MARCUS: Object to form.

15 A. I believe it was accurate.

16 BY MS. BLAIR:

17 Q. And this CMS data that is listed, that is
18 publicly reported data, correct, from CMS?

19 A. That is correct.

20 Q. And we talked about earlier that the CMS
21 data, the publicly available CMS data lags in terms of
22 what the public has access to, correct?

23 A. That's correct.

24 Q. And so this table that Heather Wehmeyer --
25 I'm sorry -- that Stephany Johnson had provided to you,

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1 it's showing for some of these CMS data that goes all
2 the way back to 2020, correct?

3 MR. MARCUS: Object to form.

4 A. They go back to 2020, yes.

5 BY MS. BLAIR:

6 Q. And that's because the publicly available
7 data from CMS was only available from that time period
8 to Leapfrog, correct?

9 MR. MARCUS: Same objection.

10 A. That's correct.

11 BY MS. BLAIR:

12 Q. Do you know or can you tell by looking at,
13 let's just take H-COMP 1, nurse communication do you
14 see how there was a score for 78, of a 78?

15 A. I do see that.

16 Q. Do you know whether that score was above the
17 average, average or below the average for Leapfrog in
18 or around November of 2024?

19 A. I wouldn't be able to tell you that without
20 the comparison data because that is constantly changing
21 depending on how hospitals are improving or not
22 improving.

23 Q. Right, because Leapfrog grades on a standard
24 deviation, correct?

25 MR. MARCUS: Object to form.

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1 A. I don't know if Leapfrog does that on a
2 standard deviation. You asked me about the HCAHPS
3 scores and CMS.

4 BY MS. BLAIR:

5 Q. Right. And I guess my question is, do you
6 know -- yeah, that was a bad question. They're not all
7 winners.

8 So if we look at the H-COMP 1 score, that
9 78, do you know if that's how you're scored by CMS on
10 H-COMP 1? In other words, do they give you a numerical
11 score like that?

12 A. They give you a numerical score, yes. But I
13 can't tell you in context if it was average, above
14 average without looking at other data with it.

15 Q. Okay. And in or around November of 2024, do
16 you know what Delray's overall CMS star rating was?

17 A. Yes.

18 Q. What was it?

19 A. A 1.

20 Q. Do you know in or around November of 2024
21 what Delray's patient experience star rating at CMS
22 was?

23 A. It was a 1.

24 Q. And do you know in or around November of
25 2024 what Delray's Google ratings were?

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1 A. Which month in '24? I'm sorry.

2 Q. November.

3 A. We were -- we were climbing. In September
4 of 2024, we were a 1.8, but we really had been working
5 on patient experience, so it was probably around a
6 2. something because we're at a 4.5 now.

7 Q. That's what I was going to ask you. You're
8 a 4.5 now?

9 A. We're a 4.5 now.

10 Q. Did you ever have any discussions with Tenet
11 home office about your CMS star ratings?

12 MR. MARCUS: Object to form.

13 A. Not that I recall with the home office.

14 BY MS. BLAIR:

15 Q. Do you recall any discussions at the
16 Palm Beach Health Network level about Delray's star
17 ratings?

18 A. Yes, we had discussion about our star
19 ratings in our group CEO meeting.

20 Q. And do you recall when or around what time
21 that was?

22 A. I don't recall the exact date just because
23 we have so many meetings, but we had that discussion, I
24 think, towards the end of '24 and we've had that
25 discussion, you know, throughout this year as well.

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1 Q. Prior to the end of 2024, do you recall any
2 discussions at the Palm Beach Health Network level
3 regarding the hospitals' -- and I'm using them, the
4 plural -- CMS star ratings?

5 A. I only started going to the group meetings
6 in July of '24 so I remember us talking about those
7 probably towards the end of the year in '24.

8 Q. Okay.

9 A. But they could have been before my time.

10 Q. What was said at the meeting about the
11 hospitals' -- again, plural -- CMS star ratings to what
12 you can recall?

13 A. We had discussion about the lagging in the
14 data so it wasn't an accurate reflection of where we
15 were at and just the need to really focus on improving
16 our publicly -- publicly reported scores and then more
17 recently just some of the tools we created to help us
18 be a predictor of where we were going to land as
19 different data rolls off.

20 Q. And were additional tools put in place in or
21 around the end of 2024 to improve scores?

22 A. Not at the end of '24, no.

23 Q. What about the beginning of 2025?

24 A. No.

25 Q. What about the middle of 2025?

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1 A. Yeah, I would say the middle more recently
2 in the last couple of months.

3 Q. Do you know what -- how much of Delray's
4 budget has been committed to these improvements that
5 began in the middle of 2025 to increase scores?

6 MR. MARCUS: Object to form.

7 A. There aren't any additional dollars that I'm
8 aware of.

9 BY MS. BLAIR:

10 Q. Any additional staff?

11 A. No.

12 Q. Do you have any understanding as to why
13 Leapfrog made the change to its methodology for fall of
14 2024?

15 A. I'm not familiar with why.

16 Q. Did you have any discussions at the med exec
17 level about Delray's CMS star ratings?

18 A. Yes.

19 Q. When did those start?

20 A. I've had those a couple of times in 2025.

21 Q. Did you have any discussions with the
22 med exec about Delray's CMS star ratings prior to
23 Leapfrog issuing its fall 2024 safety grade?

24 A. We talked. It wasn't specifically to CMS
25 star ratings, but we talked about the quality measures

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1 that feed up into those star ratings and the care
2 experience scores.

3 Q. Okay.

4 A. So that's -- in '24, we definitely did that
5 too.

6 Q. Okay. And then, I think you said you did
7 have some med exec meetings regarding the CMS star
8 ratings after the Leapfrog grade came out, correct?

9 A. Yes. And I actually went one by one through
10 every single one of the CMS measures that make up the
11 star rating and the weighted category to show where we
12 were doing well, where we had opportunities and just
13 looking at, you know, which ones we already had
14 improvement plans in place and how we were performing
15 based on our predictive model.

16 Q. Did you have that same sort of going through
17 each measure with respect to the Leapfrog hospital
18 safety grade with the med exec?

19 A. I don't think we went into it as much
20 detail. We talked about a lot of the self-reported
21 measures and then just the CMS measures that went into
22 it.

23 Q. And the CMS, do you understand that -- have
24 you ever seen the Leapfrog scoring calculator?

25 A. Yes.

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1 Q. And do you understand that 50 percent of the
2 grade is outcome measures?

3 MR. MARCUS: Object to form.

4 A. I do.

5 BY MS. BLAIR:

6 Q. And would you agree with me that of those
7 outcome measures, all of them come from publicly
8 reported CMS data?

9 A. Yes.

10 Q. And then there are twelve measures that make
11 up the structural/process measures that Leapfrog
12 reviews in putting together its hospital safety grade,
13 correct?

14 A. That's correct.

15 Q. And for a nonreporting hospital, do you
16 understand that five of those twelve measures come from
17 CMS data?

18 MR. MARCUS: Object to form.

19 A. That's not my full understanding.

20 BY MS. BLAIR:

21 Q. Okay. What is your understanding?

22 A. That four of those measures actually come
23 from self-reported data.

24 Q. Oh, yeah. So I said it the opposite.

25 A. Okay.

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1 Q. So there are twelve measures in the
2 process/structural, correct?

3 A. Uh-huh.

4 Q. Of those twelve measures, four come from --
5 are the imputed measures that we've been talking about,
6 correct?

7 A. Correct.

8 Q. And those measures are BCMA, CPOE, hand
9 hygiene and ICU physician staffing, correct?

10 A. That's correct.

11 Q. And three of those measures that make up the
12 50 percent structural process measures are declined to
13 report, and a nonparticipating hospital does not get
14 graded on them, correct?

15 A. That is correct.

16 Q. So we have the four imputed measures that
17 we've been referring to, the three decline to report
18 measures, and so there are five additional measures
19 that make up the 50 percent of the structural process
20 measures, correct?

21 A. So there's --

22 MR. MARCUS: Object to form.

23 A. -- there's the five other measures, but I'm
24 not -- without having the calculator in front of me,
25 because the percentage changes when you extrapolate out

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1 the three decline to report measures.

2 BY MS. BLAIR:

3 Q. Understood.

4 A. So I don't know that that actually is
5 50 percent.

6 Q. So and I just want to talk about -- I'm not
7 talking about weights. I'm just talking about the
8 measures themselves.

9 A. Okay.

10 Q. I want to make sure we understand.

11 So there are five other measures. Other
12 than the imputed measures we talked about and other
13 than the three measures that -- so I don't want to talk
14 about the weight. I just want to talk about what
15 measures are.

16 You understand there are five additional
17 measures, or five additional process and structural
18 measures in the Leapfrog hospital safety grade
19 methodology, correct?

20 A. That's correct.

21 Q. I was asking the question about weight, so I
22 apologize.

23 And those five measures, they come from CMS
24 data, correct?

25 A. Correct.

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1 Q. So if we were to look at the methodology
2 itself without respect to weights, because I do
3 understand your position there, you have ten outcome
4 measures plus five structural and process measures that
5 come from CMS data, correct?

6 A. That's correct.

7 Q. 15 total, then, 5 plus 10, correct?

8 A. Yes, correct.

9 Q. Do you have an understanding of how the
10 weights and the z-scores are redistributed in the
11 methodology for a nonparticipating hospital when those
12 three measures are taken out?

13 MR. MARCUS: Object to form.

14 A. I have the understanding that more weight is
15 placed on those self-reported measures. So if, for
16 example, they were initially weighted at a 6, they're
17 going to be weighted to an 8.5 or a 9. It makes them
18 carry more weight in your survey.

19 BY MS. BLAIR:

20 Q. Okay.

21 A. In your results.

22 Q. Not mine, but, okay.

23 A. Yeah, in the survey. I apologize.

24 Q. Thank you. I'm teasing.

25 So your understanding is that the weight

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1 that would have been attributed to those three decline
2 to report are distributed evenly across the remaining
3 nine measures?

4 A. I know that they're redistributed. I don't
5 know if it's evenly amongst those four measures, but it
6 makes them carry more weight collectively.

7 Q. How did you first come to learn that the
8 methodology was changing for fall, the Leapfrog
9 methodology for the hospital safety grade was changing
10 for the fall of 2024?

11 A. At Delray because we were going through a
12 transition with quality I think it came closer to the
13 time that the grades were coming out.

14 Q. And is that transition the transition of
15 Heather Wehmeyer to Stephany Johnson?

16 A. Correct. That's what I'm referencing.

17 Q. Are there -- no other transitions?

18 A. No.

19 Q. Okay. And so were you ever told as the CEO
20 of Delray that Leapfrog had put out in May of 2024 a
21 request for public comment to hospital about the change
22 in their methodology?

23 MR. MARCUS: Object to form.

24 A. Leapfrog sends those emails out to
25 healthcare leaders. I mean, we get a lot of emails,

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1 and I don't know that I opened them all and looked at
2 them.

3 BY MS. BLAIR:

4 Q. And no one at Delray provided any comment to
5 Leapfrog regarding Leapfrog's request for public
6 comment on the change in methodology, correct?

7 MR. MARCUS: Same objection.

8 A. Not that I'm aware of.

9 BY MS. BLAIR:

10 Q. And what about at the Palm Beach Health
11 Network level, are you aware of whether or not anyone
12 at the group level provided any feedback to Leapfrog's
13 request for public comment to the 2024 methodology?

14 MR. MARCUS: Object to form.

15 A. I'm not aware that anyone did.

16 BY MS. BLAIR:

17 Q. When do you recall first discussing the
18 Leapfrog fall 2024 methodology change?

19 A. I can't recall exact dates, but if I recall,
20 it's around November. It's going to be in the November
21 time frame.

22 Q. November of 2024, correct?

23 A. Correct.

24 Q. And you understand that the grades, the fall
25 safety grades are released on November 20th, 2024?

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1 A. I recall that being the case.

2 Q. What do you recall the discussions were
3 about the methodology change in or around November of
4 2024?

5 A. Just like the emails that we've looked at
6 that Stephany provided that our score was going to be
7 impacted because we declined to report those measures.

8 Q. And what was your reaction as the
9 president -- I'm sorry -- as the CEO of Delray Medical
10 to Stephany's conversation with you about the change in
11 the methodology?

12 A. Just like it says. I mean, it's
13 unfortunate. I was concerned because the public
14 doesn't understand all these scoring models, and all
15 they were going to see is the failing grade.

16 Q. And which Exhibit are you referring to when
17 you say "it's unfortunate." Are you referring to
18 Exhibit 4?

19 Sorry. There's a lot.

20 A. Yes.

21 Q. Okay. But Exhibit 4 -- okay. So that's the
22 November 2024 time frame, correct?

23 A. Correct.

24 Q. Okay. So were you -- you then say in this
25 Exhibit 4, you say, "Does your" -- "does our PR team

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1 have something prepared that talks about not
2 participating in this, hence" -- "in this, hence, the
3 low rating?"

4 Who is the PR team you're referring to then?

5 A. So that would be Shelly Weiss.

6 Q. And Shelly Weiss, is she at the group level?

7 A. She's the group level.

8 Q. And is Lisa Cook involved in this at all?

9 A. They work together.

10 Q. Lisa Cook reports to Shelly Weiss?

11 A. Lisa Cook reports to Derek Collins.

12 Q. Do you know whether or not -- well, then if
13 we look at Exhibit 4, Stephany says to you, to your
14 question about the PR team, she says, "not that I have
15 been made aware of but will inquire about it since this
16 will go public in less than two weeks."

17 Do you see that?

18 A. I do.

19 Q. What do you recall the discussions were
20 regarding how the PR -- how PR was going to react to
21 the safety grade going from a D to an F?

22 MR. MARCUS: Object to form.

23 A. Can you repeat part of that question?

24 BY MS. BLAIR:

25 Q. Sure, sure.

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1 So we're now at the November 4th, 2024 time
2 frame per Exhibit 4, correct?

3 A. Um-hum, correct.

4 Q. What do you call your discussions as the CEO
5 of Tenet Healthcare were with PR team, as you say in
6 Exhibit 4, around what the PR was going to be when the
7 F grade was released later in November of 2024?

8 A. So from what I recall, I actually went right
9 to our group president so that she would be aware of
10 what this letter grade was going to look like in case
11 she wasn't aware. And then I just asked what kind of
12 talking points we were going to have available so the
13 community could have more accurate information on why
14 we were receiving an F grade and that they could
15 understand it better.

16 Q. And was there a group meeting at the
17 Palm Beach Health Network level between all five
18 hospitals regarding what everybody's grade was going to
19 be in light of the methodology change?

20 A. We have one every month so there would have
21 been one on there.

22 Q. Are they regularly scheduled meetings?

23 A. Our CEO group meetings, yes.

24 Q. Are they the first of the month or last of
25 the month?

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1 A. They sometimes fluctuate based on if
2 someone -- like Maggie is over a couple of markets, so
3 sometimes her schedule changes, but typically they're
4 in the middle of the month.

5 Q. So do you recall whether discussions were
6 had with the other five hospitals at your regularly
7 scheduled CEO meeting or whether there was a specific
8 meeting called for the Leapfrog grade issue?

9 A. I'd have to look at my calendar. I know we
10 would have talked about it at a monthly meeting, but I
11 don't remember the additional meetings.

12 Q. And your understanding was that under the
13 new methodology all nonparticipating hospitals were
14 going to receive an F, correct?

15 A. Correct.

16 Q. But Good Samaritan got a D; isn't that true?

17 A. I don't know exactly what their score was.

18 Q. Do you know how many hospitals in the fall
19 of 2024, how many hospitals in the entire country
20 received failing grades?

21 A. I don't.

22 MS. BLAIR: We can mark this as Number 12.

23 (Defendant's Exhibit Number 12 for i.d.)

24 BY MS. BLAIR:

25 Q. Ms. Havericak, I just handed you what we've

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1 marked as Exhibit 12, which is PBHN 10789, which is an
2 email from Andrew Lofholm to several people.

3 Have you ever seen this email before?

4 A. Well, it looks like I would have gotten it,
5 yes.

6 Q. Okay. Do you recall seeing it?

7 A. I don't. I get so many emails every day,
8 hundreds of them.

9 Q. I feel that.

10 And who is Andrew Lofholm?

11 A. He is another one of our communications and
12 PR folks that works on the team for the network.

13 Q. Okay. And he's at the group level, correct?

14 A. Correct.

15 Q. And this email says, "Hello, everyone.
16 Becker's put out a list this morning naming the 14
17 F-ranking hospitals until the country."

18 Do you see that?

19 A. I see that.

20 Q. So does this refresh your recollection that
21 there were only 14 F's in the whole country?

22 MR. MARCUS: Object to form.

23 A. Based on this email and what Becker's put
24 out, I guess it does.

25 BY MS. BLAIR:

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1 Q. And so do you understand that there are
2 hundreds of hospitals that don't participate in the
3 Leapfrog Hospital Survey?

4 A. I don't know what hospitals haven't
5 participated.

6 Q. And if you see here it says, PBGMC, GCMC and
7 Delray -- I guess I was wrong -- are all on the list.
8 Do you see that?

9 A. I do.

10 Q. And PBG is Palm Beach Gardens, correct?

11 A. Palm Beach Gardens Medical Center, yes.

12 Q. And GSMC, Good Samaritan Medical Center?

13 A. That's correct.

14 Q. And Delray is your hospital, correct?

15 A. That is correct.

16 Q. And so of the -- I was wrong what I said
17 earlier. So there were two hospitals that got a D,
18 which were West Boca -- of your health network, which
19 would have been West Boca and St. Mary's, correct?

20 MR. MARCUS: Object to form.

21 A. That's correct.

22 BY MS. BLAIR:

23 Q. So does this refresh your recollection that
24 it's not the case that all nonparticipating hospitals
25 receive a failing grade?

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1 MR. MARCUS: Same objection.

2 A. No, a D is a failing grade as well.

3 BY MS. BLAIR:

4 Q. Oh. Okay. So of the hundreds of hospitals
5 that don't participate in the Leapfrog survey, is it
6 your understanding all of those hospitals in fall of
7 2024 that did not participate in the Leapfrog Hospital
8 Survey received a D or an F?

9 MR. MARCUS: Object to form.

10 A. I have to see the list of everyone who
11 participated and not participated and see their grades.

12 BY MS. BLAIR:

13 Q. Okay. But you filed the lawsuit in this --
14 you are a plaintiff in this lawsuit that we're here for
15 today, correct?

16 A. That's correct.

17 Q. And you've seen the Complaint that's been
18 filed?

19 A. I have.

20 Q. And did you see it before it was filed?

21 A. Yes.

22 Q. And do you understand that one of the
23 allegations is that under the new scoring method that
24 was put into place in fall of 2024, all
25 nonparticipating hospitals receive a failing grade?

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1 Are you aware that's one of the allegations?

2 MR. MARCUS: Object to form.

3 A. I am.

4 BY MS. BLAIR:

5 Q. What did you do to investigate whether or
6 not that allegation was true before the Complaint was
7 filed?

8 MR. MARCUS: Is it, the "you" is referring
9 to her personally?

10 MS. BLAIR: Delray Medical Center.

11 A. We worked with our counsel.

12 BY MS. BLAIR:

13 Q. Okay. Delray Medical Center didn't perform
14 any independent analysis to confirm that the
15 allegations contained in the Complaint were true prior
16 to it being filed?

17 MR. MARCUS: Object to form.

18 A. We worked with our counsel.

19 BY MS. BLAIR:

20 Q. And so you relied on counsel for those
21 allegations, correct?

22 MR. MARCUS: Object to form.

23 A. We worked with counsel.

24 BY MS. BLAIR:

25 Q. But did you rely on counsel?

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1 A. We relied on them.

2 Q. If you looked at that document I just showed
3 you, the F one, is that Exhibit 11? I apologize. 12.
4 I apologize. 12, is that a two-page document that I
5 handed you?

6 A. It was a one-page.

7 Q. Oh. Sorry, everybody. I had two pages.
8 I'm my own assistant today.

9 A. Thank you.

10 Q. And this will be a group Exhibit because
11 they did not come together, but it was meant to be a
12 group. We can mark this 13.

13 MR. MARCUS: Okay. This is a separate?

14 MS. BLAIR: Can you mark that Exhibit 13.

15 MR. MARCUS: What was it supposed to go
16 with?

17 MS. BLAIR: 12.

18 MR. MARCUS: The Bates.

19 MS. BLAIR: No, no, it was just going to be
20 a group Exhibit.

21 MR. MARCUS: They're not related. The Bates
22 numbers are very different, right?

23 MS. BLAIR: Correct.

24 MR. MARCUS: Just two separate documents.

25 MS. BLAIR: Okay. So we'll mark this as 13

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1 so there's no confusion.

2 (Defendant's Exhibit Number 13 for i.d.)

3 BY MS. BLAIR:

4 Q. Before we get to that, though, real quick,
5 in November of 2024, after you learn about the
6 methodology change but before the grade comes out, did
7 you have a meeting with the governing board of Delray
8 to discuss that the grade was going to mostly likely be
9 an F?

10 A. We did it, I think, at our regularly
11 scheduled governing board member meeting because we
12 have a governing board meeting every month.

13 Q. And do you recall what the conversations
14 were with your board of -- your governing board about
15 the fact that Delray was going to be an F in the
16 Leapfrog hospital safety grade for fall of 2024?

17 A. We talked through the measures, talked about
18 not participating and what those consequences of not
19 participating looked like. And then we went over where
20 we were not performing as well in the CMS measures and
21 the time frame of when those measures had been
22 accounted for because, again, like a lot of them are
23 lay people on that board, and they are used --
24 accustomed to seeing quality data every month, so it
25 looks very different than what they're seeing every

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1 month because we've made a lot of improvements. So we
2 just went through the methodology, went through the
3 measures and then really talked a little bit, I think
4 we did have talking points at that point that they
5 would be able to use when they were out in the
6 community as well.

7 Q. Was there anybody on the board at that
8 meeting in November of 2024 that expressed that they
9 believed that Delray should participate in the Leapfrog
10 Hospital Survey?

11 A. I don't recall anyone speaking up directly
12 to say that.

13 Q. Do you know whether or not the board was
14 told at that November 2024 meeting that all hospitals
15 that don't participate receive a failing grade?

16 A. I don't recall what I said during that
17 meeting.

18 Q. Do you recall whether or not at that meeting
19 you advised your board of directors that Leapfrog was a
20 brazen play-to-pay [sic] scheme -- pay-to-play scheme?

21 MR. MARCUS: Object to form.

22 A. I don't recall the language that I used in
23 the meeting.

24 BY MS. BLAIR:

25 Q. Do you recall making any statements to your

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1 board that hospitals that pay Leapfrog -- that
2 hospitals can pay Leapfrog for better grades?

3 A. I don't recall making that statement.

4 Q. Did you make any statements to your board
5 that Leapfrog -- that hospitals can pay Leapfrog
6 consulting fees in exchange for better grades?

7 A. I don't recall discussing that with the
8 board.

9 Q. After you learn about the methodology change
10 for the 2024 Leapfrog hospital safety grade but before
11 the grade comes out, did you have a meeting with the
12 med exec about the change, the anticipated change in
13 Delray's grade?

14 A. Well, our med exec is the week before
15 governing board, so we definitely talked about it that
16 same month.

17 Q. Do you recall what the discussions were at
18 the med exec board?

19 A. It was the same discussions that I was
20 having at the governing board level, but it was just a
21 little bit more clinical.

22 Q. Do you recall anybody on the med exec
23 expressing a desire to participate in the Leapfrog
24 Hospital Survey?

25 A. There was feedback from some of the med exec

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1 members -- I don't remember which ones they were --
2 that why would we not just do it so we don't have to go
3 through having an F because we knew kind of where we
4 would be positioned and it wouldn't be an F.

5 Q. And what was your position as the
6 president -- or I'm sorry -- as the CEO of Delray about
7 participating in the Leapfrog Hospital Survey in or
8 around that time?

9 A. What I shared with the group was that we
10 were just focusing our attention on our patient safety,
11 on our care experience and on our other accreditations
12 that we felt there was no value in.

13 Q. Did you tell either the med exec or the
14 governing board that home office did not support
15 participating in the Leapfrog Hospital Survey?

16 MR. MARCUS: Object to form.

17 A. I don't recall telling them that.

18 BY MS. BLAIR:

19 Q. Do you recall knowing that in or around
20 November of 2024?

21 MR. MARCUS: Same objection.

22 A. No.

23 BY MS. BLAIR:

24 Q. Do you recall receiving any email to that
25 effect in or around November of 2024?

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1 A. Again, I mean, I get hundreds of emails a
2 day, so I don't know when I would have received an
3 email that's a corporate office except for the ones
4 you've shown me today.

5 Q. Going back to Exhibit 13 that we previously
6 marked, these are the Delray Medical Center Leapfrog
7 key messages. Do you see that?

8 A. I do.

9 MR. MARCUS: Before you ask a question about
10 the document can -- do you have the email, the
11 apparent email?

12 MS. BLAIR: I don't.

13 MR. MARCUS: Okay. Because I'm pretty sure
14 this is not a standalone document.

15 MS. BLAIR: Well, then I'll just ask a some
16 foundational questions.

17 BY MS. BLAIR:

18 Q. Have you seen this document before today?

19 A. Yes.

20 Q. Okay. Do you recall who would have sent it
21 to you?

22 A. It would be either Lisa or Shelly.

23 Q. Lisa being Lisa Cook?

24 A. Lisa Cook or Shelly Weiss.

25 Q. Okay. And do you know who put together

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1 these talking points?

2 A. I don't know who puts them together, but I
3 typically get talking points from Lisa Cook or
4 Shelly Weiss.

5 Q. Do you know if they're approved by home
6 office?

7 MR. MARCUS: Object to form.

8 A. I don't know who approves them because I'm
9 not involved in that process.

10 BY MS. BLAIR:

11 Q. And you see one, two, three, four, five, six
12 bullet points down it says, "CMS does still assign us a
13 score, but it is relying on limited public available
14 data from secondary sources that haven't been
15 verified."

16 What does that refer to?

17 MR. MARCUS: Object to form.

18 A. That's referring to the CMS data. So CMS
19 data is just taking a subset of a population that is
20 the Medicare patient population, and you have to
21 remember at Delray Medical Center we're caring for an
22 elderly population so we're going to have a higher
23 number of complex patients, so, I mean, that's a
24 limited number. That's not all that we take care of.
25 So this CMS star rankings doesn't take into account any

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1 of our commercial payers or patients that are outside
2 of that Medicare population, so it is a limited data
3 source.

4 Q. Okay. And when you say CMS still assign --
5 not you but Delray. When Delray says, "CMS does still
6 assign us a score," is that referring to the star
7 rating?

8 MR. MARCUS: Well, object to form. How do
9 you know that Delray is saying this?

10 MS. BLAIR: Because it says "Delray Medical
11 Center Leapfrog key messages." Is this not -- I
12 guess I should ask.

13 MR. MARCUS: Do you know the author of the
14 document?

15 MS. BLAIR: She just said it was either
16 Lisa Cook or Shelly Weiss.

17 BY MS. BLAIR:

18 Q. Were these Delray Medical Center Leapfrog --

19 MR. MARCUS: She actually said that she gets
20 talking points from them. She didn't identify
21 these specifically.

22 BY MS. BLAIR:

23 Q. Are these talking points that you would have
24 gotten from Palm Beach Health Network?

25 A. They look like it, but, again, like the

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1 email that goes with it would be helpful so we could
2 see.

3 Q. Sure. I don't have it.

4 So I'm just asking, does CMS assign you a
5 score, or is that referring to the star rating, do you
6 know?

7 A. I don't know what they're referring to here.
8 In my opinion, CMS gives us a star rating.

9 Q. Okay. And then I understand when you say
10 limited public available data, you believe it's limited
11 because it would only be the Medicare or Medicaid
12 population, correct?

13 A. Correct.

14 Q. And then it says "from secondary sources."

15 Do you know what secondary sources are that
16 CMS relies on?

17 A. I'm not aware.

18 Q. And then it says "that haven't been
19 verified."

20 Do you know what that's referring to in
21 these talking points?

22 MR. MARCUS: Object to form.

23 A. I don't know what their interpretation was
24 here.

25 BY MS. BLAIR:

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1 Q. And then if you look at the bottom bullet
2 point, it says, "Recent quality awards we have won
3 include..."

4 Are those awards that Delray held in or
5 around November, December of 2024?

6 Well, excuse me. Strike that.

7 Do you see here they refer to awards that
8 you have received in 2025, correct?

9 A. Those are awards that we've had in '25, yes.

10 Q. And those are Delray awards, to the best of
11 your knowledge?

12 A. Delray has all of those awards, yes.

13 Q. And then you see the third bullet point it
14 says, "Due to the use of outdated data for this report,
15 we have made the decision not to submit or participate
16 in the annual Leapfrog Hospital Survey."

17 Correct?

18 A. I see that line, yes.

19 Q. Is the outdated data that it's referring to
20 the CMS data?

21 MR. MARCUS: Object to form.

22 A. I don't know what it's referring to.

23 BY MS. BLAIR:

24 Q. We talked a little bit about Larry Edelson
25 previously. Do you recall that?

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1 A. Yes.

2 Q. And he was a previous board member for
3 Delray, correct?

4 A. He was.

5 Q. And he was not -- he has not been on the
6 board since you've been the CEO of Delray, correct?

7 A. That's correct.

8 Q. And do you know when he first got off the
9 Delray board?

10 A. I'm not sure because it was before I came.

11 Q. Do you deal with him regularly?

12 A. Yes.

13 Q. In what capacity do you deal with him since
14 he's not on the board?

15 A. He's a strong community advocate for us in
16 the community, and he still works in the healthcare
17 space at the Proton Institute that's on our campus.

18 (A discussion was held off the record.)

19 (Defendant's Exhibit Number 14 for i.d.)

20 MR. MARCUS: So 14.

21 MS. BLAIR: 14.

22 BY MS. BLAIR:

23 Q. Ms. Havericak, I've just handed you what
24 we've marked Exhibit 14 for your deposition. And this
25 is a series of, it looks like a series of emails, but

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1 there are two, it's a group Exhibit, I think. Is it
2 two pages, what you have?

3 A. Mine are two pages, but they look like two
4 separate emails.

5 Q. I think they're two separate emails. But
6 they both, if you read that, both have to do with
7 Larry Edelson.

8 A. Yes, that's correct.

9 Q. Okay. And so I want to start with the
10 second page of this which is later in time which is the
11 December 17th, 2024 email from you to Lisa Cook and
12 Maggie Gill, the subject being Larry E.

13 If or around this time, December 17th, 2024,
14 what is Larry E's job?

15 A. He's just a community advocate.

16 Q. Okay.

17 A. And his job, though, he does consulting for
18 the South Florida Proton Institute.

19 Q. So say it -- the South Florida Proton --

20 A. The South Florida Proton Institute.

21 Q. What is the South Florida Proton Institute?

22 A. We have a proton beam institute on our
23 campus. It's a radiology oncology center.

24 Q. Got it.

25 Okay. So is he a business advocate?

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1 A. No, he does some business consulting for
2 them. He's just an advocate in our community for our
3 hospital.

4 Q. And when you say for your hospital, is that
5 like he markets Delray?

6 A. On his own, yes. He's just very connected
7 in the community. He's a key constituent in our
8 community, very influential and a big supporter of
9 Delray.

10 Q. Do you know what he did before he consulted
11 with the South Florida Proton Institute?

12 A. Yeah, he's an entrepreneur. He started like
13 1-800 Contacts. He's had a whole bunch of start-up
14 companies that he's developed and sold.

15 Q. Okay. And in this email, and I want to
16 focus on like the last sentence of the first full
17 paragraph, he's -- well, he says, "He likes to bring up
18 how things were five, ten years ago, and I reminded him
19 this is new era."

20 Do you know what he's referring to five, ten
21 years ago. I know you were not the CEO of Delray, but
22 do you have any memory of what he was talking about?

23 A. He just brings up historic things where
24 there were different leaders there that weren't always
25 focused on patient safety and quality.

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1 Q. Okay. And so is he focused on patient
2 safety and quality?

3 A. Very much so.

4 Q. Got it. And so he's not speaking about the
5 finances of the hospital. He's speaking about patient
6 safety and quality?

7 A. Correct.

8 Q. So would it be fair to say that he is
9 interested in the types of ratings Delray gets from
10 hospital reviewers like Leapfrog?

11 A. Yes.

12 Q. And then you said, "And I reminded him this
13 is a new era."

14 What do you mean by that?

15 A. That we just are looking at things very
16 differently, that I, you know, that's the year I came
17 in as the new CEO, and I have different focus than the
18 previous CEOs. I'm a clinical person by background,
19 and our top focus and priority is always going to be
20 patient safety, care experience and just recruiting the
21 top talent that we can on the physician side and the
22 staff side.

23 Q. So your, as I understand your testimony here
24 today, your mission would align with Larry's mission to
25 put patient quality first, correct?

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1 A. Correct.

2 Q. Okay. So when he's talking about how things
3 worked five, ten years ago, is he saying they were bad
4 five, ten years ago, or is he saying that they were
5 good five, ten years ago?

6 A. That they were bad.

7 Q. Got it.

8 Okay. And does he like regularly have
9 meetings with you about patient safety?

10 A. He just calls. He calls me a lot, so I make
11 time for him.

12 Q. How old is Larry?

13 A. Almost 80 maybe or late 70s.

14 Q. Okay. And then if we go to the first page
15 of group Exhibit 14, there's an email from Shelly,
16 "Good afternoon. Attached please find some of T" --
17 "some TPs for Leapfrog."

18 Do you see that?

19 A. Yes.

20 Q. Do you understand the acronym for TPs would
21 be talking points?

22 A. That's what I would interpret it as.

23 Q. And then Lisa --

24 MR. MARCUS: Is there an attachment to the
25 document?

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1 MS. BLAIR: No, the way you guys produced
2 emails, you Bates labeled the emails, and all
3 the attachments were in native so I had to go
4 try to figure that out, so, no. If there is, I
5 couldn't find it.

6 BY MS. BLAIR:

7 Q. And then Lisa Cook says, "Thanks, Shelly.
8 Heather, let me know if it's okay to send to Larry."

9 Is this type of document you would send to
10 Larry to sort of quell his concerns about patient
11 safety?

12 A. So just personally, I don't like to just
13 send documents to people, especially someone like him
14 because he's -- he likes to understand all the details,
15 so that's why I wouldn't trust him with it. I'd want
16 to sit down and explain it to him rather than just
17 sending him a piece of paper that he might not
18 understand.

19 Q. Fair enough.

20 A. Because he's very thorough.

21 Q. And I only have one of these, and it is not
22 Bates labeled, but it comes from one of those native
23 productions, so I will show this to you before I mark
24 it. And I will find the other -- find another copy for
25 you, but it comes from your production from the

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1 natives.

2 MR. MARCUS: Who created it?

3 MS. BLAIR: I don't know. It's not --
4 obviously I don't have this document. It's not
5 a big deal, but... my only question with that
6 document is going to be who is Steve Saltzman.

7 Did you just write on it?

8 MR. MARCUS: Did you just introduce it?

9 MS. BLAIR: I'm going to mark it. I only
10 have one copy.

11 MR. MARCUS: Oh. I put on "15" for you.

12 MS. BLAIR: Thank you.

13 Could you mark this as 15?

14 MR. MARCUS: We'll object if it turns out it
15 wasn't produced. How's that?

16 MS. BLAIR: Yeah. If I had found this
17 somewhere, that would be interesting.

18 (Defendant's Exhibit Number 15 for i.d.)

19 BY MS. BLAIR:

20 Q. Ms. Havericak, I'm handing you now what
21 we've marked as Exhibit 15. You'll see you're not on
22 this email. But it's in a man named Steve Saltzman to
23 Larry Edelson, the infamous.

24 I asked you earlier in this deposition if
25 you knew who Steve Saltzman was. In reading this

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1 email, does this refresh your recollection at all as to
2 who he is?

3 A. No. I don't -- I'm not familiar with him.

4 MS. BLAIR: Okay. That's the last of my
5 Larry Edelson questions so we can take a break
6 at this point. Thank you.

7 THE VIDEOGRAPHER: This is the end of media
8 three. The time is 2:16 p.m. We're going off
9 the record for a media change.

10 (A recess was taken from 2:15 p.m. to 2:31 p.m.)

11 THE VIDEOGRAPHER: This is media number four
12 in the deposition of Heather Havericak. The
13 time is 2:32 p.m. We are back on the record.

14 BY MS. BLAIR:

15 Q. Ms. Havericak, I just wanted to talk briefly
16 about your understanding of how, if at all, in your
17 words, Leapfrog verifies survey data reported to it.
18 Do you have any understanding what Leapfrog does to
19 verify data?

20 MR. MARCUS: Object to form.

21 A. In my understanding, Leapfrog doesn't come
22 on site and verify practices or data. I have never
23 seen that done in my experience.

24 BY MS. BLAIR:

25 Q. Okay. Do you know whether or not Leapfrog

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1 requests documents from hospitals to verify data?

2 MR. MARCUS: Object to form.

3 A. In my experience they've never requested
4 documents.

5 BY MS. BLAIR:

6 Q. Are you aware from your time as the CEO at
7 Broward at least that hospitals have to sign an
8 attestation when they submit their survey results?

9 A. I am.

10 Q. Are you aware that that attestation tells
11 the hospitals that Leapfrog can perform an audit of the
12 hospital on their survey data responses?

13 A. I don't remember exactly what the
14 attestation says.

15 Q. But as you sit here today, you don't know of
16 any hospital that have ever been audited, onsite
17 audited by Leapfrog?

18 A. Correct.

19 Q. And as you sit here today you're unaware of
20 any hospitals that have been requested to provide
21 documentation to verify their survey responses?

22 A. Correct.

23 Q. Are you aware that after a hospital provides
24 its answers to the Leapfrog Hospital Survey Leapfrog
25 does perform algorithmic review of that data set to see

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1 if it is accurate?

2 MR. MARCUS: Object to form.

3 A. I'm not aware of what Leapfrog does on their
4 side.

5 BY MS. BLAIR:

6 Q. You had stated earlier -- and we'll just
7 mark this as 16. And this is the last one.

8 (Defendant's Exhibit Number 16 for i.d.)

9 BY MS. BLAIR:

10 Q. Ms. Havericak, earlier in your discussions
11 at this deposition you told me that you reviewed that
12 358-page [sic] hospital survey because you thought
13 there might be the possibility that your hospital would
14 be reverting to the Leapfrog Hospital Survey. Do you
15 remember that?

16 A. Yes.

17 Q. And I just now have handed you what we've
18 marked as Exhibit 16, which is an email from you to
19 Jennifer Shoemaker, Nicole Jackson on December 11, 2024
20 entitled "Leapfrog Standards."

21 Do you see that?

22 A. Yes.

23 Q. And you say, "Sending this to you both as a
24 prep. We might be going back to Leapfrog and want you
25 both to review the Leapfrog criteria guide."

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1 Do you see that?

2 A. Yes.

3 Q. And if you look at the attachments, and I
4 specifically didn't attach, do you see attached was the
5 2024 hospital survey scoring algorithm?

6 A. Yes.

7 Q. And do you have an understanding that that
8 is the method -- you provided them with the Leapfrog
9 scoring methodology for 2024?

10 A. Yes.

11 Q. And you go on to say here, "It will show you
12 the standard" -- "what the standard is, where you can
13 meet, achieve or not meet."

14 Do you see that?

15 A. Yes.

16 Q. Does that refresh your recollection in any
17 way that there are certain scores assigned with meet,
18 achieve or not meet?

19 A. Yes.

20 Q. But you still don't recall whether or not
21 for those four imputed measures in spring of 2024 that
22 an achievement was 100 out of 100 points?

23 MR. MARCUS: Object to form.

24 A. I don't remember the exact numerical number
25 associated with those achievements.

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1 BY MS. BLAIR:

2 Q. So this doesn't refresh your recollection?

3 A. It just refreshes that there's the achieve,
4 does not meet or meet.

5 Q. Got it.

6 And then you go on to say, "Nothing has been
7 decided at this time. Just wanted to send it so you
8 all had some time to review and think about some areas
9 where we can really excel."

10 Do you see that sentence?

11 A. Yes.

12 Q. What is your understanding in or around
13 December 11, 2024, what was happening so that you could
14 relay to these women that nothing has been decided at
15 this time?

16 A. Well, that goes back to what we talked about
17 earlier, that we had had discussion of if we were to
18 potentially go back to reporting to Leapfrog.

19 Q. And do you recall who was having that
20 discussion about report to go Leapfrog?

21 A. That was the discussion that I mentioned
22 earlier we were having at our group, Palm Beach group
23 CEO meeting.

24 Q. Did you have an understanding that
25 Maggie Gill was going to ask Tenet home office

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1 whether -- for an exception for the hospitals in the
2 Palm Beach Health Network to participate in the
3 Leapfrog Hospital Survey?

4 A. There was some discussion to potentially
5 getting an exception to participate because of the
6 damage that it was causing reputationally for us.

7 Q. And do you recall what the outcome of
8 Maggie Gill's discussion was Tenet home office was
9 about getting that exception?

10 A. I just know the outcome as a whole we talked
11 about at the group level at the network level was that
12 we were not going to participate.

13 Q. So your memory is you made the decision at
14 the group level not no participate regardless of what
15 home office had said?

16 A. I recall us having a discussion about it at
17 the group level.

18 Q. Do you recall at a group level coming to the
19 consensus that you were not going to participate in the
20 Leapfrog Hospital Survey regardless of home office's --
21 home office giving you an exception or not?

22 MR. MARCUS: Object to form.

23 A. I don't -- I don't recall like what the
24 final decision was on the exception. I just recall us
25 speaking about is it as a group and that we were --

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1 still believed it was not adding value and we were not
2 going to participate.

3 BY MS. BLAIR:

4 Q. Okay. So it's your testimony on behalf of
5 Delray in your corporate capacity that the decision not
6 to participate in the Leapfrog Hospital Survey in or
7 around December of 2024 was a decision made at the
8 group level?

9 A. Correct.

10 Q. Are you aware that Maggie Gill went to home
11 office to ask for an exception for these five hospitals
12 to participate in the Leapfrog Hospital Survey?

13 MR. MARCUS: Object to form.

14 A. I'm aware that there was discussion about
15 it. I don't know what she actually went back and asked
16 for.

17 BY MS. BLAIR:

18 Q. Okay. And you don't recall whether or not
19 there was an email from home office, an email from
20 Anna Gunod to Regina West reporting back to -- also
21 CC'ing Andrea Nunez, Heather Wehmeyer,
22 Kathleen McDonald or Taylor Pool that where Anna Gunod
23 says, "It's a no from home office. Facilities who need
24 an exception due to Leapfrog participation being tied
25 to a local requirement, contract compliance or

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1 reimbursement need to submit their case for review by
2 Dr. Franklin," you don't recall that?

3 MR. MARCUS: Object to form. You want to
4 show her the email or?

5 MS. BLAIR: I only have one with my markings
6 on it, so, sorry.

7 I'll show it to you. It has my highlight on
8 it.

9 This was previously marked as
10 Sheri Montgomery's deposition, but we can mark
11 this as 17.

12 (Defendant's Exhibit Number 17 for i.d.)

13 BY MS. BLAIR:

14 Q. I'm not trying to be tricky. I just don't
15 fly with all the copies.

16 Ms. Havericak, I'm now handing you what
17 we've marked as Exhibit 17, which was previously -- I
18 don't have copies -- which was previously shown to
19 Sheri Montgomery.

20 MR. MARCUS: Can I just see it?

21 MS. BLAIR: And I'll submit for the record
22 that those highlights are my highlights.

23 BY MS. BLAIR:

24 Q. Have you seen this email before today?

25 A. I don't believe I have.

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1 Q. Okay. And you'll see it's dated
2 September of 2024, correct?

3 A. Correct.

4 Q. And do you see that sentence where -- first
5 of all, who is Anna Gunod?

6 A. She is the corporate director of
7 infection -- or I'm sorry -- national director of
8 infection prevention, so she's over infection control
9 for the whole Tenet corporation.

10 Q. Okay. And do you see where she says it's a
11 no from home office?

12 A. I see the statement, "It's a no from home
13 office."

14 Q. And what does it go on to say? What's the
15 next sentence?

16 A. "Facilities who need an exception due to
17 Leapfrog participation being tied to a local
18 requirement, contract compliance or reimbursement need
19 to submit their case for review by Dr. Franklin."

20 Q. Okay. And do you know whether or not the
21 five hospitals that are plaintiffs in this litigation
22 submitted a request for review to Dr. Franklin?

23 A. I don't know if they did. I know I didn't
24 personally submit an exception to Dr. Franklin.

25 Q. Okay. And if we look at Exhibit 16, that is

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1 an Exhibit from December of 2024, correct?

2 A. That's correct.

3 Q. And at that time you're telling your staff
4 that you may be going back to Leapfrog in that December
5 email, correct?

6 A. That's correct.

7 Q. And so as you sit here today, do you have
8 any understanding of whether or not between the
9 September 2024 time frame that I've marked as
10 Exhibit 17 and the December 2024 time frame that's
11 marked as Exhibit 16 there were ongoing discussions
12 about potentially participating in Leapfrog?

13 A. Just the discussions I told you about that
14 we talked about at the network level at our CEO
15 meetings.

16 Q. But you have no memory of being told about
17 Anna Gunod's email where she says "it's a no from home
18 office"?

19 A. No, this is the first time I'm hearing about
20 this.

21 Q. Okay.

22 A. Do you need this one back?

23 Q. No. It's going to be part of the record
24 now.

25 And then you say in this email, I'm going

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1 back to 16, Exhibit 16, I'm sorry, you say, "There are
2 many measures we can position" -- "we can be positioned
3 in the top achievement."

4 Do you see that sentence?

5 A. Yes.

6 Q. Do you recall what measures in December of
7 2024 you believed you could be positioned in the top
8 achievement?

9 A. Like I explained earlier, our improvements
10 in our hospital-acquired infections.

11 Q. Ultimately the five plaintiff hospitals did
12 not participate in the Leapfrog Hospital Survey,
13 correct?

14 A. That is correct.

15 Q. And still to this day do not participate in
16 the Leapfrog Hospital Survey, correct?

17 A. That's correct.

18 Q. And are you aware that in January of 2025,
19 there was a cease and desist letter sent by the five
20 plaintiff hospitals to Leapfrog demanding that they
21 cease and desist from grading these five hospitals for
22 the spring 2025 hospital safety grade?

23 A. That's correct.

24 Q. What involvement, if any, did -- and I don't
25 want to know any conversations you had with your

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1 counsel. But what involvement did you have, if any, in
2 making the decision to send the cease and desist letter
3 to Leapfrog?

4 A. I just reviewed the letter that was prepared
5 by counsel.

6 Q. Was the cease -- was the plan to send the
7 cease and desist letter discussed at any Palm Beach
8 Health Network meetings outside the presence of your
9 lawyer?

10 A. Not that I can recall.

11 Q. Did the Palm Beach Health Network have to
12 take a vote to make the decision to send the cease and
13 desist letter?

14 A. Not that I recall.

15 Q. Did the Palm Beach Health Network have to
16 get the permission of Tenet home office to send the
17 cease and desist letter?

18 MR. MARCUS: Object to form.

19 A. I wouldn't be involved in that discussion,
20 so I'm not sure what approvals were necessary.

21 BY MS. BLAIR:

22 Q. Who would be involved in that discussion on
23 behalf of Palm Beach Health Network?

24 A. Our group president, Maggie Gill.

25 Q. Anyone else?

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1 A. I think that would be it.

2 Q. Do you know whether or not at the time the
3 cease and desist letter was sent in January of 2025 the
4 five plaintiff hospitals had already made the decision
5 to file suit against Leapfrog?

6 MR. MARCUS: Object to form.

7 A. I'm not sure.

8 BY MS. BLAIR:

9 Q. Do you know who all -- and, again, I don't
10 want to know about any conversations you had with your
11 lawyers, but do you know who all on behalf of
12 Palm Beach Health Network was involved in the drafting
13 of the cease and -- the January cease and desist
14 letter?

15 MR. MARCUS: Object to form.

16 A. It, again, was worked on with counsel.

17 BY MS. BLAIR:

18 Q. Did you have any meetings with your
19 governing board advising them that the plan was to send
20 a cease and desist letter to Leapfrog about your
21 hospital safety grade?

22 A. I don't believe I had a conversation with
23 them about the cease and desist letter.

24 Q. Did you ever report the cease and desist
25 letter to the governing board?

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1 A. We talked about everything holistically when
2 the lawsuit was coming out so that they were aware.

3 Q. So your governing board did not take a vote
4 as to whether or not a cease and desist letter should
5 be sent to Leapfrog?

6 A. They did not take a vote.

7 Q. Did you go to your med exec about the fact
8 that you were sending a cease and desist letter in
9 January of 2025 to Leapfrog?

10 A. I believe we did discuss that in January at
11 the med exec meeting.

12 Q. What do you recall about that discussion?

13 A. Just that the cease and desist was going to
14 go out so that the letter grade could potentially be
15 retracted and not publicly reported.

16 Q. Was the expectation that the fall 2024 grade
17 would be retracted?

18 MR. MARCUS: Object to form.

19 A. I don't know what the expectation was. Just
20 we talked about the letter.

21 BY MS. BLAIR:

22 Q. And what was the outcome of discussion at
23 the med exec meeting about the sending of a cease and
24 desist letter?

25 A. They were supportive of that.

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1 Q. Do you recall any specific statements that
2 were made in support of sending the cease and desist
3 letter?

4 A. I don't remember the specifics.

5 Q. Do you recall whether any of the members of
6 the med exec were supportive of sending a cease and
7 desist letter because they believed that Leapfrog was a
8 pay-to-play scheme?

9 MR. MARCUS: Object to form.

10 A. I don't know what they each believed.

11 BY MS. BLAIR:

12 Q. Were they told that?

13 MR. MARCUS: Same objection.

14 A. I don't remember exactly what we talked
15 about.

16 BY MS. BLAIR:

17 Q. Did they see the cease and desist letter
18 before it was sent?

19 A. I did not personally share a cease and
20 desist letter.

21 Q. Do you know when the decision was made to
22 send the cease and desist letter?

23 MR. MARCUS: Object to form.

24 A. I don't know the exact dates.

25 BY MS. BLAIR:

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1 Q. Do you know who made the decision that a
2 cease and desist letter would be sent?

3 A. No.

4 Q. Do you know whether the decision to send the
5 cease and desist letter was the decision of the Palm
6 Beach Health Network or of Tenet Healthcare home
7 office?

8 MR. MARCUS: Object.

9 A. I don't know.

10 MS. BLAIR: Can you mark this as 18?

11 (Defendant's Exhibit Number 18 for i.d.)

12 BY MS. BLAIR:

13 Q. Ms. Havericak, I'm now handing you what
14 we've just now marked as Exhibit 46 [sic] to your
15 deposition. Do you have in front of you an email,
16 microscopically, dated December 13th, 2024?

17 A. Yes.

18 Q. And it's from Maggie Gill to
19 Teresa Urquhart, U-r-q-u-h-a-r-t, correct?

20 A. That's correct.

21 Q. And also Mohammad Aslam, correct?

22 A. Yes.

23 Q. Who is Teresa Urquhart?

24 A. She's the market president in the Carolinas,
25 I believe, in South Carolina for the two hospitals

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1 there, and Maggie is over that territory as well.

2 Q. Who is Mohammad Aslam?

3 A. I'm sorry. I don't know Mohammad.

4 Q. And Shelly Weiss is CC'd on this?

5 A. She is CC'd, yes.

6 Q. Okay. And if we go down to the first email
7 in this string, which would be the last email here but
8 the first time-wise, from Maggie Gill to Regina West,
9 Ricardo Ramirez, he's chief nursing officer for the
10 group, correct?

11 A. For our group in Palm Beach Health Network,
12 yes.

13 Q. Okay. And then we have Teresa Urquhart and
14 Mohammad Aslam again. And do you see Maggie Gill is
15 saying, "Please send me request, reintroduce Leapfrog
16 reporting. Include rationale, imputed score and
17 clippings of negative press/community and MD feedback."

18 Do you see that?

19 A. I see it.

20 Q. And then she goes on to say, "I will request
21 an exception for PBHN and PMC to start next reporting
22 period."

23 Do you see that?

24 A. I see that.

25 Q. Do you know what PMC is?

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1 A. Piedmont Medical Center in the Carolinas.

2 So there's Fort Mill and Piedmont.

3 Q. Got it.

4 A. Those are Teresa's hospitals.

5 Q. And then Maggie reports back but not to you,
6 she dropped some people off this, and she says, "I have
7 spoken with several members of ELT about this issue."

8 Do you see that?

9 A. Yes.

10 Q. Is ELT an acronym that's regularly used at
11 Tenet?

12 A. I don't use that. I don't know.

13 Q. Do you know whether that refers to executive
14 leadership team?

15 A. I don't know what she's referring to because
16 it's not my email.

17 Q. Okay.

18 A. And I'm not on any strings of this email.

19 Q. Understood. And you've never seen this
20 email before?

21 A. No.

22 Q. Okay. So when she says, "There are efforts
23 underway to address Leapfrog's ability to score us even
24 though we don't participate," you don't know what that
25 means?

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1 A. No.

2 Q. Okay. Do you know whether or not PMC sent a
3 cease and desist letter to Leapfrog?

4 A. I'm not aware of what they've done.

5 Q. Do you know whether or not PMC has filed
6 suit against Leapfrog?

7 A. I'm not aware that they've filed suit.

8 Q. Have you had any discussions either at the
9 Palm Beach Health Network level or with home office
10 level about any other hospitals in the Tenet Healthcare
11 system filing suit against Leapfrog based on their
12 nonparticipation in the Leapfrog Hospital Survey?

13 A. I haven't been part of any of those
14 discussions.

15 Q. Ultimately a lawsuit was filed and that's
16 what we're here for today, correct?

17 A. Correct.

18 Q. What -- and, again, I don't want to know
19 about any discussions you had with your lawyers, but
20 what discussions did you have at the Palm Beach network
21 health level -- Palm Beach Health Network level
22 regarding the decision to file suit against Leapfrog?

23 A. We just had discussion about the
24 reputational harm that had been done to all of our
25 facilities and how it had shaken the confidence of a

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1 community that trusts us to provide healthcare and had
2 given the impression, the false impression that we
3 don't provide high value, high quality care, and that's
4 where that decision came from.

5 Q. Did you have any discussions about the fact
6 that filing a lawsuit and going on a PR campaign would
7 further publicize your Leapfrog grades to the
8 community?

9 A. Which question do you want me to answer
10 because there was two questions in there?

11 Q. Sure. Did you have any discussions at the
12 Palm Beach Health Network level about the fact that
13 filing suit would further publicize your Leapfrog
14 safety grades?

15 A. I don't recall having specific conversation
16 about it further publicizing, but that was a risk that
17 existed.

18 Q. And, in fact, are you aware that the
19 Palm Beach Health Network did, in fact, publicize the
20 lawsuit in the local media?

21 A. I'm aware of a statement that went out.

22 Q. Are you aware that lawyers from Gibson Dunn
23 were on TV talking about the grades that your hospital
24 received?

25 A. I am aware.

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1 Q. And are you aware that there were several
2 articles written that displayed the fact that Delray
3 received an F as a result of the filed litigation?

4 A. I'm aware of those.

5 Q. And were there any discussions outside the
6 purview of your lawyers at the Palm Beach Health
7 Network level prior to the filing of the lawsuit that
8 the further publicization of your grades could have a
9 further harmful impact on the community's view of the
10 hospitals?

11 MR. MARCUS: Object to form.

12 A. I don't recall exactly what that
13 conversation may be. It was a risk that I think
14 everyone was aware of.

15 BY MS. BLAIR:

16 Q. Okay. Did you have a conversation -- do you
17 recall a conversation generally about that risk?

18 A. Yeah, a general conversation about that.

19 Q. Okay. And what do you recall?

20 A. Just that it could have more attention
21 around it.

22 Q. Do you know whether it did or did not have
23 more attention around it?

24 A. I can't say if it did or didn't.

25 Q. Do you know -- in all of your time as a CEO

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1 of a hospital, which has been decades, how many times
2 have you had discussions with patients about Leapfrog?

3 A. I've had them a lot recently because
4 consumers are looking at Leapfrog because of the way
5 that things are marketed.

6 Q. Well, let's talk about prior to November of
7 2024. How many conversations had you had with patients
8 about Leapfrog?

9 A. I don't think prior to 2024 I had a lot of
10 conversations with patients about Leapfrog.

11 Q. And you-- what about prior to -- and I think
12 I asked prior and I want to make sure. Prior to
13 November of 2024, how many conversations had you had
14 with patients about Leapfrog?

15 A. I mean, if I -- probably very limited.

16 Q. And that's true even when Delray's grade was
17 a D in the spring of 2024, correct?

18 A. That's correct.

19 Q. And you testified earlier that you consider
20 a D to be a failing grade, correct?

21 A. Correct.

22 Q. What discussions did you have with your
23 board about the decision to file a lawsuit against
24 Leapfrog?

25 A. We just informed them that we were moving

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1 forward with a lawsuit against Leapfrog.

2 Q. Did the board have to vote to approve a
3 lawsuit against Leapfrog?

4 A. They don't have to vote to approve that.

5 Q. Did the board have any questions about how
6 expensive a suit against Leapfrog would be?

7 A. They didn't, that I remember, ask questions
8 about the cost.

9 Q. And you understand that one of things you're
10 asking for in this lawsuit is for my client to pay
11 attorney's fees that are associated with this lawsuit,
12 correct?

13 MR. MARCUS: Object to form.

14 A. I don't -- I don't know all the things that
15 are being asked for your client.

16 BY MS. BLAIR:

17 Q. Do you know how much in fees Delray has
18 spent to date in prosecuting this lawsuit?

19 MR. MARCUS: Object to form.

20 A. I do not. I would need our financial
21 statements to be able to show you that.

22 BY MS. BLAIR:

23 Q. Do you have any idea if it's over a million
24 dollars?

25 MR. MARCUS: Same objection.

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1 A. I don't know. I need the financial
2 statements.

3 BY MS. BLAIR:

4 Q. Was the med exec told that a lawsuit was
5 going to be filed against Leapfrog before the filing of
6 the lawsuit?

7 A. Yes.

8 Q. Did the med exec have to approve the filing
9 of the lawsuit?

10 A. They do not.

11 Q. Who has to approve the filing of the
12 lawsuit?

13 A. I mean, we were -- we're able to do that
14 with our Palm Beach Health Network, and I would assume
15 probably our corporate office also has to approve that.

16 Q. Did any of the CEOs of the hospitals that
17 make up the Palm Beach Health Network object to filing
18 the lawsuit against Leapfrog?

19 A. Not that I recall.

20 Q. Do you recall that the lawsuit in this
21 action was filed on April 30th, 2025?

22 A. That date sounds correct.

23 Q. And did you review the Complaint before it
24 was filed?

25 A. I did.

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1 Q. Did anybody else at Delray review the
2 Complaint before it was filed?

3 A. I just reviewed it.

4 Q. Was there anything in that Complaint that
5 you disagreed with?

6 MR. MARCUS: Object to form.

7 A. I reviewed it with my counsel.

8 BY MS. BLAIR:

9 Q. Okay. And so outside of any discussions
10 with your counsel did you make any changes to the
11 Complaint that you can recall?

12 A. I don't recall making changes.

13 MS. BLAIR: Can we mark this as 18?

14 THE STENOGRAPHER: 19.

15 MS. BLAIR: 19.

16 (Defendant's Exhibit Number 19 for i.d.)

17 BY MS. BLAIR:

18 Q. Ms. Havericak, I am providing you with a
19 document that we've now marked as Exhibit 19. And I'll
20 submit to you that you'll see the Bates number down
21 here is Boca News Now. And it is a response to a
22 subpoena that I sent to Boca News Now. And they
23 produced back to us a press release from
24 Rebecka.Henrikson@scalestrategy.com. Do you see that
25 on page 2 of this document?

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1 A. I see that.

2 Q. Do you know who Rebecka Henrikson is?

3 A. I do not know Rebecka.

4 Q. Do you know who scalestrategy.com is?

5 A. I do not.

6 Q. And do you recognize this document that is
7 at Boca News Now 2 through 4?

8 MR. MARCUS: Object to form.

9 A. I mean, I don't know if I have seen this,
10 this particular one before.

11 BY MS. BLAIR:

12 Q. Okay. And if you look at Rebecka is writing
13 to Andrew, and she says, "I'm reaching out on behalf of
14 the Palm Beach Health Network."

15 Do you see that?

16 A. Yes.

17 Q. And your hospital is part of the Palm Beach
18 Health Network, correct?

19 A. That's correct.

20 Q. And do you see that this is at the bottom
21 right before her signature, she says, "You can read
22 more about the filing in the press release below."

23 Do you see where she says that?

24 A. Yes.

25 Q. Looking at this, did you see this press

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1 release before it was issued to the news on April 30th?

2 A. I don't remember if I saw this press release
3 before it went out.

4 Q. Is this something that someone in the
5 marketing department at Delray hospital would have seen
6 before it went out?

7 A. Yes.

8 Q. Do you see on page 3 of this press release
9 it says, "The legal action comes after repeated efforts
10 by the hospitals to engage with the Leapfrog Group"?

11 A. Yes, I see that.

12 Q. Do you know what the repeated efforts are
13 that are being referred to in the press release that
14 was put out on behalf of your hospital through
15 Palm Beach Health Network?

16 A. I don't know exactly what they're
17 referencing here, but I would imagine it follows the
18 cease and desist letter.

19 Q. Okay. So you believe the repeated efforts
20 being referred to are the cease and desist letter?

21 A. That's what I would believe it to be.

22 Q. Okay. And then if you look at the end, the
23 last sentence of that paragraph says, "Leapfrog did not
24 punish the plaintiff hospitals for the past four years
25 that they did not respond to its voluntary data request

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1 until last year when they changed their criteria to
2 deliberately fail nonparticipating hospitals."

3 Do you see that?

4 A. Yes.

5 Q. What is that based on?

6 A. That's based on the measures we've been
7 talking about today, the four self-reported measures.

8 Q. And is that based on what you told me today
9 that you believe that non -- all nonparticipating
10 hospitals fail if they don't participate in the survey?

11 MR. MARCUS: Object to form.

12 A. I believe that's consistent with what I've
13 told you.

14 BY MS. BLAIR:

15 Q. And you believe that Leapfrog just
16 deliberately fails nonparticipating hospitals, correct?

17 A. Correct.

18 Q. And so as you sit here today, you have done
19 no research to inform yourself as to whether or not
20 there are non -- there are hospitals that do not
21 participate in the Leapfrog Hospital Survey that
22 receive A's, B's and C's in their hospital safety
23 grade, correct?

24 MR. MARCUS: Object to form.

25 A. I have been going on the advice of counsel.

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1 BY MS. BLAIR:

2 Q. And you see if we go one, two, three, four,
3 five paragraphs down, it starts with "Leapfrog's
4 so-called grades."

5 Do you see that?

6 A. Yes.

7 Q. You say "Leapfrog's so-called grades are not
8 grounded in credible science or independent analysis."

9 Do you see that?

10 A. I see that.

11 Q. What is that based on?

12 A. I'm not sure. I didn't write this.

13 Q. But do you understand that that's an
14 allegation of the Complaint that was filed on behalf of
15 your hospital?

16 MR. MARCUS: Object to form.

17 A. Yes.

18 BY MS. BLAIR:

19 Q. And before filing that Complaint, did you do
20 any research to come to the conclusion as to whether or
21 not it is true that the Leapfrog grading methodology
22 is, quote, not grounded in credible science or
23 independent analysis?

24 A. I relied on counsel.

25 Q. Do you understand that Leapfrog has

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1 13 independent voluntary expert panels who advise on
2 the hospital -- both the hospital survey and the
3 hospital grading methodology?

4 MR. MARCUS: Object to form.

5 A. I do know they have experts.

6 BY MS. BLAIR:

7 Q. Do you understand that the analysis that
8 goes into the hospital safety grade methodology is
9 fully available on the LeapfrogGroup.org website?

10 MR. MARCUS: Object to form.

11 A. I do.

12 BY MS. BLAIR:

13 Q. Have you ever looked to see who the experts
14 are that make up the Leapfrog hospital safety grade
15 expert panel?

16 A. I have not.

17 Q. Do you have any understanding of whether
18 they are qualified to provide guidance to Leapfrog on
19 the issues of patient safety?

20 A. I would need to study each of their CVs and
21 resumes to understand if they're qualified to be an
22 expert.

23 Q. Okay. And you've not done that as we sit
24 here today, correct?

25 A. I have not.

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1 Q. And you say in this same sentence, and when
2 I say "you," I mean, the press release from Palm Beach
3 Health Network that was sent on behalf of all five
4 hospitals, including yours, you say that "they," being
5 the grades, "are riddled with falsehoods," and then you
6 say "distorted by undisclosed financial incentives."

7 What are the undisclosed financial
8 incentives that you believe Leapfrog bases its grades
9 on?

10 MR. MARCUS: Object to form.

11 A. It has to do with the reputational harm that
12 caused -- that is caused as a result of not
13 participating. It's not necessarily an exchange of
14 money.

15 BY MS. BLAIR:

16 Q. Okay. But do you believe that Leapfrog gets
17 a financial incentive?

18 A. They do get a financial incentive, and
19 they're causing harm to us.

20 Q. So what's the financial incentive that
21 Leapfrog gets from its methodology?

22 A. So it's not a financial incentive from the
23 methodology. It's the failure to participate that
24 causes financial harm to those hospitals that choose
25 not to participate.

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1 Q. So you're referring, though, to the
2 financial harm to the hospitals, so you don't believe
3 this refers to Leapfrog getting a financial incentive?

4 A. I believe it refers to the financial damage
5 to the hospitals.

6 Q. Okay. So you don't believe that Leapfrog is
7 motivated financially to giving failing grades to
8 hospitals, but this refers, rather, to financial issues
9 caused to the hospitals that don't participate?

10 MR. MARCUS: Object to form.

11 A. I think it has a major impact on reputation
12 and harm which is going to impact financials as well.

13 BY MS. BLAIR:

14 Q. Okay. The next paragraph of this press
15 release says, "Leapfrog aggressively pushes hospitals
16 to pay for its consulting services."

17 Do you see that?

18 A. I see that.

19 Q. What consulting services are you referring
20 to in this press release?

21 MR. MARCUS: Object to form.

22 A. Again, I didn't write this press release so
23 I don't know exactly which consulting services they're
24 referencing.

25 BY MS. BLAIR:

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1 Q. As you sit here today, are you aware of any
2 consulting services that Leapfrog provides to
3 hospitals?

4 A. I don't know the specific consulting
5 services that they provide, but I do know that Leapfrog
6 does provide consulting services.

7 Q. You believe that Leapfrog provides
8 consulting services for a fee to hospitals?

9 A. Yes.

10 Q. And what do you believe these consulting
11 services do?

12 A. They -- from what I understand, they are
13 for -- to help improve patient safety and quality in
14 hospitals.

15 Q. And who told you that?

16 A. I have heard that several times through some
17 of my professional connections from colleagues.

18 Q. Which colleagues have told you that?

19 A. I don't remember which colleagues. I have
20 colleagues from all over the country.

21 Q. Do these colleagues tell you that they pay
22 Leapfrog for the consulting services?

23 A. I have heard that you can pay Leapfrog to
24 have consulting services.

25 Q. You've heard it from colleagues, but you

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1 don't know which colleagues, correct?

2 A. Correct.

3 Q. Okay. But you can't tell me as you sit here
4 today what those consulting services are?

5 A. No, I don't have the specifics of those.

6 Q. And then you say "and professional
7 licenses."

8 Do you see that?

9 A. I do.

10 Q. Are you referring to the fact that if you
11 want to use the Leapfrog logos, you have to pay for use
12 of their trademark?

13 MR. MARCUS: Object to form.

14 A. Again, I didn't write this, but that's what
15 it would appear to me.

16 BY MS. BLAIR:

17 Q. So that would be just like Healthgrades®,
18 correct?

19 A. Correct.

20 Q. And then you say here this whole sentence,
21 "Leapfrog aggressively pushes hospital to pay for its
22 consulting services and promotional licenses in
23 exchange for better grades."

24 Do you see that?

25 MR. MARCUS: Object to form. And the use of

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1 "you."

2 A. I see that. That's a --

3 BY MS. BLAIR:

4 Q. Do you have any evidence that hospitals pay
5 Leapfrog in exchange for better grades?

6 A. I don't have evidence.

7 Q. If we look at what I think I marked
8 previously as Exhibit -- well, wait. Hold on. -- if
9 we look at what I previously marked as Exhibit 2, which
10 is your declaration, did you draft this declaration
11 yourself?

12 MR. MARCUS: Object to form.

13 A. I did not draft it. I worked with my
14 counsel on it.

15 BY MS. BLAIR:

16 Q. And I don't want to know about any
17 discussions you had with your counsel about this
18 document so I'm just going to ask you a few questions
19 about...

20 Number 15 of your -- paragraph 15 of Exhibit
21 2 which is your declaration, you say, "When the medical
22 center stopped participating in Leapfrog's -- or in
23 the -- I'm sorry -- in TLG's hospital survey, we
24 expected TLG would simply omit the medical center from
25 its hospital safety grades."

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1 Do you see that?

2 A. Yes.

3 Q. Why was that the expectation?

4 A. Because we're not -- it's a voluntary survey
5 and we're not giving data so we shouldn't be scored on
6 anything.

7 Q. And you weren't at Delray in 2021 when they
8 stopped participating, correct?

9 A. I was not.

10 Q. How do you know that in 2021 Delray expected
11 that TLG would omit Delray from the hospital safety
12 grade when it stopped participating in the survey?

13 A. Can you repeat that?

14 Q. Sure.

15 You weren't at Delray in 2021 when the
16 decision was made to stop participating in the Leapfrog
17 Hospital Survey. And I'm asking how do you know today
18 or in May of 2025 when you signed this declaration that
19 the expectation of Delray in 2021 was that they would
20 no longer be graded?

21 A. I don't -- I don't think that's relevant to
22 what we're talking about.

23 Q. Well, you say "when the medical center..."
24 which is Delray, correct?

25 A. Correct.

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1 Q. "...stopped participating in the hospital
2 survey..."

3 It says that, correct?

4 A. It says that, yes.

5 Q. And we know that they stopped participating
6 in 2021, correct?

7 A. Correct. But this document is talking about
8 2024 and 2025.

9 Q. Oh, okay. But I just read it to say like
10 when you stopped participating, which was 2021, you
11 expected to be omitted from the safety grade.

12 A. That's a reasonable expectation.

13 MR. MARCUS: Object to form.

14 BY MS. BLAIR:

15 Q. And my question is, who did you talk to at
16 Delray to come to the conclusion that that was their
17 expectation in 2021 when the medical center stopped
18 participating in TLG's hospital survey?

19 MR. MARCUS: Objection. Mischaracterizes
20 the testimony.

21 A. I didn't talk to anyone about 2021. It
22 doesn't -- that's not what the interpretation of that
23 paragraph is.

24 BY MS. BLAIR:

25 Q. Okay. If we go to paragraph 18, the second

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1 sentence, you say, "It shows that if you participate in
2 its pay-to-play time-consuming hospital survey, TLG
3 assigns you a better grade."

4 Do you see that?

5 A. I do.

6 Q. What is that based on?

7 A. It's based on the facts of what we're
8 talking about today. If we had participated and put in
9 the data, we would have had a nonfailing grade.

10 Q. What's the evidence for the pay-to-play part
11 of that sentence?

12 A. We've talked about this on several occasions
13 today on the pay-to-play. It has to do with the
14 reputational damage and harm Leapfrog has caused to us
15 from not participating in the survey.

16 Q. Do you think that the regular reader of the
17 Palm Beach post thinks that when you say Leapfrog is a
18 play -- pay-to-play scheme, it's understanding that it
19 has to do with the rep -- that statement has to do with
20 the reputational harm that's being caused to Delray?

21 MR. MARCUS: Object to form.

22 A. I don't know what the readers of the Palm
23 Beach Post, how they're going to interpret it.

24 BY MS. BLAIR:

25 Q. But that's how you meant it, correct?

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1 A. That's how we meant it.

2 Q. Is it your position that simply by virtue of
3 participating in the Leapfrog Hospital Survey, a
4 hospital gets a better grade?

5 MR. MARCUS: Object to form.

6 A. Yes.

7 BY MS. BLAIR:

8 Q. If we could go to Paragraph 22 but on PBHN
9 2124, so Paragraph 22, it starts on page 2123, PBHN
10 2123. It says, "When the user clicks on view full
11 score, she sees inaccurate and misleading information
12 about the medical center."

13 Do you see that statement?

14 A. I do.

15 Q. And then I assume if we go to the next page,
16 PBHN 2124, this is the page that you are stating shows
17 "inaccurate and misleading information about the
18 medical center," correct?

19 MR. MARCUS: Object to form.

20 A. That is correct.

21 BY MS. BLAIR:

22 Q. Okay. And if we look at this, you'll see
23 here the hospital score is listed here as a 15,
24 correct?

25 A. That's correct.

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1 Q. And there's an asterisk. Do you see the
2 asterisk?

3 A. I do.

4 Q. And the asterisk corresponds to
5 footnote four on this page. Do you see that?

6 A. Yes.

7 Q. And I understand on this page, this is a
8 reproduction of the Web page. But would you agree with
9 me that this footnote four is in bold and red ink?

10 A. I don't remember if it's in bold red ink
11 here. It looks bold here in the font, but I can't
12 recall the color of the ink.

13 Q. Okay. You don't recall looking at it on the
14 Web page?

15 A. I did look at it, but I don't recall the
16 what the color of it was.

17 Q. That's just my question --

18 A. Yeah.

19 Q. -- you don't know if it's red.

20 Okay. And I read this footnote. "The
21 hospital declined to report their performance on this
22 measure."

23 Do you see that?

24 A. Yes.

25 Q. Is that a true statement that Delray

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1 declined to report their performance on the measure?

2 A. That's correct.

3 Q. And then it goes on to say, "So a score was
4 assigned."

5 Do you see that?

6 A. I do.

7 Q. Would you agree with me that Leapfrog just
8 assigned a score, it's not part of any sort of
9 mathematical calculation?

10 MR. MARCUS: Object to form.

11 A. They assigned a score, yes.

12 BY MS. BLAIR:

13 Q. Okay. And it says, "So a score was assigned
14 to reflect the lack of information available."

15 Correct?

16 A. Correct.

17 Q. And if we go back up here, it says, "the
18 worst hospital score" -- do you see that -- is 15."

19 Do you see that, "This hospital score is
20 15*"?

21 A. Yes.

22 Q. Best hospital score is 100, correct?

23 A. Correct.

24 Q. The average hospital score is 80.23, do you
25 see that?

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1 A. Yes.

2 Q. And then it says the worst hospital score is
3 15, correct?

4 A. Correct.

5 Q. And is it accurate to say that Delray was
6 assigned the worst hospital score?

7 A. Correct.

8 MR. MARCUS: Object to form.

9 BY MS. BLAIR:

10 Q. Do you know how big the font is actually on
11 footnote 4?

12 A. I don't.

13 Q. And I think I asked you this probably four
14 times, but you are unaware as you sit here today
15 whether or not there are any hospitals out of the 3,000
16 hospitals that Leapfrog grades that receive an A and
17 yet don't participate in the hospital survey, correct?

18 MR. MARCUS: Object to form.

19 A. Correct.

20 BY MS. BLAIR:

21 Q. And I've asked you this a thousand times,
22 but you are unaware as you sit here today that when
23 Delray had a D in the spring of 2024, it actually
24 received 100 out of 100 points for all four imputed
25 measures, correct?

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1 MR. MARCUS: Object to form.

2 BY MS. BLAIR:

3 Q. You're unaware of that?

4 A. I was unaware. I just need to see the
5 document.

6 Q. Did you ever get -- did your board -- did
7 any member of your board ever get inquiries from
8 patients about Delray's Leapfrog grade when it was a D
9 in the spring of 2024?

10 A. Not that I can recall.

11 Q. What about med exec, did they ever get
12 inquiries from patients when Delray's grade was a D in
13 the spring of 2024?

14 A. Not that I can recall.

15 Q. So I want to talk about the damages in this
16 case. Do you understand --

17 Well, let me, real fast, Exhibit 2, have you
18 ever been told that your declaration has been withdrawn
19 in this litigation?

20 MR. MARCUS: Object to form.

21 A. No.

22 BY MS. BLAIR:

23 Q. Did you ever withdraw your declaration in
24 this litigation?

25 MR. MARCUS: Are you testifying this

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1 declaration has been withdrawn?

2 MS. BLAIR: I'm testifying Lee Crain has
3 said it multiple times.

4 BY MS. BLAIR:

5 Q. Are you aware whether or not your
6 declaration is still in -- is accurate?

7 A. It's been amended.

8 Q. Your declaration has been amended?

9 A. The declaration?

10 Q. Number 2, yeah, that that's what we're
11 reading.

12 MR. MARCUS: Not the Complaint.

13 BY MS. BLAIR:

14 Q. Not the Complaint.

15 A. Oh. No, no, my declaration is still as is.

16 Q. Okay. Thank you.

17 MS. BLAIR: But you are right, the Complaint
18 has been amended.

19 A. Yes.

20 BY MS. BLAIR:

21 Q. And if we talk about the Complaint, are you
22 aware that Delray Medical as well as the other
23 plaintiffs in this action have withdrawn their request
24 for monetary damages?

25 A. I am aware of that.

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1 Q. And do you understand as you sit here today
2 that Delray and the other plaintiffs are only
3 requesting injunctive and declaratory relief against
4 Leapfrog?

5 A. Yes.

6 Q. And what do you understand the injunctive
7 relief is that's being requested in this litigation?

8 A. To withdraw the letter grades.

9 Q. Is it to withdraw past letter grades or not
10 grade in the future?

11 MR. MARCUS: Object to form.

12 A. Both. Both from what I understand.

13 BY MS. BLAIR:

14 Q. I want to talk about --

15 Well, what are the types of damage that
16 Delray has suffered as a result of its Leapfrog
17 hospital safety grades post fall of 2024?

18 A. We have patients that have a less, a lesser
19 confidence in our medical center. I go out on the
20 units every single day in our hospital and do rounding
21 on patients and families, and every day we get
22 feedback.

23 We have people in there that say, "Oh, I was
24 scared to come to Delray because of that Leapfrog score
25 that we see, and I was pleasantly surprised. This is a

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1 wonderful hospital. We've had incredible care, great
2 nurses and just have been well taken care of."

3 I deal with that every single day.

4 We've had patients that don't want to come
5 for elective procedures because they're nervous about
6 that score that they've seen. We've had physicians
7 that are concerned about coming to the medical center
8 when they have choices and are on staff at multiple
9 places. And then we continue to have community members
10 that tell us, you know, people are still talking about
11 these failing grades.

12 And, you know, I can even be out in the
13 community for dinner, and I can tell you two occasions
14 out with friends, one who's a prominent business person
15 in the community saying, you know, "You have our, one
16 of our only trauma centers in the community, and it
17 makes me nervous to have to go there with that Leapfrog
18 score" and then another whose elderly parents live very
19 close to the medical center and say "We're scared if we
20 have a heart attack or stroke because we have to be
21 taken to Delray and look at that score."

22 I mean, and there's so much -- that's only a
23 little bit of what we know. There's so much damage
24 that we can't even quantify.

25 Q. So these conversations that you've had,

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1 you've had with patients when you're rounding, when did
2 they occur?

3 A. I do those every single day. Typically
4 around 2:00 p.m. I go and do my rounds.

5 Q. Yeah. So it was a bad question. I
6 apologize.

7 Did you have those conversations in
8 November of 2024?

9 A. Yeah, I've always done rounding on patients.

10 Q. Oh, okay. So my questions are bad. I
11 apologize.

12 So I want to break that down a little bit.
13 Okay. So let's talk about the patients that you said
14 are nervous to come to Delray. And I want to talk
15 about specifically about conversations you have had,
16 you personally have had with patients. When is the
17 first time you started having conversations with
18 patients about the Leapfrog grade?

19 A. After the grade came out.

20 Q. Which grade?

21 A. The fall 2024 F.

22 Q. So would that have been in November of 2024?

23 A. It was towards the end of November,
24 beginning of December.

25 Q. Approximately --

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1 The end of November, early December 2024?

2 A. And they continue.

3 Q. I understand.

4 A. I mean, they've happened last week, this
5 week.

6 Q. So between the end of November 2024 and
7 April 30th, 2025, how many patients did you speak to
8 that had concerns that were stemming from the Leapfrog
9 hospital safety grade?

10 A. I don't have the number of patients. I
11 don't keep track of those. I mean, it's just on a
12 daily basis I've been talking to patients.

13 Q. Every day?

14 A. Yes, every day, through the workweek Monday
15 through Friday.

16 Q. Okay. So Monday through Friday at least one
17 patient a day talks to you about the Leapfrog hospital
18 safety grade?

19 A. Correct.

20 Q. And these are all patients that are
21 currently in Delray?

22 A. Yes.

23 Q. So they're still coming to Delray?

24 A. They're come to go Delray, but they had
25 apprehension and anxiety about coming to Delray.

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1 Q. How many conversations have you had between
2 November of 2024 and April of 2025 with patients who
3 refused to come to Delray?

4 A. I had to intervene on a couple in the
5 elective surgical space.

6 Q. "A couple" is two?

7 A. Probably two or three, yeah.

8 Q. And for the record, what is the elective
9 surgical space?

10 A. So patients that were coming for elective
11 surgical procedures.

12 Q. And they did not want to come to Delray?

13 A. They did not.

14 Q. Did they ultimately come to Delray?

15 A. Yes.

16 Q. And then you said -- so there were patients
17 and then you said doctors.

18 A. Um-hum.

19 Q. You talked to doctors about the Leapfrog
20 safety grade?

21 A. Yes.

22 Q. And what are those conversations with
23 doctors?

24 A. That they're concerned to bring patients
25 here, and patients are complaining to them about the

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1 Leapfrog grade and just being nervous about the quality
2 that Delray is providing to the community based on that
3 grade.

4 Q. How many doctors have you talked with about
5 the Leapfrog grade?

6 A. Probably 15, 20.

7 Q. And these are all doctors that have
8 privileges at Delray?

9 A. Correct.

10 Q. Has any doctor revoked his privileges at
11 Delray?

12 A. Not that I am aware of related to this.

13 Q. When you talk to these doctors about the
14 Leapfrog grade, are they concerned at all about the
15 HCAHPS score?

16 A. They are, but they know that we're working
17 on a plan to improve those that they're a part of.

18 Q. Are they worried at all about the CMS star
19 rating?

20 A. They -- especially the medical staff
21 leadership, and then we talk about that at the
22 department level, they are, but, again, that's old
23 data, and they know about all the improvement plans in
24 place and what the data looks like today.

25 Q. And when you talk to these doctors about the

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1 Leapfrog safety grade, are they also worried about the
2 PSI 90 score of Delray?

3 A. Yeah, because that goes into the whole
4 patient safety component.

5 Q. Correct.

6 A. And we go over all of those components as
7 well.

8 Q. And when you talk to -- you told me earlier
9 that most of the patients that Delray services are
10 Medicare patients, correct?

11 A. There's a large population of Medicare,
12 managed Medicare and commercial. We don't do a lot of
13 Medicaid or underinsured.

14 Q. Do any of the patients that you talk to on a
15 daily basis about the Leapfrog hospital safety grade
16 also have concerns about the CMS star rating?

17 A. They do. They ask about it. Not all of
18 them, but some of them are more savvy than others.

19 Q. And then you said community members talk to
20 you as well, correct --

21 A. Yes.

22 Q. -- about the Leapfrog hospital safety grade?

23 A. Yes.

24 Q. Who are these community members?

25 A. Two are just personal friends and business

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1 associates. One works in healthcare; one does not.

2 Larry Edelson is constantly talking about
3 those things. And then we have other community members
4 that I've talked to just in circles from chamber
5 members and things like that.

6 Q. And your personal friend that's also in
7 healthcare, does she have an opinion about the Leapfrog
8 safety grade?

9 A. He.

10 Q. He. I'm sorry.

11 A. He. I mean, he understands it, but in
12 trying to explain that to elderly parents, it sometimes
13 sounds like you're trying to make excuses, so, you
14 know, it's a difficult story to explain.

15 Q. When you explain to these patients or
16 community members that aren't in healthcare so don't
17 really understand it, how do you explain to them the
18 fact that Delray has 1, they're a one-star CMS
19 hospital, but the Leapfrog safety grade is inaccurate?

20 A. I just go through the measures and explain
21 based on our patient population, based on the limited
22 number, because, again, CMS star ratings are not a full
23 picture of every patient we take care of. It's a
24 snapshot of CMS patients, so it's a snapshot, a piece
25 of our patient population. So I have to explain all

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1 these measures and explain that that's how we were
2 performing up until 2023. And then I pair that with
3 the data and how we're performing with our performance
4 improvement measures today because the data looks very
5 different. So it's just being able to tell that story
6 and get them to understand all those measures.

7 Q. And do you explain to them that 75 percent
8 of the Leapfrog grade is based on that same CMS data
9 that goes into the one-star rating?

10 MR. MARCUS: Object to form.

11 A. I wouldn't say it's 75 percent based on the
12 calculations I see with the weighting, but they do know
13 that the CMS star rating goes into the Leapfrog and has
14 an impact on it, yes, I explain that.

15 BY MS. BLAIR:

16 Q. Do you feel that you're fairly successful
17 when you have those conversations with patients or
18 community members in explaining to them how the
19 Leapfrog grade and/or the CMS star ratings are not
20 indicative of patient safety at your hospital?

21 A. To some extent I do.

22 Q. And, in fact, I think you told me earlier
23 that you've really not seen admissions decline after
24 the safety grade came out, correct?

25 A. We didn't see admissions decline. But I

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1 will say in August there was -- in late July there was
2 a viral video that went out that was certainly targeted
3 at our hospitals within the Palm Beach Health Network.
4 Although it didn't reference Leapfrog, it had all the
5 letters assigned to the safety grades. And we did see
6 a significant dip in admissions in the month of August
7 and a dip in people coming for elective procedures in
8 both our cardiac cath lab, electrophysiology lab and
9 our surgical procedures.

10 Q. Is this viral video, this TikTok video from
11 USA Maps?

12 A. It went on to TikTok. It went to Instagram.
13 It went to Facebook. It went everywhere. And that's
14 where there was a lot more feedback from numbers all
15 over.

16 Q. Speaking of Facebook, have you ever gone on
17 Facebook and looked at what people on Facebook say
18 about Delray in the community regardless of the TikTok
19 video?

20 A. Yes.

21 Q. And how --

22 A. We actually -- and that gets monitored so we
23 can see those comments on a realtime basis, and then we
24 can intervene when we need to, and we do.

25 Q. Would you agree with me that there have been

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1 some less than stellar reviews of Delray on Facebook in
2 2023 and 2024?

3 MR. MARCUS: Object to form.

4 A. I don't know that I've seen the 2023 ones.
5 I can say in 2024 there have been. And there -- those
6 would hold true at hospitals all over. People, it's
7 just their perception.

8 BY MS. BLAIR:

9 Q. I agree.

10 Have you done any comparison, any empirical
11 data review to make a determination as to whether or
12 not there has been an actual impact on the reputation
13 of Delray as a result of the Leapfrog hospital safety
14 grade?

15 MR. MARCUS: Object to form.

16 A. We didn't feel we needed to do that. We
17 knew based on the feedback of all of the impact that
18 this was already having. And although the numbers were
19 strong, they were strong for a reason because we had
20 strategically put out a very aggressive strategic plan
21 that we were executing on, like I said, bringing in new
22 physician, elevating quality and service, creating new
23 access points. But we can't even quantify the
24 additional damage because we could have been performing
25 even better than we were performing had this bad press

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1 not hit us and this grade not been assigned.

2 BY MS. BLAIR:

3 Q. Have you done any quantitative analyses of
4 the impact of the fact that your publicization -- I
5 don't know if that's a word -- of the lawsuit, what
6 impact that had on patient constituents in the
7 community now seeing your grades that they wouldn't
8 have seen previously?

9 MR. MARCUS: Object to form.

10 A. We have not.

11 BY MS. BLAIR:

12 Q. Okay. But you would agree with me, you
13 didn't just file this lawsuit. You also went on a
14 PR campaign --

15 MR. MARCUS: Object to form.

16 Q. -- about the lawsuit, correct?

17 MR. MARCUS: Same objection.

18 A. I wouldn't agree we went on a PR campaign.

19 BY MS. BLAIR:

20 Q. You would not?

21 A. No.

22 Q. Do you know how many stories the Palm Beach
23 Health Network pitched to local media regarding the
24 lawsuit?

25 MR. MARCUS: Object to form.

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1 A. They pitched stories to tell our side of the
2 story, but I don't think that's a PR campaign. I think
3 it's a defensive strategy to be able to protect the
4 market and give consumers accurate information when
5 they need to have healthcare which is very important
6 and critical for them.

7 BY MS. BLAIR:

8 Q. Do you think that filing the lawsuit and
9 planting these stories in the local news emphasized the
10 F grade at Delray in any way?

11 MR. MARCUS: Object to form.

12 A. I do not.

13 BY MS. BLAIR:

14 Q. Have you had any difficulty retaining
15 doctors as a result of your Leapfrog hospital safety
16 grade?

17 A. Not that I'm aware of.

18 Q. And we talked about nurses. You're not
19 experiencing any nurse retention issues, correct?

20 A. Not at this time except in those key niche
21 departments I talked about earlier.

22 Q. Are there any documents that you produced in
23 this litigation that directly link a decline in
24 admissions to the Leapfrog hospital safety grade?

25 MR. MARCUS: Object to form.

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1 A. Not that I'm aware of.

2 BY MS. BLAIR:

3 Q. Are there any documents that you're aware of
4 that directly link any decline in revenue to the
5 Leapfrog hospital safety grade?

6 MR. MARCUS: Object to form.

7 A. Not that I'm aware of.

8 BY MS. BLAIR:

9 Q. How does Delray measure its goodwill?

10 A. We look at all of the services that we have
11 provided to the community. We look at the charity care
12 that's been provided and how we've given back to the
13 community. There's a report that is put together. Our
14 chief strategy officer works on it. And how we've
15 served on boards, how we've served our community to
16 give back.

17 Q. Do you quantify in any way, like quantify
18 monetarily in any way what the goodwill of Delray is?

19 A. That's in that report.

20 Q. Oh, it is in that report?

21 A. Yes.

22 Q. Do you know the name of that report?

23 A. I don't. It's one that -- I don't know the
24 name of that one.

25 Q. And you said it's done by the group 2

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1 strategy officer?

2 A. Group chief strategy officer kind of
3 oversees everything with it.

4 Q. Okay. And that would be Derek?

5 A. Yeah, Derek. It gives you the local impact
6 and how we've served the community and the impact we've
7 had.

8 Q. And you believe that report puts a specific
9 dollar amount on the goodwill of Delray?

10 A. It might not give specifically goodwill, but
11 it gives just the total impact that Palm Beach Health
12 Network has had.

13 Q. Do you understand like when you value a
14 company, let's just say like to sell it, one of the
15 things that goes into that is not only like revenues
16 but also a value for goodwill? Do you understand
17 that's how companies value?

18 A. Yes.

19 Q. Do you know what that monetary value for
20 goodwill of Delray was prior to the fall of 2024?

21 MR. MARCUS: Object to form.

22 A. I do not.

23 BY MS. BLAIR:

24 Q. And do you know what that value associated
25 with Delray's goodwill is today?

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1 MR. MARCUS: Object to form.

2 A. I do not.

3 BY MS. BLAIR:

4 Q. But do you know whether it would be in this
5 report that the group chief strategy officer puts out?

6 MR. MARCUS: Same objection.

7 A. It may have the information that you're
8 asking for.

9 BY MS. BLAIR:

10 Q. Do you know as we sit here today whether
11 that number, that monetary valuation of goodwill for
12 Delray has decreased as a result of the Leapfrog
13 hospital safety grade?

14 MR. MARCUS: Object to form.

15 A. I'm not sure. I'd have to look at the
16 reports.

17 MS. BLAIR: Can we just take five minutes?

18 MR. MARCUS: Sure.

19 MS. BLAIR: Thank you.

20 THE VIDEOGRAPHER: The time is 3:39 p.m.

21 We're going off the record.

22 (A recess was taken from 3:39 p.m. to 3:46 p.m.)

23 THE VIDEOGRAPHER: The time is 3:48 p.m. We
24 are back on the record.

25 MS. BLAIR: Ms. Havericak, I am going to

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1 mark one more Exhibit today. This is 20. I

2 want to round it out with an even number.

3 (Defendant's Exhibit Number 20 for i.d.)

4 BY MS. BLAIR:

5 Q. I'm handing you now what we've marked
6 Exhibit 20, and it is entitled Plaintiff Delray Medical
7 Center Inc.'s Amended and Supplemented Responses and
8 Objections to Defendant Leapfrog Group's First Set of
9 Interrogatories to Delray Medical Center.

10 And if we turn to the very last page -- it
11 should be like grayed out -- is that your signature?

12 A. That is my signature.

13 Q. And you signed these interrogatories,
14 correct?

15 A. I did.

16 Q. And my one question is with respect to
17 interrogatory number 20 which says, "State and describe
18 the results of any market analyses, competitive
19 analysis or consumer perception surveys you have
20 conducted or commissioned regarding your competitors
21 from 2020 to present."

22 Do you see that?

23 A. Yes.

24 Q. And if we turn to the next page, the first
25 full paragraph starts "As agreed, during the parties'

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1 meet and confer on September 3rd, 2025, plaintiff will
2 produce documents showing the results of studies or
3 surveys plaintiff has conducted or commissioned related
4 to internal market analysis, competitive analysis or
5 consumer perception."

6 Do you see that?

7 A. Yes.

8 Q. And then it goes on to say, "Plaintiff will
9 identify the documents responsive to this interrogatory
10 by Bates number in plaintiff's production cover
11 letter."

12 Do you see that?

13 A. Yes.

14 Q. My question is, do you know whether or not
15 you were able to find and/or have produced studies or
16 surveys that Delray has conducted or commissioned
17 related to internal market analysis, competitive
18 analysis or consumer perception?

19 A. I'm not sure if we've been able to produce
20 that yet.

21 MS. BLAIR: Okay. Thank you.

22 And that is all the questions I have for you
23 today.

24 THE WITNESS: Oh, okay.

25 MS. BLAIR: Thank you.

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1 THE WITNESS: Thank you.

2 MS. BLAIR: I will not order the video. I
3 will order the rough plus regular delivery of an
4 eTran with the Exhibits attached. And I'm not
5 sure if you'll read or --

6 MR. MARCUS: We're going to -- the witness
7 will read. We're also going to designate the
8 transcript as confidential.

9 MS. BLAIR: And I will reserve all rights to
10 assert any objections over portions of this
11 transcript which do not fall within the
12 confidentiality order.

13 MR. MARCUS: And we'll also take a copy.

14 THE VIDEOGRAPHER: The time is 3:51 p.m.
15 This concludes the deposition of
16 Heather Havericak.

17 THE STENOGRAPHER: Do you need regular
18 delivery if I give you a rough tonight, or do
19 you need expedited?

20 MR. SIMMONS: Expedited.

21 THE STENOGRAPHER: When do you need it? You
22 tell me when, and that's when you'll get it.

23 MR. SIMMONS: If you're able to get the
24 final by the end of day Monday, that would be
25 helpful.

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1 THE STENOGRAPHER: Okay. Will do.
2 (Thereupon, the proceedings concluded at
3 3:51 p.m.)
4 (The witness did not waive signature.)
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1 CERTIFICATE OF OATH

2

3 THE STATE OF FLORIDA)

4 COUNTY OF PALM BEACH COUNTY)

5

6 I, the undersigned authority, certify that
7 remotely appeared before me and was duly sworn on the
8 19th day of September 2025.

9 Signed this 21st day of September 2025.

10

11

12

13

14

15

16

17

18

19

20 BARBIE GALLO, RMR-CRR
Notary Public - State of Florida
My Commission No. GG939757
21 My Commission Expires: December 18, 2027

22

23

24

25

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1 CERTIFICATE OF REPORTER

2

3 THE STATE OF FLORIDA)

4 COUNTY OF PALM BEACH)

5

6 I, Barbie Gallo, RMR-CRR, Registered Merit
7 Reporter-Certified Realtime Reporter, certify that I
8 was authorized to and did stenographically report the
9 deposition of HEATHER HAVERICAK, pages 1 through 272;
10 that a review of the transcript was requested; and that
11 the transcript is a true and complete record of my
12 stenographic notes.

13 I further certify that I am not a relative,
14 employee, attorney, or counsel of any of the parties,
15 nor am I a relative or employee of any of the parties'
16 attorney or counsel connected with the action, nor am I
17 financially interested in the action.

18

19 DATED this 21st day of September 2025.

20

21

22

23

24

25

Barbie Gallo, RMR-CRR

Heather Havericak
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1 September 21, 2025

2 Heather Havericak c/o Jeffrey Marcus
3 Marcus, Neiman, Rashbaum & Pineiro, LLP
4 125218 2 South Biscayne Boulevard
5 Suite 2530
6 Miami, Florida 33131
7 (305) 400-4268
8 jmarcus@mnrlawfirm.com

9 IN RE: GOOD SAMARITAN vs. THE LEAPFROG GROUP
10 CASE NO.: 9:25-CV-80526-DMM

11 Please take notice that on the 19th day of September
12 2025, you gave your deposition in the above cause. At
13 that time you did not waive your signature.

14 The above-addressed attorney has ordered a copy of this
15 transcript and will make arrangements with you to read
16 their copy. Please execute the Errata Sheet, which can
17 be found at the back of the transcript, and have it
18 returned to us for distribution to all parties.

19 If you do not read and sign the deposition within 30
20 days, the original, which has already been forwarded to
21 the ordering attorney, may be filed with the Clerk of
22 the Court.

23 If you wish to waive your signature now, please sign
24 your name in the blank at the bottom of this letter and
25 return it to the address listed below.

Very truly yours,

21 Barbie Gallo, RMR-CRR
22 Lexitas Legal
23 fl.production@lexitaslegal.com

24 I do hereby waive my signature.

25 HEATHER HAVERICAK
Job No.: 421986

Heather Havericak
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1 ERRATA SHEET
2 DO NOT WRITE ON TRANSCRIPT - ENTER CHANGES HERE
3 IN RE: GOOD SAMARITAN vs THE LEAPFROG GROUP
4 CASE NO.: 9:25-CV-80526-DMM
5 WITNESS: HEATHER HAVERICAK
6 TAKEN: 09/19/2025

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23 Under penalties of perjury, I declare that I have
24 read the foregoing document and that the facts stated
25 in it are true.

Date HEATHER HAVERICAK

Heather Havericak
September 19, 2025

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Exhibit 94

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA
WEST PALM BEACH DIVISION

GOOD SAMARITAN MEDICAL
CENTER, INC., et al.,

Plaintiffs,

vs.

THE LEAPFROG GROUP,

Defendant.

Case Number:

9:25-cv-80526-DMM

Video Deposition of
KAREN JUPITER
Friday, September 5, 2025
9:05 a.m.

Veritext 7574617

Reported by: Laurie Donovan, RPR, CRR, CLR

September 5, 2025

9:05 a.m.

Video deposition of KAREN JUPITER, held in person, with the witness and all parties participating in person, pursuant to the Rules of the United States District Court for the Southern District of Florida, West Palm Beach Division, subject to such stipulations as may be recited herein or attached hereto, before Laurie Donovan, a Registered Professional Reporter and notary public of the District of Columbia, who officiated in administering the oath to the witness.

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A P P E A R A N C E S

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Courtney Wood, Esq.

ALSO PRESENT:

Orson Braithwaite, videographer

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P R O C E E D I N G S

9:05 a.m.

THE VIDEOGRAPHER: Good morning. We are going on the record at 9:05 a.m. on September 5, 2025. Please note that the microphones are sensitive and may pick up whispering and private conversations. Please mute your phones at this time. Audio and video recording will continue to take place unless all parties agree to go off the record.

This is media unit one of the video-recorded deposition of Ms. Karen Jupiter, in the matter of Good Samaritan Medical Center, Inc. et al, versus the LeapFrog Group, filed in the United States District Court for the Southern District of Florida, West Palm Beach Division, case number 9:25-CV-80526-DMM.

My name is Orson Braithwaite, representing Veritext Legal Solutions, and I'm the videographer. The court reporter is Laurie Donovan from the firm Veritext Legal Solutions.

Counsel will now state their appearances and affiliations for the record, beginning with the

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1 noticing attorney.

2 MR. CHUNG: Daniel Chung, Gibson Dunn and
3 Crutcher, Washington, D.C., for plaintiffs.

4 MR. DELWICHE: Noah Delwiche, Gibson Dunn
5 and Crutcher, Washington, D.C., for plaintiffs.

6 MS. BLAIR: Kim Blair, Wilson Elser LLP,
7 appearing pro hac vice from Chicago.

8 MS. WOOD: Courtney Wood, Wilson Elser,
9 appearing pro hac vice on behalf of defendant
10 LeapFrog.

11 THE VIDEOGRAPHER: Thank you.

12 Will the court reporter please swear in the
13 witness.

14 * * * * *

15 Whereupon,

16 KAREN JUPITER,
17 having been first duly sworn, testified
18 upon her oath as follows:

19 EXAMINATION BY COUNSEL FOR PLAINTIFFS

20 BY MR. CHUNG:

21 Q Good morning, Ms. Jupiter. Could you please
22 state your full name for the record.

23 A Karen Leah Jupiter.

24 Q Have you gone by any other names?

25 A No.

1 Q And do you understand that the court
2 reporter is taking down everything that's being said
3 during today's deposition?

4 A Yes.

5 Q Okay.

6 Now, just before, before we go on to the
7 substance, I just want to go over some very common
8 deposition ground rules that are important, largely to
9 make sure that our court reporter keeps sane
10 throughout this process.

11 The first is, this is kind of a question and
12 answer process here, so it's important that we not
13 talk over each other, so I ask that you wait for me to
14 finish my question before you start your answer, and
15 of course, I'll do my best to wait for you to finish
16 your answer before I proceed with the, with the
17 following question.

18 Do you understand that ground rule?

19 A Yes.

20 Q Okay. It's also important, because the
21 court reporter is taking everything down, that your
22 responses are audible, so instead of an "uh-huh" or an
23 "huh-uh," yes or no, we ask that you answer in audible
24 words, right, for the court reporter to take down.

25 You also understand you were just put under

1 oath by the court reporter, and you understand that by
2 taking that oath, you're promising to answer my
3 questions honestly and to the best of your
4 recollection.

5 Do you understand that?

6 A Yes.

7 Q Again, that's under penalty of perjury. Do
8 you understand that?

9 A Yes.

10 Q All right. Are you taking any medications
11 or under the influence of any substance or really
12 anything that, that impairs your ability to understand
13 my questions or to answer truthfully and to the best
14 of your recollection today?

15 A No.

16 Q All right.

17 Now, if you under- -- if you do not
18 understand one of my questions, I'll ask you to ask me
19 to clarify questions. It's important that you
20 understand the question before you answer it.

21 And from time to time, I would expect that
22 your attorney -- Ms. Blair, I understand -- will --
23 may lodge objections or voice objections during the
24 proceeding. Unless Ms. Blair instructs you not to
25 answer, despite her objection, you should answer, you

1 should answer the question.

2 Do you understand that?

3 A Yes.

4 Q All right.

5 Now, it's totally up to you if and when you
6 want to take a break. One ground rule in terms of
7 breaks: We have to make sure that, that there's no
8 question pending when you take a break, so that,
9 that's just one thing. We're going to make sure you
10 have an answer to the question before we take any
11 break.

12 Do you understand that?

13 A Yes.

14 Q Okay.

15 So just some -- we'll start with some
16 background, but before we get to the background, I
17 want to ask you: Have you ever had your deposition
18 taken before?

19 A I have not.

20 Q So this is your first time?

21 A Yes.

22 Q Okay. Did you prepare for your deposition
23 today?

24 A Yes.

25 Q And how did you go about preparing for

1 today?

2 A I met with my lawyer. I went over our
3 website, looked at . . .

4 Q Okay, and by your lawyer, is it Ms. Blair?

5 A Correct.

6 Q And Ms. Wood?

7 A Correct.

8 Q Is that right? Okay, and approximately how
9 many times did you meet with them?

10 A Twice.

11 Q Okay. In addition to meeting with your
12 attorneys, did you speak to anyone else about -- in
13 preparation for your deposition today?

14 A No.

15 Q Okay. Did you speak to any of your
16 colleagues at the LeapFrog Group to prepare for your
17 deposition today?

18 A We've talked about the case in general.

19 Q Okay, and who in particular?

20 A I would say Missy Danforth and Leah Binder.

21 Q Okay, and this is in preparation for your
22 deposition today?

23 A We didn't specifically talk about the
24 deposition.

25 Q Okay.

1 A We talked about the case in general.

2 Q Okay, and what did you discuss with them?

3 MS. BLAIR: And I'm going to just object to
4 form, and to the extent your counsel was present
5 at the time, those conversations are protected by
6 the attorney/client privilege, but if you had
7 conversations that did not involve us, you need
8 to answer his question.

9 BY MR. CHUNG:

10 Q Right.

11 A Can you repeat the question. Sorry.

12 Q So putting aside any conversations you had
13 with Ms. Binder and Ms. Danforth that were in the
14 presence of counsel, right, what did you -- can you
15 describe the conversations that you had with
16 Ms. Binder and Ms. Danforth about the case?

17 A I mean Missy said "you'll do great," and I
18 said "thanks." I mean that was the extent of it.

19 Q Okay, and how about with Ms. Binder?

20 A Similar.

21 Q Okay.

22 Did you discuss with either or both of them
23 potential questions or issues that may, that you may
24 be asked in your deposition?

25 A Not without counsel.

1 Q Okay.

2 You testified just a moment ago that in
3 preparation for your deposition, you reviewed the
4 website, right? Which website are you referring to?

5 A Hospitalsafetygrade.org and
6 leapfroggroup.org.

7 Q Okay. So it's two websites --

8 A Correct.

9 Q -- that you reviewed?

10 Did you review any, any other websites in
11 preparation for your deposition?

12 A No.

13 Q Did you review any documents or other
14 materials in preparation for your deposition?

15 A I looked through emails around the safety
16 grade.

17 Q Okay. These are your LeapFrog emails --

18 A Correct.

19 Q -- relating to the safety grade issue?

20 A Correct.

21 Q Okay.

22 Did you -- and was this -- did you review
23 those documents with your counsel or kind of on your
24 own time?

25 A With counsel.

1 Q Okay. Did you do anything else -- so we've
2 gone over the two websites, right, emails relating to
3 the safety grade, and then discussions with counsel to
4 prepare for your deposition.

5 Did you do anything else besides those items
6 to prepare for today's deposition?

7 A Not that I recall.

8 Q Okay. Let's go over your background. Let's
9 start with your education.

10 Where did you go -- can you just go over
11 your educational history.

12 A Sure. I went to the College of William &
13 Mary. Got a bachelor of arts.

14 Q And a degree, am I right, in public policy?

15 A Correct.

16 Q All right. Do you have any professional
17 degrees?

18 A I have a -- well, I have a -- no, no
19 professional degrees. I have a certification --

20 Q And is that --

21 A -- for --

22 Q And is that the Certified Fundraising
23 Executive?

24 A Correct.

25 Q And you got that in 2015?

1 A Sounds right.

2 Q Okay.

3 A I don't know exactly, but yes.

4 Q Yeah, we know the answers to some of these
5 questions.

6 So that certification, the Certified
7 Fundraising Executive, what did you do to earn that
8 certificate? Let's start with that.

9 A You take a class, review ethics issues
10 around fundraising and rules around fundraising, and
11 then you take an exam.

12 Q And then that -- what does that certificate
13 allow you to do? What, what are the benefits or what
14 comes out of that certificate?

15 A It shows that you know what you're doing in
16 terms of fundraising and ethics around fundraising.

17 Q Okay, and let's start with generally
18 speaking. You mentioned that part of the education
19 before you get the certificate has to do with the
20 ethics of fundraising.

21 In general, what is that, generally
22 speaking?

23 A So you're being very clear with donors, when
24 you're soliciting donations, what those donations are
25 going to. I mean that's a big part of it is making

1 sure that you are following donor wishes and being
2 very accurate in what you're saying to donors and
3 advertising to donors.

4 Q Okay. So to put it another way, the ethics
5 that you described in obtaining the certificate has to
6 do with transparency to donors, that the money that
7 they're donating is going to a particular aim or
8 cause?

9 A Correct.

10 Q And that it's not -- that cause is not
11 against our wishes, or --

12 A Correct.

13 Q Okay.

14 Any other education? We went over the
15 bachelor of arts from William & Mary and then the
16 certificate in fundraising executive. Any other
17 education, certificates and the like that go toward
18 kind of what you do for a living?

19 A No.

20 Q All right.

21 Within the, kind of the fundraising area, do
22 you have a specialty in any particular area, or is it
23 more generalized?

24 A More generalized.

25 Q Okay.

1 Let's go into your employment history. Can
2 you just walk me through your employment history,
3 let's say after you got your degree from William and
4 Mary.

5 A Sure. I've always worked in fundraising for
6 nonprofits since college. My first job was with the
7 Massachusetts Horticultural Society as a development
8 assistant. I did that for about a year.

9 Then I worked at the Boston Symphony
10 Orchestra, doing their annual giving, for about two
11 years.

12 Then I worked at the Museum of Science in
13 Boston doing their fundraising.

14 And then I worked for Good Shepherd Housing
15 and Family Services, which is an affordable housing
16 nonprofit, as their director of development for 13
17 years.

18 And then I worked at the Conquer Cancer
19 Foundation for about six years, and then I was at
20 LeapFrog.

21 Q Okay. So LeapFrog, as I understand it, you
22 started there in, in or about 2021 --

23 A Correct.

24 Q -- is that right? Okay, and what -- when
25 you joined in 2021, what was your title with the

1 organization?

2 A Vice president of development.

3 Q All right, and is that your title now?

4 A Yes.

5 Q Okay.

6 So how did you get the job at LeapFrog? How
7 did that come about?

8 A Through a recruiter. I can't remember if
9 they reached out to me or I reached out to them, but I
10 saw an ad for the position and then applied.

11 Q Okay, and just to be clear, are you based --
12 where are you based geographically?

13 A In D.C.

14 Q In D.C.

15 A I mean Alexandria. I live in Alexandria.

16 Q Alexandria. Okay. I just saw a lot of
17 Boston --

18 A Yeah, I used to live in Boston. I moved
19 back here.

20 Q Okay, and then so it started out through, it
21 sounds like, an employment recruiter, right?

22 A Correct.

23 Q Can you just describe the process by which
24 you eventually got the job.

25 A Sure. I interviewed with the recruiter a

1 couple times to make sure that it was a good fit for
2 me, and then I interviewed with Leah Binder, who is
3 the CEO, and I interviewed with Christie Travis, who
4 was one of the board members, and then I interviewed
5 also with Missy Danforth and Erica -- I can't remember
6 her last name. She's not at LeapFrog anymore.

7 Q Okay.

8 Was there -- were you, were you taking over
9 for someone in the, in the vice president of
10 development position, or was this a new role?

11 A There was no one in that role.

12 Q Okay, and what was your understanding as to
13 why this new role was coming about that you were
14 applying for?

15 A LeapFrog just wanted to increase the
16 resources that they had and also, you know, make more
17 connections like in the healthcare industry, et
18 cetera.

19 Q Okay, and have you -- had you had experience
20 in the healthcare industry?

21 A Yes. I was at a cancer charity previously.

22 Q This was Conquer Cancer; is that right?

23 A Correct.

24 Q Okay.

25 When you, when you started out at the job,

1 what did you understand your roles and
2 responsibilities to be?

3 A I mean overseeing fundraising and developing
4 a fundraising plan for the organization.

5 Q All right, and when we talk about
6 fundraising, what does that encompass?

7 A Donations, so donations from individuals,
8 from corporate entities, foundations, events.

9 Q Okay, and I'm just reading this from the,
10 the LeapFrog website underneath, and am I correct, as
11 vice president of development, you are a member of
12 what's called the executive staff?

13 A Correct.

14 Q All right, and what does -- what is the
15 executive staff?

16 A Those are the CEO and the vice presidents.

17 Q All right, and who are the vice presidents?

18 A Me, Missy Danforth, Ralph Johnson, and we
19 actually just had a -- we have a new vice president of
20 finance who just started.

21 Q Okay. I do see -- I think for the most
22 part, you have vice presidents under the executive
23 staff, but I do see that there are a handful of
24 directors --

25 A Right. They're not -- they're --

1 Q I'm going to ask you to wait for me to
2 finish my question. That there are a number of
3 directors at least listed under the executive staff on
4 the website.

5 Are they members of the executive staff?

6 A We would consider them members of the
7 management team.

8 Q Okay. So there's some I guess overlap
9 between management and executive staff; is that right?

10 A Right.

11 Q All right.

12 When you started out as vice president of
13 development in 2021, who did you report to?

14 A Leah Binder.

15 Q Anyone else that you reported to?

16 A No.

17 Q Okay, and who reported to you?

18 A When I started, no one reported to me.

19 Q All right, and can you tell us kind of how
20 that changed over time to the present.

21 A Sure. Um, I, I'm trying to remember exactly
22 how it all happened. I took over the management of
23 Jill Berger, who was -- who is our director of
24 employer and payor relations.

25 And then I took -- we had someone leave, and

1 so I sort of took over -- the communications teams
2 answered to me. That was supposed to be temporary,
3 but I still, I still oversee them.

4 And then our corporate partnership group and
5 efforts were growing, so we hired people to do
6 corporate partnerships, and so I got two staff that
7 way.

8 Q Okay.

9 So when you started out, your
10 responsibilities had to do -- focused on, on donors
11 and giving, but am I right that over time, the role
12 has expanded to encompass communications, for one, and
13 then kind of other areas having to do with kind of the
14 financial well-being of the organization; is that
15 right?

16 A I wouldn't say the financial well-being of
17 the organization. That's more broad.

18 Q How would you describe it then?

19 A In terms of donations to the organization.
20 I mean there's other financial things I have nothing
21 to do with.

22 Q Okay. How is it that communications kind of
23 came under your ambit?

24 A Because the person who was overseeing
25 communications left, and so I took it over.

1 Q And so you're still overseeing that?

2 A Correct.

3 Q But I understand that there is a director of
4 communications --

5 A Right.

6 Q -- is that right?

7 A Correct.

8 Q And that's Lauren Bailey?

9 A Correct.

10 Q So she reports to you; is that right?

11 A Correct.

12 Q All right, and so as we sit here today,
13 you've got Lauren Bailey, Ms. Bailey reporting to you
14 as director of communications.

15 Who else is reporting to you?

16 A Nicholas Cantacuzene, who is our membership
17 coordinator, Andrea Clay, who is our director of
18 corporate giving, and Jill Berger, who is our director
19 of employer and payor relations.

20 Q Okay.

21 So just reading from what looks like your
22 profile from the website, it says that you "lead the
23 organization's fundraising strategy, donor relations,
24 special events and overall communications."

25 The "special events," what is that referring

1 to?

2 A We have an annual meeting every year, so
3 overseeing that.

4 Q Anything else?

5 A No.

6 Q Okay.

7 Overall communications -- you've already
8 testified that you oversee communications, but what
9 does "overall communications" mean?

10 A So Lauren Bailey really is our expert in
11 communications, and she reports up to me, so I work
12 with her on overall strategy, but she's really the
13 day-to-day person.

14 Q Okay. Does, does communications encompass
15 interactions with the press?

16 A Yes.

17 Q Okay. So though I understand that
18 Ms. Bailey is the director of communications and
19 reports to you, do you have involvement and
20 interactions with the press?

21 A I don't interact with the press.

22 Q Okay. Does overall communications include
23 the websites that you just referenced earlier?

24 A Yes.

25 Q So you have -- you oversee the content of

1 that website and how it's run?

2 A I don't oversee the content of the site.

3 Q So what is your kind of responsibility or
4 oversight with respect to the, the websites?

5 A If Lauren has sort of questions, she would
6 come to me, or she would ask me to, you know, possibly
7 review pages or review messages.

8 Q What do you mean by "review pages or review
9 messages"?

10 A If she says, you know, "can you look at
11 this, do things make sense here," then I would do
12 that.

13 Q Are we talking about the content of the
14 websites themselves?

15 A What do you mean by "content"?

16 Q I'm just trying to get at --

17 A Right.

18 Q -- what reviews --

19 A I mean like can you tell clearly on this
20 home page that there is information there about our
21 diabetes program, that sort of thing. Does it make
22 sense that the diabetes program is at the top of the
23 page or is at the bottom of the page.

24 Q Okay. So kind of format and placement of
25 substance on the, on the webpage?

1 A Right, but not, not every webpage, every
2 site.

3 Q Okay. Are there particular parts of the
4 web, of the webpages that, that you oversee? You
5 testified not every page or site or every single
6 little thing on the webpage, but are there particular
7 aspects of the web pages that you, that you oversee in
8 particular?

9 A No.

10 Q Okay. The profile goes on that, that
11 you're -- in your role, you're responsible for
12 "shaping and executing LeapFrog's development
13 efforts," which you testified to and we'll get into,
14 "while also overseeing the organization's external
15 messaging, branding, media relations and digital
16 communications."

17 What does, what does "organization's
18 external messaging" mean?

19 A Messages to external stakeholders.

20 Q Okay. Is that -- and who are the external
21 stakeholders?

22 A The general public, hospitals, donors, ASCs.

23 Q Okay, and what types of messaging are
24 involved here?

25 A That, you know, our main message at LeapFrog

1 is clear and transparent, and transparency saves
2 lives. In everything we do, we try and make sure it
3 says that.

4 Q Okay.

5 THE REPORTER: We try and make sure to what?
6 Make that?

7 THE WITNESS: Everything we do, we make sure
8 that we are transparent about, and that our goal
9 is to save lives, and that's why we exist.

10 BY MR. CHUNG:

11 Q Okay. Branding? What does the branding
12 encompass here?

13 A Making sure our logo is being used
14 appropriately.

15 Q So this is almost like an intellectual
16 property issue?

17 A Right.

18 Q Media relations. So you testified earlier
19 that you yourself don't interact with the, the press,
20 at least, but what -- can you, can you go over kind of
21 your responsibility with respect to media relations?

22 A I oversee Lauren, who does our media
23 relations.

24 Q Okay, and digital communications; what does
25 that encompass?

1 A Emails that we send out. Newsletters.

2 Q Okay.

3 So in terms of -- does, does the LeapFrog
4 executive staff -- do you have regular -- regularly
5 scheduled meetings?

6 A Yes. We -- the executive staff meets
7 biweekly. I think it's biweekly, depending on travel
8 and schedules, but approximately.

9 Q Okay, and just to be clear, the executive
10 staff that you're referring to that participates in
11 these biweekly meetings are the vice presidents; is
12 that correct?

13 A Correct.

14 Q Those meetings do not include the directors?

15 A We have a management meeting monthly, and
16 that includes directors.

17 Q Okay, but the biweekly executive staff
18 meeting is just vice presidents and Ms. Binder,
19 presumably?

20 A Correct.

21 Q Okay. What is the purpose of those biweekly
22 meetings?

23 A To communicate with each other and
24 understand what each other is working on.

25 Q Okay. Is there an agenda kind of preset for

1 each of those biweekly meetings?

2 A If we have agenda items, we say "I want to
3 make sure we talk about X."

4 Q Okay, and is there anyone or any folks on
5 the executive staff or maybe outside the executive
6 staff that put together those agendas?

7 A Right now it's Daran, our new CFO, but he's
8 only been there a few weeks.

9 Q Okay, and then previously who was in charge
10 of putting together the agendas for those executive
11 staff meetings?

12 A I mean we had a CFO a year ago, and he put
13 them together based on -- he would send them an email
14 saying "does anyone have any agenda items."

15 Q Okay. All right. So we'll come back to
16 that later.

17 You mentioned that as part your deposition
18 preparation, you looked at emails or materials related
19 to hospital safety grade, which I'm sure you
20 understand is one of the issues in, in the matter --
21 in this matter.

22 What is the hospital safety grade?

23 A We give hospitals a grade based on their
24 safety -- patient safety efforts.

25 Q Okay, and that is from -- it's basically

1 kind of like a school report card grading system,
2 right, A to F; is that right?

3 A Correct.

4 Q All right, and is it focused -- is it a --
5 are those ratings, are those grades focused
6 exclusively on patient safety, or are there other
7 issues that that grade is supposed to rate?

8 A So --

9 MS. BLAIR: Objection to form. Go ahead.

10 THE WITNESS: Solely patient safety.

11 BY MR. CHUNG:

12 Q All right, and how is patient safety defined
13 in this context?

14 MS. BLAIR: Objection to form.

15 THE WITNESS: I don't know how to answer
16 that.

17 BY MR. CHUNG:

18 Q Okay. What, what does patient safety
19 encompass within this grading system?

20 A If a hospital is safe for a patient.

21 Q Okay. Do you know who came up with the
22 idea, what the genesis for the hospital safety grade
23 was?

24 A I think it was Leah Binder. That was before
25 my time, well before my time.

1 Q Okay.

2 So why does -- do you have an understanding
3 as to why LeapFrog assigns a single letter grade to a
4 hospital rather than using another form of rating,
5 like a numerical rating or a percentage rating?

6 A We wanted to make it as clear and
7 transparent as possible for the public.

8 Q And how does using a letter grade system, A
9 through F, achieve that?

10 A People understand, like you had said, report
11 cards and what that means.

12 Q Okay.

13 Do you know how the cutoff for each grade is
14 decided, meaning the cutoff between one grade to the
15 next, like A to B, B to C?

16 A I don't.

17 Q Okay. Who would know how that cutoff for
18 each grade is decided?

19 A Missy Danforth.

20 Q Does LeapFrog intend for consumers to rely
21 on the hospital safety grades when making a decision
22 about which hospital to go to?

23 MS. BLAIR: Objection to form.

24 THE WITNESS: We explain that the safety
25 grade is one piece of information that they can

1 use when deciding where to go for their care.

2 BY MR. CHUNG:

3 Q Okay, and how is that, that particular
4 explanation, that the hospital safety grade is one
5 piece of information in their decision-making, where,
6 where is that made clear to, to consumers?

7 A I have seen that on the website. When we
8 give media interviews, we say this is one piece of
9 information to use when choosing where to go for your
10 care.

11 Q Okay.

12 How is it determined which hospitals are
13 assigned a hospital safety grade?

14 MS. BLAIR: Objection to form.

15 THE WITNESS: This is not my expertise. I'm
16 not on the ratings team, so I don't really deal
17 with this -- that part of it.

18 BY MR. CHUNG:

19 Q Understood. Even if it's not within your
20 area --

21 A Okay.

22 Q -- of expertise, it's based on kind of what
23 you know, right?

24 So based on what you know, how is it
25 determined which hospitals are assigned hospital

1 safety grade?

2 A I believe all hospitals are assigned safety
3 grade except pediatric hospitals and I think a couple
4 other types of hospitals, but again, that's not my
5 expertise.

6 Q Okay. Are there a particular -- let's look
7 at it another way. Are there a particular type or set
8 of hospitals that receive a hospital safety grade?

9 A We say acute care hospitals.

10 Q Okay. Does -- so within -- let's take
11 within the, kind of that universe of acute care
12 hospitals. Are all acute care hospitals given a
13 hospital safety grade?

14 MS. BLAIR: Objection to form.

15 THE WITNESS: To my knowledge.

16 BY MR. CHUNG:

17 Q Okay. So whether -- we'll get into this,
18 but there is a hospital survey, right, that LeapFrog
19 issues to hospitals. Are all hospitals, whether --
20 acute care hospitals, whether they respond to the
21 survey or not, are all those hospitals given a
22 hospital safety grade?

23 A Yes.

24 Q Does LeapFrog have a certain requirement for
25 the minimum amount of data that it needs to issue a

1 hospital safety grade?

2 A That's not my expertise.

3 Q Do you have any sense?

4 A Can you clarify?

5 Q Sure. Are there -- in order to issue,
6 right, a safety grade to a particular hospital, is
7 there a minimum amount or a minimum type of data that
8 LeapFrog needs in order to issue a health [sic] safety
9 grade to that hospital?

10 A I don't know.

11 Q Okay. Do you know who does know that?

12 A Missy Danforth.

13 Q All right. Do you know who sets minimum
14 data requirements?

15 A No.

16 Q All right. Do you -- if LeapFrog does not
17 have enough data for a particular hospital, do you
18 have a view on whether it should be graded or not?

19 A No.

20 Q Okay. How often does LeapFrog release
21 hospital safety grades?

22 A Twice a year.

23 Q And why is that? Why is it twice a year?

24 A To make sure that the information we provide
25 is as up-to-date and accurate as possible.

1 Q Has it always been like that, at least
2 during your tenure since 2021?

3 A During my tenure. I can't speak before
4 that.

5 MR. CHUNG: Okay. I want to go next into
6 scoring methodology, and we'll have our first
7 exhibit here behind tab 41.

8 So we'll mark this Exhibit 1.

9 (Exhibit 1 was marked for
10 identification.)

11 BY MR. CHUNG:

12 Q Okay. You have in front of you,
13 Ms. Jupiter, a scoring methodology from, from LeapFrog
14 from the Spring 2025 Safety Grade, and you'll see that
15 there's Bates numbers on the lower right-hand corner.
16 Those are stamps provided by LeapFrog just to kind of
17 numerically identify the documents here.

18 Are you familiar with -- have you seen this
19 document before?

20 A Yes.

21 Q Okay, and are you familiar with LeapFrog's
22 scoring methodology behind the safety grades?

23 A Not intimately.

24 Q Okay, but this is, this is a document, this
25 particular version, that you've seen before, correct?

1 A I think so.

2 Q Okay.

3 Do you have any part in -- do you have any
4 input into LeapFrog's scoring methodology?

5 A No.

6 Q All right. Do you have any kind of role,
7 any part in implementing that scoring methodology?

8 A No.

9 Q All right. Do you have any role in applying
10 it to specific hospitals?

11 A No.

12 Q Okay. Who is -- who has that role in terms
13 of design? Let's start with first the design of the,
14 of the scoring methodology.

15 MS. BLAIR: Objection to form.

16 THE WITNESS: I think it's our expert
17 panelists.

18 BY MR. CHUNG:

19 Q Okay, and who are those expert panelists?

20 A I don't know.

21 Q All right, and those are, those are not
22 members of the executive staff; is that right?

23 A Right.

24 Q Are they employees of, of LeapFrog?

25 A No.

1 Q All right. So these are kind of outside
2 experts that, that, that designed the scoring
3 methodology; is that right?

4 A Correct.

5 Q Is there anyone on the -- are there any
6 LeapFrog employees that are involved in designing the
7 scoring methodology?

8 A I know that Missy Danforth works with the
9 expert panelists.

10 Q Okay. Does Missy Danforth have folks
11 that -- have LeapFrog employees that report up to her?

12 A Yes.

13 Q Okay, and how many?

14 A Eight, maybe. I don't know exactly.

15 Q Okay, and are those individuals involved in
16 the design of, of the scoring methodology?

17 A I don't know.

18 Q Okay.

19 How about the, the implementation of the
20 scoring methodology? Who, who is, who is involved in
21 that process?

22 A I believe that's our ratings team.

23 Q Okay, and who is in charge of the ratings
24 team?

25 A Missy Danforth.

1 Q Okay. Is the, is the expert -- are the
2 expert panelists involved in the implementation of the
3 scoring methodology?

4 A I don't know.

5 Q Okay.

6 How about the application of the scoring
7 methodology to specific hospitals; who is in charge of
8 that?

9 A Repeat the question.

10 Q Sure. The -- who is in charge of applying
11 the scoring methodology to specific hospitals?

12 A I think that's our ratings team.

13 Q Okay, and that's also Ms. Danforth's team?

14 A Correct.

15 Q Okay.

16 So are you familiar, generally speaking,
17 with the types of measures that LeapFrog uses in its
18 scoring methodology?

19 A Generally.

20 Q Okay. Tell us, tell us what you know.

21 A We get information from CMS, and that is
22 part of our grading of hospitals, and then we have
23 different measures around hand hygiene, nurse
24 staffing. That's what I can recall.

25 Q Okay. So if I understand correctly, your

1 testimony is that certain -- that the measures are
2 based on, on CMS data; is that right?

3 MS. BLAIR: Objection to form.

4 THE WITNESS: Some of the information is
5 based on CMS data.

6 BY MR. CHUNG:

7 Q Okay. Do you know which measures are based
8 on CMS data?

9 A I don't know them all.

10 Q Yeah, just based on your memory, what do you
11 understand?

12 A HCAHPS, so patient experience reports.

13 THE REPORTER: You said "HCAHPS"?

14 THE WITNESS: HCAHPS.

15 Infection data I think is part of it.

16 That's all I can remember.

17 BY MR. CHUNG:

18 Q Okay, so -- but it's just some of the
19 measures are based on CMS data, correct?

20 A Correct.

21 Q And there are other measures that go into
22 the health [sic] safety grade that are not based on
23 CMS data; is that right?

24 A That's not the -- that's not called a health
25 safety grade.

1 Q I'm sorry.

2 A You said "health safety grade." We don't
3 have a health safety grade.

4 Q I'm sorry. Hospital safety grade?

5 A Correct.

6 Q Okay, and what are those measures that are
7 not based on CMS data?

8 A The one I can think of is the hand hygiene
9 measure.

10 Q Okay, and what, what kind of data is the
11 hand hygiene measure based on?

12 A Can you clarify?

13 Q Sure. So you testified that the hand
14 hygiene measure is not based on CMS data, so what type
15 of data is the hand hygiene measure based on?

16 A How clean people's hands are.

17 Q Okay. Is that -- is there certain data that
18 measures that that LeapFrog relies on, on scoring the
19 hand hygiene measure?

20 MS. BLAIR: Objection to form.

21 THE WITNESS: I assume so.

22 BY MR. CHUNG:

23 Q Okay.

24 Are you familiar with -- are you aware that,
25 among the measures, right, that go into the scoring

1 methodology, that there are what are called "process
2 measures" and "structural measures"? Are you familiar
3 with that terminology?

4 A Yes.

5 Q Okay, and what's the -- what is the
6 distinction between the two?

7 MS. BLAIR: Objection to form.

8 THE WITNESS: So a process measure is are
9 things in place to make sure -- I'm trying to
10 think of the best way to describe it. Are there
11 processes in place, are there processes in place,
12 and then the other measures I recall are outcome
13 measures, so it's how -- what is the result of
14 something that's happened.

15 BY MR. CHUNG:

16 Q Okay, and who at LeapFrog decides which of
17 these measures to include in assessing a particular
18 hospital?

19 A I believe that's our expert panel.

20 Q Okay. So I want to go through at least some
21 of the measures that are involved in the scoring
22 methodology.

23 Are you familiar with the "Computerized
24 Physician Order Entry" measure or the "CPOE"?

25 A I've heard of it.

1 Q Okay. What is it, based on your
2 understanding?

3 A It measures how well the computerized order
4 entry system is at a hospital.

5 Q Okay, and how does a hospital score well on
6 this CPOE measure?

7 MS. BLAIR: Objection to form.

8 THE WITNESS: I don't know.

9 BY MR. CHUNG:

10 Q Okay. How does CPOE reflect the safety of a
11 hospital?

12 A I don't know.

13 Q Okay. Does CMS measure CPOE?

14 A I don't know.

15 Q All right. Do you know, for this particular
16 CPOE measure, what kind of data LeapFrog relies on?

17 A I don't know.

18 Q Okay. The next measure is the "Barcode
19 Medication Administration" measure or the "BCMA."

20 Have you heard of that?

21 A Yes.

22 Q And what is that?

23 A It's when you -- I believe when you are at a
24 hospital and you have a medication, then they scan the
25 barcode on the medication and scan your wristband and

1 make sure that you are getting the correct medication
2 you're supposed to get.

3 Q Okay, and how does a hospital score well on
4 this BCMA measure?

5 MS. BLAIR: Objection to form.

6 THE REPORTER: What was the answer? I'm
7 sorry.

8 THE WITNESS: I don't know.

9 BY MR. CHUNG:

10 Q All right, and how does this measure, the
11 BCMA, reflect the safety of a hospital?

12 A I don't know.

13 Q All right. Does CMS measure BCMA?

14 A I don't know.

15 Q Okay. Do you know -- for this particular
16 measure, do you know what type of data LeapFrog uses
17 or relies on in its scoring methodology?

18 A I don't know.

19 Q Okay.

20 Next, the "ICU Physician Staffing" measure
21 or the "IPS," are you familiar with that measure?

22 A I've heard of it.

23 Q And what, what is it?

24 A I don't know.

25 Q Okay. Do you know -- same questions. How

1 does a hospital score well on this IPS measure?

2 A I don't know.

3 Q All right. Do you know how the IPS measure
4 reflects the safety of a hospital?

5 A I don't know.

6 Q Do you know whether CMS measures IPS?

7 A I don't know.

8 Q Do you know the type of data that LeapFrog
9 relies on in scoring on this IPS measure?

10 A I don't know.

11 Q Okay. The, the next measure is the "Safe
12 Practice 1: Culture of Leadership Structures and
13 Systems" measure.

14 Are you familiar with this measure?

15 A I've heard of it.

16 Q Okay, and what is it?

17 A I've heard of it.

18 Q Okay.

19 A I couldn't tell you more about it.

20 Q You don't have an understanding as to what
21 it means or what it is?

22 A No.

23 Q Okay. Do you know how a hospital scores
24 well on this particular measure?

25 A No.

1 Q Okay. Do you know how this particular
2 measure, the Culture of Leadership Structures and
3 Systems, reflects the safety of a hospital?

4 A I don't.

5 Q Do you know whether CMS measures cultural
6 leadership structures and systems?

7 A I don't.

8 Q The next measure is safe -- what's called
9 "Safe Practice 2," and we're taking this from the
10 scoring --

11 A Sure.

12 Q -- methodology.

13 "Safe practice 2: Culture Measurement,
14 Feedback and Intervention." Are you familiar with
15 this particular measure?

16 A I'm not.

17 Q You haven't heard of it?

18 A I may have heard of it. I don't --

19 Q Okay.

20 A -- know anything about it.

21 Q And same questions. Do you know how a
22 hospital can score well on this particular measure?

23 A I don't.

24 Q All right, and do you know how this measure
25 reflects the safety of a hospital?

1 A I don't.

2 Q Okay. Do you know whether CMS measures this
3 particular measure?

4 A I don't.

5 Q All right. The next is the "Total Nursing
6 Care Hours per Patient Day" measure, which I think you
7 had mentioned a bit earlier.

8 Are you familiar with this particular
9 measure?

10 A I've heard of it.

11 Q Okay, and what is it?

12 A It measures total nursing care hours per
13 patient day.

14 Q Okay.

15 THE REPORTER: Per patent "per day," or did
16 you say "day"?

17 THE WITNESS: I said "day."

18 THE REPORTER: Okay.

19 BY MR. CHUNG:

20 Q How does this total nursing care hours per
21 patient day reflect the safety of a hospital?

22 A I don't know.

23 Q All right. Do you know how a hospital
24 scores well on this particular measure?

25 A I don't.

1 Q All right. Does CMS measure total nursing
2 care hours per patient day?

3 A I don't know.

4 Q Okay. Next, the "Hand Hygiene" measure,
5 which you've talked about already; are you familiar
6 with the Hand Hygiene measure?

7 A Yes.

8 Q Okay, and what is that?

9 A It measures how well hospital staff have
10 hygienic hands.

11 Q Okay, and how does a hospital score well on
12 hand hygiene, according to the scoring methodology?

13 A I don't know.

14 Q All right, and how does hand hygiene, this
15 particular measure, reflect the safety of a hospital?

16 A I mean the cleaner someone's hands are, the
17 safer they are when they touch a patient.

18 Q Okay. Do you know whether CMS measures hand
19 hygiene in any way?

20 A I don't.

21 Q Okay, and what, what data does LeapFrog rely
22 on in scoring hand hygiene for a particular hospital?

23 A I don't know.

24 Q Okay.

25 Next is, according to the scoring

1 methodology, what's called "H-COMP-1: Nurse
2 Communication."

3 Are you familiar with that particular
4 measure?

5 A No.

6 Q Okay. Do you know how the H-COMP-1 Nurse
7 Communication measure reflects the safety of a
8 hospital?

9 A I don't.

10 Q Okay. Do you know whether CMS measures this
11 particular area?

12 A I don't.

13 Q Okay.

14 Next is "H-COMP-2: Doctor Communication."
15 Are you familiar with that measure?

16 A No.

17 Q Okay. Same questions. Do you know how this
18 particular measure reflects the safety of a hospital?

19 A I don't.

20 Q Do you know whether CMS measures doctor
21 communication?

22 A I don't.

23 Q Okay. "H-COMP-3" is the next measure,
24 "Staff Responsiveness," again, according to the
25 scoring methodology.

1 Are you familiar with this measure?

2 A No.

3 Q Okay. Do you know how this measure reflects
4 the safety of a hospital?

5 A I don't.

6 Q All right. Do you know what -- do you know
7 whether CMS -- do you know whether LeapFrog relies on
8 CMS data for this particular measure?

9 A I don't.

10 Q The next is "H-COMP-5" -- there are a few
11 more of these -- "Communications About Medicines."

12 Have you heard of or are familiar with this
13 particular measure?

14 A I've heard of it.

15 Q Okay, and what is it?

16 A How well hospital staff communicates around
17 medications.

18 Q Okay, and how does a hospital score well on
19 this H-COMP-5 Communication About Medicines measure?

20 A I don't know.

21 Q Okay, and how does this measure reflect the
22 safety of a hospital?

23 A I don't know.

24 Q Okay. Do you know whether CMS measures
25 communication about medicines?

1 A I don't.

2 Q Okay. Next is "H-COMP-6: Discharge
3 Information" measure.

4 Have you heard of or are familiar with this
5 measure?

6 A I've heard of it.

7 Q And what is it?

8 A How well a hospital communicates information
9 to a hospital -- or to a patient, upon discharge.

10 Q Okay, and how does a hospital score well
11 based on LeapFrog's scoring methodology on H-COMP-6,
12 Discharge Information?

13 A I don't know.

14 Q Okay, and how does this measure reflect the
15 safety of a hospital?

16 A I don't know.

17 Q Okay. Do you know whether CMS measures
18 discharge information in the same way that, that
19 LeapFrog does?

20 A I don't.

21 Q Okay.

22 Do you know whether -- we've gone through
23 what measures that are currently in the scoring, the
24 scoring methodology, at least according to Exhibit 1.

25 Are you aware of any process or structural

1 measures that LeapFrog used to include in its scoring
2 methodology that it no longer includes?

3 MS. BLAIR: I'm going object to form.

4 Misstates Exhibit 1. You can answer.

5 THE WITNESS: I'm not aware.

6 BY MR. CHUNG:

7 Q Okay. Do you know whether LeapFrog
8 currently is considering any different or additional
9 process or structural measures to include in its
10 scoring methodology?

11 A I don't know.

12 Q Okay. So we went over a number of process
13 and structural measures. We're going to go over now a
14 handful of "outcome measures."

15 Have you heard of that terminology before?

16 A Yes.

17 Q Okay, and I know you went into it a bit
18 earlier, but can you describe for us, based on your
19 understanding, what outcome measures are.

20 A It's a result of something that happens in a
21 hospital.

22 Q Okay. Why does LeapFrog call them "outcome
23 measures"?

24 A I don't know.

25 Q Okay, and do you know who decides which

1 outcome measures to include in the scoring
2 methodology?

3 A I think it's our expert panel.

4 Q Okay. So before we get into each of the
5 outcome measures, how does the expert panel go about
6 deciding which measures, whether they're structural,
7 whether they're process or outcome, which measures to
8 include in scoring methodology? Is there a --

9 MS. BLAIR: Objection.

10 BY MR. CHUNG:

11 Q Is there a, a process by which -- that that
12 expert panel follows in deciding or assessing which
13 measures to include in its scoring methodology?

14 MS. BLAIR: Objection to form.

15 THE WITNESS: I don't know.

16 BY MR. CHUNG:

17 Q Okay. Is it -- is this process ever
18 discussed during the, the biweekly executive staff
19 meetings that you described earlier?

20 A Not that I recall.

21 Q So let's start with the, in terms of these
22 outcome measures, the "Foreign Object Retained"
23 measure.

24 Have you heard of that one?

25 A Yes.

1 Q And what is that?

2 A Where you're in surgery and something is
3 left inside you.

4 Q Okay. How does a hospital score well on the
5 foreign object retained measure?

6 A I don't know.

7 Q Okay, and how does foreign object -- how did
8 this particular measure reflect the safety of a
9 hospital?

10 A I would assume that if something is left
11 inside you during surgery, it's not very safe.

12 Q Okay. Do you know whether CMS measures the
13 foreign object retained, basically the substance of
14 this measure?

15 A I don't know.

16 Q Okay. Do you know whether LeapFrog relies
17 on CMS data for this particular measure?

18 A I don't know.

19 Q Okay. The next is the "Air Embolism"
20 measure. Are you familiar with that?

21 A No.

22 Q Okay. Do you know how the air embolism
23 measure reflects the safety of a hospital?

24 A I don't.

25 Q Okay. Do you know whether CMS has data for

1 air embolism?

2 A I don't.

3 Q Next is the "Falls and Trauma" measure. Are
4 you familiar with that measure?

5 A I've heard of it.

6 Q And what is that?

7 A I think it's how often a patient -- how
8 patients fall.

9 Q Okay, and how does a hospital score well on
10 this falls and trauma measure?

11 A I don't know.

12 Q Do you know how falls and trauma, this
13 particular measure, reflects the safety a hospital?

14 A I don't.

15 Q Okay. Do you know whether LeapFrog relies
16 on CMS data for this particular measure?

17 A I don't.

18 Q Okay. How about the C-L-A-B-S-I measure,
19 the "CLABSI" measure?

20 A What's the question?

21 Q Are you familiar with that particular
22 measure?

23 A Yes.

24 Q And what is that?

25 A I believe it's a type of infection.

1 Q Okay. Do you know anything more specific
2 about it?

3 A I don't.

4 Q All right. Do you know how a hospital
5 scores well on the CLABSI?

6 A I don't.

7 Q Okay. Do you know how this particular
8 measure reflects the safety of a hospital?

9 A I don't.

10 Q All right.

11 Do you know whether LeapFrog uses CMS data
12 or measures for this particular measure?

13 A I don't.

14 Q Okay.

15 Are you familiar with C-A-U-T-I? I'll call
16 it the "CAUTI" measure.

17 A I've heard of CAUTI.

18 Q Okay, and what is that?

19 A Also a type of infection.

20 Q Okay. Do you know what kind of the
21 difference between CAUTI and CLABSI is?

22 A I'm thinking.

23 Q Yep.

24 A I think CAUTI has to do with catheter
25 urinary tract infections.

1 Q Okay. Do you know how a hospital scores
2 well on this CAUTI measure?

3 A I don't.

4 Q And how does CAUTI reflect the safety of a
5 hospital?

6 A I don't know.

7 Q Okay. Do you know whether LeapFrog uses CMS
8 data for this particular measure?

9 A I don't.

10 Q How about the -- the next is the "SSI:Colon"
11 measure. Are you familiar with that particular
12 measure?

13 A No.

14 Q Okay. Do you know how it reflects the
15 safety of a hospital?

16 A No.

17 Q All right. Do you know whether CMS measures
18 this particular area?

19 A I don't.

20 Q Okay. How about the M-R-S-A or the "MSRA"
21 measure; are you familiar with that?

22 A I've heard of it.

23 Q And what is that?

24 A It's another infection.

25 Q Okay. Do you know how a hospital scores

1 well on MRSA?

2 A I don't.

3 Q Do you know how it reflects the safety of a
4 hospital?

5 A I don't.

6 Q All right. Do you know how -- whether
7 LeapFrog relies on or uses CMS data for this
8 particular metric?

9 A I don't.

10 Q Okay. How about -- are you familiar with
11 the "C. diff," C, D-I-F-F, measure?

12 A I've heard of C. diff.

13 Q Okay, and what is that?

14 A Another type of infection.

15 Q Okay. Do you know how a hospital scores
16 well on C. diff?

17 A I don't.

18 Q All right. Do you know how it reflects the
19 safety of a hospital?

20 A I don't.

21 Q Okay. Do you know whether LeapFrog relies
22 on CMS data for this particular measure?

23 A I don't.

24 Q Okay. How about -- are you familiar with
25 the "PSI 4 death rate among surgical inpatients with

1 serious treatable complications" measure?

2 A No.

3 Q You haven't heard of that?

4 A No.

5 Q Okay. Do you know how that particular
6 measure, this PSI 4 measure, reflects the safety of a
7 hospital?

8 A No.

9 Q Do you know whether LeapFrog relies on CMS
10 data for this particular measure?

11 A I don't.

12 Q Okay. How about -- have you heard of the
13 "CMS Medicare PSI 90: Patient Safety and Adverse
14 Events Composite" measure?

15 A I've heard of it.

16 Q Okay, and what is that?

17 A I don't really know.

18 Q Heard of it, but don't know what it is?

19 A I've heard of it, but I don't know.

20 Q Okay. Do you know how it reflects the
21 safety of a hospital?

22 And I can repeat the whole thing, if you'd
23 like.

24 A No.

25 Q Do you know whether LeapFrog relies on CMS

1 data for this particular measure?

2 A I don't know.

3 Q Are there any -- the same question as we had
4 with the process and the structural measures. Are
5 there any outcome measures that you're aware of that
6 LeapFrog used to include in its scoring methodology
7 that it no longer includes?

8 A Not that I'm aware of.

9 Q Okay.

10 Do you know whether LeapFrog is currently
11 considering any, considering any different or
12 additional outcome measures?

13 A Not that I'm aware of.

14 Q So we've gone over a number of measures,
15 some of which you are familiar with and some of which
16 you are not.

17 Are these measures weighted differently
18 before LeapFrog arrives at a safety grade for a
19 particular hospital?

20 MS. BLAIR: Objection to form.

21 THE WITNESS: I don't know.

22 BY MR. CHUNG:

23 Q Okay. Are you familiar with -- are you
24 familiar with kind of the concept of weighting among
25 the measures?

1 A I'm familiar with the concept of weighting.

2 Q Okay. Is this something that's been
3 discussed -- that you've discussed with Ms. Danforth
4 or others?

5 A No.

6 Q Okay. Do you know how LeapFrog weighs the
7 various measures, at least generally?

8 A No.

9 Q Okay. Do you know whether the, the way or
10 the manner in which LeapFrog has weighted the various
11 measures has changed over time?

12 A I don't know.

13 Q Okay. We're going to go next into the
14 hospital survey, LeapFrog's hospital survey.

15 Are you familiar with the hospital survey?

16 A Yes.

17 Q Okay, and, and what is it?

18 A That is the -- how we survey hospitals on
19 their patient safety.

20 Q Okay, and how often does -- how, how often
21 is the survey administered?

22 A I believe it's annually.

23 Q All right, and in this survey, what, what is
24 LeapFrog seeking from hospitals?

25 A Information about their patient safety.

1 Q Okay. Have you had or do you have any role
2 in the design of the hospital survey?

3 A I don't.

4 Q Okay. Have you ever reviewed the hospital
5 survey?

6 A I have not.

7 Q Okay. Well, we'll put it in front of you
8 anyway.

9 A Sure.

10 MR. CHUNG: We'll mark this as Exhibit 2.
11 (Exhibit 2 was marked for
12 identification.)

13 BY MR. CHUNG:

14 Q So Ms. Jupiter, you have in front of you
15 what's been marked as Exhibit 2. It is, as we
16 understand it, a copy of LeapFrog's most recent
17 hospital survey that was taken directly from
18 LeapFrog's website. It's available on LeapFrog's
19 website.

20 Have you at least seen this particular
21 version of the survey?

22 A No.

23 Q Okay. Have you at any point during your
24 time at LeapFrog reviewed or leafed through any
25 version of the hospital survey?

1 A I've looked at certain pieces of the survey,
2 but I'm not well-versed in the survey.

3 Q Okay. What certain pieces have you looked
4 at?

5 A The hand hygiene piece. Pieces of the hand
6 hygiene piece.

7 Q Okay, and why the hand hygiene pieces in
8 particular?

9 A I oversee our partners advisory committee,
10 and that includes solution providers around hand
11 hygiene.

12 Q Okay. What do you mean by "solution
13 providers"?

14 A They are vendors who work with hospitals
15 around hand hygiene.

16 Q Okay. So who is -- who at LeapFrog is
17 responsible for the design or the content of the
18 hospital survey?

19 A I think that's our expert panel.

20 Q Okay. Is this the same expert panel, as you
21 understand, that, that's involved in the design of the
22 scoring methodology?

23 A Yes.

24 Q All right, and currently who is on that
25 expert panel?

1 A I don't know.

2 Q Do you know any members of the expert panel
3 currently?

4 A I think Matt Austin.

5 Q Okay. Anyone else?

6 A I don't know.

7 Q Generally speaking, how many members are
8 there on this expert panel?

9 A I don't know.

10 Q Okay. Do you have any interaction? Do you
11 ever communicate with members of the expert panel,
12 whether it's Matt Austin or others?

13 A I sometimes communicate with Matt Austin.

14 Q Okay, and what are -- why do you communicate
15 with Matt Austin?

16 A If we've had him speak before at our
17 partners advisory committee meeting.

18 Q Okay, and so what do you discuss with him?

19 A For example, he would talk about a new hand
20 hygiene measure or a hand hygiene measure and explain
21 it more.

22 Q Okay. Is there -- so you mentioned the
23 expert panel is involved in the design of the hospital
24 survey. Is there anyone at LeapFrog, any LeapFrog
25 employees that are involved in the design of the

1 hospital survey?

2 A Missy Danforth.

3 Q Okay, and what is her -- what's her role
4 with respect to the hospital survey?

5 A She is the vice president of our ratings
6 team.

7 Q Okay. So that's on the rating side, but how
8 is, how is she involved with the survey itself?

9 A I think she, she works -- she's the staff
10 liaison for the expert panel.

11 Q Okay.

12 Now, do you have any role in reviewing
13 responses, so hospitals' responses to this hospital
14 survey?

15 A No.

16 Q Okay. Do you know who at LeapFrog is
17 responsible for reviewing hospital responses to the
18 survey?

19 A I don't.

20 Q Is it the expert panel; do you know?

21 A I don't know.

22 Q Okay. Ms. Danforth?

23 A I don't know.

24 Q Don't know? So you have no idea who within
25 LeapFrog or anyone affiliated with LeapFrog that

1 handles or reviews the responses to the survey?

2 A I don't know.

3 Q So you'll see that the, the survey itself --
4 and feel free to pick it up, look through it -- is
5 over 350 pages long.

6 Does that look right to you?

7 A Yes.

8 Q Okay, and you -- how often, do you
9 understand it, is this survey issued to hospitals?

10 A I believe it's annually.

11 Q Annually? Okay. The scoring -- but, but
12 the hospital safety grades are issued twice a year,
13 correct?

14 A Correct.

15 Q All right. So the survey is sent out once a
16 year, but the health [sic] safety grades are issued
17 twice a year; is that right?

18 A It's not health safety grade.

19 Q Hospital safety grade. I will get that
20 right.

21 A That's okay. I just don't want to --

22 Q No, I -- you're, you're --

23 A -- talk about the wrong thing.

24 Q No, you're exactly right.

25 So the survey is sent out to hospitals once

1 a year, but the hospital safety grades are issued or
2 published twice a year, right?

3 A Correct.

4 Q Okay.

5 Have you received -- do you know whether
6 LeapFrog has received any feedback or heard how long
7 generally it takes for hospitals to complete the
8 survey?

9 A What's the question?

10 Q The question is: Have you heard or gotten
11 any feedback from hospitals about how long it takes
12 for a hospital to fill out or complete this survey?

13 A Yes.

14 Q Okay. Can you tell us about that, what
15 you've heard in that vein or the feedback?

16 A I've heard that it takes 40 to 80 hours a
17 year to do the survey.

18 Q Okay, and where, where are you hearing this
19 from? What's kind of the source of the information?

20 A I've heard it from LeapFrog staff.

21 Q Has -- do you know whether LeapFrog has
22 conducted any studying or collected data relating to
23 how long it takes hospitals to complete the survey?

24 A I don't know.

25 Q Okay. So the 40- to 80-hour number is just

1 kind of based on anecdotally what you've heard from
2 LeapFrog staff; is that right?

3 A That's what I've heard. I don't know what
4 it's based on.

5 Q Okay. Do you, do you know how generally
6 hospitals gather data in order to fill out the survey
7 or respond to the survey?

8 A I don't.

9 Q All right. Have you heard -- so you've
10 heard about generally the number of hours hospitals --
11 that it takes for hospitals to fill out the survey.

12 Have you heard of or seen any feedback or
13 complaints from hospitals about how long it takes to
14 fill out the survey?

15 A I haven't, no.

16 Q Okay. So you've heard no complaints from
17 any hospitals about the length of time or the amount
18 of resources it takes to respond to the survey?

19 A I haven't.

20 Q Okay. Do you know whether others have
21 within LeapFrog?

22 A I don't know.

23 Q Okay. Have -- kind of a similar question.
24 Have hospitals expressed concerns or complained about
25 the content or the, the fairness of the questions or

1 the requests in the hospital survey?

2 A Not to my knowledge.

3 Q Okay. So none, no hospitals have given such
4 feedback to you; is that right?

5 A I don't really talk to hospitals.

6 Q Okay. Do you know whether others among your
7 colleagues at LeapFrog have received that type of
8 feedback?

9 A I don't know.

10 Q Okay. How does LeapFrog use the data
11 collected through the hospital survey?

12 MS. BLAIR: Objection to form.

13 THE WITNESS: Can you clarify?

14 BY MR. CHUNG:

15 Q Sure. Is there a process by which LeapFrog
16 uses -- takes, takes the data from the hospital
17 surveys, right, from the various hospitals, and, and
18 uses it? Is there kind of a set process?

19 MS. BLAIR: Same objection.

20 THE WITNESS: I don't know.

21 BY MR. CHUNG:

22 Q Okay.

23 Do you know whether every section of the
24 hospital survey is used to generate hospital's safety
25 grade?

1 A I don't know.

2 Q Okay. How does LeapFrog verify the accuracy
3 of the information submitted by hospitals in the
4 survey?

5 A I don't know the full way they do it, but I
6 know we do document request information, and then I
7 know we work with a vendor who goes into the hospitals
8 and reviews, measures.

9 Q Okay. So let's start with the first one,
10 the document requests.

11 So are these document, document requests
12 separate from what's requested in the survey?

13 A I believe the document requests are in
14 addition.

15 Q Okay. So they're follow-ups after -- are
16 they follow-up document requests after a hospital has
17 responded to the survey?

18 A To my knowledge.

19 Q Okay, and who is in charge or who oversees
20 that process?

21 A I don't know.

22 Q How do you know this?

23 A I've heard that we do document requests.

24 Q Okay. Generally speaking or from what
25 you've heard, what types of documents are, are

1 encompassed in these document requests?

2 A The one example I can think of is when
3 someone says that they provide translated services, so
4 we would ask for a sample of a translated document.

5 Q Okay.

6 The second item that you mention or that you
7 mentioned were a vendor that goes on site; is that
8 correct?

9 A Correct.

10 Q Can you, can you explain more kind of what
11 that entails? Number one, who is the vendor?

12 A I don't know.

13 Q Okay. Can you describe, tell us more about
14 what, what those on-site visits entail?

15 A I can't.

16 Q Okay. Are these audits?

17 A I don't know.

18 Q Okay. Are these, are these on-site -- is
19 the purpose of these on-site visits to confirm,
20 through observation, what's been submitted by the
21 hospital in the survey?

22 A To my knowledge.

23 Q Okay, and what, what types of issues or
24 items are, are confirmed based on these on-site
25 visits? What are the kind of -- what are the issues

1 that these on-site visits are meant to look at?

2 A I don't know.

3 Q Okay. What -- does LeapFrog, through the
4 vendor, conduct an on-site visit for all hospitals
5 that respond to the survey?

6 A No.

7 Q How does it go about determining which
8 hospitals to do an on-site visit for?

9 A I don't know.

10 Q Does a hospital face any consequences for
11 submitting inaccurate information in its survey?

12 A I don't know.

13 Q Okay. Does a hospital face any consequences
14 for submitting an incomplete survey?

15 A I don't know.

16 Q Okay.

17 Do you know whether hospitals can update or
18 correct their survey responses after their initial
19 response?

20 A Yes.

21 Q Okay. What is that, what is that process?

22 A I know that we have a period of time after
23 they submit that they can make corrections.

24 Q Okay, and how long is that -- curative time,
25 you called it? What is the -- did you say curative

1 time?

2 Oh, period of time. What is that period of
3 time?

4 A I don't know.

5 Q Okay. Do you know whether there are any
6 kind of set deadlines?

7 A There are. I don't know what they are.

8 Q Okay. Are there any kind of penalties or
9 consequences to hospitals for not sending their
10 updates or the corrections in time?

11 A I don't know.

12 Q Okay.

13 How often does LeapFrog amend or make
14 changes to their hospital survey?

15 A I don't know.

16 Q Do you know whether LeapFrog has made
17 changes to its hospital survey during the time you've
18 been there, since 2021?

19 A Yes.

20 Q Okay. How do you know that?

21 A I've heard that we've had changes to the
22 survey.

23 Q Okay. What, what are the changes that have
24 been made?

25 A I know that there's changes in methodology.

1 Q Okay. What do you mean by that?

2 A In the way the survey is done. I'm not an
3 expert on the survey, so . . .

4 Q No. Okay. Even if you're not an expert on
5 the survey, you testified that there have -- number
6 one, that there have been changes, right, to the
7 hospital survey since you started at LeapFrog in 2021.

8 So my question is, again: Based on your
9 recollection, what have those changes been?

10 A I don't recall.

11 Q Okay.

12 Have there been any -- do you know whether
13 there -- or do you know or recall whether there have
14 been any changes to the categories of information that
15 the survey seeks from hospitals?

16 A I don't know.

17 Q Okay.

18 So this will tie back to kind of our, our
19 discussion about the various measures that are in the
20 scoring methodology, but I want to ask you some
21 questions about kind of the information that LeapFrog
22 obtains through the survey versus information that
23 LeapFrog obtains through CMS data, which you testified
24 to earlier.

25 Does LeapFrog use responses to its survey as

1 the primary data source over CMS data for some of its
2 measures?

3 A I don't know.

4 Q Okay. Well, just more specifically, do you
5 know whether -- for the CPOE measure that we discussed
6 earlier, do you know whether LeapFrog uses the
7 hospital's survey responses or CMS data as its primary
8 data source?

9 A I don't know.

10 Q Okay. How about for BCMA?

11 A I don't know.

12 Q Okay. How about for IPS?

13 A I don't know.

14 Q And for hand hygiene; do you know?

15 A I don't know.

16 Q Okay. So you don't know for each of those
17 four measures or metrics whether LeapFrog uses the
18 survey responses or CMS data as a primary data source?

19 A Correct.

20 Q Okay.

21 We're going to move on to kind of a related
22 topic, and it has to do with imputed metrics, which
23 you probably understand is, you know, part of the case
24 before us as well.

25 Are you familiar with LeapFrog's imputation

1 model in its scoring methodology?

2 A I'm familiar that LeapFrog has an imputation
3 model.

4 Q Okay. Based on that familiarity, what is
5 the imputation model?

6 A That I don't know.

7 Q Okay. Do you know generally what, what it's
8 meant to achieve or what its purpose is?

9 A I don't.

10 Q Okay. Do you know which metrics, which
11 metrics or measures use an imputation model?

12 A No.

13 Q Okay.

14 Do you know why LeapFrog chooses -- do you
15 know why LeapFrog has an imputation model in the first
16 place?

17 A Yes.

18 Q And why is that?

19 A If we don't have information, we need some
20 way to come up with the data.

21 Q Okay. So "if we don't have the information,
22 we need some way to come up with the data," so as --
23 I'm just trying to understand your, understand your
24 response here.

25 Under what circumstances would LeapFrog not

1 have information?

2 A If a hospital doesn't fill out the survey.

3 Q Okay. So we're talking about situations
4 where a hospital doesn't participate or respond to the
5 survey, correct?

6 A Correct.

7 Q Okay, and that's -- for those hospitals,
8 the -- LeapFrog would use this imputation methodology;
9 is that correct?

10 A Correct.

11 Q All right, and is it, and is it correct that
12 the reason that LeapFrog would use its imputation
13 methodology for these nonparticipating hospitals is
14 that -- what? What's, what is the reason?

15 MS. BLAIR: Objection to form.

16 THE WITNESS: Can you clarify?

17 BY MR. CHUNG:

18 Q Sure. So I'm just trying to use some
19 building blocks here, right, just given your
20 familiarity with the, with the concept overall.

21 So what is -- why does, why does LeapFrog
22 use an imputation methodology with respect to
23 hospitals that don't respond to its survey?

24 MS. BLAIR: Objection to form.

25

1 BY MR. CHUNG:

2 Q Let's start with that question.

3 A It's standard practice in measurement, if
4 you don't have a measurement, you need to figure out
5 how to use that information.

6 Q What do you mean by "standard practice"?

7 A My son is a mathematician, and he was
8 talking about imputation models as something that he
9 does in his research.

10 Q Okay. So this is standard -- in what field
11 is it standard practice as you understand it?

12 A Data science.

13 Q Okay, and this is based on -- and your
14 understanding is based on your discussion with your
15 son?

16 A And in general.

17 Q And in general. Okay.

18 So is it your under- -- is it your testimony
19 that an imputation model is a standard practice for --
20 an imputation model to be used where there is an
21 absence of data?

22 MS. BLAIR: Objection to form.

23 THE WITNESS: Correct.

24 BY MR. CHUNG:

25 Q All right, and so what does -- what does

1 an -- what does an imputation model do to address that
2 absence of data?

3 A It helps to fill in the data.

4 Q Okay, and in the, the -- in the circumstance
5 that we're describing here, where a hospital does not
6 respond to the survey, and therefore LeapFrog does not
7 have data that they normally would get through a
8 survey, how does the imputation methodology generate
9 the data that LeapFrog doesn't have?

10 MS. BLAIR: Objection to form.

11 THE WITNESS: I don't know.

12 BY MR. CHUNG:

13 Q Okay.

14 Do you have an understanding as to what
15 LeapFrog's current imputation model is?

16 A No.

17 Q Okay. Do you know which, among the various
18 measures and metrics that we've been -- that we've
19 discussed, that there are -- do you know that there
20 are four metrics where LeapFrog uses its imputation
21 methodology?

22 A I don't know.

23 Q Okay. Are you familiar -- do you know that
24 CPOE -- that LeapFrog uses its imputation methodology
25 with respect to CPOE, BCMA, IPS and hand hygiene?

1 Have you heard of that or are familiar with that?

2 A What's the question?

3 Q Do you know or have you heard that LeapFrog
4 uses its imputation methodology with respect to four
5 metrics? Those four metrics are CPOE, BCMA, IPS and
6 hand hygiene.

7 A I know that we use an imputation model. I
8 don't know the specific measurements it's for.

9 Q Okay. So you don't know the specific
10 metrics where LeapFrog uses the imputation
11 methodology; is that right?

12 A Correct.

13 Q Okay.

14 Do you have an understanding as to -- well,
15 actually, during your time at LeapFrog, has LeapFrog
16 always used some form of imputation, imputation
17 methodology?

18 A I don't know.

19 Q Okay. Do you know whether LeapFrog has
20 always used the same imputed metrics during your time
21 there?

22 A I don't know.

23 Q Okay. Have you or others received any
24 complaints or concerns about LeapFrog's imputation
25 model?

1 A I have not.

2 Q Okay. Do you know whether there are any
3 plans to revise or update the imputation model in the
4 future?

5 A I don't.

6 Q Okay. Let's go over -- so you should
7 have --

8 MS. BLAIR: Dan, we've been going about 90
9 minutes.

10 THE WITNESS: I was going to say can I use
11 the restroom.

12 MR. CHUNG: Absolutely. Yes.

13 THE VIDEOGRAPHER: The time is 10:26 a.m.

14 This ends unit 1. We're off the record.

15 (Whereupon, a short recess was taken.)

16 THE VIDEOGRAPHER: The time is 10:41 a.m.

17 This begins unit number 2. We're on the record.

18 BY MR. CHUNG:

19 Q All right, Ms. Jupiter. Before the break,
20 we were discussing the LeapFrog imputation model. Are
21 you aware that there was a change in the imputation
22 model in fall 2024 that's at issue in this lawsuit?

23 A I'm aware there was a change. I don't know
24 exactly when.

25 Q Okay. What was that change?

1 A I don't know.

2 Q Okay. Do you have a -- can you give us a
3 general idea of what you understand the change to be?

4 A I know we changed how we imputed data.

5 Q Okay, and how -- what, what exactly was that
6 change? How did -- how -- what was the change in how
7 LeapFrog imputed data?

8 A I don't know.

9 MR. CHUNG: Well, let's take a look at --
10 we're going to put another exhibit in front of
11 you, give you kind of a comparative exercise
12 here.

13 This will be Exhibit 3.

14 (Exhibit 3 was marked for
15 identification.)

16 BY MR. CHUNG:

17 Q And what we put in front of you as Exhibit 3
18 is the prior version of LeapFrog's scoring
19 methodology, prior to the version you had, that you
20 saw as Exhibit 1. Exhibit 1 is from, at least
21 according to the cover page, from spring of 2025.
22 That's after this change in the methodology, and then
23 Exhibit 3 is the preceding one, at least based on the
24 cover, from spring of 2024.

25 And I'm going to direct your attention to

1 page 14 of Exhibit 3, so the earlier imputation
2 methodology.

3 A Page 14 of which one?

4 Q Of Exhibit 3, okay, and you'll see there,
5 there is a section, "Imputation Method for CPOE, BCMA,
6 IPS and Hand Hygiene."

7 Do you see that?

8 A Yes.

9 Q Okay, and you testified earlier that you are
10 familiar to some extent with those four measures,
11 correct?

12 A I've heard of those measures.

13 Q Okay, and according to this earlier
14 methodology, there is -- you'll see that there are two
15 steps to the imputation method.

16 Do you see that?

17 A Yes.

18 Q Okay, and in step one, it says "to use" --
19 this is -- kind of the preamble to the section is that
20 "The LeapFrog Hospital Survey is voluntary" -- I'm
21 reading from the top of the page -- "is voluntary, and
22 as such, hospitals may choose not to submit a Survey,"
23 and "To address this gap in available data, the Safety
24 Grade methodology utilizes secondary data when
25 available," right?

1 Now, this is what I believe you were
2 testifying to earlier, correct?

3 A What's the question?

4 Q That it is -- does this reflect what you
5 testified to earlier about the purpose of the
6 imputation methodology being to address situations
7 where a hospital has not submitted a survey response?

8 MS. BLAIR: Objection to form.

9 THE WITNESS: Yes.

10 BY MR. CHUNG:

11 Q Okay. So according to this earlier
12 methodology, step one is -- and I'm just reading off
13 the document -- "Use a hospital's most recent score on
14 the measure."

15 Do you see that?

16 MS. BLAIR: I'm sorry. Where are you
17 reading from?

18 BY MR. CHUNG:

19 Q Step one.

20 A Yes. It says "use a hospital's most recent
21 score on the measure."

22 Q Okay, and then step two reads, "Use the mean
23 of the scores assigned to other similar hospitals in
24 the U.S. (applies to CPOE, BCMA and Hand Hygiene
25 only)."

1 Do you see that?

2 A Yes.

3 Q Okay. So does this reflect -- refresh your
4 recollection or understanding to what the imputation
5 methodology was before this change in 2024?

6 A I don't work with the imputation model. I
7 mean I'm reading this now. What you say is what it
8 says, but I don't really -- I'm not familiar with
9 this.

10 Q Okay. Well, have you had discussions with
11 stakeholders about this lawsuit and what this lawsuit
12 is about?

13 A We've discussed the lawsuit, yes.

14 Q Okay, and have they -- have you discussed --
15 as part of those discussions, have you become familiar
16 with what this lawsuit is about?

17 A With the general concept, yes.

18 Q Okay, and what do you understand the general
19 concept to be?

20 A That we changed how we impute data.

21 Q Okay, and beyond that, you have no kind of
22 sense or idea or understanding as to what that change
23 entailed?

24 A I know there was a change. I'm not a data
25 scientist.

1 Q Okay. Do you have -- do you have a sense or
2 an idea as to why that change precipitated this
3 lawsuit?

4 A Can you clarify?

5 Q Sure. Do you have an understanding as to
6 why that change in the imputation methodology
7 contributed, right, to the hospitals here, my client,
8 in bringing this lawsuit against LeapFrog?

9 A I know that your client didn't -- doesn't
10 like the imputation model change.

11 Q Okay, and do you know what -- do you know
12 what about the change in the imputation, imputation
13 methodology the hospitals didn't like?

14 A No.

15 Q Okay, so -- so we just went over the two
16 steps. I read around the two steps in the older
17 methodology. We're going to compare that to the
18 imputation methodology in, in the current methodology
19 document, so if you could flip to -- and this is in
20 Exhibit 1, starting at page 15.

21 Okay. Just let me know when you're there.

22 A Okay.

23 Q It says again, for "Imputation Method for
24 CPOE, BCMA, IPS and Hand Hygiene," it says "Step One:
25 Use hospital's -- Use a hospital's most recent score

1 on the measure (applies to CPOE, IPS and Hand Hygiene
2 only)," and you'll see that that generally is the same
3 as the prior methodology.

4 Do you see that?

5 A Yes, but it doesn't include BCMA.

6 Q Right. It doesn't include that
7 parenthetical, right?

8 THE REPORTER: It doesn't include what?

9 BY MR. CHUNG:

10 Q It doesn't include that parenthetical,
11 correct?

12 A Well, one says "CPOE, IPS and Hand Hygiene,"
13 and the other one says "CPOE, BCMA and Hand Hygiene."

14 Q Right. So in this later, the current
15 methodology, this step one has been expanded to
16 include IPS; is that right?

17 MS. BLAIR: Objection to form.

18 THE WITNESS: And what was your question
19 again?

20 BY MR. CHUNG:

21 Q Right. The -- just to be clear, the -- in
22 the current model, so in Exhibit -- the current
23 methodology in Exhibit 1, the parenthetical there has
24 been expanded to apply to IPS, right, in addition to
25 CPOE and hand hygiene -- or actually, they have

1 actually subtracted --

2 A No.

3 Q No? They have replaced, basically, some of
4 the metrics that are included here, correct?

5 MS. BLAIR: Objection; form.

6 BY MR. CHUNG:

7 Q All right. We can move on.

8 If we look to step two in Exhibit 1, you'll
9 see it says "use imputation point assignment,"
10 correct?

11 A Correct.

12 Q All right, and here it details that "if the
13 hospital does not have historical data from the last
14 two rounds of the Safety Grade" -- so referring to the
15 step one -- "the hospital is assigned a point value
16 that is equivalent to receiving Limited Achievement
17 for this measure on the LeapFrog Hospital Survey,"
18 okay?

19 Do you know -- do you have an -- what does
20 "limited achievement" mean in this context?

21 A I don't know.

22 Q Okay. Do you have an understanding that --
23 is it correct that, according to this new imputation
24 methodology, right, so step two, for any hospitals
25 that don't -- that haven't responded to the survey,

1 right, and do not have historical scores, right, on
2 this measure, that they will be automatically assigned
3 what's called this "Limited Achievement" score on
4 these metrics?

5 A That's what this says, yes.

6 Q Okay, and do you understand limited
7 achievement basically to be the lowest available score
8 on these four metrics?

9 A I don't.

10 Q Okay, but this is --

11 THE REPORTER: Are you saying "limited
12 achievement" or "limit of achievement"?

13 MR. CHUNG: Limited achievement.

14 THE REPORTER: Okay.

15 BY MR. CHUNG:

16 Q But you understand step two, step two
17 basically to be an automatic assignment of this
18 limited achievement score to these hospitals that
19 haven't responded to the survey and don't have
20 historical grades on these metrics?

21 A Yes.

22 Q Okay, and that's an automatic assignment of
23 this limited achievement score without the benefit of
24 any data, whether it's from the hospital survey or
25 from CMS or any other source; is that right?

1 MS. BLAIR: Objection to form.

2 THE WITNESS: I don't know where that comes
3 from.

4 BY MR. CHUNG:

5 Q What do you mean "where that comes from"?

6 A What's your question again?

7 Q So the question is -- I mean you testified
8 that this is basically, according to step two, any
9 hospital that does not -- that hasn't responded to the
10 survey, right, and doesn't have historical scores,
11 right, on these, on these metrics, that they're
12 automatically assigned a limited achievement score,
13 correct?

14 A Correct.

15 Q Right, and that is -- and that limited
16 achievement score is automatically assigned to the
17 hospital in the absence, right, without any
18 consideration by LeapFrog to any data relevant to
19 those metrics; is that right?

20 MS. BLAIR: Objection to form.

21 THE WITNESS: I, I don't have an answer to
22 that.

23 BY MR. CHUNG:

24 Q You don't know or you don't know the answer
25 to that?

1 A I don't know if it's not based on any data
2 whatsoever.

3 Q Okay, but if it's -- but if the limited
4 achievement score is automatically assigned, right,
5 what -- how could it be -- how could it be that any
6 other -- that other data sources are considered if
7 it's automatically assigned?

8 A I don't know. I'm not familiar with where
9 the numbers come from.

10 Q Okay. Which numbers are you referring to?

11 A Limited achievement measure score 15, 25; I
12 don't know where those numbers come from.

13 Q Okay. So you have no familiarity -- again,
14 you're referring to page 16 of Exhibit 1, correct?

15 A Correct.

16 Q All right.

17 Do you know what -- do you have an
18 understanding that limited achievement is the lowest
19 score for each of these metrics?

20 A I don't.

21 Q Okay. Do you have an understanding that
22 limited achievement basically equates to an F on each
23 of those metrics?

24 A I don't.

25 Q Okay.

1 Does LeapFrog's -- I asked you earlier. I'm
2 going to kind of reask it in a different way. Why
3 does LeapFrog use an imputation model?

4 A When we don't have -- I mean when we're
5 lacking information from them, we go to secondary
6 data.

7 Q Okay, and is it correct, according to
8 Exhibit 1, the current imputation methodology, that
9 when you don't have secondary data, that LeapFrog
10 automatically assigns this limited achievement grade
11 to the hospital, correct?

12 A Yes.

13 Q All right. Does LeapFrog's imputation model
14 basically allow it to give more hospitals safety
15 grades?

16 A I don't know.

17 Q Okay, but it's -- without the imputation
18 model, is it possible to give nonparticipating
19 hospitals a safety grade?

20 A I don't know.

21 Q Okay.

22 So in this change that we went over between,
23 between the two imputation methodologies, why did
24 LeapFrog decide to use, automatically use a limited
25 achievement score for the imputed metrics instead of

1 the average hospital score, as it had in the past?

2 MS. BLAIR: Objection to form.

3 THE WITNESS: I don't know.

4 BY MR. CHUNG:

5 Q Okay. You weren't -- were you -- did you
6 discuss kind of the reason for this change at all
7 during your meetings with the executive staff?

8 A I don't recall.

9 Q Okay. So you have no knowledge as to why
10 this change was made?

11 A No.

12 Q And is it correct that the use of the
13 limited achievement score -- automatically-assigned
14 limited achievement score instead of the average
15 hospital score lowers nonparticipating hospitals'
16 grades?

17 A I don't know.

18 Q Okay. Do you have any -- was that ever
19 discussed in executive staff meetings?

20 A Not to my knowledge.

21 Q Okay.

22 Was the purpose of this change in
23 methodology, in assigning limited achievement scores
24 to nonparticipating hospitals, to penalize
25 nonparticipating hospitals?

1 A I don't know.

2 Q Okay. Was that, was that ever discussed in
3 executive staff meetings?

4 A Not to my knowledge.

5 Q Okay. Do you have an understanding as to
6 how a nonparticipating hospital could get a better
7 safety grade under the new methodology?

8 A I don't know.

9 Q Was LeapFrog trying to encourage hospitals
10 to participate in the survey by implementing this
11 imputation method -- change in imputation methodology?

12 A We want hospitals to participate in the
13 survey.

14 Q Okay. I understand that kind of as a
15 general --

16 A Right.

17 Q -- matter, but my question is: Was that at
18 least part of the purpose for changing this, the
19 imputation methodology?

20 A I don't know.

21 Q Okay. Were there -- had you heard of or --
22 had you heard of or were you aware of any complaints
23 or feedback from hospitals that participated in the
24 survey that nonparticipating hospitals were unfairly
25 benefiting from the safety grades?

1 A Can you repeat the question.

2 Q Yes. Have had heard of any -- did you get
3 any feedback or did any of your colleagues get any
4 feedback or hear from any hospitals that did
5 participate in the survey that they thought or they
6 believed that nonparticipating hospitals were somehow
7 benefiting from the safety grades?

8 A I haven't received any feedback about that.

9 MR. CHUNG: Okay. All right. We're going
10 to move on to the next document. This is behind
11 tab 5. This will be Exhibit 4.

12 (Exhibit 4 was marked for
13 identification.)

14 BY MR. CHUNG:

15 Q All right. Ms. Jupiter, I've put in front
16 of you what's been marked as Exhibit 5 [sic]. It is
17 an email from Leah Binder to a Paul Alper, copying
18 you, on July 15 of last year, July 15 of 2024.

19 Do you recognize this email or this
20 document? Just take your time going through it.

21 A I don't remember the specific email.

22 Q Okay.

23 So what -- who is Paul Alper?

24 A He is a consultant for LeapFrog.

25 Q Okay, and what does he consult on?

1 A He works with our partners advisory
2 committee.

3 Q And do you work -- do you work with him?

4 A I work with him.

5 Q Okay, and how do you work with Mr. Alper?

6 A We discuss the partners advisory committee
7 and sponsorships for LeapFrog.

8 Q Okay. So is it that he advises just on the
9 partners advisory committee, or does he advise on
10 other things?

11 A He focuses on the partners advisory
12 committee.

13 Q Okay, and just going through this, this
14 email, what's being discussed?

15 (Witness peruses document.)

16 THE WITNESS: Slides that Paul was making.

17 BY MR. CHUNG:

18 Q Okay, and what were those slides about?

19 A I don't know exactly what the slides were
20 about.

21 Q Well, let's focus just on the last bullet
22 point in Ms. Binder's email, which reads, "We did
23 change the methodology for Fall 2024 so that hospitals
24 that don't report to the LeapFrog Survey this year or
25 last year will be imputed with the lowest score on

1 hand hygiene. I'm sure the survey team has a slide on
2 that, but please be sure you thoroughly understand
3 this change and the talking points around it if you do
4 decide to use it -- it's a very big deal to hospitals
5 (and a major incentive to report to the Survey), and
6 you could easily get a question on it," right?

7 So she -- Ms. Binder writes here that the
8 change in the methodology for fall 2024 is "a very big
9 deal to hospitals and a major incentive to report to
10 the survey."

11 Do you agree with her characterization of
12 the methodology change here?

13 A I'm not a methodology expert. I don't know.

14 Q Not talking about the methodology itself,
15 right, but do you agree with her characterization that
16 this change in the methodology is "a very big deal to
17 hospitals and a major incentive to report to the
18 survey"?

19 A I don't really have an opinion on it.

20 Q Okay. Do you have an understanding as to
21 what she's -- what she is -- what she's, what she's
22 discussing here?

23 A I know that she thinks it's a big deal to
24 hospitals.

25 Q Okay, and how is it a big deal to hospitals?

1 A I don't know.

2 Q Okay. Do you have an understanding --
3 you're, you're copied on this email, correct?

4 A Correct.

5 Q Right. Do you have an understanding as to
6 what she means by the change being "a major incentive
7 to report to the survey"?

8 This dovetails with some of my questions
9 earlier.

10 A I don't know what she means.

11 Q Okay. Doesn't she mean that if, if through
12 this new imputation methodology, a nonparticipating
13 hospital is automatically assigned the lowest score on
14 hand hygiene, that that would be a major incentive for
15 the hospital to, to respond to the survey?

16 MS. BLAIR: Objection to form.

17 THE WITNESS: What's the question?

18 BY MR. CHUNG:

19 Q So the question is: Do you -- is that your
20 understanding of what she means by this change in the
21 methodology being "a major incentive" to hospitals?

22 A Is my understanding what?

23 Q Is it your understanding -- is it your
24 understanding that if hospitals, if, if they don't
25 respond to the survey, they will basically get a

1 flunking grade on hand hygiene, automatically get a
2 flunking grade on hand hygiene, that that would
3 constitute a major incentive for them to respond to
4 the survey, whether they want to or not?

5 A I'm still not clear on exactly what your
6 question is.

7 Q So the question, I'm asking you whether it's
8 a fair -- let's put it this way, right?

9 Is it fair to say that if a hospital that,
10 that didn't participate, right, in the survey is faced
11 with the prospect of getting a flunking grade on hand
12 hygiene, right, because it didn't participate, that
13 that would be a major incentive for the hospital to
14 actually participate in the survey?

15 A I don't know -- I don't know that it's a
16 flunking grade. I'm not as familiar with --

17 Q Okay.

18 A -- the imputation, that it means a flunking
19 grade.

20 Q Well, let's say "with the lowest score on
21 hand hygiene," just to use Ms. Binder's words. If
22 that were the case, wouldn't that be a major incentive
23 for the hospitals to respond to the survey?

24 MS. BLAIR: Objection; form.

25 THE WITNESS: I'm not clear on what you're

1 asking me. I am not very familiar with that. I
2 can see that's what Leah says, yes.

3 BY MR. CHUNG:

4 Q Okay. So you have no -- and you're not
5 familiar what she's referring to here in terms of how
6 the change in the imputed, imputation methodology
7 constitutes a major incentive for hospitals to
8 actually participate in the survey?

9 A What's the question?

10 Q The question is: Do you have an
11 understanding of what she's, what she's referring to
12 here?

13 A I have a general understanding of what she's
14 referring to.

15 Q Okay. So let's start with that general
16 understanding. What is, what is your general
17 understanding?

18 A That we've changed the way we impute the
19 score when a hospital doesn't fill out the survey.

20 Q Okay, and what is, what is that change
21 exactly?

22 A That they're being assigned lowest
23 achievement if they don't fill out the survey.

24 Q Okay. Lowest achievement if they don't fill
25 out the survey, and what is Ms. -- what do you

1 understand Ms. Binder to be saying in terms of what
2 that means to nonparticipating hospitals?

3 MS. BLAIR: Objection to form.

4 THE WITNESS: I don't understand the
5 question.

6 BY MR. CHUNG:

7 Q Well, what are you understanding Ms. Binder
8 to be saying here when, because of that assignment of
9 the lowest, lowest achievement, right, just based on
10 your testimony, that -- how does that, how does that
11 affect whether -- how does that affect whether
12 hospitals will participate in the survey?

13 A She's saying it's an incentive for them to
14 report to the survey.

15 Q Okay, and how? Why, why is it an incentive?

16 MS. BLAIR: Objection; form.

17 THE WITNESS: I don't know.

18 BY MR. CHUNG:

19 Q Okay.

20 Are you aware of any criticisms from
21 hospitals about this change in the imputation
22 methodology?

23 A I mean we're in the middle of this lawsuit.

24 Q Well, apart -- let's say apart from the
25 plaintiff hospitals here, right? Have you been privy

1 to any criticisms from hospitals about the change in
2 the imputation methodology?

3 A I haven't.

4 Q Okay. So zero kind of feedback from other
5 hospitals about, about the imputation methodology?

6 A I don't talk to hospitals about the
7 imputation methodology.

8 Q Okay.

9 So just going back to Ms. Binder's, the last
10 bullet here, isn't another way of putting this is that
11 the purpose of this change, right, by assigning
12 hospitals the lowest score on hand hygiene, wasn't the
13 purpose here to basically penalize nonparticipating
14 hospitals into participating in the survey?

15 MS. BLAIR: Objection; form.

16 THE WITNESS: I don't know.

17 BY MR. CHUNG:

18 Q Okay. Wasn't it the purpose of the change
19 of this methodology to make nonparticipating hospitals
20 into participating hospitals?

21 A I don't know.

22 Q Wasn't that the incentive that -- you
23 testified about this just a moment ago, but wasn't
24 that the incentive that Ms. Binder was describing
25 here, to basically convert those nonparticipating

1 hospitals into, into participating hospitals?

2 MS. BLAIR: Objection; form.

3 THE WITNESS: It says it's "an" incentive.

4 It doesn't say it's "the" incentive or "major"
5 incentive. It doesn't say that that's the
6 reason. It's "an" incentive.

7 BY MR. CHUNG:

8 Q Okay. It's a major incentive to report to
9 the survey, correct?

10 A Correct.

11 Q Okay. So what do you understand that to
12 mean?

13 MS. BLAIR: Objection; form.

14 THE WITNESS: That it is an incentive to
15 report to the survey, but there, for all I know,
16 there could be hundreds of incentives to report
17 to the survey, and this is one of them.

18 BY MR. CHUNG:

19 Q Okay.

20 So just using Ms. Binder's words in this
21 email, with the change in the imputation methodology,
22 a nonparticipating hospital "will be imputed with the
23 lowest score on hand hygiene," right? And this is --
24 this -- correct? And this is in a scenario where the
25 hospital hasn't submitted any data with respect to

1 hand hygiene; is that correct?

2 A What's the question?

3 Q My question is: The scenario here that
4 Ms. Binder is describing is the hospital has not
5 submitted any data, has not responded to the survey at
6 all, correct?

7 A I don't see that here.

8 Q Okay. Well, she says that hospitals -- this
9 applies to "hospitals that don't report to the
10 LeapFrog survey"; is that right?

11 MS. BLAIR: Objection to form.

12 BY MR. CHUNG:

13 Q It's in the first line of that bullet.

14 A So what's the question?

15 Q The question is, right, is she describing
16 here hospitals that haven't reported or haven't filled
17 out the LeapFrog survey?

18 A Yes.

19 Q Okay, and so that means in this, in this
20 scenario, LeapFrog does not have any data from the
21 hospital about hand hygiene, correct?

22 A Correct.

23 Q All right. So what she's describing -- am I
24 correct that what she's describing is that these
25 nonparticipating hospitals will get the lowest score

1 on hand hygiene, even though LeapFrog hasn't seen any
2 data from the hospital on hand hygiene, correct?

3 MS. BLAIR: Objection; form.

4 THE WITNESS: Correct.

5 BY MR. CHUNG:

6 Q Okay, and LeapFrog is assigning the lowest
7 score for -- on hand hygiene for a nonparticipating
8 hospital without having looked at or having been able
9 to assess the hospital's safety practices around hand
10 hygiene; is that right?

11 MS. BLAIR: Objection; form.

12 THE WITNESS: I don't know the specifics of
13 it. I mean this just says they don't report to
14 the survey.

15 BY MR. CHUNG:

16 Q Correct, but it also says that the, these
17 nonparticipating hospitals will be imputed with the
18 lowest score on hand hygiene, right?

19 A Correct.

20 Q Okay. Does it say anything about -- is
21 Ms. Binder -- does Ms. Binder say anything here about
22 that, that lowest score on hand hygiene being assigned
23 after reviewing any data relating to hand hygiene?

24 A No, but she also doesn't mention that we
25 have CMS data also. I mean I can't say all the things

1 that she doesn't say.

2 Q Okay, but she -- they -- it says that they
3 will be imputed with the lowest score on hand hygiene,
4 correct?

5 A Yes.

6 Q All right, and that's -- and I think your
7 testimony earlier was that the purpose of the
8 imputation methodology is to basically come up with a
9 score for a hospital where they haven't submitted data
10 on a particular metric?

11 MS. BLAIR: Objection to form.

12 THE WITNESS: Correct.

13 BY MR. CHUNG:

14 Q Right. So in this scenario, the imputation
15 methodology is being used to impute this lowest score
16 on hand hygiene, because LeapFrog doesn't have any
17 data on hand hygiene, correct? I mean that's the
18 whole purpose of the imputation methodology, correct?

19 MS. BLAIR: Objection to form.

20 THE WITNESS: I think so.

21 BY MR. CHUNG:

22 Q Okay. So just focusing on -- going back to
23 what she wrote here about this change of the
24 imputation being "a very big deal to hospitals and a
25 major incentive to report to the survey," was

1 Ms. Binder very focused on -- was she focused on
2 increasing hospital survey participation?

3 A I have no idea what Ms. Binder was focused
4 on.

5 Q Well, you, you report to her, correct?

6 A Yes.

7 Q Right? And you regularly have conversations
8 with her, correct?

9 A Yes.

10 Q Okay, and did you ever have any discussions
11 with her about the purpose of this change in the
12 imputation methodology?

13 A No.

14 Q Are hospitals -- are hospitals informed that
15 not participating in the survey can result in imputed
16 scores or lower ratings on the hospital safety grade?

17 A I don't know.

18 Q Okay. So you're not aware of any
19 disclosures or information to hospitals that -- of
20 that consequence, right, from not participating in the
21 survey?

22 A I don't know.

23 Q Okay. Has -- do you know whether LeapFrog
24 has conducted any studies or analysis that project the
25 safety grades of hospitals that haven't participated

1 in the survey?

2 MS. BLAIR: Objection; form.

3 THE WITNESS: Can you -- I don't understand
4 the question.

5 BY MR. CHUNG:

6 Q Sure. Do you know whether LeapFrog has
7 conducted any studies or analysis that look at what
8 the safety grades would have been for hospitals that
9 did not respond to the survey?

10 MS. BLAIR: Objection to form.

11 THE WITNESS: I, I don't know. I don't
12 understand the question.

13 BY MR. CHUNG:

14 Q You don't understand the question?

15 A Correct.

16 Q Okay. So the question is: Do you know
17 whether LeapFrog has studied or conducted any analysis
18 for, for hospitals that don't respond to the survey,
19 what their safety grades would have been if they had
20 responded to the survey?

21 A I don't know.

22 Q Okay.

23 Has LeapFrog received any feedback from
24 third parties, right -- so let's put aside the
25 hospitals -- third parties that includes insurers,

1 consumers -- regarding the reliability of the safety
2 grades for nonresponding hospitals?

3 A I don't know.

4 Q Nothing? Nothing along those lines?

5 A (Shakes head.)

6 Q Okay. In your kind of role overseeing
7 communications, right, have you -- do you get feedback
8 from third parties like insurers and consumers?

9 A Do we get feedback in general?

10 Q Yes.

11 A I'm sure we get feedback. I don't
12 personally get feedback.

13 Q I'm not talking about personally. Does
14 LeapFrog get feedback from these third parties?

15 A I assume so.

16 Q Why do you assume -- I mean you oversee
17 communications, so why is that based on an assumption?

18 A Because no one has given me feedback about
19 it.

20 Q Okay. Do you know whether the organization
21 itself receives feedback?

22 A I don't know.

23 Q Okay.

24 Has LeapFrog considered not grading
25 hospitals that don't respond to the survey?

1 A I don't know.

2 Q Okay. Has that ever been a kind of idea or
3 topic of discussion between you and Ms. Binder or any
4 of your other colleagues at LeapFrog?

5 A Not to my knowledge.

6 Q Okay. So that's never come up?

7 A I can't say it's never come up. I have no
8 memory of that coming up.

9 Q Okay.

10 What's your -- do you have a view or an
11 opinion as to whether LeapFrog should be grading
12 hospitals that don't respond to the survey?

13 A I don't have an opinion on that.

14 Q Okay. Where -- do you have an opinion as to
15 whether -- in instances where LeapFrog does not have
16 data, right, on certain metrics that contribute to the
17 safety grade, do you have an opinion as to whether
18 LeapFrog should be assessing or giving scores to
19 hospitals where they don't have that data?

20 A I don't have an opinion on that.

21 Q Okay. Do you think it's fair?

22 A I don't know enough about it.

23 MR. CHUNG: All right. Why don't we move on
24 to another topic. We'll go -- we'll do tab 7.

25 This will be Exhibit 5.

1 (Exhibit 5 was marked for
2 identification.)

3 BY MR. CHUNG:

4 Q All right. So, Ms. Jupiter, I put in front
5 of you what's been marked as Exhibit 5. It is titled
6 "LeapFrog Group and Affiliate, Consolidated Financial
7 Statements" from June 30, 2024, okay.

8 Are you, are you familiar with this
9 document?

10 A Yes.

11 Q Okay, and generally what is it?

12 A It's our financial statements from 2024.

13 Q Okay. Do you -- what role do you have in,
14 in assembling or putting together the financial
15 statements?

16 A I don't assemble or put together financial
17 statements.

18 Q Do you have any input?

19 A No.

20 Q Okay, but you are familiar with it?

21 A Yes.

22 Q All right, and in kind of what, what
23 capacity are you familiar with it?

24 A I've seen that we present them to the board.

25 Q Okay. So let's, let's go through some kind

1 of the line items here.

2 If you turn to page 5 of the document, and
3 you'll see kind of that the total revenue for LeapFrog
4 last fiscal year -- we're talking about 2024
5 basically -- was \$8.36 million; is that right? Eight
6 point -- \$8,357,319.

7 A Yes.

8 THE REPORTER: I'm sorry. Can you say it
9 again. Eight million --

10 MR. CHUNG: \$8,357,319.

11 BY MR. CHUNG:

12 Q Okay. In 2023, we see that, that LeapFrog
13 operated at, at a loss in fiscal year 2023.

14 Do you see that?

15 A Yes.

16 Q Okay, and what accounted for that loss?

17 A I don't know.

18 MR. CHUNG: Okay. We're going to move --
19 we're now going to move on to tab 9, which will
20 be Exhibit 6.

21 (Exhibit 6 was marked for
22 identification.)

23 BY MR. CHUNG:

24 Q All right. Do you recognize this document?

25 A Yes.

1 Q All right, and it's titled "LeapFrog
2 Long-Range Strategic Intent" for fiscal year 2026 to
3 2032.

4 Can you just describe what this document is.

5 A I mean it looks like goals for the next six
6 years for the organization.

7 Q Were you involved in drafting this document?

8 A No.

9 Q Who was?

10 A I believe it's a committee of the board.

11 Q Okay. Do you know whether anyone from the
12 staff or any LeapFrog employees contributed to it or
13 helped the board with putting it together?

14 A I don't know.

15 Q Okay. So you'll see on the first page of
16 the document, there are three, three objectives.

17 Do you see that, objectives 1, 2, and 3?

18 Is it fair to say that these are the kind of
19 most important goals for LeapFrog's long-range
20 strategy?

21 A Yes.

22 Q Okay, and the first objective or goal listed
23 is "scale resources to the capacity needed to make
24 giant leaps for patient safety and stop avoidable
25 death and suffering."

1 And within that first -- if we turn to the
2 next page, it breaks down that first objective, right?
3 Do you see up top the same kind of language there, and
4 in the table underneath, under the "Goal" column, it
5 says "expand revenue from existing sources."

6 Do you see that, Ms. Jupiter?

7 A Yes.

8 Q All right. So expanding or increasing
9 LeapFrog's revenue is -- it looks like the first, the
10 very first goal for the, for the top line objective,
11 right, for the, for the organization; is that right?

12 A Yes.

13 Q Okay. So under Objective 1, one of the
14 benchmark indicators here says that the goal is to
15 increase revenue to \$9 million by September 2025.

16 Do you see that?

17 A Yes.

18 Q And then 2028, the benchmark is \$12 million,
19 right?

20 A Yes.

21 Q And then 2031 is \$18 million; is that
22 correct?

23 A Correct.

24 Q Okay. Are these still kind of the
25 applicable goals, as you understand them?

1 A We have adjusted them, but essentially.

2 Q In what ways have you adjusted them?

3 A Do you know the date of these? I know we
4 adjusted them like . . .

5 Q Are we talking about adjust -- just looking
6 at kind of the revenue, right, that we just went over,
7 or are we talking about adjusting upwards, downwards,
8 in other ways?

9 A I think we adjusted them downwards a little
10 bit.

11 Q Okay. Do you have a sense of by how much,
12 what the ballpark numbers are?

13 A Not a huge amount.

14 Q Okay. How are these, how are these goals
15 determined?

16 A These are very aspirational goals that we
17 discussed with the management team and where we would
18 like the direction of the organization to go.

19 Q Okay, and are those -- are these goals --
20 and I'm including these kind of dollar amounts,
21 benchmarks; are they communicated to LeapFrog staff
22 working on the hospital grades or the hospital survey?

23 A I don't know. That's not my team.

24 Q Okay. Is -- I think you testified earlier
25 that Ms. Danforth and her team, right, oversee the

1 hospital grades and the hospital survey, along with
2 the expert panelists that you mentioned.

3 A Right. Hospital safety grade.

4 Q Hospital safety grade that you mentioned.
5 Are they -- is Ms. Danforth involved in putting
6 together the strategic objectives?

7 A Yes.

8 Q Okay. So let's go to -- moving on to
9 Objective 2, just going back to the first page, it
10 reads, "Drive ever higher standards for patient safety
11 and publicly rate acute care facilities on achievement
12 of those standards."

13 Actually, before we go there, let's go
14 through kind of the rest of the benchmark indicators
15 under Objective 1.

16 So we went through kind of the revenue
17 figures. Underneath those, in that cell, there's a
18 September 2025, "eight net new partners," and then
19 there's revenue targets, and it goes down the line,
20 right? 2028, 2031.

21 What is this? What is this describing?

22 A This is our partners advisory committee.

23 Q Okay. I was going to get to it later, but
24 what -- because you've mentioned it a few times
25 already. What is the partners advisory committee?

1 A The way our board is structured is we do not
2 have people on the board who are involved in
3 healthcare organizations, and don't get funding from
4 healthcare. We try and remain transparent and very
5 clear about that.

6 So our partners advisory committee are
7 solution providers that work with hospitals.

8 Q Okay. So what, what is the -- you started
9 kind of the explanation with the, kind of the role of
10 the board members. How, how does that -- how do kind
11 of the transparency, as you described it, with respect
12 to the board members relate to the partners advisory
13 committee? I'm not understanding the link there.

14 A Sure. So the partners advisory committee,
15 for example, a member of that is Purell, and we
16 wouldn't have Purell be on our board, because they --

17 THE REPORTER: You wouldn't have Purell
18 on, be on the board?

19 THE WITNESS: Be on our board, correct.

20 BY MR. CHUNG:

21 Q And why is that?

22 A Because, you know, Purell is someone that
23 would make money from hospitals, selling to a
24 hospital.

25 Q Okay, and am I understanding correctly that

1 because Purell might make money from a hospital as a
2 vendor, presumably, that a company like Purell could
3 benefit from basically the hospital safety grades?

4 A I don't really understand the question.

5 Q What I'm trying to understand is why
6 wouldn't, you know, because -- why wouldn't Purell, as
7 a company that makes money from hospitals, why an
8 executive or someone from Purell be an appropriate
9 member of the board?

10 A Because LeapFrog was founded for consumers
11 and payors, and that's who's on our board.

12 Q Is there some sort of conflict of interest
13 issue with respect to a company like Purell being on
14 the board?

15 A I mean we represent consumers and payors, so
16 that's who would be on our board.

17 Q Okay. So, for example, who are the kind of
18 consumers and payors that are represented on the
19 board?

20 A We have patient advocates on -- you know,
21 patient advocates are on the board, as well as, you
22 know, large employers who would pay for healthcare for
23 their employees.

24 Q Okay. So the patient -- am I understanding
25 it correctly that then the role or the purpose of the

1 patient advisory committee is for other parties, like
2 a Purell, right, that do make money from hospitals, to
3 have some sort role with respect to LeapFrog?

4 A No, they're not on the patient advisory
5 committee. They're on the partners advisory --

6 Q Partners advisory committee?

7 A Right.

8 Q Yeah, and so what is the purpose of the
9 partners advisory committee?

10 A To get information from them about trends in
11 healthcare and for them to hear from us about what's
12 going on with LeapFrog.

13 Q Okay, and so just going back to the
14 strategic document here under the first objective,
15 what is this describing? You mentioned that it has to
16 do with the partners advisory committee, but what is
17 this describing here?

18 A The number of members of the partners
19 advisory committee.

20 Q Okay, and, and when it's listing revenue, is
21 that revenue from basically membership fees that, that
22 members of the partners advisory committee pay to be
23 on the committee?

24 A Correct.

25 Q Okay, and so what, generally speaking, are

1 those fees?

2 A Members pay \$35,000 to be on the committee.

3 Q Okay, and what do they get from -- what do
4 they get in exchange for that payment?

5 A They show their support for patient safety.
6 That's really the big thing they get out of it.

7 Q How do they do that?

8 A So they would get -- they get, you know,
9 like a badge that says they're a member of the
10 partners advisory committee of LeapFrog, that shows
11 that they support patient safety, and they can say we
12 support patient safety by supporting LeapFrog.

13 Q Okay.

14 The -- so the next kind of table down is --
15 has to do with data licensing revenue, right? And it
16 shows the same kind of timeframes, September 2025,
17 2028, 2031.

18 What is that referring to?

19 A I don't work at all with data licensing.

20 Q Understood. That's fine, but what is it,
21 what is it referring to? What is data licensing?

22 A Revenues we receive from licensing our data.

23 Q Okay. To whom -- like what is kind of the
24 licensing -- how does LeapFrog -- what does LeapFrog
25 license?

1 A Data. I'm not familiar with our data
2 licensing.

3 Q Okay, and then the next table down is again
4 same timeframes from the annual meetings. Is this
5 kind of profit or revenue from fees, kind of
6 attendance fees for the annual meeting?

7 A Correct.

8 Q Okay.

9 So moving on to Objective 2, so if you could
10 turn to the page ending with LeapFrog -- it's the
11 Bates number ending with 796, I believe. It says
12 "Objective 2" up top, "Drive ever higher standards for
13 patient safety and publicly rate acute care facilities
14 on achievement of those standards."

15 What do you understand this objective to
16 mean?

17 A We want high standards for patient safety.
18 We want patients to be safe.

19 Q Okay.

20 Now, the -- if you go down to the fifth cell
21 or the fifth row in this table, the goal is to
22 "increase participation in LeapFrog's hospital and ASC
23 surveys," right?

24 A Yes.

25 Q What is the ASC survey?

1 A Ambulatory surgery centers.

2 Q Okay. Is that a -- that's a separate survey
3 from the hospital survey that we went over earlier?

4 A Correct.

5 Q Okay, and then in the column next to it, the
6 proposed metric, it reads "hospital numbers and
7 percentage of beds," and using the same timeframes, it
8 has by September of this year, this month, that the,
9 that the goal is 2,433 hospitals; is that right?

10 A Yes.

11 Q And that means 78 percent of inpatient beds?

12 A Yes.

13 Q Is that -- so that's 78 percent of the
14 inpatient beds at these -- at hospitals generally, or
15 what does that 78 percent of inpatient beds refer to?

16 A So we're not saying 78 percent of hospitals,
17 because hospitals are different sizes. So it's about,
18 if you take all the beds and all the hospitals,
19 78 percent of those.

20 Q Okay, and then the goal is, for 2028, to get
21 participation, so in terms of increasing participation
22 in the surveys, right, the hospital surveys and the
23 ASC surveys, why is that increase in participation the
24 metric? Why is the metric percentage of inpatient
25 beds?

1 A As opposed to --

2 Q As opposed to let's say percentage of
3 hospitals, right?

4 A Because hospitals are different sizes. You
5 have a hospital that has -- can take 50 patients, and
6 you have a hospital that can take 500 patients.

7 Q Okay, and so why is inpatient beds, right,
8 the number percentage of inpatient beds, the more --
9 the relevant measure, right, for increasing
10 participation in, in the surveys, because it's the --
11 again, as I understand it, it's the hospitals that are
12 responding to the surveys, right?

13 A Right.

14 Q So why is kind of the relevant, the metric
15 here the number of beds or the percentage of beds?

16 A Because a bigger hospital would have more
17 beds and a greater impact on patients.

18 Q Okay. So when we look at the metric or the
19 benchmark for 2031, when it says 90 percent of
20 inpatient beds, you're looking to increase
21 participation in the surveys to a point where you're
22 covering basically 90 percent of inpatient beds among
23 all hospitals, relevant hospitals; is that right?

24 A Correct.

25 Q Let's move on to Objective 3, which starts

1 at the bottom of that same page, "Build communities
2 that achieve the mission." It says here, the first
3 under -- under the "Goal" column, the first cell says
4 "The General Public: Create communication strategies
5 that make the Hospital Safety Grade and LeapFrog
6 itself household names," right, and the proposed
7 metric there is "annual website visits."

8 So is it correct that LeapFrog hopes to
9 increase annual traffic to its websites by 100 percent
10 by 2031?

11 A Yes.

12 Q Okay, and under -- if you go a few, three
13 cells down, it says "Purchasers/Employers: Enable
14 purchasers and their contractors to tie LeapFrog
15 ratings to payment decisions."

16 What does the, what does the document mean
17 here by "enable purchasers and their contractors to
18 tie LeapFrog ratings to payment decisions"?

19 A I don't really know.

20 Q You have no clue what that means?

21 A No.

22 Q Okay. Well, let's look over to the
23 "Proposed Metric" column. The benchmarks here are, by
24 September 2025, "Engage purchasers and influencers
25 around using LeapFrog data (i.e., tie ratings to

1 payment decisions for their employee population)," and
2 then there are additional benchmarks there.

3 I mean is it -- are they -- is the goal
4 here -- again, this is under "build communities that
5 achieve the mission," right? Is the goal here to
6 basically encourage or have purchasers and their
7 contracts to use LeapFrog ratings, including the
8 hospital safety grades, in making payment decisions
9 for hospitals or to hospitals?

10 A I don't work on this. I don't know.

11 Q Who does work on it?

12 A This would probably be a Leah Binder thing.

13 Q Okay. So she, she has sole responsibility
14 for carrying this out?

15 A No, but she would know the general plan
16 around it. I, I don't work on this, so I don't really
17 know.

18 Q Okay. What do you understand this to mean
19 here? What do you understand the purpose of this goal
20 to be?

21 A I really can't speak to it. I don't know
22 about it.

23 Q No clue whatsoever?

24 A No.

25 Q Okay. Has LeapFrog been -- how successful

1 has LeapFrog been in convincing purchasers to tie
2 LeapFrog's hospital safety grades payment decisions?

3 A I don't know.

4 Q Okay. If we go two rows down, it says
5 "Health Plans." Do you see that? "Health plans:
6 Pressure plans to tie LeapFrog ratings to payment
7 decisions."

8 Do you see that?

9 A Yes.

10 Q Okay. What does this mean?

11 A I don't know. I don't work on that.

12 Q Okay. Is LeapFrog trying to pressure health
13 plans to tie the hospital safety grades to payment
14 decisions?

15 A That's what that says, but I don't know any
16 more than what the words say there.

17 Q Okay. Is the, is the goal here to
18 discourage health plans or steer health plans away
19 from hospitals that do not participate in the hospital
20 survey?

21 A I don't --

22 MS. BLAIR: Objection to form.

23 THE WITNESS: I don't know.

24 BY MR. CHUNG:

25 Q Okay, and how -- do you know whether

1 LeapFrog has had success in pressuring plans to,
2 health plans to tie the hospital safety grade to
3 payment decisions?

4 A I don't know.

5 Q So you have no insight into --

6 A No.

7 Q -- that whatsoever? Okay.

8 So in looking at all of these objectives --
9 so we went through three of them, and the first one,
10 kind of the top line is "expand revenue from existing
11 sources," right, to kind of scale resources, and the
12 second one was to, to drive higher standards for
13 patient safety, and one of those goals included the
14 increase, increased participation in the surveys,
15 right? I think we went over that.

16 A (Nods.)

17 Q And then the third is included, enabling
18 purchasers and their contractors to basically use
19 LeapFrog ratings; is that right?

20 A Yes.

21 Q And then relatedly to pressure health plans
22 to basically use LeapFrog ratings as well, correct?

23 A Mm-hmm.

24 Q All right. Is it fair to say that in order
25 to basically achieve, right, these objectives, that

1 LeapFrog, that LeapFrog isn't -- has an incentive to
2 get as many hospitals to respond to the survey as
3 possible?

4 A Can you explain the question?

5 Q Sure. In order to achieve these objectives,
6 right, to raise revenue, to have purchasers and health
7 plans, right, tie the, the hospital safety grades to,
8 to payment decisions, that in order to achieve these
9 objectives, that LeapFrog needs more hospitals to
10 respond to the surveys, correct?

11 A Yes.

12 Q Because that will generate -- because by
13 increasing hospital participation, that will yield
14 more hospital safety grades, correct?

15 MS. BLAIR: Objection to form.

16 THE WITNESS: No.

17 BY MR. CHUNG:

18 Q No? Okay. Why not?

19 A Say again what you said.

20 Q Sure. So you agree that in order to achieve
21 these objectives, LeapFrog has to get more hospitals
22 to respond to the survey, right?

23 A Yes.

24 Q Isn't the reason for that that by increasing
25 hospital participation in the surveys, that that will

1 generate more hospital safety grades, right, for more
2 hospitals; is that right?

3 MS. BLAIR: Objection to form.

4 THE WITNESS: No.

5 BY MR. CHUNG:

6 Q No? Okay. Why not?

7 A Because you get a safety grade whether or
8 not you participate in the survey.

9 MR. CHUNG: Okay. Let's go to the next
10 document, tab 10.

11 This will be Exhibit 7.

12 (Exhibit 7 was marked for
13 identification.)

14 BY MR. CHUNG:

15 Q All right. You have Exhibit 7 in front of
16 you, Ms. Jupiter. It is a -- the title of it is
17 "Annual Review: Karen Jupiter, Vice President of
18 Development," dated from earlier this year,
19 January 29.

20 Do you recognize this document?

21 A Yes.

22 Q Okay, and what, what is it?

23 A It's my annual review.

24 Q Okay, and am I right that for the most part,
25 you drafted this document? Like what we're seeing; is

1 this --

2 A Yes.

3 Q -- a document that you drafted in the
4 first --

5 A Yes.

6 Q -- instance?

7 A Yes.

8 Q All right, and there is a, kind of a red
9 line, right, and are those -- is that red line from
10 Leah Binder?

11 A I don't see a red line. There's no red.
12 It's black and white.

13 Q The, the -- whatever you call it. The, the
14 black line.

15 A Yes.

16 Q Okay. Those are comments from Ms. Binder;
17 is that correct?

18 A Yes.

19 Q Okay. So under -- if you go to number 7 --
20 this is on the page with Bates stamp LeapFrog ending
21 in 508.

22 Just kind of for future purposes, whenever
23 you see two Bates numbers in the lower right-hand,
24 right-hand corner, I'm going to refer to the one on
25 top. Okay. I don't know why there were two.

1 So under "Strategic Intent," you wrote that,
2 "We have ambitious goals outlined in the new Strategic
3 Intent document. I have increased revenue year over
4 year, and my focus will remain on growing the revenue
5 side, specifically increasing Annual Meeting revenue,
6 the number of partners, and donations. More than
7 doubling our revenue in six years is an ambitious
8 target and will require both increased staff and
9 expertise."

10 So who set the goal of doubling the revenue
11 in six years?

12 A I don't know who specifically. That was --
13 I mean I think that comes from the Strategic Intent
14 document.

15 Q Okay, and I think you testified earlier the
16 board had -- was involved in that --

17 A Right.

18 Q -- with that -- in that setting.

19 A Right.

20 Q Based on just your, kind of your long
21 employment history, your experience with nonprofit
22 organizations, is this goal of doubling revenues in a
23 six-year period, is that kind of in line with what
24 you've seen or experienced with other nonprofits that
25 you've worked with?

1 A They're all different.

2 Q They're all different, but is it -- how, how
3 does it compare to kind of your previous -- the
4 organizations that you've worked with previously?

5 A I mean I worked at Good Shepherd Housing, an
6 affordable housing nonprofit, and we went, in six
7 years, from maybe \$10,000 to \$2 million.

8 Q Okay, and so here, when we're talking about
9 doubling, we're starting at a point of \$8 million,
10 right, or thereabouts, and doubling to \$16 million.

11 So how is that -- I understand your kind of
12 example with the Good Shepherd Housing, but what's
13 your view as to kind of the achievability, right, of,
14 of the doubling within six years kind of target here
15 with respect to LeapFrog?

16 A I would say it's an ambitious goal, but
17 that's -- the goals -- we wanted very ambitious goals.

18 Q Okay, and isn't revenue drawn from the
19 hospital safety grades and the hospital survey
20 critical to accomplishing that goal?

21 A Not to my goals.

22 Q Not to your goals --

23 A Right.

24 Q -- but the general goal, right, of achieving
25 that -- the doubling of the revenue, right?

1 I'll, I'll phrase it again.

2 So you've got your goals set aside kind of
3 thing, your own kind of review. It looks like kind of
4 a year-end review here, right?

5 A Mm-hmm.

6 Q But generally speaking, for the
7 organization's goals that were set out in Exhibit 6,
8 right, the doubling of the revenue, isn't revenue
9 drawn from the hospital safety grades and the, the
10 data from the hospital survey, aren't those critical
11 to accomplishing those revenue goals?

12 MS. BLAIR: Objection to form.

13 THE WITNESS: No.

14 BY MR. CHUNG:

15 Q No? Okay. So you're saying that -- is it
16 your testimony that without revenue from, drawn from
17 the hospital safety grades and survey, that the
18 organization would be able to achieve the, the, the
19 goals of doubling, doubling its revenue?

20 A I need you to ask it more specifically.

21 Q Okay. So do you have, do you have an idea
22 of what, ballpark, what percentage of LeapFrog's
23 revenue comes from what we call "accolade revenue"?

24 A I don't know the numbers --

25 Q Okay.

1 A -- no.

2 Q Well, what's your understanding of what the
3 accolade-based revenue is? What, what does that
4 encompass?

5 A Hospitals can purchase an accolade for their
6 safety grade.

7 Q Okay, and if we go back to -- let's go back
8 to the financial statement, Exhibit 5, Ms. Jupiter.

9 So if you go to page 5 of that document,
10 right, under "Revenue and Support," the top line item
11 is "Accolade Licensing Revenue," right?

12 A Yes.

13 Q And the total from there is \$3,288,926 for
14 2024, and just a tick less, basically \$3.2 million for
15 2023, correct?

16 A Correct.

17 Q So that is -- would it be fair to say that
18 that is significantly kind of the biggest component of
19 revenue at least for 2024 and 2023?

20 A Yes.

21 Q Okay. So just going back to the question I
22 asked earlier, is the accolade license -- let's call
23 it the accolade licensing revenue. Is that a kind of
24 integral or a critical component of, of LeapFrog
25 achieving its revenue goals?

1 A It's a part of achieving our revenue goals.

2 Q You say "a part of." What do you mean by
3 that?

4 A We have, you know, a dozen different ways we
5 achieve revenue, and that's one of them.

6 Q Okay, but would you say that -- fair to say
7 that without the accolade licensing revenue, it would
8 be impossible to achieve the goals, correct?

9 MS. BLAIR: Objection to form.

10 THE WITNESS: No, I wouldn't say it's
11 impossible.

12 BY MR. CHUNG:

13 Q Okay. So is it your testimony that -- which
14 among these line items on page 5 of the financial
15 statement would basically be able to kind of make up
16 for a loss in the absence of the accolade licensing
17 revenue?

18 A I mean any of the others. We can increase
19 partnership. We can increase events. We can increase
20 contributions.

21 Q Okay. Has there been any discussion of
22 getting rid of accolade licensing revenue?

23 A Not that I know of.

24 Q Okay. So let's go back to your -- the
25 annual review document.

1 So if we turn to the next page ending in
2 Bates stamp LEAPFROG 509, going on to 510, Ms. Binder
3 writes, "How does our public profile contribute to
4 these revenue sources? For instance, when we get a
5 lot of attention on Safety Grades, it generally leads
6 to some inquiries about our data."

7 Do you agree that the publicity surrounding
8 the hospital safety grades is basically an on-ramp for
9 LeapFrog to sell its data products?

10 A No.

11 Q Okay. Why don't, why don't you -- why do
12 you disagree with that?

13 A The hospital safety grade is to be -- to
14 give information to the public about patient safety,
15 and that's the goal of it. That's the goal of the
16 media around it. That's the goal of everything.

17 Q Okay, understood, but Ms. Binder here writes
18 that "how does our public profile contribute to these
19 revenue sources," right?

20 A Mm-hmm.

21 Q And then she continues, "For instance, when
22 we get a lot of attention on the Safety Grade, it
23 generally leads to some inquiries about our data,"
24 right?

25 So what do you take her to mean here?

1 A I don't take inquiries on the data. I don't
2 know anything about the data.

3 Q Understood, but she's saying that the public
4 profile contributes to revenue sources, correct?

5 A That's what she says.

6 Q And this is, this is kind of comments or
7 feedback she's giving you on your annual review,
8 correct?

9 So what's your takeaway here as it applies
10 to you?

11 A This isn't about me. I mean I don't take
12 inquiries for data.

13 Q Okay, but do you have -- but do you agree
14 that the more the public, right, hospitals and others,
15 are -- know about the hospital safety grades, right,
16 that that is an opportunity to basically sell or at
17 least market accolade licensing-related products to
18 those hospitals?

19 A I don't know.

20 Q Okay. You don't know -- I think you said
21 you disagreed with this proposition earlier. Is it
22 that you don't have a view on it, or you disagree with
23 what Ms. Binder is writing here --

24 MS. BLAIR: Objection.

25

1 BY MR. CHUNG:

2 Q -- on your, on your review?

3 MS. BLAIR: Objection to form.

4 THE WITNESS: I don't understand what you're
5 asking.

6 BY MR. CHUNG:

7 Q Well, what I'm asking is, you know, what --
8 Ms. Binder is saying in your review here that how does
9 LeapFrog's public profile, right, contribute? How
10 does it play into revenue, right, because there's a --
11 you know, earlier on the earlier page, you're
12 discussing how you were going to go about increasing
13 revenue, right, for the organization, and she's
14 writing that when there's a lot of attention on the
15 safety grade, LeapFrog will get questions or
16 inquiries, right, about the data that it collects
17 pursuant to the surveys, right?

18 So do you, do you agree or disagree with the
19 notion that, that the, the hospital safety grades,
20 right, publicity of the hospital safety grades
21 presents an opportunity for LeapFrog to basically sell
22 its accolade licensing or accolade-related products to
23 hospitals?

24 A I have nothing to do with accolade licensing
25 or data.

1 Q Okay. Let's go to just a couple -- the next
2 paragraph, at the end of the next paragraph of
3 Ms. Binder's feedback -- and this is on LeapFrog Bates
4 ending 510.

5 She writes, "Second, for you to develop a
6 dashboard of outcomes for all of your revenue streams
7 and monitor them with me and with your team
8 regularly."

9 Do you see that?

10 A Yes.

11 Q Okay. Do you know why she asks for this?

12 A No.

13 Q Okay. Did you -- have you followed that
14 request?

15 A No.

16 Q Okay.

17 A I just read them. I was like, oh, I should
18 probably get on that.

19 Q Okay. Did you follow up with her on why
20 she, why she was asking for this, for this dashboard?

21 A No.

22 Q Okay. Has Ms. Binder -- so kind of as part
23 of or separate from this annual review process, has
24 Ms. Binder asked you to generate ideas for raising or
25 increasing revenue?

1 A Yes.

2 Q Okay, and what, what have those -- have you
3 generated new ideas for raising revenue in response to
4 her questions?

5 A Yes.

6 Q Okay, and what are those new ideas?

7 A I work with our annual meeting, so
8 developing a sponsorship and benefits program around
9 our annual meeting.

10 Q Okay. Do you know whether Ms. Binder has
11 asked other of your LeapFrog colleagues to generate
12 ideas for raising revenue?

13 A I don't know.

14 Q Okay. So let's turn to -- let's go back to
15 the financial statement, yeah, Exhibit 5, and we were
16 looking at this just a few minutes ago on page 5.

17 Okay. Let's turn to kind of the individual
18 revenue sources. Let's start with "contributions and
19 honoraria," which for 2024 was about \$578,000; is that
20 right?

21 A Correct.

22 Q Okay, and is it fair to say that compared to
23 the revenue drawn from the hospital grades and the
24 hospital survey, that contributions in honoraria is
25 much -- is a much smaller revenue source; is that

1 right?

2 MS. BLAIR: Objection to form.

3 THE WITNESS: There's no line item for
4 hospital grades and hospital surveys.

5 BY MR. CHUNG:

6 Q Well, okay. I'll be more specific.

7 It is fair to say that contributions and
8 honoraria are smaller in terms of revenue source
9 compared to accolade licensing revenue and data
10 licensure? Is that correct?

11 A Yes.

12 Q Okay, and just to be clear, the accolade
13 licensing revenue, right, what are the -- is another,
14 another way to kind of characterize that is the
15 revenue obtained from licensing hospitals, for
16 example, licensing that help the hospital safety
17 grades?

18 MS. BLAIR: Objection to form.

19 BY MR. CHUNG:

20 Q Is that one form of the licensing?

21 A Those are different things.

22 Q Okay. So can you tell me what the accolade
23 licensing revenue refers to?

24 A Accolade licensing is when a hospital
25 licenses their safety grade.

1 Q When a hospital -- but -- okay. A hospital
2 is assigned a hospital safety grade, and the hospital
3 license -- it pays, right, for a license to basically
4 market or use that hospital safety grade from, from
5 LeapFrog, correct?

6 A Correct.

7 Q Okay. The data licensure is, similarly --
8 and tell me if this is correct -- is hospitals or
9 other parties obtaining or licensing data that
10 LeapFrog collects in response principally to the
11 hospital survey; is that correct?

12 A Correct.

13 Q All right. So basically, the hospitals and
14 other parties pay a licensing fee to LeapFrog to use
15 that data, correct?

16 A No, I don't think hospitals license the
17 data.

18 Q Okay. So which parties or what types of
19 organizations license the data?

20 A Again, it's not my --

21 Q Understood. Just based on what you know.

22 A Based on what I know, that would be solution
23 providers and health plans.

24 Q Okay. So just kind of to put this in
25 perspective, the -- would contributions and honoraria

1 alone cover LeapFrog's expenses?

2 A Well, if we didn't -- I mean you have to ask
3 it a different way. Ask it again.

4 Q My question is: Would contributions and
5 honoraria alone, just alone, would those cover
6 LeapFrog's expenses?

7 A But that's not really in a vacuum --

8 Q That --

9 A -- so that wouldn't really make sense.

10 Q I'm just asking you the question. Yes or --
11 yes or no. I mean would, would -- just looking here,
12 right, contributions and honoraria for at least 2024,
13 would those -- just standing alone, would they have
14 covered the organization's expenses?

15 A Well, if that's all we had, then all you
16 would be employing is me, and yes, it would cover my
17 expenses.

18 Q Okay. About how many donors made gifts to
19 LeapFrog in the last five years or so?

20 A A thousand.

21 Q Okay, and do you have a ballpark what
22 percentage of those donors are institutions, like
23 hospitals, versus individuals?

24 A Hospitals don't donate to LeapFrog.

25 Q Okay. So they're all individuals?

1 A They're individuals or foundations.

2 Q Okay, and how do those donors generally
3 learn about or find out about LeapFrog?

4 A We do mailings or at our annual meeting or
5 on our website or social media.

6 Q Okay, and do you host events for donors?

7 A You have to be more specific.

8 Q Are there like specific events, right, that
9 you organize that -- where donors attend?

10 A We have our annual meeting.

11 Q So it's just the annual meeting?

12 A Yes.

13 Q Okay, and donors are -- donors attend these,
14 these annual meetings?

15 A Some of them, yes.

16 Q Okay, okay. So for the donors, what, what
17 generally is the pitch to the donors to get their
18 donations? Like what's, what's kind of the general
19 proposition to pitch to them?

20 A Transparency galvanizes change.

21 Q Okay, and how -- all right. That's -- and
22 how does LeapFrog do that?

23 A We --

24 Q Or is, or is how LeapFrog, the way that
25 LeapFrog goes about doing that part of the, part of

1 the pitch?

2 A Ask it again.

3 Q Yeah. So do you -- as part of that pitch,
4 do you describe to donors or potential donors how
5 LeapFrog specifically goes about achieving that?

6 A We keep things very high level for donors.

7 Q Okay. What does that mean?

8 A I mean we have five seconds to have a donor
9 read something, so we wouldn't go into details about
10 it, but if a donor wants to support patient safety,
11 then they should support LeapFrog.

12 Q Okay. Do you, do you describe at all what,
13 what, what LeapFrog does?

14 A We tell donors that we provide the hospital
15 safety grades and information about how patients can
16 stay safe in the hospital.

17 Q Okay. Do, do you discuss the hospital
18 grading system with them? What, what about the
19 hospital grading system do you discuss with potential
20 donors?

21 A We don't discuss details like that with
22 donors.

23 Q Okay. Why not?

24 A Because you have a quick sound byte to talk
25 to donors, and you want them to understand the mission

1 of the organization, and that's what we talk about.

2 Q All right. Do you get inquiries from donors
3 as to kind of the details of how the organization
4 grades hospitals?

5 A No, I haven't.

6 Q Okay. No, no curiosity from donors about
7 how exactly LeapFrog goes about grading hospitals?

8 A No.

9 Q Okay. So going back to the other, the other
10 revenue sources, membership here is 1.14 -- about
11 \$1.14 million for 2024 at least.

12 What do you mean by -- what do we mean by
13 "membership" here?

14 A That's our partners advisory committee.

15 Q Okay. Data products and reports is about
16 \$314,000.

17 What does that refer to?

18 A I don't know.

19 Q Okay. Media partnership is \$11,775. What
20 is that?

21 A We had a media partnership in the past,
22 before me, and that is some sort of left, left -- you
23 know, a final payment for something about that.

24 Q Okay. What, what -- was it a partnership
25 with a particular media outlet? Like what, what is

1 this referring to?

2 A I don't know. It wasn't something I was
3 involved in, and it was years ago.

4 Q Okay, but still revenue -- you're, you're
5 still getting revenue from it --

6 A I -- that was --

7 Q -- in 2024?

8 A -- a final payment.

9 Q Okay, and then grants in the amount of
10 \$776,520. What does that refer to?

11 A Donations from foundations.

12 Q Okay, and then investment income of \$44,330.
13 What is this referring to?

14 A Investment income.

15 Q Okay. The -- are you familiar with the
16 LeapFrog Certified Coach Program?

17 A Yes.

18 Q Okay, and what is that?

19 A That's a program mainly for solution
20 providers to learn about the survey.

21 Q Okay. To learn about -- why is it -- why,
22 why was it called a "coach"?

23 A That's sort of a catchy name.

24 Q Okay. So how does, how does that kind of
25 program work?

1 A They -- Missy Danforth presents it, and she
2 goes through the survey and explains what each of the
3 things mean.

4 Q Okay. Does the coaching -- does this
5 program also guide or give advice to hospitals on how
6 they should respond to the survey?

7 A No. It's not for hospitals, and it's not
8 about responding to the survey.

9 Q Okay. So just to be specific, who is it --
10 who is this target toward?

11 A Solution providers.

12 Q What is a solution provider?

13 A Like a Purell.

14 Q Okay, and so -- but basically for, for what
15 purpose?

16 So the coach -- so let's just kind of go
17 back to --

18 A Sure.

19 Q What are the certified coaches -- what
20 exactly are these solution providers hoping to get
21 from the -- from, from the coaching?

22 A So, for example, a Purell would want to
23 understand the hand hygiene standard. You know, what
24 does it mean when it says we observe 200 hand hygiene
25 interactions? So it's basically just explaining what

1 the survey says. I mean they could get it for free.
2 I mean it's literally -- if you just opened this up
3 and read it, that's exactly what it is, but it's
4 summarized more.

5 Q So why would a solution provider, you know,
6 company like Purell be interested, right, and might
7 want to hire a coach, right, from this program to
8 understand, let's say, the hand hygiene measure in the
9 survey? Why, why would they be interested in that?

10 A Purell wouldn't hire a coach. They --
11 Purell would send one -- I mean it's not "send." It's
12 a webinar. Purell would have one of their employees
13 learn about the survey.

14 Q But why would they be interested in learning
15 about the survey? They're not the ones -- the
16 hospitals are the ones responding to the survey,
17 right?

18 A Right.

19 Q Not a company like Purell. So why would
20 they be interested?

21 A So they understand what LeapFrog is asking
22 hospitals.

23 Q Okay, and is this, is this linked to,
24 somehow, the solution providers being on the partner
25 advisory board?

1 A No. They're totally separate.

2 Q Okay. How many LeapFrog -- how, how many of
3 these companies have used a LeapFrog or paid for a
4 LeapFrog certified coach, or how successful has this
5 program been?

6 A We just started it. I think it's been about
7 a year. I think we have like maybe 50 coaches.

8 Q Okay, and so --

9 A Maybe.

10 Q -- these -- LeapFrog's certified coaches are
11 not used by the hospitals at all?

12 A No.

13 Q All right, and this is addressed to solution
14 providers, correct?

15 A Correct.

16 Q All right. Are there any programs like the
17 LeapFrog Certified Coaching Program that are addressed
18 to hospitals?

19 A I don't work with hospitals. I don't know.

20 Q Okay. So you're not aware of any kind of
21 program where LeapFrog offers coaching or advisors or
22 counselors to hospitals on, on how to respond to or
23 just reviewing the survey?

24 A No.

25 MR. CHUNG: Okay. Let's go to tab 11, which

1 will be Exhibit 8.

2 (Exhibit 8 was marked for
3 identification.)

4 BY MR. CHUNG:

5 Q Okay. So I'm -- before we look at the
6 document, Ms. Jupiter, the, the annual -- LeapFrog's
7 annual meetings that you organize or help organize,
8 what's the, kind of the principal purpose of these
9 annual meetings or the primary goal of these annual
10 meetings?

11 A Education.

12 Q Education about what?

13 A Patient safety.

14 Q Okay. Is another kind of primary goal to,
15 to raise revenue?

16 A I wouldn't -- it's not a primary goal.

17 Q Okay, and the annual meeting, it's just one
18 meeting per year, correct?

19 A Annually.

20 Q Yeah, okay, and what percentage of the --
21 and we went over the annual meeting revenue from the
22 financial document. What percentage of that revenue
23 is from ticket sales versus other sources?

24 A That's a good question. I'm trying to --
25 what percentage from ticket sales?

1 Q Yeah.

2 A 20 percent, maybe. I'd, I would have to
3 look at numbers.

4 Q Okay, but fair to say -- again, this, I know
5 this is just ballpark --

6 A Yeah.

7 Q -- that a bigger percentage comes from
8 sponsorships versus ticket sales?

9 A Let me think about the numbers. Let me
10 think.

11 Yeah, I would say more is from sponsorships.

12 Q Okay, and generally, where do these
13 sponsorships come from?

14 A Solution providers.

15 Q Okay. Anything from hospitals?

16 A No. Hospitals don't sponsor an annual
17 meeting.

18 Q Okay.

19 All right. So let's look at Exhibit 8
20 that's in front of you, and it is a -- it's taken from
21 Slack, Slack messaging between you and I think at
22 least one of your colleagues.

23 Is, is Slack kind of the, the main -- the
24 primary messaging tool that LeapFrog uses?

25 A It depends on the person.

1 Q Okay. So is -- what do you mean by that?

2 A Like Leah doesn't use Slack, so we don't
3 communicate with Leah on Slack.

4 Q What does she use?

5 A I think email. I mean I communicate with
6 her by email.

7 Q Okay. So no -- there aren't any kind of
8 messaging platforms, instant messaging platforms that,
9 that she uses --

10 A No.

11 Q -- to communicate with LeapFrog employees?

12 A No.

13 Q Okay, but this -- but the Slack platform is
14 one -- is it one that LeapFrog provides to, to you and
15 your colleagues?

16 A Yes.

17 Q Okay. Are there other messaging
18 applications that LeapFrog provides or uses?

19 A No.

20 Q Okay. So in this exchange -- first of all,
21 who is the other person on this exchange? There's an
22 "am-hopkins 15."

23 Who is that?

24 A She's our office administrator.

25 Q Okay, and what's her name?

1 A Angela.

2 Q All right. Angela. Is it Angela Hopkins or
3 Angela Ridley?

4 A She was -- it was Ridley. When she was
5 divorced, it was Hopkins.

6 Q Okay, and she's asking you "can you remind
7 of the registration fees for the AM."

8 Is she referring to the annual meeting?

9 A Yes.

10 Q Okay, and then for 2024, and then you write,
11 "Leah said we need to raise for 2025," and she says,
12 "Yes, sorry," and she asked, "Why? Just to make more
13 money?" And then you reply -- you reply, "Yes,"
14 right?

15 Is that, is that what Leah -- is that what
16 Ms. Binder told you, that the, that the fees for the
17 annual meeting needed to be increased to basically
18 generate revenue, to make more money?

19 A We were losing money on the annual meeting.
20 It was costing us more to put on the meeting than we
21 were selling tickets for.

22 Q Okay. So the question is: What did she --
23 did you have a conversation with Ms. Binder where she
24 said you need to raise the, basically the, the ticket
25 prices for the annual meeting in order to make more

1 money?

2 A I wouldn't say to make more money; I would
3 say to lose less money.

4 Q Okay. The -- is this -- are you having this
5 kind of Slack conversation or messaging with
6 Ms. Hopkins -- it's -- it looks like it's -- this is
7 happening while there's also a call or maybe a meeting
8 happening at the same time.

9 A I assume so, because I said it's "hard to
10 hear."

11 Q "It's hard to hear Leah."

12 A Mm-hmm.

13 Q Do you remember what that meeting was about,
14 kind of going on at the same time?

15 A I don't.

16 Q Okay, okay.

17 All right. Just to be clear, your testimony
18 was that, was that hospitals do not pay for any
19 sponsorships at the annual meeting?

20 A Hospitals do not sponsor.

21 Q At all? Okay.

22 A No.

23 Q Okay, and why is that?

24 A We don't solicit hospitals to sponsor the
25 annual meeting.

1 Q Okay, and, and why is that? Why, why
2 doesn't LeapFrog solicit hospitals for sponsorships
3 for the annual meeting?

4 A We're grading hospitals, so we're not going
5 to ask them to give us money.

6 MR. CHUNG: Okay. We'll now turn to tab 12.

7 (Off the record discussion about a
8 possible lunch recess.)

9 THE VIDEOGRAPHER: The time is 12:18 p.m.
10 This ends unit 2. We're off the record.

11 (Whereupon, the lunch recess was
12 taken.)

13 THE VIDEOGRAPHER: The time is 1:10 p.m.
14 This begins unit number 3. We're on the record.

15 MR. CHUNG: All right. Ms. Jupiter, we're
16 going to put in front of you a document marked
17 Exhibit 9.

18 (Exhibit 9 was marked for
19 identification.)

20 BY MR. CHUNG:

21 Q It is a 2025 sponsorship prospectus for the
22 LeapFrog annual meeting and awards dinner, and do you
23 recognize this document?

24 A Yes.

25 Q And just generally, can you describe what it

1 is?

2 A These are the information on our annual
3 meeting and sponsorships.

4 Q Okay, and this is looking ahead to the
5 annual meeting that is going to take place on
6 December 15 of this year?

7 A Yes.

8 Q Okay. On the, on the -- in -- if you look
9 at the third page ending with Bates number LEAPFROG
10 455, under "Why Sponsor," it reads, "The LeapFrog
11 Group gathers its key stakeholders and constituents
12 for a meeting each year to discuss urgent topics," and
13 so forth.

14 And it reads, "This event provides an
15 amazing opportunity for you to elevate your brand's
16 exposure and make unparalleled connection with
17 hospital and ASC leadership. LeapFrog supports your
18 strategic growth acceleration goals."

19 So who, who is this -- who is the audience
20 here? Who, who is this -- what, what -- this
21 statement about why, why to sponsor the event, who is
22 the audience here?

23 A Solution providers.

24 Q All right. So you're soliciting
25 sponsorships from solution providers, correct?

1 A Correct.

2 Q Right, and part of the pitch here is that
3 there will be representatives from hospitals and ASCs
4 at the, at the annual meeting, correct?

5 A Correct.

6 Q All right, and it's an opportunity basically
7 to network and for solution providers potentially to
8 gain business from hospitals and ASCs, correct?

9 A Correct.

10 Q Okay, but just to be clear, the, the
11 audience, in terms of sponsorships, does not include
12 hospitals?

13 A No.

14 Q Okay. If you turn to the next page, Bates
15 ending 456, you'll see here two 2025 sponsorship
16 opportunities, and what does this -- can you describe
17 what, what's being -- what's laid out here?

18 A These are the different levels of
19 sponsorships and the benefits you receive.

20 Q Okay, and are these, are these prices or are
21 these figures kind of accurate as of today?

22 A Yes.

23 Q Okay. So \$45,000 for a platinum exclusive,
24 and then down the line, right?

25 A Yes.

1 Q Okay, and how many sponsors I guess to date
2 have paid for the platinum exclusive sponsorship?

3 A One, because it's exclusive.

4 Q Okay, and how about the next level down, the
5 gold?

6 A I think we have two gold.

7 Q Okay. Already signed up?

8 A Yes.

9 Q Okay, and how many for silver?

10 A I'm trying to picture the thing. Maybe we
11 have three silver.

12 Q Okay, and bronze?

13 A Ten.

14 Q Okay. So these are just ballpark?

15 A Yes.

16 Q And champion?

17 A I don't think we have any champion at the
18 moment.

19 Q Okay. How much does LeapFrog expect to
20 raise in sponsorships, just sponsorships from the 2025
21 annual meeting?

22 A \$300,000.

23 Q Does LeapFrog expect to make profit off the
24 2025 annual meeting?

25 A If we do, it's very minimal.

1 Q Okay, but is that a goal, to make some --

2 A I'd have to --

3 Q -- some amount of profit from the meeting?

4 A I think the goal for this year is to break
5 even.

6 MR. CHUNG: Okay. Why don't we move on to
7 tab 13, which we'll mark as Exhibit 10.

8 (Exhibit 10 was marked for
9 identification.)

10 BY MR. CHUNG:

11 Q Okay, and it is an email chain from
12 August 25 of 2023. Just take a moment to review it.

13 (Witness peruses document.)

14 BY MR. CHUNG:

15 Q Have you had a chance to look through it?

16 A Mm-hmm.

17 Q Okay. Do you recognize what's being
18 discussed here?

19 A Yes.

20 Q Okay, and what's being discussed?

21 A Our keynote speaker was Joe Kiani, and he
22 works for Masimo.

23 Q And what is Masimo?

24 A That's a great question. A healthcare
25 company.

1 Q Okay, and so you emailed Ms. Binder on
2 August 25 of 2023 to reach out -- about reaching out
3 to Masimo's, to Masimo's potential sponsorship of the
4 LeapFrog's annual meeting that year; is that right?

5 A Correct.

6 Q And so why were you pursuing Masimo as a
7 potential annual meeting sponsor?

8 A Because we were looking for sponsors for the
9 annual meeting.

10 Q Okay, and you see at the top of the page I'm
11 looking at, the first page, Bates ending 180, that
12 Ms. Binder writes, "I don't want them to sponsor. It
13 would appear that our keynote is pay-to-play, and that
14 is the kiss of death for our credibility on a lot of
15 fronts."

16 Do you see that?

17 A Yes.

18 Q Okay. What did you take her to mean there?

19 A So the head of Masimo was our keynote
20 speaker, and so she didn't want to ask them for money,
21 because that would look suspicious.

22 Q Okay.

23 A So she said stay away from that.

24 Q Just to -- what, what did she mean -- why
25 would having -- was it the CEO of Masimo --

1 A I think so.

2 Q -- okay -- be the keynote at the annual
3 meeting, how, how would that be pay-to-play, as you
4 understand it?

5 A Well, it wasn't pay-to-play, because we --
6 she didn't want to do it.

7 Q Right, but if, if a sponsorship was obtained
8 from Masimo, what, what -- how did you understand that
9 would, that would be a pay-to-play?

10 A It would look like he was making a donation
11 to speak at our annual meeting.

12 Q Okay. Has anybody kind of inside or outside
13 LeapFrog expressed concerns about any perception that
14 these sponsorships are pay-to-play?

15 A No, and we're very clear that that is not
16 something -- you know, one of the -- we've had
17 sponsors email and ask if they can be on a panel or if
18 they can speak, and we say no.

19 Q Okay. Has anybody either inside or outside
20 LeapFrog expressed any concerns that any other part of
21 LeapFrog's operations is pay-to-play?

22 A No.

23 Q Okay. So in the, in the next sentence in
24 Ms. Binder's email, she writes she will "work through
25 Joe to get them to join as a partner; then we can work

1 on them for next year as a sponsor."

2 Do you see that?

3 A Yes.

4 Q So how did you understand that plan to fix
5 the concern that the keynote is a pay-to-play?

6 A I mean that she very much wanted to stay
7 away from pay-to-play, so we could talk to them about
8 being a part of the partners advisory committee
9 possibly in the future.

10 Q Okay, and so how would potentially having
11 Masimo on the partners advisory committee address,
12 address the concern, the suspicion that, that their
13 participation is pay-to-play?

14 A It's -- they're separate things.

15 Q How are they separate?

16 A I'll need you to rephrase the question.

17 Q Can you explain kind of how, how they're
18 separate things?

19 A I mean them being part of our partners
20 advisory committee has nothing to do with the annual
21 meeting or speaking at the annual meeting. We asked
22 them to speak at the annual meeting completely
23 independent of anything else.

24 Q Okay. So the, the proposal from Ms. Binder
25 that she will work to get them -- get Masimo to join

1 as a partner on the partners advisory committee, that
2 then that would allow, open the door to, to LeapFrog
3 to pursue them the following year as a sponsor; is
4 that correct?

5 A Possibly.

6 Q Okay. Would it address the concern that
7 having anyone from Masimo or an office for Masimo --
8 would it allow the CEO of Masimo to serve as a
9 keynote?

10 A They were already serving as a keynote.
11 That was long established, well before this.

12 Q Okay. Did -- do you know if Ms. Binder
13 followed through with this -- with the proposal?

14 A I don't know.

15 Q Okay. Do you know whether Masimo eventually
16 joined either as a partner on the --

17 A They did not.

18 Q -- on the PAC or --

19 A Nope.

20 Q -- or as a sponsor?

21 MS. BLAIR: Let him finish his question.

22 THE WITNESS: Sorry.

23 No, they're not a partner, nor a sponsor.

24 MR. CHUNG: Okay. So let's go to our next
25 document, tab 14.

1 This will be Exhibit 11.

2 (Exhibit 11 was marked for
3 identification.)

4 BY MR. CHUNG:

5 Q Okay. Another email chain, Ms. Jupiter,
6 this time from earlier this year, in May 2025. Just
7 let me know when you've had a chance to review it.

8 (Witness peruses document.)

9 THE WITNESS: Okay.

10 BY MR. CHUNG:

11 Q Okay. What's being discussed in this, in
12 this email discussion?

13 A Paul is approaching a potential PAC
14 sponsor -- a PAC member about becoming a PAC member
15 with LeapFrog.

16 THE REPORTER: P-A-C-K?

17 THE WITNESS: P-A-C.

18 BY MR. CHUNG:

19 Q PAC. Partners advisory committee, right?

20 A Correct.

21 Q And so if we look at the second page, Bates
22 ending LEAPFROG 974, Mr. Alper writes to Andrea Clay
23 and Nicholas Cantacuzene.

24 And so who is Ms. Clay, Andrea Clay?

25 A She's the director of corporate giving.

1 Q Okay, and, and you mentioned Mr. Cantacuzene
2 earlier, but what's his role?

3 A Membership coordinator.

4 Q Okay. He writes to the two of them, "I
5 think what we need coming out of this is a white paper
6 that illustrates how companies are using various
7 solutions and technologies to improve their LeapFrog
8 scores. Another selling tool or proof source, if you
9 will."

10 What is he -- what's he proposing here?

11 A Honestly, that's a great question. I --

12 Q What did you understand him to be proposing
13 here?

14 A He wants a white paper about how solution
15 providers' products can improve LeapFrog's scores.

16 Q Okay, and he's saying that this is a,
17 potentially, "a selling tool or proof source, if you
18 will."

19 Do you understand what he -- do you
20 understand what he's saying here?

21 A Yes.

22 Q What is he saying here?

23 A He's saying that if we can show solution
24 providers that hospitals use their tools, they could
25 get a better LeapFrog score.

1 Q Okay, and is the idea here -- just trying to
2 make the --

3 A Sure.

4 Q -- links here. Is the idea here that by
5 presenting this white paper, right, to a solution
6 provider like -- looks like the Wolters Kluwer
7 company, that it would convince them or encourage them
8 to pay and join the partners advisory committee,
9 because it would basically give them access to
10 hospitals, right, that, based on this white paper, use
11 solutions and technologies to improve their scores,
12 correct?

13 A That's his theory, yes.

14 Q That's the idea. Okay, and then eventually
15 this, this email chain reaches you on, on May 16,
16 2025. Andrea Clay writes, "It's a ridiculous
17 overreaction for sure." And I'm looking at the top
18 of --

19 A Yes.

20 Q -- Bates 973. "I also don't think we can
21 actually say how companies are using various solutions
22 and technologies to improve their LeapFrog scores."

23 What, what does she mean by, first, "It's a
24 ridiculous overreaction, for sure"?

25 A She meant it was an overreaction, because

1 this one prospect who we were somewhat talking to
2 asked a question, and that shouldn't lead to a whole
3 project and white paper.

4 Q Okay. So it would be a big undertaking --

5 A Huge undertaking for --

6 Q Okay, and Ms. Clay also writes, "I also
7 don't think we can actually say how companies are
8 using various solutions and technologies to improve
9 their LeapFrog scores," she continues, right? And
10 then you respond, "We cannot say that. Oy, Paul."

11 Why -- how -- why did you respond in that
12 manner?

13 A Because we're, we're not going to use
14 LeapFrog scores to sell products.

15 Q LeapFrog scores to sell -- but isn't that,
16 isn't that what -- when we talked about -- when we
17 went over the, the line items regarding the accolade
18 licensing, right, revenue, right, isn't that what,
19 isn't that what LeapFrog is doing with respect to the
20 hospital safety grades?

21 MS. BLAIR: Objection to form.

22 THE WITNESS: No. I mean what you're
23 saying --

24 BY MR. CHUNG:

25 Q Okay, so --

1 A -- doesn't make sense.

2 Q Isn't, isn't LeapFrog, by licensing,
3 right -- just this is my analogy. Isn't LeapFrog, by
4 licensing, giving licenses to hospitals to use their
5 hospital safety grades, right, isn't that using
6 LeapFrog products -- i.e., the hospital safety
7 grades -- to, to raise money?

8 MS. BLAIR: Objection to form.

9 THE WITNESS: That has nothing to do with
10 this. This isn't a Leap- -- he's not talking
11 about LeapFrog products.

12 BY MR. CHUNG:

13 Q Okay. So what is he referring to here, and
14 you're, and you're responding that he cannot say?

15 A He's saying like Purell.

16 Q Okay.

17 A Like that Purell could say to a hospital.
18 "If you use our product, you'll get a better grade."

19 Q That, that, you're saying, is improper?

20 A Yes.

21 Q Okay. Why is that improper?

22 A Because we're not in the business of selling
23 Purell.

24 Q Okay, but you are selling access to
25 hospitals, right --

1 A We are --

2 Q -- to, to solution providers that pay money
3 to join the partners advisory committee; is that
4 correct?

5 MS. BLAIR: Objection to form.

6 THE WITNESS: We're not selling access to
7 hospitals. We're providing hospitals with
8 information from other solution providers.

9 BY MR. CHUNG:

10 Q Right, but solution providers are paying
11 money, right, to be able to communicate, meet, right,
12 and interact, and pitch their products or solutions to
13 hospitals through this partners advisory committee;
14 isn't that a fair, a fair description of the purpose
15 of the partners advisory committee?

16 MS. BLAIR: Objection to form.

17 THE WITNESS: No, that's not what the
18 partner advisory committee is about.

19 BY MR. CHUNG:

20 Q Then why, why would solution providers pay
21 tens of thousands of dollars to join the partners
22 advisory committee?

23 A They can network with each other and hear
24 about things that are happening with LeapFrog. They
25 don't -- we don't -- they don't meet with hospitals.

1 Q They don't meet with hospitals as part of
2 the partners advisory --

3 A No.

4 Q -- committee? Okay. So there's no
5 interaction between solution providers and the
6 partners advisory committee?

7 A Solution --

8 Q Solution providers and hospitals at meetings
9 or events involving the PAC?

10 A If a solution provider were to buy a ticket
11 to the annual meeting, and a hospital is there, they
12 would talk to them.

13 MR. CHUNG: Okay. Let's turn to, let's turn
14 to tab 16, and this will be Exhibit 12.

15 (Exhibit 12 was marked for
16 identification.)

17 BY MR. CHUNG:

18 Q Okay. You have in front of you a Slack
19 discussion, similar to the ones we looked at before,
20 and it's with -- between you and Lauren Bailey.

21 Do you see that?

22 A Yes.

23 Q Okay, and it's from March 21 of 2024. What
24 is being discussed here?

25 A I don't know.

1 Q Okay. Do you see where Ms. Bailey says that
2 one of the common questions LeapFrog gets is that it
3 is pay-for-play?

4 Do you see that?

5 A I don't -- I see where she says
6 "pay-for-play." I don't, I don't have any context for
7 what she's talking about.

8 Q Okay. Well, let's maybe -- the line before,
9 she writes -- you write, "She's in a great mood. Had
10 a DR call."

11 What is the "DR" referring to?

12 A My son was having medical issues, and I
13 called his doctor.

14 Q Got it. Okay. So it's a doctor. All
15 right.

16 What is "she" talking about? Who is the
17 "she" that you're referring to?

18 A I don't know.

19 Q Okay. So Ms. Bailey writes, "She wants CURA
20 to be ready to ask and help staff answer common
21 questions we get."

22 What is or who is CURA?

23 A CURA is our public relations firm.

24 Q Okay, and what were they doing at this time
25 with respect to LeapFrog?

1 A I don't know.

2 Q Okay. What generally -- what generally do
3 they do with respect to LeapFrog?

4 A Public relations.

5 Q Okay. So do they interact with the press
6 on, on LeapFrog's behalf?

7 A They would set up interviews on LeapFrog's
8 behalf. We -- they don't speak to the press for us,
9 but they would make connections.

10 Q All right. Do you agree that it's a common
11 question LeapFrog gets, that it's pay-for-play?

12 A No.

13 Q No? So you've never heard that terminology
14 being used to describe or refer to any of LeapFrog's
15 operations?

16 A I have in this lawsuit.

17 Q Putting aside this lawsuit, right?

18 A No.

19 Q None at all?

20 A No.

21 Q Okay. How about the next, the next line
22 under Ms. Bailey? She writes, "or a hospital gets a
23 bad CMS star rating, but an A. Why," right?

24 Is that a, a common question that LeapFrog
25 gets from consumers or hospitals or from the public?

1 A It's not a common question.

2 Q Okay. Have you gotten that question at all
3 or any sort of concern or remark along those lines at
4 all?

5 A I haven't.

6 Q Okay. Not at all?

7 A No.

8 Q Okay. Is there a -- she writes, "I told her
9 they have the commonly asked questions that we give to
10 RLs, that's right."

11 Do you know what she's referring to here?

12 A RLs are our regional leaders, and we have an
13 FAQ document that we give to regional leaders, so I'm
14 assuming that's what that's about.

15 Q Okay. What's the purpose of the FAQ
16 document?

17 A To answer frequently asked questions.

18 Q Okay. Frequently asked questions coming
19 from where?

20 A I don't know. From -- I mean to regional
21 leaders. I don't know where from.

22 Q Okay. Are you involved in putting together
23 that FAQ or the, the commonly asked questions?

24 A No.

25 Q Okay. Who is in charge of that?

1 A The regional leader FAQ is from Jill Berger.

2 Q Okay, and does she report to you?

3 A Yes.

4 Q Do you have at least an oversight over the,
5 the FAQs, commonly asked questions?

6 A I've seen them.

7 Q Okay, and how often do they go out to
8 regional leaders?

9 A I think they're on the regional leaders
10 website, so whenever they look them up.

11 Q Okay. So it's not a document that's sent
12 out? It's on a, like an internet regional leaders
13 website?

14 A Right.

15 Q Okay. Let's go back to the hospital survey,
16 the, the big document, which I think was Exhibit 2.

17 Are, are you familiar with the requirement
18 that hospitals that participate or respond to the
19 survey are required to confirm or affirm that LeapFrog
20 may use the information they submit in the survey in a
21 commercial manner for profit?

22 A No.

23 Q You're not familiar with that clause at all?

24 A No.

25 Q Okay. Are you familiar with that concept at

1 all, that hospitals know that the data that they
2 submit in response to the survey can be used by
3 LeapFrog for commercial purposes?

4 A No.

5 Q Okay. Are you aware that LeapFrog does use
6 that data that hospitals submit for commercial
7 purposes?

8 A I know that we sell the data --

9 Q Okay.

10 A -- yes.

11 Q Can a hospital opt out of, of this
12 requirement that they affirm that LeapFrog can use
13 their data for commercial purposes?

14 A I don't know.

15 Q Don't know? Okay.

16 Do you know -- have you heard any feedback
17 or any complaints from hospitals about not being able
18 to opt out, opt out of this requirement?

19 A No. I don't communicate with hospitals.

20 Q Okay. Not necessarily -- not with, directly
21 with hospitals themselves, or have you heard --

22 A No.

23 Q -- at all of any complaints?

24 A No.

25 Q No? Okay. Okay.

1 The -- so let's talk about how LeapFrog uses
2 hospital survey information commercially for profit.
3 So can you describe -- we'll go kind of one by one of
4 the different ways as we understand it.

5 The hospital safety grades, how does
6 LeapFrog use the hospital safety grades in a
7 commercial manner?

8 A I don't know.

9 Q Okay. You're not aware of how LeapFrog uses
10 commercial safety grades to, to raise revenue?

11 A I am not.

12 Q All right. I think you testified earlier
13 you are aware that, that there's a licensing
14 program --

15 A Yes.

16 Q -- right?

17 A (Nods.)

18 Q So isn't that a way for -- isn't that a way
19 that LeapFrog uses the health [sic] safety grades to
20 raise revenue?

21 A It's not --

22 MS. BLAIR: Objection to form.

23 THE WITNESS: It's not "health" safety
24 grades.

25

1 BY MR. CHUNG:

2 Q Hospital safety grades.

3 A Right. I know that it exists. I don't know
4 anything about it.

5 Q But do you understand the hospital safety
6 grade licensing program, right --

7 A No.

8 Q -- to be a way for the, for the organization
9 to raise revenue?

10 A Repeat your question.

11 Q Right.

12 So I take your point, right, that you're not
13 intimately familiar with how the licensing program
14 works, right, but are you at least aware that
15 LeapFrog -- that the licensing, that the licensing of
16 the hospital safety grades, right, by hospitals is a
17 way that LeapFrog raises revenue?

18 A Yes.

19 Q Okay. How about the hospital survey data;
20 are you aware that LeapFrog licenses, right, the
21 hospital survey data to raise revenue?

22 A Yes.

23 Q Okay, and I think you testified earlier that
24 there are certain parties to whom this hospital survey
25 data is licensed, correct?

1 A Yes.

2 Q Again, who -- generally speaking, who are
3 these parties?

4 A I'm not very intimately involved, but I
5 think to solution providers and health plans.

6 Q Okay. How about the LeapFrog value-based
7 purchasing program; are you familiar with that?

8 A I know it exists.

9 Q Okay, and what is it?

10 A That I don't know.

11 Q Okay. Is it correct that LeapFrog licenses
12 the hospital safety grades to insurance companies?
13 Are you aware of that?

14 A Yes.

15 Q Okay. How many insurers have licensing
16 deals with LeapFrog?

17 A I don't know.

18 Q All right. Do you know any specific
19 insurance companies that have licensing arrangements
20 or deals with LeapFrog?

21 A I don't.

22 Q All right. Can you describe, can you
23 describe how those licensing deals work? How, how
24 is -- how are the insurance companies licensing the
25 hospital safety grades from LeapFrog?

1 A I have no idea.

2 Q Do you know what the insurance companies are
3 using the license hospital safety grades for?

4 A I don't.

5 MS. BLAIR: Object to form.

6 BY MR. CHUNG:

7 Q Does LeapFrog approach insurance companies
8 about, about these licensing deals?

9 A I don't know.

10 Q Okay. Do you know whether insurance
11 companies approach LeapFrog about licensing the
12 hospital safety grades?

13 A I don't know.

14 Q Okay. Who at LeapFrog is in charge or
15 oversees the licensing program?

16 A Kush Banerjee.

17 Q Okay. So understanding that you're not
18 intimately familiar, right, with the licensing
19 program, isn't, isn't LeapFrog -- doesn't it make
20 sense to have as many hospitals as possible
21 participate in the survey, so that LeapFrog can
22 convince insurance companies that the, the safety
23 grades have value?

24 MS. BLAIR: Objection to form.

25 THE WITNESS: The reason we want hospitals

1 to participate in the survey is because we want
2 to have transparency around hospital safety, and
3 we want to share that information with the
4 public.

5 BY MR. CHUNG:

6 Q Okay, but I'm asking about in the context of
7 these -- the licensing arrangements, right, with the
8 insurance companies, right?

9 In order to, in order to convince insurance
10 companies, right, that these, that these licenses have
11 value, I mean isn't LeapFrog incentivized to get as
12 many hospitals as possible to participate in the
13 survey?

14 A I have no idea how that works. I don't, I
15 don't know.

16 Q Okay. It's not so much whether you know how
17 it works; I'm just kind of asking for your view,
18 right?

19 A I don't have a view on that.

20 Q No view whatsoever?

21 A (Shakes head.)

22 Q Okay. Does -- are you aware that LeapFrog
23 licenses hospital survey data that it gets from
24 hospitals to researchers?

25 Are you aware of that?

1 A I'm aware.

2 Q Okay. Do you know generally how many
3 researchers or research institutions have these
4 licensing arrangements with LeapFrog?

5 A I have no idea.

6 Q Okay. Generally speaking, are these
7 researchers like at universities or medical schools?

8 A I have no idea.

9 Q Okay. Who oversees the, the licensing
10 program or the licenses with the researchers?

11 A Kush Banerjee.

12 Q Okay. Does LeapFrog approach researchers
13 about, researchers about these licensing deals, or is
14 it the other way? Do researchers approach LeapFrog?

15 A I have no idea.

16 Q Okay. Do you know how much revenue --
17 ballpark, right -- LeapFrog earns from these licensing
18 arrangements with researchers?

19 A I don't.

20 Q Okay, and a similar question than before,
21 in order to convince researchers to actually buy these
22 licenses, right, isn't LeapFrog incentivized to have
23 as many hospitals as possible participate in the
24 survey?

25 Again, just asking for your view, not

1 because you know a lot about these licensing --

2 A I don't have a view on that.

3 Q Okay. Are you also aware that LeapFrog
4 licenses the hospital survey data that it gets from
5 hospitals to various businesses? Are you aware of
6 that?

7 A Yes.

8 Q Okay. What types of businesses have these
9 licensing deals?

10 A Solution providers.

11 Q Okay, and do, do you have a ballpark idea of
12 how many businesses have these licensing deals?

13 A I don't.

14 Q Okay. Do you have kind of any examples of
15 solution providers that have entered into these
16 licensing deals?

17 A I think GOJO might be one.

18 Q What's GOJO?

19 A Purell.

20 Q Okay. All right. Any other companies or
21 businesses that you know have these licensing deals?

22 A I know BioVigil had one.

23 Q Any others?

24 A Those are the only ones I can think off the
25 top of my head.

1 Q How about hospitals? So just to be
2 specific, competitor hospitals buying like licenses to
3 the survey data of other hospitals?

4 MS. BLAIR: Objection to form.

5 THE WITNESS: That's -- as far as I know,
6 that's not something we do. I don't think you
7 can buy another hospital's data.

8 BY MR. CHUNG:

9 Q What, what makes you think that, that you,
10 that you can't do that?

11 A I've, I've never heard of that before.

12 Q Okay. Would it surprise you to learn that,
13 that competitor hospitals can buy -- can license
14 survey data of their competitor hospitals?

15 A I don't know if it would surprise me, but
16 I've never heard of that before.

17 Q Okay. The same question as earlier: In
18 order to convince the solution providers and other
19 businesses to license this hospital survey data,
20 isn't -- doesn't it make sense for LeapFrog to get as
21 many hospitals as possible to participate in the
22 survey?

23 MS. BLAIR: Objection to form.

24 THE WITNESS: I don't know what their
25 decisions are based on, their purchasing

1 decisions are based on.

2 BY MR. CHUNG:

3 Q Okay. Would it make sense for their
4 purchasing decision, right, specific to these
5 licenses, be based on, on their assessment of how
6 valuable these licenses are?

7 A I don't know enough about the data to have
8 an opinion on it.

9 Q Okay. So we've gone over a number of ways
10 that -- a number of revenue streams, right, arising
11 out of the hospital safety grades and the hospital
12 survey data.

13 It -- is it fair to say that the revenue
14 coming from -- these revenue streams are important to
15 LeapFrog's bottom line?

16 A Yes.

17 Q Okay, and is this -- are these revenue
18 streams based on licensing of the safety grades and
19 the, and the survey data? Are these, are these
20 revenue streams a focus of, of Ms. Binder when it
21 comes to raising revenue for the, for the, for the
22 organization?

23 A I don't know.

24 Q Okay. Is it, is it something that, that
25 you've discussed with her?

1 A No.

2 Q Okay. Not at all? Like it's not a topic
3 between you and Ms. Binder?

4 A No. I discuss fundraising.

5 MR. CHUNG: Okay. Let's go to tab 17, and
6 this will be Exhibit 13.

7 (Exhibit 13 was marked for
8 identification.)

9 BY MR. CHUNG:

10 Q Okay. We've put in front of you Exhibit 13.
11 It's a -- looks like a PowerPoint from TelAffects
12 entitled "The LeapFrog Group Fall 2024 Accolades
13 Campaign Recap."

14 Are you familiar with TelAffects?

15 A I've heard of TelAffects, yes.

16 Q And what or who are they?

17 A They're the vendor who does the sales of our
18 accolades.

19 Q Okay, and so the -- so what exactly are they
20 selling?

21 A They reach out to hospitals to sell their
22 safety grade license.

23 Q Okay. So this is, this is an area that, I
24 think you testified earlier, that Mr. Banerjee kind of
25 oversees; is that right?

1 A Yes.

2 Q And does -- so does he have -- does he
3 oversee TelAffects as the vendor --

4 A Yes.

5 Q -- that sells these licenses?

6 A Yes.

7 Q Okay, and how does TelAffects go about
8 selling or marketing the hospital safety grades to, to
9 various parties?

10 A I don't know.

11 Q Okay. Have you seen this document before?

12 A I have not.

13 Q I'll give you a chance -- have a chance to
14 flip through it.

15 (Witness peruses document.)

16 BY MR. CHUNG:

17 Q Okay. After just -- after flipping through
18 the document, do you recognize the document?

19 A No.

20 Q Haven't seen this before?

21 A No.

22 Q All right, but let's turn to -- it will be
23 page 17, Ms. Jupiter, Bates ending in LEAPFROG 758.
24 Okay, and this slide is entitled "Revenue by Fiscal
25 Year: HSG," which we understand to mean hospital --

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1 corresponding hospital safety grades.

2 Here, do you see that in the years covered
3 here, between 2017 and 2025, that LeapFrog, at least
4 according to Tel- -- according to this organization,
5 has made between \$1.5 million and over \$3.5 million
6 per fiscal year from the hospital safety grade
7 accolades?

8 MS. BLAIR: Objection to form.

9 BY MR. CHUNG:

10 Q Do you see that?

11 A Yes.

12 Q Okay, and is it fair to say that that is a
13 substantial part of LeapFrog's annual revenue?

14 A It's a part of LeapFrog's annual revenue.

15 Q Okay. Is it a small part of it?

16 A It's probably around a quarter of the
17 revenue.

18 Q A quarter? Okay, and is that, is that --
19 would you consider that substantial?

20 A I would consider it a quarter.

21 Q Okay, and this figure, what, what do you
22 understand this figure to include in terms of the --
23 in terms of revenue coming from the health [sic]
24 safety grades?

25 A It's not health safety grades.

1 Q Hospital safety grades. I'm sorry.

2 A What's your question?

3 Q What do you understand this revenue to
4 include in terms of the various products?

5 A It looks like this is accolade sales.

6 Q Okay. So what does that include? What
7 types of revenue sources or products does that
8 include?

9 A The accolade licensing.

10 Q Okay. Does it include the data licensing?

11 A I don't think so.

12 Q Okay. How about the top, any revenue from
13 top hospitals, the top hospitals program? Are you
14 familiar with that?

15 A I'm familiar with it. I don't know. I, I'm
16 assuming not, because it says "HSG," so I'm assuming
17 it's just hospital safety grade.

18 Q Okay. In terms of the marketing for the
19 health -- the hospital safety grades, are you aware
20 that LeapFrog's marketing focuses on the hospitals
21 that have received an A hospital safety grade?

22 A Yes.

23 Q Okay, and why is that?

24 A Because if you have a bad grade, you don't
25 want to advertise it.

1 Q Okay, and so another way to put it: Is it
2 fair to say that the focus on the marketing is on the
3 A hospitals because they're more likely or most likely
4 to agree to license their grades, correct?

5 A Yes.

6 Q Okay, and so going back to the, kind of the
7 change in the imputation methodology that we discussed
8 earlier, by penalizing nonparticipating hospitals by
9 assigning them the limited achievement grade, is it
10 fair to say that you're helping participating
11 hospitals earn their A grades more easily?

12 MS. BLAIR: Objection to form.

13 THE WITNESS: No. It's the opposite.

14 BY MR. CHUNG:

15 Q Okay. How is it the opposite?

16 A If we wanted to make more money from
17 licensing accolades, we would give more As, not less.

18 Q Okay. Let me ask another question, somewhat
19 related.

20 By penalizing nonparticipating hospitals by
21 giving, by automatically giving them the, the limited
22 achievement score, you are -- is it fair to say that
23 LeapFrog is encouraging them, these hospitals, or
24 inducing them to participate in the future in the
25 hospital survey?

1 MS. BLAIR: Objection to form.

2 THE WITNESS: I don't understand the
3 question.

4 BY MR. CHUNG:

5 Q Okay. I'll repeat it.

6 So by penalizing the nonparticipating
7 hospitals that don't submit responses to the survey,
8 right, is it fair to say that LeapFrog is trying to
9 encourage or induce these nonparticipating hospitals
10 to participate in the future?

11 MS. BLAIR: Objection to form.

12 THE WITNESS: We want as much information
13 about patient safety as possible, yes.

14 BY MR. CHUNG:

15 Q I'm not sure that's responsive.

16 So the question was: Is it fair to say that
17 you're basically trying to encourage, right, or induce
18 these nonparticipating hospitals to, to participate in
19 the future, right, by giving them the flunking grade;
20 is that correct?

21 MS. BLAIR: Objection to form.

22 THE WITNESS: Yes to the first part of your
23 question, that we are encouraging them to
24 participate; not by giving them a flunking grade.

25

1 BY MR. CHUNG:

2 Q Okay. I think we have the testimony.

3 So just looking at kind of the overall
4 financial picture, we looked at the revenues from
5 hospital grades and the hospital survey, both in the
6 financial statement we looked at earlier and then from
7 this TelAffects presentation.

8 Could LeapFrog cover -- let's start with
9 could cover its executive compensation costs if it did
10 not have the revenue from its hospital grades and
11 hospital survey?

12 A I don't know what the executive compensation
13 costs are.

14 Q Okay. Do you think that -- let's focus on
15 Ms. Binder first. If you didn't -- if LeapFrog did
16 not have the revenue from the hospital grades and the
17 hospital survey, right, the accolade licensing
18 revenue, would LeapFrog be able to pay Ms. Binder
19 \$760,000 a year in executive comp?

20 A I mean we raise more than that from annual
21 meetings and contributions that I raise.

22 Q Okay. So is it your testimony that without
23 the accolade licensing revenue, LeapFrog would be able
24 to pay Ms. Binder the \$760,000 in annual executive
25 compensation?

1 MS. BLAIR: Objection to form.

2 THE WITNESS: It's an imaginary scenario.

3 BY MR. CHUNG:

4 Q I'm just asking for your view. Do you think
5 so? I mean you're, you're familiar with the finances
6 of the, of the organization. It's part of your job to
7 be familiar with them, so -- and we've gone over in
8 detail, right, the revenue streams over time from
9 accolade licensing, right? And I think it's your
10 testimony it looks like approximately 25 percent of
11 the organization's revenue have come from those
12 revenue streams.

13 In your view, would, would the organization
14 be able to pay Ms. Binder's compensation of \$760,000 a
15 year if it didn't have that accolade licensing
16 revenue?

17 A Yes.

18 Q You think so?

19 A Yes.

20 MR. CHUNG: Okay. Let's go to tab 47. This
21 will be Exhibit 14.

22 (Exhibit 14 was marked for
23 identification.)

24 BY MR. CHUNG:

25 Q Okay. Ms. Jupiter, this is -- you have

1 Exhibit 14 in front of you. It's an email chain from
2 April of 2024, last year. Just spend some time
3 looking at it.

4 (Witness peruses document.)

5 BY MR. CHUNG:

6 Q Have you had a chance to review it?

7 A Yes.

8 Q So first, who, who is Ben Choi?

9 A He was our former CEO.

10 Q Former CFO, okay, and you mentioned that a
11 new CFO started very recently, correct?

12 A Yes.

13 Q Okay, and who is Josh Berlin?

14 A He is a consultant for LeapFrog.

15 Q Okay, but not an employee of LeapFrog?

16 A No.

17 Q Okay. Is he a consultant kind of on the
18 finance front, or --

19 A Overall in general.

20 Q Okay. Still, still consulting for LeapFrog,
21 or --

22 A Yes.

23 Q Okay.

24 A And Ben was our acting CFO. He wasn't an
25 employee of LeapFrog.

1 Q Okay. If we look at the first page Bates
2 ending LEAPFROG 278, Ms. Binder is responding to a
3 summary from Mr. Choi.

4 She writes, "If we move toward cost
5 reduction as the primary strategy, it will be much
6 more severe than this, but I'm not going there for
7 now. We can address incremental spending issues, but
8 let's not lose focus on what managers should be
9 thinking about 24/7, which is revenues."

10 Has -- she writes "what managers should be
11 thinking about 24/7, which is revenues," right? Is
12 this some -- is this kind of direction something that
13 Ms. Binder has expressed to you and your colleagues?

14 A Not this extreme, no.

15 Q Not this extreme. Okay. How has she
16 expressed this kind of concept or direction to you and
17 your colleagues?

18 A I mean my job at LeapFrog is to help raise
19 funds, and so we always talk about how I should be
20 working to raise donations.

21 Q Okay. I'm asking about her communications
22 to you in particular, and on, on a focus on raising
23 revenues, right, so what has she said to you? It
24 hasn't -- I think your testimony is that it hasn't
25 been as extreme as what she expresses here, but how

1 has she articulated it to you?

2 A My job is to raise revenues, and that's what
3 we talk about.

4 Q Is that what she says, "your job is to raise
5 revenues"?

6 A I mean if you read my job description,
7 that's my job.

8 Q I'm asking what Ms. Binder has said to you,
9 not your job description.

10 A What's your question?

11 Q That's exactly my question. What, what has
12 Ms. Binder said to you about raising revenues?

13 A "You should raise revenues."

14 Q Okay. Has she ever told you that you should
15 be thinking about revenues 24/7?

16 A No.

17 Q Okay, anything along those lines?

18 A No.

19 Q Okay. Have you heard her say anything along
20 those lines to any of your colleagues?

21 A No.

22 Q All right. Have you ever been concerned or
23 had a reaction that Ms. Binder is overly focused on
24 raising revenues for the organization?

25 A No.

1 Q Okay. There are a handful of bullet items
2 that reflects her thinking, just using her words in
3 this email.

4 The first bullet is, "We should look closely
5 at our archival reports on the Safety Grade as an
6 opportunity, and maybe have one of your marketing
7 folks at RO3 help us with that quickly before we
8 launch the grade on May 1."

9 Do you know what she's referring to here in
10 terms of the marketing of archival reports on the
11 safety grade?

12 A I don't.

13 Q Did she discuss this with you at all?

14 A No.

15 Q Okay. "I have a nuclear strategy for the
16 CPOE report sales which I will tell you about
17 tomorrow."

18 Does that ring a bell?

19 A No.

20 Q Are you aware that there are -- that
21 LeapFrog generates reports specific to the CPOE
22 measure?

23 A I'm -- I know that we generate reports. I
24 don't know about specific CPOE reports.

25 Q Okay. Do you know whether those reports,

1 generally speaking, maybe not specific to CPOE, are
2 sold or marketed to third parties for purchase?

3 A Yes.

4 Q Okay. What -- again, generally speaking,
5 what types of reports are these?

6 A I don't know.

7 Q Okay. Are they reports of data from
8 hospitals?

9 A Yes.

10 Q Okay. I mean are we talking about -- is she
11 referring to basically the licensing of hospital
12 survey data here?

13 A I think so.

14 Q Okay, but they're in -- but it sounds like
15 they're in a report form.

16 A I think so.

17 Q Okay, and it looks like there are at least
18 reports that are specific to the CPOE data; is that
19 right?

20 A Yes.

21 Q Okay. It says, "Paul could work on sales of
22 reports on CPOE and/or another report. Maybe we
23 develop a report on technology and patient safety,
24 which is a hot topic."

25 Has Ms. Binder -- does this ring a bell?

1 Has Ms. Binder ever discussed with you the development
2 of a report to license or to sell "on technology and
3 patient safety"?

4 A No.

5 Q Okay. Do you know whether such a report
6 exists for purposes of licensing?

7 A I don't.

8 Q Okay, but it does sound like these are maybe
9 new items, new types of reports that she's proposing?

10 A That's what it sounds like, yes.

11 Q Okay. "We should offer a special deal for
12 some form of AM" -- I think annual meeting --
13 "sponsorship if booked before June 30."

14 Do you see that?

15 A Yes.

16 Q Is that something you're familiar with?

17 A Yes.

18 Q Okay. Is that something that was
19 implemented?

20 A I think so. I think we offered a discount
21 if they committed before June 30.

22 Q Okay, and the purpose of that is to
23 basically get more sponsorships in terms of volume?

24 A In the fiscal year.

25 Q Okay. Understood.

1 A That's the date.

2 Q All right.

3 The next bullet is, "We should plan for
4 special discounts/sales pushes around accolade sales
5 to get more in late May and June."

6 Do you have an understanding as to why she
7 is making the push for special discounts or sales
8 around accolade sales to get more in this timeframe,
9 that May/June timeframe?

10 A The fiscal year ends June 30.

11 Q Okay. So to get more bookable revenue
12 before the end of the fiscal year; is that right?

13 A Correct.

14 Q Okay. "Expand marketing around the
15 certified coach program." What is she referring to
16 here?

17 A We did some more social media ads around the
18 coach program to try to sell more.

19 Q Okay, and then the final bullet here is
20 "There's a lot of attention to us around the Hospital
21 Safety Grade release. How do we harness that more for
22 marketing?"

23 What do you understand her to be saying
24 here?

25 A I don't know.

1 Q Okay.

2 We looked at a document earlier about -- I
3 think it was your, the year end review, right, about
4 her comment, her feedback to you about using the
5 publicity around the hospital safety grade for
6 basically commercial purposes, right?

7 Does this bullet point kind of refresh your
8 recollection as to what she might have been discussing
9 there in your annual review?

10 A This is around marketing. I don't know
11 marketing to what.

12 Q Okay. Is she, is she saying here that where
13 there's a lot of attention publicity around the
14 release, right, of the hospital safety grade, that at
15 the same time LeapFrog should be marketing more of its
16 accolade licensing products?

17 A I can't --

18 MS. BLAIR: Objection to form.

19 THE WITNESS: I can't say what she -- I
20 wasn't on this email. I've never seen it. I
21 have no idea what she was saying.

22 BY MR. CHUNG:

23 Q Okay. Is it, is it -- is what she's
24 referring to here, was it implemented; do you know?

25 A I have no idea.

1 Q Okay.

2 Does LeapFrog compete with any other
3 organizations or companies when it comes to the
4 grading of hospitals?

5 A Not that I know of.

6 Q Okay. So there are no other entities that
7 grade hospitals that LeapFrog sees as competitors?

8 A There are other places that -- I don't know
9 if they use specific grades, but measure hospitals,
10 but we solely focus on patient safety. There aren't
11 other organizations that focus on patient safety.

12 Q Okay. There are other organizations?

13 A Not that I'm aware of.

14 Q Okay, and what are those other organizations
15 that you're, that you're thinking about?

16 A U.S. -- Newsweek or U.S. News Report [sic].
17 I don't remember which one.

18 Q U.S. News and World Report, the magazine?

19 A Yeah, or Newsweek. I can't remember. One
20 of them puts out a hospital review list.

21 Q Okay. Any other organizations or
22 publications around this?

23 A Not that I'm aware of.

24 Q Do you view these other entities as
25 competitors?

1 A No, because we solely focus on patient
2 safety.

3 Q Okay.

4 I want to go into incentives for hospitals
5 to participate in the program. It's related somewhat
6 to what we discussed previously.

7 What incentives does LeapFrog offer to
8 hospitals that respond to its hospital survey?

9 A I don't know.

10 Q Okay. Does LeapFrog provide any form of
11 recognition, public recognition, such as awards or
12 distinctions, to hospitals that participate in the
13 survey?

14 A We give Top Hospital awards. I don't think
15 you have to participate to get one.

16 Q Okay, and what -- that Top Hospital award
17 program, what does it mean? What does it encompass?

18 A We say they are a top hospital.

19 Q And how is "Top Hospital" defined under this
20 program?

21 A One of the best hospitals in terms of
22 patient safety.

23 Q Okay, and is that based on the hospital
24 safety grade that LeapFrog issues to those particular
25 hospitals?

1 A I don't know how it's determined.

2 Q Okay. Are these -- is it as simple as being
3 an A-graded hospital by LeapFrog?

4 A I don't know.

5 Q Okay, and who oversees that program, the Top
6 Hospital program or those, those awards?

7 A Missy Danforth.

8 Q Okay.

9 Does LeapFrog ever engage with hospital
10 leadership or hospital administrations to encourage
11 survey participation?

12 A I don't know.

13 Q Okay. Do you know who would know that?

14 A Probably Missy Danforth.

15 Q Okay. Are there -- are you aware of any
16 resources or tool kits or support services that are
17 offered, offered or provided hospitals to help them
18 participate in the survey?

19 A We provide information on the survey. We
20 have a HelpDesk where we answer questions.

21 Q Okay. Are there any kind of specific paid
22 programs or consultants or coaches that the
23 organization offers to hospitals to help them
24 understand or fill out the survey?

25 A Not that I'm aware of.

1 Q Okay. Are there any partnerships or
2 arrangements with employers or insurance companies
3 that use LeapFrog participation as a criterion for
4 contracting or network inclusion?

5 THE REPORTER: Network --

6 MR. CHUNG: Inclusion.

7 THE REPORTER: Inclusion, okay.

8 THE WITNESS: Not that I know of.

9 BY MR. CHUNG:

10 Q Okay. Do you know who would know that?

11 A Probably Leah Binder.

12 Q Okay.

13 Does LeapFrog track or analyze survey
14 participation, participation rates over time?

15 A We track survey participation, survey
16 participation over time, yes.

17 Q Okay, and so based on that kind of tracking,
18 what has LeapFrog observed? What are the trends?

19 A Survey participation has increased over
20 time.

21 Q Okay, and what, what does LeapFrog attribute
22 that increase in participation to?

23 A Commitment from hospitals toward accuracy
24 and transparency.

25 Q Okay. Any other factors?

1 A That they want to show their commitment to
2 patient safety.

3 Q Okay, and how, and how is that -- how is
4 that factor tracked? How did you -- how, how does
5 LeapFrog -- how did LeapFrog determine or conclude
6 that that is the factor that led to increased
7 participation?

8 A That's our goal is to increase commitment to
9 patient safety.

10 Q Okay. I understand that that's LeapFrog's
11 goal, but how was LeapFrog -- how did LeapFrog
12 determine that that was the reason that a hospital --
13 that there's been an increase in hospital
14 participation in the survey?

15 MS. BLAIR: Objection to form.

16 THE WITNESS: I don't know.

17 BY MR. CHUNG:

18 Q Okay.

19 Do you know whether participation in the
20 survey increased after the fall 2024 changes to the
21 imputation methodology?

22 A I don't know.

23 Q Okay. Has LeapFrog conducted any studies or
24 analysis over whether survey participation improves a
25 hospital's safety grade?

1 A I don't know.

2 Q Okay. Not aware of any analyses or studies
3 to that effect?

4 A No.

5 MR. CHUNG: Okay. Why don't we take a quick
6 break here before going on to the next document.

7 THE VIDEOGRAPHER: The time is 2:15 p.m.

8 This ends unit 3. We're off the record.

9 (Whereupon, a short recess was taken.)

10 THE VIDEOGRAPHER: The time is 2:26 p.m.

11 This begins unit number 4. We're on the record.

12 BY MR. CHUNG:

13 Q Ms. Jupiter, earlier in the day you
14 testified that you have -- one of your
15 responsibilities is for overall communications,
16 including LeapFrog's websites, right?

17 A Yes.

18 Q Okay. We're going to go over the websites
19 now, and I think what we're going to do to kind of
20 facilitate this is we're going to provide you with a
21 laptop so we can kind of navigate, you know, through
22 the websites instead of relying solely on hard copies.
23 So Mr. Delwiche is going to put the laptop in front of
24 you.

25 We're also going to give you paper versions

1 of pages from the laptop that are marked Exhibit 15
2 and Exhibit 16.

3 THE REPORTER: Do you want me to mark those
4 right now?

5 MR. CHUNG: Yes, might as well.

6 (Exhibit 15 was marked for
7 identification.)

8 (Exhibit 16 was marked for
9 identification.)

10 BY MR. CHUNG:

11 Q So we'll put these in front of you and kind
12 of toggle between the computer and these paper
13 exhibits.

14 So there are -- you understand that there
15 are two websites that are relevant here. One is
16 www.leapfroggroup.org, and then
17 hospitalsafetygrade.org.

18 What, what's the purpose of the first one,
19 the leapfroggroup.org website?

20 A That's general information about LeapFrog.

21 Q About the organization, correct?

22 A Correct.

23 Q All right, and that's where the mission
24 statement is articulated, it shows who, who the staff
25 are and the board and that kind of information,

1 correct?

2 A Correct.

3 Q What is the purpose of the
4 hospitalsafetygrade.org website?

5 A That's where consumers can look up their
6 hospital's safety grades.

7 Q Okay, and so to put it another way, that
8 website, in contrast to the LeapFrog website, is, is
9 geared toward -- aimed at consumers to look up their
10 hospitals and see what the, the grade is for those
11 hospitals; is that right?

12 A Both are aimed at consumers, but the
13 hospital safety grade is where they would look up the
14 safety grade, yes.

15 Q Okay, and are they both operated by the
16 organization, by LeapFrog?

17 A Yes.

18 Q Okay.

19 Now, are you aware that upon a, kind of a
20 basic Google search of the term "hospital safety
21 grade," that these are the two website -- top website
22 hits that come up?

23 A Yes.

24 Q Okay. So why don't we just -- if we could
25 trouble you to look at the interactive deposition

1 here, a Google search of "hospital safety grade."

2 A Nothing is happening.

3 Q Just a Google search of "hospital safety
4 grade," Ms. Jupiter.

5 All right, and do you see that the -- what
6 is the first kind of website hit that comes up?

7 A Hospitalsafetygrade.org.

8 Q Okay. Got it. Let's look -- and the second
9 hit is what; leapfroggroup.org?

10 A Yes.

11 Q Okay. Can we go first to the
12 leapfroggroup.org website?

13 A Okay.

14 Q And then there should be a large orange box
15 titled "Search Hospital and Surgery Center Ratings."

16 Do you see that?

17 A Yes.

18 Q Make sure you're familiar with the website.

19 A Mm-hmm.

20 Q If you can search for "Delray." Delray is
21 one of the plaintiff hospitals here in Florida.

22 Okay. Have you done that search --

23 A Yes.

24 Q -- for Delray? And the first page we see
25 upon a search, do you see that there's a page that

1 pops up? There are four facilities in your search
2 that decline to --

3 A No. This is what pops up.

4 Q Okay. Got it. What does this mean? Okay.
5 Search Delray. Okay, and Delray pops up in -- okay.
6 Got it.

7 So you see the red box there that says
8 "Declined to Respond," correct?

9 A Correct.

10 Q All right, and it says that "Thousands of
11 hospitals nationwide report to the LeapFrog Hospital
12 Survey to help patients and purchasers make better
13 healthcare decisions," and then "This hospital did not
14 participate."

15 That's what the pop-up reads?

16 A Correct.

17 Q And am I right that you can't really see
18 what's behind the pop-out box until you click out of
19 that pop-out?

20 A Correct.

21 Q Okay. Can you click out of the pop-out for
22 us?

23 A Okay.

24 Q And just for the, just for the record, what
25 you saw earlier in terms of the pop-up is what we see

1 in Exhibit 15, correct?

2 A Correct.

3 Q All right.

4 Now, once you click out of the pop-up, do
5 you see that for all the measures that are listed
6 there, the webpage says that the hospital -- in this
7 case, Delray -- declined to respond, correct?

8 A Correct.

9 Q All right, and am I right that there's no
10 safety grade -- A, B, C, D, F -- anywhere present on
11 the page here?

12 A Correct.

13 Q All right, and then if you click to
14 "preventing patient harm" -- do you see that?

15 A Mm-hmm.

16 Q All right, and then there's a handwashing
17 metric, the website says "Declined to Respond"; is
18 that correct?

19 A Correct.

20 Q All right, and there's no score present on
21 the website, right?

22 A Correct.

23 Q No limited achievement score, no numerical
24 score on the website -- on this particular webpage,
25 correct?

1 A Correct.

2 Q Okay.

3 Now let's kind of -- let's go back and then
4 go to the other website, the first hit upon the Google
5 search, if you can do that for us. That's the
6 hospitalsafetygrade.org website.

7 A So that's where we were. We were on the
8 hospitalsafetygrade.org site.

9 MS. BLAIR: No, you were --

10 BY MR. CHUNG:

11 Q No, we were on LeapFrog --

12 A Okay.

13 Q -- earlier.

14 A You want me to go to
15 hospitalsafetygrade.org?

16 Q Correct.

17 This is the -- I think you testified
18 earlier, this is, this is the one that's directed
19 toward consumers where it's designed for them to
20 search for their hospitals, right?

21 A Correct.

22 Q Okay. So are you on the
23 hospitalsafetygrade.org website?

24 A Yes.

25 Q Okay, and if you can run a search again for

1 Delray Medical Center. You're probably more familiar
2 with this website than me, so . . .

3 A Okay.

4 Q All right. Are you seeing the page for
5 Delray Medical Center?

6 A Yes.

7 Q And it shows here, once you reach the search
8 result, that this hospital's -- the graphic is saying
9 "this hospital's grade is F."

10 Do you see that?

11 A Yes.

12 Q Okay, and from spring 2025 --

13 A Correct.

14 Q -- correct? Okay.

15 Now, in contrast, unlike on the
16 leapfroggroup.org website, this website does not
17 immediately show a pop-up box, right, indicating that
18 a hospital, like Delray, did not provide data to
19 LeapFrog, correct?

20 A Correct.

21 Q All right, and then when you go to see full
22 score, right, does this again show "this hospital's
23 grade is F," that same graphic?

24 A Yes.

25 Q All right, and above the fold on the screen,

1 am I correct that all we see again is the F grade?

2 A Correct.

3 Q Okay, and then when we click on the tab
4 "practices to prevent errors," so there are a number
5 of tabs, the fourth one, right, we see for "doctors
6 order medications through a computer," do you see that
7 this hospital score is a 15?

8 Do you see that?

9 A Yes.

10 Q All right, and is this -- again, knowing
11 that you're not intimately familiar with kind of the
12 measures, is it your understanding that this measure,
13 the doctors order medications through a computer,
14 corresponds to the CPOE measure?

15 A No. I mean I don't --

16 Q Not sure?

17 A No.

18 Q Okay, and then if we go to the next tab, the
19 "Safe Medication Administration," that yields a score
20 of 25, correct?

21 A Correct.

22 Q All right, and these are all limited
23 achievement scores, correct?

24 A I don't know that.

25 Q You don't know that? Okay, all right, and

1 do you know whether this, the safe medication
2 administration measure, is actually the BCMA measure
3 that we discussed earlier?

4 A I don't.

5 Q Don't know? Okay, and then when we go to
6 handwashing, that yields a 15, a score of 15, correct?

7 A Yes.

8 Q All right, and same question: Do you know
9 whether this corresponds to the hand hygiene measure
10 that we discussed earlier in the methodology?

11 A No.

12 Q Don't know for sure? Okay, and then under
13 the tab "Doctors, Nurses and Hospital Staff," kind of
14 the top level tab, there's a measure "Specially
15 Trained Doctors for ICU Patients."

16 Do you see that?

17 A Yes.

18 Q Okay, and what score does that yield?

19 A Five.

20 Q A five, okay, and do you know whether this
21 measure corresponds to the IPS measure that we saw in
22 the methodology?

23 A I don't know.

24 Q Don't know? All right, and with each of
25 these measures, you'll see on this website that there

1 are basically these "gas gauge" scores, and is it
2 your -- for the four metrics that we just went over,
3 right, going backwards, the handwashing, doctors,
4 nurses and hospital staff, the ICU patients metric,
5 the doctors order medications through a computer, and
6 the safe medication administration, those gas gauges
7 are set to the lowest possible value, correct?

8 A Correct.

9 Q All right. We just went through the four of
10 them. Rather than a question mark with a "Declined to
11 Report" icon --

12 A Correct.

13 Q -- correct? There are other measures,
14 however, on this very website where you'll see that
15 there is a "Declined to Report" icon, correct?

16 A Correct.

17 Q All right. Why are those, why are those
18 treated differently? Why for some of these, for some
19 of these metrics are -- we went over kind of the
20 imputed methodology, right, and the four metrics,
21 right, that are given imputed metrics, right, so
22 automatically assigned them the, the limited
23 achievement score.

24 Why are those metrics given kind of the low,
25 the lowest kind of signal on the gas gauge, right, but

1 for others, right, where the hospital didn't support
2 data, the website says that, that the hospital
3 declined to report? What's the distinction between
4 those two sets?

5 MS. BLAIR: Objection to form.

6 BY MR. CHUNG:

7 Q On the measures?

8 A I don't know.

9 Q Okay, but you are, as part of your role -- I
10 mean you have multiple roles, but your role with
11 respect to communications, am I correct that you're
12 familiar with and you have discussions about the
13 content of the website?

14 A Very high-level.

15 Q Okay, and is this not --

16 A This is more --

17 Q -- kind of high-level enough?

18 A This is not high-level enough. This is more
19 detail than I get involved in.

20 Q Okay, so -- and it's only -- so we, so we're
21 looking at kind of above the folds right now on the --

22 THE REPORTER: Above the, you said "folds"?

23 BY MR. CHUNG:

24 Q Above the fold, right, on the
25 hospitalsafetygrade.org website.

1 If we scroll to the bottom, the very bottom
2 of the page, do you see kind of in the smaller font
3 between the footnotes, a note that the hospital, in
4 this case, Delray, did not provide data to LeapFrog?

5 Do you see that?

6 A Yes.

7 Q And the footnote says, or one of the
8 footnotes says, "The hospital declined to report their
9 performance on this measure, so a score was assigned
10 to reflect the lack of information available,"
11 correct?

12 A Correct.

13 Q Okay. Does -- is there anywhere in that
14 footnote or anywhere on this page, that informs the
15 consumer how a score was assigned for these four
16 metrics?

17 A It says -- there's a -- "for details on
18 sources, click here."

19 Q Okay. On the web -- on this page itself, on
20 the search result, though, is there any explanation to
21 the consumer for how these limited achievement scores
22 were assigned?

23 A No.

24 Q Okay. So we've gone over kind of the
25 disclosures between, on the one hand, the

1 leapfroggroup.org website, right, where we saw the
2 pop-ups on Exhibit 15, where it shows clearly that, in
3 our case, Delray has declined to respond, correct, and
4 it doesn't show a grade, correct?

5 You've got to answer. Sorry.

6 A Yes.

7 Q But then on the Hospital Safety Grade's
8 website, almost immediately upon a search of "Delray,"
9 the F grade is prominently displayed; is that correct?

10 A Correct.

11 Q Okay.

12 So why doesn't LeapFrog use the same
13 disclosures for nonparticipating hospitals between
14 these two websites? Why is there -- why are there
15 these differences in the disclosures between the two
16 websites?

17 MS. BLAIR: Objection to form.

18 THE WITNESS: I don't know.

19 BY MR. CHUNG:

20 Q Okay.

21 Was there ever a concern at LeapFrog that
22 consumers who visited these two websites would be
23 confused about the scores for hospitals that did not
24 participate in the surveys?

25 A I don't know.

1 Q Okay. Any -- do you remember any discussion
2 about potential confusion by consumers visiting these
3 websites about what these metrics mean for
4 nonparticipating hospitals?

5 A Not that I recall.

6 Q Okay.

7 Has LeapFrog received any feedback or
8 questions or complaints from hospitals, let's start,
9 regarding confusion or inconsistencies between the two
10 websites?

11 A Not that I know of.

12 Q Okay. How about any feedback or questions
13 or complaints from patients or consumers about
14 inconsistencies between the two websites?

15 A Not that I know of.

16 Q How about insurance providers?

17 A Not that I know of.

18 Q Any patient advocacy groups? Hear from them
19 about the inconsistencies between the two websites?

20 A Not that I know of.

21 Q Okay.

22 Has LeapFrog ever conducted any user testing
23 surveys or studies to determine whether consumers
24 understand the disclosures on each of these websites?

25 A When we built the site, we dealt with low

1 literacy website experts.

2 Q Okay. When you say "dealt with low literacy
3 website experts," what do you mean by that, if you can
4 break that down for us?

5 A This was before my time, so I don't know,
6 but I know that when we built the site, we worked with
7 experts on website development and communications for
8 it to be clear for patients.

9 Q Okay. How about, when you say "low
10 literacy," what does that mean?

11 A There's a lot of words on the site, so we
12 want to make sure it's clear to people who can't
13 necessarily read all the information on the site;
14 hence, the gas gauges and more clear interpretations.

15 Q Okay, and so is, is it kind of the
16 assumption that the visitors to the site, right, or at
17 least some number of the visitors to the site are
18 illiterate or at low literacy levels?

19 A That's not -- I assume we, if they came to
20 the site, we wanted to make sure that they would
21 understand.

22 Q Okay. The, the -- so I think you testified
23 that you're aware that there were experts that were
24 retained to consult on three websites before I think
25 you joined --

1 A Correct.

2 Q -- before you joined the organization. Were
3 there -- were experts or any kind of outside parties
4 consulted or retained to advise on these versions of
5 the websites, particularly after the change in the
6 imputation methodology took place?

7 A Not that I know of.

8 Q Okay.

9 Who was -- who at LeapFrog was in charge of
10 basically conforming, right, or adjusting the website
11 as we see it now, after the change in the imputation
12 methodology in the fall of 2024?

13 A Lauren Bailey worked with the ratings team.

14 Q Okay. So Lauren was working on the website
15 with the ratings team; is that correct?

16 A Correct.

17 Q Okay, and so why Lauren in particular?

18 A She's our director of communications.

19 Q Okay, and as director of communications, she
20 has more direct oversight over how the websites are
21 run; is that correct?

22 A Yes.

23 Q Okay, and you kind of have more of a higher
24 level oversight; is that correct?

25 A Correct.

1 Q Okay.

2 Now, just based on kind of your looking at
3 the website, your familiarity with the website, and
4 again taking into account that, you know, that there
5 may be low literacy kind of consumers, right, on the
6 websites or visitors to the websites, do you think
7 it's realistic to think that visitors to the website
8 will read, toggle down to the footnotes and understand
9 the footnotes at the bottom of the page of the
10 hospital safety grade search results?

11 MS. BLAIR: Objection to form.

12 THE WITNESS: I can't predict what people
13 will do.

14 BY MR. CHUNG:

15 Q So you don't have a view on that?

16 A No.

17 Q Okay.

18 Based on what's presented on the hospital
19 safety grade website, and taking this Delray search
20 result as an example, does LeapFrog want visitors or
21 consumers to believe that the imputed metrics, right,
22 that we went over, the four metrics, are based on
23 actual data?

24 MS. BLAIR: Objection to form.

25 THE WITNESS: Can you repeat the question.

1 BY MR. CHUNG:

2 Q Yeah. Does LeapFrog -- does LeapFrog want
3 consumers or visitors to this particular website to
4 think that the imputed metrics are based on actual
5 data submitted by the hospitals?

6 A No.

7 Q No? Okay. Understood.

8 Has -- do you know whether LeapFrog has ever
9 considered standardizing or making consistent the
10 disclosures or just the overall presentation of
11 information between the two websites?

12 A I don't know.

13 Q Okay. Do you think Lauren Bailey would know
14 more about that?

15 A Probably, yes.

16 Q Okay.

17 All right. Just going back to one kind
18 of -- one point on the hospital safety grade website,
19 so just going down to the footnotes that we were just
20 looking at a few minutes ago, the Footnote 4, right,
21 reads, "The hospital declined to report their
22 performance on this measure, so a score was assigned
23 to reflect the lack of information available."

24 Do you see that particular footnote?

25 A Yes.

1 Q Am I right, though, that this footnote does
2 not inform the consumer what the resulting hospital
3 score means?

4 A I don't understand the question.

5 Q Okay. Does it disclose that -- does it
6 disclose that LeapFrog has automatically assigned the
7 lowest score possible for these imputed metrics?

8 A It says here, "so a score was assigned."

9 Q Right, "a score was assigned to reflect the
10 lack of information available," but it doesn't, it
11 doesn't say that the lowest possible score was
12 assigned, correct?

13 A It says that. It says, "This hospital score
14 is five," and it says "worst hospital score, five."

15 THE REPORTER: Say that again, please. I'm
16 sorry.

17 THE WITNESS: It says "this hospital score,
18 five," and it says "worst hospital score, five."

19 BY MR. CHUNG:

20 Q Okay. So that, that means the consumer
21 would have to basically read those two together to
22 deduce, right, that the -- that Delray got the lowest
23 hospital score?

24 A Yes.

25 Q Okay.

1 I have some questions about LeapFrog's
2 marketing, kind of overall marketing function, and you
3 mentioned earlier that CURA -- it's CURA Strategies
4 provides public relations consulting services; is that
5 right?

6 A Yes.

7 Q Okay. Are there any other kind of outside
8 contractors or consultants that provide marketing,
9 advertising, or PR services to LeapFrog?

10 A We have a Google grant for advertising the
11 safety grade.

12 Q Okay, and there's a -- is there a vendor
13 that advises on how to best use that Google grant?

14 A Yes.

15 Q Okay. When did LeapFrog start hiring CURA
16 Strategies?

17 A I think it was two years ago.

18 Q Okay. Do you know, just ballpark, how much
19 money LeapFrog spends on these outside consultants?

20 A CURA is about \$15,000 a month.

21 Q Okay, and how about the Google grants?

22 A That's really small. I think it's \$9,000 a
23 year.

24 Q Okay, and we're going to go into some
25 documents relevant to the regional leaders, but what

1 role do the LeapFrog's leaders play in the overall
2 communication strategy for the organization?

3 A The regional leaders we say are our "boots
4 on the ground," and they reach out to hospitals to
5 encourage them to do the survey.

6 Q Okay. So how do they go about doing that?
7 Boots on the ground, and they, they are the ones
8 responsible, going out to the hospitals to encourage
9 them to participate in the survey, correct?

10 A Correct.

11 Q So are there -- is there a particular kind
12 of process or protocol that these regional leaders are
13 supposed to follow in executing on that?

14 A Yes. They send letters to the hospitals
15 saying they represent the local employers who want
16 them to participate in the survey.

17 Q So they represent to the hospitals that they
18 themselves, the regional leaders of LeapFrog,
19 represent employers?

20 A Correct.

21 Q Right, and who are these employers that
22 they're purporting --

23 A So these are --

24 Q -- to represent?

25 A -- regional coalitions of employers, so

1 they're based on a region. So, for example, the
2 Greater Philadelphia Business Coalition is a regional
3 leader, and they represent employers in the greater
4 Philadelphia area.

5 Q Okay, and so do these employers, are they --
6 do they give kind of explicit permission to these
7 LeapFrog regional leaders to represent them vis-a-vis
8 the hospitals?

9 A The employers?

10 Q Yes.

11 A That's part of belonging to the coalition,
12 yes.

13 Q Does LeapFrog have kind of an overall
14 marketing strategy?

15 A Yes.

16 Q Okay, and so what is that overall marketing
17 strategy?

18 A I guess it depends who you're marketing to.

19 Q All right. Let's break it -- what's the
20 kind of the most immediate audience you think of?

21 A Consumers.

22 Q Okay, and so what is the overall market
23 strategy with respect to consumers?

24 A We want consumers to check their hospital
25 safety grade.

1 Q Okay, and what are, what are the other
2 audiences?

3 A Market to data purchasers, employers.

4 Q Okay. So the data purchaser potential kind
5 of licensees, correct?

6 A Correct.

7 Q And hospitals as well?

8 A Hospitals for, yes, accolades and survey
9 participation.

10 Q Okay, and what is the marketing strategy
11 with respect to the, the hospital, the hospitals for
12 purposes of the, the accolade licensing?

13 A I don't really know about that.

14 Q Okay. Who is -- who would know about that?
15 Is it Mr. Banerjee?

16 A Kush, yes.

17 Q Okay, and is it the same with respect to the
18 data licensing?

19 A Correct.

20 Q Let's go to another document, tab 22.

21 A Am I done with this?

22 Q Yes. You can close it.

23 (Exhibit 17 was marked for
24 identification.)
25

1 BY MR. CHUNG:

2 Q Ms. Jupiter, you have Exhibit 17 in front of
3 you. It's entitled "2025 Regional Leader
4 Communications Toolkit: Launching LeapFrog Surveys."
5 Feel free to look through it. Let me know if you
6 recognize it.

7 A Yes.

8 Q Okay. So what, what is this document?

9 A This is the information we provide to the
10 regional leaders on how to launch the survey.

11 Q Okay. How many regional leaders are they --
12 are there?

13 A 32.

14 Q Okay, and so these are like individuals,
15 these regional leaders?

16 A They're coalitions. There's an individual
17 who represents the coalition, but it's an employer
18 coalition.

19 Q Okay, and that was my next question. So
20 each of these coalitions that is a regional leader is
21 made up of a collection of employers within the
22 relevant region, correct?

23 A Correct.

24 Q Okay, and you said that there's a, a human
25 being, a representative, right, that acts for that

1 coalition/regional leader; is that right?

2 A Correct.

3 Q And who typically is that person?

4 A A staff member of the coalition.

5 Q Okay. Is it a, is it an employee of one of
6 the employers, or is it someone that's kind of
7 independent?

8 A The coalition has staff. It's a staff
9 member of the coalition.

10 Q Okay, and are they -- are these -- how are
11 these -- are these coalitions part of LeapFrog?

12 A No.

13 Q All right. What is the relationship with
14 LeapFrog?

15 A They're our regional leaders.

16 Q Okay, but they're --

17 A They're not employed by LeapFrog.

18 Q Okay.

19 A They have similar goals for patient safety,
20 and so they work with LeapFrog.

21 Q All right. So they are independent
22 entities?

23 A Yes.

24 Q All right. Can you give us an example, the
25 name of one of these coalitions that's a regional

1 leader?

2 A The Greater Philadelphia Business Coalition.

3 Q Okay, and were these coalitions put together
4 for the purpose of becoming regional leaders for
5 LeapFrog, or did they preexist?

6 A They preexist. LeapFrog was only a part of
7 what they do.

8 THE REPORTER: They what?

9 THE WITNESS: They preexist, and LeapFrog is
10 only a part of what they do.

11 BY MR. CHUNG:

12 Q So is it fair to say that this is a
13 document, looking at Exhibit 17, that instructs
14 regional leaders how to market the LeapFrog hospital
15 survey?

16 A To hospitals?

17 Q To hospitals.

18 A It's a document that helps regional leaders
19 in getting hospitals to fill out the survey.

20 Q Okay.

21 Now, if you look at page 33 of the document,
22 Bates ending LeapFrog 517, you'll see there there's
23 kind of a table, "Common Objections to Participating
24 in LeapFrog Surveys."

25 Do you see that?

1 A Yes.

2 Q And are you, are you familiar with this
3 chart or this table that runs a few pages long?

4 A I've seen it before.

5 Q Okay. The second objection, right, common
6 objection laid out here is "LeapFrog data is
7 self-reported and therefore unreliable."

8 Are you aware that that's a common objection
9 from hospitals that are being solicited to participate
10 in the survey?

11 A I would say that's less of an objection from
12 hospitals and more from other constituents.

13 Q So at least some hospitals have voiced this
14 objection?

15 A Not that I know of.

16 Q Okay. When you say -- but you said less so
17 from hospitals --

18 A Right.

19 Q -- or from other constituents, so what
20 informs that response?

21 A I don't -- again, I don't talk to hospitals,
22 so I don't know if hospitals have made this complaint.

23 Q Okay. You said "other constituents,"
24 though, have made this complaint or this objection.
25 Who are these other constituents?

1 A Like an employer might say that.

2 Q Okay, an employer. What have you heard kind
3 of along these lines from an employer?

4 A That if the hospital is filling out the
5 survey themselves, so how can you trust that data,
6 because I, if I was giving myself a report card, I
7 would give myself straight As.

8 Q Right, and so what's the -- I know that
9 they're kind of a response here laid out, right, but
10 just kind of based on your experience, what is the
11 response to that, that type of projection?

12 A We do a lot of data verification around the
13 self-reported data, so different data verification, we
14 would look through the survey data, and if there's
15 inconsistencies, we would dig deeper on that.

16 Q Okay. If we turn to the next page, the
17 fifth objection on down, "We believe something on the
18 Survey is not risk-adjusted adequately and/or
19 invalid/unscientific."

20 Do you see that objection?

21 A Yes.

22 Q All right, and is that an objection or a
23 concern that, that hospitals have voiced?

24 A Not that I know of.

25 Q Okay. Other constituents?

1 A I haven't heard this one.

2 Q So you're not familiar with this one?

3 A I'm not.

4 Q Okay, and then -- now, we've got this
5 document, which is pretty comprehensive. Is there --
6 does, does LeapFrog do training of regional leaders on
7 how to approach or try to convince hospitals to
8 participate in the survey?

9 A We have monthly meetings with the regional
10 leaders and talk to them about the hospital survey and
11 encouraging participation.

12 Q Okay. Is there kind of dedicated training
13 to that effect?

14 A Not that I'm aware of.

15 Q Okay, and during these meetings, do the --
16 have you heard from any of the regional leaders about
17 hospitals or other constituents voicing the objections
18 we just went over?

19 A I personally haven't.

20 Q Okay, and what's the -- so in terms of
21 convincing hospitals, these regional leaders
22 convincing hospitals to participate in the survey,
23 right, is there, is there -- kind of in addition to
24 what's laid out in these tables here in the training
25 materials, right, is there training of the regional

1 leaders on how to respond to these types of
2 objections? Earlier I asked more about general
3 training, but focused on dealing with these
4 objections.

5 A I don't know of anything beyond this sort of
6 toolkit.

7 Q Okay.

8 Does LeapFrog pay for -- so those are the
9 regional leaders. Does -- in terms of the other areas
10 of marketing, does LeapFrog view search engine
11 optimization for any of its websites? Are you aware
12 of that?

13 A We just, just started doing SEO optimization
14 in July.

15 Q Okay, and does -- do you pay for -- does
16 LeapFrog pay for SEO for both websites or just one of
17 the websites?

18 A I think it's both websites.

19 Q Okay. Does LeapFrog partner with any
20 journalists or media outlets in anticipation of
21 publishing hospital safety grades when they're
22 published?

23 A We -- I mean we work with our PR firm to
24 reach out to reporters about the safety grade.

25 Q Okay, and generally how many reporters get

1 this reach-out in anticipation of the release?

2 A I don't know an exact number.

3 Q Okay. Does -- as a condition of kind of
4 working with these journalists and media outlets, does
5 LeapFrog embargo the hospital grade results?

6 A We do.

7 Q Okay, and what's the purpose of that?

8 A So we reach out to journalists a few days
9 before the safety grades come out, so they -- and we
10 give them the safety grade and the information so they
11 can write their story and be ready, so it can be
12 released on the day the safety grades come out.

13 Q Okay.

14 The -- so in terms of marketing the hospital
15 safety grades to, to consumers, right, to patients,
16 does monitor -- does LeapFrog monitor web traffic to
17 determine what kind of language attracts or retains
18 the most visitors to the websites?

19 A I don't think we monitor that specifically.

20 Q Okay. In terms of the, not only the content
21 on the websites, right, but other marketing materials,
22 does LeapFrog try to convince patients or consumers
23 that its grading methodology is objective and
24 unbiased? Is that part of the, kind of the pitch to
25 consumers?

1 A Yes, we definitely tell consumers that our
2 information is accurate and transparent.

3 Q Okay. Relatedly, does LeapFrog try to
4 convince consumers that its hospital safety grades are
5 not influenced by a hospital's participation or lack
6 of participation in the survey?

7 A I, I need the question.

8 Q Sure. Does LeapFrog try to convince
9 consumers that the hospital grades are not influenced
10 by whether a hospital participates in the survey?

11 MS. BLAIR: Objection to form.

12 THE WITNESS: Too many negatives in there.

13 BY MR. CHUNG:

14 Q Too many negatives?

15 A I'm not clear on what the question is
16 exactly.

17 Q So do you think that -- is -- when it's
18 marketing to consumers, right, on the websites or in
19 other materials, does LeapFrog try to convince
20 consumers that the hospital grades, right, that it's
21 issuing, that whether a hospital participates in the
22 survey doesn't matter, it doesn't contribute to the,
23 to the hospital's grade?

24 MS. BLAIR: Objection to form.

25 THE WITNESS: We don't normally talk about

1 whether or not a hospital participates when we
2 are posting a safety grade.

3 BY MR. CHUNG:

4 Q Okay. I guess going back to the two
5 websites, why does, why does LeapFrog have two
6 websites, right, where you can search for your
7 hospital, right? Why is that?

8 A We are a very small nonprofit with a very
9 limited budget, and the original website we had didn't
10 have the capability to have the safety grades on it,
11 so we had to set up another website.

12 Q Okay. Does, does LeapFrog earn more revenue
13 by marking the grades on two separate websites? Is
14 this kind of an economies of scale thing?

15 A No.

16 MR. CHUNG: No? Okay. Let's go to another
17 document, tab 42. This will be Exhibit 18.

18 (Exhibit 18 was marked for
19 identification.)

20 BY MR. CHUNG:

21 Q Okay. So Ms. Jupiter, this is from the
22 hospitalsafetygrade.org website, right, that we just
23 looked at, and if you go to -- first of all, are you
24 familiar with this kind of section of the website,
25 "How to Use the Grade"?

1 A I'm familiar with it.

2 Q Okay, and what's the purpose of this
3 particular section?

4 A So that consumers know how to use the safety
5 grade.

6 Q Okay. Let's go to -- if you go to page 4 of
7 this particular PDF, under the "What about past
8 grades" question, there's a sentence in that second
9 paragraph, "Displaying past rates makes it clear which
10 hospitals consistently achieve high standards of
11 patient safety and which have demonstrated a steady
12 path of improvement." Then next is "patients should
13 always decide on where to receive care based on a
14 hospital's current Safety Grade."

15 Do you see that?

16 A Yes.

17 Q Okay. So is the message to consumers that
18 visit the site that a drop, right, a downgrade in a
19 hospital's safety grade means that they should not go
20 to that hospital?

21 A No.

22 Q Okay. What, what does, what does this mean
23 then?

24 A That you should decide on where you go based
25 on what the current safety grade is.

1 Q Okay, but if a consumer sees that a
2 hospital's safety grade has gone down, right, either
3 from year to year or over, over time, is LeapFrog
4 telling the consumer through these -- through the
5 website that the hospital's become more dangerous? Is
6 that part of the message here?

7 MS. BLAIR: Objection to form.

8 THE WITNESS: It's saying that the hospital
9 is less safe than it was the last time we issued
10 the higher safety grade.

11 BY MR. CHUNG:

12 Q Okay. That's the message that's intended
13 for the consumer, correct?

14 A Correct.

15 Q Okay. So does that -- does this language
16 and that message then signal to the consumer that they
17 should be more cautious about visiting a hospital
18 whose grade has gone down?

19 A It's not necessarily whether it's gone up or
20 down; it's what is the current grade.

21 Q Okay, but I think your earlier testimony --
22 your earlier response to my earlier question is that
23 if, if a hospital's grade has gone down, right, from
24 year to year over a period of time, it's the message
25 to consumers that it's become less safe, right?

1 A Correct.

2 Q Right. So my next question was: Does that
3 also mean that the consumer, if they see that pattern,
4 right, the downgrade pattern, should be more cautious
5 about visiting a hospital with that type of pattern?

6 A The safety grade is only a portion of what
7 you should look at when you're deciding what hospital
8 you should visit.

9 Q Okay, but the sentence here, again on this
10 website, is "patients should always decide on where to
11 receive care based on a hospital's current Safety
12 Grade," right?

13 A Correct.

14 Q "Always," and I'm focusing -- well, I don't
15 need to focus. The word is "always decide on where to
16 receive care based on a hospital's current safety
17 grade."

18 A The important part of that sentence is the
19 word "current."

20 Q Okay.

21 A That's what it's saying. This is about
22 past, present, so it's saying the current safety grade
23 is more important than a past safety grade.

24 Q Okay. Can you explain that further why the
25 "current," that that language is important here?

1 A If my son had an A in math last year and he
2 has a B in math this year, I'm more concerned about
3 the B this year, and he needs to work on his testing
4 this year. It doesn't matter that he had an A last
5 year. He has a B this year.

6 Q Okay.

7 A I'm not saying my son is more stupid than he
8 was last year.

9 Q Okay. You know what? We're not going to --
10 we're not going to work with that analogy. We're
11 going to -- why don't we move on to the next sentence,
12 the rest of the paragraph, right?

13 It continues, "However, past grades can tell
14 you a lot about that hospital's track record in
15 keeping its patients safe from errors, injuries,
16 accidents and infections," right? "Keeping an eye on
17 your local hospital's safety grades over time also
18 makes it easier to spot patterns -- whether a hospital
19 is working to improve or has allowed its focus on
20 safety to slip."

21 So is this -- is the messaging to consumers
22 here that they should basically monitor a hospital's
23 safety grade for whether it, whether it goes down over
24 a period of time?

25 A Yes. We want you to keep an eye on your

1 hospital's safety grade.

2 Q Okay, and if, over time, their hospitals or
3 the one they're looking at, their safety grade goes
4 down over a period of time, I think it was your
5 testimony earlier that they should be -- that should
6 be a signal to the consumer that that hospital is less
7 safe, correct?

8 MS. BLAIR: Objection to form.

9 THE WITNESS: Can you ask it a different
10 way?

11 BY MR. CHUNG:

12 Q Sure. Is it -- is the part of the messaging
13 here, right, that if a consumer observes a hospital's,
14 their particular hospital's safety grade going down
15 over time, that that should signal to them that that
16 hospital is less safe?

17 A Correct.

18 Q Okay.

19 Let's go to the previous page, page 3.

20 There's a section "What measures are most important?"

21 Do you see that?

22 A Yes.

23 Q And the first bullet point there is -- here
24 we see the handwashing again -- "Does your hospital
25 have a handwashing policy to ensure all staff members

1 are washing their hands before and after patient
2 contact?"

3 Do you see that bullet point there?

4 A Yes.

5 Q Okay, and I think we you saw earlier that,
6 in fact, handwashing or hand hygiene was one of the
7 imputed metrics, correct?

8 A Correct.

9 Q And this handwashing or hand hygiene was one
10 of the imputed metrics, where, if a hospital didn't
11 respond to the survey, they automatically would be
12 assigned the lowest grade possible for handwashing; is
13 that correct?

14 MS. BLAIR: Objection to form.

15 THE WITNESS: Correct.

16 BY MR. CHUNG:

17 Q Okay. So here on the website, LeapFrog --
18 is it correct that LeapFrog is telling consumers that
19 one of the most important measures they should
20 consider when choosing a hospital is handwashing,
21 correct?

22 A Correct. You want your doctor to have clean
23 hands.

24 Q Okay, but is it disclosing anywhere here
25 that LeapFrog automatically gives nonparticipating

1 hospitals the lowest grade possible for hand hygiene?

2 A It would be on that hospital's site, on
3 their safety grade site.

4 Q Okay, but it's not disclosing it here in
5 this section, correct?

6 A There's no reason to disclose it here.

7 Q But it's not is my question.

8 A It also doesn't say my son got an A in math
9 here either.

10 MR. CHUNG: All right. Why don't we move on
11 to tab 43. This will be Exhibit 19.

12 (Exhibit 19 was marked for
13 identification.)

14 MS. BLAIR: And none of these are
15 Bates-labeled. They're coming right off the
16 website. Is that why?

17 MR. CHUNG: That's right.

18 MS. BLAIR: Okay. Just making sure.

19 BY MR. CHUNG:

20 Q All right. You have Exhibit 19 in front of
21 you. This is also taken from the hospital safety
22 grade website. The section is entitled "Choosing the
23 Best Hospital."

24 Are you familiar with this section of the
25 website?

1 A No, but I, I don't -- we have hundreds,
2 thousands of pages. I don't know every page on the
3 website.

4 Q Okay. There are hundreds of thousands of
5 pages on the website?

6 A No. There's hundreds, comma, thousands.
7 I'm sure there's thousands of pages on our website.

8 Q Okay. So the -- this tells -- this section,
9 the second paragraph, tells consumers, right, that
10 choosing a hospital could be a life, "a life or death
11 decision."

12 Do you see that first sentence in the second
13 paragraph?

14 A Yes.

15 Q Okay. What is the purpose of that
16 particular message to the consumer?

17 A It's important the hospital that you choose.

18 Q Okay. Is the message -- is this message,
19 "your choice of hospital could be a life or death
20 decision," is it designed to scare consumers?

21 A Not to scare consumers, but for them to
22 understand that it's an important decision.

23 Q Okay. Does LeapFrog expect consumers not to
24 be scared when they read something like that?

25 MS. BLAIR: Objection to form.

1 THE WITNESS: We want them to know that it's
2 an important decision.

3 BY MR. CHUNG:

4 Q Okay. Is, is this messaging designed to
5 encourage consumers to use the hospital safety grades
6 when choosing a hospital?

7 A Yes.

8 MR. CHUNG: Okay. Let's go to tab 44, which
9 will be Exhibit 20.

10 (Exhibit 20 was marked for
11 identification.)

12 BY MR. CHUNG:

13 Q Okay. This also -- we're just continuing
14 with various sections from the hospital safety grade
15 website. This one is entitled "FAQs About the
16 LeapFrog Hospital Safety Grade."

17 Are you familiar with this, the FAQ section
18 of the website?

19 A Yes.

20 Q Okay, and now, if we look at page 2 of the
21 document, in that middle paragraph there, there's a
22 sentence, "Johns Hopkins Medicine researchers estimate
23 that patients are twice as likely to die of a
24 preventable problem at a C, D or F hospital than an A
25 hospital."

1 Do you see that?

2 A Yes.

3 Q Have you reviewed or seen any research from
4 Johns Hopkins Medicine researchers to this effect?

5 A I haven't, no.

6 Q Okay. Similar question: I mean is this
7 message designed to scare consumers away from visiting
8 hospitals with C, D or F safety grades?

9 MS. BLAIR: Objection to form.

10 THE WITNESS: It's to encourage hospitals
11 to attend -- patients to attend the safest
12 hospital possible.

13 BY MR. CHUNG:

14 Q What do you want by "safest hospital
15 possible"?

16 A We say that an A hospital is safer than an F
17 hospital.

18 Q Okay, and so by extension, this message is
19 to basically discourage consumers from going to a C, D
20 or F hospital, right, because the claim here is that
21 they're likely to die of a preventable problem if they
22 go to one of these hospitals, correct?

23 MS. BLAIR: Objection to form.

24 THE WITNESS: They're not likely to die;
25 They're more likely to die.

1 BY MR. CHUNG:

2 Q Right, but my question is: Is the message
3 designed here to discourage consumers from going to
4 these types of hospitals?

5 A To going to low-grade hospitals, yes.

6 Q Yeah, C,D, or F hospitals in particular,
7 correct?

8 A As opposed to an A or B hospital --

9 Q Yep.

10 A -- yes.

11 Q Okay. Does LeapFrog want consumers to think
12 that visiting a hospital with a C, D, or F grade could
13 seriously injure or even kill them? Is that part of
14 the message here?

15 A Yes.

16 Q Okay, and is the messaging here designed to
17 encourage consumers to use the hospital safety grades
18 when choosing a hospital?

19 A Yes.

20 Q So the -- if you look at the next page, so
21 page 3 of the same document, in bold it says here,
22 "Does a hospital get a better Safety Grade if it
23 reports to the LeapFrog Hospital Survey," right, and
24 part of the response there is "the Hospital Safety
25 Grade reflects how well a hospital does on safety, not

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1 whether they complete the LeapFrog Hospital Survey."

2 Do you see that?

3 A Yes.

4 Q Okay, but is that true?

5 A Yes.

6 Q Okay, but if a hospital does not complete
7 the survey, it automatically receives the lowest score
8 on the four imputed metrics, right?

9 A Correct.

10 Q Okay, and that's without the benefit of any
11 data on those four metrics, correct?

12 A Correct.

13 MS. BLAIR: Objection to form.

14 BY MR. CHUNG:

15 Q Okay. So how is this particular statement
16 true, that "The Hospital Safety Grade reflects how
17 well a hospital does on safety, not whether they
18 complete the LeapFrog Hospital Survey"?

19 A There are hospitals who don't complete the
20 survey that get As and Bs.

21 Q Okay. Well, we're not -- okay. So there
22 are that set of hospitals, but when we're looking at
23 the hospitals that don't participate in the survey,
24 right --

25 A Correct.

1 Q -- and are automatically downgraded to the
2 lowest possible score on the four imputed metrics,
3 does that -- does the resulting grade reflect how well
4 that hospital does on safety?

5 A Yes. Those four imputed metrics are only a
6 portion of the hospital safety grade.

7 Q Right.

8 A So you can still not complete the survey and
9 get an A if those other measures are good.

10 Q Okay. So you're saying that in -- there
11 are -- that hospitals somehow can make up for the
12 lowest score that they get on those -- the automatic
13 lowest scores that they get on those four imputed
14 metrics?

15 A The --

16 MS. BLAIR: Objection to form.

17 THE WITNESS: The four imputed measures are
18 only a portion of the score, so we have data for
19 the rest of that score. If your data on the rest
20 of the score shows that you're a safe hospital,
21 then you will get an A.

22 BY MR. CHUNG:

23 Q Right. You'll automatically get an A?

24 A Not automatically. It depends on how well
25 you perform. These hospitals we're talking about are

1 terrible hospitals. If you're a good hospital and a
2 safe hospital, you will get an A.

3 Q Okay, and what, what is that -- what is that
4 based on? What, what is your -- what, what is that
5 kind of conclusion based on, that if you're good and a
6 safe hospital, you will -- I think you said you will
7 automatically -- you will get an A. Not
8 automatically, you will get an A.

9 What is that, what is that based on?

10 A The hospital safety grade is based on
11 information from CMS, and then if we don't have that
12 information, we impute the score. If the information
13 we get from CMS shows that you are a safe hospital,
14 you will get a good grade.

15 Q I think you said that you'll get an A,
16 right?

17 A I said you can get an A.

18 Q Okay, but at least for those four imputed
19 metrics, right, that's -- the score given to those
20 hospitals on those four imputed metrics is without the
21 benefit of any data, correct? It's just an automatic
22 assigning of the lowest, of the lowest grade, correct?

23 A No, you're not getting graded on those four
24 metrics. Those metrics go into the grade. There's
25 one grade based on all this information.

1 Q Ms. Jupiter, how can you say that those
2 hospitals, those nonparticipating hospitals are not
3 being graded on those four imputed metrics when we saw
4 on the website, Delray being an example, right, that
5 they are -- that they're assigned the lowest possible
6 score on those four -- if you can let me finish -- on
7 those four imputed metrics?

8 A A score is not a grade. You get one grade
9 based on all the different metrics. You're not
10 getting a grade on hand hygiene. You're getting a
11 score on hand hygiene that rolls up into the grade.

12 Q I understand that, and I think, just as you
13 testified, it rolls up those four imputed metrics,
14 right? The scores on those imputed metrics roll up
15 to, they contribute, they factor into what ultimately
16 becomes the end product, the health [sic] safety
17 grade, correct?

18 A It's the hospital safety grade.

19 Q Hospital safety grade. I will eventually
20 get that right by the end. Hospital safety grade,
21 correct?

22 A Correct.

23 Q Okay. All right. Let's go into another
24 section here.

25 What -- are there any processes that

1 LeapFrog has in place for collecting or soliciting
2 consumer patient feedback regarding --

3 A Yes.

4 Q -- regarding its scoring methodology and the
5 safety grades?

6 A We have a patient and family caregiver
7 panel, and that's how we receive feedback from
8 patients.

9 Q Okay, and that is dedicated to patients or
10 patients' families; is that right?

11 A Correct.

12 Q All right.

13 Has LeapFrog received consumer or patient
14 feedback specifically criticizing or questioning the
15 accuracy or fairness of its safety grades?

16 A Not that I know of.

17 Q Okay. Does LeapFrog have any policies or
18 guidelines on how consumer feedback is considered or
19 incorporated into its scoring methodology?

20 A We -- I'm not an expert on the methodology.
21 I know we receive HCAHPS scores, we receive the HCAHPS
22 scores from CMS, which is patient feedback on
23 hospitals.

24 Q Has LeapFrog ever received any feedback from
25 patients or consumers that the safety grades are

1 misleading?

2 A Not that I know of.

3 Q Okay, or that they're confusing?

4 A Not that I know of.

5 Q Okay, or that they have led to negative
6 health or hospital selection decisions?

7 A Not that I know of.

8 Q Okay.

9 Are you aware of any instances in which
10 patients or members of the public have reported
11 delaying or just foregoing altogether necessary
12 medical care as a result of relying on the hospital
13 safety grades?

14 A Not that I know of.

15 Q Okay. Are you aware of any instances in
16 which patients or members of the public have
17 transferred to a hospital that they would have
18 previously avoided based on LeapFrog's safety grade?

19 A Transferred to a hospital they would have
20 avoided?

21 Q Well, let me put it another way. Have you
22 heard of any instances where patients or members of
23 the public have transferred to a hospital, right, made
24 a different -- transferred to a -- from one hospital
25 to another based on what they read in the hospital

1 safety grade?

2 A Transferred?

3 Q Yes.

4 A No.

5 Q Okay.

6 Has LeapFrog analyzed or conducted any
7 studies regarding increased travel time prompted by
8 safety grades, by hospital safety grades?

9 A Not that I know of.

10 Q Have you heard of any instances where,
11 because of a decision by a patient to get care or get
12 admitted to a hospital that's farther, right, from
13 their more -- from their most immediate hospital based
14 on a hospital safety grade as contributing to a
15 negative outcome?

16 A I don't understand the question.

17 Q Sure. Have you, have you heard of any
18 instances where a, a patient has traveled to a
19 hospital that's further away, right, than the hospital
20 that's closest to them because of the safety --
21 hospital safety grade they saw for the hospital that's
22 closer to them?

23 A Not a specific incident.

24 Q Okay.

25 Has LeapFrog ever issued a correction or a

1 clarification of a hospital safety grade after
2 learning that a specific grade may have misrepresented
3 a hospital's actual safety or quality of care?

4 A Not that I'm aware of.

5 Q Okay.

6 Has LeapFrog ever considered or studied any
7 potential public health risks from publishing hospital
8 safety grades for hospitals where it lacks sufficient
9 or reliable data?

10 A Not that I'm aware of.

11 MR. CHUNG: Let's go to tab 23. We'll mark
12 this as Exhibit 21.

13 (Exhibit 21 was marked for
14 identification.)

15 BY MR. CHUNG:

16 Q Ms. Jupiter, this is Exhibit 21 taken from
17 the LeapFrog HelpDesk. Just give it a read.

18 (Witness peruses document.)

19 BY MR. CHUNG:

20 Q Have you seen this kind of comment from the
21 HelpDesk before?

22 A No. I have nothing to do with the HelpDesk.

23 Q Okay. Who, who oversees the HelpDesk?

24 A Missy Danforth.

25 Q Okay, and is this a, is this like a portal

1 on one of the websites or some email address? How is
2 the HelpDesk accessed?

3 A I don't know.

4 Q All right. So we'll go into kind of
5 substance of, of the report here.

6 The commenter writes that they're
7 "disappointed with the 2024 proposed changes," that
8 they "will penalize hospitals that do not submit a
9 LeapFrog Survey," and "the public will not understand,
10 nor dig into the methodology of these grades," and
11 then "hospitals will be falsely represented with a
12 lower grade, because they chose to not complete a
13 survey."

14 Does this -- is this a feedback to the
15 change in the imputation methodology that you've heard
16 before, maybe not from the HelpDesk, from other
17 sources?

18 A Not outside this lawsuit.

19 Q Okay, so this is the first time -- again,
20 outside this lawsuit, this is the first time you're
21 seeing any sort of feedback along these lines?

22 A Yes.

23 Q Okay. The commenter goes on, "The survey is
24 extremely time-intensive, and, in a time when
25 hospitals are barely breaking even financially, they

1 do not have the resources to commit to this survey."

2 So there's -- this is a comment on the
3 resource and the time it takes to fill out the survey.

4 Is this a concern or feedback that you've
5 heard of before?

6 A I don't communicate with hospitals. I have
7 not heard that.

8 Q The, the question is: Have you heard of
9 the -- heard this feedback before?

10 A No.

11 MR. CHUNG: Okay. Let's go to tab 24, which
12 will be Exhibit 22.

13 (Exhibit 22 was marked for
14 identification.)

15 BY MR. CHUNG:

16 Q Okay. So this is dated -- it's a document,
17 at least across the top, "Planned Updates to the
18 LeapFrog Hospital Safety Grade Methodology for Fall of
19 2024," and this is from June 6 of 2024.

20 Do you recognize this document or at least
21 the format of the document?

22 A No.

23 Q Okay. Are you aware that in conjunction --
24 in the process of updating the, the safety grade
25 methodology, that there was public comment that was

1 collected?

2 A Yes.

3 Q Okay, and does this, does this look like
4 some of the public comment that was collected in
5 response to the --

6 A I didn't receive any of the public comment.

7 Q Okay. Well, let's go to the second page,
8 kind of the last piece of this document.

9 The commenter here, Alana Noble, writes that
10 that the "Fall 2024, the Step 2 imputation," right,
11 which we -- do you see the -- so it starts, "We
12 strongly disagree with the proposed Fall 2024 Step 2
13 imputation."

14 Do you understand what she's referring to
15 there?

16 A Yes.

17 Q Yes? Okay.

18 If LeapFrog is going to implement this
19 change, they need to offer hospitals an option to opt
20 out of being graded rather than penalize a hospital
21 for not submitting the resource-intensive survey,
22 okay?

23 So have you heard or seen this feedback --
24 again, outside of this lawsuit -- in connection with
25 what then was the proposed as the plan change in the

1 methodology?

2 A No.

3 Q No? So nothing? You've never heard of any
4 feedback that this imputation -- change in the
5 imputation methodology is going to unfairly penalize
6 nonparticipating hospitals?

7 A No.

8 Q Okay. The commenter goes on to write, "The
9 survey is very resource-intensive outside of existing
10 regulatory, quality operations, and quality
11 improvement efforts," and it goes on to say the
12 "hospitals who do not have the resources should not be
13 so adversely punished, especially in the post-COVID
14 area where resources are increasingly hard to come by
15 and retain."

16 Again, same question: Have you heard -- did
17 you hear of this type of feedback in conjunction with
18 the plan change in the methodology?

19 A No.

20 Q Okay. Again, taking your testimony that
21 you've never heard this, at least the substance of
22 this type of feedback before, what's your reaction
23 to -- let's start with the first sentence here, right,
24 that patients or nonparticipating hospitals are being
25 unfairly penalized by, by not responding to the

1 survey.

2 A What's the question?

3 Q What's your reaction to that feedback? Is
4 it a, is it a fair criticism or reaction or unfair?
5 Let's put it that way.

6 A We want hospitals to make a commitment to
7 accuracy and transparency, and so we encourage them to
8 fill out the survey so that we have that information,
9 and it might be work to them, but that's part of a
10 commitment to patient safety.

11 Q Okay, and the second part of the, the
12 comment here that the survey is very "resource-
13 intensive outside of existing regulatory, quality
14 operations, and quality improvement efforts," and it
15 goes on to say that hospitals don't have some of these
16 resources to do the survey annually.

17 Again, what is your reaction to it? Is it a
18 fair or unfair reaction to the, to the change in
19 methodology here?

20 A If a hospital is committed to patient safety
21 and saving lives, then they will make the resources to
22 fill out the survey.

23 Q Okay. So it is -- and if they don't fill
24 out the survey, they're not committed to patient
25 safety? Is that, is that the -- is that the message

1 here?

2 A Yes.

3 Q Okay, and that's your, that's your position
4 with respect to this feedback?

5 A Yes.

6 Q Okay, and that is, and that is -- even if
7 the hospital has world class patient safety programs
8 in place, your position is that if they're not
9 responding to the survey, they are not committed to
10 patient safety?

11 MS. BLAIR: Objection to form.

12 THE WITNESS: If a hospital has world class
13 patient safety programs in place, they are
14 filling out the survey.

15 BY MR. CHUNG:

16 Q And what's the basis for that statement?

17 A Because transparency is part of having a
18 world class patient safety program.

19 Q And is that, is that based on kind of your
20 observations? Like what is that -- what, what
21 evidence is that based on? Have you seen that from
22 hospitals generally?

23 A I have never heard of a hospital with world
24 class patient safety that does not fill out the
25 survey.

1 MR. CHUNG: Okay. Let's go to the next
2 document, tab 25. This will be Exhibit 23.

3 (Exhibit 23 was marked for
4 identification.)

5 BY MR. CHUNG:

6 Q Ms. Jupiter, the format of this is similar
7 to what we saw earlier. I'm going to ask you to focus
8 on really the end, the last few sentences of the
9 document from the commenter Zubin Momin, and -- Zubin
10 Momin, and under "Imputation Step 2 Model," the
11 commenter writes, "We feel like this model is
12 unnecessarily punitive. We often skip survey
13 submission because the responses provided for IPS,
14 Hand Hygiene, BCMA and CPOE are largely unchanged in
15 the two-year period that was allotted before
16 negatively impacting grades."

17 Is that a, kind of a comment or feedback
18 that you're familiar with in response to the change in
19 methodology?

20 A I don't know, no.

21 Q What is your reaction? Is that kind of a
22 fair or unfair reaction?

23 MS. BLAIR: Objection to form.

24 THE WITNESS: I don't have an opinion on it.
25

1 BY MR. CHUNG:

2 Q Okay. You had an opinion on the previous
3 comment. Why don't you have an opinion on this one?

4 A I don't know enough about survey submission
5 specifics for IPS, Hand Hygiene, BCMA or CPOE.

6 Q Okay. Well, if the -- if a hospital's
7 previous responses to the survey for these four
8 metrics, right, were largely unchanged in the
9 preceding two years, right, is this commenter's -- is
10 this commenter kind of being fair in saying that they
11 can often skip a submission?

12 A I don't know enough about the imputation.

13 Q You don't know enough about the -- I'm
14 sorry.

15 A The imputation model.

16 Q Okay, in order to assess whether this is a
17 fair reaction?

18 A Correct.

19 Q Okay. The, the commenter goes on, "The FTE
20 resource commitment to complete the survey is already
21 significant. There is no value added by completing a
22 survey every year or every other year when practices
23 in our hospitals have not changed."

24 The commenter is saying here, where the
25 practices at a hospital have not changed, right, and

1 where they have made submissions, where they responded
2 to the survey in previous years, that the change in
3 the imputation model unnecessarily punishes
4 nonparticipating, nonparticipating hospitals; do you
5 see that as a fair reaction to the change in the
6 imputation methodology?

7 MS. BLAIR: Objection to form.

8 THE WITNESS: I can't really comment on if
9 it's fair or unfair.

10 BY MR. CHUNG:

11 Q Okay. What additional information would you
12 need?

13 A I'd need to understand exactly what they
14 mean by how much time is significant. I don't
15 understand if they -- what they mean by it hasn't
16 changed, because things change over time. I don't
17 even know what hospital this is. I don't know what
18 their grades are. I don't know anything about their
19 survey submissions.

20 Q Okay, but I think in your responses to the
21 previous questions for the other comments, you said
22 that if a hospital is committed to patient safety,
23 they will respond to the survey, correct?

24 A Correct.

25 Q All right. So is there something about this

1 particular -- something about this comment that --
2 where you can't take the same position?

3 A I would take the same position. If this
4 hospital is committed to patient safety, they will
5 fill out the survey.

6 Q Okay. So your answer is here basically the
7 same as with the other comments, correct?

8 A Yes.

9 MR. CHUNG: Okay. Let's go to the next one,
10 26, tab 26.

11 (Exhibit 24 was marked for
12 identification.

13 BY MR. CHUNG:

14 Q All right. This is a letter comment from
15 basically the Ascension kind of network of hospitals
16 from June of 2024. It's submitted to LeapFrog
17 HelpDesk.

18 Are you familiar with -- have you seen this
19 particular document?

20 A No.

21 Q Okay, and you'll see -- I want to focus on
22 the bottom paragraph of the first page. It reads,
23 "Ascension cannot support LeapFrog's proposed update
24 and strongly encourages LeapFrog to refrain from
25 implementing it."

1 Are you familiar with Ascension?

2 A No.

3 Q Okay. "We fundamentally believe that the
4 Hospital Safety Grade and the Hospital Survey should
5 remain separate; the Survey should not affect the
6 grades," and "we believe that is not in the best
7 interest of public policy, as not all hospitals have
8 the information and/or capabilities to complete the
9 Hospital Survey. Further, we believe it is
10 unreasonable for an optional survey to have such a
11 significant impact."

12 What is your reaction to this comment?

13 A I don't know enough about how the survey
14 impacts the grade and what they mean by remaining
15 separate to understand this.

16 Q Well, Ms. Jupiter, I mean we've gone over
17 this. You do know and you have testified that, that
18 according to the change in the imputation methodology,
19 right, that nonparticipating hospitals now are
20 automatically assigned the lowest, lowest possible
21 grade for the four imputed metrics, correct?

22 A No, they do not get a grade for the metrics.

23 Q The scores, right? They get the lowest
24 possible scores for those four metrics, correct?

25 A Correct.

1 Q Okay, and isn't that what this commenter is
2 referring to?

3 A Isn't what? I don't understand the
4 question.

5 Q That, that the survey should not affect the
6 grades, that nonparticipation in the survey should not
7 affect the grades.

8 A That's what they're saying, yes.

9 Q Okay, and so when he writes that "this is
10 not in the best interest of public policy," what is
11 your reaction to that?

12 A I disagree.

13 Q Okay, and why do you disagree?

14 A Because we want hospitals to share their
15 patient safety information with consumers.

16 Q Okay, and the way to -- the way that
17 LeapFrog has determined to do that is to, is to punish
18 nonparticipating hospitals by assigning them the
19 lowest score possible on those imputed metrics,
20 correct?

21 MS. BLAIR: Objection to form.

22 THE WITNESS: I don't understand your
23 question.

24 BY MR. CHUNG:

25 Q Well, your testimony has been, and you've

1 repeated it a number of times, that, that hospitals --
2 if hospitals are committed to patient safety, they
3 will respond to the survey, correct?

4 A Correct.

5 Q We've read a number of comments and feedback
6 from -- in this case, a hospital -- that they think
7 that that change, the change of methodology is unfair,
8 correct?

9 A Correct.

10 Q Right, and that it unfairly penalizes
11 nonparticipating hospitals, correct?

12 A Correct.

13 Q All right, and so wasn't the purpose of
14 changing this methodology to basically encourage
15 hospitals to participate in the survey?

16 A Yes.

17 Q Okay, because if they did not participate in
18 the survey, they were in jeopardy of receiving a lower
19 overall hospital safety grade, correct?

20 A They would get a lower score on those
21 imputed metrics.

22 Q Right, which, in turn, would at least raise
23 the risk of getting a lower overall hospital safety
24 grade; would that be a fair characterization?

25 A Yes.

1 Q This final sentence on the comment in the
2 letter, "Further, we believe it is unreasonable for an
3 optional survey to have such a significant impact."

4 Do you agree with that statement?

5 A No.

6 Q Do you agree that this is an optional --
7 that the survey, LeapFrog's hospital survey is an
8 optional survey?

9 A Yes.

10 Q Okay. Has the change in the imputation
11 methodology -- would you agree that the change in
12 imputation methodology has basically converted
13 LeapFrog's survey from an optional one to a compulsory
14 one?

15 MS. BLAIR: Objection to form.

16 THE WITNESS: No.

17 BY MR. CHUNG:

18 Q No? Why not?

19 A What's the question?

20 Q The question is: How has -- so where, where
21 hospitals will receive, right, a lowest possible score
22 on the four imputed metrics -- and again we discussed
23 this earlier -- that raised the risk of getting a
24 lower overall health -- hospital safety grade, doesn't
25 this -- doesn't that change in methodology essentially

1 make the survey effectively a required one, one that
2 hospitals have to fill out?

3 A No.

4 MR. CHUNG: No? Okay. Let's go on to the
5 next document, tab 27. This will be Exhibit 25.

6 (Exhibit 25 was marked for
7 identification.)

8 BY MR. CHUNG:

9 Q All right, Ms. Jupiter, this is a similar
10 format to the feedback on the change to imputation
11 methodology. If I could direct your attention to the
12 last kind of message coming from a Susan Boardman at
13 the end here.

14 Do you see that?

15 A Yes.

16 Q Okay. I'm sorry about the size of the font
17 here.

18 "The proposed changes to the Imputation
19 Method would result in an inaccurate portrayal of the
20 actual status of the patient safety structures and
21 processes in place for the LeapFrog grade measures
22 CPOE, BCMA, IPS and Hand Hygiene at hospitals that
23 choose not to expend the resources to submit" the
24 hospital survey for both 2024 and 2023.

25 It goes on to describe what the Step 2 of

1 the imputation methodology prescribes, right?

2 What is your reaction to the first sentence
3 in this comment?

4 A I disagree.

5 Q Why do you disagree? Why do you disagree
6 that the change in the imputation methodology would
7 result in an inaccurate portrayal of the actual status
8 of the patient safety structures and processes at a
9 particular hospital?

10 A Because I don't think it's inaccurate.

11 Q Okay. Why don't you think it's inaccurate?

12 A Because LeapFrog data is accurate.

13 Q Because LeapFrog data is accurate?

14 A Correct.

15 Q I'm not understanding. What LeapFrog data
16 are you referring to?

17 A The hospital safety grade.

18 Q So the hospital, the hospital safety grade
19 is accurate?

20 A Correct.

21 Q Okay, and in the absence of -- and in the
22 absence of hospital survey data, right, how do you
23 explain that that hospital safety grade is accurate?

24 A It is based on the data that we have. The
25 imputed metrics are just a small portion of what goes

1 into the safety grade.

2 Q Okay.

3 Now, you've testified earlier kind of in the
4 first half of our deposition that you're not really
5 familiar with how the imputation methodology works,
6 and you're not familiar with how the hospital safety
7 grades are arrived at.

8 So how are you able to make these kind of
9 conclusory statements now that, number one, that the
10 hospital safety grades are accurate?

11 A I work for a nonprofit that's committed to
12 patient safety and saving lives. Obviously, I think
13 our data is accurate.

14 Q Okay, so by virtue of just being a member of
15 the organization, you're confident that the, that
16 the -- you're calling it the "data," but the hospital
17 safety grade is accurate?

18 A Correct.

19 Q Okay, and do you have any -- can you point
20 to any, anything empirical that supports that?

21 A That supports that LeapFrog's safety grades
22 are accurate?

23 Q Yes.

24 A Everything we do at LeapFrog is around
25 accurate data.

1 MR. CHUNG: Okay. This will be Exhibit 26.
2 (Exhibit 26 was marked for
3 identification.)

4 BY MR. CHUNG:

5 Q All right. This is an -- Exhibit 26 is an
6 email chain where I think you're at least copied from
7 October of 2023. Just take some time to review it.
8 Let me know if you recognize it.

9 A I don't recognize it.

10 Q Okay. Well, let's start with the first
11 email in the chain.

12 It comes from a Lula Hailesilassie at CURA
13 Strategies, the PR firm that you've testified about,
14 and she writes to the team here that she "wanted to
15 flag a story released this morning regarding
16 St. Luke's Hospital in Kansas City. An ex-employee
17 exposed the hospital's rusty and damaged equipment
18 that is being used on patients and how the hospital is
19 extremely dangerous," and that this article mentions
20 that St. Luke Hospital "received an A grade for the
21 spring 2023" cycle, and that "this is a similar issue
22 to Bayonet Hospital but without national press."

23 And then you'll see that Ms. Bailey, Lauren
24 Bailey writes, a couple emails above, "Just following
25 up that they are receiving an A again for Fall 2023,"

1 right, for this particular St. Luke Hospital.

2 After going through kind of this email, does
3 it jog your memory as to what's being discussed here?

4 A No. I don't remember the specific instance.

5 Q Okay. So, so basically this story is, is
6 about -- is, is describing an extremely dangerous
7 hospital, St. Luke's Hospital, that received an A
8 grade, right, for spring 2023, despite using rusty and
9 damaged equipment; is that correct?

10 MS. BLAIR: Objection to form.

11 THE WITNESS: Correct.

12 BY MR. CHUNG:

13 Q Okay, and then the CURA Strategies
14 representative writes that there's a "similar issue"
15 at another hospital, correct, at the Bayonet Hospital?

16 A Yes.

17 Q Okay. Does the Bayonet Hospital -- does
18 that ring a bell?

19 A It doesn't.

20 Q Okay. So it seems here that this is not a
21 one-off issue for certain hospitals getting high
22 grades for potential unsafe hospitals; is that fair to
23 say?

24 MS. BLAIR: Objection to form.

25 THE WITNESS: They're -- they talk about two

1 hospitals, yeah.

2 BY MR. CHUNG:

3 Q Okay, and then this hospital, the St. Luke's
4 Hospital, the extremely dangerous one, according to
5 the story, with the rusty and damaged equipment is,
6 according to Ms. Bailey, receiving an A again for this
7 next cycle in fall 2023, correct?

8 A Yes.

9 Q Okay. Do these sorts of -- do these sorts
10 of reports figure into the grading for, for hospitals?

11 A What sorts of reports?

12 Q The reports that we -- that are described in
13 this email chain.

14 A I don't see a report.

15 Q Well, a news article, this press coverage.

16 A I don't think press coverage fits into the
17 safety grade.

18 Q Okay. So health -- the hospital safety
19 grades are issued notwithstanding press reports like
20 these?

21 A Correct.

22 Q Are you aware of any situations where
23 LeapFrog's hospital safety grades have let -- have
24 conflicted with other ratings or accreditations or
25 even regulatory findings for certain hospitals?

1 A Our safety grades are focused solely on
2 safety in a hospital, and there's no other ratings
3 that focus solely on safety.

4 Q So my question is: Are you aware of any
5 situations or cases where LeapFrog's hospital safety
6 grades have conflicted with or are inconsistent with
7 ratings by other agencies or organizations or
8 accreditations or regulatory findings, government
9 findings?

10 A There's no apples-to-apples way to compare
11 that -- the safety grade versus a list of good
12 hospitals in D.C.

13 MR. CHUNG: Okay. Let's turn to 1029. This
14 is Exhibit 27.

15 (Exhibit 27 was marked for
16 identification.)

17 BY MR. CHUNG:

18 Q All right. So this is an email chain from
19 February of 2023, and if you look at the first in the
20 chain, it's from Elizabeth Harmon, who is listed here
21 as a senior communication specialist for LeapFrog.

22 And, number one, do you recognize this email
23 chain or familiar with the substance of it?

24 A No.

25 Q Okay. Basically the email thread is about a

1 reporter asking why a particular hospital in North
2 Carolina received a high LeapFrog grade, despite low
3 ratings from CMS for, for patient experience and for
4 reports of poor quality care.

5 Is this an example of a situation that I
6 asked you about before, where LeapFrog's safety grade
7 conflicts with, in this case, a CMS rating that, for
8 patient experience, that, that LeapFrog itself relies
9 on in issuing its safety grades?

10 A CMS is different -- CMS patient experience
11 is different from the patient safety grade.

12 Q Okay.

13 THE REPORTER: Patient safety grade?

14 THE WITNESS: Hospital safety grade.

15 BY MR. CHUNG:

16 Q Okay. In what sense? In what, in what ways
17 is it -- are the two -- the CMS star rating system,
18 right, that this is referring to, and LeapFrog's
19 hospital safety grade system different?

20 A I don't know enough about the CMS ratings to
21 say specifically how they're different, but I know
22 they're not the same.

23 Q You know that they're not the same?
24 Generally speaking, how are they different? I
25 understand that you might not know specific, but

1 generally.

2 A Because LeapFrog is solely focused on
3 patient safety, and there's, as far as I understand,
4 other factors in the CMS star ratings.

5 MR. CHUNG: Okay. All right. Why don't we
6 take a break now. Is that fine?

7 MS. BLAIR: Sure.

8 THE VIDEOGRAPHER: The time is 4:04 p.m.
9 This ends unit 4. We're off the record.

10 (Whereupon, a short recess was taken.)

11 THE VIDEOGRAPHER: The time is 4:21 p.m.
12 This begins unit number five. We're on the
13 record.

14 BY MR. CHUNG:

15 Q Ms. Jupiter, have you been involved in
16 LeapFrog's response to this lawsuit by the five
17 hospitals?

18 A What do you mean by "response"?

19 Q Have you been involved in any way in, in --
20 either from a, from a communications standpoint or in
21 relation -- or from a development standpoint,
22 responding to the lawsuit or dealing with the kind of
23 repercussions from this lawsuit?

24 A You need to be more specific.

25 Q Well, why don't we look at some documents.

1 A Okay.

2 Q But before we do, when did you first learn
3 about the plaintiff hospitals' concerns regarding the
4 hospital safety grades that LeapFrog assigned to them
5 after the imputation methodology changed?

6 A They sent a letter maybe around January.

7 Q And that's when you first learned?

8 A Yes.

9 MR. CHUNG: Okay. Let's go to tab 31, and
10 this will be Exhibit 28.

11 (Exhibit 28 was marked for
12 identification.)

13 BY MR. CHUNG:

14 Q And Ms. Jupiter, this is another set of
15 Slack messages, and I think it's just between you and
16 Ms. Bailey, so just spend some time getting familiar
17 with it. It's from May of this year, so not long ago.

18 A Okay.

19 (Witness peruses document.)

20 BY MR. CHUNG:

21 Q Have you had a chance to review it?

22 A Uh-huh.

23 Q So what is being discussed here between you
24 and Ms. Bailey?

25 A I mean there's a lot of things being

1 discussed.

2 Q Well, what's the principal kind of task here
3 being discussed?

4 A We were talking about messaging, ADA,
5 finance, the survey.

6 Q Is it -- is the focus or one of the focuses
7 here on messaging to be sent to regional leaders?

8 A That's one of the things we discussed, yes.

9 Q Is there also discussion about a statement
10 that Ms. Binder is going to put out? Is that also
11 part of the discussion?

12 A I don't remember seeing a statement she's
13 putting out.

14 Q Okay. Why don't you focus your attention on
15 Bates number ending in 9912, essentially the last
16 page.

17 A Okay.

18 Q Okay. So at the top there, let's start with
19 Ms. Bailey writing "I think we should link to results
20 for each hospital, too, so people can see their fully
21 transparent grades," and you respond, "The 5? I can
22 do that, yeah."

23 What are you discussing here with
24 Ms. Bailey?

25 A I'm assuming we're discussing the five

1 hospitals involved in the lawsuit.

2 Q Right. What is she referring to when she
3 thinks "we should link to results for each hospital,
4 too, so people can see their transparent grades," what
5 is the "link" referring to?

6 A I don't know.

7 Q But you respond "I can do that," right?

8 A Right.

9 Q So what did you do?

10 A I don't know.

11 Q Okay. Is this referring to a, a link to the
12 hospital safety grade results for the five hospitals
13 on another -- on a website?

14 A I assume so. I don't know where it's
15 talking about linking them. I mean because they're on
16 the website.

17 Q Okay.

18 A So I don't know what this is referring to.

19 Q Is it, is it linking of the results for each
20 of these hospitals on, on a, on the statement that
21 Ms. Binder is going to put out?

22 A I don't know.

23 Q Okay.

24 Now, you continue here, "Not sure we want to
25 link expert panel. We don't really want them

1 contacted."

2 Why is that? Why did you not want the
3 expert panel to be contacted?

4 A I don't remember this exact thing, but, you
5 know, our expert panel are very busy people with lots
6 of things on their plate.

7 Q Okay. I think that applies to a lot of
8 people, but why the expert panel in particular?

9 A I couldn't tell you. I mean this was months
10 ago. I don't know what it's referring to.

11 Q About four months ago, so relatively recent,
12 right? So what are, what are you referring to here
13 that you in particular do not want the expert panel to
14 be contacted?

15 A I have no idea.

16 Q Okay. Was there a desire here to insulate
17 the expert panel from the litigation?

18 A I don't know.

19 Q You don't know? What were you thinking when
20 you wrote that?

21 A What was I thinking when I wrote this four
22 months ago?

23 Q Yes.

24 A I have absolutely no idea.

25 MR. CHUNG: Okay. Let's move on to tab 32.

1 (Exhibit 29 was marked for
2 identification.)

3 (Exhibit 30 was marked for
4 identification.)

5 BY MR. CHUNG:

6 Q Ms. Jupiter, you'll have two documents in
7 front of you, Exhibit 29 and Exhibit 30. Let's look
8 at Exhibit 29 first, which is basically the cover
9 email, okay? It's from, again, May 2025. You're
10 addressing, it looks like, a group email to regional
11 leaders.

12 What's being discussed here?

13 A The lawsuit.

14 Q Okay. What about the lawsuit?

15 A Talking points around the lawsuit.

16 Q Okay, and why are there talking points on
17 the lawsuit being sent to the regional leaders?

18 A In case regional leaders get questions about
19 the lawsuit.

20 Q Okay. Let's take a look at the talking
21 points themselves, which are on, on Exhibit 30. Well,
22 actually, let's -- focusing on the email first,
23 Exhibit 29, you write that "please refer all" -- "as a
24 reminder, please be extremely careful about your
25 communications around this lawsuit. Please refer all

1 questions or concerns about the suit to me, Missy
2 Danforth, Leah Binder or Lauren Bailey."

3 So fair to say that you're a point of
4 contact with these regional leaders about this
5 litigation?

6 A Yes.

7 Q Okay, and "given the sensitivity, we would
8 appreciate your not commenting to the media about the
9 lawsuit. Also" -- in bold -- "please avoid
10 communicating with us in writing about this matter."

11 Why, why is that?

12 A Because the regional leaders don't have very
13 much information about this, and we don't know what
14 they're going to say.

15 Q Okay. What's the concern? What are you
16 afraid that they might say that you want to avoid
17 having in writing?

18 MS. BLAIR: Objection to form.

19 THE WITNESS: I don't know what they're
20 going to say, so I don't want them putting in
21 writing things that don't make sense.

22 BY MR. CHUNG:

23 Q Okay. Going to the talking points, which
24 are Exhibit 30, were these the talking points that
25 were sent to regional leaders?

1 A Probably. I mean if you say they were, I
2 would agree.

3 Q It's not my deposition, Ms. Jupiter. Are
4 these the talking points that were sent to regional
5 leaders?

6 A Well, if you want me to open my computer and
7 look and see what I sent, I can tell you.

8 Q Well, I'm going to ask you to look at this
9 carefully and see if it refreshes your recollection as
10 to whether these are the talking points sent to the
11 regional leaders.

12 A Most likely, yes.

13 Q Okay. Were there, were there different
14 versions of these talking points sent to regional
15 leaders?

16 A Not that I remember.

17 Q Okay. So what you remember is that there
18 was one kind of version that was eventually sent out
19 to the regional leaders?

20 A That's what I remember.

21 Q Did you get input from the regional leaders
22 on the, the content of these talking points?

23 A Not that I remember.

24 Q Okay. So the, one of the top line messages
25 in these talking points to regional leaders is "we

1 encourage you to" -- and this is in the top paragraph.
2 "We encourage you to focus on the very poor
3 performance of these hospitals on patient safety first
4 and foremost, while still countering the deliberate
5 falsehoods the hospitals are spreading."

6 The -- what is the -- what information did
7 you supply to the regional leaders, regional leaders
8 about this purported "very poor performance of these
9 hospitals"?

10 A Right here under the CMS, that they have
11 high infection rates, high rates of sepsis, patient
12 reported communication is poor.

13 Q Right. So you're referring to are what's in
14 the talking points themselves, correct?

15 A Correct.

16 Q Okay, and this is in the, kind of the bottom
17 half going onto the second page of the talking points?

18 A Yes.

19 Q And you're telling the regional leaders to
20 focus on basically these bullet points toward the
21 bottom half of the, of the first page, correct?

22 A Yes.

23 Q Who is their -- who is the audience for
24 these regional leaders that you're -- that you put
25 these talking points together for?

1 A They work with employers.

2 Q Okay. So they're -- so is the idea here
3 that these are the talking points that regional
4 leaders are supposed to use in, in talking with
5 employers?

6 A Correct.

7 Q Okay, and these are -- so these are kind of
8 proactive discussions? You're instructing regional
9 leaders to go to employers and spread, spread this
10 information or these, these allegations; is that
11 right?

12 MS. BLAIR: Objection to form.

13 THE WITNESS: No. We specifically asked
14 them not to talk to people about it, but we know
15 they're going to probably anyway, and so we're
16 giving them information.

17 BY MR. CHUNG:

18 Q Okay.

19 Now, turning to the second bullet point
20 under -- so if you go to the second page, there's a
21 section, "Countering False Claims," and then there is
22 "Hospital" -- that second bullet point, "Hospital
23 participation in the LeapFrog Hospital Survey has no
24 automatic up or down impact on a hospital's safety
25 grade."

1 Do you see that bullet point?

2 A Yes.

3 Q Okay. Doesn't declining to participate in
4 the survey automatically drop four of those imputed
5 metrics down to the limited achievement score?

6 A For those metrics, yes.

7 Q Right. So is it accurate to say that
8 hospital participation in the survey has no automatic
9 up or down impact on a hospital's safety grade?

10 A It doesn't have an automatic impact on the
11 safety grade.

12 Q Okay, but there is an automatic downgrade,
13 right, on those four imputed metrics to the lowest
14 possible score, correct, on those four imputed
15 metrics?

16 A The score is only a portion of the safety
17 grade, so like I said before, there are hospitals who
18 don't do the survey that still get an A, so that would
19 show that there is not an automatic up or down impact.

20 Q Okay. Doesn't at least -- do the imputed
21 metrics, right, being automatically assigned a limited
22 achievement raise, at least raise the risk, right, of
23 a hospital, a nonparticipating hospital getting a
24 lower hospital safety grade?

25 A It could raise the risk.

1 Q Okay. Is that disclosed anywhere in these
2 talking points?

3 A That's not one of our talking points.

4 MR. CHUNG: Okay. Let's go to the next one,
5 tab 34. This will be Exhibit 31, I think.

6 (Exhibit 31 was marked for
7 identification.)

8 BY MR. CHUNG:

9 Q Exhibit 31 is an email exchange, again from
10 May of 2025. Just take a minute to look at it.

11 (Witness peruses document.)

12 BY MR. CHUNG:

13 Q And you'll see here again the representative
14 from CURA Strategies is attaching "day one coverage
15 report from today's Hospital Safety Grade
16 announcement."

17 Do you see that?

18 A Yes.

19 Q Okay, and so is this -- so is this like --
20 this is media coverage that comes out like right
21 after -- that came out right after the release of like
22 the latest hospital safety grades?

23 A Correct.

24 Q Okay, and is this something that CURA
25 Strategies regularly does for, for LeapFrog?

1 A Yes.

2 Q Does it flag or collect press coverage every
3 day for LeapFrog?

4 A No, no.

5 Q On particular important dates like this one?

6 A Correct.

7 Q Okay, and then Ms. Bailey writes or forwards
8 this to -- or flags for Ms. Binder, "There hasn't been
9 anything new today on the lawsuit that we have seen in
10 press," right? And then Ms. Binder responds, "Thanks,
11 Lauren. This coverage is great. Let's make a goal to
12 have one story at minimum every three days about Tenet
13 or one of the hospitals."

14 Do you see that?

15 A Yes.

16 Q Okay. Do you know why Ms. Binder -- why,
17 why was Ms. Binder setting this "goal to have one
18 story at minimum every three days about Tenet or one
19 of the hospitals"? Presumably she's referring to the
20 five plaintiff hospitals, correct?

21 A Right.

22 Q Why was she making this direction?

23 A We were constantly being attacked by these
24 five hospitals saying falsehoods about us in the
25 press, and we are this tiny nonprofit, and this is how

1 we responded.

2 Q Okay. When you say that you were
3 "constantly being attacked" by, by the hospitals, what
4 do you mean by that? What, what was -- where were the
5 attacks? How frequent were they?

6 A Mary Beth Maloney was going on the news and
7 saying that we were a pay-to-play organization, that
8 we were just to raise money, that we were hired -- we
9 were selling our consulting fees, things that are
10 completely false about us.

11 Q Okay, and was this -- how many -- but you
12 said that you were constantly being accused. How many
13 times did this happen? How many press reports or, you
14 know, events of this nature occurred?

15 A I don't know exact numbers.

16 Q Okay. More than -- more than one?

17 A Oh, yes.

18 Q More than ten?

19 A Yes.

20 Q More than 20?

21 A They were shared around on social media and
22 other things, so yes.

23 Q Okay, and who were the -- you mentioned Mary
24 Beth Maloney. Who were the other kind of speakers or
25 voices behind these attacks?

1 A That's the one I remember most.

2 Q Okay, and so going back to the question, why
3 was Ms. Binder making a goal to have one story every
4 three days about Tenet or one of the hospitals?

5 A I don't know why specifically those numbers.
6 That's a question you'll have to ask Leah.

7 Q Okay. Was Ms. Binder -- did she want to
8 plant negative stories about Tenet and the plaintiff
9 hospitals?

10 A Not necessarily negative stories.

11 Q Positive stories?

12 A Just to keep in the news the truth to
13 counteract the falsehoods that Mary Beth Maloney was
14 saying about LeapFrog.

15 Q Okay, so what types of stories are we
16 talking about?

17 A I don't know.

18 Q You don't know? Okay.

19 Now, Ms. Bailey responds with an ellipsis,
20 dot, dot, dot, in Exhibit 31. What did you take her
21 response here to mean? I mean she, she forwarded you
22 her response with the ellipsis.

23 A I don't know. You'd have to ask Lauren.

24 Q Did you have any follow-up conversations
25 about this directive from Ms. Binder?

1 A Not that I recall.

2 Q Okay. Who executed on this?

3 A Well, we didn't get one story every three
4 days. You know, it wasn't . . .

5 Q The question is who executed on this?

6 A Executed on what?

7 Q On this goal to have one story, at minimum,
8 every three days about Tenet?

9 A We didn't.

10 Q You did not?

11 A No.

12 Q Okay. Who was -- well, who was tasked with
13 trying to execute on this?

14 A We would work with CURA Strategies, our PR
15 firm.

16 Q And when you say "we," it's you and --

17 A Lauren.

18 Q Okay. So how did you go about doing that
19 with CURA?

20 A We didn't.

21 Q You didn't at all?

22 A We didn't -- we were not planting one story
23 every three days.

24 Q Okay. Did you plant any stories?

25 A We didn't plant any stories.

1 Q Okay. So what did you do? Even if you
2 didn't achieve the exact goal of one story at minimum
3 every three days, what did you do to follow up on
4 this, this directive from Ms. Binder?

5 A I can't recall anything specific we did.

6 THE REPORTER: You said I can't think of --

7 THE WITNESS: Anything specific.

8 BY MR. CHUNG:

9 Q Okay. How did you work with CURA Strategies
10 to try, at least try to execute on this?

11 A I'm trying to remember.

12 If we saw an article that mentioned
13 falsehoods about LeapFrog, we would have CURA reach
14 out to them to provide accurate information.

15 Q Okay. So that is more -- what you're
16 describing is more kind of a reactive reach-out to
17 that particular media outlet?

18 A Right.

19 Q Okay. How about what I'll call "proactive"
20 reach-outs to the press; anything along those lines?

21 A You have to ask Lauren or CURA.

22 Q You were not involved in that effort?

23 A Not in outreach to the press.

24 Q Okay, but you were involved in the reactive
25 effort?

1 A I mean Lauren told me what was going on.
2 You know, we -- she would say here is that article
3 where Mary Beth Maloney is saying something false
4 about us. We're going to respond with correct
5 information.

6 Q Okay, and did you work with her and CURA to,
7 to -- in an effort to correct that information?

8 A That was what CURA did. I didn't. Lauren
9 didn't reach out to press.

10 Q Okay. So what exactly was your involvement
11 in -- I mean you said "we" earlier. What -- can you
12 describe your involvement in this overall press
13 strategy?

14 A It is what I told you, where if there was a
15 false story or a story about it, Lauren would bring it
16 to my attention and then say that we were going to be
17 giving correct information.

18 Q Okay, and so what was your -- again, so
19 Lauren brings it to your attention. What would, what
20 would you then do?

21 A Nothing.

22 Q Nothing?

23 A I don't work with the press.

24 Q Okay. I'm not asking you whether you work
25 with the press, but what would you -- did you yourself

1 interact with CURA to come up with a strategy on how
2 to respond to it?

3 A No.

4 Q So you just took in what Lauren was telling
5 you, did nothing with it; is that right?

6 A Right.

7 MR. CHUNG: Let's go to tab. This will be
8 Exhibit 32.

9 (Exhibit 32 was marked for
10 identification.)

11 BY MR. CHUNG:

12 Q So Exhibit 32 is an email chain from June of
13 2025. Tell me what's being discussed here.

14 A The PR strategy around the safety grade and
15 the lawsuit.

16 Q Okay. So Ms. Bailey is writing to you, and
17 it looks like this is being folded into a CEO report;
18 is that right?

19 A Correct.

20 Q Okay. That in the second set of bullet
21 points, "We've also been proactively pitching updates
22 around the Tenet Healthcare lawsuit to national and
23 local press to own the narrative."

24 Is this what you were testifying to earlier,
25 that there were proactive outreaches to, to media

1 outlets to, to issue stories about the Tenet lawsuit?

2 A This thing is about proactively pitching
3 updates, so when Mary Beth Maloney was saying false
4 things about LeapFrog, we were updating the press with
5 correct information.

6 Q Okay. So this is -- is this the reactive or
7 the proactive efforts that you were testifying to
8 earlier?

9 A Like I said, I didn't have anything to do
10 with this. This is just information I read. I can't
11 tell you specifics about what we did.

12 Q Okay. She writes that "we've [also] been
13 proactively pitching updates . . . to national and
14 local press to own the narrative," right? What does
15 she mean by "own the narrative"?

16 A You'd have to ask her.

17 Q Well, she's writing to you as part of this
18 update to fold into the CEO report.

19 What did you take her to mean?

20 A I copied this and I pasted it into the CEO
21 report.

22 Q I'm asking you: What did you take her to
23 mean, that this outreach was "to own the narrative"?

24 MS. BLAIR: Objection to form.

25 THE WITNESS: I didn't have an opinion on

1 it.

2 BY MR. CHUNG:

3 Q I'm not asking for your opinion. What did
4 you take it to mean?

5 A I didn't take it to mean anything.

6 Q This means -- you didn't take it to mean
7 anything?

8 A I read this. I didn't analyze it.

9 Q What do you, what do you understand "the
10 narrative" to be here?

11 A From what I understand, we were working to
12 combat falsehoods that the plaintiffs and Mary Beth
13 Maloney were saying about LeapFrog.

14 Q Right. I understand that, but what is the
15 "narrative" that's being referenced here?

16 A You'll have to ask Lauren Bailey.

17 Q Okay.

18 So is it your testimony that you, as a
19 member of the executive staff at LeapFrog, have no
20 idea or -- have no idea about what the organization's
21 narrative is here with respect to the press?

22 A I told you. The narrative is contradicting
23 the falsehoods that were put out about LeapFrog.

24 Q So how, how -- in that narrative, how
25 were -- how was LeapFrog seeking to contradict what

1 you're calling the falsehoods?

2 A Mary Beth Maloney liked to say that we were
3 raising all of this money, and we were being
4 deceptive, and that is not true.

5 Q Okay. What updates here -- so you're right.
6 She's "proactively pitching updates," right, "around
7 the . . . lawsuit to national and local press to own
8 the narrative."

9 What were the updates that LeapFrog was
10 pitching to these publications?

11 A Like when Mary Beth Maloney said that we
12 were raising all this money from providing consulting
13 services to hospitals, the update would be that that
14 is completely false.

15 Q Okay. So were the updates just flat
16 denials? This is completely false, this is completely
17 false?

18 A So far as I know, but I was not in charge of
19 this.

20 Q Okay.

21 Now, you -- again, going back to kind of the
22 first principle, you do oversee communications, right,
23 at LeapFrog?

24 A No. Lauren oversees communications, and
25 Lauren Bailey reports to me.

1 Q Right, as -- and we saw in the profile from
2 the website, that you do -- just looking at the
3 profile again -- that you are responsible for "shaping
4 and executing LeapFrog's development efforts, while
5 also overseeing the organization's external messaging,
6 branding, media relations, and digital
7 communications," correct?

8 A Correct.

9 Q Like does that encompass external messaging
10 and media relations relating to the lawsuit?

11 A On a very high level, yes, but it is not
12 something I work with day to day or are intimately
13 involved with.

14 MR. CHUNG: Okay. Let's move on to tab 36.
15 This will be Exhibit 33.

16 (Exhibit 33 was marked for
17 identification.)

18 BY MR. CHUNG:

19 Q Okay. In Exhibit 33 -- it's another email
20 chain from May 2025, and we see that Ms. Hailesilassie
21 from CURA is writing to you, Lauren Bailey and others,
22 with an agenda.

23 Do you see that?

24 A Yes.

25 Q Okay, and among the bullet points are "Tenet

1 lawsuit coordination, patient story," and "paid media
2 campaign."

3 Do you see that?

4 A Yes.

5 Q Okay. The "patient story" bullet point
6 under the "Tenet lawsuit coordination," what does that
7 refer to?

8 A We actually had a lot of patients reach out
9 to our info mailbox, telling us --

10 THE REPORTER: What mailbox?

11 THE WITNESS: Info, our email box, telling
12 us about terrible things that happened to them at
13 Tenet hospitals, since they had read about the
14 lawsuit, and we were exploring those stories.

15 BY MR. CHUNG:

16 Q So this is based on patients writing to -- I
17 think an info mailbox?

18 A It's our general mailbox.

19 Q Okay. Oh, so there's like a --

20 A Info@LeapFrog.org.

21 Q Got it. That's available on the, on the
22 website --

23 A Yes.

24 Q -- okay, that they can write to?

25 A Correct.

1 Q Okay, and can you give us a sense of how
2 many of these emails came in from patients?

3 A Maybe ten.

4 Q Ten? Okay, and so what was the patient
5 story here? What was this bullet point referring to?
6 What was kind of the task here?

7 A We were discussing the patients who reached
8 out to us and told us about how horrible Tenet
9 Hospital was and how a family member died or was very
10 sick at Tenet Hospital, and if we wanted to discuss
11 that with CURA Strategies and public relations.

12 Q Okay. So what came out of it?

13 A We didn't.

14 Q Okay. The -- when you say -- you said that
15 they were making these allegations with respect to
16 Tenet Hospital.

17 Which hospital is this?

18 A When we refer to "Tenet," we're referring to
19 the, the five hospitals.

20 Q Okay. So were these patients talking about
21 all five hospitals or specific hospitals?

22 A Specific hospitals.

23 Q Okay. So the Florida hospitals that are --

24 A Correct.

25 Q -- the plaintiffs in this case?

1 A Correct.

2 Q Okay. Right underneath there, we have a
3 bullet, "Paid media campaign." What is this referring
4 to?

5 A We had discussed possibly doing a paid media
6 campaign around the lawsuit and counteracting the
7 falsehoods that were out there.

8 Q Okay. So what -- can you describe what a
9 paid media campaign is under this -- in this context?

10 A Yes. I'll also tell you we didn't get far
11 and we didn't do this, because, as I said, we're a
12 tiny nonprofit, and we do not have money for that sort
13 of thing.

14 Q Well, what was being contemplated here in
15 this bullet?

16 A Putting out like Google ads and things on
17 socia media, counteracting the falsehoods that were
18 being said about LeapFrog.

19 Q Okay, and this would be -- how would it be
20 paid?

21 A You have to pay for an ad.

22 Q Okay.

23 You made mention a number of times already
24 that this is -- that you're a "tiny nonprofit," and
25 you have kind of a long history with a number of

1 nonprofits.

2 Is a nonprofit with about \$8 million in
3 annual revenue a tiny nonprofit?

4 A Very tiny. I mean I worked for a cancer
5 charity, and we -- I mean we were probably
6 \$500 million.

7 Q So relative to kind of to your, your
8 experience, it's relatively small just in terms of
9 kind of the dollar amounts being involved?

10 A And staff.

11 MR. CHUNG: Okay. Let's move on to the
12 next, 37, which will be Exhibit 34.

13 (Exhibit 34 was marked for
14 identification.)

15 BY MR. CHUNG:

16 Q Another Slack exchange, Ms. Jupiter, from
17 May 12 of 2025, and it's between you and Nate Longmore
18 and Lauren Bailey.

19 Who is Nate Longmore?

20 A He is our communications coordinator.

21 Q And does he report to you?

22 A To Lauren.

23 Q To Lauren, okay, who, in turn, reports to
24 you?

25 A Correct.

1 Q Okay.

2 Now, in the very first message in this kind
3 of string here, you write, "She has no clue how this
4 works."

5 What are you referring to?

6 A I don't know exactly what I was referring
7 to.

8 Q Okay. To whom are you referring?

9 And if you need to read through the whole
10 thing to get context, please do.

11 (Witness peruses document.)

12 BY MR. CHUNG:

13 Q So if we go down the line here, there's a
14 back-and-forth among you, Mr. Longmore and Ms. Bailey.
15 You write, "She has no clue how this works."
16 Mr. Longmore agrees. Ms. Bailey with an emoji. You
17 write, "Why, though? What would be the point? I
18 don't get it."

19 "Why," you continue to question.

20 Mr. Longmore sighs. Lauren Bailey writes, "I'm afraid
21 to ask." Then Mr. Longmore writes, "My wifi is super
22 unstable, so just to clarify, am I checking with Noah
23 on the specific hospital names as keywords?"

24 First of all, who is Noah?

25 A Noah is the vendor who works with our Google

1 grant.

2 Q Okay, and then he writes, "And displaying
3 their" hospital safety grade, "their HSG." Are you,
4 you, kind of the three of you referring to the five
5 hospitals here?

6 A Yes.

7 Q Okay, and then you -- or Ms. Bailey writes,
8 "Leah said she wants to know if we can do ads where,
9 if someone searches those five hospitals, it shows an
10 ad with their safety grade URL and says they have an X
11 grade," and Mr. Longmore writes that he understands,
12 and then Ms. Bailey writes, "So you could send him,"
13 presumably Noah, right, "the five URLs."

14 Do you understand kind of what's being,
15 what's being discussed here?

16 A Yes.

17 Q Okay. So what is being discussed?

18 A Having ads around the five hospitals,
19 showing their -- just linking to their safety grade.

20 Q Okay. Linking to their safety grade with --
21 upon search results in Google, like where the --
22 where's -- what's the proposal? Where are the links
23 appearing?

24 A If someone were to search "Delray Medical
25 Center" in Google, their -- it would link to their --

1 there would be an ad for their safety grade.

2 Q Okay, and so you write later on at
3 2:36 p.m., "So she just wants to harass them," right,
4 and Mr. Longmore writes, "I love that the strategy is
5 to become a Disney villain," right?

6 So is -- did Ms. Binder want to further
7 publicize the plaintiff hospitals' safety grades here?

8 A Yes.

9 Q Okay. Did you think that was a good idea?

10 A I don't think I had a particular opinion on
11 it. Just trying to understand it.

12 Q Okay. Well, I mean your reaction here, and
13 I think the collective reaction here from Mr. Longmore
14 and Ms. Bailey is -- you write, "Why, though? What
15 would be the point," right?

16 So are you questioning here what the point
17 of this strategy is?

18 A Trying to understand the strategy, yes.

19 Q Okay, and then you write "what for," right?
20 So are you still trying to figure out what the
21 strategy here is?

22 A Yes.

23 Q Okay. So what did you -- through this
24 exchange, what did you understand the strategy to be?

25 A That we wanted to publicize their F grades.

1 Q Okay. For what purpose?

2 A Because these hospitals had bad grades and
3 were not safe, and we want the public to know that.

4 Q Okay, but your reaction here is "so she just
5 wants to harass" the hospitals, correct? That's what
6 you believe, that this was just a harassing strategy?

7 MS. BLAIR: Objection to form.

8 BY MR. CHUNG:

9 Q Is that right?

10 A I was wondering if that's what she wanted to
11 do, yes.

12 Q Okay, and is that, in fact, what she was
13 wanting to do?

14 Let me phrase it another way.

15 Isn't that, in fact, what you thought
16 Ms. Binder wanted to do with this strategy?

17 A I was trying to understand what she was
18 trying -- what she wanted to do.

19 Q Okay, and in trying to understand that, you
20 were, you were wondering aloud whether she just wanted
21 to harass these hospitals, correct?

22 A Correct.

23 Q Okay. So did this come about?

24 A I think we did it for a very short amount of
25 time.

1 Q Okay.

2 Now, when Mr. Longmore responds, "I love
3 that the strategy is to become a Disney villain," I
4 mean did you agree with how he was characterizing this
5 strategy?

6 A No.

7 Q Why not?

8 A I mean he said it, I heard him say it --

9 Q Okay.

10 A -- or I read it, and that was it.

11 Q What does your -- what did you mean by the,
12 the emoji reaction to that comment about being a
13 Disney villain?

14 A What did I mean by a face?

15 Q By the emoji, yeah. I mean your -- I think
16 that emoji is -- you, you typed that emoji, right?

17 A Yeah, I couldn't tell you what that emoji
18 is. It was a . . .

19 MR. CHUNG: Okay. Let's go to tab 46, and
20 this will be Exhibit 35.

21 (Exhibit 35 was marked for
22 identification.)

23 BY MR. CHUNG:

24 Q All right. So another set of Slack
25 messages, Ms. Jupiter, also from May 12, 2025,

1 actually the same, same day as the one we just looked
2 at previously. So just take a minute to review it,
3 get familiar with it.

4 Actually, before -- can you remind us who --
5 so the participants in this are you and Nicholas
6 Cantacuzene?

7 A Cantacuzene, yes.

8 Q Okay.

9 A He is our membership coordinator.

10 Q Okay. Got it.

11 (Witness peruses document.)

12 BY MR. CHUNG:

13 Q Have you had a chance to review it?

14 A (Nods.)

15 Q Okay. Now, if you, if you look at this
16 exhibit, Exhibit 35, side by side with the previous
17 one, Exhibit 34, you'll see that much of the two
18 discussions are happening at the same time.

19 Do you see that?

20 A Yes.

21 Q Yes, so it looks like you have one Slack
22 discussion going on with Ms. Bailey, Mr. Longmore, and
23 then it looks like a separate one with
24 Mr. Cantacuzene; is that right?

25 A Yes.

1 Q So between -- am I correct that while you're
2 having these two Slack discussions, there is a meeting
3 going on with, with your colleagues?

4 A I think so.

5 Q Okay, and is it -- and during these
6 discussions that are happening at the same time, is
7 Ms. Binder describing this proposal that we've been,
8 that we've been discussing?

9 A I think so.

10 Q Okay.

11 So again, we see some of the same verbiage
12 here. If you look at the 2:08 p.m. message that you
13 send, it's at the bottom of Bates ending 264.

14 A Yes.

15 Q You write, "She has no clue how this works."
16 You write "no clue how this works" in the other
17 message, and what is -- what are you referring to
18 here?

19 A Leah doesn't know how the Google Ads work.

20 Q Okay, and so are you kind of wondering --
21 you're questioning whether her proposal, right, to
22 have the hospital safety grades kind of linked for
23 those five hospitals, whether it's, whether it's
24 workable?

25 A Correct.

1 Q Okay, and then you'll see on the next
2 page -- and again we're focusing just on Exhibit 35.
3 At around 2:22, there is a blowout here of an image
4 for Tenet Healthcare with general information and
5 "individuals," and there's a number there, 33,526, and
6 you write, "Wow!" Mr. Cantacuzene responds, "Make
7 sense to you?"

8 What is, what is that exchange about?

9 A We have a database where you can look up
10 companies and employees, and so he found that there
11 were 33,000 Tenet employees.

12 Q Okay, and your reaction to that is "wow"?

13 A Right.

14 Q Just the number, the sheer number of
15 employees?

16 A Right, because again, we're a 22-person
17 organization, and we have this huge organization
18 saying incorrect, false things about us.

19 Q And then we go down to 2:33 p.m. "What is
20 the point of this?" Mr. Cantacuzene responds, "I was
21 going to ask you the same thing."

22 What, what are you discussing here?

23 A I think it's still the -- we're trying to
24 understand what Leah wants.

25 Q Okay. So you're still wondering as she's, I

1 guess, discussing this, what the point of this
2 proposal is, correct?

3 A Correct.

4 Q Okay, and then we go on to the next page,
5 we're at 2:35 p.m. You write, "Just because she is
6 mad at them?"

7 I mean is this -- I mean what are you
8 expressing here?

9 A Leah was really mad at people saying all
10 these false things about LeapFrog.

11 Q Okay, and so you write just a couple lines
12 down, "What are you trying to do? So she just wants
13 to harass them," right? So it's the same language
14 here, and so, similar to what we saw in the other
15 discussion, you were -- your takeaway from this was
16 that Leah Binder was -- just wanted to harass Tenet
17 through this, this Google search result proposal?

18 MS. BLAIR: Objection to form.

19 BY MR. CHUNG:

20 Q Is that right?

21 A What's your question?

22 Q So the question is: Was it your takeaway
23 from this discussion that Ms. Binder just wanted to
24 harass Tenet with this proposal to link their health
25 [sic] safety grades to search results?

1 A I was trying to understand if that's what
2 she was trying to do, yes.

3 Q Okay, and this was your conclusion, that she
4 just wanted to harass them?

5 A I don't know if I ever came to that
6 conclusion. I was trying to understand the strategy.

7 Q Okay. What's your conclusion now?

8 A That she wanted to counteract the
9 falsehoods.

10 Q Okay.

11 Do you think now that by employing this
12 strategy that she wanted to harass Tenet?

13 A I think she wanted to counteract the
14 falsehoods.

15 Q "And not the decision-makers, all 33,000
16 people, I guess," Mr. Cantacuzene responds here, and
17 you write, "And their friends."

18 So what are you referring to here?

19 A I don't know what I meant by "and their
20 friends," but the 33,000 I think was we would be
21 serving those ads to the 33,000 Tenet Healthcare
22 employees.

23 Q Okay, and he writes, "That seems illegal."
24 What did you take him to mean there?

25 A Nicholas is 24 years old.

1 Q Well, what did you take him to mean?

2 A You'll have to ask Nicholas. I mean I
3 didn't even --

4 Q But this is your deposition. I mean what
5 did you take him to mean there?

6 A I have no idea what he meant there.

7 MR. CHUNG: Okay. Let's go to tab 39, which
8 will be Exhibit 36.

9 (Exhibit 36 was marked for
10 identification.)

11 BY MR. CHUNG:

12 Q So fast-forward about a month. This is
13 June 12 of this year, an email chain involving
14 "nonprofit megaphone."

15 Is this the vendor that you referenced
16 earlier about the one that kind of manages or helps
17 with the Google grant?

18 A Correct.

19 Q Is that right?

20 Okay, and can you just tell us again; what
21 exactly do they do for LeapFrog?

22 A They -- we tell them information that we
23 want to spend the Google grant on, and they craft the
24 ads for the grant and launch them.

25 Q Okay, and have you had a chance to look

1 through it? I know I just put it in front of you,
2 but . . .

3 A Okay.

4 Q Okay. So is what's being discussed here
5 the, basically the proposal that Ms. Binder was making
6 in the Slack messages?

7 A Correct.

8 Q All right. So this actually came to
9 fruition; is that right?

10 A It did.

11 Q Okay.

12 So did LeapFrog pay for ads so that the
13 plaintiff hospitals' LeapFrog grades would appear in
14 these Google search results?

15 A We don't pay for the ads. We have a grant.

16 Q Okay. So basically you would be expending
17 that grant on this proposal, correct?

18 A Correct.

19 Q Okay.

20 A And it's mortifying. We had five clicks in
21 30 days. I mean we are really bad at this. Sorry.

22 MR. CHUNG: Let's go to tab 40.

23 MS. BLAIR: And before we go, Daniel, do you
24 know how much longer you have?

25 MR. CHUNG: Can we maybe go off the record

1 for a moment.

2 THE VIDEOGRAPHER: The time is 5:15 p.m.

3 This ends unit 5. We're off the record.

4 (Whereupon, a short recess was taken.)

5 THE VIDEOGRAPHER: The time is 5:15 p.m.

6 This begins unit number 6. We're on the record.

7 MR. CHUNG: We're going to mark this Exhibit
8 37.

9 (Exhibit 37 was marked for
10 identification.)

11 BY MR. CHUNG:

12 Q Okay. So Ms. Jupiter, this is also from
13 June of, June of 2025. You're on these emails with
14 Ms. Binder, Ms. Bailey, and a Karen van Caulil.

15 Who is Ms. Van Caulil?

16 A She is the president and CEO of the Florida
17 Alliance for Healthcare Value.

18 Q Okay, and what is that alliance?

19 A That's our Florida regional leader.

20 Q And so she's the head of that particular --

21 A Yes.

22 Q Is she the representative for that regional
23 leader?

24 A I think Ashley Tate Dinger is a
25 representative for it, but she is the head of the

1 coalition.

2 Q Okay. So in this email chain, there's a
3 discussion about Ms. Binder potentially visiting a
4 Jupiter Medical Center; is that right?

5 A Yes.

6 Q And was she planning to do interviews on
7 this visit?

8 A If hospitals -- not hospitals. If media
9 wanted to speak with her while she was there, yes.

10 Q Okay, and was Ms. Binder planning to speak
11 about this lawsuit during this visit with the media
12 presence?

13 A Not at Jupiter, but while she was in
14 Florida, if there was someone who wanted to talk to
15 her about the lawsuit, yes.

16 Q Okay, and was part of the strategy here for
17 LeapFrog or Ms. Binder to -- do you know that the
18 Jupiter Medical Center here is a competitor of at
19 least one of the plaintiff hospitals?

20 A Yes.

21 Q Okay, and was part of the plan here to, to
22 basically highlight Jupiter Medical Center?

23 A As an A hospital.

24 Q As an A hospital?

25 A Yes.

1 Q And was it also a part of the plan to steer
2 patients or consumers away from the competitor
3 plaintiff hospitals?

4 A That wasn't part of the strategy for this.

5 Q Okay, but if -- was there going to be
6 messaging about the hospital safety grades that the
7 plaintiff hospitals received?

8 A No. This was solely about highlighting
9 Jupiter as an A hospital.

10 Q Okay. Did this visit ever happen?

11 A No.

12 MR. CHUNG: Okay. Let me ask that we go off
13 the record and take a short break, and then we'll
14 come back and finish up.

15 MS. BLAIR: Sure.

16 THE VIDEOGRAPHER: The time is 5:18 p.m.
17 We're off the record.

18 (Whereupon, a short recess was taken.)

19 THE VIDEOGRAPHER: The time is 5:24 p.m.
20 We're on the record.

21 BY MR. CHUNG:

22 Q Ms. Jupiter, LeapFrog is a 501(c)(3)
23 organization; is that right?

24 A Correct.

25 Q Okay, and has LeapFrog, to your knowledge,

1 ever been audited or investigated to determine whether
2 its activities comply with that status?

3 A As a 501(c)(3), we have to be audited every
4 year.

5 Q Okay. Has there ever been kind of a
6 discreet investigation of its activities?

7 A Not that I'm aware of.

8 Q Okay. Do you have any involvement in
9 responding to these audits?

10 A We don't respond to the audit.

11 Q Okay. Who conducts the audits for LeapFrog?

12 A We have an independent auditing firm.

13 Q Okay. Do you, do you have any involvement
14 in those audits?

15 A Sometimes we have to provide information for
16 the audit.

17 Q Okay. What type of information?

18 A Like if they say we got a donation from this
19 person, do you have a copy of the check.

20 Q Are there audits -- does the audit include
21 an examination of LeapFrog's revenue from the hospital
22 grades and hospital surveys?

23 A Yes. It's all of our finance.

24 Q Okay. Separate question: How does -- so
25 you're a member of the executive staff. How does

1 LeapFrog set executive compensation?

2 A I don't know.

3 Q Okay. Who determines that?

4 A I think Leah Binder.

5 Q Okay, and what are the, kind of the
6 components of your compensation in particular?

7 A I mean I have metrics and goals I have to
8 meet.

9 Q Okay, and what are those metrics and goals,
10 let's say for the current compensation year?

11 A I'm in charge of fundraising, so reaching
12 those fundraising goals.

13 Q Okay. Are there -- is your compensation
14 tied to overall revenue goals for the organization?

15 A Mine is not directly tied to our revenue
16 goals.

17 Q When you say "directly tied," is there any
18 kind of indirect tie to the overall revenue goals?

19 A You'd have to ask Leah.

20 Q Okay, but your understanding is that Leah
21 sets your executive compensation?

22 A Yes.

23 Q And I think we saw that actually in the
24 annual review, correct? I think at the end of, at the
25 end of the review, she awarded a bonus; is that right?

1 A Correct.

2 Q Do you know whether any of the other members
3 of the executive staff executive compensation is tied
4 to overall revenue goals?

5 A I don't.

6 Q Okay. Do you know whether any LeapFrog
7 executive's compensation is tied to the number of
8 hospitals that participate in the hospital survey?

9 A I don't.

10 Q Okay. Do you know whether any of LeapFrog's
11 compensation depends on the total amount of licensing
12 revenue drawn from the hospital grades and the
13 hospital survey?

14 A I don't.

15 Q Okay. Are you aware that Ms. Binder's total
16 compensation has increased from about \$300,000 in 2013
17 to about \$760,000 in 2024?

18 A I don't know her exact compensation.

19 Q Okay, but do these, do these numbers sound
20 correct to you? I know you don't know the exact
21 numbers, but that wasn't my question.

22 A What's your question?

23 Q The question is: Are you, are you aware
24 that her total compensation has increased from about
25 \$300,000 in '23 to \$760,000 in 2024?

1 MS. BLAIR: Object to form. I think you
2 said "in '23." It was --

3 BY MR. CHUNG:

4 Q 2013.

5 A I don't know her compensation.

6 Q Okay. Are you aware -- do you know that
7 she -- her compensation was \$760,000 in 2024?

8 A I did not know that.

9 Q Did not know that?

10 A No.

11 Q Okay. Does it surprise you that that's,
12 that that's her compensation?

13 A No.

14 Q No? It doesn't seem -- it's not -- it
15 doesn't seem high to you, relative to the size of the
16 organization, which I think you characterized as a
17 "tiny organization"?

18 A What's the question?

19 Q So it doesn't seem high or outsized relative
20 to the, to the size of the organization?

21 A No.

22 Q No? Okay.

23 Do you have any kind of benchmarks to
24 compare that to, that lead you to that conclusion?

25 A I know the CEO of my last job made over a

1 million dollars a year.

2 Q Okay, and what was the last job again?

3 A At the Conquer Cancer Foundation.

4 Q Okay, at that Conquer Cancer Foundation,
5 what were the overall revenues? I think you testified
6 about it earlier.

7 A The Foundation I think made around
8 \$40 million.

9 Q \$40 million? How about the, the overall
10 organization?

11 A ASCO, but that wasn't my CEO.

12 THE REPORTER: I'm sorry. "How about the
13 overall organization," and what was the answer?

14 THE WITNESS: The Foundation was a part of
15 the American Society of Clinical Oncology.

16 BY MR. CHUNG:

17 Q Okay. So, so for the Conquer Cancer
18 organization revenues of about \$40 million, your CEO,
19 your former boss made about a million dollars in
20 executive compensation?

21 A Over a million.

22 Q Over a million dollars. Okay, and then for
23 about -- for your current employer at LeapFrog,
24 revenue is about \$8 million, as we saw in the
25 financial statements. We see that Ms. Binder is

1 making \$760,000, correct?

2 A Yes.

3 Q Okay, and you don't see kind of a, a
4 disparity there or kind of a disparity between those
5 two figures?

6 A If you want good people to do a good job,
7 then you need to compensate them. If you want to pay
8 someone poorly, then you'll get someone who works
9 poorly.

10 Q Okay. I'm not sure that's responsive to the
11 question.

12 Do you see a disparity between those two,
13 those two scenarios that you just described?

14 A No.

15 MR. CHUNG: Okay. That's all I have.

16 MS. BLAIR: Excellent.

17 We will order, if you can, a rough as well
18 as an E-Tran.

19 MR. CHUNG: We're off the record.

20 THE VIDEOGRAPHER: The time is 5:30 p.m.
21 We're off the record.

22 THE REPORTER: And then, and then do you
23 want -- I was told that you want the final
24 transcript in just a couple of days?

25 MS. BLAIR: Yeah, see, I just want the --

1 yeah, I don't care about the final, but I would
2 like the rough as soon as you can get it. I can
3 take the final regular delivery, but whatever
4 they want it in that order.

5 MR. CHUNG: Yes, the rough as well as soon
6 as . . .

7 THE REPORTER: And as well the two-day?

8 MR. CHUNG: Right.

9 THE REPORTER: You don't want the two-day
10 expedite?

11 MS. BLAIR: Yes, I can. Yeah.

12 THE REPORTER: Okay.

13 (Signature having not been waived, the
14 video deposition of KAREN JUPITER was
15 concluded at 5:30 p.m.)

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ACKNOWLEDGEMENT OF WITNESS

I, Karen Jupiter, do hereby acknowledge that
I have read and examined the foregoing testimony,
and the same is a true, correct and complete
transcription of the testimony given by me, and
any corrections appear on the attached Errata
sheet signed by me.

(DATE)

(SIGNATURE)

RETURN BY:

[illegible]

CERTIFICATE OF SHORTHAND REPORTER -- NOTARY PUBLIC

I, Laurie Donovan, Registered Professional Reporter, Certified Realtime Reporter, and notary public for the District of Columbia, the officer before whom the foregoing deposition was taken, do hereby certify that the foregoing transcript is a true and correct record of the testimony given; that said testimony was taken by me stenographically and thereafter reduced to typewriting under my supervision; and that I am neither counsel for, related to, nor employed by any of the parties to this case and have no interest, financial or otherwise, in its outcome.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal this 9th day of September 2025.

My commission expires: July 14, 2027

A handwritten signature in cursive script, reading "Laurie Donovan", is written over a horizontal line.

LAURIE DONOVAN
NOTARY PUBLIC IN AND FOR
THE DISTRICT OF COLUMBIA

kimberly.blair@wilsonelser.com

September 9, 2025

Good Samaritan Medical Center Inc, Et Al. v. The Leapfrog Group

DEPOSITION OF: Karen Jupiter 7574617

The above-referenced witness transcript is available for read and sign.

Within the applicable timeframe, the witness should read the testimony to verify its accuracy. If there are any changes, the witness should note those on the attached Errata Sheet.

The witness should sign and notarize the attached Errata pages and return to Veritext at errata-tx@veritext.com.

According to applicable rules or agreements, if the witness fails to do so within the time allotted, a certified copy of the transcript may be used as if signed.

Yours,

Veritext Legal Solutions

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Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

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Exhibit 95

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September 24, 2025

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Page 1

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA
WEST PALM BEACH DIVISION
CASE NO.: 9:25-CV-80526-DMM

GOOD SAMARITAN MEDICAL CENTER, INC.,
DELRAY MEDICAL CENTER, INC.,
PALM BEACH GARDENS COMMUNITY
HOSPITAL, INC. d/b/a PALM BEACH
GARDENS MEDICAL CENTER,
ST. MARY'S MEDICAL CENTER, INC.,
AND WEST BOCA MEDICAL CENTER, INC., et al.,

Plaintiffs,

v.

THE LEAPFROG GROUP,

Defendant.

VIDEOTAPED DEPOSITION OF CYNTHIA MCCAULEY
(CONFIDENTIAL)

DATE TAKEN: Wednesday, September 24, 2025
TIME: 9:08 a.m. - 4:57 p.m.
PLACE: Quest Workspaces West Palm Beach
515 North Flagler Drive
Suite 350 - Conference Room A
West Palm Beach, Florida 33401

Stenographically Reported By:
Barbie Gallo, RMR-CRR
www.lexitaslegal.com
888-811-3408

Job No.: 421987

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16

ALSO PRESENT:

17 Benny Dorlouis, videographer

18

19

20

21

22

23

24

25

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1 Thereupon,
2 the following proceedings began at 9:08 a.m.:

3 * * *

4 THE VIDEOGRAPHER: We're now on the video
5 record and the time is 9:08 a.m. This is the
6 video deposition of Cynthia McCauley taken in
7 the matter of Good Samaritan Medical Center, et
8 al. versus The Leapfrog Group.

9 This deposition is being held at
10 515 North Flagler Drive, West Palm Beach,
11 Florida on September 24th, 2025.

12 The videographer is Benny Dorlouis, and the
13 court reporter is Barbie Gallo, both in
14 association with Lexitas.

15 Will counsel please announce their
16 appearances for the record.

17 MS. BLAIR: Kim Blair on behalf of
18 defendant, Leapfrog Group.

19 MS. MALONEY: Mary Beth Maloney on behalf of
20 St. Mary's, and I'm joined by my colleague,
21 Elizabeth Dabanka.

22 THE STENOGRAPHER: If you would, raise your
23 right hand, and I'll swear you in.

24 Do you swear or affirm that the testimony
25 you're about to give in this matter will be the

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1 truth, the whole truth and nothing but the truth
2 so help you God?

3 THE WITNESS: I do.

4 THE STENOGRAPHER: Thank you.

5 THEREUPON,

6 CYNTHIA MCCAULEY,

7 Being by me first duly sworn to tell the whole truth,
8 as hereinafter certified, testified as follows:

9 DIRECT EXAMINATION

10 BY MS. BLAIR:

11 Q. Ms. McCauley, as you know, my name is
12 Kim Blair. I represent the defendant, Leapfrog Group,
13 in this matter.

14 Let the record reflect that your deposition
15 is being taken pursuant to the Federal Rules of Civil
16 Procedure as well as the local rules of the Southern
17 District of Florida.

18 Can you state and spell your name for the
19 record, please.

20 A. Um-hum. Cynthia, C-y-n-t-h-i-a; Albach,
21 A-l-b-a-c-h; McCauley, M-c-C-a-u-l-e-y.

22 Q. And, Ms. McCauley, have you ever had your
23 deposition taken before?

24 A. Yes.

25 Q. How many times?

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1 A. Once or twice.

2 Q. And were they in a professional or a
3 personal capacity?

4 A. Professional.

5 Q. And can you recall -- let's just start with
6 the first deposition you gave. Can you recall when
7 that was?

8 A. Oh, a long time ago. A long, long time ago.

9 Q. Were you working at St. Mary's at the time?

10 A. No.

11 Q. Where were you working at that point?

12 A. At that point, I worked for West Boca
13 Medical Center.

14 Q. And do you recall just generally what that
15 case was about?

16 A. It was an employee. I believe it was
17 Workers' Comp.

18 Q. And then the second matter that you were
19 deposed in, do you remember about when that was?

20 A. That was a couple years ago.

21 Q. And were you at St. Mary's then?

22 A. I was at St. Mary's.

23 Q. And do you recall like generally what that
24 case is about?

25 A. It was a case, I was being deposed as the

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1 CEO, although I wasn't the CEO at the time of the case,
2 so it was a case concerning a physician.

3 Q. Was it a med/mal case?

4 A. It was a defamation case.

5 Q. And was the physician claiming that the
6 hospital defamed him?

7 A. No.

8 Q. Was the hospital a defendant?

9 A. No. No, we weren't party to the case.

10 Q. Okay. So you were being deposed as a
11 third-party fact witness, not as a party?

12 A. Correct.

13 Q. I want to just go over a couple of ground
14 rules that you probably already know, but I'll just go
15 over them for the day.

16 As you know, Barbie is our court reporter.
17 She'll be taking down everything you say and everything
18 I say. Therefore, I'm going to try not to talk over
19 any of your answers if you could do the same for the
20 sake of the court reporter. Is that okay?

21 A. Yes.

22 Q. In addition, she's taking down everything
23 that we say, so all of your answers must be verbal.
24 She can't take down a shrug of shoulders, an "uh-huh,"
25 "huh-uh." Is that fair?

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1 A. I understand.

2 Q. If at any time you need to take break, just
3 ask. The only caveat would be that if there's a
4 question pending, I ask that you answer that question.
5 Is that fair?

6 A. Yes.

7 Q. From time to time I will ask some questions
8 that you don't understand. If at any time you need me
9 to rephrase those questions, please ask me to do so.
10 Otherwise, if I ask a question and you answer it, I'm
11 going to assume you understood the question. Is that
12 fair?

13 A. Yes.

14 Q. I want to just kind of briefly go over your
15 background.

16 Can you take me through your post high
17 school education?

18 A. After high school I got a bachelor's degree
19 in foreign language at Adelphi University. And after
20 that I got an MBA from Long Island University CW Post
21 Campus.

22 Q. What foreign language?

23 A. Oh, I speak Spanish, Italian, a little bit
24 of French.

25 Q. Oh, wow.

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1 And I see that you took a couple years off
2 between your undergrad degree and your MBA, correct?

3 A. Yes.

4 Q. What did you do in the interim?

5 A. I was working.

6 Q. Where did you work?

7 A. I believe at that time I was working for an
8 organization in Manhattan called the Population
9 Council.

10 Q. Was that a not-for-profit?

11 A. It was a not-for-profit.

12 Q. What did they do?

13 A. They did birth control studies and research
14 in third world countries. They partnered with the
15 Ford Foundation, the UNFPA to try to get funding to
16 study research on breast -- on birth control. They
17 held like sterilization days in India.

18 It was super interesting. They invented, or
19 their scientists invented the Norplant implant. It
20 was -- it was a super interesting job with amazingly
21 smart people.

22 Q. And what did you do there?

23 A. So I started back as an executive assistant,
24 and then I managed, from what I remember, I was
25 involved a lot with contracts.

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1 Q. And after you got your MBA -- well, did you
2 stick with that job while you were getting your MBA?

3 A. I might have left. I don't remember.

4 Q. And what was your first job after your MBA?

5 A. I worked for Manufacturer's Hanover Trust
6 Company as a financial analyst.

7 Q. That is not a not-for-profit?

8 A. That is not a not-for-profit.

9 Q. And as a financial -- you said you worked as
10 a financial analyst, correct?

11 A. Correct.

12 Q. And how long were you there?

13 A. I don't even think I could recall. A good
14 couple -- a good couple of years.

15 Q. And where did you go after the Hanover
16 Trust?

17 A. After Hanover Trust, I believe I left and
18 got a job closer to home working in an investment
19 company, a privately owned investment company that did
20 individual placements, but I don't recall staying there
21 for a particularly long time.

22 Q. And when you say "closer to home," what do
23 you mean by that?

24 A. So I -- so the Manny Hanny job was in
25 Manhattan, so I was a Long Island Railroad commuter,

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1 hour and a half each way every day. So I, at that time
2 lived, on Long Island, and so I got a job that I could
3 commute to in half an hour.

4 Q. And after the investment company where did
5 you go?

6 A. I think -- I think after that, unless I have
7 them reversed, I moved to Florida.

8 Q. Do you remember what year you moved to
9 Florida?

10 A. '88.

11 Q. Okay. And what was your first job in
12 Florida?

13 A. I worked at, it was called the North Broward
14 Hospital District. I think now it's called Broward
15 Health. I was a financial analyst.

16 Q. Did you work with Heather Havericak?

17 A. I -- so not at the time, but I know Heather
18 worked at Broward Health.

19 Q. And what did you do? You were -- I'm sorry.
20 You told me --

21 A. I was the financial analyst.

22 Q. Financial analyst. And how long were you at
23 Broward Health?

24 A. I was at Broward Health Coral Springs for
25 11 years.

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1 Q. So that takes us to '99, correct?

2 A. Correct.

3 Q. And at that point, I think, then you,
4 according to your LinkedIn profile, then you go over to
5 Tenet Healthcare, correct, in 1999, correct?

6 A. Correct.

7 Q. And what was your first job at
8 Tenet Healthcare in 1999?

9 A. My first job at Tenet Healthcare was at
10 Delray Medical Center as the director of finance.

11 Q. And generally speaking, what were your job
12 duties as the director of finance at Delray?

13 A. The director of finance is responsible for
14 doing journal entries, accounts payable, payroll,
15 closing the books at the end of the month, doing
16 balance sheet reconciliations, so really a very finance
17 focused on making sure the details were correct.

18 Q. And at the time in 1999, Delray was not part
19 of the Tenet Healthcare system, correct?

20 A. We were.

21 Q. In '99?

22 A. (Nodding head).

23 Q. So as we go through your employment history
24 from 1999 to present, was that always within
25 Tenet Healthcare, then?

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1 A. Yes.

2 Q. And then I assume at some point you get
3 promoted out of financial analyst, correct?

4 A. I did. So I was at Delray as the director
5 of finance, and then I got promoted to chief financial
6 officer.

7 Q. And when was that promotion?

8 A. 2001.

9 Q. And that was the chief financial officer of
10 Delray?

11 A. At West Boca.

12 Q. At West Boca.

13 And how long -- okay. So take me through
14 that. You were at Delray, but then you got promoted to
15 the CFO at West Boca?

16 A. Correct.

17 Q. And that is between two different hospitals,
18 correct?

19 A. Correct.

20 Q. Okay. Walk me through how that works.
21 They, Tenet Healthcare, will take somebody from one
22 hospital and promote them in a position to a different
23 hospital?

24 MS. MALONEY: Objection.

25 A. Correct. So within Tenet I can apply to

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1 change facilities if there is a position that I'm
2 interested in.

3 BY MS. BLAIR:

4 Q. And that's -- is that anywhere within Tenet,
5 or do you have to stay within the Palm Beach Health
6 Network hospitals?

7 A. Any --

8 MS. MALONEY: Objection. Lacks foundation.
9 If you could give me a second to interpose my
10 objection before you answer, that would be
11 great.

12 THE WITNESS: Yes, ma'am.

13 MS. MALONEY: Just give yourself a pause.
14 Thank you.

15 A. Repeat that question.

16 BY MS. BLAIR:

17 Q. Sure. I'm just trying to figure out how it
18 works. So you're talking about you can apply for
19 positions that are opened, correct?

20 A. Correct.

21 Q. And it sounds like at some point a position
22 became open for a CFO at West Boca, correct?

23 A. Correct.

24 Q. And so you applied for that job?

25 A. Correct.

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1 Q. And is it correct that you then could apply
2 as a Tenet Healthcare employee for any open positions
3 that Tenet might have regardless of geographic area?

4 A. Correct.

5 Q. Okay. So in sometime in -- oh, in 2001, you
6 became the CFO of West Boca, correct?

7 A. Correct.

8 Q. And what were your job duties as the CFO of
9 West Boca?

10 A. So as the CFO the responsibilities included,
11 we had oversight over health information management,
12 which formerly known as medical records, health
13 information management, materials management, finance
14 and accounting, admitting.

15 Q. What does admitting mean?

16 A. Admitting, so the registrars.

17 Q. Got it. And did you oversee the budget of
18 West Boca at that time as the chief financial officer?

19 A. The chief financial officer has
20 responsibility for developing the budget.

21 Q. And in or around this time, 2001, were you
22 working in concert with the other hospitals that later
23 are rebranded as Palm Beach Health Network?

24 A. I don't know that I understand the question.
25 I mean, I worked for West Boca, and we all were a part

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1 of Tenet, but so I'd have to understand what you mean
2 "work with them."

3 Q. Sure. I'll jump forward a little, then.

4 A. Okay.

5 Q. In 2022, I understand that the five
6 hospitals that are plaintiffs in this litigation, which
7 would be West Boca, St. Mary's, Good Samaritan,
8 Palm Beach Gardens -- which one am I missing --
9 St. Mary's, West Boca, Good Samaritan -- sorry -- West
10 Palm and Delray, all rebrand as Palm Beach Health
11 Network, correct?

12 A. I don't think that happened at that, in
13 2020 --

14 Q. Two?

15 A. So that's, 2022 is way after I'm at West
16 Boca.

17 Q. Correct. Right.

18 A. Correct.

19 Q. So that happens in 2022, correct?

20 A. Okay.

21 Q. And in 2001, you become the chief financial
22 officer of West Boca, correct?

23 A. Correct.

24 Q. And so my question is, prior to the
25 rebranding of these five hospitals in 2022, did these

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1 five hospitals work together in 2001 in any way?

2 MS. MALONEY: Objection.

3 A. So the hospitals worked together, for
4 example, if we have a patient that needs -- so if I was
5 at West Boca that didn't offer cardiology services and
6 we had a patient that needed cardiology, we could work
7 to transfer that -- our patient to Delray for services,
8 so there was not -- so work together, I mean, without
9 specificity I'm not really sure --

10 Q. Sure.

11 A. -- you know.

12 Q. And so I understand today there's a
13 president of Palm Beach Health Network, Maggie Gill,
14 correct?

15 A. Correct.

16 Q. And the Palm Beach Health Network kind of
17 provides an overarching governance for the five
18 hospitals that are plaintiffs in this action, correct?

19 A. Define "governance."

20 Q. Well, as I understand it, there's a
21 president of Palm Beach Health Network, correct?

22 A. Correct.

23 Q. There's a chief strategy officer of
24 Palm Beach Health Network, correct?

25 A. Correct.

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1 Q. There's a chief quality officer, Gina West,
2 of Palm Beach Health Network, correct?

3 A. Yes, but Gina also serves as my quality
4 director --

5 Q. Correct?

6 A. -- so it's a dual role.

7 Q. Right.

8 A. Right.

9 Q. And I understand that. And so I'm just
10 trying to understand, were there any people back in
11 2001 that provided these sorts of overarching roles for
12 the five hospitals, or does that come later after the
13 rebranding?

14 MS. MALONEY: Objection.

15 A. No, those -- we did have a similar
16 structure.

17 BY MS. BLAIR:

18 Q. Okay. And so taking you way back to 2001,
19 and I know it's not a memory test, but can you tell me
20 just generally what the structure was back in 2001
21 between the five hospitals?

22 A. We had -- I don't recall specific titles of
23 people.

24 Q. Understood.

25 A. There was -- I don't even remember if -- let

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1 me think what they might have been called. I can't
2 recall. They weren't called a CEO. They weren't
3 called a market president. I don't recall their title,
4 but there was somebody who would have had oversight or
5 responsibility we would have rolled up to at a local
6 Florida level.

7 MS. MALONEY: And, Counsel, I assume that
8 this portion of the deposition is in her
9 capacity as a fact witness --

10 MS. BLAIR: Yes.

11 MS. MALONEY: -- not as a 30(b)(6) witness,
12 and you'll make clear when you're examining her
13 in her capacity --

14 MS. BLAIR: Correct.

15 MS. MALONEY: -- as a 30(b)(6) witness; is
16 that right?

17 MS. BLAIR: Right.

18 BY MS. BLAIR:

19 Q. And so in 2001, how long did you stay as the
20 chief financial officer of West Boca?

21 A. This is a memory test. I believe, and I
22 reserve the right to be off a little on the dates
23 because it was a long time ago, I believe I was at
24 West Boca for about two years.

25 Q. Where did you go after West Boca?

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1 A. After West Boca I transferred to North Ridge
2 Medical Center as their CFO.

3 Q. And where is North Ridge Medical Center?

4 A. It is in -- I don't know -- I don't know
5 what city it's in. It's just over the Broward County,
6 the next county line. Tenet no longer owns that
7 hospital. It was sold.

8 Q. Okay.

9 A. It was sold. If I went there in -- 2003 or
10 '04 -- in 2006 or '07 it was sold. A long time ago.

11 Q. Okay. And so but when you were there, when
12 you were at North Ridge Medical Center, it was a
13 Tenet hospital?

14 A. Correct.

15 Q. And when did you leave them?

16 A. I believe I left there in 2007.

17 Q. Okay. And in 2007, where did you go?

18 A. In 2007, I transferred to Good Samaritan
19 Medical Center.

20 Q. And have you been at Good Samaritan -- oh,
21 no, how long were you at Good Samaritan?

22 A. I was at Good Samaritan Medical Center for
23 five years.

24 Q. And what was your position at
25 Good Samaritan?

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1 A. I was the chief financial officer.

2 Q. So that takes us to about -- oh, here, now I
3 can follow along.

4 Okay. So you were the chief financial
5 officer until about September of 2012, does that sound
6 right?

7 A. Correct.

8 Q. And after that, you become the CEO of one of
9 the Tenet hospitals?

10 A. Of the physician group.

11 Q. Okay. Oh, that's right. And tell me about
12 that. What is the physician group that you were the
13 CEO of?

14 A. So Tenet corporation employs physicians, but
15 they are not employed by the hospital. They are, all
16 the physicians are employed in a separate physician
17 group, so I became the chief executive officer over the
18 physician group.

19 Q. And how many physicians were in that group?

20 A. We had approximately 200 providers.

21 Q. And were they in a specialty?

22 A. Multiple specialties.

23 Q. Do you recall any of the specialties as you
24 sit here today?

25 A. Cardiology, neurosurgery. Oh, goodness. I

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1 think -- I think we had one or two
2 obstetrician/gynecologists, primary care, orthopedic.

3 Q. Did they work, all work at a certain
4 hospital, or did they have privileges at multiple
5 hospitals?

6 MS. MALONEY: Objection.

7 A. So it would be unusual for them to all work
8 at all hospitals because of geography, so they could,
9 depending on the office, their office location, be
10 affiliated with one hospital or multiple hospitals.

11 BY MS. BLAIR:

12 Q. And how long were you with the physicians
13 group?

14 A. Seven years.

15 Q. And then at some point thereafter you become
16 the chief administrative officer at St. Mary's Medical
17 Center in the Palm Beach Children's Hospital?

18 A. Correct.

19 Q. And was that in or around October of 2019?

20 A. Correct.

21 Q. What is -- what does the chief
22 administrator -- administrative officer do?

23 A. So the chief administrative officer is
24 similar to the chief executive officer. However, the
25 component of nursing leadership had more solid

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1 reporting to the group chief nurse.

2 Q. Okay. And who is the group chief nurse at
3 the time that you were the chief administrative
4 officer?

5 A. \$1,000, I couldn't tell you.

6 Q. And when you say "the group chief nurse,"
7 what do you mean by "group"?

8 A. So we have the Palm Beach Health Network, so
9 that group or the network has, as you referred earlier,
10 Gina was like the group quality, a group CNO.

11 Q. Got it.

12 And so your memory is that that group
13 structure was in place at least by October of -- or I'm
14 sorry -- at least in 2019 when you became the chief
15 administrative officer at St. Mary's?

16 A. Yes.

17 Q. And the Palm Beach Children's Hospital is a
18 separate hospital, correct?

19 A. It is not a separate tax ID.

20 Q. Correct. But it's a separate building?

21 A. It is a separate building that is attached
22 to the main campus.

23 Q. And it goes by Palm Beach Children's
24 Hospital?

25 A. That's correct.

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1 Q. And does it have different set of finances,
2 or does it have the same finances since it has the same
3 tax ID?

4 A. Same finances.

5 Q. Same budget?

6 A. Same budget, not a separate standalone
7 budget.

8 Q. Does it have separate director of quality?

9 A. No.

10 Q. Does it have a separate chief nursing
11 officer?

12 A. No.

13 Q. Does it have a separate chief financial
14 officer?

15 A. No.

16 Q. Okay. So is it fair to say that St. Mary's
17 and the Palm Beach Children's Hospital have the same
18 C-suite executives overseeing both?

19 A. Yes.

20 Q. And then it looks like at some point in time
21 you do become the chief executive officer at
22 St. Mary's?

23 A. Correct.

24 Q. And when does that happen?

25 A. I believe it was around May --

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1 Q. Of what --

2 A. -- of 2020, but scripturally I'm a little
3 unsure.

4 Q. So right during COVID?

5 A. Correct.

6 Q. And you maintain that job to today, correct?

7 A. Correct.

8 Q. And I note on your LinkedIn, and maybe it's
9 a distinction without a difference, but you list chief
10 executive officer St. Mary's Medical Center and then
11 chief executive officer Tenet Healthcare full time. Is
12 that the same job?

13 A. Yes.

14 Q. Okay. And are there any other, that you can
15 think of, positions that you've held at St. Mary's that
16 we didn't go over today?

17 A. No.

18 Q. And how many direct reports do you have as a
19 chief officer -- chief executive officer, excuse me, of
20 St. Mary's?

21 A. Four directs.

22 Q. And who are your direct reports?

23 A. The CFO, the COO, the CNO and an executive
24 assistant.

25 Q. Okay. And who is the CFO currently?

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1 A. Currently the CFO is Romaine Layne.
2 Q. And the COO?
3 A. Maria Morales.
4 Q. And the CNO?
5 A. We have a new CNO starting Monday.
6 Q. Okay. And who was the CNO before that?
7 A. Before that, it was Jessica Miller.
8 Q. And we talked a little bit about
9 Regina West. What is her title at St. Mary's?
10 A. Director of quality.
11 Q. And who does she report to?
12 A. She, I believe, my educated guess is that
13 she reports to the group CNO.
14 Q. So she doesn't have a direct report within
15 St. Mary's?
16 A. I'm not a thousand percent certain of who
17 Gina reports to.
18 Q. Okay. And the group CNO, is that
19 Ricky Ramirez?
20 A. It is.
21 Q. And who do you report to?
22 A. I report to Maggie Gill.
23 Q. And do you know who Maggie Gill reports to?
24 A. I believe Maggie reports to Lisa Foo.
25 Q. And that's F-o-o, correct?

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1 A. Correct.

2 Q. And do you know who Lisa Foo reports to?

3 A. I believe Lisa Foo reports to Saum Sutaria.

4 Q. And Saum Sutaria is the CEO of
5 Tenet Healthcare nationwide, correct?

6 A. Correct.

7 Q. What did you do to prepare for your
8 deposition today?

9 A. I read volumes of information, including
10 the -- refreshed my memory on the Complaint, the
11 interrogatories. I spoke with counsel. I did a lot of
12 reading.

13 Q. Do you recall any specific -- well, you
14 mentioned you --

15 A. Right, the interrogatories, the Complaint,
16 the cease and desist letter. Those I specifically
17 recall.

18 Q. Do you recall reviewing any emails?

19 A. With counsel, they showed me some emails,
20 yes.

21 Q. Do you recall what any of those emails were?

22 A. I recall an email that I had written to
23 Gina West asking, we had gotten a notice from Leapfrog
24 that our new grades were coming out, so I had asked
25 Gina, do we have an estimate of what our grade will be.

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1 Q. Do you remember essentially the time frame
2 of that? Would that have been related to the fall of
3 2024?

4 A. I think it was before then.

5 Q. Any other emails you recall?

6 A. From me, no.

7 Q. Well, any other emails you recall reviewing
8 in preparation for your deposition?

9 A. There were some emails from Gina, again,
10 about Leapfrog and potential grades.

11 Q. Did you review the Leapfrog Hospital Survey
12 in preparation for your deposition?

13 A. I did.

14 Q. Did you review the Leapfrog Hospital Safety
15 Grade methodology in preparation for your deposition?

16 A. Yes, I did.

17 Q. Did you review any financial documents in
18 preparation for your deposition?

19 MS. MALONEY: Objection. Vague.

20 A. Financial documents? Not that I recall
21 unless you ask me specifically, yeah.

22 BY MS. BLAIR:

23 Q. Sure.

24 How many times did you meet with your
25 lawyer?

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1 A. Four.

2 Q. Do you recall when the first one was?

3 A. A few months ago.

4 Q. And, again, I don't know want to know about
5 any meetings you had with your lawyers that weren't
6 related to your deposition. So those would have been
7 meetings related to your deposition?

8 A. Correct.

9 Q. And do you recall approximately how long
10 that initial meeting lasted?

11 A. A few hours.

12 Q. And you said you had four meetings, correct?

13 A. Correct.

14 Q. When was the last meeting you had with your
15 lawyers to prepare for your deposition?

16 A. Yesterday.

17 Q. And how long did that last?

18 A. Maybe five hours.

19 Q. Did you review any deposition transcripts in
20 preparation for your deposition?

21 A. No.

22 Q. Have you seen any of the depositions of the
23 other CEOs that have been taken in this case?

24 A. No.

25 Q. Have you reviewed any of the documents that

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1 were shown to the other CEOs at their depositions in
2 preparation for your deposition?

3 A. I don't know if they've seen the same
4 documents, so I can't speak to that.

5 Q. Excellent point.

6 How long would you estimate -- all four of
7 these meetings, how long would you estimate you spent
8 preparing for your deposition?

9 A. Including my own weekend research?

10 Q. Yeah.

11 A. A lot of hours. I mean, easily, easily --
12 it's hard to give a number because a lot was on my own
13 evening and weekend time reading, so I would -- if I
14 had to give a number, it could easily be a week's worth
15 of time.

16 Q. I'll mark this as Exhibit 1.

17 (Defendant's Exhibit Number 1 for i.d.)

18 BY MS. BLAIR:

19 Q. Ms. McCauley, I'm handing you what we've now
20 marked as McCauley Exhibit 1. And this is called,
21 titled the Amended Notice of Taking in-Person
22 Videotaped Deposition of Cynthia McCauley individually
23 and pursuant to Rule 30(b)(6) to St. Mary's Medical
24 Center.

25 Have you seen this document before?

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1 A. Yes.

2 Q. Did you review it in preparation for your
3 deposition?

4 A. Yes.

5 Q. And do you understand that your deposition
6 here today is not only in your personal capacity but
7 also in your capacity as a corporate representative for
8 St. Mary's?

9 A. Yes.

10 Q. And if you will look at page -- sorry -- 6
11 of this document, it says "Matters For Examination."

12 And I will submit to you that this document
13 was the product of negotiation, meet and confer
14 negotiation between myself and your counsel relating to
15 these topics.

16 And if you wouldn't mind just taking a look
17 at the topics on six through eight, and let me know if
18 those are the topics that you are prepared to testify
19 to today.

20 MS. MALONEY: Counsel, it's my understanding
21 that there was further negotiation beyond this
22 final list and that certain of these have been
23 further revised through negotiation between
24 counsel.

25 MS. BLAIR: That is not my understanding.

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1 This was just sent out two days ago after
2 speaking with Lee Crain.

3 MS. MALONEY: Okay.

4 MS. BLAIR: If you want to tell me which
5 ones, I'm happy --

6 MS. MALONEY: This is dated September 17.
7 Let's see.

8 MS. BLAIR: And I'm happy --

9 MS. MALONEY: And today's date is September,
10 what is it, 24th?

11 MS. BLAIR: 24th.

12 THE WITNESS: Yeah.

13 MS. MALONEY: Well, if an issue arises,
14 we'll address it.

15 MS. BLAIR: Yes, that's fine.

16 BY MS. BLAIR:

17 Q. Have you seen this document before?

18 A. It appears to be.

19 Q. Excellent. And from time to time,
20 Ms. McCauley, we will refer to these matters of
21 examination. To the extent that I ask you questions
22 here today that cover these areas, I'm going to assume
23 that you're testifying in your capacity as a corporate
24 representative.

25 A. Okay.

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1 Q. Do you understand the documents -- that
2 St. Mary's has produced significant amount of documents
3 in this matter as production to me in this matter, do
4 you understand that?

5 A. I know we produced documents and submitted
6 them to counsel --

7 Q. Correct.

8 A. -- who I presume submitted them to you.

9 Q. Yes. And I want to ask you, do you -- can
10 you describe to me briefly what you did -- and by
11 "you," I mean, St. Mary's --

12 A. Okay.

13 Q. -- did to gather documents responsive to the
14 request?

15 A. So I know when the documents were requested,
16 the primary person who could pull the documents was my
17 quality director, so she would have worked to pull
18 those documents and provide them to counsel.

19 Q. And, again, for the record the quality
20 director would be Gina West, correct?

21 A. That is correct.

22 Q. And have you provided to your counsel all
23 documents that set forth how St. Mary's would have
24 performed on four of the measures in the hospital
25 safety grade, which would be CPOE, BCMA hand hygiene

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1 and ICU physician staffing?

2 A. Yes.

3 Q. And do you recall any conversations you had
4 with Ms. West about what documents would be gathered to
5 provide documents sufficient to simulate how St. Mary's
6 would have performed on those four measures in the fall
7 2024 or spring '25 Leapfrog Hospital Safety Grade?

8 A. Not specifically.

9 Q. But Gina West would have been the individual
10 that prepared those documents for production, correct?

11 A. She would have pulled the reports or gone
12 and searched for the reports, correct.

13 Q. And in terms of since Gina has both this
14 dual role that you spoke about earlier, which was both
15 the director of quality for St. Mary's as well as
16 the -- is she the -- well, strike that.

17 Is she director of quality for the group?

18 A. I think her title is -- I don't know if it's
19 market quality or group. You'd have to look that up.

20 Q. Okay. To your knowledge, does Gina West
21 have essentially the same quality role for the group
22 that she does for St. Mary's?

23 MS. MALONEY: Objection.

24 A. So Gina is St. Mary's' quality director, and
25 the other facilities have quality directors focused on

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1 their facility. And Gina has oversight over all five.

2 BY MS. BLAIR:

3 Q. Okay. That was a bad question.

4 So does she do, for the group, does she do
5 anything besides quality for the Palm Beach Health
6 Network group?

7 A. Not that I'm aware of, but that would be
8 more of a Gina question.

9 Q. And in her role as the quality person -- I
10 don't know her title -- for the Palm Beach Health
11 Network, does she report to Maggie Gill?

12 MS. MALONEY: Objection. Asked and
13 answered.

14 A. Yeah, I believe -- and I said earlier, I
15 believe she reports to the group chief nurse.

16 BY MS. BLAIR:

17 Q. Ricky Ramirez, correct?

18 A. Correct.

19 Q. So Gina would have been responsible at least
20 for, with respect to those four measures that we just
21 discussed, CPOE, BCMA, hand hygiene and I'll just call
22 it IPS, ICU physician staffing.

23 A. Okay.

24 Q. She would have been responsible for
25 gathering the documents related to those areas for

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1 production in this litigation, correct?

2 A. For St. Mary's.

3 Q. For St. Mary's.

4 A. Correct.

5 Q. In terms of producing meeting minutes, was
6 Gina West involved in gathering those documents for
7 production in this case?

8 A. Which meetings -- which meeting minutes?

9 Q. St. Mary's, board meeting.

10 A. Governing board?

11 Q. Governing board.

12 A. No.

13 Q. Okay. Who gathered those documents?

14 A. So the governing board meetings would be
15 maintained by the CEO's executive assistant who would
16 have provided them to Gina to submit.

17 Q. Okay. And who is your executive assistant?

18 A. Her name is Michelle Getty.

19 Q. What about med exec, med exec board
20 meetings, who would have gathered those?

21 A. So med exec board minutes would have been
22 requested from the manager of medical staff.

23 Q. And who is the manager of medical staff?

24 A. Delia Cortes.

25 Q. And if I use the acronym QIPSC, do you know

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1 what I mean when I say QIPSC?

2 A. Yes.

3 Q. What --

4 A. Quality patient infection control [sic].
5 QIPSC. It's quality patient safety and infection
6 control [sic].

7 Q. And in terms of QIPSC -- is there a QIPSC
8 committee specific to St. Mary's?

9 A. There is.

10 Q. And who sits on that committee?

11 A. It's chaired by a physician. Gina sits on
12 it. Most of the -- I believe most of the C's, if not
13 all the C's, we sit on it. And there has been
14 community participation, like from our board member.

15 Q. Is there a specific board member that sits
16 on the QIPSC committee?

17 A. Chief Darrel Donatto was sitting on it
18 through the end of 2024.

19 Q. And do you know who would have been
20 responsible for gathering the QIPSC information from
21 St. Mary's to produce in this litigation?

22 A. I believe that would have been Gina West.

23 Q. Does St. Mary's have a marketing director?

24 A. We have a marketing, maybe her title is
25 manager.

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1 Q. And who is the marketing manager?

2 A. Her name is Ashley Peterson.

3 Q. Do you know if Ashley Peterson was involved
4 in gathering documents to be produced in this
5 litigation?

6 A. I would venture to say no.

7 Q. And why would you venture to say no?

8 A. Because I don't think she has any
9 involvement with any -- I think that's so outside of
10 her role.

11 Q. Do you know who at St. Mary's would have
12 been involved in gathering documents related to the
13 hospital's brand for production in this litigation?

14 MS. MALONEY: Objection. Vague. Lacks
15 foundation.

16 A. I'm unaware of any documents for St. Mary's'
17 brand.

18 BY MS. BLAIR:

19 Q. Okay. Do you know what year St. Mary's was
20 purchased by Tenet?

21 A. 2001.

22 Q. And so when you started at Delray Medical
23 Center in '99, it -- oh, well, do you know if Delray
24 was owned by Tenet in 1999 when you started at Delray?

25 A. It was.

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1 Q. Okay. So it -- do you know which one of
2 these five plaintiff hospitals was the first hospital
3 purchased by Tenet?

4 A. No.

5 Q. Prior to 2001 do you know whether or not
6 St. Mary's was a not-for-profit hospital?

7 A. It was.

8 Q. And as I understand it, St. Mary's has been
9 in this community for quite a while, correct?

10 A. St. Mary's has been in the community since
11 1938.

12 Q. We talked about this a little bit already,
13 but do you know when these five hospitals rebranded as
14 the Palm Beach Health Network?

15 A. I believe they rebranded maybe two years
16 ago.

17 Q. Do you know what the purpose was for the
18 rebrand?

19 A. The hospitals -- as I understand it, the
20 hospitals that are part of the Palm Beach Health
21 Network, we are the largest provider of healthcare in
22 Palm Beach, so it was felt that it was important for
23 the community to know that we were tethered together
24 and if they needed care in Palm Beach County, they
25 could get it within our network.

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1 Q. Do you know what -- why that wasn't done
2 earlier?

3 MS. MALONEY: Objection.

4 A. I can't -- I can't opine. Not in my
5 purview.

6 BY MS. BLAIR:

7 Q. Do you recall being part of any
8 conversations in or around the time that Palm Beach --
9 or in or around the time St. Mary's and the other four
10 plaintiff hospitals rebranded as Palm Beach Health
11 Network?

12 MS. MALONEY: Objection. Vague.

13 BY MS. BLAIR:

14 Q. I'm sorry. It was vague.

15 Do you recall any meetings in or around the
16 time that these five hospitals rebranded as the
17 Palm Beach Health Network around why the rebranding was
18 occurring at that time?

19 MS. MALONEY: Objection. Vague.

20 A. I don't know that I recall any specific
21 meeting or conversation as to the why.

22 BY MS. BLAIR:

23 Q. Were there discussions in or around the time
24 that these five hospitals were rebranding about how
25 resources would be shared to fund those personnel that

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1 were now going to be working as group employees?

2 A. Not that I'm aware.

3 MS. MALONEY: Objection.

4 Give me a chance.

5 A. Not that I'm aware of.

6 BY MS. BLAIR:

7 Q. Do you --

8 MS. BLAIR: Mark this as 2.

9 (Defendant's Exhibit Number 2 for i.d.)

10 BY MS. BLAIR:

11 Q. Ms. McCauley, I'm now handing you what has
12 been marked as McCauley Exhibit 2. And this is an
13 article from the Palm Beach Post dated April 22nd,
14 2022. Do you have that in front of you?

15 A. Yes.

16 Q. And you'll see the first sentence of this
17 article says, "Five Tenet Healthcare owned hospitals in
18 Palm Beach County are retooling their image to
19 emphasize ties to local physicians and communities."

20 Do you see that?

21 A. I do see that.

22 Q. Does this refresh your recollection that
23 that rebranding probably occurred in or around April of
24 2022?

25 A. It would appear that it should be timely, to

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1 my recollection.

2 Q. Okay. And the next sentence says, "This
3 move comes as more residents pour into the region and
4 rival medical providers vie for new and often wealthy
5 patients."

6 Do you see that?

7 A. I do.

8 Q. Does this refresh your recollection in any
9 way that one of the purposes of the rebranding of the
10 five hospitals into the Palm Beach Health Network was
11 to compete with new entrants into the Palm Beach
12 healthcare?

13 MS. MALONEY: Objection. Lacks foundation.

14 A. So from my perspective this is an article
15 written by a newspaper writer from the Post and
16 basically they can write it as they see it. It doesn't
17 necessarily need to be the reasons behind what we did.

18 But I -- so I would be opining on why
19 Ms. Alexandra Clough wrote what she wrote.

20 Q. Okay. Do you have any recollection of
21 discussing this article in or around the time it came
22 out?

23 A. No.

24 MS. MALONEY: Objection.

25 Objection. Lacks foundation and vague.

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1 A. I don't remember an article from three years
2 ago.

3 BY MS. BLAIR:

4 Q. And if we look at the bottom of this page,
5 it says, "Maggie Gill, chief executive of the Palm
6 Beach Health Network, said the hospital" -- "the
7 hospital company wants to showcase that it is a local
8 provider, especially to new residents who may not be
9 familiar with the Tenet brand."

10 Do you see that?

11 A. Yes.

12 MS. MALONEY: Objection. Not a quotation in
13 the article that you're reading from. Go ahead.

14 MS. BLAIR: I don't understand the
15 objection, but, okay.

16 MS. MALONEY: Mis -- well, I'll be clear.
17 It misrepresents it in that you said
18 "Maggie Gill said," which suggests this is a
19 quotation when, in fact, the article doesn't
20 quote from her.

21 BY MS. BLAIR:

22 Q. Okay. Let's do it again, then,
23 Ms. McCauley.

24 Do you see on page -- the bottom of page 1,
25 this article says, "Maggie Gill, chief executive of the

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1 Palm Beach Health Network, said the hospital company
2 wants to showcase that it is a local provider,
3 especially to new residents who may not be familiar
4 with the Tenet brand."

5 Do you see that sentence?

6 A. Yes, that is what's written.

7 Q. Do you disagree that the purpose of the Palm
8 Beach Health Network was "to showcase that it is a
9 local provider, especially to new residents who may not
10 be familiar with the Tenet brand"?

11 A. Maggie goes on where she is quoted to say,
12 "We want to share what we're doing. This is our home
13 base."

14 Q. Correct.

15 A. So I believe that it's important for
16 residents who are unfamiliar with our brand to
17 understand that we have a network here to care for
18 them.

19 Q. Okay. Yeah. And that's just my question.

20 A. Yeah.

21 Q. Do you agree that part of the reason that
22 the Palm Beach Health Network rebranding occurred was
23 to showcase that it is a local provider, especially to
24 new residents who may not be familiar with the Tenet
25 brand?

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1 MS. MALONEY: Objection. Asked and
2 answered.

3 Go ahead.

4 A. I believe it's important to show that we are
5 a network here in Palm Beach, we're a local -- you
6 know, we're local, we are here and create awareness of
7 the five hospitals, that we have five hospitals to who
8 can basically serve you wherever you are.

9 BY MS. BLAIR:

10 Q. And in April of 2022 as the CEO of
11 St. Mary's in or around that time, was it important to
12 you to showcase that St. Mary's was a local provider?

13 MS. MALONEY: Objection.

14 A. I can't recall '22 specifically as we were
15 coming out of COVID. And I do know that our community
16 is familiar with St. Mary's.

17 BY MS. BLAIR:

18 Q. Correct. Do you know if around April of
19 2022 whether the community was familiar with the Tenet
20 brand?

21 A. I am not confident that the community is
22 familiar with the Tenet brand or not.

23 Q. Do you recall whether or not in or around
24 2022 that the five hospitals that are plaintiffs in
25 this matter were spending money to upgrade facilities?

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1 If you look on page 2 of this article, it's
2 in bold, "Tenet spending 150 million to upgrade
3 facilities."

4 MS. MALONEY: Objection. She is here to
5 testify in the capacity as the CEO and corporate
6 representative of St. Mary's. This is beyond
7 the scope of the 30(b)(6) --

8 MS. BLAIR: Well, I'm asking her --

9 MS. MALONEY: -- because this is as to all
10 hospitals, if you would let me finish my
11 objection. She may answer to the extent she can
12 answer this question for St. Mary's.

13 BY MS. BLAIR:

14 Q. Well, I'm asking you in your individual
15 capacity.

16 MS. MALONEY: Then you need to clarify
17 because you had specified at the beginning that
18 all of these questions would be in her capacity
19 as a corporate representative, so if we're now
20 going to --

21 MS. BLAIR: Well, I said if it had to do
22 with the topic for which she has prepared, they
23 will be as corporate representative.

24 MS. MALONEY: You haven't specified whether,
25 for any of your questions whether they're as to

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1 a topic or not. So I'm happy to go through and
2 every time you ask a question, say --

3 MS. BLAIR: Sure.

4 MS. MALONEY: -- "is it as to a topic and
5 which one," and we can do it that way or we can
6 make sure we're clear with each question
7 whether it's in her personal capacity --

8 MS. BLAIR: I'll ask the question --

9 MS. MALONEY: -- or as a fact witness.

10 And if, again, you would allow me to finish
11 my statement on the record before you begin
12 speaking to my client.

13 MS. BLAIR: Are you finished?

14 MS. MALONEY: Go ahead. I am now.

15 BY MS. BLAIR:

16 Q. Ms. McCauley, in your capacity as an
17 individual --

18 A. Um-hum.

19 Q. -- were you aware in April of 2022 that
20 Tenet was spending money to upgrade its facility?

21 A. I'm aware that Tenet continually spends
22 money to upgrade our facilities. I can't speak to the
23 specifics of what we did in 2022, but I do know that we
24 continually invest in our facilities to upgrade them.

25 Q. And do you recall any upgrades that

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1 St. Mary's was undergoing in or around April of 2022 to
2 upgrade its facilities?

3 MS. MALONEY: And, Counsel, is this in her
4 capacity as a fact witness or --

5 BY MS. BLAIR:

6 Q. Well, it's not one of those topics, so in
7 your capacity as a fact witness, but you were also the
8 CEO of St. Mary's, can you tell me what facility
9 upgrades were occurring at St. Mary's in 2022, if you
10 know?

11 A. Specifically, I don't have that off the top
12 of my head.

13 Q. If we go on here, and we're looking at
14 page 3 of this article, third paragraph -- second full
15 paragraph, says "The Tenet hospital improvement
16 program."

17 Were you aware as to whether or not there
18 was a Tenet hospital improvement program as the CEO?
19 In your individual capacity as the CEO of St. Mary's in
20 or around April of 2022, are you aware of whether or
21 not there was a Tenet hospital improvement program
22 underway in April of 2022?

23 A. I'm unfamiliar that there was anything
24 specifically called the "Tenet hospital improvement
25 program," but we do continually work to improve our

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1 services and facilities.

2 Q. And if we look at page 4 of this article,
3 there is a bold sentence about two-thirds of the way
4 down that says, "Hospitals facing increased competition
5 for locals' out-of-state care providers."

6 Do you see that sentence?

7 A. Yes.

8 Q. As the CEO of St. Mary's in or around
9 April of 2022, was there increased competition for
10 healthcare in the Palm Beach area?

11 A. There is continued increased competition. I
12 can't recall if that was '22, '20, '25. You know,
13 there's continuing competition, you know, competition
14 in our market.

15 Q. We talked a little bit about the executive
16 leadership at St. Mary's. As the corporate
17 representative of St. Mary's, can you tell me in 2024
18 who was on the med exec committee?

19 A. I would have to pull that. So by person or
20 by title?

21 Q. Well, let's just start, who was the chair of
22 the med exec committee in 2024?

23 A. In 2024, the chair of med exec was
24 Dr. Holly Lenard.

25 Q. And what is her specialty?

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1 A. Orthopedic surgeon.

2 Q. How many members were there of the med exec
3 committee?

4 A. I would be guessing. I could pull that
5 data. It could be 15 plus, but I -- that is not a
6 scriptural number.

7 Q. Okay. Do you sit on the med exec committee?

8 A. I do.

9 Q. Do any of the other members of the C-suite
10 sit on the med exec?

11 A. So we attend. We're nonvoting members of
12 the med exec because it's a medical executive meeting,
13 so we are not voting, so the chief executive -- the
14 chief operating officer and the chief nursing officer
15 do attend med exec.

16 Q. What types of things does the -- in your
17 capacity as the corporate representative of St. Mary's,
18 what types of things do the med exec vote on at
19 St. Mary's?

20 A. So the med exec votes on, there are reports
21 that come from different committees. For example,
22 credentials committee would present the qualifications
23 of the physicians and allied health professionals that
24 are seeking to get on staff. They would present
25 doctors requesting reappointment, providers requesting

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1 resignation, any requests for expedited privileges or
2 to start before the process works the process. There
3 are reports from the chairs of medicine, surgery,
4 perinatal and pediatrics on anything that happened in
5 peer review.

6 There is a report from their treasurer.
7 There's a report from the chair of QIPSC, the physician
8 chair of QIPSC. There is a report from the physician
9 chair utilization review. There is a chief of staff
10 report and then reports from each member of my team in
11 attendance.

12 Q. And who is the physician chair of QIPSC at
13 St. Mary's?

14 A. Currently QIPSC is -- there are one or two
15 physicians, and I'm trying to think which position each
16 physician is in. QIPSC, I believe, is Dr. Faris Azar.

17 Q. Can you spell that for me?

18 A. Faris is F-a-r-i-s. Azar is A-z-a-r.

19 Q. Does the med exec vote to approve safety
20 plans?

21 A. They do.

22 Q. How many members are on the St. Mary's
23 governing board?

24 A. Eight.

25 Q. And in 2024 who was the chair of the

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1 governing board?

2 A. Chief Darrel Donatto.

3 Q. And what is he the chief of?

4 A. He's the fire chief. He at that time was
5 the fire chief for Palm Beach.

6 Q. Do you know who else was on the governing
7 board in 2024?

8 A. We had some turnover, so I'm trying to
9 recall specifically. Dr. Chad Sanborn,
10 Dr. Sunny Kukreja, Dr. Dror Paley, Ms. Barbara Cheives,
11 Ms. Barbara Cipriano, Denise-Marie Nieman, I believe
12 Robby Journey (phonetic), Chief Charley Coyle and
13 perhaps Chief Sarah Mooney.

14 MS. MALONEY: Ms. Blair, what topic on your
15 30(b)(6) topics do these questions relate to? I
16 appreciate that she's been able to answer them,
17 but --

18 MS. BLAIR: I just said I was asking her in
19 her individual capacity.

20 MS. MALONEY: No, but -- but when --

21 MS. BLAIR: I did not ask her this question
22 as a 30(b)(6) witness.

23 MS. MALONEY: "Do you know who else was on
24 the governing board" you didn't ask as in her
25 personal capacity. And earlier than that when

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1 you were going through -- I didn't know you
2 changed because when you were asking these
3 questions about the med exec committee, that was
4 specifically in her corporate capacity.

5 MS. BLAIR: Going forward, I'll ask her in
6 her corporate capacity if it's in her corporate
7 capacity.

8 MS. MALONEY: And I'd appreciate it --

9 MS. BLAIR: Okay. Fine.

10 MS. MALONEY: -- if you would also say what
11 topic it is because I --

12 MS. BLAIR: Okay. Fine.

13 MS. MALONEY: -- really don't know what
14 topic the medical exec committee related to.
15 And I just -- she did prepare a lot so I want to
16 make sure --

17 MS. BLAIR: Sure, that's fine.

18 MS. MALONEY: -- that there's no question as
19 to her being responsive to the topics that are
20 actually agreed to.

21 MS. BLAIR: And obviously if she answers a
22 question that's not on a topic, it cannot be in
23 her corporate capacity. I think we all agree
24 with that.

25 MS. MALONEY: Okay.

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1 BY MS. BLAIR:

2 Q. So I'm asking you these as the CEO of
3 St. Mary's in your factual capacity --

4 A. Okay.

5 Q. -- as a fact witness.

6 You listed three different doctors:

7 Dr. Sanborn -- I can't pronounce some of these names,
8 but are they doctors at St. Mary's or another facility?

9 A. They are at St. Mary's.

10 Q. And then Chief Coyle, what is he the chief
11 of?

12 A. He is -- he's in fire, so he is a fire
13 rescue chief in Palm Beach County.

14 Q. And Chief Sarah Mooney?

15 A. Mooney. She is the chief for the Palm Beach
16 School Board Chief of Police.

17 Q. How long is the term of a governing board
18 member for St. Mary's?

19 A. Three years.

20 Q. Do they -- are they staggered terms?

21 A. They're staggered terms.

22 Q. Are they like January to January for that
23 three-year period?

24 A. Yes.

25 Q. How many of the members of the governing

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1 board came off the board in January of 2025?

2 A. I'd have to -- it's a pretty specific
3 question.

4 Q. Have you ever had trouble filling board
5 positions?

6 A. Never.

7 Q. In terms of marketing for St. Mary's, we
8 talked a little bit earlier about, and her name escapes
9 me, that there is a marketing director I want to say.

10 A. I think she's a manager.

11 Q. And who is the marketing manager again?

12 A. Ashley Peterson.

13 Q. And what are Ashley Peterson's job duties as
14 the marketing manager at St. Mary's?

15 A. So Ashley would help us if we're doing
16 community events. For example, if we're having a NICU
17 reunion, a trauma survivor reunion, she would plan,
18 coordinate.

19 She would assist us, for example, if we were
20 having -- during stroke awareness month, she would
21 assist to get a physician and the team to go present in
22 the community to educate on the warning signs for
23 strokes so that the population is aware. She could
24 help coordinate with clinical caregivers, Stop the
25 Bleed program so that the community can know how to

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1 provide immediate response in an event.

2 She does do social media posts on events at
3 the facility, for example the educational programs.
4 That's largely what she does. She would man if you had
5 a -- if we participated at a fair, let's say The Green
6 Market Fair and had a table, she would, you know, be at
7 the table and if people wanted information, they could
8 get it.

9 Q. Does she put out press releases for
10 St. Mary's?

11 A. No.

12 Q. Who puts out press releases for St. Mary's?

13 A. Press releases would come from a market, a
14 group individual.

15 Q. And when you say "a group individual,"
16 you're referring to the Palm Beach Health Network?

17 A. Correct.

18 Q. And do you know who that would be?

19 A. That would probably be Andrew Lofholm.

20 Q. And then we talked about the fact that
21 Regina West is the quality director for St. Mary's,
22 correct?

23 A. She is.

24 Q. What type of quality committees does
25 St. Mary's have?

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1 A. The most important meeting is the QIPSC, the
2 QIPSC meeting.

3 Q. And that's the most important meeting. Are
4 there other quality committees at St. Mary's?

5 A. On a monthly basis, we have a QMOR meeting,
6 a quality monthly operating report meeting.

7 Q. And who attends those meetings?

8 A. The directors, the C-suite. Gina would lead
9 that.

10 Q. And when you say "the directors," who are
11 you referring to specifically?

12 A. So a nursing director, a lab director, a
13 pharmacy director, so our leadership team.

14 Q. And does Gina put out agendas for those
15 meetings?

16 A. Yes.

17 Q. Do you approve the agendas?

18 A. No.

19 Q. Are there minutes that result from those
20 QMOR meetings?

21 A. QMOR, I'm not certain.

22 Q. And the QIPSC meetings at St. Mary's, are
23 there agendas that are put out for those meetings?

24 A. Yes.

25 Q. And are there minutes that come out of those

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1 meetings?

2 A. Yes.

3 Q. Are there slide decks that are presented at
4 those meetings?

5 A. I believe I've seen PowerPoints.

6 Q. And how often are the QIPSC meetings at
7 St. Mary's?

8 A. I believe the QIPSC meetings are monthly.

9 Q. So we have monthly QMOR meetings and monthly
10 QIPSC meetings. Are there any other quality meetings
11 that you -- at St. Mary's that you're aware of?

12 A. Those are the two that I attend.

13 Q. And I know they're the two that you attend,
14 but are you aware of whether there's any others?

15 A. I'm not positive.

16 MS. MALONEY: If we're -- oh, sorry. If
17 we're -- I was just going to say if we could
18 take a break if you're at a good --

19 MS. BLAIR: Of course, yes.

20 MS. MALONEY: -- if you're within your
21 section, of course, but if you --

22 MS. BLAIR: No, no, no.

23 MS. MALONEY: -- if there's a good time for
24 a break.

25 MS. BLAIR: I have no sections. Yes, it's a

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1 great time for a break.

2 THE VIDEOGRAPHER: Off the record, 10:13.

3 (A recess was taken from 10:13 a.m. to 10:21 a.m.)

4 THE VIDEOGRAPHER: Back on the record,
5 10:21.

6 BY MS. BLAIR:

7 Q. Ms. McCauley, I want to turn now just to the
8 Palm Beach Health Network and the organization of that.
9 And obviously I'll be asking you these questions in
10 your factual capacity as a witness here today. This is
11 not a 30(b)(6) topic.

12 Maggie Gill is the president of Palm Beach
13 Health Network, correct?

14 A. Correct.

15 Q. Do you know when she became the president of
16 the Palm Beach Health Network?

17 A. No.

18 Q. Was Maggie Gill involved -- well, we saw an
19 article earlier today that we marked as Exhibit 2 which
20 showed that in or around April of 2022 is when that
21 Palm Beach Health Network rebranded or Palm Beach
22 Health Network was branded, correct?

23 A. Correct.

24 Q. Do you know did Maggie Gill have any role
25 with respect to in any way with respect to St. Mary's

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1 prior to April of 2022?

2 A. What was the question?

3 Q. Maggie Gill, did she have any role on any
4 sort of level with respect to St. Mary's prior to
5 April of 2022?

6 A. I believe prior to 2022 she was still in the
7 market as the group leader.

8 Q. Okay. So there was a group leader of these
9 five hospitals prior to the rebranding of these
10 hospitals as the Palm Beach Health Network, correct?

11 MS. MALONEY: Objection.

12 A. That's my -- that's my -- group leader may
13 not be her official title, but, yes, she was president
14 and had oversight.

15 BY MS. BLAIR:

16 Q. So I just want to sort of divide the time
17 between -- between prior to Palm Beach Health Network
18 becoming a brand and after that time, so I want to talk
19 about pre April of 2022. What type of support, if any,
20 did Maggie Gill provide to St. Mary's prior to April of
21 2022?

22 A. Can you define "support"?

23 Q. Yes. Well, you said you thought she was the
24 group leader, although that might not have been her
25 exact title --

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1 A. Correct.

2 Q. -- prior to April of 2022. And so my
3 question is, what services did she provide to
4 St. Mary's prior to April of 2022 in her capacity as
5 group leader?

6 A. Prior to April 2022 for the two years that I
7 was there was predominantly COVID period, so Maggie
8 would have been instrumental in coordinating our
9 efforts in working through COVID protocols and
10 establishing pathways for patients, not from a clinical
11 perspective because she's not a nurse.

12 Q. Right. And so just talking about those
13 COVID protocols, would she have been involved in COVID
14 protocols that overarched all five hospitals?

15 A. So Maggie would have coordinated or called
16 us together to ensure that we were all moving in a
17 similar fashion.

18 Q. So prior to April of 2022 before Palm Beach
19 Health Network existed did the five CEOs of the five
20 plaintiff hospitals have regular meetings?

21 A. During COVID, meetings -- the topics were
22 primarily COVID, and we would group up, not in person,
23 to review -- to make sure if we had questions about how
24 to share supplies if somebody didn't have N95s. There
25 was a lot of communication amongst us to ensure sure we

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1 could meet our patients' needs.

2 Q. Prior to April of 2022 did the five
3 hospitals coordinate their marketing efforts?

4 A. I don't recall.

5 Q. Prior to April of 2022 did the five
6 hospitals coordinate their quality efforts?

7 A. I don't recall.

8 Q. Prior to April of 2022 did the five
9 hospitals coordinate any of their financial efforts?

10 A. I don't know what that means.

11 Q. Did you share money in any way prior to
12 April of 2022?

13 A. Not that I'm aware of.

14 Q. And then post 2020 -- April of 2022 after
15 the rebranding of these five hospitals as the Palm
16 Beach Health Network did Maggie -- in your view as the
17 CEO of St. Mary's, did Maggie Gill's role change in any
18 way?

19 A. Not in my view.

20 Q. And how do you view Maggie Gill's role today
21 for the Palm Beach Health Network?

22 A. Maggie is responsible for the market.

23 Q. When you say "the market," what do you mean
24 by that?

25 A. I mean the five hospitals and the physician

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1 group.

2 Q. And when you say she's responsible for them,
3 in what way?

4 A. She would be involved with ensuring that we
5 produce a budget and deliver on our budget.

6 Q. Other than the budget does she oversee your
7 hospital in any other way?

8 A. I'm not really sure what the question means.

9 Q. Yeah. So you said she makes sure that you
10 deliver a budget and you stick to the budget, correct?

11 A. Correct.

12 Q. What about marketing, does she oversee these
13 five hospitals' marketing efforts?

14 A. I can't speak to her involvement with the
15 group marketing person.

16 Q. And the group marketing person is Lisa Cook?

17 A. Correct.

18 Q. Does she oversee quality, oversee and/or
19 coordinate the quality of these five hospitals?

20 A. I suppose what is "oversee"? Does she --
21 what does "oversee" mean?

22 Q. Well, you tell me. What involvement does
23 Maggie Gill have in the patient safety and quality of
24 the five hospitals that are the plaintiffs in this
25 litigation?

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1 A. So Maggie equally participates in a group
2 quality -- quality, we call it QMOR, score --
3 presentation that Gina leads where she would review the
4 quality metrics for each facility.

5 Q. So there are QMOR meetings specific to
6 St. Mary's, and there are QMOR meetings of the five
7 hospitals as a group; is that correct?

8 A. Correct.

9 Q. And who attends the QMOR meetings of, we'll
10 just call it Palm Beach Health Network, the five
11 hospitals?

12 A. Certainly the five CEOs. The quality
13 directors from each facility, Maggie.

14 Q. Anyone else you can think of?

15 A. I invite my chief nurse. I can't speak to
16 who the others invite.

17 Q. Is Ricky Ramirez there?

18 A. Yes, I've seen Ricky there.

19 Q. Are there agendas that are circulated for
20 the Palm Beach Health Network QMOR meetings?

21 A. I'm not positive if there's a specific
22 agenda, but there is a standard slide deck.

23 Q. Okay. So it's your memory that there's a
24 slide deck for each of these monthly QMOR meetings?

25 A. Yes.

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1 Q. Are there meeting minutes for the Palm Beach
2 Health Network QMOR meetings?

3 A. I'm not positive.

4 Q. Did you review any QMOR meeting minutes in
5 preparation for your deposition?

6 A. I reviewed a lot of documents. I can't say
7 specifically if I reviewed them for this depo.

8 Q. Does Maggie Gill communicate directly with
9 Tenet Healthcare home office on behalf of what we're
10 calling the market, these five hospitals?

11 A. I can't speak to who Maggie communicates
12 with.

13 Q. Do you have regular meetings with Tenet home
14 office related to St. Mary's?

15 A. No.

16 Q. And Maggie reports to Lisa Foo, correct?

17 A. Correct.

18 Q. And Lisa Foo is at Tenet home office,
19 correct?

20 A. Correct.

21 Q. We talked about Regina West already. Do you
22 know what types of data she tracks for Palm Beach
23 Health Network?

24 A. I know some of the data she tracks.

25 Q. What is some of it?

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1 A. I know she tracks infections.

2 Q. Anything else?

3 A. CMS reported data.

4 Q. So that would be HCAHPS, for example?

5 A. Correct.

6 Q. And when you say "infections," is that HAIs?

7 A. Correct.

8 Q. Any other data that you know of that she
9 tracks?

10 A. Gina would probably be better to respond to
11 everything she tracks.

12 Q. But to the best of your knowledge, that's
13 the type of thing she tracks for the Palm Beach Health
14 Network as a whole, correct?

15 A. Correct.

16 Q. Do you know whether or not Gina West in her
17 role as the quality director for the public -- or Palm
18 Beach Health Network produces an overall hospital
19 safety plan for the network?

20 A. I'm not certain.

21 Q. Do you know whether or not these five
22 plaintiff hospitals coordinate their hospital safety
23 plan in any way?

24 A. I'm not certain.

25 Q. When putting together the hospital safety

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1 plan for St. Mary's, do you know whether or not
2 Gina West speaks to any of the quality directors at any
3 of the other four Palm Beach Health Network hospitals?

4 A. I do not know.

5 Q. Gina West would be the right person to ask?

6 A. Yes.

7 Q. Is Gina West responsible for collecting the
8 data that's reported to CMS on behalf of St. Mary's?

9 A. Not -- I don't believe she personally
10 collects it, no.

11 Q. Okay. And I guess I thought my question
12 was, but maybe it wasn't. Do you know if she's
13 responsible for the collection of data that gets
14 submitted to CMS on behalf of St. Mary's?

15 A. I know that the information goes through the
16 quality department. So is it Gina or one of her staff?
17 I don't know.

18 Q. Okay. Is Gina in charge of the quality
19 department for St. Mary's?

20 A. Yes.

21 Q. So regardless of who collects it, would you
22 consider Gina to be responsible for the submission of
23 the CMS data?

24 MS. MALONEY: Objection to form. Vague.

25 A. I guess it depends on what you mean by

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1 "submission."

2 BY MS. BLAIR:

3 Q. Sure. Is data submitted to CMS regularly?

4 A. Yes.

5 MS. MALONEY: Objection to form. Vague.

6 Just can we make -- are you talking about

7 St. Mary's, or are you talking about --

8 MS. BLAIR: St. Mary's, yes. St. Mary's. I

9 thought that was in my earlier question.

10 MS. MALONEY: No.

11 MS. BLAIR: "Is Gina in charge of quality

12 for St. Mary's," so we're talking about

13 St. Mary's.

14 BY MS. BLAIR:

15 Q. As the CEO of St. Mary's, how does data get

16 submitted to CMS?

17 A. My understanding is that it's electronic

18 based off of claims data, but that is about as much as

19 I could answer.

20 Q. Okay. Do you know if Gina is responsible

21 for checking the accuracy for St. Mary's of the CMS

22 data that's submitted?

23 A. Gina's department would be responsible.

24 Q. Do you know if St. Mary's has ever had

25 issues with the data being submitted to CMS being

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1 inaccurate?

2 A. That would be a better question for Gina.

3 Q. So you don't know as you sit here?

4 A. I don't want to give my opinion, not
5 factual, right?

6 Q. Yeah, I don't want an opinion. I'm just
7 asking, do you know whether CMS, there has ever been
8 issues -- so factually, not your opinion, do you know
9 if there's ever been issues with respect to the
10 accuracy of the data that St. Mary's has submitted to
11 CMS?

12 A. I am unaware.

13 Q. Derek Collins is the chief strategy officer
14 of Palm Beach Health Network, correct?

15 A. Correct.

16 Q. Do you know what his jobs are or his job
17 duties are? Excuse me.

18 A. Not fully.

19 Q. So what about generally?

20 A. So he would -- let me think what he would --
21 what Derek does. Derek would coordinate with
22 St. Mary's if we were looking to fill an unmet
23 community need for a physician, and he would help us
24 strategize whether we should relocate somebody or hire
25 someone, his team could pull the data on how many are

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1 in the community so that we could determine how to meet
2 community need.

3 Q. Does he produce a business plan for the five
4 hospitals that make up Palm Beach Health Network?

5 A. I don't know that I've seen a business plan.

6 Q. Is he involved in any way in analyzing the
7 competitive position of St. Mary's as compared to
8 competitors in the area?

9 A. He may be.

10 Q. And when you say "he may be," I want to know
11 whether you know.

12 A. Yeah, if there's data, it's really old. A
13 lot of publicly available data lags a year, year and a
14 half.

15 Q. Do you know whether or not Derek Collins has
16 ever produced any market positioning reports for
17 St. Mary's?

18 A. Not that I'm aware of.

19 Q. Do you know whether he's ever produced any
20 marketing position reports for Palm Beach Health
21 Network?

22 A. I'm unaware.

23 Q. Do you know whether or not Derek Collins has
24 ever produced any brand recognition documents with
25 respect to St. Mary's?

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1 A. I'm not aware.

2 Q. Are you aware of whether anybody has
3 produced any brand recognition documents related to
4 St. Mary's?

5 A. I don't recall.

6 MS. MALONEY: Objection.

7 A. I don't recall having seen any.

8 BY MS. BLAIR:

9 Q. Does Derek Collins provide any reports
10 related to benchmarking of any of the five hospitals
11 that make up Palm Beach Network as it compares to their
12 competitors in the market?

13 MS. MALONEY: Objection. Vague. Lacks
14 foundation.

15 A. I don't recall having that conversation with
16 Derek.

17 BY MS. BLAIR:

18 Q. In terms of Ricky Ramirez, he is the group
19 chief nursing officer for Palm Beach Health Network,
20 correct?

21 A. Correct.

22 Q. And generally speaking, can you describe for
23 me what you believe his job duties are in that
24 position?

25 A. So my belief of what Ricky would do, so, for

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1 example, I have a new chief nurse starting next week,
2 so I could pair my new chief nurse with Ricky so that
3 he could onboard her from a nursing executive
4 perspective to make her aware of any tools or
5 requirements in her nursing specific role.

6 Q. Okay. So I'm paraphrasing, but he would be
7 helpful in training a new chief nursing officer for
8 St. Mary's, correct?

9 A. Yes.

10 MS. MALONEY: Objection.

11 A. Yes.

12 BY MS. BLAIR:

13 Q. Does he have any involvement in the hiring
14 of nurse staffing for St. Mary's?

15 A. No.

16 Q. Does he have any involvement in creating any
17 plans for how to increase nurse retention at
18 St. Mary's?

19 A. Say the question again.

20 Q. Sure. Let me lay a little foundation.

21 Do you at St. Mary's, does St. Mary's have
22 any issues regarding retention of nurses?

23 MS. MALONEY: Objection. Lacks foundation
24 and vague.

25 A. We have a steady pipeline and a very robust

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1 recruitment and externship program.

2 BY MS. BLAIR:

3 Q. So you don't have nurse retention issues; is
4 that fair?

5 MS. MALONEY: Objection. Vague.

6 A. I guess it would need more color to it.

7 BY MS. BLAIR:

8 Q. Sure. Do you have a nursing shortage
9 currently at St. Mary's?

10 A. I would not say we're in a nursing shortage.

11 Q. In the last three years has St. Mary's ever
12 had difficulty keeping nurses employed at St. Mary's?

13 MS. MALONEY: Objection.

14 A. I would say in the COVID, post, immediate
15 post COVID, every hospital struggled with nurse
16 retention.

17 BY MS. BLAIR:

18 Q. That's a good point. So let's take 2023 to
19 present, has St. Mary's had nurse retention issues?

20 MS. MALONEY: Objection.

21 A. We have a fairly high -- what's the word --
22 rate of keeping our nurses, especially newer nurses.
23 Like our newer nurses, we have a 95 percent retention
24 rate, success rate.

25

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1 BY MS. BLAIR:

2 Q. And so Ricky Ramirez, getting back to
3 Ricky Ramirez, he doesn't really, at least for
4 St. Mary's, he doesn't have any involvement currently
5 in any nurse retention issues at St. Mary's; is that
6 fair?

7 A. Not overtly unless I included him within an
8 issue, which I don't recall.

9 Q. Do you know whether or not Ricky Ramirez has
10 dealings with nurse unions on behalf of St. Mary's?

11 A. I don't believe he does.

12 Q. Okay. And there is a nurse's union at
13 St. Mary's, correct?

14 A. There is.

15 Q. And what is the name of that union?

16 A. SEIU 1199.

17 Q. Does Palm Beach Health Network have an
18 overarching nurse training protocol for all five
19 hospitals?

20 MS. MALONEY: Objection. Lacks foundation.
21 Vague.

22 A. We have an education department that
23 provides ongoing education.

24 BY MS. BLAIR:

25 Q. And when you say "we," are you referring to

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1 St. Mary's?

2 A. Yes.

3 Q. And so my question is, in terms of the
4 Palm Beach Health Network, do you know whether the Palm
5 Beach Health Network has an education program for
6 nurses that funnels down into St. Mary's?

7 MS. MALONEY: Objection.

8 A. We have a market education, nurse education
9 person.

10 BY MS. BLAIR:

11 Q. And who is that, if you know?

12 A. I'm trying to think of her last name. I
13 know it, but I can't think of it. I will think of her
14 name. I would be embarrassed if she knew I couldn't
15 remember her name.

16 Q. We won't tell her.

17 A. I can't think of her last name.

18 Q. That's all right.

19 And that person would be at the St. Mary's
20 level, at the local hospital level?

21 A. Her office is at St. Mary's.

22 Q. Okay. But she works on behalf of the
23 Palm Beach Health Network?

24 A. Correct.

25 Q. Shannon Wills is the group chief human

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1 resources officer, correct?

2 A. Yes.

3 Q. Is Shannon Wills a man or a woman?

4 A. A girl.

5 Q. And is Shannon Wills involved in hiring of
6 nurses?

7 A. Not for St. Mary's.

8 Q. Okay. What do you understand Shannon Wills'
9 job responsibilities to be?

10 A. So she is the -- if I have a local chief HR
11 officer, if there is something that requires a next
12 level above with an employee issue, we could loop in
13 Shannon.

14 Q. Okay. And Shannon has nothing to do with
15 safety patient or quality; is that fair?

16 A. No, that's fair.

17 Q. And Lisa Cook is the marketing director for
18 Palm Beach Health Network?

19 A. Correct.

20 Q. And what do you understand Lisa Cook's
21 responsibilities to be?

22 A. My understanding is Lisa is primarily the
23 marketing person for Delray. I understand that Lisa
24 can also coordinate if there is an event that would
25 serve multiple hospitals to coordinate which marketing

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1 person should be at that event.

2 Q. Do you know if Lisa Cook had any involvement
3 with respect to the press surrounding this lawsuit?

4 A. I would have no idea.

5 Q. So we've talked about in terms of the
6 organization, St. Mary's is part of this market group,
7 the Palm Beach Health Network, correct?

8 A. Correct.

9 Q. And then the Palm Beach Health Network is
10 part of Tenet Healthcare overall, correct?

11 A. Correct.

12 Q. Do you have -- do you know what influence,
13 if any, the Tenet health network, so the parent
14 company, has over the operations of St. Mary's?

15 MS. MALONEY: Objection. Lacks foundation.
16 Vague.

17 A. No.

18 BY MS. BLAIR:

19 Q. So you were at St. Mary's in 2021, correct?

20 A. Correct.

21 Q. And in 2021, St. Mary's stopped
22 participating in the Leapfrog Hospital Survey, correct?

23 A. Correct.

24 Q. Do you know what -- why St. Mary's stopped
25 participating in the Leapfrog Hospital Survey?

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1 A. Yes.

2 Q. Why?

3 A. So Leapfrog is not a required or regulatory
4 survey. The facility does not participate in optional
5 surveys. It was also our feeling that Leapfrog, unlike
6 other surveys, that you apply and they come on site and
7 validate your responses, that, in our experience, is
8 not the method for Leapfrog. They -- you complete a
9 survey and submit it, and it's more of a trust but
10 verify.

11 Q. Okay. And I asked you that question in your
12 individual factual capacity. But in your corporate
13 capacity on behalf of St. Mary's why did St. Mary's
14 stop participating in the Leapfrog Hospital Survey in
15 or around 2021?

16 A. My answer would be the same. It's a very --
17 it's a 300-plus-page survey that takes a significant
18 amount of time to complete, and there is no onsite
19 validation by Leapfrog to validate that the person or
20 the facility submitting the survey -- there's no
21 validation, unlike a CARF survey or an ACS survey or a
22 Joint Commission survey.

23 Q. And Joint Commission, is that regulatory?

24 A. Joint Commission is -- the Joint Commission
25 for the accreditation on healthcare, they --

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1 I'm feeling a little -- a little
2 lightheaded.

3 Q. Oh, okay. Do you want to stop? Let's stop.

4 MS. MALONEY: Yeah, let's...

5 MS. BLAIR: Yeah, we can --

6 THE WITNESS: Yeah, I have a little stomach
7 thing going on.

8 THE VIDEOGRAPHER: Off the record, 10:48.

9 (A recess was taken from 10:48 a.m. to 11:35 a.m.)

10 THE VIDEOGRAPHER: This is media unit number
11 two. The time is 11:35. We're back on the
12 record.

13 BY MS. BLAIR:

14 Q. Ms. McCauley, are you feeling better?

15 A. Much better.

16 Q. Excellent. Thank you.

17 And I did not realize you were feeling ill
18 earlier. But is there any reason that you can't answer
19 my questions clearly and completely and truthfully
20 today?

21 A. No.

22 Q. Okay. Excellent.

23 So before the break we were talking about
24 the decision by St. Mary's to stop participating in the
25 Leapfrog Hospital Safety Grade. Do you recall that?

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1 A. Yes.

2 Q. And I think you gave me a complete answer to
3 that question, but I just want to go back and make
4 sure.

5 A. Okay.

6 Q. I asked you in your capacity as the
7 corporate representative of St. Mary's what was the
8 reason that St. Mary's stopped participating in the
9 Leapfrog Hospital Survey?

10 A. So --

11 MS. MALONEY: Objection. It's been
12 answered.

13 MS. BLAIR: I know, but I wasn't sure if I
14 got a complete answer, so since we had to go off
15 the record I want to make sure.

16 A. So St. Mary's made the decision to not
17 continue with the Leapfrog survey largely due to the
18 fact that we do not participate in elective
19 nonregulatory surveys, and Leapfrog in and of itself is
20 a survey unlike CARF, ACS, Joint Commission, et cetera,
21 where you complete the survey, and they come on site to
22 validate that what you said -- you know, they come and
23 they observe firsthand what's accurate. So that's a
24 little deeper -- different than our experience with how
25 Leapfrog has worked.

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1 BY MS. BLAIR:

2 Q. And at least in '19, '20 and '21, St. Mary's
3 did participate in the safety grade, correct?

4 A. Yes, we did.

5 Q. Did Palm Beach Children's Hospital -- you
6 know what? That was a bad question.

7 At least '19, '20 and '21 St. Mary's
8 participated in the hospital survey?

9 A. That is correct.

10 Q. Did Palm Beach Children's Hospital
11 separately participate in the Leapfrog Hospital Survey?

12 A. It's not a separate tax ID, so, no, any of
13 the results from the Leapfrog, from the earlier
14 Leapfrog surveys would have represented both St. Mary's
15 and the Palm Beach Children's Hospital, which is a
16 little unusual because I thought Leapfrog didn't survey
17 children's hospitals or oncology programs. But the
18 data that was submitted earlier would have been
19 encompassing of that.

20 Q. And I think we're talking about two
21 different things. So there's the hospital survey,
22 correct?

23 A. You're talking the Leapfrog survey?

24 Q. The Leapfrog Hospital Survey.

25 A. Correct.

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1 Q. And then there's the Leapfrog Hospital
2 Safety Grade, correct?

3 A. So Leapfrog assigns a safety grade.

4 Q. Correct. And in terms of the survey,
5 participating in the survey, St. Mary's participated in
6 the survey, correct?

7 A. St. Mary's participated in the survey, but
8 it would have been inclusive of any information from
9 the Palm Beach Children's Hospital.

10 Q. Okay. So when St. Mary's responded to the
11 survey, at least in '19, '20 and '21 when you were the
12 CEO of St. Mary's, you would have included information
13 in your survey answers for both St. Mary's as well as
14 the Palm Beach Children's Hospital?

15 MS. MALONEY: Objection. Mischaracterizes
16 her testimony.

17 A. They're not separately reported so it would
18 have been aggregate.

19 BY MS. BLAIR:

20 Q. In the survey response, correct?

21 A. Correct.

22 Q. Did you understand in between 2019 and 2021
23 that Leapfrog offered a hospital survey, not the safety
24 grade, the survey for pediatric hospitals?

25 A. I don't know that I was aware of that.

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1 Q. And you understand that Leapfrog does not
2 provide safety grades to pediatric hospitals, correct?

3 A. Correct.

4 Q. As the CEO of St. Mary's in your individual
5 capacity but as a CEO, what is the most important
6 principle of an acute care hospital?

7 A. I think the most important aspect would be
8 patient safety and quality.

9 Q. Do you define "quality" separate and apart
10 from patient safety?

11 A. In my -- in my view, patient safety is a
12 part of quality.

13 Q. And how do you define patient safety?

14 A. Patient safety would encompass doing right
15 thing at the right time at the right place for the
16 patient.

17 Q. And how is, in your opinion, quality more
18 all-encompassing than patient safety?

19 A. Quality would include different components,
20 would also include infection control, and I think it's
21 a little bit more, it could be viewed as a little bit
22 more overarching, but certainly patient safety is the
23 building block for quality.

24 Q. Okay. And would you agree with me that as
25 the CEO of St. Mary's, you would want patients to leave

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1 St. Mary's after being admitted in a better position
2 than they were when they came?

3 A. If that --

4 MS. MALONEY: Objection.

5 A. If that's medically possible, yes.

6 BY MS. BLAIR:

7 Q. Would you agree with me that it's important
8 to St. Mary's that the level of hospital-acquired
9 infections be as low as possible?

10 A. Agree.

11 Q. And when I say "hospital-acquired
12 infection," what do you mean that -- what do you think
13 I mean by that?

14 MS. MALONEY: Objection.

15 BY MS. BLAIR:

16 Q. Sure.

17 A. So when we -- when we refer to HAIs, that
18 would include CAUTI, CLABSI.

19 Q. C. diff?

20 A. C. diff, MRSA.

21 Q. SSI?

22 A. Yes.

23 Q. I just want to make sure. I'm saying
24 hospital-acquired infections, and I want to make sure
25 that we're understanding.

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1 And is it your understanding that that's how
2 CMS defines HAIs as well?

3 MS. MALONEY: Objection. Lacks foundation
4 and vague.

5 A. Scripturally, I don't know if that's how
6 they define it. I don't know that I've heard that
7 definition.

8 BY MS. BLAIR:

9 Q. Do you know if CMS provides empirical
10 reports with respect to CAUTI infections at hospitals?

11 MS. MALONEY: Objection.

12 A. Empirical reports?

13 BY MS. BLAIR:

14 Q. Yes.

15 A. I knew that we provide data to CMS.

16 Q. Correct.

17 A. Right.

18 Q. So CMS tracks data related to CAUTI,
19 correct?

20 A. Correct.

21 MS. MALONEY: Objection.

22 BY MS. BLAIR:

23 Q. And do you know as the CEO of a hospital
24 whether CMS tracks data on CLABSI?

25 MS. MALONEY: Objection.

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1 A. Yes.

2 BY MS. BLAIR:

3 Q. Same question with respect to SSI.

4 MS. MALONEY: Objection.

5 A. Yes.

6 BY MS. BLAIR:

7 Q. And what about C. diff, do you know as the
8 CEO of the hospital whether CMS tracks data related to
9 C. diff at St. Mary's?

10 MS. MALONEY: Objection.

11 A. I believe it's one of the data points.

12 BY MS. BLAIR:

13 Q. Do you know what I mean when I use the
14 expression "HCAHPS"?

15 A. Yes.

16 Q. And how do you, in your experience as the
17 CEO of a hospital, define HCAHPS?

18 A. HCAHPS is the patient's perception of the
19 care they received.

20 Q. And is it important to St. Mary's as the CEO
21 of St. Mary's, is it important to St. Mary's that
22 patients have high patient experience at St. Mary's?

23 A. Yes.

24 Q. And so to put it another way, patient
25 experience is important to St. Mary's, correct?

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1 A. Correct.

2 Q. Would you agree with me that it's important
3 that patients have information publicly available to
4 them related to HAIs at hospitals?

5 MS. MALONEY: Objection.

6 A. I believe the data is available to the
7 patients should they choose to go to the CMS website to
8 find it.

9 BY MS. BLAIR:

10 Q. And do you think it's important that
11 patients have access to that type of data?

12 A. Yes.

13 Q. And would you agree with me that it's
14 important that a governing board of a hospital have
15 information related to the hospital's HAIs?

16 A. Yes.

17 Q. And would you agree with me that it's
18 important to -- that a governing board of a hospital
19 have accurate and up-to-date information related to
20 HCAHPS for a particular hospital?

21 A. Yes.

22 Q. And would you agree with me that it's
23 important that the med exec have up-to-date and
24 accurate information related to HAI's?

25 A. Yes.

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1 Q. And also important that the med exec have
2 accurate and up-to-date information related to HCAHPS
3 at a particular hospital?

4 A. Yes.

5 Q. Would you agree with me that hand hygiene is
6 important to a hospital?

7 A. Yes.

8 Q. Do you know what I mean when I say CPOE?

9 A. Physician order entry.

10 Q. And St. Mary's has a computerized physician
11 order entry system, correct?

12 A. Yes, we do.

13 Q. And would you agree with me that it's
14 important that the computerized physician order entry
15 be fully functioning at a hospital?

16 A. Yes.

17 Q. Would you agree with me that the number one
18 error at a hospital is a medication error?

19 MS. MALONEY: Objection to form. Lacks
20 foundation.

21 A. I don't know that I have the expertise to
22 weigh in on that.

23 BY MS. BLAIR:

24 Q. Do you know at St. Mary's -- well, strike
25 that.

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1 In terms of your competitors in the
2 Palm Beach area who do you consider to be a competitor
3 of Good Samaritan?

4 A. Of Good Samaritan?

5 Q. I'm sorry.

6 A. Of St. Mary's?

7 Q. St. Mary's.

8 A. I would say Jupiter Medical Center.

9 Q. And how far away is Jupiter Medical --
10 Jupiter Medical Center from St. Mary's?

11 A. Probably a 15-minute ride.

12 Q. So I'm not from Florida. Is a 15-minute
13 ride 15 miles?

14 A. Could be.

15 Q. And why do you consider Jupiter to be a
16 competitor of St. Mary's?

17 A. I would consider Jupiter a competitor
18 because we share a lot of product lines.

19 Q. And what do you mean by "product lines"?

20 A. We both offer maternity services. We both
21 offer orthopedic services.

22 Q. So essentially you consider them to be a
23 competitor because of the type of service lines that
24 they offer which are similar to St. Mary's?

25 A. Correct.

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1 Q. Do you consider Good Samaritan to be a
2 competitor of St. Mary's?

3 A. No.

4 Q. Why not?

5 A. Good Samaritan has different product lines
6 than St. Mary's.

7 Q. Which different -- do you know what
8 different product lines it has, Good Samaritan has than
9 St. Mary's?

10 A. For example, Good Samaritan has oncology,
11 adult oncology.

12 Q. And St. Mary's does not have adult oncology?

13 A. St. Mary's does not have adult oncology.

14 Q. Does St. Mary's have pediatric oncology?

15 A. St. Mary's has pediatric oncology.

16 Q. Other than adult oncology, are there any
17 other differences in the service lines?

18 A. St. Mary's -- Good Sam --

19 Q. Now you're doing it.

20 A. Thank you.

21 Good Sam has women's services, a breast
22 center and a -- a line under oncology, so if you think
23 of, right, breast cancer, so they have a big women's
24 services diagnostic center, and St. Mary's does not.

25 Q. Okay. So oncology and the breast center are

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1 the differences?

2 A. Two of the key services that are different.

3 Q. Do you have services with Good Samaritan
4 that are the same?

5 A. Generic med/surg beds.

6 Q. How far away is Good Samaritan from
7 St. Mary's?

8 A. About three miles.

9 Q. Are there any other hospitals that you
10 consider a competitor of St. Mary's?

11 A. I mean, there's other hospitals in our
12 catchment area. Whether they're competitive, the
13 competitive nature more aligns with your product lines
14 that you share.

15 Q. And I've never heard that name, that phrase
16 before, so what do you mean by "catchment area"?

17 A. Catchment area is the population you serve.

18 Q. And how do you define St. Mary's' catchment
19 area?

20 A. So we define a PSA, a primary service area,
21 which is where 75 percent -- it's the zip codes from
22 which 75 percent of your patients come from.

23 Q. And are those the same zip codes where
24 Jupiter's population comes from?

25 A. There is definitively overlap.

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1 Q. And how do you know that?

2 A. Because some of our zip codes where our
3 patients come from is Jupiter --

4 Q. Okay.

5 A. -- and Palm Beach Gardens, like that area,
6 that geographic area.

7 Q. Well, do you consider Palm Beach Gardens to
8 be a competitor of St. Mary's?

9 A. Palm Beach Gardens Medical Center?

10 Q. Yes.

11 A. No.

12 Q. Why not?

13 A. Their -- again, their product line is
14 differently. Their principal product line is cardiac
15 and we don't have cardiac.

16 Q. Do you consider Baptist Health to be
17 competitor of your hospital?

18 A. No.

19 Q. What about HCA JFK?

20 A. HCA JFK, there's two of them. JFK main is
21 too far.

22 Q. What about the other?

23 A. JFK North, they are largely behavioral
24 health. We don't do behavioral health.

25 Q. What about Wellington, is that a competitor

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1 of yours?

2 A. It's really far.

3 Q. Okay. What's "really far"? How far?

4 A. If I was to drive to Wellington, it would
5 take me 40 minutes, give or take.

6 Q. Got it. What about Broward?

7 A. Oh.

8 Q. Too far?

9 A. Way far.

10 Q. Okay. Do you consider NYU Langone to be a
11 competitor of St. Mary's?

12 A. They don't have a freestanding hospital
13 here, so, no.

14 Q. So, no?

15 What about Cleveland Clinic Martin North
16 Hospital?

17 A. They are not a competitor.

18 Q. And why do you say that?

19 A. One is they're way too far. They are over
20 an hour away.

21 Q. So is it fair to say, and I'll just mark
22 this as Exhibit 3 --

23 (Defendant's Exhibit Number 3 for i.d.)

24 BY MS. BLAIR:

25 Q. So is it fair to say that Jupiter is the

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1 main competitor of Good Samaritan?

2 A. St. Mary's.

3 Q. St. Mary's.

4 A. Yeah.

5 Q. I'll do that all day.

6 St. Mary's.

7 And if you turn to page 20 -- first of all,
8 the document I just provided you is Plaintiff,
9 St. Mary's Medical Center, Inc.'s Amended and
10 Supplemented Responses and Objections to Defendant, The
11 Leapfrog Group's, First Set of Interrogatories to
12 St. Mary's Medical Center Inc.

13 Do you see that?

14 A. Yes.

15 Q. And I think if we turn to the very last page
16 of this document, which is the verification, is that
17 your signature on these documents?

18 A. That is.

19 Q. And if we turn to page 27, interrogatory 19,
20 this is one of the answers that was not amended. And
21 if you go to the very bottom where it says "answer,"
22 the question was, "Identify all hospitals, medical
23 centers or healthcare systems that you consider to be
24 your direct competitors within the relevant geographic
25 market."

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1 Do you see that question up there and it
2 goes on?

3 A. Yes.

4 Q. And as I read your answer, it says, "Jupiter
5 Medical Center is plaintiff's competitor."

6 Do you see that?

7 A. Yes.

8 Q. And that's still true today, correct?

9 A. Yes.

10 Q. Okay. Do you keep track of how many
11 patients get transferred from Good Samaritan to -- or
12 I'm sorry -- from Jupiter to St. Mary's?

13 I'm going to do that all day. I apologize.

14 Do you keep statistics of how many patients
15 are transferred from Jupiter to St. Mary's?

16 A. Yes.

17 MS. MALONEY: Objection.

18 BY MS. BLAIR:

19 Q. And do you, as you sit here today, do you
20 know how many patients in 2024 were transferred from
21 Jupiter to St. Mary's?

22 A. Approximately -- yes, approximately 500ish.

23 Q. And that was in 2024, correct?

24 A. Correct.

25 Q. And in 2025, do you know how many patients

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1 have been transferred to date from Jupiter to
2 St. Mary's?

3 A. I know we are estimating by year-end it
4 should be close to 600.

5 Q. And those are patients that have transferred
6 from Jupiter to St. Mary's, correct?

7 A. Correct.

8 Q. Does St. Mary's transfer patients to
9 Jupiter?

10 A. Unlikely.

11 Q. And why is that unlikely?

12 A. Because we have a very comprehensive medical
13 staff and can largely address the needs of the patients
14 presenting to St. Mary's.

15 Q. Do any of the other four hospitals that are
16 plaintiffs in this litigation regularly transfer
17 patients to St. Mary's?

18 A. I wouldn't have that knowledge.

19 Q. Why wouldn't you have that knowledge?

20 A. Because I don't research what my sister
21 facilities do.

22 Q. Okay. Does St. Mary's track how many
23 patients are transferred between the five hospitals
24 that make up Palm Beach Health Network?

25 A. We have -- we do have that data. I can't

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1 say that I can speak to it.

2 Q. Do you know who at Palm Beach Health Network
3 would track that data?

4 A. Yes.

5 Q. And who is that?

6 A. We have a transfer center.

7 Q. And so that transfer center is part of the
8 Palm Beach Health Network?

9 A. I'm not sure if it's a health network or I'm
10 not sure whose entity it is.

11 Q. Okay. It could be Tenet Healthcare?

12 A. I'm not certain.

13 Q. Other than transfers from Jupiter -- well,
14 strike that.

15 Is Jupiter the largest -- does Jupiter have
16 the largest amount of transfers to St. Mary's in a
17 given year?

18 A. Yes.

19 Q. Other than Jupiter transferring patients to
20 St. Mary's, what other hospitals transfer, regularly
21 transfer patients to St. Mary's?

22 A. I'd have to explore, but there are a lot of
23 hospitals that transfer patients to St. Mary's.

24 Q. And have you seen a decline in those
25 transfers from 2024 to 2025?

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1 A. From?

2 Q. The other, the non-Jupiter hospitals that
3 transfer.

4 A. I don't know that I've looked at that.

5 Q. Are you aware that Universal Health Services
6 is building a hospital in Palm Beach?

7 A. Yes.

8 Q. Would you consider Universal Health Services
9 to be a competitor of, once it's built, of St. Mary's?

10 A. Hard to project, but we will share some
11 product lines.

12 Q. Which product lines will you share, to the
13 best of your knowledge?

14 A. They will have an obstetrical program.

15 Q. Anything else?

16 A. As a general med/surg hospital they'll have
17 med/surg, OR, ER.

18 Q. The hospitals in Port Lucie --
19 Port St. Lucie, do you consider those competitors of
20 St. Mary's?

21 A. I consider them too far away to be
22 competitors.

23 Q. My apologies. I don't know the geography.
24 Do you have any information -- or strike
25 that.

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1 Does St. Mary's keep any statistical
2 information about whether or not admissions in its
3 hospital are down in the summer months due to the
4 migratory nature of a lot of the population here?

5 A. In my experience --

6 MS. MALONEY: Objection. Lacks foundation.
7 Go ahead.

8 A. In my experience, St. Mary's isn't really in
9 an area that's impacted by the snowbirds --

10 BY MS. BLAIR:

11 Q. Okay.

12 A. -- or the migratory, we call them snowbirds.

13 Q. And is that because most of the people in
14 the zip code that St. Mary's services live in Florida
15 year-round?

16 A. It's hard to say that they all live there,
17 but it's fairly steady, our patient base. I don't --
18 there's not huge fluctuations in our admissions.
19 There's no wild fluctuations.

20 Q. Okay. Do you know whether or not Palm Beach
21 Health Network keeps statistics like that in terms of
22 fluctuations at various times of the years on admission
23 rates for the five hospitals?

24 A. I would imagine that if they -- I would
25 imagine there would be information that they could look

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1 at admissions by month.

2 Q. But that's not something you regularly are
3 provided as the CEO of St. Mary's?

4 A. Not at all.

5 Q. Okay. How does St. Mary's benchmark itself
6 against its competitors in the area?

7 MS. MALONEY: Objection to form.

8 A. I think you'd have to describe for me what
9 "benchmark" means.

10 BY MS. BLAIR:

11 Q. Sure. Some of the other witnesses in this
12 litigation have talked about the fact that their
13 hospitals at least, I don't know about St. Mary's, use
14 Trilliant software to measure their competitive
15 positions relevant to various hospitals in the area.
16 Is that the same for St. Mary's?

17 A. I am less familiar with Trilliant.

18 Q. Do you know of any reports that are -- that
19 you are provided as the CEO of St. Mary's related to
20 the competitive positioning of St. Mary's?

21 A. If there are market comparisons, my
22 understanding is they're not timely, they lag six to
23 nine months, so in my perspective, I don't heavily rely
24 on them.

25 Q. And are those, the "them" that we're talking

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1 about, are those reports that would be put out by
2 Palm Beach Health Network?

3 A. If it was a report potentially produced by
4 the Palm Beach Health Network.

5 Q. But as you sit here today, you don't have
6 any direct recollection of what those reports are?

7 A. Correct.

8 Q. And so as you sit here today, you don't have
9 any information about whether or not St. Mary's' market
10 share has decreased from 2024 to 2025?

11 A. I have knowledge in my role as a CEO that
12 certain metrics that we track, for example, births,
13 have declined by 2 percent.

14 Q. Any other metrics that have declined?

15 A. Pediatric outpatient therapy has declined.

16 Q. Do you know the percentage?

17 A. Outpatient pediatric outpatient therapy has
18 declined 17 percent.

19 Q. Any other declines?

20 A. Emergency room volume is down.

21 Q. By how much?

22 A. From recollection, so not scriptural, ten or
23 so patients a day.

24 Q. Ten per day. And what reports do you look
25 at that are giving you this information regarding the

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1 declining births, pediatric outpatient therapy and
2 emergency room?

3 A. So the volume for ER therapy, those are part
4 of our monthly close process when the books are, when
5 we close our financials and we look at volumes.

6 Q. And so that's a monthly report that's
7 generated?

8 A. It's monthly, correct.

9 Q. And is that put together by the CFO of
10 St. Mary's?

11 A. Correct.

12 Q. Do you know whether or not the Palm Beach
13 Health Network looks at the decrease in those volumes
14 as a group?

15 A. I do not know.

16 Q. What other volumes does the monthly close
17 report track other than births, patient, pediatric
18 out -- pediatric outpatient therapy and ER volume?

19 A. It tracks, we said, admissions.

20 Q. Yes.

21 A. Patient stays.

22 Q. Patient stays meaning?

23 A. Patient stays, that's head in the bed at
24 midnight.

25 Q. Anything else?

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1 A. I think we said emergency room.

2 Q. Um-hum.

3 A. Surgery, number of surgeries.

4 Q. Is that down or up, or do you know?

5 A. Outpatient surgeries are down.

6 Q. By what percent?

7 A. I think it's 2 percent, but I wouldn't --

8 I'm not a thousand percent confident on the number.

9 Q. Anything else that the monthly close report
10 tracks?

11 A. Outpatient referred visits.

12 Q. And are those the type of reports you rely
13 on in your position in this litigation that the
14 Leapfrog Hospital Safety Grade has impacted your
15 hospital?

16 A. Yes.

17 Q. Is there a year-end report?

18 A. There -- yes.

19 Q. So there would have been a year-end report
20 for 2024?

21 A. There is a monthly report, and there would
22 be one produced in December that would encompass the
23 year.

24 Q. Is there a midyear report?

25 A. Not per se.

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1 Q. And does St. Mary's' fiscal year run from
2 January 1st through December 31st?

3 A. Yes.

4 Q. Have there been declines in revenue at
5 St. Mary's from 2024 to present?

6 A. We'd be relying on my memory to recall
7 revenues, but revenues aren't purely related to volume.
8 They could be related to contracting or payer mix, so
9 it's not necessarily an indicator.

10 Q. Yeah, but my question is just do you know if
11 revenue is down?

12 A. I'm not aware that revenue is down.

13 Q. Are you aware of any documents that
14 specifically set forth what the community perception
15 was of St. Mary's in or around the summer of 2024?

16 MS. MALONEY: Objection to form.

17 A. No.

18 BY MS. BLAIR:

19 Q. Did St. Mary's do any brand studies
20 regarding the perception of St. Mary's' brand in or
21 around the summer of 2024?

22 A. Not that I'm aware of.

23 Q. Just anecdotally as a -- as the CEO of
24 St. Mary's, do you have any view of what St. Mary's'
25 brand was in or around the summer of 2024?

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1 A. What do you mean by the question?

2 Q. Well, do you have any opinions about how the
3 community perceived St. Mary's in or around the summer
4 of 2024?

5 A. I believe the community trusted St. Mary's'
6 medical care.

7 Q. As the CEO of the hospital of St. Mary's and
8 in your capacity as a corporate representative with
9 respect to reputational harm, what are the things that
10 go into St. Mary's' brand?

11 MS. MALONEY: Objection to form. Vague.

12 A. I am not --

13 MS. MALONEY: Lacks foundation.

14 A. -- an expert in --

15 THE STENOGRAPHER: Sorry. I didn't hear the
16 last objection.

17 MS. MALONEY: Vague and lacks foundation.

18 A. I'm not an expert on brand and brand
19 awareness. That's not my expertise.

20 BY MS. BLAIR:

21 Q. Do you have any understanding of the fact
22 that community perception is part of St. Mary's' brand?

23 A. I would as a general layperson believe that
24 community perception is going to influence brand.

25 Q. Okay. But for purposes of this deposition

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1 and the -- you have no documents prior to fall of 2024
2 that show what the brand awareness was of St. Mary's?

3 A. Not that I'm --

4 MS. MALONEY: Objection.

5 A. -- personally aware of.

6 Can I run to the restroom?

7 Q. Of course.

8 MS. MALONEY: Yes.

9 (A recess was taken from 12:07 p.m. to 12:12 p.m.)

10 THE VIDEOGRAPHER: Back on the record,
11 12:12.

12 BY MS. BLAIR:

13 Q. Ms. McCauley, I want to go back to
14 St. Mary's' marketing budget quickly. I may have asked
15 you this before, so I apologize. Do you know what
16 St. Mary's' marketing budget is for St. Mary's?

17 A. The dollar?

18 Q. Yes.

19 A. No.

20 Q. Do you know is it a percentage of the
21 overall budget?

22 A. I don't believe so.

23 Q. Okay. Do you know if you share your
24 marketing budget with the other four hospitals that are
25 plaintiffs in this litigation?

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1 A. Each hospital stands independently.

2 Q. Do you know whether or not Palm Beach Health
3 Network has a separate marketing budget?

4 A. I don't know.

5 Q. Do you know prior to fall of 2024 whether
6 St. Mary's had any programs in place to increase its
7 patient experience scores?

8 A. We are continually trying to achieve our --
9 improve our patient experience scores.

10 Q. And why are you continually trying to
11 improve your patient scores?

12 A. Because I know we give an excellent clinical
13 outcome. We need the patients to feel that their
14 experience was as good as their clinical outcomes.

15 Q. Since January of 2025, have you -- has
16 St. Mary's put in any new programs to increase patient
17 experience scores?

18 A. What do you mean by "new programs"?

19 Q. Sure. For example, one of the hospitals has
20 hired a patient -- a patient experience champion. Has
21 St. Mary's done anything like that?

22 A. We've had a patient experience person, so,
23 no, we've not hired anyone new.

24 Q. Since your time at St. Mary's, you've always
25 had a patient experience person?

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1 A. Since before me.

2 Q. Do you know whether or not St. Mary's uses
3 Press Ganey in connection with its patient experience
4 scores?

5 A. Yes.

6 Q. Since January of 2025, do you know if
7 St. Mary's has involved Press Ganey any further in its
8 operations to increase patient experience scores?

9 A. I'm not certain that they've been -- that
10 they've done it further. Press Ganey has been a
11 patient satis -- the patients that send us surveys, and
12 we have access to them, so...

13 Q. Do you have any understanding that
14 Press Ganey offers consulting services for hospitals in
15 order to improve their patient satisfaction scores?

16 A. I'm not sure that I know that.

17 Q. And so is it fair to say you're not aware
18 that whether or not after January of 2025 St. Mary's
19 has engaged Press Ganey on any consulting services to
20 improve patient experience scores?

21 A. We have not.

22 Q. What is Dexur Insights, D-e-x-u-r, Insights,
23 do you know?

24 A. I have no idea.

25 Q. Does St. Mary's engage in any way with

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1 Dexur Insights, D-e-x-u-r?

2 MS. MALONEY: Objection.

3 A. I have no idea who they are.

4 BY MS. BLAIR:

5 Q. I understand that St. Mary's participates in
6 several Healthgrades® programs, is that correct?

7 A. We have been the recipient of Healthgrades®
8 awards.

9 Q. Is there survey that's completed in order to
10 earn these various Healthgrades® awards?

11 A. Not to my knowledge.

12 Q. And does St. Mary's pay for the
13 Healthgrades® badge in order to be able to advertise
14 it's Healthgrades® awards?

15 MS. MALONEY: Objection.

16 A. I believe we do have to license it.

17 BY MS. BLAIR:

18 Q. Do you know how much you pay for that
19 license?

20 A. No.

21 Q. Does your hospital participate in any
22 registries?

23 MS. MALONEY: Objection.

24 A. I believe the answer is yes.

25

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1 BY MS. BLAIR:

2 Q. Do you know which ones?

3 A. No.

4 Q. Do you know how much St. Mary's pays to
5 engage in those registries?

6 A. No.

7 MS. MALONEY: Objection. Lacks foundation.

8 BY MS. BLAIR:

9 Q. Do you know whether or not St. Mary's pays
10 for any accolades associated with those registries?

11 MS. MALONEY: Objection.

12 A. I'm unaware of which registries we may
13 participate in.

14 BY MS. BLAIR:

15 Q. Understood.

16 Does Palm Beach Health Network maintain any
17 metrics where it compares the five hospitals that make
18 up Palm Beach Health Network against each other in
19 areas related to patient safety?

20 A. Maybe. If that's the QMOR that I spoke
21 about. To the best of my knowledge, I haven't seen it
22 in a side-by-side comparison, but I have seen -- I can
23 see all five hospitals' data.

24 Q. Okay. And is there like a platform you go
25 on to see all five hospitals' data?

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1 A. As the CEO, I call my quality director who
2 produces it for me.

3 Q. Okay. And that quality director would be
4 Regina West, correct?

5 A. Right.

6 Q. Do you -- are you ever provided any reports
7 about how St. Mary's' patient experience scores compete
8 with Jupiter Medical Center?

9 A. Not to my knowledge.

10 Q. Do you track any metrics that compare
11 St. Mary's to Jupiter Medical Center?

12 A. No.

13 Q. Does St. Mary's in any way benchmark itself
14 against Jupiter in the area of patient safety?

15 A. No.

16 Q. Does St. Mary's use the Leapfrog Safety
17 Grade to benchmark itself against its competitors?

18 MS. MALONEY: Objection.

19 A. We don't utilize the Leapfrog Safety Grade
20 because we believe that it's misleading -- misguided
21 and unsafe and has particularly become more misguided
22 since they started imputing scores for the four -- four
23 particular metrics, CPOE, the barcode, intensive --
24 critical care and hand washing. So I don't believe
25 that there is validity in using that as a benchmark.

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1 BY MS. BLAIR:

2 Q. Okay. So is it your position as the
3 corporate representative of St. Mary's that St. Mary's
4 does not review its Leapfrog grades to benchmark itself
5 against its competitors?

6 MS. MALONEY: Objection. Vague. Lacks
7 foundation.

8 A. I do not use the Leapfrog score to bench
9 myself against the competitor because there's no way to
10 trust but verify that the data is a good and useful
11 tool since it's a self-survey without validation.

12 BY MS. BLAIR:

13 Q. And you understand that of the 22 measures
14 that are involved in the Leapfrog Hospital Safety Grade
15 for nonparticipating hospitals, four of those measures
16 come from the survey, correct?

17 A. There are four measures that are imputed and
18 another three that since we're not participating, those
19 scores get reallocated. So technically by not
20 completing the survey, there are seven metrics that we
21 are not responding to.

22 Q. Okay. Seven of the 22, correct?

23 A. Right. But somehow Leapfrog says if you
24 don't respond to six of them, we don't give you the
25 score. But we don't respond and we don't complete

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1 those seven, but we still get a score.

2 Q. Okay. And setting aside the other seven
3 measures, would you agree with me that the remaining
4 measures come from CMS data?

5 A. They do come from CMS data which lags about
6 a year and a half.

7 Q. Right. And that's because the publicly
8 available data from CMS lags, correct?

9 A. Correct.

10 Q. And we talked a little bit earlier, and you
11 said that if a patient wanted to look at your
12 hospital-acquired infections rates, they could go on
13 CMS, correct?

14 A. Correct.

15 Q. And if a patient went on CMS today to look
16 at those hospital-acquired infection rates, the
17 information they would be looking at would be lagging,
18 correct?

19 A. Correct.

20 Q. Is your participation in Healthgrades® in
21 any way tied to a contract for the hospital?

22 MS. MALONEY: Objection to form and lacks
23 foundation.

24 A. Not that I'm -- not that I'm aware of.

25

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1 BY MS. BLAIR:

2 Q. Does Healthgrades® visit your facilities
3 when it gives out these awards?

4 A. No, but I believe Healthgrades® pulls the
5 data from CMS or, right, from information that's
6 provided.

7 Q. And the data that Healthgrades® would be
8 pulling from CMS would also be that lagging CMS data
9 that we just discussed?

10 A. There is a better person who statistically
11 understands where exactly they're pulling their data.

12 Q. Okay. And who's that?

13 A. Gina West.

14 Q. Gina West.

15 Do you know whether or not the participation
16 in Healthgrades® by St. Mary's is approved by Tenet
17 home office?

18 A. Factually, no.

19 Q. What about not factually?

20 A. Well, Healthgrades® will give us awards, but
21 it's not as if we have to engage them to come and give
22 us an award.

23 Q. Okay. So tell me, in your -- what is your
24 understanding of how Healthgrades® works?

25 A. They pull data from publicly submitted data,

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1 and they look across all the hospitals in the
2 United States and glean quality metrics and benchmark
3 the hospitals, and based on that, St. Mary's has for
4 11 years gotten awards for c-section, vaginal
5 deliveries, hip, knee, stroke, so I cannot speak to
6 their metrics or what's behind it other than, you know,
7 we provide good quality care.

8 Q. And do you know whether or not when
9 Healthgrades® looks at these awards, they speak
10 directly with patients to come to -- in coming to their
11 conclusions?

12 A. I'm not certain.

13 Q. Do you know whether or not Healthgrades®
14 speaks directly to physicians when it comes to its
15 conclusions as to who should receive an award?

16 A. I'm not certain.

17 Q. Do you know whether Healthgrades® gives out
18 an overall patient safety award to hospitals?

19 A. I'm not sure.

20 Q. Do you know whether or not St. Mary's'
21 participation in Healthgrades® is tied to any local
22 regulatory requirements for the hospital?

23 A. Not that I'm aware of.

24 Q. Does St. Mary's have any awards from
25 U.S. News & World Report?

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1 A. Yes.

2 Q. Do you know what those are?

3 A. I know it, but I can't pull it to the top of
4 my head.

5 Q. Do you know whether or not St. Mary's pays
6 U.S. News & World Report for its logos in order to
7 advertise its status as an award wing U.S. News & World
8 Report hospital?

9 A. I --

10 MS. MALONEY: Objection.

11 A. I believe that's one that we do have to pay.

12 BY MS. BLAIR:

13 Q. And same with Healthgrades®, correct, we
14 talked about earlier?

15 A. Yes.

16 MS. MALONEY: Objection.

17 BY MS. BLAIR:

18 Q. Do you know whether -- do you know what
19 U.S. News & World Report looks at in order to come to
20 its conclusion as to what hospital should get what
21 award?

22 A. No.

23 Q. Do you know whether or not U.S. News & World
24 Report comes on site and does any sort of inspection to
25 make its decision about its awards?

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1 A. I'm unaware that they come on site.

2 Q. Do you know whether or not they speak with
3 any patients when coming to the conclusion about its
4 rankings?

5 A. No, I do not know.

6 Q. And do you know whether or not U.S. News &
7 World Report speaks to any physicians with respect to
8 coming to the conclusion about its rankings?

9 A. I'm unaware.

10 Q. When you became the CEO of St. Mary's in
11 2009, I think we already established this, but
12 St. Mary's was participating in the Leapfrog Hospital
13 Survey, correct?

14 A. That is correct.

15 Q. When you came on board as the CEO of
16 St. Mary's, did you have concerns at that time in 2019
17 about St. Mary's continuing to participate in the
18 Leapfrog Hospital Survey?

19 A. Not at that time.

20 Q. And why not?

21 A. At that time, I believe our grade was a B,
22 and a B would not give the public perception that we
23 are not a safety facility.

24 Q. During your time as the CEO of St. Mary's
25 from 2019 to 2021, did Leapfrog ever charge St. Mary's

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1 to participate in the survey?

2 A. My understanding is there's no fee to
3 participate in the Leapfrog survey.

4 Q. Between -- well, at any time since you've
5 been the CEO of St. Mary's from 2019 has St. Mary's
6 ever been approached by Leapfrog to pay for consulting
7 services by Leapfrog in exchange for better grades?

8 A. So during my time as the CEO at St. Mary's,
9 in regular email communication that we would get from
10 Leapfrog when they would announce their upcoming grade,
11 in my recollection, there is a portion of that email
12 that references that you can pay \$395 to get -- to go
13 to one of, I recall three different boot camps, and it
14 would discuss the survey, completing the survey and the
15 formulation of the grade. So those paid services are
16 available should you choose to avail yourself.

17 Q. Right. And do you have -- I understand how
18 you've described those services.

19 Were those services ever offered to you as
20 services to help you improve your safety score with
21 Leapfrog?

22 A. The offering does not specifically state
23 that, but there's no, you know -- a logical person
24 would not believe I'm going to pay 400, \$395 for these
25 services without an understanding that you would have a

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1 better knowledge on how to take the tool and ultimately
2 get a better grade.

3 Q. I think you testified earlier that the
4 survey is a little over 400 pages, correct?

5 A. Yeah, I printed it and I think it was over
6 300.

7 Q. And, as I understand from your Complaint,
8 the allegation is that filling out the survey is
9 onerous, correct?

10 A. Yes.

11 Q. And would you agree with me that it's very
12 detailed?

13 A. Having looked at it, it appears very
14 detailed.

15 Q. And would you agree with me that there is --
16 it's pretty dense in terms of the information that's
17 provided?

18 A. It's a thick binder.

19 Q. And, in fact, for example, on hand hygiene,
20 there's a lot of discussion about having 200
21 observations, correct, in order to get an achievement
22 score, correct?

23 MS. MALONEY: Objection.

24 A. So the hand hygiene speaks to -- speaks to
25 having a protocol, and there is a question on do you

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1 have -- do you have 200 observations. But, again, my
2 issue with the Leapfrog survey is nobody comes to
3 observe whether I actually do what I've said on the --
4 on the survey.

5 BY MS. BLAIR:

6 Q. Does your hospital fill out hand hygiene
7 observation logs on a monthly basis?

8 A. Yes.

9 Q. In terms of fees you just talked about, the
10 \$399 to go to a boot camp, you don't have any
11 understanding as to whether or not that is simply to
12 help guide first-time users in the survey through that
13 dense 385 process as opposed to paying for better
14 grades, correct?

15 MS. MALONEY: Objection to form. Lacks
16 foundation as to "first-time users."

17 A. The email that I recall does not
18 specifically say new to Leapfrog, need help, here's
19 what. It just is more of a blanket, attend one of our,
20 you can participate in one of our three boot camps, as
21 I recall, three --

22 I can't say if there's four, you know.

23 -- one of these three boot camps for \$395.

24 Here's how to reach us.

25

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1 BY MS. BLAIR:

2 Q. Do you understand that Leapfrog offers free
3 town hall meetings for hospitals to help them complete
4 the hospital survey?

5 A. I did see that on the email.

6 Q. Do you have any understanding as to whether
7 or not the \$399 service that you just discussed is
8 essentially the same as the free town halls that are
9 offered to hospitals?

10 A. I've never attended the boot camp or the
11 free, so I can't speak to it.

12 Q. But you have no knowledge as you sit here
13 today whether or not Leapfrog exchanges better grades
14 for payment; is that fair?

15 A. It would seem to me that if I were going to
16 engage with a consultant that the end goal would be to
17 improve my scoring on the survey. I believe -- I don't
18 believe otherwise that somebody would pay a fee to an
19 organization to get the same result.

20 Q. And I want to make sure we're talking about
21 the same thing. The email that you just told me about,
22 does it say "consultant services"?

23 A. It said -- it specifically called it "boot
24 camp."

25 Q. Okay. It didn't call it coaching services?

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1 MS. MALONEY: Objection.

2 A. I believe it called it a boot camp, but we
3 could go back. I'm sure we could find the emails.

4 BY MS. BLAIR:

5 Q. Okay. And you understand that there are
6 allegations in this Complaint that hospitals that
7 participate in the hospital survey pay Leapfrog for
8 better grades. Do you understand that's an allegation
9 in the Complaint you filed?

10 A. Yes.

11 Q. What -- and as the corporate representative
12 of St. Mary's, what facts is that allegation based on?

13 A. So I believe that because you can pay for
14 consultive boot camp advice and guidance, I believe
15 that they are -- you pay -- I think that there is an
16 incentive because you pay to use your grade, that that
17 is an inducement or an attraction for a facility to
18 engage with those services of Leapfrog in an effort to
19 get a better grade.

20 Q. Okay. And so you started that answer with,
21 "I believe."

22 A. Um-hum.

23 Q. So my question is, what facts do you have
24 that, in fact, Leapfrog exchanges money for better
25 grades with hospitals that pay them for a coaching fee?

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1 A. I don't believe there's anything in the
2 email that I've seen that says, "If you pay us, you
3 will get a better grade."

4 However, I do believe that with coaching,
5 that is the nature of coaching, that that is the
6 intent.

7 Q. Are you aware that there are hospitals that
8 participate in the survey that get D's?

9 A. I am.

10 Q. And so is it your position that those
11 hospitals that participate in the survey and get D's
12 are ones that haven't paid for this consulting fee, is
13 that your position in this case?

14 A. I can't make a broad base on the percent of
15 hospitals that participate in Leapfrog.

16 Q. Okay. But other than the emails that you
17 saw about the boot camp, there are no facts that you
18 have that support your allegation in this case that
19 hospital -- that, I'm sorry -- that Leapfrog charges
20 hospitals consulting fees in exchange for better
21 grades, correct?

22 MS. MALONEY: Objection to form.

23 A. I believe that if a facility wanted to
24 improve their scores, they would engage with the
25 consultant or the boot camp to try to elevate their

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1 scores.

2 BY MS. BLAIR:

3 Q. And I understand that's what you believe.

4 A. Right.

5 Q. I'm just asking about facts.

6 MS. MALONEY: Objection.

7 A. If -- do I believe that's written? No, I do
8 not believe that it's written.

9 BY MS. BLAIR:

10 Q. And have you ever looked at the boot camp
11 materials to make a decision, an educated decision
12 about whether that's actually what's happening, that
13 Leapfrog is taking consulting fees in exchange for a
14 better grade?

15 A. I have read the boot camp descriptions which
16 appear to go through the survey and speak to completing
17 the survey.

18 Q. Other than the descriptions that you
19 received in the emails, no other documents that you've
20 seen support the position that Leapfrog charges
21 consulting fees to hospitals for better grades,
22 correct?

23 A. Correct.

24 Q. In terms of when your hospital --

25 A. Can I ask a question?

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1 Q. Oh, no, I can't answer questions.

2 A. Can I clarify my answer?

3 Q. Oh, yes, of course.

4 A. Okay. Thank you.

5 I do know that for the hospitals that do
6 participate in Leapfrog, as we used to, that when I
7 provide my data to Leapfrog, I sign off saying that all
8 my data can be used by Leapfrog basically for whatever
9 commercial purposes they want, which could include
10 monetizing, increasing the financial performance of
11 Leapfrog, so there's like an attestation, you agree,
12 I'm going to give you all this data over to you and
13 use -- and you can use it however and for whatever you
14 want. And it does say that they -- they can -- they
15 can do with it as they want and they can monetize that.

16 Q. And the other thing that the attestation
17 says is that the information that you're providing to
18 the Leapfrog survey is true and correct, correct?

19 A. Correct.

20 Q. And at any time that you as St. Mary's
21 participated in the Leapfrog Hospital Survey, did you
22 ever provide incorrect data to Leapfrog?

23 A. We never provide incorrect data. But that
24 being said, the Leapfrog score imputes -- the Leapfrog
25 grade imputes scores, which I can say factually are

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1 incorrect. Particularly for the four measures, we
2 scored 60 out of 400 points when if Leapfrog were to
3 come verify my hand washing, my CPOE, my BCMA and my
4 intensive care staffing, I would get full credit for
5 those. So I, if I were to complete the survey, would
6 complete it honestly and truthfully, but I don't know
7 that that's reciprocated by Leapfrog, particularly
8 since the fall of 2024, because they are creating a
9 fiction about how I scored on certain metrics without
10 having knowledge.

11 Q. Okay. And I appreciate that and we'll get
12 into that, but that was not my question. My question
13 was about the attestation that you were just
14 discussing. One of the attestations says is that the
15 information you're providing to Leapfrog is true and
16 correct, correct?

17 A. Yes.

18 Q. It's not just about monetizing information,
19 is it?

20 A. It's not solely about that, but you are, you
21 have to validate that, attest that your data is
22 correct.

23 Q. Correct. And in all the time that you were
24 the CEO of St. Mary's and St. Mary's participated in
25 the Leapfrog program, was your hospital ever forced to

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1 pay Leapfrog for accolades?

2 MS. MALONEY: Objection to form.

3 A. No, that is an optional program that
4 Leapfrog offers that if you want to pay for any
5 licensing, marketing fee, then you can use your grade
6 for your marketing purposes.

7 BY MS. BLAIR:

8 Q. So other than these consulting services that
9 you believe hospitals pay for in exchange for better
10 grades and this sentence in the attestation that
11 Leapfrog may use data for commercial purposes, are
12 there any other payments that you believe Leapfrog
13 takes in exchange for grades?

14 MS. MALONEY: Objection.

15 A. In exchange for grades? As I mentioned, you
16 can pay to utilize the grade to market it, and you can
17 pay to do a boot camp with, I would say, a Leapfrog
18 consultant to assist you.

19 BY MS. BLAIR:

20 Q. And the allegation in this Complaint is that
21 Leapfrog engages in a brazen pay-to-play scheme. What
22 do you understand the word "brazen" to mean as you
23 allege it in the Complaint?

24 A. Brazen is, to me, means bold, and it is --
25 it's a bold, aggressive tactic to incentivize hospitals

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1 to pay to take the survey, engage in a boot camp by
2 their consultants and, in turn, pay to market their
3 grades.

4 You could pay, I think there's a leader
5 award you can pay to nominate your person, a person in
6 your facility to get a leadership award. You can pay
7 to sit on an advisory council -- to consult with
8 advisory council panel members four times a year. So
9 there's other opportunities that are pretty bold for
10 Leapfrog to earn revenues by a facility participating
11 in a voluntary unvalidated, you know, survey.

12 Q. Do you understand that HCA sits on -- you
13 refer to the advisory panel. Do you understand that
14 HCA sits on the advisory panel?

15 MS. MALONEY: Objection to form. Lacks
16 foundation.

17 A. And that's -- is -- is --

18 BY MS. BLAIR:

19 Q. Do you know that?

20 A. I don't know the members of the panel.

21 Q. Oh, okay. Okay.

22 Do you know how many hospitals sit on the
23 advisory, patient advisory committee for Leapfrog?

24 A. No.

25 Q. Do you know how much money Leapfrog makes

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1 from hospitals that sit on the patient advisory
2 committee?

3 A. No.

4 Q. Do you know what the hospital safety grades
5 are of any of the hospitals that sit on the patient
6 advisory committee of Leapfrog?

7 A. No.

8 Q. Do you believe that only A hospitals would
9 pay to sit on the patient advisory committee of
10 Leapfrog?

11 A. I can't speak to what any other hospital
12 would do.

13 Q. And I think you told me just a minute ago
14 that during the time in which St. Mary's participated
15 in the Leapfrog Hospital Survey, St. Mary's did not
16 inflate its responses to the hospital survey, correct?

17 A. Absolutely not.

18 Q. Do you believe that your -- that your
19 competitors inflate their grades or their -- I'm
20 sorry -- their survey response to Leapfrog?

21 A. I can't speak to what a competitor does.

22 MS. BLAIR: I'll mark this as 4.

23 (Defendant's Exhibit Number 4 for i.d.)

24 BY MS. BLAIR:

25 Q. Ms. McCauley, I've handed you now what we've

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1 marked as Exhibit 4. And this is the Amended Complaint
2 in this matter. Have you seen this before?

3 A. Yes.

4 Q. And you'll see at the very top here it was
5 filed on August 28th, 2025. Do you see that at the
6 top? It's like in this weird docket. It says docket
7 8-28-25 at the top.

8 A. Yes.

9 Q. And did you see this document before it was
10 filed?

11 A. Yes.

12 Q. And did you approve its filing as one of the
13 plaintiffs in this case?

14 A. Yes.

15 Q. And if we turn to paragraph 27 of this
16 Complaint, the second sentence, it says, "The data
17 provided by hospitals that do participate in the
18 TLG hospital survey is self-reported, biased and
19 subject to manipulation."

20 Do you see that?

21 A. Yes.

22 Q. And then it goes on, "Median responses for
23 hospitals that report their own scores show that those
24 hospitals inflate their performance."

25 Do you see that?

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1 A. Yes.

2 Q. And so is it your position in this
3 litigation that hospitals that do participate in the
4 survey inflate their performance?

5 A. It's my opinion that without a trust but
6 verify, someone coming to validate what I say, that you
7 can't -- you can't state that everyone is of the same
8 ethical beliefs as myself or my team that would report
9 our data accurately. I can't -- I can't speak. I do
10 believe when you take a self-test that no one is
11 checking, that it is subject to manipulation.

12 Q. This says, "Median responses for hospitals
13 that report their own scores show that these hospitals
14 inflate their performance."

15 And my question is, what facts do you have
16 that hospitals that participate in the Leapfrog survey
17 inflate their performance?

18 A. And my response to you is without a trust
19 but verify, an onsite validation, you can't validate
20 the inverse that they don't.

21 I believe that in a self-test people
22 typically will score themselves better generically than
23 perhaps the data would show.

24 Q. Okay. But you have no facts that hospitals
25 that report their own scores inflate their performance,

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1 correct?

2 MS. MALONEY: Objection.

3 A. I cannot say hospital X definitively did Y
4 because it's never been validated.

5 BY MS. BLAIR:

6 Q. And the only hospital that you can be sure
7 of is your own hospital, and you did not inflate your
8 numbers when you participated in the survey, correct?

9 A. That is correct.

10 Q. And do you understand that the previous
11 methodology, the spring 2024 methodology, this is
12 before the methodology changed, did you understand that
13 the imputation model at that time gave St. Mary's the
14 median score of self-reporting hospitals for the four
15 measures that are at issue in this litigation?

16 A. Yes.

17 Q. So did you understand in the spring of 2024
18 for CPOE, BCMA, ICU physician staffing and hand
19 hygiene, St. Mary's received 100 out of 100, 400 points
20 for all of those measures, based on how the
21 self-reported hospitals who are participating in the
22 survey were doing, correct?

23 A. Yes.

24 Q. And so if your statement is true that these
25 hospitals were inflating their performance, then also

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1 is it your position that the 400 out of 400 points that
2 St. Mary's was getting previously was overinflated as
3 well?

4 A. I would have to pull my data for those times
5 to respond.

6 But, for example, critical care staffing, I
7 know definitively we've had a critical care contract
8 with physicians for 24/7 coverage, so I can validate
9 factually that we should have gotten full credit for
10 that. I can't speak to the other three metrics off the
11 top of my head.

12 Q. Is it your position that to get 100 out of
13 100 points on ICU physician staffing on the Leapfrog
14 survey, you just have to have a contract in place?

15 MS. MALONEY: Objection.

16 A. We would have --

17 MS. MALONEY: Misstates her testimony.

18 A. We would have to go through the entire
19 manual on that section and see and add up every
20 question.

21 BY MS. BLAIR:

22 Q. And in order to provide information in this
23 litigation that your counsel refers to as "sufficient
24 to simulate," did you do that with respect to the ICU
25 physician staffing measure?

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1 A. Did I do what?

2 Q. Did you go through the survey and add up how
3 you did on each one of the survey questions?

4 A. I did review those survey questions. I did
5 not go and recalculate each score, no.

6 Q. And do you understand that in the fall 2024
7 methodology, we'll just stick with ICU physician
8 staffing, that hospitals that didn't participate were
9 now being given limited achievement scores for the four
10 measures that are at issue in this litigation?

11 A. Yes.

12 Q. And do you under --

13 MS. MALONEY: Objection. You.

14 Need to give me a second to object.

15 THE WITNESS: Yes, ma'am.

16 BY MS. BLAIR:

17 Q. Do you understand, do you have any
18 understanding of what "limited achievement" means in
19 the 2024 Leapfrog methodology?

20 A. Limited achievement is the lowest score
21 possible.

22 Q. Do you know -- so you don't know whether or
23 not limited achievement actually refers to the lowest
24 score that a participating hospital received for that
25 measure?

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1 MS. MALONEY: Objection. Misstates
2 testimony. Lacks foundation.

3 A. When I read, when I read through the myriad
4 of documents, what I saw was there, I believe, were
5 four categories that you could get. The lowest one was
6 limited.

7 BY MS. BLAIR:

8 Q. Correct.

9 A. Correct.

10 Q. But you could get a zero, would you not
11 agree with that?

12 MS. MALONEY: Objection.

13 A. I -- I don't know. What I saw in the
14 documents I read showed "limited."

15 BY MS. BLAIR:

16 Q. Okay. Do you know how, based on the
17 documents that you saw, that limited achievement score
18 is arrived at in terms of points assigned to it?

19 MS. MALONEY: Objection.

20 A. No.

21 BY MS. BLAIR:

22 Q. In the years that St. Mary's participated in
23 the Leapfrog Hospital Survey, did it --

24 And just the survey. I don't want to talk
25 about the hospital safety grade. Just the survey.

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1 -- did St. Mary's derive any benefit from
2 participating in the survey?

3 A. Hard for me to -- hard for me to assess,
4 especially during our COVID years which were the large
5 part of my early career.

6 Q. Prior to 2019 when you were the chief
7 administrative officer at St. Mary's, was St. Mary's
8 participating in Leapfrog Hospital Survey?

9 A. I believe so.

10 Q. Did you have any involvement with the
11 hospital survey, the Leapfrog Hospital Survey prior to
12 2019?

13 A. Not tangibly that I recall.

14 Q. What about intangibly?

15 A. I don't -- I don't recall it.

16 Q. Okay. Do you know whether or not at any
17 time that St. Mary's was participating in the Leapfrog
18 Hospital Survey it used the Leapfrog Hospital Survey to
19 benchmark itself?

20 MS. MALONEY: Objection. Asked and
21 answered.

22 A. Not that I'm aware of.

23 BY MS. BLAIR:

24 Q. Do you know whether or not St. Mary's'
25 decision to stop participating in the Leapfrog Hospital

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1 Survey was a directive from Tenet home office?

2 A. It's my understanding it was not a directive
3 from the Tenet home office.

4 Q. Do you understand that -- well, strike that.

5 Did you have any discussions between 2019
6 and 2021 with anyone at Tenet home office about
7 St. Mary's' participation in the Leapfrog Hospital
8 Survey?

9 A. Not that I recall.

10 MS. MALONEY: Objection to form.

11 THE WITNESS: Sorry.

12 BY MS. BLAIR:

13 Q. During the time in which St. Mary's
14 participated in the Leapfrog Hospital Survey, how many
15 hours were spent in completing the survey annually?

16 A. In my understanding from my quality director
17 at the time, it took her more than a full calendar week
18 to complete the survey.

19 Q. Did she do it alone?

20 A. I can't validate that.

21 Q. Do you know how many FTE's worked on
22 completing the Leapfrog Hospital Survey during that
23 time?

24 A. I can't factually tell you that.

25 Q. When the decision was made in 2021 to stop

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1 participating in the Leapfrog Hospital Survey, were
2 there any discussions with the St. Mary's' executive
3 team about the decision to stop participating?

4 Are you okay?

5 A. Um-hum.

6 Amongst -- did you say amongst the
7 St. Mary's.

8 Q. The St. Mary's team.

9 A. So amongst our team?

10 Q. Yes.

11 A. A limited amount of discussion, yes.

12 Q. And what do you recall about those
13 discussions?

14 A. I recall discussing, this was post COVID.
15 And as we were assessing the limited resources we have
16 and participating in a survey that's not required, not
17 regulated and not validated that we could better use
18 our staff's time towards other responsibilities.

19 Q. And when you say "not validated," what do
20 you mean by that?

21 MS. MALONEY: Objection.

22 A. Not validated is that no one comes on site,
23 like I said earlier, like in a CARF survey or ACS
24 survey to look at the survey and validate that what you
25 responded is true and accurate.

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1 BY MS. BLAIR:

2 Q. Okay. So when you say "validated," you mean
3 that there's no onsite review?

4 A. Correct.

5 MS. MALONEY: You want to take a break?

6 BY MS. BLAIR:

7 Q. You okay?

8 A. I'm okay.

9 Q. We'll get through it.

10 MS. MALONEY: Maybe at an appropriate time
11 we should take a lunch break.

12 MS. BLAIR: Yeah, do you -- yeah, maybe --

13 MS. MALONEY: So whenever you're ready in
14 terms of where you're going...

15 MS. BLAIR: We can do it now. Okay?

16 MS. MALONEY: Okay.

17 THE WITNESS: Yeah.

18 THE VIDEOGRAPHER: Off the record, 12:56.

19 (A recess was taken from 12:56 p.m. to 1:42 p.m.)

20 THE VIDEOGRAPHER: This is media unit number
21 three. The time is 1:43. We're back on the
22 record.

23 BY MS. BLAIR:

24 Q. Ms. McCauley, when you stopped, when
25 St. Mary's stopped participating in the Leapfrog

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1 hospital survey, did anybody at St. Mary's, to your
2 knowledge, reach out to Leapfrog about whether or not
3 they would continue to be graded now that they've
4 stopped participating in the survey?

5 A. I'm unsure.

6 Q. Did you understand when you stopped
7 participating in 2021 that Leapfrog graded all adult
8 acute care hospitals across the country regardless of
9 participation in the survey?

10 A. I actually believe that when we stopped
11 participating, we would no longer receive a letter
12 grade.

13 Q. Okay. And what was that belief based on?

14 A. It was based on my understanding that if you
15 don't take a survey, somebody can't say how did you on
16 the survey.

17 Q. Okay. But you didn't read any literature
18 from Leapfrog that said if you don't participate in the
19 survey, we don't grade you, correct?

20 A. Not that I recall, no.

21 Q. In the last year that St. Mary's
22 participated in the Leapfrog Hospital Survey how was
23 compliance handled?

24 A. What's the question?

25 Q. Yes. So was there somebody that was in

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1 charge of doing the survey and they would delegate
2 tasks to others underneath them? How was it
3 coordinated to respond to the survey?

4 A. So the survey was typically coordinated by
5 the director of quality. I can't speak to how she or
6 who she would have engaged or how she would have gotten
7 that task done.

8 Q. Okay. And then the last year that you
9 participated was 2021, correct?

10 A. Correct.

11 Q. Would that have been Gina West who was the
12 director of quality at that time?

13 A. No.

14 Q. Who would that have been?

15 A. It may have been Carola Kuret, but I'm not
16 positive if that's who was in the role at that time.

17 Q. And what year did Regina West become the
18 director of quality?

19 A. At St. Mary's, I believe Gina's been there a
20 year and a half.

21 Q. To date, she's been there a year and a half?

22 A. At St. Mary's.

23 Q. Okay. What about with Palm Beach Health
24 Network?

25 A. I'm not sure.

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1 Q. Do you know what hospital she was at before
2 she came to St. Mary's?

3 A. I believe Gina was at -- I'm not positive,
4 but if I venture a guess, she may have been at
5 Good Sam.

6 Q. But would you agree with me based on
7 documents that have been produced in this litigation
8 that Gina West was the director of quality in 2024?

9 MS. MALONEY: Objection. Lacks foundation.

10 A. If Gina has been there for a year and a
11 half, she should have been there in 2024. I don't
12 recall when she started.

13 BY MS. BLAIR:

14 Q. Do you recall how much St. Mary's budgeted
15 towards the Leapfrog completing the Leapfrog survey in
16 2021?

17 A. That's not how budgets are completed.

18 Q. Do you know how much -- well, how are
19 budgets completed, then?

20 MS. MALONEY: Objection.

21 A. So when you're completing a budget for a
22 department, you would budget for number of staff, not
23 for number of tasks.

24 BY MS. BLAIR:

25 Q. Was there -- after St. Mary's stopped

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1 participating in the Leapfrog survey, was the number of
2 staff in the quality department reduced?

3 A. I do not believe so.

4 Q. Do you know if there was a number one, two,
5 three of staff that were dedicated to complying with
6 the Leapfrog survey?

7 MS. MALONEY: Objection. Asked and
8 answered.

9 Objection. Lacks foundation and vague.

10 A. I said before I don't -- I know who
11 ultimately was responsible, but I don't know who
12 completed the survey.

13 BY MS. BLAIR:

14 Q. Okay. So as you sit here today, you're
15 unaware of whether there was a dedicated FTE to
16 completing the Leapfrog survey in 2024?

17 MS. MALONEY: Objection. Asked and
18 answered.

19 A. A FTE would imply 2,080 hours, so there was
20 not a 2,080-person -- 80-hour person designated for
21 this one task.

22 BY MS. BLAIR:

23 Q. Between when you stopped participating in
24 the survey in 2021 through fall of 2024, did St. Mary's
25 have any discussions with the governing board about

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1 participation in the Leapfrog Hospital Survey?

2 A. I can't recall.

3 Q. You have no recollection of a discussion?

4 A. I can't recall without looking at minutes.

5 Q. Between 2020 and the fall of 2024, what
6 discussions do you recall St. Mary's having -- and I'm
7 asking you this in your corporate capacity --

8 A. Um-hum.

9 Q. I'll ask this question as a corporate
10 representative. Between 2020 and 2024, what
11 conversations were had between St. Mary's and
12 Palm Beach Health Network regarding participating in
13 the Leapfrog Hospital Survey?

14 A. It's difficult to sit here and recount any
15 specific conversation from a year or five years ago.

16 Q. Okay. Are you aware that every safety --
17 every Leapfrog Safety Grade cycle, the Palm Beach
18 Health Network would ask each of the five hospitals for
19 their Leapfrog Hospital Safety Grades?

20 MS. MALONEY: Objection. Lacks foundation.

21 A. I'm not certain if I'm aware or not aware of
22 that.

23 BY MS. BLAIR:

24 Q. Okay.

25 MS. BLAIR: I'm going to hand you what we're

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1 going to mark as Exhibit 4. I think this is 4,
2 right, Barbie?

3 THE STENOGRAPHER: This is 5.

4 MS. BLAIR: 5. Apologize.

5 (Defendant's Exhibit Number 5 for i.d.)

6 BY MS. BLAIR:

7 Q. Have you seen this document before today,
8 Ms. McCauley?

9 A. I am copied on the email, so I would say,
10 yes.

11 Q. Who is Carola Kuret?

12 A. Carola Kuret was the quality director at
13 that time.

14 Q. And that time, according to this email which
15 is Bates numbered PBHN 6927 through 6930, was April of
16 2023, correct?

17 A. Yes.

18 Q. And do you see that she's sharing the
19 subject is "Spring forward, spring 2023 letter grade
20 embargo period opens today," do you see that?

21 A. Yes.

22 Q. Does this refresh your recollection that
23 St. Mary's was keeping track of its Leapfrog Safety
24 Grades in 2023 at least?

25 A. This indicates that Carola was monitoring

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1 the safety grade.

2 Q. Do you have any recollection that Tenet
3 health home office was asking that these safety grades
4 be monitored?

5 A. I don't have any knowledge -- any
6 recollection.

7 Q. Okay. We'll look at the next one, then.
8 This will be 6.

9 (Defendant's Exhibit Number 6 for i.d.)

10 BY MS. BLAIR:

11 Q. I'm now handing you what we've marked as
12 Exhibit 6 to the McCauley deposition. Do you see this
13 is an email from Satyavani Nukala to several people,
14 including yourself. The subject is spring 2023 letter
15 grade. Do you see that?

16 A. Yes.

17 Q. And if we look underneath, it's
18 Jennifer Hugh is sending an email to Bonnie, correct?

19 A. It appears that way.

20 Q. And she says "FYI"?

21 A. Yes.

22 Q. Who is Jennifer Hugh?

23 A. I have no idea.

24 Q. And Bonnie says to everybody, "Thank you for
25 forwarding the email, Jennifer." And the email is, in

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1 fact, if we turn to the next page, that is, in fact,
2 the St. Mary's Leapfrog grade from 2023, correct?

3 A. Correct.

4 Q. And who is Bonnie Nukala, if I'm saying that
5 correctly?

6 A. I do not know.

7 Q. You don't know who she is?

8 A. No.

9 Q. Okay. And you see it's here it says below
10 her signature she's a biostatistician of clinical
11 operations at Tenet Healthcare, correct?

12 A. That's what it says.

13 Q. But you don't know who that is?

14 A. No.

15 MS. MALONEY: Objection.

16 (Defendant's Exhibit Number 7 for i.d.)

17 BY MS. BLAIR:

18 Q. Mrs. McCauley, I'm handing you now what
19 we've marked as Exhibit 7 to your deposition Bates
20 labeled PBHN 6838 through 6840.

21 That top email in the first page is from
22 Jessica Miller to Regina West and yourself.

23 Do you see that?

24 A. Yes.

25 Q. The subject is "Leapfrog Preview Reports,"

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1 correct?

2 A. Yes.

3 Q. And it's dated October of 2023, correct?

4 A. Yes.

5 Q. And if you turn to the second page, you'll
6 see that there is score calculators from the Leapfrog
7 calculator attached, correct?

8 A. Yes.

9 Q. Did you ask Regina West to provide these
10 reports to you related to the Leapfrog Hospital Safety
11 Grade?

12 A. I don't recall asking Gina to do that.

13 Q. Okay. Did you look at these reports for any
14 particular purpose?

15 A. Not that I recall.

16 Q. If you see, who is Jessica Miller?

17 A. She was our CNO at the time.

18 Q. Okay. And the time being, again, October of
19 2023, correct?

20 A. Correct.

21 Q. And she's not the current CNO, correct?

22 A. She is not.

23 Q. And she -- if we look at Gina's email on the
24 bottom of the first page here, she says to Jessica and
25 yourself, "The Leapfrog fall 2023 preview reports are

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1 available. We won't know our letter grade until closer
2 to November. Based on the spring 2023 distribution
3 we'll likely land in the C category."

4 Do you see that?

5 A. Yes.

6 Q. Do you have any recollection of any
7 discussions you would have had with Ms. West and/or
8 Ms. Miller in or around October 2023 regarding the
9 Leapfrog Hospital Safety Grade?

10 A. I do not recall.

11 Q. And you don't recall, again, why you would
12 have been asking for these -- this information -- or
13 I'm sorry. You don't recall if you were asking for
14 this information, correct?

15 A. That's correct.

16 Q. And if we look at Jessica's email back she
17 says, "Thank you, Gina. We have the directors getting
18 their teams and processes geared to a renewed focus on
19 patient experience as we have plenty of opportunity."

20 Do you see that?

21 A. I do.

22 Q. Do you know what she's referring to when she
23 refers to patient experience?

24 A. I didn't write the email so I can't opine as
25 to what Jes thinking at the time.

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1 Q. Would you agree with me that HCAHPS are
2 patient experience scores.

3 MS. MALONEY: Objection. Asked and
4 answered.

5 A. Yes.

6 BY MS. BLAIR:

7 Q. And if we turn to the second page, when you
8 look at the measures that are listed, at least we'll
9 take that, the middle of the second page, do you see
10 where it says H-COMP 1, H-Comp 2, H-Comp 3, 5 and 6?

11 A. Yes.

12 Q. Is it your understanding that those are
13 HCAHPS scores?

14 A. Yes.

15 Q. Do you recall in or around October 2023 any
16 discussions you would have had with your quality staff
17 related to the need to improve patient experience
18 scores?

19 A. Not specifically, no.

20 Q. And if we look again, you were not
21 participating in or around this time, October 2023, you
22 were not participating in the Leapfrog Hospital Survey,
23 correct?

24 A. Correct.

25 MS. MALONEY: Objection.

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1 BY MS. BLAIR:

2 Q. And if we look at, again, that same chart we
3 were looking at in the middle of page 2, that first
4 line, computerized first order entry, CPOE, do you see
5 that?

6 A. Yes.

7 Q. Would you agree with me that's one of the
8 four measures that is at issue in this litigation?

9 A. Yes.

10 Q. And do you see right next to it, St. Mary's
11 was receiving 100 out of 100 points for that measure?

12 A. Yes.

13 Q. And you were receiving that perfect score
14 even though you were not completing the survey,
15 correct?

16 A. Yes.

17 Q. And that would be the same if we go to the
18 second row for BCMA right below, correct?

19 A. Yes.

20 Q. And the same for physician ICU staffing
21 right below that, correct?

22 A. Yes.

23 Q. And then if we look at hand hygiene, which
24 is like four rows down, again, St. Mary's is getting
25 100 out of 100 points on the Leapfrog Safety Grade in

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1 the fall of 2023 even though it's not participating in
2 the survey, correct?

3 A. Yes.

4 Q. And I asked you this earlier, but you don't
5 know as you sit here today how Leapfrog was calculating
6 that perfect score for St. Mary's in or around fall of
7 2023, correct?

8 A. That's correct.

9 MS. BLAIR: 8?

10 THE STENOGRAPHER: Yes.

11 (Defendant's Exhibit Number 8 for i.d.)

12 BY MS. BLAIR:

13 Q. Ms. McCauley, I'm now handing you what we
14 marked McCauley Exhibit 8. This is an email stream
15 with the Bates label PBHN 6765 through 6770. The first
16 email on the top is from Regina West to yourself dated
17 February 22nd of 2024. Do you see that?

18 A. Yes.

19 Q. And Regina says, the preview -- oh, I'm
20 sorry. The subject is "Hospital Safety Grade
21 Announcements." Do you see that?

22 A. Yes.

23 Q. And if you review this, does this document
24 reflect on page 6766 that she's referring to the
25 Leapfrog Hospital Safety Grade announcement?

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1 A. Yes.

2 Q. And if you look at the middle email from you
3 to Regina West, you say, "What do we estimate our grade
4 will be? Are we still a C or have we reclaimed our B?"

5 Do you see that?

6 A. Yes.

7 Q. Does this refresh your recollection that at
8 least in February of '24 you were monitoring your
9 Leapfrog Hospital Survey?

10 A. It indicates that I was curious what our
11 grade was.

12 Q. And then Gina responds to you in the first
13 email in this chain, correct, "Hi there. The preview
14 opens on the 26th, and we can see how we compare to the
15 current national averages to get an idea."

16 Do you see that?

17 A. Yes.

18 Q. And so does this refresh your recollection
19 that at least Gina was benchmarking St. Mary's'
20 performance against the current national averages?

21 A. I don't want to weigh in on what --

22 MS. MALONEY: Objection.

23 A. -- Gina may or may not have been focused on.

24 BY MS. BLAIR:

25 Q. Okay. Do you recall any conversation was

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1 Gina West in or around this time about using Leapfrog's
2 hospital safety grade to benchmark St. Mary's against
3 other hospitals in the nation?

4 MS. MALONEY: Objection. Lacks foundation.
5 Misstates the document and misstates testimony.

6 A. No.

7 BY MS. BLAIR:

8 Q. Thank you.

9 (Defendant's Exhibit Number 9 for i.d.)

10 BY MS. BLAIR:

11 Q. Ms. McCauley, I'm handing you what the court
12 reporter has now marked as McCauley Exhibit 9, which is
13 a document Bates labeled PBHN 12734 through 12736. Is
14 that the document you have in front of you?

15 A. Yes.

16 Q. And it is an email, the first page is an
17 email from Gina West to Jessica Miller and yourself
18 dated March 7th, 2024, correct?

19 A. The front page has an email from --

20 Q. Yes.

21 A. -- from Gina to Jes and myself, yes.

22 Q. Correct. And, again, the subject is "Spring
23 2024 Leapfrog Hospital Safety Grade review period now
24 open," correct?

25 A. Yes.

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1 Q. And Gina says, "We can't get too excited
2 about this. But if Leapfrog uses the same scoring as
3 fall 2023, SMMC is set to get an A this spring."

4 And then she says "What?!?!" et cetera.

5 Do you recall receiving this email in or
6 around March of 2024?

7 A. It's difficult to recall an email from a
8 year and a half ago.

9 Q. Does it refresh your recollection in any way
10 that St. Mary's was, in fact, monitoring the Leapfrog
11 Hospital Safety Grade?

12 MS. MALONEY: Objection --

13 A. No.

14 MS. MALONEY: -- to form. Lacks foundation.

15 BY MS. BLAIR:

16 Q. And then if we look at the email that starts
17 on the bottom of page PBHN 12735 and goes on to 12736,
18 this is an email, again, from Bonnie Nukala to several
19 people. And she says, "Hello, everyone. Good morning.
20 Leapfrog has released the hospital's preliminary
21 numerical score for 2024 spring safety grades. Please
22 share your preliminary score."

23 Do you see that?

24 A. I see that.

25 Q. Does that refresh your recollection in any

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1 way that, in fact, Tenet home office was asking
2 hospitals to share their Leapfrog scores with home
3 office in or around this time?

4 A. No.

5 Q. So I take it regardless of all of the emails
6 that I may show you, you just don't have a recollection
7 that in or around 2023 through the -- well, prior to
8 the fall of 2024 that St. Mary's was in any way
9 monitoring its Leapfrog Safety Grade?

10 MS. MALONEY: Objection. Lacks foundation.
11 Mischaracterizes her testimony.

12 A. So I can't say personally that I was
13 monitoring it, but there are emails evidencing that it
14 was shared with me.

15 Q. Right. But did you, as the CEO of God -- of
16 St. Mary's in or around this time, '23 and '24, was it
17 important to you at all what the Leapfrog Hospital
18 Safety Grade was for St. Mary's?

19 A. I know that Leapfrog was not a survey we
20 participated in, so I would imagine I still was curious
21 that we were getting a score, so it would not seem
22 unusual for me to be curious how they were scoring us
23 on a survey we didn't participate in.

24 Q. Okay. But it was your position in or around
25 that time that the score that was being generated would

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1 not have been accurate in terms of St. Mary's' actual
2 patient safety, correct?

3 MS. MALONEY: Objection.

4 A. At the time of this score, they were not
5 using imputed scores, so they were -- after the change
6 in methodology in the fall, the scores became grossly
7 inaccurate.

8 BY MS. BLAIR:

9 Q. Well, they were using imputed scores. They
10 were giving you 100 out of 100 for certain data,
11 correct?

12 MS. MALONEY: Objection.

13 A. They gave us 100 out of 100, but they did
14 not use a limited achievement for metrics that we are
15 achieving.

16 BY MS. BLAIR:

17 Q. Right. You got full achievement for those
18 measures that we're in litigation for before fall of
19 2024, correct?

20 A. It appears that way, yes.

21 Q. If we go back to the interrogatory answers
22 that I marked previously as an Exhibit, I think it's
23 number 2 perhaps, do you have that in front of you,
24 Ms. McCauley?

25 A. Yes.

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1 Q. Before we get to that, in 2023, was
2 St. Mary's measuring its CPOE compliance?

3 MS. MALONEY: Objection to form. Vague.
4 Lacks foundation.

5 A. I can't attest yes. I can surmise that
6 we've been tracking and trending for quite sometime.

7 BY MS. BLAIR:

8 Q. Okay. And CPOE is one of four measures that
9 is at issue in this litigation, correct?

10 A. Correct.

11 Q. And barcode medication administration prior
12 to the fall of 2024, was St. Mary's tracking its
13 compliance with barcode administration internally?

14 MS. MALONEY: Objection.

15 A. To -- to the best of my knowledge, that is a
16 metrics that's tracked.

17 BY MS. BLAIR:

18 Q. And in 2020 -- or prior to the fall of 2024,
19 was St. Mary's measuring its compliance with its hand
20 hygiene policy?

21 MS. MALONEY: Objection.

22 A. To the best of my knowledge, yes.

23 BY MS. BLAIR:

24 Q. And if we turn to that Exhibit and
25 particularly the answer to interrogatory 13, which is

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1 on page, starts on page 21, my apologies. And the
2 question is, "Describe any steps taken by your hospital
3 to improve any and all the patient safety measures
4 considered by Leapfrog's Hospital Safety Grade."

5 Do you see that?

6 A. Yes.

7 Q. And if I look at your answer, and I just had
8 a question about your answer, the amended answer,
9 excuse me, with after the objection starts, the last
10 paragraph on page 22, it says, "Plaintiff tracks three
11 of these metrics through its safety" -- "patient safety
12 plan or as part of its quality improvement."

13 Which three is that referring to?

14 A. It is referring to hand washing, barcode
15 administration and CPOE.

16 Q. Okay. And it's not referring to ICU
17 coverage because the last sentence says, "Plaintiff has
18 24/7 ICU coverage for its intensivists unit and has had
19 that coverage for several years," correct?

20 A. Correct.

21 Q. And so you still track that, though, right,
22 the ICU coverage?

23 MS. MALONEY: Objection.

24 A. Define what you mean "track that."

25

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1 BY MS. BLAIR:

2 Q. Well, this says that there's a contract --
3 let's lay some foundation.

4 You have a contract in place, St. Mary's
5 does for 24/7 coverage for the ICU, correct?

6 A. Correct.

7 MS. MALONEY: Objection. You need to slow
8 down.

9 THE WITNESS: I'm sorry.

10 MS. MALONEY: Okay?

11 THE WITNESS: Thank you.

12 MS. MALONEY: Thank you.

13 BY MS. BLAIR:

14 Q. And I understand that. But is there some
15 way in which St. Mary's measures that, in fact, there
16 is a specialty intensivist at the unit 24/7?

17 A. So there is a calendar that identifies which
18 intensivist is on which day.

19 Q. Okay. And so there's some tracking that
20 that person is on and did come to work and was covering
21 the shift, correct?

22 MS. MALONEY: Objection. Asked and
23 answered.

24 A. It's a calendar that would say Dr. McCauley
25 is here on Thursday, right, 7:00 A or I forget if they

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1 start 7:00 A or 8:00 A.

2 BY MS. BLAIR:

3 Q. So in terms of, so I want to start with
4 CPOE. How were you monitoring CPOE? And I'm asking
5 you this as the corporate representative of St. Mary's.
6 How was St. Mary's monitoring CPOE in -- or prior to
7 the fall of 2024?

8 A. The facility has a clinical informaticist, I
9 think is the title, that can run reports to track that
10 data.

11 Q. And who is the clinical informaticist of
12 St. Mary's, let's just say, from 2023 to present?

13 A. In 2023, it would have been
14 Barbara Greathouse, and mid 2023 to present is
15 Emily Fuentes.

16 Q. Do you know whether or not the informaticist
17 runs tests on the CPOE system to make sure that the
18 alerts are functioning properly?

19 A. I can't speak to that.

20 Q. Have you seen reports from your
21 informaticist regarding how many errors, if any, in
22 CPOE occur on a regular basis?

23 A. I can't recall reading that.

24 Q. Have you produced all documents in this case
25 to substantiate that St. Mary's was in compliance with

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1 Leapfrog's CPOE standard?

2 MS. MALONEY: Objection.

3 A. We complied with all the requests for
4 documents to the best of my knowledge.

5 BY MS. BLAIR:

6 Q. And there is an agreement that the hospitals
7 that are plaintiffs in this litigation would produce
8 documents sufficient to simulate how they would score
9 on the Leapfrog survey from fall of 2024 had they
10 completed that survey. And my question is specific to
11 that. Do you -- have you produced all of the documents
12 in this case that are sufficient to simulate how
13 St. Mary's would have done on Leapfrog's CPOE standard?

14 A. I would have to go through all the document
15 production.

16 Q. But you're confident that the documents were
17 compiled by your office?

18 A. I'm confident that if the document exists
19 that we would have complied.

20 Q. Would you agree with me that CPOE is
21 important to patient safety?

22 MS. MALONEY: Objection.

23 A. Yes.

24 BY MS. BLAIR:

25 Q. Barcode medication administration, how is

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1 that done at St. Mary's?

2 A. We have a computerized system, Omnicell,
3 where medications are secured.

4 Q. Is the BCMA system at St. Mary's linked such
5 that a nurse would scan a barcode on a medication, then
6 scan the wristband of a patient to make sure that they
7 were getting the right medicine at the right time?

8 MS. MALONEY: Objection. Lacks foundation.
9 Compound.

10 A. So I can speak higher level since I don't
11 perform that function, but, yes, there would be a
12 scanning of the patient's arm band and the scanning of
13 the drug. My understanding is when they scan the drug,
14 it speaks to the computer system that identifies that
15 that's a match. And then when they've identified that
16 that is the patient, the nurse would administer the
17 drug.

18 BY MS. BLAIR:

19 Q. Are there reports issued by St. Mary's that
20 set forth the rate of errors for BCMA at St. Mary's?

21 MS. MALONEY: Objection. Lacks foundation.

22 A. I am sure there are drugs [sic] that are
23 produced that monitor the safe administration of drugs.

24 BY MS. BLAIR:

25 Q. You said "drugs." I just want to clean that

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1 up.

2 A. Medications, pharmaceuticals.

3 Q. Yeah, and I just want you to be able -- you
4 said, "I'm sure there are drugs that monitor the safe
5 administration of drugs."

6 A. Oh. Okay.

7 Q. And I assume you meant there are "reports,"
8 correct?

9 A. Correct.

10 Q. Okay. I just want to make sure that we're
11 clear.

12 Do you know what the names of any of those
13 reports are?

14 A. I do not.

15 Q. Do you know if those are reports that have
16 been produced in this litigation?

17 A. If those reports were requested, I'm
18 confident the team would have produced them.

19 Q. As you sit here today, do you know what the
20 percentage of errors are, let's just say, for the year
21 2024 for BCMA for St. Mary's?

22 MS. MALONEY: Objection.

23 A. If -- if I knew that number, I can't recall
24 it.

25

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1 BY MS. BLAIR:

2 Q. Do you know whether or not St. Mary's
3 regularly runs tests on its BCMA system to make sure
4 that it is functioning appropriately?

5 A. I am confident that there are routine
6 protocols on how to ensure that our systems are working
7 appropriately.

8 Q. Do you know who runs those routine
9 protocols?

10 A. I could make a guesstimate.

11 Q. I don't want you to guess. Do you know how
12 often those routine protocols are run?

13 A. I do not know factually.

14 Q. Would you agree with me that proper barcode
15 medication administration is important to patient
16 safety?

17 A. Yes.

18 Q. Can you describe for me what St. Mary's'
19 hand hygiene policy was in 2024?

20 A. We don't have a unique hand hygiene policy.

21 Q. Okay. How was hand hygiene monitored in
22 2024?

23 A. In 2024, hand hygiene was monitored by
24 direct observation.

25 Q. And who's observing whom in that situation?

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1 A. A department director, a nurse leader can
2 observe. Members from infection control or quality
3 management can be involved in the team that's making
4 the observations.

5 Q. And how are those observations catalogued,
6 if at all?

7 A. They observe, and then they create there's a
8 paper where they mark if the individual followed the
9 World Health Organization procedure for hand washing
10 fully.

11 Q. And where are those logs stored?

12 A. I believe they're stored in a system called
13 AMP®.

14 Q. A-m-p?

15 A. I believe.

16 Q. Are there reports produced to you as the CEO
17 of St. Mary's regarding the outcome of those hand
18 hygiene observations?

19 A. I have seen a summarized report of
20 compliance.

21 Q. Do you know if that summarized report of
22 compliance has a name?

23 A. A specific name, no.

24 Q. How often do you get the summarized report
25 of compliance with hand hygiene as the CEO of

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1 St. Mary's?

2 A. The report is produced monthly.

3 Q. And you said earlier that St. Mary's does
4 not have a unique hand hygiene policy. What did you
5 mean by that?

6 A. They are -- it's not a policy called hand
7 hygiene.

8 Q. Okay. Is there a policy called something
9 else that covers hand hygiene?

10 A. There's a patient safety plan.

11 Q. And the hand hygiene policy is within the
12 patient safety plan?

13 MS. MALONEY: Objection.

14 A. The standards would be nested in there.

15 BY MS. BLAIR:

16 Q. And is the patient safety plan unique to
17 St. Mary's or is it a patient safety plan for Palm
18 Beach Health Network?

19 A. It is a St. Mary's plan.

20 Q. Would you agree with me that hand hygiene is
21 important for patient safety?

22 A. Yes.

23 Q. We talked a little bit about ICU physician
24 staffing. And I know that you have, I've seen it, a
25 contract, correct, for ICU physician staffing for 24/7

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1 coverage, correct?

2 A. Yes.

3 Q. And we talked about how you monitor, that,
4 in fact, there is actually a person on site, correct?

5 A. Yes.

6 Q. Have you produced that calendar that you
7 discussed that confirms that there is, in fact, an ICU
8 intensivist on staff 24/7 at St. Mary's in this
9 litigation?

10 A. I would have to check to see if that was a
11 document requested.

12 Q. What was your understanding of how the
13 prefall 2024 Leapfrog methodology scored
14 nonparticipating hospitals with respect to the four
15 measures that are at issue in this litigation?

16 A. Based on what I just reviewed with you,
17 they -- it appears that we received 100 in each of
18 those four categories.

19 Q. And I think we've already established this,
20 but you don't know how that 100 was calculated; is that
21 correct?

22 A. That's correct.

23 Q. And do you understand that three measures on
24 the Leapfrog Hospital Safety Grade nonparticipating
25 hospitals were not being graded on, they were just

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1 declined to respond?

2 A. There are three that, right, we, are
3 reallocated to other questions.

4 Q. Did you have an understanding that prior to
5 fall of 2024, the ICU physician standard measure was
6 already -- well, strike that.

7 What is your understanding of how the ICU
8 physician staffing measure was applied to
9 nonparticipating hospitals in the spring of 2024?

10 A. Based on what I've seen in the documents, we
11 were given 100 points.

12 Q. Do you have any understanding that even in
13 the spring of 2024 for a hospital that did not have
14 four, a survey within four rounds, they were being
15 given a 5 for ICU physician staffing even in the fall
16 of 2024?

17 MS. MALONEY: Objection.

18 A. I'm unaware.

19 BY MS. BLAIR:

20 Q. What was St. Mary's' Leapfrog grade in the
21 spring of 2024?

22 A. I'd have to go back and see. I believe it
23 was a C.

24 Q. Did you believe the grades that St. Mary's
25 was receiving -- well, strike that.

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1 Did you believe, yeah, did you believe the
2 grades that St. Mary's was receiving prior to the fall
3 of 2024 accurately reflected the hospital's patient
4 safety?

5 A. I didn't put any credence in the score
6 because it was a survey we weren't participating in.

7 Q. Okay. So you didn't have a --

8 A. Didn't have sentiment.

9 Q. Okay. Do you have any understanding as to
10 why Leapfrog changed its methodology for the fall of
11 2024?

12 A. I'm not -- I'm not certain, but I believe
13 that there was a motivation to have nonparticipating
14 facilities receive a lower score to try to encourage or
15 increase participation by all facilities across the
16 United States.

17 Q. And what is your belief based on?

18 A. My belief is based on some of the discovery
19 documents that I have read, and I do believe
20 Ms. Binder (phonetic) had indicated that in one of her
21 communications that it would be beneficial to Leapfrog
22 to increase participation in the survey to have
23 nonparticipating facilities not receive full credit for
24 the four scores that we've been discussing.

25 Q. Okay. And you refer to documents that

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1 you've seen in discovery in this case, correct?

2 A. Correct.

3 Q. So let me ask the question a little
4 differently.

5 Prior to filing the Complaint against
6 Leapfrog, what did you base your belief that the change
7 Leapfrog made in its methodology for the fall of 2024
8 was to increase participation by nonparticipating
9 hospitals?

10 A. Can you repeat that?

11 Q. Yeah. So your answer to me earlier was
12 based on documents you've seen in discovery in this
13 litigation, correct?

14 A. Yes.

15 Q. Did you hold that -- let me ask this. Did
16 you hold the same belief before you filed the
17 Complaint, that the reason for the change in the
18 Leapfrog methodology in fall of 2024 was to force
19 nonparticipating hospitals to participate in the
20 survey?

21 A. So prior to the fall of 2024 when we were a
22 C and prior to that a B, that was not -- would not have
23 the same perception of being viewed negatively by the
24 public as the majority of the hospitals in the market
25 were a C, so I didn't have to have as much concern

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1 about a survey that we weren't participating in and,
2 you know, getting a B or a C for.

3 Q. Okay. So prior to filing the Complaint
4 against Leapfrog, prior to filing the Complaint against
5 Leapfrog what was your understanding as to why Leapfrog
6 changed its methodology for fall of 2024?

7 A. My understanding is that Leapfrog changed
8 its methodology to be punitive to nonparticipating
9 hospitals.

10 Q. And what is that based on?

11 A. That is based on my understanding and based
12 on something that I read, be it online, that there was
13 a move by Leapfrog to increase participation and
14 changing the score, changing the grading methodology,
15 they could get more hospitals to want to electively
16 participate.

17 Q. Do you know prior to the fall of 2024 how
18 many hospitals across the country were voluntarily
19 participating in the Leapfrog survey?

20 A. No. I believe 20 percent are
21 nonparticipating, about 20 percent are
22 nonparticipating, so math would say 80 percent.

23 Q. Okay. And do you recall, you said, "That is
24 based on my understanding and based on something that I
25 read, be it online, that there was a move by Leapfrog

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1 to increase participation and changing the score..."

2 Do you recall what it was you read online?

3 A. I have read so many documents, I can't
4 recall specifically at this time.

5 Q. And I'm talking obviously prior to filing
6 the Complaint.

7 A. Um-hum.

8 Q. You read this prior to filing the Complaint?

9 A. Perhaps. I have read so many documents,
10 both in my role generically as the CEO. I read and
11 consume a lot of material, so it's very hard for me to
12 pinpoint a date on anything for you.

13 Q. Do you understand that in the summer of 2024
14 Leapfrog put out for public comment the changes it was
15 making -- it was going to be making to its methodology?

16 A. I don't recall that specifically.

17 Q. So you don't recall reading that prior to
18 filing the Complaint in this matter, correct?

19 A. I can't say if I do or I don't.

20 Q. But that isn't what you read that informs
21 your belief that there was a move by Leapfrog to
22 increase participation and changing the score, changing
23 the grading methodology they could get more hospitals
24 to want to electively participate?

25 A. I believe I said I can't remember tangibly

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1 where I gleaned that from.

2 Q. And I want to make sure. I'm trying to
3 refresh your recollection. Was that based on the
4 request for public comment by Leapfrog, that is,
5 informing your belief as to the reasoning why the score
6 was being, the methodology was being changed? Excuse
7 me.

8 MS. MALONEY: Objection to form.

9 A. I can't say that it was.

10 BY MS. BLAIR:

11 Q. Have you heard -- well, strike that.

12 In '20 -- in fall of 2024 what was
13 St. Mary's' CMS star rating, overall star rating?

14 A. 1.

15 Q. And what was its perception -- I'm sorry --
16 patient experience CMS rating?

17 A. A 1.

18 Q. And when we talk about the CMS patient
19 experience star rating, do you understand that that's
20 based on HCAHPS?

21 A. Yes.

22 Q. Do you know whether or not the information
23 that St. Mary's submits to CMS is for the adult acute
24 care center or for both the adult acute care and
25 pediatric center?

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1 A. I believe there is two different surveys,
2 one more pediatrics and one for adults.

3 Q. So the CMS data is, in your view, the CMS
4 data is divided between pediatrics and adults?

5 A. Yes.

6 Q. In 2024, did you have any discussions with
7 your governing board regarding St. Mary's' CMS ratings?

8 A. I can't recall.

9 Q. Do you recall if, as we sit here today,
10 whether or not St. Mary's' CMS ratings are important to
11 the governing board?

12 A. You can ask the governing board. They -- I
13 don't know that I've specifically asked that question
14 to them, but I could surmise for them.

15 Q. Has anybody ever raised it at a board
16 meeting, to your knowledge?

17 A. Not that I recall.

18 Q. Would you agree with -- would you agree with
19 me that patient experience scores are something that
20 St. Mary's could improve upon?

21 A. Yes.

22 Q. Do you recall if you had any discussions at
23 the med exec level about St. Mary's' CMS rating?

24 A. I don't recall having a specific
25 conversation about CMS ratings.

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1 Q. Do you recall anybody on the med exec ever
2 asking questions about St. Mary's CMS' star ratings?

3 A. I don't recall that.

4 Q. Do you share information with the med exec
5 regarding the St. Mary's' CMS star ratings?

6 A. We share information with the med exec. I
7 just cannot recall if I've shared our CMS star ratings.

8 Q. Do you recall whether you've shared the CMS
9 star ratings with the governing board?

10 A. I can't recall.

11 Q. Do you recall whether you've had any
12 discussions about patient experience scores with the
13 governing board?

14 A. Yes.

15 Q. What do you recall about the discussions
16 you've had about patient experience with the governing
17 board?

18 A. We have had a lot of education with the
19 governing board about patient experience. We have our
20 children's hospital has a 4.5 or 4.6 Google star rating
21 indicating strong satisfaction with the facility. And
22 the main campus has a 3.6 overall Google score.

23 Q. And so you as a hospital look more at the
24 Google ratings than the CMS patient experience scores?

25 A. I have focused on the Google scores because

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1 they are live real time every day available. If I
2 could expand --

3 Q. Of course.

4 A. -- the Press Ganey HCAHPS, we also
5 experience, it's sent to all inpatients within two days
6 of discharge. And unfortunately, we have a -- it's
7 done by mail in English or Spanish depending on the
8 patient's language. But we have an extremely high
9 return rate of undirected or misdirected mail because
10 many of our patients do not give us their correct
11 address.

12 Q. Okay. Do you know what percentage of
13 patient experience responses St. Mary's gets back?

14 A. Somewhere between 7, 8, 9 percent.

15 Q. And do you know what percentage of patients,
16 what percent of St. Mary's' patients leave Google
17 reviews?

18 A. I don't know if I could calculate -- I've
19 never attempted to calculate a percentage.

20 Q. So you don't know if it's higher or lower
21 than the percentage you're getting from CMS?

22 A. No, but I --

23 MS. MALONEY: Objection.

24 A. Yeah.

25 And I do think that the children's hospital,

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1 they get a different survey. I'm going through my
2 mind. It may be encapsulated in that score. They
3 don't get a separate score. It is a different survey,
4 though, but I'm trying to think of the results I've
5 gotten. The children's hospital scores may be nested
6 in the aggregate score, it's just a different survey
7 tool.

8 BY MS. BLAIR:

9 Q. Okay.

10 A. Which is, I -- I would -- I believe that's
11 the case, but I will need to trust but verify. I think
12 I said -- I think I said the opposite earlier, and I
13 don't know that that's correct.

14 Q. Would the best place be to confirm that with
15 CMS itself?

16 A. Well --

17 MS. MALONEY: Objection.

18 A. I -- I could confirm that either with my
19 patient experience manager, or there's probably many
20 ways I could confirm that.

21 BY MS. BLAIR:

22 Q. Prior to the fall of 2024 as the CEO of
23 St. Mary's what area or areas would you have considered
24 to be in the most need of improvement in terms of
25 patient safety or quality?

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1 A. I believe our greatest area of opportunity,
2 especially where we've seen marked improvement, has
3 been in our CAUTI rate.

4 Q. And for the record, CAUTI, what does CAUTI
5 stand for?

6 A. It's a UTI infection.

7 Q. And do you know -- and that is a rate that
8 CMS measures, correct?

9 A. Correct.

10 Q. And the publicly available data related to
11 the CAUTI rate is lagging; isn't that correct?

12 A. Correct.

13 Q. And so the data that you have is -- I
14 already asked the question about in 2024, correct?

15 A. I don't recall.

16 Q. I don't recall either.

17 Okay. Let me ask it again.

18 Prior to -- prior to the fall of 2024 what
19 area or areas did St. Mary's consider to be in need of
20 most improvement?

21 A. Correct. Our CAUTI rate needed improvement.

22 Q. Okay. And that was true whether we were
23 looking at the publicly available CMS data that was
24 lagging as well as the current data that you had in
25 your hands?

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1 A. So the data certainly from the publicly
2 reported data, which is a year and a half old, since
3 that time we have seen an improvement between 50 -- a
4 reduction between 50 and 60 percent in our CAUTI rate.

5 Q. And what do you attribute that to?

6 A. Our reduction in device days, so catheters.
7 Our reduction in device days, additional reeducation
8 and training of the nurses about how to insert and pull
9 out a catheter. We are working with our physicians.
10 Again, we can be assisting in education, observation,
11 validating that the device is needed.

12 Q. Do you recall any discussions at the
13 Palm Beach Health Network level regarding St. Mary's'
14 CMS ratings?

15 MS. MALONEY: Objection. Lacks foundation.
16 Vague.

17 A. Not specifically focused on CMS star
18 ratings.

19 BY MS. BLAIR:

20 Q. Do you recall whether there was ever any
21 meetings regarding the five hospitals that make up
22 Palm Beach Health Network related to steps that could
23 be taken to improve CMS star ratings?

24 A. Not that I recall attending.

25 Q. Do you think the CMS rating for patient

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1 safety is fair?

2 A. I mean, the patients -- the patient score,
3 it's based on our data, so it's not a -- it's not a
4 judgment. It's not subjective.

5 Q. But it's lagging, correct?

6 A. It is, at least for that time period.

7 Q. When is the first time that you learned that
8 the Leapfrog was changing its methodology related to
9 how it was going to score the four measures at issue in
10 this litigation?

11 A. I can't say when the first time was that I
12 learned about it. However, I'm sure I became more
13 acutely aware of it after our grades were published.

14 Q. After your grades were published?

15 A. After our grades were published.

16 Q. And are you aware that the fall, Leapfrog
17 fall safety grades for 2024 were published on
18 November 20th, 2024?

19 A. On or about.

20 Q. Were you involved in any -- were you,
21 Cynthia McCauley, involved in any discussions in or
22 around September of 2024 related to requests by
23 Gina West that the hospitals that make up the Palm
24 Beach Health Network be allowed by home office to
25 participate in the Leapfrog Hospital Survey for the

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1 fall of 2024 grading period?

2 MS. MALONEY: Objection to form.

3 A. I am aware that Gina has made that request,
4 had made that request.

5 BY MS. BLAIR:

6 Q. Were you aware of the request at the time it
7 was being made?

8 A. I'm not sure if I was aware at the time it
9 was made.

10 Q. So, and I'm just trying to -- if the first
11 time you came to understand that the methodology was
12 changed for fall of 2024 was after the grade came out,
13 what involvement did you have, if any, related to the
14 potential participation in the Leapfrog survey for fall
15 of 2024?

16 A. I don't believe that the participation or
17 nonparticipation in that was something that I said,
18 yes, participate or don't participate in that.

19 Q. Okay. Do you recall any conversations you
20 had with Gina West in or around September, October of
21 2024 about the fact that due to the change in
22 methodology St. Mary's' hospital safety grade would
23 more likely than not be lowered?

24 A. I don't recall any conversations, but if
25 there was email communication, then clearly I would

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1 have seen it.

2 Q. Yeah, and I'm just asking if you have any
3 recollection of conversations.

4 A. It was a year ago.

5 Q. Was there any --

6 MS. BLAIR: We'll mark this as --

7 THE STENOGRAPHER: This will be 10.

8 (Defendant's Exhibit Number 10 for i.d.)

9 BY MS. BLAIR:

10 Q. Ms. McCauley, I'm now handing you
11 Exhibit Number 10, which is an email from Regina West,
12 where the top email is from Regina West to
13 Ricardo Ramirez dated September 7, 2024. Do you see
14 that?

15 A. Yes.

16 Q. And if we go to the last, we'll go all the
17 way to the back as to how it starts, so the second to
18 the last page is where the first email in this string
19 starts from August 23rd, and it's from Anna Gunod,
20 G-u-n-o-d.

21 Do you see that?

22 A. Yes.

23 Q. Do you know who Anna Gunod is?

24 A. She's the national director for infection
25 prevention.

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1 Q. Okay. So she works for Tenet home office?

2 A. She does.

3 MS. MALONEY: Objection.

4 BY MS. BLAIR:

5 Q. And this email says, "Good morning, quality
6 leaders, I am doing an annual check-in on Leapfrog
7 participation. Please respond to this email with
8 answers to the following questions."

9 Do you see that?

10 A. Yes.

11 Q. And there is the "to" line is only to
12 DL-DCQI only. Do you see that?

13 A. Yes.

14 Q. Do you know if Regina West falls into the
15 DL-DCQI only email?

16 A. Gina is a DCQI, so she should, but I can't
17 say that she -- you know, DLs change all the time.

18 Q. And if we look one email up from that email,
19 Regina West responds and she says, "The hospital and
20 PBHN are not participating," correct?

21 A. Correct.

22 Q. And her signature line here is both as
23 St. Mary's CMS and PBHN market quality director,
24 correct?

25 A. Correct.

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1 Q. And then if we go to the next page, there's
2 another email at the top from Regina West dated
3 September 25th. You are not on this email so I'm not
4 suggesting you are.

5 But you see here Gina West is asking
6 Anna Gunod -- if I'm pronouncing that correctly -- "If
7 we would like to participate in the next survey, are we
8 able?"

9 Do you see that?

10 A. Yes.

11 Q. And then she says, "We have done this in the
12 past so it would not be new participation. Because we
13 aren't participating, we default to imputed scoring."

14 Do you see that?

15 A. Yes.

16 Q. Do you -- does this refresh your
17 recollection in any way -- and I know you're not on the
18 email -- about whether or not you had any conversation
19 was Gina West in or around the September 25th time
20 frame about your Leapfrog Hospital Safety Grade?

21 MS. MALONEY: Objection.

22 A. Not -- not tremendously, no.

23 BY MS. BLAIR:

24 Q. Okay. And if we go to the page before that
25 Anna Gunod writes back to Regina CC'ing others, "Hi,

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1 Gina, Leapfrog participation is not supported unless it
2 is directly tied to a payment/contract or local
3 regulatory requirement."

4 Do you see that?

5 A. Yes.

6 Q. Do you know, have you ever been told by
7 Tenet that participation in certain things is not
8 supported unless it is directly tied to
9 payment/contract or local regulatory requirement?

10 A. I don't know that I would ever be in a
11 position to have a conversation to ask that question.
12 That doesn't fall directly under my purview.

13 Q. Okay. And then if we go to the -- well,
14 then the next email at the top of that page Gina says,
15 back to Anna, "Although not supported, is it left up to
16 the lead" -- "to the local markets to decide or a
17 strict "'no' from HO?"

18 Do you see that?

19 A. Yes.

20 Q. And then on the front page Anna says, "It is
21 a no from home office."

22 Again, is it your understanding that whether
23 or not your hospital can participate in the Leapfrog
24 Hospital Survey is governed by Tenet home office?

25 MS. MALONEY: Objection.

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1 A. It's my understanding that it says, unless
2 it's tied to a payment contract or local regulatory
3 requirement, we are not participating.

4 BY MS. BLAIR:

5 Q. Okay. And then Regina West says to
6 Ricardo Ramirez, "Moving you in, HO is not allowing
7 participation in Leapfrog, but they continue to ask for
8 our scores."

9 Do you see that?

10 A. Yes.

11 Q. At any time did you have any conversations
12 with Ricky Ramirez regarding St. Mary's' request to
13 participate in the fall 2024 Leapfrog Hospital Survey?

14 A. Not that I recall.

15 Q. Do you know whether or not anyone on behalf
16 of St. Mary's or Palm Beach Health Network commented in
17 any way to the requests for public comment by Leapfrog
18 regarding the fall 2024 methodology change?

19 A. I do not believe anyone made public comment.

20 Q. So in light of fact that your memory as you
21 first came to understand the change in the fall 2024
22 methodology after the scores were issued, what is the
23 first conversation you recall having about the change
24 in the Leapfrog methodology?

25 MS. MALONEY: Objection.

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1 A. I apologize. It's very difficult for me to
2 recall specific conversations that are over a -- over a
3 year old.

4 BY MS. BLAIR:

5 Q. Okay. Then tell me generally what do you
6 recall about the discussions you had after the fall
7 2024 Leapfrog Hospital Safety Grade was released
8 regarding the Leapfrog change in methodology?

9 MS. MALONEY: Objection.

10 A. So I can't recall a specific --

11 BY MS. BLAIR:

12 Q. Understood.

13 A. -- conversation, but if it -- I would
14 imagine, and it would just be truly like this is not a
15 good place to to be, because I don't recall sitting
16 down and having a meeting to discuss Leapfrog grades.

17 Q. Okay.

18 A. Okay. So that's probably my -- my most
19 truthful answer to you.

20 Q. When was the first time someone from the
21 med exec brought to your attention the Leapfrog
22 Hospital Safety Grade from fall of 2024?

23 MS. MALONEY: Objection. Lacks foundation.

24 A. I don't know if it was somebody from
25 med exec that brought that to my attention.

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1 BY MS. BLAIR:

2 Q. Did anyone from the St. Mary's governing
3 board bring to your attention that St. Mary's was now
4 receiving a D in the fall of 2024 Leapfrog Hospital
5 Safety Grade?

6 A. I don't recall.

7 Q. Do you recall if anybody from med exec
8 brought to your attention that St. Mary's was now
9 receiving a D in the fall 2024 Leapfrog Hospital Safety
10 Grade?

11 A. Again, it's so long ago I do not recall.

12 Q. Do you recall who the first person was that
13 brought to your attention that St. Mary's was now
14 receiving a D for the fall of 2024 Leapfrog Hospital
15 Safety Grade?

16 A. Factually, I do not recall.

17 Q. So is it fair to say you never had -- prior
18 to the fall of 2024 safety grade being issued, you had
19 no discussions that you can recall about St. Mary's
20 participating in the Leapfrog Hospital Survey for fall
21 of 2024?

22 MS. MALONEY: Objection.

23 A. What I said is I don't -- I can't recall
24 specific conversations.

25

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1 BY MS. BLAIR:

2 Q. Right.

3 A. Right. I can't -- I cannot recall specific
4 conversations from a year ago.

5 Q. And I don't want to know about specific
6 conversations. I'm just asking time frame.

7 A. Um-hum.

8 Q. You don't recall any conversations with
9 anyone about participating in the Leapfrog Hospital
10 Survey for fall of 2024 prior to the fall 2024 grade
11 being issued, correct?

12 MS. MALONEY: Objection.

13 A. Your question is asking me to say, Cynthia,
14 did you and when was it, and I cannot in my mind, as I
15 sit here today, go back and say in August, in
16 September, in October, in whatever month I recall a
17 specific conversation.

18 BY MS. BLAIR:

19 Q. So we know that your grade fell to a D in or
20 around November 20th of 2024, correct?

21 A. Correct.

22 Q. We know that at least from the Exhibit we
23 just saw that Gina in September of 2024 was asking to
24 participate in the Leapfrog Hospital Safety -- Hospital
25 Survey for the fall 2024 grade, correct?

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1 A. Correct.

2 Q. And I'm just trying to get a generalized
3 time frame. Do you recall whether you had any
4 conversations prior to seeing that D grade about
5 potentially -- with anyone about potentially
6 participating in the Leapfrog Hospital Survey for the
7 fall 2024 grading period?

8 MS. MALONEY: Objection.

9 BY MS. BLAIR:

10 Q. Just generally.

11 MS. MALONEY: Objection.

12 A. And my response was, do I specifically
13 recall? No.

14 BY MS. BLAIR:

15 Q. Okay. So no recollection as we sit here
16 today?

17 MS. MALONEY: Objection. Asked and
18 answered.

19 A. No recollection that I can specifically
20 recall in my mind from a year ago a specific
21 conversation or a specific encounter.

22 BY MS. BLAIR:

23 Q. Okay. And then after the D grade comes out
24 in the fall of 2024 what is the first conversation you
25 recall having about the fact that St. Mary's received a

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1 D on the 2024 Leapfrog Hospital Safety Grade?

2 A. My challenge with your question and
3 answering it honestly is that I can't -- I can't
4 factually say X was the first conversation after
5 anything that happened a year ago, so I apologize for
6 not being able to give you a granular response. There
7 is too much that goes on on a daily basis in the world
8 to recall, at least for me, specific conversation and
9 timeline off the top of my head.

10 Q. And I'm not asking for granular.

11 A. Okay.

12 Q. I'm just saying what is the first time you
13 remember talking about, not a date, just what's -- I
14 mean, somebody called me. Just in the most general
15 terms, when do you first remember hearing about the
16 fact that your hospital got a D? You filed a lawsuit
17 about that day.

18 A. Right.

19 MS. MALONEY: Objection. Argumentative.
20 Objection. You are being specific. This is not
21 generalized. You're asking for the first time.
22 Objection. She has answered this multiple times
23 now.

24 MS. BLAIR: There's been no answer.

25 MS. MALONEY: At this point this is and

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1 argumentative to the witness.

2 BY MS. BLAIR:

3 Q. What is the first conversation? I don't
4 need to know granular.

5 MS. MALONEY: That is inherently a granular
6 question.

7 BY MS. BLAIR:

8 Q. You're here as a 30(b)(6) witness on this
9 topic, Ms. McCauley.

10 MS. MALONEY: Are you asking her as a
11 30(b)(6)?

12 MS. BLAIR: Yes.

13 MS. MALONEY: You certainly didn't establish
14 that either.

15 BY MS. BLAIR:

16 Q. As a 30(b)(6) witness when is the first time
17 St. Mary's had a conversation with anyone regarding the
18 D grade that they received in the Leapfrog fall 2024
19 hospital safety grade?

20 MS. MALONEY: Objection. Asked and
21 answered.

22 Objection. Argumentative.

23 BY MS. BLAIR:

24 Q. The answer is you don't know, right?

25 MS. MALONEY: Objection. Argumentative.

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1 A. I cannot factually tell you when, no.

2 There have been -- there has been a lot of
3 information, and I can't -- I can't factually recall
4 when and with whom, at what time, where. I don't have
5 that recall.

6 BY MS. BLAIR:

7 Q. Have you ever talked to your board about the
8 fact that Leapfrog -- that St. Mary's received a
9 D grade in fall of 2024 from Leapfrog?

10 A. Yes.

11 Q. Okay. What do you recall about the
12 conversations you had with your governing board about
13 the fact that St. Mary's received a D grade for the
14 fall of 2024?

15 A. So I recall presenting that we were scored a
16 D by Leapfrog.

17 I further went to educate them that this was
18 not a survey that we participated in, that
19 20 percent of the hospitals that across the states do
20 not participate in the Leapfrog survey.

21 I further educated the governing board that
22 it is a self-test. You complete it on your own, that
23 there is no validation, that there's no correlation to
24 the survey that we had in January by Joint Commission
25 or earlier in the year by ACF or by CARF or by any

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1 other survey, accredited regulatory survey body. So I
2 explained to our governing board the difference between
3 the elective Leapfrog survey that imputes scores as
4 compared to a Joint Commission survey, which many of
5 them participated in because they sat on the
6 leadership, or the American College of Surgery
7 Pediatric Verification or the DNV neuro stroke
8 certification or the CARF accreditation.

9 So it was my job as the CEO to educate them
10 why this survey that we don't participate what the
11 grade means.

12 Q. When did that meeting occur?

13 A. Oh, we'd have to look at which month that
14 was. I don't recall.

15 Q. How often does the governing board meet?

16 A. They meet monthly.

17 Q. Would you have told them in the first
18 meeting after the D grade came out?

19 A. We'd have to go back to the minutes.

20 Q. What was the reaction of the governing board
21 once you had that conversation with them regarding the
22 D grade that St. Mary's received for fall of 2024?

23 MS. MALONEY: Objection.

24 A. My opinion is that the board was surprised,
25 and many of them were uneducated about how Leapfrog

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1 imputes its scores.

2 BY MS. BLAIR:

3 Q. Did your governing board, to your knowledge,
4 did your governing board have an understanding of what
5 Leapfrog was prior to the meeting you had with them
6 educating them about the D grade that St. Mary's had
7 received?

8 A. I can't speak to individually what they know
9 or don't know.

10 Q. Prior to that meeting that you had with your
11 governing board where you explained to them the D grade
12 that St. Mary's had received, had you ever had any
13 other conversations at a governing board meeting about
14 Leapfrog Safety Grades?

15 A. In my six years, I would give you a definite
16 maybe.

17 Q. Do you have any specific recollection of any
18 conversations about Leapfrog?

19 A. No.

20 Q. Did you also have a meeting with your
21 med exec to talk about the D grade that St. Mary's had
22 received for fall of 2024?

23 A. Yes.

24 Q. Do you know when that meeting occurred?

25 A. I don't recall which month.

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1 Q. Do you recall what you told the med exec
2 about that?

3 A. I would have told the med exec similar to
4 what I just recounted that I would have told the
5 governing board.

6 Q. Do you recall whether you had any slides, a
7 slide deck prepared on this issue?

8 A. I would not have had a slide deck prepared
9 on Leapfrog.

10 Q. For either the med exec or the governing
11 board?

12 A. Correct.

13 Q. Do you need to take a break?

14 A. No. It's just a burp.

15 Q. Okay. And do you recall any meetings that
16 you would have had at the Palm Beach Health Network
17 level regarding the D grade that St. Mary's received
18 for the 2024 safety grade period?

19 A. I don't recall a meeting specifically
20 discussing St. Mary's' D grade.

21 Q. Did you ever have any telephone calls or
22 meetings with any of the CEOs of the other Palm Beach
23 Health Network hospitals to discuss the fall 2024
24 Leapfrog hospital safety grades?

25 MS. MALONEY: Objection to form.

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1 A. There may have been.

2 BY MS. BLAIR:

3 Q. Do you recall any?

4 A. Not factually.

5 Q. What do you mean when you say "not
6 factually"?

7 A. Because if you ask me that question, you
8 would then -- I would then say "When did that happen?"
9 And I would say, "I don't recall things from a year ago
10 without going back to my calendar and looking it up."

11 So -- so do I think it could have happened?
12 Yeah, I'm fairly confident. I'm fairly confident, not
13 maybe 100 percent but 99. I'm fairly confident there
14 must have been a conversation with the group where we
15 might have discussed it. But I can't recall
16 specifically that there was a meeting and an agenda
17 item and dialogue.

18 Q. Okay. So fairly confident there would have
19 been some discussions but no recollection of when,
20 where or with whom?

21 A. Right.

22 MS. MALONEY: Can we take a break pretty
23 soon at an appropriate time?

24 MS. BLAIR: Absolutely. We can take a break
25 now.

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1 THE VIDEOGRAPHER: Off the record at 2:59.

2 (A recess was taken from 2:59 p.m. to 3:42 p.m.)

3 THE VIDEOGRAPHER: Back on the record 3:43.

4 BY MS. BLAIR:

5 Q. Ms. McCauley, at some point in time are you
6 aware that these five hospitals sent a cease and desist
7 letter to Leapfrog?

8 A. Yes.

9 Q. And do you recall before that cease and
10 desist letter was sent there was some publicity about
11 the Leapfrog grades and these five hospitals?

12 A. I remember publicity by the news. I can't
13 recall the timing on both.

14 Q. Sure.

15 11.

16 (Defendant's Exhibit Number 11 for i.d.)

17 BY MS. BLAIR:

18 Q. Ms. McCauley, I'm handing you what we marked
19 McCauley Exhibit 11. It's Bates labeled PBHN 5141
20 through 5145.

21 Do you have that document in front of you?

22 A. Yes.

23 Q. And if you look at the first page of this
24 document, there's a letter -- or, I'm sorry -- an email
25 from Andrew Lofholm, do you see that?

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1 A. Yes.

2 Q. And for the record, again, who is
3 Andrew Lofholm?

4 A. He is the, let's see, the communications and
5 community relations manager.

6 Q. For the Palm Beach Health Network?

7 A. For the Palm Beach Health Network.

8 Q. Do you know is he associated with any
9 individual hospital as well?

10 A. Not uniquely, no.

11 Q. And his email is advising you and others
12 about a piece that was published in Stet news on the
13 Leapfrog rankings, correct?

14 A. Correct.

15 Q. And the date of this email is December 10th,
16 2024. Do you see that?

17 A. Correct.

18 Q. And the hospital safety grade was released
19 at the end of November of 2024, correct?

20 A. Correct.

21 Q. Does this refresh your recollection in any
22 way about any discussions you may have had with members
23 of the -- other members of the Palm Beach Health
24 Network regarding the Leapfrog Hospital Safety Grade in
25 or around this time?

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1 A. No.

2 Q. Do you recall any discussions specifically
3 about this Stet news article?

4 A. No.

5 Q. Do you recall any discussions you may have
6 had with the governing board of St. Mary's regarding
7 this Stet news article?

8 A. I don't recall raising this article
9 specifically to the governing board.

10 Q. Okay. Do you recall having any discussion
11 specifically about this article with the med exec of
12 St. Mary's?

13 A. I don't recall specifically presenting this
14 article.

15 Q. Okay. As you sit here today -- well, is
16 this one of the documents you reviewed prior to your
17 deposition to prepare for today?

18 A. There were a lot of documents. It could
19 have been in the binder.

20 Q. Do you recall seeing this article which is
21 entitled "Tenet Hospitals At Bottom of Local Safety
22 Grades" in or around December of 2024?

23 A. Not specifically.

24 Q. Okay. And I mentioned earlier the cease and
25 desist letter. Do you recall that that letter was

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1 September in January of 2025?

2 A. Yes.

3 Q. Were you involved with the decision in
4 sending that cease and desist letter?

5 A. Yes.

6 Q. And I don't want to know about any
7 conversations you had with your attorneys, but I'm
8 going to ask you, do you recall any conversations
9 outside the presence of your attorneys that you had
10 with anyone regarding your decision to send a cease and
11 desist letter to Leapfrog?

12 A. Not that I recall.

13 Q. Okay. You have no recollection of
14 conversations with the other CEOs of the Palm Beach
15 Health Network regarding the cease and desist letter?

16 A. No.

17 Q. Did you ever have any personal conversations
18 with Maggie Gill regarding the decision to send the
19 cease and desist letter?

20 MS. MALONEY: Objection.

21 A. Not specifically that I recall.

22 BY MS. BLAIR:

23 Q. Okay. Do you recall having any
24 conversations with your governing board about sending a
25 cease and desist letter to Leapfrog in or around

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1 January of 2025?

2 MS. MALONEY: Objection.

3 A. No, I believe my conversations, as I said,
4 with the governing board were more educational and
5 informative.

6 BY MS. BLAIR:

7 Q. Do you have -- do you recall having any
8 conversations with the med exec in or around January of
9 2025 regarding a decision to send a cease and desist
10 letter to Leapfrog?

11 A. No.

12 MS. MALONEY: Objection.

13 BY MS. BLAIR:

14 Q. Did you personally write this cease and
15 desist letter that was sent to Leapfrog?

16 A. No.

17 Q. Do you know if you made any edits to the
18 cease and desist letter that was written to Leapfrog?

19 MS. MALONEY: Objection. I think this is
20 getting into attorney-client privilege, this
21 question.

22 A. I don't --

23 MS. MALONEY: Before you answer, do you want
24 to recharacterize the question?

25 MS. BLAIR: Yes.

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1 BY MS. BLAIR:

2 Q. Do you recall outside the presence of your
3 attorneys and without the input of your attorneys, did
4 you provide any personal, did you, Ms. McCauley,
5 personally provide any edits to the cease and desist
6 letter that was sent to Leapfrog in or around January
7 of 2025?

8 MS. MALONEY: Objection.

9 A. I --

10 MS. MALONEY: Objection. That calls for
11 privileged information to the extent those edits
12 were seeking legal advice. If they were only
13 factual in nature, you may answer to the extent
14 you know.

15 A. I don't recall the specific letter and
16 whether I made any factual edits or not.

17 BY MS. BLAIR:

18 Q. Okay. Did your governing board vote, have
19 to vote to agree to send a cease and desist letter to
20 Leapfrog?

21 A. No.

22 Q. What was your -- what was the expectation of
23 St. Mary's as the corporate representative of
24 St. Mary's about sending a cease and desist letter, the
25 effect of sending a cease and desist letter to

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1 Leapfrog?

2 A. The goal of the cease and desist letter
3 is -- was to have Leapfrog remove the hospitals in the
4 Palm Beach Health Network from their published grades
5 because we didn't participate in the survey. And we
6 didn't feel that it was an appropriate reflection of
7 our score given the imputed methodology that was
8 changed in the fall of 2024.

9 Q. Was it to remove just the fall 2024 hospital
10 safety grade or all previous hospital safety grades?

11 A. I believe -- I would have to refresh my
12 memory specifically, but I thought it was to remove us
13 from the times that we did not participate.

14 Q. And was the expectation that you would not
15 be graded going forward as well?

16 A. Yes.

17 Q. When did St. Mary's make the decision to
18 file a lawsuit against Leapfrog?

19 A. Timing wise, I can't recall specifically,
20 but it was after the response from Leapfrog that they
21 disagreed with the cease and desist.

22 Q. So after Leapfrog's response to the cease
23 and desist letter, correct?

24 A. Correct.

25 Q. Did the governing board of St. Mary's vote

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1 to file a lawsuit against Leapfrog?

2 A. No.

3 Q. Is there a requirement that the governing
4 board vote to file a lawsuit against someone like
5 Leapfrog?

6 A. No.

7 MS. MALONEY: Objection.

8 BY MS. BLAIR:

9 Q. Was the governing board advised prior to the
10 filing of the lawsuit that the lawsuit was being filed?
11 Advised by you. I don't want to know about your
12 attorneys. Did you as the CEO of St. Mary's advise the
13 governing board of St. Mary's that the lawsuit was
14 going to be filed outside the presence of your
15 attorneys?

16 A. No.

17 Q. Why not?

18 MS. MALONEY: Objection.

19 A. There was no need for them to be advised in
20 advance.

21 MS. BLAIR: Am I on 12?

22 THE STENOGRAPHER: Yes.

23 (Defendant's Exhibit Number 12 for i.d.)

24 BY MS. BLAIR:

25 Q. Ms. McCauley, I'm now handing you what we've

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1 marked as Exhibit 12, which is an email from
2 Maggie Gill dated December 13th, 2024 to you and, it
3 appears to be, the other CEOs of the four hospitals
4 that are plaintiffs in this litigation as well as
5 Tyler Sherrill, Ricky -- Ricardo Ramirez, and then
6 CC'ing Shelly Weiss, Lisa Cook, Derek Collins,
7 Maria Morales and Michelle Cartwright, and the subject
8 is "Leapfrog."

9 Do you have that in front of you?

10 A. Yes.

11 Q. Do you have any recollection of seeing this
12 document in or around December 13th of 2024?

13 A. I am on the email so I'm certain I received
14 it.

15 Q. But do you have any specific recollection of
16 this email in or around December of 2024?

17 A. Honestly, I get 200 emails a day. It's hard
18 to remember any specific.

19 Q. Understood.

20 And if you look at Maggie's email, the
21 second email on the first page, which is December 11th,
22 2024, at 3:34 p.m., and she says "CEOs, we have gotten
23 several media inquiries about Leapfrog."

24 Do you see that?

25 A. Yes.

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1 Q. Had you in or around this time, December of
2 2024, you as the CEO of St. Mary's, had you received
3 several media inquiries about Leapfrog?

4 A. No.

5 Q. And if we look at the first email in this
6 string -- I'm sorry -- I guess it's the last email in
7 the string on PBHN 4565 she says, Maggie Gill says to
8 all of you, "All, I have spoken with several members of
9 ELT about this issue."

10 Do you see that?

11 A. Yes.

12 Q. Who is ELT?

13 A. Executive leadership team.

14 Q. And who do you understand makes up the
15 executive leadership team that she's referring to in
16 this email?

17 A. I would think Maggie would have to ask [sic]
18 who she spoke to.

19 Q. Okay.

20 A. Answer who she spoke to.

21 Q. Let me ask it another way.

22 Is ELT an acronym that you all use regularly
23 in Palm Beach Health Network?

24 A. I personally don't use ELT, but I can
25 translate what it means.

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1 Q. Okay. And I guess my question is ELT
2 referring to you as the executive leadership team or do
3 you know?

4 A. I'm not sure.

5 Q. Okay. And do you see the next sentence
6 says, "There are efforts underway to address Leapfrog's
7 ability to score us even though we don't participate."

8 Do you see that?

9 A. Yes.

10 Q. Do you know or have any recollection of what
11 Maggie Gill was referring to about the efforts underway
12 to address Leapfrog's ability to score us even though
13 we don't participate?

14 A. Specifically at that time, no.

15 Q. Okay. Do you recall asking her?

16 A. No.

17 Q. Do you recall if anyone that was on this
18 email responded to Maggie Gill's email?

19 A. I would imagine if anyone did, it would be
20 in the discovery. I'm sure I didn't.

21 Q. And do you see below again in the middle of
22 this page Maggie Gill, the email that's addressed to
23 CEOs, she says, "This is our statement. Feel free to
24 use it." And then it's in italicized. Do you see
25 that?

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1 A. Yes.

2 Q. Do you recall in or around December of 2024
3 whether you ever had occasion to use this statement
4 with respect to the publication of Leapfrog's 2024
5 hospital safety grades as it related to St. Mary's?

6 A. I can't recall if I ever had to use this.

7 Q. Do you know whether or not Regina West ever
8 had to use this statement with respect to inquiries
9 St. Mary's was receiving about its fall 2024 Leapfrog
10 Hospital Safety Grade?

11 A. I wouldn't know if Gina had to use it.

12 Q. If she had to use it, would she have CC'd
13 you on the email?

14 A. I don't know.

15 Q. Who is Heidi Zosiak?

16 A. Zosiak. She was my executive assistant.

17 Q. Okay. Outside the presence of your
18 attorneys, I don't want to know about any
19 communications you had with your attorneys or anything
20 they've done or shown you, but did you provide -- did
21 you have any discussions outside presence of your
22 attorneys with respect to the decision to ultimately
23 file the lawsuit on April 30th, 2025?

24 A. No.

25 Q. You don't recall any conversations you may

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1 have had with any of the other CEOs that make up
2 Palm Beach Health Network regarding the filing of the
3 lawsuit?

4 A. No.

5 Q. And you don't recall any conversations you
6 may have had with Maggie Gill outside the presence of
7 your lawyers about the filing of the lawsuit on
8 April 30th, 2025?

9 A. Not that I recall.

10 Q. Do you recall any conversations you had with
11 Regina West outside the presence of your attorneys
12 about the filing of the lawsuit which occurred on
13 April 30th, 2025?

14 A. Not specifically.

15 Q. What about generally?

16 A. I can't say I did or I can't say I didn't.

17 Q. Are you aware that Palm Beach Health Network
18 issued a press release related to the filing of the
19 lawsuit in this matter?

20 A. Yes.

21 Q. Did you review the press release before it
22 was sent out?

23 A. I don't believe I did.

24 Q. Did you have any -- I might have just
25 answered my own question. But did you have any

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1 involvement in drafting the press release that was sent
2 out?

3 A. No.

4 Q. Do you recall whether you had any inquiries
5 from anyone regarding the contents of the press release
6 after it was sent?

7 A. I don't recall.

8 Q. Do you recall if there was anything in the
9 press release that you disagreed with after you read
10 it?

11 A. Not that I recall.

12 Q. Do you know who drafted the press release?

13 A. Not specifically, no.

14 (Defendant's Exhibit Number 13 for i.d.)

15 BY MS. BLAIR:

16 Q. 13.

17 Ms. McCauley, I'm handing you what we've now
18 marked as Exhibit 13. And I'll submit to you that this
19 is a subpoena response from Boca News Now to a subpoena
20 that we issued in this litigation. And on the second
21 page of this Exhibit you'll see the heading "Palm Beach
22 Health Network Hospitals File Legal Complaint against
23 the Leapfrog Group."

24 Do you see that?

25 A. Yes.

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1 Q. Do you know who Rebecka Henrikson is?

2 A. No.

3 Q. Do you know what Scales Strategy is?

4 A. No.

5 Q. And do you see she says, "Hi, Andrew, I'm
6 reaching out on behalf of Palm Beach Health Network."

7 Do you see that, the first sentence in her
8 email?

9 A. I see that in the first sentence.

10 Q. But as you sit here today you have no idea
11 what her affiliation is with Palm Beach Health Network,
12 if any.

13 A. No.

14 Q. She goes on to say that "The five hospitals
15 filed a legal Complaint against The Leapfrog Group
16 alleging its patient safety ratings are inaccurate."

17 Do you see that?

18 A. Yes.

19 Q. And we've talked a lot today about your
20 thoughts on how the methodology is inaccurate, correct?

21 A. Yes.

22 Q. And then next word is "corrupt," do you see
23 that?

24 A. Yes.

25 Q. In what way do you believe that The Leapfrog

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1 Group is corrupt?

2 A. I believe it states that the Leapfrog safety
3 ratings are corrupt. I don't think it says that
4 Leapfrog is corrupt. But I think -- I believe that
5 what this statement says is that the patient safety
6 ratings are inaccurate, the patient safety ratings are
7 corrupt. The patient safety ratings are misleading.

8 Q. And in which way, in what ways are the
9 patient safety ratings corrupt?

10 A. The patient safety ratings, as we have
11 referenced, due to their imputed -- due to
12 nonparticipation, due to the assigning of scores to the
13 survey you haven't taken, I think they're corrupt
14 because they present a very fictitious representation
15 of hospital safety.

16 Q. So is that different than being inaccurate
17 or misleading?

18 A. I didn't -- I didn't write this article.
19 Ms. Rebecka did, so I guess you could ask Ms. Rebecka.

20 Q. And you think Ms. Rebecka wrote this?

21 A. Well, it says, "Hi, Andrew." "Best,
22 Rebecka."

23 Q. That's a good point.

24 But if we look down, though, it says, "You
25 can read" -- let's go right before it says "Best,

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1 Rebecka," it says, "You can read more about the filing
2 in the press release below."

3 Do you see that?

4 A. Yes.

5 Q. And do you understand that the press release
6 was issued on behalf of your hospital and the other
7 four plaintiffs in this litigation?

8 A. Yes.

9 Q. And is it your testimony that this press
10 release was authorized by St. Mary's and the other four
11 members of Palm Beach Health Network when it was
12 issued?

13 A. I believe it was authorized by the market on
14 behalf of the five hospitals, yes.

15 Q. Okay. And so we'll talk about the use of
16 the word "corrupt" down below in the actual press
17 release. It says -- where it starts "Palm Beach,
18 Florida April 30th, 2025," do you see that, bottom?

19 A. April 30th, yes.

20 Q. And the very last sentence on this page,
21 again, it says, "The organization's hospital patient
22 safety ratings are inaccurate, corrupt and misleading."

23 Do you see that?

24 A. Yes.

25 Q. Okay. So in your own press release it uses

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1 the word "corrupt." And you made a good point that up
2 above it is Rebecka's email, but here this is your
3 press release. So is "corrupt" different than
4 "inaccurate and misleading" in this sentence that's
5 contained in the please release your hospital issued?

6 A. I think each word individually has a
7 slightly different connotation.

8 Q. Okay. And "corrupt" has the connotation
9 that you described above with respect to
10 Ms. Henrikson's email, correct?

11 A. Yes.

12 Q. And then if we go to the second page, I want
13 to talk about the first full paragraph, the last
14 sentence, it says, "Leapfrog did not punish the
15 plaintiff" --

16 Are you there? Right here, this, the first
17 full paragraph at the top of the last sentence?

18 A. Okay. Yes.

19 Q. It says, "Leapfrog did not punish the
20 plaintiff hospitals for the past four years that they
21 did not respond to its voluntary data request until
22 last year when they changed their criteria to
23 deliberately fail nonparticipating hospitals."

24 Do you see that?

25 A. Yes.

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1 Q. Is it your position that all
2 nonparticipating hospitals get a failing hospital
3 safety grade?

4 A. I believe that all nonparticipating
5 facilities get imputed score which ultimately makes it
6 very difficult, if not impossible, to score an A
7 grading.

8 Q. But this says that "Leapfrog deliberately
9 fails nonparticipating hospitals."
10 Do you see that language?

11 A. Yes.

12 Q. Do you believe that nonparticipating
13 hospitals all receive failing grades?

14 A. I have not personally reviewed the grade for
15 every hospital in the United States, but I do believe
16 that the large preponderance of nonparticipating
17 facilities are unable to score an A.

18 Q. Okay. Are you aware that there are
19 nonparticipating hospitals that do receive an A?

20 A. I believe there could be, but I do not
21 believe that that is the norm.

22 Q. Okay. So the fact that this says that
23 Leapfrog deliberately failed nonparticipating
24 hospitals, that's not true, right?

25 MS. MALONEY: Objection.

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1 A. It doesn't say "deliberately failed all
2 nonparticipating hospitals."

3 BY MS. BLAIR:

4 Q. Okay. So the missing word is here, it
5 doesn't say "all"?

6 MS. MALONEY: Objection. Mischaracterizes
7 her testimony. Argumentative.

8 BY MS. BLAIR:

9 Q. If we go down to the fourth full paragraph,
10 it says, "Leapfrog's so-called grades are not grounded
11 in credible science or independent analysis."

12 Do you see that?

13 A. Yes.

14 Q. What is St. Mary's -- as the corporate
15 representative of St. Mary's, what are you referring to
16 regarding the methodology of Leapfrog and its not being
17 grounded in credible science or independent analysis?

18 A. I believe it's arbitrary. I believe there
19 was a statement from American Hospital Association that
20 indicated that people should not rely on Leapfrog's
21 safety grade to choose a facility, that there is no
22 strong correlation between that safety grade and a
23 high-performing facility. There have been several
24 different organizations that have reviewed and made
25 statements disputing the methodology of Leapfrog for

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1 trying to promote their safety grades and adding
2 credibility to them.

3 Q. Okay. And so that's basis for the statement
4 that the methodology is not based on any credible
5 science or independent analysis?

6 MS. MALONEY: Objection.

7 A. That is my belief.

8 BY MS. BLAIR:

9 Q. Okay. Are you aware of the fact that
10 Leapfrog has an independent expert panel for its
11 hospital safety grade?

12 A. Yes.

13 Q. Have you ever looked at who the members are
14 of that independent expert panel?

15 A. Not recently, no.

16 Q. You go on to say in this sentence, "They are
17 riddled with falsehoods, distorted by undisclosed
18 financial incentives."

19 What are the undisclosed financial
20 incentives you're referring to here?

21 A. So the undisclosed financial incentives for
22 Leapfrog is the greater the participation, as we
23 discussed earlier, if I am participating and get a good
24 grade, I can pay a licensing fee to Leapfrog, so
25 there's a financial incentive to Leapfrog to get me to

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1 participate, score, you know, perhaps take the boot
2 camp, get a good grade, and publish that.

3 There's incentives from Leapfrog to get me
4 to nominate one of my leaders for one of their leader
5 awards. There are financial incentives for -- by
6 Leapfrog for me to attend their quarterly advisory
7 chats.

8 So I don't think the public understands that
9 Leapfrog, although a not-for-profit, is a
10 revenue-generating organization that is certainly
11 motivated to increase revenues, generate revenues and
12 is not just a true credible science on what a safety
13 score for a hospital is.

14 Q. You worked at a not-for-profit at one point
15 in your career, did you not?

16 A. I did.

17 Q. Did that not-for-profit generate revenue?

18 A. They certainly did.

19 Q. So you don't have an issue with
20 not-for-profits generating revenue to keep their
21 mission going, do you?

22 A. No.

23 Q. And you keep talking about nominating
24 leaders for awards. What are you referring to there,
25 again?

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1 A. In some of the Leapfrog communications, in
2 one of the emails, they're very standard emails, they
3 talk about an award that you can nominate your -- a
4 team member for to get, I don't know if they call it --
5 I don't think it was called leader of the year, but I'd
6 have to go through the Leapfrog collateral. But they
7 have leader awards.

8 Q. And you believe you pay for those?

9 A. Um-hum.

10 Q. Are you aware of hospitals that receive A's
11 that don't do the boot camp that aren't on the advisory
12 council, that don't do these things and still receive
13 A's?

14 A. I, as I said earlier, have not looked at the
15 scores and investigated every hospital across the
16 country.

17 Q. You go on in this next paragraph, you say,
18 "Leapfrog aggressively pushes hospitals to pay for its
19 consulting services."

20 Do you see that?

21 A. Yes.

22 Q. How does it aggressively push hospitals to
23 pay for consulting services?

24 A. I believe on every quarterly information
25 that comes out, it encourages you to participate in one

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1 of those boot camps or speak with one of, engage with
2 one of their consultants about the scores, you know,
3 about their programs.

4 Q. So let's put that boot camp aside. Are
5 there any other consulting services that you believe
6 Leapfrog is offering to hospitals?

7 A. Those are the ones I'm most familiar with.

8 Q. The ones or the one?

9 A. Well, there's at least three boot camps.

10 Q. Okay. Are they the same boot camp?

11 A. There was three distinct ones.

12 Q. Oh. Because there's three distinct
13 programs, correct?

14 A. We could probably go through and find it.

15 Q. No, we'll find it. I'm just trying to
16 understand what you're referring to.

17 Okay. So these boot camps, other than the
18 three boot camps, anything else that you characterize
19 as consulting services?

20 A. That's my primary recollection.

21 Q. And the aggressive nature of that, as
22 referred to here, is the fact that there are emails
23 that come out during safety grade time about the boot
24 camps?

25 A. I would say there's other communications

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1 that come -- that comes from Leapfrog throughout the
2 year.

3 Q. Do you get calls from Leapfrog? Does
4 St. Mary's get calls from Leapfrog?

5 A. I personally don't, that I'm aware of.

6 Q. Do you know if anybody in your organization
7 gets calls from Leapfrog pushing these consulting
8 services for pay?

9 A. I'm unaware.

10 Q. And then you say here, this whole sentence
11 says, "Leapfrog aggressively pushes hospitals to pay
12 for its consulting fees and promotional licenses," and
13 then it says "in exchange for better grades." Do you
14 see that?

15 A. Yes.

16 Q. Is it your position in this litigation that
17 hospitals that participate in this boot camp get better
18 grades?

19 A. It is my belief if I attended one, two three
20 boot camps at \$395 a camp that ultimately the goal
21 would be to get a better grade.

22 Q. Well, isn't always the goal to improve your
23 patient safety?

24 A. Yes, but I believe that by learning how to
25 take the survey and answer it in a way that could drive

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1 your grade up.

2 Q. Oh, okay. So you believe these boot camps
3 are kind of giving the hospitals a cheat sheet that
4 helps them get better grades?

5 A. I have not attended a boot camp so I can't
6 speak to it. But I believe that if you were to go and
7 take one of the boot camps, it specifically says that
8 it will teach you about the scoring and the survey.

9 Q. And the scoring is free to access on the
10 website for anyone, correct?

11 A. Correct.

12 Q. And the survey is also free to access for
13 anyone on the website, correct?

14 A. Correct. But it's 300 plus pages that
15 they -- that the average person is not going to glean
16 through.

17 Q. Okay. And that's what I'm trying to say.
18 This says in exchange for better grades. So is it a
19 quid pro quo if you go to the boot camp, Leapfrog gives
20 you a better grade?

21 A. Do I think that it's automatic guaranteed?
22 I don't think it's automatic guaranteed.

23 Q. But in your mind Leapfrog is pushing,
24 Leapfrog aggressively pushes hospitals to pay for its
25 consulting services and promotional licenses, and you

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1 stand by that statement, right?

2 A. I believe there's a correlation.

3 Q. You believe there's a correlation.

4 So going to the next paragraph, it says
5 here, "The hospitals are taking legal action to expose
6 this scheme, protect patients and restore integrity to
7 the way healthcare information is shared in this
8 country," correct?

9 A. Correct.

10 Q. How is information related to patient safety
11 shared in this country?

12 A. The average consumer, educated consumer
13 could no to Medicare.gov.

14 Q. Does Medicare.gov have any statistics for
15 hospital's CPOE system?

16 A. I'm not certain.

17 Q. What about BCMA, does CMS have any
18 information on CMS?

19 A. I'm not certain.

20 Q. Do you know whether or not CMS shares any
21 information related to hand hygiene?

22 A. I'm not certain.

23 Q. Do you know whether or not CMS shares any
24 information related to ICU physician staffing?

25 A. I am sure it doesn't.

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1 Q. And so with respect to at least the four
2 measures that we're in this litigation about, how is --
3 how are we restoring integrity to the way we are
4 sharing patient safety information?

5 A. So Leapfrog holds itself out with a safety
6 score with imputed methods, imputed scores for
7 hospitals that do not participate, and it expressly
8 holds out that safety grade as a solid measure of a
9 hospital's safety.

10 So patients, the generic public, I believe,
11 is unaware, albeit the information could be buried
12 somewhere in the Leapfrog website, they are unaware of
13 what the metrics mean on the survey. They would be
14 unaware of the time frames. They would be unaware that
15 it's elective, that it's self-reported, that there's no
16 trust but verify and that somebody can complete the
17 survey, but no representative from Leapfrog comes to
18 validate that what the hospital has submitted or in the
19 case of a nonparticipating hospital what the true facts
20 are.

21 Q. In --

22 A. So there's not integrity. If you don't
23 trust but verify, there is no integrity.

24 Q. Are you aware of Leapfrog's verification
25 process?

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1 A. I can assure you they don't come on site to
2 trust but verify.

3 Q. And neither does Healthgrades®, right?

4 A. But Healthgrades® is getting publicly --
5 public information from CMS.

6 Q. Correct. And --

7 A. They are not imputing any scores. And they
8 are not going to defame our facility.

9 Q. Oh. So you believe this is a defamation
10 case?

11 MS. MALONEY: Objection. Calls for a legal
12 conclusion, mischaracterizes her testimony and
13 is argumentative.

14 BY MS. BLAIR:

15 Q. You used the word "defame." What did you
16 mean by "defame"?

17 A. Leapfrog is by saying that St. Mary's earned
18 a D is not a safe facility. That is the -- that is
19 what Leapfrog is promoting. And that is what other
20 hospitals who are participating when they use their
21 marketing license collateral to hold out that because
22 they're an A, they are better than a St. Mary's' D.

23 Q. And is there anywhere that you've seen on
24 the Leapfrog website where Leapfrog promotes that you
25 are a -- I want to use your word -- not a safe

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1 hospital, unsafe hospital?

2 A. I would say by virtue of Leapfrog scoring us
3 a D, a D is not a high performance grade, so it would
4 give the false impression that we do not have the same
5 level or high quality.

6 Q. Would you agree with me that St. Mary's'
7 HCAHPS scores are below both the national average and
8 the Florida average?

9 A. Our patient safety satisfaction score?

10 Q. Correct.

11 A. Yes.

12 Q. Would you agree with me that your CMS score
13 is a 1 star which is the lowest available?

14 A. Yes, it is.

15 Q. Do you believe that consumers look at the
16 CMS star ratings when deciding what hospital to go to?

17 A. I'm not certain with a consumers look at.

18 Q. But do you believe they look at a Leapfrog
19 hospital grade?

20 A. I believe the Leapfrog hospital grade
21 because they are marketed and licensed are aggressively
22 marketed by competitor facilities.

23 Q. And you don't believe that your competitor
24 facilities aggressively market their five-star CMS
25 ratings?

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1 A. I have not seen that as much now.

2 Q. And when you're talking about your
3 competitors, you're talking about Jupiter specifically?

4 A. Correct.

5 Q. And Jupiter, is Jupiter the only A-rated,
6 Leapfrog A-rated hospital in your geographic area?

7 A. Yes.

8 Q. Do you know how Jupiter's admissions rates
9 compare to those of St. Mary's?

10 A. No.

11 THE VIDEOGRAPHER: I'm sorry to interrupt,
12 Counsel.

13 MS. BLAIR: Yes. You need to change?

14 THE VIDEOGRAPHER: Yes. This is the end of
15 media unit three. We're going off the record
16 for a media change.

17 (A recess was taken from 4:20 p.m. to 4:22 p.m.)

18 THE VIDEOGRAPHER: This is media unit number
19 four. The time is 4:22. We are back on the
20 record.

21 BY MS. BLAIR:

22 Q. Ms. McCauley, in terms of the reputational
23 damage that's been allegedly suffered by St. Mary's in
24 connection with the Leapfrog Hospital Safety Grade that
25 it received in the fall of 2022 [sic], in your capacity

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1 as a corporate representative can you describe for me
2 the reputational damage that has occurred?

3 A. So you did mean fall of 2024.

4 Q. Did I say it wrong? Probably.

5 A. Yes.

6 Q. Fall of 2024.

7 A. As indicated earlier, we have had a decline
8 in number of births delivered at our facility. We have
9 had a decline in outpatient pediatrician physical
10 therapy. We have had a decline in elective outpatient
11 surgeries. We have had a decline in volume in our
12 emergency department.

13 Q. And that you attribute all to the Leapfrog
14 grade?

15 A. I do attribute it to the Leapfrog grade.

16 And I can give an example where a patient
17 who came to the facility indicated to me that he was
18 nervous that his wife was brought to St. Mary's because
19 of what he has heard. This is fairly recent. But he
20 was pleasantly surprised at what an amazing experience
21 and outcome his spouse had at the facility. But that
22 reputation that's been developed because of the
23 Leapfrog grade has resulted in patients not selecting
24 St. Mary's as evidenced by our decreased elective
25 volumes.

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1 Q. Okay. And when did you -- you personally
2 spoke to this patient?

3 A. It was a Google review, yes.

4 Q. It was a Google review.

5 And do you recall when the date of that
6 Google review?

7 A. I don't recall the date.

8 Q. You said it was relatively recently?

9 A. It's relatively recent.

10 Q. Was it after the filing of this lawsuit?

11 A. It was past couple months.

12 Q. And you spoke with him directly?

13 A. He posted it on social media.

14 Q. So it was a social media post, correct?

15 A. Correct.

16 Q. Does he specifically refer to Leapfrog in
17 the social media post?

18 A. Not that I recall.

19 Q. Have you produced that social media post in
20 this litigation?

21 A. I'm not certain.

22 Q. Other than this one social media post,
23 Google review that you just told me about, what -- how
24 are you making the connection to the decrease in
25 elective admissions at St. Mary's to the grade

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1 St. Mary's received in the fall of 2024?

2 A. So heretofore prior to the fall of 2024

3 St. Mary's was successful in growing its volume. And

4 since the fall of 2024 and the published grades, we

5 have seen a degradation in elective volume.

6 Q. What documents do you look at in order to

7 determine that you've had a decrease in elective

8 volume?

9 A. So I recount telling you earlier today that

10 we on a monthly basis look at financials which include

11 volume data.

12 MS. BLAIR: Mark this as 14.

13 (Defendant's Exhibit Number 14 for i.d.)

14 BY MS. BLAIR:

15 Q. Ms. McCauley, I'm handing you now what we've

16 marked as Exhibit 14. And I'll submit to you this is

17 your declaration, but attached to it is only Exhibit 4

18 to your declaration for purposes of my Exhibit here

19 today.

20 If you could take a look at this document

21 and specifically turn to the last page of the

22 declaration. And my question will be, is this your

23 signature?

24 A. We're looking at --

25 Q. No, we're looking at --

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1 A. Is this a different?

2 Q. Yes. They're a group Exhibit, and I only
3 attached Exhibit 4, not the whole thing.

4 A. So on 2234, that is my signature.

5 Q. Okay. And do you recall drafting this
6 declaration and signing it in or around May of 2025?

7 A. I wouldn't have personally drafted it.

8 Q. Fair enough.

9 Do you recall reviewing it and signing it in
10 or around May 13th of 2025 as indicated by the
11 signature and date line?

12 A. Yes.

13 Q. And when is the last time you have reviewed
14 this declaration?

15 A. I reviewed this over the past few days.

16 Q. And having reviewed it over just the past
17 few days, is everything in it still true and correct to
18 the best of your knowledge?

19 A. To the best of my knowledge.

20 Q. And I want to direct your attention to
21 Exhibit 4, this is Exhibit 4 to your declaration which
22 is a document. Well, you tell me what this document
23 is.

24 A. So this document shows key indicators fiscal
25 year '24 and year to date March '25 for each of the

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1 facilities on different metrics.

2 Q. Okay. And so if we look at the top kind of
3 box, and it looks like the total lines is "Admits Palm
4 Beach Market," do you see that?

5 A. Yes.

6 Q. Does that mean everything above this box is
7 all of the admissions at each of the individual
8 hospitals?

9 A. So is the first box -- correct, they're
10 summary, admits, Palm Beach Health, Palm Beach market.

11 Q. Okay. And is this the -- this would not be
12 just the electives, correct?

13 A. No, this would be everything.

14 Q. Okay. Is there somewhere on this page where
15 the electives show up?

16 A. I don't see that.

17 Q. Okay.

18 A. Well, at the bottom, total -- well, one up
19 from the bottom, total elective encounters, Palm Beach
20 market.

21 Q. Okay. Got it. And it looks like it's
22 shaded. But is it shaded because it's in the negative?

23 A. That's what it appears.

24 Q. Okay. And is this what you were talking
25 about, then? These are the electives that you look at

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1 to make the determination that your Leapfrog Hospital
2 Safety Grade had a negative impact on the reputational
3 harm of St. Mary's?

4 MS. MALONEY: Objection.

5 A. So this is -- so this is the data for the
6 February 20 -- fiscal year '24 compared to the first
7 quarter of '25.

8 BY MS. BLAIR:

9 Q. Do you have this data for the second
10 quarter?

11 A. I'm sure it can -- do I have it? This
12 actually -- this data actually has all the market. I
13 wouldn't have all the market.

14 Q. Okay. That's a great point.

15 Does St. Mary's have the capability of
16 providing its numbers for these categories, admits,
17 total outpatient visits, total surgeries,
18 I/P surgeries, inpatient surgeries, outpatient
19 surgeries, total emergent encounters and total elective
20 encounters? Does St. Mary's have the ability to run
21 these numbers for Q2 of 2025?

22 A. Yes.

23 Q. And do they have the ability to run it in a
24 comparison type of table?

25 A. For 2024 to 2025, yes.

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1 Q. Correct. Yes.

2 And I suspect since next week will be end of
3 Q3, you will have Q3 numbers at that time, correct?

4 A. Mid October.

5 Q. Okay. Do you know -- when you told me
6 earlier about electives being down, were you referring
7 to these numbers, or were you referring to Q2 numbers?

8 A. I was referring to more year-to-date numbers
9 that I'm familiar with from participating in reviewing
10 month-end financials.

11 Q. Okay. So you're reviewing financials on a
12 monthly basis?

13 A. Correct.

14 Q. Okay. Have you ever looked at these --
15 other than what's in Exhibit 4 to your declaration,
16 have you ever looked at the quarterly, the June
17 quarterly comparisons for St. Mary's of these types of
18 numbers?

19 A. I'm not certain that I have or haven't
20 because I review our financials monthly.

21 Q. Okay. And when you're reviewing the
22 financials monthly, you can just tell by looking that
23 they're down from last year?

24 A. Correct.

25 Q. Okay. Does it show you that? I guess

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1 that's what I'm saying.

2 A. It would have -- it could have fiscal year
3 '24 or prior year to current year.

4 Q. Okay. And you get those every month?

5 A. Correct.

6 Q. Now, you told me about -- so the way that
7 you are connecting the Leapfrog Hospital Safety Grade
8 from fall of 2024 to an effect of your reputational
9 harm is directly related to volume, correct?

10 A. To elective volume.

11 Q. Elective volume, which is the bottom box on
12 Exhibit D, correct?

13 A. One up from employees, yes.

14 Q. Yes.

15 Is there any other way that you are
16 measuring the reputational harm to St. Mary's as a
17 result of the Leapfrog fall 2024 Hospital Safety Grade?

18 A. The way a hospital would measure would be
19 based on volume and patients coming to a facility.

20 Q. Other than the Google review that you told
21 me about where the husband posted that he was nervous
22 to bring his wife to St. Mary's, are there any other
23 patient reviews that you're aware of that you believe
24 substantiate that the Leapfrog fall 2024 Hospital
25 Safety Grade was the cause of the downward trend in

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1 elective volume at St. Mary's?

2 A. On a daily basis, I round and visit a lot of
3 patients, and in conversations with patients or
4 patient's family, there -- there have been concerns
5 mentioned about what they might have heard or a
6 sentiment from the media.

7 Q. Do they ever mention Leapfrog in those
8 conversations with you?

9 A. Not specifically that I recall.

10 Q. Do they ever tell you what specific media
11 they refer to, what specific media they're relying on?

12 A. I don't know that I -- that I pushed the
13 question.

14 Q. Prior to -- well, okay. So in your rounding
15 you'll talk to patients and patients' families about
16 their concerns about the reputation of what?

17 A. So I round on patients to find out how their
18 care is, how their nurse is, is there anything we can
19 do better. I thank them, if it was elective, for
20 choosing St. Mary's and try to understand, just to try
21 to get better sense for our patients.

22 Q. Okay. And it's during those conversations
23 that you've had conversations with patients and/or
24 patient's families about their concerns?

25 A. Correct.

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1 Q. Okay. So any -- so we have the Google
2 review, the rounding. How many patients would you say
3 since fall of 2024 have you talked to that have had
4 concerns about the reputation of St. Mary's?

5 A. It's hard to quantify.

6 Q. Prior to the fall of 2024 had you had any
7 conversations like that with any patients?

8 A. I don't recall specific conversation where
9 patients voiced concerns.

10 Q. In all your years as either a chief
11 administrative officer or chief executive officer of a
12 hospital, do you recall any conversations you had with
13 patients or patients' families regarding Leapfrog?

14 A. Not -- no, not specifically, no.

15 Q. So in the rounding with patients and the
16 Google reviews, are there any other discussions you've
17 had about that you feel establish that the cause of the
18 decrease in elective admissions --

19 A. Volume.

20 Q. -- volume, sorry, is directly linked to the
21 Leapfrog Hospital Safety Grade?

22 A. I mean, I recently received a letter from a
23 patient referring to our Leapfrog grade D, and the
24 patient advised me that we should no longer vaccinate
25 children because we were a Leapfrog D.

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1 Q. Have you produced that document in this
2 litigation?

3 A. I'm not sure. It's a very recent letter so
4 I sent it to counsel.

5 Q. Did you reach out to that patient?

6 A. No, I didn't.

7 Q. Other than that letter, anything else that
8 you can think of?

9 A. That is the most recent and -- the most
10 recent one that comes to mind.

11 Q. And so have you told me, then, about all of
12 the discussions you've had with patients or anyone
13 else -- not discussions but reviews you've seen,
14 letters you've received, discussions you've had with
15 patients or patients' families or anyone else that of
16 inform your belief that the Leapfrog fall 2024 Hospital
17 Safety Grade is the cause of the down turn in elective
18 volume?

19 A. I believe based on declining volumes, which
20 is a new event for St. Mary's, that that is the
21 attributing factor.

22 Q. Right. And I'm just trying to make sure
23 I've covered all my bases.

24 A. Right.

25 Q. Like have you told me about all the

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1 different categories of patients and Google reviews and
2 letters from patients? Is that everything you can
3 think of that informs your belief that Leapfrog is the
4 cause of the decline in elective volume?

5 A. At this moment, those are the things that
6 come to my mind.

7 MS. BLAIR: Can we take a quick break? I
8 think I'm almost finished if you don't mind.

9 THE VIDEOGRAPHER: Off the record. 4:38.
10 (A recess was taken from 4:38 p.m. to 4:57 p.m.)

11 THE VIDEOGRAPHER: Back on the record 4:57.

12 MS. BLAIR: Ms. McCauley, I have no further
13 questions for you?

14 THE WITNESS: Perfect. Thank you.

15 MS. BLAIR: Sorry you had to take that long
16 of a break.

17 MS. MALONEY: I'll designate the transcript
18 as confidential, please.

19 MS. BLAIR: And we'll reserve our rights to
20 dispute the confidential nature of certain parts
21 of that deposition.

22 I will order the usual, rough draft and an
23 eTran regular delivery with Exhibits.

24 MS. DABANKA: Same.

25 THE VIDEOGRAPHER: This marks the end of

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1 today's deposition. The time is 4:57. We're
2 going off the record.

3 (Thereupon, the proceedings concluded at
4 4:57 p.m.)

5 (The witness did not waive signature.)

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1 CERTIFICATE OF OATH

2

3 THE STATE OF FLORIDA)

4 COUNTY OF PALM BEACH COUNTY)

5

6 I, the undersigned authority, certify that
7 remotely appeared before me and was duly sworn on the
8 24th day of September 2025.

9 Signed this 5th day of October 2025.

10

11

12

13

14

15

16

17

18

19

20 BARBIE GALLO, RMR-CRR
Notary Public - State of Florida
My Commission No. GG939757
21 My Commission Expires: December 18, 2027

22

23

24

25

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1 CERTIFICATE OF REPORTER

2

3 THE STATE OF FLORIDA)

4 COUNTY OF PALM BEACH)

5

6 I, Barbie Gallo, RMR-CRR, Registered Merit
7 Reporter-Certified Realtime Reporter, certify that I
8 was authorized to and did stenographically report the
9 deposition of CYNTHIA MCCAULEY, pages 1 through 247;
10 that a review of the transcript was requested; and that
11 the transcript is a true and complete record of my
12 stenographic notes.

13 I further certify that I am not a relative,
14 employee, attorney, or counsel of any of the parties,
15 nor am I a relative or employee of any of the parties'
16 attorney or counsel connected with the action, nor am I
17 financially interested in the action.

18

19 DATED this 5th day of October 2025.

20

21

22

23

24

25

Barbie Gallo, RMR-CRR

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1 October 5, 2025
2 Cynthia Mccauley c/o Mary Beth Maloney
3 Gibson, Dunn & Crutcher, LLP
4 200 Park Avenue
5 New York, NY 10166
6 (212) 351-4000
7 mmaloney@gibsondunn.com

8 IN RE: GOOD SAMARITAN vs. THE LEAPFROG GROUP
9 CASE NO.: 9:25-CV-80526-DMM

10 Please take notice that on the 24th day of September
11 2025, you gave your deposition in the above cause. At
12 that time you did not waive your signature.

13 The above-addressed attorney has ordered a copy of this
14 transcript and will make arrangements with you to read
15 their copy. Please execute the Errata Sheet, which can
16 be found at the back of the transcript, and have it
17 returned to us for distribution to all parties.

18 If you do not read and sign the deposition within 30
19 days, the original, which has already been forwarded to
20 the ordering attorney, may be filed with the Clerk of
21 the Court.

22 If you wish to waive your signature now, please sign
23 your name in the blank at the bottom of this letter and
24 return it to the address listed below.

25 Very truly yours,

26 Barbie Gallo, RMR-CRR
27 Lexitas Legal
28 fl.production@lexitaslegal.com

29 I do hereby waive my signature.

30 CYNTHIA MCCAULEY
31 Job No.: 421987

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1 ERRATA SHEET
2 DO NOT WRITE ON TRANSCRIPT - ENTER CHANGES HERE
3 IN RE: GOOD SAMARITAN vs THE LEAPFROG GROUP
4 CASE NO.: 9:25-CV-80526-DMM
5 WITNESS: CYNTHIA MCCAULEY
6 TAKEN: 09/24/2025

7	PAGE	LINE	CHANGE	REASON FOR CHANGE
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23 Under penalties of perjury, I declare that I have
24 read the foregoing document and that the facts stated
25 in it are true.

Date CYNTHIA MCCAULEY

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UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA
WEST PALM BEACH DIVISION
CASE NO.: 9:25-CV-80526-DMM

GOOD SAMARITAN MEDICAL CENTER, INC.,
DELRAY MEDICAL CENTER, INC.,
PALM BEACH GARDENS COMMUNITY
HOSPITAL, INC. d/b/a PALM BEACH
GARDENS MEDICAL CENTER,
ST. MARY'S MEDICAL CENTER, INC.,
AND WEST BOCA MEDICAL CENTER, INC., et al.,

Plaintiffs,

v.

THE LEAPFROG GROUP,

Defendant.

VIDEOTAPED DEPOSITION OF SHERI MONTGOMERY
(CONFIDENTIAL)

DATE TAKEN: Monday, September 15, 2025
TIME: 9:09 a.m. - 5:45 p.m.
PLACE: Quest Workspaces West Palm Beach
515 North Flagler Drive
Suite 350
West Palm Beach, Florida 33401

Stenographically Reported By:
Barbie Gallo, RMR-CRR
www.lexitaslegal.com
888-811-3408

Job No.: 421985

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22 ALSO PRESENT:

Ashley Taylor, videographer

23

24

25

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1 Thereupon,
2 the following proceedings began at 9:09 a.m.:

3 * * *

4 THE VIDEOGRAPHER: We are now on the record
5 and the time is 9:09 a.m. This is the
6 video-recorded deposition of Sheri Montgomery
7 taken in the matter of Good Samaritan Medical
8 Center, Incorporated, et al. versus The Leapfrog
9 Group.

10 This deposition is being held in 515 North
11 Flagler Drive, West Palm Beach, Florida on
12 Monday, September 15, 2025.

13 The videographer is Ashley Taylor, and the
14 court reporter is Barbie Gallo with Lexitas.

15 Will counsel please announce their
16 appearances for the record.

17 MS. BLAIR: Kim Blair on behalf of
18 defendant, Leapfrog.

19 MR. MARCUS: Jeff Marcus of Marcus,
20 Rashbaum, Pineiro & Meyers.

21 I'm joined by Kevin Simmons of Gibson, Dunn
22 on behalf of plaintiffs.

23 THE STENOGRAPHER: And, if you would, raise
24 your right hand, I'll swear you in.

25 Do you swear or affirm that the testimony

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1 you're about to give in this matter will be the
2 truth, the whole truth and nothing but the truth
3 so help you God?

4 THE WITNESS: I do.

5 THE STENOGRAPHER: Thank you.

6 MS. BLAIR: And let the record reflect that
7 this is both the fact witness deposition of
8 Sheri as well as the corporate representative
9 30(b)(6) deposition of Good Samaritan taken
10 pursuant to agreement of counsel. I do have a
11 notice coming, And I will introduce that as an
12 Exhibit shortly. This deposition is also taken
13 pursuant to the federal Rules of Civil Procedure
14 as well as the local rules for the Southern
15 District of Florida.

16 THEREUPON,

17 SHERI MONTGOMERY,

18 Being by me first duly sworn to tell the whole truth,
19 as hereinafter certified, testified as follows:

20 DIRECT EXAMINATION

21 BY MS. BLAIR:

22 Q. Ms. Montgomery, as I just announced, my name
23 is Kim Blair. I represent the defendant, Leapfrog in
24 this matter.

25 Could you please state and spell your name

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1 for the record?

2 A. Sure. Sheri Montgomery, S-h-e-r-i;
3 Montgomery, M-o-n-t-g-o-m-e-r-y.

4 Q. And have you ever been deposed before?

5 A. I have.

6 Q. How many times?

7 A. I believe once only.

8 Q. And was that in connection with your
9 employment at Good Samaritan?

10 A. Yes.

11 Q. And so I'll just go over just a few ground
12 rules, probably things you've heard before.

13 As you know, the court reporter is taking
14 down everything I say and everything you say, so for
15 the convenience and sake of the court reporter, I will
16 try not to talk over you while you're answering. And I
17 ask that you try not to talk over me so that Barbie can
18 get down everything everyone is saying.

19 Is that okay?

20 A. Yes.

21 Q. Again, the court reporter can't take down a
22 shrug of the shoulders, an "uh-huh," "huh-uh" so all of
23 your answers must be verbal here today.

24 Does that make sense?

25 A. It does.

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1 Q. In addition, it's clearly not an endurance
2 test so if at any time you need to take a break, please
3 ask me. The only caveat is that if there's a question
4 pending I ask that you answer that question before we
5 take a break.

6 Is that fair?

7 A. Yes.

8 Q. If at any time you don't understand one of
9 my questions, and that will happen today, please ask me
10 to rephrase that question. If you answer a question I
11 ask, I'm going to assume you understood it.

12 Is that fair?

13 A. Yes.

14 Q. Can you describe for us your education
15 background, starting after high school?

16 A. I got my undergrad at FAU in business
17 administration, and then I went to Nova University for
18 my master's in business administration with a
19 concentration in finance.

20 Q. Do you hold any certificates or licensing?

21 A. I do not.

22 Q. What year did you graduate from Novo [sic]?

23 A. I think around 2010 or '11.

24 Q. And did you go straight through undergrad to
25 Novo [sic]?

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1 A. I did not.

2 Q. What did you do between FAU and Novo [sic]?

3 A. I was just working.

4 Q. Where did you work?

5 A. I believe Delray Medical Center at the time.

6 Q. What did you do at Delray Medical Center?

7 A. I was probably the controller at the time.

8 Q. So tell me a little bit about your
9 employment. So right out of FAU you began working at
10 Delray?

11 A. Yes. I was working at Delray prior to FAU.

12 Q. Okay. So did you go straight to college
13 from high school?

14 A. Probably. Palm Beach State, I was at Palm
15 Beach State for a while for my associate's degree and
16 FAU for my bachelor's.

17 Q. Okay. So when did you get your associate
18 from Palm Beach State?

19 A. I don't know.

20 Q. What about when did you graduate from FAU?

21 A. I'm not sure.

22 Q. You're not sure when you graduated?

23 A. Maybe three years prior to my master's
24 maybe.

25 Q. So in or around 2006, 2007, does that sound

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1 about right?

2 A. Potentially.

3 Q. And so you started working at Delray. Did
4 you start working at Delray after you got your
5 associate's degree but before you finished at FAU?

6 A. Before. I was working probably at Delray by
7 the age of 19, you know, and going to school at the
8 same time throughout my whole career really.

9 Q. Okay. So let's start with your job at
10 Delray in or around the age of 19. What was your job?

11 A. I worked in central supply.

12 Q. And what did you do in central supply?

13 A. You know, stock supplies, things of that
14 nature.

15 Q. What was your next -- where did you -- how
16 long did you work at Delray?

17 A. Since '94, I believe.

18 Q. And at some point you left Delray?

19 A. I was at Delray for the majority of my
20 career, and then I went to Coral Gables as the CFO.

21 Q. Okay. So --

22 A. I was there probably 20 something years.

23 Q. At Delray 20 something years?

24 A. Yeah. My whole career has -- was at Delray,
25 Coral Gables and Good Sam.

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1 Q. And so you were at Delray prior to Delray
2 being purchased by Tenet, correct?

3 A. Yes.

4 Q. What was your last position at Delray prior
5 to going to Coral Gables?

6 A. ACFO.

7 Q. And what's the A stand for in the ACFO?

8 A. Assistant CFO.

9 Q. And can you briefly describe in or around
10 2004 when you were the assistant CFO at Delray what
11 your job duties entailed?

12 A. I don't think -- I wasn't the A -- did you
13 say "2004"?

14 Q. Well, I thought you told me you left Delray,
15 you were at Delray for about ten years, 1994 to 2004.
16 That was my math.

17 A. Oh, no --

18 Q. And then you got --

19 A. -- no, I said like 20 years was --

20 Q. Oh.

21 A. -- my whole career at Delray.

22 Q. I'm so sorry. My math is bad.

23 A. I went to Coral Gables in 2012.

24 Q. Okay. Got it. That was my math mistake.

25 Okay. So when you leave Delray in 2012, you

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1 were the assistant CFO, correct?

2 A. (Nodding head).

3 Q. And what did your job duties entail in,
4 let's just use 2012, your last year at Delray as the
5 assistant CFO?

6 A. Right. Ensuring the financial statements
7 accurate, you know, working with the CFO, you know, was
8 training at the time for the next position, so I got
9 other responsibilities like departments, overseeing IT
10 maybe or case management, things like that.

11 Q. Did you have any responsibilities at Delray
12 for overseeing quality of the hospital?

13 A. No.

14 Q. So I asked a question before, and I think I
15 asked a bad question so I'm sorry.

16 So, as I understand it, Delray was purchased
17 by Tenet in 2007; is that correct?

18 A. I don't know the exact date.

19 Q. Do you recall if whether or not when you
20 were working at Delray they were owned by Tenet?

21 A. Originally when I was 19, no. It was like
22 AMI, I think, or, no, NME. They merged with AMI, so...

23 Q. By the time you leave are they owned by
24 Tenet?

25 A. Yes.

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1 Q. Okay.

2 A. Yes.

3 Q. And was there any sort of shift at Delray
4 once Delray became purchased by Tenet in terms of how
5 the hospital was organized or operating?

6 A. I don't recall.

7 Q. Did your job duties change in any way when
8 Delray became affiliated with Tenet?

9 A. I don't recall. I don't even remember if I
10 was in accounting at that time or -- it was so long
11 ago.

12 Q. So you just don't really recall any -- no
13 changes come to mind?

14 A. No. I mean, as far as I'm concerned, I
15 worked for Tenet my entire career that I recall.

16 Q. Okay. So --

17 A. You know...

18 Q. -- as far as you're concerned, you worked
19 for Tenet your whole career?

20 A. Yeah, because it was so long ago when I
21 worked for NME, I don't even know if I was a supply
22 clerk at the time or -- it -- I don't remember the year
23 that that occurred, but it was a long time ago, so...

24 Q. And in your role as the assistant CFO at
25 Delray, did you report in any way to Tenet Healthcare's

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1 home office in Dallas?

2 A. I wouldn't see it that way, but, I mean, I'm
3 sure our organization did, but, you know, I was working
4 for the CFO at the time or, you know...

5 Q. Do you recall having any direct contact with
6 the Tenet home office when you were at Delray in your
7 position as the assistant CFO?

8 A. Sure.

9 Q. And what kinds of oversight did
10 Tenet Healthcare have with respect to your functions as
11 the assistant CFO while you were at Delray?

12 MR. MARCUS: Object to form.

13 A. So the corporate office has departments like
14 revenue cycle, for example, that support us, a tax
15 department that supports us, so we would talk to them
16 about things like that, you know. Contract management
17 is done at the home office.

18 BY MS. BLAIR:

19 Q. Do you know whether or not Delray
20 participated in the Leapfrog survey while you were
21 associated with Delray?

22 A. I don't recall.

23 Q. Do you recall in your position as the
24 assistant CFO at Delray whether or not Delray paid any
25 monies to Leapfrog for participating in the survey?

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1 A. I don't recall.

2 Q. Would that have fallen within your ambit as
3 the assistant CFO?

4 A. Not necessarily.

5 Q. Would it have fallen within the ambit of the
6 CFO if payments were being paid to Leapfrog to
7 participate in the Leapfrog annual survey?

8 A. I mean, the way it works is whoever is
9 requesting, or someone could fill out a purchase order
10 that, you know, goes to, depending on the amount, it
11 might not ever reach the CFO so it really depends. You
12 know, it could be the ACFO. It could be the
13 controller. It depends on what the amount is. Since
14 there are so many payments that go through a hospital,
15 one might not know, if that makes sense.

16 Q. That makes sense.

17 A. If it's \$200,000, the CFO would know about
18 it.

19 Q. Do you have any -- let me ask it more
20 broadly.

21 Do you have any recollection of making any
22 payments to Leapfrog while you were -- strike that.

23 Do you have any recollection of Delray
24 making any payments to Leapfrog while you were the
25 assistant CFO of Delray?

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1 A. I do not.

2 Q. So after you leave Delray I think you told
3 me you went to Coral Gables, correct?

4 A. Yes.

5 Q. And that was sometime in 2012, right?

6 A. I believe that's correct.

7 Q. And you were the chief financial officer of
8 Coral Gables?

9 A. I was.

10 Q. How long were you the chief financial
11 officer of Coral Gables?

12 A. 18 months.

13 Q. And what were your job duties as the CFO of
14 Coral Gables?

15 A. Business planning, you know, ensuring
16 financial statements are accurate, contract management,
17 vendor management.

18 Q. Did you have any oversight while you were at
19 Coral Gables with respect to marketing?

20 A. No.

21 Q. Did you oversee the marketing budget in any
22 way?

23 A. I would say I was responsible ultimately
24 that they didn't overspend, yes.

25 Q. Do you recall whether or not the marketing

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1 department at Coral Gables had a budget?

2 A. Yes.

3 Q. And same question with respect to your work
4 at Delray back when you were the assistant CFO at
5 Delray, did they have a marketing budget?

6 A. Yes.

7 Q. Do you recall whether or not the marketing
8 budget of Delray was a percentage of overall revenue?

9 MR. MARCUS: Object to form.

10 A. I don't recall anything like that, no.

11 BY MS. BLAIR:

12 Q. And same question with respect to CF -- with
13 Coral Gables, do you recall whether or not the
14 marketing budget was a percentage of the overall
15 revenue?

16 A. I do not.

17 MR. MARCUS: Same objection.

18 BY MS. BLAIR:

19 Q. How is -- just speaking generally, you
20 obviously have a lot of experience in a CFO role of a
21 hospital. How generally is the marketing budget come
22 to at a hospital?

23 A. Really based off history. So, you know, if
24 you spent a certain amount the previous year, if you
25 have some business plan initiative, there's -- you're

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1 wanting to increase the budget, then obviously you
2 request for those reasons, but, honestly, it's really
3 based off history for the most part.

4 Q. And why did you leave Coral Gables after
5 18 months?

6 A. To go back to Delray Medical Center as the
7 CFO.

8 Q. Okay. So you go back to Delray. And what
9 year was that?

10 A. '14.

11 Q. And how long did you stay as the CFO of
12 Delray hospital?

13 A. I would say probably, I guess, six years
14 because, yeah, I went to Good Sam in 2020.

15 Q. What month did you start at Good Sam in
16 2020?

17 A. April.

18 Q. Right in the middle of the pandemic?

19 A. Yes.

20 Q. Prior to the Palm Beach Health Network being
21 formed in 2022, was there a connection between Delray
22 and Good Sam?

23 A. Yes.

24 Q. And what was that connection?

25 A. We were always a group, so five hospitals,

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1 we've always been a group.

2 Q. And what do you mean "always a group"? What
3 does that mean?

4 A. You know, working together, planning
5 together, having meetings together. There was group
6 leadership, you know, a CEO, a CFO, CHRO over the five
7 hospitals.

8 Q. And was that true even though -- Palm Beach
9 Gardens doesn't get owned by Tenet until 2017, so when
10 you say "always," I'm just curious.

11 A. Palm Beach Gardens. That doesn't make
12 sense.

13 Q. That doesn't make sense. Do you know when
14 Tenet -- maybe my research is wrong.

15 Do you know when Palm Beach Gardens was
16 purchased by Tenet?

17 A. I've always known them to be part of Tenet.

18 Q. Okay. So Palm Beach Health Network is
19 formed in 2022, April of 2022, correct?

20 A. That sounds about right.

21 Q. Okay. But before April of 2022, the five
22 hospitals that are the -- and when you say "the five
23 hospitals," I assume you're referring to the five
24 hospitals that are plaintiffs in this lawsuit, correct?

25 A. Yes.

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1 Q. And those five hospitals are St. Mary's,
2 Good Sam, Palm Beach Gardens, West Boca and Delray,
3 correct?

4 A. Yes.

5 Q. Yes.

6 So tell me about prior to April of 2022 how
7 the hospitals functioned as a group.

8 A. Pretty much the same. I mean, the structure
9 is there's group leadership. The reason it's five is
10 that they were the five Tenet hospitals so there's
11 local leadership that you report up to that is over the
12 five.

13 Q. And prior to April of 2022 who was the local
14 leadership of these five hospitals?

15 A. Maggie Gill, Michelle Cartwright,
16 Shannon Wills for CHRO, Ricky Ramirez for the CNO.
17 That's changed over time so I don't know exact dates
18 because before I went to Good Sam, I was the
19 Michelle Cartwright of the group, the CFO.

20 Q. Okay.

21 A. And the CFO of Delray Medical Center.

22 Q. Got it. So prior to Palm Beach Health
23 Network being formed in April of 2022, was there a
24 formalized structure for these five hospitals?

25 A. Yes.

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1 Q. From a --

2 Okay. And what did you call yourselves,
3 just were you just it was just part of Tenet?

4 A. Yeah, the Palm Beach group.

5 Q. And so if I'm understanding you correctly,
6 and please correct me if I'm wrong, there was a
7 functional group within Tenet overseeing these five
8 hospitals, and you were the functional group CFO at one
9 point, correct?

10 A. Correct.

11 Q. And prior to April of 2022, did Maggie Gill
12 work at one of the five hospitals?

13 A. Delray.

14 Q. And what was her title at Delray prior to
15 April of 2022?

16 A. So she was the CEO of Delray at sometime,
17 and then she was pulled up to not have a hospital at
18 all. I don't remember what year that was.

19 Q. Got it. So but until '20 -- April of 2022
20 when Palm Beach Health Network was formed, Maggie Gill
21 would not have been the CEO of Palm Beach Health
22 Network; is that fair?

23 MR. MARCUS: Object to form.

24 A. She was. She was at the Palm Beach group.

25 BY MS. BLAIR:

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1 Q. Okay. Yeah, that was a terrible question.

2 So functionally she was the CEO of the Palm
3 Beach group prior to April of 2022, correct?

4 A. Correct.

5 Q. And in April of 2022, these five hospitals
6 of which you are the CEO of Good Samaritan rebranded as
7 the Palm Beach Health Network, correct?

8 A. Correct.

9 Q. Okay. And Michelle Cartwright, you said she
10 was the group -- or was the group CFO at one point?

11 A. She is.

12 Q. She is now. Does she come from one of these
13 five hospitals?

14 A. Correct, yes.

15 Q. Which one?

16 A. St. Mary's.

17 Q. And then what about Shannon Willis [sic],
18 was she at a hospital, one of these five hospitals as
19 well?

20 A. Yes. Her last name is Wills.

21 Q. Oh, I'm sorry. Wills.

22 A. That's all right.

23 Q. What hospital was she at?

24 A. Delray.

25 Q. And you said CHRO. What does that stand

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1 for?

2 A. Chief human resource officer.

3 Q. And Ricky Ramirez, was he associated with a
4 specific hospital?

5 A. He's at West Boca, and he's the chief nurse
6 officer there.

7 Q. And he's still the chief nurse officer of
8 West Boca, correct?

9 A. Correct.

10 Q. And is Shannon Wills still the CHRO at
11 Delray?

12 A. She is.

13 Q. And is Michelle Cartwright still the CFO at
14 St. Mary's?

15 A. She's at Delray.

16 Q. She's currently at Delray?

17 A. Yes.

18 Q. And Maggie Gill, she -- I thought you just
19 said -- but if I'm wrong -- she no longer has any
20 responsibilities at a specific hospital; is that
21 correct?

22 A. Correct.

23 Q. Is there anyone else associated with the
24 Palm Beach Health Network that is not also associated
25 with one of the five hospitals specifically?

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1 A. That's not associated, no.

2 Q. Okay. So just Maggie Gill?

3 A. Right.

4 Q. And Maggie Gill reports directly to Tenet
5 hospital in Dallas, to the best of your knowledge?

6 A. Yes.

7 Q. Do you know who she reports to in Dallas?

8 A. Lisa Foo.

9 Q. Can you spell "Foo" for me?

10 A. F-o-o.

11 Q. And who is Lisa Foo?

12 A. She's the COO.

13 Q. Of Tenet hospitals?

14 A. Yes.

15 Q. Or I'm sorry. Tenet Healthcare?

16 A. Yes.

17 Q. Do you know who Lisa Foo reports to?

18 A. Saum Sutaria. He's the CEO.

19 Q. So with respect to your employment history,
20 in April of 2020, you become the CEO of Good Samaritan,
21 correct?

22 A. Correct.

23 Q. Can you describe for me briefly what your
24 roles are as the COO -- CEO, excuse me, of
25 Good Samaritan?

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1 A. Did you say "goals"?

2 Q. I'm sorry. Roles.

3 A. Roles.

4 Q. Yeah. Sorry.

5 A. My role is to oversee the strategy, business
6 initiatives, ensure that the hospital is, you know,
7 quality, financially sound.

8 Q. In terms of the corporate structure of
9 Good Sam, I assume if you're the CEO you're at the top,
10 correct?

11 A. Correct.

12 Q. How many direct reports do you have?

13 A. Really only the A-team, so that would be the
14 CHRO, COO, CNO and the CFO.

15 Q. Okay. And who is the CHRO?

16 A. Kevin Caracciolo. It's
17 C-a-r-r-i-c-c-l-o [sic] I think.

18 Q. And the COO?

19 A. Austin Champoux.

20 Q. The CNO?

21 A. Colleen Thielk.

22 Q. And the CFO?

23 A. Taylor Guittap.

24 Q. Is there a chief marketing officer for
25 Good Sam?

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1 A. No.

2 Q. Is there a chief quality officer?

3 A. No.

4 Q. Does the Palm Beach Health Network share a
5 chief quality officer?

6 MR. MARCUS: Object to form.

7 A. Not officers.

8 BY MS. BLAIR:

9 Q. Is there a chief quality director?

10 A. We would call them a group director.

11 Q. Who's the group director?

12 A. Gina West.

13 Q. And so her will title is the Palm Beach
14 Health Network group director?

15 A. Quality director.

16 Q. Okay. So she is the Palm Beach Health
17 Network group quality director?

18 A. Correct.

19 Q. And she oversees all five hospitals?

20 A. Yes.

21 Q. And are there quality personnel at Good Sam?

22 A. Yes.

23 Q. Who is in the quality department? My word.

24 I don't know if you call it the quality department, but
25 who's in charge for quality for Good Sam directly?

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1 A. Erin Britt.

2 Q. And what is her title?

3 A. The quality director.

4 Q. And who reports to Erin Britt?

5 A. Infection control; Lauren. I'm drawing a
6 blank on her last name. There's also an infection
7 control coordinator that reports to her.

8 Q. Does she only have one direct report?

9 A. Two. So there's two. There's the -- Lauren
10 who's really over infection control, and then there's a
11 coordinator as well, so there's two, I believe.

12 Q. Who is Taylor Pool?

13 A. She is the group infection control director.

14 Q. So Regina West, she's not associated with
15 any specific hospital?

16 A. I don't believe she is any longer.

17 Q. And what about Taylor Pool, is she
18 associated with any specific hospital?

19 A. I believe she's also the infection control
20 director at St. Mary's, but I'm not sure.

21 Q. So Gina West and Maggie Gill, they're direct
22 employees of Tenet Healthcare home office to the best
23 of your knowledge?

24 A. Gina West, no.

25 Q. Okay. What hospital is Gina West affiliated

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1 with?

2 A. I believe she either might be on my books or
3 St. Mary's.

4 Q. Does she have an office at Good Samaritan?

5 A. St. Mary's.

6 Q. So in terms of the finances of these five
7 hospitals, do you share sort of the cost of Regina West
8 if she's overseeing quality for all five hospitals?
9 How does that work?

10 A. Yes.

11 Q. So is it the case that any -- well, strike
12 that.

13 Is that the same with Maggie Gill, then?

14 A. I don't believe so.

15 Q. Okay. But it is for Regina West, correct?

16 A. Yes.

17 Q. And in your role as CEO of Good Samaritan,
18 what oversight do you have with respect to quality?

19 A. Well, the CNO is -- has direct oversight,
20 and I have oversight of the CNO, so...

21 Q. So the CNO, does -- I think it's a
22 "she" report to you regularly?

23 A. Yes.

24 Q. And that's Colleen Thielk, correct?

25 A. Correct.

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1 Q. And what are Colleen Thielk's
2 responsibilities as the chief nursing officer as it
3 relates to quality and safety?

4 A. She has direct oversight of the clinical
5 operations of the hospital, safety risk, infection
6 control.

7 Q. Does she report to you regularly regarding
8 clinical operation, safety risk and infection control?

9 A. Yes.

10 Q. Do you have regularly scheduled meetings
11 with respect to that?

12 A. We do.

13 Q. How often do you meet?

14 A. Once a week.

15 Q. And, generally speaking, what are the
16 substance of these meetings?

17 A. All types of things, I mean, down to
18 recruitment, to culture, to what we're doing, patient
19 safety, mentorships.

20 Q. How much time does Colleen Thielk spend
21 on -- well, strike that.

22 Can you tell me what are Colleen Thielk's
23 duties as the chief nursing officer of Good Samaritan?

24 A. To oversee the clinical operations of the
25 building. I mean, to me that encompasses the things

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1 that I mentioned before about risk, safety, infection
2 control, patient satisfaction, you know, all those
3 types of things.

4 Q. Does she oversee the nursing staff?

5 A. She has directors, of course, but, yes.

6 Q. And how many people report to
7 Colleen Thielk?

8 A. She probably has eight to ten direct report,
9 maybe ten direct reports, and then they have managers
10 that report to them.

11 Q. How many full-time nurses are employed by
12 Good Samaritan?

13 A. Probably about 370 maybe, 350.

14 Q. Are they unionized?

15 A. Yes.

16 Q. What union are they in?

17 A. 1199.

18 Q. Does Colleen have any direct interaction
19 with the union on behalf of the nursing -- the nurses?

20 A. Not typically. It's not very -- the union
21 there is not really active.

22 Q. What about the chief -- do you have a CHRO?

23 A. Yeah.

24 Q. You do. Kevin?

25 A. Yes.

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1 Q. I can't pronounce it. Does he have direct
2 interaction with the unions?

3 A. Very little. A union rep might come to the
4 hospital like a couple times a year maybe.

5 Q. Why did the five hospitals decide to rebrand
6 as Palm Beach Health Network?

7 A. I think it was more of, you know, getting an
8 identity to show that we're an encompassing network of
9 hospitals that work together.

10 Q. Do you compete with each other these five
11 hospitals?

12 A. No.

13 Q. All five of these hospitals are acute care
14 hospitals, correct?

15 A. They are.

16 Q. And they're all in the general geographic
17 region, correct?

18 A. Yes.

19 Q. But you don't consider each other to be
20 competitors in any way?

21 A. No.

22 Q. Why not?

23 A. We support each other. We work on business
24 plans together. We're all specialized really in
25 different areas.

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1 Every hospital has, general surgery, for
2 example, so that's not really an identifier. So Delray
3 is a trauma hospital. St. Mary's is a trauma hospital.
4 They're very far from each other. They're the only two
5 trauma hospitals in the county.

6 Q. Do you have any -- do you keep any
7 statistics as to how many patients choose one of the
8 five hospitals over the other four?

9 A. No.

10 Q. Do you understand that one of the
11 allegations that's made in this case is that people are
12 bypassing Good Sam to go to other hospitals, correct?

13 A. Correct.

14 Q. Do you know whether they bypass Good Sam to
15 go to St. Mary's or Delray or Palm Beach Gardens? Have
16 you done a study as to that?

17 A. We have not, but I would gather not.

18 Q. Why would you gather not?

19 A. Because we all had failing grades.

20 Q. Well, there's a lot of other things that go
21 into choosing a hospital, wouldn't you agree with me?

22 A. Could you be more specific?

23 Q. Well, yeah. I mean, do you have any
24 understanding that a patient may choose another
25 hospital because they like the doctor at that hospital

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1 better than another hospital?

2 MR. MARCUS: Object to form.

3 A. Sure.

4 BY MS. BLAIR:

5 Q. Right. And so I'm just sort of saying like
6 there are a lot of reasons people might choose one
7 hospital over another, correct?

8 A. Yes, but I would say with the failing
9 grades, it definitely people have chosen not to choose
10 our hospitals and would hinder people to actually
11 question their doctors to even come to our hospitals.

12 Q. Do you believe that's the same with respect
13 to a one-star CMS rating?

14 A. I do not.

15 Q. Why not?

16 A. So with CMS, in general, if you looked at
17 the Palm Beach County hospitals, there are many
18 one-star hospitals. It never hit the news. I was
19 never questioned from any patient, any doctor until we
20 were all F's and it was all over the news, which is, in
21 people's minds, obviously, a failing grade.

22 Q. So no one on your board of directors cared
23 that you're a one-star CMS hospital?

24 MR. MARCUS: Object to form.

25 A. They never said anything. They never really

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1 looked that what's -- what is a star hospital and what
2 do the stars really mean.

3 In my opinion, in Palm Beach County, CMS
4 star ratings never made the news. It was not like that
5 everyone was looking at.

6 When it makes the news that you have a
7 failing red F, that's very, very different to people,
8 so you're a failing hospital. You failed. That's what
9 it looked like.

10 BY MS. BLAIR:

11 Q. But isn't it important to you as a CFO that
12 you have good marks for patient experience whether or
13 not it's in the news or not?

14 A. Yes, patient experience is important to us.

15 Q. And you have a one-star for patient
16 experience at Good Sam, correct?

17 A. I do.

18 Q. And you've looked at the HCAHPS scores from
19 CMS for patient experience, correct?

20 A. I have.

21 Q. And so whether it's in the news or not,
22 isn't that important to your board of directors, how
23 patient experience is at Good Samaritan?

24 A. Patient experience is important, yes.

25 Q. Okay. But it's only if it's in the news

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1 that you think that should impact somebody's decision
2 to come to your hospital?

3 MR. MARCUS: Object to form.

4 A. That's not what I said at all.

5 BY MS. BLAIR:

6 Q. Okay. I just want to make sure I understand
7 what you said.

8 Patients have experiences at hospitals,
9 correct, when they're admitted?

10 A. Correct.

11 Q. And patients report on those experiences at
12 the hospitals, correct?

13 A. Some of them do.

14 Q. And that's what ultimately turns into the
15 HCAHPS scores that CMS looks at, correct?

16 A. That is correct.

17 Q. And so in your long history of working at
18 hospitals, do you have any opinion about whether or not
19 word of mouth from patients can affect whether or not
20 other patients want to go to a hospital?

21 A. Certainly.

22 Q. And have you ever looked at comments on
23 social media from patients about their experiences at
24 Good Samaritan?

25 A. I have.

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1 Q. Do you have any understanding as to
2 whether -- as to whether or not comments by patients on
3 social media impacts whether or not their friends and
4 neighbors might want to go to that hospital?

5 A. They could.

6 Q. And have you done any studies at
7 Good Samaritan to make a determination as to whether or
8 not patient experience at your hospital impacts your
9 brand?

10 A. A specific study, no.

11 Q. Getting back to the rebranding of the Palm
12 Beach -- the rebranding of these five hospitals as Palm
13 Beach Health Network, do you understand that occurred
14 in or around April of 2022?

15 A. I mean, I don't remember the exact date.

16 Q. I read a newspaper article from April of
17 2022, and it says, "Five Tenet hospital" -- "five
18 Tenet Healthcare owned hospitals in Palm Beach County
19 are retooling their image to emphasize ties to local
20 physicians and communities."

21 Does that comport with your recollection as
22 to why the rebranding occur?

23 A. I mean, local communities, yes. I'm not
24 really sure about the physician statement. I don't
25 recall that.

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1 Q. Okay. And that same article said, "The move
2 comes as more residents pour into the region."

3 In April of 2022, is it your recollection
4 that more residents were pouring into the region that
5 Good Samaritan services?

6 MR. MARCUS: Object to form.

7 A. I mean, the community has been growing for
8 quite sometime. I don't know if it had anything to --
9 in that time, April. I mean, the last several years,
10 yes, it would have been --

11 BY MS. BLAIR:

12 Q. Do you live in this community?

13 A. Yes, I do.

14 Q. And then it says -- so that sentence goes on
15 to say, "The move comes as more residents pour into the
16 region and rival medical providers vie for new and
17 often wealthy patients."

18 As the CEO of Good Samaritan in around April
19 of 2022, would you agree that rival medical providers
20 were coming to the area?

21 A. Yeah, I would definitely say so. There's
22 definitely been a movement in the Palm Beach County
23 with different organizations in healthcare.

24 Q. Does Palm Beach Health Network have a --
25 have someone that oversees marketing for these five

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1 hospitals?

2 A. Yes.

3 Q. And who is that?

4 A. Lisa Cook.

5 Q. And is Lisa Cook affiliated with any of the
6 five hospitals?

7 A. Delray.

8 Q. Is there a reason why it appears the
9 majority of people that have responsibilities for the
10 Palm Beach Health Network as the group come from Delray
11 as opposed to the other hospitals?

12 MR. MARCUS: Object to form.

13 A. No. Ricky is at West Boca. And I did
14 forget to mention Maria Morales. She's COO.

15 BY MS. BLAIR:

16 Q. And where is she from?

17 A. St. Mary's.

18 Q. What are Lisa Cook's responsibilities for
19 marketing for the Palm Beach Health Network?

20 A. So the marketing managers at the hospitals
21 have, you know, a dotted line to her, so she helps
22 oversee them and their activities, you know, assisting
23 them with budgeting, assisting them with, you know,
24 branding. We work very well as a group, I would say.

25 Q. And who is the marketing manager for

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1 St. Mary's -- or for Good Samaritan?

2 A. Nancy Morales.

3 Q. Is she related to Maria Morales?

4 A. She's not.

5 Q. What is the marketing budget for
6 Good Samaritan? Well, let's do it this way.

7 What was the marketing budget for
8 Good Samaritan in 2024?

9 A. I don't have a number.

10 Q. Is it a percentage of the overall budget?

11 A. No, it was based on whatever, honestly, we
12 spent last year.

13 Q. At any time from April of 2022 through
14 present, has Palm Beach Health Network encouraged the
15 hospitals to increase their marketing budget due to the
16 fact that rival hospitals were coming into the area and
17 competition was getting bigger?

18 A. No.

19 Q. So there was no effort to increase marketing
20 despite the fact that Cleveland Clinic and Langone and
21 other hospitals were coming to the area?

22 A. It doesn't really work like that. You know,
23 we would look at what our service lines are and that's
24 what we support. If there was something else
25 marketing-wise, a budget I'm not aware of, I'm not

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1 aware of that.

2 Q. Was there any direction from
3 Tenet Healthcare home office to increase marketing
4 efforts in the South Florida region in light of the new
5 competition coming?

6 MR. MARCUS: Object to form.

7 A. Not that I recall. I mean, there could have
8 been.

9 BY MS. BLAIR:

10 Q. Do you recall having any conversations as
11 the CEO of Good Samaritan about increasing marketing
12 efforts in the South Florida region in or around or
13 between April of 2022 and present in light of the new
14 competition coming to the area?

15 A. I would say that the conversations I recall
16 were more around branding. And obviously there was a
17 budget put out there for branding, but it's not a
18 budget I'm really aware of.

19 Q. And when you say "around branding," are you
20 referring to branding Palm Beach Health Network?

21 A. Correct.

22 Q. And what do you recall about the efforts to
23 brand the Palm Beach Health Network?

24 A. You know, the creation of a logo, tag line,
25 commercials, videos, things of that nature.

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1 Q. Was part of Good Samaritan's budget
2 earmarked for that additional branding effort?

3 A. I'm not really sure. That's why I was
4 thinking that there's a different -- there was a
5 separate budget allocated that would really be separate
6 from what we would do with our budget at the hospital.

7 Q. Do you recall if there was a marketing
8 campaign to promote Palm Beach Health Network in or
9 around April of 2022 when the branding occurred?

10 A. Yeah, I don't recall the date, but I know
11 there was -- like I said, there's a commercial.
12 There's, you know, collateral, changing the logo,
13 things like that.

14 Q. What is collateral? I don't know what that
15 means.

16 A. Like anything about our network, our
17 hospital, whether it's something that you would mail
18 out to the community, things that you would hand out
19 that talk about your business.

20 Q. Are you now called like Good Samaritan, part
21 of the Palm Beach Health Network? I mean, is that how
22 you brand yourselves now?

23 A. Yep.

24 Q. And so as part of that branding effort, do
25 you consider Good Samaritan to be tied from a branding

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1 perspective to the other four hospitals that are part
2 of the Palm Beach Health Network?

3 A. I consider us together, yes. And the whole
4 point is really to show that there are so many services
5 that we provided throughout the community.

6 Q. And when you say "so many services we
7 provide throughout the community," you're referring to
8 healthcare services?

9 A. Correct.

10 Q. Are there any other services that are
11 provided?

12 A. I mean, other than employment...

13 Q. Just want to make sure I understood.

14 We talked earlier a little bit about
15 Regina West. And she is -- I want to make sure I get
16 this right. She is the Palm Beach Health Network group
17 quality director, correct?

18 A. Yes.

19 Q. And there is no Palm Beach Health Network
20 group quality -- or, sorry -- Palm Beach Health Network
21 group chief quality officer, correct?

22 A. No.

23 Q. So she would be the highest ranking
24 individual with respect to quality at the Palm Beach
25 Health Network?

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1 A. Correct.

2 Q. What type of data does she track for the
3 network as a whole?

4 A. I'm not really sure what she does on her
5 day-to-day basis. I just know my interactions with her
6 with our quality meetings and going over our score
7 cards that have anything to do with infection,
8 mortality, things of that nature. I mean, I'm not sure
9 what she tracks on her day-to-day job.

10 Q. Does she produce quality and safety reports
11 for the network as a whole?

12 A. I mean, I'm not sure what she might send out
13 to chief nurse officers, but so we have monthly
14 meetings where we go over our, you know, score cards.
15 She normally, you know, chairs those types of meetings.

16 Q. And you -- when you refer to "score cards,"
17 what are you referring to?

18 A. So the quality balanced scorecard basically
19 is what it is.

20 Q. And what does that look like?

21 A. It has a bunch of different measures on it.
22 It has emergency room measures on it, how long a
23 patient is waiting. It has mortality. It has
24 infections, transfer acceptance rate.

25 Q. Are those called the quality reports?

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1 A. They're -- I would say they're the standard
2 score card that really gathers a lot of information on
3 one score card, but there are all types of quality
4 things that -- you know, data, other score cards, but
5 this is the main one that as leadership we review.

6 Q. Do you know if those documents were produced
7 in this litigation?

8 A. I'm not sure if the balanced scorecard was.
9 Probably.

10 Q. I'll show you some --

11 A. I'm pretty confident.

12 Q. I'll show you some document later today.

13 A. Okay.

14 Q. Maybe I've seen them and I'm just not
15 calling them the score card.

16 A. Okay.

17 Q. And speaking of documents, were you involved
18 in connection with gathering documents to produce in
19 this litigation?

20 A. Yes.

21 Q. And what did you do to gather documents to
22 produce?

23 A. I believe specifically for me it was mostly
24 emails and helping with like governing board minutes.

25 Q. Did you ask anyone else at the

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1 Good Samaritan organization to gather documents?

2 A. I did.

3 Q. Who were those people?

4 A. Amy Travland, who is the director of medical
5 staff. She keeps all the minutes for the Med Exec
6 Committee.

7 Q. Anyone else?

8 A. Laura Feak, she's my AA. She gathered like
9 governing board minutes because she's the one that
10 obviously does them. I had conversations with
11 Erin Britt who's the quality director.

12 Q. Did you ask Erin Britt to gather her emails?

13 A. Yes, it was emails, and I think there may be
14 was a request for like monthly QIPSC minutes or
15 something, so and then she started working with
16 Gina West and they gathered everything and had their
17 own thing they were doing.

18 Q. And for the record what is QIPSC?

19 A. It's Quality Improvement Patient Safety
20 Committee.

21 Q. And who is on the QIPSC?

22 A. Most leaders in the hospital, risk
23 management, infection control, CNO. I attend quite
24 often. There's a few doctors that are on it as well.
25 Our vice chief is on it. Nick Sama, director of

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1 orthopedic services is on it. It's a good group of
2 people.

3 Q. How often do you meet?

4 A. Once a month.

5 Q. And do you go over the score card at these
6 meetings?

7 A. Yes, I think it's typically on there.

8 Q. What else do you do at these meetings?

9 A. Go over blood transfusions, falls,
10 infections. Risk management normally goes through her
11 like list of any like grievances. Infection control is
12 there so they'll go over their surveillances. You
13 know, there's a whole list of like Joint Commission
14 stuff that you have to review and then other stuff. If
15 they have a PI committee or something, they'll go over
16 things like that.

17 Q. Are there meeting minutes that are produced
18 from these QIPSC meetings?

19 A. There should be.

20 Q. Are there agendas for these QIPSC meetings?

21 A. Yes.

22 Q. What types of -- and I'm really focused on
23 like patient safety type of documents, infection
24 control.

25 What type of documents in the area of

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1 patient safety or patient quality are shared at these
2 QIPSC meetings?

3 A. All of them, like down to SSIs, any
4 infection, incident reports, grievances from patients.
5 I would essentially say that mostly everything that's
6 reviewed there is around patient safety. I look at all
7 of this as patient safety, every measure.

8 Q. And what did you do to prepare for your
9 deposition here today?

10 A. I had some meetings with my attorneys,
11 reviewed -- reviewed documents that we discussed.

12 Q. Do you recall what documents you reviewed?

13 MR. MARCUS: Objection. I'm going to
14 instruct the witness not to answer that.

15 MS. BLAIR: You're going to instruct the
16 witness not to answer about documents --

17 MR. MARCUS: Documents.

18 MS. BLAIR: -- she reviewed in
19 preparation --

20 MR. MARCUS: She can talk generally, yeah.

21 MS. BLAIR: -- for her deposition?

22 MR. MARCUS: Well, she's talking about
23 conversations with her attorney.

24 MS. BLAIR: I don't know want to know about
25 conversations with your attorney.

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1 MR. MARCUS: Well, that's what she just
2 said, so...

3 MS. BLAIR: Oh. I'll rephrase the question.

4 BY MS. BLAIR:

5 Q. What documents did you review in preparation
6 for your deposition?

7 A. I reviewed quality documents. Mostly
8 quality documents. Actually, they all encompass things
9 to do with patient safety, quality, CMS.

10 Q. So CMS documents?

11 A. Yeah.

12 Q. And what kind of --

13 A. Data.

14 Q. Oh, CMS data.

15 A. Yeah.

16 Q. Do you remember for what years?

17 A. What's out there now and where we are today
18 because, as you know, it's a lagging indicator. It's
19 some of data is three years old.

20 Q. And when you say "quality documents," what
21 do you mean by "quality documents"?

22 A. Like QIPSC, tracking of infection control
23 documents.

24 Q. When you say "QIPSC," are you referring to
25 agendas or minutes?

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1 A. Yeah, like maybe looking at one of the
2 months.

3 Q. Did you look at any emails?

4 A. I did, yes.

5 Q. Do you recall any specific emails you
6 reviewed?

7 A. Anything that I was supposed to give really
8 to the attorneys that related to Leapfrog.

9 Q. And I don't want to know any discussions you
10 had with your attorneys, but so your memory is that in
11 preparation for your deposition you reviewed emails
12 that had to do with Leapfrog?

13 A. Mine.

14 Q. Your emails?

15 A. Yeah.

16 Q. Any emails stand out in your mind that you
17 reviewed in preparation for this deposition?

18 A. What do you mean by "stand out" in my mind?

19 Q. Can you recall any specific email that you
20 reviewed?

21 A. Oh, that I -- I mean, yes.

22 Q. Which ones?

23 A. An email about getting statements out or
24 like to governing board members.

25 Q. And those would have been statements about

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1 your Leapfrog grade was going to be an F or a D?

2 A. Well, more like there are emails to me about
3 the F.

4 Q. Any other emails that you can recall that
5 you reviewed in preparation for your deposition?

6 A. Other than some emails that I reviewed with
7 the attorneys.

8 Q. I'm going to mark this as Exhibit 1 now that
9 I have a copy.

10 (Defendant's Exhibit Number 1 for i.d.)

11 BY MS. BLAIR:

12 Q. Ms. Montgomery, I've handed you what we've
13 now marked as Montgomery Exhibit 1, which is titled --
14 and it's long -- "Amended Notice of Taking in Person
15 Videotaped Deposition of Sheri Montgomery, Individually
16 and Pursuant to Rule 30(B)(6) to Good Samaritan Medical
17 Center, Inc."

18 Do you see this?

19 A. I do.

20 Q. And full disclosure, this was just updated,
21 I think, over the weekend with your attorneys. So can
22 you just take a look at this? And I'm going to ask if
23 you've seen this version before, which you may not
24 have.

25 A. Okay.

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1 Q. My first question is, do you understand
2 you're here today to testify not only individually but
3 also in your capacity as the corporate representative
4 of Good Samaritan Medical Center?

5 A. Yes.

6 Q. And while we made -- do you understand that
7 your attorneys and I have had multiple conversations
8 about limiting what your testimony would be here today
9 in your capacity as the corporate representative of
10 Good Samaritan?

11 A. Yes.

12 Q. Okay. And do you understand that this
13 document is a result of the negotiations that your
14 counsel and I have had with respect to the limitations
15 that would be on your testimony as the corporate
16 representative of Good Samaritan?

17 A. Okay.

18 Q. And I understand you've seen a document like
19 this previously, correct?

20 A. Correct.

21 Q. Okay. And you are prepared to testify on
22 the topics that you just read through here today?

23 A. Yes.

24 Q. And when we talked about your preparation,
25 how many times did you -- I don't want to know what you

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1 said with your attorneys, but how many times have you
2 met with your attorneys to prepare for your deposition?

3 A. Probably five times maybe.

4 Q. And when was the first time?

5 A. Maybe a couple months ago maybe. I don't
6 know.

7 Q. Okay. You can set that aside. I just want
8 to make sure for the record we all understand you're
9 here both in your individual capacity and on behalf of
10 Good Samaritan. And I will try to make sure that my
11 questions are clear. Right now I'm just asking you
12 questions as Sheri Montgomery.

13 But from time to time I might -- may ask you
14 to clarify your question both in your individual
15 capacity and in your capacity as the corporate
16 representative for Good Samaritan?

17 Is that okay?

18 A. Yes.

19 Q. And if at any time you have a question about
20 whether or not I'm asking that in your capacity as an
21 individual or as a corporate representative of
22 Good Sam, please ask me for that clarification.
23 Otherwise, for purposes of this record, I will try to
24 make that clear.

25 Is that fine?

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1 A. Yes.

2 Q. We talked earlier about --

3 MR. MARCUS: Kim --

4 MS. BLAIR: Yeah.

5 MR. MARCUS: -- we've been going over an
6 hour. Is this a good time to take a break
7 before you get into your --

8 MS. BLAIR: Oh, sure, yeah, go ahead.

9 MR. MARCUS: Can we go off the record?

10 THE VIDEOGRAPHER: We're going off the
11 record. The time is 10:16 a.m.

12 (A recess was taken from 10:16 a.m. to 10:25 a.m.)

13 THE VIDEOGRAPHER: We are back on the
14 record. The time is 10:26 a.m.

15 BY MS. BLAIR:

16 Q. Ms. Montgomery, before we went off the
17 record, we were talking about what I've now marked as
18 Exhibit A [sic].

19 And for the record, I just want to be clear,
20 and counsel reminded me of this, that late last night I
21 had an agreement with Mr. Lee Crain from Gibson Dunn
22 that I would withdraw topic number 10, and so that will
23 be stricken from Exhibit Number 1.

24 I know there's no question, but I wanted to
25 put that on the record.

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1 A. Oh.

2 Q. No question. I just wanted you to know that
3 and counsel to know that.

4 Going back to Regina West, does she create
5 hospital safety plans for Good Samaritan?

6 A. I mean, she may be involved with that piece
7 of it. I'm not sure.

8 Q. Does Good Samaritan have a hospital safety
9 plan?

10 A. It does.

11 Q. And how often is that hospital safety plan
12 created?

13 A. Annually.

14 Q. And, to your knowledge, who creates that for
15 Good Samaritan?

16 A. I think it's really reviewed -- this is my
17 thoughts -- you know, at the corporate level and then
18 the local level and for all hospitals so that we all
19 have similar structures.

20 Q. Is there a hospital safety plan specific to
21 Good Samaritan?

22 A. Yes.

23 Q. And to the best of your understanding as you
24 sit here today, that safety plan is first reviewed at
25 the corporate level and then at the local level?

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1 A. Definitely at the local level, so they're
2 similar or, if not, the same because. We try to
3 operate as a network and have similar structures.

4 Whether the corporate office is part of
5 that, that's a possibility.

6 Q. Okay. It's a possibility, but you don't
7 know for sure?

8 A. I'm not a hundred percent.

9 Q. Do you know whether Good Samaritan's
10 hospital safety plan has been produced in this
11 litigation for 2003 [sic], 2004 [sic] and 2005 [sic]?

12 MR. MARCUS: Object to form.

13 A. I'm not 100 percent, to be honest. I
14 believe so.

15 MR. MARCUS: Did you mean 2023, 2024, 2025?

16 MS. BLAIR: Oh, see, I should be reading
17 this realtime. I'm too old for that. Yeah, let
18 me rephrase the question. I'll just go one by
19 one.

20 BY MS. BLAIR:

21 Q. Do you know whether the Good Samaritan 2023
22 hospital safety plan has been produced in this
23 litigation?

24 A. I'm not 100 percent.

25 Q. And same question with respect to the 2024

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1 Good Samaritan Hospital safety plan.

2 A. I'm not 100 percent.

3 Q. And same question with respect to 2025.

4 A. I'm not 100 percent.

5 MS. BLAIR: Thank you, Counselor. I
6 appreciate that.

7 BY MS. BLAIR:

8 Q. In your conversations as the CEO of
9 Good Samaritan, have you ever had any discussions with
10 Ricky Ramirez regarding nurse retention?

11 A. I'm sure we have.

12 Q. Can you tell me just generally about the
13 market for nursing in South Florida?

14 A. You mean as regards to what exactly?

15 Q. Yeah. Is it difficult to hire nurses in
16 South Florida?

17 A. I mean, I would say that in today's
18 environment it's better than it was, you know, but it's
19 still a challenge. There's a lot of nurses wanting to
20 do remote work, for example, and not be in a hospital,
21 so, you know, when individuals leave an organization
22 oftentimes, it's for that type of balance or work from
23 home. There's more of that these days, so...

24 Q. With respect to Derek Collins, he's the
25 chief strategy officer for Palm Beach Health Network?

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1 A. Yes.

2 Q. And is he affiliated with a specific
3 hospital?

4 A. No.

5 Q. As the chief strategy officer, do you know
6 what his duties are?

7 A. He's just really with market analysis,
8 business planning, you know, service line development
9 and things of that nature.

10 Q. Does he provide reports to the hospitals
11 that make up Palm Beach Health Network regarding the
12 competitive position of the hospitals in the South
13 Florida market?

14 A. He supplies market share data.

15 Q. And what is that market share data that he
16 supplies?

17 A. Essentially it's our primary service area
18 for all five hospitals, and then it will show by, like
19 service line, and it will show like all the hospitals
20 in that area that may have -- are in our PSA that what
21 their volumes are by service line, what the population
22 is, things of that nature.

23 Q. And when you say "PSA," what do you mean by
24 PSA?

25 A. Primacy service area.

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1 Q. And what is the primary service area for
2 Good Samaritan?

3 A. It's like 14 different zip codes. It's by
4 zip codes.

5 Q. Okay. And so he creates, if I am
6 understanding, he creates a document that will show by
7 service lines all the hospitals in the area and the
8 different volumes by service line?

9 A. (Nodding head).

10 Q. Okay. So --

11 A. I mean, he doesn't do it personally.

12 Q. Understood. He's got people, right?
13 What --

14 A. Or a system or whatever.

15 Q. What does that document look like?

16 A. Essentially it's a, I want to say like a bar
17 graph or whatever that shows, you know, various years,
18 and then it will show neurology, for example. And it
19 will show over those years, you know, what the volume
20 and market share is of that population in the PSA
21 basically.

22 Q. Does it compare your hospital to, let's say,
23 your competitors in terms of volume and market share?

24 A. I mean, all the hospitals are there if they
25 have volume in that service line, you know, so you can

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1 compare.

2 Q. Does this document that he or his people put
3 out, does it have a name?

4 A. I believe it's just, you know, we all just
5 know it as the market share data.

6 Q. Do you know whether or not that document has
7 been produced in this litigation?

8 A. I don't know.

9 Q. Did you review that document in preparation
10 for your deposition today?

11 A. I did not.

12 Q. Does he put out -- other than this document
13 that you know as the market share data, does he put out
14 any other documents analyzing your competitive position
15 in the geographic area?

16 A. Most of it is that market share data. I
17 mean, if you individually ask him for something, he'll
18 produce that data to you. If you ask for a specific,
19 you know, service line for your hospital, they can
20 produce that data for you.

21 But, for the most part what he sends out is
22 market share data which has all the hospitals on it.

23 Q. Do you know what system he uses to get the
24 data that shows the market share?

25 A. I think it's called Trilliant potentially.

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1 Q. Do you know what Good Sam's marked share was
2 in 2024 -- well, strike that.

3 Do you know what Good Sam's market share was
4 in 2023 for its primary service lines?

5 A. In 2023? Not off the top of my head. I'd
6 have to look at a document.

7 Q. I'd show you one if I had it.

8 Do you know what Good Sam's market share was
9 for its primary service lines in 2024 for the South
10 Florida area?

11 A. I really don't because they're like -- the
12 document that's provided, I'd have to say just for
13 Good Samaritan, not for the Palm Beach Health Network,
14 so for the Palm Beach Health Network, that would be
15 lower than if I looked at just primary service area for
16 Good Sam, to be honest. I look at data that's more
17 specific to Good Sam, my own volume at Good Samaritan.

18 Q. Okay. And when you look at the volume at
19 Good Samaritan, what documents are you looking at?

20 A. They're produced documents that are out of
21 the financial system that we have called S2K or an
22 Excel document that's produced by like the CFO.

23 Q. So at any time did you do a comparison of
24 Good Sam's market share for 2024 versus 2025?

25 A. I'm sure it was probably produced for

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1 business planning or something.

2 Q. As you sit here today, do you know what the
3 difference was in market share for Good Samaritan's
4 primary service lines between the -- the difference
5 between 2024 and 2025?

6 A. In 2025. Actually, the '25, probably is not
7 available.

8 Q. Okay. Then do you know -- that's a good
9 point.

10 Do you know what the difference is -- did --
11 do you know what the difference in the market share is
12 for Good Samaritan between 2024 and 2023 as you sit
13 here today?

14 A. So I believe it was down, and I know that
15 it's down in my financials 5 percent.

16 Q. Okay. So it's down from -- I want to make
17 sure I understand. So your memory is that when you
18 looked at 2023 compared to 2024, the market share is
19 down?

20 A. I -- no, '23 to '24? No, should not be down
21 because my financials are up. But, again, I don't have
22 the report. So it should be up. But '25 from what I
23 have on my financials, which we don't have, market
24 share data because I think it's six months in a lag, I
25 am down 5 percent.

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1 Q. And when you say "I am down 5 percent" --

2 A. Good Samaritan is down 5 percent and
3 admissions and OBS year over year, year to date.

4 Q. 5 percent in admissions and OBS?

5 A. Observations cases, which is essentially a
6 patient and you're in the hospital that stays two to
7 three days. Under observation it's called.

8 Q. Okay. That makes sense.

9 And you said Good Samaritan is down 5
10 percent and admissions and OBS year over year to date?

11 A. Yes.

12 Q. What's the "year over year" mean?

13 A. So looking at last year, year to date
14 compared to this year, year to date.

15 Q. Got it.

16 A. Through August.

17 And in emergency room visits, 2 percent.

18 Q. 2 percent emergency room visits are down?

19 A. Yes. Yes.

20 Q. Do you have any understanding of Palm Beach
21 Health Network as a whole, whether admissions are down?

22 A. Admissions specifically? I'm not sure.

23 Q. What about emergency --

24 A. I believe so.

25 Q. You believe so?

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1 A. I believe.

2 Q. And same thing with OBS, you believe those
3 are down?

4 A. Yes, observations.

5 Q. Have you seen any documents showing you that
6 the -- all five hospitals which make up the Palm Beach
7 Health Network are down?

8 A. So we get monthly statements that have
9 financials for the network and then -- or the group and
10 then volume. I mean, I don't necessarily hone in on
11 all of the other hospitals. We're all in the same
12 report. But from conversations and closed calls I know
13 that admits and OBS are -- have been down and, you
14 know, a lot of the hospitals have been struggling. I
15 personally know mine, obviously, at Good Samaritan
16 because that's where I'm living my day to day.

17 Q. And so these market share data reports,
18 they're monthly?

19 A. The market share data, no.

20 Q. Okay. How often does the market share data
21 report come out?

22 A. Every six months. Don't hold me to that,
23 but it should be every six months. Now did I receive
24 it every six months? It might be seven months or eight
25 months, but because the data is available every six

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1 months because I think it's claims data that it pulls
2 from, so it's not out there as soon as you want it to
3 be.

4 Q. And then the report you talked about that
5 you look at every month about admits and OBS --

6 A. Yes.

7 Q. -- who creates that report?

8 A. Michelle Cartwright.

9 Q. And what -- do you know where the data comes
10 from that monthly report that Michelle Cartwright puts
11 out?

12 A. Yep, the financial system.

13 Q. That's the S2K?

14 A. Yes.

15 Q. Do you know whether or not those monthly
16 reports regarding revenue were produced in this
17 litigation?

18 A. I'm not sure.

19 Q. And am I right that you look at -- well, I
20 don't want to ask if I'm right.

21 Are you looking at revenue to determine that
22 admits and OBS, observations are down, or are you
23 looking at actual numbers of admits and observations?

24 A. Actual numbers.

25 Q. And when you were talking about the

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1 5 percent, is that revenue is down by 5 percent or the
2 numbers of admits and observations are down?

3 A. The volume.

4 Q. In the documents or monthly reports that
5 Michelle Cartwright puts out, does that show you, since
6 it comes from the financial system, is that showing you
7 financially whether the numbers are down or, again,
8 just the number of visits?

9 A. There's a tab for EBITDA and there is a tab
10 for volume.

11 Q. Okay. And is it your understanding for
12 Good Sam -- not your understanding.

13 Is Good Sam's EBITDA down for 2020 -- year
14 to date 2024 to 2025?

15 A. It is not.

16 Q. Is revenue down year to date for
17 Good Samaritan year to date 2024 to 2025?

18 A. It is not.

19 Q. What about does Ricky Ramirez provide you
20 with any monthly reports regarding nursing retention?

21 A. It doesn't really come from him, but we do
22 have group meetings where he'll go over various things
23 in the group meeting, and I believe retention is one of
24 them, but it would really be the CHRO.

25 Q. Do you do -- well, do you know if

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1 Good Samaritan's human resource office does exit
2 interviews for nurses that are leaving?

3 A. They do.

4 Q. And do you retain that information on the
5 exit interviews?

6 A. Yes.

7 Q. Do you know if any reports are produced by
8 Good Samaritan that sort of breaks down the reasons why
9 nurses are leaving?

10 A. Yes.

11 Q. And who produces those reports?

12 A. The CHRO, Kevin.

13 Q. Kevin whose last name I cannot pronounce.

14 A. Me neither. I struggle.

15 Q. Have you ever had to as the CEO of
16 Good Samaritan raise the issue of nurse retention to
17 the corporate level?

18 A. No, I wouldn't ever. It's not really the
19 structure.

20 Q. Do you have any understanding as to whether
21 or not nurse retention has gone down from year to date
22 from 2024 to 2025?

23 A. You mean turnover?

24 Q. Yes, I guess that's what I mean, turnover.
25 I guess turnover would be up, right?

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1 A. Right, if it's...

2 We have initiative now for retention
3 essentially, so I would say year to date we're doing
4 better because we're highly focused on that indicator
5 for sure.

6 Q. And Shannon Wills, she's the human -- she's
7 the group chief human resources officer for Palm Beach
8 Health Network, correct?

9 A. Correct.

10 Q. Do you know if she keeps any metrics on
11 nurse turnover -- much better word -- of the network as
12 a whole?

13 A. Definitely.

14 Q. Do you get those reports?

15 A. Yes.

16 Q. And what do those reports look like?

17 A. We'll cover like total turnover for total
18 employees, nursing turnover and then first-year
19 turnover, first-year RN turnover.

20 Q. First-year RN.

21 Do you know if turnover has increased from
22 2024 to 2025 year to date for the health network as a
23 whole?

24 A. I don't know 100 percent.

25 Q. But these reports that Shannon Wills puts

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1 out may be able to tell me, correct?

2 A. Definitely.

3 Q. Would you characterize Good Samaritan as
4 having issues relating to difficulty retaining nurses?

5 A. "Issues." I would say that turnover is a
6 focus for us. I think turnover is difficult in this
7 industry, period, for the reasons earlier that I was
8 discussing. People --

9 And here's a perfect example. For the
10 operating room, we're 24/7. You have to take call.
11 You may get called in at 2:00 o'clock in the morning
12 for emergency service or emergency room, or I mean, an
13 operating room procedure.

14 We have nurses now that want to go work for
15 a surgery center that's Monday through Friday, they're
16 done at 5:00. So all of those, you know, stressors of
17 working in a hospital, it's very different than working
18 in a surgery center, and there are surgery centers
19 popping up everywhere, so that's a good example of how
20 people are wanting to move to things that are not
21 necessarily a hospital environment, so...

22 Q. Lisa Cook does marketing, correct?

23 A. Yes.

24 Q. And she does marketing for Good Samaritan
25 specifically?

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1 A. She works with my manager, so, I mean, she
2 might help with specific things. I mean, she does help
3 with specific things for Good Sam, but she normally
4 works with the manager.

5 Q. And who is the manager?

6 A. Nancy Morales.

7 Q. And what kind of marketing initiatives does
8 Good Sam have?

9 A. I would say it's mostly service line
10 specific, you know, our bariatric service line or, you
11 know, orthopedics, you know, the various, you know,
12 accolades that we receive, we make sure that we get
13 that out in the community so they understand the
14 quality.

15 Q. What about Erin Britt? She was recently
16 identified in Good Samaritan's amended Answers to
17 Interrogatories. And I know you talked about her
18 previously. She's an -- on the quality side?

19 A. Yes, she's the quality director.

20 Q. Okay. And she reports -- who does she
21 report to?

22 A. Colleen Thielk.

23 Q. And do you know why she was recently
24 identified in Good Samaritan's Amended Answers to
25 Interrogatories?

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1 A. I'm not really sure I understand the
2 question. So what do you mean by she was identified as
3 the amended?

4 Q. Sure. I can just mark that if I can find
5 it?

6 MS. BLAIR: Can you mark this as Exhibit 2?
7 (Defendant's Exhibit Number 2 for i.d.)

8 MR. MARCUS: Just on the Exhibits, the first
9 Exhibit you had marked as 1 and then I think you
10 referred to it as A.

11 MS. BLAIR: Oh, I did?

12 MR. MARCUS: We're going to go with numbers?

13 MS. BLAIR: Yes, numbers. Yes. I even have
14 my own chart here. I apologize if I did that.

15 MR. MARCUS: No worries.

16 BY MS. BLAIR:

17 Q. Ms. Montgomery, I've now put in front of you
18 what we've marked as Exhibit 2 to this deposition,
19 which are Good Samaritan's Amended Answers to
20 Interrogatories, do you have that in front of you?

21 A. I do.

22 Q. And if we look at page 4. Or I'm sorry. It
23 starts on 4 and goes to 5. And it actually starts on 3
24 so, I apologize.

25 The question on 3 is interrogatory number 2.

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1 And you see it says, "Identify every individual not
2 identified in your Rule 26(a) disclosures with
3 knowledge of your Complaint," et cetera.

4 Do you see that?

5 A. Oh, yeah.

6 Q. And then the original answer is on page 4,
7 and the amended answer starts at the bottom of page 4.
8 Do you see where it says "amended answer"?

9 A. Yes.

10 Q. And in the amended answer we'll see on
11 page 5, Erin Britt is identified as the quality
12 director. Do you see that?

13 A. Yes.

14 Q. And so she was not identified in the
15 original Answers to Interrogatories. I'm just curious
16 as to why she's coming up now, if you know.

17 A. I believe Gina was the quality director at
18 Good Sam at one time. Now, Erin is.

19 Q. And do you know when Gina was the director
20 at Good Sam, when she stopped being?

21 A. My thoughts are probably three years ago --

22 Q. Okay.

23 A. -- four years, somewhere around there, three
24 years.

25 Q. So just so I understand like the structure

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1 here, Erin Britt reports to Colleen Thielk, right?

2 A. Right.

3 Q. And three years ago did Regina West have the
4 same job as Colleen Thielk does now?

5 A. No.

6 Q. Okay. Did Regina West ever have the same
7 job at Colleen Thielk?

8 A. No.

9 Q. So three years ago -- and, again, I'm not
10 holding you to the three years, but at some point
11 Regina West was the quality director at Good Samaritan?

12 A. Correct.

13 Q. And now she is just at the network level; is
14 that fair?

15 A. That's fair.

16 Q. And how long has Erin Britt been --

17 A. I believe.

18 Q. How long has Erin Britt been in this
19 position of quality director at Good Samaritan?

20 A. I'm going to go with six months.

21 Q. Okay.

22 Do you know was Erin Britt employed by
23 Good Samaritan prior to six months ago?

24 A. Yes.

25 Q. And what was her position six months ago, if

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1 you know?

2 A. She was the director of surgical -- two
3 south, a nursing unit.

4 Q. Okay.

5 A. A surgical nursing unit.

6 Q. Is Erin Britt's background nursing?

7 A. Yes.

8 Q. She's an RN?

9 A. Yes.

10 Q. Okay. Is Colleen Thielk a former nurse as
11 well?

12 A. She is.

13 Q. And what about Regina West, is she also a
14 nurse?

15 A. Yes. Where, I'm not sure. I think I've
16 always known her in a quality capacity.

17 Q. And how long has Colleen Thielk been at
18 Good Samaritan?

19 A. About maybe going on two years, I think,
20 maybe.

21 Q. And did she come from another Palm Beach
22 Health Network hospital?

23 A. She did not.

24 Q. Is there any like prohibition about going
25 between hospitals with your job?

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1 A. No.

2 Q. Okay. I just noticed several of you have
3 worked at different ones. I was just curious.

4 So I want to talk a little bit about how the
5 board works for each of these hospitals. Does
6 Good Samaritan have its own board of directors?

7 A. We do.

8 Q. Is there a board of directors for the
9 Palm Beach Health Network?

10 A. There is not.

11 Q. And each -- to your knowledge, do each of
12 the five hospitals -- I'm struggling over here.
13 Sorry.

14 To your knowledge, do each of the five
15 hospitals have their own board of directors?

16 A. They do.

17 Q. And is the board of director position at
18 Good Samaritan a paid position?

19 A. They receive a stipend for the meetings.

20 Q. Do you know what the stipend is?

21 A. I think like \$200 or something minimal.

22 Q. So not significant?

23 A. Um-hum.

24 Q. How are board members selected for
25 Good Samaritan's board of directors?

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1 A. Really myself and the board members get
2 together and try to make sure there's diversity amongst
3 the board and, you know, from attorneys to fire rescue
4 people to, you know, Palm Beach Atlantic president. So
5 as their terms come up, we think about people in the
6 community that could add a value to our board. And,
7 you know, it's a collaborative meeting, so they like to
8 give a lot of input.

9 Q. How many -- how many board members are
10 there?

11 A. I think there's twelve, something like that.

12 Q. Twelve?

13 A. I think so.

14 Q. Is there a chairman of the board?

15 A. Yes.

16 Q. Are there any other positions on the board?

17 A. Like there's a treasurer, but I'd say it's
18 mostly the chairman and a treasurer.

19 Q. Are there subcommittees on the board?

20 A. Not really.

21 Q. Is there a quality patient subcommittee of
22 the board?

23 A. Not a subcommittee. It's all reviewed in
24 our board meetings.

25 Q. How long are the terms of your board

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1 members?

2 A. Two years.

3 Q. Are they staggered terms? Do you know what
4 I mean when I say that?

5 A. Yeah, I know what you mean, but I'm thinking
6 they're not. I'm not sure. I'll have to get back to
7 you on that.

8 Q. That's fine. You don't have to get back to
9 me. If you don't know, you don't know. Sounds like a
10 true CEO.

11 A. Yeah.

12 Q. Do you know, are there term limits for
13 sitting on your board?

14 A. You can go off the board for a year. Like
15 the chamber, I'm on the board of Chamber. I go off for
16 a year, but I can come back if, you know, they want me
17 to come back.

18 Q. So after two years your board members cycle
19 off the board?

20 A. Right.

21 Q. Who was on the board in 2024? Well, strike
22 that.

23 Who was the chairman of the board in 2024?

24 A. Patrick Franklin.

25 Q. And what is Patrick Franklin's background?

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1 A. He's the CEO of the Urban League.

2 Q. And who were there twelve members of board
3 in 2024?

4 A. I don't know. I'd have to go and look.

5 Q. Are the members that were on the board --
6 well, let me ask this.

7 Is the board annually like from January 1 to
8 December 31?

9 A. Yes.

10 Q. In 2024, were there certain members of the
11 board that were more active than others?

12 A. No, I'd say they're all very active and they
13 attend the meetings. It's very rare for them to miss
14 meetings.

15 Q. How often do they meet?

16 A. Once a month.

17 Q. Do you report to the board?

18 A. I would say there's a more of a
19 collaborative thing but I guess in some ways.

20 Q. What type of reports do you give to your
21 board regarding patient safety?

22 A. There's the risk plan. Risk does a whole, I
23 think probably every quarter I think they report; so
24 does quality, go over our report card, how we're doing.
25 Compliance is every quarter he presents to the board.

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1 Q. When you say --

2 A. Which would include --

3 Q. Oh, I'm sorry.

4 A. -- down to like HIPAA compliance things,
5 ethics calls, you know, any outliers in contract
6 compliance, as you can imagine, all the compliance
7 stuff.

8 Q. When you say "report card," what are you
9 referring to?

10 A. The balanced scorecard.

11 Q. And the balanced scorecard is what we talked
12 about earlier when you were talking about the score
13 card?

14 A. Correct.

15 Q. So the board sees that every month, the
16 balanced scorecard?

17 A. I think every quarter.

18 Q. And when you said "risk plan," what are you
19 referring to?

20 A. All the risk indicators. Like, you know,
21 every quarter they'll report. The Joint Commission has
22 a requirement, too, whether it's, you know, falls,
23 grievances, how many grievances you've had, things of
24 that nature, any behavioral issues that you may have
25 with physicians. They get all the medical staff. They

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1 have to approve all the MEC medical staff
2 credentialings. They see the financials.

3 We bring employees that, you know, that we
4 like to recognize, you know, whether it's a Tenet hero
5 or a good catch employee, we'll bring employees
6 sometimes to the governing board as well to allow them
7 the opportunity to thank the employees.

8 Q. The board has no control over the
9 compensation of any of the directors of Good Samaritan,
10 do they?

11 A. They do.

12 Q. Are you involved in the search for board
13 members when it occurs?

14 A. Yeah, I would say there's -- we have a
15 committee that gets together with some of the board
16 members, and we talk about, you know, people in the
17 community who we think would maybe add value, and then
18 we, you know, interview and meet with them.

19 Q. Have you ever had any trouble recruiting
20 board members for the Good Samaritan board?

21 A. Well, recently one of the board members
22 that, you know, she's part of helping recruit, you
23 know, as we have new board members, you know, had
24 concerns about recruiting new board members because of
25 our safety rating and F.

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1 Q. And I'll show you that document because I
2 think I have it.

3 Is that one of the documents you reviewed in
4 preparation for your deposition today?

5 A. It is.

6 Q. I'll mark this as 3.

7 (Defendant's Exhibit Number 3 for i.d.)

8 BY MS. BLAIR:

9 Q. Ms. Montgomery, I am handing you what we've
10 now marked as Exhibit 3. And this is an email.
11 Obviously the oldest email is on the bottom from
12 Judy Goodman to you dated December 10th, 2024 at
13 9:46 a.m. Do you see that in front of you?

14 A. Yep.

15 Q. And in or around December 10th, 2024, your
16 email address was sheri.montgomery@tenethealth.com,
17 correct?

18 A. Yes.

19 Q. And I'm not going to ask you that for every
20 email I say to you today. Is it okay for purposes of
21 this deposition that if that email address
22 sheri.montgomery@tenethealth.com is on an email, is it
23 safe to say that was your email in or around that time?

24 A. Yes.

25 Q. Okay. And that first email, first tell me

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1 who is Judy Goodman?

2 A. She's a member of the board.

3 Q. And what is her background?

4 A. She's a retired attorney.

5 Q. Do you know what firm she worked at?

6 A. I don't.

7 Q. And if you look at her email, it looks like
8 she's talking about Kara Coniglio McClure, Gail's
9 granddaughter. Do you see that?

10 A. Yes.

11 Q. Who is Gail?

12 A. I'm not -- I'm not sure who Gail is.

13 Q. Okay. She also mentions the name
14 Ted Cooney. Do you see that?

15 A. Yes.

16 Q. And then another name is Christina Matthews
17 McFarland. Do you see that?

18 A. Yes.

19 Q. And those three names in looking at this
20 email, does that refresh your recollection that she was
21 providing names of potential future board members for
22 Good Samaritan?

23 A. Yes.

24 Q. And then she says, this line here, she says,
25 "However, it's hard to recruit right now when this

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1 story appeared this morning."

2 Do you see that?

3 A. I do.

4 Q. And she's referring to a story in the
5 Stet's -- that's all caps, S-t-e-t -- Stet blog,
6 correct?

7 A. Correct.

8 Q. Are any of these three people that are
9 mentioned in this email, Kara McClure, Ted Cooney or
10 Christina McFarland, are they currently on the
11 Good Samaritan board?

12 A. They are not.

13 Q. Did the -- did new members of the
14 Good Samaritan board come on to the board in January of
15 2025?

16 A. No. It was all last year, the year before.

17 Q. 2023?

18 A. No. You said 2025, right?

19 Q. No, 2024.

20 A. Oh, I thought you said January 2025.

21 Q. Oh, I think I did say 2025, or at least
22 Barbie wrote it down that way so I apologize. Yes. So
23 I guess let's go back.

24 Were you recruiting in December of 2024 for
25 a new board to start in January of 2025?

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1 A. No.

2 Q. Okay. So what is the -- when were the new
3 board members, if any, going to start on the
4 Good Samaritan board?

5 A. It would be next -- it would be in January.

6 Q. Of '26?

7 A. Yes.

8 Q. Okay. So is this email from Judy Goodman
9 sort of like an early email discussing who might fill
10 open positions in January of 2026?

11 A. Right, because we all talk about it, and
12 throughout the year they think about who would be good
13 and then let's try to see if we can meet with them,
14 who's going to come off the board, that kind of stuff,
15 so...

16 Q. Got it.

17 A. Yeah.

18 Q. So the board as constituted in December of
19 2024 is the same board for Good Samaritan as we sit
20 here today, same board members?

21 A. Correct.

22 Q. Okay. Have you spoken to Kara McClure,
23 Ted Cooney or Christina McFarland about potentially
24 serving on the board?

25 A. I have not.

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1 Q. Do you know if Judy Goodman has?

2 A. I'm not sure if she has, honestly.

3 Q. Other than this email, which we've now
4 marked as Exhibit 3, are you aware of any other emails
5 from a board member about difficulties in recruiting
6 for the Good Samaritan board?

7 A. I am not.

8 Q. Do you anticipate difficulties in recruiting
9 for the Good Samaritan board for January of 2026?

10 A. Potentially, but my true thoughts are I have
11 a really solid board, and they could probably explain
12 to the new candidates that the F is not -- it's a false
13 grade and explain what we have explained to them about
14 the survey. And there could be potential that it
15 wouldn't be a problem.

16 Q. And new board members could look at this
17 lawsuit as well, right, and make their own conclusions?

18 A. They could.

19 Q. I've seen emails in this -- and I'm going to
20 show you some later today, but I've seen emails in this
21 litigation that refer to H/O. Is that referring to
22 Tenet home office?

23 A. Probably. I'd have to see the email.

24 Q. Okay.

25 A. I mean, it could be another acronym, but not

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1 one I can think of right now.

2 Q. Okay. I've also seen references to the
3 acronym ELT. Do you know what that refers to?

4 A. My guess would be executive leadership team.
5 I would have to see the email. That's what I know that
6 acronym could be, but it could -- if it was a quality
7 email, it could be something related to quality or
8 clinical.

9 Q. And I'll show you those emails as well. And
10 that was my understanding.

11 So is executive leadership team a phrase
12 that is used at Tenet Healthcare?

13 A. I think so. I think it's -- yeah.

14 Q. And in your mind as the CEO of
15 Good Samaritan, who would comprise the executive
16 leadership team of Tenet Healthcare?

17 A. Of Tenet Healthcare?

18 Q. Of Tenet Health.

19 MR. MARCUS: Object to form.

20 A. Lisa -- you know, the officers, I guess, you
21 know, Lisa Foo, Saum, Judy Chabot and Ernest Franklin.

22 BY MS. BLAIR:

23 Q. Who is Judy Chabot?

24 A. She's the chief nurse officer.

25 Q. And who is Ernest Franklin?

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1 A. Chief medical officer.

2 Q. Anyone else -- and Saum is the CEO we
3 discussed earlier, right?

4 A. Right.

5 Q. And Lisa Foo is the CFO?

6 A. No, COO.

7 Q. COO. Is there a CFO of Tenet Healthcare?

8 A. Yeah, Sun. Something Sun.

9 Q. Do you know if there's a chief quality
10 officer of Tenet Healthcare at large?

11 A. I don't know if there would be a chief but
12 maybe like a vice president of quality or something,
13 but they would report to Ernest probably.

14 Q. Do you know who the director, if that's the
15 right phrase, would -- of quality at Tenet Healthcare
16 would be that reports to Dr. Franklin?

17 A. No. I know there's someone that Gina speaks
18 to and reaches out to, so I don't -- I don't know.

19 Q. Do you know if there's anybody at
20 Tenet Healthcare that oversees hospital ratings issues?

21 MR. MARCUS: Object to form.

22 A. I don't know.

23 BY MS. BLAIR:

24 Q. Is there anybody at Good Samaritan that
25 oversees hospital ratings like Healthgrades™ or

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1 Leapfrog or anything like that?

2 A. Not really.

3 Q. Do you know whether or not there is a
4 quality department at Tenet Healthcare corporate?

5 A. I mean, I'm sure -- there's a lot of people
6 on our quality call, so I'm assuming there is like
7 infection control people, quality people that our group
8 people report up to, but the way our structure is, is
9 we're really on the group level, so I have issues, it's
10 Maggie. Maggie is the person that has a connection to
11 corporate.

12 Q. Got it.

13 A. I'm not saying the corporate people aren't
14 involved on a quality call like the CMO, but our group
15 leads kind of interact, if that makes sense.

16 Q. That makes sense.

17 A. So they would know the structure a little
18 more than I probably would at the corporate level.

19 Q. And is Tenet divided into regional
20 divisions, if you know?

21 A. Yes.

22 Q. And what division does the Palm Beach Health
23 Network fall into?

24 A. I guess in the eastern division.

25 Q. And judging by --

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1 A. I don't get division reports anymore, so I'm
2 not a group person, so I don't really get all that
3 information anymore.

4 Q. Well, that answers my next question, so
5 thank you.

6 Are there any documents that are put out by
7 Tenet home office about -- well, strike that.

8 Does Tenet Healthcare on the corporate level
9 have a mission statement for its hospitals?

10 MR. MARCUS: Object to form.

11 A. Yes.

12 BY MS. BLAIR:

13 Q. And is that mission statement reproduced to
14 the hospitals like either in email form or written form
15 to the various hospitals that are Tenet hospitals?

16 A. I mean, I don't really know if it's verbatim
17 over the years. I mean, I'm not really sure. I can't
18 answer that question.

19 Q. If you had to summarize the Tenet mission
20 statement, what would you say it is?

21 A. To provide quality care treating every
22 patient the same essentially but to provide quality
23 care.

24 Q. And as the CEO of Good Samaritan hospital,
25 what would you say is the most important principle for

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1 Good Samaritan?

2 A. To provide quality care to all patients in
3 our community.

4 Q. So consistent with the Tenet Healthcare
5 mission, correct?

6 A. Yes.

7 Q. In your mind as the CEO of Good Samaritan
8 hospital, do you make a distinction between quality and
9 patient safety?

10 A. To me, patient safety encompasses the
11 quality, risk management, infection control. It is all
12 the same because at the end of the day zero harm is our
13 goal. They're all intertwined and related to one
14 another.

15 THE VIDEOGRAPHER: Can we go off the record
16 for a media change?

17 MS. BLAIR: Sure.

18 THE VIDEOGRAPHER: This ends media one.

19 We're going off the record. The time is 11:17.

20 (A recess was taken from 11:17 a.m. to 11:17 a.m.)

21 THE VIDEOGRAPHER: We're back on record.

22 The time is 10:17 a.m. -- 11:17 a.m.

23 BY MS. BLAIR:

24 Q. Ms. Montgomery, right before the break for
25 the video change you said that "Zero harm is our goal,"

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1 correct?

2 A. Correct.

3 Q. Is that the goal of the Palm Beach Health
4 Network as well, or is that just Good Samaritan's goal?

5 A. I'm sure, but it should be every hospital's
6 goal, so...

7 Q. And when you say "zero harm," does that
8 include reducing preventable errors?

9 A. Everything.

10 Q. So that's "yes" --

11 A. Yes.

12 Q. -- it would include that as well?

13 A. (Nodding head).

14 Q. And so would you agree with me that patient
15 safety is the most important principle for a hospital?

16 A. Yeah, the quality, yes.

17 Q. Well, you said "the quality," and I want to
18 make sure. I thought I wrote down you said, patient
19 safety equals quality plus risk management plus
20 infection reduction, correct?

21 A. Yes, they're all quality. So we would put
22 it under an umbrella of safety if...

23 Q. That's fair.

24 A. Some others may not interpret that the same
25 way.

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1 Q. Right. But this is how you --

2 A. It's a personal thing, yes.

3 Q. But you as the CEO of Good Samaritan
4 interpret it that way?

5 A. Correct.

6 Q. And so do you see patient safety more
7 encompass -- more encompassing than quality?

8 MR. MARCUS: Object to form.

9 A. They're all intertwined, so...

10 BY MS. BLAIR:

11 Q. Yeah, and I don't disagree. I'm just trying
12 to understand.

13 So I thought patient safety includes -- so
14 I'm just in my mind.

15 A. Yeah.

16 Q. Patient safety includes quality, risk
17 management and infection control, correct?

18 A. Yeah. I could be missing a piece or two,
19 but, yes.

20 Q. Of course.

21 A. Yes.

22 Q. But patient safety is the umbrella under
23 which you would put quality, risk management and
24 infection control?

25 A. I would.

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1 Q. And would you agree with me that patient
2 experience is an important factor for a hospital to
3 consider?

4 A. It is.

5 Q. And would you agree with me that it's
6 important for a hospital to prevent hospital-acquired
7 infections?

8 A. I would agree with that.

9 Q. And would you agree with me that it's
10 important that patients have positive outcomes when
11 they leave a hospital?

12 A. Yes, I agree.

13 Q. And would you agree with me that it's
14 important that hospitals have processes in place to
15 make sure that patients suffer zero harm at a hospital?

16 A. Yes.

17 Q. And would you agree with me that it's
18 important that patients be free from medication errors
19 at a hospital?

20 A. Yes.

21 Q. And do you consider that to be part of
22 patient safety, freedom from medication errors?

23 A. I would.

24 Q. And is it important to a hospital that its
25 patients feel as if they were receiving high quality

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1 care from the hospital staff while they were admitted
2 to the hospital?

3 A. Say that again.

4 Q. Yeah. Would you agree with me that it's
5 important to a hospital that the patients receive high
6 quality care from the hospital staff while they're
7 admitted at a hospital?

8 A. Yes.

9 Q. And that's part of the patient experience
10 that we talked about earlier, correct?

11 A. Patient experience, obviously, is important,
12 right.

13 What -- another piece of what's important is
14 trying to get the patients to complete a survey so you
15 have a true understanding of what all the patients
16 experience is or at least a good amount of patients.
17 And that's where, I think, a lot of hospitals struggle
18 is getting patients to complete surveys so we truly
19 understand what they think.

20 Q. Does the hospital, Good Samaritan, go and
21 look at Facebook comments, TikTok comments, Instagram
22 comments, social media comments, Yelp reviews, Google
23 reviews outside of the CMS patient safety surveys to
24 determine what the patient experience really is at
25 Good Samaritan?

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1 A. Yes, currently we're rolling out and have,
2 we hired a patient experience liaison for a couple
3 things: One, to push Google reviews as well because if
4 you can get a patient to give feedback on the spot,
5 they normally are more willing to do that, so you can
6 capture a lot more than the mailed surveys that do go
7 to the patient.

8 And our percentage has been low so we're
9 trying to move it to where more patients will fill out
10 the HCAHPS survey to improve our overall results.

11 But our Google reviews, I think, is at a 4.0
12 right now. But I get emails on all of them, so I
13 review them.

14 Q. So when did you hire the patient experience
15 liaison?

16 A. Probably six months ago or so.

17 Q. Prior to hiring the patient experience
18 liaison who at Good Samaritan was reviewing social
19 media posts related to patient's experiences at
20 Good Samaritan?

21 A. I think it goes to the CNO. There's a team
22 that monitors patient experience stuff or social media
23 posts, so it goes to a group of people.

24 Q. Do you know that team that monitors social
25 media posts about patient experience, who do they

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1 report to at Good Samaritan?

2 A. They don't report to anyone at
3 Good Samaritan.

4 Q. At what level is this team operating?

5 A. I don't know.

6 Q. Is it at the Palm Beach Health Network
7 level?

8 A. I don't know if it's a Tenet Healthcare that
9 they hired someone or, you know, it's -- it probably
10 is, I would say. So I'm not sure who they report to.
11 I just know we're notified so we can follow up, one, if
12 it's a patient grievance, you know, so it goes to risk
13 management or just so we're aware.

14 Q. Do you get reports from this team about
15 social media posts regarding patient experience at
16 Good Samaritan?

17 A. Not -- no, they're just emails of, you know,
18 a review or a post.

19 Q. So someone would email someone at
20 Good Samaritan and say, Here's what's being posted
21 about Good Samaritan right now?

22 A. Yeah. And it could just be something
23 positive that we want to, you know, tell the staff that
24 we received this positive review or something of that
25 nature or if it's something we want to follow up on.

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1 Q. Do you know if those documents have been
2 produced in this litigation?

3 A. I have no idea.

4 Q. Are those documents shared with the board as
5 they relate to Good Samaritan, are they shared with the
6 board?

7 A. No. Patient experience is shared with the
8 board but not like emails of, you know, say, we get a
9 Google review, we have five-star Google reviews
10 employees get, like I mentioned before, we take those
11 employees to the governing board. We've had employees
12 that got five-star reviews to the governing board so
13 they're aware and they have opportunity to thank the
14 staff.

15 Q. And you used a phrase "governing board." Is
16 that what you refer to --

17 A. The board.

18 Q. The Good Samaritan board?

19 A. Yeah, they're called the governing board.

20 Q. And if I've seen emails where it just says
21 "GB," is that referring to governing board, emails from
22 you?

23 A. Probably. I don't know what else I would
24 use GB for. I'd have to see the email, but...

25 Q. Sure. I'm just trying to interpret some of

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1 things I saw.

2 A. Yeah, I would say GB is governing board.

3 Q. And if I see a reference in emails to
4 governing board, that would -- that you've written --

5 A. Yeah, normally I type governing board out,
6 so that's why it's throwing me a little.

7 Q. And governing board is the Good Samaritan
8 board of directors, the one that we discussed that
9 Judy Goodman is on, correct?

10 A. Correct.

11 Q. Okay. Does Good Samaritan believe in being
12 transparent with its patients about its safety record?

13 A. Yes.

14 Q. And as the CEO of Good Samaritan, do you
15 believe that's important to be transparent with
16 patients about Good Samaritan's safety record?

17 A. I do.

18 Q. Do you agree with me that it's important
19 that the governing board have transparent data about
20 Good Samaritan's patient safety?

21 A. I do.

22 Q. What is the Med Exec?

23 A. They really govern the medicine of the
24 hospital. It's physicians that are leaders in the
25 organization, chief of surgery, chief of orthopedics,

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1 you know, chief of medicine, chief of anesthesia.
2 They're all like basically chairs of certain service
3 lines or committees like things, you know.

4 And they review peer review things. They
5 review all the credentialing information so that the
6 chair of credentialing reports out an MEC. They really
7 govern the medicine and bylaws of, you know, the
8 medical staff essentially.

9 Q. Are they interested in patient safety data?

10 A. They are.

11 Q. And are they provided patient safety data?

12 A. They are.

13 Q. And the Med Exec, is there one for each
14 hospital, or does it sit over the whole Palm Beach
15 Health Network?

16 A. Each hospital has their own.

17 Q. And is there one for the Palm Beach Health
18 Network?

19 A. No.

20 Q. How often does the Med Exec meet?

21 A. Monthly.

22 Q. And who chairs the Med Exec?

23 A. Keith Meyer.

24 Q. And who is Keith Meyer?

25 A. He is a cardiologist at the hospital, but he

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1 is also chief of cardiology at the hospital.

2 Q. And when you say "at the hospital," you mean
3 Good Samaritan?

4 A. Good Samaritan.

5 Q. What specific reports related to patient
6 safety are provided to the Med Exec on a regular basis?

7 A. Everything to do with falls to grievances
8 to, I mean, there's a quality report, which is the
9 score card which goes over mortality, infections,
10 lending of stay in the emergency room. Risk management
11 reports out to the MEC. I mean, they review a lot, and
12 they're on par to -- you know, they're on committees.
13 Some of them attend QIPSC, for example. They're pretty
14 involved on a lot of things. Surgery committees.
15 Chair of surgery goes to the surgery committees.
16 There's committees after committees.

17 Q. Do they interact with the governing board?

18 A. They do. So Dr. Meyer is -- attends
19 governing board. All the chairs of the MECs are
20 nonvoting members of the governing board. The
21 vice chair attends as well the governing board.

22 Q. The vice chair of the Med Exec?

23 A. (Nodding head).

24 Q. And who is the vice chair?

25 A. Dr. George Gurdock.

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1 Q. Can you spell his last name?

2 A. G-u-r-d-o-c-k.

3 Q. What sort of things does the board vote on?

4 A. I mean, they basically reports -- all
5 reports come through them, whether it's the safety
6 plan, emergency management plan, you know, the quality
7 plan.

8 Q. Do they vote on filing lawsuits on behalf of
9 Good Samaritan?

10 A. They do not.

11 Q. Who makes the decision on whether or not
12 Good Samaritan should file a lawsuit?

13 MR. MARCUS: Object to form.

14 A. Maybe someone at the corporate office. I'm
15 not sure.

16 BY MS. BLAIR:

17 Q. I want to talk a little bit about your --
18 what Good Samaritan views as its competitors in the
19 South Florida region. And I will refer you to that
20 Exhibit 2 and specifically interrogatory 19, which is
21 on page 27.

22 And you'll see that question says, "Identify
23 all hospitals, medical centers or health systems that
24 you consider to be your direct competitors within the
25 relevant geographic market during the time period

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1 covered by the Complaint."

2 Do you see that?

3 A. Okay. Yes.

4 Q. And the answer, after all of the objection,
5 appears on page 28. And we have to read both the
6 answer and the supplemental answer.

7 And if you see the answer there, it says,
8 "HCA Florida JFK Hospital," correct?

9 A. Yes.

10 Q. And where is HCA Florida JFK Hospital
11 located?

12 A. Physically? Like Congress Avenue. I
13 mean --

14 Q. Oh, no, like what town.

15 A. Oh. I think they're considered Lake Worth,
16 I think.

17 Q. Lake Worth. How far is Lake Worth from
18 Good Samaritan?

19 A. Not far. HCA is probably, I don't know,
20 five miles. I'm guessing.

21 Q. Oh, five miles?

22 A. I'm just guessing.

23 Q. And the next one here is HCA Florida Palms
24 West Hospital. Do you see that?

25 A. Yes.

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1 Q. Where is that located, town-wise?

2 A. It might be considered Palms West. I'm not
3 really sure.

4 Q. Oh, is that a town?

5 A. It's probably Loxahatchee, but there might
6 be a little section that's considered Palms West.

7 Q. And forgive me. I'm not from here so I
8 don't know.

9 A. That's okay.

10 Q. How far is Loxahatchee from Good Samaritan?

11 A. Ten miles maybe? I mean, I'm just really
12 guessing.

13 Q. Yeah, I understand. I'm just trying to
14 guess a sense of the region here.

15 What about Jupiter Medical Center, where is
16 that located?

17 A. In Jupiter.

18 Q. How far is Jupiter from Palm Beach?

19 A. I'd say Jupiter is 11 miles.

20 Q. And then the next one here is Wellington
21 Regional Medical Center. What town is that located in?

22 A. In Wellington.

23 Q. And how far is Wellington?

24 A. Maybe eight miles, maybe ten. I'd say
25 they're all around ten.

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1 Q. And then if you look at the supplemental
2 answer, you talk about Cleveland Clinic, correct?

3 A. Yes.

4 Q. Now, in looking through, do you know if
5 that's Cleveland Clinic Martin South Hospital or
6 Cleveland Clinic Martin North Hospital that you're
7 referring to here?

8 A. So Cleveland Clinic -- well, one, they're
9 building a hospital in West Palm, but, two, they have
10 outpatient imaging centers in West Palm. They have
11 physicians' offices in West Palm, so does NYU Langone.

12 Q. In your supplemental answer you're referring
13 to the West Palm Cleveland Clinic facilities?

14 A. Correct.

15 Q. Okay. And then the same with NYU Langone,
16 you're referring to whatever facilities Langone
17 currently has here?

18 A. Yes, right. But Cleveland Clinic can, you
19 know, now that they are local, see patients and send
20 patients to Cleveland Clinic Weston, so that's how they
21 capture our market, I would say.

22 Q. Okay. Cleveland Clinic Weston?

23 A. Yeah.

24 Q. Where is that located in?

25 A. In Weston.

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1 Q. How far away is that?

2 A. An hour probably. Or probably, maybe an
3 hour and a half, but so they have a hospital there that
4 they send patients, you know, and they're wanting to
5 build a hospital, obviously, in West Palm.

6 Q. Okay. I just want to run through a few
7 hospitals to make sure. And we talked about this
8 earlier. You don't consider any of the other four
9 hospitals in the Palm Beach Health Network to be
10 competitors of Good Samaritan?

11 A. I don't.

12 Q. So if a patient chooses to go to Delray over
13 Good Samaritan, you don't consider that to be competing
14 with Good Samaritan, correct?

15 A. Not really. I mean, I don't think that a
16 patient would do that. I mean, they probably, they're
17 really out of my PSA, Delray, so I wouldn't really look
18 at them as a competitor.

19 Q. Are any of the other four hospitals that are
20 plaintiffs in this litigation within your PSA?

21 A. Yes.

22 Q. Which ones?

23 A. St. Mary's.

24 Q. So same question, then, if a patient chooses
25 to go to St. Mary's over Good Samaritan, do you

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1 consider that to be competition with Good Samaritan?

2 A. No. And they have like very different
3 service lines than we do, so they don't have an
4 oncology hospital. They're trauma. I'm not trauma.
5 They have, you know, a level III NICU and RIPIT clinic.
6 I don't. So they're very different service lines than
7 what we have.

8 Q. Does Jupiter medical have different service
9 lines than what you have?

10 A. Yeah, like -- well, they only have
11 open-heart that we don't have, but essentially we have
12 the same service lines.

13 Q. And same question with HCA Florida JFK
14 Hospital, do they have different service lines than you
15 have?

16 A. Did you say JFK North?

17 Q. JFK -- oh, HCA Florida JFK Hospital.

18 A. Okay.

19 Q. Am I not saying that right?

20 A. No. That's okay. I thought you said
21 "north."

22 So JFK has open-heart. We do not. So there
23 are some differences, right, but...

24 Q. Okay. What about Wellington Regional
25 Medical Center, do they have the same service lines as

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1 you do?

2 A. Pretty much.

3 Q. Do you consider Kindred Hospital to be a
4 competitor?

5 A. No, that's a long-term acute care hospital.

6 Q. Okay. What about Baptist Health Bethesda,
7 do you consider them to be a competitor?

8 A. Baptist Health Bethesda, they're really
9 removed from my PSA for the most part. They could be a
10 competitor to Delray Medical Center.

11 Q. How are they removed from your PSA for the
12 most part?

13 A. Because, you know, their zip code is not in
14 my PSA.

15 Q. Got it. What about Baptist Health
16 Boca Raton, is that in your PSA?

17 A. It is not.

18 Q. What about Broward?

19 A. No.

20 Q. This is probably my lack of geography, and I
21 apologize.

22 Holy Cross Hospital, is that within your
23 PSA?

24 A. It is not.

25 Q. What about HCA Florida Woodmont, is that

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1 within your PSA?

2 A. I've never heard of them, so I'm thinking
3 no.

4 Q. Okay. What about Florida Medical Center?

5 A. They are not in my PSA.

6 Q. What about Universal Health Services, the
7 Alan B. Miller Medical Center, do you consider that to
8 be a competitor?

9 A. So it hasn't opened yet.

10 Q. Will you consider that to be a competitor
11 when it opens?

12 A. Yes, probably because I think it's only --
13 it's probably in my PSA. I'd have to really look at
14 their zip code but a slight competitor.

15 Q. Okay. What about Florida Coast Medical
16 Center in Port St. Lucie?

17 A. It's not a competitor.

18 Q. Okay. Would you agree with me that the
19 population of Palm Beach has at least a significant
20 portion of which are what we call snowbirds?

21 A. Well, some of the snowbirds we've been
22 seeing are staying actually and not going away as much,
23 but there are definitely a good amount of snowbirds in
24 Palm Beach County.

25 Q. Has Good Samaritan performed any studies

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1 about the transient nature of the Palm Beach population
2 when it comes to healthcare services --

3 MR. MARCUS: Object to form.

4 BY MS. BLAIR:

5 Q. -- in light of --

6 MS. BLAIR: Sorry.

7 BY MS. BLAIR:

8 Q. -- in light of what I'm calling the snowbird
9 nature of the population?

10 MR. MARCUS: Same objection.

11 A. So Good Sam is a little different, I would
12 say. The transient nature would be Palm Beach Island,
13 not necessarily West Palm.

14 So in the summer are we a little slower than
15 we are in the winter? Yes, you know. But it would
16 maybe be more impactful, that analysis, to like a
17 Delray Medical Center.

18 But we do have the impact of snowbirds. I
19 think we all do. You can get into a restaurant now.
20 When we're in season, it's a challenge.

21 BY MS. BLAIR:

22 Q. And what about have you done any -- would
23 you agree that the wealth of many of the residents in
24 Palm Beach County, at least, allows them to travel for
25 elective health services?

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1 MR. MARCUS: Object to form.

2 A. I would say a small amount of people have
3 that wealth.

4 BY MS. BLAIR:

5 Q. Have you performed any studies to see
6 whether or not people in your area, geographic area
7 choose to go, let's just say, back to New York if
8 they're from New York, for elective procedures as
9 opposed to stay in the Palm Beach area for them?

10 A. I have not done any study.

11 Q. Do you know if Tenet Healthcare has?

12 A. I don't know.

13 Q. Do you know if Palm Beach Health Network
14 has?

15 A. I don't know.

16 Q. What were the discussions at Palm Beach
17 Health Network in or around the summer of 2024
18 regarding all of these new entrants into the healthcare
19 arena in Palm Beach County?

20 A. The end of the summer of '20 --

21 Q. Just generally the summer of 2024.

22 A. What was the discussion of the Palm Beach
23 Health Network about?

24 Q. Yeah. Might be a terrible question.

25 So I assume there were some -- well, you're

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1 aware that in -- we just talked about, for example,
2 Universal Health Services hasn't even opened in Palm
3 Beach, correct?

4 A. Correct.

5 Q. And as I understand the newspaper articles
6 I've read, it appears that in the summer of 2024
7 NYU Langone is coming, Cleveland Clinic is starting to
8 come. Were there discussions from a branding
9 perspective and/or marketing perspective at the
10 Palm Beach Health Network about combating a potential
11 decrease in market share as a result of new healthcare
12 facilities coming into the geographic area?

13 A. They've been here for a while, not just in
14 2024, so all the -- the not-for-profits have been in
15 Downtown West Palm for a long time because of
16 Palm Beach Island.

17 Q. Okay. And so am I wrong that NYU Langone
18 came in 2022?

19 A. I thought you said 2024.

20 Q. I was asking about 2024.

21 A. Oh. Yeah, it might be. But they've had
22 doctors, NYU Langone has had physicians here since I
23 remember, like a good period of time.

24 Q. From 2022 to 2020 --

25 A. Mount Sinai as well.

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1 Q. Mount Sinai as well, correct.

2 From 2022 to 2024, did the hospitals in the
3 Palm Beach Health Network perform any studies to
4 determine whether or not these new healthcare
5 facilities like Cleveland Clinic, like Langone, like
6 what's going to be the Universal Health Services, did
7 you do any studies to discuss what impact that might
8 have on your market share?

9 A. I would say that we have -- so Cleveland
10 Clinic announced they're going to build a hospital,
11 right, so clearly we are looking at more data now of
12 how that could impact you. But, you know, UHS
13 obviously, opening another hospital, the more beds that
14 come into a community, obviously, is going to affect a
15 hospital.

16 I don't think there was a specific analysis
17 that was done that looked at these not-for-profits that
18 I'm aware of and how it's going to impact us because
19 the not-for-profits have been here for a long time.

20 Q. Do you recall any discussions -- well, you
21 keep saying "a long time." I want to make sure we
22 understand. What's a long time to you?

23 A. Well five plus years, not like they just
24 showed up in the last year or two.

25 Q. Do you recall any discussions at any time

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1 with the other hospitals that make up the Palm Beach
2 Health Network about the potential impact of these new
3 healthcare facilities coming to Palm Beach, whether it
4 was five years ago, three years ago, yesterday? Do you
5 recall any conversations with the other hospitals about
6 the potential impact of those new entrants into the
7 healthcare market here?

8 A. Of course, yes.

9 Q. And what do you recall about those
10 discussions?

11 A. I'll just give you an example. Erik, the
12 CEO of Gardens, and I discussed UHS, them opening and
13 what impact it may have on our staff that live in that
14 area. So his hospital, Palm Beach Gardens is very
15 close to that hospital.

16 I have staff that live north of
17 Good Samaritan, Port St. Lucie, Jupiter, so if they're
18 opening a brand new hospital and they need 300 nurses,
19 how that would impact us.

20 Q. What about any discussions about competing
21 for patients with those hospitals?

22 A. I mean, not specifically about patients. I
23 mean, we have really solid service lines and what we
24 do. That hospital is not offering a service line that
25 our hospitals don't offer. I would say it's really

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1 more about the employees, physicians.

2 Q. Do all of the -- since you guys are a health
3 network, do all of the physicians at Good Samaritan
4 also have privileges at the other four hospitals and
5 vice versa?

6 A. No.

7 Q. Why not?

8 A. Because they're -- we have all different
9 governing bodies and different MECs and bylaws. Every
10 hospital has their own bylaws.

11 Q. Do you know if there's any overlap between
12 privileges at different hospitals?

13 A. Yes.

14 Q. And do you have any understanding of what
15 the percentage is of that overlap, how many doctors
16 have privileges at one or more hospitals in the
17 Palm Beach Health Network?

18 A. I don't. I don't know.

19 Q. Would you say it's more than 50 percent?

20 MR. MARCUS: Object to form.

21 A. No.

22 BY MS. BLAIR:

23 Q. No, you would not know or, no, you --

24 A. No, it would not be more than 50 percent, in
25 my opinion.

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1 Q. Okay. Do you know if it would be more than
2 25 percent?

3 MR. MARCUS: Object to form.

4 A. I would be guessing.

5 BY MS. BLAIR:

6 Q. I don't want you to guess.

7 Was there ever a written strategic plan at
8 any time, a written strategic plan for Palm Beach
9 Health Network about how they were going to compete
10 with the new entrants into the healthcare system in
11 Palm Beach?

12 A. The new entrants of --

13 Q. These other hospitals that we've been
14 talking about.

15 A. All right. There's only one, but, I mean,
16 absolutely. I'm sure that Erik, because of Gardens, is
17 the one that would be impacted more because of the
18 geographical location.

19 Q. I want to make sure. So I understood from
20 articles I've read, and please tell me if I'm wrong,
21 that in April of 2022 your five hospitals rebranded as
22 Palm Beach Health Network, correct?

23 A. Correct.

24 Q. And these articles -- and I know you weren't
25 quoted, but these articles talk about part of the

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1 reason for this rebranding was because of -- this is
2 not my words -- new entrants into the healthcare
3 market.

4 MR. MARCUS: Object to form.

5 BY MS. BLAIR:

6 Q. Do you have any memory of discussions with
7 the other five hospitals in or around April of 2022
8 about that was the purpose of organizing under the
9 umbrella of Palm Beach Health Network?

10 A. Absolutely not.

11 Q. Okay. What did you believe the purpose of
12 rebranding under Palm Beach Health Network was?

13 A. To show our identity and that we have all
14 these hospitals, we're the largest employer in Palm
15 Beach County, so, one, we want to demonstrate that. We
16 have the most -- you know, we see the most patients in
17 Palm Beach County. We wanted to put our network out
18 there that how we work together.

19 As you mentioned before, we have people that
20 are moving from one hospital to another hospital
21 because they're training at one hospital and being
22 promoted and going to the next hospital, so it's good
23 for recruitment for people to see that we have a really
24 solid organization where you have opportunities to
25 maybe start out at Delray Medical Center as a nurse and

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1 end up as the CNO or something at another one of our
2 hospitals. So it's about showing our quality, all the
3 things that we can provide in a network. We have two
4 trauma hospitals. You know, giving us an identity that
5 we're all connected. Like Baptist Health, you know,
6 they do the same thing. It's a -- it's what
7 organizations do, so...

8 Q. Right.

9 A. It wasn't like there's new entities coming
10 in, we need a brand.

11 Q. Right. And as I understand our discussion
12 earlier today, all five of these hospitals have been
13 part of Tenet system for almost over a decade by 2022,
14 correct?

15 A. Yes.

16 Q. And this situation with people training at
17 one hospital and going to a different hospital, that
18 had been happening for at least a decade, correct?

19 A. Sure.

20 Q. So I guess my question is, why in April of
21 2022 was the decision made to rebrand as Palm Beach
22 Health Network?

23 A. Like the reasons that I mentioned. And we
24 have more of a structure now, now that Maggie is there,
25 so she's a lot of the reason. She came in. She has a

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1 lot of great ideas. And we really became more Palm
2 Beach. We were part of ten hospitals at one time, all
3 in Broward and in Miami. So when we became a group, it
4 just, it ended up, I guess, fostering into that. We
5 have become more of a group now --

6 Q. Okay.

7 A. -- where we hadn't really in the past.

8 Q. So the timing of it was coincidental?

9 MR. MARCUS: Object to form.

10 A. I would say the article you read was
11 probably from the Palm Beach Post and it's the editor's
12 thoughts of why that happened. I am not aware that
13 this idea came from, we need to combat, you know, the
14 Cleveland Clinics and things like that. It's just
15 advancing and developing our brand and our network.

16 BY MS. BLAIR:

17 Q. Okay. And so in or around April of 2022, to
18 your knowledge, was there a strategic plan for
19 marketing the Palm Beach Health Network? So April of
20 2022 when you rebranded, was there a written strategic
21 plan for marketing the health network that you were
22 part of?

23 A. I don't recall it, but there probably, you
24 know, was because, you know, we have commercial, so
25 obviously funding has to go to that. You know, there

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1 was the logo, like I said, so obviously there had to
2 have been money set aside. I just don't recall like it
3 being reviewed with me or something.

4 Q. Okay. But you're sure that there was no
5 discussion about, We're doing this in order to compete
6 with new healthcare entities that are coming into the
7 market?

8 A. This is what I would say. Could there have
9 been a discussion when we're discussing all of the
10 positive reasons that branding can, you know, your
11 awareness of your institutions that are out there? I
12 can't say three years ago if that was not talked about.
13 I just cannot.

14 Q. So in 2024, is your view as the CEO of
15 Good Samaritan that the brand in 2024 is really the
16 Palm Beach Health Network as opposed to Good Samaritan
17 as an individual hospital?

18 MR. MARCUS: Object to the form.

19 A. It's Good Samaritan, part of the Palm Beach
20 Health Network.

21 BY MS. BLAIR:

22 Q. Do you believe that the patients in this
23 geographic area think of Good Samaritan as part of the
24 Palm Beach Health Network brand or as Good Samaritan
25 standing alone?

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1 MR. MARCUS: Object to form.

2 A. I'm not really sure. It could be both. You
3 know, the Palm Beach Health Network is still getting
4 out there. It takes a long time for a brand to stick
5 or for people to start understanding. And you know, it
6 takes a long time.

7 BY MS. BLAIR:

8 Q. That's fair.

9 Do you know if anyone at the Palm Beach
10 Health Network level has done any studies to see if the
11 Palm Beach Health Network brand is sticking with the
12 residents of this area?

13 A. I may have just recently saw a document.

14 Q. And what is your memory of -- well, what is
15 this document you may have recently saw?

16 A. I mean, I reviewed it with the attorneys.

17 Q. Did you review it in preparation for your
18 deposition here today?

19 A. Yes.

20 Q. What was it?

21 A. I had not seen the document before, but it
22 was maybe like a Net Promoter Score. I didn't have all
23 the details behind like who did the study or -- and I
24 think it was like Palm Beach Health Network awareness
25 maybe.

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1 Q. Okay.

2 A. Like maybe a year over year.

3 Q. Maybe a year over year, is that what you
4 said?

5 A. Right, correct.

6 Q. And what is your memory in reviewing that
7 document of what the Net Promoter Score was of
8 Palm Beach Health Network?

9 A. My memory, when I looked at it for literally
10 one minute, all I can say is that there was more
11 awareness.

12 Q. More awareness than the year before?

13 A. Correct.

14 Q. And was that document that you looked at
15 granted only for a minute or more, comparing 2025 to
16 2024 or 2024 to 2023, do you recall?

17 A. I don't recall.

18 MR. MARCUS: Is this a good time to take a
19 break, Counsel?

20 MS. BLAIR: Sure, yeah.

21 THE VIDEOGRAPHER: We're going off the
22 record. The time is 11:57 a.m.

23 (A recess was taken from 11:57 a.m. to 12:43 p.m.)

24 THE VIDEOGRAPHER: We are back on record.

25 The time is 12:43 p.m.

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1 BY MS. BLAIR:

2 Q. Ms. Montgomery, I want to just talk a little
3 bit about -- and we touched on this earlier, about how
4 Good Samaritan benchmarks itself against its
5 competitors. Do you understand what I mean by
6 "benchmark"?

7 A. Well, why don't you tell me. That way we're
8 on the same page.

9 Q. Sure. Do you ever -- does Good Samaritan
10 have any data or analysis where it looks like, for
11 example, its CAUTI scores versus the hospitals that you
12 consider to be your competitors or your HCAHPS scores
13 with CMS, do you have any -- how do you do that? Or
14 let me strike that.

15 Do you do that? Do you have data where you
16 benchmark how is Good Samaritan doing in different
17 patient safety categories versus your competitors in
18 the area?

19 A. So the balanced scorecard, I believe it's on
20 there. It might be all of Tenet or the national
21 average, whatever the goals are. And you have access
22 to all the data, so if I wanted to look at 70 plus
23 hospitals or whatnot, I could.

24 I personally don't go out there and look at
25 Good Samaritan to, you know, many other hospitals other

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1 than, you know, the tools that are provided to me.

2 Q. And when you say you could, for example,
3 look at 70 other hospitals, are those the 70 Tenet
4 hospitals?

5 A. Correct.

6 Q. And when you say the tools -- you could if
7 you looked at the tools that are provided to you, what
8 tools would those be?

9 A. That's what I'm saying is it's mostly, you
10 know, like the report card that has the 70 hospitals on
11 it. But I personally haven't gone out there to go look
12 at Good Sam and compare it to other hospitals, per se,
13 or did some analysis.

14 Q. Do you know if Tenet Healthcare does that?

15 A. I don't know. I mean, I'm --

16 Q. Do you know if Palm Beach --

17 A. I don't know.

18 Q. I'm sorry.

19 Do you know if Palm Beach Health Network
20 looks at how the five hospitals in the Palm Beach
21 Health Network compare to the competitors in various
22 areas of patient safety?

23 A. I'm not really sure.

24 Q. And you mentioned Trilliant earlier. Is
25 that where the score card comes from?

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1 A. No, that's more like market share data.

2 Q. The score card, is that generated from
3 internal Tenet data?

4 A. I don't know exactly where it pulls from.
5 It's called Kaleidoscope is where we get the
6 information from. Where it pulls from, you know, the
7 background, I'm not sure.

8 Q. Okay. Kaleidoscope just like the word?

9 A. Is the tool.

10 Q. Are you familiar with Vizient?

11 A. No.

12 Q. Do you know if Good Samaritan has ever had a
13 contract with Vizient?

14 A. Not that I'm aware of.

15 Q. What about Premier, do you know what Premier
16 is?

17 A. No.

18 Q. So I guess the follow-up question is, do you
19 know if Good Samaritan has ever had a contract with
20 Premier?

21 A. Not that I'm aware of.

22 Q. What about Healthgrades™, does
23 Good Samaritan have a contract with Healthgrades™ to
24 review its data?

25 A. Yes.

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1 Q. And is that an annual contract?

2 A. I'm not really sure if it's annual or not.

3 I don't really do that piece at all.

4 Q. Who does do that piece?

5 A. I would say the group level.

6 Q. And by group level, you mean Palm Beach
7 Health Network?

8 A. Right.

9 Q. Would Gina West know about that?

10 A. Yeah, she would probably know more about it,
11 but the contracting would, you know -- she wouldn't
12 sign a contract, per se.

13 Q. Who would sign the contract at the group
14 level?

15 A. Probably Michelle Cartwright.

16 Q. So is it your understanding that any
17 contract with Healthgrades™ would be at the group level
18 and not at the Good Samaritan level?

19 A. I really don't know if it's individual or
20 how it works.

21 Q. Do you know how much Good Samaritan pays for
22 its contract with Healthgrades™?

23 A. I don't.

24 Q. Do you know how much Palm Beach Health
25 Network pays for its contract with Healthgrades™?

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1 A. I'm not sure, but I think they pay for -- I
2 think Healthgrades™ has the data for everybody, I'm
3 sure. When I was the group CFO, I want to say it might
4 have been like 50,000 to 100 or something of that
5 nature.

6 Q. Okay. But that's a guesstimate, my word?

7 A. Yeah, I mean, yeah.

8 Q. But to the best of your knowledge, the --
9 Good Samaritan either individually or through the Palm
10 Beach Health Network still participates in
11 Healthgrades™ via contract?

12 A. Yes.

13 Q. What about are there any other services that
14 you know of that Good Samaritan contracts for to
15 provide data related to quality or patient safety?

16 A. That provides data specifically?

17 Q. Correct.

18 A. Not that I can think of right now.

19 Q. Does Good Samaritan engage in any contracts
20 with any vendors to provide consulting services with
21 respect to improvement of patient safety or quality?

22 A. Not that I can think of.

23 Q. Does the Palm Beach Health Network engage in
24 any contracts with vendors to provide consulting
25 services for patient safety or quality?

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1 A. I mean, if they do, I'm not really sure. I
2 can't think of anything right now.

3 Q. Do you know if -- you mentioned earlier a
4 patient experience champion that you were looking to
5 hire or did hire. Do you recall that?

6 A. Right.

7 Q. Is that a consultant or is that a direct
8 employee of Good Samaritan?

9 A. No, she's an employee.

10 Q. I've seen references in some of documents to
11 Press Ganey. Are you familiar with what Press Ganey
12 is?

13 A. I am.

14 Q. Does Good Samaritan utilize the services of
15 Press Ganey?

16 A. We do.

17 Q. Do you pay for those services?

18 A. I'm not really sure. I mean, they do all
19 our patient satisfaction HCAHPS distribution and
20 reports. I would think there would be a payment, but I
21 don't know.

22 Q. And I understand -- and my understanding may
23 be wrong because I'm not in the healthcare field -- but
24 that CMS does not allow -- or strike that.

25 I understand CMS requires hospital to have a

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1 third-party vendor to collect HCAHPS data; is that
2 true?

3 A. I mean, I don't know if it's a requirement,
4 but it could be.

5 Q. Okay.

6 A. Sounds right.

7 Q. Does Press Ganey provide any services to
8 Good Samaritan outside of collecting data relating to
9 the HCAHPS?

10 A. They recently were at our hospital. One of
11 the representatives came and met with the CNO. And
12 this champion I was telling you about, I think, did
13 some rounding and, you know, probably gave
14 recommendations of how to get higher participation
15 rates and things of that nature.

16 Q. Do you know -- strike that.

17 We talked a little bit about the hospital's
18 brand before the lunch break as well as the brand of
19 Palm Beach Health Network. Do you recall that?

20 A. Yes.

21 Q. I was told in this litigation that your
22 attorneys would be producing brand marketing documents.
23 Do you know, can you describe for me what type of brand
24 documents exist?

25 MR. MARCUS: Just object to form.

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1 A. Brand marketing like as in the Palm Beach
2 Health Network?

3 BY MS. BLAIR:

4 Q. Or Good Samaritan. I don't know what they
5 are, so I'm just trying to ask you, do you know what
6 brand documents would exist?

7 A. I mean, my thoughts would be the rollout of
8 our brand, the Palm Beach Health Network. It could
9 encompass a lot of things related to the brand and our
10 impact on the community, things like that.

11 Q. Your -- you, Good Samaritan and the other
12 plaintiffs, have produced an expert report from a man
13 named Mr. Chakurda. Have you read this expert report?

14 A. I have not.

15 Q. Have you ever spoken with Mr. Chakurda
16 regarding what his expert opinions were going to be in
17 this matter?

18 A. I have not.

19 Q. Do you understand that Mr. Chakurda is a
20 brand marketing expert?

21 A. I don't know that.

22 Q. Did you have an understanding before you
23 came here for your deposition today that you had hired
24 a brand marketing expert to opine in this litigation?

25 A. I read it somewhere in a document. That was

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1 just --

2 Q. And I don't want to know what you read
3 because it's probably through your attorney.

4 A. -- to the best of my knowledge.

5 Q. And in that report Mr. Chakurda says,
6 "Hospital systems have dedicated marketing
7 departments."

8 Would you agree with that statement?

9 A. Correct.

10 Q. And does Good Samaritan have a dedicated
11 marketing department?

12 A. Yes.

13 Q. Okay. And he says that, "The marketing
14 departments are responsible for advertising website and
15 digital communications, competitive intelligence,
16 patient outreach and media relations."

17 So my question is, I'm going to break that
18 down, do you know whether or not the Good Samaritan
19 marketing department is responsible for advertising for
20 Good Samaritan?

21 A. They are.

22 Q. And do you have specific advertisements for
23 Good Samaritan that are separate and apart from
24 Palm Beach Health Network?

25 A. Yes.

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1 Q. Does your marketing department oversee the
2 website for Good Samaritan?

3 A. Yes.

4 Q. And same question with respect to digital
5 communications. Does Good Samaritan have a department
6 that oversees digital communications?

7 A. Yes.

8 Q. And what do you understand the digital
9 communications to be for Good Samaritan?

10 A. Like anything that's digital and social
11 media and all of those things.

12 Q. Does Good Samaritan have social media pages?

13 A. Yes.

14 Q. And do you know who at Good Samaritan
15 oversees the social media pages?

16 A. Marketing.

17 Q. But who specifically, do you know?

18 A. Nancy --

19 Q. Morales?

20 A. -- Morales.

21 Q. Is Nancy Morales in charge of overseeing the
22 website as well?

23 A. Yes.

24 Q. How many direct reports does Nancy Morales
25 have?

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1 A. She doesn't have any.

2 Q. What about competitive intelligence? Is the
3 Good Samaritan marketing department in charge of
4 overseeing competitive intelligence?

5 A. I would have to have that really explained
6 to me of what that entails to answer that
7 appropriately.

8 Q. Do you have any understanding as you sit
9 here today how you, Sheri Montgomery, understand the
10 term "competitive intelligence"?

11 A. Yeah, I would say really understanding our
12 environment, our competitors, what they are doing, kind
13 of understanding their market that they're going after
14 as well, I would say.

15 Q. And as I understand our conversation earlier
16 this morning, that's done at the Palm Beach network
17 level, competitive intelligence; is that fair?

18 A. Well, I would say that information is shared
19 from the marketing, group marketing person with the
20 marketing managers. They meet all the time.

21 What I'm referring to, the marketing manager
22 is expected to know those things that I just referred
23 to.

24 Q. And who's the Good Sama marketing manager?

25 A. Nancy.

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1 Q. Okay.

2 A. Yeah. Morales.

3 Q. That's her title?

4 A. Yes.

5 Q. And there's a marketing manager at each of
6 the five hospitals, correct?

7 A. Yes.

8 Q. What about patient outreach, does the
9 marketing department at Good Samaritan engage in
10 patient outreach?

11 A. They do.

12 Q. How do they engage in patient outreach?

13 A. Many different ways. I mean, one could be
14 like direct mail or, say, we're having a health fair.
15 We just recently had one at one of our emergency rooms
16 where you're doing blood pressure screening, things
17 like that. She reaches out to patients and
18 communities.

19 Q. Does she reach out for patient experience
20 feedback outside of the HCAHPS process?

21 A. She'll do like patient testimonials, so I
22 would say, yes.

23 Q. Do you know how she figures out which
24 patients she would reach out to for a patient
25 testimonial?

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1 A. Sometimes it's a Google review. Sometimes
2 it's a physician that has said, "This patient had a
3 great outcome."

4 Q. What about media relations, does the
5 Good Samaritan marketing department engage in media
6 relations?

7 A. Yes.

8 Q. And what does that mean to you?

9 A. I would say that she really works -- we
10 actually have a media relations person, and they work
11 together on anything that's to do with releases, like
12 new technology at the hospital, you know. If we're
13 first in the community to offer a new technology, she's
14 going to be part of writing that release along with the
15 public relations individual.

16 Q. Okay. And who's your public relations
17 individual?

18 A. Andrew Lofholm.

19 Q. And I've seen his name in several of the
20 documents that have been introduced with this. So he
21 was also involved with the press releases surrounding
22 the filing of the lawsuit that we're all here for today
23 as well, correct?

24 A. Yes.

25 Q. And that would be part of his job as the

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1 media relations person?

2 A. Yeah.

3 Q. And would you agree that Mr. Chakurda's
4 statement where he says, "Hospital systems have
5 dedicated marketing departments responsible for
6 advertising, website and digital communication,
7 competitive intelligence, patient outreach and media
8 relations" -- I can't talk today -- "all with the aim
9 of increasing, enhancing a hospital's patient outreach
10 and media relations all with the aim of increasing and
11 enhancing a hospital's brand."

12 That's a mouthful.

13 MR. MARCUS: Object.

14 BY MS. BLAIR:

15 Q. My question is, do you agree that your
16 marketing department engages in all of these efforts to
17 increase and enhance the hospital's brand?

18 A. I'd agree with that.

19 Q. And we talked about this before. You don't
20 know as you sit here today what Good Samaritan's
21 marketing budget is, correct?

22 A. I do not.

23 Q. Do you know if Palm Beach Health Network has
24 a separate marketing budget?

25 A. I'm not quite sure. I'm not quite sure.

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1 Q. Prior to January of 2025, did Good Samaritan
2 have any programs in place to increase patient
3 experience scores?

4 A. I mean, yes.

5 Q. And what programs did you have in place
6 prior to January of 2025 to increase patient experience
7 scores?

8 A. Leadership rounding, which includes, you
9 know, we even include our ancillary directors and
10 leadership rounding, which is non, non-nurses basically
11 in the leadership rounding. The CNO actually does
12 leadership rounding. It interviews patients to see
13 what their experience has been.

14 Q. So to the layperson I don't know what
15 leadership rounding is. Can you explain that to me?

16 A. Yeah. Essentially leaders in the
17 organization, like your nurse managers or your nurse
18 directors, we will pair them up with an ancillary
19 individual, which an ancillary person is the imaging
20 director, for example, and we have them go out and
21 round on patients not in their unit, so obviously
22 outside of their units because you really want, you
23 know, unbiased, I guess, you know, and sometimes other
24 people can see things that you wouldn't see, so we have
25 them go out and round on patients, get their feedback.

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1 All of that is logged. And if there are things that
2 they're bringing up, you know, patients are bringing
3 up, say it's food related, you know, my breakfast was
4 cold this morning, following up on all those types of
5 things, so...

6 Q. And how would --

7 A. And that's a huge thing to do.

8 Q. How are they logged, these rounding? You
9 said they're logged.

10 A. Yeah, they log them. They go around and
11 they have their notepad. It's not electronic. I don't
12 know if they put it in an Excel spreadsheet. We have
13 them do that on Stoplight Reports now, and they follow
14 up on all of those items.

15 Q. Is there some sort of document that's
16 generated from all of this leadership rounding from the
17 logging of notes?

18 A. There is now what we call it a Stoplight
19 Report, a leadership Stoplight Report. So and I
20 believe patient experience is on there along with
21 employee rounding that is on the Stoplight Reports, but
22 it's an Excel opportunity.

23 Q. And you said there is now. When did that
24 first go into place?

25 A. Probably -- probably six months ago

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1 probably.

2 Q. Okay. So nothing from before November of
3 2024, fair enough?

4 A. It might have been because we had a rollout
5 on -- it might have been in November that we started
6 looking at turnover for staffing and then came up with
7 this whole, we should have a Stoplight Report where
8 we're logging trends and, you know, build like log
9 trends for employees and bring it to us so we can start
10 taking action on things.

11 Q. Are these stoplight reports something that
12 would have been discussed at a board meeting?

13 A. A governing board meeting?

14 Q. Yes. Is there another kind?

15 A. No, I guess not.

16 Q. Okay.

17 A. I don't think so. I don't know. We might
18 have mentioned, Hey, that we're starting to do this,
19 you know, to address turnover and things of that
20 nature. It could have been.

21 Q. Do you know whether or not those Stoplight
22 Reports have been produced in this litigation?

23 A. I don't know.

24 Q. Would these Stoplight Reports have been
25 discussed at a Med Exec meeting?

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1 A. I'm not sure.

2 Q. I'm just trying to figure out where's the
3 best place for me to figure out when these Stoplight
4 Reports started document-wise?

5 A. They probably started around November when
6 we started talking about Stoplight Report. I would say
7 it was probably November.

8 Q. Of 2024?

9 A. Yeah.

10 Q. Okay.

11 A. Um-hum. But, you know, there's also with
12 patient experiences there's Press Ganey provides
13 comments like actual comments that patients will leave,
14 so that's reviewed. You know, and the team works
15 towards where some of the common themes, say if
16 temperature for food is one of them, you know, working
17 with our dietary team to find out, you know, when are
18 you delivering it; what's wrong with the warmers,
19 things of that nature.

20 Q. Do you ever look at complaints from the
21 nursing staff about issues related to patients in terms
22 of evaluating patient experience?

23 A. Give me an example. What do you mean
24 exactly?

25 Q. Well, we've had a document produced in this

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1 litigation which is from SEIU1199 that lists out, you
2 know, different complaints nurses have given to their
3 union. And I'm just curious, do you look at those in
4 the context of not the nurse complaint but in the
5 context of patient experience?

6 A. I mean, I don't know really of employees
7 coming back -- other than the employees that are
8 involved in the meetings and improved patient
9 experience what you're really referring to.

10 Q. Sure. And I guess from a hypothetical
11 standpoint, let's say a nurse says, "I started my
12 shift, and I realized this patient hadn't been toileted
13 in, you know, four hours, and that's a problem."

14 Is that kind of complaint from the nurse
15 then translated into a discussion about patient
16 experience?

17 MR. MARCUS: Object to form.

18 A. I mean, depends on who it was -- who that
19 information was given to. If it was a leader of a
20 department, then it would be. If it was, you know, an
21 incident report that's investigated, why did that
22 happen.

23 BY MS. BLAIR:

24 Q. And Press Ganey, they provide -- do you know
25 what the document looks like when they provide you

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1 actual comments or common themes related to the patient
2 experience outcomes?

3 A. I do.

4 Q. What's --

5 A. They're called verbatims.

6 Q. They're called verbatims. Do you know if
7 the verbatims have been produced in this litigation to
8 date?

9 A. I do not.

10 Q. How often do you get verbatims from
11 Press Ganey?

12 A. I'm not really sure. They're not sent to me
13 personally, so I'm not sure.

14 Q. Do you know who they would be sent to?

15 A. Maybe the CNO, patient experience
16 coordinator.

17 Q. Do these verbatims get turned into any sort
18 of comprehensive report, to your knowledge?

19 A. Not to my knowledge.

20 Q. Are these verbatims shared in any way with
21 the governing board?

22 A. Not to my knowledge.

23 Q. Are these verbatims shared in any way with
24 the Med Exec Committee?

25 A. No, not to my knowledge.

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1 Q. You mentioned --

2 A. The patient experience scores are.

3 Q. Of course?

4 A. Right. Verbatims is like a way to actually
5 get a comment and dig down.

6 Q. But they -- I thought you told me, and I
7 want to make sure, that they are somehow summarized
8 into some sort of report that goes somewhere.

9 A. They're not summarized by like a theme.
10 They're just here is verbatims for a certain nursing
11 floor, for example.

12 Q. Got it. But those are summarized in some
13 way and provided maybe to the chief nursing officer or
14 the patient experience coordinator, correct?

15 A. Correct.

16 Q. You mentioned earlier that you,
17 Good Samaritan had recently had a health fair at one of
18 its emergency rooms, correct?

19 A. Yes.

20 Q. Does Good Samaritan regularly engage in
21 community sponsorships and philanthropy?

22 A. Sponsorships of what exactly? What do you
23 mean?

24 Q. Well, you know, sometimes hospitals will go
25 and they will sponsor a charity event or something else

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1 in the community, a soccer team, I don't know, a little
2 league team. Do you do things like that?

3 A. I'm trying to think of an example of a
4 sponsorship that we've done. I mean, we do a lot of
5 community events. A sponsorship. I'm trying to think
6 of one. I know that there are some out there. I just
7 can't think of one off the top of my head.

8 Q. Okay. And Tenet Healthcare is a for-profit
9 institution, correct?

10 A. Yes.

11 Q. Do you know if they have any charitable arm
12 of Tenet Healthcare?

13 A. No, not that I'm aware of.

14 Q. And then you talked about community events.
15 What type of community events is Good Samaritan
16 involved in?

17 A. Health fairs like I spoke about.

18 You know when there's events downtown West
19 Palm, you know, the, like the Susan G. Komen Race,
20 there's a sponsorship right there. We sponsor that,
21 and obviously we attend the race and are there just for
22 giving water and things of that nature, but, yes.

23 Q. What about physician relations, do you
24 engage in physician relations at Good Samaritan?

25 MR. MARCUS: Object to form.

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1 A. Yeah, relationships with physicians?

2 BY MS. BLAIR:

3 Q. Yes, do you -- for example, does
4 Good Samaritan, for example have visits to referring
5 physician offices to sort of promote Good Samaritan and
6 try to increase referrals to Good Samaritan?

7 MR. MARCUS: Object to form.

8 A. I would say that we visit their offices to
9 let them know about our services.

10 BY MS. BLAIR:

11 Q. How often are you going to referring
12 physician offices?

13 A. I am not really sure, but it's not, you
14 know, really -- I'm not going out to the physician
15 offices, so...

16 Q. Do you know who would be?

17 A. Holly --

18 Q. Who is Holly?

19 A. -- Wadownsky (phonetic). That's another
20 long one. She's a -- she works for the business
21 development team, so she works for Derek.

22 Q. What's Derek's last name?

23 A. Collins.

24 Q. And that's the business development team?

25 A. Yes.

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1 Q. I think I had it listed as something else.

2 Okay. And the business development team,
3 what kind of business are they trying to development?

4 A. You know, they'll go and visit physicians to
5 say, you know, Hey, did you know Good Samaritan has a
6 bariatric program, that it's accredited, that type of
7 stuff, let them know about the orthopedic service
8 lines, those types of things.

9 Q. Do they go to employers and ask employers to
10 engage with Good Sam on behalf of their employees?

11 A. I know that there's been meetings like that.
12 I mean, that's more Derek's umbrella.

13 Q. Do you know if Derek's team engages with
14 health insurers to try and promote Good Samaritan?

15 A. I'm not aware of that, no.

16 Q. Prior to 2020 -- well, strike that.

17 You talked to me earlier about
18 Healthgrades™, correct?

19 A. Yes.

20 Q. And as I understand it, Good Samaritan has
21 accolades with respect to Healthgrades™ as well,
22 correct?

23 A. Yes.

24 Q. Does Good Samaritan have to purchase
25 accolades in order to be able to use the Healthgrades™

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1 logo to promote the its award?

2 MR. MARCUS: Object to form.

3 A. I don't really know the details behind the
4 contract. You know, marketing and the CFO probably
5 would be able to explain that a little better than I
6 could.

7 MS. BLAIR: We're going to mark this as
8 Exhibit 4; is that correct?

9 THE STENOGRAPHER: Yes.

10 Can we go off the record for just a second?

11 MS. BLAIR: Yes.

12 THE VIDEOGRAPHER: We're going off the
13 record. The time is 1:14 p.m.

14 (A recess was taken from 1:14 p.m. to 1:16 p.m.)

15 THE VIDEOGRAPHER: We are back on the
16 record. The time is 1:16 p.m.

17 (Defendant's Exhibit Number 4 for i.d.)

18 BY MS. BLAIR:

19 Q. Ms. Montgomery, I've handed you what we've
20 just marked Montgomery Exhibit 4. It's a document. At
21 the top it says "Palm Beach Health Network." Do you
22 see that?

23 A. Yes.

24 Q. Do you know when this document was produced?
25 I don't -- that's a terrible word because I don't mean

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1 "produced" in a legal sense.

2 Do you know when this document was created?

3 A. I do not.

4 Q. In looking at this document, do you have any
5 recollection of seeing this before?

6 A. This first page doesn't look familiar to me.

7 Q. What about the second page?

8 A. Yes.

9 Q. Okay. And, for the record, this document --
10 and we refer to this, Ms. Montgomery at the bottom
11 right-hand corner as Bates labels, so, for the record,
12 this is PBHN followed by five zeros 8923 through 8924.
13 Do you see those numbers on the bottom?

14 A. 8923, yes.

15 Q. Okay. And if I turn to this -- well, let me
16 ask this.

17 Does it refresh your recollection in any
18 way? Was this the brand rollout document for
19 Palm Beach Health Network in or around April of '22?

20 MR. MARCUS: Object to form.

21 A. I mean, I don't recall.

22 BY MS. BLAIR:

23 Q. And I'll just tell you -- I'm not trying to
24 be tricky. If we look at 8924, 8924, which is the
25 second page of your Exhibit, if you look at

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1 Good Samaritan, at the bottom -- I think I answered my
2 own question -- of the Good Samaritan on the left-hand
3 side it says, "Healthgrades™ Top 10 Percent in the
4 Nation For Spine Surgery 2025."

5 Do you see that?

6 A. I do.

7 Q. So obviously this was after April of 2022,
8 correct?

9 A. I would definitely recollect that that's
10 probably a fact.

11 Q. And in looking at these awards and accolades
12 under the Good Samaritan heading, on page 8924, does
13 this accurately describe the accolades that
14 Good Samaritan currently has?

15 A. I think there's potentially more, but I'd
16 have to look at my updated list.

17 Q. Okay. And if we look at that first
18 bullet -- well, let's look under -- do you see that
19 it's all caps, it says "services"? Do you see that
20 right above "awards and accolades"?

21 A. Yes.

22 Q. Is this your -- you referred earlier in the
23 deposition to like lines of service. Is this the
24 description of your lines of service?

25 A. Right.

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1 Q. Okay. And then going to the award and
2 accolades, you say, "Designated Breast Imaging Center
3 of Excellence By the American College of Radiology,"
4 correct?

5 A. Correct.

6 Q. Do you pay for anything related to the
7 American College of Radiology for this designation?

8 A. I believe we do. Typically any accrediting
9 body that comes into your organization, one, they're
10 bringing in their expertise and their pathways that
11 they're sharing with you, and, two, they're coming into
12 your organization for like three or four days and going
13 through all your pathways and making sure that
14 everything that, you know, to be accredited that that
15 is happening. So I would say in many of these there is
16 a fee to get accredited because it's a lot of
17 information they're giving to us, and then they're
18 coming and verifying all of that and working with us
19 and our organization.

20 Q. How much -- and let's just take this first
21 bullet point, for example. How much time does
22 Good Samaritan have to dedicate to the accreditation
23 from the American College of Radiology for this
24 designation?

25 A. How much time?

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1 Q. Time.

2 A. I don't really know about the time, per se,
3 for imaging, but for, you know, bariatrics and
4 orthopedics, I mean, it's a ton of time, a lot of
5 people, a lot of resources.

6 Q. How many -- oh, sorry.

7 A. Go ahead.

8 Q. How many FTEs do you have dedicated to
9 engaging in these types of accreditation reviews?

10 A. I wouldn't say that really it is that
11 because it's an entire team, but for, say, orthopedics,
12 it's a large undertaking. We had an FTE assigned to
13 tracking everything and kind of organizing all the
14 meetings and things of that nature.

15 For those large accreditations, you do
16 assign a point person, but I wouldn't necessarily say
17 that, oh, one person is assigned to just doing
18 accreditations. So it's many FTE's involved in the
19 process.

20 Q. Okay. So is there like a person in the
21 marketing department, let's say, that kind of oversees
22 the coordination of these accreditations?

23 A. In the marketing, no.

24 Q. Who generally would be involved? I know
25 it's a team, but who generally are the types of FTE's

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1 that you would dedicate to -- and I understand they're
2 not full time, but dedicate to an accreditation
3 process?

4 A. So for bariatrics we have a bariatrics
5 coordinator. She is a full-time individual that does
6 everything for the bariatric program and does the
7 accreditation.

8 For orthopedics, we have a service line
9 individual that does all of those things. There's
10 always like a clinician involved in all of those, you
11 know, duties that need to be done, but there's always
12 one person assigned to kind of be the gatekeeper of
13 everything.

14 Q. Okay. And for the bariatric accreditation,
15 let's just stick with that, do you have any just
16 general understanding of how many hours go into the
17 accreditation process for your bariatric accreditation?

18 I'm trying to find which one it is here. I
19 apologize. I don't see it on here maybe?

20 A. Yeah, it might be not on here. Let's see.
21 You could go into breast. We have bariatrics.

22 But, you know, for breast or bariatric, so
23 many hours by so many people, including physicians, to
24 get accredited for COC, for our breast center, for
25 bariatrics. I mean, data has to be submitted to them.

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1 There's registries like for bariatrics that you have to
2 log all the data and send them all the results. It
3 takes a tremendous amount of hours to implement all the
4 standards to become accredited. I can't even give you
5 an amount of the hours but a very long time.

6 Just for orthopedics it took us probably a
7 year to prepare.

8 Q. Like one person every day to prepare?

9 A. Yeah. Always doing something for it,
10 pathways, having meetings. There's just -- it's an
11 undertaking for sure.

12 Q. Okay. And that would be sort of the same
13 for all of those accreditations, including like let's
14 look at just like the first one on here, Healthgrades™
15 five-star rated for colorectal surgery, do you see that
16 one, the third bullet point?

17 A. Yes.

18 Q. Is that the same, you would dedicate
19 somebody for a whole year to get ready for that, or is
20 that different than an accreditation?

21 A. That's different than an accreditation.

22 Q. Okay. How long do you think it would take
23 for the -- to complete and engage in the Healthgrades™
24 rating for colorectal surgery, for example?

25 A. So the way I would -- I look at it a little

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1 differently, the two. But Healthgrades™ I would say
2 that it's not really an accreditation, but it's our
3 outcomes so ensuring our best practices are there so
4 that our colorectal surgery patients have the best
5 outcomes. So I can't really say that it's
6 Healthgrades™ is saying, Hey, you have to meet all
7 these standards like a Joint Commission would.

8 Q. Okay. So --

9 A. They don't give accreditations. They give
10 awards based on outcomes.

11 Q. So the designated Breast Imaging Center of
12 Excellence by the American College of Radiology, that's
13 more like an accreditation process; is that fair?

14 A. That's correct.

15 Q. Okay.

16 A. But it's outcomes too or they wouldn't give
17 you their accreditation.

18 Q. Okay. I just -- I'm just learning as I go.

19 So like bullet point two talks about
20 accredited by the American College of Surgeons, but
21 bullet point one just says designated. I'm trying to
22 figure out which ones of these would fall into the
23 category of accreditations that you just described that
24 are like a year-long difficult process and which ones
25 don't?

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1 A. I would say they all fall under an
2 accreditation except Healthgrades™.

3 Q. Okay. And even like the second to the last
4 bullet point", Only Hospital in South Florida to Be
5 Recognized With the America's 100 Best For Spine and
6 Outpatient Orthopedic Excellence Awards," that's like
7 an accreditation?

8 A. That's Healthgrades™.

9 Q. Oh, that is Healthgrades™?

10 A. Um-hum.

11 Q. The second to last bullet point?

12 A. Yeah.

13 Q. Okay. So going back to Healthgrades™, if
14 you look at that bullet point again on Exhibit 4, it
15 says Healthgrades™. Do you see that, like every time
16 it says "Healthgrades," it says "™"?

17 A. Yes, I see it. It's very little.

18 Q. Do you know whether or not you have to pay
19 Healthgrades™ in order to use its trademark in your
20 promotional materials like this?

21 A. I think so.

22 Q. Okay. In reviewing the Palm Beach Health
23 Network Web page, it had these various patient review
24 portals. And one of them they talk about is vitals.
25 Are you familiar with vitals?

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1 A. So it was a patient review?

2 Q. It has a Web page saying "Patient Review
3 Portals." And, again, this is on the Palm Beach Health
4 Network website, not on Good Samaritan?

5 A. Okay.

6 Q. Are you familiar with the Palm Beach Health
7 Network Web page for patient review portals?

8 A. The only thing -- the portals that I am
9 aware of that my website now links Palm Beach Health
10 Network is like either where you can get your patient
11 record. Is that what you're --

12 Q. No, I'll just tell you. It lists Vitals,
13 WebMD, Rate MDs, doctor.com, Healthgrades, Google,
14 Yelp. So these are, as I see them, places that
15 Palm Beach Health Network is encouraging patients to go
16 to to review its services?

17 A. Oh, I see. Okay.

18 Q. Are you familiar with that page?

19 A. It's not ringing a bell.

20 Q. All right. Okay. And I didn't see it on
21 the Good Samaritan Web page so I just was curious
22 whether you knew anything about that.

23 A. Doesn't ring a bell.

24 Q. Do you understand that Healthgrades™ has a
25 patient review portal that patients can go to to rate

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1 hospitals and/or doctors?

2 A. Not really.

3 Q. Do you know whether Healthgrades™ provides
4 Good Samaritan or Palm Beach Health Network with
5 metrics regarding patient satisfaction?

6 A. I am not aware of that.

7 Q. You mentioned earlier the Google reviews for
8 Good Samaritan, do you recall that?

9 A. Yes.

10 Q. And I think you told me Good Samaritan
11 currently has four-star Google review, correct?

12 A. Correct.

13 Q. Do you pay for any Google analytics to be
14 run so that you can see how patients are interacting
15 with your Web page?

16 A. I'm not sure if they do that at the group
17 level or marketing or something.

18 Q. Do you know whether or not Good Samaritan
19 pays for Google ads for Good Samaritan?

20 A. No.

21 Q. I noticed on some of the -- all of the
22 Google reviews, I think, there were responses to each
23 and every one on behalf of Good Samaritan. Do you know
24 who responds to those Google reviews?

25 A. It's the same entity that was really hired

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1 to notify us, so I'm not really sure. I think it's our
2 business center that we have.

3 Q. So it's not a third-party contractor?

4 A. I'm not really sure, to be honest.

5 Q. If Good Samaritan gets a bad Google review,
6 does that get elevated to you as the CEO of
7 Good Samaritan?

8 A. It does.

9 Q. And what do you do with bad Google reviews?

10 A. Well, there's many people on the email,
11 including the CNO, but -- and risk management. They
12 investigate all of them.

13 Q. And how does -- what form does the
14 investigation take?

15 A. It depends. I mean, if it's something where
16 it's a billing complaint, for example, then the
17 director of revenue analysis will be notified. She
18 will do her investigation, reach back out. They close
19 the loop if you can identify who the patient is.
20 Sometimes you can't.

21 Q. Do you -- does Good Samaritan use Google
22 reviews to compare itself to its competitors?

23 A. We really use the Google reviews to get
24 immediate feedback from the patients. Like I stated
25 before, it's, you know, difficult to get participation

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1 in a paper survey, so we encourage the patients to give
2 us their feedback realtime.

3 I wouldn't say that I go out and say, Hey,
4 I'm this and someone else is that. I want to be
5 five-star, so that's our goal.

6 Q. Is there one platform that Good Samaritan
7 believes is the most important platform to consumers
8 when evaluating patient experience?

9 A. Evaluating patient experience. There's so
10 many ways you can get information these days to
11 evaluate things. People, you know, sometimes use -- my
12 point is like 10 percent of people, I think, or maybe
13 it's 12 percent, fill out the survey for us. That's
14 not where I want it to be. I'd rather -- you know,
15 statistically it's better when you have 25 to 35
16 percent.

17 You know, experts will even tell you that
18 you get a more solid feel, I think, of an organization.
19 Typically people don't fill out surveys unless they're
20 not happy, at least immediately, you know. Even
21 restaurant reviews, if you look at them, you know,
22 normally you leave a restaurant and it was wonderful.
23 No one goes out and, "Oh, this restaurant was
24 wonderful." It's that "The service was horrible and
25 the meal was cold" or something that somebody wants to

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1 put out a review, unfortunately.

2 So we try to encourage everyone to give the
3 feedback, you know, positive or negative because we do
4 want to know.

5 Q. But there's not one rating system, WebMD or
6 doctors.com or Google that you look at more than any
7 others?

8 A. No. I mean, HCAHPS is important to me, so
9 if I'm going to look at anything, our efforts are to
10 increase our participation in HCAHPS. That is the goal
11 so we can really get a solid understanding of our
12 opportunities.

13 Q. And HCAHPS, just for the record, that's
14 through CMS, correct?

15 A. Yes.

16 Q. And that, as we talked earlier, Press Ganey
17 is the vendor for CMS that Good Samaritan has to
18 collect those HCAHPS scores?

19 A. Yes.

20 Q. To you as the CEO of Good Samaritan, what is
21 the most important patient ratings service available?

22 MR. MARCUS: Object to form.

23 A. Important? What is important to me is that
24 we improve our HCAHPS and get our patients to respond
25 to HCAHPS.

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1 BY MS. BLAIR:

2 Q. Okay. This is going to be a group Exhibit
3 so it's going to take me a minute.

4 MS. BLAIR: Can you mark this as group
5 Exhibit 5? Thank you.

6 (Defendant's Exhibit Number 5 for i.d.)

7 BY MS. BLAIR:

8 Q. Ms. Montgomery, I am handing you what we've
9 now marked as group Exhibit 5. And I'll submit to you
10 what is before you now are printed out as of
11 9-13-2025 -- you can see that in the top left corner --
12 the CMS scores for Good Samaritan Medical Center. And
13 this first page, two pages -- well, one through four
14 you'll see at the bottom left, is the overall star
15 rating and patient survey ratings.

16 Do you see that?

17 A. Yes.

18 Q. And then the second is the breakdown of the
19 overall star ratings. And then the third is the
20 breakdown of the patient survey ratings. Do you have
21 all three of those in front of you?

22 A. I do.

23 Q. Okay. And I just want to make sure for my
24 record I understand when you're talking about HCAHPS,
25 is that the patient survey rating that we see in this

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1 group Exhibit 5?

2 A. Yes.

3 Q. Okay. And that would be the third document
4 in my group Exhibit, correct?

5 A. Yes.

6 Q. And the patient survey rating as of
7 9-13-2025 was one star, correct?

8 A. Correct.

9 Q. And the number of completed surveys is 822,
10 correct?

11 A. Yes.

12 Q. And do you understand is that 822 in a year?

13 A. That is my understanding.

14 Q. And the survey response rate was 15 percent,
15 correct?

16 A. Yes.

17 Q. Looking at this document, and, again, I'm
18 talking about the third document in group Exhibit 5
19 which is the patient survey rating, do the numbers and
20 percentages that you see on here comport with your
21 understanding of Good Samaritan's current patient
22 survey rating?

23 A. Actually, we have improved because I think
24 these are from maybe 2023. So there has been some
25 improvement in some of these questions.

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1 Q. And I think you testified earlier that the
2 reason some of this data I printed out just on
3 September 13th, 2025 is lower is because of publicly
4 available CNS data lags, correct?

5 A. It does lag.

6 Q. So the data that you may have at
7 Good Samaritan internally as of September 13th, 2025
8 would be more up to date than what I, the layperson, is
9 able to pull off of CMS, correct?

10 A. Correct.

11 Q. Do you have --

12 A. And I think this is only Medicare patients,
13 too, unfortunately not all patients, but --

14 Q. Correct.

15 A. -- yeah.

16 Q. But these were the HCAHPS scores that you
17 were just --

18 A. Right.

19 Q. -- testifying about, correct?

20 And would you agree for me for at least
21 patient scores, it appears that Good Samaritan lags in
22 both the national average and the Florida average in
23 every category except one where it is even with the
24 Florida average?

25 MR. MARCUS: Object to form.

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1 A. That's what it appears.

2 BY MS. BLAIR:

3 Q. And do you know what the publicly available
4 CMS data was for -- I'm sorry. That's a terrible
5 question.

6 Do you know what the publicly available
7 patient survey rating was for Good Samaritan in or
8 around June of 2024?

9 A. Do I actually know the scores you're saying
10 in June?

11 Q. No, the stars. I apologize.

12 A. Oh, okay. The patient safety -- or, I mean,
13 patient experience, is that what you said?

14 Q. Patient survey rating as it's described.

15 A. Okay. In 2024? Similar, I believe.

16 Q. And if we turn to the second --

17 A. I don't know.

18 Q. -- document in my group Exhibit,
19 Good Samaritan Medical Center, the overall star rating,
20 that's the page you have in front of you, right, it's
21 one of two pages?

22 A. Okay.

23 Q. This is the CMS overall star rating,
24 correct?

25 A. Yes.

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1 Q. And it's one star, correct?

2 A. Yes.

3 Q. And do you know whether or not in June of
4 2024 Good Samaritan's overall CMS star rating was
5 one star?

6 A. I believe so.

7 Q. And if you look at the first page of my
8 group Exhibit, it says here at the bottom of the first
9 page, "The overall star rating is based on how well a
10 hospital performs across different areas of quality,
11 such as treating heart attacks and pneumonia
12 readmission rates and safety of care," correct?

13 A. Yes.

14 Q. And if you turn to the next page, it says
15 here that, "The patient survey rating measures
16 patient's experiences of their hospital care. Recently
17 discharged patients were asked about important topics,
18 like how well nurses and doctors communicated, how
19 responsive hospital staff were to their needs and the
20 cleanliness and quietness of the hospital environment."

21 Do you see that?

22 A. I do.

23 Q. And is that your understanding of what the
24 CMS patient survey rating is rating?

25 A. Yes, that is some of the questions for sure.

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1 Q. And just for the record, is one star the
2 best or the worst?

3 A. The worst.

4 Q. And if we turn to the back of first document
5 in this group Exhibit page 4 of 4, you'll see this on
6 the back, "Consider this when choosing a hospital," do
7 you see that?

8 A. I do.

9 Q. And do you see under that it says, "Guide to
10 Choosing a Hospital PDF," do you see that?

11 A. I do.

12 Q. Have you ever read that document?

13 A. I have not.

14 Q. Do you have any understanding of whether or
15 not CMS instructs patients to review these star ratings
16 before they choose a hospital?

17 A. I don't know. I'd have to read the "Guide
18 to Choosing a Hospital."

19 Q. Would it surprise you if CMS tells patients
20 to look at their star ratings before choosing a
21 hospital?

22 MR. MARCUS: Object to form.

23 A. No.

24 BY MS. BLAIR:

25 Q. Have you ever had any discussions with

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1 Tenet Healthcare corporate home office about improving
2 Good Samaritan's CMS ratings?

3 MR. MARCUS: Object to form.

4 A. With corporate, I have not.

5 BY MS. BLAIR:

6 Q. Have you had any discussions with Palm Beach
7 Health Network about improving Good Samaritan's CMS
8 star ratings?

9 A. Yes.

10 Q. When did those discussions occur?

11 A. I would say specific discussions with CMS
12 star ratings, more recently. However, we have
13 discussions about everything that's on Medicare's CMS.
14 You know, there's like five domains, I believe, in CMS.
15 And those are things we work towards all the time. And
16 most of those domains are already on our balanced
17 scorecard. So, yes, we strive for CMS, but some of
18 those domains are already on our balanced scorecard
19 anyways. It's not like we don't strive to do those
20 things already.

21 Q. What is the highest CMS star rating
22 Good Samaritan has ever received?

23 A. I've only been there five years, so two
24 stars.

25 Q. And in what year was Good Samaritan a

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1 two-star CMS rated hospital?

2 A. I believe '21 and '22 maybe.

3 Q. Do you have any understanding of why the CMS
4 star rating declined in 2023, 2024, 2025?

5 A. So my understanding -- I haven't done a
6 complete analysis -- is patient experience was a big
7 driver. I'd have to look at what years are encompassed
8 in those patient experience. It's always a struggle
9 with CMS is everything is so lagging. We're always
10 trying to look at our current data and continue to
11 improve, but it takes a while as you improve to change
12 this.

13 Q. And would you agree with me that the CMS
14 data that is publicly available is that lagging data
15 that you were just discussing?

16 A. Is it lagging data?

17 Q. Yeah, so the publicly available CMS data
18 would be that lagging data that you were just
19 discussing, correct?

20 A. I'm almost positive most of it is lagging.

21 Q. And the only way for anyone other than CMS
22 to have access to current CMS data would be directly
23 from the hospitals themselves, correct?

24 A. I'm sure they can get a lot of the
25 information from CDC. I'm not sure why Medicare is

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1 lagging. It's not like the information is not there,
2 you know, so, you know, if a patient wanted to get --
3 it depends on what you're talking about out of the five
4 categories. There's a lot. There are 62 measures or
5 something in CMS score card.

6 Q. Right. And you would agree with me that CMS
7 evaluates things other than patient safety as well,
8 correct?

9 A. Correct.

10 Q. Do you know whether Good Samaritan tracks
11 its -- tracks how it's doing in hospital-acquired
12 infections as compared to competitors?

13 A. So on the balanced scorecard there's
14 targets. I believe those targets are national averages
15 or something. I'm not quite sure. I didn't develop
16 the scorecard, so...

17 Q. Who did develop the scorecard that we keep
18 talking about?

19 A. I'm not really sure.

20 MS. BLAIR: I'm going to show you a document
21 that we'll mark as Exhibit 6.

22 (Defendant's Exhibit Number 6 for i.d.)

23 BY MS. BLAIR:

24 Q. Ms. Montgomery, I've handed you now what
25 we've marked as Montgomery 6 to this deposition. This

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1 is a document that was produced in discovery just a
2 couple of days ago.

3 A. Okay.

4 Q. Is this the scorecard you keep talking
5 about?

6 A. No, but this data goes into the scorecard.

7 Q. Okay. What is this document that we're
8 looking at that we've now marked as Exhibit 6?

9 A. This is probably something from -- these
10 might be quality updates. Yeah, these are the quality
11 updates that are sent out to the CNO and myself.

12 Q. Okay.

13 A. I'm not sure who else gets it as well.

14 Q. And if you look at like the bottom of the
15 first page of this Exhibit, for I think it's the bullet
16 point C, and just below there's this chart that's sort
17 of grayed out?

18 A. Um-hum.

19 Q. And it says, "the BSC target." What's BSC
20 stand for?

21 A. Balanced scorecard.

22 Q. Okay. So that's a reference to the
23 scorecard that you've been talking about today?

24 A. Correct.

25 Q. Okay. And the target is 15 or less C. diff

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1 infections for the year; is that correct?

2 A. Correct.

3 Q. And this looks like through for 2024 you had
4 15, correct?

5 A. Correct.

6 Q. Okay. So that's how I read that.

7 So the BSC that you've been referring to
8 today, that would have targets for patient safety and
9 quality?

10 A. Yes.

11 Q. And then who puts together these quality
12 updates?

13 A. Erin Britt.

14 Q. Okay. And who is she preparing this for?

15 A. Myself, the CNO. I'm not sure if it's
16 Gina West.

17 Q. And do you see them in this form when they
18 come to you?

19 A. You mean like this?

20 Q. Yes.

21 A. Yes.

22 Q. Okay. And if you look at the last page of
23 this document, it refers to PROMs data collection.
24 What's PROMs?

25 A. It's the new standard that you have to have

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1 for orthopedic patients. I think it was rolled out by
2 Medicare. It's a bunch of different data you have to
3 submit. It's new. Wasn't anything you had to do
4 before.

5 Q. Okay. And above that, the bullet point,
6 what's "GBC extraction"?

7 A. Global business center.

8 Q. Okay. And then the third indented bullet
9 point says "PCI." What's PCI?

10 A. It's a medical term. You'd have to Google
11 it. I don't know the --

12 Q. Okay.

13 A. It's -- where is it at on here?

14 Q. It's under "GBC extraction," and it's the
15 third indented bullet point, "PCI, no cases extracted
16 since Q4 '23," "P" as in "Paul"?

17 A. I know. What page are you on?

18 Q. The very last page, quality.

19 A. Oh, sorry. I was totally on the wrong page.

20 THE STENOGRAPHER: Just read it to yourself
21 or out loud, one or the other.

22 THE WITNESS: Okay. I'll read it to myself.

23 A. I'm not quite sure.

24 BY MS. BLAIR:

25 Q. That's okay. Again, not a memory test. I'm

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1 just trying to understand documents that I have.

2 So this is not the scorecard that you keep
3 talking about, correct?

4 A. It is not.

5 Q. Okay. Thank you.

6 Is -- in order to get the accolade you get
7 for Healthgrades™, is there a survey that has to be
8 completed?

9 A. I don't believe so. I believe they pull
10 everything from the outcomes and data. I don't believe
11 so.

12 Q. And do you know whether or not participation
13 in Healthgrades™ is tied to any contract or payment
14 from Good Samaritan?

15 MR. MARCUS: Object to form.

16 A. Is it tied to any contract meaning?

17 BY MS. BLAIR:

18 Q. Healthcare contract or employer contract
19 or --

20 A. Oh.

21 MR. MARCUS: Same objection.

22 A. Not to my knowledge.

23 BY MS. BLAIR:

24 Q. Is it tied to any payment -- or I'm sorry.
25 Strike that.

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1 Is it tied to any local regulatory
2 requirement?

3 MR. MARCUS: Object to form.

4 A. Not to my knowledge.

5 BY MS. BLAIR:

6 Q. Is participation in Healthgrades™ approved
7 by Tenet home office?

8 A. I'm not sure.

9 Q. Do you know whether or not participation in
10 Healthgrades™ needs to be improved by Tenet Healthcare
11 home office?

12 A. I don't know that either.

13 Q. Is engagement -- is positive -- strike that.

14 Are accolades given to Good Samaritan from
15 Healthgrades™ tied to your compensation in any way?

16 A. No.

17 Q. Do you know whether or not Good Samaritan
18 participates in U.S. News & World Report hospital
19 rankings?

20 A. I'm not sure.

21 Q. Do you know whether or not the hospital
22 participates in the Lown Hospital, L-o-w-n, hospital
23 rating system?

24 A. I'm not aware of that.

25 Q. Have you ever heard of that before I said it

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1 to you?

2 A. I have not.

3 Q. Is your compensation tied in any way to how
4 well Good Samaritan does on its CMS star ratings?

5 A. No.

6 THE VIDEOGRAPHER: Can we go off record for
7 a media change?

8 MS. BLAIR: Sure.

9 THE VIDEOGRAPHER: This ends media two.

10 We're going off the record. The time is
11 1:56 p.m.

12 (A recess was taken from 1:56 p.m. to 2:11 p.m.)

13 THE VIDEOGRAPHER: This begins media three.

14 We're back on the record. The time is 2:11 p.m.

15 BY MS. BLAIR:

16 Q. Mrs. Montgomery, right before the break I
17 was asking about your compensation, whether your
18 compensation was tied to participation in certain types
19 of -- or on performance with respect to the hospital
20 ratings.

21 Do you recall that?

22 A. Yes.

23 Q. And if you could turn to what we previously
24 marked as Exhibit 2 and specifically interrogatory
25 number 18 on page 27, now I'm curious if whether the

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1 word "not" is missing in this answer is going to be my
2 question.

3 Once you get there, let me know.

4 So you see at the top of the page?

5 A. 27?

6 Q. Yes, at the top of page interrogatory 18
7 says, "State whether the compensation of your chief
8 executive officer" -- which would be you -- "or any
9 other executive level leadership officer is tied to or
10 related in any way to your hospital's performance on
11 patient safety, union worker contracts or your
12 hospitals's ratings by third-party ratings
13 organization, ratings publications."

14 Do you see that?

15 A. I do.

16 Q. And the amended answer says, "Plaintiffs'
17 performance on patient safety union worker contracts or
18 ratings by third-party ratings publications is related
19 in some way to the compensation of the plaintiff's
20 chief officer or other executive level officers."

21 Do you see that?

22 A. Yes.

23 Q. Is that a true statement?

24 A. Yes.

25 Q. Okay. So it may, then, be that your

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1 previous answer was that it's not related to ratings by
2 third-party ratings organization; is that true?

3 A. I think you asked me is my compensation
4 related to CMS star rating, I think, is what you said.

5 Q. So let me ask it more general. Thank you.
6 Let me ask it in a more general and I'll break these
7 down because there are multiple things here.

8 Is your compensation, your compensation tied
9 to patient safety in any way?

10 A. Yes.

11 Q. How?

12 A. The balanced scorecard.

13 Q. All right.

14 A. So there's patient safety things on the
15 balanced scorecard.

16 Q. Okay. What about union worker contracts, is
17 it tied to that?

18 A. No.

19 Q. What about ratings by third-party ratings
20 organizations?

21 A. No.

22 Q. Okay. So the -- and this question was not
23 only with respect to your compensation but other
24 executive leadership officers. Do you see that?

25 A. Or any other executives, yes, I do.

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1 Q. Are there any other executive level
2 leadership officers whose performance is tied to the
3 balanced sheet, the balanced scorecard you mentioned?

4 A. Right, yes, my administrative team.

5 Q. And who's on your administrative team?

6 A. The CNO, CFO, COO, CHRO.

7 Q. Anyone else?

8 A. No.

9 Q. And so just so my record is clear, the
10 answer to this question relates solely to patient
11 safety and specifically the balanced scorecard that
12 we've been discussing here today, correct?

13 A. Yes.

14 Q. And that balanced scorecard that I've not
15 seen, can you tell me what -- again, you may have
16 already, and I apologize -- what is on that balanced
17 scorecard?

18 A. There are a lot of measures on it, but
19 HCAHPS HAI's, HAI's are on there, transfer acceptance
20 rate is on there, ODE ratio is on there. There's an ED
21 indicator on there. It might be -- I'm not sure which
22 one it is but something related to the emergency
23 department. Might be left without being seen or
24 something of that nature.

25 What else is on there?

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1 I think SSI is on there. Adjusted
2 admissions is on there. EBITDA. I think that's the
3 majority.

4 Q. Okay. And I know what -- for the record,
5 HAI's are hospital-acquired infections, correct?

6 A. Yes.

7 Q. Transfer acceptance rates, what are those?

8 A. We have a transfer center for our network
9 accepting -- the goal is 85 percent accepting of the
10 transfers.

11 Q. Okay. I don't even know what that means so
12 I'll try to break it down.

13 There's a transfer center for your network?

14 A. Yeah. So basically the transfer from any
15 other hospital into our organization, you know, they
16 manage that whole process and reaching out to us to see
17 if we have the services, can we accommodate the
18 patient, things like that.

19 Q. And is that transfer acceptance from within
20 these five hospitals only or other hospitals as well?

21 A. It can be, yeah, it's everyone.

22 Q. Does Good Samaritan accept transfers from
23 Jupiter?

24 A. Yeah, we have.

25 Q. Do you accept transfers from any of the

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1 other four hospitals in the Palm Beach Health Network?

2 A. I mean, we can. It just depends, you know,
3 if you have a certain service and someone else doesn't
4 have it.

5 Q. Would that, if you transferred, let's just
6 say a patient from Delray into Good Samaritan, would
7 that be part of the 85 percent transfer rate you're
8 trying to get to?

9 A. Internal? Yeah, it is.

10 Q. Okay. And can you not accept patients? Is
11 that --

12 A. Yes.

13 Q. I guess I'm --

14 A. Yes.

15 Q. So it's measuring whether or not
16 Good Samaritan has put into place processes that it can
17 accept patients from other hospitals, is that what that
18 rate is measuring?

19 A. Yes. And that we, you know, we're making
20 sure that we have the coverages for services. You
21 know, sometimes it's the patient -- might be a patient
22 request to, and it might not have anything to do with
23 the service, for example, that they request a different
24 hospital, so that would be part of transfers. But it's
25 just making sure that when we're requested to take a

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1 patient that we're making every effort to ensure we can
2 accommodate a patient being transferred.

3 Q. And are you -- is Good Samaritan a level I
4 trauma center?

5 A. It is not.

6 Q. Okay. So that doesn't count like accepting
7 patients, going on bypass, for example?

8 A. Trite. Trauma centers are different.
9 They're the only two in the county, so...

10 Q. When you talk about O to E ratios, what does
11 "O to E" stand for?

12 A. Expected over observed, length of stay.

13 Q. Got it. And so is that measure measuring
14 whether or not you are discharging patients in a timely
15 manner?

16 A. You could look at it that way. It's really
17 just a measure of Medicare gives you an amount of time
18 a patient should be in a hospital, you know, for a
19 certain DRG, and are we meeting that.

20 Q. Got it. The ED indicator, emergency
21 department, correct?

22 A. Yes.

23 Q. And that, what is that measuring, to the
24 best of your knowledge?

25 A. I think it's the left without being seen,

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1 WL -- or LWBS, I think, is what's on the balanced
2 scorecard or it might be how long it took to see a
3 patient once they hit the emergency room --

4 Q. Got it.

5 A. -- you know, like the length of stay. It's
6 one of two of those measures.

7 Q. And SSI, what does that stand for?

8 A. Surgical site infection.

9 Q. And that's different than HAI, right?

10 A. Yes.

11 Q. Adjusted admission, what does that mean?

12 A. It takes admissions plus outpatient, the
13 volume and -- it's a calculation, put it that way.

14 Q. Okay.

15 A. Basically it's admissions and outpatient
16 visits combined together but equating an outpatient
17 visit to an admission, so it's relatable.

18 Q. That makes sense. And then HAI is your, I
19 assume you're looking at CAUTI and CLABSI?

20 A. Yes.

21 Q. Anything else?

22 A. C. diff, MRSA.

23 Q. And those are all things that are on our --
24 are measured by the CMS as well, correct?

25 A. Correct.

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1 Q. And I want to talk briefly about prior to
2 2020 -- prior to 2020, Good Samaritan participated in
3 the Leapfrog survey, correct?

4 A. I wasn't there, but I believe the network
5 did before 2020.

6 Q. And --

7 A. I don't --

8 Q. I'm sorry. Go ahead.

9 A. Go ahead.

10 Q. Do you have any understanding of whose
11 decision it was for the network to participate in the
12 Leapfrog survey?

13 A. To participate?

14 Q. Correct.

15 A. I don't know.

16 Q. And who was the CEO of Tenet Healthcare
17 prior to 2020?

18 A. Saum. He was still the CEO.

19 Q. He was?

20 A. Um-hum.

21 Q. He did not become the CEO in 2021?

22 A. I don't -- no, because I went to Good Sam in
23 2020 and he was the CEO then.

24 Q. Do you know when Saum became the CEO of
25 Tenet Healthcare?

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1 A. Probably in 2019, '18. I'm not sure.

2 Q. Okay. And so while Saum was the CEO of
3 Tenet Healthcare, your understanding is that these five
4 hospitals participated in the Leapfrog survey, correct?

5 A. I believe so.

6 Q. And do you have an understanding that the
7 Leapfrog survey is separate and distinction from the
8 hospital ratings program?

9 MR. MARCUS: Object to form.

10 A. What do you mean?

11 BY MS. BLAIR:

12 Q. Well, do you understand there's a survey --
13 Well, let's go back to the beginning.

14 There is a Leapfrog Hospital Survey,
15 correct?

16 A. Correct.

17 Q. Have you seen that survey before?

18 A. I have.

19 Q. And it's like three, 400 pages, correct?

20 A. Yes.

21 Q. And lots of different types of hospitals can
22 engage in the Leapfrog Hospital Survey. Do you have an
23 understanding of that?

24 A. You mean many hospitals participate in the
25 survey, is that what you mean?

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1 Q. No, I mean -- yes, that was a terrible
2 question.

3 Like children's hospitals can do the survey,
4 correct?

5 A. I don't know that.

6 Q. Okay. So there's the hospital survey on the
7 one hand, and then there's the hospital safety grades
8 on the other hand. Do you understand that?

9 A. The safety grades as in the F?

10 Q. Correct.

11 A. (Nodding head).

12 Q. You understand that?

13 A. I do.

14 Q. Do you have an understanding of how many
15 measures on the hospital safety grade exist?

16 A. 22.

17 Q. And do you understand that not all of those
18 measures come from the Leapfrog survey?

19 A. I understand that.

20 Q. So with that understanding, I'm talking
21 about just participating in the survey, because do you
22 understand that all hospitals are graded whether they
23 participate in the survey or not?

24 MR. MARCUS: Object to form.

25 A. I am aware.

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1 BY MS. BLAIR:

2 Q. Okay. Now, I was focusing just on
3 Good Samaritan. Do you know when Good Samaritan
4 started participating in the Leapfrog Hospital Survey?

5 A. I don't.

6 Q. Do you know whether or not when
7 Good Samaritan did participate in the Leapfrog Hospital
8 Survey, whether it ever had to pay a fee to participate
9 in the survey?

10 A. I don't know.

11 Q. Do you know whether or not hospitals today
12 that are participating in the Leapfrog Hospital Survey
13 pay a fee to participate in the survey?

14 A. Pay a fee to Leapfrog?

15 Q. Correct.

16 A. To take the survey?

17 Q. Correct.

18 A. No.

19 Q. Do you know whether or not hospitals pay a
20 fee -- well, strike that.

21 Do you know whether or not hospitals, all
22 acute care hospitals, whether they fill out the survey
23 or not, have access to the information contained in the
24 survey?

25 A. Do they have access, like to the survey?

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1 Q. Correct.

2 A. Yes.

3 Q. And to the best of your knowledge, Leapfrog
4 does not charge any hospital in the United States of
5 America to access its survey materials, correct?

6 MR. MARCUS: Object to form.

7 A. Not to my knowledge, but...

8 BY MS. BLAIR:

9 Q. Is there a "but" there?

10 A. Not to my knowledge.

11 Q. Do you have an understanding that the
12 Leapfrog Hospital Survey is publicly available on the
13 leapfroggroup.org website to anybody that wants to
14 download it?

15 A. Yes.

16 Q. Do you know whether or not Good Samaritan
17 has ever paid any money to Leapfrog for anything?

18 A. I don't know if they have in the past.

19 Q. Do you have an understanding that at some
20 point in the history of Good Samaritan it received an A
21 grade from Leapfrog?

22 A. Not to my knowledge.

23 Q. To your knowledge, in the history of
24 Good Samaritan hospital has Good Samaritan ever been
25 approached by Leapfrog or solicited by Leapfrog to pay

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1 for consulting services provided by Leapfrog?

2 A. I don't know if that has ever occurred. I'm
3 not aware of it.

4 Q. Do you know whether or not Leapfrog has
5 consulting services that a hospital can purchase?

6 A. That is my understanding.

7 Q. How did you come to that understanding?

8 A. I don't recall. It's just a general that
9 you can pay Leapfrog for, you know, consulting fees to
10 help you with your grade.

11 Q. Have you --

12 A. I don't recall who told me that. I don't
13 know.

14 Q. Have you ever done any independent
15 investigation into whether or not that statement is
16 true?

17 A. I have not.

18 Q. And as the corporate representative of
19 Good Samaritan, do you have any idea as to whether or
20 not the statement that Leapfrog charges for consulting
21 services is true?

22 A. Yes.

23 Q. And what is that?

24 A. I would say some of that is true.

25 Q. What is that based on?

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1 A. Well, I didn't see a document myself, but in
2 conversations with individuals that would know, like
3 quality directors.

4 Q. Which quality director told you that
5 Leapfrog charges for consulting services?

6 A. Gina West.

7 Q. So when I take Gina West's deposition, she's
8 going to testify that she indicated to you that
9 Leapfrog charges hospitals for consulting services?

10 MR. MARCUS: Object to form.

11 A. I would say, yes.

12 BY MS. BLAIR:

13 Q. Do you --

14 A. There's definitely been conversations with
15 her about the payment to Leapfrog and how it works.

16 Q. What is your understanding of the payment to
17 Leapfrog and how it works?

18 A. You could pay Leapfrog for consulting to
19 help you with your grades. You have to pay Leapfrog if
20 you want to advertise your grade. That is my
21 understanding.

22 Q. And your understanding comes solely from
23 conversations with Gina West?

24 A. I mean, it might not have just been Gina.
25 It's been a general conversation and knowledge that

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1 people have.

2 Q. And you've done nothing to investigate
3 whether or not that's true?

4 A. What, to go try to find a contract from
5 Leapfrog or something and ask them for their fees?

6 Q. Well, have you ever even looked at their
7 website to see if consulting services are offered?

8 A. I didn't go to look to see if consulting
9 services were offered. I had no reason to doubt what
10 was being -- the general idea of what everybody knows
11 to be. Just never had a doubt.

12 Q. But you signed a declaration under oath
13 that, in fact, Leapfrog charges for consulting services
14 for hospitals to get better grades, correct?

15 A. That's what I was told.

16 MR. MARCUS: Object to form.

17 BY MS. BLAIR:

18 Q. And that sworn statement under oath is based
19 on what you were told, correct?

20 A. Correct.

21 Q. And you were told that by Regina West,
22 correct?

23 A. She is one of the individuals.

24 Q. Who were the others?

25 A. I don't know exactly who they were, but I

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1 know we've had conversations about how Leapfrog
2 generates revenue.

3 Q. And you believe the answer to the question
4 as to how Leapfrog generates revenue is by charging for
5 consulting services to help hospitals get better
6 grades?

7 MR. MARCUS: Object to form.

8 A. One of them.

9 BY MS. BLAIR:

10 Q. I want to focus on the consulting services.
11 You testified that you believe the consulting services
12 are that you can pay Leapfrog to help you get better
13 grades. Are there other consulting services,
14 consulting services that you believe Leapfrog charges
15 for?

16 A. I mean, other than helping you with,
17 obviously, all the things that are in the Leapfrog
18 survey, I don't know.

19 Q. And so as you sit here today, you believe
20 that Leapfrog has a program where it will help
21 hospitals get a better grade?

22 MR. MARCUS: Object to form.

23 A. I wouldn't say the motivation is just to get
24 a better grade, but whatever is part of the survey, you
25 know, anything that they can help in those areas, yes,

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1 that's what I believe.

2 BY MS. BLAIR:

3 Q. And you believe that based on just general
4 conversations you've had with Regina West and others?

5 A. Correct.

6 Q. And other than Regina West, can you name
7 another person that you've had that conversation with?

8 A. I mean, I'm going to say, no, for now
9 because I can't identify necessarily a person. They're
10 just conversations.

11 Q. Okay. Did you ever tell the governing board
12 that Leapfrog charges for consulting services to
13 hospitals so that they can get a better grade?

14 A. I don't believe so.

15 Q. Are you aware that there's an allegation in
16 this Complaint that Leapfrog is a "brazen play [sic] to
17 pay [sic] scheme"?

18 A. I'm aware of that, yes.

19 Q. And what is the "brazen pay to play scheme"
20 in your opinion?

21 A. Well, the pay really is your participation
22 and sharing of data and information.

23 To play is, you have to participate. If you
24 don't participate, you will be failed and receive a
25 failing grade.

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1 Q. So it's your belief that if you don't
2 participate in the Leapfrog Hospital Survey, you will
3 be failed?

4 A. Yes. There are seven measures that are not
5 provided -- information is not provided, and it's
6 35 percent, so you're already starting out with a very
7 bad grade.

8 Q. Are you aware that in the State of Florida
9 there are only ten hospitals that did not participate
10 in the Leapfrog Hospital Survey, and the only Fs that
11 were given were four of the hospitals that are
12 plaintiffs in this litigation?

13 MR. MARCUS: Object to form.

14 A. No.

15 BY MS. BLAIR:

16 Q. Are you aware that there are hospitals that
17 do not participate in the Leapfrog Hospital Survey that
18 received A's?

19 MR. MARCUS: Object to form.

20 A. No.

21 BY MS. BLAIR:

22 Q. Have you undertaken any investigation before
23 filing this lawsuit to determine whether or not that's
24 true?

25 A. Yes.

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1 Q. And you don't believe there are any
2 hospitals that don't participate in the Leapfrog
3 hospital surveys that receive anything but an F?

4 MR. MARCUS: Object to form.

5 A. Or a D. It would be highly statistically
6 impossible. Maybe you could get a C, but I highly
7 doubt it.

8 BY MS. BLAIR:

9 Q. If I --

10 A. Mathematically it doesn't work.

11 Q. If I produced to you evidence that there are
12 hospitals in the United States of America that do not
13 participate in the Leapfrog Hospital Survey that
14 receive an A, would you disagree with that?

15 A. I would be incredibly shocked that that's
16 possible.

17 Q. Okay. If I produced to you -- have you read
18 any of the expert reports from defendants in this
19 matter?

20 A. What do you mean?

21 Q. Well, do you understand that my clients have
22 experts that have produced reports in this matter?

23 A. Oh, okay.

24 Q. Do you dispute there are ten hospitals in
25 the State of Florida that did not participate in the

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1 Leapfrog hospital safety grade in fall 2024?

2 A. I wouldn't know.

3 Q. Do you dispute that five of those hospitals
4 of the ten received grades of C or better?

5 MR. MARCUS: Object to form.

6 A. So five of the hospitals that did not
7 participate --

8 BY MS. BLAIR:

9 Q. In the State of Florida.

10 A. -- received an A or a B?

11 Q. No, I said a C or better.

12 A. Oh, a C or better.

13 MR. MARCUS: Same objection.

14 A. Like I stated before, it could be
15 statistically possible to get a C. You would have to
16 be next to perfect of a hospital. I don't know how it
17 would be possible to get an A statistically.

18 BY MS. BLAIR:

19 Q. But if evidence is produced in this
20 litigation that hospitals that don't participate in the
21 Leapfrog Hospital Survey receive A's, you would have no
22 reason to dispute that, correct?

23 MR. MARCUS: Object to form.

24 A. What I would say is that us not
25 participating produced an F and would not have had we,

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1 so, to me, that's what's really important to me.

2 BY MS. BLAIR:

3 Q. But I thought you said earlier that if you
4 don't participate, you get an F. Is that your belief?

5 MR. MARCUS: Object to form.

6 A. That is my belief that is what happened to
7 our five hospitals.

8 BY MS. BLAIR:

9 Q. And I don't want to talk about just your
10 five hospitals.

11 Do you believe that under the Leapfrog
12 rating methodology as it stands today that if a
13 hospital does not participate in the Leapfrog Hospital
14 Survey, it receives an F?

15 MR. MARCUS: Object to form.

16 A. I didn't say an F. A failing grade. And
17 what I did say earlier is it could be possible that you
18 could get a C if you were a perfect hospital. I don't
19 know how you would get an A. But the bottom line is I
20 would have been a C. I'm an F because I didn't
21 participate.

22 There are seven indicators in there. That's
23 35 percent of the grade that -- and it's a voluntary
24 survey -- that we didn't participate and we got a
25 failing grade.

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1 BY MS. BLAIR:

2 Q. And we'll get to that.

3 When Leapfrog -- or I'm sorry.

4 When Good Samaritan did participate in the
5 Leapfrog Hospital Survey, do you have any reason to
6 dispute that it accurately reported to the Leapfrog
7 survey?

8 MR. MARCUS: Object to form.

9 A. What do you mean exactly?

10 BY MS. BLAIR:

11 Q. Well, if we look at -- and I'll just mark
12 this now, I guess, Exhibit 7.

13 (Defendant's Exhibit Number 7 for i.d.)

14 BY MS. BLAIR:

15 Q. Ms. Montgomery, I've just now handed you
16 what we've marked as Exhibit 7 which is a copy of the
17 Amended Complaint in this matter.

18 As you'll see at the top of this document,
19 it was filed on August 28th, 2025. Have you seen this
20 document before today?

21 A. I believe so. I've seen so many that look
22 familiar like this. I mean, I think. I've seen so
23 many documents. I can take the time to read through
24 this whole thing.

25 Q. Oh, that's okay.

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1 A. I don't know if I've seen this exact
2 document. A lot of the language looks the same, so I'm
3 not sure if I read through this whole document.

4 Q. Sure. And let me just go back a little
5 ways. You understand that there was a Complaint filed
6 against Leapfrog on April 30 of 2025, correct?

7 A. Right.

8 Q. Did you have any involvement -- and, again,
9 I don't want to know about any direct communications
10 you had with any of your attorneys, but did you have
11 involvement with reviewing and filing the Complaint
12 before it was filed?

13 A. I think I reviewed things specific to like
14 me and things that I had to approve on, sign off on
15 that was for Good Samaritan. This seems like a larger
16 document than I recall.

17 Q. Okay. And just for the record, there was a
18 Complaint filed on April 30 of 2025. After some
19 discussions between the lawyers and a court appearance,
20 there was an amendment to the Complaint on August 28th.
21 And I want to direct your attention specifically to
22 paragraph 27 of the Amended Complaint.

23 And before I got this Complaint out, I asked
24 you about whether or not Good Samaritan accurately
25 reported its data to the Leapfrog Hospital Survey when

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1 it participated. And specifically looking at paragraph
2 27 of the Amended Complaint, which, for the record, is
3 identical to former paragraph 55 of the original
4 Complaint, it says "Another way TLG's deceptive methods
5 punish nonparticipating hospitals is by rewarding
6 participating hospitals with grade inflation."

7 Do you see that sentence?

8 A. I do.

9 Q. And then it goes on to say, "The data
10 provided by hospitals that do participate in the TLG
11 Hospital Survey is self-reported, biased and subject to
12 manipulation."

13 Do you see that?

14 A. I do.

15 Q. The next sentence, "The plaintiffs in this
16 case say median responses for hospitals that report
17 their own scores show that those hospitals inflate
18 their performance."

19 Do you see that?

20 A. I do.

21 Q. And so my question is, is it your position
22 that Good Samaritan inflated its performance when it
23 engaged in the Leapfrog Hospital Survey?

24 MR. MARCUS: Object to form.

25 A. It says, "...median responses for hospitals

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1 that report their own scores showed that those
2 hospitals inflate their performance."

3 Well, I'm pretty confident we didn't inflate
4 our performance.

5 BY MS. BLAIR:

6 Q. Okay. Do you have any evidence that -- any
7 evidence of a hospital inflating its performance on the
8 hospital, Leapfrog Hospital Survey?

9 A. I do not.

10 Q. And so there are no specific competitors of
11 yours that you are accusing of manipulating the data
12 that they've reported to the Leapfrog Hospital Survey?

13 A. I am not.

14 Q. One of the things that your attorneys agreed
15 to produce in this litigation was documents sufficient
16 to simulate responses for the four measures on the
17 Leapfrog Hospital Survey that we are referring to in
18 this litigation as the imputed measures. Do you have
19 an understanding that that information was requested of
20 Good Samaritan?

21 A. By who? I'm sorry.

22 Q. Your attorneys.

23 A. Okay. Yes.

24 Q. Okay. And when I say "the imputed measures"
25 for purposes of this deposition, I'm referring to four

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1 measures that are on the Leapfrog Hospital Survey.

2 They are CPOE, BCMA, IPS, which is ICU staffing, and
3 hand hygiene. Do you understand those are the four
4 imputed measures at issue in this litigation?

5 A. I do.

6 Q. And, for the record, CPOE, what does that
7 mean to you?

8 A. Physician order entry.

9 Q. Computerized?

10 A. Computerized.

11 Q. BCMA, what does that mean to you?

12 A. Barcode administration.

13 Q. Hand hygiene, what do you understand that to
14 mean in the context of Leapfrog Hospital Survey?

15 A. Hand washing, hand washing policies,
16 et cetera.

17 Q. And what about IPS or ICU staffing, what
18 does that mean to you in the context of Leapfrog
19 Hospital Survey?

20 A. Critical care trained physicians being in
21 the hospital in your ICU.

22 Q. And what types of -- on behalf of
23 Good Samaritan, what types of information did you
24 provide to be produced in this litigation "sufficient
25 to simulate responses" for those four measures?

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1 MR. MARCUS: Object to form.

2 A. Those four measures.

3 BY MS. BLAIR:

4 Q. What documents did you produce sufficient to
5 simulate?

6 A. I believe that quality produced the
7 documents. But I also did answer based on quality they
8 have systems that track this stuff, CPOE for example.

9 Q. Okay. And when you say quality produced
10 these documents, would that be Regina West?

11 A. Yes, or Erin Britt.

12 Q. Did you attempt to rerun -- did you attempt
13 to -- well, strike that.

14 What did you do as the CEO of Good Samaritan
15 to ensure that the document responses that have been
16 provided in this litigation for those four measures
17 was, in fact, accurate and sufficient to simulate
18 responses to the Leapfrog Hospital Survey from fall of
19 2024?

20 A. I saw them myself.

21 Q. You saw the documents yourself?

22 A. Right.

23 Q. Did you take the survey and match it up to
24 make sure there was sufficient information to answer
25 all the questions on the survey?

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1 A. Did I take the survey? What do you mean?

2 Q. Yeah, so your hospital gathered documents
3 that are sufficient to simulate, correct?

4 A. Yes.

5 Q. For each of these four measures, correct?

6 A. That is my understanding.

7 Q. And I think you just testified then you
8 reviewed those documents before you provided them to
9 your attorneys, correct?

10 A. Yeah, the CPOE percentage, hand washing
11 percentage, those documents I looked at.

12 Q. Okay. And in trying to figure out whether
13 or not Good Samaritan was producing sufficient
14 information to simulate the responses to the Leapfrog
15 Hospital Survey, did you compare the documents to the
16 questions on the survey itself?

17 A. I did not.

18 Q. When Leapfrog -- I'm sorry.

19 When Good Samaritan participated in the
20 Leapfrog Hospital Survey, do you know whether or not
21 Good Samaritan derived any benefit from participating
22 in the survey?

23 MR. MARCUS: Object to form.

24 A. Not to my knowledge.

25 BY MS. BLAIR:

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1 Q. Do you know whether or not Good Samaritan
2 has ever used at any time the Leapfrog Hospital Survey
3 as a benchmarking tool?

4 A. Not to my knowledge.

5 Q. Do you know whether or not Good Samaritan
6 has ever used the Leapfrog Hospital Survey to inform
7 its own patient safety plan?

8 A. To inform its own? I don't know what you
9 mean by that.

10 Q. Sure. So Good Samaritan has a patient
11 safety plan. We talked about it earlier today,
12 correct?

13 A. Correct.

14 Q. And I think you told me that there would be
15 somebody in the quality department that would -- that
16 would first corporate and then on a local level put
17 together that patient safety plan; is that fair?

18 A. That's fair.

19 Q. Do you know whether or not anyone either at
20 corporate or on the local level looks at the Leapfrog
21 Hospital Survey to figure out what should be in the
22 patient safety plan?

23 A. I mean, not to my knowledge. If that
24 occurs, I'm not aware or I don't recall.

25 Q. Who would know that?

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1 A. I would say quality.

2 Q. And quality would be Regina West?

3 A. Yes.

4 Q. And the others you've talked about today
5 that are in quality?

6 A. Right.

7 Q. Would you agree with me that the CPOE
8 measure is distinct to the Leapfrog Hospital Survey?

9 MR. MARCUS: Object to form.

10 A. No, I'm pretty confident that it was rolled
11 out originally by like Medicare, and there's -- they
12 want you to be, I think, 85 percent or something. I
13 can't recall, but...

14 BY MS. BLAIR:

15 Q. Are you aware that to comply with the
16 Leapfrog CPOE standard there is a testing of the system
17 that has to be undergone in realtime?

18 MR. MARCUS: Object to form.

19 A. A testing of the CPOE system?

20 BY MS. BLAIR:

21 Q. Correct.

22 MR. MARCUS: Same objection.

23 A. Like testing it how? What do you mean?

24 BY MS. BLAIR:

25 Q. Well, there's a two-hour test that is

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1 required to comply with the Leapfrog CPOE standard in
2 which a physician, a quality person and a nurse must be
3 present at, and they give you prompts to test the CPOE
4 system.

5 A. Oh.

6 Q. Are you aware of that?

7 A. No.

8 MR. MARCUS: Object to form.

9 BY MS. BLAIR:

10 Q. Are you aware of whether or not
11 Good Samaritan attempted to complete that test in order
12 to provide sufficient to simulate responses for the
13 CPOE measure in this litigation?

14 MR. MARCUS: Object to form.

15 A. I am not.

16 BY MS. BLAIR:

17 Q. According to your declaration -- well,
18 strike that.

19 You understand that you signed a declaration
20 in this litigation on May 15th, 2025, correct?

21 A. Yes.

22 Q. And that declaration was attached to a
23 motion for preliminary injunction, correct?

24 A. This is a lot of legal --

25 Q. Oh, sorry.

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1 A. You know, you'll have to talk hospital
2 language my way.

3 Q. That's fine. I'm trying to learn the
4 hospital language.

5 For what purpose -- for what purpose do you
6 understand your declaration was drafted and signed?

7 MR. MARCUS: And, again, don't refer to any
8 conversations with counsel.

9 MS. BLAIR: Sure.

10 MR. MARCUS: I'm not sure she can answer
11 that question.

12 BY MS. BLAIR:

13 Q. Okay. Do you have an understanding of
14 whether or not your declaration was produced in this
15 litigation?

16 A. Do I have an understanding whether it was?

17 Q. Correct.

18 A. Yes.

19 Q. And do you know whether that declaration was
20 attached to any motions that have been filed in this
21 litigation?

22 A. That is my understanding.

23 Q. Okay. What is your understanding of which
24 motion it was attached to?

25 A. There were so many documents, honestly, that

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1 I had to review back and forth that, I mean, I would
2 have to see it.

3 Q. Okay. And I can show it to you.

4 Has anybody ever told you that your
5 declaration has been withdrawn in this litigation?

6 MR. MARCUS: And, again, not -- when she
7 asks you that, she's not talking about
8 attorneys.

9 BY MS. BLAIR:

10 Q. Correct, I'm not talking about attorneys.

11 A. Not talking about attorneys meaning what?

12 Q. I don't want to know about anything your
13 attorneys have told you or not told you.

14 A. Oh, Jesus.

15 Q. I can't know that.

16 A. Right.

17 No.

18 Q. Okay. And so as far as you know, that
19 declaration that you signed under oath on May 15th,
20 2025 is still part -- as far as you know, is still part
21 of this litigation, correct?

22 A. That's my understanding.

23 Q. When did Good Samaritan stop participating
24 in the Leapfrog Hospital Survey?

25 A. I think it was 2021, I think.

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1 Q. Why did Good Samaritan stop participating in
2 the Leapfrog Hospital Survey?

3 A. The first conversations, you know, after
4 COVID about what quality was spending time on and, you
5 know, either the Leapfrog survey was brought up, and it
6 was talked about that it was time-consuming and, you
7 know, there was, you know, didn't really add much
8 value, it wasn't like an accrediting body and that we
9 wanted to spend our time more doing surveys where, you
10 know, Joint Commission, for example.

11 Q. Do you know how much time Good Samaritan was
12 spending in, let's just say the last year it engaged in
13 the Leapfrog survey, in responding to the Leapfrog
14 survey?

15 A. I don't know, but looking at it, it looks
16 time-consuming, you know.

17 Q. Was there ever an FTE assigned to responding
18 to a Leapfrog survey?

19 A. I wouldn't say it's like an FTE. It would
20 be quality, so...

21 Q. Okay. And quality, are they physicians?

22 A. No.

23 Q. And so if you started at Good Samaritan as
24 the CEO in April of 2020, was there one year in which
25 you were the CEO of Good Samaritan in which

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1 Good Samaritan participated in the Leapfrog Hospital
2 Survey?

3 A. One solid year?

4 Q. Yes.

5 A. Well, if we stopped in '21, I would say
6 there wasn't a solid year probably.

7 Q. Let me ask it a different way because it was
8 a bad question.

9 Do you understand that the Leapfrog Hospital
10 Survey is annual?

11 A. Yes.

12 Q. Do you have a recollection of whether or not
13 when you were the CEO of Good Samaritan whether
14 Good Samaritan completed a Leapfrog Hospital Survey in
15 that year?

16 A. No. It's all kind of muddy. It was a long
17 time ago. I don't remember really. I just remember
18 the subject coming up and it being time-consuming, not
19 adding value, and we were going to spend our time doing
20 other things.

21 Q. Okay. So that's the reason why
22 Good Samaritan stopped engaging in the Leapfrog
23 Hospital Survey, correct?

24 A. Yes. It was a voluntary survey, and after
25 COVID, you know, quality was, as you can imagine, busy

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1 and needed to do a lot of things so we wanted to spend
2 our energy on like getting certified for orthopedics
3 with Joint Commission and things like that.

4 Q. Okay. And just to make sure, that is
5 also -- is that also the answer for Good Samaritan, as
6 the corporate representative of Good Samaritan the
7 reason why Good Samaritan stopped participating in the
8 Leapfrog Hospital Survey?

9 A. Yes.

10 Q. Was there a directive from Tenet home office
11 to stop participating in the Leapfrog Hospital Survey?

12 MR. MARCUS: Object to form.

13 A. I don't recall that.

14 BY MS. BLAIR:

15 Q. Do you recall whether you were involved in
16 any meetings at the Palm Beach Health Network group
17 level about all five hospitals ceasing participation in
18 the Leapfrog Hospital Survey in or around 2021?

19 A. So these, the conversations was with the
20 group CNO, Libby, about, you know, what we needed to
21 spend the time on in quality, so that would be a group
22 decision.

23 Q. Okay. And did you say Libby?

24 A. Yes.

25 Q. Who is Libby?

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1 A. Philippe owe. Libby Flipppo, she was the
2 group CNO at that time.

3 Q. So that would be before Ricky Ramirez?

4 A. Right.

5 Q. When does Ricky Ramirez enter the picture
6 for the group?

7 A. When Libby left, which was probably two and
8 a half, three years ago, somewhere around there.

9 Q. Where does Libby work now?

10 A. She's semi-retired. That's my
11 understanding.

12 Q. Do you have a recollection as to whether or
13 not the reasoning -- as to whether or not
14 Tenet Healthcare home office indicated to the
15 Palm Beach Health Network hospitals in or around 2021
16 that participation in the Leapfrog survey would not be
17 supported unless it was tied to a local requirement or
18 payer reimbursement?

19 MR. MARCUS: Object to form.

20 A. I recently read an email stating that.

21 BY MS. BLAIR:

22 Q. And do you have any recollection as to
23 whether that was the position back in 2021 when the
24 five Palm Beach Health Network hospitals stopped
25 participating?

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1 A. No, I don't know anything about that.

2 Q. Do you have an understanding of what home
3 office means about "being tied directly to," "being
4 tied directly to payment or contract"?

5 MR. MARCUS: Object to form.

6 A. I don't. I don't know what else it means to
7 them.

8 BY MS. BLAIR:

9 Q. But you still participate in Healthgrades™
10 even those it's not connected to payment or contract,
11 correct?

12 A. Correct.

13 Q. What was the reaction -- and I'm talking
14 about in 2021 -- when the five Palm Beach Health
15 Network hospitals made the decision to stop
16 participating in the Leapfrog Hospital Survey? What
17 was the reaction internally at the Palm Beach Health
18 Network to that decision?

19 A. You mean like my hospital?

20 Q. Yes. Were people upset that you weren't
21 going to participate? Were they fine with it? Were
22 they glad? Do you have any memory?

23 MR. MARCUS: Object to form.

24 A. I don't recall it ever being -- there really
25 wasn't a lot of -- what's the word -- focus on Leapfrog

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1 at all, so I feel like it was a nonevent that I recall.

2 BY MS. BLAIR:

3 Q. Would you agree with me that not a lot of
4 patients know what Leapfrog is?

5 MR. MARCUS: Object to form.

6 A. I would not agree with you, no. I think
7 they're very well aware now.

8 BY MS. BLAIR:

9 Q. Right now today?

10 A. Yes.

11 Q. I would agree with that.

12 Prior, in 2021, do you believe patients were
13 well aware of what Leapfrog is?

14 MR. MARCUS: Object to form.

15 A. I don't really know. I mean, quite frankly,
16 I would say that Leapfrog is out there more in the last
17 two years than they previously have been. You know,
18 you see advertisement for it, you know, a lot more than
19 you did in the past.

20 BY MS. BLAIR:

21 Q. And you would say that's like within in the
22 last two years?

23 A. I would say, last, yeah, couple years.

24 Q. At any time between 2021 when Good Samaritan
25 stopped participating in the Leapfrog Hospital Survey

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1 and September of 2024, had there been any internal
2 discussions at the Palm Beach Health Network group
3 level about rejoining the Leapfrog Hospital Survey
4 participation?

5 A. I don't recall other than that email that I
6 just recently saw a discussion about participating. I
7 don't recall any. I mean, if it did, I just don't
8 recall.

9 Q. And it wasn't important to you as the CEO of
10 Good Samaritan, the Leapfrog hospital safety grade?

11 A. No, it was not. Our focus is more on the
12 accrediting agencies than the survey.

13 Q. Do you know how much a hospital needs in its
14 budget to comply with the Leapfrog Hospital Survey?

15 MR. MARCUS: Object to form.

16 A. How much they need to budget to complete the
17 survey?

18 BY MS. BLAIR:

19 Q. Correct.

20 A. I don't know. I mean, it looks very
21 time-consuming. I'm sure it would take a few weeks
22 probably to complete, involving a lot of other
23 individuals.

24 Q. Does it take more or less time, in your
25 opinion, than those -- than the work that you talked

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1 about earlier with respect to the accreditations?

2 A. If I had to guess what takes more or less
3 time? The accreditations would take more resources.
4 I've never completed the Leapfrog survey myself, so...

5 Q. And you don't recall whether it was
6 completed during your time as the CEO of Good Samaritan
7 in April of 2020?

8 A. I don't know when it's really due. So if it
9 was due during my tenure there, then it was completed.
10 But I just, I don't recall. That was five years ago.

11 Q. Right. And you just don't have a memory of
12 how long that took at that time; is that fair?

13 A. Yes, correct.

14 MS. BLAIR: Can you mark this as Exhibit 8?
15 (Defendant's Exhibit Number 8 for i.d.)

16 BY MS. BLAIR:

17 Q. Ms. Montgomery, I'm now handing you what
18 we've marked as Exhibit 8 to this deposition. And,
19 again, I'm going to refer to this Bates number at the
20 bottom right-hand corner, PBHN, four zeros, 11358. Do
21 you have that in front of you? It's at the bottom
22 right-hand corner.

23 A. Yes.

24 Q. I just want to make sure we're reading the
25 same thing.

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1 This is an email from Maggie Gill to you
2 dated December 11, 2024. Do you see that?

3 A. I do.

4 Q. And I want to focus on the email from you to
5 Maggie Gill right underneath that top email dated
6 Tuesday, December 10th, 2024 at 8:10 p.m.

7 Do you see that?

8 A. Yes.

9 Q. And you said, "Thank you. I appreciate it.
10 Also, Gina did say they could handle without adding
11 resources as well."

12 Do you see that sentence?

13 A. Yes.

14 Q. And if we look down at the very bottom of
15 this page, the first email in this sequence is from
16 Maggie Gill to Regina West, Ricky Ramirez,
17 Teresa Urquhart and Mohammad Aslam, correct?

18 A. Yes.

19 Q. And it has a CC to Shelly Weiss?

20 A. Um-hum.

21 Q. Who is Teresa Urquhart, U-r-q-u-h-a-r-t?

22 A. She was the CEO at Palm Beach Gardens at the
23 time.

24 Q. Okay. And what about Mohammad Aslam, who is
25 he?

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1 A. I have no idea who that is. I don't know.
2 I'm drawing a blank there.

3 Q. What about Shelly Weiss?

4 A. She's PR for the group.

5 Q. For the group?

6 A. Yes.

7 Q. Does she work at a specific hospital in
8 addition to her group duties?

9 A. No.

10 Q. And you'll see Maggie Gill is saying to you,
11 "Please send me a request to reintroduce Leapfrog
12 reporting, including rationale, imputed score and
13 clippings of negative press and MD feedback."

14 Do you see that?

15 A. I do.

16 Q. And she says, "I will request an exception
17 for PBHN and PMC to start reporting next period,"
18 correct?

19 A. Yes.

20 Q. What's "PMC"?

21 A. I wonder if that's another group she has.
22 PMC. Palm Beach Health Network and I'm not sure.

23 Q. Okay. And so in response to that email, you
24 say, "And Gina did say they could handle it without
25 adding resources as well."

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1 Do you see that?

2 A. Yes.

3 Q. Is that referring to that Gina said they
4 could handle the Leapfrog Hospital Survey without
5 adding additional resources?

6 A. Adding additional FTE's is what that means
7 really, yeah.

8 Q. Okay. So suffice it to say, is your email
9 saying that you don't have to hire a new person in
10 quality to complete the Leapfrog Hospital Survey?

11 A. Correct.

12 Q. Okay.

13 A. That's what I mean.

14 Q. Between 2020 -- or I'm sorry. Between 2021
15 when Good Samaritan stopped participating and the fall
16 of 2024, do you recall having any meetings with the
17 governing board about participating in the Leapfrog
18 Hospital Survey? With the understanding this is from
19 December of 2025. So I'm asking from 2021 to the fall
20 of 2024 before this email, do you recall any
21 discussions with the governing board about
22 participating in the Leapfrog survey?

23 A. I don't.

24 Q. Okay. And same question with respect to
25 discussions with Palm Beach Health Network. Between

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1 2021 when you stopped participating to the fall of
2 2024, do you recall any conversations with Palm Beach
3 Health Network, whoever that may be, about
4 participating in the Leapfrog survey?

5 A. So essentially after we stopped
6 participating and prior to the ratings coming out in
7 that period is what you're --

8 Q. Correct.

9 A. Do I remember talking to them about
10 participating again? I don't recall ever having that
11 conversation.

12 Q. And it wasn't important to you about
13 participating in the Leapfrog Hospital Survey during
14 that time frame?

15 A. No.

16 Q. Prior -- during the same time period, 2021
17 through the fall of 2024 when the fall of 2024 hospital
18 safety grades came out, do you recall having any
19 conversations with Tenet health system home office,
20 I'll call it, about participating in the Leapfrog
21 survey?

22 A. I don't. I don't recall anything.

23 Q. Do you understand that in that time period,
24 2021 to fall of 2024, the quality personnel at
25 Good Samaritan were monitoring Good Samaritan's

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1 Leapfrog grades?

2 MR. MARCUS: Object to form.

3 A. Were they monitoring? I mean, I know they
4 would get emails of what the grade was going to be, so,
5 I mean, like Gina, I think, specifically would get
6 emails about what the grade is going to be and things
7 like that. Is that what you mean?

8 BY MS. BLAIR:

9 Q. Yes.

10 And do you understand that every score --
11 well, do you understand that the Leapfrog -- now, I'm
12 not talking about the survey anymore. Now we're going
13 to talk about the safety grade for a minute.

14 Do you understand that the Leapfrog hospital
15 safety grade comes out twice a year?

16 A. Spring and fall.

17 Q. Correct. So you have that understanding?

18 A. I do.

19 Q. Do you have an understanding that twice a
20 year before the Leapfrog hospital safety grade comes
21 out Leapfrog provides a calculator to each and every
22 hospital so that they can calculate their own score?

23 A. They send them a calculator?

24 Q. Correct.

25 A. I don't recall that, but...

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1 Q. Okay. Do you have an understanding that at
2 all times since 2021 and before, but at least since
3 2021 that Leapfrog publishes its current scoring
4 methodology on its website for everybody to review?

5 A. I do not.

6 Q. Okay. I want to talk about
7 Good Samaritan's -- I want to focus now a little bit on
8 2023, so this would be the time period before the
9 change in the Leapfrog hospital safety grade
10 methodology. And I think you testified a little bit
11 earlier that Good Samaritan does monitor its CPOE
12 performance regularly, correct?

13 A. Yes.

14 MS. BLAIR: I'll mark this as Exhibit 9 as a
15 group Exhibit.

16 (Defendant's Exhibit Number 9 for i.d.)

17 BY MS. BLAIR:

18 Q. Mrs. Montgomery -- and before we get to this
19 document, I assume Good Samaritan monitors CPOE because
20 it's important to patient safety?

21 A. It is.

22 Q. And can you describe just as a CEO of a
23 hospital how CPOE is important to patient safety?

24 A. Errors. It reduces errors, you know. If
25 the physician is entering an order instead of telephone

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1 order telling someone who is now going to go, another
2 person go and enter an order, you know, they do it
3 directly into the system and don't do telephone orders
4 or tell the nurse what to put into it, so it obviously
5 should be more accurate for sure. It helps with
6 medication errors, too.

7 Q. Okay. And looking at this group Exhibit,
8 and it's several different CPOE, emails about CPOE, you
9 can just kind of flip through it. I think each one is
10 maybe one or two pages, and they all sort of look the
11 same, and they should be in chronological order.

12 And for my record, can you look at the first
13 page of this starts January 6th of 2023, correct?

14 A. Yes.

15 Q. And I think the last email -- and it's
16 miniature. I apologize. That's how it was produced to
17 me -- is from April 3rd, 2024 the very last one.

18 MR. MARCUS: What's the Bates number of the
19 page we're looking at?

20 MS. BLAIR: PBHN, four zeros, 11428 maybe.
21 I'm not sure if my glasses are strong enough
22 here.

23 MR. MARCUS: Okay. Because I don't have a
24 28.

25 MS. BLAIR: You don't have this tiny page?

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1 MR. MARCUS: The last -- oh, okay. Yeah.

2 MS. BLAIR: Yes, sorry. It's like
3 impossible to read.

4 MR. MARCUS: Yes. It jumps from 32 to 28?

5 MS. BLAIR: Yeah.

6 MR. MARCUS: Okay.

7 BY MS. BLAIR:

8 Q. And that last one in the sequence,
9 Ms. Montgomery, is that from April of 2024?

10 A. It is.

11 Q. Okay. And are these the documents that
12 Good Samaritan compiled in connection with the request
13 for documents related to CPOE sufficient to simulate?

14 A. I don't know.

15 Q. Okay. If we look at, and we can just look
16 at the first one, I think they're all sort of the same,
17 but the very first one is from Rachael Farahmandfar,
18 F-a-r-a-h-m-a-n-d-f-a-r, correct?

19 A. Yes.

20 Q. Who is she?

21 A. Clinical informatics. She's not with the
22 organization any longer.

23 Q. Was she at the home office level or was she
24 at the Palm Beach network level?

25 A. I'm not sure if she was a group person at

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1 all. I think she was a group lead for informatics, but
2 I'm not 100 percent sure on that.

3 Q. And you see the first line here it says,
4 "Attached is the December CPOE report," correct?

5 A. Yeah.

6 Q. And if we look at the chart that's at the
7 bottom of this page which is Bates number 11534, you
8 see where it says "metric"?

9 A. Yes.

10 Q. And then it's "CPOE percentage all
11 encounters," correct?

12 A. Um-hum.

13 Q. "CPOE percentage inpatient overall,"
14 correct?

15 A. Um-hum.

16 Q. And then the "CPOE percentage inpatient only
17 meds Leapfrog," do you see that?

18 A. I do.

19 Q. What was this measuring with respect to
20 Leapfrog?

21 A. That's a good question.

22 Q. Okay.

23 A. I don't know.

24 Q. And would you agree with me if we turn to
25 the next page, we see that again in the chart at the

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1 bottom of page 11477, right? It says, "CPOE percentage
2 inpatient meds Leapfrog," correct?

3 A. Yes.

4 Q. And, again, you don't know what this is
5 measuring?

6 A. I'm not sure.

7 Q. And I will submit to you, and you can look
8 at these, but, again, on page 11457 you've got, again,
9 a reference to Leapfrog and on and on.

10 A. Um-hum.

11 Q. Do you have any understanding as you sit
12 here today what that -- how that CPOE percentage was
13 being calculated as it relates to Leapfrog?

14 A. No.

15 Q. Do you know whether or not the -- whoever
16 was running this in informatics was running the test
17 that Leapfrog puts out in its survey to get to this
18 percentage?

19 A. I can't speak to it.

20 Q. Okay. Do you know who I would need to ask
21 to get an answer about what this reference to CPOE
22 percentage inpatient meds Leapfrog refers to?

23 A. Gina West would probably be able to answer
24 that.

25 Q. Okay. And you can set that aside. I'll

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1 mark this as Exhibit 10.

2 (Defendant's Exhibit Number 10 for i.d.)

3 BY MS. BLAIR:

4 Q. Ms. Montgomery --

5 Are you freezing?

6 A. I'm freezing in here.

7 THE WITNESS: But I didn't realize you're --
8 that's so nice of you to write it down for me,
9 the Exhibit Number.

10 BY MS. BLAIR:

11 Q. I've just handed you what we've now marked
12 as Exhibit 10, which is Bates number PBHN, four zeros,
13 11460. And it's sort of weirdly -- oh, and to 46 --
14 461, is that what you have in front of you?

15 A. 11460.

16 Q. Yes?

17 A. And 11461, yes.

18 Q. Perfect. If we look at this, it's from
19 Regina West to you and others, correct, dated
20 June 13th, 2023.

21 Do you see that?

22 A. Yes.

23 Q. And it's also to Taylor Pool, and we talked
24 about her earlier, correct? She's in the quality
25 department?

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1 A. She is.

2 Q. And then it's also CC'd to Ashley Barquin,
3 B-a-r-q-u-i-n. Who was Ashley Barquin?

4 A. She was the ACO at that time at Good Sam.

5 Q. Okay. And if you look on the -- the subject
6 of this is "Stet Media Group releases today this data
7 from Medicare compare on death rates outcomes by
8 hospital."

9 Do you see that subject line?

10 A. I do.

11 Q. What is Stet Media Group?

12 A. I don't know exactly what they are. I just,
13 you know, know that they're a media, local media group
14 is my understanding.

15 Q. Okay. And if you look on the next page
16 11461, Judy Goodman is writing to you June 13th, 2023,
17 and she says, "Dear, Sheri, Stet Media Group, all
18 former Post investigative reporters, are digging
19 through Medicare compare info and pulled out these
20 comparisons about staff vaccination rates, death rates,
21 outcomes, et cetera."

22 Do you see that?

23 A. Um-hum.

24 Q. Does this refresh your recollection of what
25 this Stet Media Group article was?

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1 A. No, I really would have to read what I said
2 to really --

3 Q. Okay. And Judy Goodman, for the record, she
4 was a board member in or around June of 2023?

5 A. Yes.

6 Q. Okay. And then your response to Judy is --
7 or I'm sorry. Maybe not to Judy.

8 So if we look at the bottom of 11460, you
9 send an email to Regina West, Taylor Pool and, again,
10 Ashley Barquin, right?

11 A. Right.

12 Q. And the substance of your email is on 11461,
13 and you say, "Check out the death rate for patients
14 with serious treatable complications after a surgery.
15 We are higher than the national average and the
16 majority of our peers."

17 Do you see that?

18 A. I do.

19 Q. Do you recall any conversations you had with
20 the governing board regarding the fact that your death
21 rates for patients with serious treatable complications
22 after surgery was higher than the national average and
23 the majority of your peers?

24 MR. MARCUS: Object to form.

25 A. I don't.

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1 BY MS. BLAIR:

2 Q. Do you recall whether Taylor Pool or
3 Ashley Barquin got back to you about your question, "Do
4 you know what is driving this? And do we track
5 mortality rates for surgical patients?"

6 A. Well, it looks like that they responded in
7 the email, right?

8 Q. Right. But do you recall conversation?

9 A. I mean, no. I'm sure we had them.

10 Q. Okay. Do you have any specific
11 recollection -- I might have just asked this so I
12 apologize -- of talking to the governing board about
13 this issue?

14 MR. MARCUS: Object to form.

15 A. I don't recall.

16 BY MS. BLAIR:

17 Q. What about any conversations you may have
18 had with Med Exec regarding the issue raised by
19 Judy Goodman in this email and this Stet news report?

20 A. I don't recall.

21 Q. Okay. Do you know if there was any measures
22 put in place at Good Samaritan to address this issue
23 after June of 2023?

24 A. So I would say we constantly, we review all
25 our mortalities all the time, every one of them and

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1 look for opportunities. A lot of mortalities, like as
2 referenced in here, and things that we have worked on
3 is documenting things that are present on admissions
4 even with infections, for example.

5 So I would say it's obviously a high
6 priority to us all the time any time there is a
7 mortality. And everyone goes through the chart. We
8 have like a three-level review of mortalities.

9 Q. Okay.

10 A. So was it implemented specifically because
11 of this? Not necessarily. We're looking at mortality
12 all the time.

13 I'm sure I was asking what specifically
14 about surgical patients were we an outlier in.

15 Q. Okay. And that would be the job of
16 Regina West, Taylor Pool and their team to sort of
17 monitor that kind of quality information?

18 A. Yeah. I mean, yeah, any mortality, all of
19 them are reviewed immediately by an entire time, so...

20 Q. Okay. And, again, we're still in 2023. And
21 we were talking about that period between 2021 and when
22 the fall safety grades came out in 2024 and about
23 Good Samaritan's position on the Leapfrog Hospital
24 Survey and safety grades during that time. And I want
25 to show you some Exhibits.

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1 MR. MARCUS: Do you want to take a break
2 before you get into an new Exhibit?

3 MS. BLAIR: Sure, yeah.

4 MR. MARCUS: Let's do that.

5 THE VIDEOGRAPHER: We're going off the
6 record. The time is 3:28 p.m.

7 (A recess was taken from 3:28 p.m. to 3:51 p.m.)

8 THE VIDEOGRAPHER: We're back on record.
9 The time is 3:51 p.m.

10 BY MS. BLAIR:

11 Q. Ms. Montgomery, right before the break we
12 were talking about how, if at all, Good Samaritan
13 monitored Leapfrog survey measures prior to the fall of
14 2024. And let me show you what we're now going to mark
15 as Exhibit 11.

16 (Defendant's Exhibit Number 11 for i.d.)

17 BY MS. BLAIR:

18 Q. Ms. Montgomery, for purposes of my record,
19 Exhibit 11 is PBHN 11442 at the bottom on the first
20 page. And it ends, this might be -- I can't tell if
21 it's double-sided for you or not, but the last document
22 should be PBHN 11446. Do you have that in front of
23 you?

24 They might be out of order.

25 A. 446? Yes.

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1 Q. Yes. And if we look at the first page of
2 this Exhibit, it's from Taylor Pool to you dated
3 November 8th, 2023, correct?

4 A. Yes.

5 Q. And the subject is "Quality Weekly Update."
6 Do you see that?

7 A. Yes.

8 Q. And you get quality -- did you -- do you
9 still get quality weekly updates from Taylor Pool?

10 A. No. She is in a different role now.

11 Q. Do you get them from anyone?

12 A. Yes.

13 Q. Who do you get them from now?

14 A. Erin Britt.

15 Q. Okay. You told me that. Sorry. And if we
16 look at this, document specifically starting at 11442,
17 she says, second full sentence, "GSMC scored a C, as
18 did all other hospitals in PBHN."

19 Do you see that?

20 A. Yes.

21 Q. And she says here, "I've attached a Leapfrog
22 calculator that shows our hospital score."

23 Do you see that?

24 A. Um-hum.

25 Q. And I think if you turn to maybe the last

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1 page of your Exhibit is the calculator itself. Mine
2 might be out of order.

3 Do you see that there?

4 A. Yes.

5 Q. And I had asked you a question earlier about
6 whether or not you knew that Leapfrog freely provides a
7 calculator to every hospital whether they participate
8 in the survey or not for them to calculate their grade.
9 Does this refresh your recollection that, in fact,
10 Leapfrog does provide that calculator?

11 A. So I'm not really sure if I was necessarily
12 aware this calculator was from Leapfrog, but, yes, I
13 understand.

14 Q. And if you see here the last sentence of
15 that or the second to last sentence of that first full
16 paragraph Taylor says, "Most of the measures include
17 data from 2020 through 2022."

18 Do you see that?

19 A. Yes.

20 Q. Do you understand that to be a reference to
21 the fact that the CMS data that we discussed earlier
22 today is lagging?

23 A. Yes.

24 Q. And then you see here she says, "Our biggest
25 opportunities for Leapfrog reporting period are as

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1 follows:"

2 And she has one, two, three, four, five,
3 six, seven bullet points, correct?

4 A. Yes.

5 Q. And then right below this bullet point she
6 says, "The measures with the greatest negative impact
7 on our grade are PSI 90."

8 Do you see that?

9 A. Um-hum.

10 Q. What do you understand PSI 90 to be?

11 A. It is a composite score of like 10 or 11
12 measures. I think they're all the PSIs added together
13 and there's a composite score is my understanding.

14 Q. And the PSI comes from CMS, correct?

15 A. Correct.

16 Q. All right. And she then says, "I put all of
17 the outcome quality measures at the mean, and it was
18 not enough to move us to a B."

19 Do you see that?

20 A. Yes.

21 Q. What do you understand her to mean "the
22 outcome quality measures"?

23 A. "Of all the outcome quality measures..."

24 "Of all the outcome quality measures..."

25 I would say it's putting all the quality

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1 measures in the scorecard at the mean.

2 Q. Okay. And did you understand or do you
3 understand as you look at this Exhibit here today that,
4 in fact, the -- these bullet points that Taylor has
5 listed, the, what did I say, seven points, were below
6 the mean?

7 A. I don't know, but she's saying our biggest
8 opportunity are these areas.

9 Q. And if we look at the calculator that is
10 attached, and I believe it's the last page of your
11 Exhibit, if we look at, do you see where it says
12 "Process Structural Measures" on left column?

13 A. Yes.

14 Q. And if you look at the first three of those
15 measures, computerized -- it's CPOE, BCMA and IPS, ICU
16 physician staffing. Do you see that?

17 A. I do.

18 Q. And at this point in time Good Samaritan was
19 given 100 points out of 100 points for those measures,
20 correct?

21 A. Okay.

22 Q. Did you understand that these three measures
23 came from the hospital survey?

24 A. On this scorecard?

25 Q. Correct.

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1 A. I'm sure at the time I would say, yes, if
2 that's what she provided when we had the C.

3 Q. Okay. And, well, in fact, in 2023, you were
4 not -- you were not engaging in the Leapfrog Hospital
5 Survey, correct?

6 A. Right, we weren't.

7 Q. Right. And my question was very inartful so
8 I apologize.

9 Do you understand that of these measures
10 that are listed on the calculator several of them come
11 from CMS; whereas, others would come from the Leapfrog
12 Hospital Survey?

13 A. Yes.

14 Q. And so my question is, do you understand
15 that the first three measures listed here, CPOE, BCMA
16 and ICU physician staffing, would, if Good Samaritan
17 had participated in the survey, have come from
18 Good Samaritan survey results?

19 A. Right.

20 Q. And do you understand that Good Samaritan
21 was getting 100 out of 100 points on those measures
22 even though it wasn't participating, correct?

23 MR. MARCUS: Object to form.

24 A. For 2023?

25 BY MS. BLAIR:

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1 Q. Correct.

2 A. It looks that way if this is the report
3 card, yes.

4 Q. And then we look a few lines down, do you
5 see hand hygiene?

6 A. Yes.

7 Q. And, in fact, Good Samaritan was getting
8 100 percent on hand hygiene on this scorecard, correct?

9 A. Yes.

10 Q. And in '23, Good Samaritan was not
11 participating in the Leapfrog Hospital Survey, correct?

12 A. That's right.

13 Q. And you understand, though, that
14 Good Samaritan was, nevertheless, receiving a perfect
15 score for hand hygiene, even though it didn't
16 participate in the survey?

17 A. They were what?

18 Q. Receiving a perfect score for hand hygiene,
19 correct?

20 A. Yes.

21 Q. Do you understand how that score was being
22 calculated in November of 2023 with respect to CPOE,
23 BCMA, ICU physician staffing and hand hygiene to give
24 Good Samaritan a 100?

25 A. Do I understand what Leapfrog did?

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1 Q. Correct.

2 A. My understanding is, from what I was -- what
3 was told to me is that they took previous information
4 and carried it forward maybe for several years. That's
5 my understanding, but...

6 Q. Have you ever been told that the way that
7 score was being calculated at a perfect score for
8 nonparticipating hospitals was by assigning
9 nonparticipating hospitals the mean score of its
10 cohorts?

11 MR. MARCUS: Object to form.

12 A. Tell me that again. Say it again.

13 BY MS. BLAIR:

14 Q. Sure. Did you ever have an understanding
15 that the way this grade was being calculated was that
16 Leapfrog would look at Good Samaritan's cohorts, like
17 hospitals, hospitals like Good Samaritan and then
18 assign Good Samaritan as a nonparticipating hospital
19 the median score -- or I'm sorry -- the mean score of
20 that cohort in order to calculate its score for the
21 four imputed measures?

22 MR. MARCUS: Object to form.

23 A. So for the imputed measures, not here?

24 BY MS. BLAIR:

25 Q. Well, those are the imputed measures,

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1 correct, we just talked about them, the first three?

2 A. Yeah, but -- yeah, but that's not what the
3 scores are now. So in this scorecard, you're saying --
4 because there's a difference now --

5 Q. Correct.

6 A. -- than here.

7 Q. Right. So I want to stick with in 2023 --

8 A. Right.

9 Q. -- did you understand that those perfect
10 scores, the 100s, were being generated by giving
11 nonparticipating hospitals the mean score for their
12 cohorts?

13 "Cohorts."

14 A. No, that was not my understanding.

15 Q. Okay. So your understanding was that that
16 score was coming from past surveys?

17 A. That's what I was told at one point.

18 Q. Did you ever have a conversation with
19 Taylor Pool as to how you were getting -- or how
20 Good Samaritan was getting 100s for those four imputed
21 measures in or around 2023?

22 A. I mean, I don't recall.

23 (Defendant's Exhibit Number 12 for i.d.)

24 MS. BLAIR: We'll mark this one as 12.

25 BY MS. BLAIR:

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1 Q. Ms. Montgomery, I'm now handing you what
2 we've marked as Montgomery Exhibit 12. And if we look
3 at this, this is, again, an email from Taylor Pool to
4 you. This one is dated April 29th, 2024, subject line,
5 "Weekly Quality Update."

6 Do you see that?

7 A. Yes.

8 Q. And, again, if we read this first full
9 paragraph, the second -- or, I'm sorry -- the third
10 sentence says, "Additionally, preliminary Leapfrog
11 grades have been released. We will remain a C."

12 Do you see that?

13 A. Yes.

14 Q. Does this refresh your recollection that
15 Good Samaritan was monitoring its Leapfrog grades and
16 monitoring them closely, correct?

17 MR. MARCUS: Object to form.

18 A. Yeah, as I stated before, I believe they
19 send emails to the quality directors informing them or,
20 you know, that the grades are coming out in the fall
21 and spring, I believe.

22 BY MS. BLAIR:

23 Q. Okay. And Taylor says to you here, the last
24 sentence of this, of the first full paragraph, "The top
25 five measures that had the greatest negative impact on

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1 our Leapfrog grade as follows:"

2 And the first four are all patient
3 experience measures, and the last is outcome falls and
4 trauma.

5 Do you see that?

6 A. Yes.

7 Q. And then she says in the first full, or
8 second full paragraph, "Moving these five measures to
9 the national mean would increase our letter grade to a
10 B."

11 Do you see that?

12 A. I do.

13 Q. Do you recall whether or not in around April
14 of 2024 you were interested in moving Good Sam's
15 Leapfrog safety grade up?

16 A. I don't recall honestly.

17 Q. Who is Michelle Thoman, T-h-o-m-a-n. I've
18 not seen her name before.

19 A. She was the COO at Good Sam.

20 Q. Okay. And she is not still the COO at
21 Good Sam?

22 A. No.

23 MS. BLAIR: Can you mark this one as 13?

24 (Defendant's Exhibit Number 13 for i.d.)

25 BY MS. BLAIR:

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1 Q. Ms. Montgomery, again, I've handed you what
2 we've now marked as Exhibit 13, which is PBHN 11409
3 through 11411. Again, this is an email from
4 Taylor Pool. And this is just days later after what
5 we've marked as Exhibit 12 to you, "Subject: Weekly
6 quality update."

7 And she writes, "In order to reach the mean
8 in patient experience measures, we'd need to improve
9 the following by the following percentage points."

10 Do you see that?

11 A. Yes.

12 Q. And, in fact, this is a response from you --
13 this is a response to your email at the bottom of this
14 page from May 1st where you say, "Thank you for the
15 info on Leapfrog. How many percentage points would we
16 need to move to get to national mean?"

17 Do you see that?

18 A. I do.

19 Q. Does this refresh your recollection as to
20 whether or not you as the CEO of Good Samaritan in or
21 around May of 2024 were -- did care about your Leapfrog
22 Hospital Survey grades?

23 A. I would say if the quality director sends
24 me, Hey, this is what it would take to be a B, I would
25 naturally ask, Hey, what percentage points is that to

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1 be a B, because at this point we weren't responding,
2 so...

3 Q. Right.

4 MS. BLAIR: Can you mark this one as
5 Exhibit 14?

6 (Defendant's Exhibit Number 14 for i.d.)

7 BY MS. BLAIR:

8 Q. Mrs. Montgomery, I've now handed you what
9 we've marked as Exhibit 14. My question about this one
10 is, the --

11 Well, for the record, it's PBHN 11398
12 through 40 -- 11401, correct? Is that what you have in
13 front of you?

14 A. 98.

15 Q. To 401.

16 A. Yes.

17 Q. Okay. And do you see how it says,
18 "Subject - America's Best Hospitals Ranked"?

19 A. Yes.

20 Q. Do you know what that refers to?

21 A. I'm not really sure, but...

22 Q. Yeah, and if we look at 11400, PBHN 11400,
23 it looks like you initiated this email string by
24 forwarding something. And I don't have the what you
25 forwarded, and I'm just curious if you have this. It

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1 refers to Jim Zisson on the last page.

2 A. Right. He must have sent "America's Best
3 Hospitals Ranked" to me, some article.

4 Q. And who is Jim Zisson, Z-i-s-s-o-n?

5 A. He's just, you know, he's been a patient at
6 the hospital, been in the community a long time.

7 Q. He doesn't sit on the board?

8 A. No, he doesn't, huh-uh.

9 Q. And who is Dr. Ray Sekula, S-e-k-u-l-a?

10 A. I'm not sure who that is.

11 Q. What about Dr. Simovitch, S-i-m-o-v-i-t-c-h?

12 A. He is an orthopedic surgeon.

13 Q. Is he at Good Samaritan?

14 A. Yes, and Jupiter. And he is employed by
15 HSS.

16 Q. What's HSS?

17 A. Hospital for Special Surgeries.

18 Q. Okay. And he's got, that's .edu. Is that
19 an educational foundation or something?

20 A. HSS is -- address is that, I think that they
21 have like GME or orthopedic surgeons training at their
22 hospital in New York. That's probably why it's a
23 .edu, I'm guessing.

24 Q. Okay. And then there is Raul Rosenthal. Do
25 you know who he is?

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1 A. I do not.

2 Q. Do you have any understanding of why
3 Mr. Zisson would be sending this to all of you?

4 A. I mean, he was -- Jimmy has always been
5 engaged with Good Sam, and, you know, his parents many,
6 many years ago donated money to Good Samaritan, so he's
7 just tied in the community and would come in the
8 hospital a lot to visit kind of deal.

9 Q. Got it. And if you look at PBHN 11399,
10 looks like Taylor Pool is putting together some sort
11 of, quote, really quick breakdown of the different
12 publicly reported scores for hospital in Palm Beach
13 County.

14 Do you see that chart?

15 A. I do.

16 Q. Did you ask her to put that together?

17 A. I don't recall doing that. I probably just
18 sent her this article and...

19 Q. And the top message on the first page of
20 this Exhibit, Colleen Thielk says, "Thank you for
21 putting this together. We are going to be moving
22 up!!!!!"

23 Do you see that?

24 A. I do.

25 Q. Do you know what she's referring to? Moving

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1 up how?

2 A. I don't want to speculate.

3 Actually, she's not on the email, is she,
4 originally, Taylor?

5 "Moving up" to me would be continuing to
6 improve on our scores is what the CNO, I'm sure, is
7 referring to.

8 Q. Okay. But you don't know as you sit here
9 today whether that specifically refers to Leapfrog?

10 A. I do not.

11 MS. BLAIR: Can we mark this one as 15?

12 (Defendant's Exhibit Number 15 for i.d.)

13 BY MS. BLAIR:

14 Q. Mrs. Montgomery, I've now handed you what
15 we've marked Exhibit 15. Can I just see yours real
16 quick, the first page of that?

17 Okay. Good. This is the first page is
18 PBHN 11018, correct?

19 A. Yes.

20 Q. Excellent.

21 And you see the subject is "CI scope of work
22 and associated transition"?

23 A. Yes.

24 Q. And do you have any understanding, what does
25 "CI" refer to?

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1 A. I'm thinking -- CI. CI could be clinical
2 informatics. Let me see.

3 (A discussion was held off the record.)

4 BY MS. BLAIR:

5 Q. And I'll just explain to you,
6 Ms. Montgomery, as you look through this document, the
7 first page of this, which is like literally impossible
8 for me to read, what I did was blow it up two times, so
9 this is how it was produced to me, this first page.

10 A. Okay.

11 Q. The second page I'm blowing it up a little
12 more.

13 A. Um-hum.

14 Q. And then this is a cut of this top part, and
15 I really want to specifically -- I have two questions
16 for you about this document. One, what does "CI" refer
17 to, if you know?

18 MR. MARCUS: Before you ask her a
19 question --

20 MS. BLAIR: Yes.

21 MR. MARCUS: -- just to clarify the
22 record --

23 MS. BLAIR: Yes.

24 MR. MARCUS: -- because there's no Bates
25 number --

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1 MS. BLAIR: Right.

2 MR. MARCUS: -- I assume that these were
3 provided to you in native form --

4 MS. BLAIR: In native.

5 MR. MARCUS: -- as an Excel, right?

6 MS. BLAIR: Correct. And I can tell you
7 that the native, it is PBHN 000011020. And so
8 these are just zoomed-in versions of the same
9 document so somebody could read it.

10 MR. MARCUS: For the record, are you
11 representing, so the last page is a zoomed
12 version of which, because there's two pages in
13 front of it?

14 MS. BLAIR: They're all the same. So the
15 first page is how it was produced, like the
16 microscopic. The second page, I blew it up a
17 little more. And the third page goes to -- and
18 you can see it -- one, two, three, four, five,
19 six, seven rows. It's just the first seven rows
20 of this giant spreadsheet.

21 MR. MARCUS: Right. But not the rest.
22 Okay.

23 MS. BLAIR: But not the rest. Yeah, so I
24 was just kind of making sure everybody could
25 read it.

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1 BY MS. BLAIR:

2 Q. So my first question, Ms. Montgomery, is, do
3 you know what "CI" refers to?

4 A. Clinical informatics.

5 Q. Okay. And clinical informatics is what?

6 A. It's really a position that we have at the
7 hospital that they're responsible for, you know, all
8 the Cerner training and Cerner training for physicians
9 and staff, that type of stuff.

10 Q. Okay. And if we turn to the very last page
11 of this document, which, for the record, is
12 PBHN 000011020. It's not on your document, but it's
13 the native that was produced. And I've blown up the
14 last several rows on that spreadsheet so you could read
15 it.

16 And I really just want to focus on this last
17 line here.

18 Do you see where it says "Audit Quality
19 Metrics Leapfrog testing"?

20 A. Yes.

21 Q. Do you know what that's referring to?

22 A. I don't.

23 Q. And if we go to the third column, it says
24 "Deployment Assignment Quality Pharmacy Administration
25 Sponsor." Do you know what that refers to?

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1 A. No.

2 Q. And the last, "approximate time, two hours,"
3 do you see that?

4 A. Yeah.

5 Q. Do you have any idea what that refers to?

6 A. No.

7 Q. And then the last column says, "Approved
8 yes/no," and it says "yes," correct?

9 A. Correct.

10 Q. Do you know what that refers to?

11 A. Based on this email from Ram, attached is
12 approved list of work that will be transitioned back to
13 the hospital staff who currently report through CEO,
14 CFO and CNOs.

15 Q. And so at some point do you understand,
16 then, that Tenet home office was monitoring Leapfrog?

17 MR. MARCUS: Object to form.

18 A. My understanding of this email is they, the
19 CIs were, "Thank you for your patience as we've worked
20 through the CI scope of responsibility with our Tenet
21 executives and identified work that is considered
22 hospital operations."

23 This email is just stating, Hey, we're not
24 going to have the CIs do this any longer. We're going
25 to transition it to hospital operators.

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1 BY MS. BLAIR:

2 Q. Okay. But in terms --

3 A. That's what I understand it to mean.

4 Q. In terms of that last sheet, you really
5 don't understand what that relates to as it relates to
6 Leapfrog, correct?

7 A. I do not.

8 Q. And who would be the best person to ask what
9 that means?

10 A. You go to Gina or you could go to there's a
11 group clinical informatics. I can't recall his name.

12 Q. Okay.

13 A. We could provide that name.

14 Q. I don't --

15 A. That's who I would -- or Ram.

16 Q. Yeah, he's on there.

17 A. Ram probably knew it very well it sounds
18 like.

19 Q. I want to transition a bit to these
20 pay-to-play allegations that we discussed earlier.
21 Would you agree with me that you've been pretty
22 outspoken in the media that, in fact, Leapfrog is a
23 pay-to-play organization?

24 MR. MARCUS: Object to form.

25 A. Yes, I have made a statement.

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1 BY MS. BLAIR:

2 Q. And I think we talked a little bit earlier
3 that the genesis of that statement is based on
4 conversations you had with other people related to
5 payments that you believe Leapfrog takes in order to
6 influence grades, correct?

7 MR. MARCUS: Object to form.

8 A. No, I mean, my -- the statement for pay to
9 play is really, in my words, having to participate.
10 And the participation really is your payment, and as a
11 result, you won't be penalized because essentially we
12 were penalized for not playing --

13 BY MS. BLAIR:

14 Q. Got it.

15 A. -- with the imputed scores.

16 Q. So you weren't referring to -- you were not
17 referring to this consulting situation where hospitals
18 could pay or you believe hospitals could pay Leapfrog
19 consulting fees to get better grades?

20 A. I mean, the payment I was referring to was
21 participating.

22 Q. Oh, okay.

23 And so would you agree with me that there is
24 no fee to participate in the survey?

25 A. Correct.

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1 Q. And did you tell me that you currently
2 utilize Press Ganey in connection with the review of
3 your HCAHPS scores?

4 A. Yes.

5 Q. And do you know who at Press Ganey
6 specifically you deal with?

7 A. No. It's normally the CNO would be
8 communicating with the Press Ganey individuals.

9 MS. BLAIR: And I'll mark this as 16.
10 (Defendant's Exhibit Number 16 for i.d.)

11 BY MS. BLAIR:

12 Q. Ms. Montgomery, I'm handing you a document.
13 The Bates labels on these are PBHN 5827 through 5829.
14 Is that the document you have in front of you?

15 A. Yes.

16 Q. Oh, wait. It looks like you have two
17 documents.

18 A. Do I have 5829? Oh, I have two copies.

19 MS. BLAIR: I have an extra copy if you want
20 it.

21 BY MS. BLAIR:

22 Q. Sorry.

23 And this is an email, the top email in this
24 chain is Naomi Seymour to Kathleen McDonald. Do you
25 see that?

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1 A. Yes.

2 Q. Who are these people?

3 A. Naomi is the CNO of Palm Beach Gardens
4 Medical Center.

5 Q. Okay. And if we look at two emails below
6 that, you've got Ricky Ramirez on this email chain as
7 well, correct?

8 A. Yes.

9 Q. And the subject line of that Ricky Ramirez
10 and of all these emails is "Recommendation: Tenet Palm
11 Beach Group Improvement Strategy." Do you see that?

12 A. I do.

13 Q. What is your understanding in or around
14 January 7th of 2025 as to the "Tenet Palm Beach Group
15 Improvement Strategy"?

16 A. My understanding from reviewing this is that
17 Press Ganey individual maybe called it the Tenet Palm
18 Beach Group Improvement Strategy."

19 Q. Okay. And do you know whether or not
20 Palm Beach Health Network reached out to Press Ganey
21 for an improvement strategy?

22 A. Well, Colleen, my CNO, reached out to
23 Press Ganey to have them come and do a visit.

24 Q. Okay. And if we look at the last page of
25 this Exhibit, 5829, and the second full paragraph,

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1 Maika, M-a-i-k-a, Joiner of Press Ganey says,
2 "Good Sam's outreach is very timely. The Leapfrog
3 Group released its fall 2024 hospital safety grade
4 which evaluates hospitals' ability to prevent medical
5 errors and accidents and infections. The Leapfrog
6 hospital safety grade is the only hospital ratings
7 program focused exclusively on preventing medical
8 errors and patient harm. It is fully transparent, free
9 to the public."

10 Do you see that?

11 A. I do.

12 MR. MARCUS: Object to form.

13 BY MS. BLAIR:

14 Q. Did you have any reservations about engaging
15 with Press Ganey with respect to an improvement
16 strategy in light of the fact that they were taking the
17 position that the Leapfrog group's safety grade is
18 fully transparent and free?

19 MR. MARCUS: Object to form.

20 A. I mean, I wasn't on this email, to my
21 knowledge.

22 BY MS. BLAIR:

23 Q. But Taylor Pool had told you before this
24 that it was free, correct?

25 A. That, what, that Press Ganey?

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1 Q. That Leapfrog was free.

2 A. Oh. Doing the survey, yes.

3 Q. Correct.

4 Did you have any understanding around
5 January of 2025 that Press Ganey was, in fact, going to
6 be giving Palm Beach group an improvement strategy?

7 MR. MARCUS: Object to form.

8 A. No.

9 BY MS. BLAIR:

10 Q. Have you had any conversations with
11 Press Ganey as we sit here today about Leapfrog?

12 A. No.

13 Q. Do you have any reason to believe that
14 Press Ganey's statements that the Leapfrog survey is
15 transparent and free to the public?

16 MR. MARCUS: Object to form.

17 A. Do I have what? Say that again. What's the
18 question?

19 BY MS. BLAIR:

20 Q. Do you have any reason to believe that
21 Press Ganey's statements in this -- in this document
22 that say the Leapfrog hospital safety grade -- I said
23 survey before -- but safety grade is the only hospital
24 ratings program focused exclusively on preventing
25 medical errors and patient harm? It is fully

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1 transparent, free to the public and updated by annually
2 in the fall and spring."

3 Do you have any reason to believe that
4 Press Ganey's statement in that regard is in error?

5 MR. MARCUS: Same objection.

6 A. I do.

7 BY MS. BLAIR:

8 Q. And what is that?

9 A. It is not fully transparent.

10 Q. What is not transparent about it?

11 A. There -- the survey is voluntary, and a
12 grade was given to my hospital, Good Sam, without
13 completing a survey, and there are seven measures that
14 equate to 35 percent of the score that we did not
15 provide, and then we were given really low scores for
16 those seven measures because we probably didn't have
17 access to the measures, and that's not transparent to
18 me.

19 Q. Well, do you understand that for three of
20 those seven measures you didn't -- it was just not
21 applicable, and they didn't score you on those
22 measures?

23 A. Which also changes the weighting of
24 everything else.

25 Q. Do you understand that in all of the years

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1 you weren't participating from 2021 to 2024 you were
2 receiving a grade?

3 MR. MARCUS: Object to form.

4 A. I'm aware.

5 BY MS. BLAIR:

6 Q. And, in fact, we -- and you weren't
7 participating in the survey during that time, correct?

8 A. We were not.

9 Q. And we just saw several Exhibits where
10 Good Sam was monitoring its hospital safety grade,
11 correct?

12 MR. MARCUS: Object to form.

13 A. I would say that we know when the grades are
14 coming out and communication about the grades is
15 obviously in those emails.

16 BY MS. BLAIR:

17 Q. Okay. And you were looking for ways to
18 improve your Leapfrog score, correct?

19 MR. MARCUS: Object to form.

20 BY MS. BLAIR:

21 Q. You saw those emails earlier?

22 A. Right.

23 Q. And at no time did anybody from
24 Good Samaritan reach out to Leapfrog and say, "We
25 should not be graded because we're not participating in

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1 your hospital survey," correct?

2 A. Not to my awareness.

3 Q. And I want to provide you with what we're
4 now going to mark as Exhibit 18.

5 THE STENOGRAPHER: 17.

6 MS. BLAIR: 17, yes, you're correct.

7 (Defendant's Exhibit Number 17 for i.d.)

8 BY MS. BLAIR:

9 Q. There is an email from you, Ms. Montgomery,
10 to Colleen Thielk dated May 1st, 2025. Do you see
11 that?

12 A. Yes.

13 Q. It is Bates labeled PBHN 1188 through 1191,
14 correct?

15 A. Yes.

16 Q. Your email says, "This went to GB and
17 medical staff," dot, dot.

18 Do you see that?

19 A. I do.

20 Q. And "GB" would be the governing board,
21 correct?

22 A. Correct.

23 Q. And as we discussed earlier today, the
24 governing board is Good Sam's board of directors,
25 correct?

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1 A. Yes.

2 Q. And would the medical staff be the medical
3 staff of Good Samaritan?

4 A. Yeah, I believe it went to the medical
5 staff.

6 Q. And attached to this email is a document
7 that says, "Palm Beach Health Network filed legal
8 Complaint against Leapfrog," correct?

9 A. Correct.

10 Q. And that message, if we turn to 8190...

11 THE VIDEOGRAPHER: Can I change the tape
12 while you do that?

13 MS. BLAIR: Yeah, sure.

14 THE VIDEOGRAPHER: This ends the media unit
15 three. We're going off the record 4:31 p.m.

16 (A recess was taken from 4:31 p.m. to 4:31 p.m.)

17 THE VIDEOGRAPHER: We are back on the
18 record. The time is 4:31 p.m.

19 BY MS. BLAIR:

20 Q. Okay. Ms. Montgomery, I was just asking you
21 about this attachment to your email, which is --
22 appears to be authored by Maggie Gill, group president.

23 Do you see that?

24 A. Yes.

25 Q. Did you have any hand in drafting this

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1 before you sent it to the governing board and the
2 medical staff?

3 A. I don't recall doing that, no.

4 Q. But you did, in fact, send it to the
5 governing board and medical staff per your cover email,
6 correct?

7 A. Yes.

8 Q. And if we look at the third full paragraph,
9 this document says, "Beginning last year, Leapfrog" --
10 "Leapfrog began actively punishing hospitals that did
11 not pay to participate in its flawed survey."

12 Do you see that?

13 A. I do.

14 Q. That's not true, is it?

15 MR. MARCUS: Object to form.

16 A. Well, depends on how you want to look at it.
17 You're thinking money to directly to Leapfrog. Our
18 payment is the participation, and there's payment to
19 all of our staff that have to complete the survey. So
20 there is a form of payment. It's just not to Leapfrog.
21 BY MS. BLAIR:

22 Q. Okay. But you say here, "Punishing
23 hospitals that did not" -- you don't say "that did not
24 participate." You say "that did not pay to
25 participate," correct?

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1 MR. MARCUS: Object to form.

2 A. Correct.

3 BY MS. BLAIR:

4 Q. And you expect the reader to understand that
5 that means you didn't pay in terms of resources to
6 complete the survey, and they should not take that to
7 mean monetary payment?

8 MR. MARCUS: Same objection.

9 A. I didn't expect the readers to -- I wasn't
10 trying to do anything here.

11 BY MS. BLAIR:

12 Q. What do you think your governing board
13 thought when they read that you did not pay to
14 participate in the flawed survey?

15 A. My governing board knows exactly what it's
16 about, and they now how it works, and they know it's a
17 voluntary survey.

18 Q. So the word "pay," the rider is supposed to
19 believe that that is referring to the resources and
20 time to fill out the survey, correct?

21 MR. MARCUS: Object to form.

22 BY MS. BLAIR:

23 Q. That's your testimony?

24 A. That is the payment that I consider a
25 payment.

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1 Q. And if we start the sentence that starts on
2 the -- at the end of 8189, "In essence, Leapfrog,
3 issues a zero score."

4 Do you see that, where it says "zero score"
5 on the top of 8109?

6 A. Yes.

7 Q. "...for any survey fields left blank."
8 Is that true?

9 A. Actually, if you look at it, I guess three
10 of the areas are zero, which are -- well, they're N/A,
11 and the other four are, I would not say they were zero.

12 Q. Okay. And you understand that the Complaint
13 that was filed in this action also claims that there
14 are -- there was payment by hospitals to participate in
15 this survey. Do you understand that allegation is made
16 in this Complaint?

17 MR. MARCUS: Object to form.

18 A. I'd have to re-review the document.

19 BY MS. BLAIR:

20 Q. As you sit here right now, do you know
21 whether or not that allegation is made in the
22 Complaint?

23 MR. MARCUS: Same objection.

24 A. I don't recall. I'd have to see the form.

25 BY MS. BLAIR:

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1 Q. Would you agree with me, though, as we sit
2 here today that there is no money exchanged between
3 hospitals that participate in the survey and Leapfrog
4 for the hospitals' participation in the survey?

5 MR. MARCUS: Object to form.

6 A. A payment to Leapfrog --

7 BY MS. BLAIR:

8 Q. Correct.

9 A. -- just to complete the survey?

10 Q. Correct.

11 A. I would agree with that statement.

12 Q. And we went over this earlier, but have you
13 ever seen a single document in this litigation that
14 Leapfrog pressures hospitals to pay for consulting
15 services in exchange for better grades?

16 A. I think the pressure really is to complete
17 the survey.

18 MS. BLAIR: I'm going to mark this one as

19 18.

20 (Defendant's Exhibit Number 18 for i.d.)

21 BY MS. BLAIR:

22 Q. Ms. Montgomery, I'm handing you now what
23 we've marked Exhibit 18, which is PBHN 8116. It's an
24 email from Shelly Weiss to several people, including
25 yourself, and the subject line is "CBS 12 Leapfrog

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1 Story."

2 And if we go down to the second to last full
3 paragraph at the end of the page, it starts, "The
4 hospital has accused Leapfrog," do you see that?

5 A. Okay. Yes.

6 Q. And the second sentence in that paragraph
7 says, "They allege Leapfrog pressures hospitals to pay
8 for consulting services in exchange for better grades."

9 It says, "...consulting services and
10 promotional licenses in exchange for better grades,"
11 but I want to focus on consulting services.

12 Have you seen any documents in this
13 litigation to substantiate the allegation by these
14 hospitals, these plaintiff hospitals that Leapfrog
15 pressures hospitals to pay for consulting services?

16 MR. MARCUS: Object to form.

17 A. I have not.

18 BY MS. BLAIR:

19 Q. And have you ever seen any evidence that
20 payment for consulting services would be in exchange
21 for better grades?

22 MR. MARCUS: Same objection.

23 A. Say that again.

24 BY MS. BLAIR:

25 Q. Have you ever seen any evidence in this --

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1 produced in this litigation or anywhere else that
2 Leapfrog pressures hospitals to pay for consulting
3 services in exchange for better grades?

4 MR. MARCUS: Same objection.

5 A. Like I said before, I'd say the pressure is
6 completing the survey.

7 BY MS. BLAIR:

8 Q. That's not what this says. This says,
9 "pressures hospitals to pay for consulting services."
10 This isn't even related to the survey, is it?

11 MR. MARCUS: Object to form.

12 A. From what I'm reading.

13 BY MS. BLAIR:

14 Q. Okay. But have you ever seen any evidence
15 that hospitals pay Leapfrog for consulting services in
16 exchange for better grades?

17 A. I have not.

18 Q. And we talked a little bit about the
19 methodology prior to fall of 2024, and you would agree
20 with me that the seven measures that you keep
21 discussing consists of three measures for which a
22 nonparticipating hospital gets an N/A and four measures
23 for which there is an imputed score, correct?

24 A. Correct.

25 Q. And I asked you this before, but do you have

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1 an understanding as to how the imputed score for those
2 four measures was decided prior to fall of 2024?

3 A. No.

4 Q. Okay. Do you believe that under the prefall
5 of 2024 grading system it was deceptive of Leapfrog not
6 to tell consumers that Good Samaritan was actually
7 earning 100 points for those four measures without
8 providing any data?

9 MR. MARCUS: Object to form.

10 A. Do I think it was deceptive of Leapfrog?

11 BY MS. BLAIR:

12 Q. Correct.

13 A. My thoughts is we should -- as long as we
14 weren't participating, we shouldn't have had a grading
15 period.

16 Q. Right. And so my question is, you did have
17 a grade, correct?

18 A. We did have a grade.

19 Q. And for those four measures that we call the
20 imputed measures, Good Samaritan was getting a perfect
21 score for those four measures prior to the fall of
22 2024, correct?

23 A. Correct.

24 Q. And do you have an understanding that the
25 grade that Good Samaritan was receiving prior to the

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1 fall of 2024 was based on how participating hospitals
2 were doing in those four measures on the Leapfrog
3 Hospital Survey?

4 MR. MARCUS: Object to form.

5 A. No.

6 BY MS. BLAIR:

7 Q. You don't understand that's how your scores
8 were being --

9 A. No, I did not.

10 Q. Okay. Do you think that's a fair way of
11 doing the methodology to give nonparticipating
12 hospitals a score based on how participating hospitals
13 were performing on those four measures?

14 A. No.

15 Q. And we saw several emails -- or, sorry,
16 several Exhibits which were emails, which I believe
17 were probably Exhibits 11, 12, 13, 14, about how
18 Taylor Pool was advising you regarding Leapfrog
19 measures in which Good Samaritan was lagging behind its
20 competitors.

21 Do you recall seeing those Exhibits?

22 MR. MARCUS: Object to form.

23 A. I recall seeing where she was saying where
24 the opportunities were, yes.

25 BY MS. BLAIR:

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1 Q. And none of those measures were the four
2 imputed measures, correct?

3 MR. MARCUS: Same objection.

4 A. I don't recall. I don't think so.

5 BY MS. BLAIR:

6 Q. Okay. Do you believe that Good Samaritan
7 was gaming the system by riding the coattails of other
8 hospitals in their cohort to get 100 percent on the
9 four imputed measures prior to the fall of 2024?

10 A. We didn't give ourselves those grades so we
11 weren't gaming anything.

12 Q. But, in fact, you were getting the same
13 grades as other hospitals in your geographic area that
14 were participating in the survey, were you not?

15 A. That's what you're telling me.

16 Q. Do you believe the scores that
17 Good Samaritan was receiving on the four imputed
18 measures, BCNA, CPOE, hand hygiene and ICU physician
19 staffing, prior to the fall of 2024 accurately
20 reflected Good Samaritan's performance on those
21 measures?

22 MR. MARCUS: Object to form.

23 A. Well, from what you showed me on that report
24 card, if it's 100 percent on every measure, I don't
25 know. I'd have to look and see what everything is now.

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1 I mean, I would think most hospitals aren't perfect,
2 but depends on everything that the survey asks. I'd
3 have to go through it.

4 BY MS. BLAIR:

5 Q. Do you have any understanding as to why
6 Leapfrog implemented the scoring change in fall of 2024
7 with respect to those four measures?

8 A. No.

9 Q. Have you ever looked at the members of the
10 Leapfrog safety grade expert panel?

11 A. I don't believe so.

12 Q. So as you sit here today, you have no
13 understanding of whether or not the members of the
14 Leapfrog safety grade expert panel are qualified to
15 provide expert opinions about imputation modeling for
16 those four measures?

17 MR. MARCUS: Object to form.

18 A. I don't recall. I mean, I only remember
19 talking about their advisory board once, but I don't
20 think that, obviously, is the same people.

21 BY MS. BLAIR:

22 Q. Okay. Do you have an understanding that
23 there is an expert panel that volunteers for Leapfrog
24 that puts together the 22 measures, the weights, the
25 Z scores and the imputation model for its hospital

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1 safety grade methodology?

2 MR. MARCUS: Object to form.

3 A. I mean, I do now.

4 BY MS. BLAIR:

5 Q. Did you before?

6 A. I don't know who they employ.

7 Q. Well, they don't employ anybody.

8 A. Who they volunteer, who they have helping
9 them with their survey.

10 Q. So you don't know today who those people
11 are, correct?

12 A. I don't.

13 Q. And so you don't have an opinion one way or
14 the other whether they're qualified to provide opinions
15 about grading hospitals on patient safety, correct?

16 A. I cannot comment on that.

17 Q. Have there ever been any discussions at the
18 Med Exec level about the fact that Good Samaritan has a
19 one-star CMS rating?

20 A. Not that I recall.

21 Q. Prior to January 2025, and we saw that email
22 where the hospitals in the Palm Beach Health Network
23 engaged Press Ganey to do an improvement plan. And
24 that was January 2025.

25 Prior to that were there any quality

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1 improvement plans in place for Good Samaritan?

2 MR. MARCUS: Object to form.

3 A. Like in general?

4 BY MS. BLAIR:

5 Q. Yeah, in general.

6 A. I mean, we have quality improvement plans
7 all the time, on patient falls, you know, on HCAHPS,
8 pressure ulcers, all of those things.

9 Q. Did you understand that the improvement
10 plan -- I think it's Exhibit 16, but I could be wrong,
11 the improvement plan that was being discussed, yes, in
12 Exhibit 16, with Press Ganey was specific to CMS
13 measures?

14 MR. MARCUS: Object to form.

15 A. Would I say that that's what they were
16 referring to?

17 BY MS. BLAIR:

18 Q. Well, yes, I'm just trying to understand. I
19 understand you're a hospital so you have improvement
20 plans all the time. So why did you need a specific
21 Tenet Palm Beach group improvement strategy with
22 Press Ganey as opposed to the quality improvement plans
23 you already had in place?

24 MR. MARCUS: Same objection.

25 A. Colleen, from my understanding on this,

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1 Colleen reached out to Press Ganey to have them come
2 and visit because we were looking at patient
3 satisfaction and wanting to improve it.

4 This headline that this person from
5 Press Ganey is saying, she's like, you know that we can
6 go visit your other hospitals.

7 BY MS. BLAIR:

8 Q. Um-hum.

9 A. I recommend conducting similar baseline
10 observations at Palm Beach Gardens, Delray Medical
11 Center, et cetera, et cetera.

12 So to me, this Tenet Palm Beach group
13 improvement strategy is something that Press Ganey, in
14 my thoughts, are, you know, saying, Well, we should go
15 out to all the other hospitals as well.

16 Q. Well, if I read last page of this Exhibit,
17 5829, Maika Joiner said to Kate Bergez "Good morning,
18 Kate. Colleen Thielk and Mellissa Heath, clinical ops
19 director from Good Sam, reached out last month to
20 improve HCAHPS performance."

21 Do you see that?

22 A. Correct.

23 Q. And HCAHPS, as I understand it, is a CMS
24 measures, correct?

25 A. Correct.

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1 Q. And those are, in fact, patient experience
2 measures, correct?

3 A. That's correct.

4 Q. So my question is, do you know whether or
5 not this improvement strategy was specifically related
6 to HCAHPS?

7 MR. MARCUS: Object to form.

8 A. This was, yes.

9 BY MS. BLAIR:

10 Q. Okay. Prior to this discussion in January
11 of 2025, had Good Samaritan had any specific quality
12 improvement strategies with respect to patient
13 experience/HCAHPS?

14 A. Yes. We talked about them earlier.

15 Q. Okay.

16 A. Leadership rounding.

17 Q. Yes, we did. Thank you. It's been a long
18 day. I forgot.

19 Prior to June of 2024 as the CEO of
20 Good Samaritan, what did you consider to be the areas
21 in most need of improvement for patient safety for
22 Good Samaritan?

23 A. Prior to June?

24 Q. Of 2024.

25 A. June 2024. It was back to the balanced

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1 scorecard that really encompasses so much about patient
2 safety would be, you know, we would always try and
3 improve on our HCAHPS, anything related to patient
4 safety that we track, you know, fall, HAIs. To me if
5 you have more than one infection, that's one too many.
6 We want to have zero. So to me, it's a continuous, you
7 know, monitoring of all of those indicators in trying
8 to get to zero ultimately. So we're always going to
9 continue to make all of those things priorities and
10 continue to improve.

11 Q. Was there any measure that you thought was
12 way lower than the others that really needed some?

13 A. Well, if you look where you're not meeting
14 national averages, you obviously would focus on those
15 areas, too, but all mortalities are important to me;
16 all HCAHPS are important to me, whether we're meeting
17 the national average or not.

18 Q. Okay. Were you aware that in June of 2024,
19 Leapfrog put out a statement or a request for public
20 comment about the methodology change that was going to
21 occur in fall of 2024?

22 A. I don't recall.

23 Q. Do you know when the first time it was
24 brought to your attention that this methodology change
25 was going to occur?

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1 A. I don't.

2 (Defendant's Exhibit Number 19 for i.d.)

3 BY MS. BLAIR:

4 Q. If we look at, we'll mark this as
5 Exhibit 19. If you look at Exhibit 19, this is an
6 email string PBHN 5132 through PBHN 5137.

7 And if we go all the way to the back of this
8 document, you'll see there's an email on page 5136 from
9 Anna Gunod to DLDCQI only.

10 "Good morning quality leaders. I'm doing an
11 annual check-in on Leapfrog participation."

12 Do you see that?

13 A. Um-hum.

14 Q. Did you have any understanding that there
15 was an annual check-in on the Leapfrog participation?

16 MR. MARCUS: Object to form.

17 A. No.

18 BY MS. BLAIR:

19 Q. And Regina West responds, "PBHN are not
20 participating," correct?

21 A. Correct.

22 Q. And then if we go to PBHN 5134, and it
23 starts, Regina West email to Ann Gunod starts at the
24 bottom of that page and goes on to 5135, she says, "We
25 would like to participate in the next survey. Are we

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1 able? We have done this in the past so it would not be
2 new participation. Because we aren't participating, we
3 default to imputing" -- "imputed scoring. This takes
4 SMMC from 100 points in each of the categories below to
5 limited achievement scores."

6 Do you see that?

7 A. I do.

8 Q. Does this comport with your understanding
9 that the first time this was brought to your attention
10 would have been in or around September of 2024?

11 A. I don't remember the date, but I'm sure at
12 some point it leveled up.

13 Q. And, to your knowledge, no one at
14 Good Samaritan or any of the PBHN hospitals provided
15 comment, public comment to Leapfrog's request for
16 public comment regarding the change in the scoring
17 methodology, correct?

18 A. I'm not aware of anything, no.

19 Q. And if you look at that same page, 5134,
20 Anna Gunod says to Regina West, and Taylor Pool is on
21 this email too. "Hi, Gina, Leapfrog participation is
22 not supported unless it was directly tied to a
23 payment/contract or a local regulatory requirement."

24 Do you see that?

25 A. Which one was that on?

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1 Q. Oh, I'm sorry. 5134.

2 A. I got it.

3 Q. Do you see that?

4 A. Yes.

5 Q. What is your understanding of what Anna
6 means by that comment?

7 A. I don't know.

8 Q. Did you have any understanding that your
9 hospital was not allowed to participate in this type of
10 event unless it was directly tied to payment contract
11 or local regulatory requirement?

12 A. No, that was not my understanding at all,
13 no.

14 Q. Okay. And then Regina says on 5133 to
15 Anna Gunod, and, again, Anna Gunod is at home office,
16 correct?

17 A. National director of infection prevention.
18 Looks that way, yes, I would say.

19 Q. And at the bottom of 5133 she responds, Gina
20 responds, "Although not supported, is it left up to the
21 local markets to decide or a strict no from HO?"

22 Do you see that?

23 A. Yes.

24 Q. Do you understand HO to mean home office?

25 A. Yes.

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1 Q. Okay. And then Anna writes at the top of
2 this page, "It is a no from home office. Facilities
3 who need an exception due to Leapfrog participation
4 being tied to a local requirement contract or
5 compliance or reimbursement needs to submit their case
6 for review by Dr. Franklin."

7 Do you see that?

8 A. I do.

9 Q. Do you know whether or not Good Samaritan or
10 any of the PBH hospitals submitted a request to
11 Dr. Franklin for participation?

12 A. I'm not aware.

13 Q. Okay. And at the bottom of 5132 Taylor Pool
14 writes to Colleen Thielk, "Sharing home office response
15 below about Leapfrog participation. The scoring system
16 now penalizes hospitals for not participating. We can
17 expect to be an F for the next reporting period due to
18 change."

19 And then Colleen sends that to you with an
20 FYI, correct?

21 A. Yes.

22 Q. What is your memory about any discussions
23 that were occurring in or around September of 2024
24 about the change in the Leapfrog methodology?

25 A. I don't recall it really being in September.

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1 Q. When do you recall it being?

2 A. I recall when a grade actually came out most
3 of the discussions, I mean, but I could be wrong.

4 Q. And do you know when the fall grade came out
5 for -- the fall of 2024 grades came out?

6 A. I think it was November.

7 Q. Right. And do you understand that Leapfrog
8 tells hospitals what their grades are going to be
9 before they come out?

10 A. Yes, I think there's like a short period of
11 time for some -- for what reason, I don't know, but...

12 Q. Do you understand that you can dispute your
13 grade with Leapfrog during that time period in which
14 the grades were under review?

15 MR. MARCUS: Object to form.

16 A. No.

17 BY MS. BLAIR:

18 Q. Okay. And for the fall 2024 grade, did
19 anyone at Good Samaritan reach out to Leapfrog to
20 object to the grade that they were going to receive?

21 MR. MARCUS: Object to form.

22 A. Not to my knowledge.

23 MS. BLAIR: Can you mark this as Exhibit 20?

24 (Defendant's Exhibit Number 20 for i.d.)

25 BY MS. BLAIR:

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1 Q. Ms. Montgomery, I'm sharing with you now an
2 email from Taylor Pool dated 11-4-24 to you CCing
3 Colleen Thielk. On the first page of this, PBHN 5120,
4 Taylor writes, "A hospital onset C. diff case was
5 identified. This brings us 15 infections year to date.
6 We cannot have another C. diff infection through the
7 end of November in order to remain green on BSC."

8 Do you see that?

9 A. I do.

10 Q. What does "remain green on BSC" mean?

11 A. Meet your target.

12 Q. Okay. And then if we look down at the
13 bottom paragraph of this page, it says, "Home office
14 has identified issues with the data collection and
15 pulled the DCQIs across the enterprise together last
16 week."

17 Do you see that?

18 A. Yes.

19 Q. Is that referring specifically to PROMs, or
20 is that referring generally to issues with data
21 collection?

22 MR. MARCUS: Object to the form.

23 A. I don't know.

24 BY MS. BLAIR:

25 Q. Okay. And if we look at the last page or

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1 the next page, I'm sorry, 5121, number three says,
2 "Leapfrog," correct?

3 A. Yes.

4 Q. And he says here, "Basically we were
5 used" -- "we used to receive 100 percent credit and we
6 now receive a negative score." I said "he." Her.

7 Do you see where it starts basically in the
8 middle of that paragraph?

9 A. Yes.

10 Q. Is it your understanding you received a
11 negative score for these four measures?

12 A. I think the negative means, you know, a
13 penalty. I'm not sure what the weighting of it says on
14 the right-hand side of the scorecard, but it's a
15 punitive negative.

16 Q. And Taylor goes on to say, "Additionally, we
17 received negative scores for all five patient
18 experience measures."

19 Do you see that?

20 A. Yes.

21 Q. And those patient experience measures would
22 have come from CMS data, correct?

23 A. Yes.

24 Q. And then Taylor goes on to say, "The top
25 five most negative scores are for PE discharge, PE

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1 communications about medication, PE nurse
2 communication, PE staff response and CPOE."

3 Do you see that?

4 A. I do.

5 Q. And so while CPOE is one of the most
6 negative scores that Taylor puts out there, she
7 certainly is informing you that there are other very
8 negative scores on the Leapfrog survey that come from
9 CMS data, correct?

10 MR. MARCUS: Object to form.

11 A. Yes.

12 BY MS. BLAIR:

13 Q. Do you have any reason to believe that
14 Taylor Pool's discussion in that regard with respect to
15 the top five most negative scores was wrong in any way?

16 A. I don't.

17 Q. And, in fact, in the fall of 2024
18 Good Samaritan received a D, correct?

19 A. In the fall, yes.

20 Q. What do you recall about discussions, if
21 any, that occurred around the fact that Good Samaritan
22 received a D in the fall of 2024 on the Leapfrog
23 hospital safety grade?

24 A. I don't really recall any discussions.

25 Q. Do you recall there was a lot of activity in

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1 December of 2024 around the Leapfrog safety grade that
2 had been published?

3 A. Yes.

4 Q. And, to the best of your memory, why was
5 there a lot of discussion about that?

6 A. The failing grades. That's why.

7 Q. Okay. How did it first come to your
8 attention that there were -- well, strike that.

9 Who complained to you about the failing
10 grades, if anyone?

11 A. Who complained to me?

12 Q. Um-hum.

13 A. I mean, many people complained to me.

14 Q. And who are the "many people"?

15 A. Do you have a couple hours? Probably mostly
16 governing board, physicians, you know, people in the
17 community, people that I know personally, just, I mean,
18 it was -- it was a big deal to have a failing grade.

19 Q. And you went from a C to a D, correct?

20 A. First we went from a C to an F and then from
21 an F to a D.

22 Q. Oh, okay. So your grade went up in spring
23 of 2025, correct?

24 A. Yes.

25 Q. Do you recall asking Andrew Lofholm in

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1 December of 2024 to do research on articles critical of
2 Leapfrog?

3 MR. MARCUS: Object to form.

4 A. I don't recall exactly what -- I'm sure we
5 talked about a lot of things regarding Leapfrog.

6 BY MS. BLAIR:

7 Q. Once you were told by home office that it
8 was a no and the Palm Beach Health Network hospitals
9 could not participate in the Leapfrog survey, did you
10 as the president of Good Samaritan come up with another
11 strategy to combat the Leapfrog hospital safety grade?

12 MR. MARCUS: Object to form.

13 A. No, other than doing what we do every day
14 and provide great care, we continue to provide great
15 care and have our processes in place to show that we
16 are a quality hospital.

17 BY MS. BLAIR:

18 Q. In December of 2024, were you as the CEO of
19 Good Samaritan contemplating a lawsuit against
20 Leapfrog?

21 A. In December?

22 Q. Yes, in December of 2024.

23 A. So it was even brought up at my Med Exec
24 committee talking about that we should sue Leapfrog
25 after they understood how things worked, so there was

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1 discussions around that time that, you know, that some
2 action should be taken.

3 Q. And when you say -- when you say the
4 Med Exec committee talking about what -- talking about
5 that we should sue Leapfrog after they understood "how
6 things worked," how did they understand things worked?
7 What are you referring to there?

8 A. When they realized that it was a voluntary
9 survey and that there are measures in there that
10 Leapfrog takes or imputes us and penalizes us for not
11 responding, so, in essence, the survey is not accurate.

12 Q. Was the Med Exec under the impression, as
13 we've seen in the press coverage and different emails
14 in this lawsuit, that other hospitals that participated
15 in the survey were paying Leapfrog for better grades?

16 MR. MARCUS: Object to form.

17 A. I don't know if that was their impression.

18 BY MS. BLAIR:

19 Q. Did you tell them that?

20 A. I did not.

21 Q. Do you know if anybody told the Med Exec
22 that the reason other hospitals were getting better
23 grades is because they were paying Leapfrog for those
24 grades?

25 A. I have no idea whether people said those

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1 things. I have no idea.

2 Q. Do you know if anybody told the Med Exec
3 that hospitals were paying consulting fees to Leapfrog
4 in exchange for better grades?

5 A. No. No, not while I was present.

6 Q. So when you say "how things worked, when the
7 Med Exec figured how things work," you're referring
8 specifically to the imputation model?

9 A. Yes, the survey that, one, it's voluntary,
10 so there's measures that anybody could put whatever
11 they wanted; two, Leapfrog doesn't come and verify any
12 of those measures because they don't come into our
13 institution like Joint Commission does when you're
14 getting accredited; and, three, that we weren't
15 participating. Then they understood.

16 Q. You also understand that there's allegations
17 in this case that Leapfrog does nothing to verify the
18 survey responses of participating hospitals, correct?

19 MR. MARCUS: Object to form.

20 A. Correct.

21 BY MS. BLAIR:

22 Q. Do you believe that's true?

23 A. I've never seen Leapfrog in our hospitals.
24 I don't know how you would ever verify it unless you're
25 actually surveying hospitals and going live to their

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1 hospitals on site. That's the only way you can verify
2 the information is accurate.

3 Q. But you don't -- but you don't participate
4 in the survey, correct?

5 A. Correct.

6 Q. So why would they come?

7 A. But we did.

8 Q. Why would they come to a hospital that
9 doesn't participate in a survey to verify something?

10 A. So hospitals that participate and when we
11 did participate, Leapfrog never came to the hospitals.

12 Q. Do you understand Leapfrog does, in fact,
13 remember verify survey data?

14 MR. MARCUS: Object to form.

15 A. I mean, there's data that's from Medicare
16 that's verified, but I don't -- no, no.

17 BY MS. BLAIR:

18 Q. I'm talking about survey data.

19 A. Right, but on the survey there is Medicare
20 data as well.

21 Q. Well, there's Medicare data on the safety
22 grade, correct?

23 A. Right, well, on the -- right.

24 Q. Right. So the survey is separate and
25 distinct from the grade, right?

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1 A. Yes.

2 Q. Have you done any research to inform
3 yourself about whether or not Leapfrog goes on site to
4 hospitals to verify data that hospitals report on their
5 survey?

6 A. Everyone that I have talked in the
7 organization and healthcare says no.

8 Q. Okay.

9 A. So I've not called the president of Leapfrog
10 and asked her, I guess.

11 Q. Are you aware that Leapfrog sends out
12 document requests for verification of survey results to
13 participating hospitals?

14 MR. MARCUS: Object to form.

15 A. Documents saying "send us documents," is
16 that what you're saying?

17 BY MS. BLAIR:

18 Q. Correct, correct.

19 A. I mean, that's part of the survey process?

20 Q. No, as part of the verification of the
21 survey process.

22 MR. MARCUS: Same objection.

23 A. I don't know.

24 BY MS. BLAIR:

25 Q. You've done nothing to figure out whether

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1 that's true or not?

2 MR. MARCUS: Same objection.

3 A. If Leapfrog sends a verification form to a
4 hospital?

5 BY MS. BLAIR:

6 Q. Oh, no, no, no, no. I'm sorry. My question
7 might have been bad.

8 Are you aware that as part of the
9 verification process -- well, strike that.

10 Are you aware that hospitals must submit
11 their survey by June 30th, and a verification process
12 takes place between June 30th and when the survey
13 closes on August 31st --

14 MR. MARCUS: Object to form.

15 BY MS. BLAIR:

16 Q. -- every year?

17 A. I don't know the process no.

18 Q. Okay. And you're unaware of any of the
19 verification process that takes place in those 60 days,
20 correct?

21 MR. MARCUS: Same objection.

22 A. Yes.

23 BY MS. BLAIR:

24 Q. And, yet, you're confident that the
25 allegations in this lawsuit that Leapfrog does nothing

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1 to verify survey results is true and accurate, correct?

2 MR. MARCUS: Same objection.

3 A. I would say they don't go into hospitals and
4 verify hand washing, for example.

5 BY MS. BLAIR:

6 Q. You don't know whether or not Leapfrog does
7 random audits of hospitals, onsite audits of hospitals,
8 do you?

9 A. I am not aware of that.

10 Q. And you've done nothing to inform yourself
11 as to whether or not that's true, do you, have you?

12 MR. MARCUS: Object to form.

13 A. Yeah, speaking to people in the industry
14 that say otherwise.

15 BY MS. BLAIR:

16 Q. Okay.

17 MR. MARCUS: Good time for a break?

18 MS. BLAIR: Sure. We've got to be almost
19 done. I'm almost done.

20 MR. MARCUS: You said that an hour and a
21 half ago.

22 MS. BLAIR: Again, if I didn't have to ask
23 about all the documents, we'd be done.

24 Off the record.

25 THE VIDEOGRAPHER: We're going off the

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1 record. The time is 5:10 p.m.

2 (A recess was taken from 5:10 p.m. to 5:21 p.m.)

3 THE VIDEOGRAPHER: We are back on the
4 record. The time is 5:21 p.m.

5 BY MS. BLAIR:

6 Q. Ms. Montgomery, I want to move on to
7 Good Samaritan's claim in this litigation that it has
8 been harmed by the Leapfrog hospital safety grades.

9 By way of just orienting you to timeline,
10 the Complaint in this case was filed April 30th of
11 2025. Does that comport with your memory?

12 A. Yes.

13 Q. And as of April 30th, 2025, Good Samaritan,
14 for which you are the CEO, had suffered harm at that
15 point in time, correct?

16 A. Correct.

17 Q. And would you agree with me that on
18 April 30th, did they -- the day -- the day the
19 complaint was filed, the five plaintiff hospitals
20 undertook a media campaign to publicize their safety
21 grades that Leapfrog had provided them both in the fall
22 of 2024 and the spring of 2025?

23 MR. MARCUS: Object to form.

24 A. In April, is that what you said?

25 BY MS. BLAIR:

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1 Q. Correct.

2 A. I thought we had gathered really that type
3 of information prior to then, but...

4 Q. Oh, yeah. I guess my question was more
5 specific. The Complaint is filed on April 30th, 2025,
6 correct?

7 A. Um-hum.

8 Q. And there are that same day press releases
9 going out from the five plaintiffs to media outlets
10 discussing the D's and F's that the five plaintiffs
11 hospitals had received from Leapfrog, correct?

12 MR. MARCUS: Object to form.

13 A. Okay.

14 BY MS. BLAIR:

15 Q. Do you recall that?

16 A. I don't recall at all.

17 Q. Okay. Do you recall any interviews you gave
18 to the media in or around late -- or April 30th to,
19 let's just say, the first week in May regarding these
20 five hospitals filing suit against Leapfrog?

21 A. I do recall questions coming up and Andrew
22 asking me questions, things of that nature for media
23 outlets.

24 Q. Did you ever sit down with a media outlet
25 and give an interview?

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1 A. I did not.

2 Q. Did you ever watch the interviews that were
3 done by your attorney, Mary Beth -- Mary Beth Maloney,
4 related to the filing of the lawsuit?

5 A. I do believe I saw them, one of -- yes, it
6 was on the news, I believe.

7 Q. Did you as the CEO of Good Samaritan have to
8 sign off on the talking points that Mary Beth Maloney
9 gave to the press --

10 MR. MARCUS: Object to form.

11 BY MS. BLAIR:

12 Q. -- and third parties?

13 MR. MARCUS: Same objection.

14 A. I signed off on -- I believe so. Normally
15 it comes through Andrew. Anything that goes out as a
16 press release, we review.

17 BY MS. BLAIR:

18 Q. And so all of statements that Mary Beth
19 Maloney gave regarding the brazen pay to play process
20 of the Leapfrog hospital safety grades, you would have
21 signed off on that?

22 MR. MARCUS: Object to form.

23 A. Not her. Not her specifically, no, but like
24 anything that is going to come through like
25 Good Samaritan.

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1 BY MS. BLAIR:

2 Q. Okay. Talking about -- have you done any
3 studies, Palm Beach Health Network, has Palm Beach
4 Health Network done any studies to determine whether or
5 not the impact of the plaintiffs' PR campaign after the
6 filing of the lawsuit in any way increased patient
7 knowledge of those five hospitals' Leapfrog hospital
8 safety grades?

9 MR. MARCUS: Object to form.

10 A. Was there an analysis done of the impact of
11 the media campaign, is that what you mean?

12 BY MS. BLAIR:

13 Q. Sure. Did anybody say, Well, X number of
14 people knew about our Leapfrog hospital safety grades
15 before we went to the press and did this media blitz,
16 and we've just publicized these grades to a much
17 farther reach after you engaged in the PR campaign?

18 MR. MARCUS: Object to form.

19 A. No, I'm not aware of one.

20 BY MS. BLAIR:

21 Q. Is there any way that you know of to make
22 the determination as to what the impact was to
23 Good Samaritan's reputation before the April 30th media
24 campaign that the plaintiffs engaged in regarding the
25 lawsuit and before?

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1 A. All the things that occurred from December
2 until then, most certainly.

3 Q. And I've seen documents that have been
4 produced in this litigation about doctors telling --
5 telling Good Samaritan that patients didn't want to
6 come to Good Samaritan hospital because of the Leapfrog
7 safety grade, correct?

8 A. Correct.

9 Q. Did you ever have any conversations -- did
10 you, Sheri Montgomery, ever have any direct
11 conversations with patients who told you they would not
12 go to Good Samaritan because of the Leapfrog hospital
13 safety grade?

14 A. No, the physicians did.

15 Q. Did the physicians ever provide you with the
16 names of the patients that they spoke to who allegedly
17 would not come to Good Samaritan because of
18 Good Samaritan's Leapfrog hospital safety grade?

19 A. No.

20 Q. Do you know how many patients refused to
21 come to Good Samaritan as a result of the Leapfrog
22 hospital safety grade?

23 A. I don't know how many.

24 Q. Are you contending that the Leapfrog
25 hospital safety grade had any impact on physician

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1 retention at Good Samaritan?

2 A. I would say that it is in the fact that
3 other contracts we may have, like for hospital for
4 special surgery, for example, is, in my opinion, that
5 the Leapfrog rating has prompted those physicians to
6 get on staff at Jupiter Medical Center because their
7 patients are complaining to them that we are an F.
8 They are only on staff at Good Samaritan Medical
9 Center. The physicians have told me that they are
10 getting on staff at Jupiter and that their patients
11 have complained about us being an F hospital.

12 Q. How many doctors are getting on staff at
13 Jupiter Medical?

14 A. So our top surgeons, so there's three or
15 four of them, the orthopedic surgeons.

16 Q. Are they revoking their privileges at
17 Good Samaritan?

18 A. No.

19 Q. Okay. So they're just adding Jupiter as a
20 hospital, correct?

21 A. Correct.

22 Q. Have they said to you how many patients they
23 have to treat at Jupiter as a result of the Leapfrog
24 hospital safety grade as opposed to treating at
25 Good Samaritan?

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1 A. No.

2 Q. So you don't have any number?

3 A. I don't have a number.

4 Q. And how many of those doctors are -- I'm
5 sorry if I already asked you this.

6 How many doctors have told you that they
7 have to go seek privileges at Jupiter due to the
8 hospital safety grade?

9 A. So that's just HSS surgeons. We have other
10 surgeons that are called splitters, meaning they're
11 already on staff at Jupiter, like Dr. Goodman, who had
12 to reschedule a surgery and go to Jupiter Medical
13 because a patient refused to come to our hospital
14 because we were an F.

15 Q. One patient?

16 A. That I could know about and could provide
17 names.

18 Q. So one patient you know about and could
19 provide a name, correct?

20 A. Oh, I could provide more names for sure.

21 Q. Oh, you could?

22 A. For the HSS.

23 Q. Okay. So let's break that down. How many
24 patients of HSS -- they're surgeons, correct?

25 A. Yeah.

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1 Q. How many patients of HSS surgeons have
2 specifically refused to come to Good Samaritan for a
3 surgery because of the Leapfrog safety grade?

4 A. I do not have a number. I do not know.

5 Q. How many names can you think of?

6 A. No, I'm saying I can obtain the names.

7 Q. You can obtain the names?

8 A. Right.

9 Q. But you don't have them as you sit here
10 today?

11 A. No. I don't have any patient names.

12 Q. And you don't have any numbers of patients,
13 right?

14 A. No.

15 Q. And so my original question was, have any
16 doctors refused to become associated with
17 Good Samaritan as a result of the Leapfrog hospital
18 safety grades?

19 MR. MARCUS: Object to form.

20 A. The physicians that are already with us on
21 staff, is that what you're referring to?

22 BY MS. BLAIR:

23 Q. Well, I guess we could break it down. Let's
24 start with, are there any doctors that you were trying
25 to recruit that said, No, I looked at your Leapfrog

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1 safety grade and I will not work with Good Samaritan?

2 A. Not that I'm aware of for Good Sam.

3 Q. Okay. And then let's talk about doctors
4 that are already on staff with you, have any of them
5 left Good Samaritan as a result of the Leapfrog
6 hospital safety grade?

7 A. No.

8 Q. And then there are those doctors that we
9 just discussed that sought privileges at Jupiter in
10 addition to Good Samaritan based on the Good Samaritan
11 hospital safety grade, correct?

12 A. Correct.

13 Q. In those discussions with the doctors that
14 are seeking privileges at Jupiter Medical Center, did
15 any of them express in any way dissatisfaction with
16 Good Samaritan's CMS star rating?

17 A. No.

18 Q. Only the Leapfrog hospital safety grade?

19 A. Yes, and the discussion was that this
20 physician wants to stay at Good Sam, loves Good Sam,
21 knows the quality of Good Sam, but HSS, they're not
22 sure if they're going to force them to do -- mostly go
23 to Jupiter or Jupiter completely.

24 Q. If home office will only allow you to
25 participate in the Leapfrog Hospital Survey if it's

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1 connected to a contract or payment, and as we saw in an
2 Exhibit earlier today, you don't have to hire anybody
3 to comply, anybody additional to comply with the
4 hospital survey, why isn't the fact that HSS cares
5 about the Leapfrog Hospital Survey enough to get a
6 dispensation from home office to participate?

7 A. Because this all happened after our F,
8 right. So all of this horrible mass destruction
9 happened after the F. So asking to be part of Leapfrog
10 prior to that was before this occurred.

11 I'm confident that we're probably not going
12 to now that there is so much -- now that there's a
13 general understanding of how it works and what occurred
14 with the F, we're certainly not going to want to be a
15 part of it.

16 Q. Well, because you filed suit, correct?

17 MR. MARCUS: Object to form.

18 A. (No response).

19 BY MS. BLAIR:

20 Q. So you could participate in Leapfrog and
21 under your allegations of this Complaint increase your
22 Leapfrog safety grade and avoid the harm, but you're
23 choosing not to, correct?

24 MR. MARCUS: Object to form.

25 A. The harm is already done.

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1 BY MS. BLAIR:

2 Q. So there's no continuing harm?

3 A. Yeah, it's going to continue. So you think
4 if all of a sudden we're going to participate and, Oh,
5 we're now a B that that's going to like -- it's just
6 not going to -- a lot of harm has already been done.
7 It's going to take a while to recover, but I wouldn't
8 want to really participate in the survey in the first
9 place because I really don't believe it does add the
10 value that the Joint Commission does, that the
11 accrediting bodies do that come and share best practice
12 with us, that meet with our leaders and go over things,
13 just like the Joint Commission when they were just in
14 our building, and we had the best emergency management
15 plan, but then they'll give us something another
16 hospital has that they think, Oh, you should -- maybe
17 you should look at this policy or doing it this way.
18 That's where we want to do a more of a collaboration
19 with than filling out the survey.

20 Q. Am I correct you're voluntarily choosing not
21 to perform in the Leapfrog Hospital Survey?

22 A. Well, it's a voluntary survey so we didn't
23 fulfill out the survey.

24 Q. And you have no intention of doing that
25 going forward, correct?

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1 A. At the end of the day, I wouldn't make that
2 decision.

3 Q. And we just discussed, even if it turns out
4 that your assumptions regarding the Leapfrog Hospital
5 Survey are wrong, you still don't want to participate
6 in that survey?

7 MR. MARCUS: Object to form.

8 A. Even if the assumptions of what?

9 BY MS. BLAIR:

10 Q. Even if the assumptions that you've made,
11 it's pay to play, you pay for consulting services to
12 get your grade, there's no science behind the
13 imputation methodology, even if all those things turn
14 out to be wrong, you still have no intention of
15 engaging in the hospital survey, correct?

16 MR. MARCUS: Object to form.

17 A. I don't make those decisions.

18 BY MS. BLAIR:

19 Q. Who does?

20 A. Tenet corporate.

21 Q. You're also requesting your attorney's fees
22 in this matter, correct? Do you understand that?

23 MR. MARCUS: Object to form.

24 A. Okay.

25 BY MS. BLAIR:

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1 Q. Well, you read the Complaint, right?

2 A. Yeah.

3 Q. Do you have any understanding of how much
4 has been incurred in attorney's fees to date?

5 MR. MARCUS: Object to form.

6 A. Do I know?

7 BY MS. BLAIR:

8 Q. Um-hum.

9 A. I mean, I've seen some allocations, but I
10 don't know how much has been spent on attorney's fees.

11 Q. What are the allocations that you've seen?

12 A. There are allocations from the home office.
13 I think it's our financial statement.

14 Q. Okay. But I'm just asking about the
15 attorney's fees. What are the allocations of
16 attorney's fees for this action that you'll be seeking?

17 MR. MARCUS: Object to form.

18 A. The amount?

19 BY MS. BLAIR:

20 Q. Um-hum.

21 A. For Good Sam, a million, a million and a
22 half maybe.

23 Q. And is that then multiplied by five since
24 there are five plaintiffs? Are you splitting it
25 equally?

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1 A. I don't know.

2 Q. What about costs, do you have any
3 understanding of what the costs are?

4 A. What do you mean?

5 Q. Well, there's expert fees, for example. Do
6 you know what those are in addition to the attorney's
7 fees?

8 A. No.

9 MR. MARCUS: Object to form.

10 BY MS. BLAIR:

11 Q. Is Good Sam currently paying the attorney's
12 fees associated with this case?

13 A. I don't -- I don't think so. I mean, we
14 are. It's in our financial statement, but, honestly, I
15 don't know what happens in accounts payable and who's
16 handling all of that information.

17 Q. Okay. But you believe the projections are
18 that Good Sam's share of the attorney's fees in this
19 case will be 1.5 million, correct?

20 MR. MARCUS: Object to form.

21 A. That is my understanding.

22 BY MS. BLAIR:

23 Q. How much time have you and your staff
24 devoted to this lawsuit since it was filed on
25 April 30th, 2025?

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1 A. I have no idea.

2 Q. More than 100 hours?

3 A. I would not be able to tell you.

4 Q. Well, I know you've spent at least seven
5 hours because we've been here almost seven, correct?

6 A. Right.

7 Q. Have you ever been told by Tenet home office
8 that the goal of this lawsuit is to stop Leapfrog from
9 grading hospitals?

10 A. No.

11 Q. Do you have any understanding as to whether
12 the goal of this lawsuit is for Tenet to have none of
13 its hospitals across the country graded by Leapfrog?

14 MR. MARCUS: Object to form.

15 A. I don't know if that's the goal or it's a
16 just that we're, you know, we don't -- if we don't
17 participate, we're just not given a grade is my
18 understanding.

19 BY MS. BLAIR:

20 Q. Have you ever had discussions with other
21 nonparticipating hospitals outside of the Tenet Health
22 network about joining your lawsuit?

23 A. No.

24 Q. Have you had any internal discussions about
25 the consequence of this lawsuit being that your

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1 competitors, like Jupiter, would look bad in the public
2 by promoting their safety grade previously?

3 A. No.

4 Q. Is the goal of this lawsuit to affect
5 competition for Good Samaritan in any way?

6 A. No.

7 Q. What is your understanding of the goal of
8 this lawsuit?

9 A. To if we don't participate that we're not
10 given a grade.

11 Q. My last question is, do you have any plans
12 of producing any additional documents -- well, strike
13 that.

14 To your knowledge, have you given your
15 attorneys all of the documents that you plan on
16 producing in this litigation?

17 MR. MARCUS: Are you asking her personally
18 or are you asking her as a corporate rep?

19 BY MS. BLAIR:

20 Q. As a corporate rep, are you done providing
21 document -- I don't have all the documents yet, and I
22 understand your attorneys are reviewing them, and I'm
23 not faulting them for that. But I'm asking you, as the
24 corporate representative of Good Samaritan, is it your
25 understanding that you now have provided your attorneys

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1 with all of the documents, whether I have them or not,
2 you've provided them to your attorneys for production
3 in this matter?

4 A. Anything that I was asked, I produced.

5 MS. BLAIR: Excellent. I have no further
6 questions.

7 MR. MARCUS: Okay.

8 MS. BLAIR: Thank you.

9 THE VIDEOGRAPHER: Before we go off the
10 record, does anyone want to order the transcript
11 or the video?

12 MS. BLAIR: I will take a rough of the
13 transcript and then regular delivery of the
14 final in an eTtran. I do not want the video at
15 this time.

16 MR. SIMMONS: We do want the video.

17 MR. MARCUS: And the witness will read.

18 THE VIDEOGRAPHER: This concludes today's
19 deposition. We're going off the record. The
20 time is 5:41 p.m.

21 THE STENOGRAPHER: And, Counsel, do you need
22 to order the transcript?

23 MR. SIMMONS: Yes, please.

24 THE STENOGRAPHER: Do you need a rough draft
25 also?

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1 MR. SIMMONS: Yes, please.

2 THE STENOGRAPHER: Regular delivery?

3 MR. SIMMONS: Yes.

4 (A discussion was held off the record.)

5 MR. MARCUS: We're designating the
6 transcript as confidential per the
7 confidentiality order that's in place.

8 MS. BLAIR: And we reserve our rights to
9 object to the confidential nature of certain
10 portions of the transcript.

11 MR. SIMMONS: Could we get a rush delivery
12 for the transcript?

13 THE STENOGRAPHER: Of course. When do you
14 need it?

15 MR. SIMMONS: Could we get it end of day
16 Wednesday?

17 THE STENOGRAPHER: Of course.
18 (Thereupon, the proceedings concluded at
19 5:45 p.m.)

20 (The witness did not waive signature.)

21

22

23

24

25

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1 CERTIFICATE OF OATH

2

3 THE STATE OF FLORIDA)

4 COUNTY OF PALM BEACH COUNTY)

5

6 I, the undersigned authority, certify that
7 SHERI MONTGOMERY remotely appeared before me and was
8 duly sworn on the 15th day of September 2025.

9 Signed this 17th day of September 2025.

10

11

12

13

14

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16

17

18

19

20 BARBIE GALLO, RMR-CRR
Notary Public - State of Florida
My Commission No. GG939757
21 My Commission Expires: December 18, 2027

22

23

24

25

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1 CERTIFICATE OF REPORTER

2

3 THE STATE OF FLORIDA)

4 COUNTY OF PALM BEACH)

5

6 I, Barbie Gallo, RMR-CRR, Registered Merit
7 Reporter-Certified Realtime Reporter, certify that I
8 was authorized to and did stenographically report the
9 deposition of SHERI MONTGOMERY, pages 1 through 313;
10 that a review of the transcript was requested; and that
11 the transcript is a true and complete record of my
12 stenographic notes.

13 I further certify that I am not a relative,
14 employee, attorney, or counsel of any of the parties,
15 nor am I a relative or employee of any of the parties'
16 attorney or counsel connected with the action, nor am I
17 financially interested in the action.

18

19 DATED this 17th day of September 2025.

20

21

22

23

24

25

Barbie Gallo, RMR-CRR

Sheri Montgomery
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1 September 17, 2025

2 Sheri Montgomery c/o Jeffrey Marcus
3 Marcus, Neiman, Rashbaum & Pineiro, LLP
4 125218 2 South Biscayne Boulevard
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6 Miami, Florida 33131
7 (305) 400-4268
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9 IN RE: GOOD SAMARITAN vs. THE LEAPFROG GROUP
10 CASE NO.: 9:25-CV-80526-DMM

11 Please take notice that on the 15th day of September
12 2025, you gave your deposition in the above cause. At
13 that time you did not waive your signature.

14 The above-addressed attorney has ordered a copy of this
15 transcript and will make arrangements with you to read
16 their copy. Please execute the Errata Sheet, which can
17 be found at the back of the transcript, and have it
18 returned to us for distribution to all parties.

19 If you do not read and sign the deposition within 30
20 days, the original, which has already been forwarded to
21 the ordering attorney, may be filed with the Clerk of
22 the Court.

23 If you wish to waive your signature now, please sign
24 your name in the blank at the bottom of this letter and
25 return it to the address listed below.

Very truly yours,

21 _____
22 Barbie Gallo, RMR-CRR
23 Lexitas Legal
24 fl.production@lexitaslegal.com

25 I do hereby waive my signature.

26 _____
27 SHERI MONTGOMERY
28 Job No.: 421985

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1 ERRATA SHEET
2 DO NOT WRITE ON TRANSCRIPT - ENTER CHANGES HERE
3 IN RE: GOOD SAMARITAN vs THE LEAPFROG GROUP
4 CASE NO.: 9:25-CV-80526-DMM
5 WITNESS: SHERI MONTGOMERY
6 TAKEN: 09/15/2025

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23 Under penalties of perjury, I declare that I have
24 read the foregoing document and that the facts stated
25 in it are true.

Date SHERI MONTGOMERY

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Exhibit 97

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA
WEST PALM BEACH DIVISION

---o0o---

GOOD SAMARITAN MEDICAL)
CENTER, INC., et al.,)
Plaintiffs,)
vs.) Case No.
THE LEAPFROG GROUP,) 9:25-CV-80526-DMM
Defendants.)
-----)

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Videotaped Deposition of
PATRICK S. ROMANO, M.D., M.P.H.
Tuesday, September 23, 2025

---o0o---

Katy E. Schmidt
RPR, RMR, CRR, CSR 13096
Job No.: 7581592

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA
WEST PALM BEACH DIVISION

---o0o---

GOOD SAMARITAN MEDICAL)
CENTER, INC., et al.,)
Plaintiffs,)
vs.) Case No.
THE LEAPFROG GROUP,) 9:25-CV-80526-DMM
Defendants.)
_____)

BE IT REMEMBERED that, pursuant to Notice,
and on Tuesday, the 23rd day of September, 2025,
commencing at the hour of 9:23 a.m., thereof, in
Sacramento, California, before me, KATY E. SCHMIDT, a
Certified Shorthand Reporter in and for the County of
Yolo, State of California, there personally appeared

PATRICK S. ROMANO, M.D., M.P.H.

called as a witness herein, who, being by me first
duly sworn, was thereupon examined and interrogated as
hereinafter set forth.

1 APPEARANCES:

2 For The Plaintiffs:

3 GIBSON DUNN & CRUTCHER, LLP

BY: SCOTT HVIDT, Esq.

4 BY: MONICA GROVER, Esq.

2001 Ross Avenue, Suite 2100

5 Dallas, Texas 75201

214.698.3317

6 SHvidt@gibsondunn.com

7 For The Defendants:

8 WILSON ELSEER MOSKOWITZ EDELMAN & DICKER, LLP

BY: MAXWELL L. BILLEK, Esq.

9 BY: KAVI MODI, Esq. (Via Zoom)

7 Giralda Farms, Suites 100/110

10 Madison, New Jersey 07940

973.624.0800

11 max.billek@wilsonelser.coms

12 Also present:

13 Nick Hemphill, Videographer

14 ---o0o---

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Examination by Mr. Hvidt

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1 SACRAMENTO, CALIFORNIA

2 TUESDAY, SEPTEMBER 23, 2025; 9:23 A.M.

3 ---oOo---

4 THE VIDEOGRAPHER: We are on the record at
5 9:23 a.m. on September 23rd, 2025. 0

6 This is Media 1 in the video deposition of
7 Patrick Romano in the matter of Good Samaritan Medical
8 Center, et al. versus The Leapfrog Group.

9 The location of this deposition is
10 1209 L Street, Sacramento, California, with an
11 appearance on Zoom.

12 My name is Nicholas Hemphill representing
13 Veritext. I'm the videographer.

14 Appearances will be noted on stenographic
15 record.

16 Would the court reporter please introduce
17 yourself for the record and then swear in the witness.

18 THE COURT REPORTER: Good morning. We're
19 going on the record.

20 My name is Kathryn Schmidt, CSR 13096, and I
21 will now swear in the witness.

22 ---oOo---

23 PATRICK ROMANO, M.D.,
24 called as a witness by the Plaintiffs, who, being
25 first duly sworn to tell the truth, the whole truth

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1 and nothing but the truth, was examined and testified
2 as follows:

3 THE WITNESS: I do.

4 THE COURT REPORTER: Thank you.

5 EXAMINATION BY MR. HVIDT

6 BY MR. HVIDT:

7 Q. Good morning, Dr. Romano.

8 This is Scott Hvidt, Gibson Dunn & Crutcher
9 here, and my colleague Monica Grover.

10 Can you state your full name for the record
11 again, please?

12 A. Patrick Scott Romano.

13 Q. And have you ever gone by any other names?

14 A. No.

15 Q. Okay. Today as we communicate with each
16 other, do you prefer that I call you Dr. Romano?

17 A. Sure.

18 Q. Okay. Are you employed, Dr. Romano?

19 A. I am.

20 Q. Where?

21 A. University of California at Davis.

22 Q. And what is your title there?

23 A. Professor.

24 Q. Professor in what?

25 A. Professor of internal medicine and

1 pediatrics.

2 Q. Do you have an affiliation with
3 The Leapfrog Group?

4 A. I do.

5 Q. And what is that affiliation?

6 A. I serve on The Leapfrog Group's hospital
7 safety grade expert panel.

8 Q. Thank you.

9 Do you understand that our court reporter is
10 taking down every question that I ask and every answer
11 you give?

12 A. I do.

13 Q. Okay. Have you been deposed before?

14 A. I have.

15 Q. So you understand the nature of how this
16 works. We just avoid giving answers that are "uh-huh"
17 or "uh-uh" or nodding or shaking of the head but
18 verbal communication.

19 Do you understand that?

20 A. I understand.

21 Q. Okay. And you understand that you are
22 testifying under oath today?

23 A. I do.

24 Q. Are you taking any medications or under the
25 influence of any substances that would impair your

1 judgment or your thinking today?

2 A. No.

3 Q. If you don't understand a question that I
4 ask, please ask that I clarify it because if you
5 answer it, we will assume that you understood the
6 question that I've asked.

7 Do you understand that?

8 A. I will do so.

9 Q. Okay. From time to time your attorney might
10 object to questions I ask. If you could give what I
11 often call a pregnant pause after I ask a question to
12 avoid us all speaking over each other, that would be
13 greatly appreciated.

14 Do you understand that?

15 A. I will do so.

16 Q. Okay. And happy to take breaks throughout
17 the day. But I just ask that you not ask for -- that
18 we not take any breaks during -- while a question is
19 pending.

20 Do you understand that?

21 A. Yes.

22 Q. Okay. So you mentioned that you had been
23 deposed.

24 What -- how many times have you been
25 deposed?

1 A. This is probably my seventh.

2 Q. Okay. And in what capacity have you been
3 deposed?

4 A. Three times as an expert witness on behalf
5 of the United States Federal Trade Commission in cases
6 involving hospital quality and antitrust.

7 Q. And can you tell me what those cases were?

8 A. The most recent case involved
9 Hackensack Meridian Health out of Hackensack,
10 New Jersey.

11 Two previous cases in Illinois: One
12 involved Evanston Northwestern Healthcare, I believe
13 now known as NorthShore Health in the Chicago area.
14 The other involved Rockford Memorial Hospital in
15 Rockford, Illinois.

16 Q. Were all three of those cases hospital
17 merger cases?

18 A. They were.

19 Q. And was your testimony regarding the quality
20 of the hospitals that were being acquired?

21 A. My testimony was based on an expert report
22 in each case. The specific topic of the expert report
23 varied slightly from case to case. In general terms,
24 the Federal Trade Commission asked me to opine on the
25 anticipated impact of the proposed acquisition on

1 hospital quality and safety.

2 Q. And you also mentioned that you've been
3 deposed in four other lawsuits.

4 What were those lawsuits?

5 A. I believe that -- so one case was a matter
6 of employment law related to an employee in our
7 research group at UC Davis Center for Healthcare
8 Policy and Research.

9 Another case was brought under the
10 Americans with Disabilities Act by a student who was
11 terminated from our medical school.

12 Q. Thank you.

13 And in the cases where you were providing
14 expert testimony, was your expert testimony ever
15 excluded from the record?

16 A. In one case there was a Daubert motion that
17 resulted in exclusion of a portion of my testimony.

18 Q. And --

19 A. Retention of the bulk of it.

20 Q. And what was the portion that was excluded?

21 A. It was a portion in which I was evaluating
22 the capacity of the hospital, in this case,
23 Hackensack University Medical Center. And I was
24 evaluating the availability of beds and the flow of
25 patients through those beds and the occupancy rate of

1 the hospital.

2 Q. And was the exclusion due to your
3 qualifications?

4 A. It was due to the belief that I was not
5 qualified to opine on the management of hospital bed
6 capacity. Correct.

7 Q. And do you understand that you're here today
8 being deposed in an ongoing lawsuit?

9 A. Yes.

10 Q. Do you know what lawsuit that is?

11 A. I can't cite the name of it, but I know that
12 it involves five hospitals owned by Tenet and
13 The Leapfrog Group.

14 Q. I'm going to mark this Exhibit 1,
15 Romano Exhibit 1 would be, if possible, a good way to
16 flag them so we can differentiate between the other
17 depositions.

18 (Exhibit 1 was marked for
19 identification.)

20 MR. BILLEK: I'm sorry. What was the
21 marking?

22 MR. HVIDT: One.

23 MR. BILLEK: Okay. Just one.

24 MR. HVIDT: Just one. It will be Romano
25 Exhibit 1, but she's going to mark the name on them

1 later --

2 MR. BILLEK: Okay. Thanks.

3 MR. HVIDT: -- for expedience purposes.

4 BY MR. HVIDT:

5 Q. Dr. Romano, I've handed you what's been
6 marked as Romano Exhibit 1.

7 Have you seen this document before?

8 A. Yes.

9 Q. Is this the Notice of Subpoena for your
10 deposition?

11 A. Yes.

12 Q. And do you see your name there under
13 "Deponent"?

14 A. I do.

15 Q. And you see today's date for the date and
16 time?

17 A. Correct.

18 Q. And the location has been adjusted due to
19 correspondence from your counsel yesterday.

20 Do you understand that we are not at
21 Magna Legal Services today?

22 A. Of course.

23 Q. And we are at the Hyatt Regency in
24 Sacramento on L Street.

25 Do you understand that?

1 A. I understand.

2 Q. And what is your understanding of the
3 lawsuit that's captioned here in this deposition
4 subpoena?

5 A. My understanding is that the plaintiffs are
6 dissatisfied with their Leapfrog Hospital safety
7 grades and they believe that they have a claim to
8 bring against Leapfrog Group related to the
9 methodology.

10 Q. And are you represented by counsel here
11 today?

12 A. I am.

13 Q. And who is your counsel?

14 A. Max, on behalf of -- well, I don't even know
15 the firm's name. But yes.

16 Q. Are you paying for your counsel's
17 representation of you?

18 A. I am not.

19 Q. And who is paying for your counsel's
20 representation?

21 A. I don't know.

22 Q. Do you have an understanding that your
23 counsel is being paid to represent you here today?

24 A. They are being paid to represent me here
25 today, yes.

1 Q. Do you think that it's The Leapfrog Group
2 that is paying for your representation?

3 A. I couldn't say specifically because I know
4 that Leapfrog has an insurance policy that covers
5 certain expenses. So I don't know the details of that
6 payment mechanism.

7 Q. Did you select your counsel to represent you
8 today?

9 A. I made the choice to accept this counsel.

10 Q. Okay. And did you prepare for your
11 deposition today?

12 A. I did a bit.

13 Q. And what did you do to prepare?

14 A. I reviewed some documents from
15 The Leapfrog Group website, and I viewed the documents
16 that I produced in response to the previous subpoena.

17 Q. Did you meet with your counsel to prepare
18 for your deposition?

19 A. I did.

20 Q. And how many times did you meet with your
21 counsel?

22 A. Once specifically to prepare for this
23 deposition.

24 Q. And which -- was it Max that you met with to
25 prepare for your deposition?

1 A. Max, together with his partner Kim.

2 Q. And when did you first meet with counsel?

3 A. And Courtney also from the same firm.

4 Q. Just want to make sure I wasn't talking over
5 you and that the court reporter was able to get that
6 down.

7 Did you -- how long did you meet with
8 counsel to prepare?

9 A. Two and a half hours.

10 Q. Did you review any documents with your
11 counsel in preparation for the deposition?

12 A. Yes.

13 Q. Did any of those documents refresh your
14 recollection as to the events you're going to be
15 testifying about?

16 A. Quite possibly. Yes.

17 Q. Do you remember which particular documents
18 those were?

19 A. There was a document about guiding
20 principles for our expert panel process and there were
21 some notes related to an in-person meeting that we
22 had, I believe back in 2013, that were shared with me
23 around that time.

24 Q. Do you have copies of those documents with
25 you today?

1 A. No.

2 Q. Dr. Romano, did you -- you can set that
3 aside.

4 Did you attend college?

5 A. Yes.

6 Q. And where did you attend college?

7 A. Princeton University.

8 Q. Wow. Me as well. Go Tigers.

9 A. Go Tigers.

10 Q. And when did you graduate Princeton?

11 A. 1979.

12 Q. All right.

13 MR. HVIDT: We'll mark this Exhibit 2.

14 (Exhibit 2 was marked for
15 identification.)

16 MR. HVIDT: Handing the witness what's been
17 marked Exhibit 2 to the Romano deposition.

18 BY MR. HVIDT:

19 Q. Dr. Romano, I'm handing you what is a
20 64-page document.

21 Can you tell me what is the document I've
22 handed you?

23 A. It looks like my CV, although I did not
24 produce this document, so I don't know its exact
25 source.

1 Q. Do you make your CV available on the
2 UC Davis website?

3 A. It's possible.

4 Q. Looking through this document, and if you
5 need a minute, does this document -- do you have any
6 reason to believe this document isn't your CV? And
7 you can let us know if there's anything in here that's
8 not accurate.

9 A. Looks reasonably accurate. Perhaps not
10 perfectly up to date, but reasonably accurate, yes.

11 Q. Okay. And do you have any professional
12 degrees?

13 A. I do.

14 Q. And what are those degrees?

15 A. I have a medical degree from
16 Georgetown University and a degree in public health
17 from University of California Berkeley.

18 Q. Following receiving those degrees, did you
19 have any medical training?

20 A. Yes. I had specialty training in internal
21 medicine and pediatrics.

22 Q. And where did you have that training?

23 A. That was at Case Western Reserve University,
24 University Hospitals of Cleveland.

25 Q. Did you get any certifications as well in

1 addition to receiving that -- the training that you
2 just mentioned at Case Western?

3 A. Yes. Yes. I'm licensed, of course,
4 originally by the State of Ohio and now by the
5 State of California for many years. I have board
6 certification in internal medicine, and I had board
7 certification in pediatrics for many years, but I've
8 allowed that to lapse.

9 Q. And can you walk me through briefly your
10 employment history from -- you know, first after
11 receiving your medical degrees to where you are
12 currently?

13 A. Right.

14 So I spent four years in Cleveland at the
15 University Hospitals of Cleveland.

16 I spent a few months as a locum tenens
17 employee with the Department of Veterans Affairs in
18 Cleveland, and then later with the Kodiak Area Native
19 Association in Kodiak, Alaska.

20 I started a fellowship in health services
21 research which was a joint program supported by the
22 U.S. Agency for Health Research and Quality at UCSF
23 and UC Berkeley.

24 I was in that fellowship program essentially
25 for three years and then transitioned to a faculty

1 role at UCSF. I remained at UCSF until -- until I
2 came to UC Davis. So that would have been in the
3 spring of 1992 I came to UC Davis. And I've been at
4 UC Davis ever since then.

5 Q. Wow. Remarkable.

6 And looking down at Exhibit 2, did you
7 prepare this or direct someone to prepare this?

8 A. I did.

9 Q. And if you look to page 3 of the document
10 that's printed double-sided, do you see where it says
11 "Peer Reviewed Publications"?

12 A. Yes.

13 Q. Okay. And if you were to flip through from
14 page 3 all the way through to page 22, are those all
15 peer-reviewed publications that you have contributed
16 to?

17 A. Yes.

18 Q. So it lists on here 245 articles for the
19 last 35 odd years.

20 Is that right?

21 A. That's correct. Technically a couple of
22 them are republications in different languages --

23 Q. Okay.

24 A. -- and may not be completely unique
25 articles. But, yes, they are all peer reviewed and I

1 contributed to all of them.

2 Q. Would you agree that's a fairly large body
3 of academic work?

4 A. I think so.

5 Q. And do your publications focus on particular
6 topics?

7 A. The primary theme of my publications is
8 related to the measurement and improvement of patient
9 outcomes and specifically healthcare quality and
10 safety.

11 Q. Does your work in developing and validating
12 quality measures, you know, using certain data, kind
13 of appear quite frequently in these peer-reviewed
14 publications as a topic, a theme?

15 MR. BILLEK: Just to note my objection to
16 the form of the question.

17 You can answer.

18 THE WITNESS: Could you clarify the
19 question, please?

20 BY MR. HVIDT:

21 Q. Yeah. Absolutely.

22 So within these articles, would you say
23 there's a fair amount of publications that deal with
24 the development and validation of quality measures to
25 be used through, you know, public reporting?

1 MR. BILLEK: Same objection.

2 You can answer.

3 THE WITNESS: Yes.

4 BY MR. HVIDT:

5 Q. Based on your work, do you consider yourself
6 to have a significant experience in the field of
7 healthcare quality and patient safety?

8 A. I do.

9 Q. Have you been disclosed as an expert, giving
10 expert opinion in this lawsuit?

11 A. Not that I know of.

12 Q. Were you contacted by counsel regarding the
13 possibility --

14 MR. BILLEK: Object to form.

15 Don't answer that question. I think that
16 imposes upon the attorney-client privilege.

17 MR. HVIDT: I'm not asking a question that's
18 designed to elicit attorney-counsel advice or reveal
19 any work product.

20 I am going to be presenting a document
21 that's been produced by Dr. Romano that will speak to
22 this.

23 MR. BILLEK: Fair enough. If we've produced
24 communications between my firm and Dr. Romano, then
25 you're fair to discuss them.

1 (Exhibit 3 was marked for
2 identification.)

3 BY MR. HVIDT:

4 Q. You can set your CV to the side.

5 I'm handing you what has been marked as
6 Exhibit 3 in the Dr. Romano deposition.

7 Dr. Romano, do you -- you work for
8 UC Davis Health Center.

9 Is that correct?

10 A. I work for UC Davis Health is the entity,
11 yes.

12 Q. Okay. And through your work with
13 UC Davis Health, do you have an e-mail associated with
14 that work?

15 A. Yes.

16 Q. And does that e-mail keep records of e-mails
17 you have sent in the past?

18 A. Of course.

19 Q. And they include timestamps as to when those
20 e-mails were sent or received?

21 A. Of course.

22 Q. And do you send e-mails in the course of --
23 in the regular course of your business?

24 A. Yes.

25 Q. Okay. And if you look here at the document

1 I've handed to you, if you could flip to the third
2 page, which is folded under Romano, the little one
3 says Romano 6 -- the one at the bottom of the page
4 says Romano 6, and then there's one just above it that
5 says Romano 43.

6 Do you see that?

7 A. Yes.

8 Q. Okay. So we're going to be using the little
9 one today due to the nature in which these documents
10 were produced.

11 So this document was produced as Romano 41
12 and we're looking now at Romano 43.

13 Do you see the e-mail from Missy Danforth to
14 you?

15 A. Yes.

16 Q. Okay. And what is Missy writing to you
17 about in this e-mail?

18 A. Well, she's writing me to remind me that
19 five Tenet hospitals have filed suit against Leapfrog
20 and that they were considering retaining me as an
21 expert.

22 Q. And what is the date of this e-mail?

23 A. August 12th.

24 Q. And did you discuss with counsel after Missy
25 sent you this e-mail?

1 A. Yes.

2 Q. If you flip over to the front of the page,
3 do you see where y'all are reaching out about the
4 timing of setting up that call?

5 A. Yes.

6 Q. And you can set that document to the side.
7 (Exhibit 4 was marked for
8 identification.)

9 MR. HVIDT: Thank you.

10 BY MR. HVIDT:

11 Q. I'm handing you what's been marked as
12 Romano Exhibit 4, which is Bates stamped Romano 3.

13 Looking at the top of the page, there's an
14 e-mail from Patrick Romano dated August 14th to
15 Kimberly Blair at Wilson Elser regarding Leapfrog
16 methodology.

17 Do you see that?

18 A. Yes.

19 Q. And if you look down at the e-mail, bottom
20 of the page, do you see where Ms. Blair is thanking
21 you for discussing the lawsuit with you -- with her?

22 A. Yes.

23 Q. She also attaches a copy of the Nicholson
24 report.

25 Do you see that?

1 A. Yes.

2 Q. Okay. And then she asked that you provide
3 her with your CV and rates for limited engagement as a
4 consulting expert.

5 Do you see that?

6 A. Yes.

7 Q. Did Leapfrog or Wilson Elser retain you as a
8 consulting expert?

9 A. No.

10 Q. And what transpired between this e-mail and
11 that decision?

12 A. Well, I think --

13 MR. BILLEK: Again, Doctor, it's my position
14 that he's not entitled to ask you about communications
15 with counsel. So if you can provide a response to him
16 that does not infringe upon those conversations, then
17 you're invited to do so, but please keep in mind that
18 limiting instruction.

19 THE WITNESS: I received a subpoena to
20 produce information and to appear at deposition as a
21 fact witness.

22 BY MR. HVIDT:

23 Q. And -- thank you.

24 And would you agree with me that before that
25 occurred, The Leapfrog Group and Wilson Elser were

1 interested in considering you to serve as a consulting
2 expert on behalf of Leapfrog in this matter?

3 A. They were interested but no decision had
4 been made.

5 Q. Do you have an understanding as to what they
6 considered you to have an expert opinion -- an
7 expert -- they considered you to be an expert in as it
8 related to the subject matter of this lawsuit?

9 A. I believe they considered me to be an expert
10 in hospital safety measures and specifically in the
11 process that Leapfrog Group has used to assess those
12 measures and incorporate them into the hospital safety
13 grade.

14 Q. And when you say Leapfrog's hospital safety
15 grade, what do you -- what is the Leapfrog hospital
16 safety grade, in your own words?

17 A. It is a composite score, which is mapped to
18 a grade from A to F that assesses the overall
19 performance of hospitals on a variety of structural
20 process and outcome measures related to healthcare
21 safety.

22 Q. Do you have an understanding of what the
23 purpose of assigning -- Leapfrog's purposes in
24 assigning hospitals a safety grade?

25 A. Yes.

1 Q. And what is your understanding of that
2 purpose?

3 A. I think their primary purpose is to drive
4 improvements in safety to help make healthcare safer
5 for all Americans, and particularly to use market
6 levers based on transparency and accountability to
7 drive that improvement.

8 Q. Does Leapfrog intend for consumers to rely
9 on the hospital safety grades when they're making
10 decisions about what hospital to go to?

11 A. I'm not in the best position to vouch for
12 Leapfrog's intent since I don't serve on Leapfrog's
13 board. I'm not their CEO. I think that it is one
14 piece of information that should be used in
15 combination with other information.

16 Q. As a member of Leapfrog's hospital safety
17 grade expert panel, do you -- in your advice and your
18 capacity of what you do for them, do you have a -- an
19 understanding that the work that you're doing for
20 them, the advice that you're giving to them, will
21 ultimately lead to a grade that consumers may rely on?

22 A. Can you explain what you mean by the term
23 "rely"?

24 Q. The consumer may look at the grade and make
25 a decision based on that grade.

1 A. Yeah. Decisions should always be made based
2 on multiple sources of information. But, yes, of
3 course, we expect that this will be one source of
4 information that consumers will use in their decision
5 making, as well as the employers, the purchasers that
6 are purchasing healthcare on behalf of consumers.

7 Q. Are all hospitals in the United States
8 assigned a Leapfrog hospital safety grade?

9 A. No.

10 Q. Which hospitals are assigned a hospital
11 safety grade?

12 A. Basically the hospitals that meet the
13 criteria of sufficiency of data. Generally, that
14 means hospitals that participate in the inpatient
15 prospective payment system, the Medicare payment
16 system, and this excludes certain types of hospitals,
17 very small hospitals, most critical access hospitals,
18 veterans affairs hospitals.

19 Q. You mentioned that the grade hospitals that
20 meet the criteria of sufficiency of data.

21 Does that mean that there are hospitals that
22 aren't graded if there's not sufficient data to grade
23 them?

24 A. Correct. Those are very small hospitals
25 that simply don't have enough patients in order to

1 generate estimates for the empirical data that we use,
2 the National Healthcare Safety Network standardized
3 instance ratios, the PSI values, so forth. Many of
4 those measures require a minimum volume of 20 cases,
5 30 cases, so forth. Very small hospitals either don't
6 meet those criteria or they're not obligated to report
7 their data because they're not paid through the
8 Inpatient Prospective Payment System.

9 Q. And that's -- when you mention the
10 Inpatient Prospective Payment System, that's the data
11 that goes to the center for Medicaid and Medicare
12 services which is often abbreviated to CMS.

13 Is that fair?

14 A. Correct.

15 Q. And does Leapfrog have a minimum data
16 requirement where, you know, if there's a certain
17 number of missing process measures, it won't give a
18 hospital a grade?

19 A. They do.

20 Q. And what is the -- that number of missing
21 measures?

22 A. I don't recall the detail offhand.

23 Q. Okay. Do you agree with the notion that if
24 Leapfrog does not have enough data for the hospital,
25 it shouldn't grade it?

1 A. No.

2 Q. You mention, though, that -- just now that
3 there are criteria that Leapfrog needs to have a
4 sufficient amount of data to grade a hospital.

5 So can you connect how -- why that is that
6 you think that Leapfrog -- you need sufficient amount
7 of data to grade it, but you don't agree with the
8 notion that if Leapfrog does not have enough data for
9 a hospital, it shouldn't grade it?

10 A. Well, yes. Because there are two reasons
11 why there may not be sufficient data; right?

12 One reason is the hospital is small and it
13 doesn't have adequate denominator volume, therefore it
14 can't possibly produce enough data.

15 The other possibility is when the hospital
16 deliberately withholds the data by refusing to
17 participate, that's a completely different problem.

18 Q. So you think that the reason for the fact
19 that the data is missing is significant to whether or
20 not Leapfrog should grade the hospital?

21 A. Of course.

22 Q. And when you say that the -- in your words
23 you said that the hospitals refuse to provide the
24 data, are hospitals required to provide Leapfrog with
25 data?

1 A. No. It's a voluntary program.

2 Q. Okay. How often does Leapfrog release
3 safety grades?

4 A. Twice a year.

5 Q. And would you agree that the reason that a
6 hospital doesn't provide Leapfrog with data could be
7 for a number of reasons?

8 MR. BILLEK: Object to form.

9 You can answer.

10 THE WITNESS: Yes.

11 BY MR. HVIDT:

12 Q. And the process through which Leapfrog gets
13 data from hospitals is one of the ways that Leapfrog
14 gets data through its hospital survey?

15 A. Correct.

16 Q. And what is Leapfrog's hospital survey?

17 A. It's an annual survey that incorporates a
18 variety of components addressing safe practices,
19 addressing computerized physician order entry systems,
20 bar code medication administration systems, hospital
21 volumes for various services, et cetera.

22 Q. Do you have a role in designing or reviewing
23 the hospital survey?

24 A. I do not have a direct role in designing and
25 reviewing the survey. I'm aware of some of the

1 contents, but I don't have a direct role.

2 Q. Do you have an indirect role?

3 A. As I say, I have an interest in the content
4 of the survey as a member of the hospital safety grade
5 expert panel, so I periodically review the survey, the
6 components of the survey. And of course I'm also
7 employed by a health system and so in that capacity as
8 well, I periodically review the survey.

9 Q. Have you ever completed the survey?

10 A. I have not personally completed the survey,
11 no.

12 Q. Do you know how long the hospital survey is?

13 A. It's long. I can't specify the exact number
14 of items.

15 Q. Do you know approximately how long it takes
16 a hospital to respond to a Leapfrog survey?

17 A. I imagine that it varies substantially
18 across different types of hospitals depending on their
19 size, the complexity, the number of service lines they
20 offer.

21 Q. So what would you -- do you have an estimate
22 of how long it would take for a complex hospital that
23 has a number of service lines to complete the survey?

24 MR. BILLEK: Object to form.

25 You can answer.

1 THE WITNESS: I would say, based on my
2 experience at UC Davis Health, that it might take
3 anywhere from 80 hours to 200 hours of staff time.

4 BY MR. HVIDT:

5 Q. And that time that you're estimating, is
6 that the actual process of completing the survey?

7 A. The actual process of people meeting to
8 discuss how to respond to the survey, yes. Typically
9 it's not one person who's doing all the work.

10 So I'm -- I'm just giving a ballpark
11 estimate based on the number of people I see involved
12 in the task and how the work is divvied up among team
13 members.

14 Q. I understand.

15 And is there time that's spent in terms of
16 implementing certain processes or procedures that the
17 hospitals need to do in order to answer the questions
18 as Leapfrog has set them up?

19 A. Could you clarify the question?

20 Q. Yeah.

21 So, I mean, if I'm answering questions on a
22 given test or before me, there's a time it takes for
23 me to answer those questions. Sometimes I might
24 actually need to do work to develop the answer to
25 those questions.

1 And so I'm asking is there time in addition
2 to the 80 to 200 hours that you estimated that is
3 required for a hospital to develop the information
4 necessary to answer the questions?

5 A. Well, I would say no. And that estimate
6 that I'm ballparking incorporates gathering the
7 evidence necessary to answer the question.

8 Now, if a hospital has systems in place to
9 respond to the survey, then they don't need to repeat
10 the efforts cycle after cycle; right? Because they
11 already have a system in place. They know exactly
12 what to expect for each component of the survey.

13 And so there's perhaps a higher cost in
14 terms of staff time with the first administration, and
15 then with each subsequent administration, they can
16 just rerun a little bit of the SAS code or Python code
17 and get the answers very quickly.

18 So it's quite different, I think, the first
19 time you do it versus subsequent times.

20 Q. Got it.

21 And so you're saying that the burden on the
22 hospital doing it the first time or the first time in
23 a few years is higher --

24 A. Yes.

25 Q. -- than doing it every year?

1 A. Correct.

2 Q. And have you ever heard of hospitals
3 expressing concern about how long it takes to complete
4 the hospital survey?

5 A. Yes.

6 Q. And in what capacity have you heard that?

7 A. In my own capacity as a faculty member who
8 is known to be involved in this at UC Davis Health, as
9 well as, you know, at professional meetings and so
10 forth.

11 Q. So just to break that down, are you saying
12 that your employer, UC Davis, has complained about the
13 burden of the length and time and resources needed to
14 complete the Leapfrog hospital survey?

15 MR. BILLEK: Object to form.

16 You can answer.

17 THE WITNESS: Yes.

18 BY MR. HVIDT:

19 Q. And you also mentioned in other professional
20 meetings.

21 Can you elaborate further on what those
22 professional meetings or in what capacity someone
23 communicated that there is a burden to completing the
24 Leapfrog hospital survey?

25 A. I'm not going to recall details because it

1 would be pre-pandemic when we went to meetings more
2 frequently. But of course it's been known for a while
3 that I've been involved in the Leapfrog process, so
4 periodically somebody might buttonhole me at an
5 academy health meeting or at a quality and safety
6 related meeting and sort of lobby me to...

7 Q. Reduce the burden?

8 A. To reduce the burden.

9 Q. Okay. And have you heard in your capacity
10 as a -- during the expert safety panel meetings for
11 Leapfrog's hospital safety grade, have you heard of or
12 discussed among that panel the burden that it takes to
13 complete the survey?

14 A. It has been discussed intermittently.

15 Q. Have you ever discussed with Leapfrog
16 personnel the burden it takes to complete the survey?

17 A. Yes.

18 Q. Have you ever communicated then your view
19 that they should reduce the burden to complete the
20 Leapfrog hospital survey?

21 A. I have suggested that, yes.

22 Q. So do you have any understanding to what
23 Leapfrog uses the data that it collects through the
24 hospital survey for?

25 A. That's a vague question.

1 Q. Yeah.

2 A. I have some understanding, yes.

3 Q. Okay. And what's your understanding?

4 A. Well, they -- there's a Safe Practices 1 and
5 Safe Practices 2 score that are derived from certain
6 components of the survey. And then there's a
7 component related to ICU physician staffing. There's
8 a component related to hand hygiene. And there are
9 components related to computerized physician order
10 entry and bar code medication administration.

11 Q. So is it fair to say that a portion of the
12 hospital's answers to the hospital survey are used as
13 a component in determining a hospital's safety grade?

14 A. Yes.

15 Q. Are there aspects to the hospital survey or
16 answers or information that are provided that go to --
17 that don't contribute to the hospital safety grade?

18 A. There are, yes.

19 Q. And does Leapfrog use the data it gets from
20 the hospital survey for purposes other than just
21 determining a hospital's safety grade?

22 A. They do.

23 Q. And what purposes do they use that data for?

24 A. Well, they have other transparency related
25 purposes. So if you go to the Leapfrog website, you

1 can find other information about hospitals that comes
2 from the survey that is not actually scored into the
3 hospital safety grade.

4 And of course they also make datasets
5 available to researchers and other members -- there
6 are members and other interested stakeholders.

7 Q. Do you have any understanding that Leapfrog
8 licenses its data for revenue?

9 A. Yes.

10 Q. And what is your understanding of their
11 licensing practices?

12 A. Well, I don't really know details about the
13 fees that they charge or the licensing mechanisms. I
14 know that they make the data available to researchers
15 at a very reasonable price.

16 Q. Mr. Romano, do you use e-mail regularly in
17 your professional capacity for -- as it relates to
18 your work with Leapfrog with an expert safety panel?

19 A. I do.

20 I just remind you, I'm a doctor.

21 Q. I'm so sorry, sir.

22 Dr. Romano, do you understand that people
23 rely on what you write in the e-mails that you provide
24 them?

25 A. Yes.

1 Q. And as a safety grade expert panelist, you
2 understand that Leapfrog takes seriously your
3 recommendations?

4 A. I hope they do.

5 Q. And you understand that Leapfrog might make
6 certain decisions based on what you recommend to them.

7 Is that fair?

8 A. Always in combination with other sources of
9 input, yes.

10 Q. And so when you are writing e-mails, do you
11 try to be accurate with the information that you're
12 providing to Leapfrog?

13 A. I try to be accurate.

14 Q. And you intend for your e-mails to be taken
15 seriously.

16 Is that fair to say?

17 A. I do. I sometimes may fail to achieve the
18 highest levels of accuracy, but I always endeavor to
19 be accurate.

20 Q. And you try to be clear and honest with
21 those communications with them.

22 Is that fair to say?

23 A. I do.

24 Q. We've talked a little bit about Leapfrog
25 safety expert panel.

1 How long have you served on the expert
2 panel?

3 A. I didn't review the full history. My guess
4 is since about 2013 or '14.

5 (Exhibit 5 was marked for
6 identification.)

7 BY MR. HVIDT:

8 Q. I'm handing you what the court reporter just
9 stamped as Exhibit 5.

10 A. I stand corrected.

11 Q. And that was not the purpose of this
12 introduction, as 2013 is a long time ago as well.

13 But I'm handing you a document that's
14 Bates labeled and produced in this litigation as
15 Leapfrog 3088977.

16 Dr. Romano, do you see the document I've
17 handed you?

18 A. I do.

19 Q. And if you look at it, do you see the title
20 page appears to be "Board Update Progress on Safety
21 Score" dated September 20, 2011? Do you see that?

22 A. Yes.

23 Q. Does this look familiar to you?

24 A. No.

25 Q. Do you understand that Leapfrog prepares

1 documents in the regular course of business?

2 A. Of course.

3 Q. Do you have any -- looking at this, do you
4 have any reason to believe that this is not a true and
5 accurate representation of the document that was
6 prepared before you?

7 A. I do not.

8 Q. Looking at the first page, it lists
9 Matt Austin, doctor Ph.D. as a survey director.

10 Do you see that?

11 A. Yes.

12 Q. Do you know who Matt Austin is?

13 A. Yes.

14 Q. Who is Matt Austin?

15 A. Matt Austin is a Ph.D. trained health
16 services researcher who is now at the Johns Hopkins
17 University Armstrong Institute for Patient Safety.

18 Q. Does he have any affiliation
19 with The Leapfrog Group?

20 A. Yes. His team is under contract with
21 The Leapfrog Group to perform many of the analyses
22 that go into the hospital safety score.

23 Q. So when you say he's under contract
24 with The Leapfrog Group, is that different than
25 serving on the expert panel?

1 A. Yes.

2 Q. Okay. So your service on the expert panel
3 is not pursuant to a contract.

4 Is that fair to say?

5 A. That's correct. I'm a volunteer.

6 Q. And do you communicate with Matt Austin?

7 A. I do.

8 Q. When was the last time you spoke with him?

9 A. Spoke with him?

10 Q. Yes.

11 A. A few months ago. I can't recall an exact
12 date.

13 Q. Have you ever communicated with him about
14 this lawsuit?

15 A. No.

16 Q. Let's look over to -- flip the page to the
17 Bates number ending in 7 -- 979. You're looking at
18 that page right now.

19 Do you see where it says "Safety Score
20 Expert Panel"?

21 A. I do.

22 Q. Is the -- what was listed as safety score
23 expert panel similar to the -- what's now referred to
24 today as the safety grade expert panel?

25 A. Yes.

1 Q. And looking down at that list, do you see
2 your name there?

3 A. Of course.

4 Q. Does this refresh your recollection that you
5 may have been on the expert safety panel dating back
6 to 2011?

7 A. Yes.

8 Q. Flipping over a few pages to the page ending
9 in 8994.

10 Do you see where it says at the top there
11 "Meeting for Missing Data"?

12 A. Yes.

13 Q. Was how to deal with missing data a topic
14 that Leapfrog was trying to -- in this expert panel,
15 was trying to figure out as far back as 2011?

16 A. Yes.

17 Q. And why -- you know, when you have missing
18 data, what's the challenge there? Like what -- can
19 you explain to me like what -- why does one need to
20 handle missing data when you are trying to grade, you
21 know, a set of, in this instance, hospitals?

22 A. Well, it's very important for the program to
23 be able to grade as many hospitals as possible to
24 serve the mission of meeting the needs of the
25 community.

1 So we always have to carefully consider how
2 to respond to missing data points, and there are a
3 variety of strategies for substituting values over
4 addressing missing data. But it's a very common
5 problem in a wide variety of context, research,
6 evaluation.

7 Q. And down below the title, it mentions that
8 there were three different strategies for handling
9 missing values.

10 Do you see that?

11 A. Yes.

12 Q. What's Option 1?

13 A. Basically to drop the measure entirely from
14 the algorithm so that it wouldn't be used for anybody
15 for any purpose.

16 Q. I understand.

17 So is that like a circumstance where if the,
18 you know, data on how many patients a hospital saw was
19 just not a data point that you could get for all the
20 hospitals, you just wouldn't grade them on the number
21 of patients that the hospitals see?

22 A. You would remove that entirely from the
23 grade, correct.

24 Q. Okay. And then what's the next strategy
25 that was outlined?

1 A. To drop the measure only for the facilities
2 that are missing data.

3 Q. And how would that work?

4 A. Well, in general, how that would work is
5 that you would take out those measures for the
6 hospitals that are missing data and then you would
7 redistribute the weight among all the other items in a
8 proportional way so that you would still generate a
9 score but it would be a score without those missing
10 measures.

11 Q. Does Leapfrog's current methodology utilize
12 that strategy for some missing data?

13 A. It does.

14 Q. And what missing data does Leapfrog apply
15 that strategy for?

16 A. I believe for the safe practices survey,
17 SP1, SP2.

18 Q. And does Leapfrog apply that strategy for
19 all missing data in its current methodology?

20 A. No.

21 Q. And if you look down to the third strategy
22 listed there, what's the third strategy there?

23 A. To impute an estimated score for those that
24 are missing data. That is, to substitute or replace
25 the missing value with an estimated value.

1 Q. And so when you impute, you're estimating a
2 value.

3 Is that fair to say?

4 A. Yes.

5 Q. You don't have actual data on them. You are
6 just estimating what the data would be had you had it?

7 A. Well, there are a variety of counterfactual
8 possibilities in that estimation. But, yes, it --
9 generally the term imputation implies an estimation
10 procedure.

11 Q. Got it.

12 Okay. So that would be a good starting
13 point.

14 What does impute mean to you? That's not a
15 term that I often come across. What does impute mean
16 to you?

17 A. Well, it means to substitute a numerical
18 value for the missing value.

19 Q. Got it.

20 And so you would only impute something if
21 you were missing the data that you need to get a score
22 for.

23 Is that fair?

24 A. In general. Obviously there are cases where
25 the reported data may be manifestly invalid, in which

1 case you might choose to ignore the reported value and
2 to impute a value instead.

3 For example, if the reported value were
4 outside the plausible range or manifestly inconsistent
5 with other information that you have, you might impute
6 a value even when there was a reported value.

7 Q. Got it.

8 So like if I said if I had a major league
9 baseball ERA of 0.02, we might impute the actual fact
10 that I just have never pitched for major league
11 baseball before?

12 A. Yeah.

13 Q. Okay. And if you look down at the -- below
14 those three options, it says, in a review of the
15 literature, it noted a number of thresholds for when
16 to drop the measure.

17 Do you see that?

18 A. Yes.

19 Q. Do you know what literature was being
20 referred to there?

21 A. I can't say exactly. Obviously Ashish Jha
22 is I think a respected leader in epidemiology and
23 health services research, so I'm confident that he did
24 a reasonable review of the literature.

25 Q. Got it.

1 Okay. And then noted that -- below the
2 literature, in order come up with the right process
3 for dealing with missing data, Leapfrog -- or one
4 should take into account two factors.

5 Do you see those?

6 A. Yes.

7 Q. Can you explain what those factors are?

8 A. Well, the first factor appears to be
9 referring to the extent of missing data versus the
10 pattern. In other words, if there were 70 percent
11 missing data versus 30 percent, that might be a
12 relevant consideration. And particularly if the
13 missing data are concentrated in certain geographic
14 regions. For example, if there is a clearly
15 identifiable pattern to the missing data, that might
16 affect the approach.

17 The second bullet refers to whether the -- a
18 random versus systematic pattern, a random error would
19 imply that some hospitals that perform well don't
20 report, some hospitals that perform poorly don't
21 report, and there's essentially a random distribution.

22 Systematic would imply that there's some
23 systematic pattern whereby hospitals that know their
24 scores would be poor, choose to fail to report.

25 Q. Got it. Okay. That's helpful.

1 So would you agree that -- strike that.

2 Flipping over to the next page, do you see
3 where it says at the top "Recommendation"?

4 And then --

5 Do you see that?

6 A. Yes.

7 Q. And then do you see down below for -- the
8 second outer bullet says "For hospitals not excluded,
9 we need an empirically driven approach to handling
10 missing data"? Do you see that?

11 A. Yes.

12 Q. And then it lists "Test different thresholds
13 for dropping the measure. And test three to four
14 different imputation methods."

15 Do you see that?

16 A. Yes.

17 Q. Did you agree with that recommendation?

18 A. Well, this is a board update. So I had no
19 role in the board meeting. I don't recall
20 specifically agreeing or disagreeing with the
21 recommendation.

22 Q. And do you see where it says "Test different
23 thresholds for dropping the measure"?

24 A. Yes.

25 Q. When you test the different thresholds, does

1 that imply that there would be some sort of difference
2 in how hospitals who are missing data might be
3 impact -- their grades might be impacted if you
4 dropped the measure?

5 A. Not exactly. I interpret that as -- for
6 example, you could say that if 50 percent of hospitals
7 are missing the measure, we'll drop it. If 40 percent
8 are missing, we'll drop it. If 60 percent are
9 missing, we'll drop it.

10 So I think when they're referring to
11 different thresholds, they're referring to the
12 percentage availability.

13 Q. Got it. That's helpful.

14 So looking down for the testing the three to
15 four different imputation methods, do you see the
16 subbullet there where it says "Examine how sensitive
17 hospital rankings are to each approach tested"? Do
18 you see that?

19 A. Yes.

20 Q. And so as it relates to that substance of
21 testing the imputation methods, do you interpret that
22 to mean whatever imputation method you might choose
23 might determine how sensitive the hospital rankings
24 are to an imputation that gives the hospitals a higher
25 versus a lower imputed score?

1 A. Yes. Different methods will yield different
2 results.

3 Q. Then one more slide on this document to look
4 at, if you could flip to the page ending in 89000.

5 A. "Outstanding Considerations"?

6 Q. Yes, sir.

7 Do you see there the second bullet? Can you
8 read that for me?

9 A. "How Leapfrog hospitals fair versus those
10 not participating in survey."

11 Q. What do you interpret that to mean?

12 A. Meaning there would be ongoing discussion to
13 monitor how hospitals that participate in the survey
14 compare with those that don't.

15 Q. Was the expert safety panel concerned that
16 there might be differences between how hospitals who
17 participate in the survey would be treated in the
18 grade versus those that didn't?

19 MR. BILLEK: Just note my objection to the
20 form of the question.

21 You can answer.

22 THE WITNESS: Yes. The panel was very
23 interested in that issue.

24 BY MR. HVIDT:

25 Q. And were you concerned with that issue?

1 A. Can you rephrase the question?

2 Q. Absolutely.

3 Did you have a concern or a view towards how
4 the Leapfrog safety grade should treat hospitals who
5 participate in the survey versus didn't participate in
6 the survey?

7 MR. BILLEK: And just to clarify, so I
8 understand the question, again, that's in connection
9 with this 2011 document and the data that went into
10 it?

11 MR. HVIDT: Yes.

12 BY MR. HVIDT:

13 Q. In 2011, around the time that we were
14 talking about the outset of the Leapfrog hospital
15 safety grade, did you have a concern or view to how
16 the Leapfrog safety grade should treat hospitals who
17 participate in this survey versus those that didn't
18 participate in the survey?

19 A. Well, I'm sure I had a view, but it was
20 14 years ago, and I'm not going to recall the details
21 of what my view was 14 years ago.

22 Q. Do you recall the views of the expert safety
23 panel at the time?

24 A. I -- again, all I recall was that it was a
25 topic of ongoing discussion throughout these 14 years.

1 And so the question has come up repeatedly, and it's
2 been addressed in different ways over the years.

3 Q. So throughout the last 14 years, there's
4 been questions of how to treat nonresponding --
5 hospitals who don't respond to the Leapfrog hospital
6 survey; correct?

7 A. Correct.

8 Q. And what is the issue that has been
9 discussed over the last 14 years as it relates to the
10 Leapfrog -- as it relates to the hospitals that don't
11 participate in the Leapfrog hospital survey?

12 A. Can you try that again? I'm sorry.

13 Q. Yeah.

14 So I'm trying to understand what's the --
15 what are the points of discussion around how to treat
16 hospitals who don't participate in the survey in the
17 Leapfrog safety grade?

18 A. Right.

19 Well, I would say in general terms -- and
20 please don't assign this view to any particular
21 meeting or any particular discussion -- but in general
22 terms, we started with the view that if a hospital
23 chose not to participate, that we should assign them
24 the best grade that we could based on other sources of
25 similar information about the hospital; right?

1 So we started with the counterfactual
2 perspective of what would this hospital have told us
3 if they had chosen to respond to the survey?

4 So in the early years, we tried to find the
5 best estimate of what hospitals would have told us if
6 they had chosen to participate in the survey.

7 Over time, that perspective changed for a
8 variety of reasons.

9 Q. When you say that you started with "the best
10 estimate," by "best," do you mean the closest to being
11 accurate?

12 A. Yes. I'm using "best" in the analytic term,
13 the best linear unbiased estimator of the true
14 parameter of interest. Yes.

15 Q. And so Leapfrog at the outset started off by
16 trying to impute for missing data for nonresponding
17 hospitals the most accurate imputed score that it
18 could under a counterfactual had that hospital
19 participated in the survey.

20 Is that fair?

21 A. Yes.

22 Q. And Leapfrog has changed from that starting
23 point since 2011.

24 Is that fair to say?

25 A. Yes.

1 Q. And how has it changed?

2 A. So it has adopted an approach for several
3 components of -- well, let me back up a second.

4 The primary data source that Leapfrog was
5 relying on to do that imputation was the
6 American Hospital Association survey. That's a survey
7 that is also voluntary but it enjoys an even higher
8 participation rate than the Leapfrog survey because
9 it's completed by most hospitals that belong to the
10 American Hospital Association.

11 The American Hospital Association survey
12 included some items related to computerized physician
13 order entry, clinical decision support systems,
14 et cetera. And so that survey allowed Leapfrog to
15 identify hospitals similar to nonresponding hospitals
16 and to use those survey estimates to generate imputed
17 estimates for the missing data.

18 Over the --

19 Q. Sorry. Go ahead.

20 Go ahead.

21 A. Well, I was going to say, and that worked
22 satisfactorily for several years. But then the
23 American Hospital Association chose, for reasons
24 unknown to me, no longer to make their survey data
25 available for this purpose. And so Leapfrog was

1 obligated to identify alternative approaches.

2 Q. And did -- fair that the American Hospital
3 Association data licensing arrangement, that that --
4 that stopped around 2020? Does that sound about
5 right?

6 A. Yes. Plus or minus a year, yes.

7 Q. But based on -- just trying to understand
8 that.

9 So before -- before the American Hospital
10 Association stopped serving as the basis for an
11 imputed score, Leapfrog would use the data that was
12 reported to -- by the hospitals to American Health
13 Association to impute a score for Leapfrog's safety
14 grade.

15 Is that fair?

16 A. American Hospital Association, yes.

17 Q. Yes. I'm sorry. So I said
18 American Health Association, and you're just saying
19 it's American Hospital Association.

20 But everything else in that prior --

21 A. Yes.

22 Q. -- question was correct. Okay.

23 A. Yes.

24 Q. And so after the American Hospital
25 Association stopped providing Leapfrog with the data,

1 how did Leapfrog's imputation methodology change?

2 A. So there -- there was a method that relied
3 heavily on previous scores for hospitals that had
4 responded to the survey in previous cycles. So I
5 think they went back to four rounds. I think that
6 would correspond to two previous years of the hospital
7 survey and used the most recent of those previous
8 responses. I think that was Step 1 in the process.

9 And there would then be a Step 2 that would
10 use information from similar hospitals that did
11 respond to the Leapfrog survey.

12 Q. And what years did Leapfrog follow that
13 general approach that you just described?

14 A. I couldn't testify to the exact years.

15 Q. Are they still following that current
16 imputation methodology?

17 A. No --

18 MR. BILLEK: Objection to form.

19 THE WITNESS: No. A further revision was
20 made more recently.

21 BY MR. HVIDT:

22 Q. Did you have any involvement in determining
23 or recommending the imputation methodology that
24 Leapfrog should use after the American Hospital
25 Association stopped providing data?

1 A. I did.

2 Q. What was your role?

3 A. As a member of the expert panel, it's been
4 an ongoing topic of discussion.

5 Q. Did you work with Mathematica in making a
6 recommendation to Leapfrog what imputation methodology
7 it should use a few years back?

8 A. Yes.

9 Q. And what is Mathematica?

10 A. Mathematica is a large employee-owned
11 consultancy that does a lot of work related to
12 healthcare quality and safety for a variety of public
13 and private clients.

14 Q. And do you have an understanding of what --
15 that Leapfrog entered into a consultant arrangement
16 with Mathematica?

17 A. Yes.

18 Q. And do you have an understanding of what
19 Leapfrog asked Mathematica to perform for them here?

20 A. I'm afraid I'm not privy to the details of
21 the consulting agreement.

22 Q. And we were talking about how the
23 methodology changed over time and you mentioned it
24 changed more recently.

25 How did Leapfrog's hospital safety grade

1 methodology change recently as it relates to the
2 imputation methodology?

3 A. Right.

4 So the Step 1 component was changed to
5 reduce the number of cycles of previous data that
6 would be used so that it now counts essentially only
7 one previous hospital survey. In other words, if a
8 hospital responded to a survey in the previous year
9 and skipped the most recent year, they would get
10 credit for that previous year.

11 If they didn't respond in either of these
12 two years, then the Step 2 method now assigns the
13 limited achievement value for three or four components
14 that are linked to the survey.

15 Q. And when you say "limited achievement
16 value," is that the lowest score that can be assigned
17 by the Leapfrog hospital safety grade methodology for
18 those measures?

19 A. That's correct.

20 Q. And going back to your answer several times
21 here, you mentioned that there were reasons that the
22 Leapfrog safety grade methodology has changed.

23 Can you, in your own words, describe for me
24 what you understand those reasons to be?

25 A. What aspect of the methodology are you

1 referring to?

2 Q. The imputation methodology, how Leapfrog is
3 handling missing data.

4 A. Yeah. Well, there are a variety of
5 considerations. So from the beginning, we've
6 maintained this 50/50 balance of structure and process
7 versus outcome measures. That's probably the only
8 thing that hasn't changed, aside from the A to F
9 scale.

10 Each year of course the survey changes in
11 various ways. In particular, I think some components
12 of the survey were retired or removed. Additional
13 measures become available. And so as those additional
14 measures become available, we have to decide how those
15 measures should be weighted and what should be done if
16 those measures are missing.

17 And then of course the decisions are made
18 about the overall distribution of the score and where
19 the specific cut points are drawn.

20 Our panel is not directly involved in
21 drawing the cut points that set the various grades,
22 but we are involved in all the steps prior to that.

23 Q. I understand.

24 So going back, you had mentioned that back
25 at the outset, around 2011 time frame, Leapfrog tried

1 to estimate through the imputed measure the most
2 accurate score for the nonresponding hospitals, and
3 that changed over time.

4 Is that correct?

5 A. Yes.

6 Q. And you mentioned that there were reasons
7 that Leapfrog changed how it treated nonresponding
8 hospitals and no longer trying to estimate the most
9 accurate score for those nonresponding hospitals.

10 Is that correct?

11 A. Yes.

12 Q. And can you describe for me what those --
13 you understand those reasons were for that change?

14 A. So we're now referring to the most recent
15 change, not the change that happened when the license
16 to AHA was lost?

17 Q. Correct.

18 A. Right.

19 So I think the most recent change was driven
20 by several factors.

21 One was by complaints from participating
22 hospitals that some nonparticipating hospitals
23 essentially were getting favorable treatment, that
24 they were getting rewarded for not participating.
25 Because the substitute values had shifted so far to

1 the right over time, so there was concern about
2 fairness towards participating hospitals.

3 There was also concern about the
4 sustainability of the program because of a decrease
5 in participation rates that was observed and reported
6 to our panel.

7 And I would say finally, there was some
8 concern about a worsening of a systematic bias whereby
9 some of the hospitals that were not participating were
10 clearly hospitals that were doing poorly on other
11 metrics and were probably worse than average
12 hospitals. So essentially by not participating, they
13 would get their score boosted in an unfair manner.

14 Q. So looking at those three reasons that you
15 mentioned, let's talk briefly about that first one.

16 Do you have an understanding that the -- the
17 imputed scores that were being provided under Step 2
18 for the Leapfrog imputation methodology were getting
19 better for -- for those nonparticipating hospitals?

20 Is that fair?

21 A. Yes.

22 Q. And is it fair to say that a reason that
23 those imputed scores might have been getting higher is
24 that the hospitals that were participating in the
25 survey were giving themselves higher grades, on

1 average?

2 A. No. That would be incorrect. They're not
3 giving themselves the grades. They're responding to
4 the survey. And the key components of the survey
5 essentially require auditing, you know. They require
6 a very standardized procedure that can be verified.

7 Q. The -- how many hospitals does Leapfrog
8 audit a year?

9 A. I don't know the exact number that they
10 audit.

11 Q. Is it fair to say it's a small percentage?

12 A. Yes.

13 Q. Is it possible that hospitals answer
14 questions to a Leapfrog survey in a favorable manner
15 that is designed to -- you know, that will lead to a
16 higher score on the Leapfrog hospital safety grade?

17 A. Aside from the SP1, SP2 component, I find it
18 implausible; right? Because, for example, the CPOE
19 component requires that you actually run some specific
20 patient information through your electronic health
21 records system and document the output of that.

22 So it would be difficult -- it would be more
23 difficult to lie than it would be to produce the true
24 information. I mean, you'd have to deliberately
25 manipulate your electronic health record system behind

1 the scenes to produce misleading information.

2 Q. For the CPOE one, is it fair to say that if
3 you have the tool for the software, that you just
4 simply need to use that tool to get a high score on
5 Leapfrog's safety grade?

6 A. Yes.

7 Q. For the hand hygiene score, Leapfrog imputes
8 that measure for nonresponding hospitals.

9 Is that right?

10 A. Yes.

11 Q. And does Leapfrog's questions on the survey
12 ask if every nurse and doctor washes their hands after
13 every patient interaction?

14 A. No. I think that component of the survey is
15 based on direct observation sample of employees and
16 encounters.

17 Q. And it simply asks if you have a policy to
18 use good hand hygiene practices.

19 Is that fair to say?

20 A. No. I think it asks if you do a particular
21 type of direct observation, to monitor and report that
22 adherence.

23 Q. And does Leapfrog audit how the observation
24 of the hand hygiene practices?

25 A. Not to my knowledge.

1 Q. The second rationale you mentioned was that
2 there had been a concern over the sustainability of
3 the program.

4 Do you recall that?

5 A. Yes.

6 Q. What was that concern?

7 A. Well, just as the -- if the participation
8 rates continue to drop, then the overall program
9 becomes less useful to consumers, to purchasers, and
10 other stakeholders.

11 Q. Was Leapfrog concerned that hospital
12 participation in its survey had dropped in 2024?

13 A. Yes.

14 Q. Was the hospital dropped in survey
15 participation one of the reasons that Leapfrog changed
16 its imputation methodology?

17 A. It was one of the factors, among the two
18 others I mentioned, yes.

19 MR. HVIDT: We've been going for about an
20 hour. Do you want to take a quick break?

21 MR. BILLEK: We can take a break.

22 THE VIDEOGRAPHER: Off the record 10:43 a.m.

23 (Break taken in proceedings.)

24 THE VIDEOGRAPHER: On the record 10:59 a.m.

25 MR. HVIDT: Dr. Romano, I'm handing you

1 what's been marked as Exhibit 6 and produced in this
2 litigation as Leapfrog 3046954. It's titled
3 "Hospital Safety Score Expert Panel Call Notes,
4 August 10th, 2012."

5 (Exhibit 6 was marked for
6 identification.)

7 BY MR. HVIDT:

8 Q. Do you see that?

9 A. Yes.

10 Q. Looking through this document, have you seen
11 this before?

12 A. I don't recall having seen it before.

13 Q. If you look at the attendees, do you see
14 your name listed there at the end of the first line,
15 carrying over onto the second?

16 A. Yes.

17 Q. Do you have any reason to dispute that you
18 were at that meeting?

19 A. No, I do not.

20 Q. If you look down to where it says "Goals of
21 the call," do you see that?

22 A. Yes.

23 Q. And goal No. 3 is to "Set out clear guiding
24 principles for Leapfrog to use."

25 Do you see that?

1 A. Yes.

2 Q. You mentioned those guiding principles
3 earlier, do you recall?

4 A. Yes.

5 Q. And if you look down under the category
6 "Debrief on first round of scores" on the bottom half
7 of the first page.

8 Do you see that section?

9 A. Yes.

10 Q. Around the fifth line of that large
11 paragraph, a few words in, it says "Patrick."

12 Do you see that?

13 A. Yes.

14 Q. Do you see that that "Patrick" is probably
15 referring to you when you look at the attendees there?

16 A. I'm sure it is.

17 Q. Okay. Can you read to me that sentence
18 beginning with "Patrick"?

19 A. "Patrick liked the idea of an
20 imputation approach that gives hospitals
21 an" quote, unquote "average score instead
22 of a low score."

23 Q. Do you recall liking that idea?

24 A. Yes.

25 Q. Can you explain what that idea really is

1 that you liked back in 2012? What did that mean?

2 A. Well, again, the idea was to use the best
3 counterfactual estimate of what the missing data would
4 have been if it were actually reported. So to use
5 empirical methods to estimate the missing data
6 typically based either on the same data from other
7 hospitals or other data elements from the same
8 hospital.

9 Q. Got it.

10 So in 2012 you liked the idea of using the
11 best counterfactual estimate of what the missing data
12 would have been had the hospital reported instead of a
13 low score.

14 Is that fair to say?

15 A. Yes.

16 Q. And as we were just discussing, that's not
17 the approach that Leapfrog uses today?

18 A. Correct.

19 Q. You can set that document to the side.

20 Thank you.

21 Bad place for a sticker. Don't want to
22 cover up any words.

23 (Exhibit 7 was marked for
24 identification.)

25 ///

1 BY MR. HVIDT:

2 Q. Doctor, I'm handing you what's been marked
3 as Exhibit 7. I'm so sorry.

4 Exhibit 7 has been produced in this
5 litigation as Leapfrog 3100665. Looking at the top,
6 it's described as an original article titled
7 "Safety in Numbers - the Development of Leapfrog's
8 Composite Patient Safety Score for U.S. Hospitals."

9 Do you see that?

10 A. Yes.

11 Q. And do you see up at the top the volume --
12 or down at the bottom, actually, is a date of
13 April 1st, 2013.

14 Do you see that?

15 A. Yes.

16 Q. And if you look at the authors that are in
17 italics underneath the title, are you one of those
18 authors?

19 A. I was, yes.

20 Q. And are the other authors of this article
21 the expert safety panel for Leapfrog as of 2013?

22 A. Well, I believe that Guy D'Andrea was not a
23 member of the expert panel, but I think -- and of
24 course Matt Austin was not. But from the third author
25 onward, yes, these were the members of our expert

1 panel.

2 Q. And so Matt Austin was -- would you have
3 described him as being involved in the Leapfrog safety
4 score?

5 A. Yes.

6 Q. But just not a member of the expert safety
7 panel?

8 A. Correct.

9 Q. His role is slightly different?

10 A. Yes. It's described in the disclosure at
11 the bottom of the page.

12 Q. Great.

13 Do you recall this publication?

14 A. As much as one might expect from a
15 publication that's 12 years old.

16 Q. And what's your understanding of the purpose
17 or what was done with this article?

18 A. Well, I think the purpose of the article was
19 full transparency, essentially, to describe the method
20 that we used to develop the composite patient safety
21 score and some of the key considerations in the
22 development process.

23 Q. So with this article, y'all were trying to
24 describe what Leapfrog did to create the hospital
25 safety grade methodology.

1 Is that --

2 A. Yes.

3 Q. -- fair to say?

4 A. Yes.

5 Q. And so with this article, y'all were trying
6 to be accurate with the information that you were
7 conveying about the underlying features that go into
8 the methodology?

9 A. Yes.

10 Q. If you look at the first sentence under
11 "Methods" there on the first page, on the left-hand
12 side, it says that "The expert panel assisted in
13 developing the safety grade."

14 Do you see that -- actually, I apologize.

15 We're going to go to the next page, so
16 strike that. The next page ending in Bates No. 666.

17 Do you see "Methods" halfway down on the
18 left-hand side?

19 A. Yes.

20 Q. Do you see where it says:

21 "The Leapfrog Group invited nine
22 national experts to serve on a panel to
23 develop a composite score to evaluate
24 patient safety in U.S. hospitals"?

25 A. Yes.

1 Q. Is that consistent with what you understood
2 your role to be on the expert safety panel?

3 A. Yes. It's been clear from the beginning
4 that The Leapfrog Group has the ultimate
5 responsibility for the design of the composite and the
6 safety grade, but we serve a very important advisory
7 role.

8 Q. And do you know who at The Leapfrog Group
9 has the ultimate responsibility for the design of the
10 composite and safety grade?

11 A. Well, currently it would be Missy Danforth.

12 Q. And what's Missy --

13 A. But obviously Missy reports to the CEO,
14 Leah Binder, and to the board. So ultimately the
15 board and the CEO have the authority.

16 Q. Does The Leapfrog Group board of directors,
17 from your understanding, approve of the -- approve
18 various aspects to the hospital safety grade
19 methodology?

20 A. To my knowledge, they don't get into the
21 details of the methodology. They opine on specific
22 controversial issues that may be brought to them by
23 the staff.

24 Q. So is it the staff that ultimately decides
25 the components of the methodology?

1 A. I think it's fair to say that the vast
2 majority of the decisions are made by staff, yes.

3 Q. And the staff that reports up to
4 Leah Binder.

5 Is that fair to say?

6 A. Yes.

7 Q. If you look down to the next column where --
8 at the bottom, the bolded portion says "Weighting of
9 individual members" -- excuse me -- "Weighting the
10 Individual Measures."

11 Do you see that?

12 A. Yes.

13 Q. And it says that -- going on to the next
14 page, "Measures" -- under "Strength of Evidence" says:

15 "Measures with stronger research
16 evidence carry higher weight than measures
17 with weaker evidence."

18 Do you see that?

19 A. Yes.

20 Q. What does that mean?

21 A. Well, there's a tradition in evidence-based
22 medicine of grading the quality of the evidence. So
23 if the evidence is based on experimental research,
24 that is, intervention research or large prospective
25 studies, that it's considered to be stronger evidence,

1 than if it's based on, for example, case reports or
2 conceptual rationale alone.

3 Q. Got it.

4 And so if you look down, there's a way -- or
5 a numerical value assigned to the strength of
6 evidence.

7 Do you see that?

8 A. Yes.

9 Q. And the first one is 1, and 1 is:
10 "Supported by either suggestive
11 clinical or epidemiological studies or
12 theoretical rationale."

13 Do you see that?

14 A. Yes.

15 Q. And then 2 is:

16 "Supported by experimental clinical
17 or epidemiological studies and strong
18 theoretical rationale."

19 Do you see that?

20 A. Yes.

21 Q. Do you understand what the difference is
22 between "theoretical rationale" and "strong
23 theoretical rationale"?

24 A. I'm not sure I can describe that difference.

25 The key difference in those two statements

1 is "or" versus "and."

2 So Level 1, a theoretical rationale alone
3 would be sufficient.

4 For Level 2, you have to have a strong
5 theoretical rationale in combination with empirical
6 data.

7 Q. Oh, interesting. Okay.

8 So with -- when Leapfrog is imputing a
9 measure, it is lacking evidence of the data for those
10 nonresponding hospitals.

11 Is that fair to say?

12 A. This has nothing to do with imputation.

13 Q. Is a score that is imputed assigned a weight
14 by Leapfrog's grading methodology?

15 A. The weight is determined -- the weight for
16 each component in the composite is determined by all
17 of these factors, but the weight is orthogonal. It's
18 unrelated to the issue of imputation.

19 Q. When a hospital submits a survey for hand
20 hygiene, it gets a -- there's a weight ascribed to the
21 score that Leapfrog assigns it for that hand hygiene.

22 Is that correct?

23 A. Yes.

24 Q. And does that weight for hand hygiene change
25 for that metric for nonresponding hospitals?

1 A. No.

2 Q. Does Leapfrog have more --

3 A. With one exception, which is that if the
4 data -- so the safe practices components, as we
5 mentioned, are not counted if the hospital didn't
6 respond in the survey. That shifts a little bit more
7 weight onto the -- all the other components, and
8 therefore, for example, the hand hygiene component
9 could get a little bit more weight for those
10 nonresponding hospitals.

11 Q. So --

12 A. But it's because of the shifting of weight
13 among the components.

14 Q. So when a hospital doesn't respond to the
15 survey, the hand hygiene score gets a higher weight
16 than it does for a hospital who does respond to the
17 survey due to the shifting of the weight because three
18 measures were taken out.

19 Is that fair to say?

20 A. Yes. I would need to be reminded about the
21 details of those three measures and how much weight
22 they have to redistribute. But in principle, yes.

23 Q. Understood.

24 And when Leapfrog -- when a hospital
25 responds to the survey for hand hygiene, does Leapfrog

1 have more evidence of how that hospital would perform
2 for the hand hygiene versus when a hospital doesn't
3 participate in the survey?

4 A. Yes.

5 Q. So even though Leapfrog has less evidence
6 how a hospital would respond -- how a hospital's
7 hand hygiene score would be if the hospital doesn't
8 respond to the survey, Leapfrog assigns a higher
9 weight to that score for the nonresponding hospital.

10 Is that fair?

11 A. Well, again, you're mixing up two completely
12 different things.

13 So what you're -- what we've been discussing
14 on page 3 of this paper, 3100667, is about the
15 strength of the evidence supporting the use of the
16 measure.

17 So that has nothing to do with the
18 determination of the imputation method or what we do
19 for missing data. It's two completely separate
20 issues.

21 Q. So I'm struggling to see how they're not
22 connected because the output of determining the weight
23 applied to a measure is actually applied to the score
24 that Leapfrog generates for hospitals.

25 Is that correct?

1 A. Try that again.

2 Q. So Leapfrog determined -- using this formula
3 of evidence and impact and opportunity, Leapfrog
4 determines a weight to apply for a metric that's
5 included in Leapfrog's hospital safety grade?

6 A. Yes.

7 Q. And that weight is actually used during the
8 scoring of a hospital.

9 Is that correct?

10 A. Yes.

11 Q. And this formula isn't changed for weighting
12 of a measure if a hospital doesn't participate in the
13 survey.

14 Is that correct?

15 A. Yes.

16 Q. And so the weight that's applied was -- one
17 of the factors that went into that weight is the
18 strength of the evidence of that weight.

19 Is that correct?

20 Strength of the evidence of that measure?

21 A. The strength of the evidence supporting the
22 use of that measure.

23 Q. And are you saying that this -- that the --
24 it is unrelated to whether or not to use that measure
25 if the evidence that's available to Leapfrog is

1 different for nonresponding hospitals?

2 A. Yes. That's unrelated to this question.
3 The strength of the evidence supporting use of the
4 measure is unrelated to the question of the data
5 reported by an individual hospital or not reported by
6 an individual hospital.

7 Q. And if Leapfrog has no evidence to -- of a
8 measure, would that justify changing the weight that's
9 applied to that measure?

10 A. Again, I may not be understanding your
11 question.

12 Obviously the weights have to add up to one.
13 That's a mathematical necessity.

14 So -- so it is necessary if you make the
15 decision to redistribute weights from missing data for
16 any reason, then by necessity the other measures get a
17 little bit more weight.

18 But that's a function of the need to
19 redistribute the weight, the mathematical problem that
20 the weights have to add up to one.

21 Q. Understanding that point, would you agree
22 that the strength of evidence of a hand hygiene score
23 for a hospital that doesn't report its hand hygiene is
24 lower than the strength of evidence for a hospital
25 that does report its hand hygiene answers?

1 A. No. No. Again, the strength of the
2 evidence is based on the literature. It's based on
3 all prior studies that have been done, as well as the
4 theoretical rationale underpinning the use of the
5 measure.

6 So the evidence applies to the entire
7 population. It doesn't pertain to any individual
8 hospital. The strength of the evidence is exactly the
9 same for every hospital in the country. There's no
10 way that I can say that certain hospitals don't have
11 to do hand hygiene. That's -- that's not plausible;
12 right?

13 The strength of the evidence is based on the
14 entire population.

15 Q. So are you saying that the evidence -- the
16 strength of the evidence is only considered in the
17 methodology as it relates to whether or not to use a
18 measure in the grading methodology at all?

19 A. Well, and whether to give it one point or
20 two points. So it gets more credit if it's considered
21 to be a measure that has stronger evidence based in
22 the population health literature.

23 Q. Turning to the next page, do you see where
24 it says on 668, "Dealing with missing data"?

25 A. Yes.

1 Q. And if you go down to the second paragraph,
2 it says that:

3 "The panelists discuss several
4 approaches for assessing hospital
5 performance when data is missing."

6 Do you see that?

7 A. Yes.

8 Q. And the options are numbered there below.

9 Do you see that?

10 A. Yes.

11 Q. Okay. Can you read the five options,
12 including the numerical paragraph number assigned to
13 them?

14 A. As you wish.

15 "1. Impute the hospital's performance
16 at the national median/mean.

17 "2. Impute the hospital's performance
18 on the missing measures using other
19 available data.

20 "3. Impute a score above or below the
21 median/mean, EG minus one standard
22 deviation.

23 "4. Give the hospital zero credit for
24 the measure, e.g., when the hospital chose
25 not to report data to Leapfrog.

1 "5. Exclude the measure and
2 recalibrate the weights for the affected
3 hospitals using only those measures for
4 which data are available."

5 Q. Do you recall the panel walking through each
6 of those options?

7 A. I don't recall the details of it, but I'm
8 sure that this is an accurate representation of the
9 panel's consideration.

10 Q. And if you look at the next paragraph,
11 again, this is back in 2013, the one that begins
12 "After conducting," the article states that the
13 expert's recommended Option 5, which was "excluding
14 the measure and recalibrating the weights for the
15 affected hospitals using only those measures for which
16 data are available."

17 Is that correct?

18 A. Yes.

19 Q. And then it specifically goes on to say
20 that -- strike that.

21 Why did the panel prefer that approach over
22 the others?

23 A. Well, as described in the paper, imputation
24 always rests on assumptions, and those assumptions are
25 always debatable. Depending on the assumptions, one

1 might yield different results.

2 So obviously No. 1, "Impute the hospital's
3 performance at the national median," the assumption
4 there is that the counterfactual, that
5 nonparticipating hospitals perform equal to the
6 national median or mean; right?

7 No. 2, "Impute the hospital's performance on
8 the missing measures using other available data."

9 Well, that requires that we have other
10 available data that we can use to generate such an
11 estimate.

12 No. 3 involves an assumption that the
13 hospitals that choose not to participate are, for
14 example, one standard deviation below the national
15 median or mean on their performance.

16 No. 4, give the hospital credit would
17 basically assume that the hospitals are at the floor
18 in terms of their performance on the measure.

19 So No. 5 involves the least assumptions in
20 that you're simply using the information that's
21 already available on the same hospital and
22 redistributing the weight.

23 Q. Got it.

24 So whenever you're using imputation, you're
25 making an assumption.

1 Is that correct?

2 A. Yes.

3 Q. Okay. And if you look here, the first
4 sentence on the top of the second column, it reads:

5 "We avoided making questionable
6 assumptions about the performance of
7 hospitals with missing data."

8 Do you see that?

9 A. Yes.

10 Q. Would you agree that by -- in 2013, that you
11 were avoiding -- that by choosing the exclusion of the
12 measure and the recalibration, you are avoiding making
13 questionable assumptions by imputing a score for the
14 hospitals?

15 A. This was a brand new program in 2013, so we
16 put a lot of emphasis on trying to encourage
17 participation and trying to minimize assumptions.
18 Yes.

19 Q. And if you look -- do you agree with that --
20 did you agree with that reasoning at that time in
21 2013?

22 A. Yes.

23 Q. Do you still agree with that?

24 A. In part. There -- when we talk about
25 missing data in epidemiology and biostatistics, there

1 are several types of missing data. We talk about
2 missing at random or MAR. We talk about missing
3 completely at random, MCAR. Or missing not at random,
4 MNAR.

5 And so without going into a full lesson, the
6 data of this type are almost always missing not at
7 random. In other words, people make deliberate
8 choices not to provide their data.

9 And so this needs to be considered over
10 time; right?

11 And so the assessment that we made in 2013
12 naturally would evolve over time because at this time
13 of course the hospital safety grade was brand new and
14 now of course it's very well established. And now
15 most hospitals, the majority of eligible hospitals,
16 have figured out how to participate year after year
17 and how to put their systems in place to manage the
18 burden of participation. And so our framework is
19 different.

20 So now we have a stronger a priori
21 assumption, if you will, that the hospitals that
22 consistently choose not to participate are almost
23 certainly worse than the average, whereas we didn't
24 have any particular a priori when this started in
25 2013, 2011.

1 Q. When a hospital chooses not to participate,
2 it could be for reasons other than the fact that it
3 has -- is a poor performing hospital.

4 Is that fair?

5 A. It could be.

6 Q. And when you are imputing the notion that it
7 is a poor performing hospital, you are making an
8 assumption that they are a poor performing hospital.

9 Is that fair?

10 A. You are.

11 Q. And in 2013, Leapfrog and the safety panel
12 rejected the idea of imputing a score, giving the
13 hospital zero credit for the measure to -- as it says
14 down here in that paragraph, "to avoid creating a
15 structural bias in favor of Leapfrog reporting
16 hospitals."

17 Do you see that?

18 A. Yes.

19 Q. Did you agree that that was why the third
20 and fourth approaches were rejected in 2013?

21 A. Yes.

22 Q. And why would Options 3 and 4 have created a
23 structural bias in favor of Leapfrog reporting
24 hospitals?

25 A. Well, because presumably if those hospitals

1 had reported, at least some portion of them would have
2 reported values greater than zero, and that would have
3 led to a higher score for those hospitals.

4 So therefore the score can only be increased
5 by participation. It can't possibly be decreased.

6 Q. And that dynamic creates a structural bias
7 in favor of responding hospitals versus nonresponding
8 hospitals.

9 Is that correct?

10 A. Yes.

11 Q. And so since today Leapfrog assigns the
12 lowest score possible for the imputed measures for
13 nonresponding hospitals that go to the Step 2 of the
14 imputed methodology, today there is a structural bias
15 in Leapfrog's methodology against nonresponding
16 hospitals.

17 Is that fair?

18 A. So, again, that structural bias applies to
19 the community of nonparticipating hospitals.
20 Obviously some of those nonparticipating hospitals are
21 exactly right on the mark because they would have
22 limited achievement, even if they had reported.

23 But when we talk about a structural bias or
24 a systematic bias, we're talking about the average,
25 and, yes, the average is biased.

1 Q. So because some hospitals who don't respond
2 to the survey are not pro-performing hospitals, those
3 hospitals receive a bias against them due to the fact
4 that they don't participate in the hospital survey.

5 Is that correct?

6 A. They do.

7 Q. If you look down at the bottom of that
8 paragraph, do you see where it says:

9 "By scoring hospitals on the
10 available data, the composite scores were
11 based on what was known about the
12 hospital's performance with no penalties
13 for missing data."

14 Do you see that?

15 A. Yes.

16 Q. Does assigning the lowest score for
17 nonresponding hospitals penalize hospitals for missing
18 data?

19 A. In aggregate, yes. And most of the
20 hospitals in that group are penalized. Again, we have
21 no way to know. Some of the hospitals are not
22 penalized, but we have no way to know which those are.

23 Q. But do you think most of the hospitals that
24 don't participate are penalized for that low score?

25 A. Yes.

1 Q. Do you have any data that goes -- underlies
2 your conclusion or your view that most hospitals who
3 don't participate in the survey are penalized by being
4 given the lowest score?

5 A. Well, when we talk about penalized, we're
6 talking about the numeric value of the score.
7 Obviously there are brackets for the great
8 assignments. And as we've explored over the years,
9 you know, the implications of various approaches, most
10 of the penalties still fall within the same grade
11 bracket so you could say, "Oh, yeah, you lost some
12 points, but your C would still be a C" or whatever.

13 But, yes, there are some hospitals that
14 would drop a grade.

15 Q. And do you have -- have you ever studied the
16 actual performance of the hospitals that don't
17 participate in the survey to understand the breakdown
18 of, you know, the hospitals that, you know, are
19 given -- by being given an imputed low score are being
20 penalized versus those that are actually low
21 performers, have you ever studied the data of those
22 nonresponding hospitals?

23 A. From time to time I think with Matt's help,
24 we've looked at their performance on other metrics,
25 and I think there have been one or two sort of

1 published empirical studies on that question as well.

2 Q. And as you're sitting here today, based on
3 the information that you are aware of -- you still --
4 you believe that most of the nonresponding hospitals
5 are penalized by being given a limited achievement
6 score because they would likely perform better than
7 that, had they participated in the survey.

8 Is that fair?

9 A. Just to be clear, they are penalized
10 numerically on the summary composite score. However,
11 most of them probably don't lose a grade point. So I
12 can't comment on what percentage actually drop a grade
13 point.

14 Q. But sitting here today, based on the
15 information you are aware of, you believe that most of
16 the nonresponding hospitals are penalized in the
17 numerical score that Leapfrog assigns them based on
18 their -- all the data before them and given the
19 limited achievement score for those imputed measures
20 because they likely would have performed better had
21 they participated in the survey?

22 A. Yes.

23 Q. You can set that article aside for a minute.

24 (Exhibit 8 was marked for
25 identification.)

1 BY MR. HVIDT:

2 Q. I am handing you what's been marked as
3 Exhibit 8 in the Romano deposition. This document has
4 been produced in this litigation as PBHN000009368.

5 And if you look up at the top, it is titled
6 "National Hospital Rating systems share few common
7 scores and may generate confusion instead of clarity."

8 Do you see that, Dr. Romano?

9 A. Yes.

10 Q. And if you look up at the authors, do you
11 see your name as one of the authors?

12 A. Yes.

13 Q. And is Matt Austin another one of the
14 authors?

15 A. Yes.

16 Q. And the other authors listed here, are they
17 also -- or were they members of the expert --
18 Leapfrog safety expert panel?

19 A. Yes.

20 Q. And what is the date of this article?

21 A. March 2015.

22 Q. And was this article peer reviewed?

23 A. It was.

24 Q. And what is the purpose of this article?

25 A. Well, I think the purpose of this article

1 was to explore consistency across different national
2 hospital rating systems, and to explore the
3 implications of the methods that were used by
4 different reporting entities.

5 Q. And if you look at the first sentence of the
6 article, it reads:

7 "Assessing the quality and safety of
8 care delivered in hospitals is
9 increasingly important for patients,
10 payors, and providers as evidenced by
11 increased public reporting of hospital
12 quality and safety data and by payment
13 changes that reimburse providers for value
14 rather than volume."

15 Do you see that?

16 A. Yes.

17 Q. Do you agree that hospital ratings and
18 grades affect consumer decisions?

19 A. Very slightly at the margin.

20 Q. Do you agree that ratings can affect
21 reimbursement decisions?

22 A. There are very limited levers, but, yes,
23 there are mechanisms by which payment may be
24 contingent on various rating systems.

25 Q. Do you agree that a negative rating can harm

1 a hospital's reputation?

2 A. It depends on the source of the rating, the
3 consistency of the rating, the severity of the rating,
4 et cetera.

5 Q. What if a hospital is assigned an F, do you
6 agree that could harm the hospital's reputation?

7 A. It could, yes.

8 Q. Looking down on page 1 still, it says
9 that -- and this is again 2015, it says "Relatively
10 little is known about what these rating systems
11 reveal" in that third sentence.

12 Do you see that?

13 A. Yes.

14 Q. And if relatively little is known about what
15 these ratings revealed, what value do you think that
16 they add for consumers, for example?

17 A. Well, there's tremendous concern and issues
18 related to hospital quality and safety, pending the --
19 the most widely cited estimates suggest that 44,000 to
20 98,000 Americans die every year as a result of
21 hospital harms, medical errors, or patient safety
22 issues that arise in hospitals. So that's a very
23 serious problem.

24 So, yes, a greater transparency and
25 accountability with respect to quality and safety

1 should help to inform the market and motivate
2 improvement efforts.

3 Q. Would you agree that there are multiple
4 ratings -- hospital ratings groups?

5 A. Of course.

6 Q. How many are you aware of?

7 A. Well, Consumer Reports has gotten out of the
8 business since this paper, but certainly at a minimum,
9 there's U.S. News, there's Healthgrades, there's
10 Leapfrog, and CMS itself. Some states have their own
11 programs. Some regional employer coalitions have
12 their own programs. But the major national programs
13 are those four.

14 Q. And back in 2015, with this article and the
15 study that y'all were doing, y'all were trying to
16 assess whether you can look at the ratings options
17 that were on the plate back then and assess any kind
18 of conclusions that could be made looking at all of
19 them in the aggregate.

20 Is that fair to say?

21 A. Yes.

22 Q. And is that because there were differences
23 across these various ratings?

24 A. Yes. I mean, part of it of course, since
25 this paper came from our expert panel, is that we

1 asked the question and were interested in exploring
2 the extent to which our Leapfrog grades were
3 correlated with other hospital rating programs, and
4 what we could learn from the similarities and
5 differences.

6 Q. And there were some that were high
7 performers on one ratings and low performers on the
8 other.

9 Is that fair to say?

10 A. Correct.

11 Q. If you look at the second column on that
12 page 1, if you flip back to 9368, the last sentence of
13 that paragraph that started on page 1, do you see
14 where it says:

15 "43 percent of hospitals classified
16 as having below average mortality by one
17 risk adjustment method were classified as
18 having above average mortality by
19 another"?

20 Do you see that?

21 A. Yes.

22 Q. Can you explain the significance of that
23 point?

24 A. Well, the point is simply -- I mean,
25 obviously this is citing to reference 11, which was a

1 paper done by some colleagues out of Harvard in 2010.
2 So the point they were making was that the results are
3 sensitive to the methodology and different methods may
4 result in different classifications.

5 So this is -- motivates the continuing
6 effort to improve the methods.

7 Q. So the methods that are used in assigning
8 these -- depending on what method is used and measures
9 that are affected, that can dramatically impact the
10 output of the methodology.

11 Is that fair?

12 A. It can, yes.

13 Q. If you flip over to the next page, the one
14 ending in 9370, the bottom of the column on the left
15 says "Approaches to Missing Data."

16 Do you see that?

17 A. Yes.

18 Q. And so these groups had different approaches
19 for missing data.

20 Is that fair?

21 A. Yes.

22 Q. And Consumer Reports and Healthgrades, how
23 did they handle missing data?

24 A. At this point I know nothing more than
25 what's described in the paper. We say in the paper

1 that they establish minimum data thresholds for a
2 hospital to receive a rating.

3 Q. So if a hospital -- if they don't have
4 enough data in the hospital, they don't report on it.

5 Is that correct?

6 A. Correct. But I have no recollection of what
7 their specific thresholds were or how they were
8 justified.

9 Q. If you turn now to page 5 of this paper
10 which ends in -- the top of the paper -- the top of
11 the page says "Study Results," and the Bates number
12 ending is 9372.

13 Do you see that?

14 A. Yes.

15 Q. And if you go down to the second paragraph,
16 it starts with "83 hospitals are rated by all four
17 rating systems."

18 Do you see that factor?

19 A. Yes.

20 Q. And "Of those 83, no hospitals were rated as
21 a high performer of all four."

22 Do you see that?

23 A. Yes.

24 Q. And it then goes on to say that -- the next
25 paragraph:

1 "No one hospital was rated as a low
2 performer on all three of the rating
3 systems that rated low performance."

4 Do you see that?

5 A. Yes.

6 Q. And with those data points, what was the
7 conclusion that y'all -- that you and your fellow
8 authors determined at that time?

9 A. Well, we determined there was a lot of
10 variation in how the different rating systems were
11 rating.

12 But I think it's important to recognize two
13 things here:

14 One is that health department grades doesn't
15 exactly rate all the hospitals. They only rate, you
16 know, hospitals that meet certain criteria. And so
17 therefore the number of hospitals that were rated by
18 all four rating systems is only 83 in the whole
19 country, so that particular analysis was limited to a
20 tiny subset of all the hospitals.

21 And then, of course, also Consumer Reports
22 abandoned their rating program. But the person who
23 was in charge of that rating program was George Peter
24 (phonetic) came over to Leapfrog's expert panel, so
25 she now helps us advise Leapfrog.

1 Q. Understood.

2 And if you continue on in the last full
3 paragraph here, of those 83 hospitals, there were
4 27 cases where a hospital was rated as a high
5 performer in one and a low performer in the other.

6 Do you see that?

7 A. Okay. The penultimate paragraph. Okay.

8 "We identify 27 cases of such extreme
9 cross-rating disagreement."

10 Right.

11 Just to be clear, that's not 27 of 83.
12 That's 27 of 1,559.

13 Q. Of the -- 27 of the 1,559, that's for the
14 three ratings as opposed to the --

15 A. Yes.

16 Q. -- other?

17 A. Correct. It's 27 of the 1,559 referenced in
18 the previous paragraph, not 27 of the 83 referenced in
19 the second paragraph.

20 Q. And do you think that the disagreement of
21 how the hospitals are rated across these various
22 ratings systems can impact how consumers make hospital
23 decisions, looking at the data that's in front of
24 them?

25 A. They could, of course. Consumers and

1 purchasers take multiple sources and information into
2 consideration, including we hope the Leapfrog score as
3 one source.

4 Q. Okay. You can set is that article aside for
5 now. We're going to go to 30...

6 A. This is just a review of my academic --
7 (Exhibit 9 was marked for
8 identification.)

9 BY MR. HVIDT:

10 Q. We have quite a -- there are 245
11 peer-reviewed articles.

12 We couldn't use all of them; correct?

13 A. Did you read them all?

14 Q. Not quite all of them, but we read a fair
15 amount of them.

16 I've handed you what has been marked as
17 Exhibit 9, which is an article that's called
18 "Impact of Reporting Hospital Performance."

19 And do you see that you are listed as a --
20 an author of this?

21 A. Yes.

22 Q. And if you look down at the bottom of the
23 page, it says there's a website for QSHC.com.

24 Do you see that?

25 A. The bottom of which page?

1 Oh, yes. I see, at the very bottom. Yes.

2 Q. Yes.

3 And so is this a peer-reviewed article that
4 you co-authored in 2005?

5 A. It's a commentary. Some journals
6 peer-review their commentary, some don't. I think
7 this probably was peer-reviewed.

8 Q. And on the first page the article frames an
9 issue, "Is public disclosure a cost effective way to
10 improve the quality of patient care?"

11 Do you see that?

12 A. Yes.

13 Q. What did you mean by that?

14 A. Well, at the time of this paper and in the
15 previous years, I was very interested in the question
16 of how information about hospital quality is reported
17 and how it's used in the market.

18 So this commentary long predates the
19 Leapfrog patient safety grade. I think this was from
20 2005.

21 So in the early stage of my career, I had a
22 couple of grants that allowed me to interview hospital
23 administrators, quality improvement managers,
24 purchasers, consumers, so forth, do a variety of data
25 analyses to kind of explore questions around how

1 hospital quality reports are used and how they can be
2 used more productively.

3 Q. And is it fair to say at that time, if you
4 look down to the third paragraph, it says in that
5 first sentence that you were having to search a little
6 harder for supportive evidence for the notion that
7 public disclosure was a cost effective way to improve
8 quality of patient care?

9 A. Can you pinpoint exactly? This is a 20-year
10 old paper.

11 Q. Absolutely.

12 So if you look down to that first sentence
13 in the third paragraph, it says:

14 "Those who look for more instrumental
15 reasons to justify the costly and complex
16 task of publishing performance information
17 have to search a little harder for
18 supportive evidence."

19 Do you see that?

20 A. Yes.

21 Q. And throughout the time, that's another way
22 of saying, like in 2005, the evidence was thin that
23 disclosure improves outcomes?

24 A. Right.

25 In other words, the argument that we're

1 making is that the primary basis for disclosure is
2 simply accountability; that it's mostly public money
3 that is going to support these institutions,
4 hospitals, and healthcare organizations. And so
5 accountability is a desirable goal in itself.

6 But if we're actually looking for empirical
7 data that publicly reporting this information drives
8 quality improvement, that's a little bit harder to
9 find. Yeah.

10 Q. Understood.

11 And if you look to the second to last full
12 paragraph on the far right column, do you see where
13 you wrote:

14 "It is difficult to judge from these
15 studies whether public disclosure is
16 something that only good hospitals are
17 willing to do or whether it actually leads
18 to improved performance"?

19 Do you see that?

20 A. Yes.

21 Q. And then if you go down to the sentence that
22 begins on the bottom of that page and carries forward
23 on to the next, do you see where you say:

24 "Despite the increasing commitment to
25 public disclosure of provider performance

1 data, there's still much that we do not
2 know about its cost effectiveness, impact,
3 and mechanisms of action"?

4 Do you see that?

5 A. Yes.

6 Q. And so at the time, you're saying that
7 there's still more that we need to understand about
8 whether public disclosure leads to improved
9 performance.

10 Is that fair?

11 A. Right.

12 I mean, as you can see, and as my memory is
13 refreshed, this was an invited commentary on a paper
14 that the same journal was publishing by Ito and
15 Sugawara. And so that paper was one more empirical
16 data point essentially evaluating the relationship
17 between accreditation disclosures -- between
18 accreditation scores and disclosure.

19 Q. And as you were saying earlier that most of
20 nonperforming Leapfrog hospital -- strike that.

21 As you were saying earlier, most of the
22 hospitals that do not participate in Leapfrog's
23 hospital survey are being penalized by being given
24 an imputed -- penalized in the numerical value of the
25 score they get by being assigned an imputed measure.

1 Is it fair to say that it's still not clear
2 that public disclosure to a particular group leads to
3 improved performance?

4 A. Oh, okay. So first let me just mind you
5 that there's a Step 1 to the imputation which is based
6 on prior reported performance by the same hospital.
7 So we're only talking now about hospitals that
8 consistently decline to participate in the survey.

9 And to your second point, I think it's fair
10 to say that the literature has evolved substantially
11 over the last 20 years. I'm not prepared here today
12 to opine on 20 years of evolution of the literature.
13 But clearly this has been studied by multiple
14 investigators over the subsequent time period in
15 different ways.

16 Q. Okay. You can set that aside.

17 I think this is the last old article that
18 we're going to look at for right now. But if we could
19 get, when you have a second, a sticker for...

20 (Exhibit 10 was marked for
21 identification.)

22 BY MR. HVIDT:

23 Q. I'm putting in front of you what has been
24 marked Exhibit 10 to the Romano deposition. This is
25 from February 1st, 2013 and it's an article on

1 Clinician.com titled "Leapfrog Safety Scores Spur
2 Debate - How Reliable Are They?"

3 Do you see that?

4 A. Yes.

5 Q. Have you ever seen this article before?

6 A. I don't recall ever seeing it.

7 Q. Do you have any reason to believe that the
8 information in this article isn't accurate?

9 A. I don't recall ever seeing it, so I'm not
10 going to comment without reading the article.

11 Q. If you turn to the last page of substance on
12 the article, on the third paragraph -- third full
13 paragraph it references "Patrick Romano MD, MPH."

14 Do you see that?

15 A. Yes.

16 Q. Okay. And flipping back -- is that you?

17 A. Must be me.

18 Q. Flipping to page 2, paragraph 2, second
19 sentence, it describes how "respected providers like
20 Mt. Sinai Medical Center in New York call Leapfrog
21 grade an incomplete and imperfect snapshot."

22 Do you see that?

23 A. Yes.

24 Q. And it goes on to say "Much of the analysis
25 is based on outdated information from disparate

1 sources."

2 Do you see that?

3 A. Yes.

4 Q. And in the next paragraph it talks about the
5 Cleveland clinic.

6 Do you see that?

7 A. Yes.

8 Q. And that it describes that they don't have
9 confidence in the Leapfrog system.

10 Do you see that?

11 A. Yes.

12 Q. And with Leapfrog's methodology, it uses
13 CMS data for some of the metrics in there; correct?

14 A. Yes.

15 Q. And the CMS data that's available for
16 Leapfrog to use is -- from then and now is from a few
17 years in the past.

18 Is that fair?

19 A. Yes.

20 Q. And if you roll forward to the last page, it
21 has quotes from Leah Binder.

22 Do you see that?

23 A. Yes.

24 Q. And then it goes on to say that -- then it
25 goes on to quote you later in the article.

1 Do you see that?

2 A. Yes.

3 Q. And in the article you are quoted as saying:

4 "It is understandable that a
5 hospital's internal data could paint a
6 different picture if it is more current
7 and complete than what was available to
8 Leapfrog."

9 Do you see that?

10 A. Yes.

11 Q. And you're then quoted as saying that:

12 "The Leapfrog Group is going to
13 assess the data and score your hospital
14 whether you participate or not. So it is
15 in your advantage to participate and help
16 us gather the most complete, accurate
17 picture of your safety experience."

18 Do you see that?

19 A. Yes.

20 Q. And so as it relates to that notion, why is
21 it that Leapfrog is going to score your hospital
22 whether you participate or not?

23 A. Well, because Leapfrog's mission is to drive
24 improvement in quality and safety. And so the
25 fulfillment of this mission requires that Leapfrog

1 score all the significant players in every hospital
2 market.

3 Q. But if Leapfrog is going to grade hospitals,
4 whether they participate or not, doesn't that create
5 kind of a pressure on the hospitals to participate,
6 even if they have valid reasons for not wanting to
7 participate unrelated to their performance?

8 A. Of course. There's nothing wrong with that.
9 The market creates lot of pressures.

10 Q. So you think that there's nothing wrong with
11 Leapfrog grading hospitals who don't participate in
12 the survey in encouraging -- in a way that is
13 structurally biased because -- strike that. I'll move
14 on.

15 All right. Why is there nothing -- no.

16 A. Perhaps we could take a lunch break soon?

17 MR. HVIDT: I'm happy to take a break right
18 now.

19 THE VIDEOGRAPHER: Okay.

20 MR. HVIDT: Off the record.

21 THE VIDEOGRAPHER: Off the record.

22 12:02 p.m.

23 (Break taken in proceedings.)

24 THE VIDEOGRAPHER: On the record.

25 12:52 p.m.

1 BY MR. HVIDT:

2 Q. Dr. Romano, earlier this morning you
3 testified that before your deposition, you had
4 reviewed Leapfrog's Expert Safety Grade Panel's
5 Guiding Principles.

6 Do you recall that?

7 A. Yes.

8 Q. I am handing you what's been marked as
9 Exhibit 11 in your deposition.

10 (Exhibit 11 was marked for
11 identification.)

12 BY MR. HVIDT:

13 Q. Looking at this document, which was
14 downloaded from Leapfrog's website, does this look
15 like those guiding principles that you looked at to
16 prepare for your deposition?

17 A. Yes.

18 Q. And what went into preparing these
19 principles?

20 A. It was a long time ago. I don't recall
21 specifically, but there were a couple of rounds of
22 discussion.

23 I think there was an earlier draft with some
24 revision, and this reflects the product of a couple of
25 rounds of discussion.

1 Q. Did you participate in those discussions
2 that led to this product?

3 A. Yes.

4 Q. And the document states at the top that:

5 "The expert panel reached a consensus
6 that the following principles will guide
7 the recommendations to Leapfrog for
8 calculating the grade."

9 Do you see that?

10 A. Yes.

11 Q. And does mean that the principles reflected
12 the consensus views of you and the rest of panel?

13 A. That's how I would interpret it, yes.

14 Q. And if you flip to the next page, do you see
15 where it says in bold italics "Scientific Soundness of
16 Measures"?

17 A. Yes.

18 Q. And did the panel prefer scientifically
19 sound measures be included in Leapfrog's safety
20 grades?

21 A. Yes.

22 Q. And the document also does note here that
23 there's a lack of existing research on scientific
24 soundness that did not automatically exclude a measure
25 from being included.

1 Is that correct?

2 A. Yes.

3 Q. Why did the panel allow inclusion of less
4 validated -- less scientifically sound measures in
5 some cases?

6 A. Well, because in some cases the evidence is
7 evolving, and so members of the panel may have a
8 strong view that a measure will be proven to be valid.
9 In the next year or two, they may have advanced
10 information essentially on the validity of a measure.
11 There may also be cases where a measure is thought to
12 be so important conceptually that it may outweigh
13 regarding the specific validity and reliability of
14 measurement.

15 Those would be limited scenarios, of course.

16 So in general, you know, we have a strong
17 preference for scientifically sound measures.

18 Q. Are there any measures on -- in the Leap --
19 included in the Leapfrog scoring methodology today
20 that you would characterize as not scientifically
21 sound?

22 A. I would say I'm not convinced that the
23 safe practices survey measure would meet reliability
24 and validity criteria in a current assessment. That's
25 not to say that they're not meaningful concepts. But

1 the reliability of the measurement is somewhat suspect
2 because of the fact that they're, you know,
3 self-reported responses to a series of questions
4 regarding safe practices that most hospitals have
5 already embedded in their system.

6 So it -- the reliability criteria in
7 particular, you know, requires that there be a certain
8 amount of what we call signal that is true variation
9 across hospitals. And so if that true variation has
10 decreased over time, then the measure may no longer
11 meet reliability criteria. That's just one example.

12 Q. And for the safe practices one, that's a
13 measure that participating hospitals get the benefit
14 of that inclusion in their score but nonparticipating
15 hospitals do not.

16 Is that correct?

17 A. Right. The weight is redistributed for
18 nonparticipating hospitals.

19 Q. And you mentioned that that was one example.
20 Are there other examples of measures,
21 including the Leapfrog safety grade methodology today
22 that you would also put in that category of not
23 scientifically sound?

24 A. Well, there are measures -- there are
25 measures of extremely rare events, such as

1 air embolism, for example, where there's, you know,
2 literally a few dozen of these events across the
3 country each year.

4 So these measures would not meet criteria
5 for reliability at the hospital level.

6 That is, you know, when we say that a
7 hospital's rate is, you know, one per 10,000, do we
8 really know it's one per 10,000 and not two per 10,000
9 or zero per 10,000?

10 Q. Or that that one per 10,000 is caused by
11 something relating to the quality or safety of the
12 procedures at the hospital.

13 A. No. That's not what I said.

14 I'm referring specifically to reliability as
15 a statistical concept, that is, the extent to which
16 the data are repeatable over time that they minimize
17 random error.

18 So there's a lot of random noise in
19 extremely rare events that some hospitals get hit by
20 one in one year and then they don't for two or
21 three years.

22 And so in any given reporting period, the
23 data may be unreliable. However, it is valid; right?
24 So the hospitals aren't lying to us. They actually
25 experience that event. It's an unfortunate event, a

1 true patient harm. And -- and so that's a case where
2 the measure might meet the validity criteria but not
3 the reliability criteria.

4 Q. I understand.

5 So when the one off event happens, it
6 impacts -- negatively impacts that hospital's
7 measure --

8 A. During that year.

9 Q. -- during that year.

10 But that outcome is not necessarily a
11 reliable indicator because it varies year to year
12 because of how rare the event is?

13 A. Correct.

14 Q. Looking further down on the same page, do
15 you see where it says "Imputing Missing Data"?

16 A. Yes.

17 Q. And in the first paragraph under "Imputing
18 Missing Data":

19 "The panel under the guiding
20 principles recommended that when data is
21 missing for a measure, the measure should
22 simply be ignored and the weights
23 recalibrated."

24 Is that correct?

25 A. Yes.

1 Q. And that's what Leapfrog does for three
2 measures in the current methodology.

3 Is that correct?

4 A. Yes.

5 Q. And is it correct that the panel also agreed
6 if too much data was missing, no grade should be
7 issued?

8 A. Where are you referring to?

9 Q. In the next paragraph still on page 2, under
10 "Imputing Missing Data."

11 Do you see where it says:

12 "In situations where a hospital does
13 not have data available from the primary
14 data source" --

15 Strike that.

16 If you go to the next page where it says:

17 "if a hospital is missing data for a
18 large number of performance measures, then
19 a grade cannot be reliably calculated."

20 Do you see that?

21 A. Yes.

22 Q. And it says, "In this situation, no grade
23 should be issued for the hospital."

24 Do you see that?

25 A. Yes.

1 Q. And was that the expert panel's consensus as
2 a guiding principle for how Leapfrog's hospital safety
3 grade should work for U.S. hospitals?

4 A. It was, contingent on the understanding that
5 the reason for missing data on a large number of
6 performance measures is that the hospital is too
7 small; that it doesn't meet the structural criteria
8 for participating, for example, in the inpatient
9 perspective payment system.

10 Q. Is reference to the hospital size included
11 in the guiding principles?

12 A. No. But as part of this discussion, it was
13 clear that this was the third sort of paragraph, if
14 you will, the fallback.

15 So we have the first paragraph, then we have
16 the second paragraph, and then in the remaining cases,
17 which basically is limited to the hospitals that are
18 so small or don't participate in CMS reporting, this
19 is the criterion that would apply.

20 Q. Do you understand the current methodology
21 that Leapfrog uses states that if a hospital is
22 missing six or more process measures, that that
23 hospital is not graded?

24 A. Yes.

25 Q. And do you understand that absent the

1 inclusion of imputed measures for nonparticipating
2 hospitals, that non- -- that Leapfrog would be missing
3 more than six measures for nonparticipating hospitals?

4 A. Can you repeat the question?

5 Q. Yeah.

6 So if a hospital doesn't participate in
7 Leapfrog's survey, there are the three measures for
8 the two safe practices and the nursing category that
9 Leapfrog doesn't grade those hospitals on. It simply
10 says that data is missing --

11 A. Right.

12 Q. -- and we'll redistribute the weight; right?

13 A. Mm-hm.

14 Q. And then -- sorry. Can I get an audible
15 answer to that?

16 A. Yes.

17 Q. Okay. And then if there are -- then there
18 are four measures for nonparticipating hospitals where
19 Leapfrog imputes a grade where it doesn't have the
20 data for the -- those hospitals.

21 Is that correct?

22 A. Yes.

23 Q. And so if you add those four imputed
24 measures and those three measures that Leapfrog
25 excludes, that equals seven measures.

1 Is that correct?

2 A. Why would you add them?

3 Q. Because -- can you -- my question is: If
4 you add four imputed measures --

5 A. Uh-huh.

6 Q. -- with three -- the three measures for the
7 safe practices in the nursing, does that equal seven
8 measures?

9 A. It does equal seven measures. But you're
10 ignoring the reason for missing this, which is
11 fundamental.

12 Q. The reason for missing this is not an aspect
13 that's stated in this paragraph here for the guiding
14 principles.

15 Is that fair?

16 A. No. Because it's implied. Because first we
17 go through the first paragraph, then we go through the
18 second paragraph.

19 And so at the time that this was written, we
20 had a secondary data source for all the hospitals that
21 were not participating. So we never got to the third
22 paragraph, you see.

23 So it was really the second paragraph that
24 guided the discussion about nonparticipating
25 hospitals. The third paragraph was inapplicable

1 because we didn't get there; right? Because that
2 issue was solved in the second paragraph.

3 Q. Leapfrog no longer has that secondary data
4 source for those four imputed measures.

5 Is that correct?

6 A. Yes.

7 Q. And this is -- the guiding principles that
8 we're looking at today are still the guiding
9 principles that apply to Leapfrog's scoring
10 methodology?

11 A. No.

12 Q. So --

13 A. Clearly not.

14 Q. Are you saying that there's an updated
15 version of the guiding principles?

16 A. No. I'm saying that we've had subsequent
17 discussions obviously in which we've migrated away
18 from some of the initial understandings as a result
19 of, for example, changes in the measures that are
20 used, the measures that are available, the market
21 context, so forth.

22 So this is a historical document but we
23 haven't -- we haven't specifically revisited and
24 revised this document in the last few years.

25 Q. So is Leapfrog's expert panel and Leapfrog

1 itself no longer following the guiding principles as
2 written here?

3 A. Well, I think it may be a question for
4 others. Obviously in recent meetings we have
5 acknowledged that, you know, we no longer have data
6 available from alternative or secondary data sources.
7 And so explicit discussion of that, you know, led to
8 some revisions. And obviously we may go back and
9 revise the guiding principles at some point. I mean,
10 these guiding principles are still guiding our general
11 approach, but obviously we can't necessarily follow
12 every detail as the circumstances change.

13 Q. Do you understand that this document is
14 linked on Leapfrog's safety grade website?

15 A. I was not aware of that actually until it
16 was pointed out, I guess, by counsel.

17 Q. And so if Leapfrog is presently linking this
18 document to users of the website that these are the
19 guiding principles underlying the methodology, is that
20 an accurate representation of the principles that are
21 guiding the current methodology if you're no longer
22 following them as written here?

23 MR. BILLEK: Object to form.

24 You can answer.

25 THE WITNESS: Well, these guiding

1 principles, if you'll notice they're guiding
2 principles on the development of the composite; right?

3 So, again, this is a historical document
4 that I don't think has been revised since -- whatever
5 date. I don't know how it's dated. But it's guiding
6 principles on the development. And I think, as we've
7 discussed, it is consistent with the development
8 process as described in our paper, internal patient
9 safety and elsewhere.

10 BY MR. HVIDT:

11 Q. Is Leapfrog still developing its principles
12 today?

13 A. I think the -- it's an ongoing process,
14 right, and so we meet typically twice a year and we
15 discuss at each meeting the possibility of bringing
16 new measures, making changes, considering the
17 weighting components, so forth.

18 So it's an ongoing evolutionary process.

19 Q. So if these principles no longer apply, what
20 principles do apply to how Leapfrog determines the
21 methodology that it uses?

22 MR. BILLEK: Object to form.

23 You can answer.

24 THE WITNESS: Well, I think that the --
25 you've probably reviewed the minutes, notes from our

1 meetings more carefully than I have. So I think you
2 could -- you could tell me and you probably have
3 documents to show how the principles have evolved over
4 time.

5 BY MR. HVIDT:

6 Q. So I'm asking you here today, as I'm not the
7 one being deposed and I wasn't involved in those and
8 you were.

9 What I'm trying to understand is are --
10 when Leapfrog's expert safety panel is meeting on
11 recommendations that they're making to Leapfrog, what
12 principles are they using to guide those
13 recommendations?

14 A. Well, I think that we're informed by the
15 principles that were used by development in the
16 development process as described here, but
17 fundamentally we're guided by the mission of the
18 organization to promote transparency and
19 accountability, and to drive the field towards
20 greater patient safety to reduce harm.

21 Q. And so are you saying that it's not
22 appropriate -- because this document was about the
23 development of Leapfrog's safety grade, it's not
24 appropriate to judge Leapfrog's current methodology
25 against these principles?

1 A. Yes. Clearly. Because as I've just
2 described, when this was written, we had alternative
3 data sources available as described in the second
4 paragraph here under "Imputed Missing Data."

5 So in the absence of that second paragraph,
6 if we had known at that time that there were no
7 alternative data sources, then we would have developed
8 an alternative second paragraph. But we don't have
9 that alternative second paragraph because that wasn't
10 necessary to develop an alternative second paragraph
11 at the time that this document was developed.

12 Q. And Leapfrog lost access to that secondary
13 data source about four or five years ago.

14 Is that correct?

15 A. Yeah. Mm-hm.

16 Q. And this document hasn't been updated since
17 then?

18 A. That's correct.

19 MR. BILLEK: Could we just take a break for
20 a second? This is not current any longer.

21 Is yours?

22 Off the --

23 MR. HVIDT: Go off the record.

24 THE VIDEOGRAPHER: Off the record 1:11 p.m. 0

25 (Break taken in proceedings)

1 THE VIDEOGRAPHER: On the record 1:16 p.m. 0

2 BY MR. HVIDT:

3 Q. Thank you, Dr. Romano.

4 We've been talking about the expert panel's
5 guiding principles document in front of you,
6 Exhibit 11.

7 If you go down to the last paragraph on
8 page 2 where it begins "In situations where a
9 hospital."

10 Do you see that?

11 A. Yes.

12 Q. And it reads:

13 "In situations where a hospital does
14 not have data available from the primary
15 data source for a particular performance
16 measure but an alternative data source is
17 available, data from the alternative or
18 secondary data source can be used in the
19 composite."

20 Do you see that?

21 A. Yes.

22 Q. And so that means that when there's
23 alternative data, instead of the data that comes in
24 through Leapfrog Hospital Safety Survey, Leapfrog
25 would prefer to use that alternative data in the first

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1 instance; correct?

2 A. Well, they would have preferred to use the
3 hospital reported data, but absent a hospital reported
4 data, then in the second instance, this becomes the
5 preferred option.

6 Q. And so that alternative or secondary data
7 means actual data about the hospital's performance but
8 that was data that was provided to another source, not
9 Leapfrog?

10 A. Well, it's not specific about the nature of
11 that alternative or secondary data source; right?
12 Conceptually that could be data previously reported by
13 the same hospital, it could be data reported by the
14 same hospital on other related measures, or it could
15 be data reported by similar hospitals on the same
16 measure.

17 All three of those would be alternative
18 sources.

19 Q. So you would consider data regarding a
20 similar cohort of hospitals that they are reporting to
21 be secondary data for -- for a nonresponding hospital;
22 that Leapfrog could use that to impute a measure for?

23 A. Yeah. An alternative source, yes. I think
24 that's the -- probably more precise is it's an
25 alternative data source.

1 Q. Got it.

2 But that data is not data from the actual
3 hospital. That's data from an alternative source?

4 A. Yes. It could be data from the same
5 hospital on the same measure at a previous time, it
6 could be data from the same hospital on other measures
7 that are related to the missing measure, or it could
8 be data from other hospitals similar to this hospital
9 on the same measure.

10 Q. Understood.

11 And if you look at the last sentence there
12 in that paragraph, the use there for when you're in
13 those three circumstances that you just walked
14 through, so if data is used from those sources, those
15 secondary data sources, it says there in quotes:

16 "Attempts should be made to provide a
17 grade that is equitable to what the
18 hospital would have earned had the data
19 been available from the primary data
20 source."

21 Do you see that?

22 A. Yes.

23 Q. And that was a -- that is a principle that's
24 included in the expert panel's guiding principles in
25 the development of the composite Leapfrog hospital

1 safety grade for U.S. hospitals; correct?

2 A. Correct. Again, obviously the situation has
3 evolved over time. These were guiding principles
4 related to the development of the composite in 2012,
5 '13, '14. And the situation has evolved.

6 Q. When you say it's evolved, are you referring
7 to how it has evolved because it's no longer an
8 assignment of providing an equitable grade to the
9 hospital, or how has it evolved?

10 A. Well, it's evolved in the sense that we are
11 less reliant in aggregate on the survey than we were
12 at the very beginning of this process, so there are
13 more measures that are now reported through CDC and
14 CMS. For example, I think the initial survey -- the
15 initial composite only had one hospital-acquired
16 infection, that is central line associated bloodstream
17 infections or CLABSI, C-L-A-B-S-I.

18 Since then additional measures have been
19 added to the program, including catheter-associated
20 urinary tract infections, clostridium difficile
21 infections, surgical -- certain surgical site
22 infections. So the PSI 90 composite measure.

23 So in aggregate, the program is now less
24 reliant on the survey than it was at the very
25 beginning. And so that means that we have to be sort

1 of less tolerant of hospitals that don't participate
2 in the survey because there's more data from other
3 sources that allow us to estimate a safety grade.

4 Q. What do you mean when you say you have to be
5 less tolerant of hospitals that don't participate in
6 the survey?

7 A. That equitability with respect to what the
8 hospital would have earned had the data been available
9 from the primary data source is no longer as strong a
10 consideration.

11 Q. So Leapfrog no longer considers the idea
12 that when it's imputing missing data, it needs to be
13 equitable to the nonparticipating hospital?

14 A. That's correct.

15 Q. So what is the principle guiding how
16 Leapfrog imputes missing data today?

17 A. Well, again, I think the preferred principle
18 is that we use -- Leapfrog uses data from previous
19 cycles of the survey so that the hospital may choose
20 that -- because the survey is burdensome, it doesn't
21 wish to participate every year. That may be a
22 reasonable choice, given the burden.

23 And so then Leapfrog would look back to the
24 previously reported performance by the hospital.

25 So that's the preferred option.

1 Q. And what's the option if Leapfrog doesn't
2 have the hospital's prior performance from the year
3 before?

4 A. Well, then it assigns the score that is
5 consistent with limited achievement.

6 Q. So is it fair to say that today, Leapfrog's
7 2025 methodology does not follow these principles?

8 A. Well, I think in general it does. I think
9 in general the guiding principles from 2012 or 2013
10 have stood the test of time. Obviously things -- some
11 of these guiding principles have evolved, yes.

12 Q. As it relates to imputing missing data, is
13 it fair to say that Leapfrog's current methodology
14 does not follow the guiding principles in Exhibit 11?

15 A. Specifically only for hospitals that
16 consistently decline to participate, yes.

17 Q. Thank you.

18 Earlier today we talked about your
19 participation in advising Leapfrog regarding how to
20 handle methodology changes following the loss of the
21 American Hospital Association data.

22 Do you recall that?

23 A. Yes.

24 Q. I'd like to mark as Exhibit 12, an e-mail
25 chain I'm handing you that's been produced in this

1 litigation as Leapfrog 01991528.

2 At the top of the page there's an e-mail
3 from Missy Danforth with Leapfrog to several
4 individuals, including Patrick Romano, dated
5 March 16th, 2021, regarding "Update on Leapfrog
6 hospital safety grade, new imputation approach."

7 (Exhibit 12 was marked for
8 identification.)

9 BY MR. HVIDT:

10 Q. Do you see that?

11 A. Yes.

12 Q. Have you seen this document before?

13 A. I must say I was asked to produce e-mails
14 from 2023 forward, so I have not seen this e-mail
15 train since it was originally sent in 2021. I have no
16 reason to doubt.

17 Q. You have no reason to doubt that this
18 document is an accurate business record regarding --
19 from Leapfrog's system, the e-mail that was produced?

20 A. No. I simply haven't seen it since 2021.

21 Q. Okay. And if we flip to the beginning of
22 the e-mail from a chronological standpoint, so the
23 last page where the Bates number ends in 1536.

24 Let me know when you are there.

25 A. Yeah.

1 Q. This chain begins with an e-mail from
2 Matt Austin dated January 13, 2021 and it's addressed
3 to the Leapfrog expert panel and some Leapfrog staff.

4 Do you see how you're included in that
5 e-mail?

6 A. Yes.

7 Q. And in that e-mail Mr. Austin is writing the
8 expert panel regarding the loss of data from
9 American Hospital Association.

10 Do you see that?

11 A. Yes.

12 Q. And do you see how the date of the loss of
13 the -- the -- when Leapfrog learned about the
14 American Hospital Association stopping the licensing
15 of its data was in September of 2020.

16 Do you see that?

17 A. Yes.

18 Q. And if you look in that e-mail,
19 Mr. Austin -- excuse me -- Dr. Austin said:

20 "Leapfrog had got ahead of it by
21 working with Mathematica to identify
22 possible alternative imputation
23 approaches" in that second paragraph.

24 Do you see that?

25 A. Yes.

1 Q. And still in that same e-mail, he wrote:
2 "With ongoing input of Patrick Romano
3 and Sara Singer, we worked with
4 Mathematica to develop a three-step
5 imputation approach."

6 Do you see that?

7 A. Yes.

8 Q. Is that different with how you would
9 characterize your role around that time in working
10 with Dr. Austin and Mathematica?

11 A. I think so. I was part of a subset of the
12 panel that was brought in to additional discussions
13 with Matt and Missy and Mathematica on this topic.

14 Q. Do you have an understanding as to why you
15 were selected among that subset of the panel to
16 participate in those additional discussions with Matt
17 and Missy and others regarding this new imputation
18 approach?

19 A. I don't know exactly what the
20 decision-making process was of those who invited me,
21 no.

22 Q. Is it fair to say that they value your
23 expert opinion in the methodology development in
24 including you to provide input?

25 A. I presume so.

1 Q. And that would probably be consistent with
2 the hundreds of articles you've written on the
3 subject.

4 Is that fair to say?

5 A. Perhaps so.

6 Q. They thought that you might know a thing or
7 two about how to help advise them on how to best
8 develop a methodology here.

9 Is that fair to say?

10 A. Yeah. Perhaps so.

11 Q. If you flip to the next page here, the
12 previous page, ending in 1535, there's an e-mail here
13 from Arjun Srinivasan.

14 Do you see that?

15 A. Yes.

16 Q. And is Dr. Srinivasan on the expert safety
17 panel?

18 A. Yes.

19 Q. And in this e-mail he writes -- he asks
20 whether Leapfrog should, quote, "consider assigning a
21 lower score to hospitals that are refusing to publicly
22 share this information."

23 Do you see that?

24 A. Yes.

25 Q. Okay. And then if you flip to the response

1 e-mail from Dr. Austin, it starts on page 1534 and
2 carries over on to the next.

3 Do you see where the second paragraph begins
4 "Leapfrog's leadership"?

5 A. Yes.

6 Q. And Dr. Austin responds:

7 "Leapfrog's leadership and board
8 continue to grapple with the decision of
9 how explicit Leapfrog wants to be with
10 penalizing hospitals that don't report to
11 the Leapfrog hospital survey."

12 Do you see that?

13 A. Yes.

14 Q. Did you participate at that time in
15 conversations with Dr. Austin or Leapfrog or
16 Dr. Singer about how explicit Leapfrog wanted to be in
17 penalizing hospitals that don't report to Leapfrog
18 hospital survey?

19 A. Well, I'm obviously not part of Leapfrog's
20 leadership or board. Certainly our expert panel
21 discussed the principles of imputation and I think
22 that's reflected in this e-mail train. But I don't
23 recall any specific discussion at this time of the
24 explicitness of a penalization approach.

25 Q. Have you ever had conversations with

1 Leapfrog about penalizing nonreporting hospitals?

2 A. Yes.

3 Q. What are those conversations?

4 A. Well, I think they're reflected in more
5 recent minutes and discussions.

6 Q. And can you tell me in your own words what
7 those conversations have entailed? Have you
8 recommended that Leapfrog penalize nonreporting
9 hospitals?

10 A. Well, as, you know, the situation has
11 evolved over time and various approaches have been
12 tested and retested, I think I came to the view --
13 which is probably reflected in documents that you'll
14 show me later this afternoon -- I came to the view
15 that Leapfrog might as well adopt a more explicit
16 approach of assigning the limited achievement score as
17 opposed to continuing to try different approaches that
18 may or may not be valid.

19 Q. And when you say Leapfrog might as well
20 adopt a more explicit approach of assigning a limited
21 achievement score, are you saying that Leapfrog might
22 as well be more explicit in its penalization --

23 A. Yes.

24 Q. -- of nonreporting hospitals?

25 A. Yes.

1 Q. In your conversations with Leapfrog, have
2 Leapfrog representatives communicated with you that
3 they are interested in penalizing nonreporting
4 hospitals the same way that you are?

5 A. Well, they've communicated that they don't
6 wish to reward hospitals for not participating.

7 So obviously the only way to avoid
8 completely rewarding hospitals for not participating
9 is to penalize them. There are flip sides of the same
10 coin, since we can't get exactly on the mark to know
11 what the counterfactual value of their reporting would
12 be.

13 Q. So it's kind of like a carrot-and-stick
14 approach, if you will.

15 MR. BILLEK: Object to form.

16 BY MR. HVIDT:

17 Q. Is that fair to say?

18 A. I don't think I know what you mean --

19 MR. BILLEK: Same objection.

20 THE WITNESS: -- by "carrot to stick."

21 BY MR. HVIDT:

22 Q. So the idea that there are ways to encourage
23 someone to do something and one approach is to use a
24 stick.

25 Is that fair to say?

1 A. One approach is to use a stick.

2 Q. One approach is to give someone a carrot?

3 A. Yes.

4 Q. And by penalizing the nonresponding
5 hospitals, Leapfrog is using a stick.

6 Is that fair to say?

7 MR. BILLEK: Object to form.

8 THE WITNESS: Let me back up.

9 So there's no neutral approach. So if
10 you -- if you remove nonparticipating hospitals,
11 you're rewarding them. If you assign the average
12 score, as that's shifted to the right, you're
13 rewarding them; right?

14 So the only alternative to those rewards is
15 to penalize.

16 BY MR. HVIDT:

17 Q. So you see there being three options.

18 You're either not grading them, which you
19 characterize as a reward.

20 Is that fair to say?

21 A. Yes.

22 Q. You are grading them through some sort of
23 imputation that assigns an average value and you're
24 characterizing that as a reward to the nonresponding
25 hospitals.

1 Is that correct?

2 A. Yes. In general, because it's a -- it's
3 migrated to a very high mean value that would, we
4 suspect, overestimate the true performance of those
5 hospitals.

6 Q. And the third option is to penalize the
7 hospitals?

8 A. Yes.

9 Q. And when you are penalizing the hospitals,
10 do you think that that is an accurate representation
11 of most of the nonresponding hospitals?

12 MR. BILLEK: Object to form.

13 You can answer.

14 THE WITNESS: Again, the penalty is a
15 numeric penalty in the -- how the composite safety
16 score is computed. In most cases that actually
17 doesn't translate to a change in the grade.

18 So, again, I'm not here to comment on how
19 often it actually eventuates in a grade change. But
20 the grade change is the actual penalty that is
21 experienced in the field.

22 BY MR. HVIDT:

23 Q. When you are --

24 A. So I'm just objecting to the word "most."

25 So I -- so most hospitals would suffer a

1 numeric penalty, but whether most hospitals actually
2 suffer a great penalty, I have no idea.

3 Q. And when that assignment of a penalty
4 occurs, is that an accurate -- is that penalty
5 accurate to how the hospital's performance actually
6 would be?

7 MR. BILLEK: Object to form.

8 THE WITNESS: Could you try that question
9 again?

10 BY MR. HVIDT:

11 Q. Yeah.

12 So when -- to use your words, when Leapfrog
13 assigns a penalty to the nonresponding hospitals, is
14 that penalty a fair and accurate representation of how
15 that hospital would have performed on that measure?

16 MR. BILLEK: Object to form.

17 THE WITNESS: Well, it's a penalty
18 essentially for opaqueness. It's a penalty for lack
19 of transparency and lack of accountability. So -- so
20 it's a penalty that has a specific purpose.

21 Its purpose is not accuracy. Its purpose is
22 ultimately to improve the program for everyone.

23 BY MR. HVIDT:

24 Q. And is the decision that was made that it is
25 preferred to assign the penalty to development of the

1 program and along the way, you might not be as
2 accurate for those nonresponding hospitals?

3 A. Correct. Those decisions are made every day
4 in public-reporting programs. I'm involved in other
5 public-reporting programs as well. Yes.

6 And so sometimes there are tradeoffs and so
7 decisions must be made to sacrifice accuracy at the
8 margin in order to achieve other programmatical...

9 Q. And going back to Exhibit 12, Dr. Austin
10 continues on the sentence that carries forward from
11 1534 to 1535 that "I don't doubt that any of them" --
12 meaning "them" in this, I believe, to refer to the
13 expert safety panel -- "would disagree with your
14 statement to Dr. Arjun" --

15 A. False. "Them" refers to Leapfrog's
16 leadership and board.

17 Q. Thank you. Thank you, Dr. Romano.

18 Okay. So going back to that sentence:

19 "I don't doubt that any of them,
20 Leapfrog's leadership and board, would
21 disagree with your statement to
22 Dr. Arjun Srinivasan that transparency is
23 likely a marker of a high-quality health
24 system. But I think they --", they being
25 Leapfrog leadership --" and board are

1 trying to balance that with a potential
2 hospital pushback; i.e., statements from
3 hospitals that Leapfrog is extorting
4 hospitals to participate in the survey."

5 Do you see that?

6 A. Yes.

7 Q. Have you heard statements from hospitals
8 that Leapfrog is extorting hospitals to participate in
9 the survey?

10 A. I can't vouch for that exact verb, but, yes,
11 I've heard statements to that effect.

12 Q. So statements from hospitals to the effect
13 that Leapfrog's methodology is pressuring them to
14 participate in the survey is there's consequences to
15 nonparticipating hospitals if they don't participate
16 in the survey.

17 Is that fair to say?

18 A. This statement is referring to potential
19 hospital pushback. And so this is part of the
20 balancing of considerations, obviously.

21 Q. And part of the balancing of considerations
22 that went into it is the possibility that hospitals
23 would push back on the penalty being assigned to them
24 for not participating; that that would be in their
25 view, those potential hospitals' view, as extortion.

1 A. Some hospitals might view it that way, yes.

2 Q. And if we carry forward in response to
3 Dr. Austin's e-mail, you have an e-mail beginning on
4 1533 dated January 19th, 2021.

5 Do you see that?

6 A. Yes.

7 Q. And in that e-mail, you say that:

8 "Dr. Austin's e-mail was very well
9 put. And we now have extensive amount of
10 data to address various what-if questions
11 as Mathematica has helped explore."

12 Do you see that?

13 A. Yes.

14 Q. And is it fair to say that in 2021, stepping
15 back, Leapfrog was still trying to come up with an
16 imputed methodology that would lead to a nonbiased
17 result for nonresponding hospitals?

18 A. Yes. Although, obviously there was active
19 debate and one of my colleagues on the expert panel
20 explicitly argued in favor of a penalty at that time.
21 So it's been an ongoing debate obviously for years.

22 Q. And as part of that ongoing debate in the
23 2021 time frame, Mathematica was involved in trying to
24 create the circumstance where Leapfrog is not
25 penalizing hospitals through giving them a low score

1 and not rewarding them by not grading them?

2 A. Mm-hm. Yes.

3 Q. And if you go on to the next page of your
4 e-mail, you start a sentence that says:

5 "It seems safe to assume that if a
6 hospital improves substantially, it would
7 want to highlight that improvement by
8 submitting another survey. Hence, using
9 the same hospital's most recent prior
10 survey result as the preferred alternative
11 seen, both conservative and proper."

12 Do you see that?

13 A. Yes.

14 Q. And that's consistent with what you said
15 today, that that's -- Leapfrog still today, with their
16 2024 or 2025 methodology, if they are missing data
17 from that hospital for that given year, their first
18 step is to use the hospital's survey responses from
19 the year before?

20 A. Yes.

21 Q. And the next sentence you say that:

22 "Previous responses by the same
23 hospital are clearly the strongest
24 predictor of subsequent performance" --
25 "subsequent responses, and it is

1 understandable that smaller hospitals
2 might find it burdensome to respond every
3 cycle."

4 Do you see that?

5 A. Yes.

6 Q. And we talked earlier about how you agree
7 that participating in the survey for hospitals can be
8 considered burdensome.

9 Is that correct?

10 A. Yes.

11 Q. And then you go on to say that:

12 "No imputation approach is truly
13 unbiased, given that missingness is not at
14 random."

15 A. Yes.

16 Q. Do you see that?

17 A. Yes. That describes what we call
18 nonresponse bias.

19 Q. And then you caution that:

20 "Imputing a worse score, then the
21 mode of responding hospitals would be
22 problematic to make that explicit
23 assumption without evidence."

24 Do you see that?

25 A. Well, it's not "and then." I think you went

1 backward.

2 My conclusion was that no imputation
3 approach is truly unbiased, giving that missingness is
4 not at random. That is MNAR.

5 Q. Apologies.

6 Earlier in the e-mail you write that "It
7 could be worse" -- excuse me.

8 Earlier in the e-mail you write that:
9 "It would be problematic to make
10 explicit assumptions without evidence."

11 Do you see that?

12 A. Okay. You're not capturing the theme of
13 this paragraph.

14 So Mathematica had done some prior work in
15 which they identified the hospitals that were part of
16 systems, multi-hospital systems.

17 And so the proposal that was on the table
18 was to say, okay, what if some hospitals in the system
19 participate in a Leapfrog survey and other hospitals
20 don't? Can we use the data from the hospitals in the
21 same system in this -- under the same ownership to
22 generate imputed estimates for the nonparticipants?

23 So that's the context for this paragraph.

24 So -- so I'm just observing, of course, that
25 this seems like it might be a reasonable assumption.

1 One would think that if a hospital in a system was
2 better than the average of the system, they would want
3 that to be known, and they would participate in the
4 survey and advertise that they're better.

5 But if they're worse, then of course they
6 might not choose to participate, and they might rely
7 on the average being better; right?

8 So then they would have an incentive -- if
9 they know that they're below the average in their
10 system, they would have an incentive not to
11 participate because their score would go up if they
12 didn't participate because we would be substituting
13 the average for that system.

14 Q. And your point is that you didn't
15 necessarily have evidence that would support the
16 notion that those nonresponding hospitals were worse
17 than their system average, and it would be problematic
18 if you didn't have that evidence to make that explicit
19 assumption.

20 Is that correct?

21 A. I think all I'm saying here in this
22 paragraph is that I'm endorsing the notion, the
23 hypothesis that hospitals within the same system are
24 more similar to each other than hospitals across
25 systems. And I'm saying that any individual hospital

1 could be either better or worse than the average for
2 that system.

3 And we have no basis for making an
4 assumption as to whether they're either better or
5 worse than the average of the system.

6 Q. And in the sentence that says it could be
7 worse, then what you're referring to there is it could
8 be worse than the system average of the responding
9 hospitals in its system, but it would be problematic
10 to make the assumption that it's worse than the system
11 average without evidence.

12 Is that a fair characterization of that
13 sentence?

14 A. Well, I think there's no proposal on the
15 table to assume that it would be worse. All I'm
16 saying is that it could be worse. But -- and I wasn't
17 prepared to assume that it was worse but that proposal
18 wasn't on the table, so I'm not voting or expressing
19 an opinion on something that wasn't on the table.

20 Q. In two e-mails prior, isn't Dr. Srinivasan
21 suggesting that the assignment of a lower score to a
22 hospital that's not participating in the system and...

23 Two e-mails prior, Dr. Srinivasan
24 suggests in saying --

25 A. Yes.

1 Q. -- "Hospitals that don't participate, a
2 lower score."

3 A. Yes.

4 Q. And then Dr. Austin responds how the
5 Leapfrog leadership and board considered how to --
6 considered the idea of penalizing nonresponding
7 hospitals and determined not to.

8 Is that correct?

9 A. Yes.

10 Q. And then in your e-mail, you're talking
11 about an explanation for, you know, we -- when you're
12 looking at a system and you're trying to assess how to
13 grade a nonresponding hospital that's part of a system
14 where there are respondents, you are providing your
15 view on that very point.

16 Is that fair to say?

17 A. No. Because I believe that Dr. Srinivasan
18 was speaking more generally about just automatically
19 penalizing all nonparticipating hospitals.

20 And I'm speaking very specifically about the
21 point of when we use a system average to help generate
22 imputed value. So I'm just saying use the system
23 average.

24 Q. So you're looking at a subset of that group
25 of nonrespondents --

1 A. Yes.

2 Q. -- and you're saying that without evidence
3 that the nonresponding hospital in the system is worse
4 than the system, it would be problematic to make that
5 assumption without that evidence.

6 Is that fair to say?

7 A. Within the very limited context of hospitals
8 that are part of multi-hospital systems where we have
9 an average that based on some participating hospitals
10 within this -- within the same multi-hospital system,
11 it's a very limited context. Yes.

12 Q. Okay. Thank you.

13 So following this exchange in 2021, Leapfrog
14 followed an imputation methodology that is different
15 than its methodology today.

16 Is that correct?

17 A. Yes.

18 Q. And that methodology involved imputing a
19 measure for nonresponding hospitals for those four
20 measures that -- that was consistent with the average
21 of a cohort mean for those who didn't have a Step 1
22 imputation option.

23 Is that fair?

24 A. Yes.

25 Q. You can put that document to the side for

1 now.

2 Did you have any role in discussions about
3 changing Leapfrog's imputation model in 2024?

4 A. Yes.

5 Q. And what was your role?

6 A. As a member of the expert panel, we had at
7 least one meeting, I think two meetings probably, at
8 which it was discussed. I think there was a meeting
9 in April perhaps that I was unable to attend because I
10 was in clinic seeing patients. And so I believe that
11 I had a separate meeting with Matt and Missy and
12 perhaps others.

13 Q. And --

14 A. And there were e-mails of course before and
15 after that meeting.

16 Q. Do you recall whether your meeting with --
17 as you mentioned with Dr. Austin and Missy Danforth at
18 Leapfrog, do you recall whether that was before the
19 April expert safety panel?

20 A. I think it was immediately before. Like
21 even maybe earlier the same day.

22 Q. Earlier the same day.

23 And do you recall the substance of that
24 discussion?

25 A. Well, I recall they previewed some slides

1 that they were planning to present at the meeting, and
2 some of those slides addressed this imputation issue.
3 And they put a proposal on the table for how to modify
4 the approach.

5 Q. And what was that proposal that they put in
6 front of you for how to modify that -- their approach?

7 A. Well, I may not recall details of that. If
8 you would like to share a document, I'd be happy to
9 look at the document to refresh my memory.

10 Q. Absolutely.

11 Before we get into that, though, do you
12 recall how you responded to their proposal?

13 A. I responded skeptically.

14 Q. Why?

15 A. Because they were proposing to eliminate the
16 Step 1 part of the imputation approach with the
17 reliance on previous scores.

18 And I felt pretty strongly that hospitals
19 should be able to skip around now and then if they
20 found it to be too burdensome, especially with the
21 recent history of the pandemic.

22 So -- so I responded skeptically,
23 particularly to dropping the Step 1 of the imputation
24 approach.

25 Q. Did you have any other reactions to the

1 other aspects of their proposal?

2 A. Yes.

3 Q. And what were those?

4 A. Well, I think that they were proposing in
5 Step 2 to adopt an alternative approach that relied
6 heavily on the mean value reported by hospitals in the
7 first year in which they had participated in the
8 survey.

9 Q. And what aspect to that proposal did you
10 have feedback on?

11 A. Well, I was skeptical about that approach
12 because it seemed like a backdoor way of penalizing
13 nonparticipation. Because we know, of course, that
14 hospitals improve over time and we know hospitals
15 focus particularly on the measures that are included
16 in the survey.

17 So empirically it's been demonstrated
18 multiple times that over the years, as a hospital
19 participates, its scores improve.

20 So imputing or claiming to impute the
21 hospital's current performance by looking at the mean
22 of a bunch of hospitals in the first year that they
23 reported, seemed like a backdoor way of penalizing
24 nonparticipation of assigning a lower score to
25 nonparticipating hospitals.

1 Q. So your criticism to that approach was that
2 by a backdoor penalization of the nonresponding
3 hospitals, it wouldn't be clear to those nonresponding
4 hospitals that they are being penalized?

5 A. Correct.

6 Q. By backdoor penalization of those
7 nonresponding hospitals, you're referring it might not
8 be clear to the consumers of the safety grades that
9 those nonresponding hospitals are being penalized
10 through that approach?

11 A. Correct.

12 Q. Do you understand that the same proposal
13 that they presented to you the morning of the expert
14 safety panel was the same proposal they had put forth
15 to the expert safety panel?

16 A. Of course.

17 Q. Is it fair to say that the approach that
18 Leapfrog ultimately adopted is not the approach that
19 was put forward to you or the expert safety panel on
20 April 12th, 2024?

21 A. Yes. That's correct.

22 (Exhibit 13 was marked for
23 identification.)

24 BY MR. HVIDT:

25 Q. I'm handing you what's been tagged as

1 Exhibit 13 and that has been produced in this
2 litigation as Leapfrog 00437361, which is a Zoom
3 invite from Dr. Matt Austin to the expert safety panel
4 of Leapfrog, including Leapfrog employees
5 Missy Danforth and Alexandra Campione regarding
6 Leapfrog Hospital Safety Grade Expert Panel Call.

7 Do you see that, Dr. Romano?

8 A. Yes.

9 Q. And do you see that you are a recipient?

10 A. Yes.

11 Q. And as we discussed, you did not attend this
12 call, you attended an earlier call with them.

13 Is that correct?

14 A. Yes.

15 Q. And do you see there's attachments to this
16 invite?

17 A. Yes.

18 Q. And if you look to the next page, do you see
19 that the document is entitled "Leapfrog Hospital
20 Safety Grade Expert Panel Meeting"? Do you see that?

21 A. Yes.

22 Q. And flipping through this, have you seen
23 this document before?

24 A. Yes.

25 Q. Did you review this document before your

1 deposition in preparation for it?

2 (Fire drill.)

3 MR. HVIDT: Can we go off the record?

4 THE VIDEOGRAPHER: Off the record 2:00 p.m. 0

5 (Break taken in proceedings.)

6 THE VIDEOGRAPHER: On the record 2:12 p.m.

7 BY MR. HVIDT:

8 Q. All right. Dr. Romano, before we broke for
9 the fire drill, the pending question was: Did you
10 review this document, Exhibit 13, before your
11 deposition?

12 A. Not immediately before.

13 Q. Did you review it in preparation for your
14 deposition?

15 A. Not specifically. I reviewed it as part of
16 the process of refreshing my memory on this imputation
17 issue as was discussed in 2024 previous to the
18 subpoena.

19 Q. And did reviewing this document refresh your
20 recollection?

21 A. Yes.

22 Q. And if you flip to Slide 4, which ends in
23 7366, do you see where it's -- it says "Re-evaluate
24 Imputation Methodology"?

25 A. Hold on a second.

1 Okay. Yes. Mm-hm.

2 Q. And if you flip to the next page, the title
3 of the slide is "Problem that we are working to
4 solve."

5 Do you see that?

6 A. Yes.

7 Q. And it goes through the history that we just
8 walked through, which is following the loss of the
9 American Hospital Association data, Leapfrog was
10 looking to -- for a way to respond to that loss of
11 data.

12 A. Yes.

13 Q. And then Leapfrog was seeking ways to
14 grade --

15 (Fire drill announcement.)

16 BY MR. HVIDT:

17 Q. Do you see that?

18 A. Yes.

19 (Fire drill announcement.)

20 MR. HVIDT: Do you need me to repeat that
21 question?

22 THE COURT REPORTER: Yes.

23 BY MR. HVIDT:

24 Q. And then underneath the "History" it says
25 "Leapfrog was also seeking for ways to grade

1 additional hospitals."

2 Do you see that?

3 A. Yes.

4 Q. And then the next bullet says "We are
5 currently facing these challenges."

6 Do you see that?

7 A. Yes.

8 Q. And the first subbullet reads:

9 "Imputed scores have crept up, making
10 imputation a more favorable choice for
11 lots of hospitals and it's de-incentivized
12 true transparency of performance."

13 Do you see that?

14 A. Yes.

15 Q. And the next bullet says:

16 "Hospitals are using Step 1
17 imputation" paren "(using their individual
18 hospital's historical data)" close paren
19 "as a reason to not report on the current
20 year's survey."

21 Do you see that?

22 A. Yes.

23 Q. So as it relates to that -- those items, do
24 both of those challenges kind of relate towards the
25 notion that there are less hospitals responding to the

1 Leapfrog hospital survey?

2 A. There was a drop in participation, yes.
3 These are two different potential explanations or
4 theories related to that drop.

5 Q. And there are potentially more theories to
6 explain a drop in hospital participation in the
7 Leapfrog survey.

8 Is that fair?

9 A. Yes.

10 Q. One could be the burden of responding to the
11 Leapfrog hospital survey.

12 Is that correct?

13 A. Well, every hospital evaluates that burden
14 against the potential benefits or consequences of not
15 participating.

16 Q. But it is the burden -- is the notion that
17 the burden of responding to the hospital outweighs the
18 benefit of responding to the hospital survey a reason
19 that some hospitals choose not to respond to the
20 Leapfrog hospital survey?

21 A. Yes.

22 Q. Flipping to the next page, do you see where
23 it says "Data sources and measure weights in the
24 process structural domain"?

25 A. Yes.

1 Q. And if you look at those rows that are gray,
2 those are the imputed -- the measures that are imputed
3 for nonresponding hospitals.

4 Is that fair to say?

5 A. Yes.

6 Q. And if you go to slide 7, the next slide --
7 I know that it's been printed in a...

8 The top of the slide reads "Current
9 Imputation Model."

10 Do you see that?

11 A. Yes.

12 Q. And is it your understanding that that was
13 explained on slide 7 as the approach that Leapfrog was
14 applying prior to the 2024 methodology change?

15 A. Yes.

16 Q. And you were involved in around 2020 and
17 2021 in advising Leapfrog regarding implementing that
18 imputation methodology.

19 Is that correct?

20 A. Yeah. To be precise, we supported the -- a
21 three-step imputation approach that also used
22 information on hospital systems. But I believe that
23 approach received too much pushback or criticism from
24 hospitals that claimed that their system affiliations
25 were out of date and that they were incorrect or

1 whatever.

2 And so I think Leapfrog board and Missy and
3 Leah made a decision to drop that step in the
4 imputation.

5 I don't recall how much we were involved in
6 that particular discussion about responding to the
7 feedback on the system issue.

8 Q. Understood.

9 So the current imputation methodology, as
10 reflected on slide 7, is -- does not include a step
11 that involved assigning a hospital a measure based on
12 how the system hospitals performed for a nonresponding
13 hospital that was part of a system --

14 A. That's correct.

15 Q. -- where there was some performance?

16 A. That's correct.

17 Q. Okay. And if you flip to slide 12, which
18 ends in 7374, do you see how the slide is titled
19 "Hospitals Eligible for Imputation"?

20 A. Yes.

21 Q. And if you look at the language underneath
22 that title, the second sentence, do you see where it
23 says:

24 "A slight dip in survey participation
25 occurred this past year as hospitals opted

1 to use past survey results in Step 1
2 imputation."

3 Do you see that?

4 A. Yes.

5 Q. Is that consistent with what we talked about
6 earlier where Leapfrog was concerned that there had
7 been a drop in hospital participation in its survey?

8 A. Yes.

9 Q. And that drop in hospital participation in
10 its survey led Leapfrog to consider changing its
11 imputation methodology.

12 Is that correct?

13 A. Among other factors that we've discussed,
14 yes.

15 Q. If you flip to slide 13 in the next slide,
16 it discusses the proposed future imputation
17 methodology.

18 Do you see that?

19 A. Yes.

20 Q. And consistent with what we were just
21 talking about before I showed you this exhibit, at --
22 going into the April 12th, 2024 expert safety panel
23 meeting, Leapfrog was recommending a new imputation
24 methodology where it would retire the Step 1 aspect
25 for imputing measures using the hospital's prior

1 year -- prior participation in the survey.

2 Is that correct?

3 A. Just to be clear, Matt Austin was leading
4 the presentation. I presume that he had vetted the
5 presentation previously with Missy. So when you say
6 Leapfrog was proposing this, I just want to make it
7 clear that it was Matt Austin and Missy Danforth who
8 were proposing this.

9 Q. Thank you.

10 The methodology change that was proposed in
11 this presentation, that was also the same methodology
12 change that was presented to you before the expert
13 safety panel call involved retiring the Step 1 of the
14 imputation methodology.

15 Is that correct?

16 A. Yes.

17 Q. And Step 1 of the imputation methodology was
18 using the hospital's prior grade -- prior survey
19 answers to determine its current grade?

20 A. Yes.

21 Q. And you talked how in your view that's the
22 preferred alternative data source is past
23 participation -- past data about that hospital might
24 be the best indicator of current metrics if you don't
25 have current metrics?

1 A. Yes.

2 Q. And instead, they -- in this proposal, their
3 proposal retiring that Step 1, and under Step 2,
4 adjusting the imputation to impute to an average of
5 how a hospital -- hospitals that respond in their
6 first year of participation.

7 Is that correct?

8 A. Yes.

9 Q. And the methodology that we're looking at
10 here on slide 13, that's not the methodology that
11 Leapfrog ends up using for 2024 forward; correct?

12 A. That's correct.

13 Q. In 2024, spring, up through June, was there
14 another -- an additional expert safety Zoom or meeting
15 where Leapfrog individuals like Missy Danforth or
16 Alex Campione met with the expert safety panel?

17 A. I don't recall an additional meeting. There
18 were certainly lots of e-mails.

19 Q. Aside from e-mail correspondence about the
20 next steps, there was no additional expert safety
21 panel with the whole -- or a quorum of the group
22 coming together to discuss a proposed methodology
23 change.

24 Is that correct?

25 A. That's my recollection. But you could

1 provide evidence that there was such a meeting. I
2 don't recall it.

3 Q. You've referenced e-mail correspondence and
4 so that is where we are going to turn to. We'll mark
5 this as Romano Exhibit 14.

6 (Exhibit 14 was marked for
7 identification.)

8 BY MR. HVIDT:

9 Q. And if we go to the last page of this -- or
10 the second to last page of this document --

11 Excuse me. Before we do that, Exhibit 14
12 has been produced in this litigation as
13 Armstrong_0008450. And at the top there is
14 communication from Patrick Romano dated May 15th, 2024
15 to Matt Austin, copying Missy Danforth and
16 Alex Campione, regarding Leapfrog proposed texts for
17 imputation change.

18 Do you see that?

19 A. Yes. I believe I also produced a version of
20 this.

21 Q. And do you believe there's differences
22 between the version you produced and then this
23 version?

24 A. I doubt it.

25 Q. And do you see that there's attachments

1 listed there to the e-mail, "AHSG, proposed imputation
2 change, fall 20240PSR.docx.

3 Do you see that?

4 A. I'm sorry.

5 Q. Underneath the subject of the e-mail,
6 there's a --

7 A. Yes.

8 Q. -- reference to "Attachments."

9 A. Yes.

10 Q. Do you see that?

11 A. Yes.

12 Q. And do you see at the end of that document
13 title, it says "PSR"?

14 A. Yes.

15 Q. Are those your initials?

16 A. They are.

17 Q. And have you seen this e-mail before?

18 A. Yes. Obviously my version doesn't have the
19 banner for external e-mail. Use caution. But yes.

20 Q. And if you flip to the beginning of this
21 e-mail chain, do you see a Bates number ending 8451
22 e-mail from Matt Austin dated May 7th, 2024?

23 A. Yes.

24 Q. Okay. And the e-mail is addressed to you.
25 Do you see that?

1 A. Yes.

2 Q. And Dr. Austin says:

3 "Since our conversation with you a
4 couple weeks ago about changing the
5 imputation approach used in Leapfrog's
6 hospital safety grade, we met with the
7 broader expert panel to hear their input
8 and have drafted the attached language to
9 share with hospitals about the proposed
10 changes."

11 Do you see that?

12 A. Yes.

13 Q. And in the next paragraph, Dr. Austin says:

14 "In the attached, I believe you will
15 see we found a path forward that still
16 uses the hospital's unique historical data
17 when available, although for a shortened
18 period of time. And when historical data
19 are not available, creates an incentive
20 for hospitals to share information about
21 their patient safety practices."

22 Do you see that?

23 A. Yes.

24 Q. And when he references "the path forward
25 that uses the hospital's unique historical data," is

1 that probably responsive to the conversation you had
2 with Dr. Austin and Missy and Alex before the
3 expert safety panel regarding your input on their
4 proposed change?

5 A. I believe so.

6 Q. And when it references an incentive for
7 hospitals to share information, was that also a
8 subject of your discussion with them from April?

9 A. Yes.

10 Q. And if we flip over to your e-mail response,
11 do you see again how there's an attachment there with
12 your -- under -- here on the first page, reference to
13 your initials?

14 A. Yes.

15 Q. If you look at the last page, you see how
16 it's in gray? It's kind of hard to see who did the
17 revisions.

18 A. Yes.

19 Q. Okay. I'm going to mark what is Exhibit 15.

20 (Exhibit 15 was marked for
21 identification.)

22 THE WITNESS: I believe if you have the
23 original document, there are a combination of
24 revisions by Matt Austin, MA, by Peter Pronovost, and
25 by me.

1 BY MR. HVIDT:

2 Q. And you'll see what I've handed you is a
3 color version of the e-mail that's included in
4 Exhibit 14 there where there's red edits and there are
5 blue edits.

6 I'll represent --

7 Do you see that?

8 A. Yes.

9 Q. And I'll represent to you that the blue
10 edits from the native -- the metadata are edits you
11 made, and that the red edits are edits that
12 Dr. Pronovost made.

13 Do you see those edits?

14 A. Yes.

15 Q. And if we're looking through your edits
16 here, why did you propose those changes?

17 A. To be more explicit of the intent of the new
18 approach to encourage survey participation and to
19 improve user's confidence in the data that are being
20 used to calculate scores.

21 Q. And did you think that that was an important
22 message that needed to be communicated to hospitals
23 and to the consumers of the safety grade as to why the
24 methodology change was occurring?

25 A. Yes. I also endorsed Dr. Pronovost's

1 recommendations. So as you can see, I could have
2 modified them, but did so only very slightly.

3 Q. Why did you feel that it was important to
4 include the intent behind the methodology change?

5 A. Well, the whole program is based on
6 transparency. So we want hospitals to be transparent.
7 Leapfrog also has to be transparent. So the
8 transparency works in both directions.

9 Q. And so you wanted Leapfrog to be more
10 transparent that it was trying to encourage hospital
11 participation through this methodology change?

12 MR. BILLEK: Object to form.

13 You can answer.

14 BY MR. HVIDT:

15 Q. Is that correct?

16 A. Yes.

17 Q. And going back, when you made these edits
18 to -- you can go back to the prior exhibit,
19 Exhibit 14, and then going to your e-mail at the front
20 page. Let me know when you are there.

21 When you sent these proposed edits to the
22 proposed imputation change, you included your view of
23 the proposed change.

24 Is that fair to say?

25 A. Yes.

1 Q. And you wrote back endorsing the change,
2 saying, "I like the simpler more direct approach
3 here."

4 Do you see that?

5 A. Yes.

6 Q. And that's consistent with what we talked
7 about in your recommendation before the expert safety
8 call that you didn't like the backdoor penalization
9 approach.

10 Is that correct?

11 A. Yes.

12 Q. And then you next state, quote:

13 "If the goal is to penalize
14 nonparticipants you, might as well do so
15 in a clear and unmistakable manner while
16 allowing for hospitals to manage their
17 burden and jump back on the bandwagon
18 after a year."

19 Do you see that?

20 A. The wagon. Yes.

21 Q. And is that an accurate statement of your
22 view towards what Leapfrog should have done in 2024?

23 A. It's slightly colloquial in a manner of
24 speech between people who have known each other for
25 many years, but yes.

1 Q. Do you agree with your characterization of
2 what -- do you agree your recommendation that you made
3 here sitting here today?

4 A. Yes.

5 Q. And when you say "if the goal is to penalize
6 nonparticipants," are you saying that if the goal is
7 to penalize nonparticipants because it was
8 communicated to you that that was a goal of the
9 imputation approach?

10 A. No. I don't think that's what I'm saying.

11 Q. Why do you reference then the goal of
12 penalizing nonparticipants?

13 A. Well, because, again, the contextual
14 considerations are at play. So we see a decline in
15 participation. We believe that participating in the
16 survey is itself beneficial because there's an
17 educational process for hospitals to convene their
18 staff and go through the survey and identify the gaps
19 in their care and figure out what to do to improve
20 their care in these domains.

21 So there's a strong shared desire to
22 encourage participation in the survey and to avoid a
23 situation where nonparticipants are riding on the
24 coattails of participants, as participants continue to
25 improve.

1 So in that context, we were discussing how
2 to motivate the greater participation.

3 Q. One of the ways to motivate greater
4 participation is so penalize nonrespondents.

5 Is that correct?

6 A. Yes.

7 Q. And is that described here, the penalization
8 of nonrespondents as a goal of Leapfrog?

9 A. In itself, that's not the goal. So that's a
10 colloquial statement to the problem; right?

11 The goal is to have more data available in
12 the marketplace of information to drive improvement in
13 patient safety. That's the goal. That's the mission.

14 So the penalization of nonparticipants is a
15 step, an intermediate step.

16 So my phrasing here is colloquial because
17 we're -- we're mindful of the real goal is reducing
18 harm and improving safety, saving lives. That's the
19 real goal.

20 Q. But here you say the goal is to penalize
21 nonparticipants.

22 Is that correct?

23 MR. BILLEK: Object to form.

24 THE WITNESS: Again, I think I've made clear
25 that the goal -- no. That's not the goal.

1 The goal is to improve patient safety, to
2 reduce hospital harm, to save lives.

3 So this was discussed as what you might call
4 a pathway towards that goal.

5 BY MR. HVIDT:

6 Q. In this sentence you do not say that the
7 goal is to save lives.

8 Is that correct?

9 A. But I think there's a shared understanding
10 that that is the goal of the program.

11 Q. Sir, I'm asking you on this page if there it
12 says that the goal is to save lives and increase
13 transparency? Or does it say the goal is to penalize
14 nonparticipants?

15 MR. BILLEK: Just note my objection to the
16 form of the question.

17 THE WITNESS: Again, I'm --

18 MR. BILLEK: It's certainly argumentative at
19 this point. Asked and answered a number of times.

20 THE WITNESS: Yeah. I'm going to say that
21 this is a colloquial phrasing.

22 We understood from the meeting and elsewhere
23 that the goal of the program is to save lives, to
24 improve patient safety, to reduce harm. So in this
25 particular wording, it's understood by both parties

1 who have known each other for many years that this is
2 simply an intermediate pathway towards that goal.

3 BY MR. HVIDT:

4 Q. And the intermediate pathway you're
5 identifying is that to get to that greater point, you
6 need to penalize nonrespondents in the first instance.

7 Is that correct?

8 A. Yes.

9 Q. And in the next sentence you go on to say
10 that "This approach is" -- "makes the consequences of
11 nonresponse more readily apparent."

12 Do you see that?

13 A. Yes.

14 Q. And do you think the consequences of
15 nonresponse would be more readily apparent to the
16 hospitals? Is that who you're referring to?

17 A. To everyone; to the hospitals to employers
18 that are represented by Leapfrog's board, to users who
19 look at the website and see that -- that a limited
20 achievement score was assigned in these cases.

21 Q. And do you think that it's apparent to a
22 viewer of the website that it's -- someone was
23 assigned a limited achievement measure because they
24 didn't participate in the survey and there's no data
25 for that?

1 A. I think it's pretty clear there's an
2 asterisk. There's red font. Yes.

3 Q. And so you think that the consumer looks
4 beyond just the letter grade up there, goes down to
5 the footnotes?

6 A. Well, an intelligent consumer should always
7 look behind the first panel, if you will, to
8 understand what goes into the grade, yes.

9 Q. Are all consumers intelligent?

10 MR. BILLEK: Object to form.

11 THE WITNESS: I believe that most consumers
12 that would end up on Leapfrog's hospital safety grade
13 page are intelligent, yes.

14 I cannot vouch for the Google analytics on
15 how many people click through to subsequent pages
16 and...

17 BY MR. HVIDT:

18 Q. Going down to the next paragraph, you go on
19 to talk about the Step B proposal.

20 That's referring to the Step B proposal in
21 that presentation we just looked at on the April 12th
22 expert safety panel.

23 Is that correct?

24 A. 2B, correct.

25 Q. And then you continue to say that:

1 "The underlying hypothesis behind"
2 your "proposed Step 2B approach was that
3 hospitals stop reporting because their
4 true performance deteriorated relative to
5 their cohort."

6 Do you see that?

7 A. Can you --

8 Q. If you go down to the fourth line, there's a
9 sentence there, "The underlying hypothesis."

10 A. Yes.

11 Q. And in that sentence, you're describing what
12 the hypothesis was behind the Step 2B approach that
13 Matt and whoever else was involved in putting together
14 that presentation, included in that presentation for
15 Step 2B?

16 A. Right.

17 So as we've discussed, imputations always
18 involve assumptions. The assumptions are usually
19 wrong in various ways. But obviously if you're using
20 the cohort mean for the first year in which the
21 measure was reported, then the underlying assumption
22 is that hospitals that are nonparticipating have sort
23 of deteriorated back to where hospitals would have
24 been in the first year. There are alternative
25 assumptions.

1 Q. Right.

2 And that was their hypothesis that they --
3 that went into their approach that you're describing;
4 correct?

5 A. I don't know that it was explicitly stated.
6 I'm just saying that it is the underlying assumption.

7 So part of my job as an academic is to help
8 clearly elucidate the assumptions that underlie
9 people's analysis.

10 Q. Totally understand.

11 And then can you read into the record the
12 next sentence beginning "My hypothesis"?

13 A. "My hypothesis by comparison was that
14 most hospitals stop reporting because it's
15 too burdensome and because they only find
16 market value in an A grade which proves
17 impossible to attain or maintain."

18 Q. And then you go on to say, "If my hypothesis
19 is correct, then the current Step 2 approach, current
20 cohort mean," there -- that's referring to not their
21 proposal but what Leapfrog is actually doing in its
22 imputation methodology up to this point?

23 A. Correct.

24 Q. And you say that the current Step 2
25 approach, quote, "would yield more accurate

1 imputations."

2 Do you see that?

3 A. Yes.

4 Q. Do you agree with that?

5 A. Under the condition that my hypothesis is
6 correct, I agree with that statement.

7 Q. And then you go on to say, quote, "But it
8 doesn't achieve your strategic objective of penalizing
9 nonparticipants."

10 Do you see that?

11 A. Yes.

12 Q. When you say "your strategic objective of
13 penalizing nonparticipants," are you referring to
14 Leapfrog's strategic objective there?

15 A. Yes. I'm referring to Leapfrog's desire to
16 address the concerns that we previously discussed,
17 including particularly complaints from participating
18 hospitals that nonparticipating hospitals were riding
19 on their coattails.

20 Q. But there you described the strategic
21 objective of penalizing nonparticipants.

22 Is that correct?

23 A. Yes. It needs to be clear that that -- it's
24 not an objective in itself. It's an objective towards
25 the goal of improving transparency, improving

1 accountability, and ultimately saving lives.

2 Q. And in this sentence, is it fair to say that
3 you're recognizing that the current Step 2 approach is
4 more accurate -- more accurate imputations than the
5 approach that Leapfrog is now proposing for the
6 imputation methodology?

7 A. Yes. More accurate in the sense that it is
8 more unbiased that it would lead to a mean for -- a
9 mean value for nonparticipating hospitals that would
10 be closer to the counterfactual mean value for the
11 same hospitals if they had chosen to participate.

12 Q. Understood.

13 And then can you read into the record the
14 last sentence -- the last two sentences of your e-mail
15 there beginning "In other words"?

16 A. "In other words, I wasn't keen on a
17 backdoor approach to penalizing
18 nonparticipation. If you want to penalize
19 nonparticipants, then don't pretend that
20 you're imputing missing values in a
21 statistically optimal way. Just be honest
22 about your goal."

23 Q. And you've referenced, as we've said a few
24 times, the notion of Leapfrog strategic objective of
25 penalizing nonparticipants that you've caveated in the

1 ways you have.

2 But when you say your strategic objective of
3 penalizing nonparticipants, was there a conversation
4 with Leapfrog that led you to -- to conclude that you
5 could describe their objective in that manner?

6 A. I don't recall because I was not at the
7 meeting in which this was discussed, and I didn't
8 listen to or review a transcript of the meeting. So I
9 can't say exactly how it was presented.

10 Q. But you wouldn't describe someone's
11 objective without having heard from them what their
12 objective was.

13 Is that fair to say?

14 A. In this context, their stated objective was
15 to incentivize participation, to motivate
16 participation. It's implicit that you motivate
17 participation by penalizing nonparticipation.

18 You've talked about carrots and sticks.

19 I'm saying that there are two sides of the
20 same instrument that, in effect, you can't motivate
21 participation without de-motivating or penalizing
22 nonparticipation.

23 So I'm stating it perhaps a little bit more
24 directly and bluntly than Leapfrog staff did.

25 Q. Aren't you also recommending that they state

1 it bluntly, if you will; you're recommending that they
2 be transparent about what they're trying to do.

3 Is that fair to say?

4 A. Right. And that's what motivated my
5 amendments to this release.

6 Q. And that's what motivated your last sentence
7 there about being honest about your goal.

8 Is that correct?

9 A. Yes. Yes.

10 Q. Do you understand that your proposed edits
11 to the messaging were removed in the final methodology
12 approach that was released?

13 A. I am not aware of what changes were made.

14 Q. Do you think that Leapfrog has been
15 sufficiently honest with its imputation change
16 explanation in the public-facing materials, that it is
17 encouraging nonparticipating hospitals to participate
18 in the survey by penalizing them through these imputed
19 measures?

20 A. I'm satisfied with the website presentation
21 of the information. I can't say that I've read every
22 document and report. I'm also satisfied with the
23 technical summary that they release with each cycle.
24 But if you have a document to share with me, I'd be
25 happy to comment on my satisfaction with it.

1 Q. Do they use the word "penalize" in their
2 public-facing documents about the limited achievement
3 score?

4 A. I can't say whether they do or not.

5 Q. Did you get a response to this e-mail from
6 Leapfrog saying that, you know, they disagree with how
7 you've characterized things?

8 A. I don't recall such a response, but I'd be
9 happy to review one if you have one.

10 (Exhibit 16 was marked for
11 identification.)

12 BY MR. HVIDT:

13 Q. I'm handing you what's been marked
14 Exhibit 13 in your deposition. It's also been
15 previously marked as an exhibit in other depositions
16 with Ms. Campione and Ms. Danforth.

17 MR. BILLEK: 13?

18 MR. HVIDT: 16. This is Exhibit 16.

19 It has been produced in this litigation as
20 Leapfrog 01081490. It's an e-mail from
21 Alexandra Campione to Patrick Romano dated May 15th,
22 2024 regarding "Leapfrog proposed text for imputation
23 change."

24 BY MR. HVIDT:

25 Q. Do you see that?

1 A. Yes.

2 Q. And who is Ms. Campione?

3 A. She's the lead analyst who works for
4 Missy Danforth.

5 Q. And she's the lead analyst for the
6 Leapfrog hospital safety grade.

7 Is that correct?

8 A. Yes. Yes.

9 Q. And how does she respond to the e-mail we
10 just looked at in Exhibit 15?

11 A. She says, "Thank you for your feedback. I
12 completely agree."

13 Q. Do you know if you ever received a response
14 from Missy Danforth to your e-mail?

15 A. I don't recall. I doubt that I saved this
16 particular e-mail since it was so short and
17 uninformative. I can't say whether Missy provided a
18 similar response or not.

19 Q. And did you ever receive a response from
20 Dr. Austin to this e-mail?

21 A. I don't recall offhand.

22 Q. So is it fair to say the recipients to your
23 e-mail below, you don't have any record or
24 recollection of them responding to your e-mail saying
25 they disagree with the characterization and the

1 communications that you have in your May 14th, 2024
2 e-mail?

3 A. It -- if they had expressed clear
4 disagreement, I probably would remember that, but I
5 have no such memory on this date.

6 Q. Thank you.

7 You can set that to the side.

8 (Exhibit 17 was marked for
9 identification.)

10 BY MR. HVIDT:

11 Q. I am handing you what has been marked
12 Exhibit 17 to the Romano deposition. It's been
13 produced in this litigation as Leapfrog 00261719. The
14 top e-mail is from Matt Austin dated June 26, 2024 to
15 several individuals, including Dr. Romano, regarding
16 "Final updates to the Leapfrog Hospital Safety Grade
17 Methodology for fall 2024."

18 Do you see that, Dr. Romano?

19 A. Yes.

20 Q. And do you see yourself among the
21 recipients?

22 A. Yes.

23 Q. And do you see how there's an attachment to
24 this e-mail?

25 A. Yes.

1 Q. And in this e-mail from Dr. Austin at the
2 top, does Dr. Austin reference in this e-mail that the
3 substance of the attachment puts forward a different
4 methodology than that presented at the April 12th,
5 2024 expert safety panel?

6 A. Well, he references that -- or he implies
7 that changes were made based on the expert panel's
8 thoughtful input and guidance, but clearly the text of
9 the e-mail is not explicit about those changes.

10 Q. And when -- with this being sent, is there
11 a, you know -- does it couple with a -- you know, a
12 vote among the expert safety panel, whether the group
13 or majority of the group agrees with a methodology
14 change like this? Is that how the process works?

15 A. No. We don't typically vote. Typically we
16 discuss and argue until we achieve some consensus,
17 some acceptable degree of consensus.

18 Q. And you weren't at the April 12th, 2024
19 meeting; correct?

20 A. Correct.

21 Q. And so as far as you're aware, there could
22 have been expert panelists at that meeting who were
23 concerned with an approach that penalized
24 nonresponding hospitals.

25 Is that fair?

1 A. Well, my understanding from separate
2 discussions -- I'm trying to recall maybe a telephone
3 call -- that my understanding was that other members
4 of the expert panel had independently expressed a
5 similar view as mine.

6 Q. And who were those discussions with?

7 A. I think with Matt.

8 Q. Were those before or after the methodology
9 change was implemented?

10 A. Well, before this, but after the April
11 expert panel meeting.

12 So I think Matt was just giving me a brief
13 update on what happened in the expert panel, and said
14 that there was more discussion and that other expert
15 panelists also favored sort of a more explicit
16 approach.

17 Q. Did he explain that there were any expert
18 panelists who did not favor a more explicit approach?

19 A. I didn't hear that if there were.

20 Q. Did he suggest that there was some expert
21 panelists who had concerns about that type of
22 approach?

23 A. I only heard that there was active
24 discussion.

25 Q. Had you heard that there were concerns from

1 expert panelists regarding penalizing nonrespondents,
2 would that have caused you to change your
3 recommendation or your view on how Leapfrog should
4 proceed?

5 A. Well, it's hard to say because that's a set
6 of hypotheticals. Obviously the expert panel includes
7 a variety of panelists who aren't shy. We're all
8 quite willing to share our opinions and perspectives.

9 And, you know, so could Peter Pronovost have
10 persuaded me differently, or Arnie Milstein, or
11 Sara Singer? It's possible.

12 Q. Have you ever seen a transcript of that
13 April 12th, 2024 expert safety panel discussion?

14 A. I think I saw some notes, but not a
15 transcript.

16 Perhaps they're the notes that Preeti refers
17 to here on May 15th.

18 Q. Right.

19 So you saw the notes, but you haven't seen a
20 transcript, per se --

21 A. No.

22 Q. Okay. And if you look to the attachment to
23 this e-mail here in Exhibit 17, do you see how this is
24 the updates to the methodology change that's designed
25 for public release of the change?

1 A. Yes.

2 Q. If you turn -- reading through this
3 document -- and please take your time. Can you let me
4 know if you see anything that suggests that the intent
5 behind this methodology change is to penalize
6 nonresponding hospitals and to encourage them to
7 participate?

8 A. Yes. Yeah.

9 Q. And where is that?

10 A. Well, so in the second paragraph on
11 page 1723, it describes the new approach, and there's
12 a subtle word change here, "but instead of imputing a
13 score based on the cohort mean, hospitals will be
14 assigned a point value that is equivalent to receiving
15 limited achievement for that measure on Leapfrog
16 hospital survey."

17 And then a sentence later:

18 "Hospitals that decline to complete
19 the survey should not inadvertently
20 benefit when compared to hospitals that
21 demonstrate through transparency that they
22 are on a pathway to achieve high standards
23 for patient safety."

24 So this I think clearly articulates that
25 we're not -- that the new method doesn't allow

1 hospitals to inadvertently benefit from
2 nonparticipation.

3 And then on page 1725, of course there's a
4 summary statement that says:

5 "Four commenters opposed penalizing
6 hospitals that choose not to devote
7 resources to completing a voluntary survey
8 each year and stressed that they be
9 allowed to opt out."

10 And then of course there's a response to
11 that from Leapfrog staff.

12 I don't know whether Matt Austin was
13 involved in that response. I wasn't personally. But
14 it clearly acknowledges the issue of penalizing
15 hospitals.

16 Q. And going back to the first instance that
17 you just talked about under the step -- new Step 2
18 imputation ending in 1723.

19 Do you see that paragraph?

20 A. Yes.

21 Q. Is that the same paragraph you just
22 referenced in your prior answer?

23 A. Yes.

24 Q. And in that paragraph, it doesn't say that
25 Leapfrog is penalizing nonparticipants in those words;

1 correct?

2 A. Not exactly in those words, right.
3 Obviously the only way to avoid any inadvertent
4 benefit is to penalize. They are flip sides of the
5 same coin.

6 Q. And if you go to the commentators that
7 oppose penalizing hospitals, does that mean that when
8 Leapfrog put this proposed methodology change out for
9 implementation and for comment on that, four
10 commentators objected to this change because they
11 feared that it would penalize hospitals that chose not
12 to participate in the hospital survey?

13 A. Well, I don't think they're describing a
14 fear. They're observing that the proposal penalizes
15 hospitals that choose not to devote resources, and
16 they're opposing that stance.

17 Q. Right.

18 So it hadn't been implemented yet. And so
19 they're just commenting on the idea that if you had
20 implemented that approach, it would penalize
21 nonresponding hospitals?

22 A. Yes.

23 Q. And even upon -- so that means that before
24 Leapfrog announced its change to its imputation
25 methodology in 2024, it had received feedback from

1 individuals that that change that they were proposing
2 would penalize nonrespondents.

3 Is that correct?

4 A. Yes.

5 Q. And they went forward with the proposed
6 change anyway.

7 Is that correct?

8 A. Yes. Because it was explicitly discussed
9 obviously prior to this date.

10 Q. And in looking at these responses to public
11 comments, how many comments do you see that were in
12 support of the methodology change?

13 A. It says "Four commenters supported the
14 change to the imputation methodology."

15 Q. And if you look at the bolded comments that
16 follow that, do you see where it says:

17 "One commenter expressed concerns
18 about public not realizing a score was
19 imputed on the hospital safety grade
20 website"?

21 Do you see that?

22 A. Yes.

23 Q. And do you see that the next bullet says:

24 "Two commentators expressed concerns
25 about Step 2 imputation misrepresenting

1 the current procedures or infrastructure
2 of the hospital to the public"?

3 Do you see that?

4 A. Yes.

5 Q. And then "Two commentators requested
6 that the proposed changes be delayed until
7 spring 2025 to allow hospitals time to
8 complete the Leapfrog hospital survey."

9 Do you see that?

10 A. Yes.

11 Q. "And four commentators opposed
12 penalizing hospitals that chose not to
13 devote resources to completing a voluntary
14 survey each year and suggested that they
15 be allowed to opt out of the hospital's
16 safety grade."

17 Do you see that?

18 A. Yes.

19 Q. So adding those up, there are nine
20 commentators who expressed concern within the 2024
21 methodology change --

22 A. I have no information that it's valid to add
23 up those numbers.

24 Q. Sir, may I complete my question first?

25 A. Oh, sorry.

1 Q. Using the numbers that are in this document,
2 the commentators, if you add up those ones we just
3 walked through, there are nine that -- commentators
4 that oppose -- that oppose the methodology change for
5 the reasons stated, and there were four commentators
6 who supported the methodology change?

7 MR. BILLEK: Object to form.

8 You can answer.

9 THE WITNESS: That's an invalid addition
10 because the commentators frequently make multiple
11 comments in the same letter. So it may have been the
12 same commenters who made the comment about Step 2
13 imputation misrepresenting current procedures and
14 opposing penalizing hospitals.

15 So I have no information. It may only have
16 been four commentators that actually had all of these
17 objections. I don't know. It could be anywhere
18 between four and nine.

19 BY MR. HVIDT:

20 Q. Anywhere between four and nine commentators
21 opposed the methodology change for various reasons
22 stated here.

23 Is that correct?

24 A. And to make a further correction, the two
25 commenters that requested the proposed changes be

1 delayed, in effect that comment was adopted because
2 hospitals were given an opportunity to submit a survey
3 before this change took effect.

4 So -- so that -- that comment essentially
5 was addressed. So the comments about imputation, so
6 you're down to one plus two plus four, so you're down
7 to seven at most.

8 Q. So in the first item, the hospitals were
9 given two more -- two months to complete the survey in
10 response to this methodology change that's being
11 announced around the same time as the typical deadline
12 to submit a survey.

13 Is that correct?

14 A. Yes.

15 Q. Okay. But it's not that they're given the
16 opportunity until spring 2025 to respond to the
17 survey, which is what the comment was.

18 A. Well, I think they explicitly said hospitals
19 that wish to have 2024 survey used will have until
20 November 30th to submit their survey. So they're
21 extending the time window.

22 Q. For the spring 2025 safety grade?

23 A. Yes.

24 And of course they are also allowing the
25 2023 data to be used for that 2025.

1 So in effect, they're addressing those two
2 comments completely.

3 Q. Have you seen the underlying comments that
4 were submitted here that --

5 A. I have not.

6 Q. -- go into this summary?

7 A. I have not.

8 Q. Do you have any understanding if these are
9 fair characterizations of the comments?

10 A. I can't speak to whether they're fair
11 characterizations. They certainly sound fair in that
12 they are honest descriptions of the -- of the nature
13 of the comments, yes. But I have not seen the
14 original comments.

15 Q. But is it fair to say even though Leapfrog
16 received comments from individuals that the
17 methodology change could misrepresent current
18 procedures, could not be realized by observers on the
19 website that a score was imputed, and that it could
20 penalize nonresponding hospitals, Leapfrog decided to
21 go forward with its methodology change even though it
22 received comments such as those?

23 MR. BILLEK: Object to form.

24 You can answer.

25 THE WITNESS: Again, Leapfrog responded to

1 the commenter concerned about the public display of
2 information, and they acknowledged that and said they
3 would add a denotation to this website to indicate
4 when a measure has been imputed or signed. And they
5 also clearly provided an extension and additional
6 opportunities.

7 So at the end of the day, this is not a
8 vote. This is -- I'm reminded of the Lake Wobegon
9 problem where every hospital thinks it's above average
10 and every hospital can't be above average.

11 So at the end of the day, obviously
12 Leapfrog Group, with input from its expert panel and
13 others, has to balance the comments and make the best
14 decision under the circumstances.

15 BY MR. HVIDT:

16 Q. Do you know how Leapfrog informs a visitor
17 to the website of The Leapfrog Safety Group --
18 The Leapfrog Group website where you go to see the
19 survey responses, that a hospital hasn't participated
20 in a survey?

21 A. I'm not sure because I think there's a
22 separate website for the hospital safety grade versus
23 the website for The Leapfrog Group per se and the
24 hospital survey.

25 So, I mean, I've been to both websites, but

1 I'm not familiar with the details of how things are
2 presented. But of course I've looked up certain
3 hospitals of interest, and so I see how the results
4 are displayed. Dashboard presentation.

5 Q. So you have no understanding whether there's
6 a difference on the one website where -- for how
7 Leapfrog communicates that a hospital hasn't completed
8 the survey, versus how Leapfrog communicates on the
9 safety grade website, how a hospital didn't complete
10 the survey?

11 Is that fair?

12 A. Well, I'm most familiar with the dashboard
13 presentation that shows the summary grade and then a
14 specific components in a series of tabs. If there's
15 another presentation, I'm not familiar with it.

16 Q. Thank you.

17 Do you think that it's reasonable for a
18 hospital to decide not to participate in the Leapfrog
19 survey?

20 A. Of course it's reasonable. It's
21 undesirable, but it's reasonable.

22 Q. Undesirable to who?

23 A. Undesirable from the standpoint of our
24 mutual interest in driving improvements in quality and
25 safety and reducing hospital harm, saving lives.

1 Q. Is there a direct correlation between
2 participating in the Leapfrog hospital survey and
3 improving quality at that hospital?

4 MR. BILLEK: Object to the form of the
5 question.

6 You can answer.

7 THE WITNESS: I believe that there is. But
8 obviously there are a variety of imperial analyses
9 that have come to a variety of conclusions.

10 BY MR. HVIDT:

11 Q. Do you have data to support that notion?

12 A. Not off the top of my head, no.

13 Q. You are affiliated through UC Davis with a
14 hospital.

15 Is that correct?

16 A. Yes.

17 Q. Does your hospital participate in the
18 Leapfrog -- did your hospital participate in the
19 Leapfrog hospital survey in 2024?

20 A. No.

21 Q. Do you know why your hospital chose not to
22 participate in the survey?

23 A. I think they felt it was too burdensome.
24 And there was some staff turnover in key quality and
25 safety office that could be responsible for completing

1 the survey.

2 Q. When you say there's "staff turnover,"
3 you're referring to the person who might be working
4 substantially on completing the survey, that that
5 person was no longer employed or shifted in
6 responsibilities?

7 A. Yes. There was a particular person who had
8 completed the survey over many cycles, let's say, at
9 least six cycles, who retired.

10 Q. And when -- in working with UC Davis, do you
11 have any interaction with folks at the hospital there?

12 A. Yes.

13 Q. In the administration?

14 A. Yes.

15 Q. And who do you have interactions with?

16 A. From time to time lots of people.

17 Q. And specifically as it relates to Leapfrog
18 or whether to participate in Leapfrog or aspects like
19 that, like who would you have conversations with?

20 MR. BILLEK: Just note my objection to the
21 form of the question. That's a totally different
22 question than the one you just asked.

23 MR. HVIDT: Okay.

24 THE WITNESS: I'll answer the last question.

25 Yes. So typically my first point of contact

1 would be the chief quality officer, who's
2 Greg Maynard, who happens to be a general internist
3 like me, or Brenda Inman who was his quality and
4 safety manager. She's now left UC Davis just
5 recently. They would typically be my first point of
6 contact.

7 BY MR. HVIDT:

8 Q. And do you know Bruce Hall?

9 A. Yes.

10 Q. And who is Bruce Hall?

11 A. He is a currently the interim
12 vice chancellor for -- for human health services,
13 human health sciences, which puts him in a position of
14 essentially overall responsibility for the clinical
15 enterprise. So he reports to the provost and the
16 chancellor of the university.

17 Q. And interacting with these folks that we
18 just mentioned involved at UC Davis Health
19 Administration, would you say that you think that
20 they're trying to act in the best interest of
21 UC Davis?

22 A. Yeah. So Bruce Hall's position has changed.
23 So he was recruited as the chief clinical officer and
24 then he was promoted to this interim vice chancellor
25 position. Obviously his primary responsibility is to

1 protect and advance the mission of the health system
2 as a business.

3 Q. And you have no reason to question that
4 that's their ultimate objective in the decisions that
5 they make.

6 Is that fair?

7 A. Yes.

8 Q. Similar to how UC Davis has a process of
9 keeping the business records of yourself, do you have
10 any understanding that UC Davis has an e-mail system
11 that makes a record of e-mails that are sent and
12 received by folks who work there?

13 A. Of course.

14 Q. And do you have an understanding that
15 UC Davis also received a subpoena in this litigation
16 to produce documents?

17 A. Yes.

18 Q. And have you seen any of those documents
19 that were produced by UC Davis?

20 A. I have not. Unless I happen to also produce
21 them.

22 Q. And would you have any reason to dispute the
23 underlying data that went into the production of the
24 UC Davis documents?

25 MR. BILLEK: Object to form.

1 You can answer.

2 THE WITNESS: You could show me a document
3 that looks visibly fraudulent, but I have no reason to
4 believe that there's a problem in our e-mail servers.

5 (Exhibit 18 was marked for
6 identification.)

7 BY MR. HVIDT:

8 Q. I'm handing you what I've marked as
9 Exhibit 18 in this litigation. This is a document,
10 Dr. Romano, I will highlight that you are not on. But
11 it's been produced in this litigation as UC Davis
12 TLG0000293.

13 Do you see that?

14 A. Yes.

15 Q. And do you see at the top e-mail is from
16 Bruce Hall at UC Davis --

17 A. Yes.

18 Q. -- to a David Lubarsky at WMC Health?

19 A. Yes.

20 Q. And if you go down to an e-mail from
21 David Lubarsky dated May 5th, 2025, do you --
22 regarding Leapfrog to Bruce Hall and a Joseph Galante.

23 Do you see that?

24 A. Yes.

25 Q. And David Lubarsky references that UC Davis

1 just got a D in Leapfrog.

2 Do you see that?

3 A. Yes.

4 Q. And when he asked, "Can you remind me again
5 why we choose not to participate?"

6 Do you see that?

7 A. Yes.

8 Q. And then if you go to Bruce Hall's e-mail
9 dated May 6, 2025, can you -- do you see where he
10 says:

11 "Although the decision to not
12 participate was immediately before I
13 joined UCD, we had made a similar decision
14 in St. Louis, based on lack of confidence
15 in several aspects of their methodology
16 and a very extortionist approach to
17 reporting if you choose not to
18 participate, we felt that a system didn't
19 need an ever increasing portfolio of
20 public ratings to chase."

21 Do you see that?

22 A. Yes.

23 Q. From your conversations with Bruce Hall and
24 the other individuals you reference at UC Davis, is
25 that consistent with your understanding of why

1 UC Davis chose to stop participating for a period of
2 time?

3 A. Well, I don't know because my understanding
4 was that the decision was made primarily because of
5 burden.

6 This e-mail doesn't reference that burden.
7 It references more of a philosophical opposition. And
8 if there was a philosophical opposition that was
9 motivating that, it wasn't explicitly discussed with
10 me at the time.

11 Q. And later in the e-mail, Bruce Hall
12 references in the last -- second to last sentence:

13 "So since it was going to be a
14 challenge to publicly justify
15 nonparticipation when all other UCs
16 participate, we decided to participate for
17 this April enrollment against our better
18 judgment."

19 Do you see that?

20 A. Yes.

21 Q. And so is it your understanding from this
22 e-mail or aside that you -- following the 2024 --
23 fall 2024 methodology change and grade release,
24 UC Davis has decided to start participating again in
25 2025?

1 A. That's correct.

2 Q. And then --

3 A. I will add I've had separate conversations
4 with Dr. Hall, both in person and probably by e-mail
5 on this point, so it's an ongoing discussion of
6 course.

7 Q. And can you tell me a little bit more about
8 those discussions in terms of the other rationales
9 that Dr. Hall has explained for their decision of
10 whether or not to participate in the Leapfrog hospital
11 survey?

12 A. Well --

13 MR. BILLEK: My objection is to the form of
14 the question. And I say that only because he's
15 discussing the decision that he made in St. Louis, and
16 saying that with regard to UC Davis, this predated his
17 involvement.

18 THE WITNESS: Right.

19 To be clear, my understanding of the
20 UC Davis decision was that it was driven primarily by
21 concerns about the burden. And perhaps --

22 MR. BILLEK: He's asking you about your
23 conversations with Mr. Hall.

24 MR. HVIDT: Excuse me. Excuse me. Excuse
25 me, sir.

1 MR. BILLEK: Yeah.

2 MR. HVIDT: Please limit your objections to
3 form.

4 MR. BILLEK: Okay.

5 MR. HVIDT: Thank you. No coaching the
6 witness.

7 MR. BILLEK: I'm not coaching the witness.

8 MR. HVIDT: I understand.

9 MR. BILLEK: You're mischaracterizing a
10 document.

11 MR. HVIDT: Sir, I am no longer talking
12 about a document. I'm asking about his conversations
13 with Dr. Hall about UC Davis' decision now.

14 MR. BILLEK: But your prior question was,
15 "Based upon this e-mail, tell me about what Dr. Hall
16 said about why UC Davis didn't participate."

17 And in this e-mail, Mr. Davis -- Mr. Hall
18 states that St. Louis didn't participate because of a
19 lack of confidence.

20 So it was a very misleading question, as
21 have many of your questions been today, and I haven't
22 objected or directed him. But this one was quite
23 blatant.

24 MR. HVIDT: Sir, please limit it to form,
25 and let's go back to the questioning.

1 BY MR. HVIDT:

2 Q. Okay. In your conversations with Dr. Hall
3 about the decision of UC Davis whether or not to
4 participate with Leapfrog's hospital survey, please
5 describe those conversations.

6 A. He and Dr. Maynard, who is our chief quality
7 officer, both expressed concern about burden and
8 concern about Leapfrog's imputation approach.

9 And I tried to provide further explanation,
10 clarification in my -- in these conversations.

11 Q. And you reference that Bruce Hall had
12 concerns about Leapfrog's imputation approach.

13 And is it fair to say that in Exhibit 18, he
14 is describing his concern about Leapfrog's imputation
15 approach as it applied to the decision he and those
16 with him at the hospital that he was at prior to
17 UC Davis made when they were in St. Louis?

18 A. I presume so.

19 Q. And he also expressed concern to you about
20 Leapfrog's imputation methodology approach as it
21 relates to the decision of whether UC Davis should
22 participate in Leapfrog's hospital survey or not.

23 Is that correct?

24 A. Yes.

25 Q. And was Dr. -- was Mr. Maynard that you

1 reference, was he --

2 A. Dr. Maynard.

3 Q. He's a doctor as well. Okay.

4 Was Dr. Maynard a -- at UC Davis in 2022 or
5 2023 when UC Davis made the decision to stop
6 participating in the Leapfrog hospital survey?

7 A. Yes.

8 (Exhibit 19 was marked for
9 identification.)

10 BY MR. HVIDT:

11 Q. Document No. -- Exhibit No. 19 was produced
12 in this litigation as UC Davis TLG0000763. It's an
13 e-mail chain between a Chad VanDenBerg at UC San Diego
14 and Gregory Maynard from UC Davis dated December 11th,
15 2024 regarding Leapfrog.

16 Do you see that, Dr. Romano?

17 A. Yes. Yes.

18 Q. And do you see that the e-mail originates
19 from Chad VanDenBerg? I don't know whether he's a
20 doctor or not.

21 A. He is, yes.

22 Q. Okay.

23 A. I believe he's the chief quality officer at
24 UC San Diego.

25 Q. Okay. And if you see below, he references

1 that they "had debated about submitting a survey for
2 they're newly acquired campus."

3 Do you see that?

4 A. Yes.

5 Q. And they ultimately decided to submit one
6 even though they had gaps.

7 Do you see that?

8 A. Yes.

9 Q. And then he asks Dr. Maynard why -- or he
10 asked Dr. Maynard regarding the decision of whether or
11 not to submit to the Leapfrog survey.

12 Do you see that?

13 A. Yes.

14 Q. And then Dr. Maynard responds in that first
15 paragraph:

16 "We made the potentially reversible
17 decision to stop participating about three
18 years ago and are actively revisiting that
19 decision based upon the bad look this
20 promotes to the public for UCDH. We think
21 they're continuing to rate us and giving
22 scores of zero in big ticket areas like
23 staffing is grossly unfair and punitive,
24 but probably to them is part of the
25 business of keeping participation high."

1 Do you see that?

2 A. Yes.

3 Q. Is that -- and then --

4 A. Of course technically they're not scores of
5 zero. They're scores of limited achievement but --

6 Q. And is the score of limited achievement the
7 lowest score you can receive?

8 A. Yes.

9 Q. And then if you go down to the next
10 paragraph, it says:

11 "My memory is that it was not a
12 detailed informed decision to stop
13 participating. Instead, it was a Gestalt
14 weighing all the effort required to submit
15 data every year when we are short staffed
16 versus our perception of the validity and
17 weight of their evaluation and ranking
18 methodology."

19 Do you see that?

20 A. Yes.

21 Q. And is that consistent with what Dr. Maynard
22 has described to you about UC Davis' decisions not to
23 participate in the survey for a few years?

24 A. Yeah. I think that better balances the
25 actual considerations at UC Davis that preceded

1 Dr. Hall's recruitment. It also reflects the fact
2 that this was a potentially reversible or temporary
3 decision, awaiting of recruitment of additional staff
4 and additional information.

5 It also reflects, to be honest, an
6 assessment of the market value of alternative grades.
7 So everybody wants an A grade, but if you know that
8 your grade is likely to be a B, and you're a major
9 academic medical center, you may choose not to
10 participate because you don't necessarily want a
11 B grade. So you want an A grade.

12 So if an A grade is out of reach during a
13 particular cycle, you may sit out that cycle.

14 Q. Would you consider a B grade hospital by
15 Leapfrog to be a poor-performing hospital?

16 A. No, not at all.

17 Q. And so that would be consistent with the
18 decision of some nonparticipating hospitals to not
19 participate and it doesn't have to do with their
20 having poor performance?

21 A. Yes.

22 Q. When you mention the value of it, you talked
23 about the value of an A grade from Leapfrog.

24 Does an A grade from Leapfrog help a
25 hospital in its reputation in the marketplace?

1 A. Yes. At the margin.

2 Q. And even if that hospital is already a good
3 hospital, you know, a major research medical center
4 that -- you know, top medical school with, you know,
5 high CMS scores, getting that A from Leapfrog could
6 still help its reputation.

7 Is that correct?

8 A. It could help its reputation, yes.

9 Q. And is it fair to say that a bad Leapfrog
10 grade, like a D that UC Davis had received in the fall
11 of 2024, can hurt the hospital's reputation?

12 A. I mean, Dr. Hall and Dr. Maynard would argue
13 that it hasn't hurt us that much; that our beds are
14 still full. We've had no discernible decrease in
15 patient volume. We're still -- we just opened a large
16 ambulatory surgery center, and we're not having any
17 difficulty filling it or filling our beds.

18 So I think they would argue that the D looks
19 bad, but it hasn't actually hurt us in any measurable
20 way.

21 Q. Here you'll note that Dr. Maynard references
22 that the D would have a bad look -- that "this causes
23 a bad look to the public for UC Davis Health."

24 Do you see that?

25 A. Yes.

1 Q. In 2024, did you communicate with UC Davis
2 about getting -- about getting participation in the
3 survey again when the methodology was going to change?

4 A. Time frame again?

5 Q. In 2024, when the methodology was going to
6 change, did you communicate with UC Davis Health about
7 participating in the Leapfrog survey?

8 A. I did.

9 Q. And did you encourage them to participate?

10 A. I did.

11 Q. And why?

12 A. Because I think participation is good. I
13 favor the overall goal of participation. And
14 specifically for my own academic health system, I
15 didn't want us to get a C or a D grade.

16 Q. Why did you think the hospital would get a
17 C or a D grade if it didn't participate in the survey?

18 A. Well, it was a rough estimate based on what
19 I knew from internal dashboards and from the most
20 recent cycle of reporting with imputed data.

21 (Exhibit 20 was marked for
22 identification.)

23 BY MR. HVIDT:

24 Q. I've put in front of you what I've marked as
25 Romano Exhibit 20, which has been produced in this

1 litigation as Leapfrog 00637922 which is an e-mail
2 chain among yourself, Matt Austin, Missy Danforth, and
3 Alexandra Campione, regarding agenda and slides for
4 Leapfrog Hospital Safety Grade Expert Panel Call.

5 Do you see that?

6 A. Yes.

7 Q. And if you go back to the beginning of this
8 chain, it starts off as that Zoom link for the expert
9 panel call.

10 Do you see that?

11 A. Yes.

12 Q. And then about two e-mails up from that,
13 starts on the very first page at the bottom, you send
14 an e-mail on May 2nd, 2024.

15 Do you see that?

16 A. Yes.

17 Q. It appears as though you may have copy and
18 paste a news article from the Sacramento Bee.

19 Do you see that?

20 A. That's correct.

21 Q. And it -- in this note it notes that
22 UC Davis Medical Center had received a C grade.

23 Is that correct?

24 A. Yes.

25 Q. And then you add at the top that, quote:

1 "Well, clearly my participation in
2 the expert panel has not led to any
3 benefit to my own academic hospital. Its
4 grade keeps dropping."

5 Do you see that?

6 A. Yes.

7 Q. And Matt Austin responds:

8 "Well, I guess one positive is that
9 the expert safety panel is not tilting the
10 grades for its own hospitals."

11 Is that fair to say?

12 A. Yes.

13 Q. And then you respond to that. It looks
14 like -- did you investigate further why your hospital
15 had gotten that grade?

16 A. Yes.

17 Q. And is it fair to say that before this
18 May 2nd, 2024, you didn't know your hospital had
19 stopped participating in the survey for the prior
20 two years?

21 A. That's correct.

22 Q. And do you recall who you spoke with or how
23 you learned about that nonparticipation in the survey
24 at this time?

25 A. I don't recall. It might have been in my

1 production. But most likely it was either
2 Brenda Inman or Greg Maynard.

3 Q. And you note that:

4 "They stopped responding after June?"
5 question mark "2022 due to what they
6 considered to be an unreasonable burden
7 greater than 1,000 hours and they decided
8 to accept the prospect of declining grades
9 over this" -- "over time as a reasonable
10 tradeoff."

11 Do you see that?

12 A. Yes.

13 Q. And is that a fair characterization of what
14 was communicated to you about the reason for UC Davis'
15 decision to stop participating?

16 A. Yes. And it's consistent with Dr. Maynard's
17 e-mail with his colleague at San Diego.

18 Q. And they communicated to you that
19 participating in the survey was an unreasonable burden
20 greater than 1,000 hours.

21 Do you see that?

22 A. Yes.

23 Q. And do you know what contributed to that --
24 their calculation that it would take greater than a
25 thousand hours to participate in the survey?

1 A. Well, I think they were dealing with the
2 fact that, again, the person who responded to the
3 survey over several cycles before had retired, and so
4 now they would have to bring a new person up to speed
5 with all the details of the survey. So they would
6 essentially be starting from scratch in terms of the
7 staffing process.

8 I earlier gave you an estimate. It was a
9 fairly broad estimate. Perhaps it didn't include a
10 thousand hours. But this was obviously based on their
11 understanding of starting from scratch.

12 Q. And so the hospital starting from scratch to
13 implement -- to implement the processes to complete
14 the Leapfrog hospital survey, it might take them a
15 thousand hours to do that.

16 Is that what --

17 A. It seems overstated in my view, especially
18 because there are people like me who they could bring
19 in to the discussion, to help them answer certain
20 items. So I thought the estimate was overstated.

21 Q. And do you think that that estimate, though,
22 is -- you know, that that was the estimate that they
23 communicated to you what they thought it would take as
24 of May 2024 to complete the survey.

25 Is that fair?

1 A. Yeah. I don't believe that I lied in this
2 e-mail. I just believe they overstated the actual
3 hours that it would take.

4 Q. And the hours that it would take to complete
5 the Leapfrog hospital survey would be a significant
6 time commitment.

7 Is that fair to say?

8 A. Yes.

9 Q. And there are other ratings agencies that
10 hospitals can choose to devote time commitment to
11 participating in their surveys.

12 Is that correct?

13 A. Well, yes and no.

14 Hospitals don't really have much choice on
15 the CMS side. They have to participate in HCAHPS, the
16 Hospital Consumer Settlement Survey. They have to
17 participate in certain CMS measures. They have to
18 participate in certain state requirements. In our
19 case, for example, coronary artery bypass graft
20 surgery reporting.

21 So there are many things that they are
22 required to participate in and under either federal or
23 state law.

24 There are other things that are required
25 under contracts with health plans, particularly on the

1 system side, the ambulatory care side.

2 So obviously managed care plans have models
3 in which primary care serves are capitated to
4 UC Davis Health, and through those models, we would be
5 required to report so-called NCQA or HEDIS, H-E-D-I-S,
6 measures.

7 So my point is that there are many things
8 that are required. There isn't anything quite like
9 the Leapfrog survey.

10 U.S. News is external. Hospitals have no
11 input into the U.S. News survey directly.

12 Healthgrades similarly.

13 Obviously hospitals can do things to try to
14 manipulate how they're rated by physicians in the
15 community but that is sort of a deliberate
16 manipulation process.

17 There's nothing quite like Leapfrog in the
18 market.

19 Q. You're describing a number of things that
20 hospitals are required to do.

21 One item that I -- along the list that I
22 didn't hear was hospitals that are accredited for
23 various things are required to participate in those
24 accreditation processes.

25 Is that correct?

1 A. That's correct. Yes. The joint commission
2 in our case.

3 Q. The joint commission in your case.

4 And there's also various accreditations or
5 credentials that hospitals might have for specialties.

6 Is that correct?

7 A. Correct. There are certifications and
8 accreditations in particular specialties.

9 Q. And there's a number of requirements that
10 they have to participate in to receive those in terms
11 of audits and submitting information.

12 Is that correct?

13 A. Correct. The cancer programs, for example,
14 are particularly important to our health system.

15 Q. And so is it fair to say that there's a lot
16 between CMS, between state requirements, between
17 accreditations, between all the number of things that
18 you listed that hospitals are required to do to
19 continue operating their business?

20 Is that correct?

21 A. Yes.

22 Q. And adding Leapfrog to the list of all
23 those -- Leapfrog's hospital survey to the list of all
24 those things they're required to do could be a
25 determination that that would be a step too far,

1 could -- that would be too much burden to add that to
2 what they're already doing for all those other things.

3 Is that fair?

4 A. Yes. That is a decision that some hospitals
5 make.

6 Q. And due to resource constraint, that was a
7 decision apparently that UC Davis made when it had
8 staff constraints.

9 Is that correct?

10 A. Yes.

11 MR. HVIDT: If we could take a quick break.
12 Now would be a good time.

13 THE VIDEOGRAPHER: Off the record 3:45 p.m. 0

14 (Break taken in proceedings.)

15 THE VIDEOGRAPHER: On the record 3:04 p.m.

16 4:03 p.m. 0

17 BY MR. HVIDT:

18 Q. Dr. Romano, I am marking Exhibit 21 to your
19 deposition, which has been produced in this litigation
20 as UC Davis TLG000635, which is an e-mail chain where
21 the top e-mail is from Patrick Romano dated May 3rd,
22 2024 to a number of individuals at UCDavis.edu
23 regarding "Theoretical question on PSI-15, accidental
24 puncture or laceration."

25 ///

1 (Exhibit 21 was marked for
2 identification.)

3 BY MR. HVIDT:

4 Q. Do you see that, Dr. Romano?

5 A. Yes.

6 Q. If you flip back in this e-mail chain, this
7 e-mail chain starts off with the e-mail from you --
8 e-mail from Leticia Dickinson to
9 Robert Jon Kucejko dated May 1st, 2024.

10 Do you see that on page 641 going over to
11 642?

12 A. I have a problem with this e-mail
13 production. It includes confidential patient
14 information that I don't think should have been
15 produced.

16 Q. Okay. We will not get into confidential
17 patient information on this -- in this examination.
18 And we are happy to go back and redact this as you or
19 your counsel would like. This was how it was produced
20 to us by UC Davis.

21 Are you okay with proceeding? If you think
22 that we're getting close to discussing confidential
23 patient information, then we will pause the
24 questioning.

25 A. Yeah. Page 642 must be removed.

1 Q. Page 642, I will not be referring to any
2 information on that page and we will propose redacting
3 it before it is published within the confidential
4 protective order parameters of this lawsuit.

5 Are you okay with that?

6 MR. BILLEK: Yeah. I think that's
7 appropriate. So --

8 THE WITNESS: Thank you.

9 MR. BILLEK: Last thing we want to do is
10 come back another day to talk about this document. So
11 that's the appropriate remedy for today.

12 Okay?

13 THE WITNESS: Thank you.

14 MR. BILLEK: Thanks.

15 BY MR. HVIDT:

16 Q. And you'll see -- and we'll get into the
17 e-mail on 640, going to 641, adds you to the chain.
18 I'm not going to get into the substance of that
19 e-mail, but that's how you were added to the chain.

20 Do you see that?

21 A. Yes.

22 Q. And then there's carryforward e-mails in the
23 subject of the e-mail exchanges where on Thursday,
24 May 2nd, 2024 at 6:38, do you see where you sent an
25 e-mail to several individuals at UC Davis regarding

1 the grade that UC Davis had received in spring of
2 2024 --

3 A. Yes.

4 Q. -- from Leapfrog?

5 And you write:

6 "Very sorry to see this story. As
7 you probably know, I serve on Leapfrog's
8 expert panel for hospital safety scoring."

9 Do you see that?

10 A. Yes.

11 Q. And you note:

12 "We used to get mostly As with an
13 occasional B. Never seen us get a C
14 before." Sad face.

15 Do you see that?

16 A. Yes.

17 Q. And then you ask, "What's driving this
18 decline?"

19 Do you see that?

20 A. Yes.

21 Q. And then Penny Jefferson adds Tami Gomez to
22 the discussion.

23 Do you see that?

24 A. Yes.

25 Q. And then in the follow-on e-mail, there's a

1 an analysis of how UC Davis performed on some measures
2 that are included in the Leapfrog scoring.

3 Do you see that?

4 A. Yes.

5 Q. And carrying forward to the first page,
6 which gets to the substance of where we're going to
7 focus the questions, Brenda Inman writes an e-mail
8 addressed to you at the bottom.

9 Do you see that?

10 A. Yes.

11 Q. And Brenda Inman was one of the individuals
12 that you said you would communicate with regarding --
13 at UC Davis Health regarding matters like
14 participation in Leapfrog.

15 Is that correct?

16 A. This looks like that communication, yes.

17 Q. Okay. And she writes:

18 "UC Davis no longer participates in
19 Leapfrog. The last data we submitted was
20 June 2022." And then she says, "I was the
21 one who submitted our data."

22 Do you see that?

23 A. Yes.

24 Q. And then carrying forward, she references
25 how she spoke with Leapfrog about their

1 discontinuation in their participation.

2 Do you see that?

3 A. Yes.

4 Q. And she communicates that she was told that
5 there would be a decline due to the lack of
6 self-reported data.

7 Do you see that?

8 A. An expected decline, yes.

9 Q. And --

10 A. Again, please understand that expectation
11 has a particular meaning, that is, not every facility
12 would decline because they might decline within the
13 bracket for a particular grade, so --

14 Q. Their grade might not drop but the
15 mathematical score that they will have will drop by
16 virtue of their nonparticipation?

17 A. Yes.

18 Q. On that note, are you aware how many
19 nonparticipating hospitals that had the step to
20 imputation methodology approach applied to them in
21 spring 2025 received an A grade?

22 A. I think a very small number. Maybe a
23 handful. Not zero, but less than 10, shall we say.

24 Q. Would the number 2 of 550 such
25 nonparticipating hospitals sound right to you?

1 A. It's possible. Not zero, less than 10.

2 Q. And two of 550 is a very small number of
3 nonparticipating hospitals that had Step 2 imputation
4 applied of 550.

5 Is that fair?

6 A. Yes.

7 Q. And are you aware that there are no
8 nonparticipating hospitals in Florida that received
9 an A grade?

10 A. I was not aware of that.

11 Q. And then moving forward back to this
12 document, you respond to -- is it Dr. Inman?

13 A. No.

14 Q. Ms. Inman.

15 And you know that "Yes, this is true
16 regarding the expected decline." And --

17 Do you see that?

18 A. Yes.

19 Q. And that's consistent with what you were
20 just describing about expected.

21 Is that fair?

22 A. Yes.

23 Q. And you then note that, quote:

24 "Leapfrog staff are exercised about
25 the fact that the response rate decreased

1 in 2023 after many consistent years of
2 increases."

3 Do you see that?

4 A. Yes.

5 Q. And in that communication regarding what the
6 Leapfrog staff are exercised about, do you reference
7 any other reasons why Leapfrog staff are interested in
8 changing the imputation methodology other than the
9 decrease in hospital participation rate?

10 A. As we discussed earlier, there's the concern
11 that the imputed scores are too high, as those imputed
12 scores have shifted upward, and that they allow
13 nonparticipating hospitals to ride on the coattails of
14 participating hospitals.

15 Q. And then you note that on those reasons that
16 you just detailed that they -- in the last sentence of
17 that first kind of carryforward paragraph, "they,"
18 Leapfrog staff, "are determined to more aggressively
19 penalize nonparticipants."

20 Do you see that?

21 A. Yes.

22 Q. And so do the Leapfrog staff communicate to
23 you that they are determined to more aggressively
24 penalize nonparticipants?

25 A. That's an overstatement for dramatic effect

1 in this e-mail. But, again, as we've discussed
2 previously, they did make clear that the goal was to
3 incentivize continued participation, and that
4 incentivization requires some penalization of
5 nonparticipants.

6 Q. Earlier we talked about when you are
7 communicating by e-mail, you try to be accurate in
8 what you are writing.

9 Is that fair?

10 A. Yes.

11 Q. And when you write a communication to your
12 employers or your fellow employees -- I don't know the
13 dynamic -- you try to be accurate in how you're
14 communicating what other people told you.

15 Is that fair?

16 A. Well, sometimes the choice of words, you
17 know, is intended to convey a message, not necessarily
18 the content.

19 So -- so nobody that I recall at Leapfrog --
20 I don't recall Missy Danforth, for example,
21 specifically saying that "We are determined to more
22 aggressively penalize nonparticipants."

23 However, it was clear from the discussion
24 that part of the shared goal was to penalize
25 nonparticipation.

1 So I'm stating a little bit more strongly
2 than what anybody at Leapfrog specifically said. I
3 just want to be clear.

4 Q. So your view here is that you're telling the
5 folks at UC Davis that Leapfrog staff are determined
6 to more aggressively penalize nonparticipants, but
7 Leapfrog -- you're telling us today that Leapfrog
8 staff did not actually communicate that to you?

9 A. I don't recall the specific use of those
10 terms that "we are determined to more aggressively
11 penalize nonparticipants." I never heard that.

12 Q. But you use those terms in communicating
13 what Leapfrog staff told you about the rationale for
14 the imputation change.

15 Is that fair?

16 A. This is a summary of the perspective that
17 was shared through the discussions. Obviously you
18 have a transcript of the meeting and you may have a
19 better idea than I do about what Leapfrog staff
20 actually said.

21 Q. But you weren't at that meeting; correct?

22 A. Correct.

23 Q. And you -- so your basis for referring to
24 how Leapfrog staff are more determined to aggressively
25 penalize nonparticipants is not based on a meeting

1 that you didn't attend.

2 Is that fair?

3 A. Right.

4 Q. It would be based on other communications
5 that you had with them.

6 Is that fair?

7 A. Right. Such as the e-mail chain that you
8 presented earlier that involved Alex Campione.

9 Q. Where in your e-mail you talked about how
10 the goal of the change is to penalize nonparticipants,
11 then you should be more forthright in doing so
12 directly; correct?

13 A. If the goal is to penalize nonparticipation
14 because it interferes with the larger goals of the
15 program, correct.

16 Q. And Ms. Campione responded to your e-mail
17 about penalizing nonparticipants, saying, "I
18 completely agree."

19 Is that correct?

20 A. Yes.

21 Q. And then the next paragraph of this e-mail,
22 you say, "They will never remove large hospitals from
23 reporting."

24 Do you see that?

25 A. Yes.

1 Q. Is the "they" in that clause Leapfrog?

2 A. Yes.

3 Q. And so what do you mean that Leapfrog will
4 never remove large hospitals from reporting?

5 A. Well, because we -- and here I'm speaking,
6 you know, collectively on behalf of the expert panel
7 that I seem to be representing, as well as Leapfrog,
8 that we could not allow a situation where hospitals
9 can remove themselves entirely from reporting simply
10 by refusing to participate in the survey.

11 So there always has to be an alternative
12 path to keep hospitals that are major players in major
13 markets in the program.

14 Q. Why would you not allow a situation where
15 hospitals are not graded?

16 A. Because it would undermine the goals of the
17 program to improve transparency and accountability and
18 to drive improvement in patient safety to save lives.

19 Q. And are achieving the goals of the Leapfrog
20 program more important than accurately grading
21 nonparticipating hospitals in a given cycle?

22 A. Well, I've devoted much of my professional
23 career to advancing the quality and safety measures,
24 and using measures to help inform markets and drive
25 improvement.

1 So I -- so I do believe that sometimes in
2 order to achieve that goal, it's necessary to
3 provide -- it's necessary to make certain assumptions
4 or imputations, if you will.

5 Q. So is it fair to characterize the Leapfrog
6 2024 methodology change as consistent with the notion
7 that the ends justifies the means?

8 A. Some ends justify some means. I think
9 that's an overly broad statement.

10 Q. But in this instance, what you're describing
11 is that because the ultimate goal of the nonprofit
12 Leapfrog is some good, some greater good, that getting
13 to that point is more important than if there are kind
14 of bumps and bruises along the way?

15 A. Yes. There are always bumps and bruises
16 along the way in any kind of public reporting or
17 accountability program.

18 Q. And so if getting to Leapfrog's goal --
19 nonprofit goal is achieved but hospital reputations
20 are negatively impacted based on inaccurate imputation
21 penalties, in your mind, that is a -- that is an okay
22 sacrifice that is -- you're willing to allow?

23 MR. BILLEK: Object to form.

24 You can answer.

25 THE WITNESS: Well, I've literally spent

1 34 years in this business, and it's frequently
2 necessary to make strategic choices to further the
3 overall goals of the program.

4 For example, we, for a number of years,
5 produced the reports on California cabbage outcomes
6 for the State of California for what's now known as
7 the California Healthcare Access -- Office of
8 Healthcare Access and Information.

9 And so we made decisions along the way about
10 particular data elements to include in our models, to
11 exclude from our models, based on the overall goals of
12 the program.

13 And those decisions may have harmed certain
14 hospitals. It may have benefited other hospitals.
15 But ultimately hospitals decide that it's worth
16 participating in the program, and they begin reporting
17 more accurate data.

18 So that's what we're looking for here as
19 well is a progressive movement towards more accurate
20 and transparent data reporting.

21 Hospitals that report inaccurate or
22 incomplete data are penalized implicitly or explicitly
23 in many different programs. Nothing unique about the
24 Leapfrog program here.

25 ///

1 BY MR. HVIDT:

2 Q. When a hospital is penalized for incomplete
3 data, do you recognize that that representation is not
4 an accurate assessment of that hospital for that given
5 cycle?

6 A. Yes.

7 MR. BILLEK: Object to form.

8 BY MR. HVIDT:

9 Q. And your point is that you're willing for
10 that inaccuracy of an assessment of a hospital to
11 occur if on a global scale that leads to more hospital
12 participation in Leapfrog's survey?

13 A. In the sense that we are always striving for
14 more accurate and complete information. And so the
15 only way to continue that movement towards more
16 accurate and complete information is to penalize
17 inaccurate and incomplete information.
18 Straightforward.

19 Q. What happens if a consumer relies on that
20 incomplete information and passes by a hospital while
21 facing an emergency and ends up getting seriously hurt
22 or more hurt; do they delay in receiving care?

23 A. Well, ambulances are generally required to
24 transport patients to the closest available facility
25 that has the --

1 Q. If it's not an ambulance. If I'm just
2 driving my wife who is hurt, and I look up the
3 hospital that's closest by and I see that it's gotten
4 an F grade, and when I look on Google, I'm on my
5 phone, I'm going fast, I don't have time to look at a
6 footnote while I'm driving, and I've gotta get her to
7 a hospital, I go, "Look, there's an A one 10 miles
8 down the road." And she gets more hurt due to the
9 delay in care there.

10 Is that an okay circumstance to occur just
11 simply because that F hospital didn't participate in
12 Leapfrog's hospital survey?

13 MR. BILLEK: Object to form.

14 THE WITNESS: You're posing a rather
15 implausible hypothetical because you're not going to
16 be searching for the Leapfrog hospital safety grade
17 while you're driving your wife to the hospital. Let's
18 be serious.

19 BY MR. HVIDT:

20 Q. Someone else might be in the -- her mother
21 might be in the car with us looking for that.

22 But if there's an emergency and I'm looking
23 and I need to figure out if a hospital is good or not,
24 and I see that there's an F grade, and I can't tell
25 until I go to a footnote three clicks in that the only

1 reason it's an F is because it didn't participate in
2 the survey --

3 A. It's --

4 MR. BILLEK: Same objection.

5 You can answer.

6 THE WITNESS: It's common sense that if
7 you're experiencing a true emergency, you get to the
8 closest hospital as quickly as you can. I would never
9 encourage anybody to look at Leapfrog hospital safety
10 grades while they're in the process of transporting a
11 patient to a hospital in an emergency.

12 BY MR. HVIDT:

13 Q. Do you think that that recommendation is
14 clear to consumers who look up a hospital on Google
15 and are directed to Leapfrog's page?

16 MR. BILLEK: Same objection.

17 You can answer.

18 THE WITNESS: I can't speak to -- one has to
19 go through several steps to find a hospital and a
20 particular hospital safety grade on the Leapfrog
21 website.

22 You don't just open up the website and get a
23 score for your closest hospital.

24 So the process of going through this website
25 is a process that people do in the comfort of their

1 homes. They don't do it while they're in the process
2 of transporting somebody for an emergency.

3 BY MR. HVIDT:

4 Q. Do you have any data to support the notion
5 that the clicks Leapfrog gets through its website come
6 from a computer as opposed to a phone?

7 A. I don't have information on that
8 specifically.

9 Q. Looking back at the exhibit in front of you,
10 one more question on this one. You note that:

11 "Unless we want to continue getting C
12 and potentially dropping to D, I would
13 advise to start participating again."

14 Do you see that?

15 A. Yes.

16 Q. What do you mean by "Unless we want to
17 continue getting C and potentially dropping to D"?
18 Like why would that occur for the hospital if they
19 don't participate?

20 A. Well, because speaking from my own hospital,
21 we have ongoing challenges related to some of these
22 measures, particularly -- we tend to do average or a
23 little bit above average on the survey based -- on the
24 consumer survey based measures, the HCAHPS measures.

25 But we often have higher-than-expected rates

1 of the hospital-acquired infections. In part, that
2 might be due to the nature of a patient population,
3 in part, it may be due to challenges in infection
4 control.

5 But I'm basically saying that from what I
6 know about the construction of the safety grade, as
7 well as our own internal data, that we would likely
8 continue getting a C if we continue not participating.

9 Q. And when you mention that the patient
10 population might be an impact to the infection rates
11 that the hospital receives, can you elaborate on that?
12 What patient population would that be?

13 A. Well, the CDC measures that come through the
14 National Healthcare Safety Network, those are the
15 measures of hospital-acquired infections, they're not
16 really well risk adjusted at the patient level.
17 They're essentially adjusted based on characteristics
18 of the unit or the hospital.

19 So therefore, for example, they don't fully
20 account for patients who are undergoing a stem cell
21 transplant who have literally zero immunity. And even
22 with the best infection control policies, many of
23 those patients develop healthcare-associated
24 infections.

25 So this is a struggle for some of the

1 hospitals that have the largest cancer programs.

2 Q. And so those hospitals that have large
3 cancer programs, they might have lower CMS measures on
4 those scores for reasons other than the quality or
5 safety at those underlying hospitals.

6 Is that fair?

7 A. I accept that. Yes. Right.

8 And we're also a major trauma center which
9 means that we get a lot of patients who have
10 penetrating trauma, meaning that a steering wheel has
11 penetrated into their chest or part of the dashboard
12 or windshield, and obviously these patients are very
13 high risk of an infection.

14 Q. Are you a Level 1 trauma center?

15 A. Yes.

16 Q. And so would you say Level 1 trauma centers
17 might have lower CMS scores for reasons other than the
18 quality or safety processes at those facilities?

19 Is that fair?

20 A. They might.

21 Q. And is it fair to say that cancer treatment
22 specialty centers might have lower CMS scores on some
23 of those measures for reasons other than the quality
24 and safety at those hospitals?

25 A. They might. Specifically for the

1 healthcare-associated infection measures that are not
2 adjusted statistically at the patient level.

3 Q. And would you say that -- we talked a little
4 bit about HCAHPS.

5 Do you recall that?

6 A. Yes.

7 Q. And are HCAHPS scores something that at a,
8 you know, Level 1 trauma center might be lower due to
9 the nature of the facility, everything going on at a
10 Level 1 trauma center?

11 A. I'm not aware of data on that point. It's
12 possible. And generally when patients recover from
13 major trauma, they're very happy to have recovered and
14 they often rate the hospital well because of their
15 recovery. But -- so I can't say specifically how
16 Level 1 trauma centers fare on HCAHPS.

17 Q. But sometimes like a busier hospital or an
18 all-comer hospital, there's a lot of patients and you
19 might have to share a room with someone when you're at
20 the hospital. That might lead to a lower HCAHPS
21 score.

22 Is that correct?

23 A. Room sharing is factor that may lead to a
24 lower HCAHPS score, yes.

25 Q. Is room sharing one of the recognized

1 contributing factors a low HCAHPS score? Like that's
2 one of the more common complaints?

3 A. In general terms, although I'll point out
4 that Leapfrog uses specifically measures that focus on
5 communication with nurses and physicians surrounding
6 medications, and surrounding the discharge process.
7 So those kinds of measures are less susceptible to the
8 patient population and perhaps more sensitive to just
9 whether the hospital has enough nurses on staff to
10 explain things to patients.

11 Q. So if there's a higher volume of patients
12 coming in and the nurses can't communicate as
13 regularly with the patient, that might impact an
14 HCAHPS score?

15 A. Higher volume relative to the nurse
16 staffing.

17 Q. Correct.

18 Is that fair to say, that a higher volume of
19 patients relative to the nurse staffing could impact
20 HCAHPS score which might not -- might not be an
21 indicator of whether it's a safe or quality hospital
22 standing alone.

23 Is that fair?

24 A. Not exactly. I mean, let me give an
25 example.

1 So I think we generally score at
2 UC Davis Health right about average on these measures.
3 Sometimes a little bit better, sometimes slightly
4 worse, but right about average. And that I think
5 reflects the fact that we have a challenging patient
6 population with a very high volume, but we also have
7 very robust nurse staffing.

8 A hospital that has a similar patient
9 population with poor nurse staffing will see lower
10 scores on these items. So the low scores on these
11 items particularly raise concerns about the adequacy
12 of nurse staffing.

13 Q. And that's volumetric of nurses.

14 Is that fair to say?

15 Not the quality of the individual nurse that
16 it's measuring against or --

17 A. No. When I talk about nurse staffing,
18 what's been shown I think repeatedly in the literature
19 is that the impact of nurse staffing on patient
20 outcomes is reflected both by what we refer to as the
21 skill mix, that is, how -- what proportion of the
22 nurses are baccalauréat trained, for example, or
23 better, as well as the amount that -- the number of
24 hours of nurses per patient day.

25 So it's standardized for volume, in other

1 words.

2 Q. Thank you.

3 You can put that one to the side.

4 (Exhibit 22 was marked for
5 identification.)

6 BY MR. HVIDT:

7 Q. I'm handing you what's been stickered as
8 Exhibit 22 to your deposition, which has been produced
9 in this litigation as UC Davis TLG0000683.

10 If you look at the top e-mail there, it's a
11 e-mail from Patrick Romano dated May 15th, 2024 to a
12 Bruce Hall, Gregory Maynard, and Brenda Inman,
13 regarding Leapfrog announcements for hospitals,
14 May 2024.

15 Do you see that?

16 A. Yes.

17 Q. Have you seen this document before?

18 A. Yes. I produced a version of this document,
19 I believe.

20 Q. And if you go back to the beginning e-mail
21 chain which starts on 684, do you see how it starts
22 out with an e-mail from The Leapfrog Group to
23 Patrick Romano regarding announcements to hospitals?

24 A. What page are you on?

25 Q. 684.

1 A. 684.

2 Q. It's the second page of the --

3 A. Yes. Got it.

4 Q. -- of the e-mail.

5 And there's a lot of images on the e-mail.

6 And if you -- it's really an announcement to
7 get started on the hospital survey with a few other
8 announcements.

9 Do you see that?

10 A. Yes.

11 Q. And you forward that announcement to
12 Brenda Inman and Gregory Maynard on May 15th, 2024.

13 Do you see that?

14 A. Yes.

15 Q. You note:

16 "Your opportunity to reconsider.

17 They are changing their imputation
18 approach so hospitals can get away with
19 responding in alternate years," close
20 quote.

21 By "can get away" there, did you mean "can't
22 get away"?

23 A. No. I meant can.

24 Q. They can get -- because they're still
25 allowing one year for Step 1 imputation of your past

1 year data, you can get away with responding alternate
2 years?

3 A. Correct.

4 Q. And then you note:

5 "But if you skip more than one year,
6 you will never get above a C. Might even
7 drop to a D."

8 Do you see that?

9 A. Yes.

10 Q. Is that correct?

11 A. It's correct in the context of my knowledge
12 of UC Davis Health's performance. In other words,
13 that we're starting with a B because we've had
14 difficulty achieving an A. So we're starting with a
15 B. And I'm anticipating that we'll be stuck with a C.
16 And it's conceivable under certain circumstances that
17 we might drop to a D.

18 It's not a generic statement. In other
19 words, about all hospitals. It's a specific statement
20 based on my knowledge of the entire dashboard of
21 metrics at UC Davis Health.

22 Q. Got it.

23 So you're saying that, you know, when
24 UC Davis participates in the hospital survey, it gets
25 a B.

1 Is that fair?

2 A. Yes.

3 Q. And then it decided in 2022 to stop
4 participating in the Leapfrog survey and when it lost
5 the benefit of that prior year data, it dropped to a
6 C.

7 Is that correct?

8 A. Yes.

9 Q. And with the imputation change, it might now
10 drop to a D.

11 Is that correct?

12 A. It -- I was just saying that people had to
13 be aware of the possibility.

14 Q. And didn't UC Davis drop to a D in fall 2024
15 after the imputation methodology changed?

16 A. It did.

17 Q. Okay. So the hospital that you work at was
18 a B when it participated in the hospital survey and
19 with the imputation methodology change in 2024, it
20 dropped to a D on the Leapfrog hospital safety grade.

21 Is that correct?

22 A. I can't say what its grade would have been
23 if it had participated in 2024. It's quite possible
24 that its grade would have been a C if it had
25 participated; right? Because the survey components

1 only correspond to about a quarter of the total grade;
2 right?

3 So the -- obviously the -- there's other
4 measures that represent at least three-quarters of the
5 total grade.

6 So those are the primary drivers; right?

7 So if those drivers have dropped to a C,
8 then nonparticipation would get us to a D. If those
9 drivers stayed at a B, then probably we would be a C.

10 But obviously I'm speaking in general terms,
11 probabilistic terms. I'm not specifically predicting
12 that UC Davis Health will drop to a D. I just wanted
13 people to be aware of that possibility.

14 Q. And when you note that 25 percent -- so a
15 quarter of the metric that goes into the
16 nonparticipating hospital are those imputed measures
17 that are assigned the lowest score that they can get.

18 Is that correct?

19 A. I'm not quoting the exact number. Shall we
20 say it's between 20 and 25 percent.

21 Q. But approximately a quarter of the grade
22 that a nonparticipating hospital will get is assigned
23 to the lowest value you can receive for those -- that
24 25 percent.

25 Is that correct?

1 A. Yes. Mm-hm.

2 Q. And that might cause a hospital who would
3 otherwise be a B, had it participated, to a D, if it
4 didn't participate.

5 Is that correct?

6 A. That could happen, yes. Much more common is
7 a one-grade shift, as we discussed.

8 Q. But there would be a grade shift
9 nonetheless.

10 Is that fair?

11 A. In most cases there would be a grade shift,
12 yes.

13 Q. So in most cases participation or lack
14 thereof leads to a grade shift in the Leapfrog
15 hospital safety grade.

16 Is that -- after this 2024 methodology
17 change.

18 Is that fair?

19 A. Again, you're not going to be able to pin me
20 down on exactly what that percentage of hospitals is
21 that saw a grade shift or would see a grade shift.
22 This is an internal communication within
23 UC Davis Health where I'm advising them that they
24 should expect a grade shift.

25 Q. You testified earlier in most cases you

1 would expect a grade shift if one did not participate
2 in the Leapfrog hospital survey due to the 2024
3 methodology change?

4 A. Well, I'm trying to clarify because I think
5 all I testified was that there would be a decrease in
6 the numerical score.

7 And I think I further testified that the
8 impact of that decrease in the numerical score on the
9 grade assignment is uncertain because it depends on
10 exactly where the grade thresholds are drawn and those
11 grade thresholds could change from year to year.

12 Q. Nonparticipation after 2024, with the
13 methodology change for Step 2, leads to an automatic
14 deduction in the numerical score that a hospital can
15 receive?

16 A. Well, it's not an automatic deduction.
17 There are some hospitals that in their response,
18 evidence limited achievement on all domains, and
19 obviously those hospitals would not see any decrease
20 in their score.

21 Q. Do you have any --

22 A. But I accept --

23 Q. -- data on how any of those hospitals exist
24 that would get a limited achievement on all four
25 scores?

1 A. I don't know how many there are.

2 Q. Do you know of one?

3 A. I don't personally know of any, no.

4 Q. So sitting here today, you can't think of a
5 hospital that's not participating in Leapfrog's
6 hospital survey that would achieve a limited
7 achievement score on all those imputed measures.

8 Is that fair?

9 A. Well, it's not my job to investigate the
10 individual situations of individual hospitals.
11 Obviously I'm familiar with my own hospital, and
12 occasionally I'm asked to opine on other hospitals or
13 to consider other hospitals in our local market, but I
14 have no knowledge of the entire universe of hospitals.

15 Q. Sitting here today, you can't think of a
16 hospital that would get limited achievement score on
17 all the imputed measures had it participated in
18 Leapfrog's hospital survey?

19 MR. BILLEK: Object to form.

20 BY MR. HVIDT:

21 Q. Is that correct?

22 A. I suspect that there is such a hospital, but
23 it's not within my scope to identify that hospital.

24 Q. You suspect there's one, but you don't know.
25 Is that fair?

1 A. I don't know. It's beyond my scope.

2 Q. When you say "scope," what scope are you
3 referring to?

4 A. I'm referring to the scope that our task as
5 an expert panel is to advise Leapfrog related to the
6 methodology as it applies to all hospitals and not to
7 review the individual situations of individual
8 hospitals that might be affected one way or the other.

9 Q. So communicating that your hospital might
10 drop to a D, were you trying to encourage them to
11 participate in the Leapfrog survey?

12 A. Of course.

13 Q. And if you look down to the response to the
14 e-mail we were just walking through on the bottom of
15 the first page of this document, do you see the e-mail
16 from Gregory Maynard?

17 A. Yes.

18 Q. And he says:

19 "Patrick, I have brought this up with
20 Dr. Hall. We are both ambivalent about
21 the value of Leapfrog, and I think that
22 ambivalence tilts even more negative when
23 our lack of participation guarantees a
24 lower grade which they still publish,
25 effectively blackmailing centers to

1 participate."

2 Do you see that?

3 A. Yes.

4 Q. Do you understand why Gregory Maynard might
5 think that Leapfrog is blackmailing nonparticipating
6 hospitals to participate by threatening a lower grade?

7 MR. BILLEK: Object to form.

8 THE WITNESS: I understand his viewpoint.

9 BY MR. HVIDT:

10 Q. Do you think it's an unreasonable viewpoint?

11 MR. BILLEK: Object to form.

12 THE WITNESS: Yes.

13 MR. BILLEK: You can answer.

14 BY MR. HVIDT:

15 Q. Why?

16 A. Well, as I articulated in my response.

17 Q. Are you referring to the one at the top of
18 the page?

19 A. Yes.

20 Q. So going to that, you note that "The value
21 of designation must be weighed against the cost."

22 Do you see that?

23 A. Yes.

24 Q. And then you say:

25 "I have been encouraging them to

1 reduce the cost, but that message" -- "but
2 not sure that message has been heard."

3 Do you see that?

4 A. Yes.

5 Q. And is that consistent with what we were
6 talking about earlier today where you had a
7 conversation with them about the burden associated
8 with completing the hospital -- them being Leapfrog
9 staff -- about the burden of completing the hospital
10 safety grade?

11 Is that correct?

12 A. Yes.

13 So I should emphasize that, first of all,
14 I'm not on the expert panel that actually designs the
15 survey.

16 And furthermore, there are components of the
17 survey that have been dropped over time, perhaps in
18 part in response to my criticisms. So I do believe
19 that they heard the message, but it's an ongoing
20 discussion, of course.

21 Q. But you said here that you're not sure that
22 they heard the message.

23 Is that fair to say?

24 A. That was as of May, yes. May 15th, 2024.

25 Q. And so you think that they've heard the

1 message since May '24.

2 Is that correct?

3 A. Yes.

4 Q. And you note in the next sentence,
5 responding to the blackmail point, "However, I will
6 push back on Greg's point a bit."

7 Do you see that?

8 A. Yes.

9 Q. And then can you read the remainder of that
10 paragraph for me, please?

11 "You can call it blackmail if you
12 want, but" quote "pay for reporting" close
13 quote "or" quote "penalty for
14 nonreporting" close quote "is a common
15 theme across many programs. Leapfrog has
16 no choice but to use the only carrots and
17 sticks available to them. This strategic
18 choice by Leapfrog is entirely rational
19 and should not trigger a more negative
20 response."

21 Q. Sitting here today, do you agree with what
22 you wrote in that response?

23 A. Yes.

24 Q. And so are you equating the notion of
25 penalty for nonreporting versus blackmail?

1 MR. BILLEK: Is that the whole question?

2 THE WITNESS: I'm not sure I understand.

3 MR. BILLEK: I didn't know if that was the
4 pregnant pause or if that was the end of question.
5 Sorry.

6 MR. HVIDT: Understood.

7 MR. BILLEK: I object to the form of the
8 question.

9 THE WITNESS: I'm not sure I understand the
10 question.

11 BY MR. HVIDT:

12 Q. Yeah.

13 You said you can call it blackmail, if you
14 want, and then you note that "but pay for reporting or
15 pay for penalty for nonreporting is a common theme
16 across many programs."

17 Is that what you said?

18 A. Yes.

19 Q. And so oftentimes when someone says you can
20 call it X or Y, you're equating X and Y.

21 Is that fair?

22 MR. BILLEK: Object to form.

23 THE WITNESS: No. Because -- because Dr. --
24 blackmail is illegal, and I know that Dr. Maynard is
25 not specifically accusing Leapfrog of violating the

1 law. He's stating his impression as a chief quality
2 officer that it feels like blackmail.

3 So I'm interpreting his context -- his
4 comment sort of knowing that he's not actually
5 accusing Leapfrog of violating the law. He's simply
6 describing how it feels to him on the front lines as a
7 chief quality officer.

8 BY MR. HVIDT:

9 Q. So as the chief quality officer of a
10 hospital, he is internalizing Leapfrog's 2024
11 methodology change as blackmail?

12 MR. BILLEK: Object to form.

13 BY MR. HVIDT:

14 Q. Is that fair?

15 A. No. He's -- he is using the adverb
16 effectively blackmailing, which I think expresses the
17 fact that it's really a feeling, it's not an
18 accusation of blackmail in the legal sense.

19 Q. And you respond to that by again
20 characterizing what Leapfrog is doing as penalty for
21 nonreporting.

22 Do you see that?

23 A. Yes.

24 Q. And you go on to note that "Leapfrog can
25 only use carrots and sticks available to them."

1 Do you see that?

2 A. Yes.

3 Q. And what do you mean by that?

4 A. I mean that Leapfrog has no authority over
5 hospitals. It's an independent nonprofit
6 organization. It's governed by its own board. It
7 doesn't have any legal or regulatory authority like
8 CMS does. It doesn't have the power of an accrediting
9 agency like the Joint Commission. So therefore it's
10 levers are more limited.

11 So effectively it could only use the grade
12 itself and the underlying score as part of its
13 mechanism to incentivize participation.

14 Q. And so when you say the "carrots" there,
15 that's a benefit.

16 Is that fair to say?

17 A. Technically it's a food, but yes.

18 Q. But you're using it here --

19 A. Metaphorically.

20 Q. -- metaphorically. It's a benefit versus a
21 stick being a consequence.

22 Is that fair?

23 A. Yes.

24 Q. And what does "pay for reporting" mean, as
25 you use it in this e-mail?

1 A. Pay for reporting is a -- an approach where
2 hospitals or healthcare providers get a bonus if they
3 agree to report certain measures. So, for example, my
4 team currently works on developing measures for a
5 program known as MIPS, M-I-P-S. Don't ask me to spell
6 it out, but it's a program that CMS operates where
7 physicians and physician organizations receive a small
8 bonus in their Medicare fee for service payment in
9 return for reporting quality measures.

10 So that would be a pay-for-reporting program
11 to give an actual bonus to organizations or entities
12 that agree to participate.

13 Q. And you are also kind of referring to a
14 carrot as maybe the grade that they could give. So if
15 you get a better grade, that could be considered a
16 carrot.

17 Is that fair to say?

18 A. Yes.

19 Q. And so would you consider a carrot as a
20 mechanism for Leapfrog as a lever it can pull being
21 that participating hospitals, those that are
22 participating in its survey, might get stronger grades
23 because they participated in the survey?

24 Is that fair?

25 A. Yes, they might.

1 Q. Moving down to the next paragraph, it says:
2 "From my perspective on their expert
3 panel, I am asking them and they have
4 agreed to be honest and transparent."

5 Do you see that?

6 A. Yes.

7 Q. And then you note:

8 "i.e., don't say you're imputing
9 missing scores. Just say that you are
10 penalizing nonparticipants by assuming
11 that they have limited achievement on
12 these domains."

13 Do you see that?

14 A. Yes.

15 Q. Has Leapfrog continued to use the term
16 "imputing missing scores" on its methodology
17 descriptions for nonparticipating hospitals since
18 May 2024?

19 A. I think they have changed the wording in
20 Step 2 to refer to assigning rather than imputing
21 scores.

22 So Step 1 is still an imputation because it
23 uses empirical data, in this case from previous
24 surveys.

25 But Step 2 is no longer an imputation. It's

1 an assignment. And I think that's the way it's
2 described in the technical report.

3 Q. What's the difference between assigning and
4 imputing?

5 A. Well, assigning makes it clear that the same
6 decision, the same value is being assigned to all
7 facilities in that situation, the same numerical score
8 values.

9 Q. So all steps to nonparticipating hospitals
10 are assigned the same value?

11 A. Correct.

12 Q. And how is that different than imputing a
13 value?

14 A. Well, in most imputation approaches,
15 different -- different missing data points would be
16 replaced with different values, not necessarily all
17 the same value.

18 So, again, as we described earlier, that
19 imputation could incorporate data on the same measure
20 from previous reporting cycles, it could use data on
21 other measures from the same reporting cycle, or it
22 could use data on the same measure from other
23 hospitals.

24 So there are a variety of ways of imputing.
25 But imputation implies that there's some variation in

1 the values that are assigned.

2 Q. So is it fair to say that post 2024
3 methodology for Leapfrog, that the values assigned for
4 those four measures, CPOE, BCMA, IPS, and hand
5 hygiene, are not imputed measures? Is that what
6 you're saying?

7 A. They're not imputed values, no. They are
8 assigned values.

9 Q. And they are assigned values at the lowest
10 amount.

11 Is that correct?

12 A. Correct.

13 Q. And when you're imputing measures, you're
14 trying to estimate what the missing data would have
15 been had it not been missing.

16 Is that fair?

17 A. Generally, yes.

18 Q. But when you are assigning data, you're no
19 longer trying to estimate what the value would have
20 been.

21 Is that fair?

22 A. Yes.

23 Q. And you think that by just using the term
24 "assigning" as opposed to "imputing," that it's clear
25 to observers of the methodology that Leapfrog is

1 penalizing nonparticipating hospitals?

2 A. Well, certainly I'm confident that all the
3 hospitals -- or all the hospitals that paid attention
4 understood what was happening. It's reflected in the
5 e-mails that we've shared today.

6 Whether -- you know, obviously there might
7 be some users in the website who might not drill down
8 to see that detail.

9 Q. So a consumer might not know the difference
10 between imputing and assigning as it's used on
11 Leapfrog's website.

12 Is that fair?

13 A. It's possible.

14 Q. Would it surprise you that I'd never known
15 what the word "imputing" was before this case?

16 MR. BILLEK: Object to form.

17 THE WITNESS: Nothing would surprise me.

18 BY MR. HVIDT:

19 Q. Okay. So UC Davis ended up not
20 participating in the 2024 hospital survey.

21 Is that correct?

22 A. Yes.

23 Q. And it received a grade from Leapfrog in
24 fall of 2024 applying the new 2024 methodology.

25 Is that correct?

1 A. Yes.

2 (Exhibit 23 was marked for
3 identification.)

4 MR. HVIDT: I'm handing you what's been
5 marked Exhibit 23 in the Romano deposition, which has
6 been produced in this litigation using the top
7 Bates number there as Romano 000208. The top
8 substantive e-mail is from Patrick Romano to
9 Bruce Hall, Gregory Maynard, Brenda Inman, and
10 Joseph Galante, "Re: Leapfrog announcements for
11 hospitals December 2024," dated December 11, 2024.

12 Do you see that?

13 A. Yes.

14 Q. And have you seen this document before?

15 A. Yes.

16 Q. Did you review this document in preparation
17 for your deposition?

18 A. No. Only as part of my production.

19 Q. Was your production just forwarding e-mails
20 that you identified?

21 A. Correct.

22 Q. And at the top of this e-mail says you
23 forwarded it to your counsel.

24 Is that correct?

25 A. It wasn't my counsel -- I guess it was my

1 counsel, yes.

2 MR. BILLEK: Excuse me.

3 THE WITNESS: This is -- yes. I mean, it
4 has a heading of "Confidential Attorney-Client
5 Privilege Internal Communications," but I suppose that
6 counsel forwarded it to you.

7 I was unclear at the time about whether this
8 e-mail was necessary to comply with your subpoena --
9 or with your firm's subpoena. So I sought advice from
10 counsel about whether these internal e-mails were
11 relevant to the subpoena or not.

12 BY MR. HVIDT:

13 Q. Understood.

14 I do not want to get into the communications
15 between you and your counsel on that notion. But I'll
16 note that below that forwarding, there is substance
17 that's unrelated to attorney-client communication.

18 Is that correct?

19 A. Correct.

20 Q. And if you go to what is the fourth page
21 which ends in Bates No. 211, do you see that the
22 e-mail starts with the announcement of the hospital
23 grades from Leapfrog to you?

24 A. Well, not exactly.

25 So this train is appended to the previous

1 train from May 15th. And then on December 11th, the
2 scores came out, and I'm cutting and pasting from
3 Google AI.

4 Q. I understand. Thank you for that
5 clarification.

6 So if you fast forward from the
7 communications we looked at earlier to your e-mail on
8 the Bates number ending 209 dated December 11th, 2024,
9 that's where you pick up with the communication you
10 just referenced of copying Google AI result into the
11 e-mail.

12 Is that correct?

13 A. Correct.

14 Q. And then above that copy you have a message
15 to Bruce Hall, Gregory Maynard, and Brenda Inman.

16 Is that fair?

17 A. Yes.

18 Q. And you write:

19 "Well, friends, we can now see the
20 consequences of our nonparticipation, a D
21 grade, in the same league as Oroville and
22 Manteca, which is embarrassing for an
23 organization that claims to be high
24 quality."

25 Do you see that?

1 A. Manteca. Yes.

2 Q. Apologies. Manteca.

3 And are Oroville or Manteca hospitals in the
4 general area?

5 A. Northern California, yes.

6 Q. And do they have reputation for not being
7 the best hospitals?

8 A. Yes.

9 Q. Is it fair to say that you don't think
10 UC Davis fits in the same category as those hospitals?

11 A. Yes.

12 Q. And you note that the reason you're being
13 put in that same category as those hospitals is the
14 consequences of our nonparticipation.

15 Do you see that?

16 A. Yes.

17 Q. And then if you look up to the e-mail
18 response, you get a response from Bruce Hall that
19 begins on the first page of this document and carries
20 forward on to the next.

21 Do you see that?

22 A. Yes.

23 Q. He starts off by thanking you for the work
24 that you do and all you've accomplished.

25 Do you see that?

1 A. Yes.

2 Q. And then he goes through the second
3 paragraph.

4 Do you see that?

5 A. I see the proverbial "but," yes.

6 Q. And Bruce Hall notes:

7 "With respect to Leapfrog
8 specifically, I think it is irresponsible
9 and reckless of them to deliver incomplete
10 assessments to the public."

11 Do you see that?

12 A. Yes.

13 Q. What do you think he means when he says
14 "incomplete assessment"?

15 A. Well, it's incomplete because it doesn't
16 include the survey data.

17 Q. And then he goes on to say:

18 "Despite that personal sense, I'm
19 asking Greg and Brenda to assemble more
20 information on what the resource burden
21 would be if we chose to participate."

22 Do you see that?

23 A. Yes. And he notes that we had planned to do
24 this for January 2025 anyway.

25 Q. Correct.

1 And so in response to receiving this and
2 they were planning to do so, had the discussion
3 anyways, they're considering participating again.

4 Is that fair?

5 A. Yes.

6 Q. And then you respond to Bruce Hall.

7 Do you see that?

8 A. Yes.

9 Q. And setting aside the appreciation, can you
10 read to me the second paragraph?

11 A. "Re Leapfrog, me thinks you folks are
12 too critical. Their decision to increase
13 the penalty for nonparticipation was a
14 simple business decision, just like our
15 decision not to participate. It's just
16 business, folks. Their business model, as
17 you know, depends on producing data that
18 add value for health plans and employers
19 and the data are not valuable if
20 participation is low."

21 Q. Do you -- did you agree with that when you
22 wrote it in December -- on December 11th, 2024?

23 A. I did, but I should clarify that when I'm
24 talking about adding value, I'm not talking about,
25 strictly speaking, adding monetary value or financial

1 value. I'm talking about adding value that supports
2 Leapfrog's mission; that is, to increase transparency
3 and to drive improvements in patient safety that save
4 lives.

5 So I'm taking a broad perspective on value.
6 I don't want that word to be misinterpreted.

7 Q. In that sentence, do you connect the word
8 "value" to -- a reference to their business model?

9 A. Yes.

10 Q. So when you're talking about business model,
11 you're not referring to any sort of financial
12 component to the value of the data?

13 A. Well, I'm referring to the mission of
14 Leapfrog as a nonprofit organization that has to have
15 a revenue stream to support its survival.

16 Q. But you don't use the word "mission" here;
17 right? You use the word "business model."

18 Is that fair?

19 A. Yes. But Leapfrog has a business model.
20 UC Davis Health has a business model.

21 So nonprofit organizations have to have
22 business models that allow them to continue to exist
23 and fulfill their mission.

24 Q. And part of that business model is
25 generating revenue to support the missions that it

1 has.

2 Is that fair?

3 A. Yes.

4 Q. And to generate revenue, Leapfrog licenses
5 the data it receives from the hospital survey.

6 Is that correct?

7 A. Leapfrog has multiple revenue streams. I'm
8 not familiar with the details of it, but they include
9 licensing the data. They also include obviously
10 advertising, branding, other revenue-generating
11 opportunities.

12 Q. And those advertising, branding,
13 revenue-generating opportunities relate to principally
14 hospitals who receive an A grade.

15 Is that correct?

16 A. An A grade or in some cases a B grade,
17 depending on the market.

18 Q. And if you look to the notion that -- for
19 the licensing of data, do you -- you represent here
20 that the data is not valuable if participation is low.

21 Do you see that?

22 A. No. I didn't say that. I'm referring to
23 the value of the data to all the entities that use the
24 data. I'm not referring to valuable in the monetary
25 sense.

1 Q. And this sentence begins with reference to
2 their business model.

3 Is that correct?

4 A. Yes.

5 (Exhibit 24 was marked for
6 identification.)

7 MR. HVIDT: Can we go off the record?

8 THE VIDEOGRAPHER: Off the record 5:08 p.m. 0

9 (Break taken in proceedings.)

10 THE VIDEOGRAPHER: On the record 5:11 p.m. 0

11 BY MR. HVIDT:

12 Q. Dr. Romano, I've handed you what's been
13 marked as Exhibit 24, what's been produced in this
14 litigation as UC Davis TLG000047. The top e-mail is
15 from Gregory Maynard dated December 11th, 2024, to
16 Patrick Romano, Bruce Hall, and Brenda Inman
17 "Re: Leapfrog announcements to hospitals
18 December 2024."

19 Do you see that?

20 A. Yes.

21 Q. And do you see that this e-mail is
22 responding to the same e-mail from yourself that we
23 were just looking at in Exhibit 2023 (sic) and earlier
24 on in the chain?

25 A. Yes.

1 Q. And so this would be what we might refer to
2 as like a different branch of that e-mail --

3 A. Yes.

4 Q. -- do you understand that?

5 A. Yes.

6 Q. And Dr. Maynard says, quote:

7 "Personally, I think it's
8 embarrassing to Leapfrog for nuking sites
9 that don't participate. They should just
10 rank not applicable. Anything else is not
11 an honest representation of the site in
12 question."

13 Do you see that?

14 A. Yes.

15 Q. Do you think Dr. Maynard's response is
16 within the range of a reasonable response that one
17 might have to having a hospital penalized for not
18 participating in the Leapfrog survey?

19 MR. BILLEK: Object to form.

20 THE WITNESS: Well, what I note is that his
21 response was at 10:24 p.m., so he was presumably
22 responding from home in what we might call a fit of
23 pique.

24 BY MR. HVIDT:

25 Q. What is a fit of pique?

1 A. P-i-q-u-e. It just -- a colloquial
2 communication that one might see between people who
3 know each other well after usual business hours.

4 Q. So do you think that he didn't think that
5 Leapfrog should just not rank hospitals that don't
6 participate in a survey?

7 MR. BILLEK: Object to form.

8 THE WITNESS: I'm referring to the use of
9 the verb "nuking." I don't think that he means by
10 that verb that we're actually using a nuclear weapon.

11 BY MR. HVIDT:

12 Q. Understand.

13 But would you agree that by using the word
14 "nuking," he is saying that this is hitting the sites
15 that don't participate pretty hard?

16 A. Yes.

17 Q. And his view is that they should just not
18 rank the hospitals that don't participate.

19 Is that fair?

20 A. Yes, that is --

21 MR. BILLEK: Object to form.

22 THE WITNESS: That is his -- that is his
23 view.

24 BY MR. HVIDT:

25 Q. And he thinks anything -- any other rating

1 would just not be an honest representation of the site
2 in question.

3 Is that fair?

4 A. That's his view.

5 Q. And he expressed that view to you after
6 receiving an e-mail regarding the facility that he
7 works at receiving a D from the Leapfrog hospital
8 survey after the fall 2024 grade release.

9 Is that correct?

10 A. Yes.

11 Now, this is a little complicated as you say
12 with the branching because he reports to Bruce Hall,
13 and Bruce Hall had already responded, I think, earlier
14 the same day. So it's a little bit confusing, you
15 know, how to interpret the set of responses. So he
16 may or may not have been aware of his boss' response.
17 I can't say.

18 Q. And you think his boss' response may have --
19 that he responded consistent with -- may have impacted
20 his communication?

21 A. It did --

22 MR. BILLEK: Object to form.

23 THE WITNESS: It's possible.

24 BY MR. HVIDT:

25 Q. Do you think that Dr. Maynard is -- that he

1 has studied the impact of, you know, how to be -- how
2 to run a hospital's quality department in a way to
3 improve its quality?

4 Do you think that he is studied in that
5 regard or qualified in that regard?

6 A. Yes. It doesn't mean that we always agree
7 but he's certainly qualified.

8 (Exhibit 25 was marked for
9 identification.)

10 BY MR. HVIDT:

11 Q. I'm handing you what's been marked as
12 Exhibit 25 in your deposition and produced in this
13 litigation by UC Davis as UC Davis TLG0000358, which
14 is an e-mail chain regarding Leapfrog announcements
15 for hospitals, December 2024, and it's among various
16 individuals at UC Davis.

17 Do you see that, Dr. Romano?

18 A. Yes.

19 Q. Do you see that you're on the e-mail at the
20 bottom of the first page?

21 A. I'm on it with respect to the e-mails that
22 we previously reviewed, but I'm obviously not on the
23 top two e-mails.

24 Q. Correct. That's exactly what I was getting
25 to.

1 But if you look at the e-mails from the
2 bottom of the page back, those are the e-mails that
3 we've been walking through in the last several
4 minutes.

5 Is that correct?

6 A. Correct.

7 Q. And so this chain carries forward after
8 you're dropped from it with an e-mail from Bruce Hall
9 dated December 15th, 2024.

10 Do you see that?

11 A. Yes.

12 Q. And is it fair to say that Bruce Hall in
13 this e-mail is trying to assemble his team to get
14 prepared to re-evaluate whether to participate in the
15 Leapfrog hospital survey?

16 A. Yes.

17 Q. And in response to that e-mail,
18 Gregory Maynard has an e-mail response back to
19 Bruce Hall and Brenda Inman and Joseph Galante.

20 Do you see that?

21 A. Yes.

22 Q. And in Gregory Maynard's e-mail, if you look
23 down to the second to last paragraph, do you see where
24 it says "Most agree"?

25 A. Yes.

1 Q. And he says:

2 "Most agree that Leapfrog
3 participation does not spur actual Q/S
4 improvement in their centers. And the
5 main reason to participate is the
6 reputational hit you take for poor scores
7 or not participating."

8 Do you see that?

9 A. Yes.

10 Q. Had Gregory Maynard ever shared that view
11 with you before?

12 A. I don't recall. I don't recall that
13 specifically.

14 Q. And when he says "Q/S," is that a common
15 abbreviation or an abbreviation one might use for
16 "quality/safety"?

17 A. Yes.

18 Q. And have you heard that view from others
19 other than Dr. Maynard, that Leapfrog participation
20 does not spur actual quality/safety improvement in
21 their facilities?

22 A. I don't recall a specific instance where I
23 actually heard that view. I can't say right here
24 today that I've never heard that view, but I don't
25 recall any instance hearing that view.

1 Q. And in this instance, Dr. Maynard's
2 communicating to the -- to Bruce Hall who is his boss;
3 correct?

4 A. Yes.

5 Q. That most agree that Leapfrog participation
6 doesn't spur actual quality/safety improvement in
7 their centers.

8 Is that correct?

9 A. Yeah. I have no idea what the "most" is
10 that he's referring to.

11 Q. But that what he communicates to his boss?

12 A. Yes.

13 Q. And he also communicates that:

14 "The main reason to participate is a
15 reputational hit you take for poor scores or not
16 participating."

17 Is that correct?

18 A. That's what he says.

19 Q. And that terminology that he uses could be
20 consistent with the notion that there's a penalty for
21 not participating that we've talked about today.

22 Is that correct?

23 A. Well, obviously I disagree with his
24 statement here, but I respect him. We're entitled to
25 disagree.

1 But, yes, what he says here is consistent
2 with other statements that we've reviewed.

3 Q. And you agree that a hospital could take a
4 reputational hit for poor scores.

5 Is that correct?

6 A. Yes.

7 I'm pleased to see that the actual estimates
8 of the labor needed to participate are much closer to
9 my original estimates than that thousand hours. I
10 don't know where that came from.

11 Q. It does appear that the data, if you add up
12 his data in that e-mail, that he gets close to around
13 200 hours.

14 Is that correct?

15 A. Yes.

16 Q. But that doesn't include whatever data polls
17 by Jeff's staff are required.

18 Is that correct?

19 A. Yeah.

20 Q. And --

21 A. Twenty hours, 40 hours there.

22 (Exhibit 26 was marked for
23 identification.)

24 BY MR. HVIDT:

25 Q. Dr. Romano, I'm going to hand you a document

1 that's been produced in this litigation as
2 UC Davis TLG0005346. I'll represent to you that you
3 are not on this e-mail chain.

4 Exhibit 26 at the top is an e-mail between
5 Robert Jon Kucejko, Gregory Maynard, and Brenda Inman
6 dated December 19, 2024 regarding responding to
7 patient questions about rankings.

8 Do you see that?

9 A. Yes.

10 Q. And we've talked about Gregory Maynard and
11 Brenda Inman today.

12 Is that correct?

13 A. Yes.

14 Q. And we've looked at a variety of e-mails
15 from December 2024 in the last bit.

16 Is that correct?

17 A. Yes.

18 Q. And who is Robert Jon Kucejko?

19 A. He is a colorectal surgeon on our faculty
20 who is I think just an assistant professor in
21 colorectal surgery. But he has a position as the
22 physician lead for clinical documentation improvement,
23 which means that he's given the task of reviewing all
24 of our patient safety indicator events and ensuring
25 that they've been investigated and that if there are

1 errors in our data reporting, that those errors are
2 corrected.

3 Q. I understand.

4 And if you flip to the next page, you see
5 how this document originated.

6 Do you see the e-mail from HS Ambulatory
7 Care Leadership to a list of unlisted UC Davis
8 recipients? Do you see that?

9 A. Yes.

10 Q. And then if you look up at the next e-mail,
11 there's the e-mail from Mohit Gulati to surgery
12 clinics.

13 Do you see that?

14 A. Yes.

15 Q. And who's Mohit Gulati?

16 A. I honestly don't know.

17 Q. And in his e-mail to surgery clinics, are
18 you -- would you have received that? Are you on the
19 list serve for surgery clinics?

20 A. No.

21 Q. And if you look down at the second paragraph
22 in Mohit Gulati's e-mail, do you see where it says
23 "the recent release"?

24 A. Yes.

25 Q. It says:

1 "The recent release from Leapfrog
2 results indicated a low quality score for
3 UCDH. As a result, unfortunately we have
4 seen some patients canceling appointments
5 and/or procedures."

6 Do you see that?

7 A. Yes.

8 Q. Do you have any reason to dispute that
9 UC Davis actually saw some canceled appointments and
10 procedures from -- due to the low Leapfrog score from
11 December 2024?

12 MR. BILLEK: Object to form.

13 THE WITNESS: It's possible. We still
14 appear to be quite full in our aggregate statistics,
15 but it's possible that a few patients canceled
16 appointments and/or procedures.

17 BY MR. HVIDT:

18 Q. So it's possible that the aggregate number
19 is just -- you know, there's a lot of factors that go
20 into that.

21 Is that correct?

22 A. Yes.

23 Q. And that a factor that may be pushing down
24 on that aggregate factor could be canceled procedures
25 from people looking at the Leapfrog score that

1 UC Davis received and choosing not to go there?

2 MR. BILLEK: Object to form.

3 THE WITNESS: At the same time, demand may
4 be going up because of increased referrals from other
5 sources, so we may not see any aggregate change.

6 BY MR. HVIDT:

7 Q. Got it.

8 So you could have patients choosing not to
9 go to the hospital due to receiving -- seeing that
10 Leapfrog score, but the aggregate data for the
11 hospital remains constant due to a variety of other
12 factors?

13 A. For what it's worth, I heard of one patient
14 who perhaps was one of the patients who are mentioned
15 here who scheduled another appointment with their
16 surgeon, and then was reassured by their surgeon and
17 proceeded with the planned procedure just a little bit
18 later.

19 Q. Looking back to the first page of this
20 document, do you see where Robert Kucejko sends an
21 e-mail to Brenda Inman and Gregory Maynard in response
22 to receiving the e-mail from Mohit Gulati?

23 A. Yes.

24 Q. And he notes that:

25 "This is probably a marketing issue

1 more so than an actual safety issue, but
2 interesting how we can see the direct
3 effects."

4 Do you see that?

5 A. Yes.

6 Q. And if you go up to Gregory Maynard's
7 response.

8 Do you see that?

9 A. Yes.

10 Q. And he notes that there's conversations
11 ongoing about this and they're reaching out to other
12 UCs.

13 Do you see that?

14 A. Yes.

15 Q. And then he notes the problem.

16 Do you see that?

17 A. Yes.

18 Q. He says:

19 "Participating in Leapfrog surveys is
20 time consuming but does not give us value
21 in terms of insight or driving
22 improvement. The benefit is strictly
23 limited to avoid taking the blackmail-like
24 reputational hits."

25 Do you see that?

1 A. Yes.

2 Q. And that's consistent with the communication
3 he shared with you regarding his feeling about
4 blackmail, if you will --

5 A. Yes.

6 Q. -- is that correct?

7 A. Blackmail-like again. Avoiding making a
8 legal accusation, yes.

9 Q. And in response seeing an e-mail referencing
10 blackmail, Robert Jon Kucejko responds.

11 Do you see that?

12 A. Yes.

13 Q. And he says:

14 "Yeah. I mean, I agree with all
15 that. It truly is marketing blackmail.
16 Can't we sue Leapfrog?"

17 Do you see that?

18 A. Yes.

19 MR. BILLEK: That's the question?

20 THE WITNESS: He asked me if I saw that.

21 MR. BILLEK: Yes.

22 THE WITNESS: I interpret that as -- that,
23 yes, I see that.

24 MR. BILLEK: Okay.

25 THE WITNESS: Clearly I don't agree with

1 suing Leapfrog.

2 MR. BILLEK: There's no question pending.

3 MR. HVIDT: I think we can go off the record
4 for a second.

5 THE VIDEOGRAPHER: Off the record 5:28 p.m. 0

6 (Break taken in proceedings.)

7 THE VIDEOGRAPHER: On the record 5:34 p.m. 0

8 MR. HVIDT: All right. At this time the
9 plaintiffs will reserve their time for further
10 questions and rest.

11 MR. BILLEK: No questions.

12 THE VIDEOGRAPHER: Still on the record.

13 Max, from you, can we get transcript
14 purchase order and video orders, please?

15 MR. BILLEK: By on the record, you mean you
16 want me to tell you that we're ordering it? Yes.

17 THE VIDEOGRAPHER: And is that for video as
18 well?

19 MR. BILLEK: Yes.

20 THE VIDEOGRAPHER: Synced?

21 MR. BILLEK: Synced meaning the video synced
22 with the audio?

23 THE VIDEOGRAPHER: Yeah. Synced to the
24 transcript.

25 MR. BILLEK: Okay. Have you been doing

1 these depositions up until this one? I'm not familiar
2 with how my office has been ordering them.

3 THE VIDEOGRAPHER: I'll put standing order.

4 This concludes today's testimony. Off the
5 record at 5:34 p.m. 0

6 THE COURT REPORTER: They gave me a standing
7 order for Gibson Dunn, but they didn't give me one for
8 Wilson Elser.

9 MR. BILLEK: So, yes, we'll order the same
10 means and methods of producing this as counsel does as
11 well.

12 (Whereupon, the deposition adjourned at 5:35 p.m.)

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REPORTER'S CERTIFICATE

---o0o---

STATE OF CALIFORNIA)
) ss.
COUNTY OF YOLO)

I, KATY E. SCHMIDT, a Certified Shorthand Reporter in and for the State of California, duly commissioned and a disinterested person, certify:

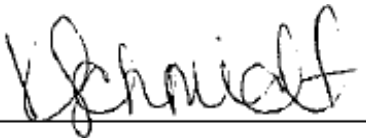
That the foregoing deposition was taken before me at the time and place herein set forth;

That PATRICK S. ROMANO, M.D., M.P.H., the deponent herein, was put on oath by me;

That the testimony of the witness and all objections made at the time of the examination were recorded stenographically by me to the best of my ability and thereafter transcribed into typewriting;

That the foregoing deposition is a record of the testimony of the examination.

IN WITNESS WHEREOF, I subscribe my name on this 25th day of September, 2025.



Katy E. Schmidt, RPR, RMR, CRR, CSR 13096
Certified Shorthand Reporter
in and for the
County of Sacramento,
State of California
Ref. No. 7581592 KES

Good Samaritan Medical Center Inc, Et Al. v. The Leapfrog Group
Patrick S. Romano, M.D., M.P.H. (#7581592)

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Patrick S. Romano, M.D., M.P.H. Date

1 Good Samaritan Medical Center Inc, Et Al. v. The Leapfrog Group
2 Patrick S. Romano, M.D., M.P.H. (#7581592)

3 ACKNOWLEDGEMENT OF DEPONENT

4 I, Patrick S. Romano, M.D., M.P.H., do hereby declare that I
5 have read the foregoing transcript, I have made any
6 corrections, additions, or changes I deemed necessary as
7 noted above to be appended hereto, and that the same is
8 a true, correct and complete transcript of the testimony
9 given by me.

10
11 _____
12 Patrick S. Romano, M.D., M.P.H. Date

13 *If notary is required

14 SUBSCRIBED AND SWORN TO BEFORE ME THIS
15 _____ DAY OF _____, 20____.

16
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18 _____
19 NOTARY PUBLIC
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[3 - acceptable]

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Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

DISCLAIMER: THE FOREGOING FEDERAL PROCEDURE RULES ARE PROVIDED FOR INFORMATIONAL PURPOSES ONLY.

THE ABOVE RULES ARE CURRENT AS OF APRIL 1, 2019. PLEASE REFER TO THE APPLICABLE FEDERAL RULES OF CIVIL PROCEDURE FOR UP-TO-DATE INFORMATION.

VERITEXT LEGAL SOLUTIONS

COMPANY CERTIFICATE AND DISCLOSURE STATEMENT

Veritext Legal Solutions represents that the foregoing transcript is a true, correct and complete transcript of the colloquies, questions and answers as submitted by the court reporter. Veritext Legal Solutions further represents that the attached exhibits, if any, are true, correct and complete documents as submitted by the court reporter and/or attorneys in relation to this deposition and that the documents were processed in accordance with our litigation support and production standards.

Veritext Legal Solutions is committed to maintaining the confidentiality of client and witness information, in accordance with the regulations promulgated under the Health Insurance Portability and Accountability Act (HIPAA), as amended with respect to protected health information and the Gramm-Leach-Bliley Act, as amended, with respect to Personally Identifiable Information (PII). Physical transcripts and exhibits are managed under strict facility and personnel access controls. Electronic files of documents are stored in encrypted form and are transmitted in an encrypted

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Exhibit 98

Gina West
September 25, 2025

Page 1

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA
WEST PALM BEACH DIVISION
CASE NO.: 9:25-CV-80526-DMM

GOOD SAMARITAN MEDICAL CENTER, INC.,
DELRAY MEDICAL CENTER, INC.,
PALM BEACH GARDENS COMMUNITY
HOSPITAL, INC. d/b/a PALM BEACH
GARDENS MEDICAL CENTER,
ST. MARY'S MEDICAL CENTER, INC.,
AND WEST BOCA MEDICAL CENTER, INC., et al.,

Plaintiffs,

v.

THE LEAPFROG GROUP,

Defendant.

VIDEOTAPED DEPOSITION OF GINA WEST
(CONFIDENTIAL)

DATE TAKEN: Thursday, September 25, 2025
TIME: 9:09 a.m. - 4:41 p.m.
PLACE: Quest Workspaces West Palm Beach
515 North Flagler Drive
Suite 350 - Conference Room A
West Palm Beach, Florida 33401

Stenographically Reported By:
Barbie Gallo, RMR-CRR
www.lexitaslegal.com
888-811-3408

Job No.: 421988

Gina West
September 25, 2025

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1 APPEARANCES:

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18

19

20

21

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25

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1 Thereupon,
2 the following proceedings began at 9:09 a.m.:

3 * * *

4 THE VIDEOGRAPHER: We're now on the video
5 record and the time is 9:09 a.m. This is the
6 video deposition of Regina West taken in the
7 matter of Good Samaritan Medical Center, Inc.
8 et al. Versus The Leapfrog Group.

9 This deposition is being held at 515 North
10 Flagler Drive West Palm Beach Florida on
11 September 25th, 2025. The videographer is
12 Benny Dorlouis, and the court reporter is
13 Barbie Gallo, both in association with Lexitas.

14 Will counsel please announce their
15 appearances for the record.

16 MS. BLAIR: Kim Blair on behalf of the
17 defendant, Leapfrog Group.

18 MR. TAKAGAKI: Marc Takagaki on behalf of
19 the plaintiffs and the witness, and I'm joined
20 by my colleague, Mary Beth Maloney.

21 THE STENOGRAPHER: If you would, raise your
22 right hand, and I'll swear you in.

23 Do you swear or affirm that the testimony
24 you're about to give in this matter will be the
25 truth, the whole truth and nothing but the truth

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1 so help you God?

2 THE WITNESS: I do.

3 THE STENOGRAPHER: Thank you.

4 THEREUPON,

5 REGINA WEST,

6 Being by me first duly sworn to tell the whole truth
7 testified as follows:

8 DIRECT EXAMINATION

9 BY MS. BLAIR:

10 Q. Hi, Ms. West. As you know, my name is
11 Kim Blair. I represent the defendant, Leapfrog Group,
12 in this matter.

13 Could you please state and spell your name
14 for the record.

15 A. My name is Regina West, R-e-g-i-n-a,
16 W-e-s-t.

17 Q. And have you ever been deposed before?

18 A. Yes.

19 Q. How many times?

20 A. One time.

21 Q. Okay. And I'm going to go over just a few
22 ground rules with respect to your deposition, many
23 you've probably heard from your own lawyers. But
24 obviously this is a question and answer format, and,
25 therefore, Barbie is taking down everything I say and

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1 everything you say, so I'm going to do my best not to
2 talk over your answers, and I'd ask that you not talk
3 over my questions for the sake of the court reporter.

4 Is that okay?

5 A. Yes.

6 Q. It's not an endurance test. If at any time
7 you need to take a break, just ask and we will take as
8 many breaks at whatever time you want. The only caveat
9 being that to the extent a question is pending I'm
10 going to ask that you answer that question before we
11 take a break.

12 Is that okay?

13 A. Yes.

14 Q. Again, Barbie is taking down everything that
15 you say and I say, and so all of your answers must be
16 verbal. She can't take down a shrug of shoulders, an
17 "uh-huh," "huh-uh."

18 Is that okay with you?

19 A. Yes.

20 Q. And from time to time your lawyer will make
21 an objection. Unless he instructs you not to answer,
22 I'm going to ask that you answer the question as asked.

23 Is that okay?

24 A. Yes.

25 Q. And I promise you that from time to time I

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1 will ask questions that you might not understand. If
2 you don't understand those questions, please ask me to
3 rephrase them and I will do so. To the extent you've
4 answered any of my questions, I'm going to assume you
5 understood those questions.

6 Is that fair?

7 A. Yes.

8 Q. And I want to start by just kind of asking
9 you to go -- well, let's talk about the deposition you
10 just told me about. You've given testimony one time in
11 a deposition?

12 A. That's correct.

13 Q. Was that in your professional or personal
14 capacity?

15 A. Professional.

16 Q. And how long ago was that deposition?

17 A. Maybe 15, 20 years ago.

18 Q. Okay. And if you can recall from 15, 20
19 years ago, generally what was the type of case that it
20 was?

21 A. It was a med/mal case.

22 Q. And I assume you were not a party to that
23 case individually, correct?

24 A. Correct.

25 Q. And where were you working at the time you

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1 gave that deposition?

2 A. In Woodville, Virginia.

3 Q. And I assume at a hospital, correct?

4 A. It was in a long-term care facility.

5 Q. All right. Can you tell me a little bit
6 about your education starting with after high school?

7 A. I received an associate's in nursing. I
8 received a bachelor's degree in healthcare
9 administration and a master's degree in healthcare
10 administration.

11 Q. In what year did you get your master's
12 degree in healthcare administration?

13 A. Approximately 2000.

14 Q. And in terms of your work history did you
15 ever work as a bedside nurse?

16 A. I worked as a home health nurse.

17 Q. And when did you work as a home health
18 nurse?

19 A. Between 1996 and 2002.

20 Q. Okay. So you worked as a home health nurse
21 while you were getting your education?

22 A. It was right after my education and in
23 between a long-term care facility position.

24 Q. Okay. So what year did you graduate with
25 your bachelor's degree?

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1 A. 1997.

2 Q. Okay. So can you just describe to me your
3 work history beginning in 2000 after you got your
4 healthcare administration master's degree?

5 A. I served as a senior director of quality;
6 following that, a chief quality officer; an
7 administrative director of quality; and a market
8 director of quality.

9 Q. Okay. So the senior director of quality,
10 where was that at?

11 A. At Carilion New River Valley Medical Center.

12 Q. And where is that located?

13 A. In Christiansburg, Virginia.

14 Q. And how long were you at that job?

15 A. Approximately three years.

16 Q. And where did you go after Carilion?

17 A. I went to Genesis Healthcare System.

18 Q. And what was your title at Genesis?

19 A. Chief quality officer.

20 Q. And is Genesis an acute care facility?

21 A. Yes, it is.

22 Q. And Carilion I think you said? Am I saying
23 that right?

24 A. Is in Zanesville.

25 Q. Was that an acute care center as well?

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1 A. Correct.

2 Q. And how long were you at Genesis?

3 A. Approximately six and a half years.

4 Q. And where did you go after Genesis?

5 A. To Tucson, Arizona.

6 Q. And where did you work in Tucson?

7 A. Northwest Medical Center.

8 Q. Again, is that an acute care facility?

9 A. It is.

10 Q. And how long were you at Tucson, in Tucson,

11 Arizona?

12 A. Approximately three years.

13 Q. And what was your job after Northwest

14 Medical Center?

15 A. Yuma, Arizona.

16 Q. It was in Yuma, Arizona?

17 A. In Yuma, yes.

18 Q. Okay. And what was the name of your

19 employer at Yuma?

20 A. Yuma Regional, Y-u-m-a.

21 Q. Oh, "Yuma." I'm not saying it right. Okay.

22 A. Regional Medical Center.

23 Q. And that was in Arizona?

24 A. Correct.

25 Q. And that was an acute care facility as well?

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1 A. Correct.

2 Q. And where did you go after Yuma?

3 A. I came to the Palm Beaches.

4 Q. And what was your first job when you came to
5 the Palm Beaches?

6 A. Market director of quality.

7 Q. For what system?

8 A. For Palm Beach Health Network.

9 Q. And what year did you take on that job?

10 A. 2019.

11 Q. Have you had any other jobs for the
12 Palm Beach Health Network other than the market
13 director of quality?

14 A. I have covered individual hospitals as the
15 director of quality.

16 Q. Which individual hospitals have you covered?

17 A. Delray Medical Center, Good Samaritan
18 Medical Center, St. Mary's Medical Center.

19 Q. Those three?

20 A. Yes.

21 Q. And what years were you at Delray as
22 director of quality?

23 A. An approximate, this is an estimation,
24 between 2019, October 2019 through June of 2020.

25 Q. And did you go right from Delray to

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1 Good Samaritan?

2 A. I did.

3 Q. So you started at Good Samaritan in 2020?

4 A. Yes.

5 Q. And when did you leave as director of
6 quality for Good Samaritan?

7 A. It was around July of 2023.

8 Q. And since July of 2023 have you been the
9 director of quality at St. Mary's?

10 A. Correct.

11 Q. And if we go back to 2023 when you were at
12 Carilion in Virginia -- was that the name of the
13 hospital?

14 A. Carilion.

15 Q. Carilion. I'm sorry. I can't read my own
16 handwriting.

17 Carilion. Was that the name of the
18 hospital?

19 A. Yes.

20 Q. Was it a system?

21 A. It was part of a system.

22 Q. And you were the senior director of quality
23 for that individual hospital, correct?

24 A. That's correct.

25 Q. Do you know whether or not Carilion when you

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1 were there as the senior director of quality
2 participated in the Leapfrog Hospital Survey?

3 A. I don't recall.

4 Q. When you were at Genesis, was that the name
5 of hospital, Genesis?

6 A. Yes.

7 Q. Was that a healthcare system?

8 A. Yes, it was.

9 Q. And were you the chief quality of director
10 of the entire stem?

11 A. Yes.

12 Q. How many hospitals were in that system?

13 A. Originally there were two. That became one.

14 Q. And what were the name of those two
15 hospitals?

16 A. They were both Genesis Healthcare System.
17 They were on different campuses.

18 Q. Okay. And you were there for six and a half
19 years, so at any time during the six and a half years
20 you were with Genesis Healthcare Systems did either of
21 those hospitals participate in the Leapfrog Hospital
22 Survey?

23 A. I don't recall.

24 Q. And then after that you went to Northwest
25 Medical Center, correct?

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1 A. Correct.

2 Q. And that's in Tucson, Arizona, correct?

3 A. Correct.

4 Q. And you were there for three years?

5 A. Yes.

6 Q. Northwest Medical Center, is that a
7 standalone hospital or part of a system?

8 A. It's part of a system.

9 Q. And you were the market director -- were you
10 the administrative director of quality, administrative
11 director of quality for that?

12 A. I was also the chief quality officer.

13 Q. For that individual hospital, Northwest
14 Medical Center, correct?

15 A. That's correct.

16 Q. Do you know whether or not Northwest Medical
17 Center participated in the Leapfrog Hospital Survey
18 while you were the chief quality officer?

19 A. I don't recall.

20 Q. And then you went to Yuma Regional Medical
21 Center, correct?

22 A. Yes.

23 Q. And while you were at Yuma -- well, is Yuma
24 Regional a standalone hospital?

25 A. Yes.

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1 Q. When you were at Yuma, did Yuma Regional
2 Medical Center participate in the Leapfrog Hospital
3 Survey?

4 A. I don't recall.

5 Q. When you became the market director of
6 quality for Palm Beach Health Network for 2019, all
7 five of the hospitals that make up the Palm Beach
8 Health Network were participating in the Leapfrog
9 Hospital Survey, correct?

10 A. To my recollection, yes.

11 Q. What did you do to prepare for your
12 deposition here today?

13 A. I reviewed policies, looked at outcomes, I
14 looked at emails.

15 Q. Do you recall any of the emails you reviewed
16 in preparation for your deposition today?

17 A. I don't recall the content.

18 Q. Did you review the Leapfrog Hospital Survey
19 in preparation for your deposition here today?

20 A. I did not.

21 Q. Did you review the Leapfrog methodology in
22 preparation for your deposition today?

23 A. I did not.

24 Q. Did you review any news articles related to
25 this lawsuit in preparation for your deposition here

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1 today?

2 A. I did not.

3 Q. Did you review any press releases that were
4 issued by Palm Beach Health Network in connection with
5 this lawsuit in preparation for your deposition today?

6 A. I did not.

7 Q. Did you review notes and minutes from QMOR
8 meetings in preparation for your deposition today?

9 A. I did not.

10 Q. Did you review meeting minutes from QIPSC
11 meetings in preparation for your deposition today?

12 A. I did not.

13 Q. And so when you talk about policies, what
14 policies do you recall reviewing in preparation for
15 your deposition here today?

16 A. I recall reviewing standard precautions,
17 medication administration. Those two stand out.

18 Q. And when you say "standard precautions," is
19 that a specific policy that you're talking about?

20 A. Yes.

21 Q. And when you say that you reviewed outcomes,
22 what are you referring to?

23 A. Reviewed outcomes for HAI prevention.

24 Q. Did you review the HCAHPS scores for any of
25 the hospitals in preparation for your deposition today?

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1 A. I did not.

2 Q. Did you meet with your -- I do not want to
3 know anything you said with your lawyers, but did you
4 meet with your lawyers to prepare for your deposition?

5 A. I did.

6 Q. How many times did you meet with your
7 lawyers?

8 A. I met three times.

9 Q. When was the first time you met with your
10 lawyer?

11 A. I don't recall the exact date.

12 Q. Approximately how long did, combined, did
13 these three meetings last?

14 A. Approximately twelve hours.

15 Q. Did you review any deposition transcripts
16 from this litigation in preparation for your
17 deposition?

18 A. I did not.

19 Q. Did you review the Complaint that was filed
20 in this action in preparation for your deposition?

21 A. I did not.

22 Q. Did you speak with any of plaintiff's
23 experts in preparation for your deposition?

24 A. I did not.

25 Q. Did you speak with any of the CEOs from any

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1 of the five Palm Beach Health Network hospitals in
2 connection with your deposition here today?

3 A. I did not.

4 Q. Did you speak with Maggie Gill in connection
5 with your deposition here today?

6 A. I did not.

7 Q. Did you speak with Ricky Ramirez in
8 connection with your deposition here today?

9 A. I did not.

10 Q. Were you involved in the gathering of
11 documents to be produced in this litigation?

12 A. Yes, I was.

13 Q. And what did you do to gather documents to
14 be produced in this litigation?

15 A. I --

16 MR. TAKAGAKI: I just want to object here
17 just to caution the witness not to reveal
18 certain privileged conversations that --

19 THE WITNESS: Okay.

20 MR. TAKAGAKI: -- you might have had with
21 counsel. She already said that, but I just want
22 to --

23 BY MS. BLAIR:

24 Q. Yes. I don't ever -- just to be clear for
25 this record, the whole time we're here today I don't

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1 want to know anything about any discussions you've had
2 with any of your lawyers. So I'm asking about what you
3 did to gather documents responsive to my client's
4 document request in this matter.

5 A. Under the direction of counsel I gathered
6 certain documents and requested them from each
7 hospital. I gathered them for St. Mary's Medical
8 Center and then I uploaded into a share site for
9 counsel.

10 Q. Did you receive the requests for production
11 that were issued in this litigation?

12 A. I did not.

13 Q. And, again, I don't want to know anything
14 about what you said with your attorneys. So did you
15 gather meeting minutes -- well, strike that.

16 Did you gather materials related to QMOR
17 meetings for production in this case?

18 A. Yes, I did.

19 Q. Did you gather documents related to QIPSC
20 meetings in connection with this litigation?

21 A. Yes.

22 Q. Did you search through your emails to
23 produce documents responsive in this litigation?

24 A. No.

25 Q. Did you gather -- for example, we are told

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1 that Delray keeps handwashing logs related to their
2 hand hygiene policy. Did you gather the completed hand
3 hygiene logs to be produced in this litigation?

4 MR. TAKAGAKI: Objection to form.

5 A. I did not.

6 BY MS. BLAIR:

7 Q. Did you have any discussions with anyone
8 else at Palm Beach Health Network about gathering
9 documents responsive to the document requests in this
10 litigation?

11 A. I spoke with other hospital leaders in
12 regards to what counsel had requested.

13 Q. And, again, I don't want to know about what
14 your counsel requested. But what other leaders did you
15 speak with in order to gather documents?

16 A. I spoke with CEOs and directors of quality.

17 Q. And did you rely on those CEOs and directors
18 of quality to gather documents specific to their
19 hospital to respond?

20 A. That is -- that is correct.

21 Q. I want to talk a little bit about your role
22 at Palm Beach Health Network specifically. So you were
23 hired in 2019, correct?

24 A. Correct.

25 Q. How did you come to get the job at

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1 Palm Beach Health Network? Did you apply? Did you see
2 an ad? Were you recruited? How did that work?

3 A. I don't recall the exact methodology.

4 Q. But you relocated to get to -- from Arizona
5 to Palm Beach, correct?

6 A. Correct.

7 Q. And you don't recall if a recruiter reached
8 out or the hospital reached out?

9 A. I don't really recall.

10 Q. And Yuma Regional Medical Center, was that a
11 Tenet hospital?

12 A. It was not.

13 Q. And so was your employment with Palm Beach
14 Health Network the first employment you had with Tenet
15 hospital?

16 A. That's correct.

17 MR. TAKAGAKI: Objection to the form.

18 A. That's correct.

19 BY MS. BLAIR:

20 Q. Do you recall who you interviewed with at
21 Palm Beach Health Network when you were applying for
22 the job?

23 A. I remember interviewing with Libby Flipppo
24 and some of the other leaders.

25 Q. So let's start with Libby Flipppo. Who is

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1 Libby Flipppo?

2 A. The market chief nursing officer.

3 Q. Is she still the market chief nursing
4 officer?

5 A. She is not.

6 Q. And when did she stop being the market chief
7 nursing officer?

8 A. I don't recall.

9 Q. And you said you spoke with Libby Flipppo and
10 other Palm Beach leaders. Who were the other leaders
11 that you recall interviewing with?

12 A. I don't recall.

13 Q. Do you recall whether or not you interviewed
14 with Maggie Gill?

15 A. Yes, I do recall.

16 Q. And was Maggie Gill the president of
17 Palm Beach Health Network in 2019?

18 A. Correct.

19 Q. Do you have any memory that Palm Beach
20 Health Network actually branded as Palm Beach Health
21 Network in 2022?

22 MR. TAKAGAKI: Objection to form.

23 A. I don't recall.

24 BY MS. BLAIR:

25 Q. Okay. But it's your memory that when you

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1 began working in the Palm Beach area in 2019 you were
2 working for Palm Beach Health Network?

3 MR. TAKAGAKI: Objection to form.

4 A. That is correct.

5 BY MS. BLAIR:

6 Q. And were your paychecks written from
7 Palm Beach Health Network in 2019?

8 MR. TAKAGAKI: Objection to form.

9 A. I don't get a paycheck.

10 BY MS. BLAIR:

11 Q. Okay.

12 A. It goes direct deposit.

13 Q. Okay. Do you know who the payer is with
14 respect to -- who the payer was in 2019 that was direct
15 depositing your pay?

16 A. Delray Medical Center.

17 Q. And today in 2025 is that still the case?

18 A. That is not the case.

19 Q. Who is the payer of your direct deposit
20 today in 2025 for the pay that you get from your job?

21 A. Good Samaritan Medical Center.

22 Q. What are your job duties as the director of
23 quality for Palm Beach Health Network?

24 A. I'm the market lead.

25 Q. And what does that mean?

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1 A. That means I coordinate with the other
2 directors of quality.

3 Q. And what do you coordinate?

4 A. Could be new measures that have been
5 introduced by CMS, meetings and reports.

6 Q. You said new reports?

7 A. Reports.

8 Q. Reports.

9 Do you put together patient safety plans for
10 the network?

11 A. I do not.

12 Q. Does each individual hospital have a patient
13 safety plan?

14 MR. TAKAGAKI: Objection.

15 A. To my knowledge.

16 BY MS. BLAIR:

17 Q. Does Tenet Healthcare home office have a
18 patient safety plan for the network overall that the
19 Palm Beach hospitals follow?

20 MR. TAKAGAKI: Objection to form.

21 A. I don't recall.

22 BY MS. BLAIR:

23 Q. Have you ever been involved in your role as
24 the director of quality at Palm Beach Health Network in
25 putting together patient safety plans for any of the

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1 five hospitals?

2 A. I have not.

3 Q. Have you ever had the occasion as the market
4 lead for Palm Beach Health Network to review the
5 patient safety plans for each of the five hospitals?

6 A. Yes, I have.

7 Q. And what is your role in reviewing the
8 patient safety plans for each hospital?

9 A. I coordinate with the patient safety officer
10 to ensure that the plan has been reviewed and updated
11 annually and it has been approved through our governing
12 body.

13 Q. And when you say "our governing body," what
14 are you referring to?

15 A. The hospital's governing body.

16 Q. The individual hospital's governing body,
17 correct?

18 A. Correct.

19 Q. Palm Beach Health Network does not have a
20 governing body, correct?

21 A. Correct.

22 MR. TAKAGAKI: Objection to form.

23 A. That's correct.

24 BY MS. BLAIR:

25 Q. And who, for example, is the patient safety

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1 officer at Delray?

2 A. Joe Gerasci.

3 Q. And do you know what the -- are you familiar
4 with what the job duties of the patient safety officer
5 is at each of the individual hospitals are?

6 A. At a very high level.

7 Q. And what is your understanding at a very
8 high level?

9 A. They mitigate risk. They are owners of the
10 patient safety plan. They manage the event recording
11 system. And they manage the complaint process.

12 Q. What is the complaint process?

13 A. If a patient has a concern, they can elevate
14 that to that department.

15 Q. Okay. And so these patient safety officers,
16 do they keep logs of the complaints they get from
17 patients?

18 MR. TAKAGAKI: Objection to form.

19 A. That is correct.

20 BY MS. BLAIR:

21 Q. And then who -- structurally do you know who
22 the patient safety officers for the individual
23 hospitals report to?

24 A. Yes.

25 Q. Who do they report to?

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1 A. They report either to the chief nursing
2 officer or to the director of quality.

3 Q. And in the case of, let's just say, Delray,
4 Joe Gerasci, do you know who he report to?

5 A. Yes.

6 Q. Who does he report to?

7 A. Chief nursing officer.

8 Q. Do the patient safety officers put out
9 reports?

10 A. Yes.

11 Q. And do you know what the titles of those
12 reports are?

13 A. I don't recall the title.

14 Q. Do you know what the consistency of the
15 reporting is? Is it monthly weekly quarterly?

16 A. At least quarterly.

17 MR. TAKAGAKI: Objection to form.

18 BY MS. BLAIR:

19 Q. And to the best of your knowledge as the
20 market lead for quality for Palm Beach Health Network,
21 are these reports, at least quarterly reports put out
22 for all five of the hospitals by patient safety
23 officers?

24 A. That's correct.

25 Q. Do you recall whether you gathered those

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1 documents in connection with the production request in
2 this matter?

3 A. I don't recall.

4 Q. So if we think about the structure and your
5 role at Palm Beach Health Network, you are the market
6 lead, correct?

7 A. Correct.

8 Q. And all five hospitals have a director of
9 quality, correct?

10 A. Correct.

11 Q. And underneath the director of quality do
12 you know how many reports or what type of reports
13 directors of qualities for each individual hospital
14 have?

15 MR. TAKAGAKI: Objection to form.

16 A. Could you clarify the question?

17 BY MS. BLAIR:

18 Q. Sure.

19 So at least in some circumstances you said
20 patient safety officers would report to the director of
21 quality for an individual hospital, correct?

22 A. Correct.

23 Q. But in the case of Delray he reports to the
24 chief nursing officer, correct?

25 A. Correct.

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1 Q. Do you know what -- and let's just take
2 Delray. Let's just be specific so it's not too
3 confusing with all five.

4 With respect to Delray, do you know who,
5 titles, reports to the director of quality for Delray?

6 A. Yes.

7 Q. And who is that?

8 A. There is a quality coordinator, peer review
9 nurse, infection prevention manager. I think that's
10 it.

11 Q. Okay. And then in some cases, and not in
12 Delray, so in other hospitals the patient safety
13 officer would report to the director of quality?

14 MR. TAKAGAKI: Objection to form.

15 A. That only occurs in Palm Beach Gardens
16 Medical Center.

17 BY MS. BLAIR:

18 Q. Okay. And do you know why the patient
19 safety officer reports to the chief nursing officer in
20 the other four hospitals as opposed to the director of
21 quality?

22 MR. TAKAGAKI: Objection to form.

23 A. I don't know. It was set up like that when
24 I got there.

25 BY MS. BLAIR:

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1 Q. So that was not your decision, correct?

2 A. No.

3 Q. How often do you meet with the quality
4 directors at the five hospitals?

5 A. It depends on the need.

6 Q. Do you have any formal meetings like regular
7 formal meetings with the directors of quality at the
8 five hospitals?

9 A. I do.

10 MR. TAKAGAKI: Objection to form.

11 BY MS. BLAIR:

12 Q. Sorry. And how often do those occur?

13 A. Depends on the need. And we have started a
14 meeting with the group chief nursing officers and that
15 is monthly.

16 Q. Okay. And so when you say "we have started
17 meeting with the group of chief nursing officers," do
18 you mean you and the quality directors?

19 A. Correct.

20 Q. And what is the purpose of those meetings?

21 A. To share information, to problem solve if we
22 need to.

23 Q. And what type of information do you share?

24 MR. TAKAGAKI: Objection to form.

25 A. We share outcomes.

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1 BY MS. BLAIR:

2 Q. And when you talk about outcomes, are you
3 talking about HAIs?

4 A. Could be one of the things.

5 Q. And what other outcomes could there be?

6 A. The structural measures.

7 Q. Any other type of outcomes?

8 A. There are. They just don't come to mind
9 right now.

10 Q. And when you say "structural measures," what
11 are you referring to?

12 A. New CMS measures.

13 Q. Can you be specific as to the new CMS
14 measures that you're referring to?

15 A. Yes.

16 Q. There are quite a few. What are you
17 referring to?

18 A. There's new age-friendly measure and a new
19 safety measure.

20 Q. Do you talk about outcomes as they relate to
21 like PSI 90s?

22 MR. TAKAGAKI: Objection to form.

23 A. We do that in our QIPSC meetings. Quality
24 improvement patient safety meeting.

25 BY MS. BLAIR:

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1 Q. What about any of the other PSIs, are those
2 discussed at these meetings that you're now having with
3 the directors of quality as well as the chief nursing
4 officers?

5 MR. TAKAGAKI: Objection to form.

6 A. No.

7 BY MS. BLAIR:

8 Q. Do you have any direct reports?

9 A. Yes.

10 Q. And who are your direct reports?

11 A. I have a quality coordinator.

12 Q. Who's the quality coordinator?

13 A. Michael Germain.

14 Q. Anyone else?

15 A. I have a quality manager.

16 Q. And who is that?

17 A. Erica Kerns (phonetic).

18 Q. Is that with K?

19 A. Yes.

20 Q. Anyone else?

21 A. Peer review nurse.

22 Q. And who is that?

23 A. Loraina Mills (phonetic).

24 Q. Anyone else?

25 A. Yes, cardiac program manager.

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1 Q. And that is whom?

2 A. Heather Wehmeyer.

3 Q. Anyone else?

4 A. Vascular program manager.

5 Q. And who is that?

6 A. Sarah Saleh.

7 Q. With respect to really the quality
8 coordinator, Michael Germain what are his duties?

9 A. His duties are to coordinate the sepsis
10 bundle compliance, ensuring education and follow-up,
11 validation, making sure abstracted measures having been
12 completed, and he also completes validation of
13 Joint Commission audits.

14 Q. And what about the quality manager,
15 Erica Kerns?

16 A. One of her major duties is ensuring that
17 data has been collected for Joint Commission required
18 measures, the clinical contract measures, follow-up
19 with the dashboard measures and ensuring that that is
20 placed in a presentation, analyzed, recommendations are
21 made, reported up through QIPSC.

22 Q. And when you say "put into a presentation,"
23 is that a slide deck?

24 A. It's a slide deck.

25 Q. And is that slide deck then presented at

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1 QIPSC meetings?

2 A. Yes.

3 MR. TAKAGAKI: Objection to form.

4 BY MS. BLAIR:

5 Q. And did you gather those slide decks from
6 '23 to 2025 to be produced in this litigation?

7 A. Yes.

8 Q. And you talked about dashboards a minute
9 ago. Can you tell me what are you referring to when
10 you refer to dashboards?

11 A. Joint Commission required data, clinical
12 contracts, KPIs and some other various department
13 measures.

14 Q. Yeah, my question was bad so I apologize.
15 Is the dashboard called anything?

16 A. It's called a dashboard.

17 Q. Okay. Is -- are there reports that are
18 printed out from the dashboard?

19 MR. TAKAGAKI: Objection to form.

20 A. There are no reports printed from the
21 dashboard.

22 BY MS. BLAIR:

23 Q. Other witnesses have talked about a
24 scorecard. Do you know what that refers to in terms of
25 what you do as the director of quality for Palm Beach

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1 Health Network?

2 MR. TAKAGAKI: Objection to form.

3 A. Can you further clarify it?

4 BY MS. BLAIR:

5 Q. Yeah. I am told there is a quality
6 scorecard that exists. And I'm curious whether or not
7 in your role as the quality director of Palm Beach
8 Health Network you are responsible in any way for
9 scorecards?

10 MR. TAKAGAKI: Objection.

11 A. I'm responsible for quality management
12 operations report being given to senior leaders.

13 BY MS. BLAIR:

14 Q. So that's the QMOR report, correct?

15 A. That is correct.

16 MR. TAKAGAKI: Objection to form.

17 THE VIDEOGRAPHER: I'm sorry, Counsel.
18 Something happened to your microphone. I'm not
19 sure if it fell off.

20 MS. BLAIR: Oh, yeah, it's no longer
21 attached.

22 BY MS. BLAIR:

23 Q. So what -- in your area as the quality
24 director of Palm Beach Health Network, are you
25 unfamiliar with the term "scorecard"?

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1 MR. TAKAGAKI: Objection to form.

2 A. I'm not unfamiliar with the term
3 "scorecard."

4 BY MS. BLAIR:

5 Q. In your capacity as the director of quality
6 for Palm Beach Health Network what is your
7 understanding of the term "scorecard" as it relates to
8 your job?

9 MR. TAKAGAKI: Objection to form.

10 A. That's broad.

11 BY MS. BLAIR:

12 Q. Okay. Does Palm Beach Health Network
13 produce scorecards for quality?

14 MR. TAKAGAKI: Objection to form.

15 A. If you could further clarify.

16 BY MS. BLAIR:

17 Q. I really can't. Are you familiar with the
18 term "scorecard" as it relates to Palm Beach Health
19 Network quality?

20 MR. TAKAGAKI: Objection to form.

21 A. We don't have a document that's called a
22 "scorecard."

23 BY MS. BLAIR:

24 Q. Okay. Have you ever heard anybody
25 associated in any way with Palm Beach Health Network

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1 use the term "scorecard"?

2 MR. TAKAGAKI: Objection to form.

3 A. I haven't.

4 BY MS. BLAIR:

5 Q. Okay. So if people have testified about
6 reviewing scorecards, you don't know what they're
7 referring to, is that fair?

8 A. That's --

9 MR. TAKAGAKI: Objection to form.

10 A. That's correct.

11 BY MS. BLAIR:

12 Q. In terms of the peer review nurse or the
13 peer -- is it a peer review nurse that reports to you?

14 A. Yes.

15 Q. Ms. Mills, correct?

16 A. Yes.

17 Q. What are her job responsibilities?

18 A. She collects information after cases have
19 been referred to her. She completes a timeline, and
20 then she works with the medical director who chairs the
21 peer review committee to review the cases.

22 Q. And what kind of cases are referred to her?

23 A. It would be --

24 MR. TAKAGAKI: Objection.

25 A. It would be any type of request from any --

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1 any really any staff member within the hospital to
2 review a case at the provider level.

3 BY MS. BLAIR:

4 Q. And when you say "the provider level," does
5 that mean the nursing level?

6 A. It's a physician or a mid level.

7 Q. And then the quality manager, Erica Kerns,
8 what are her responsibilities?

9 A. She oversees the dashboard and the measures
10 that go into that. She will complete -- she'll gather
11 the information, ensure that it's complete, develop
12 presentations for the Quality Improvement Patient
13 Safety Committee.

14 Q. And what measures go into the dashboard?

15 MR. TAKAGAKI: Objection to form.

16 A. Joint Commission required data, clinical
17 contract, key performance indicators. And there are
18 other ones as well.

19 BY MS. BLAIR:

20 Q. What are the key performance indicators that
21 are put into the dashboard?

22 MR. TAKAGAKI: Objection to form.

23 A. Some of those would include measures that
24 have been reviewed upon by the clinical contract
25 representative and the hospital. Information is

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1 gathered and analyzed. Recommendations are made from
2 the data that's collected.

3 BY MS. BLAIR:

4 Q. Is CPOE one of the key performance
5 indicators that's on the dashboard?

6 A. It's not.

7 Q. What about BCMA, is that a key performance
8 indicator on the dashboard?

9 A. It's not.

10 Q. What about hand hygiene, is that a key
11 performance indicator that's on the dashboard?

12 A. It's not.

13 Q. Is CPOE on the dashboard in any capacity
14 even if it's not a key performance indicator?

15 MR. TAKAGAKI: Objection to form.

16 A. No.

17 BY MS. BLAIR:

18 Q. Same question with respect to BCMA, is it on
19 the dashboard in any capacity even if it's not a key
20 performance indicator?

21 A. No.

22 MR. TAKAGAKI: Objection.

23 BY MS. BLAIR:

24 Q. Do you in any way track hand hygiene on
25 behalf of the five hospitals?

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1 MR. TAKAGAKI: Objection.

2 A. I don't personally.

3 BY MS. BLAIR:

4 Q. Does anybody that reports to you at
5 Palm Beach Health Network track hand hygiene for the
6 five hospitals?

7 MR. TAKAGAKI: Objection to form.

8 A. No one that reports to me.

9 THE STENOGRAPHER: I'm sorry. I didn't
10 hear.

11 A. No one that reports to me.

12 BY MS. BLAIR:

13 Q. What would you say your purpose as the job
14 as the quality director of Palm Beach Health Network
15 is?

16 MR. TAKAGAKI: Objection to form.

17 A. To ensure that the quality improvement plan
18 exists, that it's reviewed, updated and current, that
19 we're following it, that it's been standardized across
20 the market.

21 BY MS. BLAIR:

22 Q. And when you say "across the market," how do
23 you define "market"?

24 A. The five hospitals in the Palm Beach Health
25 Network.

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1 Q. Would you agree with me that one of the
2 purposes of your job as the quality director for Palm
3 Beach Health Network is to ensure patient safety across
4 the five hospitals?

5 MR. TAKAGAKI: Objection to form.

6 A. It's all of our jobs to ensure patient
7 safety.

8 BY MS. BLAIR:

9 Q. Who do you directly report to?

10 A. I report to Ricardo Ramirez in the market
11 role and -- he's the market chief nursing officer.

12 Q. Correct.

13 A. And to the chief nursing officer at
14 St. Mary's Medical Center in my role at the hospital.

15 Q. Who is the chief nursing officer at
16 St. Mary's Medical Center?

17 A. Gerri DeStefano is the interim at the
18 moment.

19 Q. And I understand a new chief nursing officer
20 is about to be hired at St. Mary's, correct?

21 A. Correct.

22 MR. TAKAGAKI: Objection to form.

23 That's okay. Just take a breath so I can
24 object first.

25 MS. BLAIR: Yes. He's going to object to

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1 every question.

2 MR. TAKAGAKI: Objection. Object to that.

3 MS. MALONEY: He's going to object to the
4 form of the questions.

5 BY MS. BLAIR:

6 Q. Maggie Gill is the president of PBHN?

7 A. That is correct.

8 Q. And does Ricky Ramirez report to
9 Maggie Gill?

10 A. I am not sure how that relationship is.

11 Q. Okay. Do you know who Maggie Gill reports
12 to?

13 A. Yes.

14 Q. Who does Maggie Gill report to?

15 A. Saum Sutaria.

16 Q. And who is Saum Sutaria?

17 A. President of Tenet.

18 Q. And when you say "president of Tenet," do
19 you mean Tenet health system, correct?

20 A. That's correct.

21 MR. TAKAGAKI: Objection.

22 BY MS. BLAIR:

23 Q. Do you oversee QMOR for Palm Beach Health
24 Network?

25 MR. TAKAGAKI: Objection.

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1 A. In some capacity.

2 BY MS. BLAIR:

3 Q. In what capacity do you oversee QMOR for
4 Palm Beach Health Network?

5 A. Once the report has been established I
6 create templates for all five hospitals. We follow a
7 Tenet script to report our outcomes. I schedule
8 meetings with the CEOs and the other senior leaders.
9 And we review the outcomes.

10 Q. Do you run the QMOR meetings?

11 MR. TAKAGAKI: Objection to form.

12 A. I run local meetings.

13 BY MS. BLAIR:

14 Q. And so for QMOR, is it right that there is a
15 QMOR -- and that's a committee. Let me ask this.

16 Is QMOR a committee?

17 A. It is not.

18 Q. Okay. How would you define QMOR?

19 A. As a report.

20 Q. Okay. Are there meetings that occur around
21 the QMOR report?

22 A. Yes.

23 MR. TAKAGAKI: Objection.

24 BY MS. BLAIR:

25 Q. And do those meetings occur at the

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1 Palm Beach Health Network level?

2 MR. TAKAGAKI: Objection.

3 A. That's correct.

4 BY MS. BLAIR:

5 Q. And do the meetings around the QMOR report
6 also occur at the individual hospital level?

7 A. Not to my knowledge.

8 Q. And when you say you run the local meetings,
9 what are you referring to there?

10 A. I was referring to the market meetings.

11 Q. And, again, the market being the five
12 hospitals that make up Palm Beach Health Network,
13 correct?

14 A. That's correct.

15 Q. When you say you then have a Tenet script to
16 report the outcomes, what are you referring to when you
17 say "Tenet script"?

18 A. There are certain elements of investigation
19 that we have to go through and ensure that we have
20 reviewed all of the different areas.

21 Q. And does the Tenet script come from the
22 Tenet home office at the healthcare level?

23 MR. TAKAGAKI: Objection to form.

24 BY MS. BLAIR:

25 Q. I'm sorry. The health network level.

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1 A. Would you mind repeating that?

2 Q. Sure. When you refer to a Tenet script, is
3 that something created at the Palm Beach Health Network
4 level, or is that something that comes from the home
5 office level?

6 MR. TAKAGAKI: Objection.

7 A. It comes from the home office level.

8 BY MS. BLAIR:

9 Q. And to the best of your knowledge, have you
10 produced all of the QMOR reports for this litigation
11 from 2023 through 2025?

12 MR. TAKAGAKI: Objection to form.

13 A. That is correct.

14 BY MS. BLAIR:

15 Q. And how often do the meetings around the
16 QMOR report occur?

17 MR. TAKAGAKI: Objection to form.

18 A. Mostly monthly.

19 BY MS. BLAIR:

20 Q. Every month?

21 A. Yes.

22 Q. And who is -- who attends the meetings
23 surrounding the QMOR report?

24 MR. TAKAGAKI: Objection.

25 A. Senior leadership.

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1 BY MS. BLAIR:

2 Q. And when you say "senior leadership," are
3 you referring to the senior leadership of each of the
4 five hospitals?

5 A. Correct.

6 Q. Does the senior leadership of
7 Tenet Healthcare also attend?

8 MR. TAKAGAKI: Objection.

9 A. Correct.

10 BY MS. BLAIR:

11 Q. And who do you consider to be senior
12 leadership of each of the five hospitals?

13 A. The officers.

14 MR. TAKAGAKI: Objection.

15 A. The officers.

16 BY MS. BLAIR:

17 Q. And those would be any chief officers,
18 correct?

19 MR. TAKAGAKI: Objection. Are you asking
20 just in general who senior leadership is or the
21 ones who attend?

22 MS. BLAIR: I'm asking her in general.

23 MR. TAKAGAKI: In general.

24 BY MS. BLAIR:

25 Q. Who do you consider to be senior leadership

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1 of the five hospitals?

2 A. The officers.

3 Q. And when you say "officers," are you
4 referring to anybody that holds a chief officer title?

5 A. Correct.

6 Q. And of those officers, which of those
7 officers attend the QMOR -- the meetings around the
8 QMOR report?

9 MR. TAKAGAKI: Objection.

10 A. They're all invited.

11 BY MS. BLAIR:

12 Q. Are there any regular attendees of these
13 meetings, these monthly meetings surrounding the QMOR
14 report?

15 MR. TAKAGAKI: Objection to form.

16 A. Yes.

17 BY MS. BLAIR:

18 Q. And who are they?

19 A. Maggie Gill, CEOs, the CNOs, CFOs and COOs.

20 Q. When you say "chief nursing officers," would
21 that also include Ricky Ramirez?

22 MR. TAKAGAKI: Objection to form.

23 A. Yes.

24 BY MS. BLAIR:

25 Q. And so just so I'm clear, it's not a

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1 specific committee, the Q -- there's no QMOR committee,
2 correct?

3 MR. TAKAGAKI: Objection.

4 A. Correct.

5 BY MS. BLAIR:

6 Q. And QMOR, then, refers just to this report,
7 correct?

8 MR. TAKAGAKI: Objection to form.

9 Are you talking about how you've been
10 referring to it?

11 MS. BLAIR: Yeah, I want to make sure I'm
12 understanding her testimony.

13 BY MS. BLAIR:

14 Q. Right, there's no committee, there's no QMOR
15 committee?

16 A. Correct.

17 Q. But there's a QMOR report, correct?

18 MR. TAKAGAKI: Objection. Asked and
19 answered.

20 A. Correct.

21 BY MS. BLAIR:

22 Q. Thank you.

23 The QMOR report, does that get sent to Tenet
24 health home office?

25 MR. TAKAGAKI: Objection.

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1 A. It does not.

2 BY MS. BLAIR:

3 Q. Does the QMOR report get incorporated in any
4 way into the patient safety plans of the five
5 hospitals?

6 MR. TAKAGAKI: Objection. Calls for
7 speculation.

8 A. Not to my knowledge.

9 BY MS. BLAIR:

10 Q. In your view as the director of quality for
11 the market, what do you believe is the purpose of the
12 QMOR report?

13 A. It has strategic measures that hits targets
14 and our current performance to those targets.

15 Q. So is it fair to say that the QMOR report is
16 a way that these five hospitals benchmark themselves
17 against the targets that you have for them?

18 MR. TAKAGAKI: Objection to form.
19 Mischaracterizes her testimony.

20 A. Could you repeat the question?

21 BY MS. BLAIR:

22 Q. Sure. I thought you testified -- this QMOR
23 report has targets in it, correct?

24 A. Correct.

25 MR. TAKAGAKI: Objection.

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1 Q. And the QMOR report is an output about how
2 each of these five hospitals is doing with respect to
3 those targets, correct?

4 MR. TAKAGAKI: Objection.

5 A. Correct.

6 BY MS. BLAIR:

7 Q. And so would you agree with me that the QMOR
8 report is a way in which the hospitals are benchmarking
9 themselves as to how they're doing against those
10 targets that are set, correct?

11 MR. TAKAGAKI: Objection.

12 A. We're reviewing how well we're doing against
13 the targets.

14 BY MS. BLAIR:

15 Q. Thank you.

16 Now I want to talk a little bit about QIPSC.
17 What does QIPSC stand for?

18 A. Quality Improvement Patient Safety
19 Committee.

20 Q. So is that actually a committee?

21 A. Yes.

22 Q. And is that committee at the Palm Beach
23 Health Network level?

24 MR. TAKAGAKI: Objection to form.

25 A. It is not.

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1 BY MS. BLAIR:

2 Q. So there is five separate QIPSCs for each of
3 the five hospitals that make up the Palm Beach Health
4 Network, correct?

5 A. That's correct.

6 Q. Do you participate in all five of those
7 QIPSC committees?

8 MR. TAKAGAKI: Objection.

9 A. I do not.

10 BY MS. BLAIR:

11 Q. Do those QIPSC committees put out reports
12 that are provided to you as the market lead of quality
13 for Palm Beach Health Network?

14 MR. TAKAGAKI: Objection.

15 A. They do not.

16 BY MS. BLAIR:

17 Q. Do you ever have the opportunity to review
18 reports from the local hospital QIPSC committees?

19 A. Yes.

20 Q. And for what purpose do you review the
21 reports from the local QIPSC committee?

22 MR. TAKAGAKI: Objection.

23 A. I review them at least annually to complete
24 an evaluation.

25 BY MS. BLAIR:

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1 Q. And what are you evaluating?

2 MR. TAKAGAKI: Objection. Are you asking
3 for each individual time she got it what she was
4 looking at?

5 MS. BLAIR: No, I'm asking generally.

6 BY MS. BLAIR:

7 Q. You review it annually, correct?

8 A. Do you mind repeating the question? I'm so
9 sorry.

10 Q. Sure.

11 You told me that you review the individual
12 QIPSC reports annually, correct?

13 A. At least annually.

14 MR. TAKAGAKI: Objection.

15 BY MS. BLAIR:

16 Q. And for what purpose do you review them
17 annually?

18 MR. TAKAGAKI: Objection.

19 A. I review outcomes.

20 BY MS. BLAIR:

21 Q. And when you talk about outcomes, are you
22 talking about HAIs?

23 A. It could be included in the report.

24 Q. Okay. What all outcomes are you referring
25 to when you say you review these for outcomes?

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1 MR. TAKAGAKI: Objection.

2 A. We have a reporting calendar. All measures
3 within that reporting calendar gets reported up through
4 QIPSC. I review all the measures from that reporting
5 calendar.

6 BY MS. BLAIR:

7 Q. Do you, after you do your annual review of
8 the QIPSC information that you get, at least annually,
9 I'm not trying to put words in your mouth, do you
10 create any sort of output? Do you create a report
11 yourself based on your review of those reports?

12 MR. TAKAGAKI: Objection.

13 A. Yes, I do.

14 BY MS. BLAIR:

15 Q. And what kind -- what is the name of that
16 report that you put out?

17 MR. TAKAGAKI: Objection.

18 Could you be more specific in terms of what
19 year, which hospital, because this is a very
20 general question right now?

21 BY MS. BLAIR:

22 Q. Ma'am, do you do a report for each
23 individual hospital at least annually when you review
24 the QIPSC reports?

25 A. I do not do individual reports.

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1 Q. Okay. So you do one omnibus report for all
2 five hospitals, correct?

3 A. That is correct.

4 MR. TAKAGAKI: Objection.

5 BY MS. BLAIR:

6 Q. And what -- does that report have a name
7 that you put out at least annually with respect, the
8 omnibus report with respect to all five hospitals?
9 Does it have a name?

10 A. It's the Performance Improvement Evaluation
11 for that current year.

12 Q. And that Performance Improvement Evaluation
13 for the current year is the Performance Improvement
14 Evaluation for all five hospitals in one report,
15 correct?

16 MR. TAKAGAKI: Objection.

17 A. That's correct.

18 BY MS. BLAIR:

19 Q. And did you produce the Performance
20 Improvement Evaluation that you did from -- for 2023,
21 2024 in this litigation for production?

22 MR. TAKAGAKI: Objection. Are you asking if
23 she produced it to the defendants in this case?

24 MS. BLAIR: I'm asking if she collected it.

25 BY MS. BLAIR:

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1 Q. Did you collect the performance improvement
2 education [sic] report for '23 and '24 for production
3 in this litigation?

4 MR. TAKAGAKI: Objection.

5 A. I don't remember.

6 BY MS. BLAIR:

7 Q. What data, to the best of your knowledge as
8 the market lead for quality for Palm Beach Health
9 Network, what data are the local hospital QIPSC
10 committees monitoring?

11 MR. TAKAGAKI: Objection.

12 A. Joint Commission required data, clinical
13 contract, key performance indicators, infection
14 prevention indicators and service line reports.

15 BY MS. BLAIR:

16 Q. Do the QIPSC committees have targets for the
17 data that they're collecting? That might be a bad
18 question, so I don't know if -- let me ask it another
19 way.

20 You recall you told me about the QMOR report
21 and there's targets that are in those, in that document
22 about how the hospitals should be performing on certain
23 targets, correct?

24 MR. TAKAGAKI: Objection. Mischaracterizes
25 her testimony.

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1 A. Can you repeat your question, please?

2 BY MS. BLAIR:

3 Q. Sure.

4 With respect to the QMOR report that we
5 talked about a little bit earlier, there are targets
6 you told me that are included within that report,
7 correct?

8 A. Correct.

9 Q. Are there targets included within QIPSC
10 reports?

11 A. Yes, that's a component.

12 Q. And who sets those targets?

13 MR. TAKAGAKI: Objection. Calls for
14 speculation.

15 A. Committees approve the targets.

16 BY MS. BLAIR:

17 Q. And when you say the committees, you're
18 referring to each of the five local QIPSC committees?

19 A. Correct.

20 Q. Does Tenet home office approve the targets
21 in any way for the QIPSC committees?

22 MR. TAKAGAKI: Objection. Calls for
23 speculation.

24 A. For the measures that carry over from the
25 quality management operations report.

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1 BY MS. BLAIR:

2 Q. So that's a "yes" with respect to the
3 measures that carry over from the quality measures
4 operations report, correct?

5 A. Correct.

6 MR. TAKAGAKI: Objection.

7 BY MS. BLAIR:

8 Q. What about the measures that don't carry
9 over from the quality measures operation report, do you
10 know if Tenet health has any -- Tenet health on the
11 home office level has any involvement in setting those
12 targets?

13 MR. TAKAGAKI: Objection. Calls for
14 speculation.

15 BY MS. BLAIR:

16 Q. I'm asking if you know. I don't want you to
17 speculate.

18 A. Not to my knowledge.

19 Q. Thank you.

20 What types of reports -- as the market lead
21 for quality for Palm Beach Health Network, are you
22 familiar with the reports that the QIPSC committees put
23 out?

24 MR. TAKAGAKI: Objection.

25 A. Yes.

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1 BY MS. BLAIR:

2 Q. Do you know what the names of those reports
3 are?

4 A. They vary by report.

5 Q. What are some of names of reports that you
6 can recall as you sit here today?

7 A. Infection prevention would be one. There
8 are more. They're just not popping to memory.

9 Q. It's not a memory test.

10 A. Okay.

11 Q. And we talked about you told me all of the
12 data that you believe they're tracking,
13 Joint Commission data, contract, KPIs, infection
14 prevention indicators, service lines.

15 Are there any other type of data that you
16 can think of that the local hospital QIPSC committees
17 are tracking that you haven't described?

18 MR. TAKAGAKI: Objection.

19 A. There are also risk management reports.

20 BY MS. BLAIR:

21 Q. The reports that are put out by the QIPSC
22 committees, are they all sent to you as the market lead
23 for -- of quality for Palm Beach Health Network?

24 MR. TAKAGAKI: Objection.

25 A. They're not sent to me.

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1 BY MS. BLAIR:

2 Q. Do you know who they're sent to?

3 MR. TAKAGAKI: Objection.

4 A. Yes.

5 BY MS. BLAIR:

6 Q. Who are they sent to?

7 A. Erica Kerns.

8 Q. And who is Erica Kerns?

9 A. The quality manager.

10 Q. And Erica Kerns reports to you, correct?

11 MR. TAKAGAKI: Objection.

12 A. That's correct.

13 MR. TAKAGAKI: Are you saying "Eric" or
14 "Erica"? I just, I can't understand. I was
15 asking --

16 MS. BLAIR: I'm saying "Erica." Is it
17 "Eric"?

18 MR. TAKAGAKI: Oh, I thought you were
19 saying -- I thought you said "Eric."

20 BY MS. BLAIR:

21 Q. Oh, I thought it was Erica. It's Erica,
22 yes?

23 A. Yes.

24 Q. Okay. And what does Erica do with these
25 reports.

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1 MR. TAKAGAKI: Objection.

2 A. She ensures that they're compiled
3 completely.

4 BY MS. BLAIR:

5 Q. Okay.

6 A. That they contain data analysis and
7 recommendations and that the full report is ready for
8 the quality improvement patient safety meetings.

9 Q. So when you say "the full report is ready
10 for the quality improvement patient safety meetings,"
11 you're referring to those local level meetings,
12 correct?

13 A. That is correct.

14 Q. So she will, Erica Kerns, reviews the data
15 in preparation for each of the individual hospitals for
16 preparation for the QIPSC committee meetings, correct?

17 MR. TAKAGAKI: Objection. Calls for
18 speculation.

19 BY MS. BLAIR:

20 Q. I thought that's what you just told me so I
21 want to make sure.

22 A. Can you repeat?

23 MR. TAKAGAKI: Objection.

24 BY MS. BLAIR:

25 Q. Sure.

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1 Erica Kerns puts together -- reviews the
2 information from the QIPSC committees and you said to
3 ensure that a full report is ready for the quality
4 improvement patient safety meetings, correct, that's
5 what you said?

6 MR. TAKAGAKI: Objection.

7 A. Correct.

8 BY MS. BLAIR:

9 Q. And so I'm just trying to get a timeline.
10 So they, the quality -- the QIPSC committees for each
11 local hospital provides data to Erica Kerns that she
12 reviews prior to the local QIPSC meetings?

13 MR. TAKAGAKI: Objection. Calls for
14 speculation.

15 A. That is not correct.

16 BY MS. BLAIR:

17 Q. Okay. And I thought I was missing something
18 so I'm just trying to understand the process and how it
19 works.

20 For what purpose is Erica Kerns reviewing
21 the data from the local QIPSC meetings?

22 MR. TAKAGAKI: Objection. Calls for
23 speculation.

24 BY MS. BLAIR:

25 Q. Are you Erica Kerns' boss?

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1 A. I am Erica Kerns' boss.

2 Q. Do you know why she's reviewing the data
3 that you told me about from the QIPSC meeting?

4 A. Yes, I do.

5 Q. Okay. And why is she reviewing that data,
6 for what purpose?

7 A. She coordinates it for St. Mary's Medical
8 Center.

9 Q. Got it.

10 So your involvement is with respect to
11 St. Mary's individually and not on the Palm Beach
12 Health Network level --

13 MR. TAKAGAKI: Objection.

14 BY MS. BLAIR:

15 Q. -- with respect to QIPSC meetings, correct?

16 MR. TAKAGAKI: Sorry.

17 Objection.

18 A. Correct.

19 MR. TAKAGAKI: We've been going for about an
20 hour.

21 MS. BLAIR: Sure, would you like a break?

22 MR. TAKAGAKI: You want to take a break?

23 THE WITNESS: Sure.

24 MS. BLAIR: Sure.

25 THE VIDEOGRAPHER: Off the record, 10:10.

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1 (A recess was taken from 10:10 a.m. to 10:26 a.m.)

2 THE VIDEOGRAPHER: Back on the record 10:26.

3 BY MS. BLAIR:

4 Q. Ms. West, are you involved in any way,
5 whether at the Palm Beach Health Network level or at
6 the local level, in the hospital, the plaintiffs
7 hospitals' involvement in ratings for hospitals?

8 MR. TAKAGAKI: Objection.

9 BY MS. BLAIR:

10 Q. Do you know what I mean by "ratings"?

11 A. No. Can you clarify?

12 Q. So, for example, several of these hospitals
13 have awards from Healthgrades®, for example. Are you
14 aware of that?

15 A. Yes.

16 Q. And you're at -- in addition to your duties
17 at Palm Beach Health Network, you also are the quality
18 director for St. Mary's, correct?

19 A. Correct.

20 Q. Are you involved -- so we'll just take with
21 respect to St. Mary's, are you involved in any way in
22 St. Mary's' participation in Healthgrades®, for
23 example?

24 MR. TAKAGAKI: Objection.

25 A. Could you clarify "participation"?

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1 BY MS. BLAIR:

2 Q. Sure.

3 Well, in terms of the awards that -- and I
4 want to talk -- we'll talk about St. Mary's
5 specifically.

6 In terms of the Healthgrades® awards that
7 are awarded to St. Mary's, do you as the quality
8 director of St. Mary's have to provide any information
9 to Healthgrades® in order to for St. Mary's to be
10 evaluated for those awards?

11 A. I do not.

12 Q. In connection with the awards, Healthgrades®
13 awards that are awarded to St. Mary's, does
14 Healthgrades® perform any onsite visits to St. Mary's
15 with respect to those awards, to your knowledge?

16 A. I can't speculate.

17 Q. Okay. So you don't know as you sit here
18 today whether that occurs?

19 A. I do not know.

20 Q. Have you ever personally been involved with
21 an onsite inspection by Healthgrades® in connection
22 with any awards that have been awarded to St. Mary's?

23 A. Can you clarify "onsite inspection"?

24 Q. Sure. Well, I don't know if one occurs.

25 But do you know whether Healthgrades® comes

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1 to St. Mary's and performs any sort of onsite
2 verification when it is considering St. Mary's for a
3 Healthgrades® award?

4 MR. TAKAGAKI: Objection.

5 A. I don't have knowledge of that.

6 BY MS. BLAIR:

7 Q. Do you know whether or not St. Mary's
8 submits any information whatsoever to Healthgrades® in
9 order for Healthgrades® to evaluate St. Mary's with
10 respect to any of the awards it receives from
11 Healthgrades®?

12 A. I don't have knowledge of that.

13 Q. Do you know whether or not St. Mary's pays
14 Healthgrades® in any way with respect to the awards it
15 receives from Healthgrades®?

16 A. I don't have knowledge of that.

17 Q. Have you ever had any conversations with
18 anyone at St. Mary's related to the Healthgrades®
19 awards that St. Mary's receives?

20 A. Not that I recall.

21 Q. Are you involved in any way, and let's stick
22 with St. Mary's, with respect to any awards that
23 St. Mary's receives from U.S. News & World Report?

24 A. I am not.

25 Q. Are you aware of any -- are you aware of any

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1 of the five hospitals that are plaintiffs in this
2 litigation, the Palm Beach Health Network hospitals,
3 engaging in any ratings that require completion of a
4 survey other than Leapfrog?

5 MR. TAKAGAKI: Objection.

6 A. Not that I recall.

7 BY MS. BLAIR:

8 Q. Are you aware of any ratings organizations
9 other than Leapfrog that rate hospitals specifically on
10 patient safety?

11 MR. TAKAGAKI: Objection.

12 A. Would you mind repeating your question?

13 BY MS. BLAIR:

14 Q. Yeah, let me go back.

15 As the director of quality for Palm Beach
16 Health Network and St. Mary's on a local level and
17 based on all your experience in the area of quality, is
18 there a distinction in your mind between quality and
19 patient safety?

20 MR. TAKAGAKI: Objection. Compound.

21 A. Could you further clarify?

22 BY MS. BLAIR:

23 Q. Sure. Would you agree with me that quality
24 and patient safety are not necessarily synonymous?

25 MR. TAKAGAKI: Objection.

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1 A. I guess I don't understand your question.

2 BY MS. BLAIR:

3 Q. Sure. What do you consider -- and you've
4 been in the quality area for a very long time, correct?

5 A. Correct.

6 Q. What do you consider to be quality when we
7 use that term as it relates to a chief quality officer
8 or director of quality? What does quality at a
9 hospital mean to you?

10 MR. TAKAGAKI: Objection.

11 A. Positive outcomes.

12 BY MS. BLAIR:

13 Q. Does it include patient safety?

14 MR. TAKAGAKI: Objection.

15 A. It can include patient safety.

16 BY MS. BLAIR:

17 Q. Does it include things other than patient
18 safety?

19 A. I don't understand your question.

20 Q. Okay. And so there have been a lot of
21 articles, peer-reviewed articles discussed by the
22 experts in this case that talk about the difference
23 between patient safety and quality. And I'm just
24 asking you generally as the director of quality, do you
25 see any distinction between quality and patient safety?

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1 MR. TAKAGAKI: Objection. Lack of
2 foundation. I don't think you've established
3 with her that there are experts in this case
4 that they've reviewed articles as you've
5 testified to.

6 A. I haven't reviewed those articles.

7 BY MS. BLAIR:

8 Q. Understood.

9 A. We collaborate very well between patient
10 safety and quality, so there's -- there's high
11 collaboration.

12 Q. Understood.

13 And so, in your mind, are there members of
14 the local -- well, let's just talk about the patient
15 safety coordinator. So we talked about a patient
16 safety coordinator previously. Do you recall that?

17 A. I do not.

18 Q. Let's see. What did we call him? Patient
19 safety officer, do you recall that?

20 A. Yes.

21 Q. Okay. So the patient safety officer that is
22 at these hospitals, is he part of the quality team?

23 MR. TAKAGAKI: Objection. Are you talking
24 about each hospital or a single person?

25 BY MS. BLAIR:

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1 Q. We'll talk about, you told me there's a role
2 called patient safety officer, correct?

3 A. Correct.

4 Q. And the patient safety officer in some cases
5 at Palm Beach Gardens reports to the director of
6 quality, correct?

7 A. That's correct.

8 Q. And in other cases the patient safety
9 officer for the other four hospitals reports to the
10 chief nursing officer, correct?

11 A. Correct.

12 Q. So in terms of Palm Beach Health Network,
13 the patient safety officer, is he considered to be part
14 of the quality team for that hospital that he works?

15 MR. TAKAGAKI: Objection.

16 A. Patient safety officer for the market is
17 Amy Buzzelli. It's a female.

18 BY MS. BLAIR:

19 Q. All right.

20 A. And she is a part of the Quality Improvement
21 Patient Safety Committee at St. Mary's Medical Center.

22 Q. And her name is Amy Buzzelli, correct?

23 A. Buzzelli.

24 MR. TAKAGAKI: Objection.

25 BY MS. BLAIR:

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1 Q. And she's the patient safety coordinator for
2 the market?

3 A. That is not correct.

4 MR. TAKAGAKI: Objection.

5 BY MS. BLAIR:

6 Q. Okay. What is her role?

7 A. She is the patient safety officer.

8 Q. Okay. She's the patient safety officer for
9 Palm Beach Health Network, correct?

10 A. That's correct.

11 Q. And who does she directly report to?

12 A. She directly reports to Ricardo Ramirez for
13 the market.

14 Q. Ricardo Ramirez is a chief nursing officer
15 for the market, correct?

16 A. Correct.

17 Q. So as the director of quality for Palm Beach
18 Health Network, do you make a distinction at all
19 between patient safety and quality?

20 MR. TAKAGAKI: Objection. Vague.

21 A. We work collaboratively together. We have
22 distinct tasks.

23 BY MS. BLAIR:

24 Q. As the director of quality, do you oversee
25 in any way the patient safety officer for the Palm

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1 Beach Health Network?

2 A. I don't.

3 Q. Does the patient safety officer,
4 Amy Buzzelli, deal solely with patient safety issues?

5 MR. TAKAGAKI: Objection.

6 A. We collaborate.

7 BY MS. BLAIR:

8 Q. To the best of your knowledge, what are
9 Amy Buzzelli's job duties as the patient safety officer
10 of Palm Beach Health Network?

11 A. She manages the patient safety plan to
12 ensure that it has been maintained, reviewed and
13 approved annually. She manages the event reporting
14 system and she manages the complaint process.

15 Q. What is the event reporting system?

16 A. Anyone who finds an event that occurs
17 outside of what's expected can report it through that
18 system.

19 Q. And that's all five hospitals can report it
20 through that system?

21 A. Yes.

22 Q. And when you say "anyone who has an
23 event" -- "anyone who finds an event," anyone, what do
24 you mean by "anyone"?

25 A. Any staff member, any physician, anyone who

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1 has access to the system.

2 Q. And when you talk about the fact that
3 Amy Buzzelli manages the complaint process, what are
4 you referring to? What is the complaint process?

5 A. Anyone can raise an issue to her department.
6 It gets investigated, and the person who may have filed
7 the issue gets a response back.

8 Q. And we talked earlier about the patient
9 safety officers. Is there -- let me ask this. Is
10 there a patient safety officer at each of the five
11 hospitals?

12 A. Yes.

13 Q. Does Amy Buzzelli, in addition to her duties
14 for the Palm Beach Health Network, is she a patient
15 safety officer for any specific hospital?

16 A. Yes.

17 Q. Which one?

18 A. St. Mary's Medical Center.

19 Q. But she is also patient safety officer for
20 the market, meaning the Palm Beach Health Network as
21 well, correct?

22 A. She is collaborator like I am for quality.
23 She does not have direct reports, such as the patient
24 safety officers don't report to her from the other
25 hospitals.

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1 Q. And she reports to Ricky Ramirez, correct?

2 MR. TAKAGAKI: Objection.

3 A. That's correct.

4 BY MS. BLAIR:

5 Q. And so is there a separate complaint process
6 for the market separate and distinct from the complaint
7 process for each of the individual hospitals?

8 MR. TAKAGAKI: Objection.

9 A. There's not.

10 BY MS. BLAIR:

11 Q. So when you say she oversees the complaint
12 process, all complaints go to the Palm Beach Health
13 Network level?

14 MR. TAKAGAKI: Objection.

15 A. I'll clarify and say for St. Mary's Medical
16 Center.

17 BY MS. BLAIR:

18 Q. For St. Mary's Medical Center.

19 Okay. So she oversees the complaint process
20 for St. Mary's Medical Center, correct?

21 A. Correct.

22 Q. Does she oversee the complaint process for
23 the Palm Beach Health Network as a whole?

24 A. She does not.

25 Q. But she does have a position as the patient

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1 safety officer for the Palm Beach Health Network as a
2 whole?

3 MR. TAKAGAKI: Objection.

4 A. She's the market lead.

5 BY MS. BLAIR:

6 Q. And what does it mean to be the market lead
7 for patient -- as the patient safety officer?

8 A. Other patient safety officers do not report
9 to her.

10 Q. So how does she lead the market as a patient
11 safety officer?

12 MR. TAKAGAKI: Objection.

13 A. She collaborates with the other patient
14 safety officers.

15 BY MS. BLAIR:

16 Q. Does she have any extra duties as the market
17 lead patient safety officer that the patient safety
18 officers at the local hospitals do not have?

19 A. Not to my knowledge.

20 Q. Are you aware that Leapfrog has a hospital
21 survey that it puts out for hospitals to complete?

22 A. Yes, I am.

23 Q. Are you aware of any other organization that
24 puts out a hospital survey related to patient safety
25 other than Leapfrog?

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1 MR. TAKAGAKI: Objection.

2 A. Not anything that comes to mind today.

3 BY MS. BLAIR:

4 Q. And CMS -- are you involved in any way at
5 the market level for Palm Beach Health Network in
6 compiling data for CMS?

7 A. I am not.

8 Q. At the St. Mary's Medical Center level are
9 you involved in any way in compiling information for
10 CMS for St. Mary's?

11 A. I am not.

12 Q. Who at St. Mary's is involved in compiling
13 data for CMS for St. Mary's?

14 MR. TAKAGAKI: Objection.

15 A. Could you repeat your question?

16 BY MS. BLAIR:

17 Q. Sure. St. Mary's Medical Center -- or I'm
18 sorry.

19 CMS collects data for individual hospitals.
20 You're aware of that, correct?

21 MR. TAKAGAKI: Objection.

22 A. Yes.

23 BY MS. BLAIR:

24 Q. Are you aware of whether or not St. Mary's
25 is required to submit any data to CMS at CMS's request?

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1 MR. TAKAGAKI: Objection.

2 A. Yes, I am.

3 BY MS. BLAIR:

4 Q. Okay. And are you aware of who at
5 St. Mary's collects the data to provide to CMS at CMS's
6 request?

7 A. I am not aware of who collects the data.

8 Q. Who would know who collects the data for --
9 at St. Mary's for CMS?

10 MR. TAKAGAKI: Objection.

11 A. Could you further clarify "data"?

12 BY MS. BLAIR:

13 Q. Sure.

14 For example, CMS collects data on HAIs,
15 correct? Are you aware of that?

16 A. Yes.

17 Q. CAUTI, correct?

18 A. Correct.

19 Q. And CLABSI, for example, correct, CMS
20 collects data, correct?

21 A. Correct.

22 Q. Do you know whether that data is collected
23 from claims --

24 MR. TAKAGAKI: Objection.

25 BY MS. BLAIR:

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1 Q. -- submitted by St. Mary's?

2 MR. TAKAGAKI: Objection.

3 A. I do know.

4 BY MS. BLAIR:

5 Q. Okay. And what do you know about that
6 process?

7 A. It is not collected from claims.

8 Q. How is it collected?

9 A. It's collected --

10 MR. TAKAGAKI: Objection.

11 A. It's collected through data entry into NHSN.

12 BY MS. BLAIR:

13 Q. And do you know who is responsible at
14 St. Mary's for ensuring that the data that is entered
15 for St. Mary's through NHSN is accurate?

16 A. Could you repeat that?

17 Q. Sure.

18 The data -- CMS you told us, you said CMS
19 collects data for St. Mary's through data that is
20 entered through HSN [sic], correct?

21 MR. TAKAGAKI: Objection. Misstates her
22 testimony.

23 BY MS. BLAIR:

24 Q. Let me ask another way.

25 You tell me. How, to your knowledge as the

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1 market lead director of quality, does CMS get access to
2 St. Mary's' data that is entered in NHSN?

3 A. We enter it into NHSN.

4 Q. Right. And is there anybody responsible at
5 St. Mary's for doing some sort of audit or verification
6 to make sure that the data that's being entered by
7 St. Mary's into NHSN is accurate?

8 A. Yes.

9 Q. And who is that?

10 A. The market director of infection prevention.

11 Q. And who is the market director of infection
12 prevention?

13 A. Taylor Pool. She is also the director of
14 infection prevention at St. Mary's.

15 Q. She's currently at St. Mary's?

16 A. That's correct.

17 Q. Was she previously at Good Samaritan?

18 A. That is correct.

19 Q. And at Good Samaritan, she was the director
20 of quality, correct?

21 A. Correct.

22 Q. And when did she switch from being the
23 director of quality at Good Samaritan to being the
24 director of infection prevention at St. Mary's, do you
25 know?

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1 A. Sometime around January of 2025.

2 Q. Do you know why she switched from being the
3 director of quality at Good Samaritan to being the
4 director of infection prevention at St. Mary's?

5 MR. TAKAGAKI: Objection.

6 A. I don't want to speculate.

7 BY MS. BLAIR:

8 Q. Have you ever had any conversations with her
9 about her move?

10 A. Yes.

11 Q. And what did she tell you about why she
12 moved from Good Samaritan to St. Mary's?

13 A. It was an advancement for her.

14 Q. Does Taylor Pool report to you in any
15 capacity now that she's the director of infection
16 prevention at St. Mary's?

17 A. She does not.

18 Q. Do you collaborate with her, though?

19 A. Yes, I do.

20 Q. So Taylor -- for St. Mary's -- is it -- to
21 the best of your knowledge, is it the case that the
22 directors of infection prevention at each of the five
23 hospitals are responsible for ensuring the accuracy of
24 data that is entered into the NHSN system?

25 A. That is correct.

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1 Q. Do you have any involvement -- and let's
2 just start at the local level. Do you have any
3 involvement with respect to marketing for St. Mary's?

4 A. I do not.

5 MR. TAKAGAKI: Objection.

6 BY MS. BLAIR:

7 Q. Do you have any involvement in marketing at
8 the Palm Beach Health Network level?

9 MR. TAKAGAKI: Objection.

10 A. I do not.

11 BY MS. BLAIR:

12 Q. Do you have any involvement in public
13 relations at St. Mary's?

14 MR. TAKAGAKI: Objection.

15 A. I do not.

16 BY MS. BLAIR:

17 Q. Do you have any involvement in public
18 relations at the Palm Beach Health Network level?

19 A. I do not.

20 Q. You were at Delray Medical Center beginning
21 in 2019, correct?

22 A. Correct.

23 Q. And are you aware that Delray Medical Center
24 participated in the Leapfrog Hospital Survey in 2019?

25 A. I am not aware.

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1 Q. Are you aware of any participation by Delray
2 in the hospital -- in the Leapfrog Hospital Survey?

3 A. Yes.

4 Q. And what is your knowledge of Delray's
5 participation in the Leapfrog Hospital Survey?

6 MR. TAKAGAKI: Objection.

7 A. I don't recall today outside of we
8 participated.

9 BY MS. BLAIR:

10 Q. Okay. When Delray participated, did you
11 have any involvement in gathering documents responsive
12 to the Leapfrog Hospital Survey?

13 A. I do.

14 Q. And can you tell me a little bit about what
15 your involvement was in compiling documents to respond
16 to the Leapfrog Hospital Survey when you were at
17 Delray?

18 MR. TAKAGAKI: Objection.

19 A. I don't recall.

20 MR. TAKAGAKI: Can you be a little more
21 specific as was she there during the survey
22 submission?

23 BY MS. BLAIR:

24 Q. Ma'am, you were at Delray from 2019 through
25 2020. Through 2020, correct?

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1 A. Correct.

2 Q. And you understand that the Leapfrog
3 hospital survey is annual. Do you understand that?

4 A. I do.

5 MR. TAKAGAKI: Objection.

6 BY MS. BLAIR:

7 Q. And do you understand that the submission
8 for the Leapfrog Hospital Survey occurs in or around
9 June every year?

10 A. I do.

11 Q. And tell me, again, when did you start at
12 Delray, what month in 2019?

13 A. October.

14 Q. And so you would not have had any
15 involvement in the Leapfrog Hospital Survey in October
16 of 2000 -- or sorry -- in 2019 since the submission
17 would have already occurred before you got there,
18 correct?

19 A. Correct.

20 Q. And when did you leave Delray, what month?

21 A. On or around June of 2020.

22 Q. Okay. So there would have been only one
23 Leapfrog Hospital Survey while you were at Delray that
24 you were involved with, correct?

25 A. Correct.

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1 Q. So with that foundation, what can you tell
2 me about your involvement in Delray's response to the
3 Leapfrog 2020 hospital survey in the time in which you
4 were at Delray?

5 A. Sitting here today, I do not recall the
6 involvement in the 2020 survey.

7 Q. Do you recall even in the most general sense
8 how long it took Delray to complete the Leapfrog
9 Hospital Survey?

10 MR. TAKAGAKI: Objection.

11 A. I don't recall.

12 BY MS. BLAIR:

13 Q. So is it fair to say if I asked you
14 questions, you really have no recollection of how
15 Delray compiled information to respond to the Leapfrog
16 Hospital Survey in 2020; is that correct?

17 A. That's correct.

18 MR. TAKAGAKI: Objection.

19 BY MS. BLAIR:

20 Q. And then you moved on to St. -- to Good --
21 let me make sure I got this right.

22 You moved on to Good Samaritan for 2020
23 through 2023, correct?

24 A. On or around June 2020 through on or around
25 July 2023.

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1 Q. Okay. And so is it fair to say that you had
2 no involvement with Good Samaritan's participation in
3 the 2020 Leapfrog Hospital Survey?

4 A. Not that I recall.

5 Q. And you would not have been at
6 Good Samaritan until June of 2020, correct?

7 A. Correct.

8 Q. And do you understand as you sit here today
9 that the Complaint alleges the last year that any of
10 these five hospitals participated in the Leapfrog
11 Hospital Survey was 2021?

12 MR. TAKAGAKI: Objection.

13 A. I am not aware.

14 BY MS. BLAIR:

15 Q. Okay. Are you aware as you sit here today
16 of any participation by Good Samaritan Medical Center
17 while you worked at Good Samaritan Medical Center in
18 the Leapfrog Hospital Survey?

19 A. Yes, I am.

20 Q. And can you tell me what you recall about
21 Good Samaritan's involvement in the Leapfrog Hospital
22 Survey for the 2021 hospital survey?

23 MR. TAKAGAKI: Objection.

24 A. I recall participating, coordinating data
25 and entering data.

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1 BY MS. BLAIR:

2 Q. Were you primarily responsible for
3 Good Samaritan's submission of the 2021 Leapfrog
4 Hospital Survey?

5 MR. TAKAGAKI: Objection.

6 A. Yes, that I recall.

7 BY MS. BLAIR:

8 Q. How many people did you have helping you
9 compile data to comply with the 2021 Leapfrog Hospital
10 Survey?

11 MR. TAKAGAKI: Objection.

12 A. I don't remember the exact number. I would
13 estimate around six.

14 BY MS. BLAIR:

15 Q. Do you recall just generally what types of
16 people these six people were that helped you compile
17 information for the Leapfrog Hospital Survey in or
18 around 2021?

19 MR. TAKAGAKI: Objection.

20 A. Yes.

21 BY MS. BLAIR:

22 Q. And who were they?

23 A. It would have been someone in finance,
24 someone in infection control, a contract administrator.
25 That's who I recall.

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1 Q. Okay. And do you recall whether in or
2 around 2021 when you were participating for
3 Good Samaritan in the submission of the Leapfrog
4 Hospital Survey how many hours it took to comply with
5 the survey?

6 MR. TAKAGAKI: Objection.

7 A. Yes.

8 BY MS. BLAIR:

9 Q. And what is your recollection of how many
10 hours?

11 A. For myself, just me, between 40 and
12 60 hours.

13 For the other people that were involved,
14 such as contract administrator, it could have taken up
15 to two days, a few hours for the other people.

16 But I will say that in the other hospitals,
17 such as St. Mary's Medical Center, it took many more
18 hours. And it really varies by the person who's
19 completing it, how many times they've completed it
20 before, how quickly they can work. So that number is
21 representative of my time only.

22 Q. And you just talked a little bit about how
23 long it took St. Mary's. Do you know how long it took
24 St. Mary's in your role as the Palm Beach Health
25 Network director of quality?

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1 MR. TAKAGAKI: Objection.

2 A. It was reported to me that it took hundreds
3 of hours.

4 BY MS. BLAIR:

5 Q. And who reported that to you?

6 A. The director of quality, market chief
7 nursing officer. We collaborated as a group to do an
8 analysis of the time that we were spending on the
9 survey.

10 Q. Okay. So who was the director of quality
11 for St. Mary's that reported to you the hundreds of
12 hours it took them to comply?

13 A. Carola Kuret.

14 Q. And who was the chief nursing officer at
15 St. Mary's that told you it took hundreds of hours to
16 comply?

17 A. Jessica Miller.

18 Q. And do you recall when this conversation
19 took place?

20 MR. TAKAGAKI: Objection.

21 A. It was during the same time that I completed
22 it for Good Samaritan Medical Center.

23 BY MS. BLAIR:

24 Q. What do you recall about that conversation?

25 MR. TAKAGAKI: Objection.

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1 A. I recall that I was told that it was
2 overwhelming, that she couldn't complete her other
3 duties and that we needed to have a conversation about
4 it.

5 BY MS. BLAIR:

6 Q. And when you say "she couldn't complete her
7 other duties," who was the "she" in that sentence?

8 A. Carola.

9 Q. Do you know why it was taking her hundreds
10 of hours? Did she ever say what the issue was on her
11 end at St. Mary's?

12 A. I don't recall.

13 Q. Do you know whether or not Carola told you
14 whether she called the Leapfrog help desk to get help
15 in completing the survey?

16 A. I don't recall.

17 Q. And you also said that you collaborated as a
18 group to do an analysis of the time that we were
19 spending on the survey. Who all was involved in that
20 collaboration?

21 MR. TAKAGAKI: Objection.

22 A. Chief nursing officers, the market chief
23 nursing officer, the directors of quality. And I know
24 that there was some involvement with the CEOs as well.

25 BY MS. BLAIR:

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1 Q. And in or around -- was this an in-person
2 meeting?

3 A. Yes, it was.

4 MR. TAKAGAKI: Objection.

5 THE WITNESS: Oh, sorry.

6 MR. TAKAGAKI: It's okay.

7 BY MS. BLAIR:

8 Q. Do you know when this in-person meeting
9 occurred?

10 A. I don't recall.

11 Q. Do you recall even generally the year it
12 would have occurred?

13 A. It was during the same time that I completed
14 Good Samaritan's --

15 Q. So 2021?

16 A. -- last Leapfrog survey.

17 Q. I didn't mean to cut you off. I apologize.

18 What do you recall specifically about the
19 conversation that occurred with the CNOs, the market
20 CNOs, the directors of quality and maybe some of the
21 CNOs in or around 2021 about continuing to engage in
22 the Leapfrog survey?

23 MR. TAKAGAKI: Objection.

24 And sorry. When you use conversation there,
25 are you speaking like generally over time, or

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1 are you talking about a specific day?

2 BY MS. BLAIR:

3 Q. I thought you testified that you had a
4 meeting, correct?

5 MR. TAKAGAKI: Objection.

6 A. We did.

7 BY MS. BLAIR:

8 Q. Okay. I'm talking about that meeting. What
9 do you recall about the conversations that occurred at
10 that meeting in or around 2021 that involved the CNOs,
11 the market CNO, the director of quality and maybe some
12 of the CEOs with respect to continuing participation in
13 the Leapfrog survey?

14 A. Very broadly, I remember that there was
15 concern about the amount of time that it was taking.
16 St. Mary's in general was taking the longest. It was
17 taking some of the other directors of quality also like
18 long periods of time. And the concern was that it was
19 taking them away from other things that they would
20 coordinate, such as stroke surveys, some of the other
21 certification and accreditation tasks that we had.

22 Q. Anything else that you remember broadly
23 about the conversation that occurred at this meeting
24 sometime in 2021 regarding the decision to stop
25 participating in the Leapfrog Hospital Survey?

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1 A. Not that comes to mind right now.

2 Q. When the meeting ended, was there a
3 consensus at the group about whether or not the five
4 hospitals that make up the Palm Beach Health Network
5 were going to continue to engage in the Leapfrog
6 Hospital Survey?

7 MR. TAKAGAKI: Objection.

8 A. In that meeting a recommendation was made.
9 It was supported. And a determination was made to stop
10 participating.

11 BY MS. BLAIR:

12 Q. Do you recall who made the recommendation?

13 A. The market chief nursing officer in
14 agreement with the other chief nursing officers and the
15 other directors of quality.

16 Q. So that the market chief nursing officer at
17 the time of this meeting in 2021, was that
18 Ricky Ramirez?

19 A. It was Libby Flipppo.

20 Q. Do you recall any -- anything that
21 Libby Flipppo said in connection with her recommendation
22 that the five hospitals that make up the Palm Beach
23 Health Network ceased participating in the Leapfrog
24 Hospital Survey?

25 A. I don't recall her exact words.

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1 Q. Understood. I don't expect you to recall
2 her exact words.

3 Do you recall generally what -- anything
4 that Libby Flipppo said regarding her recommendation
5 that the five hospitals stop participating in the
6 Leapfrog Hospital Survey?

7 A. I don't recall.

8 Q. Do you recall whether the recommendation
9 that Ms. Flipppo was making was along the same lines
10 that you described that there was a concern about the
11 amount of time it was taking to do the survey and the
12 time that it was taking away from other things like
13 certifications? Was that the basis of her
14 recommendation based on your best memory?

15 A. It is.

16 MR. TAKAGAKI: Objection.

17 A. It is.

18 BY MS. BLAIR:

19 Q. Do you recall anything that anyone else said
20 at this meeting in or around 2021 regarding the
21 decision not to engage in the Leapfrog Hospital Survey?

22 A. Just very broadly --

23 Q. Yes.

24 A. -- I remember Carola discussing the hundreds
25 of hours that it was taking to complete it. And I

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1 remember the other DCQIs discussing how long it was
2 taking them to complete it just in general.

3 Q. Understood. Anything else you remember?

4 A. No.

5 Q. Do you recall when you engaged in the
6 Leapfrog Hospital Survey for Good Samaritan in 2021
7 whether the HAIs for Good Samaritan in or around that
8 time, the CMS data for HAIs, was below the national
9 average for Good Samaritan?

10 A. I don't --

11 MR. TAKAGAKI: Objection.

12 A. I don't recall that time period.

13 BY MS. BLAIR:

14 Q. Do you recall whether in or around 2021 when
15 you were gathering data to respond to the Leapfrog
16 Hospital Survey, whether Good Samaritan had in place a
17 hand hygiene policy?

18 A. To the best of my recollection, yes.

19 Q. Do you recall when you were gathering
20 documentation for Good Samaritan to comply with the
21 2021 Leapfrog Hospital Survey whether Good Samaritan
22 had completed logs of observations related to hand
23 hygiene?

24 A. I don't recall.

25 Q. Do you recall when you were working on

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1 responding to the 2021 Leapfrog Hospital Survey for
2 St. Mary's whether St. Mary's engaged in the CPOE test
3 required by the Leapfrog Hospital Survey?

4 A. Yes, I recall.

5 Q. And what do you recall about that test?

6 A. I recall that we completed that as a
7 multi-disciplinary team.

8 Q. Do you recall what the results were?

9 A. I recall that we passed.

10 Q. Do you recall how long it took to do the
11 CPOE test?

12 A. I don't recall.

13 Q. Do you recall that it was a two-hour test
14 required that -- do you recall that the test requires
15 an interdisciplinary team and it takes about two hours?

16 MR. TAKAGAKI: Objection.

17 A. I recall that it requires a
18 multi-disciplinary team, but I do not remember the time
19 span.

20 BY MS. BLAIR:

21 Q. Do you know whether today in your role as
22 the director of quality for Palm Beach Health Network
23 any of the five hospitals engage in an
24 interdisciplinary test of their CPOE systems on a
25 regular basis?

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1 A. I don't have knowledge.

2 Q. Have you ever been involved in an
3 interdisciplinary test of St. Mary's CPOE system?

4 A. I have not.

5 Q. When -- and we'll just stick with
6 Good Samaritan since you remember the participation in
7 the Leapfrog hospital survey then.

8 Were you the quality director of
9 Good Samaritan when you were there from 2020 to 2023?

10 A. Correct.

11 Q. Do you -- in your role as the quality
12 director for Good Samaritan from 2020 to 2023, and I
13 want to specifically talk about 2020 through 2021, did
14 Good Samaritan derive any benefit from participating in
15 the Leapfrog Hospital Survey?

16 MR. TAKAGAKI: Objection.

17 A. Not to my knowledge.

18 BY MS. BLAIR:

19 Q. To your knowledge as the director of quality
20 for Palm Beach Health Network today, do you know
21 whether or not the five hospitals that make up
22 Palm Beach Health Network use Leapfrog standards for
23 benchmarking in any way?

24 MR. TAKAGAKI: Objection. Vague.

25 A. Not to my knowledge.

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1 BY MS. BLAIR:

2 Q. Do you know as you sit here today whether
3 any of the five hospitals use or have used Leapfrog
4 standards for determining whether or not any of their
5 structural or process measures are operating
6 sufficiently for patient safety?

7 MR. TAKAGAKI: Objection. Vague.

8 A. Will you clarify your question, please?

9 BY MS. BLAIR:

10 Q. Sure.

11 Are you aware as you sit here today whether
12 any time prior to today any of the five hospitals that
13 make up Palm Beach Health Network have used the
14 Leapfrog standards to benchmark whether their patient
15 safety standards are good?

16 MR. TAKAGAKI: Objection. Vague. Asked and
17 answered.

18 A. Nothing comes to mind right now.

19 BY MS. BLAIR:

20 Q. Okay. Do you at any time that you have been
21 the quality director for Palm Beach Health Network,
22 have you become aware that Leapfrog charges for
23 consulting services?

24 A. Can you repeat it, please?

25 Q. Yes. Do you have any understanding as you

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1 sit here today that Leapfrog charges for consulting
2 services?

3 A. Yes.

4 Q. And what consulting services do you believe
5 that Leapfrog charges for?

6 A. It's a voluntary service, but in order to
7 receive the consulting services, I understand that
8 there is a fee.

9 Q. And what consulting -- what do you -- what
10 do you understand the consulting services to be?

11 A. It would be a request for services to help
12 improve the grade. I understand that Leapfrog also
13 charges for webinars related to their grades. And I
14 understand there are other consultants on behalf of
15 Leapfrog that charge for consulting services.

16 Q. Do you know who these other -- do you know
17 who these other consultants on behalf of Leapfrog are
18 that charge for consulting services?

19 A. I can't give the name today because I don't
20 remember it, but I have known it in the past.

21 Q. Okay. And how much do you think these other
22 consultants on behalf of Leapfrog charge?

23 MR. TAKAGAKI: Objection.

24 A. I don't know how much they charge. So they
25 reach out to me, say, on behalf of Leapfrog, we can

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1 consult with you to improve your grade.

2 BY MS. BLAIR:

3 Q. And you don't know who that is?

4 A. I don't recall.

5 MR. TAKAGAKI: Objection.

6 BY MS. BLAIR:

7 Q. Do they send you emails?

8 A. That is correct.

9 Q. Have you produced those emails in this
10 litigation?

11 MR. TAKAGAKI: Objection.

12 Again, are you asking if she has or the
13 plaintiffs have?

14 BY MS. BLAIR:

15 Q. I'm asking you, have you produced those to
16 your lawyers in this litigation?

17 MR. TAKAGAKI: Objection.

18 A. I have not personally that I recall.

19 BY MS. BLAIR:

20 Q. So you believe there are consultants that
21 send you emails telling you, on behalf of Leapfrog,
22 saying that they can help you improve your grade if you
23 pay them consulting fees?

24 MR. TAKAGAKI: Objection. Asked and
25 answered.

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1 A. It was at least one consultant.

2 BY MS. BLAIR:

3 Q. And you don't recall the name as you sit
4 here today?

5 A. I'm sorry. I don't.

6 MR. TAKAGAKI: Objection. Asked and
7 answered.

8 BY MS. BLAIR:

9 Q. Is there anything I could show you that
10 would refresh your recollection as to the name of the
11 consultant that sent you an email on behalf of Leapfrog
12 saying that in exchange for paying consulting services
13 they could help you improve your grade?

14 MR. TAKAGAKI: Objection.

15 A. You have the email.

16 BY MS. BLAIR:

17 Q. With respect to the services that you
18 believe Leapfrog itself -- so let's put aside this
19 consultant's email. To the extent you believe there
20 are services that Leapfrog charges hospitals in
21 exchange -- do you believe -- well, strike that.

22 Do you believe that Leapfrog provides
23 consulting services to hospitals for money in exchange
24 for better grades?

25 A. Yes.

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1 MR. TAKAGAKI: Objection.

2 BY MS. BLAIR:

3 Q. And what is that based on?

4 A. Years prior, and I don't have an exact date,
5 but years prior in another organization where I was
6 involved with collecting data for Leapfrog I reviewed
7 the entire website to see what was available, you know,
8 to determine if there was any extra information, and I
9 found that there was a consulting component to it.
10 That's what I remember.

11 Q. And what organization was that that you were
12 compiling Leapfrog data for?

13 A. I don't recall.

14 Q. Was it one of those places of employment
15 that we went through at the beginning of your
16 deposition?

17 A. It would have been.

18 Q. So at least one of those places that you
19 worked for prior to Palm Beach Health Network did
20 participate in the Leapfrog Hospital Survey?

21 A. Yes.

22 Q. Do you know, was it just one or are there
23 others?

24 A. I don't recall.

25 Q. And what do you recall about participating

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1 in the Leapfrog Hospital Survey for that organization
2 that you were just telling me about?

3 A. Beyond the consulting, I don't have a recall
4 for it.

5 Q. Would you have been responsible in your role
6 at that organization for compiling the data that was
7 submitted to Leapfrog?

8 A. I don't remember my exact role at the time.

9 Q. Okay. But your role did involve at least
10 looking at the Leapfrog website in some way?

11 A. Correct.

12 Q. And you recall coming across something
13 wherein you believe Leapfrog charged hospitals for
14 consulting services in order to give them a better
15 grade. That's your recollection?

16 MR. TAKAGAKI: Objection.

17 A. I do.

18 MR. TAKAGAKI: Asked and answered.

19 BY MS. BLAIR:

20 Q. Have you had a chance to look at the
21 Leapfrog website since this lawsuit has been filed to
22 determine whether that is indeed case?

23 A. I have not.

24 THE VIDEOGRAPHER: Sorry to interrupt,
25 Counselor. We need to break for a media change.

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1 MS. BLAIR: Yes, we can do it right now.

2 THE VIDEOGRAPHER: This is the end of media
3 unit one. We are going off the record for a
4 media change at 11:14.

5 (A recess was taken from 11:14 a.m. to 11:32 a.m.)

6 THE VIDEOGRAPHER: This is media unit number
7 two. The time is 11:32. We're back on the
8 record.

9 BY MS. BLAIR:

10 Q. Ms. West, right before the break, we had
11 been talking about the consulting services that you
12 believe Leapfrog charges for. And I want to set aside
13 the email that you believe you received from a
14 consultants on behalf of Leapfrog that stated that you
15 could pay that consultant a fee for a better grade.
16 And I want to focus on the information on the Leapfrog
17 website that you reviewed that you believe talks about
18 the fact that Leapfrog charges for consulting services.
19 Okay?

20 A. (Nodding head).

21 Q. Do you recall the names of any of these
22 consulting services that Leapfrog allegedly offers in
23 exchange for better grades?

24 A. I don't remember.

25 MS. BLAIR: I'm going to hand you what we're

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1 going to mark as Exhibit A.

2 THE STENOGRAPHER: Do you mind if we use
3 numbers?

4 MS. BLAIR: Oh, I'm sorry. Yes. 1. We've
5 been using numbers.

6 (Defendant's Exhibit Number 1 for i.d.)

7 BY MS. BLAIR:

8 Q. My apologies, Ms. West. I'm going to hand
9 you what we are now marking as West Exhibit 1, and
10 you'll see this is a printout from the Leapfrog website
11 dated this morning, 9-25-25.

12 Do you see at the top it says "become a
13 Leapfrog certified coach"? Do you see that?

14 A. I do.

15 Q. Does this refresh your recollection of
16 whether or not this is one of the consulting services
17 that you believe Leapfrog offers to hospitals in
18 exchange for a fee to receive a better grade?

19 A. It doesn't because this is referencing 2024
20 and 2025 and I haven't reviewed it.

21 Q. Okay. Have you ever heard this "become a
22 Leapfrog certified coach" before?

23 A. I have not.

24 Q. When you look at this document about the
25 certified coaching, this does not refresh your

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1 recollection as to whether or not this is the -- these
2 are the consulting services that you're referring to
3 that Leapfrog offers for a fee?

4 A. No.

5 Q. Okay. And we'll go to Exhibit 2.

6 (Defendant's Exhibit Number 2 for i.d.)

7 BY MS. BLAIR:

8 Q. Ms. West, I've now handed you what we've
9 marked West Exhibit 2. And you'll see, again, this is
10 printed off of the Leapfrog website on September 24th,
11 2025. And it says, "2025 Deep Dive Sessions."

12 Do you see that?

13 A. Yes.

14 Q. If you wouldn't mind taking a moment to look
15 at this and tell me if this refreshes your recollection
16 in any way as to whether or not these are the services
17 that you are referring to that Leapfrog offers to
18 hospitals in exchange for a better grade?

19 A. It is not.

20 Q. Okay. And so you believe that somewhere on
21 the Leapfrog -- do you believe that Leapfrog is
22 currently as we sit here today in September of 2025
23 offering consulting services to hospitals for a fee in
24 exchange for better grades?

25 A. Yes.

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1 Q. Okay. And is it your belief that that
2 offering of consulting services in exchange for a fee
3 for better grades is currently advertised on the
4 Leapfrog website somewhere?

5 A. I don't know if it's advertised on the
6 Leapfrog website. However, I've received emails such
7 as the webinar where you would have to pay to like get
8 it -- the additional information.

9 Q. And so it's your understanding that Leapfrog
10 offers paid for webinars that hospitals can pay for in
11 exchange for learning how to get a better grade?

12 A. Correct.

13 MR. TAKAGAKI: Objection.

14 BY MS. BLAIR:

15 Q. Is it your understanding that those
16 webinars -- well, what is your understanding? Is it
17 related to the safety grade or the survey
18 participation?

19 A. So my understanding was from years back.

20 Q. Okay.

21 A. And unless it's changed, my opinion hasn't
22 changed because I don't know that it's changed.

23 Q. Okay.

24 A. If that makes sense.

25 Q. That makes sense. And I'm just trying to

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1 get a sense. So what you recall about years back was a
2 webinar?

3 MR. TAKAGAKI: Objection. Misstates her
4 testimony.

5 A. The webinar -- the webinar is current.

6 BY MS. BLAIR:

7 Q. Okay.

8 A. From prior years back I reviewed the
9 information on the consulting fees.

10 Q. Okay. And but I want to make sure I
11 understand your testimony. So there's the reviewing of
12 consulting fees years back, correct?

13 A. Correct.

14 Q. And then your belief that Leapfrog charges
15 for consulting services in exchange for a fee for a
16 better grade is also based on webinars that are
17 current, is that a fair recitation of your testimony?

18 A. Emails received regarding webinars where
19 there's a charge.

20 Q. And I want to focus just on the webinars
21 where there's a charge. Do you have any recollection
22 of whether those webinars were related to the survey or
23 the hospital safety grade?

24 A. I don't recall. But if you have a document,
25 I'm happy to look at it.

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1 Q. I don't.

2 Do you recall how much the fee was for
3 engaging in the webinar?

4 MR. TAKAGAKI: Objection.

5 A. It was around \$350.

6 BY MS. BLAIR:

7 Q. Okay. And did you save those emails?

8 A. I believe so.

9 Q. Okay. And do you believe those emails were
10 produced in this litigation? I'm sorry. Do you
11 believe you collected those emails and produced them to
12 your counsel for production in this litigation?

13 A. I don't recall.

14 Q. Do you recall having any conversations with
15 anyone associated with Palm Beach Health Network at any
16 time up until today outside the presence of your
17 counsel about your belief that Leapfrog charges
18 hospitals consulting fees in exchange for better
19 grades?

20 A. I don't recall.

21 Q. Do you recall ever having a conversation
22 with Sheri Montgomery at any time outside the presence
23 of your counsel about your belief that Leapfrog charges
24 hospitals consulting fees in exchange for better
25 grades?

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1 A. I recall having a conversation with
2 Sheri Montgomery in regards to what Leapfrog charges
3 for, what I know they charged for and what I don't know
4 that they charged for.

5 Q. Okay. And tell me about that conversation.
6 What do you recall you told Sheri Montgomery about what
7 they charge for, what they don't charge for and what
8 you don't know they charge for?

9 A. I did not think that they, that Leapfrog
10 charged to enter data on the website. I do recall that
11 we had a discussion about the licensing fee and the use
12 of the logo, the amount of money that it was taking for
13 employees to complete, hours and time and money to
14 complete the survey. And at that time I think that was
15 all.

16 Q. Okay. And when you say "licensing fee and
17 use of logo," what do you mean by "licensing fee"?

18 A. To use the logo.

19 Q. So that's all one, licensing fee and use of
20 logo is the licensing fee to use the logo?

21 A. Correct.

22 Q. And are you aware of whether or not any of
23 the five hospitals that make up the Palm Beach Health
24 Network pay a licensing fees to use the Healthgrades®
25 logo?

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1 A. I'm not aware.

2 Q. And so when you said there's no charge for
3 entering data, what did you mean by that?

4 A. To put it into the website.

5 Q. And so is it fair to say that there's no
6 charge for completing the survey?

7 MR. TAKAGAKI: Objection.

8 A. I wouldn't necessarily say that because
9 there's time and energy, all the time that goes into
10 completing the survey, the time that goes into prepping
11 for CPOE, completing CPOE. You know, that has monetary
12 value.

13 BY MS. BLAIR:

14 Q. Of course. And so I want to separate that
15 out. I want to ask about charges that Leapfrog charges
16 for. So set aside time and energy to complete the
17 survey.

18 Is it fair to say that Leapfrog does not
19 charge a hospital a fee that comes back to Leapfrog for
20 completing the survey?

21 A. It's fair to say that we're not charged for
22 entering data into the website.

23 Q. And even if you don't participate in the
24 Leapfrog survey, would you agree with me that you can
25 go on the website and print out for free the survey

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1 itself and use it in any form you want?

2 A. Yes, I am aware of that.

3 Q. And are you aware of whether or not after
4 these five hospitals, the five hospitals that are
5 plaintiffs in this litigation stopped participating in
6 the Leapfrog Hospital Survey, whether they used the
7 Leapfrog Hospital Survey in any way from 2021 to
8 present day?

9 MR. TAKAGAKI: Objection. Vague.

10 A. Not that I recall.

11 BY MS. BLAIR:

12 Q. Do you know whether or not any hospital that
13 you ever have been associated with has paid for the
14 licensing use of the Leapfrog logo?

15 A. I'm not aware.

16 Q. Do you know whether St. Mary's has ever paid
17 for the use of the Leapfrog logo?

18 A. I'm not aware.

19 Q. While you were the director of quality for
20 Good Samaritan and you had some responsibility for
21 completing the 2021 hospital survey for Good Samaritan,
22 did Good Samaritan accurately report its data to the
23 Leapfrog survey?

24 MR. TAKAGAKI: Objection.

25 A. To my knowledge.

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1 BY MS. BLAIR:

2 Q. Are you aware of any hospital that
3 purposefully overinflates its survey results on the
4 Leapfrog Hospital Survey?

5 MR. TAKAGAKI: Objection.

6 A. I'm not aware.

7 BY MS. BLAIR:

8 Q. When Good Samaritan participated in the
9 Leapfrog survey in 2021, was there staff dedicated to
10 just the Leapfrog Hospital Survey?

11 MR. TAKAGAKI: Objection.

12 A. There weren't staff just dedicated for
13 Leapfrog survey.

14 BY MS. BLAIR:

15 Q. When Good Samaritan engaged in the
16 Leapfrog Hospital Survey in 2021, were there physicians
17 that were -- did time get taken away from physicians to
18 complete the Leapfrog Hospital Survey?

19 MR. TAKAGAKI: Objection. Vague.

20 A. Yes.

21 BY MS. BLAIR:

22 Q. Okay. And in what way do you believe that
23 time was taken away from physicians to complete the
24 hospital -- the Leapfrog Hospital Survey at
25 Good Samaritan in 2021?

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1 A. With CPOE tests.

2 Q. And, again, do you know how long that CPOE
3 test took?

4 MR. TAKAGAKI: Objection. Asked and
5 answered.

6 A. I don't recall.

7 BY MS. BLAIR:

8 Q. Other than physicians being involved in the
9 CPOE test for the Leapfrog Hospital Survey in 2021
10 while you were at Good Samaritan, do you know of any
11 other physician time that was taken away from the
12 physician to complete the hospital survey?

13 A. Just broadly I'll say the physician advisor
14 collaborated with us on the CPOE prep, the test and the
15 data review.

16 Q. Okay.

17 A. But I don't know how much time they spent.

18 Q. And other than the CPOE measure, are you
19 aware of any physician time in 2021 while you were
20 associated with St. Mary's in completing the Leapfrog
21 Hospital Survey, any other physician time that was
22 taken away to complete any other measures on the
23 Leapfrog Hospital Survey?

24 MR. TAKAGAKI: Objection.

25 A. I wasn't at St. Mary's.

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1 BY MS. BLAIR:

2 Q. I'm sorry. Good Samaritan. Thank you.

3 A. Could you repeat your question?

4 Q. Sure.

5 So you've told me, correct, you told me
6 about physician time that was taken away for a
7 physician to engage in the CPOE measure, correct?

8 A. Correct.

9 Q. Are you aware of any other physician time
10 other than the CPOE that was spent in 2021 at
11 St. Mary's -- at Good Samaritan -- sorry -- at
12 Good Samaritan in completing the Leapfrog Hospital
13 Survey?

14 A. Not that I recall.

15 Q. And then let's do the same thing with
16 respect to nurses. Are you aware of nursing time that
17 was taken away in 2021 when you were completing the
18 Leapfrog Hospital Survey for Good Samaritan that was
19 taken away to help complete the Leapfrog Hospital
20 Survey?

21 MR. TAKAGAKI: Objection.

22 A. Not that I recall specifically.

23 BY MS. BLAIR:

24 Q. What about generally?

25 A. Directors of quality are nurses, so I'm

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1 trying to make the distinction. Not that I recall.

2 Q. How long does it take -- and let's just talk
3 about your involvement at St. Mary's now present day.

4 How many hours does it take to prepare for
5 and engage with Joint Commission on an annual basis?

6 MR. TAKAGAKI: Objection.

7 A. I don't recall sitting here today, but we
8 complete survey readiness every day.

9 BY MS. BLAIR:

10 Q. Every day of the year?

11 A. Every day of the year.

12 Q. Are there any measures on the Leapfrog -- to
13 your knowledge, are there any measures on the Leapfrog
14 Hospital Survey that are similar to data requests
15 contained for the Joint Commission?

16 MR. TAKAGAKI: Objection.

17 A. I'm going through it in my head right now.

18 BY MS. BLAIR:

19 Q. That's all right. Take your time.

20 A. Yes.

21 Q. And what are those?

22 A. CLABSI prevention, CAUTI prevention, C. diff
23 prevention, MRSA prevention. That's what we do on a
24 daily basis.

25 Q. Are you aware of any regulatory agency that

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1 measures CPOE compliance?

2 MR. TAKAGAKI: Objection.

3 A. Not that I recall.

4 BY MS. BLAIR:

5 Q. Are you aware of any regulatory compliance
6 that measures BCMA compliance?

7 MR. TAKAGAKI: Objection.

8 A. May I go back one --

9 BY MS. BLAIR:

10 Q. Sure, yeah.

11 A. -- for CPOE and clarify that? Yes, I'm
12 aware in terms of Joint Commission activity when they
13 are on site, they review how physicians enter orders
14 into the electronic medical record.

15 They also while they're on site will watch
16 medication pass, they'll look at barcode scanning and
17 make sure that we're going through the five patient
18 rights.

19 They will also review the medication policy.

20 They will review the bylaws and the rules
21 and regulations.

22 And they will observe and speak to staff.

23 Q. And so that would cover both, as I
24 understand your answer, but you tell me, CPOE and BCMA,
25 correct?

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1 A. That is correct.

2 Q. And that was the Joint Commission, correct?

3 A. That is correct.

4 Q. Are you aware of any regulatory agency that
5 reviews compliance with hand hygiene?

6 MR. TAKAGAKI: Objection.

7 A. Yes.

8 BY MS. BLAIR:

9 Q. And what regulatory agency reviews
10 compliance with hand hygiene?

11 A. The Joint Commission and the agency on
12 healthcare administration in Florida.

13 Q. And the Agency for Health Care
14 Administration in Florida, is that acronym AC -- AHCA?

15 A. Yes.

16 Q. And can you tell just tell me a little bit
17 about how the Joint Commission reviews hand hygiene
18 protocols for hospitals, to the best of your knowledge?

19 A. Okay. They review our standard precautions
20 policy. They observe staff while they're on site
21 correctly performing hand hygiene, whether it's through
22 soap and water or alcohol-based hand rub. They review
23 our audits and our outcomes.

24 Q. And what do you mean by "audits"?

25 A. We complete review observations of hand

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1 hygiene.

2 Q. And are those the logs that each hospital
3 keeps on the observations of hand hygiene?

4 A. So I can't necessarily speak to the logs,
5 but I can speak to the data that are collected and the
6 data that are reported.

7 Q. Okay. And how is the data collected for
8 these five hospitals as it relates to the audits for
9 hand hygiene?

10 A. It is my understanding that each leader
11 chooses an observer that has had education and
12 competency to observe staff appropriately either
13 washing with soap and water or utilizing the
14 alcohol-based hand rub.

15 Q. And is there an audit report that is
16 generated specifically with respect to hand hygiene for
17 each of the five hospitals that are plaintiffs in this
18 litigation?

19 A. Yes.

20 Q. And do you know whether that hand hygiene
21 audit report has -- was gathered by you and produced to
22 your attorneys for production in this litigation?

23 A. It was requested by attorneys, and hand
24 hygiene information was produced.

25 Q. And then you said, with respect to the

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1 Joint Commission's review of hand hygiene, they also
2 review outcomes. Do you recall that?

3 A. Yes.

4 Q. What did you mean by "outcomes"?

5 A. They have a data review session and they
6 review it during that time.

7 Q. And are the outcomes the outcomes of the
8 observations of the hand washing?

9 A. Correct.

10 Q. So the word "outcomes" doesn't mean outcomes
11 to patients like infection, correct?

12 A. It could, but what I was referring to was
13 observations.

14 Q. Right. In this context you're referring to
15 the observations, correct?

16 A. Yes.

17 Q. And then how does the AHCA observe
18 hand hygiene in the hospitals? I'm sorry. I said
19 "observe."

20 How do they monitor compliance with
21 hand hygiene in the hospital?

22 A. I'll give you a great example.

23 Q. Excellent.

24 A. They were just on site in the spring for all
25 five hospitals specifically focused on quality of care,

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1 infection control and hand hygiene. It was a large
2 focus for them. And they observed staff at that time.
3 They reviewed policies. They looked at our audits.
4 They looked at our hand hygiene outcomes. We had no
5 findings. So they basically validated our program.

6 Q. And is there any regulatory agency -- so you
7 told me about the Joint Commission and the AHCA with
8 respect to hand hygiene. Any other regulatory agencies
9 you can think of that monitor the hospitals' hand
10 hygiene?

11 A. None that comes to mind.

12 Q. And then with respect to ICU physician
13 staffing, are there any regulatory agencies that you're
14 aware of that monitor the hospital's ICU physician
15 staffing?

16 MR. TAKAGAKI: Objection.

17 A. Not to my knowledge.

18 BY MS. BLAIR:

19 Q. Are you aware -- and I want to talk
20 specifically about the Joint Commission.

21 Are you aware that whether or not the Joint
22 Commission's findings with respect to CPOE, hand
23 hygiene and BCMA are available to the public?

24 A. I do not believe that the Joint Commission
25 findings are, but AHCA should be.

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1 Q. AHCA, that's a-h-c-a?

2 A. Yes.

3 Q. And so and AHCA, a-h-c-a, they only observe
4 with respect to those three, the hand hygiene?

5 MR. TAKAGAKI: Objection.

6 A. The last -- the last that they were on site,
7 that's what they surveyed to.

8 BY MS. BLAIR:

9 Q. Okay. Do they ever do CPOE or BCMA?

10 A. They could in the same way that the
11 Joint Commission does in terms of observing, reviewing
12 medical records, reviewing audits.

13 Q. And do you know if they ever have, at least
14 for these five hospitals, to the best of your
15 knowledge, done a review of the CPOE system for any of
16 the five hospitals that make up Palm Beach Health
17 Network?

18 A. I can speak confidentially to their review
19 of how that system works, how there's information that
20 guides the physician, monitoring it through the medical
21 record -- or reviewing it through the medical record.
22 It's basically those two things.

23 Q. So AHCA will come in and monitor that for
24 CPOE?

25 A. Not specifically. But while they're on

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1 site, that is a component, that could be a component of
2 their review.

3 Q. And to the extent they do review CPOE when
4 they're on site, are the findings that -- are AHCA's --
5 sorry -- findings reported publicly for the public to
6 review?

7 A. To my knowledge, they're available.

8 Q. Okay. We talked earlier today about the
9 decision by the five hospitals to stop participating in
10 Leapfrog Hospital Survey in or around 2021. To the
11 best of your knowledge, was anybody from Tenet home
12 office involved in that decision?

13 A. To the best of my knowledge, no one was.

14 Q. Okay. Talking specifically about
15 Good Samaritan in or around 2021, do you recall once
16 Libby Flipppo made the recommendation that there would
17 no longer be -- and it was agreed to -- no longer be
18 participation in the Leapfrog Hospital Survey, do you
19 recall any conversation -- do you recall what the
20 reaction was among your direct reports at
21 Good Samaritan regarding that decision?

22 MR. TAKAGAKI: Objection.

23 A. We supported the decision.

24 BY MS. BLAIR:

25 Q. Do you recall whether or not anyone

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1 expressed any concern to you about the fact that --
2 and, again, just Good Samaritan in 2021 -- that
3 Good Samaritan was stopping participating in the
4 Leapfrog Hospital Survey?

5 A. Not that I recall.

6 Q. Do you recall any discussions among -- any
7 discussions with anyone after the decision was made in
8 2021 about whether or not the five hospitals would
9 still receive a grade, a Leapfrog Hospital Safety Grade
10 after the hospital stopped participating in the
11 Leapfrog survey?

12 A. So very broadly, yes.

13 Q. And what do you recall very broadly about
14 that discussion?

15 A. Once we stopped, we were concerned still how
16 that would be reflected to our community and to our
17 patients. We didn't know if it was going to have
18 negative effect on the grade, how it would be perceived
19 by the public.

20 Q. And when you say how that would be perceived
21 by the public, are you referring to the fact that
22 you're no longer participating in the survey?

23 A. Correct.

24 Q. And was there any change in perception by
25 the public once you stopped participating in the

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1 Leapfrog Hospital Survey?

2 MR. TAKAGAKI: Objection.

3 A. Yes.

4 BY MS. BLAIR:

5 Q. And what was it?

6 A. When it changed to imputed scoring and our
7 grades just automatically dropped because we were no
8 longer participating --

9 Q. Okay.

10 A. -- that's when I became aware that we were
11 losing patients and we were going to potentially lose
12 surgeons because of that methodology change.

13 Q. Okay. So I want to walk back in time. So I
14 want to talk about 2021 when the decision is made to
15 stop participating in the Leapfrog Hospital Survey.
16 Were there any discussions in or around that time about
17 the impact, if any, that not participating in the
18 survey would have on the hospitals?

19 A. I mean, I just don't recall specifically,
20 but if you can show me something.

21 Q. Yeah, I'm just trying to ask right now for
22 your general recollection.

23 A. Okay.

24 Q. And let's just kind of go back.

25 Do you understand that the hospital survey

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1 is separate and distinct from the hospital safety
2 grade?

3 MR. TAKAGAKI: Objection.

4 A. Yes.

5 BY MS. BLAIR:

6 Q. Okay. And would you agree with me that the
7 hospital survey that we've been discussing this morning
8 that's quite lengthy and you described measures many
9 things other than the four imputed measures that this
10 litigation is about?

11 A. Yes.

12 MR. TAKAGAKI: Objection.

13 BY MS. BLAIR:

14 Q. And in 2021 when the hospitals stopped
15 participating in the Leapfrog Hospital Survey, were
16 there any discussions about whether or not the
17 hospitals would continue to be graded by Leapfrog
18 despite the fact that they were no longer participating
19 in the hospital survey?

20 A. I just don't recall specifically.

21 Q. Do you recall any conversations where -- any
22 conversations at all where anyone associated with
23 Palm Beach Health Network stated their belief that
24 because the hospital was no longer, any one of these
25 five hospitals was no longer participating in the

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1 Leapfrog Hospital Survey, they would no longer receive
2 a safety grade?

3 A. I don't recall.

4 MR. TAKAGAKI: Objection. Sorry. You're
5 talking about '21 still?

6 MS. BLAIR: Yes.

7 BY MS. BLAIR:

8 Q. Same question with respect to 2022 -- well,
9 let's talk about 2022 now. We'll go to 2022.

10 2022 would be the first year that these five
11 hospitals were not participating in the Leapfrog
12 survey, correct?

13 A. Correct.

14 Q. And, yet, these five hospitals receive
15 hospital safety grades in 2022, correct?

16 A. Correct.

17 Q. When the hospital safety grades came out in
18 2022, let's just talk about the spring of 2022, was
19 there any discussion that you can recall that you were
20 surprised that Leapfrog was continuing to grade
21 hospitals in light of the fact that you were no longer
22 participating in the survey?

23 MR. TAKAGAKI: Objection.

24 A. I don't recall that for 2022.

25 BY MS. BLAIR:

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1 Q. As the director of quality in 2022 for both
2 the Palm Beach Health Network and for Good Samaritan,
3 did you have a belief as to whether or not
4 nonparticipating hospitals -- and by that I mean,
5 nonparticipating in the survey -- received hospital
6 safety grades from Leapfrog?

7 A. Would you mind repeating the question?

8 Q. Yes. I'm trying to figure out what your
9 understanding was as the director of quality for both
10 Palm Beach Health Network and Good Samaritan in or
11 around 2022 as to whether or not nonparticipating
12 hospitals received hospital safety grades from
13 Leapfrog.

14 A. I'm so sorry. I don't recall.

15 Q. Okay. But you did receive a grade, you did
16 receive grades from Leapfrog in 2022, correct?

17 A. To my knowledge.

18 Q. Do you recall any discussions as the
19 director of quality for Palm Beach Health Network with
20 anybody at any of the five hospitals about the fact
21 that the hospitals were still receiving a hospital
22 safety grade even though the hospitals were not
23 participating in the survey?

24 A. I don't recall sitting here today, but I'm
25 happy to look at a document.

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1 Q. I don't have a document. Sorry. I will.

2 To your --

3 MR. TAKAGAKI: I'm sorry. Are you still on
4 2022?

5 MS. BLAIR: Yes.

6 MR. TAKAGAKI: Okay. The last question
7 didn't clarify that, so that's why. I
8 apologize.

9 BY MS. BLAIR:

10 Q. Okay. To your knowledge, was there an
11 expectation ever discussed in 2022 when the hospital
12 safety grades came out that hospitals that did not
13 participate in the hospital survey should not receive a
14 grade from Leapfrog?

15 MR. TAKAGAKI: Objection.

16 A. I don't recall.

17 BY MS. BLAIR:

18 Q. In 2023, the five hospitals that are
19 plaintiffs in this litigation also received hospital
20 safety grades from Leapfrog, correct?

21 A. Correct.

22 Q. In 2023 when hospital safety grades came out
23 in both the spring or the fall, do you have any
24 recollection of any conversations with anyone at any of
25 the five hospitals about the fact that your expectation

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1 would be that a hospital that does not participate in
2 the Leapfrog Hospital Survey is still getting a
3 hospital safety grade?

4 MR. TAKAGAKI: Objection.

5 A. I don't recall.

6 BY MS. BLAIR:

7 Q. You don't recall any conversations about
8 that?

9 A. In 2023?

10 Q. Right.

11 MR. TAKAGAKI: Objection.

12 A. That is correct.

13 BY MS. BLAIR:

14 Q. Okay. So just to recap, in 2021, 2022 and
15 2023, you don't recall any conversations with anyone
16 expressing to you that they were surprised that the
17 hospitals were still receiving a hospital safety grade
18 in light of the fact that the hospitals were no longer
19 participating in the Leapfrog Hospital Survey?

20 MR. TAKAGAKI: Objection.

21 A. I don't recall any specific conversations.

22 BY MS. BLAIR:

23 Q. As the director of quality for Palm Beach
24 Health Network and Good Samaritan in 2020 through 2023,
25 did you understand how the Leapfrog Hospital Safety

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1 Grade worked?

2 A. Yes.

3 Q. And did you understand in or around that
4 time that Leapfrog provided hospital safety grades for
5 approximately 3,000 acute care centers around the
6 country?

7 A. I was not aware of the number.

8 Q. Were you aware that it was more than just
9 Florida?

10 A. Yes.

11 Q. Were you aware that it was across the
12 country?

13 A. I feel like that's so broad because I know
14 that it's voluntary and not everyone participates.

15 Q. Right. And I'm talking about two separate
16 things.

17 A. Okay.

18 Q. So the survey is voluntary, correct?

19 A. Correct.

20 Q. Do you have any understanding of whether the
21 hospital safety grade is voluntary?

22 A. Yes.

23 Q. Okay. And what is your understanding as to
24 whether or not the hospital safety grade is voluntary?

25 A. I understand that there are measures that

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1 come from CMS that are publicly reported that go into
2 the safety grade, and that is not voluntary.

3 Q. Right. Do you understand that Leapfrog
4 grades all acute, adult acute care centers regardless
5 of whether they participate in the survey or not?

6 A. Could you clarify?

7 Q. Sure. So there are hospitals that
8 participate in the hospital survey, correct?

9 A. Correct.

10 Q. And do you have any understanding of the
11 percentage of adult acute care hospitals that
12 participate in the Leapfrog Hospital Survey in 2025?

13 A. Off the top of my head I want to say
14 80 percent.

15 Q. Okay. And so I'm not holding you to that
16 number, but let's just say 80 percent. So there are 20
17 percent of adult acute care hospitals in the United
18 States that do not participate, then, in the Leapfrog
19 Hospital Survey, correct?

20 A. On or about.

21 Q. Excellent.

22 Do you have an understanding, though, that
23 all of those hospitals, whether they submit a survey or
24 not, get a hospital safety grade?

25 A. Yes.

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1 Q. And did you have that understanding in '21,
2 '22 and '23 when you were the director of quality for
3 Palm Beach Health Network during those years?

4 MR. TAKAGAKI: Objection.

5 A. Yes.

6 BY MS. BLAIR:

7 Q. Okay. Sorry to make that so confusing.
8 So prior to the fall of 2024 -- well, hold
9 on one second.

10 MS. BLAIR: I'm getting into a new topic.
11 Is everybody okay to keep going, or would you
12 like to take a lunch break in light of the fact
13 it's noon?

14 MR. TAKAGAKI: I'll defer to the witness.

15 MS. MALONEY: How long have we been on the
16 record since the break?

17 MR. TAKAGAKI: About 40 minutes, I think.

18 THE VIDEOGRAPHER: 37.

19 MS. BLAIR: Oh, I can keep going. I just, I
20 don't want to make anybody --

21 MR. TAKAGAKI: Yeah, no reason.

22 (A discussion was held off the record.)

23 BY MS. BLAIR:

24 Q. And I want to now focus on, you understand
25 that Leapfrog changes its methodology from time to

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1 time, correct?

2 A. I'm aware of that.

3 Q. And are you aware that there was a change in
4 the Leapfrog methodology in 2023?

5 A. I don't recall.

6 Q. Now I have some documents, and I don't know
7 why this printed out on half bond paper and half not,
8 but here we are. This is the only one that did.

9 (Defendant's Exhibit Number 3 for i.d.)

10 BY MS. BLAIR:

11 Q. Ms. West, I'm handing you what's now been
12 marked as Exhibit 3 to your deposition. This is an
13 email from Andrea Nunes to Ricardo Ramirez and yourself
14 dated January 26, 2023. Do you see that in front of
15 you?

16 A. I do.

17 MR. TAKAGAKI: I'm sorry, Counsel. Before
18 you continue --

19 MS. BLAIR: There's no Bates labels because
20 I printed it out from your natives. So sorry.

21 MR. TAKAGAKI: I see. Do you know the
22 Bates?

23 MS. BLAIR: I don't, but I can get these for
24 you at the end of deposition.

25 MR. TAKAGAKI: Sure, that's fine.

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1 MS. BLAIR: There will be a few that look
2 like this.

3 MR. TAKAGAKI: No problem. Thanks.

4 MS. BLAIR: But I promise you, it's not from
5 my documents.

6 BY MS. BLAIR:

7 Q. And you'll see the subject here is "Forward:
8 Just Published 2023 Hospital Safety Grade Methodology
9 Leapfrog."

10 Do you see that?

11 A. I do.

12 Q. And in or around 2023, who was Andrea Nunes?

13 A. Director of quality at West Boca Medical
14 Center.

15 Q. Is she still?

16 A. She is.

17 Q. And she is informing both you and
18 Mr. Ramirez of new revisions for 2023. Do you see
19 that?

20 A. Can I have a moment to --

21 Q. Oh, yes, please, take your time.

22 A. Can I look at the whole thing?

23 Q. Absolutely. Just let me know when you're
24 ready.

25 MR. TAKAGAKI: I'm sorry, Kim. While you're

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1 looking, the staples came off a little bit, but
2 I assume these are part of the document, right?

3 MS. BLAIR: Yes, they're part of mine, yeah,
4 exactly.

5 MR. TAKAGAKI: Okay. Thanks.

6 MS. BLAIR: Oh, yeah, those have Bates
7 numbers so we'll be able to figure out the other
8 Bates numbers.

9 BY MS. BLAIR:

10 Q. Ms. West, have you had a chance to review
11 what we have now marked Exhibit 3 to your deposition?

12 A. Yes.

13 Q. Having seen this document and reviewed it,
14 does this refresh your recollection as to what may have
15 been occurring with respect to Leapfrog Safety Grade
16 methodology change in or around 2023?

17 A. Yes, it hasn't triggered a memory, but I
18 understand what I've read.

19 Q. Okay. But you have no -- as you sit here
20 today, you have no memory of this email; is that a fair
21 statement?

22 A. That's fair.

23 Q. And do you see here that Andrea Nunes is
24 saying that it appears that we will continue to receive
25 the score of five for ICU staffing. Do you see that?

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1 A. Yes.

2 Q. Having reviewed this document now, do you
3 have an understanding of what she's referring to when
4 she is telling you that?

5 A. Yes.

6 Q. And what is your understanding?

7 A. My understanding is that if the five would
8 be carried over to the new grade.

9 Q. Okay. And do you understand why West Boca
10 was receiving a five for ICU staffing in or around
11 January of 2023?

12 A. I do.

13 Q. And what is that understanding?

14 A. They did not receive full credit for their
15 staffing model during that time period.

16 Q. And was that based on a survey submission
17 that they had made?

18 A. Yes, to my knowledge.

19 Q. And then you see here it says, also the
20 second paragraph it said, "We could have an opportunity
21 for a B if we resubmit it. Our risks include BCMA has
22 not achieved 95 percent."

23 Do you see that?

24 A. I see it.

25 Q. And what do you understand the phrase "BCMA

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1 has not achieved 95 percent" to refer to?

2 A. She's referring to the Leapfrog threshold.

3 Q. And so is it your understanding that they
4 would not receive full credit for BCMA in 2023 due to
5 the fact that BCMA has not achieved a 95 percent
6 threshold?

7 A. Andrea's email says, "Our risks include BCMA
8 has not achieved 95 percent."

9 Q. Okay. And I thought you just told me, but
10 maybe I'm wrong, that it was the Leapfrog threshold is
11 95 percent, correct?

12 A. Correct.

13 Q. And then she says, "Our patient satisfaction
14 is worse."

15 Do you see that?

16 A. Yes.

17 Q. Do you have an understanding of whether or
18 not when she refers to patient satisfaction she's
19 referring to the HCAHPS scores?

20 A. I don't know exactly what she was referring
21 to.

22 Q. Okay. And she goes on to say, "CAUTI
23 increased in 2022," correct?

24 A. Correct.

25 Q. And CAUTI is the UTI infections from

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1 catheters, correct?

2 A. Correct.

3 Q. And she goes on to say, "I do know that
4 Christen," C-h-r-i-s-t-e-n, Mayer stated we would not
5 participate as a system in 2023."

6 Do you see that?

7 A. I do.

8 Q. Who is Christen Mayer?

9 A. At the time, she was a national director of
10 quality.

11 Q. Okay. And when you say "national director
12 of quality," is that at the Tenet home office level?

13 A. Yes, it is.

14 Q. And so does that mean that at least for 2023
15 home office had directed that the five hospitals that
16 make up Palm Beach Health Network would not be
17 participating in Leapfrog in 2023?

18 A. According to this email.

19 MR. TAKAGAKI: Objection.

20 A. According to this email.

21 BY MS. BLAIR:

22 Q. And when he says, "We will not participate
23 as a system," do you know what that means, "a system"?

24 A. Yes.

25 Q. And what does that mean to you?

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1 A. Tenet Healthcare.

2 Q. So that means all of the hospitals within
3 Tenet Healthcare, correct?

4 MR. TAKAGAKI: Objection.

5 A. Correct.

6 BY MS. BLAIR:

7 Q. And then they say, "This is a topic that we
8 need to discuss."

9 I say "they." Andrea, "This is a topic we
10 need to discuss?"

11 Do you see that's how she ends her email?

12 A. Yes.

13 Q. Do you recall whether there were any
14 discussions about West Boca participating in the
15 Leapfrog Hospital Survey for 2023?

16 A. I don't recall this one in particular. I do
17 recall just broadly that there had been discussions
18 over time.

19 Q. And do you recall as you reviewed this
20 document and the attachments that all hospitals that
21 did not have survey results for four rounds were also
22 going to receive a 5 for ICU physician staffing going
23 forward?

24 A. Yes.

25 MR. TAKAGAKI: Objection.

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1 BY MS. BLAIR:

2 Q. And so, as I understand it, or do you have
3 an understanding that in -- for the spring 2024
4 Leapfrog Hospital Safety Grade the other four
5 hospitals, sans West Boca, were receiving 100 percent
6 for ICU physician staffing because they still had
7 survey materials in the system with Leapfrog from four
8 rounds prior?

9 MR. TAKAGAKI: Objection. I think you said
10 spring 2024.

11 MS. BLAIR: Correct, I did.

12 MR. TAKAGAKI: Okay.

13 A. Yes.

14 (Defendant's Exhibit Number 4 for i.d.)

15 BY MS. BLAIR:

16 Q. Thank you. And then if we go to
17 Exhibit 4, Ms. West, I'm handing you what we've now
18 marked West Exhibit 4, which is, again, an email with
19 no Bates numbers --

20 MS. BLAIR: And I will get those for you at
21 the end of this deposition, Counsel.

22 BY MS. BLAIR:

23 Q. -- but this is an email from you to
24 Libby Flipppo at the top dated January 27th, 2023. Do
25 you have that email in front of you?

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1 A. I do.

2 Q. And this is one day after the Exhibit we
3 just saw that was marked as Exhibit 3, correct?

4 A. Correct.

5 Q. Do you having -- do you need time to review
6 this?

7 A. Yes.

8 Q. Okay. Do you recall sending this email in
9 or around January of 2023?

10 A. I don't recall sending it, but I see that I
11 did.

12 Q. Okay. And, again, who is Libby Flipppo?

13 A. She's the market chief nursing officer.

14 Q. And it says here, you are saying, "Hi,
15 Libby. West Boca would like to participate in
16 Leapfrog's survey. Required elements in order to
17 change the ICU coverage results."

18 Do you see that?

19 A. Yes.

20 Q. Do you recall that you did reach out to
21 Libby Flipppo and asked her for an exemption for
22 West Boca to participate in the Leapfrog survey?

23 A. In general, yes.

24 Q. Okay. Do you recall what Libby Flipppo's
25 response to you was in or around this time?

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1 A. I do not recall.

2 Q. Do you know whether or not West Boca ended
3 up participating in the Leapfrog Hospital Survey for
4 spring of 2023?

5 A. Not to my knowledge.

6 Q. Do you know why they did not participate in
7 the Leapfrog Hospital Survey for the spring of 2023?

8 A. Yes.

9 Q. And why?

10 A. We were upholding the decision to focus in
11 on other required areas of our work.

12 Q. And even though you were with -- upholding
13 that decision, you still reached out to Libby Flipppo
14 for the exemption, correct?

15 A. I did.

16 Q. And so is it your memory, to the best of
17 your recollection, that after consultation with
18 Libby Flipppo, the decision was made that you would
19 withhold the decision not to participation in Leapfrog
20 surveys for any of the five hospitals?

21 MR. TAKAGAKI: Objection.

22 A. I recall that we did not continue to
23 participate.

24 BY MS. BLAIR:

25 Q. Do you recall whether it was your decision

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1 or Libby Flipppo's decision that West Boca not
2 participate in the spring of 2023 in the Leapfrog
3 Hospital Survey?

4 MR. TAKAGAKI: Objection.

5 A. I don't recall.

6 BY MS. BLAIR:

7 Q. Is there a reason that you reached out to
8 Libby Flipppo regarding West Boca's permission to
9 participate in the survey for 2023 as opposed to anyone
10 else?

11 A. I reported to her at the time.

12 Q. Okay. Do you know if Libby Flipppo would
13 have needed to reach out to anyone else to see if there
14 was permission granted for West Boca to participate in
15 the Leapfrog survey in 2023?

16 MR. TAKAGAKI: Objection.

17 A. I don't have knowledge of it.

18 BY MS. BLAIR:

19 Q. Based on the reporting system in place for
20 Palm Beach Health Network, would Libby Flipppo have had
21 the authority on her own to make the decision as to
22 whether or not West Boca would participate in the
23 Leapfrog Hospital Survey for the spring of 2023?

24 MR. TAKAGAKI: Objection.

25 A. I don't want to speculate on that because I

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1 truly don't know.

2 BY MS. BLAIR:

3 Q. Okay. Are you aware of any email response
4 from Libby Flipppo back to you regarding the decision as
5 to whether or not West Boca could participate in the
6 Leapfrog Hospital Survey in 2023?

7 A. I don't recall.

8 Q. Other than West Boca's request to
9 participate in the Leapfrog Hospital Survey in 2023,
10 are you aware of any other hospitals that are part of
11 the Palm Beach Health Network that requested permission
12 to participate in the Leapfrog Hospital Survey in 2023?

13 A. Sitting here today, I just can't pull that
14 from my memory. But if you have a document --

15 Q. I don't. I just want to know your memory.

16 Are you aware of -- other than this West
17 Boca situation do you have any recollection of another
18 hospital asking to participate?

19 A. I don't.

20 Q. And are you aware in 2023 whether any of the
21 other hospitals other than West Boca that make up the
22 Palm Beach Health Network were receiving any scores
23 other than 100 out of 100 for ICU physician staffing?

24 MR. TAKAGAKI: Objection.

25 A. No.

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1 BY MS. BLAIR:

2 Q. And are you aware as you sit here today that
3 for the other three measures that are at issue in this
4 litigation, BCMA, CPOE and hand hygiene, all five of
5 the hospitals that make up the Palm Beach Health
6 Network were receiving 100 out of 100 points for those
7 three measures?

8 MR. TAKAGAKI: Objection.

9 A. I'd have to look at it.

10 BY MS. BLAIR:

11 Q. Okay. Do you have any understanding of how
12 the Leapfrog methodology prior to the fall of 2024
13 treated those four measures, BCMA -- CPOE, BCMA,
14 hand hygiene and ICU physician staffing, for
15 nonparticipating hospitals in the hospital safety
16 grade?

17 MR. TAKAGAKI: Objection.

18 A. I am aware that the calculation methodology
19 changes over time. I'm aware that there are cohort
20 averages assigned, that there are imputed scoring
21 methodologies assigned, but I do not recall the exact
22 time frames for all of those changes.

23 BY MS. BLAIR:

24 Q. Okay. And I'm not trying to be tricky. So
25 for, let's just take the spring of 2024, do you have an

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1 understanding that for those four measures, CPOE, BCMA,
2 hand hygiene and ICU physician staffing, that Leapfrog
3 had a two-step method wherein step one, a hospital that
4 had a survey done within the last two years would
5 receive the score from that survey, and if it hadn't,
6 it would receive the mean of its cohort?

7 A. I just re-read this in this document.

8 Q. Oh. Yes, that's from 2023, correct?

9 A. Okay. Yes.

10 Q. So now I'm asking about --

11 A. 2024?

12 Q. -- '24. Do you have any understanding of
13 how the imputation model worked in the spring of 2024
14 before the methodology change that we're here today in
15 this litigation for? So I just want to know what your
16 understanding was as to how the five hospitals at
17 Palm Beach Health Network were scored on the four
18 measures that are at issue in this litigation, and
19 let's just take for the spring of 2024.

20 A. I don't have a great memory for it because
21 we weren't participating at the time. I wasn't doing a
22 lot with Leapfrog so I just do not recall for that
23 moment.

24 Q. Okay. And you recall -- you do know,
25 though, that a change went into place in fall of 2024,

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1 correct?

2 A. I am aware of that, yes.

3 Q. And what is your understanding of the
4 difference between how the scoring worked in spring of
5 2024 versus how it was going to work in the fall of
6 2024?

7 A. So my own words --

8 Q. Your own words.

9 A. -- the scoring changed on those four
10 measures: ICU staffing, CPOE, BCMA, hand hygiene, to
11 an imputed scoring system that would give hospitals the
12 lowest score if they did not participate.

13 Q. Did you have an understanding that for
14 spring of 2024, those four measures also had an imputed
15 scoring system?

16 A. Yes, high level, not at the lowest scoring
17 possible.

18 Q. Right. And you had mentioned in one of your
19 answers about the cohort. What is your memory about
20 how that worked?

21 MR. TAKAGAKI: Objection.

22 A. I don't have a great memory for it so I
23 don't feel like I can give a great response.

24 BY MS. BLAIR:

25 Q. Okay. So you just know that there was a

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1 change, and the change was for fall of 2024 for those
2 four measures, nonparticipating hospitals were going to
3 receive limited achievement for those four measures,
4 correct?

5 A. Correct.

6 Q. Did you have an understanding in or around
7 fall of 2024 what was meant by "limited achievement"?

8 MR. TAKAGAKI: Objection.

9 A. My understanding, if we're still talking
10 about imputed scoring --

11 BY MS. BLAIR:

12 Q. Yes. Sorry.

13 A. -- is that the lowest score possible would
14 be assigned in those areas.

15 Q. Did you have an understanding that limited
16 achievement referred to the lowest score received by a
17 participating hospital?

18 A. Yes.

19 Q. And do you have an understanding that the
20 way Leapfrog's methodology works --

21 MR. TAKAGAKI: I think she wasn't done
22 answering.

23 BY MS. BLAIR:

24 Q. Oh, I'm sorry. Yeah.

25 A. I'd like to back up because you said a

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1 participating hospital, and I said "yes."

2 Q. Correct.

3 A. But my understanding is, it's for
4 participating -- for nonparticipating hospitals --

5 Q. Okay.

6 A. -- that didn't participate with the survey
7 would get the lowest imputed score possible, so I did
8 not answer you correctly.

9 Q. Okay. So that is -- that's your -- okay.
10 Let's go back through it. Good, thank you.

11 A. Okay. Okay.

12 Q. So your understanding is -- so let's just
13 rewind a little because I want to make sure my record
14 is clear and I understand, so I'm sorry I looked away.

15 Tell me one more time, what is your
16 understanding of what limited achievement means in the
17 Leapfrog scoring methodology?

18 A. When it comes to the safety grade, my
19 understanding is that the imputed scoring gets assigned
20 to hospitals that do not participate in the survey.

21 Q. Okay. And let's just take ICU physician
22 staffing for just for a moment because we just saw
23 that, right, in Exhibit 3, that email talks about ICU
24 physician staffing, correct?

25 A. Correct.

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1 Q. And you see in that email, Exhibit 3, that a
2 hospital is going to get a score of five for ICU
3 physician staffing, correct?

4 A. Correct.

5 Q. And do you understand that a score of five
6 is associated with limited achievement on the Leapfrog
7 scoring system?

8 A. Yes.

9 Q. And do you understand that that five is
10 associated with the lowest score earned by a hospital
11 that did participate in the Leapfrog Hospital Survey?

12 A. Yes.

13 MS. BLAIR: And I thought you guys said you
14 wanted to go a break, so I'm happy to do so
15 whenever.

16 MR. TAKAGAKI: Yes, whenever, that's fine.

17 THE VIDEOGRAPHER: Off the record 12:34.

18 (A recess was taken from 12:34 p.m. to 1:28 p.m.)

19 THE VIDEOGRAPHER: Back on the record 1:28.

20 BY MS. BLAIR:

21 Q. Ms. West, before the break we were starting
22 to talk about how the Leapfrog scoring methodology for
23 the hospital safety grade worked prior to 2024, do you
24 recall that?

25 A. Yes.

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1 Q. I'm sorry. Prior to fall of 2024. Do you
2 recall that?

3 A. Yes.

4 Q. And I think for purposes of this deposition,
5 can you agree with me that the methodology in spring of
6 2024 as it related to the four measures that are at
7 issue in this litigation was different or changed for
8 fall of 2024?

9 A. Yes.

10 Q. And do you have an understanding -- and I'm
11 trying to find something to show you. Do you have an
12 understanding that the scoring for the Leapfrog
13 Hospital Safety Grade consists of 22 different
14 measures?

15 A. Yes.

16 Q. And do you understand that they are divided
17 into two separate domains? Do you know what I mean
18 when I say that?

19 A. Yes.

20 Q. Okay. And twelve of the measures are in the
21 domain of process and structural measures, correct?

22 A. Yes.

23 Q. And ten of the measures are in the domain of
24 outcomes, correct?

25 A. Yes.

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1 Q. And if we talk just briefly about those
2 measures that are in the outcome domain, do you have
3 any understanding of what those ten measures that are
4 in the outcome domain of the Leapfrog Hospital Safety
5 Grade scoring methodology are?

6 A. Yes.

7 Q. And what is your understanding of what they
8 are?

9 A. If I recall, those measures are received
10 from publicly reported data.

11 Q. And when you say "publicly reported data,"
12 are you referring to CMS data?

13 A. I am.

14 Q. I'm just trying to find, see if I've got
15 something I can show you.

16 And then with respect to the twelve process
17 and structural measures, do you have an understanding
18 of what those twelve structural and process measures
19 are in the Leapfrog Hospital Safety Grade methodology?

20 A. Could you show me a document?

21 Q. Yeah, I'm trying to find one.

22 But just generally speaking, you understand
23 that there are twelve measures that make up the
24 structural and process measures of the
25 Leapfrog Hospital Safety Grade methodology, correct?

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1 A. I am.

2 Q. Do you understand that four of the measures
3 that are in the structural and process domain of the
4 Leapfrog Hospital Safety Grade methodology are the four
5 measures that we've been referring here today: BCMA,
6 CPOE, ICU physician staffing and hand hygiene?

7 A. Can you say that again, please?

8 Q. Sure. That was fast. Sorry.

9 So of the twelve measures that we just
10 discussed that are in that domain of process and
11 structural measures, do you understand the four
12 measures that are at issue in the litigation fall
13 within that process and structural domain?

14 A. I am.

15 Q. Okay. And do you understand that four of
16 the twelve measures -- I'm sorry -- five of the twelve
17 measures that fall within that process and structural
18 domain of the Leapfrog hospital grade come from
19 CMS data as well?

20 A. If you can show me a document.

21 Q. I am going to do that. Do you understand of
22 the twelve measures that fall within the process and
23 structural -- here we go -- structural domain, three of
24 those measures for nonparticipating hospitals are
25 simply coded as "declined to respond" and do not factor

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1 into the ultimate hospital safety grade score that's
2 given to a nonparticipating hospital?

3 MR. TAKAGAKI: Objection.

4 A. I am.

5 MS. BLAIR: I don't know who copied this,
6 but here we are. I'm going to mark this now as
7 Exhibit 5.

8 BY MS. BLAIR:

9 Q. Ms. West, I've now handed you what we've
10 marked as Exhibit 5 to this deposition. Have you ever
11 seen this document before?

12 A. Yes.

13 Q. And what is your understanding of what this
14 document is?

15 A. This is the scoring methodology document for
16 spring 2024 safety grade.

17 Q. Okay. And if we turn to page 5 of this
18 document -- it might be 4 and 5. Oh, I'm sorry. Maybe
19 5 and 6. Do you see it starts with process structural
20 measures, twelve?

21 MR. TAKAGAKI: I'm sorry.

22 A. I don't have a five.

23 MR. TAKAGAKI: The page numbers are kind of
24 all over it. Like goes from 7 to 24 --

25 MS. BLAIR: Oh, yeah. I thought the copies

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1 were weird, too.

2 MR. TAKAGAKI: -- 11 to 12.

3 MS. BLAIR: My copy is strange as well.

4 MR. TAKAGAKI: Yeah.

5 MS. BLAIR: You know what? I'm going to
6 strike that Exhibit. I thought the copies were
7 weird.

8 THE WITNESS: I don't have a five.

9 MS. BLAIR: Let's strike that Exhibit, then,
10 from your -- from this deposition. I'll get it
11 later. I'm get you a full copy later. So this
12 is strange.

13 MR. TAKAGAKI: I think they're out of order.

14 MS. BLAIR: I think it looks like it was
15 double sided, and they only copied the even
16 sides is what that looks like.

17 So put that aside. I'll save it.

18 BY MS. BLAIR:

19 Q. With respect to the measures, the four
20 measures that are at issue in this litigation -- let's
21 go back in time.

22 Do you have an understanding that
23 Tenet Healthcare required at least the five hospitals
24 that make up the Palm Beach Hospital Network to provide
25 its leap score, Leapfrog Hospital Safety Grade scores

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1 at every grading period?

2 MR. TAKAGAKI: Objection.

3 A. Could you clarify, please?

4 BY MS. BLAIR:

5 Q. Sure. So do you have any recollection, at
6 least from 2023 through 2025, as to whether or not
7 Tenet home office requested the five hospitals that are
8 plaintiffs in this litigation send home office copies
9 of their Leapfrog scores every six months when they
10 came out from Leapfrog?

11 A. I am aware.

12 Q. And do you know for what purpose there was a
13 request from Tenet home office to supply those scores?

14 MR. TAKAGAKI: Objection.

15 A. Yes.

16 BY MS. BLAIR:

17 Q. And what do you understand the purpose was?

18 A. A collection of the grades.

19 Q. Do you know why they were collecting the
20 grades?

21 MR. TAKAGAKI: Objection.

22 A. I don't know.

23 BY MS. BLAIR:

24 Q. Did you as the director of quality for
25 Palm Beach Health Network ever have any discussions

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1 with Maggie Gill about the reason that Tenet home
2 office continued to collect Leapfrog scores even though
3 the five hospitals were not participating in the
4 survey?

5 A. I don't recall having a discussion with
6 Maggie Gill.

7 Q. Do you recall having a discussion with
8 anybody about why home office was continuing to request
9 the five hospitals to send in their Leapfrog hospital
10 safety grades even though the hospitals were not
11 participating?

12 A. Yes, I do.

13 Q. And who did you have that conversation with?

14 A. I had it with a biostatistician, Bonnie. I
15 forgot her last name.

16 Q. Nukala?

17 A. Yes. Thank you.

18 Q. And Bonnie Nukala, who does she work for, to
19 the best of your knowledge?

20 A. To the best of my knowledge, she reports to
21 Tanushree Tomer.

22 Q. And does Tanushree Tomer work for
23 Tenet healthcare home office?

24 A. She does.

25 Q. And what was the substance of the

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1 conversation you had with Bonnie Nukala about why
2 Tenet home office was continuing to collect Leapfrog
3 hospital safety grades even though the hospitals were
4 not participating in the Leapfrog Hospital Survey?

5 A. Just broadly speaking --

6 Q. Yes.

7 A. -- to get an understanding.

8 Q. To get an understanding of what?

9 A. Of why we continued to submit.

10 Q. Of why you continue to submit what?

11 A. The scores to the home office.

12 Q. Oh, okay. So you called Bonnie to get an
13 understanding. And what did she tell you about why you
14 continued to submit scores to the home office?

15 A. I actually emailed Bonnie, and she stated
16 that Alex Kim was -- continued to collect them.

17 Q. And who is Alex Kim?

18 A. Tanushree Tomer reports to Alex Kim and I've
19 forgotten his exact title.

20 Q. And did she tell you why Alex Kim continues
21 to collect them?

22 A. Not that I recall.

23 Q. Do you know if a report was ever produced in
24 any way related to the Leapfrog Hospital Safety Grades
25 that the Palm Beach hospitals were submitting to Tenet

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1 home office?

2 MR. TAKAGAKI: Objection.

3 A. Could you ask that one more time?

4 BY MS. BLAIR:

5 Q. Sure.

6 You told me Alex Kim was still collecting
7 the Leapfrog Hospital Safety Grades at least for these
8 five hospitals, correct?

9 A. Correct.

10 Q. Do you know whether or not Tenet home office
11 ever produced a report related to the hospital safety
12 grades that these five offices continued to submit to
13 Tenet home office?

14 A. Not to my knowledge.

15 Q. Beyond the conversations you had with
16 Bonnie Nakula regarding -- to get an understanding of
17 why you were continuing to submit these, did you have
18 any other conversations with anyone else about why
19 these five Palm Beach Health Network hospitals were
20 continuing to be asked to submit their Leapfrog
21 hospital safety grades?

22 A. Yes.

23 Q. Who else?

24 A. If my memory serves me correctly, it was
25 Anna Gunod.

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1 Q. And who is Anna Gunod?

2 A. The market director of infection control.

3 Q. And so when you say "market director," does
4 that mean she's over the Palm Beach Health Network
5 market?

6 A. I need to correct myself.

7 Q. Okay.

8 A. She is the national director.

9 Q. So she works for Tenet home office?

10 A. Correct.

11 Q. And what did she tell you about why the
12 Palm Beach hospital network hospitals were continuing
13 to be asked to submit their Leapfrog hospital safety
14 grades even though the hospitals were not participating
15 in the survey?

16 A. She asked me who had requested the grades.

17 Q. And what do you recall -- did you answer
18 her?

19 A. I answered her.

20 Q. And what did you tell her?

21 A. I recall that I explained that I was
22 submitting them to Bonnie Nukala.

23 Q. And was that in email?

24 A. Yes.

25 Q. And did you review that email in preparation

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1 for your deposition today?

2 A. No.

3 Q. And then did you have any further
4 conversations with Anna Gunod regarding -- after you
5 told Anna Gunod that Bonnie was requesting the grades?

6 A. Say that just one more time.

7 Q. Sure, yeah.

8 A. Sorry.

9 Q. I'm confusing myself at this point.

10 After you had that conversation -- or after
11 you had that email exchange with Anna Gunod where she
12 asked you who was requesting the Leapfrog grades and
13 you answered her, Bonnie, do you recall whether or not
14 there was any further email exchange from Anna about
15 this topic, sharing the Leapfrog hospital grades?

16 A. Not that I recall.

17 Q. Did you have any follow-up with Bonnie about
18 the fact that Anna Gunod asked you about who was
19 requesting the grades?

20 A. Not that I remember.

21 Q. Other than the conversation you told me with
22 Bonnie Nukala and Anna Gunod, do you recall any other
23 conversations you may have had with anybody regarding
24 the fact that Tenet Healthcare was still requesting
25 Leapfrog grades be submitted even though the hospitals

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1 were no longer participating in the survey?

2 A. As I sit here right now, I don't remember.

3 Q. That's fine.

4 A. But I'd be happy to look at a document.

5 Q. Just trying to figure out the extent of your
6 memory.

7 Is it the case that since your time as
8 director of quality for the Palm Beach Health Network
9 that Tenet home office has requested the five hospitals
10 to provide their Leapfrog Safety Grades to them on a
11 biannual basis?

12 A. I don't know when the request started and
13 for how long it was, you know, carried out
14 (Defendant's Exhibit Number 5 for i.d.)

15 MR. TAKAGAKI: Is this going to be 5 or 6?

16 MS. BLAIR: 5. I withdrew 5.

17 BY MS. BLAIR:

18 Q. Ms. West, I am handing you what we marked
19 Exhibit 5. Again, it does not have a Bates number.
20 And I will get that for counsel after the deposition.

21 This is an email from you to Andrea Nunes,
22 Carola Kuret, Heather Wehmeyer, Taylor Pool and
23 Kathleen McDonald, and the subject is "Leapfrog Market
24 Analysis."

25 Do you see that?

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1 A. Yes.

2 Q. And the date of this email is April 17th,
3 2023, correct?

4 A. Correct.

5 Q. And you say, "Hi, fellow quality leaders. I
6 completed an analysis of our Leapfrog scores for 2023."
7 Do you see that?

8 A. Yes.

9 MR. TAKAGAKI: Objection. You left out
10 "spring."

11 BY MS. BLAIR:

12 Q. Oh. "I completed a analysis of our Leapfrog
13 scores for spring 2023."

14 Do you see that?

15 A. Yes.

16 Q. Do you know as you look at this email today
17 in September of 2025 whether or not you were completing
18 an analysis of the Leapfrog scores for Tenet home
19 office?

20 A. It was not.

21 MR. TAKAGAKI: Objection.

22 A. It was not for Tenet home office.

23 BY MS. BLAIR:

24 Q. What do you recall about why you were
25 completing an analysis of the Leapfrog scores for

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1 spring of 2023?

2 A. I recall doing this each time that the
3 numerical scores were published.

4 Q. And for what purpose did you do this each
5 time?

6 A. I did it just so we could see what the
7 scores looked like.

8 Q. Did you use the Leapfrog hospital scores to
9 benchmark yourself in terms of how your performance was
10 as compared to other hospitals in the area?

11 MR. TAKAGAKI: Objection.

12 A. No, I did not.

13 BY MS. BLAIR:

14 Q. And you say, the first bullet point you say,
15 "All five hospitals scored at a C level," correct?

16 A. Correct.

17 Q. And this would have been for the spring
18 2020 -- 2023 Leapfrog Hospital Safety Grade, correct?

19 A. Yes.

20 Q. And you say here, "The largest opportunity
21 continues to lie in patient experience."

22 Do you see that?

23 A. I do.

24 Q. Do you know what you were referring to when
25 you referred to patient experience?

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1 A. The category of patient experience.

2 Q. Does that refer in any way to the HCAHPS
3 scores that are used to calculate the Leapfrog Hospital
4 Safety Grade?

5 A. Yes.

6 Q. You then say in the next sentence, "West
7 Boca would need to participate in the fall 2023 survey
8 and change their BCMA and IPS performance as well."

9 Do you see that?

10 A. I do.

11 Q. And do you recall we saw an email earlier in
12 this deposition where West Boca -- well, where you on
13 behalf of West Boca was asking for an exemption to
14 participate in the Leapfrog Hospital Survey, correct?

15 A. Correct.

16 Q. Were you as the director of quality for the
17 Palm Beach Health Network supportive of West Boca
18 participating in the fall 2023 survey?

19 A. I was.

20 Q. And why were you supportive of that?

21 A. Because we didn't want this to show
22 negatively in the community. We didn't want for
23 patients to be leaving our hospitals, to be leaving the
24 area, for physicians to be leaving us, so a request was
25 made each time to participate so that we wouldn't be

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1 punished.

2 Q. Okay. How in fall of 2023 would you be
3 punished?

4 A. Well, we were being punished because of BCMA
5 and IPS at West Boca, so the grade was showing lower
6 than what they were actually performing. So their
7 community wouldn't know that they were actually
8 performing better than what was within the Leapfrog
9 grade.

10 Q. Did we not see an email from West Boca that
11 we had marked previously, it's the January 2026 [sic]
12 email. I believe it's Exhibit 3 in front of you there.
13 It's the one with the weird colored paper. This is
14 from Andrea Nunes. And if you look, I'm looking at
15 Exhibit 3, she says that the BCMA has not achieved
16 95 percent. Do you see that?

17 A. I do.

18 Q. So is it your understanding that West Boca
19 was being punished somehow by Leapfrog in the spring of
20 2023 for its BCMA score?

21 MR. TAKAGAKI: Objection.

22 A. Between January and April, I'm not sure how
23 that could have changed. It could have gotten better
24 between that time. But with all of these requests, it
25 was in an effort to not show worse in a Leapfrog grade

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1 than we were actually performing for our community.

2 BY MS. BLAIR:

3 Q. Understood. In fall -- in spring of 2023,
4 though, you understand that methodology change that
5 we're in this litigation about had not yet been put
6 into place, correct?

7 A. I understand.

8 Q. Okay. And so do you have any belief when we
9 look at Exhibit 5 that West Boca was going to be
10 punished for its BCMA grade based on the Leapfrog
11 methodology?

12 MR. TAKAGAKI: Objection.

13 A. The request was to be able to re-enter the
14 data to get all of the credit possible so that we
15 wouldn't leave any credit on the table if that makes
16 sense.

17 BY MS. BLAIR:

18 Q. Okay. That makes sense.

19 MS. BLAIR: Mark this as Exhibit 6.

20 (Defendant's Exhibit Number 6 for i.d.)

21 BY MS. BLAIR:

22 Q. Ms. West, I'm handing you what we've now
23 marked as Exhibit 6, which is a calendar entry from
24 Ashley Barquin. And it's the -- do you see that there?

25 A. Yes.

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1 Q. And it says, "The location of this meeting
2 is Gina's office." I assume you're Gina with respect
3 to this.

4 A. Um-hum.

5 Q. And the subject line, is "Accepted
6 Leapfrog-Good Sam."

7 And this is Friday. The meeting is set to
8 take place on Friday 21st at 2023. Do you have any
9 recollection of in or around the spring of 2023 what
10 the purpose of this meeting would have been with
11 Ashley Barquin?

12 A. I do not recall.

13 Q. And for the record, who is Ashley Barquin?

14 A. 2023. Ashley Barquin is a registered nurse
15 who has worked at St. Mary's Medical Center and
16 Good Samaritan Medical Center. At St. Mary's she was
17 the assistant chief nursing officer. At Good Samaritan
18 Medical Center she was the chief nursing officer.

19 Q. Okay. And do you have any understanding of
20 what her involvement would have been in or around
21 April of 2023 with respect to Leapfrog?

22 A. I don't recall. I don't recall meeting with
23 Ashley at all.

24 Q. Okay. Do you know in 2023 was she the
25 assistant chief nursing officer at St. Mary's or

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1 Good Sam?

2 A. So she held more than just that role at
3 St. Mary's Medical Center. It would either have been
4 the ACNO or a different role. And I've forgotten which
5 department she was in at the time.

6 Q. And to ask it maybe a different way, in 2023
7 was she working at St. Mary's?

8 A. I don't really recall.

9 Q. Do you recall whether in or around April of
10 2023 in your capacity as the director of quality for
11 the Palm Beach Health Network you had an opinion about
12 whether or not the five Palm Beach Health Network
13 hospitals should be participating in the Leapfrog
14 survey?

15 A. I felt like we should.

16 Q. And why did you feel like you should?

17 A. So that we didn't leave any credit on the
18 table.

19 MS. BLAIR: Can you mark this one as 7?

20 (Defendant's Exhibit Number 7 for i.d.)

21 BY MS. BLAIR:

22 Q. Mrs. West, I'm handing you what we are now
23 marking as west Exhibit Number 7. It's another
24 calendar entry.

25 I apologize. It says here "From

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1 Regina West." It doesn't say who it's to.

2 It says, "You are the organizer. The
3 location will be at your office." And, again, the
4 subject is "Leapfrog work."

5 And the meeting is set for one hour on the
6 29th of January 2024. Do you have that document in
7 front of you?

8 A. I do.

9 Q. Do you have any recollection of what the
10 Leapfrog work meeting was about in January of 2024?

11 MR. TAKAGAKI: Objection.

12 A. In general, I put meeting invites on my
13 calendar with each piece of work that I do just to jog
14 my memory of when I'm working on stuff. It doesn't
15 mean that it's going to take an hour. Most of the time
16 I don't put notes in in terms of like what I'm
17 reviewing, what I'm looking at, so it appears that
18 sometime between 12:00 o'clock and 1:00 o'clock I
19 looked at some sort of Leapfrog document.

20 BY MS. BLAIR:

21 Q. Okay. And you would have scheduled yourself
22 that time to look at some sort of Leapfrog documents
23 prior to noon on January 29th, 2024, is that generally
24 how you operate?

25 A. It happens that way sometimes, but also

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1 retrospectively when I'm working on things, just to get
2 like an idea of how I've spent my time, I'll go back
3 and pencil it in.

4 Q. I should probably do that.

5 Do you have any recollection of what type of
6 Leapfrog work you would be doing in January of 2024?

7 A. I don't.

8 Q. And in January of 2024, none of the five
9 hospitals that are plaintiffs in this litigation were
10 participating in the Leapfrog Hospital Survey, correct?

11 A. Correct.

12 Q. Were you still regularly monitoring various
13 aspects of the five hospitals' quality performance that
14 are listed on the Leapfrog Hospital Survey even though
15 the hospitals weren't participating in the survey?

16 MR. TAKAGAKI: Objection to form.

17 A. Each time the numerical grade came out I
18 would do some sort of work with it, just a review and
19 an analysis.

20 BY MS. BLAIR:

21 Q. Okay. But to the best of your recollection,
22 do any of the Leapfrog grades, Hospital Safety Grades
23 come out in January of 2024?

24 A. No.

25 Q. Okay. But as you sit here today, you don't

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1 recall what kind of Leapfrog work you would have been
2 doing in January of 2024?

3 A. I'm sorry, I don't.

4 Q. That's all right.

5 A. Do you have a document that goes with this?

6 Q. I don't.

7 A. Okay.

8 MS. BLAIR: We'll do this one as 8.

9 (Defendant's Exhibit Number 8 for i.d.)

10 BY MS. BLAIR:

11 Q. Ms. West, I'm now handing you what we've
12 marked as west Exhibit 8, and this is an email from
13 Maureen Colandrea to you, CCing Maritza Ortiz and
14 Taylor Pool, and subject is "Leapfrog SAR benchmark
15 numbers for Good Samaritan."

16 Do you see that?

17 A. Yes.

18 Q. And who is -- well, I see at the bottom,
19 this Maureen Colandrea in or around March of 2024 was
20 the infection prevention nurse for Good Samaritan,
21 correct?

22 A. That's correct.

23 Q. And who was Maritza Ortiz?

24 A. She was another infection prevention nurse.

25 Q. And in March of 2024 did Taylor Pool work at

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1 Good Samaritan?

2 A. Yes, she did.

3 Q. And was she an infection prevention at
4 Good Samaritan in or around March of 2024?

5 A. She was the director of quality.

6 Q. That's right. Sorry.

7 And Maureen says to you and others, "Good
8 morning. Maritza, kindly provided me the following
9 numbers. See below. Please let me know if you have
10 any questions. Thanks, Maureen."

11 And then right underneath that in bold it
12 says, "The number of cases Good Samaritan can have in
13 order to meet Leapfrog benchmarks."

14 Do you see that?

15 A. Yes.

16 Q. Does this refresh your recollection in any
17 way that any of the five hospitals that make up the
18 Palm Beach Health Network were using the Leapfrog
19 standards as benchmarks?

20 MR. TAKAGAKI: Objection.

21 A. No.

22 BY MS. BLAIR:

23 Q. Do you know -- do you have any understanding
24 of what Maureen means when she says, "The number of
25 cases Good Samaritan can have in order to meet Leapfrog

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1 benchmarks"?

2 A. No, because she says infection type, number
3 of cases, CMS, current and projected."

4 Q. Correct.

5 A. I don't know.

6 Q. Do you recall any discussions you would have
7 had with the infection prevention nurses and/or
8 Taylor Pool, the director of quality at Good Samaritan,
9 in or around March of 2024 related to these infection
10 numbers that they're providing you?

11 MR. TAKAGAKI: Objection.

12 A. I don't recall anything specific.

13 BY MS. BLAIR:

14 Q. Looking at the numbers that Maureen is
15 reporting to you in this email, let's just take CLABSI.
16 And the CMS score is 1.45. Do you see that?

17 MR. TAKAGAKI: Objection.

18 A. I see it.

19 BY MS. BLAIR:

20 Q. Is that the CMS standard, to the best of
21 your recollection?

22 MR. TAKAGAKI: Objection.

23 A. I don't know.

24 BY MS. BLAIR:

25 Q. And I guess, generally speaking, looking at

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1 this chart that is in the kind of center of Exhibit 8,
2 is this the type of data that you're often provided by
3 hospitals from Palm Beach Health Network related to
4 HAIs?

5 MR. TAKAGAKI: Objection.

6 A. I was often provided number of cases for all
7 units. I don't recall the CMS column or what she was
8 referring to. It just says current 2024, so I don't
9 know if this was a rate of what she was referring to
10 here and then projected. It's just difficult to speak
11 to.

12 BY MS. BLAIR:

13 Q. Okay. And so as you sit here, you don't
14 know if that current and projected refers to the
15 Leapfrog benchmarks for that time period?

16 MR. TAKAGAKI: Objection.

17 A. It does not appear to.

18 BY MS. BLAIR:

19 Q. Okay. And why do you say it does not appear
20 to?

21 A. There is nothing outside of this statement
22 at the top that shows this is a Leapfrog benchmark.
23 There's nothing that would draw my attention here that
24 would help me understand that.

25 Q. Okay. And you don't have any specific

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1 recollection of any conversations you would have had
2 with anybody on this email regarding the statement that
3 number of cases Good Samaritan can have in order to
4 meet Leapfrog benchmarks, correct?

5 A. I just don't recall in the moment.

6 Q. We talked a little earlier, I think it's
7 Exhibits 1 and 2 I showed you about West Boca's
8 question in 2023 to participate in the Leapfrog
9 Hospital Survey. Do you recall the ultimate reason
10 that was given for why West Boca would not be allowed
11 to participate in the Leapfrog Hospital Survey in 2023?

12 A. It's related --

13 MR. TAKAGAKI: Objection.

14 A. It's related to one --

15 BY MS. BLAIR:

16 Q. Oh, I'm sorry. It's Exhibit 3. I
17 apologize. Thank you so much. It's Exhibits 3 and 4.

18 A. 3 and 4.

19 My recollection for this is and for each
20 time that I made the request and we didn't move forward
21 with it, it was so that we could focus on other work at
22 the time.

23 MS. BLAIR: I'll mark this one as 9. It's
24 3-hole punched.

25 (Defendant's Exhibit Number 9 for i.d.)

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1 BY MS. BLAIR:

2 Q. Ms. West, I'm providing you what we've now
3 marked as West Exhibit 9, which is an email from you to
4 Andrea Nunes, Heather Wehmeyer, Taylor Pool and
5 Kathleen McDonald CC'ing Ricardo Ramirez. The subject
6 is "CPOE response to EHR SAFER® survey."

7 Do you see that?

8 A. I do.

9 Q. What is the EHR SAFER® survey?

10 A. It is a survey we're required for each year
11 the hospitals are maintained in the EHR system to
12 maintain a SAFER® guide survey.

13 Q. Okay. And the SAFER® guide survey, is that
14 a regulatory survey?

15 A. Yes, it is.

16 Q. And what regulatory body requires the SAFER®
17 guide survey?

18 A. My understanding it's the Centers for
19 Medicare & Medicaid.

20 Q. So CMS?

21 A. Yes.

22 Q. And you write to this group of people and
23 you say, "Hi, everyone. Just wanted to alert you to a
24 corporate response regarding CPOE testing. If you are
25 planning to copy and paste corporate responses, please

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1 remove reference to Leapfrog."

2 Do you see that?

3 A. I do.

4 Q. What in or around April of 2024, what CPOE
5 testing was being performed by the five hospitals that
6 make up Palm Beach Health Network?

7 MR. TAKAGAKI: Objection.

8 A. We didn't have testing in place, so this
9 is -- I misspoke when I said "testing."

10 BY MS. BLAIR:

11 Q. Okay. And then you go on to say, "If you
12 are planning to copy and paste corporate responses,
13 please remove the reference to Leapfrog."

14 Do you see that?

15 A. Yes.

16 Q. What were the corporate responses that
17 you're referring to here?

18 A. Tenet did an independent review of our
19 system and made that available to us, and then each
20 director of quality was responsible to meet the
21 informaticist and someone within the IT of the hospital
22 that would have knowledge of the responses, determine
23 if they were the same for the hospital, if we should
24 made edits and how we would respond on our own, so
25 that's the process that we went through.

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1 Q. Okay. And so when you say that Tenet did
2 independent testing of all the systems, you mean that
3 Tenet did independent testing of each hospital CPOE
4 system?

5 A. Again, if I said "testing," then I am
6 misspeaking.

7 Q. Oh, that's okay. Oh, you did not. You did
8 not so let me correct my question.

9 I'm not good with all this technology.

10 You said, "Tenet did an independent review
11 of our system and made that available to us," correct?

12 A. Correct.

13 Q. Okay. To your knowledge, what was the
14 review that was done by Tenet of the CPOE system?

15 A. Well, one of the questions -- and I don't
16 recall all of the questions, but one of them is right
17 here in this email where it says "hardware and software
18 modifications and system/system interfaces are tested
19 pre and post to go live to ensure that data are not
20 lost or incorrectly displayed or transmitted within or
21 between EHR system components."

22 That would be one question.

23 And the corporate response included for
24 Leapfrog Group's evaluation tool which we were no
25 longer completing, so the request was, please remove

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1 that language.

2 Q. How often do you do this SAFER® guide
3 survey?

4 A. It's completed annually.

5 Q. Okay. And this is dated 2024, correct?

6 A. Correct.

7 Q. And by this point none of the five hospitals
8 had participated in the Leapfrog Hospital Survey for
9 three years; isn't that true?

10 A. Correct.

11 Q. And so had this response, this -- that you
12 just referred to, The Leapfrog Group's evaluation tool
13 for computerized physician order entry is used, had
14 that been in the SAFER® -- the EHR SAFER® survey since
15 2021?

16 MR. TAKAGAKI: Objection.

17 A. I don't know.

18 BY MS. BLAIR:

19 Q. So is it fair to say that 2021 to 2024 none
20 of the five hospitals were using The Leapfrog Group's
21 evaluation tool for computerized physician order entry?

22 MR. TAKAGAKI: Objection.

23 A. We were not.

24 BY MS. BLAIR:

25 Q. And when you say Tenet did an independent

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1 review of all of systems and provided that to you, how
2 did they -- in what form did they provide the findings
3 of their independent review to each hospital?

4 A. It's web based.

5 Q. And that was -- do you know what year that
6 Tenet did the independent review of the CPOE system?

7 MR. TAKAGAKI: Objection.

8 A. I don't know how long it went back, but
9 we -- we've done it annually since it's been required.

10 BY MS. BLAIR:

11 Q. And is that something that you provided to
12 your counsel for production in this matter?

13 A. I don't recall.

14 Q. Do you recall what the findings were of the
15 independent review by Tenet hospitals of the five
16 hospital CPOE systems that make up Palm Beach Health
17 Network in 2024?

18 MR. TAKAGAKI: Objection.

19 A. Let me clarify again.

20 BY MS. BLAIR:

21 Q. Sure.

22 A. Tenet completes it for the entire Tenet
23 system. And then each hospital within the Palm Beach
24 Health Network was required to do an independent
25 review, so we could consider corporate responses,

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1 consider if those matched what actually was happening
2 in our hospitals or if we needed to make edits or
3 modifications to our responses, so this request to
4 remove was a request to modify our response back in
5 terms of our SAFER® EHR review.

6 Q. Okay. And so with respect to the five
7 hospitals that did their independent review, in
8 response to the EHR SAFER® survey, four years, '21,
9 '22, '23, prior to 2024, did the response for each of
10 these five hospitals say The Leapfrog Group evaluation
11 tool for CPOE is used to access point of care CDS
12 intervention, is that how that worked?

13 MR. TAKAGAKI: Objection.

14 A. I don't recall.

15 BY MS. BLAIR:

16 Q. Okay. And so there is an EHR SAFER® survey
17 that is done annually by each independent hospital that
18 makes up the Palm Beach Health Network?

19 A. Yes.

20 Q. And --

21 A. Can I clarify real fast?

22 Q. Yes, please.

23 A. In the last year that I completed it I was
24 able to complete it in 2025 for the market because
25 we're all on the same computer, what's called a hub, so

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1 in order to make modifications in that hub, all five
2 hospitals would have to agree to it, so technically all
3 of those would be same.

4 So once it was completed, then that went out
5 to the hospitals to review to see if any modifications
6 needed to be made.

7 Q. Okay.

8 A. But I did complete it for the market this
9 last year.

10 Q. So that was for 2025, correct?

11 A. Correct.

12 Q. But if we're talking about 2024, 2023, that
13 would have been each individual hospital, correct?

14 A. Prior to me completing it this year --

15 Q. Correct.

16 A. -- each individual hospital would have done
17 that.

18 Q. And do you know how each individual hospital
19 tested the operational ability of their CPOE testing --

20 Or I'm sorry. That's a terrible question?

21 Prior -- I don't want to talk about 2025.

22 Let's just stick with 2024 when this email is dated.

23 Do you know how each individual hospital associated
24 with the Palm Beach Health Network reviewed its CPOE
25 system in order to answer this particular question on

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1 the SAFER® survey?

2 A. At a high level, each director of quality
3 was responsible for coordinating that for the hospital,
4 and each director of quality would have collaborated
5 within the hospital with either the clinical
6 informaticist, an IT representative. But at least as a
7 group to review the responses and determine if we
8 wanted to make edits, add, take away, like this one is
9 taking away.

10 Q. And do you know whether or not CMS makes the
11 results of the EHR surfer -- oh, my gosh -- EHR SAFER®
12 survey available to the public?

13 A. I don't know.

14 Q. Ultimately the hospitals all received grades
15 for spring of 2024 from the Leapfrog Hospital Safety
16 Grade, correct?

17 A. Yes.

18 Q. Do you recall what the grades were for the
19 five hospitals in the spring of 2025?

20 A. Not off the top of my head.

21 Q. Do you recall that Delray was already a D in
22 the spring of 2024?

23 A. Not off the top of my head.

24 Q. Is that something as the director of quality
25 you would have known at least at that time?

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1 A. Yes.

2 Q. And would the hospitals have provided you
3 with their Leapfrog hospital safety scores when they
4 came out in the spring of 2024?

5 A. Yes.

6 Q. And, again, we talked about this earlier,
7 but would you have provided those scores to
8 Bonnie Nukala of Tenet home office in or around when
9 those grades came out in spring of 2024?

10 A. I didn't provide them all. Each director of
11 quality would have provided that.

12 Q. As the director of quality for Palm Beach
13 Health Network, would it have been your expectation
14 that each quality director for each of the five
15 hospitals provided their spring 2024 hospital safety
16 grade to Bonnie in or around that time?

17 A. Yes.

18 Q. Are you aware that prior to any methodology
19 change Leapfrog puts out for public comments the
20 methodology changes that it's contemplating?

21 A. Yes.

22 Q. And during your time as the -- well, at any
23 time in your career, let's just say, because you've
24 always been in quality, have you ever had -- have you
25 ever commented during the Leapfrog public comment

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1 period on any methodology changes that Leapfrog has
2 proposed?

3 A. Not to my knowledge.

4 Q. And that would include with respect to the
5 methodology change that was proposed for fall of 2024,
6 correct?

7 A. Correct.

8 MS. BLAIR: We can mark this as 10?

9 THE VIDEOGRAPHER: And I'm sorry to
10 interrupt, Counsel.

11 MS. BLAIR: Yeah, sure.

12 THE VIDEOGRAPHER: I need to change media.

13 MS. BLAIR: Sure, go ahead.

14 THE VIDEOGRAPHER: We're going off the
15 record 2:15.

16 (A recess was taken from 2:16 p.m. to 2:17 p.m.)

17 THE VIDEOGRAPHER: This is media unit number
18 three. The time is 2:18. We're back on the
19 record.

20 (Defendant's Exhibit Number 10 for i.d.)

21 BY MS. BLAIR:

22 Q. Ms. West, I've now handed you what we've
23 marked as west Exhibit 10 for this deposition.

24 As you will see, this is an email from
25 Andrea Nunes to you and Ricky Ramirez dated May 21st,

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1 2024. Do you see that?

2 A. I do.

3 Q. And for timing sake, do you understand that
4 the spring Leapfrog Hospital Safety Grades come out in
5 April every year?

6 A. Yes.

7 Q. So this would have been approximately a
8 little less than a month after the Leapfrog spring
9 safety grade came out, correct?

10 A. Correct.

11 Q. And Andrea Nunes, again, is the -- we talked
12 about her a lot -- the director of clinical quality
13 improvement for West Boca, correct?

14 A. Correct.

15 Q. And she says to you and Mr. Ramirez, and the
16 subject line -- well, let's just say this. The subject
17 line of this email is "Review planned updates to the
18 fall 2024 hospital safety grade."

19 Do you see that?

20 A. I do.

21 Q. Okay. And she says to you, "Leapfrog is
22 revising their scoring methodology, and this will
23 affect those hospitals who have not submitted a survey.
24 It is" -- it says, "it a hospital, does not submit
25 survey for two cycles, then the new imputation

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1 methodology is utilized."

2 Do you see that?

3 A. Yes.

4 Q. And taking a look at what she copies on this
5 page, is this your understanding of what the new
6 imputation model was going to be for nonreporting
7 hospitals for the fall of 2024?

8 A. Yes.

9 Q. And do you recall any conversations you had
10 with anyone after you received this email from
11 Andrea Nunes in or around May of 2024?

12 MR. TAKAGAKI: Objection.

13 A. Broadly speaking, I recall having
14 conversations about something to refer to. I wouldn't
15 be able to give the details right now.

16 BY MS. BLAIR:

17 Q. Do you recall what your opinion was when you
18 first heard about the changes that were going to occur
19 to the Leapfrog Hospital Safety Grade methodology for
20 the fall of 2024?

21 A. Could you repeat that, please?

22 Q. Sure. So I don't want to know about
23 conversations at this appointment.

24 Like do you recall what your reaction was
25 when you first came to learn about the changes that

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1 were going to occur for fall of 2024 to the Leapfrog
2 Hospital Safety Grade?

3 A. Yes, my opinion was that it was pretty scary
4 for hospitals.

5 Q. And why did you believe it was pretty scary
6 for hospitals?

7 A. Because these imputed scores could
8 potentially hurt hospitals' reputations and hurt it in
9 a way that didn't accurately represent the hospital,
10 and it could be misleading to the public.

11 Q. Do you recall having that conversation about
12 your reaction to this methodology change with anybody
13 associated with the Palm Beach Health Network in or
14 around the spring or summer of 2024?

15 A. I don't remember the details around it.

16 Q. Do you recall generally who you talked to
17 about the change in methodology in or around the spring
18 or summer of 2024?

19 A. Generally speaking, it would have been to
20 CEOs, CNOs and directors of quality.

21 Q. And do you recall any specific -- let's just
22 start with the CEOs. So this would be, I want to talk
23 about the time frame from when you received this email
24 from Andrea Nunes and when the fall safety grades came
25 out on November 20th of 2024, so that kind of spring,

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1 summer, early fall time period.

2 Do you recall any conversations you had with
3 CEOs regarding the methodology change?

4 A. I don't recall right now, but if you have
5 something to show me...

6 Q. Do you have any memory of conversations you
7 had with chief nursing officers between May of 2024 and
8 the release of the fall 2024 safety grades off the top
9 of your head?

10 A. Off the top of my head, I do not recall.

11 Q. And same question with respect to directors
12 of quality. Between that May 2024 time frame and the
13 release of the fall 2024 safety grades on
14 November 20th, 2024, do you recall any specific
15 conversations with chief nursing officers about the
16 change in Leapfrog methodology?

17 A. I don't recall the specifics.

18 Q. Do you recall generally what the reaction
19 was from those stakeholders with respect to the change
20 in the Leapfrog methodology for fall of 2024?

21 A. Yes.

22 MR. TAKAGAKI: Objection.

23 BY MS. BLAIR:

24 Q. What do you recall generally what the
25 reaction was to this methodology change?

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1 A. I recall that there was concern over how it
2 would be published and how we would be portrayed.

3 Q. And when you talk about "how it would be
4 published," what are you referring to?

5 A. Referring to Leapfrog and potentially the
6 media.

7 Q. And when you say "portrayed," what do you
8 mean when you use that word?

9 A. Imputed scoring that potentially moved a
10 hospital down a grade or two doesn't accurately show
11 the quality of care that the hospital is providing.
12 It's not an accurate representative of the services or
13 the quality.

14 Q. Is it your opinion that a more accurate
15 representative would be a scoring methodology that
16 relied on just the CMS data?

17 MR. TAKAGAKI: Objection.

18 A. No, not necessarily because we already have
19 CMS data. My opinion about it is that hospitals that
20 don't participate should not be included. It's a
21 voluntary program, and my opinion is that the hospital
22 should be removed if they're not participating.

23 BY MS. BLAIR:

24 Q. My question is just a little different.

25 A. Okay.

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1 Q. Let's say we took all of the measures that
2 are used to calculate this hospital safety grades that
3 come from the survey, and the hospital safety grade is
4 now based solely on CMS data. Would you have an issue
5 with the methodology that scored or gave hospitals a
6 safety grade based on the measures that come from CMS?

7 MR. TAKAGAKI: Objection.

8 A. I guess personally I just don't understand
9 duplication for that.

10 BY MS. BLAIR:

11 Q. You don't understand the? I'm sorry. I
12 didn't hear you.

13 A. The duplication. Why would Leapfrog take
14 information from CMS to give hospitals a grade?

15 Q. Well, you would agree with me that CMS
16 already provides a star rating for hospitals, correct?

17 A. Correct.

18 Q. And do you know what the star ratings are of
19 the five -- the CMS star ratings are currently for the
20 five hospitals that are plaintiffs in this litigation?

21 A. So I can't repeat them to you today, but,
22 yes, I've seen them.

23 Q. And would you agree with me that they're one
24 and two stars?

25 A. Yes.

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1 Q. And with five stars being the best, correct?

2 A. Correct.

3 Q. And would you agree with me that CMS, the
4 measures that go into that star rating include a whole
5 host of things in addition to what Leapfrog uses as CMS
6 measures to calculate its safety grade?

7 MR. TAKAGAKI: Objection.

8 A. Let's say they're very different.

9 BY MS. BLAIR:

10 Q. They are very different, right. So I'm just
11 curious how -- is it your position the CMS star rating
12 is just a duplication of the Leapfrog grade?

13 A. No.

14 MR. TAKAGAKI: Objection.

15 A. And I guess what I was trying to say I would
16 really just see your model in order to have an opinion
17 about it.

18 BY MS. BLAIR:

19 Q. Okay.

20 A. If the model is moving from just CMS
21 measures and they're moving into a Leapfrog system, how
22 that would produce a grade.

23 Q. Okay.

24 A. And I guess I don't understand why Leapfrog
25 would do that if they're already reported through CMS.

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1 I guess I don't understand what the -- what the
2 rationale would be for it.

3 Q. Will you agree with me that CMS does not
4 create any sort of grade or star rating based on the
5 CMS measures that Leapfrog looks at for patient safety,
6 just on those measures, correct?

7 MR. TAKAGAKI: Objection.

8 A. Could you repeat it, please?

9 BY MS. BLAIR:

10 Q. Yes. So CMS, the CMS issues the star
11 rating, the overall CMS star rating. You're familiar
12 with that, correct?

13 A. Yes.

14 Q. And the CMS overall star rating contains
15 several different measures that CMS looks at to come to
16 that star rating, correct?

17 A. Yes.

18 Q. And of all of those measures that look at,
19 that CMS looks at to come to that star rating, there
20 are several that are not patient safety measures that
21 Leapfrog looks at when it's looking at its hospital
22 safety grade. Would you agree with that?

23 MR. TAKAGAKI: Objection.

24 A. I don't know that I would categorize it as
25 not patient safety. I'd just have to look at them one

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1 by one.

2 BY MS. BLAIR:

3 Q. Do you understand that in coming to the
4 conclusion as to what measures Leapfrog considers in
5 its hospital safety grade, it consults with an expert
6 panel?

7 A. Yes, I'm aware.

8 Q. And do you understand that that expert panel
9 has not taken the position that every measure that CMS
10 looks at should also be a measure that Leapfrog looks
11 at for patient safety?

12 A. Yes.

13 MR. TAKAGAKI: Objection. You're asking her
14 her knowledge of what Leapfrog's expert panel
15 talks about in its meetings and considers?

16 MS. BLAIR: Yeah, I'm asking her questions.

17 BY MS. BLAIR:

18 Q. And, ma'am, so you use the word
19 "duplication," and I'm trying to get at what you meant
20 by "duplication."

21 And so I understand that CMS measures that
22 go into the overall CMS star rating are not the same,
23 are not one to one with the measures that Leapfrog
24 looks at for its rating. Do you understand that to be
25 the case?

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1 MR. TAKAGAKI: Objection.

2 A. I would really need to see them side by side
3 in terms of patient satisfaction, how are they similar,
4 how are they different. CAUTI, CLABSI, C. diff, MRSA,
5 how is it same; how is it different; how would Leapfrog
6 take that information. If all of the measures and --
7 if that's what you suggested, right? All CMS measures
8 and Leapfrog would give them a grade?

9 Q. Yeah, I'm not suggesting anything. I'm just
10 trying to figure out what you meant when you used the
11 word "duplication."

12 A. Duplication. I understood you to say, ask
13 me about Leapfrog taking all of the CMS measures,
14 putting them into the Leapfrog system and producing a
15 grade from there. And I didn't understand the, you
16 know, the idea of the duplication of that.

17 Q. Understood. Okay. So let's go through
18 this.

19 We talked before that there are 22 measures,
20 right, that the Leapfrog Hospital Survey grades on?

21 A. Yes.

22 Q. And we talked about the ten outcome
23 measures. Do you recall that?

24 A. Yes.

25 Q. And those ten outcome measures, the data

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1 that Leapfrog uses comes from CMS, do you understand
2 that?

3 A. I do.

4 Q. And then of the twelve process measures,
5 five of those come from CMS data, do you understand
6 that?

7 A. Yes.

8 Q. And the other seven come from the Leapfrog
9 Hospital Safety Grade, correct?

10 A. Correct.

11 Q. And so I'm asking if we took out those seven
12 measures, we, being Leapfrog, and the grade simply
13 consisted of the 15 measures that come from CMS data --
14 and I'm sorry I was unclear -- that come from CMS data,
15 would it be your opinion that that would be a more
16 accurate representation of a hospital's safety?

17 MR. TAKAGAKI: Objection. Incomplete
18 hypothetical. Vague. Calls for speculation.
19 Lack of foundation.

20 A. I would really need to see it because I -- I
21 don't know what the weighting would be. I don't know
22 what the final grade would be. There's just so many
23 variables that just a hypothetical doesn't get into.

24 BY MS. BLAIR:

25 Q. Okay. And so I'm just trying to make sure.

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1 Your issue with the change in the fall 2024 Leapfrog
2 methodology, was it with just the imputation method, or
3 do you have other issues with the fall 2024
4 methodology?

5 MR. TAKAGAKI: Objection.

6 A. My opinion --

7 BY MS. BLAIR:

8 Q. Yeah.

9 A. -- is that it further hurt hospitals and
10 hurt their reputation because the information that I've
11 received is that we started losing patients because of
12 that. We started, you know, having physicians state
13 that they didn't want to come to our hospitals. We
14 have excellent hospitals. We have level I trauma
15 centers. You know, we have -- we have pediatric -- we
16 have a pediatric hospital. We provide great care, and
17 to have that in the media as part of our reputation is
18 very hurtful.

19 BY MS. BLAIR:

20 Q. And what was the -- you used the word "it,"
21 and I want to make sure we understand. You said, "My
22 opinion is that it further hurt hospitals..." And I
23 want to know, what do you -- what is the "it"?

24 A. The change in the scoring methodology and
25 change in the grades.

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1 Q. Okay. And my question was, is your issue
2 with the change in the methodology related to the new
3 imputation model for these four measures, BCMA -- BCMA,
4 CPOE, hand hygiene and ICU physician staffing?

5 A. It didn't help. If I were able to give a
6 recommendation, I would recommend for any hospital not
7 participating in the Leapfrog survey not be included.

8 Q. And in what way would any consumer -- let me
9 ask you this.

10 Do you think consumers deserve to be
11 provided with transparent information related to a
12 hospital's patient safety?

13 MR. TAKAGAKI: Objection.

14 A. Yes, I do.

15 BY MS. BLAIR:

16 Q. And do you believe that consumers are --
17 should be provided with transparent information with
18 respect to a hospital's HAIs, for example?

19 MR. TAKAGAKI: Objection.

20 A. Yes, I do.

21 BY MS. BLAIR:

22 Q. And do you believe that patients should be
23 provided with transparent information regarding whether
24 or not a hospital's CPOE system is functioning
25 properly?

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1 MR. TAKAGAKI: Objection.

2 A. I don't have an opinion about that.

3 BY MS. BLAIR:

4 Q. Okay. And why don't you have opinion about
5 the CPOE system?

6 MR. TAKAGAKI: Objection.

7 A. If I understood your question correctly, it
8 was whether or not the community or the public should
9 be provided the information, so I don't really have an
10 opinion about that.

11 I know from the way that we're surveyed that
12 that they're looking at this when we're surveyed
13 multiple times to make sure that we have an appropriate
14 system in place, that we're utilizing it correctly,
15 we're collecting data, we're providing information,
16 that we are transparent. So I don't know that I can
17 say --

18 Q. Well, when you say you're surveyed --

19 MR. TAKAGAKI: Well, let her -- was she
20 done answering?

21 BY MS. BLAIR:

22 Q. Oh, I'm sorry. Were you done answering?

23 A. It's fine.

24 Q. I didn't mean to cut you off. Are you done
25 answering?

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1 A. I'll be finished.

2 Q. When you say "when we are surveyed," are you
3 referring to the SAFER® survey?

4 A. I'm referring to like the Joint Commission
5 surveys, the agency on healthcare administration, the
6 AHCA, AHCA.

7 Q. AHCA.

8 A. That's where we're validated.

9 Q. And I understand that, but I thought you
10 told me earlier that the Joint Commission doesn't
11 provide any actual data to consumers on CPOE.

12 MR. TAKAGAKI: Objection.

13 A. That's correct.

14 BY MS. BLAIR:

15 Q. AHCA does, however, as I understand your
16 previous testimony, correct?

17 A. Yes.

18 Q. In what way do you understand that AHCA
19 provides transparent publicly available data to
20 consumers about the CPOE system of a hospital?

21 A. They make the survey results public.

22 Q. And then with respect to hand hygiene, does
23 the Joint Commission make its findings on hand hygiene
24 public to consumers?

25 A. No.

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1 Q. Do you think it's important that patients
2 have transparent information related to a hospital's
3 commitment to hand hygiene?

4 MR. TAKAGAKI: Objection. Vague.

5 A. Yes.

6 BY MS. BLAIR:

7 Q. Are you aware of any publicly available data
8 through any source that gives consumers publicly
9 available and transparent data related to a hospital's
10 hand hygiene?

11 A. Yes.

12 Q. And what is that?

13 A. It's my understanding that AHCA makes their
14 surveys available to the public. We were surveyed
15 extensively just at the beginning of this year.
16 Hand hygiene was a huge component of that.

17 Q. And HCA -- AHCA is specific to Florida,
18 correct?

19 A. Correct.

20 Q. Other than AHCA, is there any other publicly
21 available data for a hospital that you know of related
22 to hand hygiene?

23 A. Not that I recall right now.

24 Q. Do you know if there's any -- do you believe
25 that the public is entitled to have transparent

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1 information about a hospital's ICU physician staffing?

2 MR. TAKAGAKI: Objection.

3 A. I don't have an opinion about that.

4 BY MS. BLAIR:

5 Q. And why don't you have an opinion about
6 that?

7 MR. TAKAGAKI: Objection.

8 A. I don't have one.

9 BY MS. BLAIR:

10 Q. Okay. Do you have an opinion about whether
11 or not consumers deserve to have transparent
12 information related to barcode medication
13 administration errors at hospitals?

14 MR. TAKAGAKI: Objection.

15 A. May I ask a clarifying question?

16 BY MS. BLAIR:

17 Q. Sure.

18 A. When you say "transparent data," do you mean
19 hospitals that report to Leapfrog, or do you mean
20 hospitals that have been validated after they've
21 reported through Leapfrog?

22 Q. I'm not --

23 A. When we're talking transparency, is it only
24 the information that's been reported, or is it
25 information that's been validated?

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1 Q. This question has nothing to do with
2 Leapfrog. I'm asking in general do you believe that
3 patients deserve to have transparent data related to
4 errors resulting from barcode medication
5 administration?

6 MR. TAKAGAKI: Objection. Vague.
7 Incomplete hypothetical.

8 A. Yes.

9 BY MS. BLAIR:

10 Q. And I think you told me earlier that the
11 Joint Commission does some surveying, correct, of
12 barcode administration for hospitals, correct?

13 A. Correct.

14 Q. Do you know if the Joint Commission makes
15 that, their findings for each hospital publicly
16 available to consumers?

17 A. Not to my knowledge. But AHCA --

18 Q. I was just going to ask you, does AHCA make
19 their findings related to barcode administration
20 available to consumers?

21 A. Yes, to my knowledge.

22 Q. And, again, AHCA is only with respect to
23 Florida hospitals, correct?

24 A. Correct.

25 Q. Do you have an understanding that prior to

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1 the --

2 MS. BLAIR: Well, actually can we take a
3 quick break?

4 MR. TAKAGAKI: Sure.

5 MS. BLAIR: Yeah, sorry.

6 THE VIDEOGRAPHER: Off the record 2:41.

7 (A recess was taken from 2:41 p.m. to 2:56 p.m.)

8 THE VIDEOGRAPHER: Back on the record 2:56.

9 BY MS. BLAIR:

10 Q. Ms. West, I want to take you back to that
11 May 2024 time frame when you first are told, I think
12 it's the last Exhibit we looked at, when you were first
13 told that there's going to be a change to the Leapfrog
14 methodology. Did you have an opinion at that point in
15 time as to whether or not the five hospitals that make
16 up the Palm Beach Health Network should participate in
17 the Leapfrog Hospital Survey?

18 A. Yes.

19 Q. And what was your opinion?

20 A. I felt like we should participate.

21 Q. I'm sorry. Your answer was, yes, you felt
22 like you should?

23 A. Correct.

24 Q. And why?

25 A. To avoid negative press and damage to the

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1 hospitals' reputation.

2 Q. Did you have any discussions with anyone in
3 public relations for the Palm Beach Health Network in
4 or around this, you know, May 2024 through summer 2024
5 time frame about potential negative press related to
6 the Leapfrog methodology change?

7 A. I don't recall.

8 Q. Do you recall any communications you would
9 have had with Ricky Ramirez regarding potentially
10 negative press related to the 2024 -- fall of 2024
11 methodology change on the Leapfrog Hospital Safety
12 Grade?

13 A. Yes.

14 Q. What do you recall about the conversations
15 you had with Ricky Ramirez?

16 A. We had email communication, and I recall
17 that negative press had already come out at that time.

18 Q. And I want to reorient you.

19 A. Okay.

20 Q. I'm talking about before the grades come
21 out.

22 A. Before the grades come out? If you have
23 anything you can show me.

24 Q. Sure, we can go over some documents.

25 A. Okay.

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1 Q. I just want to know, do you recall like
2 Ricky Ramirez's reaction to the methodology change?

3 A. Not specifically, but I'm happy to look at a
4 document.

5 Q. I don't know if I have any on that regard,
6 but we'll show you some documents.

7 Do you recall whether or not you had any
8 conversation with Maggie Gill between May of 2024 and
9 when the hospital safety grades came out about
10 potential negative publicity as a result of the
11 hospital -- I'm sorry -- as a result of the methodology
12 change in the hospital safety grade scoring by
13 Leapfrog?

14 MR. TAKAGAKI: Objection.

15 And when you say "when the grades came out,"
16 you mean the November '24 grades?

17 MS. BLAIR: The November 2024 Hospital
18 Safety Grades.

19 A. I do not remember exact time frames for
20 discussions.

21 BY MS. BLAIR:

22 Q. Okay. And I'm just trying to get a sense of
23 you get this email that we've marked as Exhibit 10,
24 right, that's in front of you?

25 A. Yes.

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1 Q. And that's May of 2024. And there is
2 clearly a discussion, at least with respect to
3 Ms. Nunes, where she's alerting you to the fact that
4 this methodology change is coming, correct?

5 A. Correct.

6 Q. And do you recall -- you know, you've told
7 me what your reaction is. Do you recall whether your
8 reaction to that was in or around the same time that
9 you were informed of the methodology change?

10 A. I don't recall.

11 Q. And do you recall that this methodology
12 change was put out for public comments by Leapfrog
13 asking hospitals and others to comment as to whether or
14 not they supported the methodology change or not?

15 A. Yes, I do.

16 Q. Did you as the director of quality for
17 Palm Beach Health Network follow any of the public
18 comment that was being given to Leapfrog with respect
19 to the proposed fall 2024 methodology change?

20 A. I did not.

21 Q. Did you have any conversations with anybody
22 at the Palm Beach Health Network about whether or not
23 any of the five hospitals or the Palm Beach Health
24 Network itself should make a public comment with
25 respect to this methodology change?

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1 A. It's so broad. And, again, I'm happy to
2 look at any document that you have and then comment on
3 that.

4 Q. Sure, my understanding --

5 A. But --

6 Q. I don't mean to cut you off.

7 MR. TAKAGAKI: I was going to say, finish
8 your answer.

9 BY MS. BLAIR:

10 Q. Yes, finish your answer. I didn't mean to
11 cut you off.

12 A. It's okay.

13 Q. I understand from the interrogatory answers
14 that have been provided in this case that there was no
15 communication between any of these five hospitals and
16 Leapfrog related to the public comment period for this
17 methodology change.

18 And so I'm asking you, is that consistent
19 with your understanding?

20 A. Yes, it is.

21 MR. TAKAGAKI: Objection. Lack of
22 foundation.

23 BY MS. BLAIR:

24 Q. And so even though there was no public
25 comment -- even though none of the five hospitals

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1 publicly commented to Leapfrog regarding the
2 methodology change, do you recall whether there was any
3 discussions internally about whether you should
4 publicly comment on the methodology change?

5 A. Yes, I do.

6 Q. Okay. And what do you recall about those
7 conversations?

8 A. I recall an email thread -- again, I don't
9 know what the time frame is -- where a question was
10 posed as to whether or not we were going to comment,
11 and I responded that we were not going to comment.

12 Q. Okay. And what was the basis for your
13 position that "we're not going to comment"?

14 A. Generally we don't comment at a local level
15 hospital to hospital. We work through Tenet Healthcare
16 system to make any type of comment that would be public
17 in nature.

18 Q. Do you recall whether or not you reached out
19 to anyone at Tenet health system about commenting on
20 the Leapfrog methodology change that was proposed for
21 fall of 2024?

22 A. I don't recall.

23 Q. Do you recall whether you had any
24 conversations with Maggie Gill about your opinions
25 about whether Tenet health system should comment

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1 publicly with respect to the proposed methodology
2 change by Leapfrog for fall of 2024?

3 A. I do not recall.

4 Q. Do you recall whether or not any of the
5 directors of quality for any of the five hospitals
6 provided their opinion to you about whether or not the
7 hospitals should publicly comment about the methodology
8 change?

9 A. No, I don't recall.

10 MS. BLAIR: We'll mark this as Number 11.

11 (Defendant's Exhibit Number 11 for i.d.)

12 BY MS. BLAIR:

13 Q. Ms. West, I'm now handing you what we've
14 marked Exhibit Number 11 to your deposition. This is
15 an email from you to Anna Gunod, G-u-n-o-d, CC'ing
16 Andrea Nunes, Heather Wehmeyer, Kathleen McDonald and
17 Taylor Pool dated September 25th, 2024. And the
18 subject is "Leapfrog."

19 Do you see that?

20 A. I do.

21 Q. And the first sentence from you it says, "If
22 we would like to participate in the next survey, are we
23 able?"

24 Do you see that?

25 A. I do.

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1 Q. And are you aware of whether there were any
2 conversations between May of 2024 in Exhibit 10 and
3 this Exhibit 11 which is September of 2024 between you
4 and any of the directors of quality about participating
5 in the next Leapfrog Hospital Survey?

6 A. That's so broad, and sitting here today, I'm
7 not able to recall that right now, but I'm able to
8 comment on any document you may have.

9 Q. Okay. So but this says, "If we would like
10 to participate," and it's CC'd to the quality
11 directors, and so I'm just wondering if that refreshes
12 your recollection as you look at this document as to
13 whether there was a request on behalf of not only
14 yourself but all the directors of quality for the five
15 hospitals that make up Palm Beach Health Network?

16 A. That would be correct.

17 Q. And does this, this document, and I
18 understand you have no specific recollection, and it's
19 not a guessing game, but does this document in any way
20 refresh your recollection about what those
21 conversations would have been?

22 A. Could you further clarify "conversations"?

23 Q. Sure. Do you recall any one of the quality
24 directors of any of the five hospitals that make up
25 Palm Beach Health Network objecting to participating in

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1 a Leapfrog Hospital Survey going forward?

2 A. I don't recall that.

3 Q. Do you recall any of the five directors of
4 quality for the five hospitals that make up Palm Beach
5 Health Network telling you that they would have to hire
6 additional staff in order to participate in the
7 Leapfrog Hospital Survey?

8 A. I do not remember that for this period. I
9 do remember that for the prior period. And it was
10 something that came up during the initial conversation.
11 And one of the decisions, one of the reasons that we
12 decided not to participate was how much time we were
13 spending just on Leapfrog, the survey response,
14 gathering the data, collecting it, putting it in usable
15 format to get it to where we could enter it and those
16 other duties were falling to the side. So I remember
17 that being a component early on. I do not remember
18 that being a component during this time period.

19 Q. And just for my record when you say "a
20 component early on," are you referring to that
21 conversation we had back in -- that you and I had about
22 back in 2021 when the design was made to stop during
23 the survey?

24 A. That is correct.

25 MR. TAKAGAKI: Objection.

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1 BY MS. BLAIR:

2 Q. Do you recall any conversations between that
3 time in 2021 and this email in September of 2025 [sic]
4 where there was a discussion to potentially restart
5 participation in the Leapfrog Hospital Survey where the
6 issue of having to add additional staff was discussed?

7 MR. TAKAGAKI: Objection.

8 A. I don't recall that.

9 MR. TAKAGAKI: And I think you referred to
10 this email as "2025."

11 MS. BLAIR: Oh, I meant "2024."

12 MR. TAKAGAKI: I think you meant 2024.

13 MS. BLAIR: I meant September 25, 2024.

14 Thank you very much.

15 BY MS. BLAIR:

16 Q. If we look at this email the second sentence
17 from you, you said, "We have done this in the past so
18 it would not be new participation."

19 Do you see that?

20 A. I do.

21 Q. Are you referring to the fact that you had
22 participated back in 2021?

23 A. Correct.

24 Q. And then you say, "This takes SMMC" -- is
25 that St. Mary's?

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1 A. It is.

2 Q. -- "from 100 points in each of the
3 categories below to limited achievement scores."

4 Do you see that?

5 A. I do.

6 Q. Does this refresh your recollection that the
7 five hospitals who were not participating in the
8 Leapfrog Hospital Survey were receiving 100 out of
9 100 points for the imputed measures prior to fall of
10 2024?

11 A. Yes.

12 Q. And you were going to go from 100 points to,
13 if we look at this like chart in the middle of the
14 page, these were going to be the limited achievement
15 points that were going to be awarded to
16 nonparticipating hospitals for these four hospitals --
17 I'm sorry -- five hospitals under the limited
18 achievement category for the fall 2024 methodology,
19 correct?

20 A. Correct.

21 Q. And then you say, "We will likely decrease
22 an entire letter and score a D this time around."

23 Do you see that?

24 A. Yes.

25 Q. And when you say "we," are you referring to

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1 St. Mary's there?

2 A. Yes.

3 Q. Because Delray was already a D, correct?

4 A. I would --

5 MR. TAKAGAKI: Objection.

6 A. I would have to look at a document.

7 BY MS. BLAIR:

8 Q. Okay. Do you -- is it your belief that if a
9 hospital under the fall of 2024 methodology, if a
10 hospital does not participate in the Leapfrog Hospital
11 Survey, they automatically receive a D or an F?

12 A. No.

13 Q. And if you look at this document, if we go
14 to the bottom of the second page, there's an email that
15 starts from Anna Gunod to DLDCQI only. Do you see
16 that?

17 A. Yes.

18 Q. Would you be -- have been part of the DLDCQI
19 only group?

20 A. Yes.

21 Q. And she says here, "Good morning quality
22 leaders. I'm doing an annual check-in on Leapfrog
23 participation."

24 Do you see that?

25 A. I do.

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1 Q. Is this similar to what we were discussing
2 earlier this morning about the fact that Tenet home
3 office checked in regularly about participation on the
4 Leapfrog Hospital Safety Grade?

5 MR. TAKAGAKI: Objection.

6 A. This is a different check-in.

7 BY MS. BLAIR:

8 Q. Okay. And what is this check-in?

9 A. This is an independent check-in by
10 Anna Gunod.

11 Q. And she's checking in with respect to
12 Leapfrog participation in the hospital survey?

13 A. That is correct.

14 Q. And was it your understanding in or around
15 this time, which is September of 2024, that no
16 hospitals of Tenet were participating in a Leapfrog
17 Hospital Survey system wide?

18 MR. TAKAGAKI: Objection.

19 A. I didn't have an understanding of that.

20 BY MS. BLAIR:

21 Q. And if we look back at Exhibit 3, which is
22 an Exhibit from Andrea Nunes, you see here she says in
23 the second to last paragraph, "I do know that
24 Christen Mayer stated we would not participate as a
25 system in 2023."

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1 Do you see that?

2 A. I do.

3 Q. Was Andrea mistaken about whether or not
4 Tenet as a system was going to participate in the
5 hospital survey in 2023?

6 MR. TAKAGAKI: Objection.

7 A. I don't recall.

8 BY MS. BLAIR:

9 Q. Okay. And Christen Mayer that we discussed
10 was the national director of --

11 A. Quality.

12 Q. -- quality, correct?

13 A. Correct.

14 Q. And so when Anna Gunod, who is the national
15 director of infection prevention in our Exhibit 11, is
16 doing a different annual check-in, did you have any
17 understanding in or around this time, September of
18 2024, as to whether any hospitals in the Tenet system
19 were participating in the Leapfrog Hospital Survey?

20 A. I didn't have a sense.

21 Q. And then if we go back to the second page of
22 this email, you write, "The hospitals in PBHN are not
23 participating," correct?

24 A. Correct.

25 Q. And that's based on what we had talked about

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1 earlier this morning that in 2021 a decision was made
2 by the five hospitals to stop participating in the
3 Leapfrog Hospital Survey due to the large amount of
4 resources it took to comply, correct?

5 A. Yes.

6 MR. TAKAGAKI: Objection.

7 BY MS. BLAIR:

8 Q. And that email we just looked at,
9 Exhibit 11, do you recall -- you said "If we would like
10 to participate in the next survey, are we able?"

11 Do you recall whether Anna Gunod got back to
12 you or not?

13 A. Yes, I do.

14 Q. Okay. And what -- did she get back to you
15 in an email?

16 A. Yes.

17 Q. And what do you recall her email saying?

18 A. I recall her email saying that we were not
19 able to participate.

20 Q. And did you have a follow-up call with her
21 about that fact?

22 A. Not that I recall.

23 Q. So is it fair to say all the communications
24 you had with Anna Gunod related to whether or not the
25 five hospitals that make up Palm Beach Health Network

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1 could participate in the Leapfrog Hospital Survey for
2 fall of 2024 was in writing?

3 MR. TAKAGAKI: Objection.

4 A. Yes.

5 (Defendant's Exhibit Number 12 for i.d.)

6 BY MS. BLAIR:

7 Q. And so we can mark that as Exhibit 12. Can
8 I see it real fast? I might have given you the wrong
9 one. Oh, no, I didn't. Sorry. Thank you.

10 Ms. West, I've handed you what we've now
11 marked as Exhibit 12. And if we go to the second --
12 oh, this is a document, the first, the email on the
13 first page is an email from you to Ricky Ramirez dated,
14 excuse me, September 27th, 2024, correct?

15 A. Correct.

16 Q. And if we go to the second page of this
17 Exhibit, it starts with an email from Anna Gunod on
18 September 26, 2024 to you. Do you see that?

19 A. I do.

20 Q. And she says, "Hi, Gina. Leapfrog
21 participation is not supported unless it is directly
22 tied to a payment contract or a local regulatory
23 requirement."

24 Do you see that?

25 A. I do.

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1 Q. Do you know what she means by
2 "payment/contract" or "local regulatory requirement"?

3 A. I don't know.

4 Q. And is Leapfrog related in any way to a
5 payment or contract for any of the five hospitals that
6 are plaintiffs in this litigation?

7 A. Not to my --

8 MR. TAKAGAKI: Objection.

9 A. Not to my knowledge.

10 THE WITNESS: Sorry.

11 BY MS. BLAIR:

12 Q. And then you respond at the top of the
13 second page of this email, you say, "Although not
14 supported, is it left up to the local markets to decide
15 or a strict no from home office?"

16 Do you see that?

17 A. Yes.

18 BY MS. BLAIR:

19 Q. And what is your -- she responds then if we
20 go to the first page of this Exhibit, Ms. Gunod
21 responds to you, "It is a no from home office."

22 Do you see that?

23 A. I do.

24 Q. What was your understanding of home office's
25 role in making decisions about whether or not

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1 Palm Beach Health Network hospitals could participate
2 in the Leapfrog survey?

3 A. I'm sorry. Could you repeat it?

4 Q. Sure. As I understood our discussion
5 earlier today, in 2021, it was the decisions -- it was
6 the decision of these five hospitals collectively to
7 stop participating in the Leapfrog Hospital Survey,
8 correct?

9 A. Correct.

10 MR. TAKAGAKI: Objection to the extent it
11 mischaracterizes previous testimony and lacks
12 foundation.

13 BY MS. BLAIR:

14 Q. And then subsequently we see in this
15 Exhibit Number 11 [sic] that home office is making the
16 decision as to -- I'm sorry -- Exhibit 12 -- that home
17 office is making the decision for you about whether or
18 not you can participate in the Leapfrog hospital survey
19 going forward, correct?

20 MR. TAKAGAKI: Objection. Lacks foundation.

21 A. It's not necessarily just the home office
22 decision, but in terms of that piece of it where the
23 home office did not want us to participate, that would
24 have been an area that I would have wanted to clear or
25 make sure that we had support, you know, just if we

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1 were going to make a different request somewhere else
2 make through the market again.

3 BY MS. BLAIR:

4 Q. Okay. I want to make sure I understand your
5 answer. You said, "It's not necessarily just the home
6 office decision, but in terms of that piece of it..."

7 What is "that piece of it" that you're
8 referring to?

9 A. So we already had a decision that we weren't
10 going to participate. And then we had the home office
11 that had asked for whether or not we were
12 participating. I responded that we weren't.

13 But then I asked could we, and the response
14 was, no, it's a no from the home office. So it's a no
15 from the home office even though we've already made a
16 decision not to do it. It's really information
17 gathering.

18 Q. Okay. So at this point, if I understand
19 you, at this point on, in or around September 27th,
20 2024, you, the five hospitals, have already made the
21 decision that you're not going to participate in the
22 Leapfrog Hospital Survey for fall of 2024?

23 A. Correct.

24 MR. TAKAGAKI: Objection.

25 BY MS. BLAIR:

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1 Q. Got it.

2 (Defendant's Exhibit Number 13 for i.d.)

3 BY MS. BLAIR:

4 Q. And if we look at Number 13, what we'll mark
5 as 13, Ms. West, I'm handing you a document that the
6 first email that -- well, it's Bates labeled finally,
7 PBHN 5092 through PBHN 5093. Do you have that in front
8 of you? Those are the little numbers on the bottom
9 right-hand side.

10 A. I do.

11 Q. And if we look at your email in the middle
12 of the first page of this Exhibit, from you to
13 Ricky Ramirez, "Subject: Leapfrog Scores," do you see
14 that email?

15 A. I do.

16 Q. And it's dated September 25th, 2024,
17 correct?

18 A. Correct.

19 Q. And this is, I believe, the same date as the
20 document we saw, or close to the same dates of the
21 document we saw as Exhibit 11 and 12, correct?

22 That's all right. You can look at it.

23 A. Okay. Would you mind repeating your
24 question?

25 Q. Sure. So if we look at Exhibit 11, that's

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1 dated September 25th, correct?

2 A. Correct.

3 Q. And then if we look at what I just marked as
4 Exhibit 13, the middle email from you to Ricky Ramirez
5 is also dated September 25th, correct?

6 A. Correct.

7 Q. And in your email to Ricky Ramirez, you say,
8 "Ricky, Our Leapfrog scores will take a huge dive
9 across the market in fall reporting period because we
10 haven't participated in the survey process for two
11 years. I respectfully request to begin the process
12 begin."

13 Do you see that?

14 A. I do.

15 Q. Okay. So on September 25th were you wanting
16 to participate in the Leapfrog Hospital Survey for fall
17 of 2024 on behalf of all five hospitals, or had you
18 already made the decision that you -- that the five
19 hospitals that make up Palm Beach Health Network were
20 not going to participate?

21 MR. TAKAGAKI: Objection.

22 A. The decision had already been made. It
23 hadn't changed since 2021.

24 But, again, knowing how this was going to
25 affect us, I made the request to participate.

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1 BY MS. BLAIR:

2 Q. And then if we look at Exhibit 12, which is
3 the one, Exhibit 12 where they say, "It's a no from
4 home office," do you see that as your request to
5 participate being denied by home office?

6 A. Yes.

7 MR. TAKAGAKI: Objection.

8 A. It states, "Facilities would need an
9 exception due to Leapfrog participation being tied to
10 local requirement, contract compliance or reimbursement
11 need to submit their case for review by Dr. Franklin."

12 BY MS. BLAIR:

13 Q. Okay. And did you submit your case for
14 review by Dr. Franklin?

15 A. I did not.

16 Q. And do you recall with respect to your email
17 of September 25th, 2024 which we've marked as
18 Exhibit 13 -- it's in the middle -- do you recall any
19 discussions you had with Ricky Ramirez in or around
20 that time related to your request on behalf of the five
21 hospitals that make up Palm Beach Health Network to
22 participate in the Leapfrog Hospital Survey?

23 A. I don't recall a verbal request, but I do
24 remember this, the email request.

25 Q. Okay. So as you sit here today, you just

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1 don't recall any discussions with Ricky Ramirez?

2 A. Verbal, verbal discussions.

3 Q. Do you recall whether or not Ricky Ramirez
4 was supportive of your request to participate in the
5 Leapfrog Hospital Survey for fall of 2024?

6 A. I remember that Ricky Ramirez was not
7 supportive of that request.

8 Q. And what is your memory about why he was not
9 supportive?

10 A. I don't remember all of the details.

11 Q. Sure.

12 A. But if you can show me a document...

13 Q. I don't have a document. I'm just asking
14 you what you recall.

15 A. I don't remember if it went past the
16 original reason of it being very lengthy and
17 time-consuming and we needed to focus on some of the
18 other work we had.

19 Q. Sure.

20 Did you have you any discussions with
21 Ricky Ramirez that you can recall about what impact a
22 downgrade in the Leapfrog grade may have from a PR
23 perspective for the hospitals?

24 A. I remember an email thread.

25 Q. And what do you recall about that email

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1 thread?

2 A. I do not recall the details.

3 Q. And it was not this email thread that we
4 were just discussing which we've marked as Exhibit 13?

5 A. That's correct.

6 Q. Okay. Did you review that email thread that
7 you just told me about in preparation for your
8 deposition today?

9 A. I may have.

10 Q. Okay. Ultimately, the five hospitals that
11 make up Palm Beach Health Network did not participate
12 in the fall 2024 Leapfrog Hospital Survey, correct?

13 A. Correct.

14 Q. And do you have any recollection of what the
15 grades were that were posted for these five hospitals
16 from the fall of 2024 methodology?

17 A. I do not off the top of my head.

18 Q. Do you recall that they were all D's and
19 F's?

20 A. Yes, I do.

21 Q. What is your involvement, if any, in public
22 relations?

23 A. Could you further clarify?

24 Q. Sure. Well, let's talk about a document
25 maybe.

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1 MS. BLAIR: We'll mark this as 14.

2 (Defendant's Exhibit Number 14 for i.d.)

3 BY MS. BLAIR:

4 Q. Ms. West, I'm handing you what we've now
5 marked as Exhibit 14. This is an email with -- or this
6 is an Exhibit with Bates numbers PBHN 5094 through
7 5096.

8 Is this the email thread if we go back to --
9 let's just go back to, I guess, the bottom of the first
10 page, Ricky says, same date, September 25th, 2024, same
11 date as Exhibit 13 that we saw, he says, "I understand.
12 Honestly, I don't see the value in Leapfrog, but please
13 send me all of projected grades for the market and I
14 will discuss with Maggie."

15 Do you see that?

16 A. I do.

17 Q. Is this the email thread you were referring
18 to earlier?

19 MR. TAKAGAKI: Objection.

20 A. It's not. And the email thread that comes
21 to mind to me was one where the grades are -- had
22 already been published and there was already negative
23 media postings.

24 BY MS. BLAIR:

25 Q. Okay. And so if we look at the email in the

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1 middle of this page from you to Ricky Ramirez,
2 "Subject: Leapfrog scores," and this is now
3 November 4th, 2024, do you see that?

4 A. I do.

5 Q. Do you recall any conversations you may have
6 had with Ricky Ramirez between September of 2024 and
7 November of 2024 regarding the anticipated grades for
8 the five hospitals, the anticipated Leapfrog grades for
9 the five hospitals that make up the Palm Beach Health
10 Network?

11 A. Outside of the emails, I do not recall
12 verbal conversations.

13 Q. Okay. And do you see Ricky says, "I will
14 discuss it with Maggie?"

15 I'm referring to the bottom of this page
16 email. Do you see that?

17 A. I do.

18 Q. Do you understand that Maggie would be
19 Maggie Gill, the CEO of Palm Beach Health Network?

20 A. Yes.

21 Q. Were you ever -- did you ever become aware
22 of what Maggie Gill's position was with respect to
23 whether or not the five hospitals associated with the
24 Palm Beach Health Network could participate in the fall
25 of 2024 Leapfrog Hospital Survey?

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1 MR. TAKAGAKI: Objection.

2 A. I don't recall the details of what her
3 recommendations were.

4 BY MS. BLAIR:

5 Q. Okay. But ultimately there was no
6 participation in the survey, correct?

7 A. Correct.

8 Q. And then if we see here your email in the
9 middle of the page Regina West November 24, 2024 you
10 said, "I'm being asked if we have a marketing
11 communication plan ready."

12 Do you see that?

13 A. Yes, I do.

14 Q. What do you recall about the marketing
15 communication plan that was being asked of you in or
16 around November of 2024?

17 A. I don't recall honestly.

18 Q. Do you recall who was asking you about
19 whether there was a marketing plan in place?

20 A. No, I'm sorry, I don't.

21 Q. And then you see here, the grades for
22 Delray, F; Good Sam, F; Palm Beach Gardens, F;
23 St. Mary's, D; and West Boca D. Do you see that?

24 A. I do.

25 Q. Is that your -- were you relaying to Ricky

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1 in this message what the projected grades were going to
2 be or had they already come out?

3 A. They had already come out.

4 Q. And so I asked you, I started this whole
5 thing by asking you what involvement you had in public
6 relations surrounding the release of the fall 2024
7 hospital safety grades. Did you have any involvement?

8 A. I didn't.

9 Q. So despite the fact that somebody was asking
10 for a marketing communication plan, you wouldn't have
11 had any involvement in putting that together?

12 MR. TAKAGAKI: Objection.

13 A. I recall at some point someone sending to me
14 a response, but I don't know if it was premedia,
15 postmedia. I can't remember, but I do recall reading a
16 response.

17 BY MS. BLAIR:

18 Q. Okay. I'm going to show you some documents
19 about responses. It's not a memory test.

20 A. Okay.

21 Q. But other than someone showing you a
22 premedia or postmedia response, did you have any
23 involvement in putting together a public relations plan
24 related to the release of the Leapfrog fall 2024 safety
25 grades?

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1 A. No.

2 Q. Were you involved in any way with drafting
3 of any responses related to the release of the fall
4 2024 safety grades?

5 A. I recall reading a response, but, again, I
6 don't know if it was pre or post.

7 Q. Right. And I don't know. In my mind
8 there's a difference between reading and drafting so I
9 want to be very clear.

10 Were you involved in drafting any media
11 responses?

12 A. No.

13 Q. Were you involved in giving any edits to
14 media responses related to the release of the fall 2024
15 hospital safety grade?

16 A. If I could review a document, that's going
17 to help me answer your question.

18 Q. But without any documents in front of you,
19 you have no recollection of any of that; is that fair?

20 A. Correct.

21 Q. Who was involved in public relations for the
22 Palm Beach Health Network in or around November of
23 2025?

24 A. Because I can't recall, I don't want to
25 speculate.

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1 Q. Okay. Who was in charge of public relations
2 for the Palm Beach Health Network today?

3 A. Lisa Cook.

4 Q. Do you know if Lisa Cook was employed by
5 Palm Beach Health Network in or around 2024?

6 A. Yes, she was.

7 Q. And do you know what capacity she was
8 employed in for the Palm Beach Health Network in or
9 around November of 2024?

10 A. Yes.

11 Q. And what --

12 A. I don't know her exact title.

13 Q. Okay.

14 A. But essentially it's the marketing director
15 of marketing.

16 Q. Okay.

17 A. The director of marketing for the Palm Beach
18 Health Networks is a better way to put it.

19 Q. That was going to be my question. So she's
20 at the group level, correct?

21 A. At the market level.

22 Q. Or the market level.

23 Does she have any job responsibilities for
24 any specific hospitals that you know of?

25 A. I don't know her specific job

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1 responsibilities.

2 Q. And Lisa Cook does not report to you,
3 correct?

4 A. Correct.

5 Q. And you do not report to Lisa Cook, correct?

6 A. Correct.

7 MS. BLAIR: 15. If you could mark this as
8 Exhibit 15.

9 (Defendant's Exhibit Number 15 for i.d.)

10 BY MS. BLAIR:

11 Q. Ms. West, I'm handing you what's been marked
12 as Exhibit 15, and granted you are not on these emails
13 that I can see, but my question is, if we go to the
14 bottom here, you'll see that Andrew Lofholm is sending
15 several people an email on December 10th, 2024 and
16 subject is Stet news coverage of Leapfrog rankings.

17 Do you see that?

18 A. Yes.

19 Q. And if we turn to the next page, there's a
20 newspaper article entitled "Tenet hospitals at bottom
21 of local safety grades."

22 And my question is, did you see this article
23 in or around December of 2024?

24 A. It feels familiar.

25 Q. I know it's hard. But do you have any

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1 specific recollection of receiving this?

2 A. I don't.

3 Q. Do you recall whether this was the first
4 article that was published regarding the Leapfrog
5 Hospital Safety Grades for the fall of 2024 that were
6 received by the five hospitals that make up the Palm
7 Beach Health Network?

8 A. I do not recall if this was the first.

9 Can I comment on this?

10 Q. Yes.

11 A. It's very interesting that Jupiter Medical
12 Center is the lone local A grade in ranking by
13 The Leapfrog Group. This medical center sends many
14 patients to our hospitals. They don't keep them and
15 care for them. And that's not all of them. But they
16 send us hundreds of patients, this A hospital --

17 Q. I'm aware.

18 A. -- sends to ours.

19 Q. Right, okay. Yeah.

20 MR. TAKAGAKI: Did you have anything else to
21 say there?

22 THE WITNESS: No.

23 BY MS. BLAIR:

24 Q. And after -- well, let's talk about that for
25 a second. After these grades came out in or around

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1 November of 2024, has Jupiter slowed its transfer of
2 patients to the five hospitals that make up Palm Beach
3 Health Network?

4 MR. TAKAGAKI: Objection.

5 A. I don't have knowledge of that.

6 BY MS. BLAIR:

7 Q. Do you recall in or around December of 2024
8 any discussions that were occurring with anyone
9 associated with Palm Beach Health Network regarding the
10 publicity that was occurring from the publication of
11 the fall 2024 Leapfrog Hospital Safety Grade?

12 A. Yes.

13 Q. And what do you recall about those
14 discussions?

15 A. I had a discussion with Sheri Montgomery in
16 regards to essentially how scary it is to have quality
17 hospitals viewed so negatively.

18 Q. And Sheri Montgomery, for the record, was
19 the CEO of Good Samaritan in or around December of
20 2024, correct?

21 A. Correct.

22 Q. What else do you recall Ms. Montgomery
23 saying to you about the publicity surrounding the
24 publication of the Leapfrog fall 2024 hospital safety
25 grade?

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1 A. At some point, and I don't know what the
2 time frame is, she talked to me about patients that had
3 cancelled their surgeries, about physicians that no
4 longer wanted to work at Good Sam. I guess that's
5 essentially it.

6 Q. Any other discussions? So you told me
7 about -- have you told me everything you recall about
8 your discussion with Sheri Montgomery in or around the
9 time that the initial publicity surrounding the fall
10 2024 hospital safety grade came out?

11 A. Yes.

12 Q. Any discussions with anyone else you recall
13 in or around this time?

14 A. No, not around this time frame.

15 Q. And that time frame that we're discussing is
16 December of 2024, correct?

17 A. Yes.

18 Q. What about later in January of 2025, do you
19 recall any conversations you had with anybody related
20 to publicity surrounding the publication of the fall of
21 2024 Leapfrog Hospital Safety Grade?

22 A. Not off the top of my head.

23 Q. What about February of 2025, any memory of
24 any conversation?

25 A. No.

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1 Q. Okay. What about between December of 2024
2 when you had this conversation with Sheri Montgomery
3 that you told me about and April of 2025 when the
4 spring 2025 Leapfrog Hospital Safety Grades came out,
5 do you recall any discussions with anyone regarding the
6 negative publicity surrounding the current at that time
7 Leapfrog Hospital Safety Grades for the five hospitals
8 that make up the Palm Beach Health Network?

9 A. I don't remember any verbal discussions.

10 Q. Do you remember any written discussions?

11 A. Not off the top of my head.

12 Q. Do you attend the governing board meetings
13 for St. Mary's?

14 A. I don't.

15 Q. Do you attend the governing board meetings
16 for any of the five hospitals?

17 A. I don't.

18 Q. Do you attend the med exec for St. Mary's?

19 A. I don't.

20 Q. Do you attend the med exec meetings for any
21 of the other hospitals that make up the Palm Beach
22 Health Network?

23 A. I don't.

24 Q. Have you ever spoken to any member of any of
25 the governing boards of any of the five hospitals that

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1 make up the Palm Beach Health Network regarding
2 negative publicity surrounding any of the five
3 hospitals that are plaintiffs in this litigation?

4 A. Can I back up for a minute?

5 Q. Sure.

6 A. I need to correct --

7 Q. Oh, yes, of course.

8 A. -- my testimony.

9 I stated that I don't go to the board
10 meetings for St. Mary's, but I do go to the pediatric
11 board meetings for St. Mary's.

12 Q. Okay. That's a great distinction. Yes, I'm
13 just talking about the adult acute care center that I'm
14 referring to St. Mary's.

15 A. I do not.

16 Q. Thank you.

17 I'm going to show you this email.

18 MS. BLAIR: We'll mark this as Exhibit 16.

19 (Defendant's Exhibit Number 16 for i.d.)

20 BY MS. BLAIR:

21 Q. Mrs. West, you had just told me about a
22 conversation you had or recalled with Sheri Montgomery,
23 correct, regarding the negative publicity in or around
24 December of 2024.

25 A. (Nodding head).

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1 Q. And I've now handed you a document that
2 we've now marked as West Exhibit 16, which is an email
3 from you to Sheri Montgomery dated December 11th, 2024,
4 correct?

5 A. Correct.

6 Q. And you say here to Ms. Montgomery -- well,
7 the subject is "Leapfrog healthcare advisory board."
8 Do you see that?

9 A. I do.

10 Q. And you say, "Looks like the insurance
11 companies dropped off for 2025."

12 Do you see that?

13 A. I do.

14 Q. Does this refresh your recollection, was
15 this part of the conversation that you had with
16 Sheri Montgomery in December of 2024 related to the
17 launch of the fall 2024 hospital safety grades?

18 MR. TAKAGAKI: Objection.

19 A. I do not recall why I sent this to her.

20 BY MS. BLAIR:

21 Q. That was going to be my next question.
22 Thank you.

23 MS. BLAIR: We'll mark this one as 17.

24 (Defendant's Exhibit Number 17 for i.d.)

25 BY MS. BLAIR:

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1 Q. Ms. West, I'm handing you now an email that
2 we've marked West Exhibit 17, which is an email from
3 you -- or, I'm sorry -- from Maggie Gill to you dated
4 February 13th 2025 and the subject is "Leapfrog." Do
5 you see that?

6 A. I do.

7 Q. And it says, "Hi, Gina. Corporate is
8 completing a review of issues related to Leapfrog
9 inaccurate portrayal of hospital quality and safety."
10 Do you see that?

11 A. Yes.

12 Q. And then she goes on to say, "What
13 regulatory agency survey results (Joint Commission
14 and/or other) can we share that speak to quality and
15 safety?"

16 Do you see that?

17 A. I do.

18 Q. Was this email followed up by any telephone
19 conversations between yourself and Ms. Gill?

20 A. I do not recall getting this and I don't
21 recall responding to it.

22 Q. Do you recall if you had any understanding
23 in or around February of 2025 of the review of issues
24 that corporate was completing?

25 A. I do not.

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1 Q. Were you involved in any discussions about
2 corporate reviewing Leapfrog in or around February of
3 2025?

4 A. Not that I recall.

5 Q. Do you understand that there was a cease and
6 desist letter sent by Palm Beach -- well, the hospitals
7 that make up Palm Beach Health Network to Leapfrog in
8 January of 2025?

9 MR. TAKAGAKI: Objection.

10 A. I recall that.

11 BY MS. BLAIR:

12 Q. Did you have any involvement in drafting
13 that cease and desist letter?

14 A. No, I did not.

15 Q. Did you have any involvement in approving
16 that cease and desist letter?

17 A. Not that I recall.

18 Q. Did you have any involvement in making the
19 decision as to whether or not a cease and desist letter
20 should be sent to Leapfrog?

21 A. Not that I recall.

22 Q. So is it your memory that you just were
23 aware of the fact that a cease and desist letter was
24 being sent but you had no involvement in drafting it?

25 A. I recall finding out about it through media.

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1 Q. And when you say "through media," what does
2 "media" mean?

3 A. It was somewhere on the internet.

4 Q. Oh. I just want to make sure when you said
5 "through media," that's not some internal department
6 I'm unaware.

7 So that would be media that would be
8 publicly available to everyone, right?

9 A. Right.

10 Q. Did the way in which you operated from a
11 quality standpoint after January of 2025 change in any
12 way?

13 MR. TAKAGAKI: Objection.

14 A. Can you further clarify?

15 BY MS. BLAIR:

16 Q. Sure.

17 Did the Leapfrog Hospital Safety Grades from
18 fall of 2024 have any impact on the way in which you as
19 the director of quality for Palm Beach Health Network
20 reviewed patient safety at the five hospitals that make
21 up the Palm Beach Health Network?

22 MR. TAKAGAKI: Objection.

23 A. Not that -- not that I recall.

24 BY MS. BLAIR:

25 Q. Were you involved in any meetings at the

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1 Palm Beach Health Network group level before April --
2 outside the presence of your attorneys -- before
3 April 30th, 2025 related to decisions to file a lawsuit
4 against Leapfrog?

5 A. Not that I recall.

6 Q. Going back to, I asked you some questions
7 earlier about using the -- whether or not the five
8 hospitals used the Leapfrog Hospital Survey, not safety
9 grade, survey as a benchmark for quality at the five
10 hospitals. Do you recall that?

11 MR. TAKAGAKI: Objection. Vague.

12 A. Yes.

13 BY MS. BLAIR:

14 Q. And I just, I'm going to hand this to you
15 17? 18.

16 (Defendant's Exhibit Number 18 for i.d.)

17 BY MS. BLAIR:

18 Q. I'm handing you what we've now marked
19 Exhibit 18, and this is an email from you dated
20 March 27th, 2025 at that Andrea Nunes,
21 Stephany Johnson, Kathleen McDonald, Erin Britt and
22 Taylor Pool, CC'ing Ricardo Ramirez. And the subject
23 is 'Leapfrog benchmarks.'"

24 Do you see that?

25 A. Yes.

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1 Q. And you say to these quality directors,
2 "Please make sure that any quality/infection control
3 benchmarkings/goals are not based on Leapfrog
4 information."

5 Do you see that?

6 A. Yes.

7 Q. Does this refresh your recollection that at
8 least maybe some of these hospitals were using Leapfrog
9 information as benchmarking/goals?

10 A. May I look through these documents?

11 Q. Yeah, of course.

12 A. Because what I can recall is sending the
13 email regarding the SAFER® EHR, and I want to see if it
14 was around the same time because that's what jumps to
15 mind. That's what jumps to my mind.

16 Q. Understood.

17 A. So this was a different year, but it could
18 be related to completion again of the SAFER® EHR.

19 Q. Okay.

20 A. So it's just a request to take a look and
21 make sure that there were no references to Leapfrog --

22 Q. Okay.

23 A. -- since we weren't participating.

24 Q. And was there any reason that the email that
25 you sent related to references to Leapfrog is sent in

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1 March of 2025 as opposed to earlier after the hospitals
2 stopped participating in Leapfrog?

3 A. Do you mind asking me again?

4 Q. Sure. So, as I understand it, the hospitals
5 stopped participating in the Leapfrog survey in 2021,
6 correct?

7 A. Correct.

8 Q. Was there anything that you can recall that
9 spurred you in March of 2025 to send this email to your
10 quality directors requesting that they remove any
11 Leapfrog benchmarking from their -- from their goals?

12 MR. TAKAGAKI: Objection.

13 A. It could have been, again, that I was
14 looking at the SAFER® EHR. It's around the same time
15 frame where I've asked to make sure we've removed it,
16 and it could have just been a reminder. This email is
17 a reminder.

18 BY MS. BLAIR:

19 Q. Got it.

20 A. But it could have been related to the
21 SAFER® EHR because it's during the same time frame.

22 Q. And "during the same time frame," are you
23 referring to like the time of year?

24 A. Yes.

25 Q. Okay. But as you sit here today you have no

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1 specific recollection as to why you sent that email
2 when you did?

3 A. No.

4 Q. Do you recall if at any QIPSC meetings there
5 were discussions at any time from 2023 to March of
6 2025, do you recall if there were discussions of any
7 QIPSC meetings regarding using Leapfrog standards as
8 benchmarking standards for the five hospitals, any of
9 the five hospitals that make up the Palm Beach Health
10 Network?

11 A. I don't recall.

12 Q. Would the best place for me to look to see
13 if that was being done, the minutes from those QIPSC
14 meetings?

15 MR. TAKAGAKI: Objection.

16 A. Correct.

17 MS. BLAIR: 19.

18 (Defendant's Exhibit Number 19 for i.d.)

19 BY MS. BLAIR:

20 Q. Ms. West, I'm now handing you what we've
21 marked as West Exhibit 19, which is an email from
22 Amy Buzzelli, B-u-z-z-e-l-l-i, to you at the top.

23 And if we go way down to the bottom of this
24 one-page Exhibit, she's writing to you and others,
25 "AH" -- AHCA -- "AHCA has arrived to West Boca."

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1 Do you see that?

2 A. I do.

3 Q. And she says, "As expected, AHCA has arrived
4 to West Boca. The complaint is the same."

5 Do you see that?

6 A. I do.

7 Q. What was "the complaint"?

8 MR. TAKAGAKI: Objection.

9 A. I don't recall that being shared with us,
10 but that goes back to the spring of when AHCA came to
11 the hospitals to do that thorough quality infection
12 quality control and hand hygiene review. And if I
13 remember correctly, it was around the same time that
14 all of the media coverage was occurring.

15 BY MS. BLAIR:

16 Q. Okay. And by "media coverage," just for the
17 record, you're referring to media coverage regarding
18 the hospital safety grades that these five hospitals
19 received from Leapfrog for the fall of 2024?

20 A. Yes.

21 Q. And you say to Amy, "Why are they saying
22 'complaint'?"

23 Do you see that?

24 A. I do.

25 Q. And then she said, "Heard [sic] is wondering

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1 if Leapfrog complaint."

2 Do you see that?

3 A. I do.

4 Q. Who is Heard?

5 A. She meant she heard.

6 Q. Oh, okay. I thought that was a person.

7 And so she heard that Leapfrog complained
8 about the hospital?

9 A. Correct.

10 MR. TAKAGAKI: Objection.

11 BY MS. BLAIR:

12 Q. Did you have any conversations with her
13 regarding who she heard that from?

14 MR. TAKAGAKI: Objection. Lack of
15 foundation.

16 A. I don't recall Amy saying who she heard it
17 from, but I do remember when the surveyors came on
18 site, they mentioned Leapfrog a lot at some of
19 hospitals, and they really focused in on hand hygiene,
20 and they really focused on our methodology, our
21 observations, the data that was collected, how it was
22 reported publicly on our units, how we had completed
23 performance improvement in those areas. They did
24 continue to refer to Leapfrog.

25 BY MS. BLAIR:

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1 Q. Did you ever come to find out whether
2 Leapfrog complained about this hospital?

3 A. I didn't come to find out.

4 Q. Do you know if anybody came to find that
5 out?

6 A. Not to my knowledge.

7 Q. As you sit here today do you believe that
8 Leapfrog complained to AHCA regarding the Tenet
9 hospitals in Palm Beach?

10 A. I don't have an opinion about it.

11 After this, do you mind if we take a quick
12 break so I can run to the restroom?

13 MS. BLAIR: Oh, sure. Do you want to do it
14 right now?

15 MS. MALONEY: Why don't we take a break now.

16 THE WITNESS: Do you mind?

17 MS. BLAIR: No, sure.

18 THE VIDEOGRAPHER: Off the record, 3:58.

19 (A recess was taken from 3:58 p.m. to 4:13 p.m.)

20 THE VIDEOGRAPHER: This is media unit number
21 four. The time is 4:13. We're back on record.

22 BY MS. BLAIR:

23 Q. Ms. West --

24 MS. BLAIR: Let's mark this one as 20.

25 (Defendant's Exhibit Number 20 for i.d.)

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1 BY MS. BLAIR:

2 Q. Ms. West, I'm handing you what we've now
3 marked as Exhibit 20. This is an email from you to
4 Ricardo Ramirez dated April 28, 2025. Do you see that?

5 A. I do.

6 Q. And you say to him what we were talking
7 about this morning, correct?

8 A. Correct.

9 Q. And below that email is an email from you to
10 Andrea Nunes, Stephany Johnson, Erin Britt and
11 Kathleen McDonald, correct?

12 A. Correct.

13 Q. Were they quality directors for the
14 individual, the other four individual hospitals that
15 make up Palm Beach Health Network?

16 A. Yes.

17 Q. And you say, "FYI, to each hospital spring
18 2025 scores along with the following what-if'
19 scenarios."

20 Do you recall that, or do you see that? I'm
21 sorry?

22 A. Yes.

23 Q. Do you recall what the circumstances were
24 surrounding your drafting of this email?

25 A. So, first of all, let me start with saying,

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1 I'm a registered nurse. I'm not a statistician. So
2 this is a simple exercise each time the scores would
3 come out utilizing Leapfrog's calculator to complete
4 what-if scenarios, just as talking points and FYI
5 information.

6 Q. And so is it your recollection that you did
7 a chart like this each time the safety grades came out?

8 MR. TAKAGAKI: Objection.

9 A. Yes.

10 BY MS. BLAIR:

11 Q. And in this particular chart it says, the
12 first bullet point says, "What if the hospital
13 participated in the survey and received full credits,
14 100 percent in the areas that we usually receive full
15 credit?"

16 Do you see that?

17 A. Yes.

18 Q. What were the areas that you usually
19 received full credit that you were referring to in this
20 bullet point?

21 A. That would be the four areas of imputed
22 scoring.

23 And if I can just clarify to say, this is
24 the first time that I ever did the N/A on it.

25 Q. Okay. Thank you. I was going to ask that

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1 question.

2 And then so you were receiving 100 percent
3 in prior safety grades for BCMA, CPOE, ICU physician
4 staffing and hand hygiene, correct?

5 A. With the exception of West Boca.

6 Q. With the exception of West Boca, correct?
7 Correct?

8 A. Yes, correct.

9 Q. And we talked about this a little earlier.
10 Is it your understanding that you were receiving
11 100 percent on those four measures even though Leapfrog
12 had no data from those hospitals that were receiving
13 100 percent, sans West Boca, for those four measures,
14 correct?

15 MR. TAKAGAKI: Objection to the extent it
16 mischaracterizes previous testimony and lacks
17 foundation.

18 BY MS. BLAIR:

19 Q. Do you know whether or not -- let's start
20 over.

21 Do you know whether or not for these four
22 measures the four hospitals, sans West Boca, were
23 receiving 100 out of 100 for those four measures?

24 MR. TAKAGAKI: Objection.

25 A. It's my understanding for a period of time,

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1 yes.

2 BY MS. BLAIR:

3 Q. And would that period of time have been from
4 when you stopped participating in the survey until fall
5 of 2024?

6 A. I would have to look at a document to know
7 for sure.

8 Q. Well, let's just talk about the spring of
9 2024, then. Is it your understanding that with the
10 exception of -- well, no.

11 Is it your understanding that in the spring
12 of 2024 all five hospitals were receiving 100 out of
13 100 points for CPOE, BCMA, hand hygiene and ICU
14 physician staffing?

15 A. For the exception of West Boca, yes.

16 Q. With the exception of West Boca.

17 Am I also correct that for the spring of
18 2024 with the exception of West Boca, those four
19 hospitals were receiving 100 out of 100 points on those
20 four measures even though they did not submit a
21 Leapfrog Hospital Survey?

22 A. That is what I recall.

23 Q. And is that is what -- is that what you are
24 trying to articulate in this first bullet point when
25 you say, "Received full credits (underlined 100 percent

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1 in the areas that we usually receive full credit)?"

2 A. Correct.

3 Q. And then your second bullet point is, "What
4 if Leapfrog applied N/A to the categories where the
5 hospital declined to participate?"

6 Do you see that?

7 A. I do.

8 Q. Okay. And so if we look at your chart, this
9 first section, spring 2025, is this what you are
10 anticipating your spring 2025 grades to be for the
11 Leapfrog Hospital Safety Grade?

12 A. That is correct.

13 Q. And is it your understanding that as of the
14 date that you wrote this email, April 24th, 2025, the
15 spring hospital safety grades for 2025 had not yet been
16 issued?

17 A. I don't recall.

18 Q. Okay. And then if we look at the middle box
19 where you say "What if 100 percent," do you see that?

20 A. Yes.

21 Q. And does that suggest what if the scoring
22 methodology had not changed for your hospitals?

23 A. That's correct.

24 Q. And when we look at West Boca, which is the
25 last row of your chart, are you assuming that West Boca

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1 is going to get 100 percent?

2 A. Again, it's a simple exercise.

3 Q. Sure.

4 A. It was nothing that was official, nothing
5 sanctioned. It was my attempt to analyze potential
6 what-ifs and just make that information available.

7 Q. And I guess my question, though, is just
8 specific with respect to West Boca, do you know whether
9 or not you were inputting West Boca's score here as
10 100 percent for all four measures?

11 A. That's --

12 MR. TAKAGAKI: Objection.

13 A. That is correct.

14 BY MS. BLAIR:

15 Q. And you did not take into account when you
16 were putting together this center box the fact that
17 nonparticipating hospitals based on the Leapfrog 2023
18 methodology would have been getting fives for ICU
19 physician staffing, correct?

20 A. That's correct.

21 MR. TAKAGAKI: Objection.

22 A. So no changes to the Leapfrog methodology,
23 no changes to the calculator, which is flawed in
24 itself, because the mean would have changed, obviously,
25 as these changed as the other hospitals received the

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1 same N/A, so simple exercise, flawed in the exercise
2 admittedly.

3 Q. Yeah, I'm just trying to figure out what
4 inputs you had put on the 100 percent.

5 And so that is 100 percent for all five
6 hospitals for all four measures, correct, in that
7 middle box?

8 A. Yes.

9 MR. TAKAGAKI: And just objection.

10 Are you asking -- when you say "inputs,"
11 you're referring to inputs of this chart or the
12 Excel that was attached?

13 MS. BLAIR: I'm talking about the inputs
14 that Ms. West put into the calculator to get
15 these grades that say "what if 100 percent."

16 BY MS. BLAIR:

17 Q. And I am assuming -- but you tell me because
18 I don't want to assume -- that you would have put in
19 100 out of 100 points for this middle box for each of
20 those four measures for all five hospitals; is that
21 correct?

22 MR. TAKAGAKI: Objection. Vague.

23 A. That's correct.

24 BY MS. BLAIR:

25 Q. Okay. And then for this last box -- I

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1 understand it's a simple exercise. I understand that.
2 But what you were doing was simply -- well, you tell
3 me. What did you do with respect to "what if any"?

4 MR. TAKAGAKI: Objection.

5 A. I removed the imputed scores and replaced it
6 with N/A.

7 BY MS. BLAIR:

8 Q. Correct. And so you didn't reweight
9 anything; is that fair?

10 A. That's correct.

11 Q. And so do you understand that, we talked a
12 little bit earlier that the Leapfrog scoring
13 methodology in the calculator is separated into two
14 different domains, correct?

15 A. Yes.

16 Q. And so one domain has ten measures that are
17 all outcome measures, correct?

18 A. Correct.

19 Q. And that accounts for 50 percent, 50, five
20 zero, percent of the Leapfrog score, correct?

21 MR. TAKAGAKI: Objection.

22 A. Correct.

23 BY MS. BLAIR:

24 Q. And then we've got the other domain, which
25 is process and structural measures, that has twelve

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1 different measures included in it, correct?

2 A. Yes.

3 Q. And so for this exercise, again, a simple
4 exercise, and I understand, you would have removed or
5 created N/A for seven of those twelve measures,
6 correct?

7 MR. TAKAGAKI: Objection.

8 A. That's not correct.

9 BY MS. BLAIR:

10 Q. That's not correct. How many measures did
11 you enter N/A for?

12 A. Four.

13 Q. Okay. But three of those would have already
14 been N/A, correct?

15 A. Correct.

16 Q. Did you keep them as N/A for this very
17 simple exercise?

18 A. Yes.

19 Q. Okay. So the scoring methodology that you
20 used here -- albeit very simple, I understand. I just
21 want to make sure I understand what you did -- would
22 have had with respect to the process and structural
23 measures 50 percent of the weight -- or 50 percent of
24 the score would have been based just on the H-Comp
25 scores that are the other five measures of the process

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1 and structural measures that are contained in that
2 domain, correct?

3 A. I have --

4 MR. TAKAGAKI: I just want to object here to
5 note that the actual Excel calculator is not an
6 Exhibit here. She doesn't have it in front of
7 her.

8 A. I was going to say...

9 MS. BLAIR: I understand.

10 BY MS. BLAIR:

11 A. Just off your best memory, N/A, seven
12 measures were counted as N/A when you did this
13 calculation; would that be fair?

14 MR. TAKAGAKI: Objection.

15 A. Yes.

16 BY MS. BLAIR:

17 Q. Thank you.

18 And do you recall whether you had any
19 conversations with Vicki Ramirez regarding document
20 after you sent it to him?

21 A. The email indicates that I did, but I do not
22 recall that conversation.

23 Q. Do you recall if Ricky Ramirez asked you to
24 prepare this document?

25 A. He did not.

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1 Q. Do you recall if anyone asked you to prepare
2 this document?

3 A. No one asked me to prepare this document.

4 Q. And for what purpose did you prepare this
5 document, to the best of your recollection?

6 MR. TAKAGAKI: Objection. Asked and
7 answered.

8 A. Just a simple exercise to see how it would
9 change in the moment.

10 BY MS. BLAIR:

11 Q. Did any of the recipients of this email have
12 any conversations with you with respect to your simple
13 exercise?

14 A. No, not to my knowledge, not that I recall.

15 Q. Do you recall whether or not after the
16 spring 2025 safety grades were published you had any
17 meetings with Maggie Gill regarding the Palm Beach
18 Health Network's Leapfrog Safety Grades?

19 A. I did not.

20 Q. Okay. Do you recall whether at any time you
21 had any conversations with anyone associated with the
22 Palm Beach Health Network regarding the release of the
23 spring 2025 hospital safety grades for the five
24 hospitals?

25 MR. TAKAGAKI: Objection.

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1 A. Your question is about meetings?

2 BY MS. BLAIR:

3 Q. Did you have any discussions with anybody?
4 So we've talked about, right, the release of the fall
5 2024 safety grades and all the discussions you had
6 after that release.

7 And now we're looking at documents that are
8 dated in April of 2025, correct?

9 A. Correct.

10 Q. And you understand that Leapfrog would issue
11 a spring hospital safety grade for these five
12 hospitals, correct?

13 A. Correct.

14 Q. And, in fact, Leapfrog did issue hospital
15 safety grades for these five hospitals for the spring
16 of 2025, correct?

17 A. Correct.

18 Q. And so I'm asking, after those grades were
19 released on April 30th, 2025, did you have any
20 discussions with anybody associated with Palm Beach
21 Health Network regarding the grades that these five
22 hospitals received for the spring of 2025?

23 A. Not that I recall.

24 Q. Are you aware -- I hate to do this, but
25 we're going to go fast.

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1 Let me mark this as 21.

2 (Defendant's Exhibit Number 21 for i.d.)

3 BY MS. BLAIR:

4 Q. Ms. West, I've just handed you what we've
5 now marked as Exhibit 21 to your deposition, which is
6 entitled "Leapfrog Hospital Survey Hard Copy.
7 Questions and Reporting Periods End Notes Measure
8 Specifications and FAQs."

9 Do you have that before you?

10 A. Yes, I do.

11 Q. And have you ever seen this copy in hard
12 copy before?

13 A. I have not.

14 Q. And did you -- when's the last time that you
15 reviewed this document in hard copy, to the best of
16 your memory?

17 A. I remember doing a quick review of the
18 hospital survey in 2024.

19 Q. Okay. In connection with this litigation
20 and getting together documents sufficient to simulate
21 how these five hospitals would have performed on the
22 four imputed measures at issue in this litigation, did
23 you utilize or refer to in any way the Leapfrog
24 Hospital Survey with respect to these four measures?

25 MR. TAKAGAKI: Objection. Lacks foundation.

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1 Vague.

2 A. I did not.

3 BY MS. BLAIR:

4 Q. Oh, okay. Then you can set that aside.

5 A. Okay.

6 Q. You understand that there was a lawsuit
7 filed in this action on April 30 -- with regard to the
8 matter you're being deposed in, filed on April 30th,
9 2025?

10 A. I am aware that there was a lawsuit, but I
11 don't know what date.

12 Q. Okay. Did you have any involvement in
13 drafting -- I'm sorry.

14 Did you have any involvement in putting
15 together the lawsuit that was filed against Leapfrog?

16 A. I did not.

17 Q. Did you -- outside the presence of your
18 attorneys, did you have any involvement in editing the
19 lawsuit that was ultimately filed in this matter?

20 A. I did not.

21 Q. Were you involved in any discussions outside
22 the presence of your lawyers with anybody associated
23 with Palm Beach Health Network related to whether or
24 not a lawsuit should be filed against Leapfrog in this
25 action?

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1 A. No.

2 Q. Were you involved in any governing board
3 meetings of any of the five hospitals related to the
4 decision as to whether or not a lawsuit should be filed
5 against Leapfrog in this action?

6 A. No.

7 Q. Were you involved in any way with commenting
8 to the press in or around April or May of 2025 with
9 respect to the filing of the lawsuit that we're at
10 today?

11 A. No.

12 Q. Did you help prepare any media or press
13 releases related to the filing of the lawsuit that was
14 filed in April of 2025?

15 A. No.

16 Q. Did you have -- are you aware that there was
17 an Amended Complaint filed in this action?

18 A. I was not.

19 Q. So you weren't involved in any way with that
20 as well, correct?

21 A. Correct.

22 Q. Have you signed any affidavits in connection
23 with this litigation?

24 A. No.

25 Q. Were you involved in any way in helping put

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1 together the press release that was issued on
2 April 30th, 2025 by Palm Beach Health Network with
3 respect to this litigation?

4 A. No.

5 Q. Were you involved in any conversations with
6 anyone at the market level regarding the decision to
7 file the lawsuit that was -- in this action that was
8 filed on April 30th, 2025?

9 A. No.

10 Q. Are you involved in any way in -- were you
11 involved in any way -- well, strike that.

12 A. I wasn't involved in any way for this
13 lawsuit. That covers all of the components.

14 Q. Thank you.

15 Give me one second to look at my notes.
16 Thank you very much.

17 Do you consider a D on the Leapfrog Hospital
18 Safety Grade to be a fail grade?

19 A. It's not a good grade.

20 Q. Do you consider it to be a failing grade?

21 MR. TAKAGAKI: Objection.

22 A. As Leapfrog defined a D is failing.

23 BY MS. BLAIR:

24 Q. Do you as the quality director --

25 A. I've never defined it as failing.

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1 Q. Do you believe that the hospital were fairly
2 graded by Leapfrog prior to the fall of 2024 change of
3 methodology?

4 MR. TAKAGAKI: Objection. Vague.

5 A. It's my belief that if hospitals don't
6 participate, they should not be included, and they
7 should not receive a grade.

8 BY MS. BLAIR:

9 Q. But my question was, do you believe that
10 they were fairly graded prior to the change in
11 methodology in 2024?

12 MR. TAKAGAKI: Objection. Asked and
13 answered. Vague.

14 A. I don't have an opinion about it.

15 MS. BLAIR: Just one more Exhibit, and I
16 don't have another copy of it. What is this,
17 Barbie, 22?

18 THE STENOGRAPHER: 22.

19 (Defendant's Exhibit Number 22 for i.d.)

20 BY MS. BLAIR:

21 Q. Ms. West, I'm handing you an Exhibit that
22 we've just marked West Exhibit 22, which appears to be
23 a calendar entry, again, on your calendar dated
24 April 29th, 2025, that appears to represent a meeting
25 that is going to occur between you and Maggie Gill.

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1 Do you see that?

2 A. I see the entry in my calendar.

3 Q. And what is the subject on that entry, for
4 the record?

5 A. "Data for Maggie, Leapfrog."

6 Q. Do you have any recollection of what it was
7 that you were compiling for -- well, strike that.

8 Does "Maggie" refer to Maggie Gill in your
9 calendar entry?

10 A. It appears that way, yes.

11 Q. Okay. And is this an invitation to
12 Maggie Gill to join a meeting?

13 A. No, it is not.

14 Q. Okay. And does this calendar entry refresh
15 your recollection in any way as to what the meeting or
16 what you were going to do -- not a meeting -- what you
17 were going to do on April 29th, 2025 with respect to
18 data for Maggie Leapfrog?

19 A. I don't recall this at all. And I would
20 need -- again, this is just, it's a calendar entry for
21 me. Occasionally I'll put things on that reoccur. I
22 don't know if this could have been one of those
23 recurrences. I'm not sure. I don't have anything in
24 the body of it to like -- and I do not recall this at
25 all.

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1 MS. BLAIR: Okay. Thank you. I have no
2 further questions. Thank you very much.

3 THE WITNESS: Thank you.

4 MS. BLAIR: I don't know if you're going to
5 reserve signature, or what do you want to do?

6 MS. MALONEY: Hold on a second. I think we
7 need a moment to determine --

8 MS. BLAIR: Oh, I apologize.

9 MS. MALONEY: -- if he's going to do any
10 redirect [sic].

11 MR. TAKAGAKI: I don't believe so.

12 MS. MALONEY: You want to take a break?

13 MR. TAKAGAKI: Sure, we can take a quick
14 break.

15 THE VIDEOGRAPHER: Off the record, 4:38.

16 (A recess was taken from 4:38 p.m. to 4:40 p.m.)

17 THE VIDEOGRAPHER: Back on the record 4:41.

18 MR. TAKAGAKI: I have no questions. I just
19 want to designate the transcript as
20 confidential.

21 And, Counsel, if you could send us the Bates
22 numbers for the Exhibits, that will be very
23 helpful.

24 MS. BLAIR: I will send you the Bates
25 numbers for the Exhibits, and I will reserve my

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1 right to contest any designation of this
2 transcript as confidential.

3 And, for the record, Barbie, I will order a
4 rough draft as well as an eTran to be delivered
5 regular delivery for me.

6 And, Benny, I don't need the video.

7 THE VIDEOGRAPHER: This marks the end of
8 today's deposition. The time is 4:41. We're
9 going off the record.

10 (Thereupon, the proceedings concluded at
11 4:41 p.m.)

12 (The witness did not waive signature.)

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September 25, 2025

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1 CERTIFICATE OF OATH

2

3 THE STATE OF FLORIDA)

4 COUNTY OF PALM BEACH COUNTY)

5

6 I, the undersigned authority, certify that
7 remotely appeared before me and was duly sworn on the
8 25th day of September 2025.

9 Signed this 9th day of October 2025.

10

11

12

13

14

15

16

17

18

19

20 BARBIE GALLO, RMR-CRR
Notary Public - State of Florida
My Commission No. GG939757
21 My Commission Expires: December 18, 2027

22

23

24

25

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1 CERTIFICATE OF REPORTER

2

3 THE STATE OF FLORIDA)

4 COUNTY OF PALM BEACH)

5

6 I, Barbie Gallo, RMR-CRR, Registered Merit
7 Reporter-Certified Realtime Reporter, certify that I
8 was authorized to and did stenographically report the
9 deposition of GINA WEST, pages 1 through 276; that a
10 review of the transcript was requested; and that the
11 transcript is a true and complete record of my
12 stenographic notes.

13 I further certify that I am not a relative,
14 employee, attorney, or counsel of any of the parties,
15 nor am I a relative or employee of any of the parties'
16 attorney or counsel connected with the action, nor am I
17 financially interested in the action.

18

19 DATED this 9th day of October 2025.

20

21

22

23

24

25

Barbie Gallo, RMR-CRR

Gina West
September 25, 2025

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1 October 9, 2025
2 Gina West c/o Mary Beth Maloney
3 Gibson, Dunn & Crutcher, LLP
4 200 Park Avenue
5 New York, NY 10166
6 (212) 351-4000
7 mmaloney@gibsondunn.com

8 IN RE: GOOD SAMARITAN vs. THE LEAPFROG GROUP
9 CASE NO.: 9:25-CV-80526-DMM

10 Please take notice that on the 25th day of September
11 2025, you gave your deposition in the above cause. At
12 that time you did not waive your signature.

13 The above-addressed attorney has ordered a copy of this
14 transcript and will make arrangements with you to read
15 their copy. Please execute the Errata Sheet, which can
16 be found at the back of the transcript, and have it
17 returned to us for distribution to all parties.

18 If you do not read and sign the deposition within 30
19 days, the original, which has already been forwarded to
20 the ordering attorney, may be filed with the Clerk of
21 the Court.

22 If you wish to waive your signature now, please sign
23 your name in the blank at the bottom of this letter and
24 return it to the address listed below.

25 Very truly yours,

26 Barbie Gallo, RMR-CRR
27 Lexitas Legal
28 fl.production@lexitaslegal.com

29 I do hereby waive my signature.

30 GINA WEST
31 Job No.: 421988

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September 25, 2025

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1 ERRATA SHEET
DO NOT WRITE ON TRANSCRIPT - ENTER CHANGES HERE
2 IN RE: GOOD SAMARITAN vs THE LEAPFROG GROUP
CASE NO.: 9:25-CV-80526-DMM
3 WITNESS: GINA WEST
TAKEN: 09/25/2025
4

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23 Under penalties of perjury, I declare that I have
24 read the foregoing document and that the facts stated
in it are true.

25 _____
Date GINA WEST

Gina West
September 25, 2025

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Exhibit 99

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA
WEST PALM BEACH DIVISION

CASE NO. 9:25-CV-80526-DMM

GOOD SAMARITAN MEDICAL
CENTER, INC., et al.,

Plaintiffs,

v.

THE LEAPFROG GROUP,

Defendant.

**PLAINTIFF DELRAY MEDICAL CENTER, INC.’S
AMENDED AND SUPPLEMENTED RESPONSES AND OBJECTIONS TO
DEFENDANT THE LEAPFROG GROUP’S FIRST SET OF
INTERROGATORIES TO DELRAY MEDICAL CENTER, INC.**

Pursuant to Federal Rules of Civil Procedure 26 and 33 and the *Pretrial Scheduling Order and Order Referring Case to Mediation* (ECF No. 36) (the “Pretrial Scheduling Order”), Plaintiff Delray Medical Center, Inc. (“Plaintiff” or “Delray”), by and through its undersigned counsel, hereby submit its amended and supplemented responses and objections (“Responses”), to Defendant The Leapfrog Group’s (“TLG”) First Set of Interrogatories, dated July 11, 2025 (the “Interrogatories” and each numbered interrogatory, an “Interrogatory”) in the above-captioned action (the “Action”).

Plaintiff’s Responses to the Interrogatories are made solely for purposes of this Action and to the best of Plaintiff’s present knowledge, information, and belief regarding the matters about which inquiry have been made. Discovery is ongoing, and Plaintiff reserves the right to amend, supplement, clarify, or further explain its Responses at any time prior to the trial in

this Action. Plaintiff further reserves the right to raise any additional objections deemed necessary or appropriate in light of any further review.

OBJECTIONS TO INSTRUCTIONS AND DEFINITIONS

1. Plaintiff objects to the definition of terms “Plaintiffs” and “Plaintiff Hospitals” as overbroad, unduly burdensome, and not proportional to the needs of the case to the extent it seeks to require Plaintiffs to respond on behalf of entities or individuals other than themselves.

2. Plaintiff objects to the definition of the terms “Delray,” “Delray Medical Center,” “Plaintiff,” “You,” and “Your” to the extent each term seeks to require Plaintiff to respond on behalf of entities or individuals other than itself, including on behalf of agents, employees, directors, or other non-party entities that are not part of this litigation. Such information is overbroad and beyond the scope of permissible discovery. Accordingly, Plaintiff states that its Responses are on behalf of itself only.

3. Plaintiff objects to the definition of the terms “Tenet Healthcare” and “Tenet” to the extent it seeks to require Plaintiff to respond on behalf of entities or individuals other than itself, including on behalf of Tenet, Tenet’s agents, employees, directors, or other non-party entities that are not part of this litigation. Such information is overbroad and beyond the scope of permissible discovery. Accordingly, Plaintiff states that its Responses are on behalf of itself only.

4. Plaintiff objects to the definition of “identify, when referring to a person,” as overbroad and unduly burdensome to the extent it calls for the “address” and “present or last-known employer” of identified individuals. Such information is overbroad and beyond the scope of permissible discovery.

5. Plaintiff objects to the instruction that the relevant time period for the Interrogatories begins on January 1, 2020. Plaintiff will apply to each Interrogatory the time period

of November 1, 2023 to present (the “Relevant Time Period”). Any response to an Interrogatory that provides information that falls outside of the Relevant Time Period should not be construed as an admission that the Relevant Time Period begins prior to November 1, 2023.

SPECIFIC RESPONSES TO INTERROGATORIES

Interrogatory No. 1: State the full name, address, job title or position, and hospital or employer affiliation of all individuals that assisted with responding to these interrogatories.

Answer: The following individuals assisted with responding to these Interrogatories.

Full Name	Address	Job Title / Position	Hospital or Employer Affiliation
Heather Havericak	c/o Gibson, Dunn & Crutcher LLP 200 Park Avenue New York, NY 10166	Chief Executive Officer	Delray Medical Center
Regina West	c/o Gibson, Dunn & Crutcher LLP 200 Park Avenue New York, NY 10166	Market Quality Director	Palm Beach Health Network and St. Mary's Medical Center

Interrogatory No. 2: Identify every individual not identified in Your Rule 26(a) initial disclosures with knowledge of facts pertaining to the allegations in Your Complaint in this Lawsuit (and any subsequent amendments) and/or whom You believe may have discoverable knowledge, information or data regarding this matter, including those who You expect to call as a fact or opinion witness at any hearing in this proceeding or whose testimony (by affidavit, deposition or testimony) You intended to submit in connection with this proceeding, and the substance of his/her testimony or affidavit, and, with respect to each person identified, provide:

- A. full name,
- B. address,
- C. telephone number,
- D. job title or position,
- E. hospital or employer affiliation,
- F. and describe in detail the facts possessed by each such person.

Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks the identity of “every individual...with knowledge” or who “may have discoverable knowledge, information or data regarding this matter.” Plaintiff will not provide more than the identity of individuals most likely to have knowledge regarding this matter. Plaintiff further objects to this Interrogatory as premature because it requests disclosure of Plaintiff’s witnesses for hearings and the substance of witness testimony before such disclosure is required under applicable law or the Pretrial Scheduling Order. Plaintiff will submit its trial witness list on October 2, 2025, per the Pretrial Scheduling Order, and disclose any other witnesses and witness testimony as further ordered by the Court or otherwise required by applicable law. Plaintiff also objects to this Interrogatory’s request for the identity of “opinion witness[es]” as vague, since witnesses are either “fact” or “expert” witnesses. Plaintiff will interpret “opinion witness” to mean “expert witness.” Plaintiff submitted expert reports on August 7, 2025, per the Pretrial Scheduling Order.

Answer: Subject to the foregoing objection, Plaintiff will amend its Rule 26(a)(1) Initial Disclosures to identify additional individuals who may have knowledge of facts pertaining to the allegations in the Complaint.

Amended Answer: In addition to those disclosed in Plaintiff’s supplemental disclosures, the following individuals may have relevant factual knowledge:

Full Name	Address	Job Title / Position	Hospital or Employer Affiliation
Regina West	c/o Gibson, Dunn & Crutcher LLP 200 Park Avenue New York, NY 10166	Market Quality Director	Palm Beach Health Network and St. Mary’s Medical Center

Full Name	Address	Job Title / Position	Hospital or Employer Affiliation
Stephany Johnson	c/o Gibson, Dunn & Crutcher LLP 200 Park Avenue New York, NY 10166	Quality Director	Delray Medical Center

In addition to the individuals identified above, persons identified in documents produced in this dispute have knowledge of facts pertaining to the allegations in the Amended Complaint. *See* Fed. R. Civ. P. 33(d). Discovery is ongoing, and Plaintiff reserves the right to supplement, amend, correct, clarify, or modify this Response as further information becomes available.

Interrogatory No. 3: Describe in detail all factual bases for Your contention that Leapfrog’s published Safety Grade for Your hospital was false, inaccurate, misleading, deceptive, or unfair. In so answering, identify with particularity each measure, data point, or metric that You contend was inaccurately reported, calculated, or misrepresented by Leapfrog in calculating the Safety Grade for Your hospital.

Answer: Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks “all factual bases” for Plaintiff’s contention. *See Megdal Assocs., LLC v. La-Z-Boy, Inc.*, 2016 WL 4503337, at *6 (S.D. Fla. Feb. 1, 2016) (finding interrogatories asking for “‘all’ facts or witnesses that support an opposing party’s case” to be “unduly broad”) (citing 8B Wright, Miller, & Kane, Federal Practice and Procedure: Civil 3d § 2167 (2015)). Plaintiff further objects to this Interrogatory as premature to the extent it requests that Plaintiff “[d]escribe in detail all factual bases” to support its contention. *In re Reliance Fin. & Inv. Grp., Inc.*, 2006 WL 8435541, at *4 (S.D. Fla. Feb. 14, 2006) (Contention interrogatories “are more appropriately used after a substantial amount of discovery has been conducted--typically, at the end of the discovery period.”). Plaintiff also objects to this

Interrogatory to the extent it attempts to limit or mischaracterize Plaintiff's claim as just challenging the false, inaccurate, misleading, deceptive, or unfair nature of TLG's Safety Grade. As the Court explained in its order denying TLG's motion to dismiss, the core of the Complaint is "a challenge to Defendant's representations about its methodology, which they claim mislead consumers by failing to distinguish between absent data and damning data, and professing that grades are not influenced by a hospital's lack of survey participation." *Order on Motion to Dismiss* 6 (ECF No. 41). Plaintiff also challenges the provably false facts and deceptive scoring system underlying these grades, which TLG admits it relies on to arrive at its deceptive Safety Grades.

Subject to the foregoing objections and as more fully stated in the *Amended Complaint* (ECF No. 74) ("Complaint"), TLG has engaged in deceptive and unfair business practices and misrepresentations when issuing the Safety Grade for Plaintiff's hospital as part of TLG's annual "Hospital Survey." TLG posts these Safety Grades online at hospitalsafetygrade.org.

To arrive at these Safety Grades, TLG uses CMS data, survey responses from participating hospitals, and other supplemental data sources. For participating hospitals, TLG uses the hospitals' self-reported responses to the Hospital Survey for 12 of the 22 measures. For non-participating hospitals, TLG uses other sources for those 12 measures. For the remaining four measures—Computerized Physician Order Entry, Bar Code Medication Administration, ICU Physician Staffing, and Hand Hygiene Score (the "Deceptive Score Categories")—TLG devised and uses a so-called "imputation model." Prior to Fall 2024, TLG's imputation model assigned non-participating hospitals a score based on the average score applicable to a similarly situated hospital. Beginning in Fall 2024, TLG modified its imputation model. TLG now assigns the lowest possible score to non-participating hospitals, which has the effect of punishing non-participating hospitals and artificially deflating their Safety Grades. TLG has even admitted the changes in Fall 2024

were designed to penalize non-participating hospitals. TLG also misleads consumers about how it grades hospitals, stating “[t]he Hospital Safety Grade reflects how well a hospital does on safety, not whether they complete the [TLG] Hospital Survey.” *Declaration of Lee Crain* (ECF No. 21) (“Crain Decl.”), Ex. 1 at 4 (“Frequently Asked Questions About the Leapfrog Hospital Safety Grade”).

As TLG explains, “not all hospitals have enough data publicly available to be eligible for a grade.” Crain Decl. Ex. 1 at 5. “As per the National Expert Panel guidance, [TLG] has requirements for the minimum amount of data [it] need[s] to issue an accurate grade.” Crain Decl. Ex. 1 at 5. According to TLG, “[h]ospitals missing more than six process measures” are “not graded.” Crain Decl. Ex. 2 at 6. Non-participating hospitals should fall easily into that “not graded” bucket, because their decision not to participate in TLG’s survey necessarily means TLG is missing seven process measures that rely on voluntary submission of hospital data.¹

TLG then deceptively conceals how it makes up grades for the four “imputation” measures and even suggests on its website that TLG *does* have data sufficient to score TLG on those four measures. By way of example, TLG acknowledges that Plaintiff “Declined to Report” information in response to questions about “Staff work[ing] together,” but then tells consumers—as if it were a fact—that Plaintiff is “Worse Than Average” on “Handwashing,” “Communication,” “medication administration,” and the like—even though TLG has no basis whatsoever to adopt those conclusions. Crain Decl. Ex. 32 at 2. TLG itself says handwashing is among the “most important” measures in its survey, Crain Decl. Ex. 15 at 4, yet it deceptively conceals that it has no data with which to grade the Plaintiff hospital on that measure. *Defendant The Leapfrog*

¹ Those seven include CPOE, BCMA, IPS, Safe Practice 1: Culture of Leadership Structures and Systems; Safe Practice 2: Culture Measurement, Feedback & Intervention; Total Nursing Care Hours per Patient Day; and Hand Hygiene.

Group's Responses to Plaintiffs' Requests for Production at 7 ("Leapfrog is not itself in possession of data showing Plaintiffs' performance on the 'imputed metrics' considered by the methodology.")). Of course, Plaintiff in fact has a comprehensive and thorough handwashing policy. And had Plaintiff merely filled out TLG's survey, it would have received a full two letter grades higher on TLG's score. *Expert Report of Professor Sean Nicholson* (Aug. 7, 2025), Ex. 6.

Based on the foregoing, and as more fully set forth in the Complaint, TLG engages in deceptive trade practices by, among other things, deceiving consumers about its grading methods by implying that Plaintiff has failed on certain measures that, in truth, TLG has no data or other basis to evaluate; deceiving consumers by telling them the Hospital Safety Grade reflects how well a hospital does on safety, not whether they complete the Hospital Survey; deceiving consumers when it represents that it does not grade hospitals if it lacks sufficient data, when, in truth, it does grade hospitals by "imputing" or making up a grade for the Deceptive Score Categories; hiding the truth about its "imputation model" from consumers by burying it in fine print on a separate website; punishing non-participating hospitals by "imputing" scores, which artificially deflate a hospital's Safety Grade; and favoring participating hospitals. Additional factual bases for the Plaintiff's claims are presented in the Complaint.

Interrogatory No. 4: Describe the scoring or grading methodology You believe Leapfrog should have used to assess Your hospital's patient safety performance and explain why that method would yield a different result.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Plaintiff's provision of an alternative scoring or grading methodology has nothing to do with the claims and defenses in this case related to TLG's

decision to use deceptive business practices. Plaintiff further objects to this Interrogatory to the extent it calls for speculation.

Answer: Plaintiff declines to respond to this Interrogatory.

Amended Answer: Subject to the foregoing objections, Plaintiff responds that TLG should use a scoring system that is not unfair or deceptive. By way of example only, TLG could decline to grade hospitals that do not participate in TLG's survey, because their decision not to participate means TLG is missing seven process measures that rely on voluntary submission of hospital data. This would yield a different result, because the hospitals would not receive a grade at all. TLG's methodology certainly should not affirmatively assign an arbitrary low score to a particular metric just because a hospital does not provide data for that metric.

Interrogatory No. 5: State whether You submitted any data, corrections, or appeals to Leapfrog regarding the Safety Grade Your hospital received, and for each such submission, identify the date of the submission, the medium of the submission (i.e. telephone, video conference, email, letter, etc.), who was involved in the submission, and the content of the submission.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Whether or not Plaintiff submitted "any data, corrections, or appeals to Leapfrog regarding the Safety Grade" Plaintiff hospital received has nothing to do with the claims and defenses in this case related to TLG's decision to use deceptive business practices. Plaintiff further objects to this Interrogatory to the extent it seeks information that is already in TLG's possession, custody and control, or equally available to TLG.

Answer: Subject to the foregoing objections, Plaintiff engaged in correspondence prior to the commencement of this case demanding that TLG reform its deceptive practices and cease and desist reporting deceptive and unfair Safety Grades, but at every turn TLG refused.

Amended Answer: Subject to the foregoing objections, Plaintiff did not submit any data, corrections or appeals to Leapfrog regarding the Safety Grades it has received.

Interrogatory No. 6: State whether You provided any comment or input in any form during Leapfrog's requests for public comments for planned updates to the Leapfrog Hospital Safety Grade methodology that was proposed for the calculation of Hospital Safety Grades (including but not limited to for the Fall 2024 methodology update). If yes, please identify the date of the comment, the medium of the submission (i.e. telephone, video conference, email, letter, etc.), who was involved in the comment and the content of the comment. If no, please state the reason why You chose not to comment.

Answer: Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Whether or not Plaintiff submitted "any comment or input" in response to TLG's request for public comments has nothing to do with claims and defenses in this case related to TLG's decision to use deceptive business practices. Plaintiff further objects to this Interrogatory to the extent it seeks information that is already in TLG's possession, custody and control, or equally available to TLG.

Subject to the foregoing objections, Plaintiff did not provide comments in response to Leapfrog's requests for public comments for planned updates to the Leapfrog Hospital Safety Grade scoring system because Plaintiff generally does not respond to requests for public comment from private entities like TLG.

Interrogatory No. 7: Describe all actions Your hospital took in response to (or in deciding not to respond to) its Safety Grade or the Hospital Survey, including internal meetings, media statements, or public relations efforts. In so answering, state the date of the action, the individuals involved in the action and the content of the action.

Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks “all actions” Plaintiffs may have taken in response to TLG’s Safety Grades. *See Megdal Assocs., LLC v. La-Z-Boy, Inc.*, No. 14-81476-CIV, 2016 WL 4503337, at *6 (S.D. Fla. Feb. 1, 2016) (finding interrogatories asking for “‘all’ facts or witnesses that support an opposing party’s case” to be “unduly broad”) (citing 8B Wright, Miller, & Kane, Federal Practice and Procedure: Civil 3d § 2167 (2015)). Plaintiff further objects to this Interrogatory to the extent it seeks information that is subject to a claim of privilege or otherwise protected from disclosure, including seeking information protected by the attorney-client privilege, work-product doctrine, or other immunity.

Answer: Subject to the foregoing objections, Plaintiff devoted substantial time and resources that could have otherwise been spent continuing to improve patient care to respond to the significant harm and disruption caused by TLG’s deceptive and unfair Safety Grade. Plaintiff’s response included meeting internally with Plaintiff’s leadership team, medical executive committee, and governing board, corresponding with TLG to demand that TLG reform its deceptive practices and cease and desist reporting deceptive and unfair Safety Grades, and devoting substantial time and resources to facilitate the preparation and prosecution of this Action.

Amended Answer: Subject to the foregoing objections, Plaintiff devoted substantial time and resources that could have otherwise been spent continuing to improve patient care to respond to the significant harm and disruption caused by TLG’s deceptive and unfair Safety Grades. Plaintiff’s response included meeting internally with Plaintiff’s leadership team, medical executive

committee, and governing board, corresponding through Plaintiff's corporate parent with TLG to demand that TLG reform its deceptive practices and cease and desist reporting deceptive and unfair Safety Grades, and devoting substantial time and resources to facilitate the preparation and prosecution of this Action. Plaintiff has also held many phone calls and meetings with physicians and other stakeholders about the TLG grades, explaining how the grades were deceptive and did not accurately reflect the hospital quality and patient safety at Plaintiff.

Interrogatory No. 8: Identify any and all persons, whether internal or external (e.g., patients, vendors, affiliates, parents, agents, partners, media) with whom You communicated in any way with respect to the Safety Grade or the Hospital Survey. In so answering, state the date of the communication, the individuals involved in the communication, the medium of the communication (i.e. telephone, video conference, email, letter, etc.) and the content of the communication.

Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks the identity of "any and all persons, whether internal or external." Plaintiff will disclose the categories of individuals with whom Plaintiff communicated about the Safety Grade or Hospital Survey during the Relevant Time Period. Plaintiff also objects to this Interrogatory to the extent it seeks protected health information that Health Insurance Portability and Accountability Act ("HIPAA"), among other statutes and regulations, bars Plaintiff from disclosing. Plaintiff further objects to this Interrogatory to the extent it seeks information that is subject to a claim of privilege or otherwise protected from disclosure, including seeking information protected by the attorney-client privilege, work-product doctrine, or other immunity.

Answer: Subject to the foregoing objections, Plaintiff communicated with the following categories of people regarding the Safety Grade or the Hospital Survey: Plaintiff's governing board, its medical executive committee, department directors, and physicians and nurses when

asked about the Safety Grade or Hospital Survey. These communications occurred in and after Fall 2024, after TLG released its deceptive and unfair Safety Grade for Plaintiff's hospital. Most of these communications occurred during regularly scheduled meetings, during which attendees were told about TLG's release of the deceptive and unfair Safety Grade, that Plaintiff does not participate in the Hospital Survey because it is unreliable and not an accurate reflection of hospital quality and safety or patient outcomes, and that the Safety Grade, which was not based on any information provided by Plaintiff, was misleading. The Palm Beach Health Network also issued a press release and since then, has engaged in various social networking and other marketing campaigns to counteract TLG's deceptive scores on behalf of Plaintiff and other affected members of the network.

Amended Answer: Subject to the foregoing objections, Plaintiff communicated with the following categories of people regarding the Safety Grade or the Hospital Survey: Plaintiff's governing board, its medical executive committee, department directors, physicians and nurses, and patients when asked about the Safety Grades or Hospital Survey. These communications occurred in and after Fall 2024, after TLG released its deceptive and unfair Safety Grades for Plaintiff's hospital. Most of these communications occurred during regularly scheduled meetings, during which attendees were told about TLG's release of the deceptive and unfair Safety Grade, that Plaintiff does not participate in the Hospital Survey because it is unreliable and not an accurate reflection of hospital quality and safety or patient outcomes, and that the Safety Grade, which was not based on any information provided by Plaintiff, was misleading. The Palm Beach Health Network also issued a press release and has engaged in marketing efforts, including through social media, to counteract TLG's deceptive scores on behalf of Plaintiff and other affected members of

the network. Plaintiff also engaged in email discussions about TLG's misleading grades, either as sender or recipient, which TLG has through Plaintiff's production of documents.

Interrogatory No. 9: Describe all instances in which a third party declined to contract with, refer patients to, or work with Your hospital, where Leapfrog's grade was cited or discussed. In so identifying list the name of the individuals involved in the communication, the medium of the communication (i.e. telephone, video conference, email, letter, etc.), the date of the communication and the content of the communication.

Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it requires Plaintiff to "[d]escribe all instances" in which a third party took an action in response to TLG's deceptive grade.

Answer: Subject to the foregoing objection, Plaintiff is not aware of any responsive instances.

Amended Answer:

Subject to the forgoing objection, by way of example, medical professionals have expressed concern about working with the Medical Center due to the grade TLG assigned it.

Interrogatory No. 10: Describe with specificity the basis for each and every category of damage You claim You incurred as a result of the Leapfrog Safety Grade. In so identifying, list each category of damages and the dollar value of each category of damage You claim.

Plaintiff objects to this Interrogatory to the extent it seeks information that is the subject of expert testimony.

Answer: Plaintiff will submit expert reports on August 7, 2025, per the Pretrial Scheduling Order.

Amended Answer: Plaintiff has served the expert report of Thomas Chakurda, which addresses the issue of reputational harm and harm to Plaintiff's goodwill. Plaintiff further objects

to this Interrogatory as overbroad and unduly burdensome to the extent it seeks “each and every” category of claimed damages.

Subject to the foregoing objections and as agreed during the parties’ September 3, 2025 meet and confer, Plaintiff will limit its response to the live non-monetary claims, including injunctive and declaratory relief, to remedy harm to Plaintiff’s reputation and goodwill. Plaintiff’s reputation and goodwill has been damaged by TLG’s false and misleading methodology and resulting Safety Grades. Plaintiff’s claim for reputational harm is based on, among other things, concerns raised by patients, doctors, staff, and community members, as well as false and misleading statements based on TLG’s false and misleading methodology and Safety Grades made in newspapers, viral social-media videos, television programs, and blogs.

By way of example, our Medical Executive Committee has received direct inquiries from patients regarding their concerns as to TLG’s grades and related public reports. Patients have told physicians that they do not want to go to the Medical Center for surgeries after seeing TLG’s grade and associated press reports. Medical professionals have expressed concern about working with the Medical Center due to the grade TLG assigned it. Further, we have received reports from patients and doctors that patients have planned to drive past the Medical Center to a farther away medical facility due to the grade assigned by TLG to the Medical Center. Community members have given negative feedback related to the rating. The harm caused by TLG’s false and misleading Safety Grade is ongoing.

Interrogatory No. 11: Identify all adverse patient events which occurred at Your hospital, including any citations received from regulatory agencies, accrediting agencies, and third party payors such as The Joint Commission, CMS, state health departments, etc. during the period covered by each Leapfrog Safety Grade publication of which You complain (i.e., Fall 2024, Fall 2025, etc.), as well as any complaints received from patients regarding the same.

Plaintiff objects to this Interrogatory because it is overly broad, unduly burdensome, seeks discovery of information that is irrelevant to the claims and defenses in this Action, seeks information that is beyond the scope of Leapfrog's Hospital Survey, and is not reasonably calculated to lead to the discovery of admissible evidence. TLG does not include "all adverse patient events," "citations received from" agencies or payors, or "complaints received from patients" in TLG's determination of its Hospital Safety Grades or request such information in the Hospital Survey, so any such information is irrelevant to whether TLG's actions constitute unfair or deceptive trade practices. TLG has, therefore, only propounded this Interrogatory for purposes of harassment. Plaintiff also objects to this Interrogatory to the extent it seeks protected health information that HIPAA, among other statutes and regulations, bars Plaintiff from disclosing.

Answer: Plaintiff declines to respond to this Interrogatory.

Amended Answer: Defendant has agreed to withdraw this Interrogatory.

Interrogatory No. 12: Describe in detail how Your hospital compares nationally on on [sic] any other ranking of patient safety performance, including but not limited to Vizient, Inc., Premier, Inc., HealthTrust Purchasing Group, The Joint Commission, HealthGrades, US News, Newsweek, Statista, Definitive Healthcare, or any other quality benchmarking entity including benchmarking on patient safety including on adverse events and on healthcare-acquired infections.

Plaintiff objects to this Interrogatory's request that Plaintiff "[d]escribe in detail how Your hospital compares nationally" based on undisclosed "benchmarking" as vague and confusing. To the extent this Interrogatory seeks the top-line rankings of the identified organizations, Plaintiff objects to this Interrogatory because such information is publicly and equally available to TLG. To the extent this Interrogatory asks Plaintiff to compare itself to the named and unnamed entities, that request is overly broad, unduly burdensome, and not proportional to the needs of this Action. Plaintiff further objects to this Interrogatory because it seeks discovery of information that is

irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Other organizations' rankings have nothing to do with the claims and defenses in this case related to the Deceptive Score Categories or TLG's decision to use deceptive business practices.

Answer: Subject to the foregoing objections, Plaintiff has received numerous awards and accolades. For example, Plaintiff was awarded the Resuscitation Center of Excellence award for 2025, becoming the first hospital in Palm Beach County to be named a Florida Resuscitation Center of Excellence. To do so, Plaintiff met approximately 15 criteria for patient care that were established by the Florida Resuscitation Center Committee, including intensive neurological monitoring, strong collaboration with Emergency Medical Services partners, and community outreach programs to promote health and lifestyle modifications to decrease the prevalence of cardiac disease. Additionally, the American College of Surgeons awarded Plaintiff the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program ("MBSAQIP") Surgery Center of Excellence award, which is dedicated to enhancing the safety and quality of care for bariatric patients in the United States and Canada. MBSAQIP accreditation promotes uniform standards and continuous quality improvement.

Plaintiff also earned DNV GL Comprehensive Stroke certification, which means Plaintiff gives the highest quality of care to most complete patient cases and offers evidence-based treatments with cutting-edge research protocols. Additionally, Plaintiff earned the VQI (Vascular Quality Initiative) Carotid Care Champion this year, which honors participants that are dedicated to improving the safety and effectiveness of vascular care. Plaintiff is also accredited by the Joint Commission, the nation's largest hospital accreditor that evaluates hospitals' quality performance standards through an objective evaluation process. Plaintiff also earned a Certification for the

American Association of Cardiovascular and Pulmonary Rehabilitation Program. This accreditation is peer-reviewed and designed to review individual facilities.

The American Heart Association honored Plaintiff with “Get with the Guidelines” Gold Plus awards in three specializations. First, Plaintiff earned the Target Stroke Honor Roll Elite, meaning Plaintiff is able to achieve door-to-needle times of within 60 minutes for at least 85% of applicable patients. Second, Plaintiff earned the Target Stroke Honor Roll Advanced Therapy, meaning that 50% of applicable patients are able to achieve door-to-device times of 90 minutes or less in the case of directly arriving patients, and 60 minutes or less for transfer patients. Third, Plaintiff earned the Target Type II Diabetes Honor Roll, meaning that Plaintiff met numerous requirements, including qualifying for a Silver level or higher Achievement Award in the “Get with the Guidelines-Heart Failure, Stroke, and/or Coronary Artery Disease” modules. The entities that award and assign these accreditations and certifications visit the healthcare facility and perform regular periodic in-person reviews, audits, surveys, and assessments of the facility.

In 2025, the medical ranking organization Healthgrades named Plaintiff one of the top 250 hospitals in the country. To assess and evaluate hospitals, Healthgrades relies on data from Medicare medical claims records and states’ data on Medicare and commercially insured patient outcomes to determine patients’ actual clinical outcomes when visiting a given hospital. Healthgrades also assigned Plaintiff the following awards:

a. Cardiac Care

- i. Five-Star Recipient for Valve Surgery (2024-2025, two years in a row)
- ii. Five-Star Recipient for Treatment of Heart Attack (2024-2025, two years in a row)

- iii. Five-Star Recipient for Treatment of Heart Failure (2003-2025, 23 years in a row)
- iv. Five-Star Recipient for Defibrillator Procedures (2024-2025, two years in a row)
- v. Five-Star Recipient for Treatment of Stroke (2008-2025, 18 years in a row)
- vi. Five-Star Recipient for Coronary Interventional Procedures (2024)

b. Pulmonary Care

- i. One of Healthgrades America's 100 Best Hospitals for Pulmonary Care in 2025
- ii. Recipient of the Healthgrades 2025 Pulmonary Care Excellence Award
- iii. Top 5% in the Nation for Overall Pulmonary Services (2025)
- iv. Top 10% in the Nation for Overall Pulmonary Services (2025)
- v. Five-Star Recipient for Treatment of Pneumonia (2024-2025, two years in a row)

c. Critical Care

- i. Recipient of the Healthgrades 2025 Critical Care Excellence Award
- ii. Top 5% in the Nation for Critical Care (2025)
- iii. Top 10% in the Nation for Critical Care (2025)
- iv. Five-Star Recipient for Treatment of Sepsis (2004-2025, 22 years in a row)
- v. Five-Star Recipient for Treatment of Respiratory Failure (2023-2025, three years in a row)

d. Gastrointestinal

- i. Five-Star Recipient for Upper Gastrointestinal Surgery (2022-2024, three years in a row)
- ii. Five-Star Recipient for Small Intestine Surgeries (2017-2021 (five years in a row), 2024)

e. Neurosurgery

- i. Five-Star Recipient for Cranial Neurosurgery (2024)

In addition, Plaintiff will produce and identify documents reflecting some of Plaintiff's rankings from other organizations.

Amended Answer: Subject to the foregoing objections, Plaintiff has received numerous awards and accolades. For example, Plaintiff was awarded the Resuscitation Center of Excellence award for 2025, becoming the first hospital in Palm Beach County to be named a Florida Resuscitation Center of Excellence. Additionally, the American College of Surgeons awarded Plaintiff the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program ("MBSAQIP") Surgery Center of Excellence award, which is dedicated to enhancing the safety and quality of care for bariatric patients in the United States and Canada.

Plaintiff also earned DNV GL Comprehensive Stroke certification. Additionally, Plaintiff earned the VQI (Vascular Quality Initiative) Carotid Care Champion this year, which honors participants that are dedicated to improving the safety and effectiveness of vascular care. Plaintiff is also accredited by the Joint Commission, the nation's largest hospital accreditor that evaluates hospitals' quality performance standards through an objective evaluation process. Plaintiff also earned a Certification for the American Association of Cardiovascular and Pulmonary Rehabilitation Program.

The American Heart Association honored Plaintiff with “Get with the Guidelines” Gold Plus awards in three specializations: Target Stroke Honor Roll Elite, Target Stroke Honor Roll Advanced Therapy, and Target Type II Diabetes Honor Roll.

In 2025, the medical ranking organization Healthgrades named Plaintiff one of the top 250 hospitals in the country. Healthgrades also assigned Plaintiff the following awards:

a. Cardiac Care

- i. Five-Star Recipient for Valve Surgery (2024-2025, two years in a row)
- ii. Five-Star Recipient for Treatment of Heart Attack (2024-2025, two years in a row)
- iii. Five-Star Recipient for Treatment of Heart Failure (2003-2025, 23 years in a row)
- iv. Five-Star Recipient for Defibrillator Procedures (2024-2025, two years in a row)
- v. Five-Star Recipient for Treatment of Stroke (2008-2025, 18 years in a row)
- vi. Five-Star Recipient for Coronary Interventional Procedures (2024)

b. Pulmonary Care

- i. One of Healthgrades America’s 100 Best Hospitals for Pulmonary Care in 2025
- ii. Recipient of the Healthgrades 2025 Pulmonary Care Excellence Award
- iii. Top 5% in the Nation for Overall Pulmonary Services (2025)
- iv. Top 10% in the Nation for Overall Pulmonary Services (2025)

- v. Five-Star Recipient for Treatment of Pneumonia (2024-2025, two years in a row)

c. Critical Care

- i. Recipient of the Healthgrades 2025 Critical Care Excellence Award
- ii. Top 5% in the Nation for Critical Care (2025)
- iii. Top 10% in the Nation for Critical Care (2025)
- iv. Five-Star Recipient for Treatment of Sepsis (2004-2025, 22 years in a row)
- v. Five-Star Recipient for Treatment of Respiratory Failure (2023-2025, three years in a row)

d. Gastrointestinal

- i. Five-Star Recipient for Upper Gastrointestinal Surgery (2022-2024, three years in a row)
- ii. Five-Star Recipient for Small Intestine Surgeries (2017-2021 (five years in a row), 2024)

e. Neurosurgery

- i. Five-Star Recipient for Cranial Neurosurgery (2024)

In addition, Plaintiff will produce and identify documents reflecting some of Plaintiff's rankings from other organizations.

Also, Plaintiff does not participate in Vizient and has not done so during the Relevant Time Period.

Interrogatory No. 13: Describe any steps taken by Your hospital to improve any and all of the patient safety measures considered by Leapfrog's Hospital Safety Grade (as set forth on Leapfrog's

published scoring methodology documents; see ECF No. 21-3 at 6-10; ECF No. 21-43 at 6-9), before and after each Safety Grade publication of which You complain.

Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks the identity of Plaintiff's improvements to "any and all" patient safety measures considered by Leapfrog's Hospital Safety Grade. Plaintiff further objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks information on metrics other than TLG's Deceptive Score Categories and to the extent it seeks information that is beyond the scope of Leapfrog's Hospital Survey.

Answer: Plaintiff declines to respond to this Interrogatory.

Amended Answer: Subject to the foregoing objection, Plaintiff is committed to continual improvement of patient safety measures, motivated by our commitment to ensuring the best possible patient safety—not chasing the best possible Leapfrog grade. To achieve this core objective, Plaintiff devotes significant time and resources to improving its delivery of the highest possible quality of care for those in the community it serves, including efforts to improve its performance in areas related to the four metrics Plaintiff has chosen to impute in its survey.

Hand hygiene is reviewed at Plaintiff's monthly quality meeting by unit and by discipline. BCMA by unit is reviewed monthly by Plaintiffs' Chief Nursing Officer, and CPOE compliance is reviewed monthly through its hospitalists meetings, ensuring that providers are meeting metric.

ICU staffing is not something that needs to be monitored ongoing because Plaintiff has ICU coverage onsite 24/7 for regular critical care patients and trauma critical care patients.

Interrogatory No. 14: State whether You are aware of specific patients who have relied on the Leapfrog Safety Grade in declining to receive healthcare services at Your hospital. In so answering, identify the individual patient that declined to receive services, the date of such declination, the type of service the patient declined to receive, the medium for the communication from the patient (i.e. telephone, video conference, email, letter, etc.), the content of the communication, and the reason given for the stated decision.

Plaintiff objects to this Interrogatory as seeking protected health information that is protected from disclosure by HIPAA, among other statutes and regulations. Plaintiff will only produce this information as needed and subject to a Qualified Protective Order entered by this Court.

Answer: Subject to the foregoing objection, Plaintiff has received reports that patients considered or decided not to use Plaintiff's facility because of TLG's misleading grades.

Amended Answer: Subject to the foregoing objection, since the release of TLG's false and misleading grades, Plaintiff has received numerous reports from doctors that patients considered or decided not to use Plaintiff's facility due to concerns related to TLG's misleading grades.

Interrogatory No. 15: Describe any effort Your hospital has made to influence public perception of Your hospital's performance on patient safety following the publication of the Leapfrog Safety Grade.

Plaintiff objects to this Interrogatory as vague and ambiguous because it does not specify which Leapfrog Safety Grade is at issue. Plaintiff will construe this Interrogatory to reference TLG's deceptive Safety Grades beginning in Fall 2024. Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks "any effort" Plaintiff "has made to influence public perception" after the release of TLG's deceptive and unfair Safety Grades because there have been many such "efforts" and those

“efforts” are ongoing given the significant harm caused by TLG’s deceptive and unfair business practices.

Answer: Subject to the foregoing objections, Plaintiff continues to influence public perception by, among other things, delivering the highest quality care to the community it serves, which, as discussed in response to Interrogatory 12, has led to numerous awards, accreditations, and accolades. In addition, several public statements disputing the misleading nature of the Safety Grade have been made on Plaintiff’s behalf.

Supplemental Answer: In addition to the above, members of hospital leadership have communicated with patients, doctors, or community members on a regular basis to dispel the misleading nature of the Leapfrog Safety Grades. For instance, Plaintiff communicated its governing board, its medical executive committee, department directors, physicians and nurses, and patients when asked about the Safety Grades or Hospital Survey. These communications occurred in and after Fall 2024, after TLG released its deceptive and unfair Safety Grades for Plaintiff’s hospital. The Palm Beach Health Network also issued a press release and has engaged in marketing efforts, including through social media, to counteract TLG’s deceptive scores on behalf of Plaintiff and other affected members of the network. Plaintiff also engaged in email discussions about TLG’s misleading grades, either as sender or recipient, which TLG has through Plaintiff’s production of documents.

Interrogatory No. 16: Describe the due diligence Your hospital undertakes to ensure the accuracy of its own publicly reported safety data (including but not limited to data submitted to CMS, the CDC, and third party organizations).

Plaintiff objects to this Interrogatory as vague and ambiguous due to its use of the undefined term “due diligence.” Plaintiff further objects to this Interrogatory because it seeks

discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Any “due diligence” Plaintiff performs when reporting to *third parties* has nothing to do with the claims and defenses in this case related to TLG’s decision to use deceptive business practices, especially when TLG does nothing to ensure the accuracy of information that hospitals that participate in its survey self-report.

Answer: Plaintiff declines to respond to this Interrogatory.

Amended Answer: Subject to the foregoing objections, Plaintiff makes reasonable efforts to ensure the accuracy of the data it reports to third-party organizations. For instance, Plaintiff employs data abstractors, quality coordinators and a Quality Director, who are all responsible for abstracting, validating, and submitting safety data.

Interrogatory No. 17: Describe in detail how You communicate to the shareholders, board members, collective bargaining representatives and investors of Tenet Healthcare System the outcome of any and all healthcare safety ratings, evaluative publications, studies, or performance analyses that Your Hospital receives.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Plaintiff’s communication, if any, with the shareholders, board members, collective bargaining representatives and investors of Tenet Healthcare System, all non-parties to this litigation, has nothing to do with the claims and defenses in this case related to TLG’s decision to use deceptive business practices.

Answer: Plaintiff declines to respond to this Interrogatory.

Amended Answer: Subject to the foregoing objection, Plaintiff communicates with Tenet stakeholders, including employees who work to support the Palm Beach Health Network, on a range of matters, including issues related to patient safety and outcomes and in particular related to TLG and the Safety Grades by email and oral communication. Those communications included discussions about the reasons for particular grades, the method used to calculate Safety Grades, the value of Safety Grades, and responses to the Safety Grades. In addition, identified below are documents Plaintiff produced evidencing communications between the Plaintiff and Tenet related to TLG, the Leapfrog survey, and Safety Grades.

Start Page	End Page
PBHN000004822	PBHN000004822
PBHN000004890	PBHN000004892
PBHN000004924	PBHN000004926
PBHN000006397	PBHN000006401
PBHN000002090	PBHN000002094
PBHN000002071	PBHN000002071
PBHN000004919	PBHN000004919
PBHN000004562	PBHN000004563
PBHN000004564	PBHN000004564
PBHN000004574	PBHN000004581

PBHN000004889	PBHN000004889
PBHN000004485	PBHN000004485
PBHN000004565	PBHN000004569
PBHN000004704	PBHN000004704
PBHN000004715	PBHN000004719
PBHN000004887	PBHN000004887
PBHN000005509	PBHN000005511
PBHN000005518	PBHN000005521
PBHN000005526	PBHN000005529
PBHN000006465	PBHN000006466

Discovery is ongoing, and Plaintiff reserves the right to amend, modify or supplement the response to this Interrogatory.

Interrogatory No. 18: State whether the compensation of Your Chief Executive Officer or any other executive-level leadership officers is tied to or related in any way to Your hospital's

performance on patient safety, union worker contracts or Your hospital's ratings by third party ratings organizations' ratings publications (including but not limited to the Leapfrog Hospital Safety Grade).

Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Plaintiff's method of compensating its Chief Executive Officer and other executive-level leadership **has nothing to do with the** claims and defenses in this case related to TLG's decision to use deceptive business practices.

Answer: TLG has, therefore, only propounded this Interrogatory for purposes of harassment. Plaintiff declines to respond to this Interrogatory.

Amended Answer: Subject to the foregoing objection, Plaintiff's performance on patient safety, union worker contracts, or ratings by third party ratings organizations' ratings publications is related in some way to the compensation of Plaintiff's Chief Executive Officer or other executive-level leadership officer(s).

Interrogatory No. 19: Identify all hospitals, medical centers, or healthcare systems that you consider to be your direct competitors within the relevant geographic market during the time period covered by the Complaint and describe in detail the criteria you use to determine whether another hospital or healthcare provider is a competitor.

Answer: Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is not reasonably calculated to lead to the discovery of admissible evidence. The identity of Plaintiff's competitors and "the criteria" used to determine whether a hospital or provide is a competitor has nothing to do with the claims and defenses in this case related to TLG's decision to use deceptive business practices. Plaintiff

also objects to this Interrogatory to the extent it seeks confidential, proprietary information, and commercially sensitive information related to Plaintiff's scoring system and "criteria" used to determine whether a hospital or provide is a competitor.

Subject to the foregoing objections and on condition that this response is considered "Confidential" under the forthcoming agreed confidentiality order, Bethesda Hospital East, Bethesda Hospital West, Boca Raton Regional Hospital, and HCA Florida JFK Hospital are Plaintiff's competitors. Plaintiff considers these hospitals competitors because of their proximity to Plaintiff, their competing services lines, and that patients within Plaintiff's service area go to these hospitals for medical care.

Interrogatory No. 20: State and describe the results of any market analysis, competitive analysis, or consumer perception surveys you have conducted or commissioned regarding your competitors from 2020 to present, and identify the individuals or entities that prepared or participated in such analyses.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is not is not proportional to the needs of this Action. The results of any market analysis, competitive analysis, or consumer perception surveys and the identity of those who prepared or participated in such analyses has nothing to do with the claims and defenses in this case related to TLG's decision to use deceptive business practices.

Answer: Plaintiff declines to respond to this Interrogatory.

Amended Answer: Plaintiff further objects to this Interrogatory to the extent it requests information from outside of the relevant time period of January 1, 2023, to present. Plaintiff also

objects to this Interrogatory as unduly burdensome to the extent it asks Plaintiff to “state and describe” various market analysis.

As agreed during the parties’ meet and confer on September 3, 2025, Plaintiff will produce documents showing the results of studies or surveys Plaintiff has conducted or commissioned related to internal market analysis, competitive analysis, or consumer perception. Plaintiff will identify the documents responsive to this Interrogatory by Bates number in Plaintiffs’ production cover letter.

Interrogatory No. 21: Identify with specificity any comments or concerns raised by any third party payor, bank or lender, or investor related to Your hospital’s reputation and/or public perception on issues in any way involving patient safety or satisfaction.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is overly broad, unduly burdensome and irrelevant to the claims and defenses in this Action and is not proportional to the needs of this case to the extent it seeks “comments and concerns” from third parties related generally to Plaintiff’s reputation that has nothing to do with the specific and significant reputational harm caused by TLG’s misleading grades.

Answer: Subject to the foregoing objections, Plaintiff will produce and identify documents related to the significant reputational harm caused by TLG’s deceptive and unfair Safety Grades that provide sufficient detail to respond to this Interrogatory.

Amended Answer: Subject to the foregoing objections, Plaintiff is unaware of any documents related to this Interrogatory.

Interrogatory No. 22: Identify and describe any complaints, concerns, or comments from patients, community members, or referring physicians that relate to the hospital’s reputation or comparisons to other hospitals in the region.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is overly broad, unduly burdensome and irrelevant to the claims and defenses in this Action and is not proportional to the needs of this Action to the extent it seeks “comments and concerns” from patients, community members, or referring physicians that have nothing to do with the significant reputational harm caused by TLG’s misleading grades. Plaintiff also objects to this interrogatory as seeking protected health information that is protected from disclosure by HIPAA, among other statutes and regulations. Plaintiff will only produce this information as needed and subject to the agreed protective order entered by this Court.

Answer: Subject to the foregoing objections, Plaintiff has received reports that patients and physicians considered or decided not to use Plaintiff’s facility because of TLG’s misleading grades.

Amended Answer: Subject to the foregoing objections, Plaintiff has received reports that patients and physicians considered or decided not to use Plaintiff’s facility because of TLG’s misleading grades. In addition, concerns have been raised by patients, doctors, staff, and community members, and Plaintiff is aware of false and misleading statements based on TLG’s false and misleading methodology and Safety Grades made in newspapers, viral social-media videos, television programs, and blogs.

Our Medical Executive Committee has received direct inquiries from patients regarding their concerns as to TLG’s grades and related public reports. Patients have told physicians that they do not want to go to the Medical Center for surgeries after seeing TLG’s grade and associated press reports. Medical professionals have expressed concern about working with the Medical Center due to the grade TLG assigned it. Further, we have received reports from patients and

doctors that patients have planned to drive past the Medical Center to a farther away medical facility due to the grade assigned by TLG to the Medical Center. Community members have given negative feedback related to the rating. The harm caused by TLG's false and misleading Safety Grade is ongoing.

In addition, the following produced documents evidence such harm.

Start Page	End Page
PBHN000006771	PBHN000006773
PBHN000002082	PBHN000002085
PBHN000002066	PBHN000002070
PBHN000002615	PBHN000002617
PBHN000006397	PBHN000006401
PBHN000002090	PBHN000002094
PBHN000002071	PBHN000002071
PBHN000004919	PBHN000004919

PBHN000004484	PBHN000004484
PBHN000004564	PBHN000004564
PBHN000004574	PBHN000004580
PBHN000004557	PBHN000004557
PBHN000004887	PBHN000004887
PBHN000008718	PBHN000008718
PBHN000006461	PBHN000006462
PBHN000008914	PBHN000008914
PBHN000008915	PBHN000008915

Discovery is ongoing, and Plaintiff reserves the right to amend, modify or supplement the response to this Interrogatory.

Interrogatory No. 23: List with specific detail each and every concern, complaint or comment made by any union, collective bargaining unit or employee association in any way related to patient safety at Your hospital.

Answer: Plaintiff objects to this Interrogatory because it seeks discovery of information that is overly broad, unduly burdensome and irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks "each and every concern, complaint or comment " from third parties that have

nothing to do with the significant reputational harm caused by TLG's misleading grades. Plaintiff also objects to this Interrogatory to the extent it seeks health information that is protected from disclosure by HIPAA, among other statutes and regulations. Plaintiff will only produce this information as needed and subject to the agreed protective order entered by this Court.

Subject to the foregoing objections, there is no union, collective bargaining unit, or employee association at Plaintiff.

Interrogatory No. 24: Identify any and all criticism You have received since 2020 from Tenet Healthcare Corporation and/or from any individual executive of Tenet Healthcare Corporation regarding Your hospital's performance in any way.

Answer: Plaintiff objects to this Interrogatory because it seeks discovery of information that is overly broad, unduly burdensome and irrelevant to the claims and defenses in this Action and is not reasonably calculated to lead to the discovery of admissible evidence. Any so-called "criticism" has nothing to do with the claims and defenses related to TLG's decision to use deceptive business practices. TLG has, therefore, only propounded this Interrogatory for purposes of harassment. Plaintiff declines to respond to this Interrogatory.

Amended Answer: As discussed during the parties' meet and confer on September 3, 2025, TLG agreed to narrow this Interrogatory to concern only "criticism...regarding Your hospital's patient safety." After a reasonable and diligent search, Plaintiff is unaware of having received "criticism" from Tenet Health Corporation regarding patient safety. Plaintiff is always working to improve its performance, quality, and safety in a constructive way and engages with Tenet Health Corporation as needed to ensure Plaintiff provides the best patient care possible.

Dated: September 8, 2025

Respectfully submitted,

By: /s/ Lee R. Crain

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Attorneys for Delray Medical Center, Inc.

CERTIFICATE OF SERVICE

This is to certify that true and correct copies of Plaintiff's Amended and Supplemented Responses and Objections to Defendant The Leapfrog Group's First Sets of Interrogatories to Plaintiff have been served on counsel for The Leapfrog Group by electronic transmission.

/s/ Lee R. Crain
Lee R. Crain

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA
WEST PALM BEACH DIVISION

CASE NO. 9:25-CV-80526-DMM

GOOD SAMARITAN MEDICAL
CENTER, INC., et al.,

Plaintiffs,

v.

THE LEAPFROG GROUP,

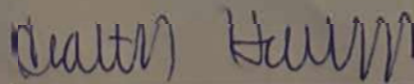
Defendant.

**AFFIDAVIT OF HEATHER HAVERICAK IN SUPPORT OF
PLAINTIFF DELRAY MEDICAL CENTER, INC.'S
AMENDED AND SUPPLEMENTED RESPONSES AND OBJECTIONS TO
DEFENDANT THE LEAPFROG GROUP'S FIRST SET OF
INTERROGATORIES TO DELRAY MEDICAL CENTER**

I, Heather Havericak, declare as follows:

1. I am over 21 years of age and competent to give this testimony.
2. I am the Chief Executive Officer of Delray Medical Center, Inc. ("Plaintiff"). I am the corporate representative of Plaintiff for the purpose of answering Defendant The Leapfrog Group's First Set of Interrogatories to Delray Medical Center. I have read the foregoing interrogatories and the answers to those interrogatories, which are true according to the best of my knowledge, information, and belief.
3. I declare under penalty of perjury that the foregoing is true and correct.

Executed on September 8, 2025.



Heather Havericak

Exhibit 100

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA
WEST PALM BEACH DIVISION

CASE NO. 9:25-CV-80526-DMM

GOOD SAMARITAN MEDICAL
CENTER, INC., et al.,

Plaintiffs,

v.

THE LEAPFROG GROUP,

Defendant.

**PLAINTIFF GOOD SAMARITAN MEDICAL CENTER, INC.’S
AMENDED AND SUPPLEMENTED RESPONSES AND OBJECTIONS TO
DEFENDANT THE LEAPFROG GROUP’S FIRST SET OF
INTERROGATORIES TO GOOD SAMARITAN MEDICAL CENTER, INC.**

Pursuant to Federal Rules of Civil Procedure 26 and 33 and the *Pretrial Scheduling Order and Order Referring Case to Mediation* (ECF No. 36) (the “Pretrial Scheduling Order”), Plaintiff Good Samaritan Medical Center, Inc. (“Plaintiff” or “Good Samaritan”), by and through its undersigned counsel, hereby submit its amended and supplemented responses and objections (“Responses”), to Defendant The Leapfrog Group’s (“TLG”) First Set of Interrogatories, dated July 11, 2025 (the “Interrogatories” and each numbered interrogatory, an “Interrogatory”) in the above-captioned action (the “Action”).

Plaintiff’s Responses to the Interrogatories are made solely for purposes of this Action and to the best of Plaintiff’s present knowledge, information, and belief regarding the matters about which inquiry have been made. Discovery is ongoing, and Plaintiff reserves the right to amend, supplement, clarify, or further explain its Responses at any time prior to the trial in

this Action. Plaintiff further reserves the right to raise any additional objections deemed necessary or appropriate in light of any further review.

OBJECTIONS TO INSTRUCTIONS AND DEFINITIONS

1. Plaintiff objects to the definition of terms “Plaintiffs” and “Plaintiff Hospitals” as overbroad, unduly burdensome, and not proportional to the needs of the case to the extent it seeks to require Plaintiffs to respond on behalf of entities or individuals other than themselves.

2. Plaintiff objects to the definition of the terms “Good Samaritan”, “GSMC” “Plaintiff,” “You,” and “Your” to the extent each term seeks to require Plaintiff to respond on behalf of entities or individuals other than itself, including on behalf of agents, employees, directors, or other non-party entities that are not part of this litigation. Such information is overbroad and beyond the scope of permissible discovery. Accordingly, Plaintiff states that its Responses are on behalf of itself only.

3. Plaintiff objects to the definition of the terms “Tenet Healthcare” and “Tenet” to the extent it seeks to require Plaintiff to respond on behalf of entities or individuals other than itself, including on behalf of Tenet, Tenet’s agents, employees, directors, or other non-party entities that are not part of this litigation. Such information is overbroad and beyond the scope of permissible discovery. Accordingly, Plaintiff states that its Responses are on behalf of itself only.

4. Plaintiff objects to the definition of “identify, when referring to a person,” as overbroad and unduly burdensome to the extent it calls for the “address” and “present or last-known employer” of identified individuals. Such information is overbroad and beyond the scope of permissible discovery.

5. Plaintiff objects to the instruction that the relevant time period for the Interrogatories begins on January 1, 2020. Plaintiff will apply to each Interrogatory the time period

of November 1, 2023 to present (the “Relevant Time Period”). Any response to an Interrogatory that provides information that falls outside of the Relevant Time Period should not be construed as an admission that the Relevant Time Period begins prior to November 1, 2023.

SPECIFIC RESPONSES TO INTERROGATORIES

Interrogatory No. 1: State the full name, address, job title or position, and hospital or employer affiliation of all individuals that assisted with responding to these interrogatories.

Answer: The following individuals assisted with responding to these Interrogatories.

Full Name	Address	Job Title / Position	Hospital or Employer Affiliation
Sheri Montgomery	c/o Gibson, Dunn & Crutcher LLP 200 Park Avenue New York, NY 10166	Chief Executive Officer	Good Samaritan Medical Center
Regina West	c/o Gibson, Dunn & Crutcher LLP 200 Park Avenue New York, NY 10166	Market Quality Director	Palm Beach Health Network and St. Mary’s Medical Center

Interrogatory No. 2: Identify every individual not identified in Your Rule 26(a) initial disclosures with knowledge of facts pertaining to the allegations in Your Complaint in this Lawsuit (and any subsequent amendments) and/or whom You believe may have discoverable knowledge, information or data regarding this matter, including those who You expect to call as a fact or opinion witness at any hearing in this proceeding or whose testimony (by affidavit, deposition or testimony) You intended to submit in connection with this proceeding, and the substance of his/her testimony or affidavit, and, with respect to each person identified, provide:

- A. full name,
- B. address,
- C. telephone number,
- D. job title or position,
- E. hospital or employer affiliation,
- F. and describe in detail the facts possessed by each such person.

Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks the identity of “every individual...with knowledge” or who “may have discoverable knowledge, information or data regarding this matter.” Plaintiff will not provide more than the identity of individuals most likely to have knowledge regarding this matter. Plaintiff further objects to this Interrogatory as premature because it requests disclosure of Plaintiff’s witnesses for hearings and the substance of witness testimony before such disclosure is required under applicable law or the Pretrial Scheduling Order. Plaintiff will submit its trial witness list on October 2, 2025, per the Pretrial Scheduling Order, and disclose any other witnesses and witness testimony as further ordered by the Court or otherwise required by applicable law. Plaintiff also objects to this Interrogatory’s request for the identity of “opinion witness[es]” as vague, since witnesses are either “fact” or “expert” witnesses. Plaintiff will interpret “opinion witness” to mean “expert witness.” Plaintiff submitted expert reports on August 7, 2025, per the Pretrial Scheduling Order.

Answer: Subject to the foregoing objection, Plaintiff will amend its Rule 26(a)(1) Initial Disclosures to identify additional individuals who may have knowledge of facts pertaining to the allegations in the Complaint.

Amended Answer: In addition to those disclosed in Plaintiff’s supplemental disclosures, the following individuals may have relevant factual knowledge:

Full Name	Address	Job Title / Position	Hospital or Employer Affiliation
Regina West	c/o Gibson, Dunn & Crutcher LLP 200 Park Avenue New York, NY 10166	Market Quality Director	Palm Beach Health Network and St. Mary’s Medical Center

Full Name	Address	Job Title / Position	Hospital or Employer Affiliation
Erin Britt	c/o Gibson, Dunn & Crutcher LLP 200 Park Avenue New York, NY 10166	Quality Director	Good Samaritan Medical Center

In addition to the individuals identified above, persons identified in documents produced in this dispute have knowledge of facts pertaining to the allegations in the Amended Complaint. *See* Fed. R. Civ. P. 33(d). Discovery is ongoing, and Plaintiff reserves the right to supplement, amend, correct, clarify, or modify this Response as further information becomes available.

Interrogatory No. 3: Describe in detail all factual bases for Your contention that Leapfrog’s published Safety Grade for Your hospital was false, inaccurate, misleading, deceptive, or unfair. In so answering, identify with particularity each measure, data point, or metric that You contend was inaccurately reported, calculated, or misrepresented by Leapfrog in calculating the Safety Grade for Your hospital.

Answer: Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks “all factual bases” for Plaintiff’s contention. *See Megdal Assocs., LLC v. La-Z-Boy, Inc.*, 2016 WL 4503337, at *6 (S.D. Fla. Feb. 1, 2016) (finding interrogatories asking for “‘all’ facts or witnesses that support an opposing party’s case” to be “unduly broad”) (citing 8B Wright, Miller, & Kane, Federal Practice and Procedure: Civil 3d § 2167 (2015)). Plaintiff further objects to this Interrogatory as premature to the extent it requests that Plaintiff “[d]escribe in detail all factual bases” to support its contention. *In re Reliance Fin. & Inv. Grp., Inc.*, 2006 WL 8435541, at *4 (S.D. Fla. Feb. 14, 2006) (Contention interrogatories “are more appropriately used after a substantial amount of discovery has been conducted--typically, at the end of the discovery period.”). Plaintiff also objects to this Interrogatory to the extent it attempts to limit or mischaracterize Plaintiff’s claim as just

challenging the false, inaccurate, misleading, deceptive, or unfair nature of TLG's Safety Grade. As the Court explained in its order denying TLG's motion to dismiss, the core of the Complaint is "a challenge to Defendant's representations about its methodology, which they claim mislead consumers by failing to distinguish between absent data and damning data, and professing that grades are not influenced by a hospital's lack of survey participation." *Order on Motion to Dismiss* 6 (ECF No. 41). Plaintiff also challenges the provably false facts and deceptive scoring system underlying these grades, which TLG admits it relies on to arrive at its deceptive Safety Grades.

Subject to the foregoing objections and as more fully stated in the *Amended Complaint* (ECF No. 74) ("Complaint"), TLG has engaged in deceptive and unfair business practices and misrepresentations when issuing the Safety Grade for Plaintiff's hospital as part of TLG's annual "Hospital Survey." TLG posts these Safety Grades online at hospitalsafetygrade.org.

To arrive at these Safety Grades, TLG uses CMS data, survey responses from participating hospitals, and other supplemental data sources. For participating hospitals, TLG uses the hospitals' self-reported responses to the Hospital Survey for 12 of the 22 measures. For non-participating hospitals, TLG uses other sources for those 12 measures. For the remaining four measures—Computerized Physician Order Entry, Bar Code Medication Administration, ICU Physician Staffing, and Hand Hygiene Score (the "Deceptive Score Categories")—TLG devised and uses a so-called "imputation model." Prior to Fall 2024, TLG's imputation model assigned non-participating hospitals a score based on the average score applicable to a similarly situated hospital. Beginning in Fall 2024, TLG modified its imputation model. TLG now assigns the lowest possible score to non-participating hospitals, which has the effect of punishing non-participating hospitals and artificially deflating their Safety Grades. TLG has even admitted the changes in Fall 2024 were designed to penalize non-participating hospitals. TLG also misleads consumers about how

it grades hospitals, stating “[t]he Hospital Safety Grade reflects how well a hospital does on safety, not whether they complete the [TLG] Hospital Survey.” *Declaration of Lee Crain* (ECF No. 21) (“Crain Decl.”), Ex. 1 at 4 (“Frequently Asked Questions About the Leapfrog Hospital Safety Grade”).

As TLG explains, “not all hospitals have enough data publicly available to be eligible for a grade.” Crain Decl. Ex. 1 at 5. “As per the National Expert Panel guidance, [TLG] has requirements for the minimum amount of data [it] need[s] to issue an accurate grade.” Crain Decl. Ex. 1 at 5. According to TLG, “[h]ospitals missing more than six process measures” are “not graded.” Crain Decl. Ex. 2 at 6. Non-participating hospitals should fall easily into that “not graded” bucket, because their decision not to participate in TLG’s survey necessarily means TLG is missing seven process measures that rely on voluntary submission of hospital data.¹

TLG then deceptively conceals how it makes up grades for the four “imputation” measures and even suggests on its website that TLG *does* have data sufficient to score TLG on those four measures. By way of example, TLG acknowledges that Plaintiff “Declined to Report” information in response to questions about “Staff work[ing] together,” but then tells consumers—as if it were a fact—that Plaintiff is “Worse Than Average” on “Handwashing,” “Communication,” “medication administration,” and the like—even though TLG has no basis whatsoever to adopt those conclusions. Crain Decl. Ex. 32 at 2. TLG itself says handwashing is among the “most important” measures in its survey, Crain Decl. Ex. 15 at 4, yet it deceptively conceals that it has no data with which to grade the Plaintiff hospital on that measure. *Defendant The Leapfrog Group’s Responses to Plaintiffs’ Requests for Production* at 7 (“Leapfrog is not itself in possession

¹ Those seven include CPOE, BCMA, IPS, Safe Practice 1: Culture of Leadership Structures and Systems; Safe Practice 2: Culture Measurement, Feedback & Intervention; Total Nursing Care Hours per Patient Day; and Hand Hygiene.

of data showing Plaintiffs' performance on the 'imputed metrics' considered by the methodology."'). Of course, Plaintiff in fact has a comprehensive and thorough handwashing policy. And had Plaintiff merely filled out TLG's survey, it would have received a full letter grade higher on TLG's score. *Expert Report of Professor Sean Nicholson* (Aug. 7, 2025), Ex. 6.

Based on the foregoing, and as more fully set forth in the Complaint, TLG engages in deceptive trade practices by, among other things, deceiving consumers about its grading methods by implying that Plaintiff has failed on certain measures that, in truth, TLG has no data or other basis to evaluate; deceiving consumers by telling them the Hospital Safety Grade reflects how well a hospital does on safety, not whether they complete the Hospital Survey; deceiving consumers when it represents that it does not grade hospitals if it lacks sufficient data, when, in truth, it does grade hospitals by "imputing" or making up a grade for the Deceptive Score Categories; hiding the truth about its "imputation model" from consumers by burying it in fine print on a separate website; punishing non-participating hospitals by "imputing" scores, which artificially deflate a hospital's Safety Grade; and favoring participating hospitals. Additional factual bases for the Plaintiff's claims are presented in the Complaint.

Interrogatory No. 4: Describe the scoring or grading methodology You believe Leapfrog should have used to assess Your hospital's patient safety performance and explain why that method would yield a different result.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Plaintiff's provision of an alternative scoring or grading methodology has nothing to do with the claims and defenses in this case related to TLG's

decision to use deceptive business practices. Plaintiff further objects to this Interrogatory to the extent it calls for speculation.

Answer: Plaintiff declines to respond to this Interrogatory.

Amended Answer: Subject to the foregoing objections, Plaintiff responds that TLG should use a scoring system that is not unfair or deceptive. By way of example only, TLG could decline to grade hospitals that do not participate in TLG's survey, because their decision not to participate means TLG is missing seven process measures that rely on voluntary submission of hospital data. This would yield a different result, because the hospitals would not receive a grade at all. TLG's methodology certainly should not affirmatively assign an arbitrary low score to a particular metric just because a hospital does not provide data for that metric.

Interrogatory No. 5: State whether You submitted any data, corrections, or appeals to Leapfrog regarding the Safety Grade Your hospital received, and for each such submission, identify the date of the submission, the medium of the submission (i.e. telephone, video conference, email, letter, etc.), who was involved in the submission, and the content of the submission.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Whether or not Plaintiff submitted "any data, corrections, or appeals to Leapfrog regarding the Safety Grade" Plaintiff hospital received has nothing to do with the claims and defenses in this case related to TLG's decision to use deceptive business practices. Plaintiff further objects to this Interrogatory to the extent it seeks information that is already in TLG's possession, custody and control, or equally available to TLG.

Answer: Subject to the foregoing objections, Plaintiff engaged in correspondence prior to the commencement of this case demanding that TLG reform its deceptive practices and cease and desist reporting deceptive and unfair Safety Grades, but at every turn TLG refused.

Amended Answer: Subject to the foregoing objections, Plaintiff did not submit any data, corrections or appeals to Leapfrog regarding the Safety Grades it has received.

Interrogatory No. 6: State whether You provided any comment or input in any form during Leapfrog's requests for public comments for planned updates to the Leapfrog Hospital Safety Grade methodology that was proposed for the calculation of Hospital Safety Grades (including but not limited to for the Fall 2024 methodology update). If yes, please identify the date of the comment, the medium of the submission (i.e. telephone, video conference, email, letter, etc.), who was involved in the comment and the content of the comment. If no, please state the reason why You chose not to comment.

Answer: Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Whether or not Plaintiff submitted "any comment or input" in response to TLG's request for public comments has nothing to do with claims and defenses in this case related to TLG's decision to use deceptive business practices. Plaintiff further objects to this Interrogatory to the extent it seeks information that is already in TLG's possession, custody and control, or equally available to TLG.

Subject to the foregoing objections, Plaintiff did not provide comments in response to Leapfrog's requests for public comments for planned updates to the Leapfrog Hospital Safety Grade scoring system because Plaintiff generally does not respond to requests for public comment from private entities like TLG.

Interrogatory No. 7: Describe all actions Your hospital took in response to (or in deciding not to respond to) its Safety Grade or the Hospital Survey, including internal meetings, media statements, or public relations efforts. In so answering, state the date of the action, the individuals involved in the action and the content of the action.

Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks “all actions” Plaintiffs may have taken in response to TLG’s Safety Grades. *See Megdal Assocs., LLC v. La-Z-Boy, Inc.*, No. 14-81476-CIV, 2016 WL 4503337, at *6 (S.D. Fla. Feb. 1, 2016) (finding interrogatories asking for “‘all’ facts or witnesses that support an opposing party’s case” to be “unduly broad”) (citing 8B Wright, Miller, & Kane, Federal Practice and Procedure: Civil 3d § 2167 (2015)). Plaintiff further objects to this Interrogatory to the extent it seeks information that is subject to a claim of privilege or otherwise protected from disclosure, including seeking information protected by the attorney-client privilege, work-product doctrine, or other immunity.

Answer: Subject to the foregoing objections, Plaintiff devoted substantial time and resources that could have otherwise been spent continuing to improve patient care to respond to the significant harm and disruption caused by TLG’s deceptive and unfair Safety Grade. Plaintiff’s response included meeting internally with Plaintiff’s leadership team, medical executive committee, and governing board, corresponding with TLG to demand that TLG reform its deceptive practices and cease and desist reporting deceptive and unfair Safety Grades, and devoting substantial time and resources to facilitate the preparation and prosecution of this Action.

Amended Answer: Subject to the foregoing objections, Plaintiff devoted substantial time and resources that could have otherwise been spent continuing to improve patient care to respond to the significant harm and disruption caused by TLG’s deceptive and unfair Safety Grades. Plaintiff’s response included meeting internally with Plaintiff’s leadership team, medical executive

committee, and governing board, corresponding through Plaintiff's corporate parent with TLG to demand that TLG reform its deceptive practices and cease and desist reporting deceptive and unfair Safety Grades, and devoting substantial time and resources to facilitate the preparation and prosecution of this Action. Plaintiff has also held many phone calls and meetings with physicians and other stakeholders about the TLG grades, explaining how the grades were deceptive and did not accurately reflect the hospital quality and patient safety at Plaintiff.

Interrogatory No. 8: Identify any and all persons, whether internal or external (e.g., patients, vendors, affiliates, parents, agents, partners, media) with whom You communicated in any way with respect to the Safety Grade or the Hospital Survey. In so answering, state the date of the communication, the individuals involved in the communication, the medium of the communication (i.e. telephone, video conference, email, letter, etc.) and the content of the communication.

Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks the identity of "any and all persons, whether internal or external." Plaintiff will disclose the categories of individuals with whom Plaintiff communicated about the Safety Grade or Hospital Survey during the Relevant Time Period. Plaintiff also objects to this Interrogatory to the extent it seeks protected health information that Health Insurance Portability and Accountability Act ("HIPAA"), among other statutes and regulations, bars Plaintiff from disclosing. Plaintiff further objects to this Interrogatory to the extent it seeks information that is subject to a claim of privilege or otherwise protected from disclosure, including seeking information protected by the attorney-client privilege, work-product doctrine, or other immunity.

Answer: Subject to the foregoing objections, Plaintiff communicated with the following categories of people regarding the Safety Grade or the Hospital Survey: Plaintiff's governing board, its medical executive committee, department directors, and physicians and nurses when

asked about the Safety Grade or Hospital Survey. These communications occurred in and after Fall 2024, after TLG released its deceptive and unfair Safety Grade for Plaintiff's hospital. Most of these communications occurred during regularly scheduled meetings, during which attendees were told about TLG's release of the deceptive and unfair Safety Grade, that Plaintiff does not participate in the Hospital Survey because it is unreliable and not an accurate reflection of hospital quality and safety or patient outcomes, and that the Safety Grade, which was not based on any information provided by Plaintiff, was misleading. The Palm Beach Health Network also issued a press release and since then, has engaged in various social networking and other marketing campaigns to counteract TLG's deceptive scores on behalf of Plaintiff and other affected members of the network.

Amended Answer: Subject to the foregoing objections, Plaintiff communicated with the following categories of people regarding the Safety Grade or the Hospital Survey: Plaintiff's governing board, its medical executive committee, department directors, physicians and nurses, and patients when asked about the Safety Grades or Hospital Survey. These communications occurred in and after Fall 2024, after TLG released its deceptive and unfair Safety Grades for Plaintiff's hospital. Most of these communications occurred during regularly scheduled meetings, during which attendees were told about TLG's release of the deceptive and unfair Safety Grade, that Plaintiff does not participate in the Hospital Survey because it is unreliable and not an accurate reflection of hospital quality and safety or patient outcomes, and that the Safety Grade, which was not based on any information provided by Plaintiff, was misleading. The Palm Beach Health Network also issued a press release and has engaged in marketing efforts, including through social media, to counteract TLG's deceptive scores on behalf of Plaintiff and other affected members of

the network. Plaintiff also engaged in email discussions about TLG's misleading grades, either as sender or recipient, which TLG has through Plaintiff's production of documents.

Interrogatory No. 9: Describe all instances in which a third party declined to contract with, refer patients to, or work with Your hospital, where Leapfrog's grade was cited or discussed. In so identifying list the name of the individuals involved in the communication, the medium of the communication (i.e. telephone, video conference, email, letter, etc.), the date of the communication and the content of the communication.

Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it requires Plaintiff to "[d]escribe all instances" in which a third party took an action in response to TLG's deceptive grade.

Answer: Subject to the foregoing objection, Plaintiff is not aware of any responsive instances.

Amended Answer: Subject to the forgoing objection, by way of example, our Chief Nursing Officer reported that a nursing candidate questioned the quality of care of the hospital in her interview for a job opening. In addition, the recently hired Director of Cardiac Cathater Lab shared with the Chief Operating Officer that he considered rescinding his acceptance of the position after learning that the hospital had received an F from TLG, but he was glad that he didn't do so because Good Samaritan is a high-quality hospital and he is happy to be part of the organization.

Interrogatory No. 10: Describe with specificity the basis for each and every category of damage You claim You incurred as a result of the Leapfrog Safety Grade. In so identifying, list each category of damages and the dollar value of each category of damage You claim.

Plaintiff objects to this Interrogatory to the extent it seeks information that is the subject of expert testimony.

Answer: Plaintiff will submit expert reports on August 7, 2025, per the Pretrial Scheduling Order.

Amended Answer: Plaintiff has served the expert report of Thomas Chakurda, which addresses the issue of reputational harm and harm to Plaintiff's goodwill. Plaintiff further objects to this Interrogatory as overbroad and unduly burdensome to the extent it seeks "each and every" category of claimed damages.

Subject to the foregoing objections and as agreed during the parties' September 3, 2025 meet and confer, Plaintiff will limit its response to the live non-monetary claims, including injunctive and declaratory relief, to remedy harm to Plaintiff's reputation and goodwill. Plaintiff's reputation and goodwill has been damaged by TLG's false and misleading methodology and resulting Safety Grades. Plaintiff's claim for reputational harm is based on, among other things, concerns raised by patients, doctors, staff, and community members, as well as false and misleading statements based on TLG's false and misleading methodology and Safety Grades made in newspapers, viral social-media videos, television programs, and blogs.

By way of example, our Medical Executive Committee has received direct inquiries from patients regarding their concerns as TLG's grades and related public reports. Our Chief Nursing Officer reported that a nursing candidate questioned the quality of care of the hospital in her interview for a job opening. Patients have asked independent physicians that use both our facilities and those of Jupiter Medical Center (a nearby hospital) to schedule their surgeries at Jupiter Medical Center and not at ours. Those patients chose not to use our hospital specifically because of the Leapfrog grades. These independent surgeons have told us that they believe TLG has misled these patients about the quality of the Medical Center. The harm caused by TLG's false and misleading Safety Grade is ongoing.

Interrogatory No. 11: Identify all adverse patient events which occurred at Your hospital, including any citations received from regulatory agencies, accrediting agencies, and third party payors such as The Joint Commission, CMS, state health departments, etc. during the period covered by each Leapfrog Safety Grade publication of which You complain (i.e., Fall 2024, Fall 2025, etc.), as well as any complaints received from patients regarding the same.

Plaintiff objects to this Interrogatory because it is overly broad, unduly burdensome, seeks discovery of information that is irrelevant to the claims and defenses in this Action, seeks information that is beyond the scope of Leapfrog's Hospital Survey, and is not reasonably calculated to lead to the discovery of admissible evidence. TLG does not include "all adverse patient events," "citations received from" agencies or payors, or "complaints received from patients" in TLG's determination of its Hospital Safety Grades or request such information in the Hospital Survey, so any such information is irrelevant to whether TLG's actions constitute unfair or deceptive trade practices. TLG has, therefore, only propounded this Interrogatory for purposes of harassment. Plaintiff also objects to this Interrogatory to the extent it seeks protected health information that HIPAA, among other statutes and regulations, bars Plaintiff from disclosing.

Answer: Plaintiff declines to respond to this Interrogatory.

Amended Answer: Defendant has agreed to withdraw this Interrogatory.

Interrogatory No. 12: Describe in detail how Your hospital compares nationally on on [sic] any other ranking of patient safety performance, including but not limited to Vizient, Inc., Premier, Inc., HealthTrust Purchasing Group, The Joint Commission, HealthGrades, US News, Newsweek, Statista, Definitive Healthcare, or any other quality benchmarking entity including benchmarking on patient safety including on adverse events and on healthcare-acquired infections.

Plaintiff objects to this Interrogatory's request that Plaintiff "[d]escribe in detail how Your hospital compares nationally" based on undisclosed "benchmarking" as vague and confusing. To the extent this Interrogatory seeks the top-line rankings of the identified organizations, Plaintiff objects to this Interrogatory because such information is publicly and equally available to TLG.

To the extent this Interrogatory asks Plaintiff to compare itself to the named and unnamed entities, that request is overly broad, unduly burdensome, and not proportional to the needs of this Action. Plaintiff further objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Other organizations' rankings have nothing to do with the claims and defenses in this case related to the Deceptive Score Categories or TLG's decision to use deceptive business practices.

Answer: Subject to the foregoing objections, Plaintiff has received numerous awards and accolades, including many that are directly relevant to patient care for the community we serve. As a full-service cancer hospital, it is important to Plaintiff that it is accredited by the Commission on Cancer (CoC). In order to be accredited, Plaintiff had to undergo an on-site visit on a triennial basis, in which a trained CoC reviewer visited Plaintiff and reviewed its required cancer program activity documentation to ensure compliance with the standards.

The American College of Surgeons has designated Plaintiff a National Accreditation Program for Breast Centers for 13 years in a row. The American College of Radiology designated Plaintiff a Breast Imaging Center of Excellence, which it received only after accomplishing the highest level of care in breast imaging, including being committed to patients, providers, and payers. Plaintiff has been accredited as a Comprehensive Center by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program, a joint Quality Program of the American College of Surgeons and the American Society for Metabolic and Bariatric Surgery.

Plaintiff is accredited by the Joint Commission, the nation's largest hospital accreditor that evaluates hospitals' quality performance standards through an objective evaluation process. Plaintiff has also been accredited by Joint Commission for specialization certifications for Gold

Seal of Approval for Total Hip and Knee Replacement, Shoulder Replacement and Spine Surgery—certification designed for hospitals providing the critical elements to achieve long-term success in improving critical medical outcomes—which signifies our services have delivered evidence-based proof of clinical quality sought by patients and payers alike. The entities that award and assign these accreditations and certifications visit the healthcare facility and perform regular periodic in-person reviews, audits surveys and assessments of the facility.

Plaintiff has also recently received the Florida Department of Health and Florida Agency for Health Care Administration Excellence for Maternal Care Award, which highlights hospitals that surpass Florida Department of Health’s goal of reducing the rate of C-sections among first-time mothers with low-risk pregnancies. Plaintiff was recognized by BlueCross BlueShield with a Blue Distinction Centers for Bariatric Surgery designation, as part of the Blue Distinction Specialty Care program, and for Knee and Hip Replacement. Plaintiff earned this recognition by providing a full range of bariatric surgical care services, including inpatient care, postoperative care, follow-up, and patient education that operate to standards set by BlueCross BlueShield, in partnership with physician experts and medical organizations. Aetna has also designated Plaintiff as an Aetna Institute of Quality orthopedic facility for total joint replacement and spine surgery, which it earned by consistently delivering safe and effective orthopedic care.

Healthgrades has awarded Plaintiff numerous Healthgrades accolades. To assess and evaluate hospitals, Healthgrades relies on data from Medicare medical claims records and states’ data on Medicare and commercially insured patient outcomes to determine patients’ actual clinical outcomes when visiting a given hospital. Plaintiff also received several awards from Healthgrades for various specialties, including:

a. Labor and Delivery

- i. Five-Star Recipient for C-Section Delivery for four years in a row (2022-2025)
- ii. Five-Star Recipient for Vaginal Delivery for 12 years in a row (2014-2025)

b. Outpatient Orthopedic

- i. Five-Star Recipient for Outpatient Back and Neck Surgery (except Spinal Fusion) (2025)
- ii. Recipient of the Healthgrades Outpatient Orthopedic Surgery Excellence Award (2025)

c. Spine Surgery

- i. Five-Star Recipient for Spinal Fusion
- ii. Recipient of the Healthgrades America's 100 Best Hospitals for Spine Surgery Award (2025)
- iii. Top 10% in the Nation for Spine Surgery (2025)
- iv. Recipient of the Healthgrades 2025 Spine Surgery Excellence Award

d. Gastrointestinal

- i. Five-Star Recipient for Treatment of Gastrointestinal Bleed (2024)

In addition, Plaintiff will produce and identify documents reflecting some of Plaintiff's rankings from other organizations.

Amended Answer: Subject to the foregoing objections, Plaintiff has received numerous awards and accolades. For example, Plaintiff has been accredited by the Commission on Cancer (CoC) for 31 years. The American College of Surgeons has designated Plaintiff a National

Accreditation Program for Breast Centers for 13 years in a row. The American College of Radiology designated Plaintiff a Breast Imaging Center of Excellence. Plaintiff has been accredited as a Comprehensive Center by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program, a joint Quality Program of the American College of Surgeons and the American Society for Metabolic and Bariatric Surgery. Plaintiff received the American Heart Association Stroke Gold Plus award for 2025.

Plaintiff is accredited by the Joint Commission. Plaintiff has also been accredited by Joint Commission for specialization certifications for Gold Seal of Approval for Total Hip and Knee Replacement, Shoulder Replacement and Spine Surgery.

Plaintiff has also recently received the Florida Department of Health and Florida Agency for Health Care Administration Excellence for Maternal Care Award. Plaintiff was recognized by BlueCross BlueShield with a Blue Distinction Centers for Bariatric Surgery designation, as part of the Blue Distinction Specialty Care program, and for Knee and Hip Replacement. Aetna has also designated Plaintiff as an Aetna Institute of Quality orthopedic facility for total joint replacement and spine surgery.

Healthgrades has awarded Plaintiff numerous Healthgrades accolades. Plaintiff also received several awards from Healthgrades for various specialties, including:

a. Labor and Delivery

- i. Five-Star Recipient for C-Section Delivery for four years in a row (2022-2025)
- ii. Five-Star Recipient for Vaginal Delivery for 12 years in a row (2014-2025)

b. Outpatient Orthopedic

- iii. Five-Star Recipient for Outpatient Back and Neck Surgery (except Spinal Fusion) (2025)
- iv. Recipient of the Healthgrades Outpatient Orthopedic Surgery Excellence Award (2025)

c. Spine Surgery

- i. Five-Star Recipient for Spinal Fusion
- ii. Recipient of the Healthgrades America's 100 Best Hospitals for Spine Surgery Award (2025)
- iii. Top 10% in the Nation for Spine Surgery (2025)
- iv. Recipient of the Healthgrades 2025 Spine Surgery Excellence Award

d. Gastrointestinal

- i. Five-Star Recipient for Treatment of Gastrointestinal Bleed (2024)

In addition, Plaintiff will produce and identify documents reflecting some of Plaintiff's rankings from other organizations.

Also, Plaintiff does not participate in Vizient and has not done so during the Relevant Time Period.

Interrogatory No. 13: Describe any steps taken by Your hospital to improve any and all of the patient safety measures considered by Leapfrog's Hospital Safety Grade (as set forth on Leapfrog's published scoring methodology documents; see ECF No. 21-3 at 6-10; ECF No. 21-43 at 6-9), before and after each Safety Grade publication of which You complain.

Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks the identity of Plaintiff's improvements to "any and all" patient safety measures considered by Leapfrog's Hospital Safety

Grade. Plaintiff further objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks information on metrics other than TLG's Deceptive Score Categories and to the extent it seeks information that is beyond the scope of Leapfrog's Hospital Survey.

Answer: Plaintiff declines to respond to this Interrogatory.

Amended Answer: Subject to the foregoing objection, Plaintiff is committed to continual improvement of patient safety measures, motivated by our commitment to ensuring the best possible patient safety—not chasing the best possible Leapfrog grade. To achieve this core objective, Plaintiff devotes significant time and resources to improving its delivery of the highest possible quality of care for those in the community it serves, including efforts to improve its performance in areas related to the four metrics Plaintiff has chosen to impute in its survey.

Plaintiff monitors its BCMA rate, but the rate is already nearly 100%, so there is very little scope for improvement. Plaintiff consistently tracks CPOE and hand hygiene. For CPOE, Plaintiff trains new hires one-on-one on how to implement CPOE properly, meets with providers to address any barriers, shares compliance reports with individual providers, and clinical informatics educators visit physicians' offices to address any access issues. Plaintiff also trains new hires in proper compliance with Plaintiff's hand hygiene policy and requires annual continuing education on it. Plaintiff surveils hand hygiene compliance monthly and provides real time education on the importance of hand hygiene. Compliance with Plaintiff's hand hygiene policy is also reviewed at periodic committee meetings, and leadership shares data with staff and holds them accountable for the results.

Plaintiff already has 24/7 ICU coverage for its intensivist unit and has had that coverage for several years, so it does not need to track this metric.

Interrogatory No. 14: State whether You are aware of specific patients who have relied on the Leapfrog Safety Grade in declining to receive healthcare services at Your hospital. In so answering, identify the individual patient that declined to receive services, the date of such declination, the type of service the patient declined to receive, the medium for the communication from the patient (i.e. telephone, video conference, email, letter, etc.), the content of the communication, and the reason given for the stated decision.

Plaintiff objects to this Interrogatory as seeking protected health information that is protected from disclosure by HIPAA, among other statutes and regulations. Plaintiff will only produce this information as needed and subject to a Qualified Protective Order entered by this Court.

Answer: Subject to the foregoing objection, Plaintiff has received reports that patients considered or decided not to use Plaintiff's facility because of TLG's misleading grades.

Amended Answer: Subject to the foregoing objection, since the release of TLG's false and misleading grades, Plaintiff has received numerous reports from doctors that patients considered or decided not to use Plaintiff's facility due to concerns related to TLG's misleading grades.

Interrogatory No. 15: Describe any effort Your hospital has made to influence public perception of Your hospital's performance on patient safety following the publication of the Leapfrog Safety Grade.

Plaintiff objects to this Interrogatory as vague and ambiguous because it does not specify which Leapfrog Safety Grade is at issue. Plaintiff will construe this Interrogatory to reference TLG's deceptive Safety Grades beginning in Fall 2024. Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks "any effort" Plaintiff "has made to influence public perception" after the release of TLG's

deceptive and unfair Safety Grades because there have been many such “efforts” and those “efforts” are ongoing given the significant harm caused by TLG’s deceptive and unfair business practices.

Answer: Subject to the foregoing objections, Plaintiff continues to influence public perception by, among other things, delivering the highest quality care to the community it serves, which, as discussed in response to Interrogatory 12, has led to numerous awards, accreditations, and accolades. In addition, several public statements disputing the misleading nature of the Safety Grade have been made on Plaintiff’s behalf.

Supplemental Answer: In addition to the above, members of hospital leadership have communicated with patients, doctors, or community members on a regular basis to dispel the misleading nature of the Leapfrog Safety Grades. For instance, Plaintiff communicated its governing board, its medical executive committee, department directors, physicians and nurses, and patients when asked about the Safety Grades or Hospital Survey. These communications occurred in and after Fall 2024, after TLG released its deceptive and unfair Safety Grades for Plaintiff’s hospital. The Palm Beach Health Network also issued a press release and has engaged in marketing efforts, including through social media, to counteract TLG’s deceptive scores on behalf of Plaintiff and other affected members of the network. Plaintiff also engaged in email discussions about TLG’s misleading grades, either as sender or recipient, which TLG has through Plaintiff’s production of documents.

Interrogatory No. 16: Describe the due diligence Your hospital undertakes to ensure the accuracy of its own publicly reported safety data (including but not limited to data submitted to CMS, the CDC, and third party organizations).

Plaintiff objects to this Interrogatory as vague and ambiguous due to its use of the undefined term “due diligence.” Plaintiff further objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Any “due diligence” Plaintiff performs when reporting to *third parties* has nothing to do with the claims and defenses in this case related to TLG’s decision to use deceptive business practices, especially when TLG does nothing to ensure the accuracy of information that hospitals that participate in its survey self-report.

Answer: Plaintiff declines to respond to this Interrogatory.

Amended Answer: Subject to the foregoing objections, Plaintiff makes reasonable efforts to ensure the accuracy of the data it reports to third-party organizations. For instance, Plaintiff employs data abstractors, quality coordinators and a Quality Director, who are all responsible for abstracting, validating, and submitting safety data.

Interrogatory No. 17: Describe in detail how You communicate to the shareholders, board members, collective bargaining representatives and investors of Tenet Healthcare System the outcome of any and all healthcare safety ratings, evaluative publications, studies, or performance analyses that Your Hospital receives.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Plaintiff’s communication, if any, with the shareholders, board members, collective bargaining representatives and investors of Tenet Healthcare System, all non-parties to this litigation, has nothing to do with the claims and defenses in this case related to TLG’s decision to use deceptive business practices.

Answer: Plaintiff declines to respond to this Interrogatory.

Amended Answer: Subject to the foregoing objection, Plaintiff communicates with Tenet stakeholders, including employees who work to support the Palm Beach Health Network, on a range of matters, including issues related to patient safety and outcomes and in particular related to TLG and the Safety Grades by email and oral communication. Those communications included discussions about the reasons for particular grades, the method used to calculate Safety Grades, the value of Safety Grades, and responses to the Safety Grades. In addition, identified below are documents Plaintiff produced evidencing communications between the Plaintiff Hospitals and Tenet related to TLG, the Leapfrog survey, and Safety Grades.

Start Page	End Page
PBHN000006509	PBHN000006513
PBHN000005132	PBHN000005137
PBHN000002076	PBHN000002078
PBHN000005043	PBHN000005050
PBHN000005060	PBHN000005068
PBHN000006397	PBHN000006401
PBHN000002090	PBHN000002094
PBHN000002095	PBHN000002102
PBHN000002071	PBHN000002071
PBHN000005083	PBHN000005085

PBHN000004562	PBHN000004563
PBHN000004564	PBHN000004564
PBHN000004574	PBHN000004581
PBHN000004556	PBHN000004556
PBHN000004565	PBHN000004569
PBHN000004704	PBHN000004704
PBHN000004715	PBHN000004719
PBHN000005036	PBHN000005042
PBHN000005138	PBHN000005140
PBHN000006465	PBHN000006466

Discovery is ongoing, and Plaintiff reserves the right to amend, modify or supplement the response to this Interrogatory.

Interrogatory No. 18: State whether the compensation of Your Chief Executive Officer or any other executive-level leadership officers is tied to or related in any way to Your hospital's performance on patient safety, union worker contracts or Your hospital's ratings by third party ratings organizations' ratings publications (including but not limited to the Leapfrog Hospital Safety Grade).

Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Plaintiff's method of compensating its Chief Executive Officer and other executive-level leadership **has nothing to do with the** claims and defenses in this case related to TLG's decision to use deceptive business practices.

Answer: TLG has, therefore, only propounded this Interrogatory for purposes of harassment. Plaintiff declines to respond to this Interrogatory.

Amended Answer: Subject to the foregoing objection, Plaintiff's performance on patient safety, union worker contracts, or ratings by third party ratings organizations' ratings publications is related in some way to the compensation of Plaintiff's Chief Executive Officer or other executive-level leadership officer(s).

Interrogatory No. 19: Identify all hospitals, medical centers, or healthcare systems that you consider to be your direct competitors within the relevant geographic market during the time period covered by the Complaint and describe in detail the criteria you use to determine whether another hospital or healthcare provider is a competitor.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is not reasonably calculated to lead to the discovery of admissible evidence. The identity of Plaintiff's competitors and "the criteria" used to determine whether a hospital or provide is a competitor has nothing to do with the claims and

defenses in this case related to TLG's decision to use deceptive business practices. Plaintiff also objects to this Interrogatory to the extent it seeks confidential, proprietary information, and commercially sensitive information related to Plaintiff's scoring system and "criteria" used to determine whether a hospital or provide is a competitor.

Answer: Subject to the foregoing objections and on condition that this response is considered "Confidential" under the forthcoming agreed confidentiality order, HCA Florida JFK Hospital, HCA Florida Palms West Hospital, Jupiter Medical Center, and Wellington Regional Medical Center are Plaintiff's competitors. Plaintiff considers these hospitals competitors because of their proximity to Plaintiff, their competing services lines, and that patients within Plaintiff's service area go to these hospitals for medical care.

Supplemental Answer: Cleveland Clinic and NYU Langone are also Plaintiff's competitors.

Interrogatory No. 20: State and describe the results of any market analysis, competitive analysis, or consumer perception surveys you have conducted or commissioned regarding your competitors from 2020 to present, and identify the individuals or entities that prepared or participated in such analyses.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is not is not proportional to the needs of this Action. The results of any market analysis, competitive analysis, or consumer perception surveys and the identity of those who prepared or participated in such analyses has nothing to do with the claims and defenses in this case related to TLG's decision to use deceptive business practices.

Answer: Plaintiff declines to respond to this Interrogatory.

Amended Answer: Plaintiff further objects to this Interrogatory to the extent it requests information from outside of the relevant time period of January 1, 2023, to present. Plaintiff also objects to this Interrogatory as unduly burdensome to the extent it asks Plaintiff to “state and describe” various market analysis.

As agreed during the parties’ meet and confer on September 3, 2025, Plaintiff will produce documents showing the results of studies or surveys Plaintiff has conducted or commissioned related to internal market analysis, competitive analysis, or consumer perception. Plaintiff will identify the documents responsive to this Interrogatory by Bates number in Plaintiffs’ production cover letter.

Interrogatory No. 21: Identify with specificity any comments or concerns raised by any third party payor, bank or lender, or investor related to Your hospital’s reputation and/or public perception on issues in any way involving patient safety or satisfaction.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is overly broad, unduly burdensome and irrelevant to the claims and defenses in this Action and is not proportional to the needs of this case to the extent it seeks “comments and concerns” from third parties related generally to Plaintiff’s reputation that has nothing to do with the specific and significant reputational harm caused by TLG’s misleading grades.

Answer: Subject to the foregoing objections, Plaintiff will produce and identify documents related to the significant reputational harm caused by TLG’s deceptive and unfair Safety Grades that provide sufficient detail to respond to this Interrogatory.

Amended Answer: Subject to the foregoing objections, Plaintiff is unaware of any documents related to this Interrogatory.

Interrogatory No. 22: Identify and describe any complaints, concerns, or comments from patients, community members, or referring physicians that relate to the hospital's reputation or comparisons to other hospitals in the region.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is overly broad, unduly burdensome and irrelevant to the claims and defenses in this Action and is not proportional to the needs of this Action to the extent it seeks "comments and concerns" from patients, community members, or referring physicians that have nothing to do with the significant reputational harm caused by TLG's misleading grades. Plaintiff also objects to this interrogatory as seeking protected health information that is protected from disclosure by HIPAA, among other statutes and regulations. Plaintiff will only produce this information as needed and subject to the agreed protective order entered by this Court.

Answer: Subject to the foregoing objections, Plaintiff has received reports that patients and physicians considered or decided not to use Plaintiff's facility because of TLG's misleading grades.

Amended Answer: Subject to the foregoing objections, Plaintiff has received reports that patients and physicians considered or decided not to use Plaintiff's facility because of TLG's misleading grades. In addition, concerns have been raised by patients, doctors, staff, and community members, and Plaintiff is aware of false and misleading statements based on TLG's false and misleading methodology and Safety Grades made in newspapers, viral social-media videos, television programs, and blogs.

Our Medical Executive Committee has received direct inquiries from patients regarding their concerns as TLG's grades and related public reports. Our Chief Nursing Officer reported that a nursing candidate questioned the quality of care of the hospital in her interview for a job opening.

Patients have asked independent physicians that use both our facilities and those of Jupiter Medical Center (a nearby hospital) to schedule their surgeries at Jupiter Medical Center and not at ours. Those patients chose not to use our hospital specifically because of the Leapfrog grades. These independent surgeons have told us that they believe TLG has misled these patients about the quality of the Medical Center. The harm caused by TLG's false and misleading Safety Grade is ongoing.

In addition, the following produced documents evidence such harm.

Start Page	End Page
PBHN000006771	PBHN000006773
PBHN000002082	PBHN000002085
PBHN000002066	PBHN000002070
PBHN000002076	PBHN000002078
PBHN000002615	PBHN000002617
PBHN000005016	PBHN000005021
PBHN000005022	PBHN000005028
PBHN000005043	PBHN000005050
PBHN000005060	PBHN000005068
PBHN000005169	PBHN000005175
PBHN000006397	PBHN000006401

PBHN000002090	PBHN000002094
PBHN000002095	PBHN000002102
PBHN000004484	PBHN000004484
PBHN000004564	PBHN000004564
PBHN000004574	PBHN000004580
PBHN000004557	PBHN000004557
PBHN000005138	PBHN000005140
PBHN000008718	PBHN000008718
PBHN000002079	PBHN000002081
PBHN000006461	PBHN000006462
PBHN000008914	PBHN000008914
PBHN000008915	PBHN000008915

Discovery is ongoing, and Plaintiff reserves the right to amend, modify or supplement the response to this Interrogatory.

Interrogatory No. 23: List with specific detail each and every concern, complaint or comment made by any union, collective bargaining unit or employee association in any way related to patient safety at Your hospital.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is overly broad, unduly burdensome and irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks “each and every concern, complaint or comment ” from third parties that have nothing to do with the significant reputational harm caused by TLG’s misleading grades. Plaintiff also objects to this Interrogatory to the extent it seeks health information that is protected from disclosure by HIPAA, among other statutes and regulations. Plaintiff will only produce this information as needed and subject to the agreed protective order entered by this Court.

Answer: Subject to the foregoing objections, Plaintiff is unaware of any concern, complaint or comment regarding TLG deceptive scores made by the union at Plaintiff’s hospital.

Amended Answer: Subject to the foregoing objections, Plaintiff is unaware of any concern, complaint, or comment regarding TLG’s deceptive scores or regarding patient safety made by the union at Plaintiff’s hospital.

Interrogatory No. 24: Identify any and all criticism You have received since 2020 from Tenet Healthcare Corporation and/or from any individual executive of Tenet Healthcare Corporation regarding Your hospital’s performance in any way.

Answer: Plaintiff objects to this Interrogatory because it seeks discovery of information that is overly broad, unduly burdensome and irrelevant to the claims and defenses in this Action and is not reasonably calculated to lead to the discovery of admissible evidence. Any so-called “criticism” has nothing to do with the claims and defenses related to TLG’s decision to use deceptive business practices. TLG has, therefore, only propounded this Interrogatory for purposes of harassment. Plaintiff declines to respond to this Interrogatory.

Amended Answer: As discussed during the parties' meet and confer on September 3, 2025, TLG agreed to narrow this Interrogatory to concern only "criticism...regarding Your hospital's patient safety." After a reasonable and diligent search, Plaintiff is unaware of having received "criticism" from Tenet Health Corporation regarding patient safety. Plaintiff is always working to improve its performance, quality, and safety in a constructive way and engages with Tenet Health Corporation as needed to ensure Plaintiff provides the best patient care possible.

Dated: September 8, 2025

Respectfully submitted,

By: /s/ Lee R. Crain

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*Attorneys for Good Samaritan Medical Center,
Inc.*

CERTIFICATE OF SERVICE

This is to certify that true and correct copies of Plaintiff's Amended and Supplemented Responses and Objections to Defendant The Leapfrog Group's First Sets of Interrogatories to Plaintiff have been served on counsel for The Leapfrog Group by electronic transmission.

/s/ Lee R. Crain
Lee R. Crain

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA
WEST PALM BEACH DIVISION

CASE NO. 9:25-CV-80526-DMM

GOOD SAMARITAN MEDICAL
CENTER, INC., et al.,

Plaintiffs,

v.

THE LEAPFROG GROUP,

Defendant.

**AFFIDAVIT OF SHERI MONTGOMERY IN SUPPORT OF
PLAINTIFF GOOD SAMARITAN MEDICAL CENTER, INC.'S
AMENDED AND SUPPLEMENTED RESPONSES AND OBJECTIONS TO
DEFENDANT THE LEAPFROG GROUP'S FIRST SET OF
INTERROGATORIES TO GOOD SAMARITAN MEDICAL CENTER, INC.**

I, Sheri Montgomery, declare as follows:

1. I am over 21 years of age and competent to give this testimony.
2. I am the Chief Executive Officer of Good Samaritan Medical Center, Inc. ("Plaintiff"). I am the corporate representative of Plaintiff for the purpose of answering Defendant The Leapfrog Group's First Set of Interrogatories to Good Samaritan Medical Center, Inc. I have read the foregoing interrogatories and the answers to those interrogatories, which are true according to the best of my knowledge, information, and belief.
3. I declare under penalty of perjury that the foregoing is true and correct.

Executed on September 8, 2025.


Sheri Montgomery

Exhibit 101

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA
WEST PALM BEACH DIVISION

CASE NO. 9:25-CV-80526-DMM

GOOD SAMARITAN MEDICAL
CENTER, INC., et al.,

Plaintiffs,

v.

THE LEAPFROG GROUP,

Defendant.

**PLAINTIFF PALM BEACH GARDENS MEDICAL CENTER'S
AMENDED AND SUPPLEMENTED RESPONSES AND OBJECTIONS TO
DEFENDANT THE LEAPFROG GROUP'S FIRST SET OF
INTERROGATORIES TO PALM BEACH GARDENS MEDICAL CENTER**

Pursuant to Federal Rules of Civil Procedure 26 and 33 and the *Pretrial Scheduling Order and Order Referring Case to Mediation* (ECF No. 36) (the “Pretrial Scheduling Order”), Plaintiff Palm Beach Gardens Medical Center (“Plaintiff” or “Palm Beach Gardens”), by and through its undersigned counsel, hereby submit its amended and supplemented responses and objections (“Responses”), to Defendant The Leapfrog Group’s (“TLG”) First Set of Interrogatories, dated July 11, 2025 (the “Interrogatories” and each numbered interrogatory, an “Interrogatory”) in the above-captioned action (the “Action”).

Plaintiff’s Responses to the Interrogatories are made solely for purposes of this Action and to the best of Plaintiff’s present knowledge, information, and belief regarding the matters about which inquiry have been made. Discovery is ongoing, and Plaintiff reserves the right to amend, supplement, clarify, or further explain its Responses at any time prior to the trial in

this Action. Plaintiff further reserves the right to raise any additional objections deemed necessary or appropriate in light of any further review.

OBJECTIONS TO INSTRUCTIONS AND DEFINITIONS

1. Plaintiff objects to the definition of terms “Plaintiffs” and “Plaintiff Hospitals” as overbroad, unduly burdensome, and not proportional to the needs of the case to the extent it seeks to require Plaintiffs to respond on behalf of entities or individuals other than themselves.

2. Plaintiff objects to the definition of the terms “Palm Beach Gardens,” “Palm Beach Gardens Medical Center,” “Plaintiff,” “You,” and “Your” to the extent each term seeks to require Plaintiff to respond on behalf of entities or individuals other than itself, including on behalf of agents, employees, directors, or other non-party entities that are not part of this litigation. Such information is overbroad and beyond the scope of permissible discovery. Accordingly, Plaintiff states that its Responses are on behalf of itself only.

3. Plaintiff objects to the definition of the terms “Tenet Healthcare” and “Tenet” to the extent it seeks to require Plaintiff to respond on behalf of entities or individuals other than itself, including on behalf of Tenet, Tenet’s agents, employees, directors, or other non-party entities that are not part of this litigation. Such information is overbroad and beyond the scope of permissible discovery. Accordingly, Plaintiff states that its Responses are on behalf of itself only.

4. Plaintiff objects to the definition of “identify, when referring to a person,” as overbroad and unduly burdensome to the extent it calls for the “address” and “present or last-known employer” of identified individuals. Such information is overbroad and beyond the scope of permissible discovery.

5. Plaintiff objects to the instruction that the relevant time period for the Interrogatories begins on January 1, 2020. Plaintiff will apply to each Interrogatory the time period

of November 1, 2023 to present (the “Relevant Time Period”). Any response to an Interrogatory that provides information that falls outside of the Relevant Time Period should not be construed as an admission that the Relevant Time Period begins prior to November 1, 2023.

SPECIFIC RESPONSES TO INTERROGATORIES

Interrogatory No. 1: State the full name, address, job title or position, and hospital or employer affiliation of all individuals that assisted with responding to these interrogatories.

Answer: The following individuals assisted with responding to these Interrogatories.

Full Name	Address	Job Title / Position	Hospital or Employer Affiliation
Erik Cazares	c/o Gibson, Dunn & Crutcher LLP 200 Park Avenue New York, NY 10166	Chief Executive Officer	Palm Beach Gardens Community Hospital
Regina West	c/o Gibson, Dunn & Crutcher LLP 200 Park Avenue New York, NY 10166	Market Quality Director	Palm Beach Health Network and St. Mary’s Medical Center

Interrogatory No. 2: Identify every individual not identified in Your Rule 26(a) initial disclosures with knowledge of facts pertaining to the allegations in Your Complaint in this Lawsuit (and any subsequent amendments) and/or whom You believe may have discoverable knowledge, information or data regarding this matter, including those who You expect to call as a fact or opinion witness at any hearing in this proceeding or whose testimony (by affidavit, deposition or testimony) You intended to submit in connection with this proceeding, and the substance of his/her testimony or affidavit, and, with respect to each person identified, provide:

- A. full name,
- B. address,
- C. telephone number,
- D. job title or position,
- E. hospital or employer affiliation,
- F. and describe in detail the facts possessed by each such person.

Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks the identity of “every individual...with knowledge” or who “may have discoverable knowledge, information or data regarding this matter.” Plaintiff will not provide more than the identity of individuals most likely to have knowledge regarding this matter. Plaintiff further objects to this Interrogatory as premature because it requests disclosure of Plaintiff’s witnesses for hearings and the substance of witness testimony before such disclosure is required under applicable law or the Pretrial Scheduling Order. Plaintiff will submit its trial witness list on October 2, 2025, per the Pretrial Scheduling Order, and disclose any other witnesses and witness testimony as further ordered by the Court or otherwise required by applicable law. Plaintiff also objects to this Interrogatory’s request for the identity of “opinion witness[es]” as vague, since witnesses are either “fact” or “expert” witnesses. Plaintiff will interpret “opinion witness” to mean “expert witness.” Plaintiff submitted expert reports on August 7, 2025, per the Pretrial Scheduling Order.

Answer: Subject to the foregoing objection, Plaintiff will amend its Rule 26(a)(1) Initial Disclosures to identify additional individuals who may have knowledge of facts pertaining to the allegations in the Complaint.

Amended Answer: In addition to those disclosed in Plaintiff’s supplemental disclosures, the following individuals may have relevant factual knowledge:

Full Name	Address	Job Title / Position	Hospital or Employer Affiliation
Regina West	c/o Gibson, Dunn & Crutcher LLP 200 Park Avenue New York, NY 10166	Market Quality Director	Palm Beach Health Network and St. Mary’s Medical Center

Full Name	Address	Job Title / Position	Hospital or Employer Affiliation
Kathleen McDonald	c/o Gibson, Dunn & Crutcher LLP 200 Park Avenue New York, NY 10166	Quality Director	Palm Beach Gardens Community Hospital

In addition to the individuals identified above, persons identified in documents produced in this dispute have knowledge of facts pertaining to the allegations in the Amended Complaint. *See* Fed. R. Civ. P. 33(d). Discovery is ongoing, and Plaintiff reserves the right to supplement, amend, correct, clarify, or modify this Response as further information becomes available.

Interrogatory No. 3: Describe in detail all factual bases for Your contention that Leapfrog’s published Safety Grade for Your hospital was false, inaccurate, misleading, deceptive, or unfair. In so answering, identify with particularity each measure, data point, or metric that You contend was inaccurately reported, calculated, or misrepresented by Leapfrog in calculating the Safety Grade for Your hospital.

Answer: Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks “all factual bases” for Plaintiff’s contention. *See Megdal Assocs., LLC v. La-Z-Boy, Inc.*, 2016 WL 4503337, at *6 (S.D. Fla. Feb. 1, 2016) (finding interrogatories asking for “‘all’ facts or witnesses that support an opposing party’s case” to be “unduly broad”) (citing 8B Wright, Miller, & Kane, Federal Practice and Procedure: Civil 3d § 2167 (2015)). Plaintiff further objects to this Interrogatory as premature to the extent it requests that Plaintiff “[d]escribe in detail all factual bases” to support its contention. *In re Reliance Fin. & Inv. Grp., Inc.*, 2006 WL 8435541, at *4 (S.D. Fla. Feb. 14, 2006) (Contention interrogatories “are more appropriately used after a substantial amount of discovery has been conducted--typically, at the end of the discovery period.”). Plaintiff also objects to this Interrogatory to the extent it attempts to limit or mischaracterize Plaintiff’s claim as just

challenging the false, inaccurate, misleading, deceptive, or unfair nature of TLG's Safety Grade. As the Court explained in its order denying TLG's motion to dismiss, the core of the Complaint is "a challenge to Defendant's representations about its methodology, which they claim mislead consumers by failing to distinguish between absent data and damning data, and professing that grades are not influenced by a hospital's lack of survey participation." *Order on Motion to Dismiss* 6 (ECF No. 41). Plaintiff also challenges the provably false facts and deceptive scoring system underlying these grades, which TLG admits it relies on to arrive at its deceptive Safety Grades.

Subject to the foregoing objections and as more fully stated in the *Amended Complaint* (ECF No. 74) ("Complaint"), TLG has engaged in deceptive and unfair business practices and misrepresentations when issuing the Safety Grade for Plaintiff's hospital as part of TLG's annual "Hospital Survey." TLG posts these Safety Grades online at hospitalsafetygrade.org.

To arrive at these Safety Grades, TLG uses CMS data, survey responses from participating hospitals, and other supplemental data sources. For participating hospitals, TLG uses the hospitals' self-reported responses to the Hospital Survey for 12 of the 22 measures. For non-participating hospitals, TLG uses other sources for those 12 measures. For the remaining four measures—Computerized Physician Order Entry, Bar Code Medication Administration, ICU Physician Staffing, and Hand Hygiene Score (the "Deceptive Score Categories")—TLG devised and uses a so-called "imputation model." Prior to Fall 2024, TLG's imputation model assigned non-participating hospitals a score based on the average score applicable to a similarly situated hospital. Beginning in Fall 2024, TLG modified its imputation model. TLG now assigns the lowest possible score to non-participating hospitals, which has the effect of punishing non-participating hospitals and artificially deflating their Safety Grades. TLG has even admitted the changes in Fall 2024 were designed to penalize non-participating hospitals. TLG also misleads consumers about how

it grades hospitals, stating “[t]he Hospital Safety Grade reflects how well a hospital does on safety, not whether they complete the [TLG] Hospital Survey.” *Declaration of Lee Crain* (ECF No. 21) (“Crain Decl.”), Ex. 1 at 4 (“Frequently Asked Questions About the Leapfrog Hospital Safety Grade”).

As TLG explains, “not all hospitals have enough data publicly available to be eligible for a grade.” Crain Decl. Ex. 1 at 5. “As per the National Expert Panel guidance, [TLG] has requirements for the minimum amount of data [it] need[s] to issue an accurate grade.” Crain Decl. Ex. 1 at 5. According to TLG, “[h]ospitals missing more than six process measures” are “not graded.” Crain Decl. Ex. 2 at 6. Non-participating hospitals should fall easily into that “not graded” bucket, because their decision not to participate in TLG’s survey necessarily means TLG is missing seven process measures that rely on voluntary submission of hospital data.¹

TLG then deceptively conceals how it makes up grades for the four “imputation” measures and even suggests on its website that TLG *does* have data sufficient to score TLG on those four measures. By way of example, TLG acknowledges that Plaintiff “Declined to Report” information in response to questions about “Staff work[ing] together,” but then tells consumers—as if it were a fact—that Plaintiff is “Worse Than Average” on “Handwashing,” “Communication,” “medication administration,” and the like—even though TLG has no basis whatsoever to adopt those conclusions. Crain Decl. Ex. 32 at 2. TLG itself says handwashing is among the “most important” measures in its survey, Crain Decl. Ex. 15 at 4, yet it deceptively conceals that it has no data with which to grade the Plaintiff hospital on that measure. *Defendant The Leapfrog Group’s Responses to Plaintiffs’ Requests for Production* at 7 (“Leapfrog is not itself in possession

¹ Those seven include CPOE, BCMA, IPS, Safe Practice 1: Culture of Leadership Structures and Systems; Safe Practice 2: Culture Measurement, Feedback & Intervention; Total Nursing Care Hours per Patient Day; and Hand Hygiene.

of data showing Plaintiffs' performance on the 'imputed metrics' considered by the methodology."'). Of course, Plaintiff in fact has a comprehensive and thorough handwashing policy. And had Plaintiff merely filled out TLG's survey, it would have received a full two letter grades higher on TLG's score. *Expert Report of Professor Sean Nicholson* (Aug. 7, 2025), Ex. 6.

Based on the foregoing, and as more fully set forth in the Complaint, TLG engages in deceptive trade practices by, among other things, deceiving consumers about its grading methods by implying that Plaintiff has failed on certain measures that, in truth, TLG has no data or other basis to evaluate; deceiving consumers by telling them the Hospital Safety Grade reflects how well a hospital does on safety, not whether they complete the Hospital Survey; deceiving consumers when it represents that it does not grade hospitals if it lacks sufficient data, when, in truth, it does grade hospitals by "imputing" or making up a grade for the Deceptive Score Categories; hiding the truth about its "imputation model" from consumers by burying it in fine print on a separate website; punishing non-participating hospitals by "imputing" scores, which artificially deflate a hospital's Safety Grade; and favoring participating hospitals. Additional factual bases for the Plaintiff's claims are presented in the Complaint.

Interrogatory No. 4: Describe the scoring or grading methodology You believe Leapfrog should have used to assess Your hospital's patient safety performance and explain why that method would yield a different result.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Plaintiff's provision of an alternative scoring or grading methodology has nothing to do with the claims and defenses in this case related to TLG's

decision to use deceptive business practices. Plaintiff further objects to this Interrogatory to the extent it calls for speculation.

Answer: Plaintiff declines to respond to this Interrogatory.

Amended Answer: Subject to the foregoing objections, Plaintiff responds that TLG should use a scoring system that is not unfair or deceptive. By way of example only, TLG could decline to grade hospitals that do not participate in TLG's survey, because their decision not to participate means TLG is missing seven process measures that rely on voluntary submission of hospital data. This would yield a different result, because the hospitals would not receive a grade at all. TLG's methodology certainly should not affirmatively assign an arbitrary low score to a particular metric just because a hospital does not provide data for that metric.

Interrogatory No. 5: State whether You submitted any data, corrections, or appeals to Leapfrog regarding the Safety Grade Your hospital received, and for each such submission, identify the date of the submission, the medium of the submission (i.e. telephone, video conference, email, letter, etc.), who was involved in the submission, and the content of the submission.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Whether or not Plaintiff submitted "any data, corrections, or appeals to Leapfrog regarding the Safety Grade" Plaintiff hospital received has nothing to do with the claims and defenses in this case related to TLG's decision to use deceptive business practices. Plaintiff further objects to this Interrogatory to the extent it seeks information that is already in TLG's possession, custody and control, or equally available to TLG.

Answer: Subject to the foregoing objections, Plaintiff engaged in correspondence prior to the commencement of this case demanding that TLG reform its deceptive practices and cease and desist reporting deceptive and unfair Safety Grades, but at every turn TLG refused.

Amended Answer: Subject to the foregoing objections, Plaintiff did not submit any data, corrections or appeals to Leapfrog regarding the Safety Grades it has received.

Interrogatory No. 6: State whether You provided any comment or input in any form during Leapfrog's requests for public comments for planned updates to the Leapfrog Hospital Safety Grade methodology that was proposed for the calculation of Hospital Safety Grades (including but not limited to for the Fall 2024 methodology update). If yes, please identify the date of the comment, the medium of the submission (i.e. telephone, video conference, email, letter, etc.), who was involved in the comment and the content of the comment. If no, please state the reason why You chose not to comment.

Answer: Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Whether or not Plaintiff submitted "any comment or input" in response to TLG's request for public comments has nothing to do with claims and defenses in this case related to TLG's decision to use deceptive business practices. Plaintiff further objects to this Interrogatory to the extent it seeks information that is already in TLG's possession, custody and control, or equally available to TLG.

Subject to the foregoing objections, Plaintiff did not provide comments in response to Leapfrog's requests for public comments for planned updates to the Leapfrog Hospital Safety Grade scoring system because Plaintiff generally does not respond to requests for public comment from private entities like TLG.

Interrogatory No. 7: Describe all actions Your hospital took in response to (or in deciding not to respond to) its Safety Grade or the Hospital Survey, including internal meetings, media statements, or public relations efforts. In so answering, state the date of the action, the individuals involved in the action and the content of the action.

Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks “all actions” Plaintiffs may have taken in response to TLG’s Safety Grades. *See Megdal Assocs., LLC v. La-Z-Boy, Inc.*, No. 14-81476-CIV, 2016 WL 4503337, at *6 (S.D. Fla. Feb. 1, 2016) (finding interrogatories asking for “‘all’ facts or witnesses that support an opposing party’s case” to be “unduly broad”) (citing 8B Wright, Miller, & Kane, Federal Practice and Procedure: Civil 3d § 2167 (2015)). Plaintiff further objects to this Interrogatory to the extent it seeks information that is subject to a claim of privilege or otherwise protected from disclosure, including seeking information protected by the attorney-client privilege, work-product doctrine, or other immunity.

Answer: Subject to the foregoing objections, Plaintiff devoted substantial time and resources that could have otherwise been spent continuing to improve patient care to respond to the significant harm and disruption caused by TLG’s deceptive and unfair Safety Grade. Plaintiff’s response included meeting internally with Plaintiff’s leadership team, medical executive committee, and governing board, corresponding with TLG to demand that TLG reform its deceptive practices and cease and desist reporting deceptive and unfair Safety Grades, and devoting substantial time and resources to facilitate the preparation and prosecution of this Action.

Amended Answer: Subject to the foregoing objections, Plaintiff devoted substantial time and resources that could have otherwise been spent continuing to improve patient care to respond to the significant harm and disruption caused by TLG’s deceptive and unfair Safety Grades. Plaintiff’s response included meeting internally with Plaintiff’s leadership team, medical executive

committee, and governing board, corresponding through Plaintiff's corporate parent with TLG to demand that TLG reform its deceptive practices and cease and desist reporting deceptive and unfair Safety Grades, and devoting substantial time and resources to facilitate the preparation and prosecution of this Action. Plaintiff has also held many phone calls and meetings with physicians and other stakeholders about the TLG grades, explaining how the grades were deceptive and did not accurately reflect the hospital quality and patient safety at Plaintiff.

Interrogatory No. 8: Identify any and all persons, whether internal or external (e.g., patients, vendors, affiliates, parents, agents, partners, media) with whom You communicated in any way with respect to the Safety Grade or the Hospital Survey. In so answering, state the date of the communication, the individuals involved in the communication, the medium of the communication (i.e. telephone, video conference, email, letter, etc.) and the content of the communication.

Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks the identity of "any and all persons, whether internal or external." Plaintiff will disclose the categories of individuals with whom Plaintiff communicated about the Safety Grade or Hospital Survey during the Relevant Time Period. Plaintiff also objects to this Interrogatory to the extent it seeks protected health information that Health Insurance Portability and Accountability Act ("HIPAA"), among other statutes and regulations, bars Plaintiff from disclosing. Plaintiff further objects to this Interrogatory to the extent it seeks information that is subject to a claim of privilege or otherwise protected from disclosure, including seeking information protected by the attorney-client privilege, work-product doctrine, or other immunity.

Answer: Subject to the foregoing objections, Plaintiff communicated with the following categories of people regarding the Safety Grade or the Hospital Survey: Plaintiff's governing board, its medical executive committee, department directors, and physicians and nurses when

asked about the Safety Grade or Hospital Survey. These communications occurred in and after Fall 2024, after TLG released its deceptive and unfair Safety Grade for Plaintiff's hospital. Most of these communications occurred during regularly scheduled meetings, during which attendees were told about TLG's release of the deceptive and unfair Safety Grade, that Plaintiff does not participate in the Hospital Survey because it is unreliable and not an accurate reflection of hospital quality and safety or patient outcomes, and that the Safety Grade, which was not based on any information provided by Plaintiff, was misleading. The Palm Beach Health Network also issued a press release and since then, has engaged in various social networking and other marketing campaigns to counteract TLG's deceptive scores on behalf of Plaintiff and other affected members of the network.

Amended Answer: Subject to the foregoing objections, Plaintiff communicated with the following categories of people regarding the Safety Grade or the Hospital Survey: Plaintiff's governing board, its medical executive committee, department directors, physicians and nurses, and patients when asked about the Safety Grades or Hospital Survey. These communications occurred in and after Fall 2024, after TLG released its deceptive and unfair Safety Grades for Plaintiff's hospital. Most of these communications occurred during regularly scheduled meetings, during which attendees were told about TLG's release of the deceptive and unfair Safety Grade, that Plaintiff does not participate in the Hospital Survey because it is unreliable and not an accurate reflection of hospital quality and safety or patient outcomes, and that the Safety Grade, which was not based on any information provided by Plaintiff, was misleading. The Palm Beach Health Network also issued a press release and has engaged in marketing efforts, including through social media, to counteract TLG's deceptive scores on behalf of Plaintiff and other affected members of

the network. Plaintiff also engaged in email discussions about TLG's misleading grades, either as sender or recipient, which TLG has through Plaintiff's production of documents.

Interrogatory No. 9: Describe all instances in which a third party declined to contract with, refer patients to, or work with Your hospital, where Leapfrog's grade was cited or discussed. In so identifying list the name of the individuals involved in the communication, the medium of the communication (i.e. telephone, video conference, email, letter, etc.), the date of the communication and the content of the communication.

Answer: Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it requires Plaintiff to "[d]escribe all instances" in which a third party took an action in response to TLG's deceptive grade.

Subject to the foregoing objection, Plaintiff is not aware of any responsive instances.

Interrogatory No. 10: Describe with specificity the basis for each and every category of damage You claim You incurred as a result of the Leapfrog Safety Grade. In so identifying, list each category of damages and the dollar value of each category of damage You claim.

Plaintiff objects to this Interrogatory to the extent it seeks information that is the subject of expert testimony.

Answer: Plaintiff will submit expert reports on August 7, 2025, per the Pretrial Scheduling Order.

Amended Answer: Plaintiff has served the expert report of Thomas Chakurda, which addresses the issue of reputational harm and harm to Plaintiff's goodwill. Plaintiff further objects to this Interrogatory as overbroad and unduly burdensome to the extent it seeks "each and every" category of claimed damages.

Subject to the foregoing objections and as agreed during the parties' September 3, 2025 meet and confer, Plaintiff will limit its response to the live non-monetary claims, including

injunctive and declaratory relief, to remedy harm to Plaintiff's reputation and goodwill. Plaintiff's reputation and goodwill has been damaged by TLG's false and misleading methodology and resulting Safety Grades. Plaintiff's claim for reputational harm is based on, among other things, concerns raised by patients, doctors, staff, and community members, as well as false and misleading statements based on TLG's false and misleading methodology and Safety Grades made in newspapers, viral social-media videos, television programs, and blogs.

By way of example, we have received reports from patients that they decided not to use our hospital due to the misleading grade TLG assigned to the hospital. Our Medical Executive Committee has received direct inquiries from patients regarding their concerns about TLG's grades and related public reports. Patients have asked independent physicians that use both our facilities and those of Jupiter Medical Center (a nearby hospital) to schedule their surgeries at Jupiter Medical Center and not at ours. These independent surgeons have told us that they believe TLG has misled these patients about the quality of the Medical Center because these surgeons believe our hospital provides higher-quality care. Doctors have had patients express that they do not want to come to the Medical Center, specifically because of the Leapfrog grade. The harm caused by TLG's false and misleading Safety Grade is ongoing.

Interrogatory No. 11: Identify all adverse patient events which occurred at Your hospital, including any citations received from regulatory agencies, accrediting agencies, and third party payors such as The Joint Commission, CMS, state health departments, etc. during the period covered by each Leapfrog Safety Grade publication of which You complain (i.e., Fall 2024, Fall 2025, etc.), as well as any complaints received from patients regarding the same.

Plaintiff objects to this Interrogatory because it is overly broad, unduly burdensome, seeks discovery of information that is irrelevant to the claims and defenses in this Action, seeks information that is beyond the scope of Leapfrog's Hospital Survey, and is not reasonably

calculated to lead to the discovery of admissible evidence. TLG does not include “all adverse patient events,” “citations received from” agencies or payors, or “complaints received from patients” in TLG’s determination of its Hospital Safety Grades or request such information in the Hospital Survey, so any such information is irrelevant to whether TLG’s actions constitute unfair or deceptive trade practices. TLG has, therefore, only propounded this Interrogatory for purposes of harassment. Plaintiff also objects to this Interrogatory to the extent it seeks protected health information that HIPAA, among other statutes and regulations, bars Plaintiff from disclosing.

Answer: Plaintiff declines to respond to this Interrogatory.

Amended Answer: Defendant has agreed to withdraw this Interrogatory.

Interrogatory No. 12: Describe in detail how Your hospital compares nationally on on [sic] any other ranking of patient safety performance, including but not limited to Vizient, Inc., Premier, Inc., HealthTrust Purchasing Group, The Joint Commission, HealthGrades, US News, Newsweek, Statista, Definitive Healthcare, or any other quality benchmarking entity including benchmarking on patient safety including on adverse events and on healthcare-acquired infections.

Plaintiff objects to this Interrogatory’s request that Plaintiff “[d]escribe in detail how Your hospital compares nationally” based on undisclosed “benchmarking” as vague and confusing. To the extent this Interrogatory seeks the top-line rankings of the identified organizations, Plaintiff objects to this Interrogatory because such information is publicly and equally available to TLG. To the extent this Interrogatory asks Plaintiff to compare itself to the named and unnamed entities, that request is overly broad, unduly burdensome, and not proportional to the needs of this Action. Plaintiff further objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Other organizations’ rankings have nothing to do with

the claims and defenses in this case related to the Deceptive Score Categories or TLG's decision to use deceptive business practices.

Answer: Subject to the foregoing objections, Plaintiff has received numerous awards and accolades, including many that are especially relevant to patient care for the over-65 patient community that represent over 50% of the patients we serve. Plaintiff is accredited by the Joint Commission, the nation's largest hospital accreditor that evaluates hospitals' quality performance standards through an objective evaluation process. Plaintiff has also been accredited by Joint Commission as an Advanced Primary Stroke Center—a certification designed for hospitals providing the critical elements to achieve long-term success in improving stroke outcomes—and Total Joint Hip/Knee Certification—which signifies our services have delivered evidence-based proof of clinical quality sought by patients and payers alike. Additionally, it has a lab accreditation from the College of American Pathologists—requirement to perform testing on specimens from human beings—and was selected as a certified program with the American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR)—the only peer-reviewed accreditation process designed to review individual facilities for adherence to standards and guidelines developed and published by the AACVPR. These accreditations and certifications are only awarded after in-person visits to Plaintiff where our health care professionals are interviewed and patient care is reviewed first hand. We are subject to regular periodic in-person reviews, audits, surveys, and assessments of the facility.

Plaintiff has also received numerous awards that exemplify its quality such as Blue Distinction Center+ Designation for Quality and Cost-Efficiency in Knee and Hip Replacement Surgeries by BlueCross BlueShield, the Joint Commission's Gold Seal of Approval for Hip and Knee Replacement, an Aetna Institute of Quality Orthopedic Facility for Total Joint Replacement

and Spine Surgery, Get with the Guidelines Gold Plus Stroke Recognition Award from the American Heart Association for 10 years straight, and the Gold Plus Diabetes Recognition Award for the last three years, among several other awards.

In 2025, the medical ranking organization Healthgrades gave Plaintiff the award for “America’s 100 Best for Spine and Outpatient Orthopedic Excellence Award.” To assess and evaluate hospitals, Healthgrades relies on data from Medicare medical claims records and states’ data on Medicare and commercially insured patient outcomes to determine patients’ actual clinical outcomes when visiting a given hospital. Healthgrades also assigned Plaintiff five-star awards for various specialties, including:

a. Cardiac Care

- i. Five-Star Recipient for Valve Surgery (2023, 2025)
- ii. Five-Star Recipient for Treatment of Heart Failure for three years in a row (2023-2025)
- iii. Five-Star Recipient for Carotid Procedures for three years in a row (2023-2025)
- iv. Recipient of the Healthgrades 2023 Cardiac Surgery Excellence Award
- v. Top 10% in the Nation for Cardiac Surgery (2023)

b. Critical Care

- i. Five-Star Recipient for Respiratory Failure for two years in a row (2024-2025)

c. Gastrointestinal

- i. Five-Star Recipient for Colorectal Surgeries (2025)
- ii. Five-Star Recipient for Treatment of GI Bleed (2024)

d. Neurosurgery

- i. Five-Star Recipient for Treatment of Stroke (2025)

e. Pulmonary

- i. Five-Star Recipient for Treatment of Pneumonia for three years in a row (2023-2025)
- ii. Recipient of the Healthgrades Pulmonary Care Excellence Award (2024, 2025)
- iii. Top 10% in the Nation for Pulmonary Care (2024, 2025)
- iv. Five Star Recipient for Treatment of Chronic Obstructive Pulmonary Disease (2024).

In addition, Plaintiff will produce and identify documents reflecting some of Plaintiff's rankings from other organizations.

Amended Answer: Plaintiff has received numerous awards and accolades. For example, Plaintiff is accredited by the Joint Commission. Plaintiff has also been accredited by Joint Commission as an Advanced Primary Stroke Center and earned Total Joint Hip/Knee Certification. Additionally, it has a lab accreditation from the College of American Pathologists and was selected as a certified program with the American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR).

Plaintiff has also received the Blue Distinction Center+ Designation for Quality and Cost-Efficiency in Knee and Hip Replacement Surgeries by BlueCross BlueShield, an Aetna Institute of Quality Award, Get with the Guidelines Gold Plus Stroke Recognition Award from the American Heart Association, and the Gold Plus Diabetes Recognition Award, among several other awards.

In 2025, the medical ranking organization Healthgrades assigned Plaintiff five-star awards for various specialties, including:

a. Cardiac Care

- i. Five-Star Recipient for Valve Surgery (2025)
- ii. Five-Star Recipient for Treatment of Heart Failure for three years in a row (2023-2025)
- iii. Five-Star Recipient for Carotid Procedures for three years in a row (2023-2025)

b. Critical Care

- i. Five-Star Recipient for Respiratory Failure (2024, 2025)

c. Gastrointestinal

- i. Five-Star Recipient for Colorectal Surgeries (2025)

d. Neurosurgery

- i. Five-Star Recipient for Treatment of Stroke (2025)

e. Pulmonary

- i. Five-Star Recipient for Treatment of Pneumonia for three years in a row (2023-2025)
- ii. Recipient of the Healthgrades Pulmonary Care Excellence Award (2024, 2025)

In addition, Plaintiff will produce and identify documents reflecting some of Plaintiff's rankings from other organizations.

Also, Plaintiff does not participate in Vizient and has not done so during the Relevant Time Period.

Interrogatory No. 13: Describe any steps taken by Your hospital to improve any and all of the patient safety measures considered by Leapfrog's Hospital Safety Grade (as set forth on Leapfrog's published scoring methodology documents; see ECF No. 21-3 at 6-10; ECF No. 21-43 at 6-9), before and after each Safety Grade publication of which You complain.

Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks the identity of Plaintiff's improvements to "any and all" patient safety measures considered by Leapfrog's Hospital Safety Grade. Plaintiff further objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks information on metrics other than TLG's Deceptive Score Categories and to the extent it seeks information that is beyond the scope of Leapfrog's Hospital Survey.

Answer: Plaintiff declines to respond to this Interrogatory.

Amended Answer: Subject to the foregoing objection, Plaintiff is committed to continual improvement of patient safety measures, motivated by our commitment to ensuring the best possible patient safety—not chasing the best possible Leapfrog grade. To achieve this core objective, Plaintiff devotes significant time and resources to improving its delivery of the highest possible quality of care for those in the community it serves, including efforts to improve its performance in areas related to the four metrics Plaintiff has chosen to impute in its survey.

Plaintiff reviews its CPOE, BCMA, and Hand Hygiene metrics at periodic meetings to ensure patient safety and compliance and develop and review remedial plans as necessary.

Plaintiff already has 24/7 ICU coverage for its intensivist unit and has on call providers in case additional resources are needed. Plaintiff also continuously reassesses the staffing needs for the department.

Interrogatory No. 14: State whether You are aware of specific patients who have relied on the Leapfrog Safety Grade in declining to receive healthcare services at Your hospital. In so answering, identify the individual patient that declined to receive services, the date of such declination, the type of service the patient declined to receive, the medium for the communication from the patient (i.e. telephone, video conference, email, letter, etc.), the content of the communication, and the reason given for the stated decision.

Plaintiff objects to this Interrogatory as seeking protected health information that is protected from disclosure by HIPAA, among other statutes and regulations. Plaintiff will only produce this information as needed and subject to a Qualified Protective Order entered by this Court.

Answer: Subject to the foregoing objection, Plaintiff has received reports that patients considered or decided not to use Plaintiff's facility because of TLG's misleading grades.

Amended Answer: Subject to the foregoing objection, since the release of TLG's false and misleading grades, Plaintiff has received numerous reports from doctors that patients considered or decided not to use Plaintiff's facility due to concerns related to TLG's misleading grades.

Interrogatory No. 15: Describe any effort Your hospital has made to influence public perception of Your hospital's performance on patient safety following the publication of the Leapfrog Safety Grade.

Plaintiff objects to this Interrogatory as vague and ambiguous because it does not specify which Leapfrog Safety Grade is at issue. Plaintiff will construe this Interrogatory to reference TLG's deceptive Safety Grades beginning in Fall 2024. Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks "any effort" Plaintiff "has made to influence public perception" after the release of TLG's deceptive and unfair Safety Grades because there have been many such "efforts" and those

“efforts” are ongoing given the significant harm caused by TLG’s deceptive and unfair business practices.

Answer: Subject to the foregoing objections, Plaintiff continues to influence public perception by, among other things, delivering the highest quality care to the community it serves, which, as discussed in response to Interrogatory 12, has led to numerous awards, accreditations, and accolades. In addition, several public statements disputing the misleading nature of the Safety Grade have been made on Plaintiff’s behalf.

Supplemental Answer: In addition to the above, members of hospital leadership have communicated with patients, doctors, or community members on a regular basis to dispel the misleading nature of the Leapfrog Safety Grades. For instance, Plaintiff communicated its governing board, its medical executive committee, department directors, physicians and nurses, and patients when asked about the Safety Grades or Hospital Survey. These communications occurred in and after Fall 2024, after TLG released its deceptive and unfair Safety Grades for Plaintiff’s hospital. The Palm Beach Health Network also issued a press release and has engaged in marketing efforts, including through social media, to counteract TLG’s deceptive scores on behalf of Plaintiff and other affected members of the network. Plaintiff also engaged in email discussions about TLG’s misleading grades, either as sender or recipient, which TLG has through Plaintiff’s production of documents.

Interrogatory No. 16: Describe the due diligence Your hospital undertakes to ensure the accuracy of its own publicly reported safety data (including but not limited to data submitted to CMS, the CDC, and third party organizations).

Plaintiff objects to this Interrogatory as vague and ambiguous due to its use of the undefined term “due diligence.” Plaintiff further objects to this Interrogatory because it seeks

discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Any “due diligence” Plaintiff performs when reporting to *third parties* has nothing to do with the claims and defenses in this case related to TLG’s decision to use deceptive business practices, especially when TLG does nothing to ensure the accuracy of information that hospitals that participate in its survey self-report.

Answer: Plaintiff declines to respond to this Interrogatory.

Amended Answer: Subject to the foregoing objections, Plaintiff makes reasonable efforts to ensure the accuracy of the data it reports to third-party organizations. For instance, Plaintiff employs data abstractors, quality coordinators and a Quality Director, who are all responsible for abstracting, validating, and submitting safety data.

Interrogatory No. 17: Describe in detail how You communicate to the shareholders, board members, collective bargaining representatives and investors of Tenet Healthcare System the outcome of any and all healthcare safety ratings, evaluative publications, studies, or performance analyses that Your Hospital receives.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Plaintiff’s communication, if any, with the shareholders, board members, collective bargaining representatives and investors of Tenet Healthcare System, all non-parties to this litigation, has nothing to do with the claims and defenses in this case related to TLG’s decision to use deceptive business practices.

Answer: Plaintiff declines to respond to this Interrogatory.

Amended Answer: Subject to the foregoing objection, Plaintiff communicates with Tenet stakeholders, including employees who work to support the Palm Beach Health Network, on a range of matters, including issues related to patient safety and outcomes and in particular related to TLG and the Safety Grades by email and oral communication. Those communications included discussions about the reasons for particular grades, the method used to calculate Safety Grades, the value of Safety Grades, and responses to the Safety Grades. In addition, identified below are documents Plaintiff produced evidencing communications between the Plaintiff Hospitals and Tenet related to TLG, the Leapfrog survey, and Safety Grades.

Start Page	End Page
PBHN000006509	PBHN000006513
PBHN000004819	PBHN000004821
PBHN000006397	PBHN000006401
PBHN000002090	PBHN000002094
PBHN000002071	PBHN000002071
PBHN000004562	PBHN000004563

PBHN000004564	PBHN000004564
PBHN000004574	PBHN000004581
PBHN000004565	PBHN000004569
PBHN000004704	PBHN000004704
PBHN000004715	PBHN000004719
PBHN000006465	PBHN000006466

Discovery is ongoing, and Plaintiff reserves the right to amend, modify or supplement the response to this Interrogatory.

Interrogatory No. 18: State whether the compensation of Your Chief Executive Officer or any other executive-level leadership officers is tied to or related in any way to Your hospital's performance on patient safety, union worker contracts or Your hospital's ratings by third party ratings organizations' ratings publications (including but not limited to the Leapfrog Hospital Safety Grade).

Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Plaintiff's method of compensating its Chief Executive Officer and other executive-level leadership **has nothing to do with the** claims and defenses in this case related to TLG's decision to use deceptive business practices.

Answer: TLG has, therefore, only propounded this Interrogatory for purposes of harassment. Plaintiff declines to respond to this Interrogatory.

Amended Answer: Subject to the foregoing objection, Plaintiff's performance on patient safety, union worker contracts, or ratings by third party ratings organizations' ratings publications is related in some way to the compensation of Plaintiff's Chief Executive Officer or other executive-level leadership officer(s).

Interrogatory No. 19: Identify all hospitals, medical centers, or healthcare systems that you consider to be your direct competitors within the relevant geographic market during the time period covered by the Complaint and describe in detail the criteria you use to determine whether another hospital or healthcare provider is a competitor.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is not reasonably calculated to lead to the discovery of admissible evidence. The identity of Plaintiff's competitors and "the criteria" used to determine whether a hospital or provide is a competitor has nothing to do with the claims and defenses in this case related to TLG's decision to use deceptive business practices. Plaintiff also objects to this Interrogatory to the extent it seeks confidential, proprietary information, and commercially sensitive information related to Plaintiff's scoring system and "criteria" used to determine whether a hospital or provide is a competitor.

Answer: Subject to the foregoing objections and on condition that this response is considered “Confidential” under the forthcoming agreed confidentiality order.

Jupiter Medical Center is Plaintiff’s competitor. Plaintiff considers this hospital a competitor because of its proximity to Plaintiff, its competing services lines, and that patients within Plaintiff’s service area go to this hospital for medical care.

Interrogatory No. 20: State and describe the results of any market analysis, competitive analysis, or consumer perception surveys you have conducted or commissioned regarding your competitors from 2020 to present, and identify the individuals or entities that prepared or participated in such analyses.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is not is not proportional to the needs of this Action. The results of any market analysis, competitive analysis, or consumer perception surveys and the identity of those who prepared or participated in such analyses has nothing to do with the claims and defenses in this case related to TLG’s decision to use deceptive business practices.

Answer: Plaintiff declines to respond to this Interrogatory.

Amended Answer: Plaintiff further objects to this Interrogatory to the extent it requests information from outside of the relevant time period of January 1, 2023, to present. Plaintiff also objects to this Interrogatory as unduly burdensome to the extent it asks Plaintiff to “state and describe” various market analysis.

As agreed during the parties’ meet and confer on September 3, 2025, Plaintiff will produce documents showing the results of studies or surveys Plaintiff has conducted or commissioned related to internal market analysis, competitive analysis, or consumer perception. Plaintiff will

identify the documents responsive to this Interrogatory by Bates number in Plaintiffs' production cover letter.

Interrogatory No. 21: Identify with specificity any comments or concerns raised by any third party payor, bank or lender, or investor related to Your hospital's reputation and/or public perception on issues in any way involving patient safety or satisfaction.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is overly broad, unduly burdensome and irrelevant to the claims and defenses in this Action and is not proportional to the needs of this case to the extent it seeks "comments and concerns" from third parties related generally to Plaintiff's reputation that has nothing to do with the specific and significant reputational harm caused by TLG's misleading grades.

Answer: Subject to the foregoing objections, Plaintiff will produce and identify documents related to the significant reputational harm caused by TLG's deceptive and unfair Safety Grades that provide sufficient detail to respond to this Interrogatory.

Amended Answer: Subject to the foregoing objections, Plaintiff is unaware of any documents related to this Interrogatory.

Interrogatory No. 22: Identify and describe any complaints, concerns, or comments from patients, community members, or referring physicians that relate to the hospital's reputation or comparisons to other hospitals in the region.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is overly broad, unduly burdensome and irrelevant to the claims and defenses in this Action and is not proportional to the needs of this Action to the extent it seeks "comments and concerns" from patients, community members, or referring physicians that have nothing to do with the significant

reputational harm caused by TLG's misleading grades. Plaintiff also objects to this interrogatory as seeking protected health information that is protected from disclosure by HIPAA, among other statutes and regulations. Plaintiff will only produce this information as needed and subject to the agreed protective order entered by this Court.

Answer: Subject to the foregoing objections, Plaintiff has received reports that patients and physicians considered or decided not to use Plaintiff's facility because of TLG's misleading grades.

Amended Answer: Subject to the foregoing objections, Plaintiff has received reports that patients and physicians considered or decided not to use Plaintiff's facility because of TLG's misleading grades. In addition, concerns have been raised by patients, doctors, staff, and community members, and Plaintiff is aware of false and misleading statements based on TLG's false and misleading methodology and Safety Grades made in newspapers, viral social-media videos, television programs, and blogs.

We have received reports from patients that they decided not to use our hospital due to the misleading grade TLG assigned to the hospital. Our Medical Executive Committee has received direct inquiries from patients regarding their concerns about TLG's grades and related public reports. Patients have asked independent physicians that use both our facilities and those of Jupiter Medical Center (a nearby hospital) to schedule their surgeries at Jupiter Medical Center and not at ours. These independent surgeons have told us that they believe TLG has misled these patients about the quality of the Medical Center because these surgeons believe our hospital provides higher-quality care. Doctors have had patients express that they do not want to come to the Medical Center, specifically because of the Leapfrog grade. The harm caused by TLG's false and misleading Safety Grade is ongoing.

In addition, the following produced documents evidence such harm.

Start Page	End Page
PBHN000006771	PBHN000006773
PBHN000002082	PBHN000002085
PBHN000002066	PBHN000002070
PBHN000002615	PBHN000002617
PBHN000006397	PBHN000006401
PBHN000002090	PBHN000002094
PBHN000004484	PBHN000004484

PBHN000004562	PBHN000004563
PBHN000004564	PBHN000004564
PBHN000004574	PBHN000004580
PBHN000004557	PBHN000004557
PBHN000008718	PBHN000008718
PBHN000006461	PBHN000006462
PBHN000008914	PBHN000008914
PBHN000008915	PBHN000008915

Discovery is ongoing, and Plaintiff reserves the right to amend, modify or supplement the response to this Interrogatory.

Interrogatory No. 23: List with specific detail each and every concern, complaint or comment made by any union, collective bargaining unit or employee association in any way related to patient safety at Your hospital.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is overly broad, unduly burdensome and irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks “each and every concern, complaint or comment ” from third parties that have nothing to do with the significant reputational harm caused by TLG’s misleading grades. Plaintiff also objects to this Interrogatory to the extent it seeks health information that is protected from disclosure by HIPAA, among other statutes and regulations. Plaintiff will only produce this information as needed and subject to the agreed protective order entered by this Court.

Answer: Subject to the foregoing objections, Plaintiff is unaware of any concern, complaint or comment regarding TLG deceptive scores made by the union at Plaintiff's hospital.

Amended Answer: Union personnel have in the past registered complaints or disagreements with Plaintiff's hospital's management, including alleged concerns about patient safety. Plaintiff carefully considers such allegations but finds generally that they are attempts to gain leverage in contract negotiations and are less genuine concern about patients. The union at Plaintiff's hospital made allegations in December 2023, February 2024, and March 2024. On April 5, 2024, the union publicly retracted those statements, rightly saying they were "entirely inappropriate to make," that "the Union should not have made the negative statements," and one after another, that the union did "not have any basis for believing" the accusations were true. After that, the union made only one other accusation of which Plaintiff is aware, and that was on April 10, 2024 concerning allegedly high turnover. But, the union's proposed remedies showed that the accusation was only an ordinary attempt to increase member wages: four of its five recommended "resolution[s]" were raising wages. The last "resolution" was that "hospital must staff based on the acuity of the patient," which Plaintiff already does. Plaintiff looked into the allegations anyways and found they lacked merit.

Interrogatory No. 24: Identify any and all criticism You have received since 2020 from Tenet Healthcare Corporation and/or from any individual executive of Tenet Healthcare Corporation regarding Your hospital's performance in any way.

Answer: Plaintiff objects to this Interrogatory because it seeks discovery of information that is overly broad, unduly burdensome and irrelevant to the claims and defenses in this Action and is not reasonably calculated to lead to the discovery of admissible evidence. Any so-called "criticism" has nothing to do with the claims and defenses related to TLG's decision to use

deceptive business practices. TLG has, therefore, only propounded this Interrogatory for purposes of harassment. Plaintiff declines to respond to this Interrogatory.

Amended Answer: As discussed during the parties' meet and confer on September 3, 2025, TLG agreed to narrow this Interrogatory to concern only "criticism...regarding Your hospital's patient safety." After a reasonable and diligent search, Plaintiff is unaware of having received "criticism" from Tenet Health Corporation regarding patient safety. Plaintiff is always working to improve its performance, quality, and safety in a constructive way and engages with Tenet Health Corporation as needed to ensure Plaintiff provides the best patient care possible.

Dated: September 8, 2025

Respectfully submitted,

By: /s/ Lee R. Crain

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*Attorneys for Palm Beach Gardens Medical
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CERTIFICATE OF SERVICE

This is to certify that true and correct copies of Plaintiff's Amended and Supplemented Responses and Objections to Defendant The Leapfrog Group's First Sets of Interrogatories to Plaintiff have been served on counsel for The Leapfrog Group by electronic transmission.

/s/ Lee R. Crain
Lee R. Crain

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA
WEST PALM BEACH DIVISION

CASE NO. 9:25-CV-80526-DMM

GOOD SAMARITAN MEDICAL
CENTER, INC., et al.,

Plaintiffs,

v.

THE LEAPFROG GROUP,

Defendant.

**AFFIDAVIT OF ERIK CAZARES IN SUPPORT OF
PLAINTIFF PALM BEACH GARDENS MEDICAL CENTER'S
AMENDED AND SUPPLEMENTED RESPONSES AND OBJECTIONS TO
DEFENDANT THE LEAPFROG GROUP'S FIRST SET OF
INTERROGATORIES TO PALM BEACH GARDENS MEDICAL CENTER**

I, Erik Cazares, declare as follows:

1. I am over 21 years of age and competent to give this testimony.
2. I am the Chief Executive Officer of Palm Beach Gardens Community Hospital, Inc. d/b/a Palm Beach Gardens Medical Center ("Plaintiff"). I am the corporate representative of Plaintiff for the purpose of answering Defendant The Leapfrog Group's First Set of Interrogatories to Palm Beach Gardens Medical Center. I have read the foregoing interrogatories and the answers to those interrogatories, which are true according to the best of my knowledge, information, and belief.

3. I declare under penalty of perjury that the foregoing is true and correct.

Executed on September 8, 2025.



Erik Cazares

Exhibit 102

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA
WEST PALM BEACH DIVISION

CASE NO. 9:25-CV-80526-DMM

GOOD SAMARITAN MEDICAL
CENTER, INC., et al.,

Plaintiffs,

v.

THE LEAPFROG GROUP,

Defendant.

**PLAINTIFF ST. MARY'S MEDICAL CENTER, INC.'S
AMENDED AND SUPPLEMENTED RESPONSES AND OBJECTIONS TO
DEFENDANT THE LEAPFROG GROUP'S FIRST SET OF
INTERROGATORIES TO ST. MARY'S MEDICAL CENTER, INC.**

Pursuant to Federal Rules of Civil Procedure 26 and 33 and the *Pretrial Scheduling Order and Order Referring Case to Mediation* (ECF No. 36) (the "Pretrial Scheduling Order"), Plaintiff St. Mary's Medical Center, Inc. ("Plaintiff" or "St. Mary's"), by and through its undersigned counsel, hereby submit its amended and supplemented responses and objections ("Responses"), to Defendant The Leapfrog Group's ("TLG") First Set of Interrogatories, dated July 11, 2025 (the "Interrogatories" and each numbered interrogatory, an "Interrogatory") in the above-captioned action (the "Action").

Plaintiff's Responses to the Interrogatories are made solely for purposes of this Action and to the best of Plaintiff's present knowledge, information, and belief regarding the matters about which inquiry have been made. Discovery is ongoing, and Plaintiff reserves the right to amend, supplement, clarify, or further explain its Responses at any time prior to the trial in

this Action. Plaintiff further reserves the right to raise any additional objections deemed necessary or appropriate in light of any further review.

OBJECTIONS TO INSTRUCTIONS AND DEFINITIONS

1. Plaintiff objects to the definition of terms “Plaintiffs” and “Plaintiff Hospitals” as overbroad, unduly burdensome, and not proportional to the needs of the case to the extent it seeks to require Plaintiffs to respond on behalf of entities or individuals other than themselves.

2. Plaintiff objects to the definition of the terms “St. Mary’s” and “St. Mary’s Medical Center,” “Plaintiff,” “You,” and “Your” to the extent each term seeks to require Plaintiff to respond on behalf of entities or individuals other than itself, including on behalf of agents, employees, directors, or other non-party entities that are not part of this litigation. Such information is overbroad and beyond the scope of permissible discovery. Accordingly, Plaintiff states that its Responses are on behalf of itself only.

3. Plaintiff objects to the definition of the terms “Tenet Healthcare” and “Tenet” to the extent it seeks to require Plaintiff to respond on behalf of entities or individuals other than itself, including on behalf of Tenet, Tenet’s agents, employees, directors, or other non-party entities that are not part of this litigation. Such information is overbroad and beyond the scope of permissible discovery. Accordingly, Plaintiff states that its Responses are on behalf of itself only.

4. Plaintiff objects to the definition of “identify, when referring to a person,” as overbroad and unduly burdensome to the extent it calls for the “address” and “present or last-known employer” of identified individuals. Such information is overbroad and beyond the scope of permissible discovery.

5. Plaintiff objects to the instruction that the relevant time period for the Interrogatories begins on January 1, 2020. Plaintiff will apply to each Interrogatory the time period

of November 1, 2023 to present (the “Relevant Time Period”). Any response to an Interrogatory that provides information that falls outside of the Relevant Time Period should not be construed as an admission that the Relevant Time Period begins prior to November 1, 2023.

SPECIFIC RESPONSES TO INTERROGATORIES

Interrogatory No. 1: State the full name, address, job title or position, and hospital or employer affiliation of all individuals that assisted with responding to these interrogatories.

Answer: The following individuals assisted with responding to these Interrogatories.

Full Name	Address	Job Title / Position	Hospital or Employer Affiliation
Cynthia McCauley	c/o Gibson, Dunn & Crutcher LLP 200 Park Avenue New York, NY 10166	Chief Executive Officer	St. Mary’s Medical Center
Regina West	c/o Gibson, Dunn & Crutcher LLP 200 Park Avenue New York, NY 10166	Market Quality Director	Palm Beach Health Network and St. Mary’s Medical Center

Interrogatory No. 2: Identify every individual not identified in Your Rule 26(a) initial disclosures with knowledge of facts pertaining to the allegations in Your Complaint in this Lawsuit (and any subsequent amendments) and/or whom You believe may have discoverable knowledge, information or data regarding this matter, including those who You expect to call as a fact or opinion witness at any hearing in this proceeding or whose testimony (by affidavit, deposition or testimony) You intended to submit in connection with this proceeding, and the substance of his/her testimony or affidavit, and, with respect to each person identified, provide:

- A. full name,
- B. address,
- C. telephone number,
- D. job title or position,
- E. hospital or employer affiliation,
- F. and describe in detail the facts possessed by each such person.

Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks the identity of “every individual...with knowledge” or who “may have discoverable knowledge, information or data regarding this matter.” Plaintiff will not provide more than the identity of individuals most likely to have knowledge regarding this matter. Plaintiff further objects to this Interrogatory as premature because it requests disclosure of Plaintiff’s witnesses for hearings and the substance of witness testimony before such disclosure is required under applicable law or the Pretrial Scheduling Order. Plaintiff will submit its trial witness list on October 2, 2025, per the Pretrial Scheduling Order, and disclose any other witnesses and witness testimony as further ordered by the Court or otherwise required by applicable law. Plaintiff also objects to this Interrogatory’s request for the identity of “opinion witness[es]” as vague, since witnesses are either “fact” or “expert” witnesses. Plaintiff will interpret “opinion witness” to mean “expert witness.” Plaintiff submitted expert reports on August 7, 2025, per the Pretrial Scheduling Order.

Answer: Subject to the foregoing objection, Plaintiff will amend its Rule 26(a)(1) Initial Disclosures to identify additional individuals who may have knowledge of facts pertaining to the allegations in the Complaint.

Amended Answer: In addition to those disclosed in Plaintiff’s supplemental disclosures, the following individuals may have relevant factual knowledge:

Full Name	Address	Job Title / Position	Hospital or Employer Affiliation
Regina West	c/o Gibson, Dunn & Crutcher LLP 200 Park Avenue New York, NY 10166	Market Quality Director	Palm Beach Health Network and St. Mary’s Medical Center

In addition to the individuals identified above, persons identified in documents produced in this dispute have knowledge of facts pertaining to the allegations in the Amended Complaint. *See* Fed. R. Civ. P. 33(d). Discovery is ongoing, and Plaintiff reserves the right to supplement, amend, correct, clarify, or modify this Response as further information becomes available.

Interrogatory No. 3: Describe in detail all factual bases for Your contention that Leapfrog’s published Safety Grade for Your hospital was false, inaccurate, misleading, deceptive, or unfair. In so answering, identify with particularity each measure, data point, or metric that You contend was inaccurately reported, calculated, or misrepresented by Leapfrog in calculating the Safety Grade for Your hospital.

Answer: Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks “all factual bases” for Plaintiff’s contention. *See Megdal Assocs., LLC v. La-Z-Boy, Inc.*, 2016 WL 4503337, at *6 (S.D. Fla. Feb. 1, 2016) (finding interrogatories asking for “‘all’ facts or witnesses that support an opposing party’s case” to be “unduly broad”) (citing 8B Wright, Miller, & Kane, Federal Practice and Procedure: Civil 3d § 2167 (2015)). Plaintiff further objects to this Interrogatory as premature to the extent it requests that Plaintiff “[d]escribe in detail all factual bases” to support its contention. *In re Reliance Fin. & Inv. Grp., Inc.*, 2006 WL 8435541, at *4 (S.D. Fla. Feb. 14, 2006) (Contention interrogatories “are more appropriately used after a substantial amount of discovery has been conducted--typically, at the end of the discovery period.”). Plaintiff also objects to this Interrogatory to the extent it attempts to limit or mischaracterize Plaintiff’s claim as just challenging the false, inaccurate, misleading, deceptive, or unfair nature of TLG’s Safety Grade. As the Court explained in its order denying TLG’s motion to dismiss, the core of the Complaint is “a challenge to Defendant’s representations about its methodology, which they claim mislead consumers by failing to distinguish between absent data and damning data, and professing that grades are not influenced by a hospital’s lack of survey participation.” *Order on Motion to Dismiss*

6 (ECF No. 41). Plaintiff also challenges the provably false facts and deceptive scoring system underlying these grades, which TLG admits it relies on to arrive at its deceptive Safety Grades.

Subject to the foregoing objections and as more fully stated in the *Amended Complaint* (ECF No. 74) (“Complaint”), TLG has engaged in deceptive and unfair business practices and misrepresentations when issuing the Safety Grade for Plaintiff’s hospital as part of TLG’s annual “Hospital Survey.” TLG posts these Safety Grades online at hospitalsafetygrade.org.

To arrive at these Safety Grades, TLG uses CMS data, survey responses from participating hospitals, and other supplemental data sources. For participating hospitals, TLG uses the hospitals’ self-reported responses to the Hospital Survey for 12 of the 22 measures. For non-participating hospitals, TLG uses other sources for those 12 measures. For the remaining four measures—Computerized Physician Order Entry, Bar Code Medication Administration, ICU Physician Staffing, and Hand Hygiene Score (the “Deceptive Score Categories”)—TLG devised and uses a so-called “imputation model.” Prior to Fall 2024, TLG’s imputation model assigned non-participating hospitals a score based on the average score applicable to a similarly situated hospital. Beginning in Fall 2024, TLG modified its imputation model. TLG now assigns the lowest possible score to non-participating hospitals, which has the effect of punishing non-participating hospitals and artificially deflating their Safety Grades. TLG has even admitted the changes in Fall 2024 were designed to penalize non-participating hospitals. TLG also misleads consumers about how it grades hospitals, stating “[t]he Hospital Safety Grade reflects how well a hospital does on safety, not whether they complete the [TLG] Hospital Survey.” *Declaration of Lee Crain* (ECF No. 21) (“Crain Decl.”), Ex. 1 at 4 (“Frequently Asked Questions About the Leapfrog Hospital Safety Grade”).

As TLG explains, “not all hospitals have enough data publicly available to be eligible for a grade.” Crain Decl. Ex. 1 at 5. “As per the National Expert Panel guidance, [TLG] has requirements for the minimum amount of data [it] need[s] to issue an accurate grade.” Crain Decl. Ex. 1 at 5. According to TLG, “[h]ospitals missing more than six process measures” are “not graded.” Crain Decl. Ex. 2 at 6. Non-participating hospitals should fall easily into that “not graded” bucket, because their decision not to participate in TLG’s survey necessarily means TLG is missing seven process measures that rely on voluntary submission of hospital data.¹

TLG then deceptively conceals how it makes up grades for the four “imputation” measures and even suggests on its website that TLG *does* have data sufficient to score TLG on those four measures. By way of example, TLG acknowledges that Plaintiff “Declined to Report” information in response to questions about “Staff work[ing] together,” but then tells consumers—as if it were a fact—that Plaintiff is “Worse Than Average” on “Handwashing,” “Communication,” “medication administration,” and the like—even though TLG has no basis whatsoever to adopt those conclusions. Crain Decl. Ex. 32 at 2. TLG itself says handwashing is among the “most important” measures in its survey, Crain Decl. Ex. 15 at 4, yet it deceptively conceals that it has no data with which to grade the Plaintiff hospital on that measure. *Defendant The Leapfrog Group’s Responses to Plaintiffs’ Requests for Production* at 7 (“Leapfrog is not itself in possession of data showing Plaintiffs’ performance on the ‘imputed metrics’ considered by the methodology.”). Of course, Plaintiff in fact has a comprehensive and thorough handwashing policy. And had Plaintiff merely filled out TLG’s survey, it would have received a full letter grade higher on TLG’s score. *Expert Report of Professor Sean Nicholson* (Aug. 7, 2025), Ex. 6.

¹ Those seven include CPOE, BCMA, IPS, Safe Practice 1: Culture of Leadership Structures and Systems; Safe Practice 2: Culture Measurement, Feedback & Intervention; Total Nursing Care Hours per Patient Day; and Hand Hygiene.

Based on the foregoing, and as more fully set forth in the Complaint, TLG engages in deceptive trade practices by, among other things, deceiving consumers about its grading methods by implying that Plaintiff has failed on certain measures that, in truth, TLG has no data or other basis to evaluate; deceiving consumers by telling them the Hospital Safety Grade reflects how well a hospital does on safety, not whether they complete the Hospital Survey; deceiving consumers when it represents that it does not grade hospitals if it lacks sufficient data, when, in truth, it does grade hospitals by “imputing” or making up a grade for the Deceptive Score Categories; hiding the truth about its “imputation model” from consumers by burying it in fine print on a separate website; punishing non-participating hospitals by “imputing” scores, which artificially deflate a hospital’s Safety Grade; and favoring participating hospitals. Additional factual bases for the Plaintiff’s claims are presented in the Complaint.

Interrogatory No. 4: Describe the scoring or grading methodology You believe Leapfrog should have used to assess Your hospital’s patient safety performance and explain why that method would yield a different result.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Plaintiff’s provision of an alternative scoring or grading methodology has nothing to do with the claims and defenses in this case related to TLG’s decision to use deceptive business practices. Plaintiff further objects to this Interrogatory to the extent it calls for speculation.

Answer: Plaintiff declines to respond to this Interrogatory.

Amended Answer: Subject to the foregoing objections, Plaintiff responds that TLG should use a scoring system that is not unfair or deceptive. By way of example only, TLG could decline

to grade hospitals that do not participate in TLG's survey, because their decision not to participate means TLG is missing seven process measures that rely on voluntary submission of hospital data. This would yield a different result, because the hospitals would not receive a grade at all. TLG's methodology certainly should not affirmatively assign an arbitrary low score to a particular metric just because a hospital does not provide data for that metric.

Interrogatory No. 5: State whether You submitted any data, corrections, or appeals to Leapfrog regarding the Safety Grade Your hospital received, and for each such submission, identify the date of the submission, the medium of the submission (i.e. telephone, video conference, email, letter, etc.), who was involved in the submission, and the content of the submission.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Whether or not Plaintiff submitted "any data, corrections, or appeals to Leapfrog regarding the Safety Grade" Plaintiff hospital received has nothing to do with the claims and defenses in this case related to TLG's decision to use deceptive business practices. Plaintiff further objects to this Interrogatory to the extent it seeks information that is already in TLG's possession, custody and control, or equally available to TLG.

Answer: Subject to the foregoing objections, Plaintiff engaged in correspondence prior to the commencement of this case demanding that TLG reform its deceptive practices and cease and desist reporting deceptive and unfair Safety Grades, but at every turn TLG refused.

Amended Answer: Subject to the foregoing objections, Plaintiff did not submit any data, corrections or appeals to Leapfrog regarding the Safety Grades it has received.

Interrogatory No. 6: State whether You provided any comment or input in any form during Leapfrog's requests for public comments for planned updates to the Leapfrog Hospital Safety

Grade methodology that was proposed for the calculation of Hospital Safety Grades (including but not limited to for the Fall 2024 methodology update). If yes, please identify the date of the comment, the medium of the submission (i.e. telephone, video conference, email, letter, etc.), who was involved in the comment and the content of the comment. If no, please state the reason why You chose not to comment.

Answer: Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Whether or not Plaintiff submitted “any comment or input” in response to TLG’s request for public comments has nothing to do with claims and defenses in this case related to TLG’s decision to use deceptive business practices. Plaintiff further objects to this Interrogatory to the extent it seeks information that is already in TLG’s possession, custody and control, or equally available to TLG.

Subject to the foregoing objections, Plaintiff did not provide comments in response to Leapfrog’s requests for public comments for planned updates to the Leapfrog Hospital Safety Grade scoring system because Plaintiff generally does not respond to requests for public comment from private entities like TLG.

Interrogatory No. 7: Describe all actions Your hospital took in response to (or in deciding not to respond to) its Safety Grade or the Hospital Survey, including internal meetings, media statements, or public relations efforts. In so answering, state the date of the action, the individuals involved in the action and the content of the action.

Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks “all actions” Plaintiffs may have taken in response to TLG’s Safety Grades. *See Megdal Assocs., LLC v. La-Z-Boy, Inc.*, No. 14-81476-CIV, 2016 WL 4503337, at *6 (S.D. Fla. Feb. 1, 2016) (finding interrogatories asking for “‘all’

facts or witnesses that support an opposing party's case" to be "unduly broad") (citing 8B Wright, Miller, & Kane, Federal Practice and Procedure: Civil 3d § 2167 (2015)). Plaintiff further objects to this Interrogatory to the extent it seeks information that is subject to a claim of privilege or otherwise protected from disclosure, including seeking information protected by the attorney-client privilege, work-product doctrine, or other immunity.

Answer: Subject to the foregoing objections, Plaintiff devoted substantial time and resources that could have otherwise been spent continuing to improve patient care to respond to the significant harm and disruption caused by TLG's deceptive and unfair Safety Grade. Plaintiff's response included meeting internally with Plaintiff's leadership team, medical executive committee, and governing board, corresponding with TLG to demand that TLG reform its deceptive practices and cease and desist reporting deceptive and unfair Safety Grades, and devoting substantial time and resources to facilitate the preparation and prosecution of this Action.

Amended Answer: Subject to the foregoing objections, Plaintiff devoted substantial time and resources that could have otherwise been spent continuing to improve patient care to respond to the significant harm and disruption caused by TLG's deceptive and unfair Safety Grades. Plaintiff's response included meeting internally with Plaintiff's leadership team, medical executive committee, and governing board, corresponding through Plaintiff's corporate parent with TLG to demand that TLG reform its deceptive practices and cease and desist reporting deceptive and unfair Safety Grades, and devoting substantial time and resources to facilitate the preparation and prosecution of this Action. Plaintiff has also held many phone calls and meetings with physicians and other stakeholders about the TLG grades, explaining how the grades were deceptive and did not accurately reflect the hospital quality and patient safety at Plaintiff.

Interrogatory No. 8: Identify any and all persons, whether internal or external (e.g., patients, vendors, affiliates, parents, agents, partners, media) with whom You communicated in any way with respect to the Safety Grade or the Hospital Survey. In so answering, state the date of the communication, the individuals involved in the communication, the medium of the communication (i.e. telephone, video conference, email, letter, etc.) and the content of the communication.

Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks the identity of “any and all persons, whether internal or external.” Plaintiff will disclose the categories of individuals with whom Plaintiff communicated about the Safety Grade or Hospital Survey during the Relevant Time Period. Plaintiff also objects to this Interrogatory to the extent it seeks protected health information that Health Insurance Portability and Accountability Act (“HIPAA”), among other statutes and regulations, bars Plaintiff from disclosing. Plaintiff further objects to this Interrogatory to the extent it seeks information that is subject to a claim of privilege or otherwise protected from disclosure, including seeking information protected by the attorney-client privilege, work-product doctrine, or other immunity.

Answer: Subject to the foregoing objections, Plaintiff communicated with the following categories of people regarding the Safety Grade or the Hospital Survey: Plaintiff’s governing board, its medical executive committee, department directors, and physicians and nurses when asked about the Safety Grade or Hospital Survey. These communications occurred in and after Fall 2024, after TLG released its deceptive and unfair Safety Grade for Plaintiff’s hospital. Most of these communications occurred during regularly scheduled meetings, during which attendees were told about TLG’s release of the deceptive and unfair Safety Grade, that Plaintiff does not participate in the Hospital Survey because it is unreliable and not an accurate reflection of hospital quality and safety or patient outcomes, and that the Safety Grade, which was not based on any

information provided by Plaintiff, was misleading. The Palm Beach Health Network also issued a press release and since then, has engaged in various social networking and other marketing campaigns to counteract TLG's deceptive scores on behalf of Plaintiff and other affected members of the network.

Amended Answer: Subject to the foregoing objections, Plaintiff communicated with the following categories of people regarding the Safety Grade or the Hospital Survey: Plaintiff's governing board, its medical executive committee, department directors, physicians and nurses, and patients when asked about the Safety Grades or Hospital Survey. These communications occurred in and after Fall 2024, after TLG released its deceptive and unfair Safety Grades for Plaintiff's hospital. Most of these communications occurred during regularly scheduled meetings, during which attendees were told about TLG's release of the deceptive and unfair Safety Grade, that Plaintiff does not participate in the Hospital Survey because it is unreliable and not an accurate reflection of hospital quality and safety or patient outcomes, and that the Safety Grade, which was not based on any information provided by Plaintiff, was misleading. The Palm Beach Health Network also issued a press release and has engaged in marketing efforts, including through social media, to counteract TLG's deceptive scores on behalf of Plaintiff and other affected members of the network. Plaintiff also engaged in email discussions about TLG's misleading grades, either as sender or recipient, which TLG has through Plaintiff's production of documents.

Interrogatory No. 9: Describe all instances in which a third party declined to contract with, refer patients to, or work with Your hospital, where Leapfrog's grade was cited or discussed. In so identifying list the name of the individuals involved in the communication, the medium of the communication (i.e. telephone, video conference, email, letter, etc.), the date of the communication and the content of the communication.

Answer: Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it requires Plaintiff to “[d]escribe all instances” in which a third party took an action in response to TLG’s deceptive grade.

Subject to the foregoing objection, Plaintiff is not aware of any responsive instances.

Interrogatory No. 10: Describe with specificity the basis for each and every category of damage You claim You incurred as a result of the Leapfrog Safety Grade. In so identifying, list each category of damages and the dollar value of each category of damage You claim.

Plaintiff objects to this Interrogatory to the extent it seeks information that is the subject of expert testimony.

Answer: Plaintiff will submit expert reports on August 7, 2025, per the Pretrial Scheduling Order.

Amended Answer: Plaintiff has served the expert report of Thomas Chakurda, which addresses the issue of reputational harm and harm to Plaintiff’s goodwill. Plaintiff further objects to this Interrogatory as overbroad and unduly burdensome to the extent it seeks “each and every” category of claimed damages.

Subject to the foregoing objections and as agreed during the parties’ September 3, 2025 meet and confer, Plaintiff will limit its response to the live non-monetary claims, including injunctive and declaratory relief, to remedy harm to Plaintiff’s reputation and goodwill. Plaintiff’s reputation and goodwill has been damaged by TLG’s false and misleading methodology and resulting Safety Grades. Plaintiff’s claim for reputational harm is based on, among other things, concerns raised by patients, doctors, staff, and community members, as well as false and misleading statements based on TLG’s false and misleading methodology and Safety Grades made in newspapers, viral social-media videos, television programs, and blogs.

By way of example, our Board of Directors has informed me that they have been barraged by community constituents and leaders about the Medical Center's poor TLG Hospital Safety Grade. Further, our medical leadership has received direct inquiries from patients regarding their concerns about TLG's grades and related public reports. The harm caused by TLG's false and misleading Safety Grade is ongoing.

Interrogatory No. 11: Identify all adverse patient events which occurred at Your hospital, including any citations received from regulatory agencies, accrediting agencies, and third party payors such as The Joint Commission, CMS, state health departments, etc. during the period covered by each Leapfrog Safety Grade publication of which You complain (i.e., Fall 2024, Fall 2025, etc.), as well as any complaints received from patients regarding the same.

Plaintiff objects to this Interrogatory because it is overly broad, unduly burdensome, seeks discovery of information that is irrelevant to the claims and defenses in this Action, seeks information that is beyond the scope of Leapfrog's Hospital Survey, and is not reasonably calculated to lead to the discovery of admissible evidence. TLG does not include "all adverse patient events," "citations received from" agencies or payors, or "complaints received from patients" in TLG's determination of its Hospital Safety Grades or request such information in the Hospital Survey, so any such information is irrelevant to whether TLG's actions constitute unfair or deceptive trade practices. TLG has, therefore, only propounded this Interrogatory for purposes of harassment. Plaintiff also objects to this Interrogatory to the extent it seeks protected health information that HIPAA, among other statutes and regulations, bars Plaintiff from disclosing.

Answer: Plaintiff declines to respond to this Interrogatory.

Amended Answer: Defendant has agreed to withdraw this Interrogatory.

Interrogatory No. 12: Describe in detail how Your hospital compares nationally on on [sic] any other ranking of patient safety performance, including but not limited to Vizient, Inc., Premier, Inc., HealthTrust Purchasing Group, The Joint Commission, HealthGrades, US News, Newsweek,

Statista, Definitive Healthcare, or any other quality benchmarking entity including benchmarking on patient safety including on adverse events and on healthcare-acquired infections.

Plaintiff objects to this Interrogatory's request that Plaintiff "[d]escribe in detail how Your hospital compares nationally" based on undisclosed "benchmarking" as vague and confusing. To the extent this Interrogatory seeks the top-line rankings of the identified organizations, Plaintiff objects to this Interrogatory because such information is publicly and equally available to TLG. To the extent this Interrogatory asks Plaintiff to compare itself to the named and unnamed entities, that request is overly broad, unduly burdensome, and not proportional to the needs of this Action. Plaintiff further objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Other organizations' rankings have nothing to do with the claims and defenses in this case related to the Deceptive Score Categories or TLG's decision to use deceptive business practices.

Answer: Subject to the foregoing objections, Plaintiff has received numerous awards and accolades, including many that are directly relevant to patient care for both the low-income underserved community in which it resides and the greater central Florida east coast.

Plaintiff has several accreditations that demonstrate the high-quality of care it provides to pregnant women and children in the community. For example, it is an accredited acute care hospital that is a Level I adult and pediatric Trauma Center. A Level I Trauma Center is a healthcare facility that is central to the trauma system and capable of providing the highest level of care for every aspect of injury for both adults and children. Plaintiff is also a Level III NICU, meaning it provides lifesaving care for babies born before 32 weeks' gestation and / or weighing less than 1,500 grams (approximately 3.3 pounds) or babies with specific medical conditions that require

surgery or specialized pediatric care. Additionally, Plaintiff is one of only 11 designated hospitals by the Florida Department of Health as a Regional Perinatal Intensive Care Center (RPICC) that provides obstetrical services to women who have a high-risk pregnancy and care for newborns with special health needs, such as critical illness or low birth weight. Plaintiff is also certified by the American College of Surgeons for the Verified Pediatric Surgery Program, which recognizes hospitals that properly address the surgical care of infants and children.

Plaintiff is also a Commission on Accreditation of Rehabilitation Facilities (“CARF”) accredited facility for its stroke, brain injury and amputation specialty services. Achieving CARF accreditation means that our hospital meets CARF’s standards and has demonstrated a commitment to being among the best available to patients. We are also a Certified Comprehensive Stroke Center, which means we are dedicated to raising the bar for evaluating and evolving the care of patients at every part of the stroke care continuum. Additionally, Plaintiff has achieved a Det Norske Veritas (DNV) for Comprehensive Stroke Certification. A DNV Comprehensive Stroke Certification demonstrates that Plaintiff provides the highest quality of care and offers evidence-based treatments with cutting-edge research protocols for stroke patients. In order to be accredited, Plaintiff had to undergo an on-site visit on a triennial basis, in which a trained DNV site visit reviewer visits the facility and reviews its required stroke program activity documentation to ensure compliance with the standards. The entities that award and assign these accreditations and certifications visit the healthcare facility and perform regular periodic in-person reviews, audits, surveys and assessments of the facility.

Additionally, Plaintiff is accredited by the Joint Commission, the nation’s largest hospital accreditor that evaluates hospitals’ quality performance standards through an objective evaluation process. Plaintiff has been accredited by the Joint Commission for specialization certifications for

Spine Surgery and Total Joint Replacement for Hip and Knee—a certification designed for hospitals providing the critical elements to achieve long-term success in improving critical medical outcomes—which signifies our services have delivered evidence-based proof of clinical quality sought by patients and payers alike.

These accreditations and certifications are particularly important given Plaintiff's patient population. With its accreditation and specialties, Plaintiff provides patients care they are not able to receive at other facilities. Plaintiff sees more transfers to its facility from nearby hospitals who are unable to provide patients with the care they need than any other Palm Beach County hospital. Also, due to its location in a low-income community, Plaintiff treats a significant number of high-risk pregnancies in which infant mortality is a serious risk and heartbreaking reality.

Plaintiff has also received numerous awards that exemplify its quality. Plaintiff received multiple Get with the Guidelines awards, including Stroke Gold Plus Award 2024 (13th Consecutive Year); Stroke Elite Plus Honor Roll; Stroke Advance Therapy Honor Roll; and Type 2 Diabetes Honor Roll. The Get with the Guidelines Stroke program is designed to improve stroke care by promoting consistent adherence to the latest scientific treatment guidelines.

Additionally, Plaintiff has been recognized by BlueCross BlueShield with a Blue Distinction Centers for Knee, Hip Replacements, Spine Surgery and Maternity Care designation, as part of the Blue Distinction Specialty Care program. The Blue Distinction Specialty Care is a national designation program that recognizes health providers that demonstrate expertise in quality and affordable health care to meet consumers' specialty care needs.

Plaintiff has also received numerous awards that recognize the high-quality care it provides to pregnant women and children. For example, it recently received the Florida Department of Health and Florida Agency for Health Care Administration Excellence for Maternal Care Award,

which highlights hospitals that surpass Florida Department of Health's goal of reducing the rate of C-sections among first-time mothers with low-risk pregnancies. Similarly, the Florida Hospital Association also recently awarded Plaintiff the Excellence in Maternity Care designation, which is awarded to a hospital that demonstrates exceptional dedication to maternal health care.

Additionally, the Palm Beach Post has awarded Plaintiff with Community Choice Awards for Best Hospital, Best Orthopedic/Sports Medicine 2024 and Best Maternity and Childbirth Center 2024 & 2025. The Palm Beach County Community Choice Awards celebrate the best business and organizations in the area, with people in the community voting on these designations.

The medical rankings organization Healthgrades awarded Plaintiff numerous accolades. To assess and evaluate hospitals, Healthgrades relies on data from Medicare medical claims records and states' data on Medicare and commercially insured patient outcomes to determine patients' actual clinical outcomes when visiting a given hospital. Plaintiff has received several awards from Healthgrades for various specialties, including:

a. Labor and Delivery

- i. Five-Star Recipient for C-Section Delivery for 11 years in a row
- ii. Five-Star Recipient for Vaginal Delivery for 11 years in a row

b. Orthopedic

- i. Five-Star Recipient for Hip Fracture Treatment (2024)
- ii. Five-Star Recipient for Knee Replacement (2024)

c. Spine Surgery

- i. Five-Star Recipient for Spinal Fusion (2025)

In addition, Plaintiff will produce and identify documents reflecting some of Plaintiff's rankings from other organizations.

Amended Answer: Subject to the foregoing objections, Plaintiff has received numerous awards and accolades. For example, Plaintiff has several accreditations that demonstrate the high-quality of care it provides to pregnant women and children in the community. For example, it is an accredited acute care hospital that is a Level I adult and pediatric Trauma Center. Additionally, Plaintiff is one of only 11 designated hospitals by the Florida Department of Health as a Regional Perinatal Intensive Care Center (RPICC) that provides obstetrical services to women who have a high-risk pregnancy and care for newborns with special health needs, such as critical illness or low birth weight. Plaintiff is also certified by the American College of Surgeons for the Verified Pediatric Surgery Program, which recognizes hospitals that properly address the surgical care of infants and children.

Plaintiff is also a Commission on Accreditation of Rehabilitation Facilities (“CARF”) accredited facility for its stroke, brain injury and amputation specialty services. We are also a Certified Comprehensive Stroke Center. Additionally, Plaintiff has achieved a Det Norske Veritas (DNV) for Comprehensive Stroke Certification.

Additionally, Plaintiff is accredited by the Joint Commission. Plaintiff also has been accredited by the Joint Commission for specialization certifications for Spine Surgery and Total Joint Replacement for Hip and Knee.

Plaintiff has also received multiple Get with the Guidelines awards, including Stroke Gold Plus Award 2024 (13th Consecutive Year); Stroke Elite Plus Honor Roll; Stroke Advance Therapy Honor Roll; and Type 2 Diabetes Honor Roll.

Additionally, Plaintiff has been recognized by BlueCross BlueShield with a Blue Distinction Centers for Knee, Hip Replacements, Spine Surgery and Maternity Care designation, as part of the Blue Distinction Specialty Care program.

Plaintiff recently received the Florida Department of Health and Florida Agency for Health Care Administration Excellence for Maternal Care Award. Similarly, the Florida Hospital Association also recently awarded Plaintiff the Excellence in Maternity Care designation.

Additionally, the Palm Beach Post has awarded Plaintiff with Community Choice Awards for Best Hospital, Best Orthopedic/Sports Medicine 2024 and Best Maternity and Childbirth Center 2024 & 2025.

The medical rankings organization Healthgrades awarded Plaintiff numerous accolades, including:

a. Labor and Delivery

- i. Five-Star Recipient for C-Section Delivery for 11 years in a row
- ii. Five-Star Recipient for Vaginal Delivery for 11 years in a row

b. Orthopedic

- i. Five-Star Recipient for Hip Fracture Treatment (2024)
- ii. Five-Star Recipient for Knee Replacement (2024)

c. Spine Surgery

- i. Five-Star Recipient for Spinal Fusion (2025)

In addition, Plaintiff will produce and identify documents reflecting some of Plaintiff's rankings from other organizations.

Also, Plaintiff does not participate in Vizient and has not done so during the Relevant Time Period.

Interrogatory No. 13: Describe any steps taken by Your hospital to improve any and all of the patient safety measures considered by Leapfrog's Hospital Safety Grade (as set forth on Leapfrog's published scoring methodology documents; see ECF No. 21-3 at 6-10; ECF No. 21-43 at 6-9), before and after each Safety Grade publication of which You complain.

Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks the identity of Plaintiff's improvements to "any and all" patient safety measures considered by Leapfrog's Hospital Safety Grade. Plaintiff further objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks information on metrics other than TLG's Deceptive Score Categories and to the extent it seeks information that is beyond the scope of Leapfrog's Hospital Survey.

Answer: Plaintiff declines to respond to this Interrogatory.

Amended Answer: Subject to the foregoing objection, Plaintiff is committed to continual improvement of patient safety measures, motivated by our commitment to ensuring the best possible patient safety—not chasing the best possible Leapfrog grade. To achieve this core objective, Plaintiff devotes significant time and resources to improving its delivery of the highest possible quality of care for those in the community it serves, including efforts to improve its performance in areas related to the four metrics Plaintiff has chosen to impute in its survey.

Plaintiff tracks three of these metrics through its patient safety plan or as part of its quality improvement patient safety committee. For example, Plaintiff does random hand washing audits every month on every unit and addresses any negative trends. Plaintiff already has 24/7 ICU coverage for its intensivist unit and has had that coverage for several years, so it does not need to track this metric.

Interrogatory No. 14: State whether You are aware of specific patients who have relied on the Leapfrog Safety Grade in declining to receive healthcare services at Your hospital. In so

answering, identify the individual patient that declined to receive services, the date of such declination, the type of service the patient declined to receive, the medium for the communication from the patient (i.e. telephone, video conference, email, letter, etc.), the content of the communication, and the reason given for the stated decision.

Plaintiff objects to this Interrogatory as seeking protected health information that is protected from disclosure by HIPAA, among other statutes and regulations. Plaintiff will only produce this information as needed and subject to a Qualified Protective Order entered by this Court.

Answer: Subject to the foregoing objection, Plaintiff has received reports that patients considered or decided not to use Plaintiff's facility because of TLG's misleading grades.

Amended Answer: Subject to the foregoing objection, since the release of TLG's false and misleading grades, Plaintiff has received numerous reports from doctors that patients considered or decided not to use Plaintiff's facility due to concerns related to TLG's misleading grades.

Interrogatory No. 15: Describe any effort Your hospital has made to influence public perception of Your hospital's performance on patient safety following the publication of the Leapfrog Safety Grade.

Plaintiff objects to this Interrogatory as vague and ambiguous because it does not specify which Leapfrog Safety Grade is at issue. Plaintiff will construe this Interrogatory to reference TLG's deceptive Safety Grades beginning in Fall 2024. Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks "any effort" Plaintiff "has made to influence public perception" after the release of TLG's deceptive and unfair Safety Grades because there have been many such "efforts" and those "efforts" are ongoing given the significant harm caused by TLG's deceptive and unfair business practices.

Answer: Subject to the foregoing objections, Plaintiff continues to influence public perception by, among other things, delivering the highest quality care to the community it serves, which, as discussed in response to Interrogatory 12, has led to numerous awards, accreditations, and accolades. In addition, several public statements disputing the misleading nature of the Safety Grade have been made on Plaintiff's behalf.

Supplemental Answer: In addition to the above, members of hospital leadership have communicated with patients, doctors, or community members on a regular basis to dispel the misleading nature of the Leapfrog Safety Grades. For instance, Plaintiff communicated its governing board, its medical executive committee, department directors, physicians and nurses, and patients when asked about the Safety Grades or Hospital Survey. These communications occurred in and after Fall 2024, after TLG released its deceptive and unfair Safety Grades for Plaintiff's hospital. The Palm Beach Health Network also issued a press release and has engaged in marketing efforts, including through social media, to counteract TLG's deceptive scores on behalf of Plaintiff and other affected members of the network. Plaintiff also engaged in email discussions about TLG's misleading grades, either as sender or recipient, which TLG has through Plaintiff's production of documents.

Interrogatory No. 16: Describe the due diligence Your hospital undertakes to ensure the accuracy of its own publicly reported safety data (including but not limited to data submitted to CMS, the CDC, and third party organizations).

Plaintiff objects to this Interrogatory as vague and ambiguous due to its use of the undefined term "due diligence." Plaintiff further objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Any "due diligence"

Plaintiff performs when reporting to *third parties* has nothing to do with the claims and defenses in this case related to TLG's decision to use deceptive business practices, especially when TLG does nothing to ensure the accuracy of information that hospitals that participate in its survey self-report.

Answer: Plaintiff declines to respond to this Interrogatory.

Amended Answer: Subject to the foregoing objections, Plaintiff makes reasonable efforts to ensure the accuracy of the data it reports to third-party organizations. For instance, Plaintiff employs data abstractors, quality coordinators and a Quality Director, who are all responsible for abstracting, validating, and submitting safety data.

Interrogatory No. 17: Describe in detail how You communicate to the shareholders, board members, collective bargaining representatives and investors of Tenet Healthcare System the outcome of any and all healthcare safety ratings, evaluative publications, studies, or performance analyses that Your Hospital receives.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Plaintiff's communication, if any, with the shareholders, board members, collective bargaining representatives and investors of Tenet Healthcare System, all non-parties to this litigation, has nothing to do with the claims and defenses in this case related to TLG's decision to use deceptive business practices.

Answer: Plaintiff declines to respond to this Interrogatory.

Amended Answer: Subject to the foregoing objection, Plaintiff communicates with Tenet stakeholders, including employees who work to support the Palm Beach Health Network, on a range of matters, including issues related to patient safety and outcomes and in particular related

to TLG and the Safety Grades by email and oral communication. Those communications included discussions about the reasons for particular grades, the method used to calculate Safety Grades, the value of Safety Grades, and responses to the Safety Grades. In addition, identified below are documents Plaintiff produced evidencing communications between the Plaintiff Hospitals and Tenet related to TLG, the Leapfrog survey, and Safety Grades.

Start Page	End Page
PBHN000006509	PBHN000006513
PBHN000006548	PBHN000006550
PBHN000005092	PBHN000005093
PBHN000005094	PBHN000005096
PBHN000006397	PBHN000006401
PBHN000002090	PBHN000002094
PBHN000002071	PBHN000002071

PBHN000004562	PBHN000004563
PBHN000004564	PBHN000004564
PBHN000004574	PBHN000004581
PBHN000004565	PBHN000004569
PBHN000004704	PBHN000004704
PBHN000004715	PBHN000004719
PBHN000006465	PBHN000006466

Discovery is ongoing, and Plaintiff reserves the right to amend, modify or supplement the response to this Interrogatory.

Interrogatory No. 18: State whether the compensation of Your Chief Executive Officer or any other executive-level leadership officers is tied to or related in any way to Your hospital's performance on patient safety, union worker contracts or Your hospital's ratings by third party ratings organizations' ratings publications (including but not limited to the Leapfrog Hospital Safety Grade).

Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Plaintiff's method of compensating its Chief

Executive Officer and other executive-level leadership **has nothing to do with the** claims and defenses in this case related to TLG's decision to use deceptive business practices.

Answer: TLG has, therefore, only propounded this Interrogatory for purposes of harassment. Plaintiff declines to respond to this Interrogatory.

Amended Answer: Subject to the foregoing objection, Plaintiff's performance on patient safety, union worker contracts, or ratings by third party ratings organizations' ratings publications is related in some way to the compensation of Plaintiff's Chief Executive Officer or other executive-level leadership officer(s).

Interrogatory No. 19: Identify all hospitals, medical centers, or healthcare systems that you consider to be your direct competitors within the relevant geographic market during the time period covered by the Complaint and describe in detail the criteria you use to determine whether another hospital or healthcare provider is a competitor.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is not reasonably calculated to lead to the discovery of admissible evidence. The identity of Plaintiff's competitors and "the criteria" used to determine whether a hospital or provide is a competitor has nothing to do with the claims and defenses in this case related to TLG's decision to use deceptive business practices. Plaintiff also objects to this Interrogatory to the extent it seeks confidential, proprietary information, and commercially sensitive information related to Plaintiff's scoring system and "criteria" used to determine whether a hospital or provide is a competitor.

Answer: Subject to the foregoing objections and on condition that this response is considered "Confidential" under the forthcoming agreed confidentiality order, Jupiter Medical Center is Plaintiff's competitor. Plaintiff considers this hospital a competitor because of its

proximity to Plaintiff, its competing services lines, and that patients within Plaintiff's service area go to this hospital for medical care.

Interrogatory No. 20: State and describe the results of any market analysis, competitive analysis, or consumer perception surveys you have conducted or commissioned regarding your competitors from 2020 to present, and identify the individuals or entities that prepared or participated in such analyses.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is not is not proportional to the needs of this Action. The results of any market analysis, competitive analysis, or consumer perception surveys and the identity of those who prepared or participated in such analyses has nothing to do with the claims and defenses in this case related to TLG's decision to use deceptive business practices.

Answer: Plaintiff declines to respond to this Interrogatory.

Amended Answer: Plaintiff further objects to this Interrogatory to the extent it requests information from outside of the relevant time period of January 1, 2023, to present. Plaintiff also objects to this Interrogatory as unduly burdensome to the extent it asks Plaintiff to "state and describe" various market analysis.

As agreed during the parties' meet and confer on September 3, 2025, Plaintiff will produce documents showing the results of studies or surveys Plaintiff has conducted or commissioned related to internal market analysis, competitive analysis, or consumer perception. Plaintiff will identify the documents responsive to this Interrogatory by Bates number in Plaintiffs' production cover letter.

Interrogatory No. 21: Identify with specificity any comments or concerns raised by any third party payor, bank or lender, or investor related to Your hospital's reputation and/or public perception on issues in any way involving patient safety or satisfaction.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is overly broad, unduly burdensome and irrelevant to the claims and defenses in this Action and is not proportional to the needs of this case to the extent it seeks "comments and concerns" from third parties related generally to Plaintiff's reputation that has nothing to do with the specific and significant reputational harm caused by TLG's misleading grades.

Answer: Subject to the foregoing objections, Plaintiff will produce and identify documents related to the significant reputational harm caused by TLG's deceptive and unfair Safety Grades that provide sufficient detail to respond to this Interrogatory.

Amended Answer: Subject to the foregoing objections, Plaintiff is unaware of any documents related to this Interrogatory.

Interrogatory No. 22: Identify and describe any complaints, concerns, or comments from patients, community members, or referring physicians that relate to the hospital's reputation or comparisons to other hospitals in the region.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is overly broad, unduly burdensome and irrelevant to the claims and defenses in this Action and is not proportional to the needs of this Action to the extent it seeks "comments and concerns" from patients, community members, or referring physicians that have nothing to do with the significant reputational harm caused by TLG's misleading grades. Plaintiff also objects to this interrogatory as seeking protected health information that is protected from disclosure by HIPAA, among other

statutes and regulations. Plaintiff will only produce this information as needed and subject to the agreed protective order entered by this Court.

Answer: Subject to the foregoing objections, Plaintiff has received reports that patients and physicians considered or decided not to use Plaintiff's facility because of TLG's misleading grades.

Amended Answer: Subject to the foregoing objections, Plaintiff has received reports that patients and physicians considered or decided not to use Plaintiff's facility because of TLG's misleading grades. In addition, concerns have been raised by patients, doctors, staff, and community members, and Plaintiff is aware of false and misleading statements based on TLG's false and misleading methodology and Safety Grades made in newspapers, viral social-media videos, television programs, and blogs.

Our Board of Directors has informed me that they have been barraged by community constituents and leaders about the Medical Center's poor TLG Hospital Safety Grade. Further, our medical leadership has received direct inquiries from patients regarding their concerns about TLG's grades and related public reports. The harm caused by TLG's false and misleading Safety Grade is ongoing.

In addition, the following produced documents evidence such harm.

Start Page	End Page
PBHN000002082	PBHN000002085
PBHN000002066	PBHN000002070
PBHN000002615	PBHN000002617
PBHN000006397	PBHN000006401
PBHN000002090	PBHN000002094
PBHN000004484	PBHN000004484

PBHN000004564	PBHN000004564
PBHN000004574	PBHN000004580
PBHN000004557	PBHN000004557
PBHN000008718	PBHN000008718
PBHN000006461	PBHN000006462
PBHN000008914	PBHN000008914
PBHN000008915	PBHN000008915

Discovery is ongoing, and Plaintiff reserves the right to amend, modify or supplement the response to this Interrogatory.

Interrogatory No. 23: List with specific detail each and every concern, complaint or comment made by any union, collective bargaining unit or employee association in any way related to patient safety at Your hospital.

Answer: Plaintiff objects to this Interrogatory because it seeks discovery of information that is overly broad, unduly burdensome and irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks “each and every concern, complaint or comment ” from third parties that have nothing to do with the significant reputational harm caused by TLG’s misleading grades. Plaintiff also objects to this Interrogatory to the extent it seeks health information that is protected from disclosure by HIPAA, among other statutes and regulations. Plaintiff will only produce this information as needed and subject to the agreed protective order entered by this Court.

Answer: Subject to the foregoing objections, Plaintiff is unaware of any concern, complaint or comment regarding TLG deceptive scores made by the union at Plaintiff’s hospital.

Interrogatory No. 24: Identify any and all criticism You have received since 2020 from Tenet Healthcare Corporation and/or from any individual executive of Tenet Healthcare Corporation regarding Your hospital’s performance in any way.

Answer: Plaintiff objects to this Interrogatory because it seeks discovery of information that is overly broad, unduly burdensome and irrelevant to the claims and defenses in this Action and is not reasonably calculated to lead to the discovery of admissible evidence. Any so-called

“criticism” has nothing to do with the claims and defenses related to TLG’s decision to use deceptive business practices. TLG has, therefore, only propounded this Interrogatory for purposes of harassment. Plaintiff declines to respond to this Interrogatory.

Amended Answer: As discussed during the parties’ meet and confer on September 3, 2025, TLG agreed to narrow this Interrogatory to concern only “criticism...regarding Your hospital’s patient safety.” After a reasonable and diligent search, Plaintiff is unaware of having received “criticism” from Tenet Health Corporation regarding patient safety. Plaintiff is always working to improve its performance, quality, and safety in a constructive way and engages with Tenet Health Corporation as needed to ensure Plaintiff provides the best patient care possible.

Dated: September 8, 2025

Respectfully submitted,

By: /s/ Lee R. Crain

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Attorneys for St. Mary's Medical Center, Inc.

CERTIFICATE OF SERVICE

This is to certify that true and correct copies of Plaintiff's Amended and Supplemented Responses and Objections to Defendant The Leapfrog Group's First Sets of Interrogatories to Plaintiff have been served on counsel for The Leapfrog Group by electronic transmission.

/s/ Lee R. Crain
Lee R. Crain

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA
WEST PALM BEACH DIVISION

CASE NO. 9:25-CV-80526-DMM

GOOD SAMARITAN MEDICAL
CENTER, INC., et al.,

Plaintiffs,

v.

THE LEAPFROG GROUP,

Defendant.

**AFFIDAVIT OF CYNTHIA MCCAULEY IN SUPPORT OF
PLAINTIFF ST. MARY'S MEDICAL CENTER, INC.'S
AMENDED AND SUPPLEMENTED RESPONSES AND OBJECTIONS TO
DEFENDANT THE LEAPFROG GROUP'S FIRST SET OF
INTERROGATORIES TO ST. MARY'S MEDICAL CENTER**

I, Cynthia McCauley, declare as follows:

1. I am over 21 years of age and competent to give this testimony.
2. I am the Chief Executive Officer of St. Mary's Medical Center, Inc. ("Plaintiff"). I am the corporate representative of Plaintiff for the purpose of answering Defendant The Leapfrog Group's First Set of Interrogatories to St. Mary's Medical Center. I have read the foregoing interrogatories and the answers to those interrogatories, which are true according to the best of my knowledge, information, and belief.
3. I declare under penalty of perjury that the foregoing is true and correct.

Executed on September 8, 2025.

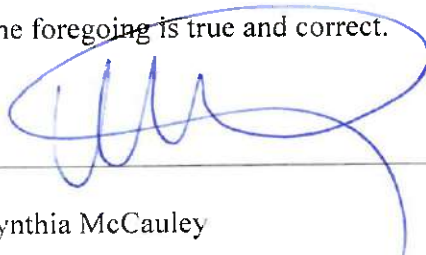

Cynthia McCauley

Exhibit 103

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA
WEST PALM BEACH DIVISION

CASE NO. 9:25-CV-80526-DMM

GOOD SAMARITAN MEDICAL
CENTER, INC., et al.,

Plaintiffs,

v.

THE LEAPFROG GROUP,

Defendant.

**PLAINTIFF WEST BOCA MEDICAL CENTER, INC.’S
AMENDED AND SUPPLEMENTED RESPONSES AND OBJECTIONS TO
DEFENDANT THE LEAPFROG GROUP’S FIRST SET OF
INTERROGATORIES TO WEST BOCA MEDICAL CENTER, INC.**

Pursuant to Federal Rules of Civil Procedure 26 and 33 and the *Pretrial Scheduling Order and Order Referring Case to Mediation* (ECF No. 36) (the “Pretrial Scheduling Order”), Plaintiff West Boca Medical Center, Inc. (“Plaintiff” or “West Boca Medical Center”), by and through its undersigned counsel, hereby submit its amended and supplemented responses and objections (“Responses”), to Defendant The Leapfrog Group’s (“TLG”) First Set of Interrogatories, dated July 11, 2025 (the “Interrogatories” and each numbered interrogatory, an “Interrogatory”) in the above-captioned action (the “Action”).

Plaintiff’s Responses to the Interrogatories are made solely for purposes of this Action and to the best of Plaintiff’s present knowledge, information, and belief regarding the matters about which inquiry have been made. Discovery is ongoing, and Plaintiff reserves the right to amend, supplement, clarify, or further explain its Responses at any time prior to the trial in

this Action. Plaintiff further reserves the right to raise any additional objections deemed necessary or appropriate in light of any further review.

OBJECTIONS TO INSTRUCTIONS AND DEFINITIONS

1. Plaintiff objects to the definition of terms “Plaintiffs” and “Plaintiff Hospitals” as overbroad, unduly burdensome, and not proportional to the needs of the case to the extent it seeks to require Plaintiffs to respond on behalf of entities or individuals other than themselves.

2. Plaintiff objects to the definition of the terms “West Boca,” “West Boca Medical Center,” “Plaintiff,” “You,” and “Your” to the extent each term seeks to require Plaintiff to respond on behalf of entities or individuals other than itself, including on behalf of agents, employees, directors, or other non-party entities that are not part of this litigation. Such information is overbroad and beyond the scope of permissible discovery. Accordingly, Plaintiff states that its Responses are on behalf of itself only.

3. Plaintiff objects to the definition of the terms “Tenet Healthcare” and “Tenet” to the extent it seeks to require Plaintiff to respond on behalf of entities or individuals other than itself, including on behalf of Tenet, Tenet’s agents, employees, directors, or other non-party entities that are not part of this litigation. Such information is overbroad and beyond the scope of permissible discovery. Accordingly, Plaintiff states that its Responses are on behalf of itself only.

4. Plaintiff objects to the definition of “identify, when referring to a person,” as overbroad and unduly burdensome to the extent it calls for the “address” and “present or last-known employer” of identified individuals. Such information is overbroad and beyond the scope of permissible discovery.

5. Plaintiff objects to the instruction that the relevant time period for the Interrogatories begins on January 1, 2020. Plaintiff will apply to each Interrogatory the time period

of November 1, 2023 to present (the “Relevant Time Period”). Any response to an Interrogatory that provides information that falls outside of the Relevant Time Period should not be construed as an admission that the Relevant Time Period begins prior to November 1, 2023.

SPECIFIC RESPONSES TO INTERROGATORIES

Interrogatory No. 1: State the full name, address, job title or position, and hospital or employer affiliation of all individuals that assisted with responding to these interrogatories.

Answer: The following individuals assisted with responding to these Interrogatories.

Full Name	Address	Job Title / Position	Hospital or Employer Affiliation
Jerad Hanlon	c/o Gibson, Dunn & Crutcher LLP 200 Park Avenue New York, NY 10166	Chief Executive Officer	West Boca Medical Center
Regina West	c/o Gibson, Dunn & Crutcher LLP 200 Park Avenue New York, NY 10166	Market Quality Director	Palm Beach Health Network and St. Mary’s Medical Center

Interrogatory No. 2: Identify every individual not identified in Your Rule 26(a) initial disclosures with knowledge of facts pertaining to the allegations in Your Complaint in this Lawsuit (and any subsequent amendments) and/or whom You believe may have discoverable knowledge, information or data regarding this matter, including those who You expect to call as a fact or opinion witness at any hearing in this proceeding or whose testimony (by affidavit, deposition or testimony) You intended to submit in connection with this proceeding, and the substance of his/her testimony or affidavit, and, with respect to each person identified, provide:

- A. full name,
- B. address,
- C. telephone number,
- D. job title or position,
- E. hospital or employer affiliation,
- F. and describe in detail the facts possessed by each such person.

Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks the identity of “every individual...with knowledge” or who “may have discoverable knowledge, information or data regarding this matter.” Plaintiff will not provide more than the identity of individuals most likely to have knowledge regarding this matter. Plaintiff further objects to this Interrogatory as premature because it requests disclosure of Plaintiff’s witnesses for hearings and the substance of witness testimony before such disclosure is required under applicable law or the Pretrial Scheduling Order. Plaintiff will submit its trial witness list on October 2, 2025, per the Pretrial Scheduling Order, and disclose any other witnesses and witness testimony as further ordered by the Court or otherwise required by applicable law. Plaintiff also objects to this Interrogatory’s request for the identity of “opinion witness[es]” as vague, since witnesses are either “fact” or “expert” witnesses. Plaintiff will interpret “opinion witness” to mean “expert witness.” Plaintiff submitted expert reports on August 7, 2025, per the Pretrial Scheduling Order.

Answer: Subject to the foregoing objection, Plaintiff will amend its Rule 26(a)(1) Initial Disclosures to identify additional individuals who may have knowledge of facts pertaining to the allegations in the Complaint.

Amended Answer: In addition to those disclosed in Plaintiff’s supplemental disclosures, the following individuals may have relevant factual knowledge:

Full Name	Address	Job Title / Position	Hospital or Employer Affiliation
Regina West	c/o Gibson, Dunn & Crutcher LLP 200 Park Avenue New York, NY 10166	Market Quality Director	Palm Beach Health Network and St. Mary’s Medical Center

Full Name	Address	Job Title / Position	Hospital or Employer Affiliation
Andrea Nunes	c/o Gibson, Dunn & Crutcher LLP 200 Park Avenue New York, NY 10166	Quality Director	West Boca Medical Center

In addition to the individuals identified above, persons identified in documents produced in this dispute have knowledge of facts pertaining to the allegations in the Amended Complaint. *See* Fed. R. Civ. P. 33(d). Discovery is ongoing, and Plaintiff reserves the right to supplement, amend, correct, clarify, or modify this Response as further information becomes available.

Interrogatory No. 3: Describe in detail all factual bases for Your contention that Leapfrog’s published Safety Grade for Your hospital was false, inaccurate, misleading, deceptive, or unfair. In so answering, identify with particularity each measure, data point, or metric that You contend was inaccurately reported, calculated, or misrepresented by Leapfrog in calculating the Safety Grade for Your hospital.

Answer: Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks “all factual bases” for Plaintiff’s contention. *See Megdal Assocs., LLC v. La-Z-Boy, Inc.*, 2016 WL 4503337, at *6 (S.D. Fla. Feb. 1, 2016) (finding interrogatories asking for “‘all’ facts or witnesses that support an opposing party’s case” to be “unduly broad”) (citing 8B Wright, Miller, & Kane, Federal Practice and Procedure: Civil 3d § 2167 (2015)). Plaintiff further objects to this Interrogatory as premature to the extent it requests that Plaintiff “[d]escribe in detail all factual bases” to support its contention. *In re Reliance Fin. & Inv. Grp., Inc.*, 2006 WL 8435541, at *4 (S.D. Fla. Feb. 14, 2006) (Contention interrogatories “are more appropriately used after a substantial amount of discovery has been conducted--typically, at the end of the discovery period.”). Plaintiff also objects to this Interrogatory to the extent it attempts to limit or mischaracterize Plaintiff’s claim as just

challenging the false, inaccurate, misleading, deceptive, or unfair nature of TLG’s Safety Grade. As the Court explained in its order denying TLG’s motion to dismiss, the core of the Complaint is “a challenge to Defendant’s representations about its methodology, which they claim mislead consumers by failing to distinguish between absent data and damning data, and professing that grades are not influenced by a hospital’s lack of survey participation.” *Order on Motion to Dismiss* 6 (ECF No. 41). Plaintiff also challenges the provably false facts and deceptive scoring system underlying these grades, which TLG admits it relies on to arrive at its deceptive Safety Grades.

Subject to the foregoing objections and as more fully stated in the *Amended Complaint* (ECF No. 74) (“Complaint”), TLG has engaged in deceptive and unfair business practices and misrepresentations when issuing the Safety Grade for Plaintiff’s hospital as part of TLG’s annual “Hospital Survey.” TLG posts these Safety Grades online at hospitalsafetygrade.org.

To arrive at these Safety Grades, TLG uses CMS data, survey responses from participating hospitals, and other supplemental data sources. For participating hospitals, TLG uses the hospitals’ self-reported responses to the Hospital Survey for 12 of the 22 measures. For non-participating hospitals, TLG uses other sources for those 12 measures. For the remaining four measures—Computerized Physician Order Entry, Bar Code Medication Administration, ICU Physician Staffing, and Hand Hygiene Score (the “Deceptive Score Categories”)—TLG devised and uses a so-called “imputation model.” Prior to Fall 2024, TLG’s imputation model assigned non-participating hospitals a score based on the average score applicable to a similarly situated hospital. Beginning in Fall 2024, TLG modified its imputation model. TLG now assigns the lowest possible score to non-participating hospitals, which has the effect of punishing non-participating hospitals and artificially deflating their Safety Grades. TLG has even admitted the changes in Fall 2024 were designed to penalize non-participating hospitals. TLG also misleads consumers about how

it grades hospitals, stating “[t]he Hospital Safety Grade reflects how well a hospital does on safety, not whether they complete the [TLG] Hospital Survey.” *Declaration of Lee Crain* (ECF No. 21) (“Crain Decl.”), Ex. 1 at 4 (“Frequently Asked Questions About the Leapfrog Hospital Safety Grade”).

As TLG explains, “not all hospitals have enough data publicly available to be eligible for a grade.” Crain Decl. Ex. 1 at 5. “As per the National Expert Panel guidance, [TLG] has requirements for the minimum amount of data [it] need[s] to issue an accurate grade.” Crain Decl. Ex. 1 at 5. According to TLG, “[h]ospitals missing more than six process measures” are “not graded.” Crain Decl. Ex. 2 at 6. Non-participating hospitals should fall easily into that “not graded” bucket, because their decision not to participate in TLG’s survey necessarily means TLG is missing seven process measures that rely on voluntary submission of hospital data.¹

TLG then deceptively conceals how it makes up grades for the four “imputation” measures and even suggests on its website that TLG *does* have data sufficient to score TLG on those four measures. By way of example, TLG acknowledges that Plaintiff “Declined to Report” information in response to questions about “Staff work[ing] together,” but then tells consumers—as if it were a fact—that Plaintiff is “Worse Than Average” on “Handwashing,” “Communication,” “medication administration,” and the like—even though TLG has no basis whatsoever to adopt those conclusions. Crain Decl. Ex. 32 at 2. TLG itself says handwashing is among the “most important” measures in its survey, Crain Decl. Ex. 15 at 4, yet it deceptively conceals that it has no data with which to grade the Plaintiff hospital on that measure. *Defendant The Leapfrog Group’s Responses to Plaintiffs’ Requests for Production* at 7 (“Leapfrog is not itself in possession

¹ Those seven include CPOE, BCMA, IPS, Safe Practice 1: Culture of Leadership Structures and Systems; Safe Practice 2: Culture Measurement, Feedback & Intervention; Total Nursing Care Hours per Patient Day; and Hand Hygiene.

of data showing Plaintiffs' performance on the 'imputed metrics' considered by the methodology."'). Of course, Plaintiff in fact has a comprehensive and thorough handwashing policy. And had Plaintiff merely filled out TLG's survey, it would have received a full two letter grades higher on TLG's score. *Expert Report of Professor Sean Nicholson* (Aug. 7, 2025), Ex. 6.

Based on the foregoing, and as more fully set forth in the Complaint, TLG engages in deceptive trade practices by, among other things, deceiving consumers about its grading methods by implying that Plaintiff has failed on certain measures that, in truth, TLG has no data or other basis to evaluate; deceiving consumers by telling them the Hospital Safety Grade reflects how well a hospital does on safety, not whether they complete the Hospital Survey; deceiving consumers when it represents that it does not grade hospitals if it lacks sufficient data, when, in truth, it does grade hospitals by "imputing" or making up a grade for the Deceptive Score Categories; hiding the truth about its "imputation model" from consumers by burying it in fine print on a separate website; punishing non-participating hospitals by "imputing" scores, which artificially deflate a hospital's Safety Grade; and favoring participating hospitals. Additional factual bases for the Plaintiff's claims are presented in the Complaint.

Interrogatory No. 4: Describe the scoring or grading methodology You believe Leapfrog should have used to assess Your hospital's patient safety performance and explain why that method would yield a different result.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Plaintiff's provision of an alternative scoring or grading methodology has nothing to do with the claims and defenses in this case related to TLG's

decision to use deceptive business practices. Plaintiff further objects to this Interrogatory to the extent it calls for speculation.

Answer: Plaintiff declines to respond to this Interrogatory.

Amended Answer: Subject to the foregoing objections, Plaintiff responds that TLG should use a scoring system that is not unfair or deceptive. By way of example only, TLG could decline to grade hospitals that do not participate in TLG's survey, because their decision not to participate means TLG is missing seven process measures that rely on voluntary submission of hospital data. This would yield a different result, because the hospitals would not receive a grade at all. TLG's methodology certainly should not affirmatively assign an arbitrary low score to a particular metric just because a hospital does not provide data for that metric.

Interrogatory No. 5: State whether You submitted any data, corrections, or appeals to Leapfrog regarding the Safety Grade Your hospital received, and for each such submission, identify the date of the submission, the medium of the submission (i.e. telephone, video conference, email, letter, etc.), who was involved in the submission, and the content of the submission.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Whether or not Plaintiff submitted "any data, corrections, or appeals to Leapfrog regarding the Safety Grade" Plaintiff hospital received has nothing to do with the claims and defenses in this case related to TLG's decision to use deceptive business practices. Plaintiff further objects to this Interrogatory to the extent it seeks information that is already in TLG's possession, custody and control, or equally available to TLG.

Answer: Subject to the foregoing objections, Plaintiff engaged in correspondence prior to the commencement of this case demanding that TLG reform its deceptive practices and cease and desist reporting deceptive and unfair Safety Grades, but at every turn TLG refused.

Amended Answer: Subject to the foregoing objections, Plaintiff did not submit any data, corrections or appeals to Leapfrog regarding the Safety Grades it has received.

Interrogatory No. 6: State whether You provided any comment or input in any form during Leapfrog's requests for public comments for planned updates to the Leapfrog Hospital Safety Grade methodology that was proposed for the calculation of Hospital Safety Grades (including but not limited to for the Fall 2024 methodology update). If yes, please identify the date of the comment, the medium of the submission (i.e. telephone, video conference, email, letter, etc.), who was involved in the comment and the content of the comment. If no, please state the reason why You chose not to comment.

Answer: Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Whether or not Plaintiff submitted "any comment or input" in response to TLG's request for public comments has nothing to do with claims and defenses in this case related to TLG's decision to use deceptive business practices. Plaintiff further objects to this Interrogatory to the extent it seeks information that is already in TLG's possession, custody and control, or equally available to TLG.

Subject to the foregoing objections, Plaintiff did not provide comments in response to Leapfrog's requests for public comments for planned updates to the Leapfrog Hospital Safety Grade scoring system because Plaintiff generally does not respond to requests for public comment from private entities like TLG.

Interrogatory No. 7: Describe all actions Your hospital took in response to (or in deciding not to respond to) its Safety Grade or the Hospital Survey, including internal meetings, media statements, or public relations efforts. In so answering, state the date of the action, the individuals involved in the action and the content of the action.

Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks “all actions” Plaintiffs may have taken in response to TLG’s Safety Grades. *See Megdal Assocs., LLC v. La-Z-Boy, Inc.*, No. 14-81476-CIV, 2016 WL 4503337, at *6 (S.D. Fla. Feb. 1, 2016) (finding interrogatories asking for “‘all’ facts or witnesses that support an opposing party’s case” to be “unduly broad”) (citing 8B Wright, Miller, & Kane, Federal Practice and Procedure: Civil 3d § 2167 (2015)). Plaintiff further objects to this Interrogatory to the extent it seeks information that is subject to a claim of privilege or otherwise protected from disclosure, including seeking information protected by the attorney-client privilege, work-product doctrine, or other immunity.

Answer: Subject to the foregoing objections, Plaintiff devoted substantial time and resources that could have otherwise been spent continuing to improve patient care to respond to the significant harm and disruption caused by TLG’s deceptive and unfair Safety Grade. Plaintiff’s response included meeting internally with Plaintiff’s leadership team, medical executive committee, and governing board, corresponding with TLG to demand that TLG reform its deceptive practices and cease and desist reporting deceptive and unfair Safety Grades, and devoting substantial time and resources to facilitate the preparation and prosecution of this Action.

Amended Answer: Subject to the foregoing objections, Plaintiff devoted substantial time and resources that could have otherwise been spent continuing to improve patient care to respond to the significant harm and disruption caused by TLG’s deceptive and unfair Safety Grades. Plaintiff’s response included meeting internally with Plaintiff’s leadership team, medical executive

committee, and governing board, corresponding through Plaintiff's corporate parent with TLG to demand that TLG reform its deceptive practices and cease and desist reporting deceptive and unfair Safety Grades, and devoting substantial time and resources to facilitate the preparation and prosecution of this Action. Plaintiff has also held many phone calls and meetings with physicians and other stakeholders about the TLG grades, explaining how the grades were deceptive and did not accurately reflect the hospital quality and patient safety at Plaintiff.

Interrogatory No. 8: Identify any and all persons, whether internal or external (e.g., patients, vendors, affiliates, parents, agents, partners, media) with whom You communicated in any way with respect to the Safety Grade or the Hospital Survey. In so answering, state the date of the communication, the individuals involved in the communication, the medium of the communication (i.e. telephone, video conference, email, letter, etc.) and the content of the communication.

Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks the identity of "any and all persons, whether internal or external." Plaintiff will disclose the categories of individuals with whom Plaintiff communicated about the Safety Grade or Hospital Survey during the Relevant Time Period. Plaintiff also objects to this Interrogatory to the extent it seeks protected health information that Health Insurance Portability and Accountability Act ("HIPAA"), among other statutes and regulations, bars Plaintiff from disclosing. Plaintiff further objects to this Interrogatory to the extent it seeks information that is subject to a claim of privilege or otherwise protected from disclosure, including seeking information protected by the attorney-client privilege, work-product doctrine, or other immunity.

Answer: Subject to the foregoing objections, Plaintiff communicated with the following categories of people regarding the Safety Grade or the Hospital Survey: Plaintiff's governing board, its medical executive committee, department directors, and physicians and nurses when

asked about the Safety Grade or Hospital Survey. These communications occurred in and after Fall 2024, after TLG released its deceptive and unfair Safety Grade for Plaintiff's hospital. Most of these communications occurred during regularly scheduled meetings, during which attendees were told about TLG's release of the deceptive and unfair Safety Grade, that Plaintiff does not participate in the Hospital Survey because it is unreliable and not an accurate reflection of hospital quality and safety or patient outcomes, and that the Safety Grade, which was not based on any information provided by Plaintiff, was misleading. The Palm Beach Health Network also issued a press release and since then, has engaged in various social networking and other marketing campaigns to counteract TLG's deceptive scores on behalf of Plaintiff and other affected members of the network.

Amended Answer: Subject to the foregoing objections, Plaintiff communicated with the following categories of people regarding the Safety Grade or the Hospital Survey: Plaintiff's governing board, its medical executive committee, department directors, physicians and nurses, and patients when asked about the Safety Grades or Hospital Survey. These communications occurred in and after Fall 2024, after TLG released its deceptive and unfair Safety Grades for Plaintiff's hospital. Most of these communications occurred during regularly scheduled meetings, during which attendees were told about TLG's release of the deceptive and unfair Safety Grade, that Plaintiff does not participate in the Hospital Survey because it is unreliable and not an accurate reflection of hospital quality and safety or patient outcomes, and that the Safety Grade, which was not based on any information provided by Plaintiff, was misleading. The Palm Beach Health Network also issued a press release and has engaged in marketing efforts, including through social media, to counteract TLG's deceptive scores on behalf of Plaintiff and other affected members of

the network. Plaintiff also engaged in email discussions about TLG's misleading grades, either as sender or recipient, which TLG has through Plaintiff's production of documents.

Interrogatory No. 9: Describe all instances in which a third party declined to contract with, refer patients to, or work with Your hospital, where Leapfrog's grade was cited or discussed. In so identifying list the name of the individuals involved in the communication, the medium of the communication (i.e. telephone, video conference, email, letter, etc.), the date of the communication and the content of the communication.

Answer: Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it requires Plaintiff to "[d]escribe all instances" in which a third party took an action in response to TLG's deceptive grade.

Subject to the foregoing objection, Plaintiff is not aware of any responsive instances.

Interrogatory No. 10: Describe with specificity the basis for each and every category of damage You claim You incurred as a result of the Leapfrog Safety Grade. In so identifying, list each category of damages and the dollar value of each category of damage You claim.

Plaintiff objects to this Interrogatory to the extent it seeks information that is the subject of expert testimony.

Answer: Plaintiff will submit expert reports on August 7, 2025, per the Pretrial Scheduling Order.

Amended Answer: Plaintiff has served the expert report of Thomas Chakurda, which addresses the issue of reputational harm and harm to Plaintiff's goodwill. Plaintiff further objects to this Interrogatory as overbroad and unduly burdensome to the extent it seeks "each and every" category of claimed damages.

Subject to the foregoing objections and as agreed during the parties' September 3, 2025 meet and confer, Plaintiff will limit its response to the live non-monetary claims, including

injunctive and declaratory relief, to remedy harm to Plaintiff's reputation and goodwill. Plaintiff's reputation and goodwill has been damaged by TLG's false and misleading methodology and resulting Safety Grades. Plaintiff's claim for reputational harm is based on, among other things, concerns raised by patients, doctors, staff, and community members, as well as false and misleading statements based on TLG's false and misleading methodology and Safety Grades made in newspapers, viral social-media videos, television programs, and blogs.

By way of example, our Medical Executive Committee has received direct inquiries from patients regarding their concerns with TLG's grades and related public reports. An emergency-department patient, who needed surgery, said that he was leaving because of the Leapfrog grade. The harm caused by TLG's false and misleading Safety Grade is ongoing.

Interrogatory No. 11: Identify all adverse patient events which occurred at Your hospital, including any citations received from regulatory agencies, accrediting agencies, and third party payors such as The Joint Commission, CMS, state health departments, etc. during the period covered by each Leapfrog Safety Grade publication of which You complain (i.e., Fall 2024, Fall 2025, etc.), as well as any complaints received from patients regarding the same.

Plaintiff objects to this Interrogatory because it is overly broad, unduly burdensome, seeks discovery of information that is irrelevant to the claims and defenses in this Action, seeks information that is beyond the scope of Leapfrog's Hospital Survey, and is not reasonably calculated to lead to the discovery of admissible evidence. TLG does not include "all adverse patient events," "citations received from" agencies or payors, or "complaints received from patients" in TLG's determination of its Hospital Safety Grades or request such information in the Hospital Survey, so any such information is irrelevant to whether TLG's actions constitute unfair or deceptive trade practices. TLG has, therefore, only propounded this Interrogatory for purposes of harassment. Plaintiff also objects to this Interrogatory to the extent it seeks protected health information that HIPAA, among other statutes and regulations, bars Plaintiff from disclosing.

Answer: Plaintiff declines to respond to this Interrogatory.

Amended Answer: Defendant has agreed to withdraw this Interrogatory.

Interrogatory No. 12: Describe in detail how Your hospital compares nationally on on [sic] any other ranking of patient safety performance, including but not limited to Vizient, Inc., Premier, Inc., HealthTrust Purchasing Group, The Joint Commission, HealthGrades, US News, Newsweek, Statista, Definitive Healthcare, or any other quality benchmarking entity including benchmarking on patient safety including on adverse events and on healthcare-acquired infections.

Plaintiff objects to this Interrogatory's request that Plaintiff "[d]escribe in detail how Your hospital compares nationally" based on undisclosed "benchmarking" as vague and confusing. To the extent this Interrogatory seeks the top-line rankings of the identified organizations, Plaintiff objects to this Interrogatory because such information is publicly and equally available to TLG. To the extent this Interrogatory asks Plaintiff to compare itself to the named and unnamed entities, that request is overly broad, unduly burdensome, and not proportional to the needs of this Action. Plaintiff further objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Other organizations' rankings have nothing to do with the claims and defenses in this case related to the Deceptive Score Categories or TLG's decision to use deceptive business practices.

Answer: Subject to the foregoing objections, Plaintiff has received numerous awards and accolades, including many that are directly relevant to patient care for children and women that we serve. For example, Plaintiff is the only Level III NICU facility in southern Palm Beach County. Level III NICUs provide lifesaving care for babies born before 32 weeks' gestation or babies with specific medical conditions that require surgery or specialized pediatric care. The American College of Radiology accredited Plaintiff for Imaging Modalities including Nuclear

Medicine, Ultrasound, MRI, CT—which provides us the ability to care for the Level III NICU children and at-risk pregnancy mothers that we treat and ensures we are using best practices. Relatedly, Plaintiff has an accredited education program in radiology through Joint Review Committee on Education and Radiologic Technology, which is the only agency recognized by the United States Department of Education and the Council for Higher Education Accreditation for the accreditation of traditional and distance delivery educational programs in radiography, radiation therapy, magnetic resonance, and medical dosimetry. This program provides our clinical staff with educational opportunities to ensure our patients receive quality care.

Plaintiff is accredited by the Joint Commission, the nation’s largest hospital accreditor that evaluates hospitals’ quality performance standards through an objective evaluation process. Plaintiff has also been accredited by Joint Commission for specialization certifications for Joint-Replacement – Hip, Joint Replacement – Shoulder, and Joint Replacement – Knee—a certification designed for hospitals providing the critical elements to achieve long-term success in improving critical medical outcomes—which signifies our services have delivered evidence-based proof of clinical quality sought by patients and payers alike. The entities that award and assign these accreditations visit the healthcare facility and perform regular periodic in-person reviews, audits, surveys, and assessments of the facility.

Plaintiff has also received numerous awards that exemplify its quality such as Get with the Guidelines Silver Plus Stroke Recognition Award and Diabetes Honor Roll. In addition, as a facility that primarily treats mothers and children, it is important to us that we implement the American Academy of Pediatrics best practices and have been recognized for doing so by receiving the Silver designation from the Cribs for Kids’ National Safe Sleep Hospital Certification program, which signifies our facility’s commitment to infant safe sleep to reduce the risk of Sudden

Unexpected Infant Death, Accidental Suffocation and Strangulation in Bed, SIDS, and unsafe sleep injuries.

Healthgrades has awarded Plaintiff numerous Healthgrades accolades. To assess and evaluate hospitals, Healthgrades relies on data from Medicare medical claims records and states' data on Medicare and commercially insured patient outcomes to determine patients' actual clinical outcomes when visiting a given hospital. Plaintiff also received several awards from Healthgrades for various specialties, including:

a. Critical Care

- i. Five-Star Recipient for Treatment of Sepsis for four years in a row (2022-2025)

b. Gastrointestinal

- i. Recipient of the Healthgrades Gastrointestinal Care Excellence Award (2022-2025)
- ii. Recipient of the Healthgrades Gastrointestinal Surgery Excellence Award (2025)
- iii. Top 10% in the Nation for overall Gastrointestinal Services (2025)
- iv. Top 10% in the Nation for Gastrointestinal Surgery (2025)
- v. Five-Star Recipient for Colorectal Surgeries for three years in a row (2023-2025)
- vi. Five-Star Recipient for Treatment of Bowel Obstruction (2025)

c. Labor and Delivery

- i. Five-Star Recipient for C-Section Delivery for 11 years in a row (2015-2025)

- ii. Five-Star Recipient for Vaginal Delivery for 11 years in a row (2015-2025)

d. Pulmonary Care

- i. Five-Star Recipient for Treatment of Respiratory Failure for three years in a row (2023-2025)

In addition, Plaintiff will produce and identify documents reflecting some of Plaintiff's rankings from other organizations.

Amended Answer: Subject to the foregoing objections, Plaintiff has received numerous awards and accolades. For example, the American College of Radiology accredited Plaintiff for Imaging Modalities including Nuclear Medicine, Ultrasound, MRI, and CT. Relatedly, Plaintiff has an accredited education program in radiology through Joint Review Committee on Education and Radiologic Technology.

Plaintiff is accredited by the Joint Commission for specialization certifications for Joint-Replacement – Hip, Joint Replacement – Shoulder, and Joint Replacement – Knee.

Plaintiff has also received Get with the Guidelines Silver Plus Stroke Recognition Award and Diabetes Honor Roll. In addition, Plaintiff has received the Silver designation from the Cribs for Kids' National Safe Sleep Hospital Certification program.

Healthgrades has awarded Plaintiff numerous Healthgrades accolades, including:

a. Critical Care

- i. Five-Star Recipient for Treatment of Sepsis for four years in a row (2022-2025)

b. Gastrointestinal

- i. Recipient of the Healthgrades Gastrointestinal Care Excellence Award (2022-2025)
- ii. Recipient of the Healthgrades Gastrointestinal Surgery Excellence Award (2025)
- iii. Top 10% in the Nation for overall Gastrointestinal Services (2025)
- iv. Top 10% in the Nation for Gastrointestinal Surgery (2025)
- v. Five-Star Recipient for Colorectal Surgeries for three years in a row (2023-2025)
- vi. Five-Star Recipient for Treatment of Bowel Obstruction (2025)

c. Labor and Delivery

- i. Five-Star Recipient for C-Section Delivery for 11 years in a row (2015-2025)
- ii. Five-Star Recipient for Vaginal Delivery for 11 years in a row (2015-2025)

d. Pulmonary Care

- i. Five-Star Recipient for Treatment of Respiratory Failure for three years in a row (2023-2025)

In addition, Plaintiff will produce and identify documents reflecting some of Plaintiff's rankings from other organizations.

Also, Plaintiff does not participate in Vizient and has not done so during the Relevant Time Period.

Interrogatory No. 13: Describe any steps taken by Your hospital to improve any and all of the patient safety measures considered by Leapfrog's Hospital Safety Grade (as set forth on Leapfrog's

published scoring methodology documents; see ECF No. 21-3 at 6-10; ECF No. 21-43 at 6-9), before and after each Safety Grade publication of which You complain.

Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks the identity of Plaintiff's improvements to "any and all" patient safety measures considered by Leapfrog's Hospital Safety Grade. Plaintiff further objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks information on metrics other than TLG's Deceptive Score Categories and to the extent it seeks information that is beyond the scope of Leapfrog's Hospital Survey.

Answer: Plaintiff declines to respond to this Interrogatory.

Amended Answer: Subject to the foregoing objection, Plaintiff is committed to continual improvement of patient safety measures, motivated by our commitment to ensuring the best possible patient safety—not chasing the best possible Leapfrog grade. To achieve this core objective, Plaintiff devotes significant time and resources to improving its delivery of the highest possible quality of care for those in the community it serves, including efforts to improve its performance in areas related to the four metrics Plaintiff has chosen to impute in its survey.

Plaintiff tracks three of these metrics through its patient safety plan or as part of its quality improvement patient safety committee. For example, Plaintiff does random hand washing audits every month on every unit and addresses any negative trends. Plaintiff already has 24/7 ICU coverage for its intensivist unit and has had that coverage for several years, so it does not need to track this metric.

Interrogatory No. 14: State whether You are aware of specific patients who have relied on the Leapfrog Safety Grade in declining to receive healthcare services at Your hospital. In so answering, identify the individual patient that declined to receive services, the date of such declination, the type of service the patient declined to receive, the medium for the communication from the patient (i.e. telephone, video conference, email, letter, etc.), the content of the communication, and the reason given for the stated decision.

Plaintiff objects to this Interrogatory as seeking protected health information that is protected from disclosure by HIPAA, among other statutes and regulations. Plaintiff will only produce this information as needed and subject to a Qualified Protective Order entered by this Court.

Answer: Subject to the foregoing objection, Plaintiff has received reports that patients considered or decided not to use Plaintiff's facility because of TLG's misleading grades.

Amended Answer: Subject to the foregoing objection, since the release of TLG's false and misleading grades, Plaintiff has received numerous reports from doctors that patients considered or decided not to use Plaintiff's facility due to concerns related to TLG's misleading grades.

Interrogatory No. 15: Describe any effort Your hospital has made to influence public perception of Your hospital's performance on patient safety following the publication of the Leapfrog Safety Grade.

Plaintiff objects to this Interrogatory as vague and ambiguous because it does not specify which Leapfrog Safety Grade is at issue. Plaintiff will construe this Interrogatory to reference TLG's deceptive Safety Grades beginning in Fall 2024. Plaintiff objects to this Interrogatory as overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks "any effort" Plaintiff "has made to influence public perception" after the release of TLG's deceptive and unfair Safety Grades because there have been many such "efforts" and those

“efforts” are ongoing given the significant harm caused by TLG’s deceptive and unfair business practices.

Answer: Subject to the foregoing objections, Plaintiff continues to influence public perception by, among other things, delivering the highest quality care to the community it serves, which, as discussed in response to Interrogatory 12, has led to numerous awards, accreditations, and accolades. In addition, several public statements disputing the misleading nature of the Safety Grade have been made on Plaintiff’s behalf.

Supplemental Answer: In addition to the above, members of hospital leadership have communicated with patients, doctors, or community members on a regular basis to dispel the misleading nature of the Leapfrog Safety Grades. For instance, Plaintiff communicated its governing board, its medical executive committee, department directors, physicians and nurses, and patients when asked about the Safety Grades or Hospital Survey. These communications occurred in and after Fall 2024, after TLG released its deceptive and unfair Safety Grades for Plaintiff’s hospital. The Palm Beach Health Network also issued a press release and has engaged in marketing efforts, including through social media, to counteract TLG’s deceptive scores on behalf of Plaintiff and other affected members of the network. Plaintiff also engaged in email discussions about TLG’s misleading grades, either as sender or recipient, which TLG has through Plaintiff’s production of documents.

Interrogatory No. 16: Describe the due diligence Your hospital undertakes to ensure the accuracy of its own publicly reported safety data (including but not limited to data submitted to CMS, the CDC, and third party organizations).

Plaintiff objects to this Interrogatory as vague and ambiguous due to its use of the undefined term “due diligence.” Plaintiff further objects to this Interrogatory because it seeks

discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Any “due diligence” Plaintiff performs when reporting to *third parties* has nothing to do with the claims and defenses in this case related to TLG’s decision to use deceptive business practices, especially when TLG does nothing to ensure the accuracy of information that hospitals that participate in its survey self-report.

Answer: Plaintiff declines to respond to this Interrogatory.

Amended Answer: Subject to the foregoing objections, Plaintiff makes reasonable efforts to ensure the accuracy of the data it reports to third-party organizations. For instance, Plaintiff employs data abstractors, quality coordinators and a Quality Director, who are all responsible for abstracting, validating, and submitting safety data.

Interrogatory No. 17: Describe in detail how You communicate to the shareholders, board members, collective bargaining representatives and investors of Tenet Healthcare System the outcome of any and all healthcare safety ratings, evaluative publications, studies, or performance analyses that Your Hospital receives.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Plaintiff’s communication, if any, with the shareholders, board members, collective bargaining representatives and investors of Tenet Healthcare System, all non-parties to this litigation, has nothing to do with the claims and defenses in this case related to TLG’s decision to use deceptive business practices.

Answer: Plaintiff declines to respond to this Interrogatory.

Amended Answer: Subject to the foregoing objection, Plaintiff communicates with Tenet stakeholders, including employees who work to support the Palm Beach Health Network, on a range of matters, including issues related to patient safety and outcomes and in particular related to TLG and the Safety Grades by email and oral communication. Those communications included discussions about the reasons for particular grades, the method used to calculate Safety Grades, the value of Safety Grades, and responses to the Safety Grades. In addition, identified below are documents Plaintiff produced evidencing communications between the Plaintiff Hospitals and Tenet related to TLG, the Leapfrog survey, and Safety Grades.

Start Page	End Page
PBHN000005541	PBHN000005542
PBHN000002082	PBHN000002085
PBHN000005475	PBHN000005477
PBHN000006746	PBHN000006752
PBHN000006509	PBHN000006513
PBHN000006397	PBHN000006401
PBHN000002090	PBHN000002094
PBHN000002071	PBHN000002071

PBHN000002103	PBHN000002103
PBHN000004562	PBHN000004563
PBHN000004564	PBHN000004564
PBHN000004574	PBHN000004581
PBHN000005509	PBHN000005511
PBHN000005518	PBHN000005521
PBHN000005526	PBHN000005529
PBHN000006414	PBHN000006419
PBHN000006465	PBHN000006466

Discovery is ongoing, and Plaintiff reserves the right to amend, modify or supplement the response to this Interrogatory.

Interrogatory No. 18: State whether the compensation of Your Chief Executive Officer or any other executive-level leadership officers is tied to or related in any way to Your hospital's performance on patient safety, union worker contracts or Your hospital's ratings by third party ratings organizations' ratings publications (including but not limited to the Leapfrog Hospital Safety Grade).

Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action. Plaintiff's method of compensating its Chief Executive Officer and other executive-level leadership **has nothing to do with the** claims and defenses in this case related to TLG's decision to use deceptive business practices.

Answer: TLG has, therefore, only propounded this Interrogatory for purposes of harassment. Plaintiff declines to respond to this Interrogatory.

Amended Answer: Subject to the foregoing objection, Plaintiff's performance on patient safety, union worker contracts, or ratings by third party ratings organizations' ratings publications is related in some way to the compensation of Plaintiff's Chief Executive Officer or other executive-level leadership officer(s).

Interrogatory No. 19: Identify all hospitals, medical centers, or healthcare systems that you consider to be your direct competitors within the relevant geographic market during the time period covered by the Complaint and describe in detail the criteria you use to determine whether another hospital or healthcare provider is a competitor.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is not reasonably calculated to lead to the discovery of admissible evidence. The identity of Plaintiff's competitors and "the criteria" used to determine whether a hospital or provide is a competitor has nothing to do with the claims and defenses in this case related to TLG's decision to use deceptive business practices. Plaintiff also objects to this Interrogatory to the extent it seeks confidential, proprietary information, and

commercially sensitive information related to Plaintiff's scoring system and "criteria" used to determine whether a hospital or provide is a competitor.

Answer: Subject to the foregoing objections and on condition that this response is considered "Confidential" under the forthcoming agreed confidentiality order, Baptist Health South Florida, Bethesda Hospital East, Bethesda Hospital West, Boca Raton Regional Hospital, Broward Health Hospital in Coral Springs, and HCA Florida Northwest Hospital are Plaintiff's competitors. Plaintiff considers these hospitals competitors because of their proximity to Plaintiff, their competing services lines, and that patients within Plaintiff's service area go to these hospitals for medical care.

Interrogatory No. 20: State and describe the results of any market analysis, competitive analysis, or consumer perception surveys you have conducted or commissioned regarding your competitors from 2020 to present, and identify the individuals or entities that prepared or participated in such analyses.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is irrelevant to the claims and defenses in this Action and is not is not proportional to the needs of this Action. The results of any market analysis, competitive analysis, or consumer perception surveys and the identity of those who prepared or participated in such analyses has nothing to do with the claims and defenses in this case related to TLG's decision to use deceptive business practices.

Answer: Plaintiff declines to respond to this Interrogatory.

Amended Answer: Plaintiff further objects to this Interrogatory to the extent it requests information from outside of the relevant time period of January 1, 2023, to present. Plaintiff also

objects to this Interrogatory as unduly burdensome to the extent it asks Plaintiff to “state and describe” various market analysis.

As agreed during the parties’ meet and confer on September 3, 2025, Plaintiff will produce documents showing the results of studies or surveys Plaintiff has conducted or commissioned related to internal market analysis, competitive analysis, or consumer perception. Plaintiff will identify the documents responsive to this Interrogatory by Bates number in Plaintiffs’ production cover letter.

Interrogatory No. 21: Identify with specificity any comments or concerns raised by any third party payor, bank or lender, or investor related to Your hospital’s reputation and/or public perception on issues in any way involving patient safety or satisfaction.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is overly broad, unduly burdensome and irrelevant to the claims and defenses in this Action and is not proportional to the needs of this case to the extent it seeks “comments and concerns” from third parties related generally to Plaintiff’s reputation that has nothing to do with the specific and significant reputational harm caused by TLG’s misleading grades.

Answer: Subject to the foregoing objections, Plaintiff will produce and identify documents related to the significant reputational harm caused by TLG’s deceptive and unfair Safety Grades that provide sufficient detail to respond to this Interrogatory.

Amended Answer: Subject to the foregoing objections, Plaintiff is unaware of any documents related to this Interrogatory.

Interrogatory No. 22: Identify and describe any complaints, concerns, or comments from patients, community members, or referring physicians that relate to the hospital’s reputation or comparisons to other hospitals in the region.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is overly broad, unduly burdensome and irrelevant to the claims and defenses in this Action and is not proportional to the needs of this Action to the extent it seeks “comments and concerns” from patients, community members, or referring physicians that have nothing to do with the significant reputational harm caused by TLG’s misleading grades. Plaintiff also objects to this interrogatory as seeking protected health information that is protected from disclosure by HIPAA, among other statutes and regulations. Plaintiff will only produce this information as needed and subject to the agreed protective order entered by this Court.

Answer: Subject to the foregoing objections, Plaintiff has received reports that patients and physicians considered or decided not to use Plaintiff’s facility because of TLG’s misleading grades.

Amended Answer: Subject to the foregoing objections, Plaintiff has received reports that patients and physicians considered or decided not to use Plaintiff’s facility because of TLG’s misleading grades. In addition, concerns have been raised by patients, doctors, staff, and community members, and Plaintiff is aware of false and misleading statements based on TLG’s false and misleading methodology and Safety Grades made in newspapers, viral social-media videos, television programs, and blogs.

Our Medical Executive Committee has received direct inquiries from patients regarding their concerns with TLG’s grades and related public reports. An emergency-department patient, who needed surgery, said that he was leaving because of the Leapfrog grade. The harm caused by TLG’s false and misleading Safety Grade is ongoing.

In addition, the following produced documents evidence such harm.

Start Page	End Page
PBHN000006771	PBHN000006773
PBHN000002082	PBHN000002085
PBHN000002066	PBHN000002070
PBHN000002615	PBHN000002617
PBHN000006397	PBHN000006401
PBHN000002090	PBHN000002094
PBHN000002103	PBHN000002103

PBHN000004484	PBHN000004484
PBHN000004564	PBHN000004564
PBHN000004574	PBHN000004580
PBHN000004557	PBHN000004557
PBHN000008718	PBHN000008718
PBHN000006461	PBHN000006462
PBHN000008914	PBHN000008914
PBHN000008915	PBHN000008915

Discovery is ongoing, and Plaintiff reserves the right to amend, modify or supplement the response to this Interrogatory.

Interrogatory No. 23: List with specific detail each and every concern, complaint or comment made by any union, collective bargaining unit or employee association in any way related to patient safety at Your hospital.

Plaintiff objects to this Interrogatory because it seeks discovery of information that is overly broad, unduly burdensome and irrelevant to the claims and defenses in this Action and is overly broad, unduly burdensome, and not proportional to the needs of this Action to the extent it seeks “each and every concern, complaint or comment ” from third parties that have nothing to do with the significant reputational harm caused by TLG’s misleading grades. Plaintiff also objects to this Interrogatory to the extent it seeks health information that is protected from disclosure by HIPAA, among other statutes and regulations. Plaintiff will only produce this information as needed and subject to the agreed protective order entered by this Court.

Answer: Subject to the foregoing objections, Plaintiff is unaware of any concern, complaint or comment regarding TLG deceptive scores made by the union at Plaintiff’s hospital.

Amended Answer: Subject to the foregoing objections, Plaintiff is unaware of any concern, complaint, or comment regarding TLG's deceptive scores or regarding patient safety made by the union at Plaintiff's hospital.

Interrogatory No. 24: Identify any and all criticism You have received since 2020 from Tenet Healthcare Corporation and/or from any individual executive of Tenet Healthcare Corporation regarding Your hospital's performance in any way.

Answer: Plaintiff objects to this Interrogatory because it seeks discovery of information that is overly broad, unduly burdensome and irrelevant to the claims and defenses in this Action and is not reasonably calculated to lead to the discovery of admissible evidence. Any so-called "criticism" has nothing to do with the claims and defenses related to TLG's decision to use deceptive business practices. TLG has, therefore, only propounded this Interrogatory for purposes of harassment. Plaintiff declines to respond to this Interrogatory.

Amended Answer: As discussed during the parties' meet and confer on September 3, 2025, TLG agreed to narrow this Interrogatory to concern only "criticism...regarding Your hospital's patient safety." After a reasonable and diligent search, Plaintiff is unaware of having received "criticism" from Tenet Health Corporation regarding patient safety. Plaintiff is always working to improve its performance, quality, and safety in a constructive way and engages with Tenet Health Corporation as needed to ensure Plaintiff provides the best patient care possible.

Dated: September 8, 2025

Respectfully submitted,

By: /s/ Lee R. Crain

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CERTIFICATE OF SERVICE

This is to certify that true and correct copies of Plaintiff's Amended and Supplemented Responses and Objections to Defendant The Leapfrog Group's First Sets of Interrogatories to Plaintiff have been served on counsel for The Leapfrog Group by electronic transmission.

/s/ Lee R. Crain
Lee R. Crain

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA
WEST PALM BEACH DIVISION

CASE NO. 9:25-CV-80526-DMM

GOOD SAMARITAN MEDICAL
CENTER, INC., et al.,

Plaintiffs,

v.

THE LEAPFROG GROUP,

Defendant.

**AFFIDAVIT OF JERAD HANLON IN SUPPORT OF
PLAINTIFF WEST BOCA MEDICAL CENTER, INC.'S
AMENDED AND SUPPLEMENTED RESPONSES AND OBJECTIONS TO
DEFENDANT THE LEAPFROG GROUP'S FIRST SET OF
INTERROGATORIES TO WEST BOCA MEDICAL CENTER**

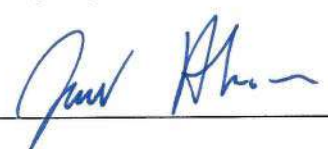
I, Jerad Hanlon, declare as follows:

1. I am over 21 years of age and competent to give this testimony.

2. I am the Chief Executive Officer of West Boca Medical Center, Inc. ("Plaintiff"). I am the corporate representative of Plaintiff for the purpose of answering Defendant The Leapfrog Group's First Set of Interrogatories to West Boca Medical Center. I have read the foregoing interrogatories and the answers to those interrogatories, which are true according to the best of my knowledge, information, and belief.

3. I declare under penalty of perjury that the foregoing is true and correct.

Executed on September 8, 2025.



Jerad Hanlon